Introduction

The health of a population is shaped by a complex interplay of economic, political, social, cultural and biological factors that transcend national borders. In this chapter, we consider how these factors work together within the Association of Southeast Asian Nations (ASEAN), a supra-national regional political space encompassing a population of over 600 million across ten countries. Specifically, we query how economic liberalization and corollary increases in the movement of people, goods and services are challenging and transforming entrenched ideas about who is entitled to and responsible for health and social care within and across ASEAN member states’ national borders.

Our discussion unfolds over three sections. In the first section, we examine regional-level economic and social policies/charters shaping contemporary national and regional healthcare discourses and practices within ASEAN. We show how ideological shifts from national toward regional and global health governance affect ASEAN member states’ governments, citizen and non-citizen residents, welfare structures and industries. In so doing, we pay attention to how measures that understand access to healthcare as both a human right and an economic good work to privilege certain political, economic and social subjects over others and how these different actors comply with, resist and/or ignore them.

In the second section we consider how a range of ASEAN member states have worked to establish universal health coverage (UHC) for their (national) populations, and identify some of the challenges they face as healthcare access becomes increasingly multi-tiered. Not only do neoliberal reforms work to further polarize access between rich and poor through the privatization of health and social care, they also work to exacerbate the divide between citizens and non-citizens. Though many ASEAN member states host ever-larger populations of economic migrants, asylum seekers and stateless peoples (many of whom hail from other ASEAN member states), healthcare coverage and social protection within them continue to be linked to citizenship and thus exclude large vulnerable portions of these countries’ populations. This predicament is especially ironic when contrasted with substantial regional promotion of and growth in trans-border flows of private healthcare investment, ownership, provision and travel.
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Building on this distinction between citizens’ and non-citizens’ healthcare access and social entitlements, in the third section we depict the challenges and vulnerabilities faced by peoples rendered mobile both within and outside of their country of origin. Specifically, we demonstrate how inequalities generated through intersections of gender and politico-legal status shape migrants’ health and well-being and their options for accessing care and caring for themselves. These examples reveal problems in how governments in both destination and source countries manage tensions between citizenship and human rights. They also clarify the limited reach and application of regional- and global-level social charters meant to harmonize practices in order to ensure greater protection for all.

From national to regional and global health and healthcare governance

ASEAN’s stated aim is to “enhance the well-being and livelihood of the peoples of ASEAN by providing them with equitable access to opportunities for human development, social welfare and justice” (ASEAN 2012). The dominant means for accomplishing this objective have been the “deepen[ing] and broaden[ing] internal economic integration and linkages with the world economy” (ASEAN 2004) to realize an ASEAN Economic Community (AEC). Regional integration is held to be strengthened “through liberalization and facilitation measures in the area of trade in goods, services and investments; and promot[ion of] private sector participation” (ASEAN 2009c). This involves measures such as the harmonization of goods and services standards and regulations, increasing transport of goods through the improvement of transport network infrastructure and services and the streamlining of customs procedures, public-private partnerships, liberalization of trade in services, mutual recognition agreements (MRAs), facilitated mobility of skilled labor, visa harmonization and the elimination of visa requirements for ASEAN nationals.

Yet to ensure peace, stability and shared prosperity in the region, ASEAN Community policies are geared not only at economic integration but also at improving the social welfare of those living within the member states. One of the main challenges to the latter objective resides not only in the significant differences between lower- and higher-income countries but also within them. To address these differences, the ASEAN Socio-Cultural Community (ASCC) Blueprint was developed. Its social welfare and protection clauses focus on seven fields: hunger and poverty alleviation; social safety net and protection from the negative impacts of integration and globalization; food security and safety; access to healthcare and promotion of healthy lifestyles; control of communicable diseases; a drug-free ASEAN; and, finally, disaster resiliency and safer communities (ASEAN 2009a).

Healthcare, earmarked as a priority for regional integration, is conceptualized in ASEAN policies both as a marketable industry to be developed and as a human right vulnerable to the effects of globalization. As a result, diverse policies – based on the stance that “accessible health services for citizens is no longer the sole responsibility of the state” (Hashim et al. 2012) – focus not only on improving health equity and public health outcomes but also on developing and opening up healthcare as an industry. This interest in fostering self-responsibility by “empower[ing] consumers to become active participants in health care” (ASEAN 2009b, 75) is explicit: “Access to health care and promotion of healthy lifestyles focuses on improving primary health care and public health education and coordination as well as strengthening capacity and competitiveness in health products and services” (ASEAN 2009a, 8–9).

