Final Report

The study of Migrants' health seeking behavior, health and medical services utilization, for appropriate health care financing and health service system for migrants and families development

Cases Study from Samutsakorn province and Rayong province

by

Health Insurance System Research Office (HISRO)

Health Systems Research Institute (HSRI)

Granted by

Raks Thai Foundation

Privention of HIV/AIDS Among Migrant Workers in Thailand (PHAMIT2)

September 2011

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Research Team

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Introduction

Myanmarese and Cambodian were the most 2 nationalities who migrated to work in Thailand. Most of their works were dirty, difficult and dangerous and needed unskilled workers, which there was difficult to find Thai workers to work such as fishing and fishing related works. In the year 2011 the illegal migrants administrative committee estimated that there were 3 millions migrant workers in Thailand. These migrant workers were in the part of Thailand economic development and Growth but on the other hand they carried contagious diseases and contained risk to health for themselves and Thai people. The ministry of labor and the ministry of public health formulated policy together to provide health checkup under 600 Bahts expense, health insurance under 1,300 Bahts expense and work permission for the ministry of interior 38/1 registered migrants. Anyway, there was no formal health insurance system for the unregistered migrants so Raks Thai Foundation, who concerned about the poor and the out of reach groups, and the Thai health insurance development research institution supported this research to find the way to support them.

There were many organizations at the ministry level and provincial level, NGO and GO who supported this study. The research team need to thank to Samutsakon and Rayong provincial health office and also all hospitals and provincial labor authority, provincial social security office, national police office, employers, migrant health workers, migrants and families in both provinces and also ministry of labor and ministry of public health for the support and provide information to the study until completely finished.

Thanks to Raks Thai Foundation and Health Insurance System Research Office for the fund support to the research.

Research Team

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Abstract

Objective

The objective of research included studying migrant workers' health insurance and benefits understanding, health seeking behaviors and utilization of the health services, the cost and burden for health facilities access and also proposed appropriate health insurance and the choice of expansion and increasing antiretroviral therapy.

Methodology

The prospective quantitative and qualitative study were designed. The relevant literature was review, information was collected from the Rayong and Samutsakon's provincial health office, providing hospitals. The migrants were non randomized purposive sampling to collect answers from the questionnaire, the sample size determined by Taro Yamane method and the questionnaire validity was approved by provincial and central expert, the Test-Retest for reliability was done in 30 migrants and reliability value was 0.91. Other information collected from focus group in 2 provinces.

Result

Migrant workers in Rayong and Samutsakon who had health insurance understood their right for medical services 92.59% and 87.63% but only 21.36% and 25.16% who knew the medical emergency services and just 30.19% and 27.88% who knew about the health promotion and disease prevention services. Most of the migrants in both provinces got drugs from drug store or just rest 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 their hospitals, only 22.60% and 29.60% of uninsured migrants in Rayong and Samutsakon visited to the hospitals. Even most of the insured migrants could access to the hospitals and paid 137.15 Baht and 73.83 Baht cost per Rayong and Samutsakon insured migrant, but the uninsured migrants paid a lot more, 711.70 Baht and 459.66 Baht were average cost per Rayong and Samutsakon uninsured migrant.

There were 32.19% of the insured migrantsand 22.94% of the uninsured migrants in Rayong province who had been consulted and got VCT but there were only 9.85% of the insured migrants and 15.44% of the uninsured migrants in Samutsakon who got these services. Among the groups who got VCT, there were 96.46% of the insured migrants and 95.52% of the uninsured migrants who were tested for HIVat Rayong province, but there were only 85.10% of the insured migrants and 15.79% of the uninsured migrants who were tested for HIV. So the opportunity to extend ARV accessibility could be increased by expansion of the VCT into the rest who were not got VCT. And the VCT could be effectively provided by the migrant health worker.

This study demonstrated the benefit of the compulsory migrant health insurance scheme for reducing the medical cost of the insured migrant. This scheme also provided health promotion and disease prevention and promoted migrant community participation initiated by migrant health worker. The hospital's financial burden mostly originated at the higher proportion of the uninsured migrant. So this scheme should be the choice to provide health and medical services for the insured migrant and should extend to cover the uninsured migrant and families too. For the ARV coverage expansion could be promoted by increasing the VCT activities those were provided by the training migrant health worker into the one who didn't get VCT. The financing for ARV drug expansion could be possible by expanding the NAPHA target group and there were some HIV infected migrants who could subsidize the cost of ARV drug by themselves so another choice was to formulate pool financing for the ARV among the migrants.

There were evidences showed that the average duration of these migrant staying in Thailand was 4 years, and most of them could speak and listen Thai language. The Thai literacy improvement significant related to the staying in Thailand duration.

Chapter 1

Introduction

Thailand has faced with the legal and illegal migrant workers from neighboring countries that impacted on Thailand in various fields such as economic and social stability, particularly public health. Factors affecting the migration are due to destination country and in the country of origin of these migrants. Thailand was already Aging society (Aging Society, older than 65 years accounted for 7%), which is fast moving into the Aged society (Aged Society, older than 65 years accounted for 14% of the population), and also the Thai Total Fertility Rate is now reduced to 1.5 means that a Thai woman had an average 1.5 children that are not sufficient to maintain the number of Thai population which need 2.1 children in average.So the proportion of working age population decline and there is labour shortage in Thailand. The demands for low cost unskilled workers in Thailand increase to maintain competitiveness with low labor cost countries, such as China, India, Vietnam, etc. So the employers could not find the Thai workers to work. Factors within the countries of origin, include economy, social, politics and also the quality of life in their countriesare very different compared to Thailand. Civil war, between the government and the ethnic minorities, reinforces the migration. The Thai - Myanmar border is consecutive long as 2401 Kilometers, Thailand - Laos has undertaken a long 1810 Kilomiters (1,108 Kilometers as the Mekong River. and the earth 702 Kilometers) and 803 Kilometers long border between Thailand – Cambodia, people of these countries migrate across border for a very long time without effective legalen forcement[(1)] so the migration for cheap labor in Thailand can be done easily.

The report In December 2553 from the Office of Foreign Administration, Department of Employment, Ministry of Labour showed that the registed, three nationalities, workers who already got Citizen ID 38/1, the nationalities approved workers and the imported workers under the Memorandom Of Understanding between Thailand and these three countries, these three groups were 1,168,824workers, they were already got work permit in Thailand and could be identified as Myanmar 940,376 workers, Lao 105,955 workers and Cambodia, 122,493 workers. Three provinces with the most foreigner workers were Bangkok, SamutSakhon and Chiang Mai. There were 844,329 unskilled labors,148,211 were in the agricultural sector,171,857 in construction and 101,849 in fishery. And 87,926 migrants worked as home

servant [2] since the employers could legally employ the migrant workers to work as unskilled laborers and household servants.

Migrant workers are permitted to work in each category below.

1. Fishermen will receive a blue card.
2. Farmers will get a green card.
3. Career building. Will receive a yellow card.
4. Career continued fishing. The identity card will be orange.
5. Occupation servant in the house. The identity card will be gray.
6. Other careers included 19 other groups such as the slaughter continued agricultural Lathe food, beverages, etc. will have a pink card.

The impact of migrants on public health issues were the following

1. Impact to public health service. These foreign migrants carried some communicable diseases from their own countries.The study of Chirawat Nijnate [3] from the migrant health checkup reported by the Phuket Provincial Health Office in 2004 showed that the 763 migrants who needed to keep track for treatment were 565 tuberculosis, 14 Elephantiasis,178 syphilis and 6 cases of malaria. As well as the health status studies of Uraiwan Tantariya [4] in 12,253 registed migrant workers at PhangNga province showed that 94.4% of these were healthy, 2.6% needed to be followed up for disease control and another 2.4% were prohibited to be in Thailand. The most common prohibited conditions consisted of severe disseminated tuberculosis that prevalent rate per 100,000 population was 563.3, Leprosy 73.5, Elephantiasis 1167.1, syphilis 612.1, Addiction 24.5, Alcoholism 49.0, Psychosis 8.2. And the prevalent rate per 100,000 population of the follow up group included malaria 24.5, Flu 32.7, pregnancy 253.0 and cardiomegaly 16.3. In addition to treatment other diseases such as dermatitis, respiratory system diseases. Diseases of the digestive system. Childbirth and abortion and diseases of the circulatory system.

In the field of reproductive health, most of the female migrant workers didn't knowabout family planning so there was a lot of unwanted pregnancy and abortion in these migrants. Junchai Tragoondee [5] reported that most migrant women had low knowledge of general health and women's health, moderate

knowledge of self care for basic necessities in life. Most of their knowledge in reproductive health and health knowledge resources were at the low level. There was evidence that the spreading of HIV/AIDS was enhanced in the migrant worker camp by their behaviors, working And housing conditions. Especially those crowded migrants who lived in a small room together.

Sompong SaKaeo [6] reported that the patterns of foreign workers health lifestyle effected their health

1. The work pattern of the SamutSakon migrant workers, most were in fishing boat and fishery related business,caused health problem and physical stress by a lot of work on longer working hours, 10-12 hours per day, depend on demand and urgent requirement of the products, working conditions were not conducive to health and relaxation.
2. The patterns of recreation affected health status. Most workers took a break in the accommodation. Drinking and sexual services from prostitutes without condom in the area near the workplace, mostly these were karaoke and place for sex, were unsafe risk behaviors for sexually transmitted disease and AIDS. Once they got sick by sexual transmitted diseases, they treated themselves from drug store or some clinic near by. When their symptoms didn't improve, they went to see a doctor
3. These migrants had poor environment and poor sanitation. They lived in the house often filled with sewage and waste, wastewater flooding, a source of breeding and spreading infectious diseases such as diarrhea, skin diseases and respiratory diseases, etc. There were not enough toilets and also restricts air circulation in their room. Samrit Srithamrongsawat[7]discussed the impact of immigration to health and social that may lead to various social problems such as crime, drug and traffickers, which were presented by the media including sexual abuse, rape, attacked and also killed their employers. It also found that the migrant workers could be involved in the illegal actions and illegal employment. These migrants also introduced some diseases, those were already be controlled in Thailand, for example, Leprosy, Elephantiasis, Poliomyelitis. These health problems were difficult to controlled because of the lack of migrant personal information.

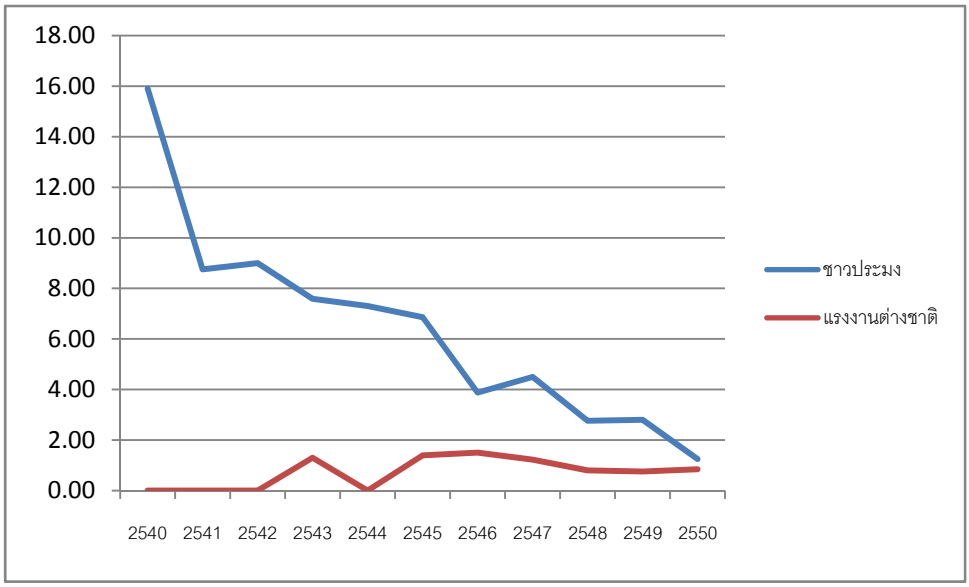
1. **The accessibility to health services and health seeking behaviors** of these registed and unregisted migrant workers were studied by Sompong SaKaeo in SamutSakon[6] The ill migrants rarely visited to health service delivery unit, mostly they were self-reliance by purchasing drugs from drug store until their symptoms were severe, then they visited private clinics, if not improved then the public health delivery units such as health centers and hospitals. Busarat Kanchanadit [8] reported that the main obstacles to prevent accessibility to the public hospital were unfamiliar, fear, the unrealized of their health insurance right, lack of Thai literacy, long distance contracted hospital from workplace and their home, too expensive travel cost and health care worker's discrimination. Suthat Khongkunthot [9] reported the in accessibility problems from the provider that included communication gap, lack of legal knowledge, increased workload, lack of skill to deal with different culture migrant and the public regulation to restrict foreign translator and assistant.

   The migrants and families themselves also caused in accessibility to health services [10].

   1. They didn't understand the insurance concept and the benefits, unfamiliar, fear, unbeknown about health care provider and their languages were different and uncommunicated.
   2. Some of them had bad experience during the trip to hospital such as arrested by the police, extort assault or being over charged for the travel costs. So they tried to get help from the nearby providers where they had to pay instead of the insured hospitals where they had the right.
   3. Their illness habits were self-medication and unsafe self-care until they got severe illness then they would seek help from the hospitals so they caused a lot of expense.

The obstracles of HIV/AIDS infected migrants to access for Anti Retro Virus (ARV) drugs and treatment, even they were registered, included the need for easily access ARV providing to continuing the long course of treatment, the high prevalence rate of HIV/AIDS infection among the migrants. The Thailand HIV/AIDS situation report [11] showed that the prevalence rate of HIV infection among migrants increased, 1.53% in the year 2009, compared 1.25% in the fishermen that decreased from the year 2008 (Figure 1.1). So the migrants would become priority for the prevention of the new cases and the ARV accessibility for the infected migrants that still be problem.

Figure 1.1. Prevalence of HIV Infection among Migrant Workers and Fishermen in Thailand 2540 – 2550 (1997-2007)



The NAPHA Extension Program operation guidance [12] mentioned that the psychosocial factors of the HIV/AIDS patients influenced the ARV drugs continuous administration. These factors included

1. Language, the migrant worker couldn't communicate in Thai and the health care professional couldn't communicate in their languages.
2. They were low health literacy, some migrant workers believed that pulmonary tuberculosis was genetics disease.
3. Their work conditions included hard working, low income, unscheduled work and relocated work all time.
4. These illegal migrant workers feared to expose to the service system because of the chance to be arrested and sent back home.
5. Social discriminated against these migrant workers, they were accused to be enroacher and shared resources that would be for Thai people.
6. The migrant's personal poor sanitation caused aversion and avoidance because of the fear of communicable diseases.
7. The infected migrant workers were anxiety, they feared to be arrest during seeking the treatment, feared to be sent back and be disgust by community, friends and also employers then feared to be fired from their jobs.

8. The health workers' attitude toward migrant workers, who seek for health and medical services, was burden.
9. The employer didn't co-operate with the health service provider to continue long term treatment and left burden to the hospital.

All these factors caused inaccessible to ARV, especially the unregistered migrants and their families, there was very little chance to access for the ARV or health service system. Even though the Global fund provided ARV for these HIV/AIDS infected migrants, there still were a lot of challenges to overcome before we could provide universal ARV to these marginal group of people. How to overcome these obstacles would be interested research question.

2. The hospital impacted and financial burden were estimated by the estimation of the insurance fee 1,300 Baht for one year health and medical care coverage and also the health check up fee. The number of, the total amount of insurance fee and the health check up fee were shown on table 1.1

Table 1.1 Estimated Revenue of Insurance and Health check up fee Calculated from registered migrants in Thailand 2006-2008 [13]

Year	Cabinet Approved (Migrant Workers 3 Nationality)	Revenue of Insurance fee 1,300 (Baht)	Revenue of Health check up fee 600 (baht)
2006	668,576	869,148,800	401,145,600
2007	535,732	696,451,600	321,439,200
2008 (August)	501,570	652,041,000	300,942,000

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

"Anyway, the Ministry of Public Health still bear burden from the 700,000 unregistered migrants" mentioned by Dr. Supachai Kunaratanapruk, the Director General of Health Service Support Department

in the Second National Health Service System for migrant population conference with the theme "Universal Access to health and medical services for the health security" that cost more than 155 millions Bath. The MoPH also reported that [14] the result of migrant health check up in the year 2007 were found that the total health check up migrants were 462,236, the infected migrants with Elephantiasis, Leprosy, Syphilis, Malaria and parasitic infestation that needed to be follow up for treatment were 4,915, the prohibited severe disseminated infected migrants mostly pulmonary tuberculosis that needed to sent back home were 113. In the first half year 2008, the infected migrants that needed to be follow up for treatment were 3,147 and the prohibited severe disseminated infected migrants were 77, and there were another 7,000 pregnant migrant women to cause more financial burden. In the year 2007, the 343,527 registered migrants insurance fee were 446 millions Baht but the health and medical expenditure for these was 1,343 millions Baht that cost by registered insurant migrants about 947 millions Baht and unregistered non insurant migrants 396 million Baht so the MoPH annually bear burden for these migrants about 214 millions Baht.

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

Fiscal Year	High Cost Care			
	Income		Expenditure	
	Number of Insurant (Person)	Amount of Income (Baht)	Number of Insurant (Person)	Amount of Expenditure (Baht)
2004	263,875	8,444,017.00	261	1,393,419.00
2005	713,688	35,684,410.00	359	2,277,377.25
2006	726,478	36,323,879.00	500	6,552,464.45

Fiscal Year	High Cost Care			
	Income		Expenditure	
	Number of Insurant (Person)	Amount of Income (Baht)	Number of Insurant (Person)	Amount of Expenditure (Baht)
2007	534,481	26,724,048.00	587	7,793,826.58
2008	443,489	22,174,440.00	855	15,173,859.67
Total	2,682,011	129,350,794.00	2,562	33,190,946.95

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

The high cost care for migrant scheme's income increased in the year 2005-2006 (From 8.4 millions Baht increased to 35.6 millions Baht.) because of the Carbinet approved new registration in the year 2004 to cover migrant workers and family. These policy solved the main problem of the unregistered migrant families so the high cost care fund covered the real expenditure, after that the policy swang into the security focus policy and the families were prohibited for registration so the high cost care fund was decreased [15] This finding was confirmed by Samrit Srithamrongsawat [7]who found that the high cost care for these migrant workers increased from 2,294277, 8,958,417 and 15,796,429 in the year 2005, 2006, 2007 respectively and the high cost care cases were 366, 502, 914 respectively. But the income of the high cost care fund decreased from 44,159.340, 30,411,900 and 21,721,478 in the year 2005, 2006 and 2007 respectively. (as shown in table1.3)

Table 1.3. Revenue and Reimbursements of High Cost Care for Migrant Workers During Year 2005-2007

Category	2005	2006	2007
Revenue (Baht)	44,159,340	30,411,900	21,721,478
Number of patients approved for high cost care	366	502	914
Outpatients	NA	91	222
inpatients	NA	411	692
Cost reimbursements (baht)	2,294,277	8,958,417	15,796,429
Percentage of high cost reimbursement to revenue	5.2%	29.5%	72.7%

The study also showed that the most expensive cost of migrant high cost care were Injuries, poisoning and certain other consequences of external causes, Neoplasm and Diseases of the eye and adnexa those cost 69.3%, 10.0% and 4.6% in the year 2006 and 65.2%, 16.3% and 4.9% in the year 2007. (as shown in table 1.4)

Table 1.4. Amount and Percentage of High cost Care Category by Disease

During Year 2006-2007

Category)	2006		2007	
	Amount	**Percentage**	**Amount**	**Percentage**
Infectious diseases	8	1.9	12	1.7
Neoplasm	41	10.0	113	16.3
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	1	0.2	0	0.0
Endocrine, nutritional and metabolic diseases	1	0.2	0	0.0
Diseases of the nervous system	2	0.5	1	0.1
Diseases of the eye and adnexa	19	4.6	34	4.9
Diseases of the circulatory system	14	3.4	31	4.5
Diseases of the respiratory system	0	0.0	1	0.1
Diseases of the digestive system	10	2.4	14	2.0
Diseases of the musculoskeletal system and connective tissue	19	4.6	23	3.3
Diseases of the genitourinary system	1	0.2	2	0.3
Pregnancy, childbirth and the pueperium	1	0.2	0	0.0
Congenital malformations, deformations and chromosomal abnormalities	2	0.5	6	0.9

Category)	2006		2007	
	Amount	Percentage	Amount	Percentage
Injuries, poisoning and certain other consequences of external causes	285	69.3	451	65.2
Factors influencing health status and contact with health services	7	1.7	4	0.6
Total	411	100	692	100

Source : Health Financing Office, MOPH

Chirawat Nijnat and Adul Ratanaso [3] reported that the migrant workers in Phuket caused health impact to Thai people included that.

1. Communicable diseases from unregistered migrants without health checkup were very difficult to control.
2. The migrant's crowded workplace and household condition caused poor environment and promoted dissemination of communicable diseased,
3. The migrant birth rate annually increased because they were reproductive age group and there were no vaccination for the newborn so the poor immunity caused more illness and delayed growth and development among these migrant children.
4. The re-emerging diseases that were controlled several years ago would became increased and uncontrollable again.
5. The migrant health and medical services impacted on health worker who already bear a lot of workload for Thai people and also caused financial burden to the poor liquidity hospitals. The MoPH needed to subsidized these migrant health expenditure many millions Baht and increased annually.

The Phuket hospital subsidized uninsured migrant health expenditure about 1,895,609 Bath in the year 2004, and 3,754,653 Baht for 8 months in the year 2005. The registered migrant worker seeked more health and medical services every year and cost 15 millions Baht in the year 2005.

