M-FUND

The Migrant Fund

Ensuring healthcare protection of all migrants, and health security for all – lessons learned from the Migrant Fund (M-FUND), a low-cost not-for-profit health protection scheme for migrants in Thailand

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CONTENTS

Acknowledgements 2

Executive Summary 4

1. Successes and gaps in healthcare protection for migrants in Thailand 5

1.1. Snapshot of migration in Thailand 5
1.2. Healthcare protection schemes for migrant populations 5
1.3. Remaining gaps in healthcare protection for migrants in Thailand 6

2. Overview of the M-FUND project 7

2.1. Goals of M-FUND project 7
2.2. History of M-FUND 7
2.3. Design, costs and coverage 7
2.3.1. Operational design 7
2.3.2. Costs and coverage 8
2.4. Progress and achievements 9
2.4.1. Enrollment and member characteristics 9
2.4.2. Healthcare covered 12
2.4.3. Costs of care and progress towards financial sustainability 13

3. Lessons learned from M-FUND on effective healthcare protection for migrants in Thailand 15

3.1. Strengths and value of M-FUND 15
3.1.1. Filling the gaps in the country's Universal Health Coverage (UHC) 15
3.1.2. Peer-driven community enrollment and digital solutions are keys to success 15
3.1.3. Monthly contribution is most suitable for migrants 16
3.1.4. Coverage of care in more than one hospital is desirable 16
3.2. Challenges and limitations 17
3.2.1. Adverse selection from voluntary enrollment 17
3.2.2. Low retention, from high mobility and other structural challenges 18
3.2.3. Reaching financial sustainability while maintaining optimum healthcare coverage 18
3.2.4. Monthly collection of cash contributions 19

4. Way forward for M-FUND 20

5. Policy recommendations 21

EXECUTIVE SUMMARY

Although Thailand has achieved Universal Health Coverage for Thai citizens and allows registered migrants to enroll in the Social Security Scheme or the Migrant Health Insurance, an estimated one million unregistered migrants are ineligible for these schemes and still lack health protection.

In September 2017, the social enterprise and foundation Dreamlopments (DLP) launched the Migrant Fund (M-FUND), a low-cost not-for-profit health access scheme for migrants uncovered by government health insurance.

M-FUND is currently implemented in Tak, Sakaeo and Kanchanaburi provinces in Thailand, as well as Myawaddy township in Myanmar, opposite to Tak. In this voluntary scheme, community workers and community relays conduct promotion and community-based enrollment of peers, using M-FUND digital application on tablets or smartphones. Upon enrollment, an electronic membership card is created and linked to a QR code given to members that can be scanned in partner facilities to confirm membership details and give access to care. As of September 2021, M-FUND collaborates with 148 partner facilities, from government hospitals, private and non-government organization clinics. Enrollment in M-FUND involves a contribution of 100 THB per member per month (ppm) for people without pre-existing health conditions. Persons with chronic diseases (CD), pregnant women (P) and senior members (S, ≥50 years old) must take specific plan options, requiring an additional contribution of 200 THB ppm (CD, P) or 100 THB ppm (S) and to enroll with two other members without any such preexisting conditions. M-FUND membership covers broad quality healthcare services in outpatient consultations up to 5,000 THB per person per year (ppy), and inpatient admissions up to 45,000 THB ppy.

Since its inception and as of 31 August 2021, a total of 31,792 members have voluntarily enrolled in M-FUND across all project areas. 67% of members are women, and 25% are children below 18 years of age. As many as 36,371 healthcare events have already been covered for members in partner facilities, including 30,463 outpatient consultations and 5,908 hospital admissions. These services have been covered while succeeding in making great progress in controlling costs, towards the ultimate objective that has been set, of reaching M-FUND financial sustainability. Lessons learned from M-FUND implementation are discussed in this report.

Efforts led by the Thai Ministry of Public Health are ongoing to propose a resolution to the National Health Assembly on “Protection of Equitable Access to Health Services by Specific Populations in Crisis”. The draft resolution includes a specific focus on the needs of migrants and persons with citizenship problem. We believe that any new scheme or revised scheme of health protection for migrants should be enforced by law (rather than cabinet resolutions or ministerial regulations), at all times (rather than during crisis). The funding of such schemes should not be borne by migrant workers only, and contributions from migrants should be aligned with their income pattern and ability to pay, and include the possibility of monthly or quarterly installments, which would likely increase participation. Use of modern technology and digital payments should be leveraged to collect contributions. We reckon that dependents of migrant workers (notably spouses and children) should be included in schemes of health protection, to leave no one behind and reinforce health security for all. We advocate for the integration/recognition of M-FUND by the government, among formal options/schemes of health protection of migrants in Thailand.

1. SUCCESSES AND GAPS IN HEALTHCARE PROTECTION FOR MIGRANTS IN THAILAND

1.1. Snapshot of migration in Thailand

There are 4.9 million non-Thai residents within Thailand, including approximately 3.9 million migrant workers from Myanmar, Cambodia, Laos, and Viet Nam,[1] 500,000 of whom are children.[2] Reports from these countries indicate that at least 430,000 migrant workers have returned home since the start of the Covid-19 pandemic, the vast majority from Thailand.[3] In March 2021, official records show that there were about 2.4 million registered migrants in Thailand,[4] and it is estimated that there may also be 1 million unregistered migrant workers still living in the country.

1.2. Healthcare protection schemes for migrant populations

To access healthcare services, registered migrants can enroll into the government Social Security Scheme (SSS) under the Ministry of Labor (MOL) or the Migrant Health Insurance (MHI) under the Ministry of Public Health (MOPH). Typically, migrants working in the formal sector (having work permits and passports) enroll in the SSS. They and their employers each make monthly contribution of 5% of the employees' salary (but not exceeding 750 Baht, or 23 US$) while the government contributes 2.75%. Three months after registration, enrollees are entitled to receive free outpatient and inpatient healthcare services in a public hospital where they register (referral to higher level facilities is possible if medically indicated), and although there is no coverage ceiling,[5] there are limitations on the types of services that can be received under the scheme. Registered migrants working in the informal sector (e.g. agriculture, domestic workers) and migrants workers waiting for their SSS benefits must buy the MHI of the MOPH. Children of migrant workers below 18 years old can also in principle buy the MHI. The one-year insurance card costs 1,600 THB (48 US$) per person (not including 500 THB for the health checkup) but only 365 THB (11 US$) for children under 7 years old. Two-years and six-months coverage can also be purchased, as well as three months but only for migrants waiting to receive benefits under the SSS.[6] Like with the SSS, migrants insured under the MHI can seek medical services at the hospital where they register, with comparable coverage benefits. However, the SSS offers additional benefits in case of death, disability, or unemployment.

