Chapter 7
Citizenship and Legal Status in Healthcare: Access of Non-citizens in the ASEAN: A Comparative Case Study of Thailand and Malaysia

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7.1 Introduction

Malaysia and Thailand are major destination countries for migrant populations in the ASEAN, both labour migrants and refugees. As of December 31, 2020, there are 1.4 million foreign workers in Malaysia with active Temporary Workers Passes (Adam, 2021). Pre-pandemic, the estimated number of migrant workers was 3.43 million (UNDESA, 2019), alongside another 1.23–1.46 million migrant workers of irregular status (ILO, 2020a). Additionally, as of January 2021, about 178,710 refugees and asylum-seekers registered with the United Nations High Commissioner for Refugees (UNHCR) in Malaysia, of whom 154,140 are from Myanmar (UNHCR, 2021b). Refugees lack the formal right to work and education in Malaysia. Low-skilled and semi-skilled migrant workers are prohibited from marrying Malaysians while they work in the country.

Regarding Thailand, as of December 2020, there were some three million registered migrant workers, with about 2.7 million from Myanmar, Laos, Cambodia, and Vietnam (Promchertchoo, 2021). Additionally, populations of concern include 91,818 Myanmar refugees, 5325 urban asylum-seekers and refugees, and 480,549 persons registered by the Royal Thai Government (RTG) as stateless (UNHCR, 2021a). Refugees lack the formal right to work, but migrant children have access to free public education (Dewansyah & Handayani, 2018).

Despite a significant presence of migrant populations in both countries, migrants' access to healthcare has been an ongoing issue of contestation, with healthcare seen as an entitlement of citizens (Chan, 2018). This debate on the entitlement of migrants' access to healthcare based on their (un)deservingness as non-citizens and/or undocumented status unfolds within broader global discourses on human rights,

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migration and citizenship, and regional developments related to expanding access to healthcare.

For example, the United Nations, through a range of international instruments, has emphasized substantive equality in access to healthcare as a fundamental human right without prejudice to migrant populations (Committee on Economic Social and Cultural Rights, 2000; United Nations, 1976). The World Health Organization has posited Universal Health Coverage (UHC) as the organizing principle of health systems to ensure and expand healthcare coverage (World Health Organization, 2021). UHC refers to ensuring that all people have access to preventive, promotive, curative, and rehabilitative health services that they need, when and where they need them**,** without financial hardship (World Health Organization, 2021). Read in tandem with the constitution of the World Health Organization which espouses the right to the highest attainable standard of health (World Health Organization, 1946) and the 2030 Agenda for Sustainable Development which is predicated on the principle of healthcare access as a universal right, the argument that healthcare entitlements must vary per citizenship and legal status, stands out in contrast.

The contending discourses on the (un)deservingness of migrants to healthcare have also simultaneously come to play out in a global/regional context marked by a shift in the framing of healthcare as a public good to a marketable commodity. This development is also evident in the ASEAN States, which are turning to market solutions as stretched health systems struggle to meet escalating healthcare needs. However, market asymmetries skew access to healthcare. The market model subjects players to the neoliberal notion of autonomy which compromises individual responsibility to the collective and social solidarity, both of which underpin the right to healthcare in traditional social protection models. Thus, as migrant healthcare gets relocated to the market, migrants must navigate health systems based on the logic, forces, and politics of markets and concomitantly contend with populist and State-centric discourses of their (un)deservingness to healthcare.

Using case examples of Malaysia and Thailand, this chapter appraises their contrasting health systems models and how healthcare access of migrant populations is conceptualised. The focus is on how Universal Health Coverage, an avowed goal of health systems in both countries and the ASEAN, is interpreted and reconciled differently.

The choice of Malaysia and Thailand is guided by the fact that both countries achieved UHC (Tangcharoensathien et al., 2020; World Health Organization, 2018) as middle-income countries with competing developmental needs and fiscal constraints. Both countries also attribute an instrumental value to health in achieving the broader goals of economic growth by expanding private healthcare and promoting medical tourism. Additionally, Malaysia and Thailand also exemplify the phenomenon of temporary and circular labour migration for semi-skilled and unskilled migrants, which include short, fixed-term employment contracts, return to home country upon expiry of contract/work permit, and prohibition of transfer of work permits to other employment sectors and employers and family reunification. These policies engender and sustain the fragility of status and the flexibilisation of labour (Kaur, 2010). Both Malaysia and Thailand have not ratified the 1951 Convention on

the Status of Refugees or its 1967 Protocol, deeming refugees and asylum seekers as irregular in status.