Sanon Sangpapan [17] found that the hospitals who provided uninsured migrant health and medical services mostly subsidized for inpatient expenditure, 84.14% compare to the outpatient expenditure that the uninsured migrant could absorb the cost by themselves. (as shown in Table 1.5)

Table 1.5 Expenditure form Patients Out of Pocket Klang, Hospital Rayong, In Fiscal Year 2007

Cost of Care (baht)		**Cost of Payment** (baht)		**Cost of Unpaid** (baht)	
		Amount (baht)	**Percentage**	**Amount** (baht)	**Percentage**
Outpatients	1,558,351	1,477,212	94.79	81,139	5.21
Inpatients	1,625,776	257,809	15.86	1,367,967	84.14
Total	3,184,127	1,735,021	54.49	1,449,106	45.51

Research Question

1. What is the migrant knowledge and understanding in health insurance benefits, rights and also how to seek health and medical services ?
2. What are the insured and uninsured migrant's health seeking behavior, health and medical utilization pattern and also the different between the insured and uninsured ?
3. What is the migrant health care financial management and migrant health service at the provincial and hospital level? How do we improve these management to be more feasible and more effective ?

4. What is the HIV/AIDS infected migrants' ARV accessibility? How do we improved the access to these group of people? And how much does it cost? What is the alternative and possibilities ?

Objective of the study

1. To determine the migrant knowledge and understanding in health insurance benefits, rights and also how to seek health and medical services.
2. To study the insured and uninsured migrant's health seeking behaviors, health and medical utilization patterns and also the different between the insured and uninsured.
3. To determine the migrant health care utilization rate, health and medical services and costs and also compare between insured and uninsured migrant.
4. To analyze the migrant health care financial management and migrant health service at the provincial and hospital level and propose the improvement to be more feasible and more effective.
5. To analyze the HIV/AIDS infected migrants' ARV accessibility and propose the improvementalternative and possibilities for the better access.

Definition

Migrant population refers to labor migrants, their families and dependents, who are of Myanmarese, Laotian, Cambodian and other nationalities. The term includes those who have been registered with the Ministry of Interior (with a 13-digit identification number) and those who have not been registered (no 13-digit identification number), as well as ethnic minorities living in Thailand. However, this term does not include any persons displaced from civil conflict who are residing in the temporary shelters.

Scope of study

1. Registered, Unregistered, insured, uninsured, nationality approved and imported according to MOU migrant workers and also families who are Myanmarese and Combodian not include Laoses in Rayong and SamutSakon provinces.
2. Migrant Health information from provincial health office and hospitals in Rayong and SamutSakon provinces

3. Migrant Health information from Health Administration Bureau, Health Insurance Division, Office of Permanent secretary, Bureau of AIDS and Sexual Transmitted Diseases, Department of disease control and also Bureau of Foreigner Labor administration, Ministry of Labor.

Chapter 2

Review Literature

Migrant worker and family Situation

Myanmarese, Laosese and Cambodian were the three most migrant worker working in Thailand respectively. Their works included Dirty, Difficult and Dangerous unskilled job that rarely to employ or too high wage for the Thai worker, for example fishery and related fishery business, etc. The foreign labor administrative committee estimated that there were 3,000,000 migrant workers and families from the three countries in the year 2011, including registered and unregistered.

The Migrant worker and family, from the Myanmar, Laos PDR and Cambodia, situation was reported in December 2010 from the Bureau of Foreign Labor Administration, Department of Employment, Ministry Labour as shown in table 2.1

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

Region	Total Number (person)	Legal Migrant Worker					Illegal Migrant Worker			
		Include legal Migrant Worker (person)	Article 9			Article 11	Article 12	Include Illegal Migrant Worker (person)	Article 13	
			Lifetime	General	Nationality Approved	Imported Migrant Workers (MOU)	Investment Promoted		Minority	Cabinet Approved 3 nationality
Whole kingdom	1 ,300,281	344,686	14,423	70,449	210,044	26,525	23,245	955,595	23,340	932,255
Bangkok metropolis	329,097	160,655	7,306	40,263	99,049	574	13,463	168,442	2,792	165,650
Office of Foreign Administration	159,502	159,502	7,306	39,985	99,049	-	13,162	-	-	-

Region	Total Number (person)	Legal Migrant Worker					Illegal Migrant Worker			
		Include legal Migrant Worker (person)	Article 9			Article 11	Article 12	Include Illegal Migrant Worker (person)	Article 13	
			Lifetime	General	Nationality Approved	Imported Migrant Workers (MOU)	Investment Promoted		Minority	Cabinet Approved 3 nationality
Office of Provincial employment 1-10	169,595	1,153	-	278	-	574	301	168,442	2,792	165,650
Provinces	971,184	184,031	7,117	30,186	110,995	25,951	9,782	787,153	20,548	766,605
Provinces around Bangkok	284,881	50,200	269	5,848	38,012	4,180	1,891	234,681	1,418	233,263
Central Region	240,393	77,936	1,191	8,077	44,654	17,498	6,516	162,457	2,740	159,717

The Nationality Approved migrant workers in the year 2010 were 210,044, increased from 60,995 in the year 2009. And the Imported migrant workers according to the MOU in the year 2010 were 26,525, increased from 18,883 the year 2009 [18 ,19,20]

1 Migrant's Knowledge and Understanding of the Health Insurance Benefits

The migrant worker and family didn't realize their own right and health insurance benefits. The migrant worker in SamutPrakan and SamutSakon provinces weren't get the health insurance cards and work permit licenses because their employers took their cards and work permit licenses for ensuring that they would work for their employers without moving into the new one so they couldn't access into the health service provider. Sometime the other uninsured migrant worker showed health insurance card of the insured one for medical treatment at the contracted hospital in case that there was no owner's picture in the health insurance card.[21]

The infected migrant workers, who would be followed up for the continuous treatment, were move away after acknowledged he health check up result because of the fear for sending back to their origin country.[22]

Many pregnant migrant women tried to terminate pregnancy before the health check up, some switched their urine with the others who were not pregnant[23] because of the fear for sending back home. The abortion rate also was high among migrant pregnant women and the family planning wasn't interested by this group.

2 Migrant's Health Seeking Behavior

3 Migrant and family's Health Problem

The migrant worker and family might carry some diseases from original country, and they also might be faced health problems in the destination country. The maternal and child health, the sanitation and environment were problem in this migrant worker and family, [24] and also the outreached group of people from health and medical services could be the risk for communicable disease in the destination country.

There was evidence that the pregnant migrant women were outnumbered of the migrant hospital labor cases, and also the survival newborn were less than the pregnant women. The migrant maternal mortality during pregnancy or within 42 days after giving birth were 160 cases from 10,332 of the migrant pregnant women so the maternal mortality rate was 1.5%. Another problem was teenage pregnancy among migrant women, so the under 20 years old migrant mother was 12% of total migrant pregnancy .[25]

The communicable diseases, that were found in the migrant workers and families and could be potential to disseminate to Thai people, included the respiratory tract infection such as Influenza, Pneumonitis and Pulmonary Tuberculosis, the vector born diseases such as Malaria, Elephantiasis, the poor sanitation food and water induced diseases such as Diarrhea, Typhoid, Amoebiasis, and also the skin diseases.

The sexual transmitted diseases and HIV/AIDS were likely to disseminated because of the lack of prevention knowledge among the migrant sex workers.

The Re-Immerging Disease Bureau, Department of Disease Control analyzed the trend of the re-immerging diseases in Thailand and summarized into table 2.2 [26]

Table 2.2 Trend of Re-immerging Diseases in The Migrant Workers in Thailand [27]

Group 1 re-immerging diseases in Thailand	Group 2 re-immerging diseases transmission from Foreign country	Group 3 re-immerging diseases In Thai country
1. Influenza A (H1N1) 2009 Include risk of disease transmission more severe in first Infection 2. Avian Influenza H5N1 3. Hand-foot-and mouth disease from Enterovirus 71 4. Legionellosis	5. Nipah Virus Meningitidis 6. West Nile virus Meningitidis Alzheimer's disease from bovine spongiform encephalopathy 7. Viral Hemorrhagic Fever such as Ebola virus, Marburg Virus. 8. Zoonotic Disease: Monkey Smallpox (African green monkey) 9. Biological Torrorism Disease such as Bacillus Anthracis , Smallpox, Plague etc.	10. Neisseria meningitidis from serogroup W135 and other type transmission from migrant worker 11. Acute hemorrhagic conjunctivitis from EV70, Coxsackie A24, Adenovirus etc.

4 HIV/AIDS infected Migrant and Access to the ARV

Apichat Chamratrithirong and Watinee Boonchalaksi [28] reported in the evaluation of The Prevention of HIV/AIDS Among Migrant Workers In Thailand Project that the migrant workers HIV/AIDS general, prevention knowledge and also right attitude that were high in the year 2004, was very higher in the year 2008 especially the knowledge about comdom for HIV prevention among fisherman workers increased from 79% into 89% and 76% to 95% among migrant women in the provinces nearby the sea.

The safe sex behaviors of these migrant workers were also changed, the 1.6% condom used with regular sex partner increased to 7% and 42% condom used with irregular sex partnet increased to 90%, and also 91% condom used with sex workers increased to 97%. The STD and HIV/AIDS knowledge also increased from 56% into 85%. The prevalence rate of STD in male migrant workers decreased from 2.7% to 1.2% but increased a little bit among the female migrants.

There were evidence that the migrant workers could increase access to the diseases prevention and health promotion services [30] under the PHAMIT project and these outcome related to the PHAMIT activities.

Anyway, there was not enough information about the ARV access among the HIV/AIDS infected migrant workers at this moment.

Health Service System for Migrant and family

The Cabinet Approved registration for migrant worker from Myanmar was started since 1992 but not until 1996 that the Cabinet Approved registration covered Myanmar, Laos PDR and Cambodia and also the health service system for migrant worker started with 500 Baht health fee since then. [31]

1 Policy and regulation for Migrant and family

As the migrant workers from Myanmar, Laos PDR and Cambodia did not legally pass across the border and they hadn't any identification document so the process to let them temporary working in Thailand needed Carbinet Approved regulation year by year since 1992. Unfortunately, these policy swing year by year according to the socioeconomic and political situation in that year, mostly the 2 main priorities driven were security and economy. The health and human right were never became priority but just supplementary migrant policy.

In the year 2004, the government started to approach insufficient unskilled labor and the migrant worker problem more systematically. The Ministry of Labor, Government Security Organization, Ministry of Public Health and also other stakeholders formulated balanced integrated strategies that covered security, economy and also health and human right perspection for migrant worker management. The migrant worker and family were registered then got health check up and health insurance for one year and they could got work permit license. All the activities focused on changing illegal migrant workers and families into the semi-legal one, the later well developed policy also proposed voluntary nationality approved for the registered migrant worker and family by the original countries then they could get temporary passport and VESA so becoming into the legal migrant worker finally. Another policy was the bilateral agreement MOU between Thailand and Laos PDR, Thailand and Cambodia and also Thailand and Myanmar to support and promote unskilled worker to work legally in Thailand by getting passport and VESA conveniently. There was the Foreign Labor Management Committee, that consisted of all stakeholders, who formulated policy and proposed for cabinet approval annually. The balanced policy induced 1,284,920 registered migrant workers and families in the year 2004. Anyway, because the management needed Cabinet Approved policy year by year so there was unlikely to balance between

security, economy and also health and human right. After the year 2004, [32] the government security organization gradually dominated migrant management policy then the migrant families were prohibited to register and derived into the security focused policy in the year 2007 so the registered migrant workers were less than 500,000. Anyway, the unregistered migrant workers and families or undertable were increased that caused more problem in security, economy and also health and human right perspection such as trafficking, bribery, etc.

1.1 Cabinet Approved Regulation

The Cabinet Approved Regulation consisted all these steps,the migrant worker and family were registered by Ministry of Interior with 100 Baht registeration fee then the Ministry of Public Health provided health check up and health insurance for one year those cost 600 Baht and 1300 Baht fee then they could got work permit license with 3800 Baht cost. [33] The foreign labor administration committee proposed to change voluntary registered migrant worker into the legal one by original country nationality approved. 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. Anyway, in the year 2010 the government changed the nationality approved to be compulsory.

Nationality Approved by original country.[33]

The nationality approved process of Myanmar, Laos PDR and Cambodia were different according to the regulation of each countries and also fee. Laos PDR needed request form, work permit license 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 license 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 license 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 VESA and Thai Ministry of Foreign Affair needed employer's documents, the migrant worker documents, 500 Baht fee to provide the VESA L-A. After that, they needed to reapply for the new temporary work permit license at the Department of Employment, Ministry of Labor.

1.2 Memorandam of Understanding for Importing Legal Migrant [34]

The Thai employers, who needed the imported legally migrant worker according to the MOU, should request to the Department of Employment then they would get the permission documents. The documents included the specific worker exported company in the original country. After the documents

completion, the Department of Employment would send all documents and request to the original country embassy, then the embassy processed these documents to their Ministry of Labor who would contact the referenced company to prepare the workers list and the permission to work aboard for these workers then contacted the requested Thai employers. The Thai employers would process the worker lists to get permission from the Department of Employment to work in Thailand, after permission the Department of Employment would contact the Thai embassy in the original country to permit the Non-Emigrant VESA L-A for these workers. After that the employers would take these workers into Thailand and they needed to contact the MoPH hospitals within 3 days for health checkup before they could get the work permit license.

1.3 **Social Security Act and Benefits** [35]

1.4 The social security act 1990, modified in the year 1994 and 1999 designated to support social insurance and welfare to the formal sector private workers who contribute their income to the social security fund that collect from employer, employee and government budget.

The social insurance 7 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 withing 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 is not cover work related injury and illness because there is another work related fund that is contributed from the employers, and also this scheme is not cover health promotion and disease prevention activities too.

Migrant and family Health Service Management [36]

1. Compulsory Health Insurance by MoPH

According to the Cabinet Approved Regulation, the migrant workers, who would like to get temporary work permit license, must be registered by the MoI then checked up their health from the MoPH and get MoPH health insurance.[40] The MoPH'mission for the registered migrant workers included the following activities.

- Health check up
- Health and Medical services providing
- Health promotion and diseases prevention

- Diseases surveillance

Although the Cabinet Approved regulation for the registered migrant workers but the MoPH also has public health mission to prevent the disseminated communicable diseases from the unregistered migrant too according to the Public Health Act [37, 38] and couldn't deny to provide medical services to any people who need them according to the Medical Service Provider Act[39] so the MoPH hospitals practically provided health checkup and health insurance for the voluntary unregistered migrant workers and families.

Sompong Srakaew [40] found that in SamutSakon province, even though the registered migrant workers were already checked up their health to show at the provincial labor office and already got work permit license, but they might not purchase health insurance. So when they got sick, they couldn't get the medical services.

2 **Health Care Financial Management**

3 Samrit Srithamrongsawatet 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 of 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 locating and 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 Thai people. 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.

Performance of Compulsory Migrant Health Insurance

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 [41]

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 reinsurance 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 Recommendation From Literature review

1 International Guidance and Recommendation

IOM[42] recommendation

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 amore 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/AIDS 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 [43]

Under the following circumstance:

1. Effectiveness of the border control measure is still remaining 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 a long way.

Policy Recommendations

- At central level, it is recommended to develop a mechanism to **utilise 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 the required health information system 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 involving 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 MHWs.
- Continue to seek cooperation from the neighbouring countries to establish a pilot project on binational 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 –Strengthening the 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 priorities diseases e.g. AI, M. 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

Specific recommendations to each system are outline in the table above.

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 center should be equipped with necessary equipments such as computer.

2 **Recommendation and Guidance from other studies**

Health Service System Management

Kritiya Archavanichakul [44] proposed that the MoPH was expected to formulate long term policy and strategy because the Myanmarese , Laosese and Cambodian migrant workers would become long term problem for a very long time. During the year 1996-2006, Thai government, by cabinet approved regulation year by year, but there was no long term public health

policy and strategy even though there was MoPH health checkup and health insurance but there was under the year by year regulation rather than the long term strategy that would be more efficient and more effective.

Another problem included the migrant workers who got health checkup from MoPH were outnumbered by the migrant workers who got work permit license from the MoL.[44]

Kritiya Archavanichakul[45] also reported that there was no policy and regulation for HIV/AIDS prevention in the migrant workers during the year 1996-2004 but some provinces already implemented the specific plan for HIV/AIDS prevention in the migrant workers supported and co-operated in the local area by International Fund and NGOs. Anyway, the public sector reform in the year 2001-2003 induced the termination of Sexual Transmitted Disease (STD) clinic in the Provincial Health Office and delegated this mission into the general or regional hospital in the province, but this was not the priority mission of the hospital who already bore a lot of burden from 30 Baht program services so the HIV/AIDS and STD prevention was weaken in every aspect.

Kritiya Archavanichakul, et al[46] also found that some hospitals, where there were a lot of unregistered migrant workers in those area, would be in financial crisis condition. Some provinces, for example Kanchanaburi, Pang-nga and Rayong, allocated migrant health insurance according to the workload so the profitable hospitals subsidized for the lost hospitals.

Another report of Kritiya Archavanichakul [47] demonstrated the improvement of the MoPH migrant health policy and strategy to be more advance and active. The Migrant Health Strategy was formulated and also the National HIV/AIDS Plan for mobility people, there were many active activities at the provincial level, co-operation among Public organization, NGOs, and Local Authorities. The mobile clinic for migrant worker, the Migrant Health Worker and Voluntary migrant health worker, who were trained and provided preventive and health promoting activities to the registered and unregistered migrant workers and families, were established. Anyway, some of the registered and insured migrant workers and families, whose health card were kept by their employer to ensure that they couldn't move to other place, still were not access

to the hospital for illness and health problems. The health care personnel's attitude also was problem, the services for migrant workers and families were evaluated as more burden additional to the universal coverage of health care for Thai people workload and some estimated the migrant workers and families as the treat to national security, especially the unregistered and uninsured migrant workers and families who might be sent to the police after treatment. In term of systematic approach, the MoPH and MoL should prepare and provide the practical standard guidelines and recommendation for necessary activities such as the guideline for ARV drugs providing to the HIV/AIDS infected migrant worker and family, the guideline for recruitment of the Migrant Health Workers, etc to the provincial health office and labor office.

Kritiya Archavanichakul, et al [48] proposed the challenge for Migrant health improvement that included 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 Thai people.
2. The disease prevention and health promotion activities need co-operation with the NGOs and other parties who knew and were 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 encourage active activities among multi-sector and multi-disciplinary parties and also formulate 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. The guidance for health insurance fee management to subsidize the lost hospitals from the benefit hospitals would improve the migrant health service and also allocate some budget for specific diseases such as pulmonary tuberculosis, HIV/AIDS, disability from injuries, from the 120 Baht for management.

5. The migrant health insurance should be more options according to the work and condition environment for attracting the migrant workers and families to insure, for example the whole family insurance, the right to access into any hospitals in the health service network and the more private hospitals involvement, etc.
6. The integrated services for migrant workers and families among the departments in the contracted hospital should be encouraged for better access to the health and medical services.
7. The adequate health and medical infrastructure especially the migrant health worker and voluntary migrant health worker should be prepared for these more workload.
8. The communication and co-operation among the original and destination countries should be developed between governments and also ministries, the 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 also the effectiveness of the interventions.

Other specific interventions were recommended included the following.[49,50]

1. The ARV drugs should be provided to the HIV/AIDS migrant pregnant women.
2. The counseling system for the HIV infection should be formulated to improve the competency of the migrant health worker and also the NGOs personnels.
3. The birth certification of the migrant's newborn would be provided.
4. The migrant language literacy was required to improve access and communication.
5. The co-operation and encouragement for the NGOs to participate with the migrant service system should be stabilized to reach the migrant workers and families in the community.

Lesson learned from the specific provinces.

Tak province cased study.[51]

1. The MoPH and Provincial migrant information were different, so the situation analysis would be inaccurate.

2. The co-operation among the NGOs and public organization was problem at the provincial level because of the different working culture.
3. The policy and duration for register were not feasible for the real life environment, there was a lot of limitation and also the incompatible duration between MoL work permit license and MoPH health insurance.
4. The migrant reproductive health needed budget from NGOs that was not sustainable
5. The prevalence rate of communicable diseases among the migrant worker and families were higher than Thai people, the effective preventive activities needed implementation by community under supporting from public organization and NGOs.
6. The ARV drugs for the HIV/AIDS migrant workers and families were not accessed especially the HIV/AIDS infected pregnant migrant women.
7. The hospitals at border had more expenditure because of the outnumbered uninsured migrant workers and families.
8. The migrant women would like to give birth by the traditional midwives.
9. The migrant newborn faced stateless condition.
10. The sex workers eradication policy and the pulmonary tuberculosis control were not compatible.

Kanchanaburi cased study[52]

There was a lot of Agriculture employers so the migrant workers could easily move to work into the other provinces for better wages.

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 co-operation among the NGOs and public sector.

UbonRachathani cased study[53]

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

2. The hospitals should be encouraged to spend more for the migrant health promotion and disease prevention especially the active activities by initiation of the participatory process, 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 would be united.

SamutSakon and Samutprakan cased study[21]

The health insurance fee in SamutSakon and Samutprakan provinces were adequate and could provide services for the migrant children and older people. There were 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 could improve the effective and efficiency of the prevention and promotion activities in SamutSakon province. The model consisted of the prospective allocation of the all migrant health insurance prevention and promotion budgets to all hospitals, 96 Baht for SamutSakon hospital, 80 Baht for Sriwichai 5 hospital and 30 Baht for provincial health office. So they could do the active role for communicable diseases immediately without cost concerned and also they could initiate the active role for migrant reproductive health and family planning and also migrant's newborn birth certification.

The STD and HIV/AIDS still were problem because the hospitals didn't prioritized these as main mission and the provincial health office who took care these diseases in the past was changed to be just the management office so the recommendation would 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 for example the green channel to reduce waiting time, encourage not for profit private hospitals to provide the services.
3. The competition to provide services should be encouraged.

