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Risk entrepreneurship and the construction of healthcare deservingness for 'desirable', 'acceptable' and 'disposable' migrants in Malaysia

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ABSTRACT

In recent years, scholars have focused on the concept of healthcare deservingness, observing that healthcare professionals, state authorities and the broader public make moral judgements about which migrants are deserving of health care and which are not. Such literature tends to focus on migrants with irregular status. This article examines how state calculations of healthcare deservingness have also been applied to authorised migrants. Focusing on Malaysia, we examine the ways in which state authorities construct migrants as 'desirable', 'acceptable' and 'disposable', differentiated through calculations of their biological and economic risks and potential contribution to 'the nation'. To do this, we analyse recent government and commercial policies, plans and practices to reflect on how such biopolitical orderings create the conditions for risk entrepreneurship – where public and private actors capitalise on profit-making opportunities that emerge from the construction of risky subjects and risky scenarios – while reinforcing hierarchies of healthcare deservingness that exacerbate health inequalities by privileging migrants with greater economic capital and legitimising the exclusion of poor migrants.

KEYWORDS

Health care privatisation; deservingness; risk entrepreneurship; Malaysia; migrants

Introduction

On what basis do states construct the healthcare deservingness of different categories of migrants? How do these constructions relate to states' strategies and tactics for regulating migration? In recent years, scholars have focused on the concept of healthcare deservingness, observing that healthcare professionals, state authorities and the broader public make moral judgements about which migrants are deserving of government-subsidised health care and which are not – such judgements, usually linked to migration status, are sometimes internalised by migrants themselves (Larchanché 2012; Willen 2012). Assessments of healthcare deservingness are intimately tied to ideas about how biological and economic risks should be distributed and managed within a given society. While those who take a rights-based approach to health find it ethically problematic to restrict or deny care to

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anyone regardless of their migration status, political and fiscal conservatives find differential extensions of the state's duty of care to citizens and non-citizens to be both legitimate, even necessary (see Singer and Castro 2004; Jacobs and Skocpol 2010; Sargent and Larchanché 2011; Willen, Mulligan, and Castañeda 2011). With the spread of neoliberal austerity measures and political populism around the globe, therefore, migrants with irregular status are increasingly framed as less deserving of – and more of a risk to and burden on – government-subsidised health and social care resources than citizens and authorised migrants, leading to greater discrimination and poorer care access and health outcomes (Fassin 2005; Quesada 2012; Ormond and Lunt 2019).

While much of the literature on healthcare deservingness has focused on migrants with *irregular* status,[1] in this article we examine how calculations of such deservingness are also increasingly applied differentially to migrants with *authorised* status in Malaysia, a middle-income country with one of the largest populations of migrants in Southeast Asia. The current biopolitical era has been described by sociologist Nikolas Rose as one primarily concerned with the government of risk, whereby diverse actors 'try to identify, treat, manage or administer those individuals, groups or localities where risk is seen to be high' (Rose 2001, 7) through actuarial and epidemiological management strategies. Relations between many states and their subjects are being reconfigured through the management strategy of a specifically neoliberal 'risk shift' (Turner 2007, 305), individualising and privatising health responsibility while commodifying healthcare goods and services previously understood to be 'public' or subject to special protective regulation (Raghuram, Madge, and Noxolo 2009, 6; Jarman 2014; Lunt 2017). This re-drawing of the parameters of healthcare deservingness is by no means smooth and uncontested. In the case of Malaysia, the gradual, heavily contested retreat of the state from direct provision of health care to *citizens* (Chee and Barraclough 2007) is being accompanied by a more explicit – yet far less publicly challenged – rejection by the state of a duty of care for their *non-citizen* counterparts, regardless of whether they are regularised. In the process of neoliberal 'risk shift', we can observe the growth of Malaysian state narratives that displace attention from the implementation of controversial economic policies by scapegoating migrants as burdens on and threats to the future of dwindling public healthcare resources and their 'rightful' owners and users (i.e. citizens). As Ormond (2013, 39) observes:

> This contentious divide between citizens' and non-citizens' entitlement to care in the public system illustrates the 'dichotomy in a health service where both costs and rights are emphasized more than ever before' (Borman 2004, 60). It constructs the national health system as a symbolic pillar of national progress in which citizens are supposed to feel pride and yet, at the same time, provides an outlet for critical mourning for its weakened and overburdened state, displacing the source of some of its present woes to its (ab)use by 'ungrateful' foreigners.

The Malaysian state's rejection of a duty of care to migrants reflects strategies for articulating and ordering both citizen and non-citizen bodies in its public and private health sectors in ways that both construct *and* seek to mitigate the biological and economic risks posed to citizens and healthcare providers 'unfairly' shouldered with the 'burden' of caring for migrants who cannot afford to pay for their health care. At the same time, the Malaysian state also recognises the significant profits that can be made by serving (relatively affluent) migrants who can afford to pay for private health care, those who Whittaker and Chee (2016) call 'flexible bio-citizens' who seek to acquire different 'biovalue'

(Waldby 2002) by travelling abroad. Interventions by the Malaysian state create the conditions for 'risk entrepreneurship', enabling both public and private healthcare actors to capitalise on the construction, identification and manipulation both of 'risky' migrant subjects and of the tools to control or manage their (potential) behaviour and effects (Rose 2001).