Concerning health coverage for migrant populations, Thailand and Malaysia provide an interesting contrast in their policy frameworks. Thailand's migrant healthcare policy extends accessibility to non-citizens based on the twin rationale of providing the country with a healthy workforce, including migrants (economic rationale), and of reducing the impact of communicable diseases to citizens (security rationale) (Tharathep, 2011). On the other hand, Malaysia's migrant healthcare policy, also guided by concerns of national security and economic efficiency in healthcare, adopts a deterrent approach that restricts the access of migrant populations to healthcare. While both countries espouse the neoliberal model of migration, they also represent contrasting models of health systems in the way access to healthcare for migrant populations is organized. While the overall health policy approach toward migrants in both countries mirror norms of deservingness, this norm is differently reflected in the two countries. Additionally, the market plays a significantly more substantial role in Malaysia in the distribution of healthcare.

In the following section, migrant healthcare policy is discussed in UHC in Malaysia and Thailand.

7.2 UHC and Healthcare Access for Migrant Populations: Malaysia and Thailand

Both Malaysia and Thailand have a pluralistic health system comprising public and private healthcare providers where UHC is achieved via a healthcare financing system based predominantly on general taxation and covering all citizens.

In Malaysia, the benefits include a comprehensive package of highly subsidised public healthcare services available to all citizens at primary, secondary, and tertiary care levels (Ng, 2015). Private health insurance is usually purchased by individuals for themselves and their families and/or by employers as a fringe benefit for employees. Other social protection schemes, e.g., the Employees Provident Fund (EPF) and the Social Security Organization (SOCSO), make disbursements toward medical expenses for critical illnesses and work-related injury and accidents respectively (Government of Malaysia, 1969; Samy, 2010).

In Thailand, UHC is supported by (i) the Civil Servants' Medical Benefit Scheme under the finance ministry (CSMBS (ii) The Social Security Scheme (SSS) under the labour ministry covering private sector employees; and (iii) the Universal Coverage Scheme (UCS) under the public health ministry. The UCS was established under the National Health Security Act, 2002. It is co-financed through general taxation and a 30-Baht co-payment with exemption from co-payment for several beneficiary groups. The UCS provides a comprehensive benefit package of in-patient and outpatient care, surgery, and drugs (Sakunphanit, 2008) and preventive care (Sakunphanit & Suwanrada, 2011).

Table 7.1 Non-citizen ward charges, deposit and discharge (RM)

	Medical (RM)	Surgery (RM)	Maternity (O&G) (RM)
First class	7000	11,000	7000
Second class	3000	5000	5000
Third class	1400 *(RM20)*	2800 *(RM30)*	2800 *(RM15)*
Outpatient clinic	RM 40 excluding investigations & procedures *(RM1)*		
Specialist clinic	RM 120 excluding investigations and procedures *(RM5 for first visit and RM 30 for first visit if referred by a private doctor)*		

Source: Hospital Kuala Lumpur (2020)
Note: *Charges for Malaysians in italics*

7.2.1 Cost of Healthcare for Citizens and Non-citizens in Public Hospitals

7.2.1.1 Malaysia

In Malaysia, State-subsidised healthcare in public hospitals is a privilege enjoyed by citizens only. All non-citizens, documented or undocumented, must pay fully unsubsidized "foreigners' rates" at government hospitals. Table 7.1 highlights the wide gap in healthcare costs for citizens and non-citizens. Furthermore, prescriptions from public hospitals are restricted to a five-day supply from government hospital pharmacies for non-citizens, limiting access to care for chronic conditions.

Although non-citizens are charged a higher fee in public hospitals, UNHCR-recognised refugees and asylum seekers get a 50% discount off foreigners' rates. Healthcare costs are still unaffordable for them because they lack the formal right to work (Balasundaram, 2011).

7.2.1.2 Thailand

In contrast, in Thailand, citizens and non-citizens pay similar fees in public hospitals. However, as the following sections reveal, migration and legal statuses play a defining role in migrants' access to UHC in the country.

7.2.2 Mandatory Health Insurance for Documented Labour Migrants

In both Malaysia and Thailand, healthcare financing of labour migrants is sourced from health insurance. The difference, however, is that in Thailand, documented labour migrants fall under a comprehensive social health insurance scheme, the Social Security Scheme (SSS) managed by the Social Security Office under the Ministry of Labour, while in Malaysia, the insurance is covered by private insurance

companies. Further, in Thailand, fully documented migrant workers fall under the same health insurance as private sector Thais, namely, the SSS. There is a significant difference in the benefits of documented labour migrants under the labour tax-financed social health insurance in Thailand and the private health insurance in Malaysia. Nevertheless, in both countries the health insurance schemes lack portability.

