PERCEPTION AND USAGE OF COMPULSORY MIGRANT HEALTH INSURANCE SCHEME BY ADULT MYANMAR MIGRANTS IN BANG KHUN THIAN DISTRICT, BANGKOK METROPOLITAN AREA, THAILAND

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ABSTRACT:

Background: The Ministry of Public Health (MOPH), Thailand, has been implementing the Compulsory Migrant Health Insurance Scheme (CMHI) for registered migrant workers since 1997. This study assessed the perception and usage of compulsory migrant health insurance scheme among adult Myanmar Migrant Workers in Bang Khun Thian district, Bangkok Metropolitan area, Thailand.

Methods: This was a cross-sectional study with both quantitative and qualitative methods. Four hundred Myanmar migrant workers, male and female who registered and unregistered in Ban Khun Thian district was selected in this study by using inclusion criteria of age 18 years and above, who can speak Burmese Language though they are not Burmese ethnicity, who are willing to participate in the research and exclusion criteria for who has difficulty in communicating in Burmese, temporary stay in Bang Khun Thian and who are working as volunteer at community based NGO team. Structured questionnaire for quantitative and in-depth interview for quantitative data were carried out. Quantitative data were organized and analyzed by the researcher using SPSS for quantitative study. Frequency, percentage are used for socio-demographic variables, working condition, medical disease, and accessibility to health care services. Chi-square test was used to analyze the statistical relationship with statistical significance p-value = 0.05 together with analysis of qualitative data.

Results: Among the respondents with registration status, 43.5 % own CMHI card as they cannot have the CMHI without the registration card. Among the respondents who owned CMHI card, 145 respondents use the card which is 36.2%. The accessibility variables such as been to hospital, translation services and general satisfaction towards health services and usage of CMHI card are positively associated with high significant level of $p<0.001$. Having an illness during last 6 months and usage of CMHI are positively associated with significant level $p<0.05$. There was no significant association between sociodemographic characteristics and usage of CMHI card. Registration status and duration in current job are not associated with usage of CMHI card. There is no relationship between perception scores and the usage of CMHI card.

Conclusions: The usage of CMHI card is associated with having an illness, been to the hospital, translator assistance and satisfaction towards health services from hospital. The recommendation from this study is that raising awareness on compulsory migrant health insurance scheme should be done together with promotion on usage and ownership of CMHI card.

Keywords: Health insurance, Compulsory Migrant Health Insurance Scheme, Myanmar migrant, Migrant workers

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INTRODUCTION

Thailand is a major destination country for an international migration especially for migrants from neighboring countries, namely Cambodia, Lao PDR and Myanmar. Migrants in Thailand can be classified in 2 groups such as regular and irregular migrants. Migrants come into Thailand with several purposes including traveling, seeking for an employment opportunity and fleeing from the unrest in their homeland [1]. At the end of December 2012, the statistical data provided by the National

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Statistical Office stated that there were around 1.133 million migrant workers in Thailand. Many scholars pointed that there is an estimation of 3 million migrant workers influx into Thailand both legally and illegally. The migrant workers from the three neighboring countries account for 87.73 percent over overall migrant workers in Thailand [2]. International migration since 1997 is mainly the consequent of the economic reason because there is the shortage of low skill workers in Thailand; therefore Thailand needs to import migrant workers [3]. Registered migrants can receive an annual check-up and health services through a Compulsory Migrant Health Insurance (CMHI) if they bought CMHI card [4]. Although access to primary health care is a basic human right, being in remote areas excludes migrants from well-established Thai public health system. Improving health conditions among migrants will ultimately benefit and assist with maintaining the health security of host communities. The Ministry of Public Health (MOPH) has been implementing the Compulsory Migrant Health Insurance Scheme (CMHI) for registered migrant workers since the cabinet resolution on 24 June 1997 but actual provision of services remains a significant challenge [4]. This study's objective is to study the perception and usage of compulsory migrant health insurance scheme among adult Myanmar Migrant Workers in Bang KhunThian district, Bangkok Metropolitan area, Thailand and to find out the association of the socio-demographic characteristics, working conditions, medical condition, accessibility and perception with ownership and usage of CMHI.

