Special Article

Health Insurance for Undocumented Migrants: A Literature Review in Developed Countries

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Background: *Undocumented migrants are a population that is of concern in the policy discourse in many countries, including Thailand.*
Objective: *Draw lessons regarding the health insurance management for undocumented migrants in certain developed countries.*
Material and Method: *Literature reviews were conducted on academic literatures of the European Union (EU) and relevant journals and websites. Constant comparison was used for data analysis. Four EU nations (France, Germany, Italy, and the United Kingdom) and two non-EU nations (Japan and the United States) were selected.*
Results: *In principle, the degree of care could be categorized into three levels, namely, 1) emergency services, 2) primary care and emergency services, and 3) (almost) full range of care. These levels were overlapping and the countries always faced operational problems from different legal interpretations and ignorance of health care rights and benefits amongst both providers and users. Based on the constant comparison synthesis, the insurance management for migrants in most countries was sorted into four tiers, 1) the insurance for legal migrants, 2) the insurance for illegal migrants who later registered with the state, 3) the insurance for certain populations, such as pregnant women and children and patients with communicable diseases, and (4) the special funding for health facilities to recoup the treatment cost from caring the uninsured patients.*
Conclusion: *The review findings here may serve as a valuable lesson for Thailand to better manage its health care system for migrants (particularly amongst the undocumented) and to make it more effective and equitable implement.*

Keywords: *Migrants, Health insurance, Literature review, Health financing*

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At present, human mobility is reached its peak in the world history. It is estimated that more than 214 million people are living outside their own countries. The International Organization for Migration (IOM) estimated that if the international migration continues at the same pace as in the last two decades, the size of international migrants worldwide will exceed 405 million by 2050[1].

Traditionally, most policy discourses emphasized on the movement of population from low and middle income countries (LMICs) to more developed countries, most of which are situated above the equator, so-called 'South-North' migration. Yet, recent evidence shows that the number of 'South-South' migration has been sharply growing, from less than 20 million in 1990 to almost 60 million in 2010, almost a triple expansion in two decades, whereas the 'South-North' migration remained stable at 45 million during the same period[2]. This phenomenon is likely explained by many factors such as an increasing demand for labor in response to fast economic growth in the developing nations, political instability, and domestic violence. Therefore, the 'South-South' migration pathway has drawn much attention from many policy makers and academicians, leading to a significant change in the sphere of political debates in the migration field[2,3].

Thailand is a country in the Southeast Asia region that serves as one of the popular destinations of migrants. So far, the country is the residence of over 3 million migrants. The majority of these migrants are migrant workers and dependents from neighboring countries (Cambodia, Lao PDR, and Myanmar [CLM])

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who crossed the borders illegally. These population are regarded as 'illegal' or 'undocumented' migrants.

The current government attempted to address the illegality problems by endorsing the One Stop Service (OSS) policy, aiming at registering 'all' illegal or undocumented migrants and dependents in Thailand[4]. Those undertaking the OSS will be issued the work permit and legitimate residence permit, and will be insured for their health. The health insurance for the registered migrants is called the 'Health Insurance Card Scheme' (HICS). The insured migrants are required to buy the insurance card with a premium of 1,600 Baht for adult (plus 500 Baht for annual health check) and 365 Baht for a child less than 7 years for a one-year coverage. Most of the card revenue is pooled at the registered hospital. A small portion of the revenue (360 Baht per an adult card, and 17 Baht per a child card) is pooled at the Ministry of Public Health (MOPH) to reimburse the expense of advanced treatment (or high cost care) and antiretroviral drugs for HIV/AIDS patients. The benefit package of the card is comprehensive. In theory, it comprises a wide range of treatments, including outpatient care, inpatient care, specialized treatment, disease prevention, and health promotion[5].

Despite a seemingly large benefit package of the insurance and rigorous enforcement of the OSS policy by the junta, there are still number of problems in implementing this policy. The problems include the following 1) there are numbers of illegal migrants who failed to take part in the OSS registration and did not return to their home country, 2) certain hospitals are reluctant to sell the insurance card for migrants due to fear of having small volume of registered migrants that cannot meet the hospital's cost recovery, and 3) there are confusions in policy implementation and varying interpretations of laws, such as whether the unregistered migrant is eligible to buy the insurance card[6,7].

