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REVIEW ARTICLE

A narrative literature review on health insurance policies for undocumented/illegal migrant children and its policy implications in Thailand

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Abstract

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Health of migrants is one of the major contemporary discourses globally due to a dramatic increase in population mobility in many regions. This study sought to draw international experiences regarding health insurance policies for undocumented/illegal migrant children through a literature review approach, especially in the matter of health promotion and disease prevention. The population scope included either migrant children crossing the national border without valid travel documents, or those migrating into the receiving country in a lawful manner but then failing to renew their visa. Literature was searched mainly from grey article databases in the European Union with some additional articles from Medline and relevant websites. Six countries where migrant children were concentrated were purposively selected (France, Italy, the Netherlands, Spain, United Kingdom, and United States).

All reviewed countries considered health promotion and disease prevention, especially vaccination, as basic benefit package all migrant children should be able to access without financial or nationality barriers. Besides, an 18-years cut-off age to determine whether a migrant child would be eligible to enjoy such services free of charge. However, many challenges in policy implementation still remained, including various legal interpretations amongst health care providers and a lack of knowledge in eligible services for migrants. Comparing these points with migrant policies in Thailand, though Thailand has implemented the Health Insurance Card policy for a migrant child aged less than 7 years with an annual premium around 365 Baht (US$ 11), there still exist some children who fail to be enrolled in the insurance. This phenomenon has raised a concern in public health perspectives, not only for migrant communities but for the Thai society at an entirety, if the health of non-insured migrant children is not sufficiently cared.

Keywords: migrant child, health insurance, disease prevention, health promotion

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นโยบายหลักประกันสุขภาพสำหรับเด็กต่างด้าวผิดกฎหมาย: การทบทวนวรรณกรรมเชิงพรรณนาและประโยชน์เชิงนโยบายในบริบทประเทศไทย

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นโยบายหลักประกันสุขภาพสำหรับเด็กต่างด้าวผิดกฎหมาย:
การทบทวนวรรณกรรมเชิงพรรณนาและประโยชน์เชิงนโยบายในบริบทประเทศไทย
ว สาธารณสุขและการพัฒนา 2560;15(3):99-111

สุขภาพคนต่างด้าวเป็นหนึ่งในประเด็นที่มีการกล่าวถึงกันอย่างกว้างขวางในวงการนโยบายสุขภาพโลกในปัจจุบัน เนื่องด้วยการเคลื่อนย้ายถิ่นฐานประชากรที่เพิ่มขึ้นอย่างมากในหลายภูมิภาค การศึกษานี้มีวัตถุประสงค์ที่จะถอดประสบการณ์เรื่องนโยบายประกันสุขภาพ โดยเฉพาะในมิติที่เกี่ยวกับการส่งเสริมสุขภาพและป้องกันโรคสำหรับเด็กต่างด้าวผิดกฎหมายในต่างประเทศผ่านกระบวนการทบทวนวรรณกรรม ขอบเขตประชากรของการศึกษานี้ คือ เด็กต่างด้าวที่มีสถานะผิดกฎหมาย ทั้งที่ข้ามพรมแดนโดยที่ไม่มีเอกสารเดินทางที่ถูกต้อง หรือ เด็กที่เข้าประเทศอย่างถูกต้องตามกฎหมายแต่ไม่ได้รับการต่อวีซ่าเพื่ออาศัยอยู่ในประเทศปลายทาง วรรณกรรมส่วนใหญ่ที่รวบรวมได้ มาจากฐานข้อมูล grey literature ของสหภาพยุโรป และบางส่วนได้จากฐานข้อมูล Medline และเว็บไซต์ที่เกี่ยวข้อง ในที่นี้เจาะจงที่ประเทศที่มีเด็กต่างด้าวอาศัยอยู่อย่างหนาแน่น จำนวน 6 ประเทศ (ฝรั่งเศส, อิตาลี, เนเธอร์แลนด์, สเปน, สหราชอาณาจักร และสหรัฐอเมริกา)