While the differences in healthcare deservingness between citizens and non-citizens as a whole may be fairly well-recognised in Malaysia, less attention has been given to how different categories of migrants are made to fit within this 'hierarchy of acceptability' (McDowell 2009). We argue that calculations of the potential profitability of private healthcare provision for migrants together with an assessment of their biological and economic risks to 'the nation' lead to the construction of categories of 'desirable', 'acceptable' and 'disposable' migrants. This is a specifically neoliberal articulation of healthcare deservingness that is visible not only in governmental policies and practices but also their commercial manifestations.

In the next section of this article, we review literature on the confluence of factors that have enabled neoliberal valuations of different categories of migrants, judgements about their healthcare deservingness and the legitimisation of differential treatment. Then, drawing upon an analysis of government documents, reports by commercial actors, studies by academic scholars and non-governmental organisations, as well as our own research on health care and migration policies in Malaysia, we look at how state authorities have embarked on entrepreneurial strategies to attract 'desirable' migrants, in particular, 'medical tourists' (those who travel temporarily to the country for medical care and then return home), skilled expatriates, international students and international retirement migrants. We also focus on how authorities manage 'semi-skilled' and 'unskilled' migrant workers differently, using policies and practices to transform them into 'acceptable' migrants. Finally, we observe how Malaysian state authorities, vexed about the presence of migrants with irregular status, see little, if any, state responsibility for the health needs of this 'disposable' population.

Health care, foreignness, privilege and precariousness

Whether as 'refugees', 'unskilled migrants', 'skilled expatriates', 'international students' or '(medical) tourists', non-citizens are incorporated into receiving countries' polities and economies in (strategically) different ways. The ways in which non-citizens are signified as being 'deserving' of health care offer up a useful lens through which to examine these incorporations. Stereotypes and public discourses about different types of non-citizens shape the way that healthcare providers, policy-makers and migrants themselves think about 'deservingness', thus influencing laws, policies and administrative practices regarding their rights and entitlements to health care (Ormond and Lunt 2019).

Authorised migrant workers are typically granted the right to work for specified periods of time, with some having pathways to permanent residency and citizenship. Some governments rely heavily on temporary labour migration schemes because they – ostensibly – allow them to fill labour shortages without enabling permanent settlement (Kaur 2010). However, these schemes often lead to migrants staying on and losing their status (Kaur 2010; Lenard and Straehle 2010). Migration through authorised channels is also often expensive, bureaucratic and inaccessible without the aid of labour brokers in the

'migration industry' (Lindquist, Xiang, and Yeoh 2012; Gammeltoft-Hansen and Sorensen 2013). As such, many migrants travel to destination countries either by themselves or with the help of smugglers. Similarly, as visa regimes and border control practices tighten, refugees are often forced to travel through irregular routes in search of asylum.

Scholarship and policy-making regarding authorised and irregular migrant workers' and refugees' health have generally either focused on the monitoring and screening of them as potential public health threats or attended to the multifaceted structural obstacles to sustaining and improving their health – such as mental and physical trauma from source and transit country contexts; linguistic barriers; legal status, access to medical treatment and health insurance coverage; occupational hazards, un(der)employment, discrimination and vulnerability to violence; and the lack of social support in host countries (Zimmerman, Kiss, and Hossain 2011; Chavez 2012; Willen 2012). More recent work has drawn attention to migrant workers' and refugees' agency, pointing to the broad range and interplay of formal and informal transnational care strategies and practices that migrants, faced with such obstacles, engage in to meet their needs and those of their families (Thomas and Gideon 2013; Phillimore et al. 2018).

Migration scholars have generally focused on populations considered to be more vulnerable and at risk of marginalisation (Lucassen and Smit 2016). This has resulted in comparably little attention being paid to migrant groups thought to possess greater social, economic and political capital and privilege, producing a somewhat skewed and limiting picture of who migrants are (Fechter and Walsh 2010). Governments keen on attracting foreign direct investment have made it easy for companies to hire skilled expatriates, among the most privileged categories of migrant workers (de Smet 2013). Numerous countries also attract international students and retirement migrants to reap the advantages derived from 'their prolonged length of stay, heavy expenditure, willingness to tour the country, stimulation of visiting friends and relatives (VFR) and return travel, good word of mouth publicity and resilience to economic downturn' (Henderson 2004, 176). International students are valued for what they can 'do' for a destination country, such as providing external sources of funding to improve the quality of higher education without raising costs for citizens and offering destination countries a 'soft power' outlet to demonstrate their 'good global citizenry' by supporting international development through education (Madge, Raghuram, and Noxolo 2009, 39).

