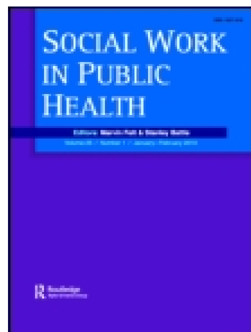

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Public Health Services for Foreign Workers in Malaysia

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ABSTRACT

The objective of this study was to know the status of the foreign workers' access to public health services in Malaysia based on their utilization pattern. The utilization pattern covered a number of areas, such as frequency of using health services, status of using health services, choice and types of health institutions, and cost of health treatment. The study was conducted on six government hospitals in the Klang Valley area in Kuala Lumpur, Malaysia. Data were collected from 600 foreign patients working in the country, using an interview method with a structured questionnaire. The results showed that the foreign workers' access to public health services was very low. The findings would be an important guideline to formulate an effective health service policy for the foreign workers in Malaysia.

KEYWORDS

Foreign workers; public health services; accessibility; social exclusion; Malaysia

Introduction

The provision of social services to increase people's quality of life is the responsibility of the government, though large segments of the population in developing countries are deprived of this fundamental right: access to basic health care (Hossen & Westhues, 2011). In this globalized world the provision of this type of service is not only consumed by the citizens of a country, but also extended to the foreigners. After 1990, the Malaysian Government started to encourage the employment of foreign workers, especially from Asian countries to solve the problem of labor shortage. The foreign workers in Malaysia are increasing over time because of the excess demand for laborers associated with rapid economic growth, as well as the relatively cheaper cost (Noor, Isa, Said, & Jalil, 2011). The Malaysian Government approves applications for the foreign workers in a number of sectors, such as manufacturing, plantation, agriculture, construction, and services. According to the immigration rules, an application for quota approval must be made at the Local Centre of Approval, Ministry of Foreign Affairs. The new application procedures for the foreign workers are to obtain approval and pay levy at the Local Centre of Approval, Ministry of Home Affairs, and employers apply for Visa With Reference (VDR) and the Visitor's Pass (Temporary Employment). They require a number of documents when applying for a Visa, which include an application letter from the employer, Visa Applications By Reference Form, letter of approval from the Ministry of Home Affairs, original receipts of levy paid, Form IMM.12, payment form, VDR Application form for the new foreign workers, bank draft (payment PLKS, PROCESS, and Visa), Deposit/Insurance Guarantee/Bank Guarantee (valid for at least 18 months), copy of worker's passport, worker's photograph (one copy), stamped personal bond, medical report from the country of origin approved by the Ministry of Health, Malaysia. They also need some additional documents, such as the copies of the registration form (Form 49/Form B & D), Representative Company Card (Yellow Card), the original approval letter outsourcing foreign workers, and certified copies of the VDR application. The foreign workers should remain outside the country

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while the application is being processed. The employees will only be allowed to enter Malaysia after the application for VDR and PLKS have been approved (Immigration Department of Malaysia, 2012).

There is a growing concern in the Malaysian policy circles that wage suppression is a result from the heavy dependence on migrant labor, which is a key factor that has locked the Malaysian economy in the "the middle-income trap" (Athukorala & Devadason, 2011). The Ministry of Human Resources is the main Malaysian Government agency on labor issues. Its mission is to develop a competitive workforce in an environment of industrial harmony and social justice. The literature reported many examples of the exploitation of the foreign workers. For example, Amnesty International (2010) reported that thousands of men and women travel to Malaysia every year from Bangladesh, India, Indonesia, Nepal, Vietnam, and other countries for employment. Once they arrive, many of them work for 12 hours each day or longer, often in unsafe conditions, sometimes enduring physical and verbal abuse from their employers. Many do not receive the wages they were promised in their home countries. The Government of Malaysia has a responsibility to prevent such abuses, which can include exploitation, forced labor, and trafficking in persons. But the state fails to do so. The workmen injury compensation in Malaysia is not practically helpful toward the foreign workers. According to the present law, the foreign workers are covered for employment and non-employment injuries under the Workmen's Compensation Act of 1952 (amended 1996) and the Workmen's Compensation (Foreign Worker's Scheme) (Insurance) Order 1993 (amended 2005; The Commission of Law Revision, Malaysia, 2006). All foreign workers who earn 500 Malaysian Ringgit (RM 500; U.S. $131.58) or less per month or who are manual workers can claim injury benefits. Under the Foreign Worker's Scheme, the employer is required to contribute RM 86 (U.S. $22.63) per year for each foreign worker (U.S. Department of Labor, Bureau of International Labor Affairs and U.S. Embassy, Kuala Lumpur, 2002). But the fact is that none of the current foreign workers is receiving this benefit as most of their income is higher than the amount mentioned in this government order.