METHODS

Researcher used both cross-sectional descriptive study for quantitative study and qualitative study methods (Mixed-method) in this study. Cross-sectional study and qualitative study was used to assess the perception and usage of compulsory migrant health insurance scheme among adult Myanmar migrant workers in Bang Khun Thian district of Bangkok Metropolitan area, Thailand. The primary unit of the study were Myanmar migrant workers aged 18 years and above, male and female, registered and unregistered, from different backgrounds and ethnic group of Burmese, Karen, Mon, Rakhine, Shan, etc with inclusion criteria of age 18 years and above, who can speak Burmese Language though they are not Burmese ethnicity, who are willing to participate in the research and exclusion criteria for who has difficulty in communicating in Burmese, temporary stay in Bang KhunThien and who are working as volunteer at community based NGO team.

A total of 400 interviews were made with structured questionnaires after getting ethical approval by Chulalongkorn University (Code no.0271/58). Out of 400 participants, six participants were chosen purposively for deeper understanding of research problem according to the participant's willingness to give information regarding perception and usage of CMHI scheme.

Data collection tool was structured questionnaire with face to face interviewed by researcher and team for quantitative study and in-depth interview by researcher for qualitative study. Pilot testing of the questionnaire was conducted on 30 Myanmar migrant workers in Bang Bon district one month before doing an actual survey. Data were collected through interviewing the respondents by the researcher and assistants who understand Myanmar language well using structured pre-tested questionnaire. Data was organized and analyzed by the researcher using SPSS version 22.0 (University license). Descriptive statistics such as frequency, percentage was used for socio-demographic variables, working condition, medical condition, and accessibility to health care services. We used analytic statistics test; Pearson's Chi-square test to identify the relationship between the variables. The qualitative data was organized, interpreted and conclusion of the results was done.

RESULTS

Socio demographic characteristics are described in Table 1. A total of 400 migrant workers were interviewed. The age of respondents ranged from 18 to 58 years. 55.5 % were males and 44.5 were females. Half of respondents (52.5%) were Burmese and second most common ethnicity (14.7%) was Rakhine. 59% of the respondents were married and 36.5% were single. 2.3% were divorced, 0.5% widowed and 1.7% co-habit. 42.7% of respondents had achieved middle school education and 34.3% of the respondents got primary school education. 55.7% has been living in Thailand for more than 1 year but less than 5 years. 34.0% has been living in Thailand over 5 years. Occupation among the migrants, over two third of the respondents (80.7%) were working in factories and 7.5% were unemployed. Regarding average monthly income 54.7% earned more than 9,000 Thai Baht when 34.7% earned from 6,000 – 8,000 Thai Baht. For Thai language skills, 71.3% of the respondents could communicate basically and 14.3% could not communicate at all. Average person living in the same house is 2 and ranged from 1 to 6 persons. It can be seen from Table 1 that around 80.0% of Myanmar migrant workers were registered and the

Table 1 Socio-demographic characteristics of the respondents (n=400)

Variables	Frequency	Percentage
Age (years)		
18-29	236	59
30-39	129	32.3
> 40	35	8.7
Gender		
Male	222	55.5
Female	178	44.5
Ethnicity		
Burmese	210	52.5
Karen	34	8.5
Mon	28	7
Rakhine	59	14.7
Shan	5	1.3
others	64	16.0
Average monthly income (n= 398)		
no income	29	7.3
<5,000 THB	11	2.7
6,000 – 8,000 THB	139	34.7
> 9,000 THB	219	54.7
Thai language skills		
cannot speak at all	57	14.3
Can speak basically	285	71.3
Can speak Thai language fluently but cannot read and write	48	12.0
Fluent in Thai language / can read and write	10	2.5
Registration status		
yes	319	79.7
no	81	20.3

Table2 Registration status and ownership of CMHI

Do you have registration card? (n= 400)	Do you own CMHI card now or not?	
	yes	no
yes (n= 319)	174 (43.5%)	145 (36.2%)
no (n=81)	28 (7%)	53 (13.2%)

remaining were unregistered.