Given the above complexities in the insurance management, recently, there was a proposal to the MOPH that there should be a safety net system that covered any patient regardless of his/her immigration/ citizenship status, who are suffering from emergency condition and catastrophic illness without creating much additional financial burden on the facilities[8]. Therefore, it is imperative to draw lessons from other countries about to what extent they manage health insurance for cross-border migrants, especially the safety net system for undocumented ones. It is hoped that the review will serve as knowledge grounds for the development of the health insurance system from cross-border migrants in Thailand.

Material and Method

Narrative review was conducted. The literature was purposely searched from the database of the 'Platform for International Cooperation on Undocumented Migrants (PICUM)', which explored policy approaches regarding access to care for undocumented migrants for the European Union (EU) member states[9]. In order to make the review more comprehensive, sources of literature outside the EU was explored, such as the Asia Pacific Journal and official websites of the authorities accounting for health care management for undocumented migrants in certain countries[10,11].

The review will begin with a classification of EU countries based on the degree of rights to care for undocumented migrants. Four countries (namely, France, Germany, Italy, and UK) were purposely selected in order to represent different health financing systems (general tax versus contribution) with varied degree of benefit package. Additional references from non-EU countries, namely, Japan, and US were recruited.

The review findings were analyzed by constant comparison method.

Results

Overall, the EU countries can be divided into three levels according to the degree of care the state provided to undocumented migrants, those are: 1) emergency services, 2) primary care and emergency services, and 3) (almost) full range of care, as suggested by Caudra and Cattacin (2010)[9]. It should be noted that 'anybody' can enjoy services without showing his/ her legal identity. In practice, the laws in each country almost always require an undocumented migrant patient to undertake certain kinds of registration/ legalization. Taking into account, the financing system, and the degree of care in the EU countries can be classified into six groups as shown in Table 1.

Viewing from this point onwards, the present study will focus on countries where at least basic primary care is provided to undocumented migrants. In order to have maximal variability, UK (basic right, general tax), Germany (basic right, premium), Spain (full benefit, general tax), and Netherlands (full benefit, premium) were raised as a representative for each financing system. Besides, additional instances from countries outside Europe are presented. In this category, lessons from Japan and the US were drawn

Table 1. Level of rights to health care for undocumented migrants in 27 EU countries

Level of rights	General tax financing	Premium or payroll tax financing
No rights	Finland, Ireland, Malta, Sweden	Bulgaria, Czech Republic, Latvia, Luxembourg, Romania
Minimum rights	Cyprus, Denmark, UK	Austria, Belgium, Estonia, Germany, Greece, Hungary, Lithuania, Poland, Slovak Republic, Slovenia
Rights	Italy, Spain, Portugal	France, Netherlands

Source: Cuadra and Cattacin[9] and Gray and van Ginneken[13]

since they are the most popular destinations of migrants in Asia and America respectively.

United Kingdom (UK)

Of the 62 million residents in the UK, there are about seven million non-British nationals. As of 2009, the number of undocumented migrants (most of them are failed asylum seekers) is approximately 155,000 to 283,500. The main authority responsible for insuring health of the UK residents is the National Health Service (NHS). The eligible beneficiaries of the NHS are 'ordinary residents' as specified in the 1989 Statutory Instrument No. 336. This definition of the ordinary resident is guided by the intent of the person to remain in the UK for a significant period of time. Generally, a person residing more than three years in the UK can be defined as an ordinarily resident, and this term normally includes legal immigrants. Ordinary residents are allowed to enjoy free NHS service in all range of care (primary care, secondary care, health promotion and disease prevention, etc.). For undocumented migrants, only certain services are provided for free, which include (but not limited to), outpatient emergency care, compulsory treatment under court order, psychosis treatment, treatment for potential public threats (such as cholera, tuberculosis (TB), encephalitis, HIV/AIDS (in England and Scotland, but not in Wales), influenza, family planning, treatment for victims of torture or violence)[15]. Note that maternity care is regarded as secondary care where undocumented migrants are liable to pay the treatment expense. However, doctors are not allowed to delay the treatment for patients with urgent need, given the patients' inability to pay the treatment cost but the incurred debts will be pursued later.