Likewise, countries invite relatively healthy, affluent and autonomous older people to live a more affordable, leisurely and enjoyable life (King, Warnes, and Williams 2000). Such international retirement migrants are valued for their purchasing power and non-competition with locals over jobs and other resources (O'Reilly and Benson 2009; Toyota and Xiang 2012). Comparatively more attention has been paid to the healthcare concerns and practices. Studies show that a significant factor in whether such migrants decide to stay is their ability to secure satisfactory health care with their financial resources (Casado-Díaz, Kaiser, and Warnes 2004). Caught up in and articulated through the web of regimes of the countries they have lived in both previously and currently, these migrants may experience privilege and precariousness simultaneously (Ackers and Dwyer 2002; Botterill 2016). Indeed, in the wake of economic crisis and neoliberal healthcare and social welfare reforms that have rendered certain types of care arrangements unaffordable in their home countries, retirement migrants concerned with how to meet long-term care

needs have increasingly generated care alternatives through novel transnational configurations of familial, community and state resources (Ono 2015; Hall and Hardill 2016).

Migration in Malaysia

Malaysia is home to around 2.1 million authorised migrants and over a million migrants with irregular status (World Bank 2015). The government's immigration regime draws rigid distinctions not only between citizens and non-citizens but also between different categories of non-citizens, creating a 'hierarchy of rights' based on their potential economic contribution to 'the nation' (Nah 2012). While the country continues to rely heavily on foreign labour to sustain its economy, the government's embrace of neoliberalism since the 1990s has privileged the growth of diverse transnational mobility regimes that welcome specific foreign populations temporarily, primarily as consumers and investors with limited political entitlements (Ono 2015).

Malaysian authorities differentiate clearly between 'foreign workers' and 'expatriates', governing each differently. Foreign workers, by far the largest category of migrant workers in Malaysia (see Table 1), are considered 'semi-skilled' or 'unskilled' and subject to more stringent regulation. They are only permitted to work in five designated sectors (i.e. manufacturing, construction, agriculture, plantations and services), can only come from approved countries of origin, must be 18–45 years of age, must pass Immigration Security Clearance in their country of origin and must be certified 'medically fit' by approved healthcare providers in their country of origin prior to entering Malaysia and in routine screenings once in Malaysia. They are not allowed to bring family members with them and are only permitted to work for up to ten years, after which they are expected to return to their home countries (Immigration Department Malaysia 2017).

Expatriates – permitted to work in Malaysia as an incentive for foreign direct investment and to facilitate the training of Malaysian citizens – have greater rights and privileges than foreign workers. They have the right to sponsor dependents (typically, spouses and children), and to marry and to enter and leave Malaysia freely. While accounting for a very small proportion of all migrant workers in Malaysia (see Table 1), their presence in cities like Kuala Lumpur is conspicuous and their needs served by the production of internationalised urban amenities such as international schools, high-end supermarkets and expensive residences.

Since the late 1980s, the Malaysian government has also been wooing other 'desirable' categories of migrants, in particular, international students and retirement migrants. There has been significant growth in government-led campaigns to attract international students to Malaysia, with expectations of 200,000 by 2020 (*The New Straits Times*, 1 July 2013) (see Table 1). Numbers have risen with the rapid growth of private universities in the country and investment to attract international branches of foreign universities. In 1998, the national government launched the Malaysia My Second Home (MM2H) programme for retirees over 50 years of age as part of a policy to 'increase Malaysia's profits from tourism and stimulate the Malaysian economy through active foreign investment and foreign currency acquisition' (Ono 2015, 10). In 2002, MM2H was redesigned to attract not only retirees but also foreigners with sufficient regular income, leading to the abolition of age and nationality limitations and the partial relaxation of entry requirements (see Table 1). MM2H participants are celebrated as consumers, valued for their financial

Table 1. Countries of origin of authorised foreign residents in Malaysia, 2010–13.

	MM2H (aggregate)[a]		International students		Corporate expatriates		Foreign workers	
Year	2010	2013	2010	2013	2006	2012	2011	2013
Rank/ Total	14,816	24,105	86,923	103,000	32,600	44,140	1.57 million	2.1 million
1	China (17%)	China (20%)	Iran (14%)		India	India (20%)	Indonesia (47%)	Indonesia (44%)
2	Bangladesh (12%)	Japan (13%)	China (12%)		Japan	China (10%)	Nepal (15%)	Nepal (17%)
3	UK (11%)	Bangladesh (11%)	Indonesia (11%)		China	Indonesia (7%)	Bangladesh (12%)	Bangladesh (15%)
4	Japan (8%)	UK (8%)	Nigeria (7%)		UK	Philippines (7%)	Myanmar (10%)	Myanmar (8%)
5	Iran (5%)	Iran (5%)	Yemen (7%)		Singapore	Japan (6%)	India (4%)	India (6%)
6	Singapore (5%)	Singapore (4%)	Libya (4%)			UK (5%)	Vietnam (4%)	
7	Taiwan (4%)	Taiwan (4%)	Sudan (3%)			Korea (4%)	Philippines (2%)	
8	India (4%)	Pakistan (4%)	Saudi Arabia (3%)			Pakistan (4%)	Cambodia (2%)	
9	Pakistan (4%)	Korea (3%)				Singapore (3%)	Pakistan (1%)	
10	Korea (4%)	India (3%)				Australia (3%)	Thailand (1%)	

Source: ICEF 2014; IIE 2016; Imson 2013; Kassim 2014; MM2H 2016; World Bank 2015.