7.2.2.1 Malaysia

Even documented migrant workers are not eligible for State-subsidised healthcare and must purchase full-cost, unsubsidised healthcare in public hospitals. To finance these healthcare costs, they are required to buy a mandatory private health insurance (the Foreign Worker Hospitalization and Surgical Scheme [2011]), known by the Bahasa Malaysia acronym, SPIKPA.

Under SPIKPA, migrant workers pay an annual premium of RM 127.20 (or USD 30), which provides health insurance protection up to a maximum of RM20,000 (or USD 4751) per year, with the premium for domestic and plantation sector workers being covered by employers. Benefits include hospital fees and surgical fees. It does not cover hospitalization or surgical charges for pre-existing illnesses and specified illnesses during the first 120 days of cover. Outpatient treatment, health promotion and prevention, healthcare costs related to antenatal care, mental health, and attempted suicide or self-harm are excluded. When the hospital bill exceeds the maximum pay-out and is beyond the worker's capacity to settle, the penalty is non-renewal of the work permit. Notably, migrants' work permits are specific to their employers. So, a change of employer would divest them of legal status and entitlements to insured healthcare. The revenues generated by SPIKPA have been envisioned as a "quick-win" strategy under the country's economic transformation programme to achieve high-income, developed country status (PEMANDU, 2010, p. 559).

Significant critiques of the scheme include the workers' low level of knowledge about their entitlements and the withholding of insurance cards by employers, making it impossible for them to seek care when required (Alhadjri & Cheng, 2013). The high cost of healthcare charged to non-citizens also makes coverage under SPIKPA inadequate and raises concerns about delayed healthcare seeking (Loganathan et al., 2020b). Notably, despite purchasing private health insurance, migrant workers in Malaysia are not covered for outpatient care, health promotion, and prevention, leave alone antenatal care and mental healthcare.

7.2.2.2 Thailand

In Thailand, the access of migrants to different health financing schemes depends on their migration status: fully legal, half-legal, and unregistered. Fully legal migrants are those who have entered Thailand legally with a passport and possess

authorisation to work. Half-legal migrants (illegal entry, legal employment) can become fully legal migrants by going through the Nationality Verification process and acquiring legal documents from their country of origin. This program was initiated only for migrant workers from Myanmar, Cambodia, and Laos. Fully legal migrants must make a mandatory contribution to the SSS health insurance like Thai citizens working in the private sector. Domestic workers and seafarers are excluded from the SSS. Registered labour migrants' authorisation to work is specific to their employer. They can request a change of employment only under specific conditions (Hall, 2011). Failure to comply with these terms could change the migration status from fully legal to unregistered, jeopardising their health protection benefits (Olivier, 2018).

SSS benefits cannot be utilised during the first three to five months after the first contribution. Further, old-age benefits and unemployment allowances are not portable and thus impractical for migrants under SSS. Often, employers fail to make the required contributions. Simultaneously, migrant workers are also equally averse to payroll deductions toward SSS contributions (Kunpeuk et al., 2020). Additionally, benefits are only claimable at designated hospitals, and the migrant must remain in formal employment. Further, there are limits on medicines that can be obtained (Chamchan & Apipornchaisakul, 2012). Importantly, migrants themselves are often unclear about their entitlements, deductions, and contributions (Hall, 2011).

7.2.3 Access to Healthcare for Undocumented Migrants

7.2.3.1 Malaysia

All migrants, documented or undocumented, are charged the same non-citizen user fee at public hospitals. However, undocumented migrants have reported barriers to accessing care at public hospitals because of the lack of documentation. Per a Ministry of Health directive, undocumented migrants are eligible for treatment even if they do not have legal status (Ministry of Health, 2001). However, this same directive, although not consistently practiced, mandates hospital staff to report all cases of illegal migration to the police, as per provisions under Section 6 (3) and Section 15 (4) of the Immigration Act 159/63 (Revised 1997) (Ministry of Health, 2001).

To monitor unpaid bills by non-citizens and reduce this component in the government's health budget, a pilot project started in 2014 included establishing an immigration counter in a public hospital in Kuala Lumpur. Under the scheme, hospital staff were required to report undocumented migrants who present for treatment, who were then arrested and detained after obtaining treatment (Hospital Kuala Lumpur, 2014). Undocumented women accessing maternal healthcare were particularly affected by this policy (Verghis, 2014). This policy did not become standard practice across the country. However, there are reported instances of non-citizens being turned away if they are unable to put down deposits for admission or if they are undocumented.