In practice, it is found that there are still confusions in the NHS' guideline/regulation in dealing with undocumented migrants. Some NHS staff were not recognized the rights of undocumented migrants. Some health care staff (mis)understood that they must report to the immigration control if they found undocumented migrants showing up at the health facility. Nevertheless, the NHS attempted to resolve these confusions by establishing a hotline service where health care staff can contact in order to check for the rights of each individual patient. Besides, some Primary Care Trusts have collaboration with non-profit clinics or charitable agencies in order to help undocumented migrants access to care as some of them may be afraid of being discovered by the public officials[16].

Germany

There are about 8.2 million non-German nationals in Germany, constituting approximately 10% of its population. Second generation migrants take up about 19% of the total residents. It is estimated that the size of undocumented migrants might be as large as 1.5 million. The refugee crisis of European region in recent years might make expand the volume of asylum seekers by 330,000[17,18].

The main public insurance of Germany follows Bismarck concept where social health insurance plays a dominant role. Standard insurance is funded by a combination of employee contributions, employer contributions and government subsidies on a scale determined by income level. Germany has a universal multi-payer system where private insurance companies under the state regulation, numbering over 200, can take part in. This is a so-called pluralistic system. The contribution is waived in certain beneficiary groups, such as children and pregnant women. The benefit package is comprehensive, comprising a wide range of activities, including health promotion, primary care, secondary care, and long term care (endorsed in 1995). Legal migrants are required to make the contribution to the insurance similar to the German nationals. In summary, the German health insurance system is tightly linked with work status and residence permit in the country[13].

The rights to care of undocumented migrants are limited to certain services, such as post-natal care and care for infectious diseases (including HIV/AIDS, TB, and sexually transmitted diseases [STDs]).

For such services, there will be no charge incurred by an undocumented migrant patient if he/she applies for the Health Card (Krankenschein) with the Welfare Office. The state will then issue a Toleration Certificate, so-called 'Duldung', which warrants the rights to care of a patient, while he/she is under a temporary suspension of expulsion. In some local regulations, the coverage of the Duldung expands to pregnant women (6 weeks before delivery and 8 to 12 weeks after delivery and children) as well. Germany also endorse the Law of Infectious Diseases which allows undocumented migrants to participate in anonymous disease screening and counselling free of charge without showing the legal identity (but the Health Card or the Duldung must be shown to the officials). The undocumented migrants without the Duldung are allowed to enjoy emergency care without any charge incurred to the user. Health care providers can later reimburse this emergency treatment expense from the Social Welfare Office upon the condition that the providers need to report to the responsible authorities about the residence permit of these migrants according to the law (Section 87 AufenthG). This practice indirectly creates barriers to care for some undocumented migrants who are afraid of being exposed to the immigration officials[13].

Italy

It is found that of the 60 million residents in Italy, 3.5 million (~5.8%) are foreign-born. The volume of undocumented migrants varies between 200,000 and 1,000,000. The main insurance system is the Italian Health Service, financed by general tax. The insurees are required to register with the local authorities in order to obtain the Health Card (Tessera Sanitaria). The Health Card holders will be eligible to enjoy comprehensive health services, which include specialized care/treatment. There is co-payment at point of care incurred by a patient (the payment scale varying by tax credit) but this is capped by a ceiling specified by laws. Certain populations are exempted from co-payment, such as elderly aged above 65, low-income people, prisoners, persons suffering from chronic diseases, and pregnant women. Legal migrants are under the same regulation as the Italian nationals[13].

Undocumented migrants are eligible to acquire 'Temporary Residing Foreigner Code', with a 6-month validity. This will serve as a health card guaranteeing the rights to enjoy a variety of essential services. However, there seems to be a subtle difference in the interpretation of the scope of essential service between health care providers in different regions. Normally, this includes treatment for infectious diseases, HIV/AIDS, TB, occupational injuries, and maternal and child care[19]. The health care providers in Italy are not obliged to inform the immigration control or the police about the presentation of undocumented migrants since this is protected by the Italian laws, except suspecting that the patients are involved in criminal offense[20].