ผลการศึกษาพบว่า ทุกประเทศได้กำหนดให้บริการส่งเสริมสุขภาพและป้องกันโรคเป็นสิทธิประโยชน์พื้นฐานที่เด็กต่างด้าวทุกคนพึงได้รับโดยปราศจากอุปสรรคในเรื่องสัญชาติและอุปสรรคทางการเงิน นอกจากนั้นจุดตัดอายุให้เด็กต่างด้าวสามารถรับบริการส่งเสริมสุขภาพและป้องกันโรคโดยไม่เสียค่าใช้จ่ายมักกำหนดที่ 18 ปี อย่างไรก็ยังมีความท้าทายหลายประการในการนำนโยบายไปสู่การปฏิบัติ อาทิ ความแตกต่างในการตีความทางกฎหมายของผู้ให้บริการ และการขาดความรู้ในเรื่องสิทธิประโยชน์ของคนต่างด้าว เมื่อเทียบเพียงกับประเทศไทยพบว่า แม้ว่าประเทศไทยได้ดำเนินนโยบายขายบัตรประกันสุขภาพแก่เด็กต่างด้าวอายุไม่เกิน 7 ปี ในราคา 365 บาทต่อปี (11 ดอลล่าร์สหรัฐฯ) มาอย่างต่อเนื่อง แต่ก็ยังมีเด็กต่างด้าวที่ตกหล่นจากการประกันสุขภาพ ปรากฏการณ์นี้นำมาซึ่งความกังวลในทางสาธารณสุข ไม่เพียงเฉพาะในชุมชนคนต่างด้าว แต่รวมถึงสังคมไทยในภาครวม หากสุขภาพของเด็กต่างด้าวที่ตกหล่นจากการประกันสุขภาพเหล่านี้ไม่ได้รับการดูแลที่ดีเพียงพอ

คำสำคัญ: เด็กต่างด้าว, ประกันสุขภาพ, การป้องกันโรค, การส่งเสริมสุขภาพ

Introduction

Health of migrants is one of the major contem-porary discourses globally. The importance of this agenda is the concept of 'leave no one behind' was included in the Sustainable Development Goals (SDGs).[1] The term 'migrants' in this regard comprises not only those entering destination countries in a lawful manner, but also the illegal ones. The International Organization for Migration (IOM) predicted that the number of international migrants worldwide might exceed 405 million by 2050 if human mobility continued at the current pace.[2]

In Southeast Asia, Thailand is one of many countries that have attracted a huge volume of migrants, particularly from Cambodia, Lao PDR, and Myanmar, the so-called CLM nations. The recent census in 2010 estimated that there existed around 3.2 million non-Thai populations in Thailand. The majority of them were CLM migrant workers and their dependants.[3]

Most of the time, the discussions on health of migrants in Thailand were centered on 'migrant workers', while migrant children were not on the political radar. This can be seen from the fact that the insurance policy for migrant children was just established in 2013, almost ten years after the implementation of the insurance policy for migrant workers in 2004.[4-5]

Year 2004 was the first time when the Thai Ministry of Public Health (MOPH) officially introduced a nationwide health insurance policy, so-called 'Health Insurance Card' (HIC) for migrant workers, who were not enrolled in the Social Security System. Actually, before 2004, there was insurance policy for migrants, but it was limited to some provinces where migrants were populated. Then in 2013 the HIC benefit package was expanded to cover HIV/AIDS treatment, and its target populations were extended to dependants of migrant workers. Since then, a migrant child, aged less than 7 years, has been eligible to the insurance.[5] At present, the annual premium of the HIC is 1,600 Baht (US$ 48) for a migrant adult and 365 Baht (US$ 11) for a migrant child.[6]

Despite several attempts to insure 'all' migrant children in Thailand, a number of challenges were observed. For instance, in 2016 around 70,000 migrant children had the insurance card, whereas the estimated number of all migrant children in Thailand was approximately 250,000.[7] Another troubling example is some health care providers denied selling the insurance card to unhealthy children as they deemed that the revenue from selling the card to sick children was far less than the incurred cost from treating them.[8]

It is vital to learn from other countries how they designed and managed policies for protecting the health of migrant children. Therefore the objective of this article is to explore the insurance design, particularly for health promotion and disease prevention activities, for undocumented/illegal migrant children from the experiences in developed nations. The population scope is migrant children who either crossed the national border without valid travel documents, or migrated into the receiving country in a lawful manner but then failed to renew their visa (over-stayers). Nevertheless this article has touched upon some services beyond health promotion and disease prevention and undocumented/illegal migrants in general aside from children to some extent. It is hoped that the international experiences presented in this

study are beneficial to policy makers and academics involved in the development and implementation of migrant health policies in Thailand.