As subjects of political, economic and social intervention, ASEAN member states’ populations are distinctly envisioned as national citizens who are regional consumers. To date, ASEAN’s
approach to healthcare has assumed a largely conventional international health governance (IHG) perspective. Due to the “primacy of national sovereignty, the prevalence of national interests over the common good and the culture of rule by consensus” (Lamy and Phua 2012, 238), ASEAN’s engagement in health issues can be conceptualized as a “useful mid-way organization relaying engagements of international agreements to the region” (Lamy and Phua 2012, 248). Challenged by member states’ reticence to politically and financially cooperate on the basis of a shared vision of health’s status as a global public good, health remains little more than a trans-border security issue in times of emergency. Indeed, while member states’ health ministers may appear to cooperate through coordination and dialogue on public health concerns (e.g., communicable diseases, tobacco regulation, air pollution, natural disasters, etc.), healthcare policy and regulation of access to healthcare are still primarily deemed national concerns. For example, the ASCC health and development agenda – which calls attention to the need for improved access to adequate and affordable healthcare, medical services and medicines, and promotion of healthy lifestyles – has so far mainly privileged control over communicable diseases and food quality (Acuin et al. 2011; Pocock 2015). By contrast, joint action regarding the management of cross-border population and health-related flows, the sharing of health resources and the development of trans-border universal health coverage remains limited. The national versus regional sovereignty question thus indicates an impasse to enacting meaningful region-wide improvements to healthcare.

A global health governance (GHG) perspective on ASEAN’s approach to health and social welfare reveals a more nuanced picture. It entails paying attention to more than government-to-government commitments (as with the IHG perspective) by also examining multi-sector engagements (e.g., with actors from industry and civil society). The strategic objective to “ensure that all ASEAN peoples are provided with social welfare and protection from the possible negative impacts of globalization and integration by improving the quality, coverage and sustainability of social protection and increasing the capacity of social risk management” (ASEAN 2009a, 6) does not stipulate individual member states’ responsibilities but rather indicates a broader post-national regional and market-led responsibility to accomplish the objective. With the ASEAN Free Trade Agreement’s (AFTA) liberalization of trade in services within the region, for example, healthcare has constituted one of the first priority services sectors – alongside air transport, information technology and tourism – to be liberalized (ASEAN 2009c, 13).

One key aspect of this liberalization was the reduction of visa requirements for intra-regional travel by ASEAN nationals in order to facilitate temporary cross-border travel for individuals seeking to access market-based healthcare options to satisfy personal healthcare needs (a.k.a. ‘medical tourism’) (ASEAN 2009b, 26). This has been considered a concrete step toward “realising an ASEAN Community that is people-centred and socially responsible with a view to achieving enduring solidarity and unity among the nations and peoples of ASEAN by forging a common identity and building a caring and sharing society which is inclusive and harmonious where the well-being, livelihood, and welfare of the peoples are enhanced” (ASEAN 2009a, 1, our emphasis). Yet, as we observe in the following sections in greater detail, this regional effort privileges the health and well-being of certain socio-economic, political and legal categories of mobile individuals while rendering the domestic and cross-border healthcare pursuits of others (e.g., low-income nationals, documented and undocumented migrants and refugees, etc.) more suspect and prone to criticism, abuse and exploitation as well as posing risks to the public health systems in both source and destination countries (Ormond 2014).

Another key aspect of this region-wide harmonization-via-liberalization approach has been the ASEAN Framework Agreement on Services’ (AFAS) push to enable the intra-ASEAN
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mobility of much-needed doctors, nurses and dentists to mitigate member states’ often severe domestic health worker shortages (Kittrakulrat et al. 2014). This move has been welcomed by the Philippines, a major global player in health worker outsourcing and, now, potent regional supplier (Rodriguez 2010). Yet, several potential destination member states are resistant because their national professional associations and smaller healthcare players wish to both protect the quality of care provision and limit competition to ensure the stability of their practices. Such protectionism has led Vietnam to require foreign doctors wishing to practice there to pass a language test, for example, thus significantly limiting numbers (Luiistro 2015). Significantly, regional liberalization of the healthcare ‘industry’ promises the greatest benefits to both higher-income individual ‘free agents’ and large corporate players that can more easily move between and invest in other countries (e.g., major multi-national hospital conglomerates, pharmaceutical and device producers, etc.) (Center for International and Strategic Studies 2009).