France

France is composed of 64.7 million residents, with about 3.6 million of them are foreign-born (~5.8%). The number of undocumented migrants is approximately 300,000 to 500,000 (~0.7%). The French public health insurance is operated under the Universal Coverage Act. Employees and employers must pay contributions to the Social Health Insurance, controlled by the Ministry of Social Security. The contributions can be exempted in some populations, such as pregnant women and children, and persons with a yearly wage less than €6,600. The benefit package is comprehensive. For outpatient care, a patient must pay for the treatment cost first, this can reimburse from the scheme up to 70% of the total expense. However, the beneficiaries can avoid the rest 30% charge by being insured by the private insurance (optional).

Undocumented migrants have been eligible to access to a wide range of services since 2010. The benefit package comprises of primary care, secondary care, maternity and child care, emergency care, vaccination, family planning, public health threat treatment (including HIV/AIDS and TB). Those migrants need to apply for the State Medical Assistance (Aide Médicale d'Etat, AME) certificate. The evidence required for the application is composed of birth certificate, expired passport and proof of residence and monthly income. The AME certificate can be applied as an individual or as a household. As the scheme is mainly targeting the poor, an applicant individual must have monthly income of less than €598. Should there are two applicants in the same household, the total monthly wage of the applicants must not exceed €897.

To make the reimbursement scheme more feasible in terms of the budget limitation and to avoid free riders, the French Health Care System classified the benefit for undocumented migrants into three tiers according to length of stay in the country as follows:

• For the first three months of residence, the patients can only access to emergency care free of charge. This includes treatment for life threatening

situations, all illnesses that need hospitalization, treatment of contagious diseases, all types of health care for children, maternity care and abortion for medical reasons, but excludes treatment of chronic diseases and high cost care.

• After three months, the rights of undocumented migrants will expand to the wider range of the AME benefit as stated above, with some exceptions, such as prostheses and corrective lenses.

• If undocumented migrants have been residing in France for at least three years, they will be eligible for 'home medical assistance' (Assistance Médicale à Domicile), and other services almost similar to the French nationals.

Besides, in 2004, the French government established the special fund for unpaid debt of the health facilities from providing emergency care to the uninsured patients (including undocumented migrants). The organization, namely, the Caisse Nationale d'Assurance Maladie (CNAM) is the governing body of the fund. The request for reimbursement is considered on a case-by-case basis. The facilities must provide evidence to the CNAM to show that the patients are uninsured and the treatment is really related to emergency condition. Despite a comprehensive design of the health insurance for undocumented migrants, in practice, it is found that about 10% of undocumented migrants are not cognizant of the existence of the AME, and the AME application process in terms of document preparation is quite cumbersome[13,21].

Japan

Japan is one of the top destination countries of migrants in East Asia with about 2.2 million immigrants as per the 2010 IOM report[1]. However, the volume of undocumented migrants in Japan is much smaller than other developed countries. Fujimoto (2013) suggested that the size of undocumented migrants in Japan was around 67,000[22]; most of them were Chinese and Korean. Calain-Watanabe and Lee (2012) argued that the number of this population might be as large as 92,000[24].

The Japanese health insurance system is basically based on the Bismarck model, where employers and employees are required to pay contributions. In details, there are four main sub-schemes, those are: 1) the Social Health Insurance for large companies/enterprises, contributed by employers and employees, 2) the Social Health Insurance for small-scaled companies/enterprises, financed by the tripartite contribution (employers, employees, and the government), 3) the Citizen's Health Insurance for the self-employed population, financed by the individual contribution plus the government's subsidy (note that the management of this scheme varies by municipalities), and 4) the insurance for the elderly aged over 75, subsidized by the central government with some additional budgets cross-funded by the three main schemes mentioned earlier. The benefit package of all schemes is comprehensive but the beneficiary is required to co-pay at point of care by 30% of the total expense (except for the elderly where the exemption is applied)[23]. Legal migrant workers are required to pay contributions to the Social Health Insurance similarly to the Japanese citizens.