Methods

A narrative literature review was applied. Articles were searched mainly from grey literature databases concerning undocumented/illegal migrants in the European Union (EU), the NOWHERELAND project in particular. The project contained 27 country reports. Additional references were searched from Medline and official websites of the authorities managing migrant health insurance schemes in certain countries. Examples of search terms included "refugee/ migrant/ immigration health", "health care for undocumented migrants", "international migration statistics", and "right to health". The authors (PN and RS) screened all recruited papers. A paper would be selected if it met all the following inclusion criteria: (i) sufficient information about insurance design for undocumented/ illegal migrant children was provided, (ii) migrants in this sense referred to cross-border migrants, not internal migrants, and (iii) the information shown in the paper covered health promotion and disease prevention activities. On the contrary, a paper would be excluded if it was written in other languages but English, or the information presented in the paper did not have sufficient link to the insurance arrangement for undocumented/illegal migrant children. Any disagreements were resolved by series of discussions between the screeners. The rest of the authors helped extract and synthesize content of the selected papers.

Note that as this research employed a narrative review approach, the inclusion and exclusion criteria above were just a rough guideline for selecting articles that met the review objectives rather serving as stringent article selection and quality appraisal processes. The methodological shortcomings of this review were later discussed in the 'Discussion' section below. To make the review more concise, six countries where migrants are concentrated were selected as an example, namely, France, Italy, the Netherlands, Spain, the United Kingdom (UK), and the United States (US). The selection was exercised by taking into account maximal variability in terms of health system characteristics, that is, Italy, Spain and the UK for tax-based financing state-run insurance, the Netherlands for private insurance regulated by state, France for social health insurance, and the US for mixed insurance system.

Accordingly, a total of 5 country reports from the EU, 2 official websites of the health authorities from the US (focusing on certain cities, namely, Illinois and San Francisco) and 17 academic articles were recruited for the final review. Thematic analysis was employed with deductive coding. Three key themes were identified: (i) volume of undocumented/ illegal migrants, (ii) insurance design focusing on health promotion and disease prevention (in terms of financing and benefit package), and (iii) barriers to care.

Results

France

(i) Volume of undocumented/illegal migrants

France was composed of 64.7 million citizens. About 3.6 million of them were foreign-born (~5.8%). The volume of undocumented/illegal migrants was approximately 300,000-500,000, mostly from Portugal, Algeria, and Morocco.[9]

(ii) Insurance design

French public health insurance was managed under the Universal Coverage Act. Employees and employers must pay contributions to the Social Health Insurance. The contributions were exempted in some populations, such as pregnant women and children, and persons with a yearly wage less than €6,600. The benefit package was comprehensive. For outpatient care, a patient must pay for the treatment first but up to 70% of the total expense could be later reimbursed from the scheme. The benefit package comprised primary care, secondary care, maternity and child care, emergency care, vaccination, family planning, public health threat treatment (including HIV/AIDS and TB). Undocumented/illegal migrants were required to apply for the State Medical Assistance Certificate first (Aide Médicale d'Etat: AME). Evidence required for the AME application was birth certificate, expired passport and proof of residence and monthly income. Health promoting services including vaccination were provided free of charge for migrant children aged less than 18 years.[9-10]

(iii) Barriers to care

Even these systems in place, there were still practical difficulties in receiving care. The main reasons included (1) uneven interpretation of the law across regions, (2) lack of awareness of the services in the patients, and (3) lack of documents or adequate evidence to apply for the AME. The Médecins du Monde reported that only 10.2% of undocumented/illegal migrants in their health facilities had access to the AME.11

Italy

(i) Volume of undocumented/illegal migrants

Of the 60 million residents in Italy, 3.5 million (~5.8%) were foreign-born. The majority of immigrants were from Romania, Albania, and Morocco. The number of undocumented migrant was 200,000-1,000,000 or 0.6-1.3% of all population.[12] About 60 - 75% of undocumented migrant were over-stayers. In recent years Italy faced a huge influx of immigrants from war-torn regions and Africa, the so-called refugee crisis in the Mediterranean Sea.[13]

(ii) Insurance design

The main insurance system is the Italian Health Service, financed by general taxation. Insurees are required to register with the local authorities to obtain a Health Card (Tessera Sanitaria). The Health Card holder is eligible to enjoy comprehensive health services, including specialized care/treatment, but there is co-payment at point of care (around US$ 48 for each specialist visit).[14] Certain populations are exempted from co-payment, such as children aged below 6 years, the elderly aged over 65 years, low-income, prisoners, persons suffering from chronic diseases, and pregnant women. Legal migrants are under the same regulations as Italian nationals. Undocumented/illegal migrants are eligible to acquire a 'Temporary Residing Foreigner Code', with 6-month validity. This serves as a guarantee to enjoy a variety of essential services. In general, there was no significant difference between the benefit package for Italian children and undocumented/illegal migrant children aged less than 18 years.

