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WHY WORKERS DO NOT USE HEALTH CARE SERVICES IN PUBLIC CLINICS- A CASE OF NON-CITIZENS IN MALAYSIA

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ABSTRACT

Migration of large number of people creates opportunities for the transmission of common or novel infectious diseases. Most non-citizens in this country are from least developed and poor countries, therefore, receiving treatment in public sector is more affordable for them as the Malaysian government subsidizes health care heavily. This study is aimed to find the reasons that hinder immigrant workers to use public clinic services.

To achieve the objective of the study survey was conducted to target immigrant workers in the urban regions in Malaysia. From 360 questionnaires distributed we managed to collect 352 samples (97.77% response rate). Questionnaire was divided into three sections; demographic characteristics, general questions and questions related to barriers.

The result of this study shows that, most of the respondents (75.9%) seek treatment in private clinic when they are ill and 58% refer to private clinics for routine medical checkup. Around 73% of our sample population believes inequality exists in access to primary health care services between immigrant workers and citizens.

The main personal factor was the participants' belief about necessity of receiving the services from the clinics. Long waiting time and long distance to public clinics were the most important structural factors. Transportation cost and having insurance coverage which could benefit at private clinics are known as financial barriers for the respondents. However, the most important barriers amongst these three types are structural barrier followed by personal barrier, and financial barrier seems to be less significant.

Keywords: Immigrants, Health Care, Public Clinics, Utilization

INTRODUCTION

One longstanding and polarized debate in global health concerns the appropriate role and balance of the public and private sector in providing healthcare services to populations in low-and middle-income countries (Berendes *et al.*, 2011). Public sector advocates have highlighted inequities in access to health care resulting from the inability of the poor to pay for private services. They have noted that private markets often fail to deliver public health goods including preventative services and lack coordinated planning with public health systems, required to curb epidemics. However, both sectors have their own limitations and strengths. Private sector healthcare systems tended to lack published data by which to evaluate their performance, had greater risks of low-quality care, and served higher socio-economic groups, whereas the public sector tended to be less responsive to patients and lacked availability of supplies (Basu *et al.*, 2012). Proper treatment on an outpatient basis would usually not require inpatient admission (Epstein, 2001) which is more significant for low-income groups.

In Malaysia, primary health care is provided in both private and public health care providers. Public health care is funded by government and foreigners pay nominal sum for treatment while private sector is free for service where patients pay out-off - pocket or funded by insurance or employer (Mimi *et al.*, 2011). . Private sector healthcare delivery in low-and middle-income countries is sometimes argued to be more efficient, accountable, and sustainable than public sector delivery. Conversely, the public sector is often regarded as

providing more equitable and evidence-based care(Basu *et al.*, 2012)..

Besides citizens health, immigrant's health is important for the host country because they may come with communicable disease or with their susceptibility to certain conditions, cultural based health beliefs, and level of exposure to infectious agents, and epidemiological profiles (WHO, 2008). Therefore, it can burden public health facilities especially by diseases that require prolonged and extensive treatment (MOHR, 2013). Inequality prevention between host population and migrants, reduces excess morbidity and mortality, decrease the negative influence of migration process on migrant's health outcome, improving migrants' access to preventive and curative interventions and ensure migrants health rights, which are the primary health rights of natives, are considered as the basic principles of a public health approach to the health of immigrants (WHO, 2008). Hence, foreign workers with disease need to be treated, especially in chronic disease like tuberculosis and hypertension (Leong, 2006).

This issue is very important for the countries like Malaysia. Since, Malaysia use foreign workers to ease labor shortage (Nayagam, 1992) and over is dependent on the foreign workers over the past decade (Mohamed, Ramendran & Yacob, 2012). It has been estimated that Malaysia has over 6.7 million foreign workers including 4.5 million illegal workers (Irsyad, 2014). According to Ministry of Human Resource of Malaysia's published Report in 2015, there are 2,073,414 registered unskilled workers and 97,908 skilled workers in Malaysia (MOHR, 2015). Therefore, this country is a destination for many foreigners to reside and make up a large part of the population in this country. Migration of large number of people creates opportunities for the transmission of common or novel infectious diseases (Soto, 2009).