Note: Percentages are indicated where known to indicate the weight of different nationalities represented.

[a]Little is known about the composition of MM2H households, since statistics released are based on the applicant, do not indicate the number of people included in the applicant's household having moved with him/her to Malaysia and do not include the age profiles of participants. A household, however, depending on the age of the applicant, can include not just spouses but also school-aged children under the age of 21 and elderly dependents and scholarly work suggests that MM2H participants rarely move to Malaysia on their own (Kohno et al. 2016). As such, a more meaningful way to understand their relevance relative to use of and demand for health and care services in Malaysia would be to aggregate applications over time (since families can stay for periods of up to 10 years, after which their MM2H visa must be renewed).

capacity to purchase property, services and entertainment. To further facilitate consumption, the MM2H programme provides tax exemptions on pensions and foreign income brought into the country and enables participants' children to study in international schools.

As noted above, Malaysia is also home to many migrants with irregular status. Some come to Malaysia through irregular means, while others breach the conditions of their visas. Some foreign workers, for example, run away from employers to escape exploitation and labour rights abuses, as recourse to legal justice is limited (Nah 2014). Asylum seekers, refugees and stateless persons come to Malaysia to seek refuge and avoid poverty. However, as Malaysia is signatory neither to the 1951 Convention Relating to the Status of Refugees nor its 1967 Protocol and does not recognise the status of asylum seekers and refugees in its domestic legal framework, they are formally without legal status and at risk of punishment for immigration offences (Hedman 2008; Nah 2011). The UN High Commissioner for Refugees (UNHCR) plays a crucial role in their protection, and over the past two decades, has registered significant growth in these groups – from 52,183 in 2002–150,845 at the end of March 2017 (UNHCR 2007; UNHCR Malaysia 2017). Thousands, however, remain unregistered.

Hierarchies of health care in an entrepreneurial state

Malaysia's national health system provides universal health coverage to Malaysian citizens. However, in practice, it has been described as a 'mixed public-private system' (Chee and Barraclough 2007), with the private sector providing most primary care and the public sector most tertiary care. Over the last 30 years, in efforts to manage rising healthcare costs and the demands of a growing (and ageing) middle class, the state has gradually retreated from its role as a healthcare provider and assumed an entrepreneurial role in fostering the privatisation of healthcare services (Chee 2007; Chee and Barraclough 2007). Through transnational public-private partnerships, state authorities also have been aggressively promoting Malaysia as a prime destination for international travel ('medical tourism'), thus integrating it into the growing global healthcare marketplace (Ormond 2013).

Treatment at government-subsidised medical facilities involves a two-tier payment system. Citizens benefit from government subsidies, enabling them to pay little out-of-pocket. Authorised migrants, until recently, could use public facilities at subsidised cost, just like Malaysian citizens (MOH n.d.). However, in a clear example of the 'fragile labour of welcoming' (Darling 2018, 224), after the Health Minister proclaimed in 2014 that foreigners were 'eating up our [Malaysian citizens'] medical subsidy' (Zuhrin 2014) foreigners were required to cover the real cost of their treatment at public health facilities, resulting in an exponential increase in medical costs for them. For example, a consultation with a public medical specialist costing citizens MYR5 (US$1) would cost migrants MYR60 (US$14) (Van Minh et al. 2014).[2] In April 2017, the Ministry of Health announced a sharp increase in deposits for migrants seeking treatment at public hospitals, raising these by 130-230% (*The Malay Mail Online* 2017).

Amongst the places where we can see most clearly the Malaysian state authorities' construction of hierarchies of healthcare deservingness is its Economic Transformation Programme (ETP), the sweeping national development plan launched in 2010 to transform

Malaysia from a middle-income economy to a high-income economy by 2020. The ETP aims to attract US$444 billion in foreign direct investment and to create 3.3 million new jobs through interventions and projects in twelve National Key Economic Areas (NKEAs) (Pemandu 2017). One of the NKEAs focuses on 'the larger healthcare eco-system' (Pemandu 2012): pharmaceuticals and biotechnology, medical technology and a broad range of health services. To reach its objectives, several Entry Point Projects (EPPs) have been identified, targeting both Malaysians and foreigners. These projects are officially divided into 'quick wins', 'strategic opportunities' and 'longer-term bets' (Pemandu 2012, 202) and involve an explicit calculation of authorised migrants' economic potential as healthcare consumers.