1 IOM, PROMISE Quarterly Newsletter- October-December 2020, available on https://thailand.iom.int/sites/thailand/files/PROMISE/IOM%20PROMISE%20Quarterly%20Newsletter_Oct-Dec%202020.pdf, accessed in May 2021.
2 Ratanapaskorn, Peerapas. "Migrant Children Need Education." Bangkok Post, 1 July 2020, available on https://www.bangkokpost.com/opinion/opinion/1943776/migrant-children-need-education, accessed on 7 Sept 2021
3 IOM, PROMISE Program Brief-Supporting Socio-Economic Recovery from the COVID-19 Pandemic for Migrant Workers in Cambodia, Lao People's Democratic Republic, Myanmar, and Thailand, available on https://thailand.iom.int/sites/thailand/files/COVID19Response/PROMISE%20Programme%20Brief%20-%20Supporting%20Socioeconomic%20Recovery%20from%20COVID-19%20for%20Migrant%20Workers%20in%20CLMT.pdf, accessed in May 2021
4 Foreign Workers Administrations Office of Thailand, available on https://www.doe.go.th/prd/assets/upload/files/alien_th/945ef7c31755e7e937ecd5da4a1d24d7.pdf, accessed on 9 Aug 2021.
5 Handbook for Social Security Members, the Social Security Office of Thailand, http://www.oic.go.th/FILEWEB/CABINFOCENTER2/DRAWER056/GENERAL/DATA0000/00000578.PDF, accessed on 9 Oct 2020.
6 Notification of the Ministry of Public Health on Medical Checkup and Health Insurance for Migrant Workers (No.2), 10 July 2020.

1.3. Remaining gaps in healthcare protection for migrants in Thailand

Although the SSS and the MHI are mandatory schemes for registered migrants, as of 23 June 2021, there were only about 900,000 migrant workers with active MHI cards.[7] Challenges for higher coverage include enforcement on the employers of migrants, inadequate awareness of the existence of the insurance among migrants, and unaffordability of the insurance premium for migrant workers/employers.[8] In addition, unregistered migrants and dependents of registered migrants over 18 years old (notably female partners of male workers, and parents) are not eligible for either scheme and represent the only sub-population of people living in Thailand having no healthcare protection and no access to free health care services.

In some areas, non-government organizations provide specific and free of charge healthcare services for migrants under no government health insurance, but these remain limited, and they have been entirely dependent on long-term support from external donors, which has decreased significantly over the past few years. Support from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) has permitted to cover some services for migrants in government hospitals of provinces that host large numbers of migrants, but this remains also limited. For uninsured migrants who seek services in government hospitals, cost of care that cannot be paid out of pocket, notably for severe illnesses, must be absorbed by hospitals and can represent significant financial burdens. Migrants would typically use any saving available, borrow money, sell assets, and yet remain unable to cover all costs of care. According to the National Legislative Assembly, in 2017 the Thai government had to bear medical costs of undocumented uninsured migrants for approximately 400 to 500 million Baht a year. These costs of care were generally higher in hospitals along the border and in Tak alone, the healthcare costs that could not be collected were higher than 100 million Baht per year.[9]

7 Open Data Government of Thailand, Digital Government Development Agency, available on https://data.go.th/dataset/dhesmoph, accessed on 9 August 2021.

8 Watinee Kunpeuk et al., Understanding the Problem of Access to Public Health Insurance Schemes among Cross-Border Migrants in Thailand through Systems Thinking, *International Journal of Environmental Research and Public Health* 2020, 17, 5113, http://ihppthaigov.net/DB/publication/attachinter/435/Full-text.pdf, accessed on 9 August 2021

9 National Legislative Assembly, the “Study Report on Migrant Workers Situations in Thailand”, September 2017, available on https://www.senate.go.th/document/Ext17002/17002533_0002.PDF, accessed on 7 September 2021

2. OVERVIEW OF THE M-FUND PROJECT

2.1. Goals of M-FUND project

The Migrant Fund (M-FUND) was set up by Dreamlopments Social Enterprise and Foundation (DLP) as a private low-cost and not-for-profit health insurance for migrants not covered by government insurance schemes, aiming to provide access to broad quality healthcare services for this population, in a sustainable manner.

2.2. History of M-FUND

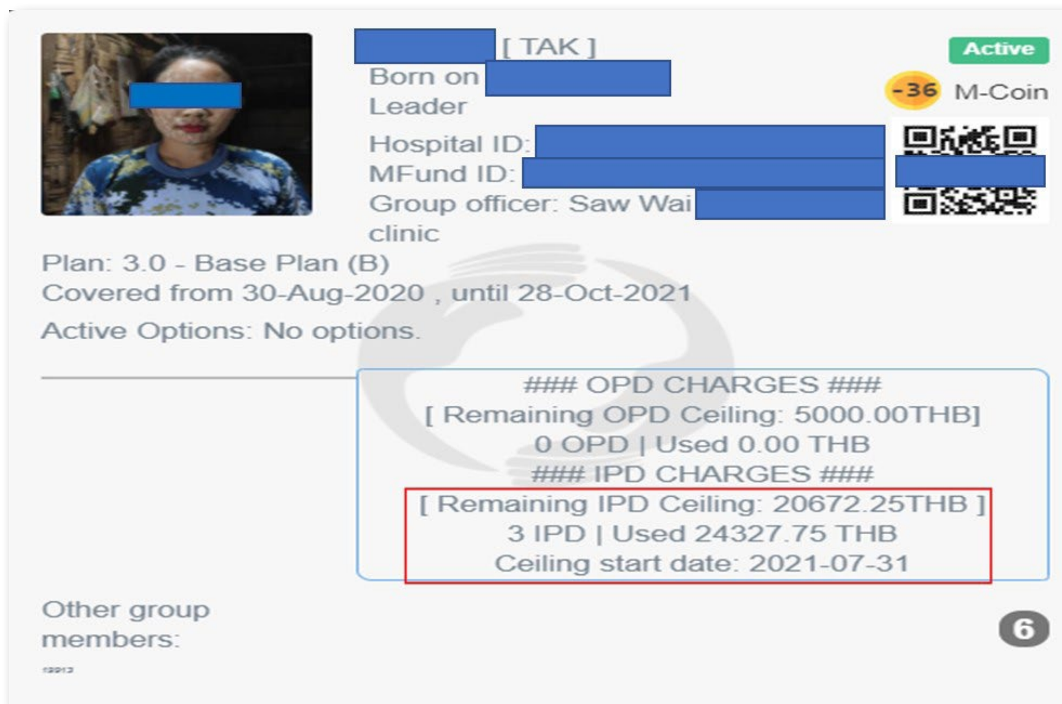
The M-FUND project was initiated in Maesot District in Tak Province along the Thai-Myanmar border in September 2017, and has since expanded across Maesot, Mae Ramat and Phop Prah Districts, where large numbers of migrants reside. In August 2019, the scheme was established in Myawaddy Township in Myanmar (opposite to Tak) to offer effective healthcare protection to cross-border populations. M-FUND has since also been extended in Sakaeo Province along the Thai-Cambodia border starting in September 2019, and in Kanchanaburi Province, south to Tak Province, since June 2020. Over the years, the project has received support from the Thai Ministry of Public Health, and financial support from donors including UNICEF, the European Union, the Global Fund to Fight AIDS, Tuberculosis and Malaria, L'Initiative, and private supporters.