4. The biological identification should be collected to improve access to the health service system in case of the insured migrant workers didn't carry health cardswhich were kept by their employers.
5. The uninsured migrant workers and families should be provided services by the separated system and the budget allocation should support this and also the high cost, chronic, HIV/AIDS care.
6. The translators should be prepared at the health service delivery unit and also the migrant language documents.
7. The traditional midwives should be improved their skills, safety services and information collection knowledge to reduce the postpartum hemorrhage and abortion and also improve the information system.
8. The migrant health worker should be encouraged and improved their skill and knowledge to collect specific information for example the giving birth at home, abortion and also the HIV/AIDS suspected cases.

PungNga and Phuket cased study[54]

Most of the PungNga migrant workers were in Agriculture, mostly rubber and fishery but in Phuket they were in construction and work in small shops. The health insurance fees were adequate but the prevention and promotion activities still were problem because of the frequent moving migrant workers, the communication and also the unreachable migrant workers. The recommendation included following.

1. The information system should be improved the quality, accuracy, updated for better utilization.
2. The health infrastructure should be better prepare for the workload from the migrant workers and families health and medical services, the standard guidances should be provided or else the services would be provided according to the decision and situation.
3. The NGOs could support the public sector for better services so the co-operation and encouragement would be initiated especially the recruitment of migrant health worker that was not permitted to the public hospitals.
4. The strategic formulation among NGOs, public sectors were challenged.

Rayong and Trad cased study [55]

The health service infrastructure should be improved especially the migrant health worker to communicate and increased accessibility and also the co-operation between government to government of the origin and destination countries.

1. The migrant management system should be adjusted to be more feasible with the migrant work environment and context, the strategy and guidance should be more sustainable for the long term management and the health insurance should be varied and more option for all migrant workers and families for example the all year register, etc, so we could move the under table migrant to be on the table.

Kritiya Archavanichakul, et al, summarized that the MoPH policy improvement consisted of the following.

1. The compulsory migrant health checkup.
2. The compulsory migrant health insurance.
3. The prevention and health promotion especially the HIV/AIDS program
4. The migrant family planning.

Anyway, the MoPH still faced the following problems

1. The communicable diseases among migrant workers and families
2. The migrant workers and families health and medical expenditure.
3. The migrant maternal and child health and also reproductive health.
4. The migrant sanitation and environment.
5. The migrant management expenditure.
6. The effective information system.

Anyway, there were some problems in the migrant health service system that needed to be improved, including to the disease prevention, health promotion, migrant information and migrant health insurance as following.

1. The provincial health office structure was not supported to the migrant health strategy because of non-permanent personal who would take care this problems and this mission need continuous co-operation among parties.
2. The frequent moving migrant workers and families caused difficulty to follow up especially the infected one. There was an example province that the 200 pulmonary tuberculosis cases were found but there was no system and no plan to follow up and provide medication. Anyway there were some provinces such as Tak, SamutSakon, Ranong and some district in Kanjanaburi where were very strong in preventive activities.
3. The workplace environment and condition were not support good health for the migrant and also easily disseminated communicable diseases. Most of the employers didn't co-operate in disease prevention especially healthy workplace promotion.
4. The HIV/AIDS and STD clinics in the provincial health offices were terminated and transfer to be the hospitals responsibility but the skill and experienced personals stayed in the provincial health office and also the hospital environment was different and needed identification that the sex workers couldn't access to the preventive services so these diseases prevention was weaken. Some provinces, such as Supanburi, maintained their STD clinics and could demonstrate the effective prevention activities.
5. The health personals didn't authorized the employers and factories so they couldn't get co-operation from them and also didn't get enough budget to support active role in the workplace prevention.
6. The international communicable diseases prevention needed knowledge and experience so there were not enough health personals in the inner provinces. The transfer knowledge and experience among the border provinces and inner provinces would be helpful.
7. The effective and efficient information system needed 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 gap due to the discontinuing and moving among new divisions of health personals.

The maternal and child health recommendation included the following.

1. There was evidence that some migrant women avoided pregnancy test and reported by abortion or else sent other non-pregnant women to test.
2. There were more migrant women giving births than Thai women in some provinces where there were more migrant workers than 10% of total population such as Ranong 33.7%, Tak 24.2%, SamutSakon 22.7%, PungNga 12.7% and Phuket 11.3%.
3. The still birth, spontaneous abortion and criminal abortion rate were very high in the migrant pregnancy especially at the border such as Mae-Sai, Chiengrai because of the lacking of family planning and communication problem so the ANC rate was just 1/3 of the total pregnancy in the migrant women. Some areas could demonstrate better outcome by more active health promotion program, increased the traditional midwives skill and knowledge and also implemented the migrant health workers to support the health service system.
4. The migrant health workers and voluntary migrant health workers could reduce the communication problem and also contact with the outreached migrant communities so the policy should empower and encourage these migrant health worker by legally recruit them by the public hospitals and provincial health offices.
5. The migrant newborn birth certification still was problem and need some solution.
6. The migrant HIV/AIDS infected pregnant women were not access to the ARV drugs.
7. There was evidence that family planning could reduce the migrant birth rate from 12.9/1000 in the year 2002 into 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 into 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 didn't get any health insurance and right to access to the health and medical services.

3. The migrant information was not integrated, incomplete and poor quality especially the migrant workers' name easily to changed, even the MoI cevil identification system let other ministries to connect but they needed ministry to ministry co-ordination.
4. The problem of the prohibited migrant workers were sent to the wrong country because of the miscommunication for example sent the Cambodian to Sanklaburi, Kanchanaburi province.
5. The migrant health and medical services expenditure caused more burden to the hospitals who provided health and medical care.
6. There were no sustainable strategy and guidance for the migrant families.

The National Socioeconomic Advisory Council also proposed the policy for migrant as following.[56]

1. There should be long term strategy and master plan for the long term migrant workers management formulated by all parties and the policy would be focused on human right, labor protection, feasible to operate and customized to the migrant work environment and condition for example the whole year registration but the security context should be kept in mind.
2. The migrant families should be prohibited because of the more migrant families the more migrant community settlement that could be treated to the Thailand security in the long run. Anyway, the migrant workers should be taken care about health and human right.
3. The provincial regulation the violated to the human right should be stopped.
4. The temporary work permit license should be more accessible for the migrant workers by reduction of the requesting steps and improved efficiency in operation.

And they also recommended the following.

1. The migrant regulation should be customized according to each provinces' 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 minimal wages should be applied for the migrant workers employment equally to Thai workers. The safety workplace, environment and also household should be implemented and enforced.

4. The registration, the health checkup and health insurance providing and also the temporary work permit license providing should be supported adequate budgets and also 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, utilized and also validated into one logical database.**
7. The migrant problems should be effective and efficient solved. There should be an assigned authority to take responsibility.

The recommendation for regulation included the following.

The temporary work permit license fee should be reduced to encourage the employers to registered their migrant workers.

Sirikanchana Patanasak[57] from the Ministry of Labor reported and recommended the following.

1. The migrant workers should be national agenda and national organization to take responsibility. The law and regulation should be improved and added the punishment especially for the illegal employers.
2. There should be policy and management for the unregistered migrant workers and improve the labor law to accommodate with the international labor law and also endorse the unendorsed international labor law.
3. The migrant workers management mechanism should be more efficient and transparent, the participation among NGOs, GOs parties should be encouraged.
4. The employers, the consumers should be communicated to improve their knowledge and realization of the human and labor right, everyone should co-operate to solve this problem.
5. The migrant workers should be empower and encourage to know and perceive the labor law and human right and also better quality of life
6. MoL should improve the migrant request process for temporary work permit license to be more efficient by extending the duration and frequency and also minimizing the levy.

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 employers card with reasonable fee.
9. The law enforcement should be encouraged for reducing the unregistered migrant workers and also their employers. This activities should encourage the registered migrant workers and their employers.
10. The labor right for migrant workers should be monitored and improved by increasing the labor inspector and dissemination of the guideline 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. The prevention to increase the illegal migrant workers should be done at the border, the human trafficking should be eradicated.
14. The legal migrant workers should be promoted especially the imported Myanmarese migrant workers and nationality approved migrant workers.
15. The human right and labor protection according to the international law should be enforced equally to all workers, Thai or migrant, registered or unregistered.
16. The human right and labor protection in Thailand should be communicated among countries and international or global to be recognized.

Samrit Srithamrongsawat, et al [7] also proposed the Policy recommendations as the following.

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. Management Information Systems must be strengthened as a matter of priority. 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:

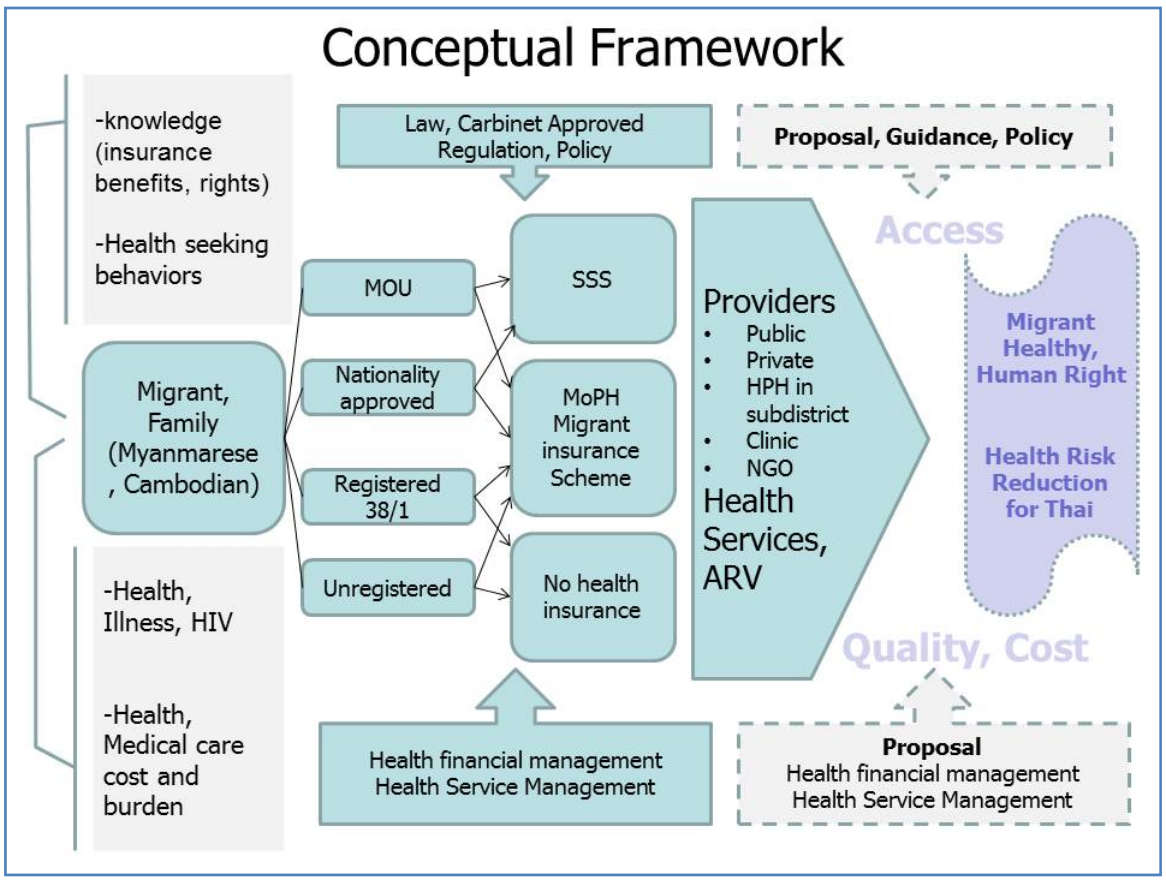
a. Additional budget allocations are required to support hospital exemption for migrant workers in communities where many unregistered migrants reside. Theoretically, health care costs incurred by migrant workers should be paid by those who benefit from the presence of migrant workers, including employers, 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 117 - 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 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

4. The knowledge and understanding in health insurance benefits, rights and also health seeking behavior and also health and medical services utilization of the registered, unregistered, insured, uninsured, nationality approved and imported according to Memorandom Of Understanding migrant workers and also families who are Myanmarese and Combodian not include Laotian in Rayong and SamutSakon provinces will be collected from their samples in the individual primary information format by questionnaire.

5. 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

collect in term of electronic medical record and reports from provincial health office and hospitals in Rayong and SamutSakon provinces and also Health Administration Bureau, Health Insurance Division, Office of Permanent secretary and Bureau of Foreigner Labor administration, Ministry of Labor.

6. The HIV/AIDS infected migrants' ARV accessibility and cost will be collected from the Migrant Health information from the Bureau of AIDS and Sexual Transmitted Diseases, Department of disease control and also provincial health office and hospitals in Rayong and SamutSakon provinces.

Unit of Analysis

The Rayong and SamutSakon was selected by Non Randomized (Purposive) Sampling because they were under Pharmit Project and most of the migrant were fisherman and fishery related business.

1. In Rayong province, there were registered migrants who already got civil registration 38/1 and work permit

license about 20,117, the nationality approved 3,962 and also the imported migrants according to the MOU 1,589, 56.55%of these migrants were Cambodian. The sample size, that was calculated by Taro Yamane[.(58)] method at 95% confident, was 394 samples.

2. In SamutSakon province, there were registered migrants who already got civil registration 38/1 and work permit license about 124,454, no report of the nationality approved and also no report of the imported migrants according to the MOU, 84.25%of these migrants were Myanmarese. The sample size, that was calculated by Taro Yamane method at 95% confident, was 400 samples

Migrant worker and their family

Because of the migrant workers distribution in Rayong and SamutSakon were 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 Myanmarese and Cambodian migrant workers who was imported legally according to the

MOU between Thai and Myanmar and also Thai and Cambodia.

2. The Myanmarese and Cambodian migrant workers who were registered by the Ministry of Interior and already got Civil Registration 38/1 form, and also were nationality approved by their original countries

3. The Myanmarese and Cambodian migrant workers who were registered by the Ministry of Interior and already got Civil Registration 38/1 form, but weren't nationality approved.

4. The Myanmarese and Cambodian migrant workers who weren't registered by the Ministry of Interior and hadn't Civil Registration 38/1 form.

The 1, 2 groups might got social security benefits because of their formal employers, or MoPH health insurance because of their informal employers. The 3,4 groups might got MoPH health insurance, or not. Each group would be selected by purposive method to cover their 6 job categories especially the 6th group that was identified into 19 subgroups in Rayong and SamutSakon, as they were dictated by Ministry of Labor, as much as possible.

Tools for collecting information

The Modifies Health Seeking Behavior and Health System reponse Model that was proposed by Susanna Hausmann-Muela [(59)] was adjusted and validated by 10 experts from public and NGO in Rayong, SamutSakon and also Ministry of Public Health to form the 2 collecting information Questionaire from migrant workers who already got any documents and legally got work permit license and also the undocumented migrant workers and the migrant families who didn't got any document.

Because of the limitation of the communication, the rating scale answers were avoided and the health seeking behaviors and health system response were quite personnel issues so for getting accurate

and reliable information, the interviewer and the sample migrant worker should not be friends or familiar person. [60]

The reliability of questionnaires were tested by test-retest method in 20 samples from SamutSakon and 9 samples from Rayong. 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 processed.

1. The law and regulation related to the illegal migration, literature search gathered published material on international migration in Thailand both in Thai and English were review including related health insurance.
2. The questionaires for measuring the migrant's knowledge and understanding in health insurance benefits, rights and also health seeking behavior and also health and medical services utilization were developed, validated, reliability test and improved.
3. The co-research committee in Rayong and SamutSakon were established.
4. A comprehensive desk review was undertaken and complemented with informal interviews and fieldvisits in Rayong and SamutSakon.
5. The samples were selected in Rayong and SamutSakon and the migrant health workers in Rayong and SamutSakon were introduced and trained for collecting information from the samples.
6. The survey was conducted in both provinces.
7. The migrant electronic records and also the ARV access or indicated for HIV/AIDS infected migrants were correct from the hospitals in Rayong and SamutSakon and also Provincial Health Offices.
8. The information from Bureau of health service system development, Insurance division, Bureau of HIV/AIDS and Sexual Transmitted Diseases, Bureau of Foreign Labor Administration were collected.

9. All information were analyzed and drafted financial management model and migrant health service model were formulated.
10. Field visited and the informal interviews were conducted with various stakeholders, including representatives of migrant related officers, NGO for adapting the models and also filling the knowledge gap.
11. The proposals of the models were analyzed for feasibility and concluded.

Chapter 4

Results of the study

1. Situation of the Migrant workers and Families from the Office of Foreign Worker Administration

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

The data correction by the office of foreign worker administration presented in table 4.1, it showed the amount of the 3 countries Illegal migrant workers, Myanmarese, Laosese and Cambodian, who got work permit from the office of foreign worker administration in the year 2004-2010.

The information of migrant workers was started to systematically collect in the year 2004 then the amount of these workers decreased in the year 2005 and 2006 then continuous decreased in the 2007 and was minimum in 2008 if excluded the year 2011 that the amount of registered migrant workers was impacted by the nationality approved migrant workers and imported migrant workers according to the MOU interventions.

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

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

source: The Office of Foreign Worker Administration

The office of foreign worker administration informed that in the year 2005 there was the policy to charge more fee from the employers who recruited these illegal migrant workers for their business with the very high rate started at 50,000 Baht then 10,000 Baht after there were a lot of negative critique, so the employers were discouraged to continue registered their illegal migrant workers. The information also showed that the amount of Cambodian workers decreased from the year 2004 to 2005 around 60.62% compared to 55.87% of the Laosese workers and 14.88% of the Myanmarese workers.

In the year 2007 and 2008 the cabinet approved policy lost balance and moved into more security focus so there was less continuing registered migrant workers. And the Cambodian was proved to be more sensitive than Laosese and Myanmarese to the migrant policy again by reduced 89.07% in the year 2008 from the year 2004, compared to 87.03% Laosese and 24.91% Myanmarese.

The amount of migrant workers increased into maximum in the year 2009 when there was exemption of the regulation and started the new registered for all illegal migrant workers again. Anyway, after the year 2009, the impact of the nationality approved migrant workers and imported migrant workers according to the MOU interventions decreased the amount of the registered migrant workers in the year 2010. In the year 2011, these impact, that was supplemented by the security focus policy to enforce the regulation and started to arrest the unregistered migrant workers that started in the end of the year 2010, minimized the amount of registered migrant workers in the year 2011 so there were only 295,136 registered migrant workers.

The table 4.2 showed the percent of illegal 3 Nationalities migrant workers who got work permit license in the year 2004-2010. The Myanmarese was highest compared to other 2 nationalities. The ratio of Laosese and Cambodian in the year 2008 indicated that these 2 nationalties would be less tolerance to the restriction policy and less likely to work in Thailand in future so the Myanmarese would became the main supplyof cheap unskilled workers for Thailand.

Table 4.2 Percentage of Migrant Workers (Illegal 3 Nationalities) with work permit licenses during 2004-2010

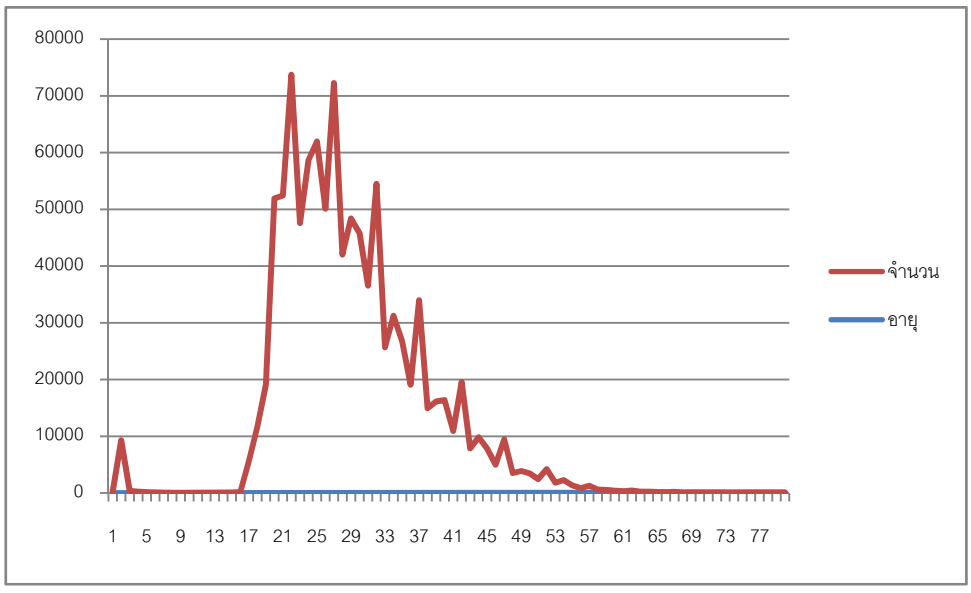
Nationality/%	Year 2004	Year 2005	Year 2006	Year 2007	Year 2008	Year 2009	Year 2010
Myanmarese	74.59	85.70	85.09	91.18	94.87	82.07	80.45
Laosese	12.39	7.38	7.68	4.04	2.72	8.43	9.07
Cambodian	13.02	6.92	7.23	4.78	2.41	9.49	10.48

source: the Office of Foreign Worker Administration

1.2 Trend of the illegal migrant workers and legal migrant workers

The government policy suggested by the foreign labor administrative committee tried to change the illegal migrant workers into the semi-legal by registration then change these semi-legal into the legal one by origin country nationality approved since the year 2005. But the outcome of the policy just impacted on the last 2 years as shown in the figure 4.1

Figure 4.1 Amount of legal Migrant Workers During Year 2006-2011 Nationality Approved , Imported and MOU



Source : the Office of Foreign Worker Administration

The imported migrant Laosese and Cambodian workers according to the MOU between Thailand and Cambodia, Thailand and Laos PDR showed the effectiveness in the year 2007 but this was not work for the MOU between Thailand and Myanmar. This process was not supported during the more security focus policy was implement in the year 2008, the effect of this policy also effected the legalized national approved migrant worker too. So there was less imported workers in the year 2008 and the nationality approved process didn't increased.