Through these EPPs, diverse commercial and government actors come together to develop and consolidate an industry designed both to capture and to provide for migrants' different needs and wants in ways that require the (re)conceptualisation, (re)regulation, (re)development and (re)distribution at national, state and municipal levels of a range of care resources. These, in turn, are mobilised by a host of actors, including an array of intermediaries in legal and care services, real estate, construction and so on (King 2002; Ono 2015), that distinctively shape diverse spaces – such as hospitals and clinics, rehabilitation and convalescence centres, resorts and gated communities, institutional care facilities, leisure amenities and consumption spaces, hospitality and travel infrastructure – throughout the country.

Attracting 'desirable' migrants

'Desirable' migrants are specifically targeted to advance national economic development objectives through the development of high-end private medical and long-term care options. Below we look at policies and practices related to 'healthcare travel' (EPP4), considered a 'strategic opportunity' in the ETP, and 'institutionalised aged care' (EPP16) and 'retirement villages' (EPP17), both framed in the ETP as 'longer-term bets'.

Reinvigorating healthcare travel

While generally understood as a form of 'tourism' rather than 'migration', international healthcare travel – popularly known as 'medical tourism' – is a growing phenomenon, with many governments positioning their lower- and middle-income countries as destinations home to 'world-class' medical facilities that are relatively affordable and easy to access (Ormond 2013). Rather than being an exceptional practice of economic elites, international healthcare travel now involves larger numbers of middle-class consumers, both those 'frustrated by their own diminishing entitlements' (Sparke 2009, 295) in the context of neoliberal austerity measures and by those from lower- and middle-income countries without medical care services of reliable quality (Vearey et al. 2018; Ormond and Sulianti 2017). States in Southeast Asia – in particular, Thailand, Singapore and Malaysia – have recognised international healthcare travel as a lucrative source of income and have been reconfiguring infrastructure and services to cater to foreign healthcare consumers.

In 1998, the Malaysian government identified international healthcare travel as a national economic growth engine, engaging with the private sector to develop the country as a key destination. A decade later the Malaysia Healthcare Travel Council

(MHTC) was launched by the government to develop and promote the sector. Numbers of officially recorded 'medical tourists' have grown exponentially, from 39,114 in 1998 to more than 860,000 in 2016, when the industry recorded MYR1 billion (US$234.2 million) in revenue (Ormond 2013; *The Star Online* 13 February 2017b). Strong growth is predicted, with annual revenue projected to reach MYR2.7 billion (US$633 million) by 2020 (Arukesamy 2017). With the ETP's 'Health Care EPP4: Reinvigorating health care travel' objective, the Malaysian government is further investing in the development of 'medical tourism' on several fronts. Previously-existing tax incentives continue to be availed to healthcare companies so that they may improve the stock of medical facilities, equipment and skills on offer for non-Malaysian private healthcare consumers (Pemandu 2010, 102; MIDA 2014). The largest Malaysian hospital chain KPJ has made extensive use of this scheme to build six new hospitals, renovate many more and set up four International Patient Centres in its Kuala Lumpur metropolitan-area hospitals to provide 'one-stop' service for foreigners, complete with 'patient liaison officers' fluent in Arabic, Indonesian, Japanese, Farsi and Korean (KPJ 2013, 102, 2016). Many other Malaysian private hospitals have also been able to pursue costly international accreditation (e.g. Joint Commission International (JCI)) under this scheme based on the widespread belief that 'in order to attract foreign patients, we [hospitals] need to be able to guarantee internationally recognised healthcare standards' (KPJ 2015a, 23).

The country's 'medical tourism' growth is widely touted by the Malaysian government. Each year, the Malaysian government releases figures on the annual number of 'medical tourists' having made use of private medical facilities and the revenue they generate, leading to headlines in local newspapers like 'Medical tourism a lucrative industry, with more tourists opting to undergo procedures in Malaysia' (*The Star Online* 7 December 2015). Yet while 'medical tourism' would seem to suggest a short-term stay (see, e.g. Chee and Whittaker 2019), some 40% of the 583,000 'medical tourists' reported to have received care in Malaysia in 2011 were actually other types of 'desirable' migrants already residing in and around the country's capital, Kuala Lumpur, and able to afford private-sector care (MHTC, in Pollard 2012; see also NaRanong and NaRanong 2011 on Thailand). Indeed, one of the two largest contributors to the KPJ Group's 'medical tourism' business was its KPJ Ampang Puteri Specialist Hospital in the Kuala Lumpur metropolitan area because of the sheer number of 'desirable' migrants (i.e. expatriate workers, retirement migrants and international students) living there (KPJ 2013).