Most noncitizens in this country are from least developed and poor countries like; Indonesia, Bangladesh, Philippines, Myanmar, Nepal, Cambodia and Vietnam. Poor people have lower access to health care services and lack of financial resources can create barriers to access healthcare services (Wagstaff, 2002). Accordingly, immigrants are more likely to have lower family income (Gordon-Larsen et al., 2003, Gadd et al., 2005) and low-income people have worse health with higher level of disease. Health for this group of people is an important economic asset (WHO, 2003). When health care is needed but is not obtained or delayed, individual's health worsens, which in turn leads to lost income and higher health care costs. Both of which contribute to poverty (Peters *et al.*, 2008). Therefore, receiving treatment in public sector is more affordable for them as the Malaysian government subsidizes health care heavily (Leong, 2006), however, subsidiaries is excluded to foreigners.

This study is aimed to find the reasons that hinder immigrant workers to use public clinic services. According to Ministry of Health report, only 3.6% of foreigner's visits are at public clinics (38% of female and 61.3% of male). Most of the studies in Malaysia focus on the non-citizens health care utilization and little data is available on the attitudes of foreign nationals as regards their performance for public or private health care (Hooi and Hooi, 2003) and foreign workers are unable to get benefits from Malaysia's health care system (Karim and Diah, 2015).

METHODS

To achieve the objective of the study survey was conducted to target immigrant workers in the urban in Malaysia mainly in Johor Bahru and Klang Valley from May to September 2015. Data were collected through convenient sampling in which majority of respondents were approached either in clinics, houses and working places. Trained enumerators approached non-citizens mainly Bangladeshis and Indonesians in these areas. From 360 questionnaires distributed we managed to collect 352 samples (97.77% response rate) which was prepared in both English and Malay language. Since many respondents are not highly educated, enumerators were tasked to explain the questions meaning. The classification of barriers used in this research is based on the Institute of Medicine model, which divided into three categories; personal, structural and financial. Questionnaire has been divided into three sections such as demographic characteristics, general questions and questions related to barriers. After respondents completed the socio-demographic background, they answered the general questions such as "Where do you/your family usually obtain routine health care check-up?", "If you or your family feel sick, where do you normally go for treatment?", "As a non-citizen, do you think that you have equal access to public health care just like Malaysian residence?" And "For the past 5 years, how often do you use the services provided by public clinics?". There were multiple choices answers which respondents could select to answer each question. In the last part of questionnaire one question ("What is your MAIN reason for not using the public clinic's ??") was asked for three times but three categories of answers have been provided as personal,

structural and financial barriers. Answers related to personal barrier include; "was not necessary to go", "low budget"," I don't understand the language used", "no same gender doctor", and "none of the above". Second options of answers were related to structural barrier. Participants could choose the answers from, "Clinic is too far", "Transport is not available", "No proper clinic facilities", "Waiting time is too long", "Difficult to get appointment", "Does not trust the doctor", "No doctor available"," Less proper medication", and "None of the above". For the financial barrier section answers include; "I own a policy insurance that can be benefitted at private clinic", "No transportation cost", "Having someone to finance me", and "None of the above". Next question is "Among reasons listed under the category of personal, structural, and financial problems, what is the MAIN reason that prevented you from getting treatment at public clinic?" to clarify which barrier is more hinder for the participants to not use public clinic services. The answers were "reasons related to personal barrier", "reasons related to structural barriers", "reasons related to financial barriers" and "none of the above". Respondents had eight options of answers to respond the question "If you go to private clinics, who will finance you?" such as; "My own saving", "My own pocket", "My family members, relatives or friends", "borrowing", "Employer", "Insurance policy", "a righteous person", "Charities", and "Others". The last question was asking about the most important advantage of the private clinic. Answers were selected among the options such as; "proper facilities", "working time is longer", "more qualified doctor", "Getting appointment is easier", "clinic is not too crowded", "clinic is more pleasant", "clinic is more accessible", "shorter waiting time", "more proper medications", and "Others". All the answers were analysed by using SPSS Statistics version 20 by using descriptive statistics and crosstab.