2.3. Design, costs and coverage

2.3.1. Operational design

The M-FUND is a peer-driven, community-based scheme designed to suit the needs of target beneficiaries. DLP employs community workers (CWs) from migrant communities who provide information about M-FUND and conduct community-based enrollment in M-FUND, at times and locations that suit migrants. Enrolment in M-FUND is voluntary. CWs use tablets or smart phones and conduct enrollment on the secured M-FUND digital application. Socio-demographic characteristics and contact information are captured. No identification documents are requested, but pictures are taken and used for member identification. Upon member and group creation in the application, a digital membership card is generated and linked to a unique and anonymous QR code, given to members. When seeking care in partner facilities, members present their QR code cards which can easily be scanned by personnel to display details of membership status. (see Figure 1) Active members are offered to receive services and bills are sent directly to M-FUND teams.

Figure 1 – Example of a M-FUND member card



2.3.2. Costs and coverage

M-FUND was launched in September 2017 with use of Plan 1.0. Since then, there have been a few iterations, and M-FUND 4.0 is now in use since February 2021. (see Figure 2) The iterations have been guided by routine monitoring of key project indicators, and regular thorough analyses and financial models done by micro-insurance experts. In Plan 4.0, people with no pre-existing health conditions are asked to contribute a payment of 100 THB per person per month (ppm, approximately 3.0 US$). All members are covered up to 5,000 THB (approximately 160 US$) per year for outpatient services and up to 45,000 THB (1,400 US$) per year for inpatient services, for a total coverage benefit of 50,000 THB (1,560 US$) per person per year (ppy). Persons with existing chronic illnesses (e.g. diabetes, hypertension, HIV, others) can join M-FUND but must take the Chronic Diseases Option where they are asked to contribute an additional 200 THB ppm and bring with them two additional members with no pre-existing conditions. Women enrolled in M-FUND who become pregnant must similarly take the Pregnancy Option and pay a supplement of 200 THB ppm and bring two additional members. Persons aged 50 years and above must take the Senior Option and contribute an additional 100 THB ppm as well as enroll with two other members. As M-FUND is a voluntary scheme, the mandatory element of enrolling with other members for those with existing health conditions and high need for health care was introduced with Plan 2.0 in July 2018, after a financial analysis revealed a large adverse selection under Plan 1.0, where many of the enrolled members had existing health conditions. In Plan 3.0, we separated coverage of outpatient and inpatient services and aligned coverage ceilings for all options, after a new financial analysis revealed the need to make further progress in reducing the ratio of cost of care over contributions collected. Finally, under Plan 4.0 which was guided by the latest financial model conducted between October and December 2020, we discontinued the possibility for women who are already pregnant to enroll in M-FUND, except in the area of Tak/Myawaddy where the specific NGO Pregnancy Option can be taken for women seeking antenatal care (ANC) in partner NGO clinics. Costs of care provided in the partner clinics are currently covered by donor grants still received by the partner NGOs, while M-FUND covers costs of care in partner hospitals when it is needed for management of more complex conditions (e.g. cesarean sections, or care for premature babies). Finally, a special School Plan where base contribution is reduced to 75 THB ppp exists for children enrolling as a group of 25 members or more, in migrant learning centers.

It must be noted that during the peaks of Covid-19 waves, M-FUND aimed to support members by waiving and subsidizing (from donor support and some M-FUND reserves) membership fees for periods of four to twelve weeks. (see Graph 2) Enrollment of new members in the communities was paused only during the hardest time of Covid spread and lockdowns, in July and August 2021. (see Graph 1)

Figure 2 – M-FUND Plan 4.0

<table>
<tr><th rowspan="2"></th><th rowspan="2">Contribution per month</th><th colspan="3">Benefit Limit Per Year</th></tr>
<tr><th>OPD</th><th>IPD</th><th>Total</th></tr>
<tr><td>Base Plan</td><td>100 THB or 5,000 Kyat</td><td rowspan="6">5,000 THB
or
250,000 Kyat</td><td rowspan="6">45,000 THB
or
2,250,000 Kyat</td><td rowspan="6">50,000 THB
or
2,500,000 Kyats</td></tr>
<tr><td>School Plan (min 25)</td><td>75 THB or 3,750 Kyat</td></tr>
<tr><td>Chronic Option</td><td>+ 200 THB or 10,000 Kyat and 2 other members</td></tr>
<tr><td>Community Pregnancy Option</td><td>+ 200 THB or 10,000 Kyats and 2 other members</td></tr>
<tr><td>NGO Pregnancy Option (Tak/Myawaddy)</td><td>+ 100 THB or 5,000 Kyat and 1 other member
+P2 fee=300 THB or 15,000 K.
+P3 fee=600 THB or 30,000 K.</td></tr>
<tr><td>Senior Option</td><td>+ 100 THB or 5,000 Kyat and 2 other members</td></tr>
</table>

2.4. Progress and achievements

2.4.1. Enrollment and member characteristics

Since the beginning of the project until 31 August 2021, a total of 31,792 migrants and border residents have voluntarily enrolled in M-FUND across all project areas. Graph 1 presents the cumulative enrollment, and key member characteristics are summarized in Table 1. Most members have been enrolled in Tak Province (74.3%), although the proportion of members enrolled in other areas gradually increases. A majority (67%) are women, 25.4% are children below 18 years old, and 4.4% are adults of 60 years and above. Most members are married or living with partners (61.6%). With regards to occupation, most of migrants enrolled in M-FUND are daily workers (15.6%), and as many as 39.4% reported being unemployed at the time they enrolled in M-FUND. Finally, among all members ever enrolled, 64.4% had the M-FUND Base or School Plan, and a total of 35.6% had an Option (Chronic Diseases, Pregnancy, Senior Option).

