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BARRIERS TO HEALTH-CARE ACCESS: A CASE STUDY OF BANGLADESHI TEMPORARY MIGRANT WORKERS IN KUALA LUMPUR, MALAYSIA

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ABSTRACT

The primary objective of this study was to identify the barriers to accessing health-care services as perceived by Bangladeshi temporary workers' in Kuala Lumpur, Malaysia. The participants comprised 300 migrants working in the construction, manufacturing, and service sectors from three areas of Kuala Lumpur with the highest concentration of Bangladeshis. Following an analysis of the face-to-face structured interviews, the findings indicated that the main barriers were health-care providers not understanding migrant workers' health problems, high medical costs, self-medication, and lack of transportation. It is recommended, therefore, that a pre-departure orientation program should be developed to familiarize migrant workers with the Malaysian health-care system and procedures, as well basic courses in Malay (*Bahasa Melayu*) and English, to help them access and use health-care services. In addition, it is suggested that a further, larger study is conducted to extend the findings to other states in Malaysia where there are Bangladeshi temporary migrant workers from similar backgrounds.

Contribution/Originality: This study is one of very few studies investigating the reasons for migrant workers not using health-care services. Its findings has enormous implications for the growing concern on improving access to health-care services among foreign workers, especially Bangladeshi temporary migrant workers in Malaysia.

1. INTRODUCTION

According to international labor migration studies, access to health-care services continues to be a major concern for a range of organizations, such as agencies in migrants' countries of origin and destination, the International Labour Organization (ILO) (Olivier, 2018; WHO, 2014). Moreover, the health problems of migrant workers and their (lack of) access to health-care providers, particularly when vulnerable to work-related injuries, dominate the discourse among policymakers, academics, and researchers alike (Abdul-Aziz, 2001; Kanapathy, 2006). Despite the availability of modern health-care facilities in Malaysia, few migrant workers seek their services, either not wishing to or unable to for certain reason. For instance, a recent study of Bangladeshi workers in Malaysia revealed that 58% of respondents who suffered with serious diseases received no treatment through their employers (Karim & Diah, 2015). One reason relates to cost: Foreign workers pay higher fees for health care than Malaysians in both public and private facilities. Kanapathy (2006) suggested that this could be a barrier to health care for some migrant workers are without legal status, more at risk, in the lowest-paid jobs, and without company medical insurance.

In addition, strong evidence exists that migrants' lack of awareness of and familiarity with the local healthcare system has a significant impact on health-care access (Lee et al., 2014; Yao, 2008), and Bangladeshi workers poor knowledge of Malaysian health-care services does appear to be a barrier to access (Karim & Diah, 2015). Furthermore, low wages, the majority of which is sent back to support family in their country of origin, prevents migrant workers from using health-care services (Lee et al., 2014). This study, therefore, investigates the main barriers to health-care access among Bangladeshi temporary migrant workers in Malaysia.

2. LITERATURE REVIEW

The current literature on barriers to health-care access for migrant workers suggests that the major causes are: high medical fees (Kanapathy, 2006; (Littleton, Park, Thornley, Anderson, & Lawrence, 2008; Oxman-Martinez et al., 2005), lack of medical insurance (Mou et al., 2009), language barriers (Hennebry, Preibisch, & McLaughlin, 2009; Karim & Diah, 2015; Otero & Preibisch, 2010), anxiety over employment and immigration status (Arcury, Vallejos, Feldman, & Quandt, 2006; Hennebry et al., 2009; Kanapathy, 2006), and linguistic and cultural differences (Norredam, Nielsen, & Krasnik, 2010).

As with other demographic attributes, educational level affects the use of health-care services (Andersen, 1968, 1995; Pol & Thomas, 2001): a higher educational level results in better self-reporting of health status and use of health-care services (Liem, 2004). Furthermore, monthly income is a strong determinant for health-care access (Andersen, 1968, 1995; Lee et al., 2014): Lee et al. (2014) found a higher salary and visiting a doctor within three months.

In addition, Wee and Jomo (2007) suggested that the distance traveled is directly related to transport costs that affects the frequency with which health-care services are used: use declined as distance and costs rose. They also discovered from official data that even though government health services were more affordable than the private sector, since 1973–1974, they have become less so with the increase in transport costs, in part (2007: 107). Moreover, they noted that waiting times were major barriers health-care use in Malaysia. Heller (1976) and Meerman (1979) presented similar findings. According to Heller (1976), the average travel, waiting, and treatment times for an outpatient appointment at a government medical facility in Peninsular Malaysia was 65 minutes, with 25 minutes spent traveling, in 1973–1974, and the longer spent traveling, the lower the demand for government health services. In fact, lower-income appeared more likely than higher-income groups to use government health services, in which has become more common over the last 20 years.