Until the year 2009 the migrant policy moved back into more economy focus, so the process of nationality approved, and imported migrant were promoted again. The obstacle of the Thailand and Myanmar MOU was eradicated so the number of imported Myanmarese migrant worker since the year 2009 and the number of nationality approved Myanmarese migrant worker rapidly increased in the year 2010 and 2011. So in future, the legal migrant Myanmarese workers would became the main source of unskilled migrant worker in Thailand.

2 Rayong province situation.

2.1 Trend of the Migrant workers from Myanmar, Laos PDR and Cambodia in Rayong province.

The information from Rayong provincial health office showed in table 4.3 that the registered migrant workers who got work permit license was 31,690 in the year 2009 and 20,020 in the year 2010.

Table 4.3 Registered Migrant Workers in Rayong during year 2009-2010

	Yr 2009			**Yr 2010**		
	Male	Female	Total	Male	Female	Total
Myanmarese	6,185	4,106	10,291	4,699	2,983	7,682
Laosese	1,732	1,515	3,247	1,117	989	2,106
Cambodian	12,181	5,971	18,152	6,912	3,320	10,232
Total	**20,098**	**11,592**	**31,690**	**12,728**	**7,292**	**20,020**

source from Rayong Provincial health office.

Most of the decreased migrant workers were 7,920 Cambodians so the ratio of the Cambodian, Myanmarese and Laosese registered migrant workers in Rayong that was 57.28 : 32.47 : 10.25 in the year 2009, changed into 51.11 : 38.37 : 10.52 in the year 2010. Mostly they were male workers and the ratio of female workers was 0.577 of the male workers in the year 2009 and 0.573 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, 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 4.4 Legal and semi-legal migrant workers in Rayong during year 2009-2011

	Rayong		
	2009	2010	2011
Total	**36,134**	**29,033**	**19719**
Legal migrant workers	5 ,115	8,668	11018
Long term work permit license	9	9	0
General work permit license	1,086	1,240	1162
Nationality Approved	2,081	3,962	6079
Imported according to the MOU	293	1,589	1815
Investment support	1,646	1,868	1962
Illegal	31,019	20,365	8701
Ethic group	168	248	281
Registered Migrant workers	**30,851**	**20,117**	**8420**

source: the Office of Foreign Worker Administration

The nationality approved migrant workers and imported migrant workers according to the MOU increased as shown in the table. Most of these two groups of migrant workers would get health service under the social security scheme, anyway the social security benefit didn't cover the 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 would be problem for the Rayong provincial

health office because of the migrant disease prevention and health promotion budget allocated from the registered migrant workers. 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 but the registered migrant workers decreased outnumbered to the increasing of the legal migrant workers.

2.3 The health checkup and health insurance in Rayong province.

The information from Rayong provincial health office showed in table 4.5 that the migrant workers who got health checkup were 32,030 even though there were only 31,690 registerd migrant workers who got work permit license in the year 2009. Most of them were checkup in Rayong hospital 40.64%, Klang hospital 21.54% and Bankai hospital 12.37% respectively. The rest were check up by other 5 hospitals.

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

Hosp	**Nationality**			**Total**	**Percentage**
	Myanmarese	Laosese	Cambodian		
Rayong	4,927	1,074	7,017	13,018	40.64
Klang	1,803	546	4,550	6,899	21.54
Ban Kai	1,498	755	1,708	3,961	12.37
Banchang	470	190	1,261	1,921	6.00
Plukdang	426	69	1,981	2,476	7.73
Wangchan	393	198	965	1,556	4.86
Koachamou	239	85	95	419	1.31
Mabtapud	980	258	542	1,780	5.56
Total	**10,736**	**3,175**	**18,119**	**32,030**	**100.00**

source : Rayong Provincial Health Office

But in the year 2010, the health check up migrant workers were only 17,267, compares to 20,020 registered migrant workers who got work permit license. Anyway, the distribution of the health checkup migrant worker were nearly the same as the year 2009, they were 42.21% in Rayong hospital and 21.18% in Klang hospital and also9.60% in Bankai hospital as shown in table 4.6

Table 4.6 Migrant Workers with Health Checkup in Rayong categorized by Hospitals in year 2010

Hosp	Nationality			Total	Percentage
	Myanmarese	Laosese	**Cambodian**		
Rayong	2,467	753	4,068	7,288	42.21
Klang	1,264	272	2,122	3,658	21.18
Bankai	680	360	617	1,657	9.60
Banchang	299	80	335	714	4.14
Plukdang	316	32	904	1,252	7.25
Wangchan	240	116	279	635	3.68
Koachamou	113	30	65	208	1.20
Mabtapud	703	151	219	1,073	6.21
Nicompatana	240	54	488	782	4.53
Total	**6,082**	**1,794**	**8,609**	**17,267**	**100.00**

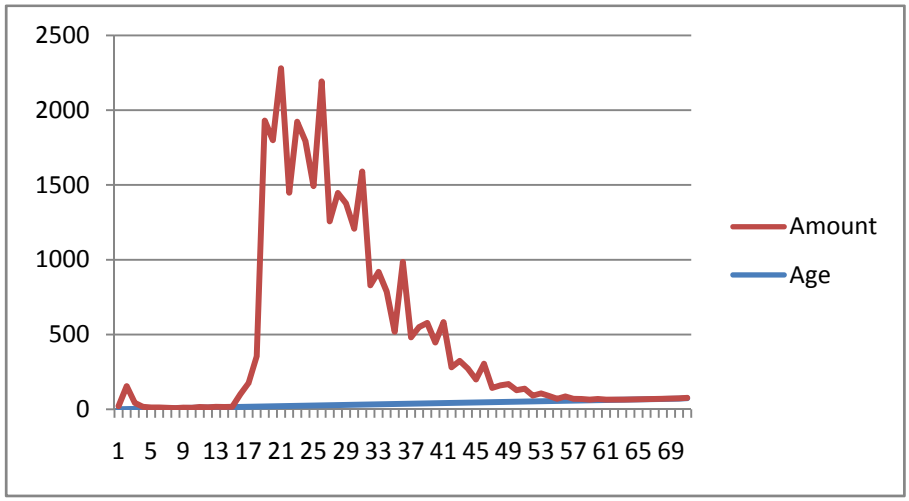
Source : Rayong Provincial Health Office**.**

2.4 The Rayong health checkup migrant workers and families age's distribution.

The distribution Rayong health checkup migrant workers age in the year 2009 showed in figure 4 and in the year 2010 showed in figure 4.2

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.

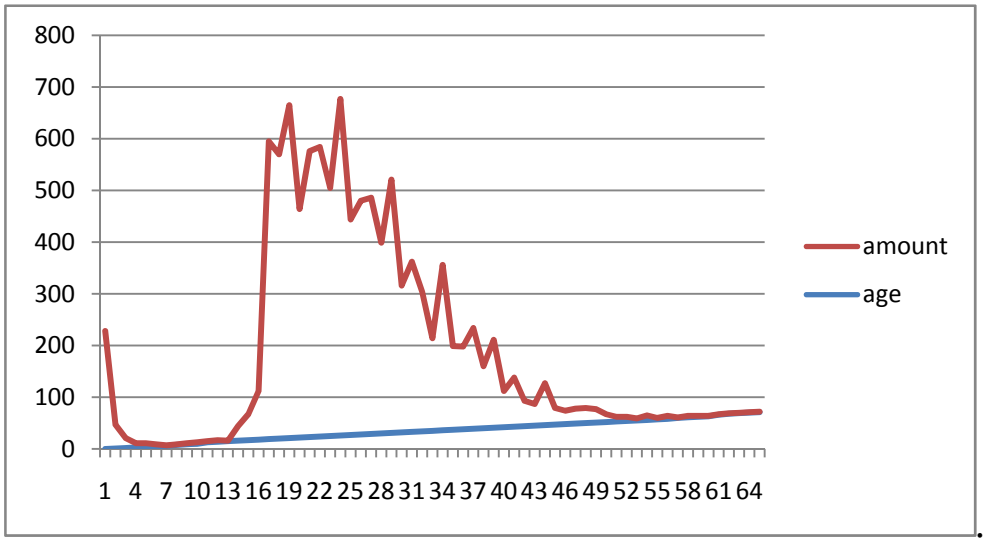
Figure 4.2 Amount of Migrant Workers and Families with health checkup and age's distribution In Rayong year 2009



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 were not normal. The most frequent health checkup age group was 21 years old and 26 years old showed that most of the 21 years old migrant workers would immigrate to Thailand when the new registration started and the 26 years old peak was 21 years old at the year 2004 which started the new registration too, that group of migrant workers was 26 years old in the year 2009

Figure 4.3 Amount of Migrant Workers and Families with Health Checkup versus Age's Distribution in Rayong Year 2010

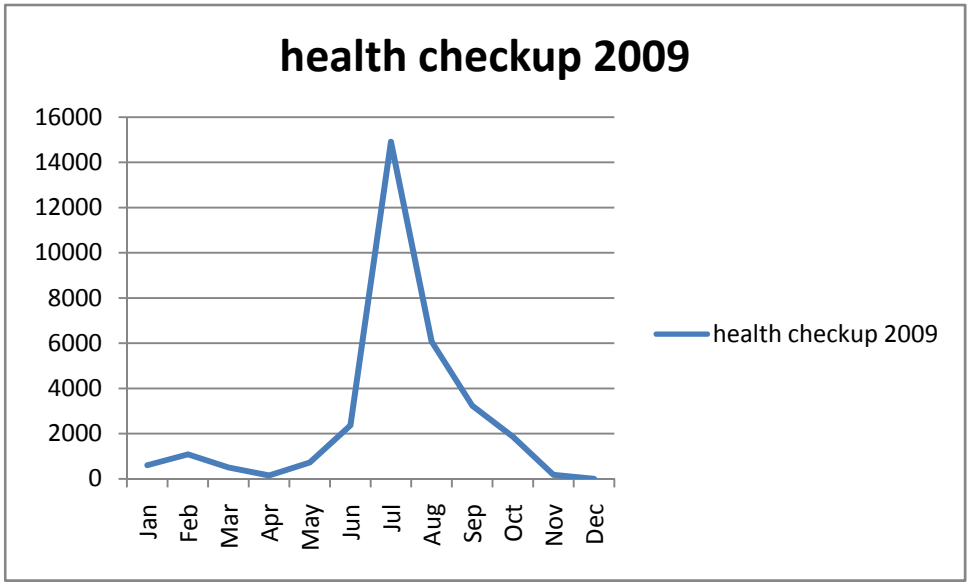


Source:Rayong Provincial Health Office.

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

The health checkup by Rayong province hospitals distributed into every months, whole year, in the year 2009 and the most frequent checkup during June to August, the peak was July as shown in figure 4.4 happened

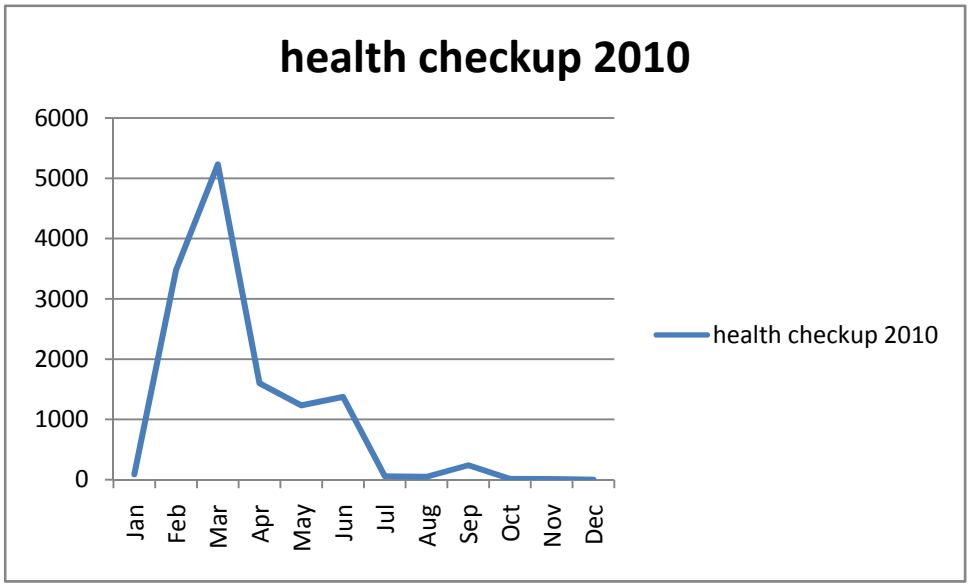
Figure 4.4 Amount of Migrant Workers and Families with Health Checkup for months' distribution in Rayong in year 2009.



source :Rayong Provincial Health Office.

And the health checkup by Rayong province hospitals that distributed into every months, whole year, in the year 2010 but the most frequent checkup happened during Febuary to April, the peak was March as shown in figure 4.5.

Figure 4.5 Amount of Migrant Workers and Families with Health Checkup for months' distribution in Rayong in year 2010.



source : Rayong provincial health office.

2.5 The result of health checkup in Rayong.

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

Amount of Migrant Workers Health Checkup	2009	Percentage	2010	Percentage
Normal (type 1)	26,534	96.26	16,492	95.51
Need to follow up (type 2)	478	1.73	264	1.53
Prohibited from work (type 3)	23	0.08	31	0.18
Pregnancy (tye 4)	531	1.93	480	2.78
Total	**27,566**	**100.00**	**17,267**	**100**

Table 4.8 Results of Health Checkup with Disease Needed to follow up (type 2) in Rayong during 2009-2010

Disease needed to follow up	2009	percentage	2010	percentage
Tuberculosis	54	11.30	10	25.64
Elephantiasis.	-	-	-	-
Leprosy	-	-	-	-
Syphilis	75	15.69	28	71.79
Malaria	1	0.21	-	-
Intestinal Parasitic Infection	-	-	-	-
Other Disease	348	72.80	1	2.56
Total	478	100	39	100.00

Table 4.9 Results of Health Checkup with Work Prohibition (type 3) in Rayong during 2009-2010

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

2.6 HIV/AIDS and ARV situation in Rayong province.

The HIV/AIDS infected patients who already could access to the ARV at Rayong province in the year 2010 showed in table 4.10, mostly they were covered by social security scheme 7 cases, universal coverage of health care scheme 6 cases, there was no civil servant medical benefit scheme.

Table 4.10 Amount of HIV/AIDS Access to ARV at Rayong in year 2010

Rayong	HCS (Health Care Scheme)	SSS (social Security scheme)	CSMBS	Other	Total
at present Patient	2	1	0	0	3
Accumulated Patient	6	7	0	0	13

source :Bureau of Sexual Transmitted Disease and HIV/AIDS.

The HIV/AIDS infected patients who could not access to the ARV at Rayong province in the year 2010 showed in table 4.11, mostly they were unknown scheme or waiting to approve Thai people 53 cases, unregistered migrant workers 40 cases, health insurance migrant workers 25 cases, registered migrant workers 21 cases.

Table 4.11 HIV/AIDS Patients could not access to ARV at Rayong in year 2010

Rayong HIV/AIDS	**unknown scheme/ Waiting to Approve**	**registered migrant workers**	**Unregistered Migrant Workers**	**Health Insurance Migrant Workers**	**Refugee**	**Other**	**Total**
at present Patient	42	18	33	21	0	0	114
Accumulated Patient	53	21	40	25	0	0	139

source :Bureau of Sexual transmitted disease and HIV/AIDS**.**

3 SamutSakon Province Situation

3.1 Trend of the Migrant workers from Myanmar, Laos PDR and Cambodia in SamutSakon province.

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

Nationality	Yr 2009			Yr 2010		
	Male	Female	Total	Male	Female	Total
Myanmarese	6,185	4,106	10,291	4,699	2,983	7,682
Laosese	1,732	1,515	3,247	1,117	989	2,106
Cambodian	12,181	5,971	18,152	6,912	3,320	10,232
Total	**20,098**	**11,592**	**31,690**	**12,728**	**7,292**	**20,020**

Source : Rayong Provincial Health Office.

3.2 Trend of the illegal migrant workers and legal migrant workers in SamutSakon province.

The amount of legal and semi legal migrant workers in SamutSakon province decreased from 289,531 in the year 2009, 124,849 in the year 2010 and 58,053 in the year 2011 corresponding with the national trend as shown in table 4.13.

Table 4.13 The legal and Semi-legal Migrant Workers in Samut-Sakon during year 2009-2011

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

source: the Office of Foreign Worker Administration

But the nationality approved 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 from18,530 in the year 2009 to 0 in the year 2010 then increased 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 39,720 in the year 2011, this situation would be even more problem for the SamutSakon provincial health office than Rayong because the registered migrant worker 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 SamutSakon province.

Table 4.14 Migrant Workers Got Health Checkup in SamutSakon Classified by Hospitals in Year 2009

Hospital	Nationality			Total	Percentage
	Myanmarese	Laosese	Cambodian		
SamutSakon	51,453	1,808	665	53,926	34.66
Banpaew	2,140	117	30	2287	1.47
katumban	17,311	2,016	596	19,923	12.80
Srivichai 5	76,838	1,859	766	79,463	51.07
Total	**147,742**	**5,800**	**2,057**	**155,599**	**100**

source :SamutSakon Provincial Health Office.

Table 4.15 Migrant Workers Got Health Checkup in SamutSakon Classified by Hospitals in Year 2010

Hospital	Nationality			Total	Percentage
	Myanmarese	Laosese	Cambodian		
SamutSakon	46,675	1,183	365	48,223	38.02
Banpaew	1,952	60	7	2,019	1.59
katumban	15,528	1,263	475	17,266	13.61
Srivichai 5	57,979	1,060	283	59,322	46.77
Total	**122,134**	**3,566**	**1,130**	**126,830**	**100**

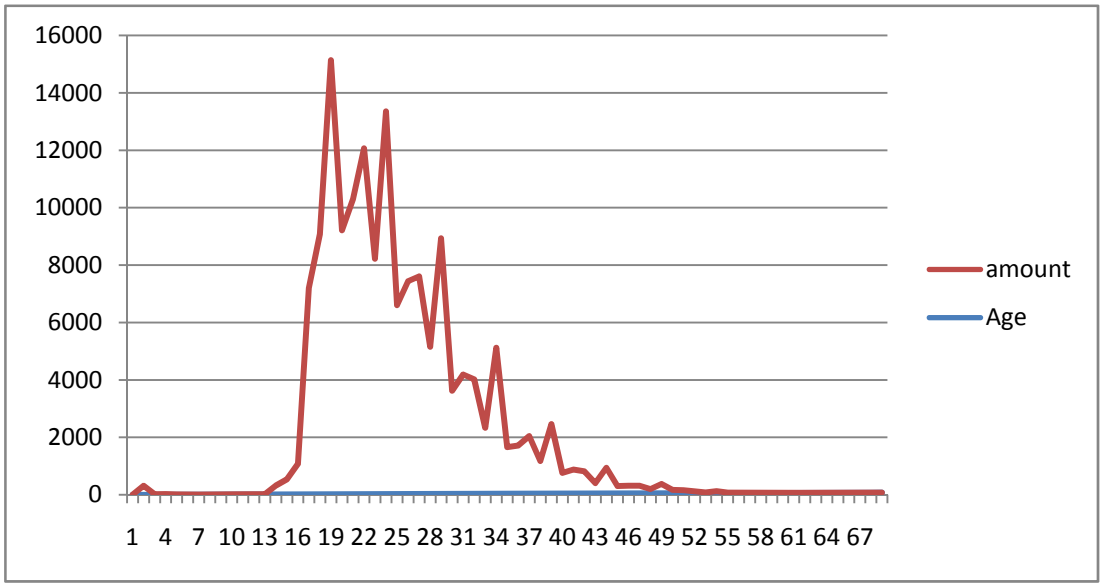
source :SamutSakon Provincial Health Office**.**

The SamutSakon health checkup migrant workers and families age's distribution.

The distribution of SamutSakon health checkup migrant workers age in the year 2009 showed in figure 8 and in the year 2010 showed in figure 4.6

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, the same as Rayong.

Figure 4.6 Health Checkup Migrant Workers and Families Age's distribution in SamutSakon in year 2009

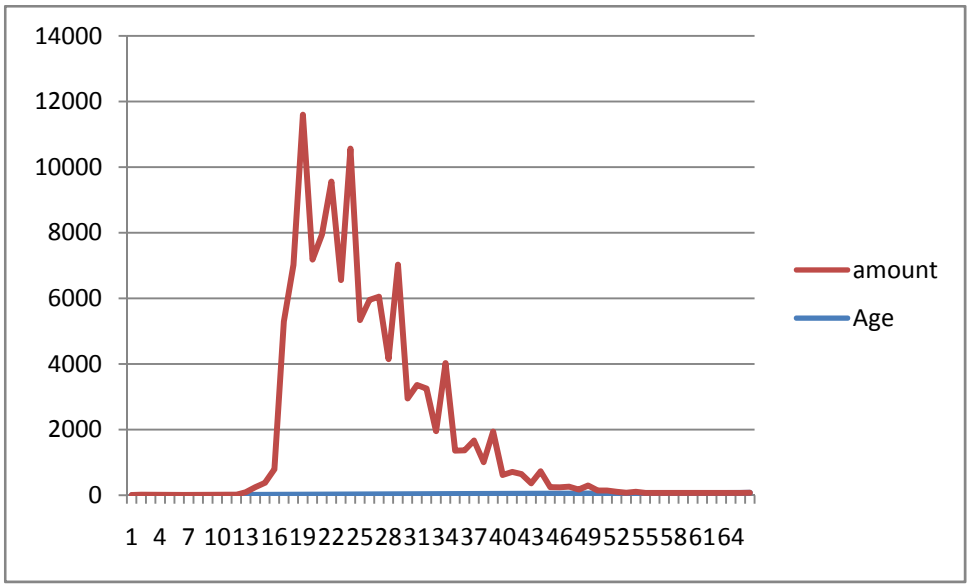


source : Samut-Sakon provincial Health Office.