Entrepreneurial state authorities have tapped into the population of (longer-term) 'desirable' migrants for a number of reasons. First, in consuming private health care, they are not 'burdening' a public health system increasingly reserved for Malaysian citizens. Second, those who live for longer periods of time in Malaysia are repeat healthcare consumers. Those who can afford to pay are actively courted by private insurers, hospitals and care institutions since their continual private healthcare consumption provides stability in what is recognised as a volatile global 'medical tourism' market (KPJ 2015a, 15, 117). Third, significant concentrations of such 'desirable' migrants can serve as an impetus to 'internationalise' hospitals and clinics in the areas in which they live (Cohen 2008; Connell 2013), providing the transport and hospitality infrastructure, cultural amenities and medical infrastructure and expertise attractive to both 'pure' medical tourists and 'desirable' migrants. Finally, 'desirable' migrants are found to reliably generate 'pure' medical tourism through word-of-mouth promotion by encouraging family

members in their countries of origin to receive care in Malaysia. As such, private hospitals' promotional events take place not only in foreign patients' countries of origin but also target 'desirable' migrant communities in Malaysia (KPJ 2013, 102, 2015a, 2016, 138).[3]

Institutionalised aged care and retirement villages

As with many other middle-income countries with rapidly growing middle-classes coming to terms with how to manage population ageing (Lamb 2009), there has been a lag in economic, social and cultural responses in Malaysia to the effects that demographic and socio-economic transformations have on ageing 'well' and the feasibility and logistics of care-giving. While retirement homes and villages are growing in appeal, nursing homes – widely understood to be a 'western' model for providing care for the dependent elderly – continue to be highly stigmatised (Ormond 2014). Given Malaysia's ageing population and its growing prominence as an international retirement migration destination, the ETP's 'Health Care EPP16: Institutional aged care' seeks to appeal to both Malaysian and foreign investors and clients. Projects like Eden-on-the-Park and KPJ Senior Living Care, modelled on assisted living and aged care facilities abroad (e.g. Australia), have been feted as viable first steps towards responding to a 'pressing need for quality and dependable senior active living and aged care which can be sustainable in the long term under a non-government funded or non-welfare regime' (Pemandu 2014).

Eden-on-the-Park (2016), a retirement village for seniors with active lifestyles combined with a senior care residence praised by the government for providing the quality of care expected in higher-income countries and serves as a benchmark for senior care in Malaysia (Pemandu 2014), promotes itself to older MM2H participants. Likewise, the KPJ Senior Living Care nursing home in the Kuala Lumpur metropolitan area that emulates Australian senior care (KPJ 2016, 26) seeks to appeal to foreign 'snowbirds': 'Leveraging on Malaysia's warm weather, rich culture and outstanding food, our next step is to look into the potential of attracting senior citizens overseas to our shores to escape their harsh winters' (KPJ 2015a, 123, 2015b). As these projects are in the early stages of development, it is not clear how popular these types of private-sector aged-care facilities will be. However, several aged care facilities catering explicitly to foreigners have opened in other parts of Southeast Asia and in Eastern Europe in recent years, indicating broader interest in the sector (Horn et al. 2016). A market may develop over time, especially among migrants from countries with significant care labour deficits. Toyota and Xiang (2012, 712) and Ono (2015), for example, have observed in their fieldwork that growing numbers of Japanese MM2H participants have opted to bring their elderly parents with them to access and make use of less expensive health and long-term care options in Malaysia. Kohno et al. (2016, 7) furthermore note that many Japanese MM2H participants living far from their adult children in Japan plan to spend the rest of their lives in Malaysia. Regardless of whether these plans will be successful, attempts not only to borrow aged-care models from Global North countries but also to attract older foreign clients from these countries are symbolic of the ways in which the Malaysian government is making use of 'desirable' migrants' embodied needs and concerns to advance national economic interests and to develop new perspectives in Malaysian society that link dignified ageing with private-sector living and care facilities.

Producing 'acceptable' migrants

Two key entrepreneurial initiatives have brought foreign workers into the realm of 'acceptability' within the context of Malaysia's neoliberalising healthcare system: mandatory routine health screenings and private health insurance to cover the cost of services at public hospitals and clinics.

Mandatory health screenings

Foreign workers are often framed in popular discourse as disease vectors in Malaysia carrying tuberculosis, malaria or parasites (see, e.g. Loh 2017) and as financial burdens on the public healthcare system. In the 1990s, the Malaysian government introduced mandatory health screenings to 'detect communicable diseases among foreign workers and to reduce the burden on public healthcare facilities due to foreign workers with chronic conditions requiring prolonged and extensive treatment' (Pantai FOMEMA 2011). In 1997, the Malaysian government awarded the private-sector company FOMEMA Sdn Bhd a concession to implement the mandatory health screening programme for authorised foreign workers, which it has renewed repeatedly (see Table 2). All foreign workers are required to undergo mandatory medical screenings in their country of origin, again within a month after entry in Malaysia, and then annually for the first three years of employment within the country. Foreign workers testing positive for tuberculosis, HIV, malaria, drug use and other conditions are repatriated. Women are also required to take a pregnancy test on top of the mandatory screening and are repatriated if pregnant. According to the Immigration Department, around 2.6% of foreign workers fail their medical tests in Malaysia (*The Star Online* 2 August 2017a).