Regarding medical conditions, 90.0% doesn't have any disease diagnosed by medical personal and 7.0% has disease diagnosed by medical personnel. 84.0 % does not have any illness. Migrants changed during the time living in Thailand ranged from 0 to 20 jobs. 86.3 % were working 6 days per week. Half of the respondents have been less than 1 year in current job. Only 2.0 % has been working at the same job for more than 5 years. Out of 400 respondents, 285 persons (71.3%) have been to the hospital but 115 respondents have never been to the hospital. The duration from home to health center, 40.3% took 15-30 minutes from their home to the hospital. 62.7% replied that the travelling cost is not expensive for them but 7.3% said it is expensive. Most of them, don't know the source of health information (36.5%). Waiting time at health center is 15-30 minutes for 26.7% and more than 30 minutes for 24.7%. Doctors' fee is not expensive for 46.3% of the respondents. Main language used is Thai language being 68.7% and 56.5% stated that hospital has translator. Half of the respondents stated that they are satisfied with the services.

The scores of perception towards health services (high, moderate, low) and 54.5 % had moderate perception score, 34.5% had low level of perception score and 11.0 % had high level of perception score. Perception means the respondents' opinion of agree or disagree with the statement concerning the health care services towards migrant workers.

Table 2 showed that out of 319 respondents who had registration status, 43.5% own CMHI card now.

Table 3, Out of 202 respondents owned CMHI card, 36.2% (145 respondents) use the card. For the channels that migrants buy CMHI card, 39% of the respondent bought CMHI by selves and 30% of the respondent by their employer. 3.5% of the respondent via friends and 1%via family.

Table 3 Ownership and Usage of CMHI

Do you own CMHI card now or not?	Usage of CMHI	
	Yes	No
Yes (n= 202)	145 (36.2%)	174 (43.5%)
No (n=81)	53 (13.2%)	28 (7%)

Table 4 Relationship between medical conditions, working condition and usage of CMHI (n = 202)

	Frequency (%) of usage of CMHI		*p-value*
	Yes	No	
Medical condition			
Diseases diagnosed by medical staff			
Yes	9 (4.5)	4 (2.0)	0.198
No/ Don't know	96 (47.5)	93 (46.0)	
Any illness during last 6 months?			
Yes	25 (12.4)	12 (5.9)	0.036
No/ Don't know	80 (39.6)	85 (42.1)	
Working condition			
Do you have registration card?			
Yes	90 (44.6)	84 (41.6)	0.856
No	15 (7.4)	13 (6.4)	
Duration in current job			
less than 1 year	56 (29.6)	45 (23.8)	0.224
more than 1 year	41 (21.7)	47 (24.9)	

Table 5 Relationship between perception towards health services and usage of CMHI (n = 202)

Perception towards health services score	Frequency (%) of usage of CMHI		*p-value*
	Yes	No	
High perception	14 (6.9)	11 (5.4)	
Moderate perception	68 (33.7)	50 (24.8)	0.059
Low perception	23 (11.4)	36 (17.8)	

Relationship among variables

For relationship between socio-demographic characteristics and ownership of CMHI, there was no significant association between socio-demographic characteristics such as age, gender, ethnicity, marital status, number of people living in the same household, average monthly income, stay in Thailand, Thai language skills and educational achievement and ownership of CMHI card. There was an association between occupation and ownership of CMHI card with *p-value* = 0.019.

Having a disease diagnosed by medical personnel and having an illness during last 6 months ago are not associated with ownership of CMHI card. There is significant association between registration status and ownership of CMHI card with *p-value* = 0.001. Duration in current job is not associated with ownership of CMHI card.

For the accessibility towards health services and ownership of CMHI card, been to the hospital before, doctors' fee, waiting time, translator services and general satisfaction towards health services are highly associated with ownership of CMHI with *p-value* < 0.001. The perception score and ownership of CMHI are not associated.

There was no significant association between socio-demographic characteristics such as age, gender, ethnicity, marital status, number of people living in the same household, average monthly income, stay in Thailand, occupation, Thai language skills and educational achievement and usage of CMHI card.

Table 4 describes the relationship between medical condition, working condition and usage of CMHI card. Disease diagnosed by medical staff is not associated with the usage of CMHI card whereas illness during last 6 months is associated significantly with usage of CMHI by *p-value* = 0.036. Duration in current job and registration status are not associated with usage of CMHI card.