There were more newborn 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 Rayong province hospitals distributed into every months, whole year, in the year 2009 and the most frequent checkup happened during June to August, the peak was July as shown in figure 4.7.

Figure 4.7 SamutSakon Health Checkup Migrant Workers and Families Age's distribution in year 2010



The results of health checkup in SamutSakon

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

Amount of Migrant Workers Health Checkup	2009/ Amount	Percentage	2010 / Amount	percentage
Normal (tye 1)	153,626	98.73	124,552	98.20
Needed to follow up (tye 2)	340	0.22	165	0.13
Prohibited from work (tye 3)	0	0	0	0
Pregnancy (tye 4)	1,633	1.05	2,113	1.67
Total	**155,599**	**100**	**126,830**	**100**

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

Disease need to followup	2009	Percentage	2010	Percentage
Tuberculosis	185	54.41	79	47.88
Elephantiasis.	23	6.77	4	2.42
Leprosy	0	0	0	0
Syphilis	132	38.82	82	49.70
Malaria	0	0	0	0
Intestinal Parasitic Infection	0	0	0	0
Other Disease	0	0	0	0
Total	340	100	165	100

There was no Work prohibition (type 3) in Sumutsakon in the year 2009-2010.

3.3 HIV/AIDS and ARV situation in SamutSakon province.

The HIV/AIDS infected patients who already could access to the ARV at SamutSakon province in the year 2010 showed in table 4.19, mostly they were covered by 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 Amount of HIV/AIDS Accessible to ARV in SamutSakon in year 2010

SamutSakon province	**HCS (Health Care Scheme)**	**SSS (social security scheme)**	**CSMBS**	**Other**	**Total**
at present Patient	1	1	1	1	4
Accumulated Patient	9	15	2	3	29

source :Bureau of Sexual transmitted disease and HIV/AIDS.

The HIV/AIDS infected patients who could not access to the ARV in SamutSakon province in the year 2010 showed in table 4.20 , mostly they were health insurance migrant workers 31 cases, registered migrant workers 25 cases, unregistered migrant workers 17 cases, unknown scheme or waiting to approve Thai people 16 cases.

Table 4.20 HIV/AIDS Patients Non-Accessible to ARV in SamutSakon in year 2010

SamutSakon Province	unknown scheme/ Waiting to Approve	registered migrant workers	Unregistered Migrant Workers	Health Insurance Migrant Workers	Refugee	other	Total
at present Patient	2	14	10	20	0	0	46
Accumulated Patient	16	25	17	31	0	0	89

Source: Bureau of Sexual Transmitted Disease and HIV/AIDS.

4 Migrant workers and families' health seeking behavior and health care utilization

4.1 Migrant workers and families'characteristic in this study

The 1,243 questionnaires for registered migrant workers and unregistered migrants were collected, 643 questionnaires from Rayong province mostly they were Cambodian and 600 questionnaires from Samutsakon province mostly they were Myanmarese. The details were shown in Table 4.21

Table 4.21 Characteristic of migrant workers and families in this study

	Rayong	**Samutsakon**
Registered and Insured	351	477
Male:Female	140:211 (1:1.50)	221:256 (1:1.16)
Age	17-56 (mean 30.39)	17-54 (mean 28.66)
Myanmarese: Cambodia	132:219	473:4
Unregistered and uninsured	292	123
Male:Female	137:155 (1:1.13)	84:39 (1:0.46)
Age	13-60 (อายุเฉลี่ย 28.8)	14-50 (อายุเฉลี่ย 28.70)
Myanmarese: Cambodia	46:246	123:0

The Rayong registered migrant workers' averaged income was 5,606.62 Bath and unregistered averaged income was 4,518.18 Bath, and the registered migrant workers were found to have higher income than the unregistered (Independent Samples test, t=5.124, df=638.113, p<0.01) as shown in table 4.22.

Table 4.22 Rayong registered migrant workers and unregistered averaged income

Rayong Migrant	Amount	Averaged Income(Bath) Mean	Std. Deviation	Std. Error Mean	t	p
Registered and Insured	351	5,606.62	3,029.73	161.715	5.124	0.00*
Unregistered	292	4,518.18	2,353.90	137.752		

The Samutsakon registered migrant workers' averaged income was 6,225.66 Bath and unregistered averaged income was 5,755.12 Bath, and the registered migrant workers were found to have higher income than the unregistered (Independent Samples test, t=3.170, df=165.521, p<0.05) as shown in table 4.23.

Table 4.23 Samutsakon registered migrant workers and unregistered averaged income

Samutsakon Migrant	Amount	Averaged Income(Bath) Mean	Std. Deviation	Std. Error Mean	t	p
Registered and Insured	477	6,225.66	1232.784	56.445	3.170	0.024*
Unregistered	123	5,755.12	1522.581	137.286		

Most of the Rayong migrants and families stayed in Thailand more than 4 years. The 565 migrants, who stayed 4.13 years in average, could listen and understand Thai. The 78 migrants who stayed 2.86 years in average, couldn't understand Thai. The migrants who could listen and understand Thai were found to stay longer than the migrants who couldn't understand Thai (Independent Samples test, t=-5.810, df=641, p<0.01).

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

Table 4.24 Rayong migrants' Thai literacy and averaged work duration in Thailand

Thai literacy		Amount	Duration (Year)	Std. Deviation	Std. Error Mean	t	p
Listen, understand	No	78	2.86	1.771	.201	-5.810	0.00
	Yes	565	4.13	1.824	.077		
Speak	No	107	2.75	1.738	.168	-7.837	0.00
	Yes	536	4.23	1.790	.077		

Most of the Rayong migrants and families stayed in Thailand more than 4 years. The 444 migrants, who stayed 4.52 years in average, could listen and understand Thai. The 156 migrants who stayed 3.01 years in average, couldn't understand Thai. The migrants who could listen and understand Thai were found to stay longer than the migrants who couldn't understand Thai (Independent Samples test, t=-10.091, df=598, p<0.01).

The 527 migrants, who stayed 4.36 years in average, could speak Thai. The 73 migrants, who stayed 2.41 years in average coundn't speak Thai. The migrants who could speak Thai were found to stay longer than the migrants who couldn't speak Thai (Independent Samples test, t=-9.642, df=598, p<0.01). As shown in Table 4.25

Table 4.25 Samutsakon migrants' Thai literacy and averaged work duration in Thailand

Thai literacy		Amount	Duration (Year)	Std. Deviation	Std. Error Mean	T	p
Listen, understand	No	156	3.01	1.762	1.762	-10.091	0.00
	Yes	444	4.52	1.556	1.556		
Speak	No	73	2.41	1.606	1.606	-9.642	0.00
	Yes	527	4.36	1.624	1.624		

4.2 Migrant workers and families' realization about insurant benefit packages

Most of the Rayong and Samutsakon registered migrant workers realized their medical services, accident and emergency, health promotion and disease prevention benefits. The 95% of them knew that they could bring insurant card to visit hospital. The 92.59% of Rayong registered migrant workers knew their medical services benefit package compared to 87.63% of Samutsakon registered migrant workers. The detail was shown in table 4.26

Table 4.26 The registered migrant workers and benefit packages realization

Benefit package knowledge	**Rayong**		**Samutsakon**	
	unknown	**known**	**unknown**	**Know**
Bring the Insurant card to hospital	12 (3.51%)	338 (96.49%)	20 (4.19%)	457 (95.80%)
Medical Services	26 (7.40%)	325 (92.59%)	59 (12.37%)	418(87.63 %)
Health promotion, Disease prevention	106(30.19%)	245(69.80%)	133(27.88)	344 (72.12%)
Accident, Emergency	75(21.36%)	276(78.63%)	120(25.16)	357(74.84 %)

Most of the Rayong unregistered migrants realized the medical services, accident and emergency, health promotion and disease prevention benefits of the insurance. But the Samutsakon unregistered migrants realized the medical services benefits and more than half of them didn't know about the health promotion and disease prevention and also accident and emergency benefits. The detail was shown in table 4.27

Table 4.27 The unregistered migrants and benefit packages realization

Benefit package knowledge	Rayong		Samutsakon	
	unknown	Known	unknown	known
Bring the Insurant card to hospital	61(20.89%)	231(79.11%)	30 (24.39%)	93 (75.61%)
Medical Services	112(38.36%)	180(61.64%)	77(62.61%)	46(37.39%)
Health promotion, Disease prevention	101(34.59%)	191(65.41%)	64(52.03%)	59(47.97%)

4.3 Migrant workers and families Health seeking behavior

When the migrants in Rayong and Samutsakon got minor illness, most of them treated themselves by purchasing drugs from pharmacies, some of them visited the insured hospital when they got minor illness as shown in table 4.28

Table 4.28 The migrants health seeking behaviors for minor illness

Health seeking behaviors	Rayong		Samutsakon	
	insured	Uninsured	insured	Uninsured
Rest	20 (5.70 %)	41(14.04%)	32 (6.70%)	9 (7..32%)
Pharmacy	136 (38.74%)	116(39.73%)	161 (33.75%)	22 (17.89%)
Rest and Pharmacy	61(17.37%)	59 (20.21%)	153 (32.08%)	32 (26.02%)
Health Center	55 (15.67%)	33(11.30%)	21 (4.40%)	9 (7.32 %)
Hospital	46(13.11%)	22(7.53%)	40 (8.38%)	19 (15.45%)

Health seeking behaviors	Rayong		Samutsakon	
	insured	Uninsured	insured	Uninsured
Traditional Medicine	3 (0.85%)	5 (1.71%)	18 (3.77%)	10 (8.13%)
Others	30 (8.55 %)	16 (5.48%)	52 (10.98 %)	22 (17.87%)
Total	351 (100%)	292 (100%)	477 (100%)	123 (100%)

When the migrants got serious illness, 75.51% of the Rayong and 51.15% of the Samutsakon registered migrant workers visited insured hospitals, but only 22.60% of the Rayong and 29.70% of the Samutsakon unregistered migrants visited public hospitals as shown in table 4.29

Table 4.29 The migrants health seeking behaviors for serious illness

Health seeking behaviors	Rayong		Samutsakon	
	insured	uninsured	Insured	uninsured
Health Center	27 (7.40%)	40 (13.70%)	10 (2.09 %)	5 (3.06%)
Pharmacy	10 (2.86%)	52 (17.80%)	15 (3.14%)	14 (10.38%)
Private Clinic	18 (5.19%)	50 (17.12%)	61 (12.79%)	16 (12.50%)
Insured/ Public hosptials	258 (73.51 %)	66 (22.60%)	244 (51.15 %)	39 (29.70%)
Other/Private hospital	7 (1.99%)	43(14.74%)	5 (1.05%)	13 (10.56%)
Others	31(8.85%)	41(14.04%)	142 (29.77%)	46 (34.39 %)
Total	351 (100%)	292 (100%)	477 (100%)	123 (100%)

4.4 Migrant workers and families' medical services utilization

The Rayong registered migrant worker and unregistered migrants'averaged outpatient visits per year were 2.094 visits/migrant and 2.037 visits/migrant compared to Samutsakon registered migrant worker and unregistered migrants'averaged outpatient visits per year were 1.447 visits/migrant and 1.618 visits/migrant. In Samutsakon province, 76.94% of the registered migrant workers and 88.61% of unregistered migrants had been visited the OPD, 61.38% of the registered migrant workers but only 31.19% of the unregisted migrants had been visited insured or public hospitals. In Rayong province, 50.14% of the registered migrant workers and 53.08% of unregistered migrants had been visited the OPD, 37.60% of the registered migrant workers but only 8.90% of the unregisted migrants had been visited insured or public hospitals. The detail was shown in table 4.30

Table 4.30 Migrant workers and families' medical services utilization

Health seeking behaviors	**Rayong**		**Samutsakon**	
	insured	**uninsured**	**insured**	**uninsured**
Average OPD utilization/year	2.094	2.037	1.447	1.618
Had been visited to OPD	176 (50.14 %)	155 (53.08 %)	367(76.94 %)	109 (88.61 %)
Visited to the insured or public hospital' OPD	132 (37.60 %)	26 (8.90 %)	228 (60.38%)	34 (31.19%)
Had been admitted to IPD	38 (10.82 %)	28 (9.58 %)	34 (7.13 %)	14 (11.38 %)
Total	351	292	477	123

4.5 Migrants medical expenditure

In Rayong province, 83.76% of the registered migrant workers had been paid for medical services in the hospitals compared to 47.26% of the unregistered and only 5.48% of them couldn't fully pay. In

Samutsakon province, 74.63% of the registered migrant workers had been paid for medical services in the hospitals compared to 98.37% of the unregistered and only 8.94% of them couldn't fully pay.

In Rayong province, 84.33% of the registered migrant workers paid only 30 Bath and only 3.13% paid more than 30 Bath, 40-3500 Bath but only 1.71% of the unregistered paid 30 Bath and 38.71% of them paid 50-15,000 Bath. In Samutsakon province, 67.92% of the registered migrant workers paid only 30 Bath and only 6.92% paid more than 30 Bath, 50-1620 Bath and 34.69% of the unregistered paid only 30 Bath and 36.58% of them paid 40-3,000 Bath. The details were shown in table 4.31

Table 4.31 Migrant workers and families' medical services expenditure burden

Medical services expenditure burden	**Rayong**		**Samutsakon**	
	Insured	**uninsured**	**insured**	**Uninsured**
Had been paid to the hospital (migrants)	294 (83.76 %)	138 (47.26%)	356(74.63%)	121 (98.37%)
Not fully paid (migrants)		16 (5.48%)		14 (8.94 %)
The amount paid to the hospitals				
Migrants who paid Only 30 Bath (migrants)	296 (84.33%)	5(1.71%)	324(67.92%)	43 (34. 96%)
More than 30 Bath (Bath)	40-3,500	50-15,000	50-1,620	40-3,000
Migrants who paid more than 30 Bath (migrants)	11(3.13%)	113 (38.71%)	33(6.92%)	45(36.58%)
Total migrants	**351**	**292**	**477**	**123**

The Rayong registered migrant workers' averaged expense for total medical services was 137.15 Bath/migrant and unregistered was 711.70 Bath/migrant. The registered migrant workers were found to have more total medical services expense than the unregistered migrants (Independent Samples test, t=-

5.598, df=329.776, p<0.01). The Samutsakon registered migrant workers' averaged expense for total medical services was 73.83 Bath/migrant and unregistered was 459.66 Bath/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 Rayong registered migrant workers' averaged vehicle cost to the hospital was 70.11 Bath/migrant and unregistered was 64.10 Bath/migrant. The Samutsakon registered migrant workers' averaged vehicle cost to the hospital was 42.11 Bath/migrant and unregistered was 56.50 Bath/migrant as shown in table 4.32

Table 4.32 The migrants' averaged expense for medical services, vehicles compared between registered and unregistered migrants.

<table>
<tr><th rowspan="2">Medical services and Vehicle expense</th><th colspan="4">Rayong</th><th colspan="4">Samutsakon</th></tr>
<tr><th>Insured</th><th>Uninsured</th><th>t</th><th>p</th><th>Insured</th><th>uninsured</th><th>T</th><th>p</th></tr>
<tr><td>Drugs, Clinic (Bath)</td><td rowspan="2">67.04 (0- 3,500)</td><td>175.70 (0-4500)</td><td rowspan="2">-4.471</td><td rowspan="2">0.002</td><td rowspan="2">31.72 (30-1680)</td><td>281.36 (0-600)</td><td rowspan="2">-3.178</td><td rowspan="2">0.000</td></tr>
<tr><td>Hospital expense (Bath)</td><td>471.90 (0-15,000)</td><td>121.80 (0-3000)</td></tr>
<tr><td>Vehicles (Bath)</td><td>70.11 (0-200)</td><td>64.10 (0-2500)</td><td></td><td></td><td>42.11 (0-300)</td><td>56.50 (0-250)</td><td></td><td></td></tr>
<tr><td>Total expense (Bath)</td><td>137.15</td><td>711.70</td><td rowspan="2">-5.598</td><td rowspan="2">0.000</td><td>73.83</td><td>459.66</td><td rowspan="2">-8.923</td><td rowspan="2">0.000</td></tr>
<tr><td>Total migrants</td><td>351</td><td>292</td><td>477</td><td>123</td></tr>
</table>

5 Migrants HIV/AIDS situation in Rayong and Samutsakon provinces

5.1 Consultation and VCT

Most of the migrants in Rayong and Samutsakon provinces were never got consultation about HIV/AIDS. Only 32.19% of the registered migrant workers and 22.94% of the unregistered got consultation in Rayong and 9.85% of the registered migrant workers and 15.44% of the unregistered got consultation in Samutsakon as shown in table 4.33.

Table 4.33 The migrants and Consultation and VCT

Medical services expenditure burden	**Rayong**		**Samutsakon**	
	Insured	**uninsured**	**Insured**	**Uninsured**
Got consultation (VCT)	113	67	47	19
	32.19%	22.94%	9.85%	15.44%
Didn't got consultaion	238	225	423	104
	67.80%	75.05%	88.67%	84.55%
Total	351	292	477	123

In Rayong province, 59.29% of the registered migrant workers and 55.32% of the unregistered got consultation and VCT from nurse but in Samutsakon province, 52.24% of the registered migrant workers and 100% of the unregistered got consultation and VCT from the migrant health workers as shown in table 4.34.

Table 4.34 The migrants' Consultation and VCT providers

Consultation and VCT provider	Rayong		Samutsakon	
	Insured	**uninsured**	**Insured**	**uninsured**
Migrant health worker	44	35	21	19
	38.93 %	52.24 %	44.68 %	100 %
Nurse	67	32	26	0
	59.29 %	47.76 %	55.32 %	0
Total	113	67	47	19

In Rayong province, 96.46% of the registered migrant workers and 95.52% of the unregistered accepted for HIV blood test. But in Samutsakon province, 85.10% of the registered migrant workers and 15.79% of the unregistered accepted for HIV blood test as shown in table 4.35.

Table 4.35 The migrants Blood test for HIV after consultation and VCT

Consultation and VCT provider	Rayong		Samutsakon	
	Insured	**uninsured**		**Insured**
Voluntory Blood test for HIV	109	64	40	3
	96.46%	95.52%	85.10%	15.79%
No Blood test for HIV	4	3	7	16
Consultation, VCT	113	67	47	19
No Consultation, VCT	238	225	430	104

5.2 Anti-retrovirus accessibility

In Rayong province, there are 139 HIV infected migrants in the year 2010 reported by Bureau of AIDs, TB and STIs, Department of Disease Control as shown in table 4.36

Table 4.36 The HIV infected migrants in Rayong province, 2010

Rayong	People wait for proof of citizenship	Migrant with immigration documents	Unregistered Migrant	Registered migrant	Refugee	Others	Total
Existing Patients	42	18	33	21	0	0	114
Accumulated patients	53	21	40	25	0	0	139
Total infected patients	95	39	73	46	0	0	253

In the year 2010, the Rayong provincial health office collected the information of 141 HIV infected migrants who got ARV drugs, only 97 cases (68.79%) got 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 The HIV infected migrants who got ARV in Rayong Province, 2010

Hospital	Cases	ARV from NAPHA (cases)	Out of pocket (cases)
Rayong	110	70	40
Glang	9	9	0
Bankai	3	3	0
Pluakdang	4	4	0
Banchang	10	8	2
Wanjan	3	3	0
Maptaput	2	0	2
Koachamou	0	0	0
Nikompattana	0	0	0
Total	141	97 (68.79%)	44 (31.21%)

In Samutsakon province, there are 89 HIV infected migrants in the year 2010 reported by Bureau of AIDs, TB and STIs, Department of Disease Control as shown in table 4.38

Table 4.38 The HIV infected migrants in Samutsakon province, 2010

Rayong	People wait for proof of citizenship	Migrant with immigration documents	Unregistered Migrant	Registered migrant	Refugee	Others	Total
Existing Patients	2	14	10	20	0	0	46
Accumulated patients	16	25	17	31	0	0	89
Total infected patients	18	39	27	51	0	0	135

In the year 2010, the Rayong provincial health office collected the information of 100 HIV infected migrants who got ARV drugs, only 63 cases (63%) got ARV from the NAPHA project, the rest (36 cases, 36%) only 18 cases (18%) could paid for ARV by themselves, another 18 cases could afford as shown in table 4.39

Table 4.39 The HIV infected migrants in Samutsakon province, 2010

Hospital	Cases	ARV from NAPHA (cases)	Out of pocket (cases)	Couldn't afford
Samutsakon	70	40	15	15
Kratumban	24	17	4	3
Banpaew	6	6	0	0
Total	**100**	**63**	**19**	**18**

6 Health Service system and Health financing for Migrants and families

The ministry of public health (MOPH) provided physical checkup, health services and health insurance for registered migrant workers according to the year by year carbinet resolution. The fee for physical checkup was 600 Bath, and 1,300 Bath for health insurance. The provincial health office took responsibility to assign public and private hospitals at that 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 got physical checkup and purchased health insurance. After high cost and management cost deduction, the income for Rayong province was 39,312,960 Bath, 28,977,456 Bath was allocated for hospitals medical services, the allocation for health promotion and disease prevention activities in hospitals was 5,224,819 Bath, the allocation for health promotion and disease prevention activities in provincial health office was 1,306,205 Bath and the allocation for management was 3,804,480 Bath as shown in table 4.40

Table 4.40 Health checkup and Health insurance fee and resource allocation in Rayong, 2009