7.2.3.2 Thailand

Among the health financing schemes for half-legal migrants registered and authorised to work by the Thai government and unregistered workers and their children, the most prominent is the Health Insurance Card Scheme (HICS) of the Ministry of Public Health (MOPH). HICS costs 1600 Baht (USD 48) plus 500 Baht (USD 15) for a health check annually for an adult migrant (Pudpong et al., 2019). It is like the UCS for Thais in that it covers those who are excluded from the SSS. Children of migrants below age seven can enrol at the rate of THB 365 (USD 12), which includes a full schedule of immunisation (Pudpong et al., 2019). At least in principle, the HCIS makes it possible for every migrant to be eligible for health insurance, regardless of their registration status (Hall, personal communication, January 03, 2014). By 2015, some 1.3 million migrants were covered by HICS (Tangcharoensathien et al., 2017). However, HICS migrants are excluded from the UCS database for citizens. Notably, the HICS is administered by the Ministry of Public Health and not the National Health Security Office which has oversight of UCS covering citizens.

HICS provides health screening, curative care, health promotion, and disease surveillance and prevention services (IOM, 2009). It covers both in-patient and outpatient care (Tharathep, 2011) but excludes HIV/AIDS treatment, mental health disorders and drug dependence, and chronic dialysis treatment (Pudpong et al., 2019). The problems with this scheme are that the list of excluded conditions is extremely expensive (Chamchan & Apipornchaisakul, 2012) and the insurance premium is unaffordable for migrants who are socio-economically deprived (Pudpong et al., 2019). Moreover, the administrative loopholes allow informal sector migrants to avoid contributing to the HICS (Kunpeuk et al., 2020).

Various studies have shown that although utilization rates of outpatient and in-patient services by migrants increased relative to the uninsured, UCS's in-patient admission rate for citizens was greater than that of HICS (IOM, 2009; Kosiyaporn et al., 2020). However, the HICS has reduced in-patient and out-of-pocket payments for healthcare (Pudpong et al., 2019). Yet, the voluntary character of the scheme saw adverse selection and self-exclusion from healthy migrants, while undocumented status was found to be a barrier to enrolment (Pudpong et al., 2019; Srisai et al., 2020; Tangcharoensathien et al., 2017). Thus, the Thai migrant health insurance scheme is not without its problems due to insufficient enrollees to ensure a sufficient pool of risks (IOM, 2009; Kunpeuk et al., 2020; Pudpong et al., 2019). Yet, the role of the Public Health Ministry to expand health insurance coverage, even for undocumented migrants, is noteworthy. At the same time, the Thai government's efforts to address the precarious legal status and citizenship problems of undocumented migrants by initiating the Nationality Verification exercise (Kunpeuk et al., 2020; Pudpong et al., 2019) is commendable. Unfortunately, the registration process itself did not guarantee the full legalisation of their precarious citizenship status (Suphanchaimat et al., 2017).

7.2.4 Alternative Private Health Insurance

Although there is thin evidence for private health insurance's mediating role in accessing healthcare, it becomes a source of pre-paid healthcare financing for the healthcare needs of population groups that do not fall within the formal system. This phenomenon is evidenced in Malaysia in the case of refugees. In Thailand, on the other hand, private health insurance schemes tend to cover high-income groups (JICA, 2010).

7.2.4.1 Malaysia

REMEDI, a social insurance plan, launched in 2014 by UNHCR for refugees, did not require a pre-enrolment medical examination. A waiting period was not required, except for cancer and cardiac conditions. The scheme including a premium of RM 164.34 (USD 40) per refugee annually, covered in-patient treatment, room, and board for up to 25 days, intensive care for up to 12 days, hospital supplies and services, operating theatre, surgical fees, anaesthetists' fees, in-hospital physician visits, in-hospital specialist consultations, ambulance fee and medical reports (Verghis & Balasundaram, 2019).

REMEDI had enrolment problems initially, but enrolment increased from 5.2% of total refugees registered with UNHCR in 2016 to 20.3% in 2017. In 2018, the enrolment figure dropped to 12.7%, increasing the loss ratio to 142% in 2018. The increased loss ratio could largely be attributed to the increment in public hospitals' fees for non-citizens which escalated the costs of claims, leading the insurer to withdraw from providing insurance coverage to refugees (Verghis & Balasundaram, 2019). The case of REMEDI points to migrants' financial barriers to access because of the high cost of healthcare charged to non-citizens in public hospitals and the unsustainability of market-based solutions for healthcare financing for this population.