(iii) Barriers to care

There were subtle differences in the interpretation of scope of 'essential service' migrants were eligible between regions.[9] Fear of deportation, administrative hurdles, and linguistic and cultural differences also served as significant barriers.[15-16]

The Netherlands

(i) Volume of undocumented/illegal migrants

In the Netherlands, of the total 16 million citizens, about 700,000 were foreign born. The majority of them were from Turkey, Morocco and Germany. The estimated number of undocumented/illegal migrants was around 60,000 to 225,000, equivalent to 0.4-1.4% of the total population.[17]

(ii) Insurance design

The Dutch health care system was rooted in the Bismarckian social insurance tradition. A major revision was made in 2006, where a single compulsory insurance scheme in which a wide range of private health insurers compete for insured persons was established. Immigrants without a residence permit could not apply for basic health insurance. Nonetheless, based on Article 10(2) of the Aliens Act, they were entitled to 'medically necessary care', which covered basic primary care and health promotion. However, the patients needed to pay for most of the services. If they could not afford the bill, health care providers would seek reimbursement for 80%–100% of the cost of care from the National Health Care Institute. To receive the reimbursement, health care providers must prove that they first attempted to collect the owed amount from the patient. When it comes to preventive health care specifically, undocumented/illegal migrant children below 18 years of age were entitled to free vaccinations, free preventive care and check-ups. Pre-natal screening for pregnant women was also free of cost.[18-19]

(iii) Barriers to care

In practice, undocumented/illegal migrants faced some financial and practical hurdles in accessing care. About a quarter of the patients reported being denied by health care providers as undocumented/illegal migrant children did not receive official invitations for the vaccination program. Moreover, their parents were often too scared to become visible to the government officials. As a result, they did not have their children register for the necessary preventive health care measures. Furthermore, undocumented/illegal migrants were increasingly missing out of influenza vaccinations because the number of vaccinations available for the population as a whole was limited.[19-20]

Spain

(i) Volume of undocumented/illegal migrants

In 2008 there existed around 5.2 million foreign born residents in Spain (~11.6% of the total population).21 Amongst this population, about 150,000-350,000 were considered undocumented (~1% of the total population), mostly from Morocco and Latin Americas.[21-22]

(ii) Insurance design

The Spanish National Health System (NHS) was funded by general taxation. Spanish citizens were eligible to general health care services free of charge. Legal migrants were eligible to care in similar fashion

to Spanish citizens. Undocumented/illegal migrants were included if they registered as residents with a municipality but they still needed to pay a monthly premium to the NHS (€60 for a migrant aged up to 65 years and €157 for above 65 years).19 The only exceptions were (i) emergency care, (ii) care to children aged under 18 years (including health promotion and vaccination programs), and (iii) pre- and post-natal care, where everybody (regardless of their immigration status) could access without any cost, as stipulated in the Spanish bylaw (Laws 4/2000, Royal Decree 16/2012).19

(iii) Barriers to care

Despite a broad benefit for undocumented/illegal migrant children, there were still some practical irregularities. For instance, some providers sent invoices to the patients after they received preventive health care despite the fact that the Spanish NHS had already covered such service. Besides, there were inconsistencies in migrant policies in Spain. In 2012 the conservative party introduced laws that limited rights to health of undocumented/illegal migrants but since the regional elections in May 2015, there had been attempts from some Autonomous Communities to re-expand the benefit of undocumented/illegal migrants by appealing this issue to the Constitutional Court.[9, 19]

United Kingdom

(i) Volume of undocumented/illegal migrants

As of 2010, the total number of population in the UK was around 62 million. Foreign-born population accounted for about 7% of the total population, mostly from Poland and India. The volume of undocumented/illegal migrants was approximately 618,000 to 1.1 million.[23] About three–quarters of them were residing in London.[23]