In contrast, the insurance system for undocumented migrants is not well established. However, there were some attempts to endorse the laws that provide safety net to these undocumented migrants, for instance, the Infectious Diseases Law ratifying the rights to TB treatment for everybody in Japan (but this does not include HIV/AIDS), or the Tertiary-Level Emergency Care Unpaid Bill Reimbursement that aims to subsidize unpaid debt to the health facilities that provided complicated treatment for the uninsured patients. Nonetheless, the request for reimbursement is not always successful as this is considered on a case-by-case basis, and it is in effect only in Kanto region.

Currently, some prefectures allow undocumented migrant patients to apply for the No-Visa Holder Identification Card, giving the card holders rights to utilize inpatient care in certain clinics/hospitals. For outpatient care, the patients must pay a monthly premium and there is a co-payment at point of care. Note that the premium size varies by municipalities, for instance in Kanagawa the monthly premium is around ¥2,000. The Japanese health system also provides pregnant women and their newborns rights to maternity care regardless of their immigration status according to the Mother and Child Health Law, with the benefit including antenatal care, postnatal care and vaccination. The beneficiaries can enjoy such services according to the number of coupons received. These services are equally financed by the central government and the local municipality. However, in reality, the undocumented migrants often encounter several barriers to health services. It is estimated that more than 18% of the officials in the welfare centers opposed the idea of providing care to undocumented migrants, and this made the provision of care become haphazard[10,24].

United Sates (US)

The US is the nation with the greatest diversity of populations' ethnics. It is approximated that the size of undocumented migrants in the US might be about 11.3 million in 2014[26]. Only in California, the number of undocumented migrants might reach 2.6 to 3 million (~7% of California's total population). The health insurance system of the US varies by states. Normally, each state applies pluralistic system, which is a combination of private and public insurances. The main insurance schemes are: 1) the Social Health Insurance financed by the contributions of employers and employees, 2) the public insurances for the vulnerable groups, Medicaid for the low-income populations and Medicare for the elderly, and 3) the voluntary private insurances. Those who are not entitled to any scheme above are liable to out-of-pocket payment at point of care. Legal immigrants and foreign-born residents also have the same rights as the US citizens.

An instance was drawn from California where the policy for undocumented migrants is quite open. The California's local government has established the city's insurance project for undocumented migrants, namely, the restricted Medi-Cal. In order to be entitled to the scheme, the applicants must provide a proof of residence to the officials, such as expired VISA or LA residence card[27,28]. The basic benefit package includes:

• Emergency treatment for any conditions specified by the Federal Statue (42 USC Section 130b (v)), that is, any condition, which is not treated in a timely manner, will pose a serious impairment/ dysfunction to organs of life of a patient.

• Acute, ongoing, and maintenance renal dialysis services.

• Maternity and child care (family planning, antenatal care, delivery care, and post-natal care up to 60 days).

The beneficiaries can utilize such services free of charge. Aside from these services, the patients are liable to have co-payment. However, the disadvantaged or the poor beneficiaries can apply to the Ability-to-Pay Plan (ATP), which is the program that helps relieved treatment expense. The program will subsidize cost of care with respect to the patient's income. Individuals interested in applying for the ATP can get coverage at no cost if, after deductions (current taxes, medical insurance, child care, and support payments), their monthly income is less than 138% of the poverty line (around US$ 1,343 for single applicant). If, after deductions, the applicants' monthly income is still above that threshold, they must pay the monthly premium, varying between US$ 60 to 500 in order to be eligible to outpatient care (regardless of how many visits they used), and pay the treatment expense at any time the inpatient care is utilized. The ATP can also help the patients negotiate with a health facility in order to pay for the treatment cost in instalment rather than lump sum. The applicants are required to show proof of address and identity. Income is based on the applicant's verbal declaration under penalty of perjury. However, the County has the right to request income verification at a later date[29].