Hu (2010) investigated the role health insurance played in influencing the use of health-care services in Thailand across three groups—Thai, Thai ethnic minorities, and ethnic minority migrants—between 2000 and 2004. It became evident that the higher the health insurance coverage, the higher the use of health-care services by each ethnic group; thus, ethnic minority migrants with the lowest health insurance coverage had the lowest use of healthcare services. Hu also indicated that ethnic minority migrants experienced linguistic and cultural barriers to health-care access on the Thailand–Myanmar border.

3. METHODOLOGY

Initially, data provided by the Bangladesh High Commission indicated the main areas where large numbers of Bangladeshi migrant workers were located, from which three clusters in Kuala Lumpur were selected: Klang (Port Klang, Northport, and Westport apartments); central Kuala Lumpur (Gombak, the Bangladesh High Commission, and Batu Caves); and Kuala Lumpur surrounds (Nilai). These clusters comprised the factories, development sites, and mega shopping malls and restaurants in which most Bangladeshi worked; thus, a two-stage sampling procedure—cluster followed by random—was used to select 100 male migrants from each of the construction, manufacturing, and service sectors. A survey method based on face-to-face structured interviews with 300 Bangladeshi temporary, non-professional migrant workers in the Malaysian construction, manufacturing, and

service sectors was then adopted. The researcher asked a standardized series of questions and recorded the responses of every worker, each interview taking approximately 40–55 minutes, mainly over a two-day weekend. Finally, the data were analyzed using IBM® SPSS® Statistics 22.

4. RESULTS

4.1. Demographic Profiles

As shown in Table 1, the Bangladeshi migrant workers are sociodemographically diverse, in terms of their age, marital status, educational level, and monthly income. The majority is aged between 31 and 35 years old (51%), followed by those between 26 and 30 years of age (26%). Their age may account for 79.3% of the respondents being married, and marital status can influence the use of health-care services.

Table 1 also shows that the majority of respondents had received formal education to the level of either primary school (28%) or, more often, secondary school (47.3%); very few had completed undergraduate (4.3%) or postgraduate (0.3%) studies. To conclude, although the Malaysian government has set the minimum monthly salary for foreign workers at RM900, the construction, manufacturing, and service sectors pay migrants different rates according to type of job, overtime, and so forth (Ullah, 2011). As can be seen from Table 1, this study identified seven monthly salary bands, ranging from RM900 to RM2001 and over. The majority earned either RM1401–1600 (30.7%) or RM1601–1800 (22.3%) per month, while, interestingly, a similar proportion (9.3%) earned monthly salaries immediately below (RM1201–1400) and above (RM1801–2000); only 2% earned RM2000 or more.

Table-1. Demographic profile of respondents.

Demographics	Frequency (n)	Percentage (%)
Gender		
Male	300	100
Age		
≤ 25 years	21	7.0
26–30 years	78	26.0
31–35 years	154	51.3
36–40 years	35	11.7
41–45 years	11	3.7
46–50 years	0	0
≥ 51 years	1	0.3
Marital Status		
Married	238	79.3
Unmarried	62	20.7
Educational Level		
Uneducated	3	1.0
Primary school	84	28.0
Secondary school	142	47.3
Higher secondary school	57	19.0
Degree/Honors	13	4.3
Masters	1	0.3
Monthly Income		
RM900–RM1000	22	7.3
RM1001–RM1200	57	19.0
RM1201–RM1400	28	9.3
RM1401–RM1600	92	30.7
RM1601–RM1800	67	22.3
RM1801–RM2000	28	9.3
≥ RM2001	6	2.0

4.2. Payment Methods Used by Migrant Workers for Medical Expenses

In Malaysia, foreign workers are entitled to health insurance, which is a requirement for applying for or renewing a work visa. In practice, workers do not use this insurance to pay for primary health care, unless involved in a serious accident or dying in the workplace. Therefore, it is important to determine examine data on how workers' pay their medical expenses at public, private, and other medical facilities: the majority of Bangladeshi migrant workers (60%) pay for their treatment themselves (i.e., self-payment/out-of-pocket payment); most of the others (28%) use labor health insurance or their company's medical allowance; however, some (12%) are rely on whether and how much their employers will contribute to the expenses, on receiving appropriate documentation (see Table 2). It is evident, then, that the majority of Bangladeshi migrants are not entitled to any health care while working in Malaysia, which supports the findings of Karim and Diah (2015), while Mou et al. (2009) revealed that those migrant workers without health insurance tend to visit private medical facilities as self-paying patients. Nevertheless, even when Bangladeshi migrant workers have health insurance, access to primary care, doctor appointments, and other health-related services. Furthermore, performing a cross-tabulation revealed that whereas 59% of manufacturing workers used labor health insurance or their company's medical allowance, the majority of construction (81%) and service workers (62%) were self-paying patients. Interestingly, though, Malaysian construction companies provide the Construction Industry Development Board (CIDB) Green Card, which covers the health and safety of all their workers, native and foreign, in the workplace (Lee, Connor, & Tsuyoshi, 2011); however, very few respondents found the green card program beneficial.