The accessibility variables (Been to hospital or not, translation services presence or not and general satisfaction towards health services) and usage of CMHI card are highly associated significantly with

p-value <0.001.

Table 5 showed the relationship between perception scores and the usage of CMHI card. Perception level and usage of CMHI are not associated significantly.

Qualitative data analysis

Accessibility towards health services

Accessibility towards health services was explored in terms of the affordability, waiting time, language barrier and general satisfaction towards health services. Regarding affordability, the respondents mentioned that the cost for the CMHI scheme is expensive because they need to pay together with the registration process. But in regarding the doctors' fee and costs at the hospital, it is in the affordable range of the migrants. For waiting time, they need to wait for the doctor depending on the queue number. They need to wait a bit for processing when using the CMHI card. For language barrier, the hospital provided the migrants with the interpreter and the communication between the interpreter and migrants has some level of difficulty if they are from different ethnicities. Most of the respondents satisfied with the services provided by the hospital.

The following are some of examples from the quotations by Myanmar migrants during in-depth interviews.

> *"….we can't get treatment for major illnesses. If we need to do blood tests, you need to pay 1,000 - 2,000 in addition to 30 Baht"* 31 years old, male, factory worker, A

> *"If you have fever, you can get certificate by doctor to show to your employer"* 31 years old, male, factory worker, B

> *"There are 3 translators but Myanmar migrants have many different ethnic groups so we need different translators"* 27 years old, male, factory worker, C

Perception towards health services

The respondents stated that the quality health services they received in Thailand are much better than compared to in Myanmar. Having CMHI card also benefit them as it will only cost them 30 Baht when they visit to hospital but when in Myanmar, the cost will be mostly out of pocket payment. Doctors and nurses at the hospital cared for the migrants. There is some difficulty during the major operations and hospital admission due to the financial difficulty and language difference. The assistance of translator is highly required for the migrants because although they can communicate basic Thai language, when it comes to medical problems, they cannot explain enough to doctors and nurses. Please see the following examples from qualitative in-depth interview expressed in regards to perception towards health services and experiences of migrants.

> *"I have been to hospital for my baby delivery. They welcomed me very well. The nurses and doctors took care of me very well."* 25 years old, female, factory worker, D

> *"We've been told that hospital staffs do not understand the way we speak Thai"* 27 years old, male, factory worker, E

Ownership and usage

Most of the people owned the CMHI insurance card through the registration process and they continue to renew it. We found out during the interviews is that even though they own the CMHI card, they do not know the information regarding coverage details and services excluded from the card. For the usage, the migrants are in age group of healthy adult who are in between 19-39, therefore they are healthy and do not have to go to hospital as much as older unhealthy individuals may need to go. Please see the following statements;

> *"I still do not know about the details of services covered by CMHI card"* 25 years old, female, factory worker, F

> "*This card is mostly bought by the pregnant ladies."* 25 years old, female, factory worker, G

DISCUSSION AND CONCLUSION

Among the 400 adult Myanmar migrant workers in Bang Khun Thian district, age range is from 18 to 58. 55.5% are male and 44.5% are female. Most of them were Burmese and Rakhine. As Burmese is the main ethnic group in Myanmar, it is also in Myanmar migrants in Thailand. This information is consistent with the finding presented in Thailand Migration report 2014 by IOM [5]. Half of the respondents (59%) were married and 36.5 % were single. Educational level of the majority was in middle school and primary school. Around half of them stayed in Thailand in between 1-5 years. Half of the respondents have the income of 9,000 Baht per month. The observation by researcher found that there were many factories in Bang Khun Thian area

and over two third of respondents are working as factory workers.