7.3 How Universal Is Universal Health Coverage?

The preceding sections highlighted the location of migrant healthcare policy within Universal Health Coverage in Malaysia and Thailand. The case studies of migrant healthcare in Malaysia and Thailand expose fault lines in ongoing global initiatives such as UHC which seeks to ensure that *all people* have access to healthcare without financial risk (World Health Organization, 2021). The inherent contradictions in the exclusion of migrants from initiatives with universal reach is better understood through the lens of the twin concepts of universalism and selectivism which guide social protection policies and access to healthcare.

The concept of universalism in social welfare policy highlights universal standards in the allocation of benefits and social services to the entire population without discrimination (Kildal & Kuhnle, 2002). Universalism and selectivism, two predominant approaches to social policy and welfare provision, are sometimes combined in practice (Mackenbach et al., 2002). They differ in their different approaches to organising the membership of beneficiaries, allocation of benefits, the role of the State, the role of the market, and underlying norms of fairness in the allocation of resources. The distribution of benefits in universalism incorporates the redistributive principle of equity (Kildal & Kuhnle, 2002), where the State plays an essential role in developing broader social solidarity and justice (Stegăroiu, 2013). Within a universalist paradigm, both labour and welfare services are de-commodified, and the State actively regulates the protection of social rights (Stegăroiu, 2013). Selectivism, on the other hand, refers to the distribution of different benefits and services to people with different needs based on individual means-tested selectivity (Mackenbach et al., 2002). Selectivism accords importance to the market through the commodification of labour and welfare benefits. With the price it commands in the labour market, labour as a commodity must purchase welfare while the State plays a limited role in regulating and upholding social and labour rights. This model reinforces norms of self-regulation of the market and self–responsibility of individuals in the distribution of resources and earning of welfare goods and services. It is blind to the structural and contextual determinants of social vulnerability.

An assessment of the healthcare policies covering migrants in Malaysia and Thailand indicates that the intersecting factors of citizenship status (citizen vs. non-citizen), migration status (labour migrant vs. refugee), and documentation status (documented vs. undocumented) impact healthcare access for migrant populations in UHC differently in these two countries.

Thailand's system is a combination of universalism and selectivism. It is stronger bent toward universalism which is seen in the expansion of benefits to all its citizens, is guided by the codification of health as a right in the Thai constitution. Its universalistic approach is also seen in the extension of its UHC to documented labour migrants who received equal treatment with Thai citizens working in the private sector, as the SSS covered both. Thailand's universalistic bent can also be traced to its efforts to include even half-legal and undocumented migrants into a system of health protection. However, it does not escape attention that half-legal and undocumented migrants were excluded from the UCS program which covers citizens. They were included in HICS, the exclusive program for undocumented and half-legal migrants, which provides unequal benefits and lower sustainability than UCS. Such a sequestering of non-citizens based on documentation status alludes to problems of selectivism that must be addressed for the system to become genuinely universalistic.

Unlike Thailand, there is no legislative framework in Malaysia protecting the right to health, even for citizens. Reflecting selectivism, there is an increasing impetus to target poor populations for subsidised public healthcare while creating spaces for the rich to switch to private healthcare by promoting the expansion of the private healthcare sector (Jaafar et al., 2012). Decreasing incentives for the affluent to

participate in cross-subsidization of overall healthcare costs in the country poses the risk of creating differences in healthcare quality in the public and private sectors. While Thailand indicates an increasing role of the government in its UHC, Malaysia reflects a trend toward a retreating role of the State. Thus, within hierarchies of deservingness to State-subsidised public healthcare created, besides healthcare for the affluent, migrant healthcare is also devolved to poorly regulated market forces, reflecting a selectivist approach. Further, the State fails to assume regulatory responsibility to ensure equitable social protection and health insurance schemes for migrants who lack the same economic agency as the affluent in the market. Yet, the salient neoliberal ethic of autonomy and individual responsibility makes it contingent on less-resourced individual migrants to retain status and functioning regardless of weak labour and social protection policies, thereby exacerbating their social vulnerability. Unsurprisingly, despite contributing to a mandatory private health insurance program, migrant health is not substantively protected. They lack access to outpatient care, prevention, and health promotion. Emerging evidence shows that selectivism is associated with "privatisation and corporate profiteering, often at the expense of those least able to bear the impact." (Danson et al., 2013, p. 5). This phenomenon is perhaps exemplified in the Malaysian case study where labour migrant healthcare through mandatory private health insurance was relegated to market forces and entities for whom it was profitable (JICA, 1999; The Sun Daily, 2014). Regarding refugees too, although UNHCR attempted a market-based solution for health insurance, it proved unsustainable.