RESULTS

Table 1 shows the profile of 352 participants in this study. Around two-third of respondents are male (64.5%) and many respondents are from Indonesia (60.5%), followed by other ethnics (20.2%) and Bangladeshis (19.3%). More than half of the respondents are younger than 30 years old (57.1%). More than half of the participants have primary and secondary education certificate, and 26.7% have diploma. Most of them are private employed and two-third of them has less than RM 3000 household income per month.

Table 1: Respondents Demographic Characteristics

		Frequency	Percentage
Gender	Male	227	64.5
	Female	125	35.5
Age	≥30	201	57.1
	31-40	119	33.9
	41-50	23	6.5
	50≤	9	2.5
Highest education level	Primary	94	26.7
	Secondary	98	27.8
	Certificate/Diploma	93	26.4
	Bachelor's degree	21	6.0
	Master's degree	24	6.8
	Doctorate degree	9	2.6
	Others	13	3.7
Ethnic	Bangladeshi	68	19.3
	Indonesian	213	60.5
	Others	71	20.2
Occupation	Unemployed/ housewife	16	4.5
	Self employed	83	23.6
	Government employed	3	0.9
	Private employed	218	61.9
	Retired	1	0.3
	Part time employee	7	2.0
	Others	24	6.8
Total family income	Less than 2000	114	32.4
	RM2001-RM3000	111	31.5
	RM3001-RM4000	85	24.1
	More than RM4001	42	11.9

Figure 1 shows the source of treatment when the respective study population falls sick. Around 75.9% of this population refers to private clinic, 13.1% are using pharmacy's facilities and medication, 6% are going to private hospitals, 2.8% use public clinic health care services, 2% are using alternative medications, and 0.3% refers to public hospitals.

Figure 1: Source of Treatment When the Respondents Feel Sick

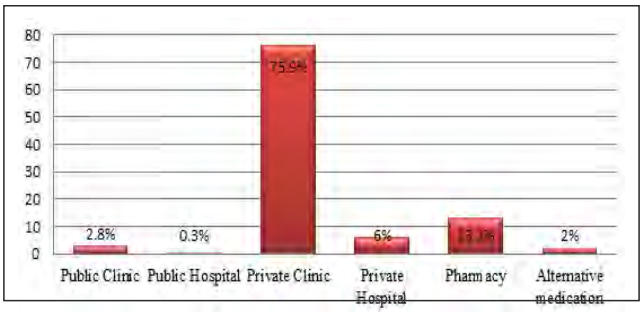
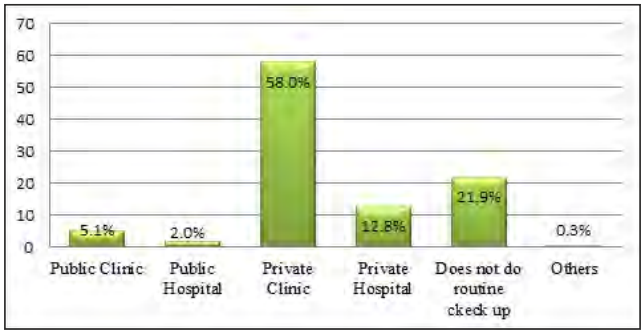


Figure 2 presents the source of routine health care check-up. Around 58% of respondents using private clinic's health care services for their routine medical checkup, 21.9% are not doing routine medical check-up, 12.8% refer to private hospitals, 5.1% use public clinics, 2% went to public hospitals and 0.3% uses other sources.