Divergent healthcare access and entitlements to citizens and non-citizens

The divergent perspectives outlined above vis-à-vis trans-border healthcare commoditization versus regionally negotiated social entitlements to healthcare are starkly evident within ASEAN, where politico-legal and socio-economic statuses play a significant role in determining healthcare access at the national level. National health systems are undergoing major transformations in order to extend coverage to more of their citizens all the while adhering to neoliberal reforms to cut care costs and to make citizens more financially responsible for their own health. At the same time, some member states (e.g., Malaysia, Singapore and Thailand) have emerged both as major players in the privatized regional health market and as hosts to sizeable migrant worker populations from other ASEAN (e.g., Indonesia, Myanmar and the Philippines) and South Asian (e.g., Bangladesh and Nepal) source countries, leading to new national and trans-border regional challenges to guaranteeing and managing access to quality care for non-nationals.

In recent years, World Health Organization (WHO) member states have been urged to hasten national-level reforms to ensure timely, universal access to quality health services as and when needed, without healthcare users falling into financial hardship (World Health Assembly 2005, 2011). Notwithstanding recent moves to corporatize some public healthcare institutions, Malaysian and Singaporean citizens have long benefited from widely accessible tax-funded government healthcare, while Brunei nationals (who do not pay personal income tax) enjoy widespread health and social benefits at public expense. In Thailand, the 2002 National Health Security Act extended healthcare coverage beyond civil servants and their dependents, and employees in the formal (private) sector, to the vast bulk of those who hitherto had limited access to necessary healthcare. This new initiative (Universal Coverage Scheme, or UCS), covering about 75 percent of the population, is financed by general tax revenues and offers a comprehensive package of services encompassing curative and preventive care. Public healthcare facilities are the main providers of care for more than 95 percent of UCS beneficiaries (Health Systems Research Institute 2012). In Indonesia, ten years after the National Social Security System Law was enacted, the Social Security Management Agency was established in 2014 to implement a national health insurance scheme. Building on the experience with the Jakarta Health Card scheme he introduced for the city’s underserved when he was Jakarta’s governor (2012–2014), President Joko Widodo launched the National Health Insurance Scheme on 3 November 2014 with the ambitious targets of enrolling 121.6 million citizens in the first year and achieving universal coverage for a projected 250 million citizens by 2019 (Sciortino 2014).
In a national context, however, universal health coverage (UHC) often translates into citizenship-based entitlements, leaving (documented and undocumented) migrant workers, refugees and asylum-seekers to fall through the cracks. Considering that Southeast Asia is home to major labor-exporting and -receiving countries, this constitutes an urgent priority for the ASEAN regional agenda. Indeed, of the 14 million international migrant workers originating from ASEAN member states, about 6 million are intra-ASEAN migrants, with 90 percent of them hosted by Malaysia, Singapore and Thailand (Baruah 2012). The presence of sizeable populations of undocumented migrants in particular presents distinctive public health challenges. Recall that the SARS pandemic erupted, and subsided, over an eight-month period in 2002–2003 in the absence of therapeutics, clinically useful diagnostics and vaccines. One of the key control measures that helped break the chains of transmission and extinguish the pandemic – quarantine and meticulous contact-tracing – would be difficult to implement when large populations of undocumented migrants have a strong incentive to avoid contact with government agencies. At the end of his country visit to Malaysia (19 November–2 December 2014), UN Special Rapporteur on the Right to Health Dainius Pūras noted that undocumented migrants are considered illegal in the country [Malaysia] and face criminal penalties for being undocumented, ranging from fines to imprisonment and caning. During my visit, I learned about the establishment of immigration counters inside public hospitals to facilitate the referrals of undocumented migrants and asylum seekers to the police when they come seeking medical attention. I consider that this practice goes against public health interests and the code of ethics of doctors. The establishment of these counters will deter undocumented migrants from seeking health care for fear of being reported, which among other things could cause the spread of communicable diseases. (in OHCHR, 2014; see also Hospital Kuala Lumpur 2014)

The pandemic potential of the MERS coronavirus, a more lethal but less transmissible relative of SARS, is amplified for the region by the annual flows of Hajj pilgrims traveling between Southeast Asia and the Saudi epicenter. When contemplating unsettling but quite plausible scenarios (e.g., if SARS or MERS were to spread into large undocumented migrant populations), it is all too easy to slip into a counter-productive health policing mind-set that reinforces xenophobic sentiments toward ‘the diseased and threatening other.’ A pragmatic (rights-based) public health approach at both national and supra-national regional levels, therefore, coupled with deterrent penalties for human trafficking and illicit employment of vulnerable and compliant undocumented migrants, would be more effective in the internal and trans-border control of communicable diseases and the protection of migrants’ health and well-being (Mann et al. 1994).