Graph 1: Enrollment in M-FUND

Table 1: M-FUND members characteristics

Characteristics	N (%)
Total enrolled	**31,792**
Tak	23,631 (74.3%)
Sakaeo	3,129 (9.8%)
Kanchanaburi	1,642 (5.1%)
Myawaddy	3,390 (10.7%)
Sex	
Females	21,296 (67.0%)
Males	10,496 (33.0%)
Age (years old)	
Median (min-max)	28.1 (0 -105)
< 18	8,068 (25.4%)
< 7	*4,318 (13.6%)*
18-29	9,275 (29.2%)
30-39	6,903 (21.7%)
40-49	4,265 (13.4%)
50-59	1,871 (5.9%)
60 and above	1,410 (4.4%)
Marital status	
Married/living with partner	19,584 (61.6%)
Single	11,756 (37.0%)
Divorced	151 (0.5%)
Widowed	301 (0.9%)

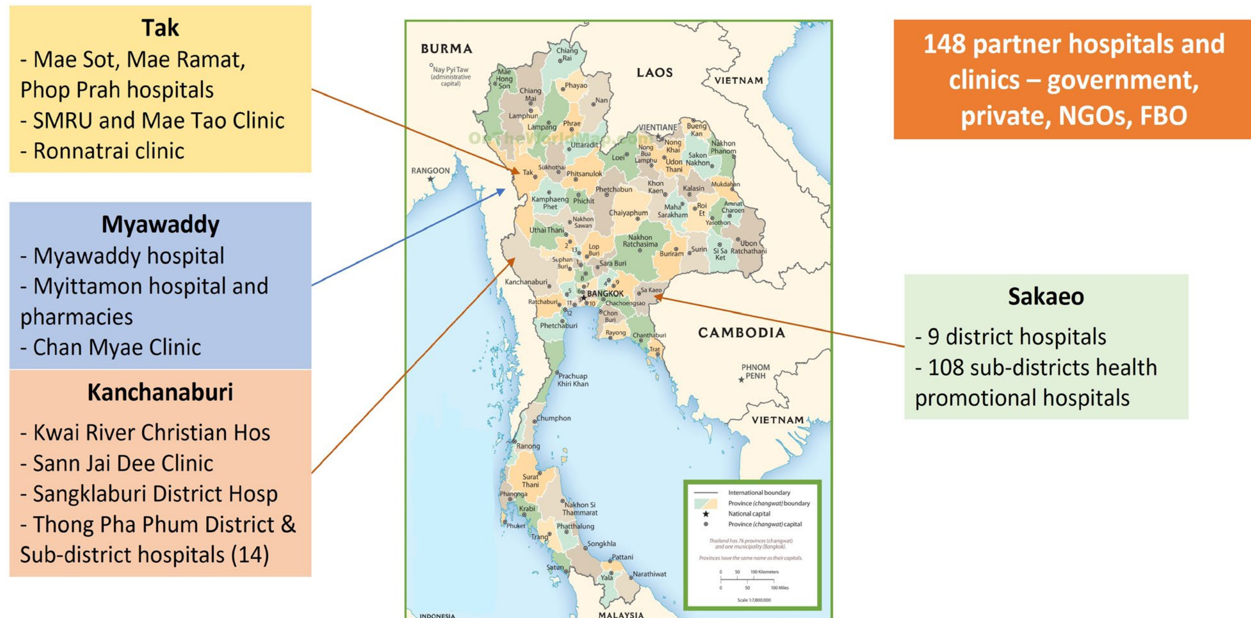
Characteristics	N (%)
Occupation	
Daily work	4,975 (15.6%)
Student	3,567 (11.2%)
Agriculture	2,943 (9.3%)
Self-employed (e.g. vendor)	1,305 (4.1%)
Factory worker	1,286 (4.0%)
Construction worker	323 (1.0%)
Domestic worker	239 (0.8%)
NGO/company/religious	442 (1.4%)
Other occupations	4,200 (13.2%)
Unemployed	12,512 (39.4%)
M-FUND option	
Base Plan (healthy)	20,081 (63.2%)
Chronic diseases	1,341 (4.2%)
Pregnancy	3,097 (9.7%)
Pregnancy NGO	4,645 (14.6%)
Senior	2,247 (7.1%)
School Plan	381 (1.2%)

There is a significant default rate among members enrolled in M-FUND. Cumulatively as of 31st August 2021, a total of 15,460 members (48.6%) interrupted their subscription (temporarily, N=4,654) or permanently, N=10,806) and became "inactive" members (not covered under M-FUND). For 46.0% of these, in this migrant, highly-mobile population, M-FUND community workers (CWs) were not able to make contact with migrants/ members, either because they returned to home countries, moved to another province in Thailand, changed phone numbers or lived too far. With the Covid-19 crisis, a large number of migrants in the project areas have lost their jobs, and some returned home and could not come back to Thailand due to closure of borders.

2.4.2. Healthcare covered

Across all project areas, M-FUND currently partners with a total of 148 healthcare facilities, i.e. 15 government district hospitals, 121 sub-district health promotional hospitals (SHPH), 6 NGO/FBO clinics and hospitals, and 4 private clinics/hospitals. (See Figure 3)

Figure 3: M-FUND partner healthcare facilities



From project inception until 31 August 2021, M-FUND covered as many as 36,371 medical events for the 31,792 members ever enrolled, including 30,463 outpatient consultations and 5,908 hospital admissions. (see Table 2). Among all admissions, 602 were covered for babies of pregnant women upon delivery, as babies are included under their mother membership until after discharge from hospital following birth. Among the 31,792 members enrolled, 8,810 (27.7%) received medical services (consultation or admission), whereas 72.3% did not seek/ receive services. More female than male M-FUND members sought/received medical services (30.0% versus 23.1%). Among all outpatient consultations, 60.3% occurred among “healthy members” having none of the M-FUND Plan options. 18.5% occurred among the 1,341 members enrolled with a Chronic Disease Option (4.2% of all registered members). Regarding inpatient admissions, 36.0% occurred among members without M-FUND option, and as many as 54.2% were covered among pregnant women, who represent 24.3% of all enrolled members.