Figure 2: Source of Routine Healthcare Checkup



Most of the respondents (73%) believe that inequality in access to public healthcare clinics exit between Malaysian citizens and non-citizens and they do not have equal access to public health care just like Malaysian citizens (Figure 3).

Figure 3: As non-citizen, do you think that you have equal access to public health care just like Malaysian residence?

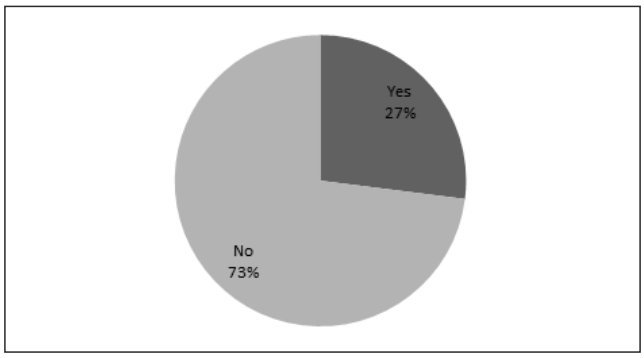


Table 2 shows some aspects of personal, structural and financial barriers, the advantage of private clinics, and source of finance for getting treatment in private clinics. For the question related to personal barrier, more than half of the respondents (57.5%) reported they had no personal reason. Around 28% of the sample size mentioned it was not necessary to go to public clinic which consist of 42.6% of Bangladeshis followed by 26.2% of Indonesian and 21.1% of other ethnic groups. Around 13.1% of Indonesians states they had low budget, 2.9% of Bangladeshis mentioned they do not understand the language that health care provider use, and 7% of other ethnics reported they avoided seeking care in public clinic because there was no same gender doctor. Answers related to structural part shows, 38.5% of participants did not use public clinic due to long waiting time and 14.4% because the clinic is far from their living area. However, 19.8% of the individuals did not face any aspects of structural barriers selected for this study. In financial section, 63.2% did not have any financial reason for not using public clinic, but 16.4% avoided seeking care in these clinics due to transportation costs consist of 22.9% Indonesian and 13.2% of Bangladeshis. 13% of participants in this study did not use public clinic due to having policy insurance (13.6% Indonesian, 14.7% Bangladeshis, and 9.9% of other ethnics). In addition, 7.4% use private clinics because they have someone to finance them.

Table 2: Barriers of Getting Health Care Services in Public Clinic

		Indonesian	Bangladeshi	Others	Total
What is your main reason for not using the public clinic's services? (Personal)	Was not necessary to go	26.2	42.6	21.1	28.3
	Low budget	13.1	2.9	0.0	8.5
	I don't understand the language used	0.9	2.9	2.8	1.7
	No same gender doctors	3.7	1.5	7.0	4.0
	None of above	56.1	50.0	69.0	57.5
What is your main reason for not using the public clinic's services? (structural)	Clinic is too far	17.3	16.2	4.2	14.4
	Transport is not available	9.8	4.4	0.0	6.8
	No proper clinic facility	4.2	0.0	8.5	4.2
	Waiting time is too long	37.9	38.2	40.8	38.5
	Difficult to get appointment	5.1	11.8	8.5	7.1
	Does not trust the doctor	2.3	4.4	12.7	4.8
	No doctor available	0.9	2.9	2.8	1.7
	Less proper medication	2.3	2.9	2.8	2.5
	None of above	20.1	19.1	19.7	19.8
What is your main reason for not using the public clinic's services? (Financial)	I own a policy insurance that can be benefitted at private clinic	13.6	14.7	9.9	13.0
	No transportation costs	22.9	13.2	0.0	16.4