While ASEAN member states continue to struggle with commitments on migrants’ rights and benefits, governments in Malaysia, the Philippines, Singapore and Thailand are decidedly keen to attract a different category of health-seeking foreigner: ‘medical tourists’ (Ormond and Mainil 2015). The Malaysian federal government, for instance, which controls the world’s second largest listed healthcare provider, IHH Healthcare, is more preoccupied with developing an integrated regional health market than with developing an interventionist social charter that regionalizes UHC on a multilateral basis (e.g., portability of benefits, tax options and social entitlements for foreign workers, etc.) (ASEAN 2009c; Chan 2012; PEMANDU 2015). Indeed, unlike Thailand, Malaysia and Singapore prefer to rely on private insurers for migrants’ health coverage (Guinto et al. 2015). It is sobering to note that, just as the New Deal and the British
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A welfare state emerged from the wreckage of the Great Depression and the Second World War, a regionally negotiated social contract for UHC and other entitlements ultimately also may require as midwife a (global) trauma on the scale of the apocalyptic scenarios envisaged by climate change catastrophists or uncontrolled pandemic outbreaks (Trajano 2015).

Health rights for and vulnerabilities of internally and internationally mobile peoples

Within ASEAN, international migration has largely been driven by economic differentials between countries and political and ethnic conflict within certain countries. Internal migration, meanwhile, consisting mainly of rural-urban migration and environmental displacement (as witnessed, for example, in the aftermath of the 2004 tsunami and the 2008 Cyclone Nargis), has been propelled by uneven national economic development and the region’s vulnerability to natural hazards (IOM 2010; Cole et al. 2015; Sugiyarto 2015).

However, internal and international migration are not discrete processes (Huguet and Chartritthirong 2011; Soda 2014). The in- and out-migration flows within and from Indonesia’s Riau Islands, for example, highlight the fluidity of migration and the ever-shifting identity of migrants as internal and/or international migrants traversing the continuum of geographical spaces and geo-political boundaries between Indonesia, Malaysia and Singapore (Lyons and Ford 2007). Migratory processes such as these have consequences for health equity, rights and justice for mobile populations because the healthcare entitlements that these migrants can claim vary as per their changing migratory status from internal to international migrants as they cross national borders. Equally, being documented or undocumented impacts their access to healthcare once they are international migrants who have crossed from Indonesia into Malaysia or Singapore. Simultaneously, even within the same geographical jurisdiction, the health needs and vulnerabilities of internal and international migrants and of different categories of international migrants differ. Thus, for example, the government of Indonesia would be challenged to develop distinctive policies to address the unique health(care) needs of internal migrants coming into the Riau Islands and of international migrants preparing to travel overseas or international migrants returning home after successfully completing their contract vis-à-vis deportees from Malaysia or Singapore.

Thus, it is within complex inter-relationships between intra- and trans-national mobility that multiple intersecting inequalities transpire. One of these relates to the intersection of gender, race and immigration status in the labor sector. For instance, both internal and international migration flows within ASEAN evidence a trend toward feminization. Women comprise the majority of migrants leaving source countries and engage in gendered occupations like domestic work, nursing and entertainment (Baruah 2012; UNDP 2015). However, domestic work is generally excluded from employment ordinances that protect labor and health rights, thus subjecting migrant women workers to social isolation, sexual abuse, and denial of labor and health rights (UN Women 2013). Furthermore, much intra-ASEAN migration is irregular in nature and eludes official statistics, which exacerbates the vulnerability of undocumented migrants to abuse, exploitation and exclusion from healthcare entitlements (CARAM Asia 2009; Sugiyarto 2015). The absence of durable solutions for the stateless and asylum-seekers, a factor exacerbating human smuggling and trafficking in the region, was patent in two important events in 2015: the discovery of mass graves of trafficked migrants in Thailand and Malaysia (Beh 2015) and the humanitarian crisis involving the stateless Rohingyas stranded at sea, whose boats were initially pushed back by Malaysian and Thai authorities (Associated Press 2015).
However, immigration documentation status and the distinction between documented and undocumented within ASEAN member states is often fluid and tenuous. Migrants have limited options to obtain and retain legal status owing to restrictive admission policies, border controls, immigration policies that discourage social integration, weak enforcement of labor laws, and few options for legal redress of grievances. Furthermore, being documented is a necessary but not sufficient condition for being able to access public healthcare because, as noted above, access to healthcare in most Southeast Asian destination countries is mediated by legal citizenship. In Malaysian public hospitals, for instance, not only do undocumented migrants risk arrest after obtaining treatment, but all non-citizens pay substantially higher user fees, are only eligible for a five-day supply of medication and must pay out-of-pocket for the treatment of infectious diseases. Thailand, too, in spite of progressive policies that allow even undocumented migrants to purchase health insurance, separates its Compulsory Migrant Health Insurance (CMHI) from UCS, the UHC scheme for its own citizens. Not only were the CMHI utilization rates found to be lower than UCS rates but, as the numbers of registered migrants decreased by 2006, CMHI’s role in financing migrants’ health needs was found to be eclipsed by out-of-pocket payments and hospital exemptions (IOM 2009).

