HEALTH SERVICE UTILIZATION AMONG BANGLADESHI MIGRANT WORKERS IN MALAYSIA

BY

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ABSTRACT

The present work is an empirical study of Bangladeshi workers' use of healthcare services in Malaysia. It is guided by Andersen's (1968, 1995) Behavioural Model of population characteristics frameworks that consist of three factors that predispose services use (e.g. demographic), enabling use (financial resources) and need for care. The study also investigates the barriers that Bangladeshi temporary workers perceive to prevent their access to healthcare services. It further assesses their present health status in Malaysia and factors affecting their health. A questionnaire was administered to 300 respondents involved in construction, manufacturing and services sectors. The study employed two statistical methods. First, Chi-square test was used to find the significant association among variables. Second, binary logistic regression analysis was used to test the hypotheses. The key finding indicates that Bangladeshi workers' education level is a strong significant predictor of maintaining sound health condition in Malaysia. In contrast, their health deteriorates because of long duration of stay in Malaysia. This study reveals that many Bangladeshi workers (n-212) are not consistent in visiting doctors, hospitals or clinics and emergency rooms when they experience sickness in the past one year. The reason is that the majority of them (n=131) were found to practicse self-treatment or self-medication to overcome various illnesses. Further, the majority of the workers do not get any medical facility from their employers. The theoretical implication of Andersen's behavioural model is that predisposing and need factors are found significantly and positively associated with the use or visit to doctors, hospitals or clinics in one year. The findings reveal that predisposing factors, including age and marital status; and need factors, including self-rated health status, suffering chronic illnesses in the previous one year, have the greatest impact on healthcare utilization. Bangladeshi workers' who are married and have better health condition, suffer from chronic illnesses in the last one year were more likely to use healthcare services. It is also found that the Andersen's model is most useful for predicting doctor, hospital or clinic visits in one year. However, Andersen's behavioural model for Bangladeshi migrant workers was not a good framework for use or visit to emergency rooms and overnight stay at the hospital. The major findings indicate that healthcare providers do not understand workers' problems, high medical costs, self-treatment and lack of transportation which are the primary barriers for the majority of respondents from using healthcare services. According to binary logistic regression analysis, there is no statistical significance for the relationship between education, duration of stay in Malaysia and workers' involvement in three working sectors with any types of healthcare services utilization. Finally, the study suggests that adequate measure should be taken to provide pre-departure training related to existing healthcare system in Malaysia including existing health insurance coverage and extension of services to the expected migrant workers.

خلاصة البحث

هذه الدراسة دراسة ميدانية عن استخدام العمال البنغلاديشيون للخدمات الصحية في ماليزيا. استرشدت الدراسة بالمنهج السلوكي لأندرسون الذي يتكون من ثلاثة عوامل تدفع لاستعمال الخدمات: العامل الديمغرافي، والقدرة على استعمال (المصادر المالية) والحاجة للرعاية الصحية. والدراسة أيضًا استقصت المعوقات التي يتصور العمال البنغلاديشيون الحاليون أنها تمنعهم من الولوج إلى الخدمات الصحية. أكثر من ذلك قيّمت الدراسة الوضع الصحي الحالي للعمال البنغلاديشيين والعوامل التي تؤثر في صحتهم. وزعت الدراسة استبيانًا على ثلاثمائة (300) شخصٍ يعملون في قطاعات البناء، والمصانع، والخدمات. استخدمت هذه الدراسة أسلوبين من الأساليب الإحصائية. أولًا: اختبار مربع كاي استخدم لمعرفة أهمية الربط بين المتغيرات. ثانيًا: ثنائي تحليل الانحدار اللوجستي استخدم لاختبار الفرضيات، وتشير النتائج الأساسية التي توصل إليها البحث إلى أن العمال البنغلاديشيين في ماليزيا يمتلكون ثقافة صحية قوية تمكنهم من البقاء بصحة جيدة. بالمقابل تدهور صحتهم سببه هو طول مدة الإقامة فى ماليزيا. كشفت هذه الدراسة أن كثيرًا من العمال البنغلاديشيين (212)عاملًا ليسوا من معتادي زيارة الأطباء، والمستشفيات أو العيادات والحالات المستعجلة عند تعرضهم للمرض في السنة الماضية. والسبب فى ذلك أن أغلبهم (131) عاملًا يمارسون العلاج أوالتطبيب الذاتي للتغلب على أمراض مختلفة. وعلاوة على ذلك، غالبية العمال لم يحصلوا على أي تسهيلات أو خدمات طبية من طرف مشغليهم. الجانب النظري للأنموذج السلوكي لأندرسون يفيد أن العوامل الداعية للفعل واحتياجه كان لهما تأثير مهم وإيجابي في زيارة الأطباء والمستشفيات في سنة واحدة، النتائج المتحصل عليها تفيد أن العوامل المهيئة مثل السن، والحالة الاجتماعية، وكذلك عوامل الحاجة للرعاية الصحية مثل الحالة الصحية للشخص والمعاناة من الأمراض المزمنة الخ في السنة الماضية كان لها أكبر تأثير في استعمال الرعاية الصحية. العمال البنغلاديشيون المتزوجون، والعمال الذين يتمتعون بصحية جيدة، وكذلك الذين عانوا من أمراض مزمنة أو غير مزمنة في السنة الماضية كانوا أكثر عرضةً لاستعمال خدمات الرعاية الصحية. الدراسة أيضًا وجدت الأنموذج أندرسون كان مفيدًا جدًا في التنبؤ بزيارة الدكتور أو المستشفى في سنة واحدة. لكن الأنموذج السلوكي لأندرسون حول العمال البنغلاديشيين المهاجرين لم يكن جيدا فى فيما يتعلق باستعمال أو زيارة الحالات المستعجلة والمبيت ليلًا في المستشفى. أهم النتائج التي توصل إليها البحث تشير إلى أن عدم فهم مقدمي الرعاية الصحية لمشاكل العمال، وغلاء التكاليف الطبية، والعلاج الذاتي، ونقص وسائل النقل تعتبر أولى الحواجز التي تمنع الذين تمّ استطلاع آرائهم حول استعمال الخدمات الصحية. طبقًا لثنائي تحليل الانحدار اللوجستي، لا توجد دلالة إحصائية على العلاقة بين التعليم، وبين مدة الإقامة فى ماليزيا و اندماج العمال في ثلاثة قطاعات مع استعمال أي صنف من أصناف خدمات الرعاية الصحية. وختامًا يقترح البحث اتخاذ إجراءات مناسبة لتعريف العمال بالنظام الصحي الموجود في ماليزيا بما في ذلك التأمين الصحي قبل مجيئهم إلى ماليزيا، وكذلك تمديد الخدمات لتشمل العمال المحتمل قدومهم استقدامهم.