Table-2. Payment methods used for medical expenses.

Payment methods		Frequency (n)	Percentage (%)
	Labor health insurance/company medical allowance	84	28
	Self-payment/out-of-pocket payment	180	60
	Other/employer contribution	36	12
	Total	300	100

4.3. Respondents' Visits to Health-Care Providers over 12 Months

This study also assessed the extent to which migrant workers used health-care services provided by their employers and the government: participants were asked whether and how many times they had visited a doctor or nurse or used a clinic or hospital. Table 3 indicates that the majority of respondents (69.3%) had not visited any health-care providers over the past 12 months, while a cross-tabulation to compare the difference of between the construction, manufacturing, and service sectors, which is depicted in Table 4, revealed the same finding. However, migrant workers in the manufacturing sector accessed health-care services the most, with 48% having visited compared with 52% having not visited their health-care providers.

Table-3. Visits to health-care providers over 12 months.

Visits to health-care providers		Frequency (n)	Percentage (%)
	Yes	92	30.7
	No	208	69.3
	Total	300	100.0

Table-4. Cross-tabulation of visits to health-care providers over 12 months.

Visits over 12 months		Sector-wide access to health-care providers			Total
		Construction	Manufacturing	Services	
	Yes	26%	48%	18%	30.7%
	No	74%	52%	82%	69.3%
Total		100%	100%	100%	100.0%
N		100	100	100	300

4.4. Respondents' Views on Barriers Health-Care Access

Table 5 presents the barriers to health-care access encountered by Bangladeshi temporary migrant workers. The main issues for over half of the respondents were that their health-care providers did not understand their health problems (69%), the medical costs were too expensive (66.3%), and so self-medication was preferred (57.7%). In addition, just under half lacked the transport and time to visit medical facilities, experienced language/communication problems, and suffered financial difficulties, including no financial support from their employers. Their financial problems were serious, since having sent enough money to support their families in their home country, they were sometimes forced to borrow from and gradually repay their friends and coworkers, meaning health care became unaffordable. Some respondents reported other barriers as well, in descending order: not feeling welcomed by health-care providers; being unfamiliar with the health-care system; and anxiety over losing their job should their employer think they are unfit to work.

Table-5. Respondents' views on barriers to health-care access.

Barriers	Yes		No	
	(n)	(%)	(n)	(%)
Do not understand my problems	207	69.0	93	31.0
Too expensive	199	66.3	101	33.7
Self-medication	173	57.7	127	42.3
No transport/too far away	147	49.0	153	51.0
Do not speak my language	137	45.7	163	54.3
Medical expenses not provided by company	134	44.7	166	55.3
Financial difficulty	128	42.7	171	57.0
Time constraints	125	41.7	175	58.3
Do not feel welcome	65	21.7	235	78.3
Do not know where health services are available	48	16.0	252	84.0
Will lose my job	40	13.3	260	86.7

5. DISCUSSION

In terms of barriers to health-care access, most Bangladeshi migrant workers (69%) believed health-care providers did not understand their health-related problems, which is a significant obstacle. However, this could be a misapprehension due to their socioeconomic background and that the majority had only completed formal education between primary and secondary school. Furthermore, the majority of respondents held a negative attitude toward Malaysian health care, finding it inadequate for their needs: Bangladeshi workers brought over-the-counter medicines from their own country and sometimes used cough, and cold, or other preventive medications from their coworkers or Bangladeshi shops in Kuala Lumpur. This finding supplements the research conducted by Karim and Diah (2015), while those of Oxman-Martinez et al. (2005), Kanapathy (2006), Hesketh, Jun, Lu, and Mei (2008), Hoerster, Beddawi, Peddecord, and Ayala (2010), Joshi, Simkhada, and Prescott (2011), Pithara, Michalinos, and Mamas (2012), Weigel and Armijos (2012), Karim and Diah (2015), and Liang and Guo (2015)and are also supplemented by the finding that the higher medical costs prevent most of the participants accessing health care (66.3%. Kanapathy (2006) demonstrated the potential for medical costs to affect health-care access in Malaysia, but Peng, Chang, Zhou, Hu, and Liang (2010) discovered the same situation among 2,478 migrant workers in Beijing, China. In fact, Kasper (2000) claimed that the financial and huge insurance costs were the main barriers health-care access even in the USA, pointing out that those on lower incomes in poorer health used health-care services far less than wealthier people.