The above-described binary opposition of national and non-national also exposes the tensions between citizenship rights and human rights with regard to healthcare within ASEAN member states’ migration regimes. As much as they are contested within ASEAN countries, citizenship and citizenship rights – as an exclusionary membership in a political community with concomitant privileged entitlements and protections – drive a wedge between citizen and non-citizen populations in accessing healthcare, as evidenced in the examples of Malaysia and Thailand above. Thus, as ASEAN member states strive for greater cohesion as a regional grouping, they are challenged to reconcile the interpretation of the concept of ‘universality’ in UHC with their regional and global endorsements, notably the ASEAN Socio-Cultural Community (ASCC) Blueprint 2009–15, the ASEAN Declaration on the Protection and Promotion of the Rights of Migrant Workers (ASEAN 2007), the ASEAN Declaration of Commitment: Getting to Zero New Infections, Zero Discrimination, Zero AIDS-Related Deaths, 2011 (ASEAN 2011), and, more importantly, the 2008 World Health Assembly (WHA) Resolution on the Health of Migrants (WHO 2008), which calls for migrant-sensitive health policies.

ASEAN member states also need to reconcile their disparate approaches – of promoting the development of a market-led, profit-focused health system with one premised on health as a human right. None of the region’s top three destinations for migrants and refugees – Malaysia, Singapore and Thailand – have ratified the 1990 International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (UN General Assembly 1990), the 1951 Refugee Convention (UN General Assembly 1951) or the 1954 Convention relating to the Status of Stateless Persons (UN General Assembly 1954). Furthermore, Malaysia and Singapore, among the most affluent countries in ASEAN, are not party to the 1996 International Covenant on Economic Social and Cultural Rights (UN General Assembly 1966), which spells out the norms for the right to health. They have also not codified the right to health in their constitutions for their own citizens. Malaysia’s two-tiered healthcare system, for example, has increasing space for affluent citizens to opt out of the public health system. This development has evaded debate on the long-term consequences for health equity and on the risks associated with decreased incentives for the affluent to cross-subsidize public healthcare.

Healthcare for migrants has also been instrumentalized for profit, with migrant workers now legally required to purchase private health insurance from companies assigned by the Malaysian government. While the revenue from this insurance scheme contributes to Malaysia’s economic
transformation, with the aim of elevating it to the level of a developed nation (PEMANDU 2010), migrant workers subscribing to the two private health insurance schemes are not covered for out-patient care, health promotion or prevention. Although Thailand also aligns with ASEAN’s approach of attributing an instrumental value to health in achieving its broader economic goals, it has attempted to accommodate a rights-based approach to health and healthcare, even incorporating it as a constitutional guarantee, through an expanded social protection role for the state in the provision of healthcare, investment in healthcare infrastructure, healthcare financing and poverty alleviation (Sakunphanit and Suwanrada 2011). However, challenges remain with regard to the inclusion of migrant workers in the country’s UHC.

Conclusion

In the last two decades, deregulated financial markets and their capital flows have led to financial volatility worldwide with spill-over damage at a range of scales. In a competitive race to the bottom, poorly (or arbitrarily) regulated labor inflows undermine social compacts by weakening the leverage of domestic labor and rendering undocumented migrants more vulnerable to abuse and exploitation. To secure equitable gains, regional economic development initiatives in which Southeast Asian countries are engaged (e.g., the ASEAN Free Trade Agreement [AFTA], the ASEAN Economic Community [AEC] and the Trans-Pacific Partnership Agreement [TPPA], essentially a bill of rights for investors and traders) need to be balanced by a regional social charter with binding commitments on the rights and entitlements not only of national citizens of the region’s nation-states but also of the trans-border (labor) migrants residing within them.