Table 2: Medical events covered for M-FUND members

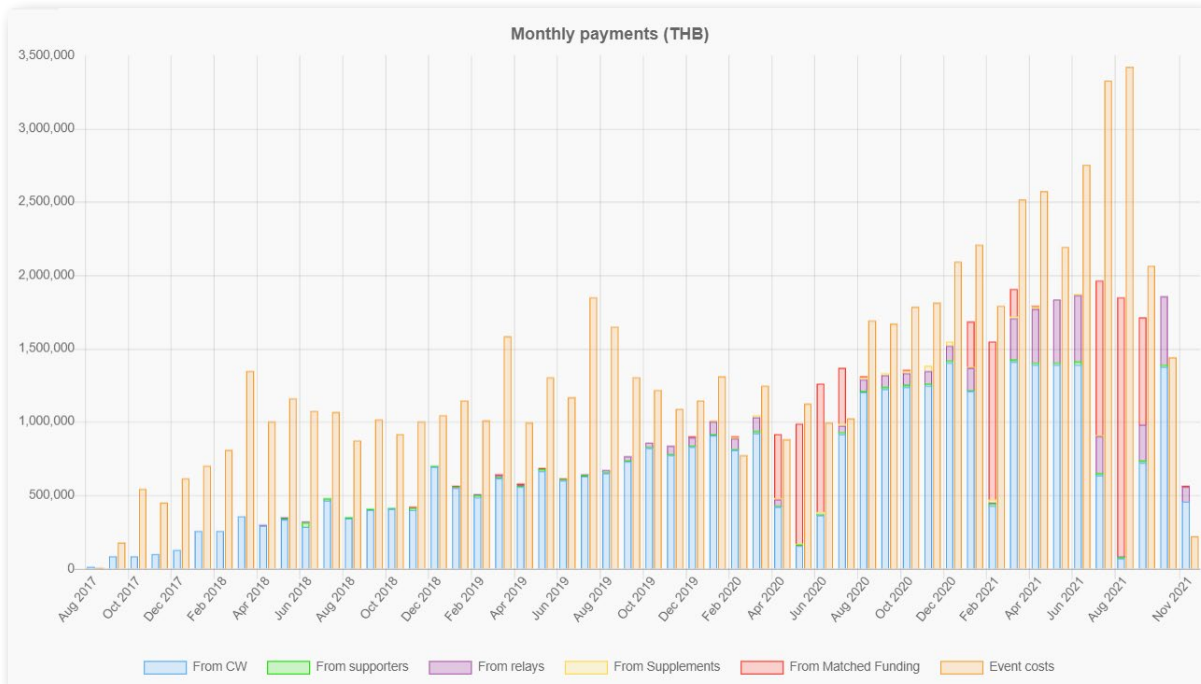
Description	N (%)
Medical events covered	**36,371**
Outpatient consultations	30,463 (83.8%)
Inpatient admissions	5,908 (16.2%)
Inpatient admissions among members	4,861 *(82.3%)*
*Inpatient admissions among newborns**	*1,047 (17.7%)*
Persons receiving services among all members	8,810/31,792 (27.7%)
Females	6,385/21,296 (30.0%)
Males	2,425/10,496 (23.1%)
Children below 18 years old	2,246/8,068 (27.8%)
Persons not receiving services among all members	22,982/31,792 (72.3%)
Outpatient consultations within M-FUND options	
None (Base Plan)	18,365 (60.3%)
School Plan	2 (0.01%)
Pregnancy Option	4,692 (15.4%)
Chronic Diseases Option	5,624 (18.5%)
Senior Option	1,780 (5.8%)
Inpatient admissions within M-FUND options	
None (Base Plan)	2,126 (36.0%)
School Olan	1 (0.02%)
Pregnancy Option	3,202 (54.2%)
Chronic Diseases Option	423 (7.2%)
Senior Option	156 (2.6%)

*newborns are covered under their mother's benefits following birth

2.4.3. Costs of care and progress towards financial sustainability

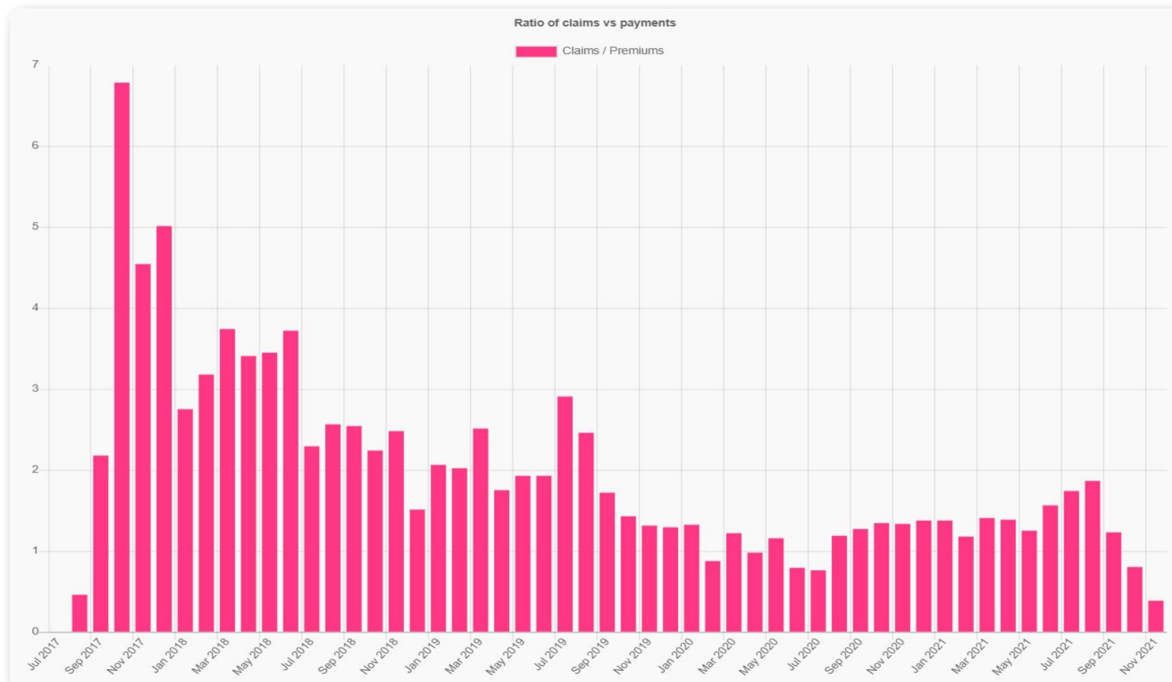
The evolution of costs of care in M-FUND since the beginning of the project and until 31 August 2021 is shown in Graph 2. Overall, 65.8 million THB of healthcare services have been covered by M-FUND and paid to partner hospitals, essentially Thai government hospitals. In comparison, a total of 42.1 million THB was collected as member contributions, representing a ratio between costs of care and member contributions of 1.56 since the beginning of the project. However, Graph 3 presents the evolution of this ratio since the beginning of the project under the different M-FUND Plans, and demonstrates the major progress that has already been achieved towards covering costs of care with member contributions and reaching financial sustainability. Since the use of Plan 3.0 in October 2019, an average ratio of only 1.3 has been achieved, and as Plan 4.0 continues to be rolled-out, it is anticipated that M-FUND could cover all costs of care and a part of operational costs with member contributions. Between June to August 2021, an increase in costs of care occurred mainly in Tak, where several M-FUND members were admitted in Maesot hospital with Covid infection (with costs of care charged to M-FUND). Partner NGO clinics were each closed during few weeks, which resulted in more pregnant women than usual delivering babies directly in partner hospitals. Gaps in funding have been supported by donor support (see Acknowledgments), and in situations where members use services above their M-FUND coverage ceiling, costs of care are usually covered by government partner hospitals.