The two case studies show us two different social protection approaches of the governments of Malaysia and Thailand to migrants. While neither country allowed portability of health insurance benefits even for documented migrants, the universalistic-selectivist approach of Thailand considered documented migrants deserving of treatment on par with Thai workers in the private sector under the SSS. In contrast, half-legal or undocumented migrants were deemed undeserving of equal treatment with citizens. They were assigned to the migrant-exclusive HICS, making the intersection of documentation status with citizenship moot to accessing healthcare. The more selectivist approach in Malaysia considered all non-citizens regardless of their documentation status to be undeserving of equal access to public healthcare with citizens, and UNHCR recognized refugees and asylum seekers given a 50.0% discount off the non-citizens' rates in public hospitals. Undocumented non-citizens, however, are targeted with specific provisions requiring their notification by healthcare providers, although this policy is not widely practiced. These phenomena align with global evidence where discursive representations of migrants focusing on their moral undeservingness to healthcare as non-citizens (Carmel & Sojka, 2020; Castañeda, 2013; Gottlieb & Davidovitch, 2017; Gottlieb & Mocha, 2018; Holmes et al., 2021; Sargent, 2012), and as undocumented persons (Bianchi et al., 2019; Burgoon & Rooduijn, 2021; Quesada, 2012) are used to perpetuate their disenfranchisement and create barriers to healthcare. In such a context, global initiatives like UHC in its current form fail to provide migrants with equality of opportunity to a system of healthcare. But importantly, it highlights the importance of deservingness in discourses related to migrant/non-citizen access to healthcare.

7.4 Citizenship and Undocumented Status and Frames of Deservingness/Undeservingness in Migrants' Access to Healthcare

According to Castañeda (2012, p. 830), *deservingness* discourses refer to "migrants' shifting and historically produced experiences of socio-political exclusion from their countries of residence, often leading them to be portrayed as unwanted, undesirable, and unworthy of services." In contrast to *entitlement* from the human rights discourse or social justice and equity arguments defined by universalism, *deservingness* is a moral assessment which discriminates in the distribution of such an entitlement/service. *Deservingness* is frequently invoked in non-citizens' access to healthcare and is relational and constructed by the appraisal of one's own deservingness and the social connection to the person being assessed (Willen, 2012a). Thus, while human rights and universalism in social protection have universal relevance based on shared humanity, deservingness is contextual and relative (Castañeda, 2012; Willen, 2012a) and defined by the frames (Viladrich, 2012) that are applied to the assessment.

The commonly used public health frames of *deservingness* (Castañeda, 2012; Marrow, 2012; Viladrich, 2012) to justify accessibility to healthcare for migrant populations span a range of perspectives including: (i) a utilitarian outlook on the cost-effectiveness of providing preventive and curative health interventions to migrants with the view that it will reduce higher future costs in the form of emergency care or transmission of disease to the host population; (ii) worthiness of work which appreciates the position of hard-working migrants who make fiscal contributions and contribute to the productivity of the country, yet experience poor work/life conditions and underutilise health services compared to host populations; (iii) humanitarian and professional norms which require that care providers provide care regardless of status; and (iv) imaging of certain migrants as victims and vulnerable toward whom policymakers have a moral obligation to alleviate their ordeals.

Frames for *undeservingness* comprise of perspectives which cast migrants, especially undocumented migrants as freeloaders, criminals, bogus, unhygienic, backward, threats to national stability/security/identity, and a burden on resources (Castañeda, 2012; Grove & Zwi, 2005; Larchanché, 2012; Vas Dev, 2009). Such frames render them unfit to claim entitlements to healthcare (Viladrich, 2012) and participate in the broader social and political community (Horton & Barker, 2010). As such, discourses of undeservingness usually disregard structural inequalities and political, economic, social, and cultural contexts that spawn inequalities, although indeterminate legal status is simultaneously a "juridical status, a socio-political condition, and mode of being in the world" (Willen, 2012b, p. 805). In this context, it is observed that negative perceptions and mistrust of migrants are also significantly associated with a strong sense of national identity and cultural unity in destination countries (Sides & Citrin 2007).