For Thai language skills, around 71.3% can communicate basically although 14.3% cannot speak Thai language. Eighty percentage of the respondents were registered. It is consistent with the study done for Myanmar migrants by IOM, 2013 namely assessing potential changes in migration pattern [6]. Regarding medical conditions of the respondents, 90.0% does not have any disease diagnosed by medical personnel and only 7.0% has disease diagnosed. Three percentage does not know whether they have the disease or not. In the last 6 months, 15.7% has illness or disease and 84.0% does not have any illnesses. Jobs changed during the time living in Thailand ranged from 0-20 jobs. More than half of the respondents have 8 working hours and around 13% have 12 hours. Majority of the respondents work 6 days per week. Nearly 40% has been at their job in between 1-5 years. Regarding accessibility, 40.3% of the respondents took 15-30 minutes duration of travelling. Nearly 62.7% responded that travelling cost is not expensive. Waiting time at the health center is 15-30 minutes for 26.7%. Doctors' fee is not expensive for 46.3 % of the respondents. Half of the respondents are satisfied with the services from health center. For perception towards health services, half of the respondents showed moderate level of perception.

When calculating relationship between socio-demographic characteristics and ownership of CMHI, there was no significant association between sociodemographic characteristics such as age, gender, ethnicity, marital status, number of people living in the same household, average monthly income, stay in Thailand, Thai language skills and educational achievement and ownership of CMHI card. There was an association between occupation and ownership of CMHI card with *p-value* = 0.019. This finding is not consistent with the findings from the study by Lan Le My [7] that the results revealing gender and age, educational level, economic status, health status and occupation have significantly impact on the enrollment in voluntary scheme except for occupation.

Regarding working conditions, the registration status and ownership is highly associated with *p-value* – 0.001. But since this CMHI scheme is compulsory when the migrants come for registration, this finding is as expected. Duration in current job is not associated with ownership. When calculating accessibility towards health services and ownership of CMHI card, been to the hospital before, doctors' fee, waiting time, translator services and general satisfaction towards health services are highly associated with ownership of CMHI with *p-value* < 0.001. These findings are consistent with a study by Ghosh in 2014 [8]. That study was to find out access to and utilization of the health services among the patients in a Government Homeopathic Hospital in India which reveals utilization of the health services were influenced by understanding of Bengali language (P < 0.05) [8].

The perception towards health services score and ownership are not associated. It may be because migrants can buy the compulsory migrant health insurance when they are in registration process. Regarding relationship between socio-demographic characteristics and usage of CMHI card, there was no significant association between socio-demographic characteristics and usage of CMHI card. This finding is different with the findings from a study by Ghosh [8] in Bangladesh where utilization of the health services were influenced by residence and monthly household income (P < 0.05).

The relationship between medical conditions and usage of CMHI card, disease diagnosed by medical personal is not associated with the usage of CMHI card. But having an illness during last 6 months is associated significantly with usage of CMHI by p-value = 0.036. This can be explained by that when a person has a disease or illness, they will go to hospital and will use insurance card if they have one. When the migrants are healthy, they will not use the card even if they own one. This finding is also consistent with the finding in a study done in Jordan by Abdullah Alkhawaldeh [9] which is many factors were associated with PHC service utilization, the strongest predictor of PHC service utilization was chronic illnesses. For relationship between working conditions and usage of CMHI card, duration in current job and registration status are not associated with usage of CMHI card. When calculating, the relationship between the accessibility and usage of CMHI card, the variables such as been to hospital or not, translation services presence or not and general satisfaction towards health services and usage of CMHI card are highly associated significantly with *p-value* <0.001. There is no relationship between perception scores and the usage of CMHI card. The usage can be low when the respondents are in age group of young adults with no illness during last 6 months. Overall findings suggested that the usage of CMHI card is associated with the occupation, having an illness, being healthy, translator assistance and satisfaction towards health services from hospital.

RECOMMENDATIONS

Migrants who are unemployed could be

recruited and trained as community health volunteers so that they could help in giving out information towards migrant. Raising awareness on compulsory migrant health insurance scheme should be done. For further study, the cross-sectional studies which compare the ownership and usage of CMHI among migrant groups in different province areas should be done. Qualitative studies on key persons such as employers, district health officers and community based volunteers should be undertaken.

LIMITATIONS

This study is done only in Bang Khun Thian district, Bangkok Metropolitan area so the findings could not be generalized to the whole Myanmar migrant workers populations in Thailand. Another limitation of the study is that we only have small number of in-depth interviews for qualitative data collection.

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