Mandatory health insurance coverage

When more than a third of unpaid medical bills at public hospitals and clinics were attributed to foreigners in 2008, an editorial in a Malaysian national newspaper declared: 'This is not the kind of medical tourism we want' (*The New Sunday Times,* January 6 2008). Even though most documented migrant workers pay either taxes or foreign levies that fund the public health system, the Malaysian government – using rhetoric resonating with that in the United Kingdom and elsewhere about foreigners' lack of 'deservingness' to use government-subsidised health resources (Hanefeld, Mandeville, and Smith 2017) – has sought to design a buffer to 'protect' its public health system from foreign '(ab)users'. Within the scope of the ETP's 'Health Care EPP1: Mandating health insurance for foreign workers' objective, the government launched a mandatory basic public health insurance scheme

Table 2. Regulations on foreigners' healthcare responsibilities.

Categories of documented foreigners in Malaysia	Medical screening required?	SPIKPA required?	Private health insurance required?
Foreign workers	Yes	Yes	No
Corporate expatriates	No	Yes	No, but encouraged
International students	Yes	No	Yes
MM2H participants	Yes	No	Yes, but can be temporary travel insurance
'Pure medical tourists' and conventional tourists	No, but border control checks	No	No, but mooted

Source: MM2H 2016; EMGS 2017; FOMEMA 2017.

for documented foreign workers[4] known as the Hospitalization and Surgical Scheme for Foreign Workers (SPIKPA) in 2011 (see Table 2). Considered by the ETP to constitute a 'quick win', over 1.7 million foreign workers were insured by 2015 (Pemandu 2015). Foreign workers pay a premium of MYR120 (US$27) to one of 28 designated private insurance providers to receive medical coverage capped at MYR10,000 (US$2342) in government-subsidised medical facilities (Pemandu 2015).

The introduction of this scheme has been controversial. The Federation of Malaysian Manufacturers (FMM), for example, protested that it placed greater administrative and financial burdens on employers (FFM 2017).[5] They estimated that premiums paid by employers for an estimated 1.8 million workers would amount to MYR216 million – far greater than the MYR18 million in unpaid medical bills estimated by the Ministry of Health in 2010. Opining that the coverage provided by SPIKPA did not fully cover outpatient treatment, they observed that employers would still bear significant medical costs. Indeed, the earlier mentioned recent increases in healthcare costs for migrants effectively translate into even less-than-adequate coverage by SPIKPA, leaving the more severely ill or injured migrant workers underinsured and placing the burden of greater financial risk on both employers and migrants.

Rendering migrants 'disposable'

Migrants with irregular status are, perhaps unsurprisingly, not included in the ETP. Not viewed as economically beneficial to 'the nation', they are excluded from health care, neglected in places of detention and subject to whipping, thus treated 'disposably'. This group's challenges in access to health care include the inability to pay (especially at the abovementioned higher rates for foreigners), fear of arrest and of physical violence while travelling to and within healthcare facilities, and difficulties communicating with healthcare providers (Médecins Sans Frontières 2007; Health Equity Initiatives 2010). Some public hospitals report pregnant migrants with irregular status to immigration officials who arrest and detain them after delivery, along with their newborns (Health Equity Initiatives 2014; Pūras 2014). Because of these challenges, refugees tend to delay treatment, seek medical assistance only when conditions become severe or simply bear their medical conditions without treatment (Health Equity Initiatives 2010). These barriers to health care result in worry, anxiety, stress, depression, sadness, sleeplessness, problems with daily activities, loss of work and loss of income (Verghis and Pereira 2009), adding to pre-existing trauma and ongoing insecurity in Malaysia. While the Ministry of Health stated in 2005 that refugees holding UNHCR cards would be eligible for a 50% discount on foreigner treatment rates in public facilities, in practice, there has been variation in how this is implemented, and refugees have been denied treatment at government hospitals (Adnan 2012; Migration Working Group 2013).

Barriers to health care constitute just one facet of the health challenges facing 'disposable' migrants. Difficulties with access to justice make migrants with irregular status easy targets for exploitation, extortion, forced labour and trafficking (Azis 2014; Franck 2016). In a study of more than one thousand asylum seekers and refugees from Burma (Myanmar), the non-governmental organisation Health Equity Initiatives (2011) found that around one-third had experienced forced labour. Of those, 70.2% showed symptoms of anxiety, while 68.7% showed symptoms of depression. Similarly, the International

Rescue Committee (2012) found that around one-third of the one thousand Burmese refugees they surveyed reported experiencing abuse in the workplace. As migrants with irregular status also tend to take on dangerous work in construction, manufacturing and agriculture, they are also vulnerable to workplace injury without compensation (Hoffstaedter 2014).