Given a continuing increase in the volume of undocumented migrants, some hospitals encountered a growth in unpaid debt from providing care for undocumented migrants. Accordingly, some states imposed an additional levy on general tax with an aim to pay off the rise in public health care cost. This situation is evident in emergency services where hospitals cannot deny the patients according to the Emergency Medical Treatment and Active Labor Act (EMTALA). It is estimated that between 1993 and 2003, there were about 60 hospitals that terminated the emergency unit due to the hospital hardship. However, this phenomenon might be derived from other factors, not just from treating undocumented migrant patients[30].

Discussion

The literatures showed that there is varied degree of rights to care for undocumented migrants between countries. In addition, the differentiation of countries as presented above is just a theoretical presumption. The review shows that there is a substantial room of legal interpretation, for example, in Italy, where undocumented migrants are eligible to enjoy 'essential care', the problem arises as the municipalities interpret the scope of essential care differently[19]. With the constant comparison, it can be concluded that the level of care provided to undocumented migrants can be categorized into four levels as presented in Table 2.

The first level is the health insurance for legal migrants with legitimate residence permit. In this level, legal migrants are eligible to utilize services almost at the same degree as the native citizens.

The second level is the insurance for previously illegal migrants who underwent the registration with the authorities. The degree of care for this level varies between countries. Normally, the registered patients are able to utilize emergency services and primary care with free of charge or minimal charge.

Table 2. Health insurances for non-national populations in France, Germany, Italy, Japan, Thailand, UK, and US (California): constant comparison analysis

Country	Level 1: insurance for national citizens and legal migrants	Level 2: insurance for registered illegal migrants	Level 3: insurance for disease specific groups	Level 4: special funding for recouping cost of treating the uninsured patients
France	Universal Coverage Act (CMU): payroll tax for social health insurance, comprehensive benefit package (pay first then reimburse)	State Medical Assistance (AME) • Less than 3 months residence: covered only emergency care, maternal and child health care, and care for contagious diseases that cause public health threat • More than 3 months residence: as above plus primary and secondary care	Special funds for maternal and child care, vaccination, emergency care, HIV/AIDS and TB treatment, and contagious diseases that cause public health threat	CNAM: Caisse nationale d'assurance maladie, for subsidising facilities with unpaid debt derived from providing emergency care to the uninsured
Germany	Social health insurance: premium-based, pluralistic system, comprehensive benefit package	Duldung (managed by Social Welfare Office): tax deducted, covering maternal and child health care, emergency services, treatment for sexually transmitted diseases	Undistinguished with level-2 safety net	Not clear
Italy	Italian Health Service: tax-based, co-payment with ceiling (excepting vulnerable patients), comprehensive benefit package	STP code (health card), covering urgent care, essential care, maternal and child health care, tuberculosis and HIV/AIDS	Undistinguished with level-2 safety net	Not clear
Japan	Mixed systems between social insurances, community insurances and insurance for the elderly: 30% copayment with comprehensive benefit package	Not clear (but some prefectures have no-visa holder identification card that ratifies right to OP and IP care for undocumented migrants)	Mother and Child Health Law: vouchers for antenatal care, post natal care and vaccination	Tertiary-Level Emergency Care Unpaid Bill Reimbursement; but endorsed only in Kanto prefecture
United Kingdom	National Health Service: tax system, comprehensive package, no or little co-payment	Must be registered with NHS but limited to some services: emergency conditions, psychosis, family planning and public health threat diseases	Undistinguished with level-2 safety net	Not clear
United States (only in California)	1) Social health insurance, 2) State funded insurance (Medicare & Medicare), 3) Private insurance (note that the uninsured need to pay out of pocket): benefit package varied according to premium	Restricted Medi-Cal: including urgent care plus dialysis, maternal and child health care, and family planning	Not clear	Not clear

CMU = Couverture Maladie Universelle; AME = Aide Médicale d'Etat; STP = straniero temporaneamente presente; OP = outpatient; IP = inpatient; NHS = national health service

The third level is the population- or disease-specific insurance for certain population groups, such as pregnant women and children, or persons with communicable diseases. The grounds of the insurance are for protecting public health threats and safeguarding health of the potential vulnerable. Common diseases appearing in the benefit package of the insurance for undocumented migrant are TB, HIV/AIDS, and sexually transmitted diseases.