Graph 2: Membership contributions and cost of care



*From CW = membership collected by community workers; from supporters = financial support from private individuals; from relays = membership collected by community relays; from supplements = co-payment for outpatient care in excess of coverage ceiling in plan 3.0; from matched funding = subsidies of membership during covid waves; event costs = costs of care in partner hospitals.

Graph 3: Ratio of costs of care over membership fees collected



3. LESSONS LEARNED FROM M-FUND ON EFFECTIVE HEALTHCARE PROTECTION FOR MIGRANTS IN THAILAND

3.1. Strengths and value of M-FUND

3.1.1. Filling the gaps in the country's Universal Health Coverage (UHC)

As discussed in Section 1, although Thailand has extended UHC to migrants through two government insurance schemes, only registered migrant workers and their children below 18 years old are eligible. Unregistered migrants are not eligible for either the SSS or the MHI, and in case of illness, they can seek services but pay out-of-pocket, which is typically beyond their reach. Adult dependents, notably female partners of male migrant workers, are not eligible for the MHI, although in practice some border hospitals allow them to enroll. In addition, it is estimated that there could be well over 1 million registered migrants who are not covered or do not maintain coverage under the SSS or MHI.

In this context, the M-FUND's objective is to ensure that this underserved population, and anyone who is not reached and effectively covered by government insurance, can enroll in the M-FUND health protection scheme, has access to medical services, and is not left behind. The M-FUND has already enrolled 31,792 members, most of whom are unregistered migrants and 67% are female migrants who have no access to government insurance schemes. Although M-FUND currently operates in only 3 areas in Thailand and has enrolled only a small proportion of the migrant population who do not have access government insurance in the country, the current enrolment figures in Tak, Sakaeo and Kanchanaburi illustrate the high demand and great needs for health protection that exist in this vulnerable population.

3.1.2. Peer-driven community enrollment and digital solutions are keys to success

In all project sites, community workers (CWs) are the backbone that drives the M-FUND. DLP recruits CWs from migrant communities it wishes to serve, to disseminate information about M-FUND, enroll members and collect membership contributions. This enables M-FUND to establish and gain a fundamental trust about the project. CWs speak the languages of their peers (Burmese, Karen, Cambodian, Thai), know the communities, their needs and their living and working conditions. In addition, M-FUND CWs conduct enrollment and membership renewals in migrants houses or workplaces, at times that suit them. Migrants and employers alike have occasionally reported that enrolling in the government MHI involves administrative steps that require travels, waiting times, taking time off from employment, which all likely represent some deterrents to enrollment.

Another key pillar of M-FUND's design and success is the use of modern digital technologies. All CWs use the secured M-FUND digital application on tablets or smart phones (see Picture 1). They capture member socio-demographic characteristics and contact information, and a digital picture for identification. Upon enrollment, an M-FUND ID number is generated in the system. An electronic member card is also created and linked to an individual anonymous QR code card that is handed over to members and can be scanned in any partner facility to reveal membership coverage details. Previous use of services and balance coverage for both outpatient and inpatient services are shown on members' cards.

These two design pillars are undoubtedly elements of acceptance and success of M-FUND scheme among migrant communities, and with partner facilities.

Picture 1: Use of M-FUND application on tablet by community worker

3.1.3. Monthly contribution is most suitable for migrants

In M-FUND application, CWs collect information on members occupations. As shown in Table 1, 39.4% of M-FUND members report being unemployed, and 15.6% being daily workers. Earlier research conducted by DLP found that the average daily income of migrant workers in Tak is about 180 THB. While doing the feasibility assessment and design of M-FUND, over 90% of migrants surveyed reported that they wanted to enroll in a health protection scheme that allows monthly payment of contributions, to better align with their income patterns. Since the beginning of the project, and in a manner that has been highly consistent over the 4 years of the project, in all project areas, approximately 80% of M-FUND members have been opting to pay their contribution monthly, and less than 20% to pay every two (or more) months. Although collection of members monthly contribution is cumbersome for M-FUND CWs, this appears to be essential to ensure participation.

For migrants enrolled in the SSS, contribution is deducted/paid monthly. However, in the MHI, most migrants are required to pay premium upfront for six months, one year or two years. Due to their income pattern, this represents a significant challenge. The cost of health check-up and health insurance adds to the cost of processing work permit, and for families with more than one-member, accumulated fees for obtaining work permit(s) and MHI can quickly represent insurmountable obstacles to be fully documented and comply with registration rules. The design and modes of payment of work permits and MHI seemingly represent structural limitations to having more migrants registered in the country.

3.1.4. Coverage of care in more than one hospital is desirable

Since launch of M-FUND in Maesot in September 2017, the network of partner health facilities providing services to M-FUND members has been progressively and markedly expanded. In Tak, partner facilities include Maesot, Mae Ramat and Phop Prah District Hospitals, as well as 2 NGO clinics from the Shoklo Malaria Research Unit (SMRU) and Mae Tao Clinic, and a private clinic. For border populations in Myawaddy, partnership exists with Myawaddy government hospital, 2 private hospitals/clinics and a FBO hospital. In Sakaeo, DLP signed a Memorandum of Understanding (MoU) with the Provincial Health Office (PHO) which seals partnership with all 9 provincial/district hospitals and the 108 SHPH of the province. In Kanchanaburi, partnership now exists with

2 FBO hospital/clinic, a private clinic and the district hospital of Sangklaburi, as well as the district hospital and the 13 SHPH of Thong Pha Phum District. In all areas, M-FUND members can receive services in any of the partner facilities, and referral between facilities for different levels of services that may be needed is common. In all facilities, member coverage status and details are visualized on M-FUND membership cards by simple scan of members QR codes. Active members do not pre-pay services, and facilities bill M-FUND directly. A mechanism has been created where facilities send preliminary information on use of services by M-FUND members on a daily basis. M-FUND medical officers capture this information in the M-FUND platform to ensure real-time update of coverage balance.

In the SSS and MHI, migrants must select a hospital where their benefits are attached. When needed, referral to higher level facilities is possible. However, insured migrants cannot freely seek services in different facilities, and in the common situation where migrant workers change workplace between districts or provinces, their benefits are not portable. While it is possible to formally change hospitals where benefits can be claimed under the SSS or the MHI, this requires cumbersome administrative procedures. We believe that this represents another structural limitation to effective health protection of migrants under government insurance schemes.