APPROVAL PAGE

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DECLARATION

I hereby declare that this dissertation is the result of my own investigations, except where otherwise stated. I also declare that it has not been previously or concurrently submitted as a whole for any other degrees at IIUM or other institutions.

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Signature…..... Date ……..

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This dissertation is dedicated to my (Late) Father Nur Nobi Chowdhury, Mother Mrs. Hosneara Begum, my wife Sungita Sultana, Sisters Mrs. Jesmin Aktar, Mrs. Yesmin Aktar and Mrs. Norun Nahar Begum Dalia. My brothers Md. Salah Uddin Masud, Md. Sahab Uddin Sobog, and Mahmudun Nobi Azim

&

I would like to dedicate my dissertation to Bangladeshi migrant workers in Malaysia.

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LIST OF ABBREVIATIONS

BM	Behavioural Model
ILO	International Labor Organization
U.S.	United States
U.K.	United Kingdom
BMET	Bureau of Manpower, Employment and Traning
NHIS	National Health Interview Survey

CHAPTER ONE

INTRODUCTION

1.0 BACKGROUND OF THE STUDY

Migrants' health issues and the degree of utilization of health care services, as portrayed in international labour migration studies, remain an agenda of pivotal concern for a myriad of organizations, e.g., agencies of destinations and countries of origin, International Labour Organization (ILO), World Health Organization (WHO) (WHO: 2014a), etc. Recently, WHO and associates had discussed workers' health coverage in which the aspect of migrant workers came up prominently (WHO: 2014a). This WHO meeting highlighted the serious consequences of workers' health issues concerning access of workers to interventions and their work related injuries and diseases. From this crucial meeting they have concluded that the universal health coverage would be possible if all working people, whether in informal settings or in small enterprises, and others – rural, agricultural and migrant workers – have access to basic health services to prevent occupational and work related diseases (WHO, 2014a). This is followed up by another report that portrays the perils of more than 85% of workers in small enterprises and informal sectors and migrants who do not have any occupational health coverage (WHO, 2014b). This finds echo in a study by Abdul-Aziz (2001) on Bangladeshi site operatives working in the construction sector in Malaysia. Abdul-Aziz (2001) notes that there is no apposite medical coverage for these site operatives even while they succumb to serious accidents such as broken limbs, head injuries or fractured wounds. In a recent study conducted among migrants of three nationalities, namely from Bangladesh, India and Myanmar on health seeking

behaviour in Singapore, Lee et al. (2014) concur with the above that huge numbers of migrant workers continue their work even when they fall ill due to work related injury with severe pain and functional impairment. The health issues of migrant workers and their access (or the lack of it) to health care services, particularly when they are vulnerable to work-related injuries thus occupy the dominant discourse among policymakers, academicians and researchers alike (Kanapathy, 2006; Abdul-Aziz, 2001). Thus, the current study focuses on Bangladeshi migrant workers' health status, the degree of their health care utilization as well as health seeking behaviour and the barriers faced by them to access any physicians or hospitals/clinics in their host country.