	Having someone to finance me	4.2	0.0	23.9	7.4
	None of above	59.3	72.1	66.2	63.2
Among reasons listed under the category of personal, structural, and financial problems, what is the main reason that prevented you from getting treatment at public clinic?	Personal	15.0	50.0	22.5	23.2
	Structural	51.4	38.2	62.0	51.0
	Financial	22.4	8.8	8.5	17.0
	None of above	11.2	2.9	7.0	8.8
What is the most important advantage of the private clinics?	Proper facility	16.4	5.9	16.9	14.4
	Working time is longer	13.1	4.4	4.2	9.6
	More qualified doctor	7.9	2.9	19.7	9.3
	Getting appointment is easier	5.6	14.7	4.2	7.1
	Clinic is not crowded	18.7	19.1	16.9	18.4
	Clinic is more pleasant	12.1	22.1	18.3	15.3
	Clinic is more accessible	18.7	13.2	12.7	16.4
	Shorter waiting time	6.5	14.7	7.0	8.2
	More proper medications	0.9	2.9	0.0	1.1
If you go to private clinics, who will finance you?	Using my saving	35.5	7.4	42.3	31.4
	My family members	11.7	0.0	5.6	8.2
	Borrow money	13.6	1.5	0.0	8.5
	Employer	16.8	77.9	11.3	27.5
	Insurance policy	3.7	5.9	7.0	4.8
	A righteous person	0.5	0.0	0.0	0.3
	Charities	0.9	0.0	0.0	0.6
	Out of Pocket	17.3	7.4	32.4	18.4
	Others	0.0	0.0	1.4	0.3

Amongst these three types of barriers, the most important factor for Indonesian is related to Structural barriers (51.4%), for Bangladeshis is related to personal barriers (50%), and other ethnics also mostly report structural barriers (62%) as the most important factors associated to use private sector. In general, 51% of total sample population mentioned structural barrier is their main reason for not using the public clinic services, followed by personal barriers (32.2%) and financial barriers (17%).

As the advantage of private clinic, around 18.4% of the sample believe that private clinic is not crowded, 16.4% mentioned these clinics are more accessible, 15.5% stated private clinic is more pleasant, and 14.4% said private clinic have proper facilities. Nearby one-third of participants (31.4%) use their savings to cover the financial cost of using private clinics, 27.5% are getting their employers support, 18.4% pay out- of- pocket, 8.5% borrow money and 8.2% get their family members supports. Only 4.8% are using health insurance to cover the costs. The majority of Indonesian (35.5%) and other ethnics (42.3%) use their savings and Bangladeshis (77.9%) are financing by their employer.

DISCUSSION

Though primary health care is well developed in Malaysia, curative services are mainly provided by private clinics (Leong, 2006). Based on the report published by Ministry of Health of Malaysia, primary health care utilization among foreigners in Malaysia is 6.8% of total encounters in private and public clinics and only 3.6% of these visits are at public clinics (Sheamini, 2016).

This study shows that most of the respondents refer to private clinic to get treatment and around one-fifth of the sample size do not do any medical check-up. There are small numbers of participants who are using alternative medications when they are ill. Remarkably, most of the respondents believe that they do not have equal access to public clinic as Malaysian citizens. The main personal factor was the participants' belief about necessity of referring to clinic. Long waiting time and long distance to public clinics were the most important structural factors. Transportation cost and having insurance coverage which could benefit at private clinics are known as financial barriers for these sample groups. However, the most important barriers amongst these three types are structural barrier followed by personal barrier, and financial barrier seems to be less significant. Interestingly there is a difference between Indonesian and other ethnic and Bangladeshis in type of barrier. Indonesian and other ethnics seem to face more structural barrier, while Bangladeshis face more personal barriers. There are number of individuals who do not face any aspects that included in this study, but they refer to use private health care clinics. As understanding of access barriers has increases efforts to help low income people obtain health care will expanded to include more funding for health centers and public clinics and educational programs about health issue (Swartz, 2009).

CONCLUSION

The key advantages of private clinics are less crowded, more accessible, more pleasant, and have proper facilities. On the other hand, longer working time, more qualified doctors, shorter waiting time, and easy getting appointment are some other advantages that are undeniable. The most important financial resources savings followed by employer supports.

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