The government regularly engages in public 'crackdowns' on migrants with irregular status. These public spectacles are designed to frighten migrants with irregular status and to prompt them to leave Malaysia (Nah 2011). Hygiene, dietary and safety conditions at immigration detention depots where people are held prior to deportation have been repeatedly shown to be sub-standard. Detainees – men, women and children alike – suffer from malnutrition, dehydration, and intestinal and respiratory infections (Sepang District Health Office 2011; Pūras 2014; Nah 2015). Ex-detainees report difficulties in accessing health care for conditions such as stroke, epilepsy, complicated hernia, obstetric complications, ante-natal problems and abdominal problems requiring emergency treatment (Migration Working Group 2009). They also suffer from mental health problems, including depression, severe and chronic post-traumatic stress disorder, anxiety disorder and suicidal ideation (International Federation for Human Rights and SUARAM 2008). In December 2008, the National Human Rights Commission of Malaysia (SUHAKAM) observed that around 1,300 detained migrants died in detention centres, prisons and police lock-ups over a six-year period, suggesting that this was because they were denied timely medical treatment (*The Star Online*, December 18 2008). Perhaps the most troubling treatment of migrants with irregular status is the punishment of whipping for immigration offences, a practice introduced in 2002 in amendment to the Immigration Act 1959/63 as a measure to curtail irregular migration. Between 2002 and 2008, 34,923 migrants were whipped for immigration offences (Liew 2009), a practice amounting to cruel, inhuman and degrading treatment.[6]

Conclusion

In this paper, we observe how entrepreneurial states in the Global South that have embraced the neoliberal self-responsibilisation for and commodification of health care have developed strategies for articulating migrant bodies in private and public healthcare systems that enable them to maximise profit and manage the biological and economic risks of hosting migrant populations. These biopolitical strategies create the conditions for risk entrepreneurship, wherein public and private actors capitalise on opportunities for profit-making that emerge from the construction of risky subjects and risky scenarios. Crucially, state authorities can engage in such risk entrepreneurship because they are able to manipulate conditions for the provision of health care to migrants with greater flexibility than they can for citizens.

Risk entrepreneurship is exercised in different ways in relation to different types of migrants. In this paper, we trace how public and private actors (re)configure goods, services and infrastructure to woo 'desirable migrants' – 'pure' medical tourists, expatriates, international students and international retirement migrants – who are attractive because they consume private health care without 'burdening' the state. Those that reside in Malaysia for longer periods are often repeat customers and potentially stimulate further medical tourism through social networks. Public and private actors have been

collaborating to produce strategies in the fields of international healthcare travel and institutionalised age care to distinguish, capture, discipline, expand and capitalise on this new private care 'market'.

State authorities have also engaged in entrepreneurial initiatives to transform riskier subjects into 'acceptable' migrants. Mandatory health screening and Insurance schemes for millions of foreign workers are a significant source of revenue for commercial actors authorised to provide such services. The way that these initiatives are organised enables state authorities to consolidate economic and political power while ostensibly reducing the financial risk that foreigners pose on public healthcare systems. Such initiatives, however, do not necessarily benefit some of the economic actors forced to participate in them. As discussed above, such schemes have resulted in greater financial and administrative burdens on both foreign workers and their employers, without necessarily providing the former with the level of healthcare provision they need.

Not all migrants are willing and able to engage in flexible bio-citizenship (Whittaker and Chee 2016); not all are 'biovaluable' in the eyes of an entrepreneurial state. Vexed at the presence of migrants with irregular status, state authorities have excluded, neglected and punished them, rendering them 'disposable'. Without access to insurance schemes, such migrants are forced to bear often unaffordable healthcare costs at public and private facilities. Vulnerability to exploitation, poor conditions of detention and corporal punishment to deter irregular migration further complicate their healthcare needs. As we have demonstrated in this article, the wide array of healthcare practices fuelled by risk entrepreneurship and legitimised through hierarchies of deservingness contributes to stark health inequalities amongst migrants, with more privileged migrants feted and given access to 'world-class' healthcare facilities while poorer, uninsured and insecure migrants experience significantly worse health outcomes.

Notes

1. Some scholars draw a distinction between 'migrants' and 'immigrants' (Willen 2012) – the former temporary and the latter with longer-term interests. In this paper, we use the term 'migrant' deliberately, as most non-citizens – including those who stay for many years in Malaysia – are given only temporary status without pathways to permanent residence and citizenship (Nah 2012).
2. All patients receiving private health care in Malaysia – regardless of their political or legal status – pay the same amount for treatment under the 1998 Private Healthcare Facilities and Services Act.
3. Yet the government's assumption that 'desirable' migrants are comparatively more self-responsible for and pro-active regarding managing their health and more financially autonomous than other categories of migrants may not necessarily hold. For instance, some MM2H participants do not meet the programme's monthly financial requirements (Wong and Musa 2017). Potentially without adequate health insurance cover (see Table 2), they may encounter difficulties in covering their care costs.
4. Foreign domestic workers, however, are exempt from this scheme.
5. In practice, employers sometimes pass on the cost of SPIKPA to foreign workers through wage deductions.
6. Amnesty International (2010, 5) describes this practice as follows: government officials regularly tear into the flesh of prisoners with rattan canes (*rotan*) travelling up to 160 kilometres per hour. The cane shreds the victim's naked skin, turns the fatty tissue into pulp, and leaves permanent scars that extend all the way to muscle fibres. Blood and flesh splash off the

victim's body, often accompanied by urine and faeces. This gruesome spectacle is kept hidden from public view. The pain inflicted by caning is so severe that victims often lose consciousness as a result. Afterwards the suffering can last for weeks or even years, both in terms of physical disabilities and psychological trauma.

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