Regarding Thailand, it is possible to infer that the *deservingness* of migrants, even the undocumented to healthcare access, is guided by utilitarian rationales of

economic and political security, although there is a significant negative public perception of migrants as a security threat and a vector of disease which some scholars have attributed to the sense of national pride in native Thais (Sunpuwan & Niyomsilpa, 2012). This was evidenced in the 2014 political crisis leading to a mass exodus of Cambodian migrants causing retrograde effects on the Thai and Cambodian economies. This situation prompted the initiation of the "One Stop Service" (OSS) policy, the Nationality Verification exercise, and the decision to extend access to healthcare to undocumented migrants. These actions met the Ministry of Public Health's twin objectives of contributing to economic security through the supply of high productive labour and promoting political security by preventing communicable diseases and protecting the health of Thai people (Tharathep, 2011). Some experts also attribute pressure from the Trafficking in Persons (TIP) reports and rankings (Suphanchaimat et al., 2019), and Thailand's support to the ASEAN Consensus on the Protection and Promotion of the Rights of Migrant Workers, 2017, as motivating factors to support healthcare access even for undocumented migrants. However, problems with legal status persist for many (Suphanchaimat et al., 2019).

Regarding the Malaysian healthcare policy on migrants, it can be argued that the relativity in moral assessments of deservingness may be linked to the perception of citizens, who, as bona fide members of the political community of the country, are entitled to heavily subsidised rates. Refugees and asylum seekers, although also viewed negatively by the public (Daniel, 2020), either on humanitarian grounds as vulnerable individuals or as individuals with credible asylum claims verified by UNHCR, are possibly viewed by the State as deserving of the 50% discount off the non-citizens' rates in public hospitals. Undocumented migrants, on the other hand, as uncredible, bogus freeloaders and a burden on resources (Latiff & Ananthalakshmi, 2020; Mathiaparanam, 2020) are viewed as undeserving of the discount provided to recognized refugees and even deserving of arrest and detention after obtaining treatment.

The above aligns with Larchanché's claim that frames of undeservingness are used to "apprehend undocumented individuals in moral terms, which then underlie therapeutic and administrative interventions" (Larchanché, 2012, p. 863). These include barring them from the "political … [and] moral community" through exclusionary citizenship and migration regimes (Willen, 2012b, p. 806), where discourses of undeservingness reinforce migration strategies of deterrence and punishment, especially in relation to undocumented migrants (Grove & Zwi, 2005; Vas Dev, 2009). Referring to the citizenship-migration nexus, Dauvergne (2008, pp. 119, 123) states that "citizenship law and migration law work together in creating the border of the nation" with the "messy policing of the national boundary by inquiring into debt and disease, criminality and qualifications" being left to migration law and a "rhetorical domain of formal equality and liberal ideals" taken up by citizenship law. Such a situation also creates tensions between citizenship rights and human rights for migrants.

The contemporary practice of citizenship rights and human rights are exercised within the context of a political community. However, citizenship rights derive from

exclusive national identity and exclusionary membership in a political community (Cohen, 1999), whereas human rights are based on personhood and global notions of shared humanity, offering internationally protected rights (Kiwan, 2005). The current praxis of citizenship rights confers on a citizen: (i) political recognition; (ii) legal status; (iii) national identity; (iv) entitlements and freedoms; and (v) the ability to participate in political activities to enjoy their rights (Kingston et al., 2010). Thus, while the discourse on citizenship rights and the deservingness of entitlements concomitant with this status are actively used to address asymmetries in substantive citizenship and push for the rights of disenfranchised citizens, it is also used to create legal and socio-political exclusions for non-citizens who are not members of that political community (Arendt, 1973). These exclusions are mainly implemented through (i) migration governance arrangements which Menjívar (2006, p. 1000) claims "actively irregularises" people by making it impossible to retain legal status over time" and (ii) state-centred discourses on civic deficits and undeservingness of entitlements that accompany it (Latt, 2013; Marciniak, 2013; Pulitano, 2013; Riaño & Wastl-Walter, 2006; Vas Dev, 2009). Irregularity of status or undocumented status, which is further to non-citizen status, exacerbates the exclusions. In that sense, the rhetoric of deservingness-undeservingness straddling the discourses of citizenship rights and migration creates social exclusions for migrants and gnaws at the foundational principles of universalism underpinning universal health coverage and human rights in general.

Equally, the tension between the practice of citizenship rights underpinning the rationale for exclusion and selectivism toward migrants, and human rights and universalism reinforcing social solidarity and equity is rooted in the salience of immigration and nationality laws.