The fourth level is the special funding program that aims to recoup the treatment cost that the facilities shouldered from catering care for the uninsured populations. Not all the reviewed countries had this funding system. Only Japan and France implemented this system; while Japan focuses on tertiary care, the French system is limited only to emergency care. One of the interesting remarks on this issue is to reimburse from this fun, the facilities need to submit the patient details and extensive information of the patient's treatment to the funding authority, and the reimburse requested will be considered case-by-case[10,13,21,24].

Though the present review did not intend to point out that Thailand should fully adopt the policy approaches of other countries in caring for migrants, there are a few points that are worth learning for the Thai context.

First, in most developed countries, there are laws and regulations that aim to safeguard public health security by giving rights to 'anybody' with potential

public health threaten diseases to enjoy free services (or at least with minimal charge). Thailand also has this kind of safety net program by mobilizing resources from the Global Fund (GF) for treating the unregistered (and uninsured) migrants with TB, AIDS, and malaria. However, the quota for eligible patients is limit. Besides, there exists a critical concern over the sustainability of such practice, if in the coming years Thailand will not be eligible to apply for funding from the GF as the country has been upgraded to the upper-middle-income country category[32].

Second, the degree of rights to health care for an individual migrant in most of the reviewed countries is designed according to the length of stay and social contribution to the host country. The longer (legal) stay, the more benefit a migrant will be eligible to enjoy. This principle is commonly applied in most developed countries. An obvious evidence is found in France where the AME benefit is divided into three levels with reference to duration of residence[13]. In the Thai health care system, the migrant insurance, which is regulated by the MOPH, uses the nationality concept instead, that is, only migrants from the CLM nations are eligible to be insured. Though, this is not a wrong concept, it has created huge challenges to the government in the emergence of ASEAN Community, since many more migrants from both non-CLM and CLM countries may enter for various reasons[33].

Third, those entered the country legally and those used to be illegal immigrant but later undertook the nationality verification and became fully legalized will be insured by the main insurance scheme similar to the citizen of the host country. In contrast, the Thai health insurance for migrants is financed by the card revenue which is pooled at individual hospital. Such circumstance inevitably poses a financial challenge in the health facilities located in the areas where migrants are less-populated.

The present study has some limitations. First, as the study objective is quite broad as it serves as a starting point for further research, the authors applied narrative review approach rather than systematic review. Therefore, the review did not screen for quality of evidence and the review protocol here was less stringent and less comprehensive than the systematic review. Additionally, evidence from developing countries is missing. This limitation will definitely affect the generalized power of the study. Second, the term 'undocumented migrants', appearing in the international literature mostly includes failed asylum seekers as well. As most developed countries are the members of the 1951 Refugee Convention while Thailand is not a signatory to the Convention and does not have a formal national asylum framework. This legal framework definitely shaped the policy approaches of the countries. Thus, to adopt the international experience to the Thai context, one might thoroughly consider difference in the legal basis as well[35]. Further studies that aim to explore the feasibility of adopting the insurance models of other countries in the Thai context in the actual practice are recommended.

Conclusion

The rights to health care for migrants in the international experience can be sorted into four levels: 1) the insurance for legal migrants, 2) the insurance for illegal migrants who later registered with the state, 3) the insurance for certain populations, such as pregnant women and children and patients with communicable diseases, and 4) the special funding for the health facilities for recouping the treatment cost from caring the uninsured patients. In this practice, the implementation of such measures always faces operational constraints, for example, there is substantial room for legal interpretation about the scope of benefit the undocumented migrants can utilize without treatment charge (or at least with minimal charge), and some migrants are ignorant about their benefit. The review findings here may serve as a valuable lesson for Thailand in order to better manage its migrant health care system and to make it more effective and equitable implement.

What is already known on this topic?

At international level, the health insurance management for migrants has been explored in some academic literature. Most literature focuses on challenges to care experienced by individual migrants and providers without exploring the issue at a policy level.