Hospital	Physical Checkup / insure migrants	Allocation for Hospitals			Allocation for Provincial Health office		
		Medical Services (Bath)	Health promotion/Disease prevention (Bath)	Total hospital income	Management (Bath)	Health promotion/ Disease Prevention (Bath)	Total
Rayong	12,578	11,496,292	2,072,854.40	13,569,146.40	1,509,360	518,213.60	2,027,573.60
Glang	7,112	6,500,368	1,172,057.60	7,672,425.60	853,440	93,014.40	1,146,454.40
Bankai	4,211	3,848,854	693,972.80	1,078,826.80	505,320	173,493.20	678,813.20
Banchang	1,848	1,689,072	304,550.40	1,993,622.40	221,760	76,137.60	297,897.60
Pluakdang	2,439	2,229,246	401,947.20	2,631,193.20	292,680	100,486.80	393,166.80
Wanjan	1,299	1,187,286	214,075.20	1,401,361.20	155,880	53,518.80	209,398.80
Koachamou	431	393,934	71,028.80	464,962.80	51,720	17,757.20	69,477.20
Maptaput	1,786	1,632,404	294,332.80	1,926,736.80	214,320	73,583.20	287,903.20
Total	**31,704**	**28,977,456**	**5,224,819**	**34,202,275**	**3,804,480**	**1,306,205**	**5,110,685**

In Rayong province, there were 20,020 registered migrants in the year 2010 but there were 17,267 migrants who got physical checkup and purchased health insurance. After high cost and management cost deduction, the income for Rayong province was 21,411,080 Bath, 15,782,038 Bath was allocated for hospitals medical services, the allocation for health promotion and disease prevention activities in hospitals was 2,845,602 Bath, the allocation for health promotion and disease prevention activities in provincial health office was 711,400 Bath and the allocation for management was 2,072,040 Bath as shown in table 4.41

Table 4.41 Health checkup and Health insurance fee and resource allocation in Rayong, 2010

Hospital	Physical Checkup/ insure migrants	Allocation for Hospitals			Allocation for Provincial Health office		
		Medical Services (Bath)	Health promotion/Disease prevention (Bath)	Total hospital income	Management (Bath)	Health promotion/Disease prevention (Bath)	Total
Rayong	7,288	6,661,232	1,201,062.40	7,862,294.40	874,560	300,265.60	1,174,825.60
Glang	3,658	3,343,412	602,838.40	3,946,250.40	438,960	150,709.60	589,669.60
Bankai	1,657	1,514,498	273,073.60	1,787,571.60	198,840	68,268.40	267,108.40
Banchang	714	652,596	117,667.20	770,263.20	85,680	29,416.80	115,096.80
Pluakdang	1,252	1,144,328	206,329.60	1,350,657.60	150,240	51,582.40	201,822.40
Wanjan	635	580,390	104,648.00	685,038.00	76,200	26,162.00	102,362.00
Koachamou	208	190,112	34,278.40	224,390.40	24,960	8,569.60	33,529.60
Maptaput	1,073	980,722	176,830.40	1,157,552.40	128,760	44,207.60	172,967.60
Nikompattana	782	714,748	128,873.60	843,621.60	93,840.00	32,218.40	126,058.40
Total	17,267	15,782,038	2,845,602	18,627,640	2,072,040	711,400	2,783,440

In Samutsakon province, there were 155,599 registered migrants who got physical checkup and purchased health insurance in the year 2009. After high cost and management cost deduction, the income for Samutsakon province was 192,942,760.00 Bath, 142,217,486 Bath was allocated for hospitals medical services, the allocation for health promotion and disease prevention activities in hospitals was 25,642,715.20 Bath, which Sriwichai 5 private hospital got the biggest share, the allocation for health promotion and disease prevention activities in provincial health office was 6,410,678.80 Bath and the allocation for management was 18,671,880 Bath as shown in table 4.42

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

Hospital	Physical Checkup/ insure migrants	Allocation for Hospitals			Allocation for Provincial Health office		
		Medical Services (Bath)	Health promotion/Disease prevention (Bath)	Total hospital income	Management (Bath)	Health promotion/Disease prevention (Bath)	Total
Samutsakon	53,926	49,288,364	8,887,004.80	58,175,368.80	6,471,120	2,221,751.20	8,692,871.20
Sriwichai 5	79,463	72,629,182	13,095,502.40	85,724,684.40	9,535,560	3,273,875.60	12,809,435.60
Banpaew	2,287	2,090,318	376,897.60	2,467,215.60	274,440	94,224.40	368,664.40
Kratumban	19,923	18,209,622	3,283,310.40	21,492,932.40	2,390,760	820,827.60	3,211,587.60
Total	155,599	142,217,486	25,642,715.20	167,860,201.20	18,671,880	6,410,678.80	25,082,558.80

In Samutsakon province, there were 126,830 registered migrants who got physical checkup and purchased health insurance in the year 2010. After high cost and management cost deduction, the income for Samutsakon province was 157,269,200 Bath, 115,922,620 Bath was allocated for hospitals medical services, the allocation for health promotion and disease prevention activities in hospitals was 20,901,584 Bath, which Sriwichai 5 private hospital got the biggest share, the allocation for health promotion and disease prevention activities in provincial health office was 5,225,396 Bath and the allocation for management was 15,219,600 Bath as shown in table 4.43

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

Hospital	Physical Checkup/ insure migrants	Allocation for Hospitals			Allocation for Provincial Health office		
		Medical Services (Bath)	Health promotion/Disease prevention (Bath)	Total hospital income	Management (Bath)	Health promotion/Disease prevention (Bath)	Total
Samutsakon	48,223	44,075,822	7,947,150.40	52,022,972.40	5,786,760	1,986,787.60	7,773,547.60
Sriwichai 5	59,322	54,220,308	9,776,265.60	63,996,573.60	7,118,640	2,444,066.40	9,562,706.40
Banpaew	2,019	1,845,366	332,731.20	2,178,097.20	242,280	83,182.80	325,462.80
Kratumban	17,266	15,781,124	2,845,436.80	18,626,560.80	2,071,920	711,359.20	2,783,279.20
Total	126,830	115,922,620	20,901,584.00	136,824,204.00	15,219,600	5,225,396.00	20,444,996.00

6.2 Medical Service and hospitals expenditure for migrants in selected hospitals

There were 782 registered migrant workers insured at Nikompattana hospital in the year 2010. The hospital health insurance income was 843,621.60 Bath, but the hospital provided medical services for 1,973 registered and unregistered migrant visits. The hospital expenditure was 883,602.00 Bath as shown in table 4.42, if the unregistered migrant didn't pay for the medical services the hospital health insurance income could not covered this expenditure.

Table 4.44 Medical Service and hospitals expenditure for migrants in Nikompattana hospital, 2010

Medical Services for	Hospital Visits	Expenditure
Cambodian	1,159	566,425.00
Myanmarese	659	254,608.00
Cambodian Kao Kong	6	2,248.00
Loas	149	60,321.00
Total	**1,973**	**883,602.00**

There were 685 registered migrant workers insured at Wangjan hospital in the year 2010. The hospital health insurance income was 685,038 Bath, but the hospital provided medical services for 2,220 registered and unregistered migrant visits. The hospital expenditure was 752,744 Bath, but only 449 visits

were the registered migrant worker utilization and caused hospital expense about 137,957 Bath as shown in table 4.45.

Table 4.45 Medical Service and hospitals expenditure for migrants in Wangjan hospital, 2010

Medical Services for	Wangjan Medical Services Provision			
	Registered Migrants (Visits)	Expenditure for Registered Migrants (Bath)	Total Migrants (Visits)	Total Expenditure for Migrants (Bath)
Cambodian	224	66,540.00	1,023	358,604.00
Myanmarese	148	39,587.00	486	182,753.00
Cambodian Koa Kong	1	50.00	20	3,647.00
Loas	76	31,780.00	691	207,740.00
Total	**449**	**137,957**	**2,220**	**752,744**

All hospitals in Samutsakon province provided medical services for migrants 104,785 OPD visits in the year 2009 (287 visits/day) and increased to 140,673 OPD visits (385 visits/day) in the year 2010. There were 5,831 IPD admission (18,400 hospital days) in the year 2009 and increased to 6,349 IPD admission (28,248 hospital days) as shown in table 4.46

Table 4.46 Medical Service for migrants in Samutsakon province, 2010

Year	OPD (Visits)	OPD Visits/day	Hospital admission	Hospital days
2009	104,785	287	5,831	18,400
2010	140,673	385	6,349	28,248

Samutsakon hospital medical services expenditure in the year 2009 was 19,674,669 Bath for registered migrant and 6,061,986 Bath for the unregistered migrant who couldn't pay for the medical services so the total expenditure for providing medical services to migrants was 25,736,655 Bath.

Kratumban hospital medical services expenditure in the year 2009 was 3,131,405 Bath for registered migrant and 2,378,848 Bath for the unregistered migrant who couldn't pay for the medical services so the total expenditure for providing medical services to migrants was 5,510,253 Bath.

The Banpaew hospital expenditure for registered migrants was 828,658 Bath and Sriwichai 5 hospital was 42,662,233 Bath. So the Samutsakon total expenditure for registered and unregistered migrants was 74,737,799 Bath as shown in table 4.47

Table 4.47 Hospitals expenditure for migrants medical services in Samusakon province, 2009

Hospitals	(1) Expenditure for registered Migrants (Bath)	(2) Expenditure for unregistered Migrants and couldn't pay (Bath)	(3=1+2) (Bath)	(4) Unregistered Migrants paid for medical services (Bath)
Samutsakon	19,674,669	6,061,986	25,736,655	1,778,928
Kratumban	3,131,405	2,378,848	5,510,253	550,080
Banpaew	828,658	0	828,658	1,736,791
Sriwichai 5	42,616,854	45,379	42,662,233	1,026,442
Total	66,251,586	8,486,213	74,737,799	5,092,241

Samutsakon hospital medical services expenditure in the year 2010 was 14,567,908 Bath for registered migrant and 1,214,909 Bath for the unregistered migrant who couldn't pay for the medical services so the total expenditure for providing medical services to migrants was 15,782,817 Bath.

Kratumban hospital medical services expenditure in the year 2009 was 2,787,201 Bath for registered migrant and 1,297,777 Bath for the unregistered migrant who couldn't pay for the medical services so the total expenditure for providing medical services to migrants was 4,084,978 Bath.

The Banpaew hospital expenditure for registered migrants was 962,722 Bath and Sriwichai 5 hospital was 65,089,190 Bath. So the Samutsakon total expenditure for registered and unregistered migrants was 85,919,707 Bath as shown in table 4.48

Table 4.48 Hospitals expenditure for migrants medical services in Samusakon province, 2010

Hospitals	(1) Expenditure for registered Migrants (Bath)	(2) Expenditure for unregistered Migrants and couldn't pay (Bath)	(3=1+2) (Bath)	(4) Unregistered Migrants paid for medical services (Bath)
Samutsakon	14,567,908	1,214,909	15,782,817	17,396,501
Kratumban	2,787,201	1,297,777	4,084,978	798,123
Banpaew	962,722	0	962,722	1,955,267
Sriwichai 5	64,827,882	261,308	65,089,190	706,279
Total	83,145,713	2,773,994	65,089,190	20,856,170

7 Focus Group and in-depth interview result

The provincial health administrators, migrant health personals, migrant health workers, provincial labor administrators, polices and employer focus group and interview

7.1 Medical Service area for migrants in the hospital

The hospital services area were limited in the confined space for migrants because of the unexpected services for the unplanned group of people. Rayong hospital tried to solve problems by arranging OPD at the four corners of the Rayong city for Thai people as the gate keeper but couldn't provide medical services for the migrants because of the limited number of migrant health workers and foreign documents, so they separated ANC clinic for migrants in the main hospital because they could pool migrant health workers at the migrant ANC clinic for communication and provided health literacy.

Anyway, there were a lot of complaints from Thai people who needed to visit the four corners OPD before they could get services at the Rayong hospital

In Samutsakon hospital, there were 7,500 admissions and 200 OPD visits per day from migrants in the year 2010. The Myanmarese migrant OPD visits were 10.8% of the total OPD visits. The IPD especially for labor there were averaged 3,000 migrant cases per year that impact to ANC, labor room and also the obstetrics ward. These caused irritability for Thai people who seeked medical services and were impacted by the migrants even the local newspaper and monks mentioned this in their speech that the Thai people got poorer services than the migrant in hospitals.

7.2 Communication and the role of Migrant health workers

The migrant health workers were the migrants who could communicate with Thai language and also could read and write the foreign language, they should be more educated than average migrants. Their roles included interpreter, communicator, primary care health councilors after training programs so they could support hospital activities, health promotion, disease prevention, follow up and also rehabilitation and also HIV counselors and VCT providers in communities.

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, by their own revenue, but the Glang hospital, Rayong local authorities could hire migrant health workers who were Thai and could speak Cambodian and Myanmarese by the provincial health office revenue so there was no communication problem in Rayong.

The migrant health workers could effectively support health service providers and provincial health office for public health activities, especially the Thai migrant health workers, for example when there was found that the elephantiasis test positive in one of the migrant and the hospital, the employer couldn’t find him, the Thai migrant health workers could find him in his community and provided the treatment. Anyway, the migrant health workers mentioned that their roles were too overload , to take care the Thai and migrants in communities, translators, communicators, so they were exhausted.

There were only 3 migrant health workers in Rayong hospital, 2 Cambodians and 1 Myanmarese. They followed the migrant cases in communities by mobile telephone to their networks in each communities but most of the migrants frequently changed their numbers.

In Samutsakon province, there were many courses for Thai language among migrants so they could speak and understand Thai, some of them could clearly sing the national Thai song. Most of hospitals in this province hired the migrant health workers for communication and also supporting public health activities but Banpaew hospital, the hospital migrant health workers already resigned. The amount of migrant health worker in Samutsakon province was shown in table 4.49

Table 4.49 The migrant health workers in Samutsakon province according to hospitals

Hospital	Migrant health workers (person)
Samutsakon	18
kratumban	1
Banpaew	-
Sriwichai 5	9
รวม	**28**

The ministry of labor representative in Samutsakon province commented that the migrants' Thai literacy would be security issue because they could understand the Thai employers discussion but the employers didn't understand their employees. Anyway, there were many Myanmarese language courses in Samutsakon so the Thai people who needed to work with migrants could communicate with them even the community college started to teach other languages.

The migrant health workers in Samutsakon worked as the voluntary health workers, progressive public health program in communities for example, home visit, interpreters, co-operation and work together with Thai voluntary health workers. Their salary was very cost-effective. The provincial labor authority translated the regulation so the migrant health workers would be under 19th categories according to ministry of labor regulation, then every public organization such as provincial court, schools requested for the migrant workers.

7.3 Health promotion and Disease prevention

Disease prevention programs were very important for the migrants because they might carry contagious diseases from the original countries but most of these diseases could be controlled, another

important activities were followed the infected cases to get the treatments so they couldn't disseminate to other migrants and also Thai people.

In Rayong province, the health promotion and disease prevention activities for migrants were priorities, they co-operated with the NGO network so they could refer cases to each other. Anyway, there were problems about the movement migrants especially the temporary employee for temporary jobs from other provinces.

So there was an cholera epidemic incident on December 2009, the 30-40 fishing migrant workers from Pattani province were source of infection, there were also 2 Thai workers in that boat and there were 2 death in the boat before arrived Rayong because of no treatment on the boat. When they arrived, the cholera infection severely disseminated so they could found the bacteria in Rayong river. The Epidemic Bureau, ministry of public health was needed to control the infection. During the Flu 2009 epidemic in Thailand, there was epidemic in Rayong too, most of the cases were pupils and workers. There were some mortality in migrants from Malaria in Rayong province.

The health personals in Samutsakon province informed that the migrants behaviors were definitely different from Thai people, for example, they were never missed the appointment for ANC, they believed the hospital staffs and their migrant health worker very much, they also supported each other for warning not to forget the appointment from the hospital. The pulmonary Tuberculosis migrants were also never missed the appointment to get their drugs, they supported each other and these behaviors applied to the Well Baby Clinic too. The employers and the migrants themself tried to support the pulmonary Tuberculosis migrant cases to get full treatment compared to Thai cases those always lost follow up even the migrant cases got drugs allergy symptoms such as jaundice they didn't stop medication but the Thai cases would not tolerate with even small symptoms from Tuberculosis medication. Anyway, there were problems in the moving migrants to another employers and the new employers didn't realize their infected migrant workers.

The Samutsakon provincial health office delegated health promotion and disease prevention activities responsibility into each area for each hospital. The Samutsakon hospital took care the

Samutsakon Meung district except Tasai district which were took care by Sriwichai 5 hospital, the Kratumban hospital took care the Kratumban district and Banpaew hospital took care the Banpaew district.

The Samutsakon provincial labor authority proposed that they would like to help in case the infected migrants need continuous medication if the provincial health office informed them so they could support the migrants for continuous medication. The employers representative proposed that the migrants shouldn't change their employers until 1 year because they already paid for the migrants health checkup, health insurance and also work permit fee.

The Sriwichai 5 and Samutsakon hospital provided activities at the workplaces, they provided knowledge about the common diseases among migrants and the employers could request for supporting to the 2 hospitals, in communities the hospitals provided knowledge and vaccination for the migrants. There was a cholera epidemic incident in the year 2010, the moving infected migrant workers from other province arrived Samutsakon for the shrimp catching temporary job, mostly they arrived at night and worked until morning then moved to other workplace, most of them were unregistered, so it was very difficult to control and created the surveillance system for these moving migrants.

7.4 Referral system for migrants

Rayong province set the criteria for within province referral migrant cases and payment rate 700 Bath per OPD referral visit and 9,000 Bath per RW referral admission. But the National Health Security Office pay rate only 7,300 Bath for Universal coverage referral admission. In case of across province referral migrant cases, Rayong province would pay as the referral hospital's price, mostly they refered migrant cases 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 incompletely claim.

Samutsakon province referred migrant cases to private hospitals or Children National institute without problem, in case of the moving migrants to another district they set the system to change contracted hospital into another district according to the migrants. The migrant referral system was the

same as Thai referral system, the contracted hospital took responsibility to pay for the treatment in the referral hospitals according to their prices. For the high cost cases, they 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 personals commented that the 1,300 Bath health insurance fee and 600 Bath 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 the unregistered migrants who burdened the health service system and they were more severe ill and needed more expense compared to the registered migrant worker.

There were accidents at Rayong and the migrants, who registered and insured from private hospital, got injuries and were sent to Rayong hospital. When Rayong hospital claimed for the medical services to the contracted hospital, the contract hospital didn't pay.

The Rayong social security organization informed that there were more national approved migrant workers and also the legally imported migrant according to the MOU. These 2 groups of migrant workers should be under the social security system except for the fishing and agriculture industries.

The employer representatives weren't willing to co-operate with social security system because of the problems of the migrants and also the social security system. The migrants problems were moving and changing employers and the social security system problems included too complicated system, monthly deductible the migrant salary and sent to social security office, the benefit packages needed formal request. The employers would like to support compulsory health insurance by ministry of public health, even for the unregistered migrants, who didn't register, should be insured under this scheme. Some employers pooled the 1,300 Bath per migrant together to pay for the unregistered migrants medical services' bill when the hospital didn't provide health insurance for the unregistered migrants.

The Samutsakon hospital's personal informed that the complicated migrant cases, labor cases preferred to insure at Samutsakon hospital. The normal labor costed 3,000 Bath, so the 1,300 Bath health

insurance fee was very worth. The chronic ill migrants also preferred to insure at Samutsakon. Anyway, the 1,300 Bath health insurance fee was adequate if there was not include medical services for unregistered migrants who couldn't afford to pay.

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

The migrants believed that the labor in Thailand was more safety to mother and child than their own countries so they planned to have 2 children during working in Thailand.

7.6 The most favorable health insurance scheme for the hospitals

Rayong provincial health office preferred social security scheme because of the less frequent visits compare to other scheme then the compulsory health insurance for migrant workers, the universal coverage of health care and civil servant medical benefit scheme were the worst system because they paid under the medical services cost and the hospitals lost. The unregistered migrants were another caused of problem to the hospitals.

The social security officer informed that most of the social security beneficiaries at Rayong province also purchased insurance from the private hospitals so they preferred to seek medical services from the private hospitals more than contracted hospitals under social security system so there were less cases than average.

Samutsakon province preferred compulsory health insurance for migrants because of the income was higher than the cost, then social security system. Anyway, some private hospitals who focused on social security system started to loss. The civil servant medical benefit scheme was worse than the first 2 schemes but better than universal coverage of health care scheme that caused all hospitals lost.

Both Rayong and Samutsakon would like to maintain the compulsory health insurance for migrants (1,300 Bath for health insurance fee and 600 Bath for health checkup fee) because of better management, better benefit package and cost covered. The scheme also provided flexible health promotion and disease

prevention program and flexible resources allocation according to the provincial contexts. The scheme also provided migrant health workers who could proactive provided health promotion and disease prevention services in the migrant communities and also at the workplaces.

Most of the group believed that the health insurance fee was adequate and could cover some part of unregistered migrants.

7.7 Resource allocation for health promotion and disease prevention

Rayong provincial health office delegated 80% (164.80 Bath) of responsibility and prevention and promotion part (206 Bath) to the hospitals, they kept 20% (41.20 Bath) and management part (120 Bath) at the provincial health office.

Samutsakon provincial health office delegated 95% of prevention and promotion part to the hospitals and kept 5% of 206 Bath and management part (120 Bath) at the provincial health office.

7.8 Migrant problems and System management

The security organizations, such as the national police, had separated security policies without integration with other ministries. The police policy included 2600 migrants arrested within 3 months at Samutsakon province, and also other target for other province. In some province, the polices waited to arrest at the front of the hospital for the ill migrants who seek medical services so they could meet their target.

The provincial health office structure problem was no formal structure to take responsibility of this important problem eventhrough there were more and more migrants and more and more risks for Thai people.

The inadequate of ARV provision for the HIV infected migrants was another problem, and also there was no budget support for these registered and unregistered migrants. So the hospitals bore the burden or else the HIV infected migrants could access to the ARV.