Stand-alone, national-level government commitments continue to be patchy and prove insufficient in an era of global health governance. To reinforce this observation using an example discussed above, Thailand’s introduction of a government-run Compulsory Migrant Health Insurance scheme (CMHI) in 2001 for documented and undocumented migrant workers alike – which can be considered a pioneering policy approach within the region – still offers differential benefits when compared with the Universal Coverage Scheme (UCS) reserved for Thai citizens. Other implementation issues such as the restricted portability of healthcare coverage, annual medical examinations requisite for CMHI policy renewal (chargeable to migrant workers themselves) and the reluctance of undocumented migrants to identify themselves as such have contributed, as of 2013, to a low CMHI registration rate of 60,000 out of a targeted 1 million registrants (Guinto et al. 2015).

Even if there were political will at the national and regional levels to tackle human trafficking, dubious migrant labor brokering practices and jurisdictional irregularities along the labor ‘supply chain’ (Szep and Grudgings 2013; Chao 2014; Al-Mahmood 2015), both sending and receiving countries within ASEAN remain wary about enforcing binding commitments fully compliant with international human rights and migrant rights conventions. An interim measure that perhaps could find traction is a multilateral binding agreement among ASEAN member states on taxation options for migrants and their dependents, which would entitle them to ‘citizen-equivalent’ healthcare and social benefits in their host country. This would not be a one-size-fits-all solution, but would be customized to the taxation and social entitlement regimes of respective ASEAN member states, i.e., an expanded notion of ‘adoptive’ citizen rights and obligations with arguably universal appeal.

The journey to realizing the right to health for all – including migrants – in ASEAN member states is going to be a long one. A first step toward moving forward as a politically, socially, economically and culturally cohesive regional grouping in relation to health, healthcare and
migrant rights includes achieving greater conceptual, normative and operational clarity of the avowed goals. Equally important would be the negotiation of the meaning of community and identity, and the manners in which member states manage and project their borders aside from geo-political boundaries.

Notes

1 Delegates attending the Issues and Challenges of Foreign Workers in Malaysia conference (16 December 2014, Kuala Lumpur) reported about 2.9 million legal foreign workers in Malaysia (out of an estimated 6 million), citing police sources; an earlier World Bank report estimated about 1.8 million registered foreign workers, and another 1 to 2 million unregistered workers in 2010 (Del Carpio et al. 2013).

2 The Bangkok office of the International Organization for Migration (IOM) estimated a total of 2.46 million low-skilled migrants from three neighboring countries (Cambodia, Laos and Myanmar), of whom 1.4 million were unregistered (Huguet and Chamratrithirong 2011).

3 Some 200,000 pilgrims from Indonesia and 30,000 from Malaysia, in addition to Thai, Brunetian and Filipino Muslim pilgrims travel annually to Saudi Arabia for the Hajj.

4 Recall that it was a regional initiative, led by the Indonesian government, which rallied health ministers of 18 Asia Pacific countries to issue the Jakarta Declaration (2007) calling upon the WHO "to convene the necessary meetings, initiate the critical processes and obtain the essential commitment of all stakeholders to establish the mechanisms for more open virus and information sharing and accessibility to avian influenza and other potential pandemic influenza vaccines for developing countries." These proposals were tabled at the 60th World Health Assembly in Geneva (14–23 May 2007) as part of a resolution calling for new mechanisms for virus sharing and for more equitable access to vaccines developed from these viral source materials, which were largely adopted (WHA 60.28).

5 Consider, for example, the contestation of citizenship with regard to Highland people in Thailand (Vadhanyphuti et al. 2002) and of the Rohingya in Myanmar (de Chickera 2010) and the dichotomization of citizenship rights in Malaysia (Koh 2015).

6 In 2014, documented migrant workers in the plantation, construction and manufacturing sectors in Malaysia were already contributing de facto tax revenues of MYR 1611 (US$503) per worker per annum by paying for the annual levy, temporary visitor work pass, multiple entry visa, processing fee, Foreign Workers Compensation Scheme and annual medical check-up.

References


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