Likewise, just as revealed by other studies (Aung, Rechel, & Odermatt, 2010; Horton & Stewart, 2012) migrant workers tended to avoid health-care providers and self-medicated (57.7%) for the aforementioned common and minor health conditions; emergencies and serious health conditions were the only exceptions. With regard to the other barriers to health-care access, similar findings were reported by this and previous studies. Bangladeshi migrant workers encountered problems traveling to medical facilities (49%), which was also the case in the studies

of Pithara et al. (2012) and Wee and Jomo (2007); they also experienced linguistic differences and communication problem with their health-care providers (45.7%), as did the participants in the studies conducted by Aung et al. (2010), Djafar (2012), Karim and Diah (2015), and Pithara et al. (2012). In addition, similar to Karim & Diah (2015), difficulties were created by the lack of any medical allowance from their employers (44.7%), as well time constraints (41.7%). It is worth reviewing a few studies in more detail, though. Joshi et al. (2011) investigated the health problems suffered and accidents experienced by 408 Nepalese migrants in three Gulf countries: Qatar, Saudi Arabia, and United Arab Emirates (UAE).

They found that only one third of respondents were covered by company health insurance, leading to medical costs as well as the lack of sick leave and fear of losing their job discouraging the use of health care services. Moreover, they found that health-care providers without the necessary language skills and cultural understanding would be impeded in treating migrant workers in construction and agriculture who were more likely to suffer health-related problems and accidents in their workplace. In relation to this latter point, Tudor (2013) investigated the cultural barriers to Mexican migrant farmworkers from seeking and receiving treatment from health-care providers in the state of Ohio.

He argued that cultural elements, such as language, religion/spirituality, traditional health practices, trust in American health-care providers and procedures, and intrinsic beliefs about health and wellness, influenced whether migrant workers would access US health-care services. Furthermore, in a study by Simbiri, Hausman, Wadenya, and Lidicker (2010), discrepancies were uncovered among African immigrants in accessing US health-care services: Anglophone Africans experienced better access than Francophone Africans. They identified the main barriers to be the lack of legal documentation, transportation, language proficiency, and familiarity with the health-care system. In contrast to these studies, despite the many similarities, migrant workers in this study experienced the least difficulty with becoming familiar with the health-care system (16%) in Malaysia or risking the loss of their job (13.3%), while the lack of legal documentation was not identified as a barrier, albeit only legal migrant workers in Kuala Lumpur were interviewed.

6. CONCLUSION

This study highlights the extent to which Bangladeshi temporary migrant workers in Kuala Lumpur, Malaysia access health-care services, pointing out that despite health insurance being mandatory for foreign workers in Malaysia, several barriers to health-care access remain in three broad areas. First, there existed a lack of understanding and trust between migrant workers and health-care providers due to language and cultural differences, combined with the Bangladeshi's unfamiliarity with the Malaysian health-care system and their preference to self-medicate.

Consequently, migrant workers tended to avoid visiting doctors when ill and depend on over-the-counter medicines from their country of origin or fellow migrants. Therefore, the governments of both the countries of origin and destination should disseminate information about the serious consequences of self-medication, particularly as it might affect their health in the future. In addition, a pre-departure orientation program should be developed to familiarize migrant workers with the Malaysian health-care system and procedures, as well as basic courses in Malay (*Bahasa Melayu*) and English to facilitate their access to and use of health-care services. In Bangladesh, this type of welfare program could be promoted by either the Department of Youth Development within the Ministry of Youth and Sports or the Bureau of Manpower, Employment and Training within the Ministry of Expatriates' Welfare and Overseas Employment. Second, migrant workers experienced financial difficulty in paying for expensive health care, especially when their employers provided no health insurance.

It is thus recommended that the government of the destination country should enact and enforce legislation across all employment sectors—construction, manufacturing, services, and agriculture—to ensure health insurance coverage is provided for all workers. However, the third and final area concerning the amount of time required to

visit health-care providers, sometimes exacerbated by travel distance and transport problems, along with the risk of losing their job if their employer considers them unfit for work still creates barriers for migrant workers.

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