There was complete HIV/AIDS information at provincial but they sent reports to different central organization for example the 506/1 report was sent to Epidemic Bureau, the CD4 results reported to AIDS TB and STIs Bureau, the Universal coverage of health care scheme HIV cases reported to National Health Security Office but the Social security beneficiary HIV cases reported to Social security organization.

Chapter 5

Discussion and Recommendation

1. Migrant knowledge and understanding in health insurance benefits,rights.

1.1 Knowledge and understanding gap

There was evidence demonstrated by JunthaiTragoondee [5], UraiwanTantariya[4], Chirawat Nijnate[3] and also Samrit Srithamrongsawat[7] that there was knowledge and understanding gap among migrant workers and families in these areas included the following.

1.1.1 Family planning, reproductive health, women health

1.1.2 General Knowledge, self care

1.1.3 Human trafficking, Violence

1.1.4 Human right to access and treat equally at the health services providers

These knowledge gap could impacted on the migrant workers and families health status as the evidence showed their high prevalence rate in many communicable diseases and behavioral induced diseases.

1.2 There were evidences proved by Kritiya Archavanichakul, et al[22] ApichatGamrad-ritirong and Watinee Boonchalaksi [28] and also the IOM [41] that the health risk behaviors and knowledge gap could be filled by improved communication and appropriate education providing to the migrant workers and families. So they could change their lifestyle and improve healthy behavior such as condom usage and safe sex, etc.

1.3 This study found that the registered migrant workers at Rayong and Samutsakon province realized the medical services benefit as high as 92.59% and 87.63% and 96.49% and 95.80% of them understood that they needed to bring their health card to identify themselves at the hospitals. Anyway, 21.36% and 25.16% of them didn't know the accident and emergency benefit and 30.19% and 27.88% of these group of people didn't know the health promotion and disease prevention benefit, which were very important to reduce the health risks and decrease communicable diseases dissemination, in Rayong and Samutsakon province respectively.

Even 79.11% and 75.61% of the unregistered migrants in Rayong and Samutsakon province knew the medical services benefit. In rayong province 65.41% of the unregistered migrants knew the accident and emergency benefit, and 61.64% of them knew the health promotion and disease prevention benefit compared to Samutsakon province, only 47.97% knew the accident and emergency benefit, and 37.39% of them knew the health promotion and disease prevention benefit

1.4 The migrant workers and families' communication problem were decreased because of more than half of the them in this study could understand and speak Thai. This study also showed that the average duration of migrant workers and families to 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 the migrants' Thai literacy were improved in Rayong and Samutsakon province. **The hospitals and provincial health offices still hired the migrant health workers by the health insurance fee for co-ordination**, health communication and also supporting public health activities in their communities and they effectively worked as one of the public health team. So the NGOs were no need to hired the migrant health workers for the hospitals and the provincial health offices in these provinces.

1.6 The information from the focus group at Rayong and SamutSakon province supported the researches of Kritiya Archavanichakul et al, Aphichat Chamratrithirong and Watinee Boonchaluksi and also IOM, those reported that the migrants' knowledge gaps and health risk behaviors could improved which were different from others reports. This study showed that the migrants' health behaviors were better than Thai people especially pregnant migrants who needed to attend ANC, they attended regularly and also pulmonary Tuberculosis cases who needed continuous medication, they were never missed their follow up, even though they had jaundice or others drug reaction they didn't stop their medication. The migrants also supported and warned each other to follow up for ANC and get medication as their appointment.

2 Health and medical services seeking behavior.

2.1 Sompong SaKaeo in SamutSakon[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 attitude caused obstacle as the ill migrants rarely visited to health service delivery unit, mostly they were self-reliance by purchasing drugs from drug store until their symptoms were severe, then they visited private clinics, if not improved then the public health delivery units such as health centers and hospitals.

2.1.2 The main obstacles to prevent accessibility to the public hospital were unfamiliar, fear, the unrealized of their health insurance right, lack of Thai literacy

2.1.3 Long distance contracted hospital from workplace and their home, too expensive travel cost.

2.1.4 Extra cost of Medical services and Health Services, Need Questionaire result

This study supported Sompong SaKaeo and Busarat Kanchanadit's finding that the 56.11% of registered migrant workers and 59.94% of unregistered migrants in Rayong province would purchase drugs from pharmacies for minor illness. In Samutsakon 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 convenient access. But when they were serious sick, the health seeking behavior changed, 73.51% and 51.15% of the registered migrant workers in Rayong and Samutsakon province would visit the hospitals but only 22.60% and 29.70% of the unregistered migrants in Rayong and Samutsakon province would visit the hospitals

Anyway, this study showed evidence that was different from the other researches about the obstacle of the migrants' health and medical seeking behaviors about the Thai literacy, too expensive travel cost and also the migrants' attitude. This study found that most of the migrants could understand and speak Thai, most of them knew their right as the insurance card holders that they could access to the hospital for medical services with just 30 Bath payment and the hospitals also provided the migrant health workers for recommendation and health communication with them. The study also showed that the average cost of vehicle for hospital access of the registered and unregistered migrants were 70.11 Bath per

visit and 64.10 Bath per visit in Rayong province and 42.11 Bath per visit and 56.50 Bath per visit in Samutsakon province, those were within limited to pay without trouble.

2.2 Another new finding of this study that was different from other studies was the health care worker's discrimination and their negative attitude. The result of focus group showed that in Rayong province, Rayong hospital separated migrants' ANC from the Thai so they could provide migrant health workers and also foreign language documents and signs to the migrants, the migrant could access to Rayong hospital directly compared to Thai patients who need to be screened at the 4 corners clinics before visiting to Rayong hospital. Thai people were not happy with this discrimination, they understood that the migrants got better services. In Samutsakon 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 Samutsakon province found that most of the hospitals would like to provide medical services to the migrants then social security beneficiaries because these systems paid to the hospital adequately compared to the civil servant medical benefit scheme and universal coverage of health care scheme which were not enough payment to the hospitals. Anyway, for the migrants health insurance, everyone agreed that the compulsory health insurance for migrants from ministry of public health was appropriate.

2.4 The Security Government Officers also were the main obstacle for health and medical seeking of the migrants as found in other studies. The focus group in Rayong and Samutsakon province showed that most of the migrants and families familiar with being coerced for money by the policemen sometime during illness on the way to the hospitals, the security policy for example national police office's policy designated amount of the arrested migrants as the goal for each month, the goal would be changed month by month for each district in Rayong province and the fixed goal as 2,600 arrested migrants per 3 months in Samutsakon province. If the actual arrested migrants were under the goal then the polices would be wait for the ill migrants near the hospitals.

3 Health and medical utilization patterns and also the different 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/AIDS than other groups of patients. This study found that there were 146 HIV/AIDS 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 compared to 1.447 visits/migrant and 1.618 visits/migrant in Samutsakon province.

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

4 Financial management model and health services providing by provincial health offices and hospitals, recommendation for 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 Samutsakon 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 Samutsakon 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 mostly they were unregistered, the hospital expenditure was 883,602 Baht, so the health insurance fee nearly covered medical services for registered and unregistered migrants. Anyway, the study showed that only 5.48% of the unregistered migrants in Rayon province could pay partly 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 worker so the expense was 137,957 Bath and 2,220 visits of unregistered migrants so the expense was 752,744 Baht but most of the uregistered migrants could pay out of pocket.

Every hospitals In Samutsakon province, the health insurance fee could cover all cost to provide medical services for registered migrant workers and unregistered migrants except Sriwichai 5 hospital that reported 64,827,882 Baht expenditure in the year 2010 increased from 42,616,854 Bath in the year 2009 even though the registered migrants reduced from 79,463, so the hospital got 85,724,684.40 Baht as health insurance fee, in the year 2009 to 59,322, so the hospital got 63,996,573.60 Baht as health insurance fee, in the year 2010. Anyway, the Sriwichai 5 just lost 831,308.40 Baht in the year 2010 but gain 43,107,830.40 Baht in the year 2009 and also claimed the high cost medical services for the registered migrants to the insurance division, ministry of public health and got paid as the second highest of hospital who got paid from the division.

This study concluded that the health insurance fee for registered migrant workers could cover the cost of medical services for registered and unregistered migrants. Anyway, the hospitals who provided health and medical services for migrants would be more workload burden but not financial burden.

4.3 This study found that the trend of the migrants and families would move into these direction.

4.3.1The Myanmarese will increase but the Loasese and Cambodian will decrease or be stable because of the rapid GDP growth in these 2 countries compared to Myanmar. And the political conflict between Thailand and Cambodia effected the amount of Cambodian migrant in Thailand.

4.3.2 The registered migrant workers were motivated then were forced to be nationality approved or legally imported according to the MOU by the Thai government policy, so the registered migrant worker would be changed into the social security scheme.

4.3.3 The unregistered migrants in Rayong and Samutsakon were increased. This study showed that the registered migrant worker were decreased a lot but the nationality approved migrants and legally imported migrants according to MOU were not increased even though the labor requirement in these 2 province would be higher and there were evidences showed that there were more unregistered migrants visited for medical services at every hospitals in these 2 provinces, so there were more unregistered migrants.

4.4 There were 2 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, the legal migrant worker who was employee of the legal formal employer need to be under 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 structure and also a lot of financial fund.

The problems were the benefits related to the contribution period so there were some gaps for each benefits during there not fully contribution, and also the prevention and promotion were not included in the medical services benefit. There were long term benefits that the short stay migrants wouldn’t get benefit and the complicated and too many steps to request for benefit was the big obstacle.

The most major problem was most of the migrant workers work in the informal sectors so they was not covered by the social security scheme.

4.4.2 Compulsory health insurance by MoPH according to the carbinet resolution year by year.

The advantage of this scheme included that this scheme was flexible and adjustable according to the provincial context, most of the participant were familiar with the scheme for example the registered migrants, hospitals, provincial health office, NGO, etc. The hospitals and the provincial health offices were autonomy to manage the system finance. The scheme also included health promotion and disease prevention.

The problems included the financial burden at the unregistered migrants over number. The benefit was not cover the work related disability and death, there was no compensation for unemployed compensation and also other long term and cash benefit. And the scheme depended on the cabinet resolution year by year.

4.4.3 Samrit Srithamrongsawat, 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 equally services, the scheme got government budget so the migrants and families had no need to pay but the government would bear the burden.

Anyway, there was no definition for individual by the national health insurance act 2003 so the application of this scheme to cover the migrants need to identify 'individual' by other laws, but all of other laws didn't endorse individual status of other nationality and non-Thai and the budget bureau didn't want to bear burden of the migrants and the scheme was rigid and inflexible compared to the compulsory health insurance by MoPH. So it's 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 desirable health insurance and health service system for migrants and families consisted of the following characteristic.

- There would be sustainable long term policy and management.
- The comprehensive health care financial system which could cover registered and unregistered migrant workers and families.
- Improve the compulsory health insurance by MoPH to be more coverage.

- Improve the information system to be more integrated and sharing among network.
- The work permission fee, and other fee should not be too expensive for the 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 adjusted according to the provincial context.
- The health and medical services should include the family planning and also sexual and reproductive health.
- The financial management guideline should be provided to the provincial health office.
- The migrants' individual, families and communities self care and participation should be promoted.
- Multisectoral, multiministry approached, private and public participation and also migrants and family should be integrated and co-operation.
- Update the regulation and adjusted to each provincial context and also promote law enforcement.

And they recommended to avoid these following situation.

- Security focused policy.
- Increase fee such as registration fee, work permission fee, health insurance and health checkup fee.
- Increase steps and make too complicated process or obstacle to access.
- The employers deny to co-operate

4.6 The information from focus group in this study showed that most of the provincial health offices, hospitals, employers, 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 should be considered

among the compulsory health insurance scheme by MopH, the social security scheme and the universal coverage of health care scheme.

After compared the three schemes, the compulsory health insurance by MoPH was more flexible and opened for the provincial health office and also hospitals to adjusted according to the provincial context so the scheme could be adjusted to meet the desirable model as shown in table 5.1

Table 5.1 The desirable model compared among 3 possible migrant health insurance.

Objective of desirable model	Universal coverage of health care scheme	Social security scheme	Compulsory health insurance scheme
There would be sustainable long term policy and management.	No	Yes	Yes
The comprehensive health care financial system which could cover registered and unregistered migrant workers and families.	No	No	Possible
Improve the compulsory health insurance by MoPH to be more coverage.	No	No	Yes
Improve the information system to be more integrated and sharing among network.	No	No	Possible
The work permission fee, and other fee should not be too expensive for the migrants and families.	No	No	Less Burden
The registration, the work permission and also the health checkup and health insurance should be opened for access throughout the year.	No	Yes	Possible
The system should be flexible to adjusted according to the provincial context.	No	No	Yes
The health and medical services should include the family planning and also sexual and reproductive health.	Yes	No	Yes

Objective of desirable model	Universal coverage of health care scheme	Social security scheme	Compulsory health insurance scheme
The financial management guideline should be provided to the provincial health office.	No	No	Yes
The migrants' individual, families and communities self care and participation should be promoted.	Possible	No	Yes
Multisectoral, multiministry approached, private and public participation and also migrants and family should be integrated and co-operation.	No	No	Possible
Update the regulation and adjusted to each provincial context and also promote law enforcement.	No	No	Possible

4.8 The undesirable characteristic of the desirable model should be prevented. After compared the three schemes, the compulsory health insurance by MoPH was more flexible and opened so the scheme could be adjusted to prevent the desirable characteristic as shown in table 5.2.

Table 5.2 The undesirable characteristic of the migrant health insurance model

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

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 the voluntary employer to support and participate the health promotion and disease prevention for migrant workers and families, the result of focus group showed that the employers were willing to co-operate and support the treatment, follow up of the sick migrants who need for regular treatment. The guideline and information sharing should be done and also could reduce the moving migrants problem.

4.9.2 The migrant health workers should start their role since health checkup so they can provide information, knowledge and also improve health literacy of the registered migrant workers to prevent the preventable 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 accessibility of HIV/AIDS infected migrants to ARV, expense and financial possibility to extend the accessibility.

5.1.1 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 Samutsakon province, who didn't get consultation and VCT. Most of the migrants, 96.46% and 95.52% of the registered and unregistered in Rayong province and also 85.10% of the registered but only 15.79% of unregistered in Samutsakon province, who got consultation and VCT, consented to HIV/AIDS blood test so the blood test positive migrants had the chance to access to ARV drugs.

There was no chance to get the ARV drugs for the migrants who couldn't access to consultation and VCT, so there was no blood test, unless the signs and symptoms of HIV infection were prominent or there was complication.

5.2 The migrants' burden of ARV drugs expense was demonstrated in the study. 68.79% of the

HIV/AIDS infected migrants (97), in Rayong province, got ARV drugs from NAPHA project but 31.21% of them (44) paid out of pocket for ARV drugs expense. In Samutsakon province, 63% of the HIV/AIDS infected migrants (63) got ARV drugs from NAPHA project but 18% of them (18) didn't got treatment and 19% of them (19) paid out of pocket for ARV drugs expense. So the information from AIDs TB and STIs Bureau was different from Rayong and Samutsakon province and NAPHA project still couldn't provide ARV drugs for all HIV/AIDS infected migrants who needed them.

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

- The integrated information system should be developed, linked and shared among the ministerial and provincial level.
- The consultation and VCT should be promoted to increase the chance for HIV blood test and would increase the chance to access for ARV drugs. At this moment there are the gaps in Rayong and Samutsakon province that can be improved. This study showed that the migrant health workers could provide effective and efficient consultation and VCT so the NGO and migrant health workers should be strengthening to fill these gaps.
- Because of the inadequate for ARV drugs provided by NAPHA project, and this study found that the HIV/AIDS infected migrants in Rayong province bore burden of the ARV drugs expense by themselves and the unregistered migrant in Rayong and Samutsakon could pay out of pocket for their own medical services expense and very few paid partially so one of the possibility to increase access for ARV drugs among HIV/AIDS infected migrants is establishment the effective and efficient system to sharing risk and pooling resources among the migrants to support ARV drugs for the infected migrants.

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Appendix

แบบสัมภาษณ์ชุดที่ 1

การสอบถามแรงงานข้ามชาติ (พม่า/กัมพูชา)

(รหัสจังหวัด) (รหัสอำเภอ)(รหัสโรงพยาบาล) [ ][ ] [ ][ ][ ] [ ][ ][ ]

เลขที่แบบสัมภา [ ][ ][ ]

แบบ A สำหรับแรงงานข้ามชาติที่มีใบอนุญาตทำงาน

โปรดเติมคำลงในช่องว่างหรือใส่เครื่องห / ลงในช่องที่ตรงกับความเป็นจริงของผู้ตอบ

ข้อมูลทั่วไป

1.ผู้ให้สัมภาษณ์ ชื่อ นามสกุล.....

2.เพศ ❑ ชาย ❑ หญิง อายุ ..... ปี

3.สัญชาติ ❑พม่า ❑กัมพูชา

4.การใช้ภาษาของตนเอง ❑อ่านไม่ออกเขียนไม่ได้ ❑ อ่านออก ❑ เขียนได้

5.การใช้ภาษาไทยในการพูด ❑ พูดไม่ได้ ❑ พูดได้

การฟัง ❑ ฟังไม่รู้เรื่อง ❑ฟังรู้เรื่อง

6.ท่านทำงานอยู่ในประเทศไทยมากี่ปี? ❑1 ปี ❑2 ปี ❑3 ปี❑4 ปี ❑5 ปี ❑มากกว่า 5 ปีขึ้นไป

7.ที่พักอาศัย❑โรงงาน / บ้านนายจ้าง ❑ เช่าอยู่เอง ❑เช่าอยู่กับเพื่อน ❑เช่าอยู่กับญาติ

8.สมาชิกที่อาศัยอยู่ด้วยกัน(นับรวมตัวเองด้วย)……คน

9.สมาชิกที่อาศัยอยู่ด้วยกันมีบัตรประกันสุขภาพหรือไม่? ❑ มี …….. คน.❑ไม่มี …….คน

10.สมาชิกที่อาศัยอยู่ด้วยกันเกี่ยวข้องกับท่านโดยเป็น ❑พ่อ/แม่❑พี่/น้อง❑สามี/ภรรยา❑เพื่อน❑ญาติ

(ข้อ 10 ตอบได้มากกว่า 1 ข้อ)

ข้อมูลการทำงาน

11.ประเภทของการทำงานตามใบอนุญาตอยู่ในกลุ่มอาชีพใด? ระบุ……..

12.ปีที่ผ่านมา(พ.ศ.2553) ท่านย้ายงานมาแล้วกี่ครั้ง ❑ไม่เคยย้าย

❑เคยย้าย ❑ 1ครั้ง ❑ 2 ครั้ง ❑ 3 ครั้ง ❑ มากกว่า 3 ขึ้นไป

13.สาเหตุที่ท่านย้ายงานบ่อยๆเพราะ❑เงินเดือนน้อย ❑ นายจ้างเอาเปรียบ❑งานหนักมาก

14.ท่านได้รับค่าจ้างเดือนละเท่าไร? ระบุจำนวนเงิน……บาท

ข้อมูลด้านสุขภาพและพฤติกรรมการใช้บริการ

15. ก่อนรับใบอนุญาตทำงานครั้งนี้ ผลการตรวจสุขภาพของท่านเป็นอย่างไร?❑พบปกติ ❑พบโรคที่ต้องรักษา

16.ท่านมีโรคประจำตัวหรือไม่? ❑ไม่มี ❑ มี

ถ้ามีระบุโรค ❑ เบาหวาน❑ ความดันเลือดสูง ❑โรคหัวใจ ❑มะเร็ง ❑โรคปอด/หลอดลม❑โรคกระเพาะอาหาร/ลำไส้ ❑โรคระบบเลือด/น้ำเหลือง ❑โรคผิวหนัง ❑กระดูก/กล้ามเนื้อ/ประสาท ❑โรคจิต ❑ระบบอวัยวะสืบพันธุ์ ❑โรคเกี่ยวกับเพศสัมพันธุ์ ❑โรคไตและระบบปัสสาวะ❑โรคภูมิแพ้ (ข้อ16 ตอบได้หลายข้อ)

17.ในรอบปีที่ผ่านมา(2553)ท่านป่วยกี่ครั้ง? ❑ 1 ครั้ง ❑ 2 ครั้ง ❑3 ครั้ง❑4 ครั้ง ❑ 5 ครั้ง ❑มากกว่า 5 ครั้งขึ้นไป

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

❑ไม่เคย(ข้ามไปตอบข้อ 21)

❑ เคย (ถ้าเคยตอบข้อ19,20)

19.ในรอบปีที่ผ่านมาท่านไปตรวจและรักษาโรคกี่ครั้ง ❑1 ครั้ง ❑ 2 ครั้ง ❑3 ครั้ง❑4 ครั้ง ❑ 5 ครั้ง ❑ มากกว่า 5 ครั้งขึ้นไป

20.ในรอบปีที่ผ่านมาถ้าท่านเคยไปตรวจโรคที่? ❑โรงพยาบาลส่งเสริมสุขภาพตำบล (รพสต./สอ.) ❑คลีนิคเอกชน ❑โรงพยาบาลที่ประกันสุขภาพไว้ ❑โรงพยาบาลอื่นๆ (ข้อ 20 ตอบได้มากกว่า 1 คำตอบ)

21. เมื่อท่านไม่สบายเล็กน้อย ท่านตัดสินใจดูแลตนเองอย่างไรบ้าง?❑นอนพักเฉยๆ/รักษาตนเอง❑ซื้อยากินเอง ❑ไปหา พสต/อสต.❑โรงพยาบาลส่งเสริมสุขภาพตำบล (รพสต./สอ.) ❑ไปตรวจที่คลีนิคเอกชน ❑ไปที่ โรงพยาบาลที่ประกันสุขภาพไว้ ❑ ไปโรงพยาบาลอื่นๆ (ข้อ 21 ตอบได้มากกว่า 1 คำตอบ)

22.เมื่อท่านไม่สบายมาก ท่านตัดสินใจดูแลตนเองอย่างไรบ้าง?❑นอนพักเฉยๆ/รักษาตนเอง❑ซื้อยากินเอง ❑ ไปหาพสต./ อสต❑โรงพยาบาลส่งเสริมสุขภาพตำบล (รพสต./สอ.) ❑ไปตรวจที่คลีนิคเอกชน ❑ไปที่โรงพยาบาลที่ประกันสุขภาพไว้❑โรงพยาบาลอื่นๆ (ข้อ 22 ตอบได้มากกว่า 1 คำตอบ)

23.ยากินที่ได้มาจากโรงพยาบาล ท่านกินจนหมดหรือไม่?