There are multiple factors that influence an individual's health and his utilization of care services. As mentioned by Young (2004), the health status and the uses of health care utilization vary depending on the economic, social, cultural, and geographic situation of the person seeking such care. In a similar vein, Kasper (2000: 323) argues that barriers to health care services in developing countries are of a different nature than those of developed nations like the United States (U.S.), the United Kingdom (U.K.) and Canada. This is exemplified by providing a scenario contrasting the rural health problems in the U.S. and other developed nations with a developing country like South Africa, where a large number of the people residing in rural areas rely on walking as their principal means of transportation. Apart from the insufficient number of medical clinics and service providers, the majority of its population are worse off in almost every aspect of their lives, e.g., lack of drinking water and electricity, poor sanitation, and overcrowded housing with rising costs, distance and long waiting time contributing significantly to a very low level of utilization of health care facilities (Hirshowitz & Orkin, 1995 cited in Kasper, 2000).

Achieving and maintaining high degree of utilization thus surface as an intricate problem amongst a few pertinent factors: the individual with health care needs, the social network in which the individual is imbedded, and the health care systems in place to satisfy those needs (Cockerham, 2004: 111-112). In developing countries accessibility to health care centers poses a serious concern; although Malaysia has a good coverage of health services that are accessible to a large majority of the population, there still remains people with needs and those who do not seek help for their medical problems (Krisnashwamy et al., 2009).

As regards the use of health services, research has indicated that migrants have lower use of health services than the local population, but this is not due to their lower need of care (Liem, 2004). It has been found that migrants are less familiar with health care services (Lu Yao, 2008; Lee et al., 2014; Liem, 2004) and have more difficulty accessing health care services (Leclere et al., 1994; VanLandingham, 2003). Various studies have documented that both the underutilization and delayed utilization of formal health services among migrants are a common scenario (Lee et al., 2014; Ell & Castaneda, 1998). Delayed access to health care in Singapore has been documented as a major problem among Bangladeshi, Indian and Myanmar migrant workers (Lee et al., 2014). In addition, migrants have been spending much lower health expenditure compared to the non-migrant population (Liem, 2004; Bollini & Siem, 1995). This is due to the migrants' remittances and the high costs in places of destinations where medical cost is higher than in the country of origin (Yao, 2008). It is further highlighted that migrants avoid spending money; rather they save their income to send money back as remittances. Despite the unfamiliarity with the destinations' health care system, sending a huge amount of remittances. (Yao, 2008; Lee et al., 2014; Hagewen, 2005; Liem, 2004) and high cost of health care services in cities, the need

for health care services remains. Yet migrants are found to have less effective use of such services (Lu Yao, 2008). According to Hu (2010), factors leading to underutilization of health care services have been a complex ethno-cultural relationship, where respondents from certain areas, ethnic minority groups and backgrounds have poor service utilization. Furthermore, the lower level use of health care is associated with worse health outcome. Utilization of health care services, therefore, carries special significance. As Heng and Yut (2007: 142) put it:

> "While keeping in mind that utilization of services is not an indicator of access to health care, utilization rates nonetheless provide a general picture of health seeking behaviour. Furthermore, if certain services are not well utilized, it behooves us to investigate if there are barriers preventing their utilization and, therefore, access."

Among South-East Asia, Malaysia has a history of both labour receiving and importing country (Danecker, 2009; Karim et al., 1999). Due to its rapid economic growth and industrialization in the 1980s and onwards, there was a huge influx of foreign workers into Malaysia through various bilateral agreements between its neighbouring countries and those in South Asia. Besides its history with Indonesia and the Philippines, Malaysia has a history with importing migrant workers from South Asian labour surplus countries such as Bangladesh (Karim & Diah, 2015; Abu-Bakar, 2002; Zamir, 2006; Abdul-Aziz, 2001). After Indonesia, Bangladeshi migrant workers are leading as the second largest foreign worker group in this country working in various sectors such as construction, manufacturing, services and agriculture. A recent statistics indicates that there are approximately 699,655 Bangladeshi migrant workers in Malaysia (Bureau of Manpower, Employment and Training (BMET), cited in Alam, 2012: 8). These foreign workers' health conditions and their limited access to

and use of health care services have attracted the attention of social scientists (Karim & Diah, 2015; Kanapaty, 2006; Bakar, 2002; Karim et al., 1999; Karim, 2013). Empirical study has also found that 23.3 per cent foreign workers did not get any medical facilities from the employers (Karim, et al., 1999: 62).