Historically and culturally, Malaysia and Thailand have had porous borders. But as Garcés-Mascareñas (2015, p. 129) says, "no border control does not mean no immigration control." In fact, weak border control is compensated by constricting immigration policies (Frank, 2014) and exclusionary social protection policies covering non-citizens, which effectively prevent their integration into mainstream society.

In Thailand, the 2008 Nationality Act and the 1979 Immigration Act emphasize the salience of citizenship and concomitant imperatives of national identity and legal status respectively (Suphanchaimat et al., 2017). In the context of Malaysia, the Malaysian Immigration Act 1959/63 regulates the entry of foreigners, and the Employment Restriction Act 1968 regulates the employment of foreigners. Along with the provisions for nationality/citizenship in the Federal Constitution (Art.14), these two laws draw the boundary between citizen and non-citizen and who can/cannot work in the country; with all three laws being implemented through a regime that emphasises the salience of documents to validate status/identity. Those lacking such documents cannot engage with legal processes to acquire legal status, the legal right to work, and access to social protection.

Thus, although border control on the frontier may be weak, social protection policies resisting principles of universalism coalesce with punitive immigration regimes to draw borders and obstruct entry and membership into the political/social

community of the nation. Such restrictive policies also constrict and immobilise migrant populations to spaces that evade mainstream life and public scrutiny and accountability. Prominently, it transforms spaces of everyday life like clinics, hospitals, and schools into sites of contestation of legal citizenship (Miklavcic, 2011) by bringing the border to the hinterland. Within this scheme of things, critical issues are sidestepped—that migrants make robust contributions to the economies of Malaysia (World Bank, 2013) and Thailand (ILO, 2020b; Martin, 2007), and that contrary to principles of healthcare financing, although migrant workers pay high taxes vis-à-vis citizens with similar income levels (Loganathan et al., 2020a) reciprocity is not accorded in extending them subsidised public healthcare. While Memoranda of Understanding between countries spell out terms of recruitment and work responsibilities, entitlements to social protection are not substantively included because of the territoriality nature of social protection systems.

7.5 Conclusion

Using Malaysia and Thailand as case examples, this chapter reviewed their migrant healthcare policies in the context of UHC and migration regimes. Although Thailand's migrant healthcare policies lean more toward universalism than Malaysia's predominantly selectivist approach, citizenship, migration, and documentation status intersected in different ways in the two countries to hinder migrants' access to healthcare and UHC on par with citizens. While undocumented migrants in both countries were subject to unstable healthcare financing mechanisms and even the risk of arrest and detention in Malaysia, the insurance schemes covering documented migrants in both countries lacked portability. In Malaysia, even for documented migrants, the coverage under SPIKPA was inadequate because of the high cost of healthcare although humanitarian migrants were given a 50% discount off foreigners' rates. Frames of deservingess mediated the type of access each migrant group experienced.

Against the backdrop of universalism and human rights which premise global initiatives like UHC and 2030 Agenda for Sustainable Development, through the case studies, this paper examined the highly complex terrain of migration, the overarching legal and political contexts within which UHC is implemented, and the significance of citizenship rights and their intersection within migration regimes highlighting labyrinthine contexts that migrants navigate to access healthcare. Such national level policy dynamics in destination countries which obfuscate the realisation of a common regional ASEAN response to social protection for migrants are also evidenced in sending countries where the normative foundation buttressing institutional responses are also fraught with discrepancies (Santoso, 2017). This chapter thus highlighted the need for concerted efforts to include migrant populations in measures which are purportedly universal in nature. In this way, it also showed the need for inter-disciplinary and multi-disciplinary scholarship in examining empirical problems of healthcare accessibility for migrant populations.

The over-representation of migrant workers in COVID-19 positive cases in Singapore and Malaysia (Asadullah, 2020) and the likelihood of pandemics occurring in the future create an urgency to resolve this problem. For this, the mediating role of citizenship and legal status in the ability of migrants to have access to healthcare with financial protection needs to be interpreted more expansively from a human rights perspective to make UHC responsive to one of the most significant global phenomena of our times, namely, migration. On a broader level, the case of migrant populations in Malaysia and Thailand concerning UHC exposes contradictions in normative thought and empirical practice that need to be reconciled for gains from UHC to be genuinely sustainable and fruitful. These are important points to consider and clarify as the ASEAN as a community strives to achieve regional peace and a just and democratic environment with shared prosperity for all.

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