❑ หมด (ถ้าหมดไปตอบข้อ 25) ❑ไม่หมด (ถ้าไม่หมดไปตอบข้อ 24)

24.สาเหตุที่กินยาไม่หมดเพราะ ❑ลืมกิน ❑คิดว่าโรคหายแล้ว ❑ได้ยามากเกินไป ❑กินแล้วไม่ดีขึ้น ❑แพ้ยา

25.ในรอบปีที่ผ่านมา ท่านเคยนอนรักษาตัวในโรงพยาบาล(IPD)หรือไม่?

❑ไม่เคย(ข้ามไปตอบข้อ 30)❑เคย (ถ้าเคยตอบข้อ 26,27,28,29)

26.ถ้าเคยนอนรักษาตัวในโรงพยาบาล ท่านนอนที่โรงพยาบาลกี่วัน? ระบุจำนวนที่นอน❑ 1 วัน❑ 2 วัน ❑3 วัน ❑4 วัน ❑ 5 วัน ❑ มากกว่า 5 วัน

27. การนอนรักษาตัวในโรงพยาบาลในครั้งนี้ ท่านทราบหรือไม่ว่าป่วยเป็นโรคอะไร? ❑ไม่ทราบ❑ทราบ

28. ท่านคิดว่าโรงพยาบาลรักษาโรคหายหรือไม่? ❑ไม่หาย ❑หาย

29. หลังออกจากโรงพยาบาล แพทย์ได้นัดหมายให้ไปตรวจโรคอีกหรือไม่❑ไม่ได้นัด ❑นัดให้ไปตรวจทุกอาทิตย์❑นัดไปตรวจทุกเดือน

30.ท่านรู้จักพนักงานสาธารณสุขต่างด้าว (พสต./อสต.)หรือไม่? ❑ไม่รู้จัก(ข้ามไปตอบข้อ 32) ❑ รู้จัก

31.พนักงานสาธารณสุขต่างด้าว (พสต./อสต.) ได้ช่วยเหลือท่านด้านสุขภาพหรือไม่อย่างไร?

❑แนะนำการป้องกันโรค❑ให้คำแนะนำการปฏิบัติตัวตอนป่วย ❑ช่วยพาโรงพยาบาล

❑เยี่ยมเมื่อเจ็บป่วย❑แนะนำการกินยา❑แนะนำไปตรวจตามนัด❑อื่นๆระบุ……..

(ข้อ 31ตอบได้มากกว่า 1 คำตอบ)

32.ท่านได้รับบริการให้คำปรึกษา (VCT)เพื่อเจาะเลือดตรวจเชื้อเอดส์หรือไม่?

❑ไม่ได้(ข้ามไปตอบข้อ35) ❑ได้(ตอบข้อ 33,34)

33.ถ้าท่านเคยได้รับคำปรึกษา(เพื่อเจาะเลือดตรวจเชื้อเอดส์) ท่านได้รับจากใคร? ❑พนักงานสาธารณสุขต่างด้าว (พสต./อสต.) ❑พยาบาล

34. หลังจากที่ท่านได้รับคำปรึกษา (VCT) แล้ว ท่านยินยอมเจาะเลือดตรวจเชื้อเอดส์หรือไม่?

❑ไม่ยอม ❑ยอม

ภาระค่าใช้จ่ายในการรักษา

35.ท่านมีบัตรประกันสุขภาพของโรงพยาบาลอะไร? ระบุชื่อโรงพยาบาล…….

36. ค่าประกันสุขภาพ 1,300 บาท และค่าตรวจสุขภาพก่อนขอใบอนุญาตทำงาน 600 บาท (รวม1,900 บาท) ใครเป็นผู้ออกเงิน❑ตนเอง (ตอบข้อ 37) ❑บริษัท/นายจ้าง (ข้ามไปตอบข้อ 38)

37.ถ้าจ่ายด้วยตนเอง ท่านจ่ายจาก❑ เงินของตนเอง ❑กู้/ยืมมา

38.ถ้านายจ้างออกให้ มีการหักเงินเดือนภายหลังหรือไม่? ❑หักเงินเดือน ❑ไม่ได้หักเงิน

39.ท่านเจ็บป่วยไปรับบริการที่โรงพยาบาลมีการจ่ายเงินหรือไม่? ❑ไม่ได้จ่าย ❑จ่าย

40.ถ้ามีการจ่ายเงินให้โรงพยาบาล ท่านจ่ายไปเท่าไร? ระบุจำนวนเงิน ……บาท

41.ท่านจ่ายเงินเป็นค่าเดินทางไป-กลับโรงพยาบาลครั้งละเท่าไร? ระบุจำนวนเงิน ……บาท

ความรู้ความเข้าใจในสิทธิประโยชน์ของการมีบัตรประกันสุขภาพ

42.ท่านคิดว่าเงินที่จ่ายเพื่อการประกันสุขภาพ มีความคุ้มค่ากับการคุ้มครองด้านสุขภาพตามสิทธิประโยชน์? ❑ไม่คุ้ม❑คุ้ม

43.ท่านทราบหรือไม่ว่า เมื่อไปรับบริการยังโรงพยาบาลท่านต้องนำบัตรประกันสุขภาพไปด้วยทุกครั้ง

❑ไม่ทราบ ❑ ทราบ

44.ท่านทราบหรือไม่ว่า การมีบัตรประกันสุขภาพนั้น ท่านจะได้รับการรักษาโรคตามสิทธิ ในโรงพยาบาลที่ประกันสุขภาพไว้? ❑ ไม่ทราบ ❑ทราบ

45.ท่านทราบหรือไม่ว่า การมีบัตรประกันสุขภาพ สามารถใช้สิทธิเพื่อการตรวจคัดกรองโรคได้

❑ ไม่ทราบ ❑ทราบ

46. ท่านทราบหรือไม่ว่า การมีบัตรประกันสุขภาพ เมื่อเจ็บป่วยฉุกเฉิน / อุบัติเหตุ ท่านสามารถใช้บริการที่โรงพยาบาล ❑ ไม่ทราบ ❑ทราบ

47.ท่านมีปัญหาอุปสรรคในการใช้บริการที่โรงพยาบาล หรือไม่? ❑ ไม่มี ❑ มี

48.ท่านมีข้อเสนอให้โรงพยาบาลที่ประกันสุขภาพไว้ปรับปรุง /พัฒนาบริการหรือไม่?

❑ไม่มี ❑ มี……ระบุ……..

49.ท่านต้องการมีสิทธิรักษาพยาบาลแบบใด? ❑ประกันสุขภาพแรงงานต่างด้าว ❑ประกันสังคม

ชื่อผู้เก็บข้อมูลการสัมภาษณ์ นาย/นาง/นางสาว…….

เก็บข้อมูลที่ชุมชน……..หมู่ที่……. ตำบล……อำเภอ…….

ลงชื่อ นาย /นาง…….ทำหน้าที่ล่าม

หมายเหตุ : modified from Health Seeking Behavior and Health System response Model Susanna Hausmann-Muela, Muela Riber. and Isaac Nyamongo, August 2003.

แบบสัมภาษณ์ชุดที่ 2

การสอบถามแรงงานข้ามชาติ (พม่า/กัมพูชา)

(รหัสจังหวัด) (รหัสอำเภอ)(รหัสโรงพยาบาล) [ ][ ] [ ][ ][ ] [ ][ ][ ]

เลขที่แบบสัมภาษณ์

แบบB เฉพาะแรงงานและผู้ติดตามที่ไม่มีใบอนุญาตทำงานมีบัตรหรือไม่มีบัตรประกัน [ ][ ][ ]

โปรดเติมคำลงในช่องว่างหรือใส่เครื่องหมาย / ลงในช่องที่ตรงกับความเป็นจริงของผู้ตอบ

ข้อมูลทั่วไป

1.ผู้ให้สัมภาษณ์ ชื่อ นามสกุล.....

2.เพศ ❑ ชาย ❑ หญิง อายุ ..... ปี

3.สัญชาติ ❑พม่า ❑กัมพูชา

4.การใช้ภาษาของตนเอง ❑อ่านไม่ออกเขียนไม่ได้ ❑ อ่านออก ❑ เขียนได้

5.การใช้ภาษาไทยในการพูด ❑ พูดไม่ได้ ❑ พูดได้

การฟัง ❑ ฟังไม่รู้เรื่อง ❑ฟังรู้เรื่อง

6.ท่านทำงานอยู่ในประเทศไทยมากี่ปี? ❑1 ปี ❑2 ปี ❑3 ปี❑4 ปี ❑5 ปี ❑มากกว่า 5 ปีขึ้นไป

7.ที่พักอาศัย❑โรงงาน / บ้านนายจ้าง ❑ เช่าอยู่เอง ❑เช่าอยู่กับเพื่อน ❑เช่าอยู่กับญาติ

8.สมาชิกที่อาศัยอยู่ด้วยกัน (รวมผู้ถูกสัมภาษณ์ด้วย)……คน

9.สมาชิกที่อาศัยอยู่ด้วยกันมีบัตรประกันสุขภาพหรือไม่? ❑ มี …….. คน.❑ไม่มี …….คน

10.สมาชิกที่อาศัยอยู่ด้วยกันเกี่ยวข้องกับท่านโดยเป็น ❑พ่อ/แม่❑พี่/น้อง❑สามี/ภรรยา❑เพื่อน❑ญาติ

(ข้อ 10 ตอบได้มากกว่า 1คำตอบ)

ข้อมูลการทำงาน

11.ประเภทของงานที่ท่านทำอยู่ปัจจุบัน ระบุ……

12.ในปีที่ผ่านมา(พ.ศ.2553) ท่านย้ายงานมาแล้วกี่ครั้ง ❑ไม่เคยย้าย(ไปตอบข้อ 14)

❑เคยย้าย ❑ ย้าย 1ครั้ง ❑ ย้าย 2 ครั้ง ❑ ย้าย 3 ครั้ง ❑ ย้ายมากกว่า 3 ขึ้นไป (เคยย้ายไปตอบข้อ 13)

13.สาเหตุที่ท่านย้ายงานบ่อยๆเพราะ❑เงินเดือนน้อย❑นายจ้างเอาเปรียบ❑งานหนักมาก(ตอบได้เพียง 1 ข้อ)

14.ท่านได้รับค่าจ้างเดือนละเท่าไร? ระบุจำนวนเงิน……บาท

15. ท่านเคยถูกส่งตัวกลับไปประเทศตนเองหรือไม่ ❑ไม่เคย(ไปตอบข้อ 17)❑ เคย (ถ้าเคยไปตอบข้อ 16)

16.ถ้าเคยถูกส่งตัวกลับ จำนวนครั้งที่เคยถูกส่งตัวกลับ❑ 1 ครั้ง ❑2 ครั้ง ❑3 ครั้ง❑มากกว่า 3 ครั้ง

17ท่านอยากได้ใบอนุญาตทำงานหรือไม่? ❑ไม่อยาก ❑ อยาก

ข้อมูลด้านสุขภาพและพฤติกรรมการใช้บริการ

18. ท่านมีโรคประจำตัวหรือไม่? ❑ไม่มี ❑ มี ถ้ามีระบุโรค ❑ เบาหวาน❑ ความดันเลือดสูง ❑โรคหัวใจ

❑มะเร็ง ❑โรคปอด/หลอดลม❑โรคกระเพาะอาหาร/ลำไส้ ❑โรคระบบเลือด/น้ำเหลือง ❑โรคผิวหนัง

❑กระดูก/กล้ามเนื้อ/ประสาท ❑โรคจิต ❑ระบบอวัยวะสืบพันธุ์ ❑โรคเกี่ยวกับเพศสัมพันธุ์❑โรคไตและระบบปัสสาวะ ❑โรคภูมิแพ้ (ข้อ18 ตอบได้หลายข้อ)

19.ในรอบปีที่ผ่านมา(2553)ท่านป่วยกี่ครั้ง?❑ 1 ครั้ง ❑ 2 ครั้ง ❑3 ครั้ง❑4 ครั้ง ❑ 5 ครั้ง ❑มากกว่า 5 ครั้งขึ้นไป

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

❑ไม่เคย(ข้ามไปตอบข้อ 23)

❑ เคย (ถ้าเคยตอบข้อ 21,22)

21.ถ้าเคยท่านไปตรวจและรักษาโรคกี่ครั้ง ❑1 ครั้ง ❑ 2 ครั้ง ❑3 ครั้ง❑4 ครั้ง

❑ 5 ครั้ง ❑ มากกว่า 5 ครั้งขึ้นไป

22.ถ้าท่านเคยไปตรวจโรคแบบผู้ป่วยนอก ท่านไปที่ใด? ❑โรงพยาบาลส่งเสริมสุขภาพตำบล (รพสต./สอ.)

❑คลีนิคเอกชน ❑โรงพยาบาลที่ประกันสุขภาพไว้ ❑โรงพยาบาลอื่นๆ (ข้อ 22 ตอบได้หลายคำตอบ)

23. เมื่อท่านไม่สบายเล็กน้อย ท่านตัดสินใจดูแลตนเองอย่างไรบ้าง?❑นอนพักเฉยๆ/รักษาตนเอง❑ซื้อยากินเอง ❑ไปหา พสต./สอต.❑ไปโรงพยาบาลส่งเสริมสุขภาพตำบล (รพสต./สอ.) ❑ไปตรวจที่คลีนิคเอกชน ❑ไปที่โรงพยาบาลที่ประกันสุขภาพไว้ ❑ ไปโรงพยาบาลอื่นๆ (ข้อ 23 ตอบได้หลายคำตอบ)

24.เมื่อท่านไม่สบายมาก ท่านตัดสินใจดูแลตนเองอย่างไรบ้าง?❑นอนพักเฉยๆ/รักษาตนเอง❑ซื้อยากินเอง ❑ ไปหา พสต./อสต.❑โรงพยาบาลส่งเสริมสุขภาพตำบล (รพสต./สอ.) ❑ไปตรวจที่คลีนิคเอกชน ❑ไปที่โรงพยาบาลที่ประกันสุขภาพไว้❑โรงพยาบาลอื่นๆ (ข้อ 24 ตอบได้หลายคำตอบ)

25.ยากินที่ได้มาจากโรงพยาบาล ท่านกินจนหมดหรือไม่? ❑ หมด ❑ไม่หมด (ถ้าไม่หมดไปตอบข้อ 26)

26.สาเหตุที่กินยาไม่หมดเพราะ ❑ลืมกิน ❑คิดว่าโรคหายแล้ว ❑ได้ยามากเกินไป ❑กินแล้วไม่ดีขึ้น ❑แพ้ยา

27.ในรอบปีที่ผ่านมา ท่านเคยนอนโรงพยาบาล(IPD)หรือไม่? ❑ ไม่เคย(ข้ามไปตอบข้อ 32)

❑เคย (ไปตอบข้อ 28.29,30,31)

28.ถ้าเคยนอนโรงพยาบาล ท่านนอนที่โรงพยาบาลกี่วัน? ระบุจำนวนที่นอน❑ 1 วัน❑ 2 วัน ❑3 วัน ❑4 วัน ❑ 5 วัน ❑ มากกว่า 5 วัน

29. การนอนรักษาตัวในโรงพยาบาลในครั้งนี้ ท่านทราบหรือไม่ว่าป่วยเป็นโรคอะไร? ❑ไม่ทราบ❑ทราบ

30. ท่านคิดว่าโรงพยาบาลรักษาโรคหายหรือไม่? ❑ไม่หาย❑หาย .....

31. หลังออกจากโรงพยาบาล แพทย์ได้นัดหมายให้ไปตรวจโรคอีกหรือไม่❑ไม่ได้นัด ❑นัดให้ไปตรวจทุกอาทิตย์❑นัดไปตรวจทุกเดือน

32.ท่านรู้จักพนักงานสาธารณสุขต่างด้าว (พสต./อสต.)หรือไม่? ❑ไม่รู้จัก ❑ รู้จัก

33.พนักงานสาธารณสุขต่างด้าว (พสต./อสต.) มีส่วนช่วยเหลือสนับสนุนด้านสุขภาพแก่ท่านหรือไม่อย่างไร?

❑แนะนำการป้องกันโรค❑แนะนำการปฏิบัติตัวตอนป่วย ❑พาโรงพยาบาล

❑เยี่ยมเมื่อเจ็บป่วย❑แนะนำการกินยา❑แนะนำไปตรวจตามนัด (ข้อ 33 ตอบได้หลายคำตอบ)

34.ท่านได้รับบริการให้คำปรึกษา (VCT) เพื่อเจาะเลือดตรวจเชื้อเอดส์หรือไม่? ❑ไม่ได้(ข้ามไปตอบข้อ37)

❑ได้ (ไปตอบข้อ 35,36)

35.ถ้าท่านเคยได้รับคำปรึกษา (เพื่อเจาะเลือดตรวจเชื้อเอดส์)ท่านได้รับจากใคร? ❑พนักงานสาธารณสุขต่างด้าว (พสต./อสต.) ❑พยาบาล

36.หลังจากที่ท่านได้รับคำปรึกษา (VCT)แล้ว ท่านยินยอมเจาะเลือดตรวจหาเชื้อเอดส์หรือไม่?

❑ไม่ยอม ❑ยอม

ภาระค่าใช้จ่ายในการรักษา

37.เมื่อท่านป่วยไปรับบริการที่คลีนิคเอกชน ท่านจ่ายเงินไปเท่าไร? ระบุจำนวนเงิน ……บาท

38.เมื่อท่านป่วยไปโรงพยาบาล ท่านจ่ายเงินไปเท่าไร? ระบุจำนวนเงิน ……บาท

39. การจ่ายเงินให้โรงพยาบาล ท่านจ่ายเต็มตามที่โรงพยาบาลเรียกเก็บหรือไม่?❑จ่ายครบ❑จ่ายไม่ครบ

40.ท่านจ่ายเงินเป็นค่าเดินทางไป-กลับโรงพยาบาลครั้งละเท่าไร? ระบุจำนวนเงิน ……บาท

ความรู้ความเข้าใจในสิทธิประโยชน์ของการมีบัตรประกันสุขภาพ

41.ท่านมีบัตรประกันสุขภาพหรือไม่?❑ไม่มี (ตอบข้อ 42) ❑ มี (ข้ามไปตอบข้อ 43.44)

42.ถ้าไม่มีบัตรประกันสุขภาพ ท่านอยากมีหรือไม่ ❑ไม่อยาก ❑อยากมี

43.ถ้ามีเป็นบัตรประกันสุขภาพของโรงพยาบาลใด? ระบุชื่อโรงพยาบาล…….

44.ถ้ามีบัตรประกันสุขภาพใครเป็นผู้ซื้อ ❑ตนเอง (ข้ามไปตอบข้อ 45) ❑บริษัท/นายจ้างออกให้ (ข้ามไปตอบข้อ 46)

45.ถ้าซื้อด้วยตนเอง ท่านใช้เงินจาก❑ เงินที่มี ❑เงินกู้/ยืม

46.ถ้านายจ้างออกให้ มีการหักเงินเดือนภายหลังหรือไม่? ❑หักเงินเดือน ❑ไม่ได้หัก

47.ตามความคิดของท่าน คิดว่าเงินที่เสียไปในการประกันสุขภาพ มีความคุ้มค่ากับการคุ้มครองด้านสุขภาพตามสิทธิประโยชน์? ❑ไม่คุ้ม❑คุ้ม

48.ท่านทราบหรือไม่ว่า การมีบัตรประกันสุขภาพนั้น ท่านจะได้รับการรักษาโรคตามสิทธิ ในโรงพยาบาลที่ประกันสุขภาพไว้? ❑ ไม่ทราบ ❑ทราบ

49.ท่านทราบหรือไม่ว่า การมีบัตรประกันสุขภาพ สามารถใช้สิทธิเพื่อการตรวจคัดกรองโรคได้

❑ ไม่ทราบ ❑ทราบ

50. ท่านทราบหรือไม่ว่า การมีบัตรประกันสุขภาพ เมื่อเจ็บป่วยฉุกเฉิน / อุบัติเหตุ ท่านสามารถใช้บริการที่โรงพยาบาล ❑ ไม่ทราบ ❑ทราบ

51.ท่านมีปัญหาอุปสรรคในการใช้บริการที่โรงพยาบาล หรือไม่? ❑ ไม่มี ❑ มี

52.ท่านมีข้อเสนอให้โรงพยาบาลที่ท่านไปรับบริการปรับปรุง /พัฒนาบริการหรือไม่?

❑ไม่มี ❑ มี ระบุ……..…..

53.ท่านต้องการมีสิทธิรักษาพยาบาลแบบใด? ❑ประกันสุขภาพแรงงานต่างด้าว ❑ประกันสังคม

ชื่อผู้เก็บข้อมูลการสัมภาษณ์ นาย/นาง/นางสาว…….

เก็บข้อมูลที่ชุมชน……..หมู่ที่……. ตำบล……อำเภอ…….

ลงชื่อ นาย /นาง……..ทำหน้าที่ล่าม

หมายเหตุ : modified from Health Seeking Behavior and Health System response Model Susanna Hausmann-Muela, Muela Riber. and Isaac Nyamongo, August 2003.