3.2. Challenges and limitations

3.2.1. Adverse selection from voluntary enrollment

Unlike the government's SSS and the MHI schemes that are compulsory for migrant workers who register for work permit, M-FUND is a voluntary scheme, where migrants can elect to enroll, or end membership whenever they want. As a result, M-FUND has been confronted with the challenge of adverse selection (a concept known in insurance), where migrants with existing illnesses or higher need for healthcare show higher interest to enroll. The different iterations of M-FUND Plans have intended to address this challenge, while maintaining its core principle of wanting to give protection and access to care for those most in need. In July 2018, with launch of Plan 2.0., M-FUND introduced a mandatory component in its voluntary scheme, where people with chronic diseases, pregnant women, and senior persons (50 years old and above) could continue to enroll in M-FUND, but were now required to bring and maintain other members without similar conditions, to enroll with them. This significantly contributed to diversify the pool of M-FUND members, better share risks, and reduce the gap of cost of care over contributions collected. In Plan 1.0-3.0, pregnant women up to their third trimester of pregnancy were allowed to enroll in M-FUND (being required to bring two other members with them in Plan 2.0 and 3.0). However, low retention was observed among pregnant women after delivery. (see also section 3.2.2) To address this adverse selection issue, in Plan 4.0, women already pregnant are no longer allowed to enroll in M-FUND. Women of reproductive age are encouraged to enroll early, before being pregnant, and should they become pregnant, they are able to take the Pregnancy Option during pregnancy. We expect that this will have further positive impact to control costs, and it encourages early follow up of pregnancy which could also result in positive health outcomes for women and their babies. A specific situation exists in Tak and Myawaddy where women who are already pregnant can take the NGO Pregnancy Option if they receive antenatal care and undergo simple vaginal delivery in NGO clinics, the cost of which is still mainly born by the partner NGOs. M-FUND takes responsibility of covering costs of care in partner hospitals when referral is required for more complex conditions.

3.2.2. Low retention, from high mobility and other structural challenges

M-FUND is also confronted with a significant default rate among members enrolled. As shown in section 2.4.1, out of 31,792 members who enrolled since the beginning of the project, a total of 15,460 members (48.6%) ended membership as of 31 July 2021. For 46.0% of these, in this migrant, highly-mobile population, M-FUND community workers (CWs) were not able to make contact with members, either because they returned to home countries, moved to another province in Thailand, changed phone numbers or lived too far. With the Covid-19 crisis, a large number of migrants in the project areas have lost their jobs, and some returned home and could not come back to Thailand due to border closure. Another 31.3% of members ended subscription for financial reasons (have no means of paying, or no longer wish to pay), and 7.2% report having enrolled in a government scheme and no longer need M-FUND. Other members have ended subscription for other reasons. As discussed in section 3.2.1, drop-out of M-FUND has been particularly high among pregnant women, and the project has aimed to partly address this challenge with the modifications that have been introduced in Plan 4.0, where women will be further sensitized to the importance of enrolling early and maintaining coverage following delivery.

Since the beginning of the project, overall, the average duration of enrolment in M-FUND has been 16 months. While M-FUND aims to address adverse selection and low retention to increase duration of membership, it is important to emphasize that M-FUND has ensured effective health protection for 31,792 migrants and border populations, while they were in the project areas and/or needed it. A study from the International Organization for Migration (IOM)[10] conducted in Tak showed that a little less than 50% of migrants from Myanmar stay in Tak, Thailand for more than a year. Section 4 of this report discusses further measures that are going to be introduced to cover migrants under M-FUND in any area in Thailand, in section 4.

3.2.3. Reaching financial sustainability while maintaining optimum healthcare coverage

DLP's goal in M-FUND is to both open access to broad quality healthcare services for migrants most in need, and reach financial sustainability. Although achieving this combined objective represents a great challenge, DLP has already made enormous progress. M-FUND has continued to expand since its launch in September 2017, has enrolled 31,792 members, covered 36,371 outpatient and inpatient services, and reduced the gap of costs of care over contributions collected from a ratio of 4.0 with Plan 1.0 to 1.3 with Plan 3.0. Under the current Plan 4.0 launched in February 2021, we project to become able to cover all costs of care incurred by M-FUND, and part of the project operations costs, with contributions from members.

The progress in controlling costs of M-FUND while maintaining access to care for members has been realized by a) strong routine monitoring of key program indicators through the M-FUND application, and b) commissioning regular financial analyses and modeling from independent micro-insurance experts. The participation of notably Maesot Hospital in absorbing costs of inpatient care above M-FUND coverage ceiling for some of the members also contributes to building the stability of the project, and maintaining a win-win partnership. As a truly non-profit scheme, M-FUND is committed to maintain the highest possible level of healthcare coverage for members. To achieve further gains towards financial sustainability of M-FUND, in the coming years DLP will most notably pursue to achieve greater coverage and greater efficiencies in the conduct of its operations through a) scaling up operations in new areas, b) introducing digital payment solutions to collect member contributions, c) introducing and expanding online enrollments and renewals of membership, as well as d) seeking yet greater collaborations with and support from government partners. (see Section 3.2.4 and 4)

10 Flow Monitoring Surveys: Insights into the Profiles and Vulnerabilities of Myanmar Migrants to Thailand (Round Three), International Organization for Migration (IOM), August 2019

3.2.4. Monthly collection of cash contributions

Although one of the strengths of M-FUND is to allow members to pay monthly contributions as to fit their income patterns, this represents a significant operational challenge, and costs, for DLP. For the most part, member contributions are collected in cash, by CWs. This requires that all CWs cover significant distances across their designated catchment areas to meet their members every month. Significant time and costs are incurred, in traveling.

To address these challenges and inefficiencies, the project increasingly involved Community Relays (CRs) to collect membership. CRs are members of the migrant communities (M-FUND members for some of them) who have shown great interest and good understanding of M-FUND operations. CRs who own smart phones are given secured and controlled access to a phone version of the M-FUND application that we have developed, and as such become able to renew membership, as well as enroll new members, in their communities. They are given a 10% commission on all contributions collected. CWs can then coordinate with their CRs to transfer funds collected to M-FUND. This approach has started to show promises in achieving greater efficiencies and reducing costs, and will be further developed across all project areas.

DLP has also been eager to introduce digital payment solutions to collect membership fees. However, as most M-FUND members are un-banked and unregistered, this has proven to be challenging, given that mobile payment applications typically require a valid identification and link to a bank account. In Myawaddy, we have been able to use WaveMoney, as most members are Myanmar citizens. However, for migrants in Thailand, this has not yet been possible. We have been unable to establish collaboration with convenience stores, as the volume of our operations remains limited, and is of little interest to the largest chains of stores. At last, we have identified opportunities that are discussed in Section 4.

4. WAY FORWARD FOR M-FUND

Dreamlopments thrives to a) share any possible valuable lesson learned from M-FUND, with government counterparts and other partners, to contribute to the design/reform of schemes of access to care for migrants, and b) also to complement such schemes by directly filling any possible gap of access and coverage. (See also section 5, on Policy Recommendations)

We continue to scale up M-FUND in the current areas of implementation. Furthermore, DLP has initiated discussions with provincial health authorities in Chiang Mai and Chiang Rai provinces to extend M-FUND in these locations. We project to continue to engage with health authorities in other provinces in Thailand.