The government of Malaysia remains concerned about foreign workers' health and provision to seeking care, urging the employers to address workers' health issues. In addition, it has enacted a law in 2011 stipulating that all foreign workers are entitled to health insurance (Teck & Ho, 2012). This recent development of health policy for foreign workers encourages all registered foreign workers (numbering up to 2 million) to subscribe to the Foreign Worker Hospitalization and Surgical Insurance Scheme, which is also a condition for the renewal of work permits. The insurance provides medical coverage up to RMY10,000 yearly for an annual premium of RMY120 paid by the workers themselves or employers and up to the end of 2011, a total of 1.4 million foreign workers have been covered (Teck & Ho, 2012). This noteworthy initiative seemed to have improved foreign workers' health care issues and access to services utilization. Yet, this introduction to compulsory health insurance for migrant workers with an annual payment of RMY120 premium remains unclear as to who bears the cost (Kawon et al., 2011).

In reality, the Bangladeshi workers do not get any benefits from this insurance coverage even though it is a requirement for the renewal of visa and legislation for foreign workers, The Worker's Compensation Act 1952; is mostly applied if there is a very serious accident or the death of a worker. A recent study by Karim and Diah (2015) highlights the plight of around 87% Bangladeshi workers who do not receive any medical support and are not protected by any insurance during their times of crisis. Bangladeshi workers working in various sectors like construction, factories and

in other hazardous working conditions are very much prone to accidents, sickness and temporary disability (Karim & Diah, 2015: 6). They are often sick due to laborious work and extra physical pressure. Besides, a study conducted in Japan by Mahmud (1994) shows that employers denied taking care of Bangladeshi workers' health related expenses even in cases of injury and accidents at work. Since utilization rates provide a general picture of the workers' health seeking behaviour as well as the barriers to access faced by them, it is important to investigate Bangladeshi migrant workers' degree of utilization and their rate of access.

Apart from the enumeration mentioned above, migrant workers often show very little knowledge about health care system in their destination country, the insurance benefits and how to utilize this insurance (Yao, 2008). For instance, a Singapore based study found that lower income migrant workers have shown uncertainty about who would pay if they seek health care in hospital and clinic (Lee et al., 2014) even though there are induction courses for foreign workers before their departure from their country to Malaysia (Kawon et al., 2011). In addition, there is compulsory rule for foreign workers to undergo medical examination under the Foreign Medical Examination Malaysia (FOMEMA). This is under Pantai Holdings Berhad, the largest health care conglomerate in Malaysia, entrusted with the responsibility and supervision of medical screening and registration of foreign workers in Malaysia (Chee, 2010: 454).

Foreign workers' health examination covers various chronic and communicable diseases such as tuberculosis, malaria, leprosy, sexually transmitted diseases and AIDS (Karim et al., 1999: 70). According to a report by the Ministry of Health Malaysia (Country Health Plan, 2010-2015: 5), 2.32 million non-Malaysian citizens were residing in Malaysia in 2010 (Department of Statistics, 2011) and this

constituted 8.2% of the total population for the year. In 2007, 1.3 million foreign workers were registered with the Foreign Medical Examination Malaysia (FOMEMA) and had undergone medical examination (Country Health Plan, 2010-2015: 5). This massive flow of foreign workers to Malaysia has created various health care problems (Kanapathy, 2006; Masitah et al., 2008). The Ministry of Health of the government of Malaysia had also expressed its concerns about the health condition of migrant workers and found that in March 1998 as many as 1,030 or 3.3% of the total of 31,228 migrant workers were suffering from serious infectious diseases, such as tuberculosis, hepatitis, cancer, epilepsy, leprosy, HIV/AIDS, etc. (Abu-Bakar, 2002: 25). The workers were from Indonesia (758), Bangladesh (238), Pakistan (11), the Philippines (8) India (3) and Myanmar (1). Some of these illnesses had previously been eradicated in Malaysia, and many academics, policy makers, and humanitarian organizations feared that through their daily interactions with the local community, migrant workers would reintroduce these diseases (Abu-Bakar, 2002).

Studies have found that migrants are less healthy than destination population (Brockerhoff, 1990; Loue, 1998; Ha & Ha, 2001). Migrant workers in Singapore are also reported to have suffered from such infectious diseases like typhus, dengue and pneumonia due to the unhygienic and density living conditions (Chen et al., 2001; Seet et al., 2005; Ministry of Health Singapore, 2008 as cited in Lee et al., 2014). About 60% of malaria cases reported in Selangor were primarily caused by predominantly male foreign workers of economically active age group (Masitah, 2008: 56).

According to Masitah et al. (2008), many of these workers came to Malaysia to work as unskilled and semi-skilled labourers. However, public hospitals are set up to meet social objectives by providing health care to all, irrespective of patient's ability