(ii) Insurance design

The main authority responsible for insuring the health of the UK residents was the National Health Service (NHS). The eligible beneficiaries of the NHS were 'ordinary residents' as specified in the 1989 Statutory Instrument No 336. Generally, a person residing more than 3 years in the UK was defined as ordinary resident, and this term normally included legal immigrants. Ordinary residents were allowed to enjoy free NHS services in all range of care. For undocumented/illegal migrants, only certain services were provided free of charge, including (but not limited to), outpatient emergency care, compulsory treatment under court order, psychosis treatment, treatment for potential public threats (such as cholera, tuberculosis, and influenza), and family planning. Undocumented/illegal migrant children (aged less than 18 years) were eligible to primary care and health promotion services, including vaccination free of charge under the condition that they must register with general practitioners (GPs) first.[18]

(iii) Barriers to care

In practice, there were still confusions in the NHS guidelines and regulations for dealing with undocumented/illegal migrants. Some NHS staff were unaware of the rights of migrants.[24] Nevertheless, the NHS attempted to resolve confusions by establishing a hotline service where health care staff could check

the rights of each patient. Some Primary Care Trusts collaborated with non-profit organizations to alleviate this problem.[25]

United States

(i) Volume of undocumented/illegal migrants

The US was the nation with the most ethnically diverse population. As of 2014, of 305 million citizens in the US, about 11.3 million were undocumented/illegal migrants. In the past, most of the foreign-born populations were from Mexico. Currently, the number of migrants from Mexico declined, while those from Asia and Central America were on the rise.[26] Cities with the highest numbers of undocumented migrants were New York, Florida, Illinois, and New Jersey.[26-27]

(ii) Insurance design

The health insurance system varied across states. Normally, each state applied a pluralistic system (a combination of private and public insurance). The main insurance arrangements were (1) public insurance for the vulnerable groups, that is, Medicaid for low-income populations and Medicare for the elderly, and (2) voluntary private insurance. Those who were not entitled to any scheme were liable to out-of-pocket payment at point of care. In 2010, the Affordable Care Act (Obamacare) was enacted. The Act made it illegal for insurers to refuse to insure an individual due to pre-existing conditions. It also increased coverage by expanding Medicaid to cover individuals and households near the poverty line, and by subsidising private insurance for middle-income people.[28] Legal immigrants and foreign-born residents had the same rights as US citizens. Undocumented/illegal migrant children were not eligible to Medicaid.[29] However some states provided state-sponsored insurance for undocumented/illegal migrants and individuals who were medically uninsurable through private insurance, for instance, Healthy Kids Program in San Francisco (SFHP) and All Kids Program (AKP) in Illinois. Both schemes provided basic health benefit package including routine check-up and immunizations for undocumented/illegal migrants. Yet, there were subtle differences between schemes. The AKP set the cut-off age for a child at 18 years while the SFHP applied the 19-years cut-off. The SFHP required an insuree to pay for a yearly premium around US$ 189 and a co-payment around US$ 10-15 per visit, whereas the AKP calculated a premium per family according to family income and number of family members. For example, a family of four that made up to US$ 36,168 of gross income each year did not have to pay for premiums or co-payments.[30-31]

(iii) Barriers to care

Many barriers were identified. For example, some migrant parents were afraid of being deported as a result of traveling and using health services. This fear made their children have poor access to services. In addition, there were societal discourses that undocumented/illegal immigrants did not deserve health care. This problem was compounded by experiences of the patients in being asked for proof of documentation from specific hospitals that adhered to strict document regulation.[32]

Discussion and recommendations

In summary, it is clear that all reviewed countries considered health promotion and disease prevention as basic benefit package that all migrant children should be

able to access without financial or nationality barriers. Going beyond the findings above, the researchers had synthesized some worth-learning points as follows.[9] Firstly, the most common health promotion services to which undocumented/illegal migrant children in all reviewed countries are eligible with no cost (except for some states in the US), is immunization. Secondly, almost all reviewed countries set an 18-years cut-off age to determine whether a migrant child would be eligible to health promotion and disease prevention services free of charge. The only exception was in the US where each state has its own regulation; for instance, San Francisco set the cut-off age at 19 years. Thirdly, health promotion policies for undocumented/illegal migrant children from the reviewed countries did not specify 'country of origin' of the beneficiaries as preconditions in receiving services. Lastly, hurdles to care in the real practice are quite common in all reviewed countries, that is, poor attitude of providers, inconsistency in legal interpretations, and health care providers' lack of awareness of the benefits for migrants.[33-34] Yet, this study by no means intends to argue that if Thailand mimics the migrant policies from developed countries, most of the current problems regarding migrant health will be much alleviated. The bottom line is, from the review, there are several worth-exploring lessons, which the Thai government may learn from, with some examples as follows.