In Myanmar, Cambodia, or Laos, in border locations opposite to areas of interventions in Thailand, we aim to continue to deploy M-FUND to provide health protection to local residents in poor communities, and to inform the design of national insurance schemes. Ultimately, DLP aims to replicate M-FUND in other countries in the region or globally, to extend health care protection to some among the millions of migrants and refugees who currently lack such basic benefit.

The M-FUND operations, healthcare coverage Plan and application have been proven to work in all settings where we operate. We increasingly mobilize community relays, and partners, who upon signing a simple agreement with DLP, can be given access to the M-FUND application, receive training, and implement M-FUND under supervision and monitoring from DLP staff. Our mobile phone application is already being used successfully by many CRs in the current areas of intervention, for membership renewal and new member enrollment.

To increase coverage and enrollment of migrants living in areas where DLP has no teams or partners, a video call center was developed where CWs can conduct remote online enrollment and membership renewals. We aim to widely disseminate the availability of this option, to allow migrants in other areas and settings to enroll. Use of digital payment will be required, but members will be able to seek healthcare services in hospitals that are not partners of M-FUND, and to claim quick reimbursement of costs of care from M-FUND.

Use of digital payment becomes an operational necessity for M-FUND. As many vendors do for countless services, we have now opted to use a simple QR code attached to DLP's bank account. Although most of our members are unable to use mobile banking applications, we believe that they will be able to solicit neighbors or contacts who can process these payments on their behalf. This orientation will now be pursued actively.

With use of M-FUND Plan 4.0, we project to become able to cover all costs of healthcare for members, and part of M-FUND operational costs, with member contributions. We also project that use of digital payments and online enrollment will reduce operational costs, create efficiencies, reduce drop-out, and support expansion of the M-FUND pool of members, which will all achieve further gains towards financial sustainability. A future iteration of M-FUND Plan could be required to realize this objective, which we aim to achieve by the end of 2024.

5. POLICY RECOMMENDATIONS

Thailand has made great progress in achieving the 2015 United Nations Sustainable Development Goals (SDGs), to ensure healthy lives and promote well-being for all at all ages (SDG Goal 3) in line with the country's Twenty-Year National Strategy (2018-2037)[11], the National Health Plan No. 12 (2017-2021)[12] and the NHSO's Operational Plan (2018-2022)[13]. It has successfully offered health protection to all Thai citizens, through its Universal Health Coverage schemes. Furthermore, a large number of regular migrants working in the country also benefit from effective health protection through the Social Security Scheme and the Migrant Health Insurance. However, an estimated one million irregular migrants and at least one million registered migrants are thought to be uncovered by and out of reach of the government insurance.

Uninsured migrants face having to bear high out-of-pocket and catastrophic health expenditures if they need health services. This represents an obstacle to individual health rights, and also a collective health security risk. The debut of the current Covid-19 epidemic in Thailand involved among other factors transmission within a community of migrant workers in the province of Samut Sakorn, in December 2020. Despite intense efforts to control the epidemic, the spread of Covid-19 continued unabated in the country as of August 2021. We reckon that ensuring effective health protection of all persons living in the country and in any country is critically important for individual health rights, as well as collective health security.

Health for all cannot be achieved if not all are protected.

M-FUND has aimed to provide effective health protection for those left behind, out of reach of government insurance schemes. We ambition to cover those in need and generate lessons that are of possible value for the design/reform of schemes of access to care for all migrants in the country.

Efforts led by the Thai Ministry of Public Health are ongoing to propose a resolution to the National Health Assembly on "Protection of Equitable Access to Health Services by Specific Populations in Crisis". Public hearings have been initiated about the resolution, which should undergo voting in December 2021. It aims to address gaps and needs of different populations (including for example disabled persons and prisoners), and specifically migrants and persons with citizenship problem (stateless persons).

The draft resolution is taking a step towards the right direction. DLP's opinion and policy recommendations are as follows:

- Schemes/mechanisms of health protection of specific populations, notably migrants and persons with citizenship problem, **should be enforced as a law**, rather than cabinet resolutions or ministerial regulations.
- Health protection of specific populations, notably migrants and persons with citizenship problems, **should always be enforced,** rather than during crisis, as this may indeed prevent or reduce the extent of health crisis.

11 Thailand's National Strategy Committee, National Strategy (2018-2037), available on https://sto.go.th/sites/default/files/2019-12/National-Strategy-Eng-Final-25-OCT-2019.pdf, access on 7 September 2021

12 Ministry of Public Health, National Health Plan No. 12 (2017-2021), available on https://bps.moph.go.th/new_bps/sites/default/files/HealthPlan12_2560_2564.pdf, access on 7 September 2021

13 National Health Security Office, Operational Plan (2018-2022), available on https://www.nhso.go.th/storage/downloads/main/144/%E0%B9%81%E0%B8%9C%E0%B8%99%E0%B8%9B%E0%B8%8F%E0%B8%B4%E0%B8%9A%E0%B8%B1%E0%B8%95%E0%B8%B4%E0%B8%A3%E0%B8%B2%E0%B8%8A%E0%B8%81%E0%B8%B2%E0%B8%A3%E0%B8%82%E0%B8%AD%E0%B8%87_%E0%B8%AA%E0%B8%9B%E0%B8%AA%E0%B8%8A_.pdf, access on 7 September 2021

- The **funding** of access to care/health protection schemes for migrants **should not be borne only by migrant workers**.
    - We believe costs could be borne by the government, and for example be designed as an extension of the 30-Bahts scheme. Migrants working in Thailand, both registered and unregistered, contribute to building the economy, and pay taxes that could in part be leveraged to finance this protection scheme.
    - Should this policy orientation not be suitable for the government, allocations in this specific fund should involve a fair contribution from employers, employees, and the government.
    - Contributions from migrants should be aligned with their ability to pay. As we have shown in this report, the vast majority of M-FUND members elect to pay their membership contribution monthly. Most migrants struggle to contribute yearly advanced payments in the Migrant Heath Insurance of the Ministry of Public Health. Giving the opportunity to also pay monthly or quarterly premium would likely increase participation and retention in government schemes.
    - Modern technology and digital payments should be leveraged for contribution in a new health protection fund.
- **Dependents (notably spouses and children)** of migrant workers should be considered as special populations needing attention, and should be included in schemes of health protection. Experience from M-FUND clearly shows that a majority of migrants not covered by existing health insurance schemes are women. A high proportion are unemployed, and commonly, they appear to be uninsured spouses of registered male migrant workers. Twenty-five percent of M-FUND members are children in need of protection.
- We reckon that **M-FUND** should be further supported by the government and formally integrated as a possible option of health protection of migrants (including registered migrants) in Thailand.