At domestic level, Thailand is a country that has experienced (undocumented) migrants problems for years. The Ministry of Public Health introduced health insurance card scheme for migrants since 2004. Problems are still existed since a due number of migrants failed to register with the government agency, and were uninsured by the scheme.

What this study adds?

This article drew experience in instigating health insurance for undocumented migrants from

international literatures and compared to the Thai health care system.

The article also analyzed similarities and differences in the insurance pattern on the issue across countries. It is found that the rights to health care for migrants in international experiences can be sorted into four levels: 1) the insurance for legal migrants, 2) the insurance for illegal migrants who later registered with the state, 3) the insurance for certain populations, such as pregnant women and children and patients with communicable diseases, and 4) the special funding for the health facilities for recouping the treatment cost from caring the uninsured patients.

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Ethical clearance

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Potential conflicts of interest

None.

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ประกันสุขภาพสำหรับคนต่างด้าวที่ขาดเอกสารแสดงตน: ทบทวนวรรณกรรมประเทศที่พัฒนาแล้ว

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คนต่างด้าวที่ขาดเอกสารแสดงตน เป็นกลุ่มประชากรที่ได้รับความสนใจอย่างมากในเรื่องนโยบายสาธารณสุขในหลายประเทศ รวมทั้งประเทศไทย การศึกษานี้มีวัตถุประสงค์เพื่อถอดบทเรียนการบริหารจัดการเกี่ยวกับการประกันสุขภาพสำหรับคนต่างด้าวที่ขาดเอกสารแสดงตน ในประเทศที่พัฒนาแล้วผ่านการทบทวนวรรณกรรม โดยส่วนใหญ่ใช้รายงานการดูแลคนต่างด้าวของสหภาพยุโรป รวมถึงวารสารวิชาการ และเว็บไซต์ที่เกี่ยวข้องการศึกษานี้ได้เปรียบเทียบนโยบายการดูแลคนต่างด้าวที่ขาดเอกสารแสดงตน ใน 4 ประเทศ จากสหภาพยุโรป (ฝรั่งเศส เยอรมัน อิตาลี และสหราชอาณาจักร) และอีก 2 ประเทศ นอกสหภาพยุโรป (ญี่ปุ่น และสหรัฐอเมริกา) ผลการศึกษาพบว่า โดยหลักการแล้ว การดูแลสุขภาพบุคคลต่างด้าวสามารถแบ่งออกเป็น 3 ระดับ ได้แก่ 1) การบริการฉุกเฉิน 2) การบริการปฐมภูมิและฉุกเฉิน และ 3) การบริการเต็มรูปแบบ ซึ่งทั้ง 3 ระดับนี้มีความทับซ้อนกัน และแต่ละประเทศมักเผชิญกับปัญหาการการตีความทางกฎหมายที่แตกต่างกัน และความไม่รู้ในสิทธิการดูแลสุขภาพและสิทธิประโยชน์ ทั้งในผู้ให้บริการและผู้รับบริการ ในทางปฏิบัติสามารถสรุปและจำแนกการจัดการประกันสุขภาพสำหรับบุคคลต่างด้าวในประเทศส่วนใหญ่ออกเป็น 4 กลุ่ม คือ 1) ประกันสุขภาพสำหรับแรงงานต่างด้าวที่เข้าเมืองถูกกฎหมาย 2) ประกันสุขภาพสำหรับแรงงานต่างด้าวที่เข้าเมืองผิดกฎหมาย 3) ประกันสุขภาพเฉพาะโรค และ 4) การมีกองทุนเฉพาะชดเชยค่ารักษาพยาบาลที่เรียกเก็บไม่ได้ ผลการศึกษานี้น่าจะเป็นบทเรียนที่มีค่าสำหรับประเทศไทย ในการพัฒนาระบบบริหารจัดการประกันสุขภาพคนต่างด้าวโดยเฉพาะกลุ่มที่เป็นคนต่างด้าวที่ขาดเอกสารแสดงตน ในประเทศไทย และทำให้การนำนโยบายไปสู่การปฏิบัติมีประสิทธิภาพและเป็นธรรมมากขึ้น