Firstly, while most of the reviewed countries did not require their migrant children to pay premiums before receiving health promotion services, the Thai MOPH stipulated that to be insured with the HIC, a migrant child must pay for the health card (US$ 11) first. Though the money is quite small, it may create negative effect on migrants as some providers deem that the revenue from selling the card is far less than the potential cost of treatment. As a result, some providers may refuse to sell the health card to migrant children, especially the unhealthy ones; and this phenomenon has already happened in the real world.[8]

Another point of concern is to be insured with the HIC, a migrant child must be a dependant of migrant workers from CLM nations only. Besides, during the military government era, to be enrolled in the insurance, all migrants must undertake the registration specified by the government, so-called, the One Stop Service (OSS) first. In other words, the Thai policy for migrant children does not open to 'all' undocumented/illegal migrants in practice. This is contrast to the review findings where health insurance policies in the reviewed nations are open to 'all' undocumented migrant children (at least in principle) 'all' the time.[8]

Last but not least, the cut-off age of migrant is also troublesome. From the review, all countries specified the cut-off age at 18 years or above, while Thailand applies the cut-off at 7 years. This point renders a concern for the Thai health care system, that is, a child aged between 8 and 15 years is likely to fall into the policy gap since he/she is neither able to acquire the work permit nor eligible to buy the 365-Baht insurance.[35]

Thus, some key policy recommendations are provided. Firstly, the Thai MOPH should send a clear message to the wider public as to whether the current insurance policy is still open to 'all' migrant children or just to 'dependants' of registered migrant workers. If Thailand wishes to pursue the vision in protecting 'health' of 'everybody' on the Thai soil, expanding

coverage to 'all' migrant children is likely to be an importing stepping stone to achieve that goal. In terms of national politics, such a message is not something new as many public authorities have already recognized this; for instance, the NHSO strategy for 2012-2016 stated that, 'All people in Thailand are assured under the Universal Health Coverage', and the MOPH Border Health Plan (2012-2016) also emphasized the word 'all people' in one of its strategies.[36-37]

Secondly, the problematic detail in the HIC regulation should be revised. The cut-off age for migrant insurance should be expanded to 15-18 years to meet international standards. This revision, in the same time, can reduce a probability that a migrant child aged between 8 and 15 years is left uninsured.

Lastly, when mentioning 'health insurance', the discussion of necessity includes which benefits are to be covered. The Thai government may adopt lessons from the developed countries that services with externality benefits, such as immunization and health screening, should be provided to 'everybody' regardless of his/her citizenship and insurance statuses. The concept is such services are provided with an aim to protect 'the whole' society, not only migrant children. Of course, when it comes to implementation, there are subtle details to be concerned, such as who will finance the cost of services, and how much to pay. It is difficult to address this point in this article as it goes beyond the study's objectives. Further studies on the appropriateness and feasibility of adopting the model from countries to the Thai context are recommended. For instance, one can learn from the Netherlands' model that allows health care providers to be reimbursed 80-100% of the unpaid debt from providing care for undocumented/illegal migrants from the central authority.[19]

This study still faced some limitations. Firstly, the researchers opted to use a narrative review as the main data collection technique instead of a systematic review, because, normally, a systematic review approach is more suitable for specific research question or hypothesis-testing objective whereas this article aimed to present an overview of health care policies for undocumented/migrant children. Of course, there is a trade-off for this approach. A narrative review is more prone to bias than a systematic review in several respects, such as a lack of rigorous data selection and quality appraisal processes.[38] Secondly, the selected papers were limited to those written in English only, rendering a language bias. Thirdly, in reality, the citizenship status of a person is very fluid, and it may be defined differently across countries. An undocumented/illegal immigrant may participate in a legalization process, and this allows his/her to turn his citizenship status from illegal to legal. In contrast, a legal/documented migrant may stay in a destination country longer than the allowed period specified in his/her visa. Hence the situation of each country presented in the review might not be up to date.

Last but not least, there were subtle details in the insurance arrangement in each country. Each country has its own idiosyncratic health system features, including history of health system development, human resources management, and infrastructure investment. Therefore the benefits of this article should serve as starting points for further studies on insurance management for migrant health, rather than as a silver

bullet for solving migrant-related problems in Thailand. Applying and generalizing the review results to the Thai context should be made with caution.

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