The general perception of the public health services in Malaysia has been mentioned as impressive in terms of its physical infrustructure, modern health technologies, hospital facilities, number of doctors and support services, health budget, and health managments, but this has been challenged due to the foreign workers' lower access to this services than the locals (Kanapathy, 2006; Karim, Abdullah, & Bakar, 1999; Karim & Diah, 2015; Masitah, Nor, & Mas, 2008). The objective of this article is to show the status of the foreign workers' access to the public health services in Malaysia in terms of their utilization pattern, such as using health services, choice and types of health institutions, and cost of health treatment.

Literature review

This article includes two important concepts: foreign workers and access to public health services. The term *foreign workers* has been defined in the literature in different ways. According to Karim et al. (1999), the foreign workforce is a group of the foreign nationals who are legal to work in a country, where they have been officially recruited. In Malaysian context, Marhani, Adnan, Baharuddin, Esa, and Hassan (2012) mentioned a foreign worker as a person who is legal or illegal, skilled, or unskilled and working in any industry in the country. We have used the operational definition for the study: the foreign workers are those who came to Malaysia from other countries legally or illegally, are not citizens, and reside in the country for a certain period of time for employment. The literature gives some variations about the definitions of the access to health services. *Access* is generally taken to refer to the extent to which appropriate methods and services can be obtained by individuals in a given location (Howlader & Bhuiyan, 1999). The terms *access* and *accessibility* are often used interchangeably assume a continuum of effort required to obtain services (Osmani, 2006). Hossen and Westhues (2011) defined *access* (or accessibility) as the degree to which services and supplies may be obtained at a level of effort and cost that is acceptable to and within the means of a large majority of the population.

We have a significant variation in the literature regarding the total number of foreign workers in Malaysia. Noor et al. (2011) mentioned that currently there are about 1.8 million legal foreign workers in Malaysia, who constitute 16% of the labor force. On the other hand, the Ministry of Finance, Malaysia (2010) stated that Malaysia is the biggest net importer of labor in Asia with a migrant work force of

around two million (21% of the total workforce), as of 2008. According to the statistics provided by the Ministry of Home Affairs, Malaysia (2009), the total number of foreign workers in Malaysia was 2,062,596, where 1,085,658 were from Indonesia, 315,401 from Bangladesh, 26,713 from Philippines, 21,278 from Pakistan, 21,065 from Thailand, and 591,481 from other countries. The total number of foreign workers in Malaysia is increasing over time due to the expansion of the development activities in the country. As a result, the pressure of the medical care for these foreign workers is also increasing.

The healthcare in Malaysia is under the Ministry of Health. Malaysia generally has an efficient and widespread system of health care, operating a two-tier healthcare system consisting of government-run universal health care system and coexisting private healthcare system. The vision of the health care is "a nation working together for better health." The mission is to lead and work in partnership: (a) to facilitate and support the people to attain fully their potential in health, appreciate health as a valuable asset, take individual responsibility and positive action for their health; (b) to ensure a high-quality health system, that is customer centered, equitable, affordable, efficient, technologically appropriate, environmentally adaptable, and innovative; and (c) to emphasis on professionalism, caring and teamwork value, respect for human dignity, and community participation (Ministry of Health, Malaysia, 2012). According to the statistics in August 2011, there were 145 public hospitals, 2,880 health clinics, and 165 mobile health clinics nationwide. In the private sector, there were 217 private hospitals, 34 maternity and nursing homes, 36 ambulatory care centers, and 6,442 medical clinics (Maierbrugger, 2013).

The general perception about the healthcare system in Malaysia is highly positive. The Malaysian Medical Association (1999) mentioned that the health delivery system in Malaysia is significantly impressive, especially in terms of service preparation and prevention for patients who are low income. Chua and Cheach (2012) stated that Malaysia's relatively higher spending on health per capita gross domestic product (GDP) at U.S. $379 (in 2008) is decent within the developing countries and has catered to the provision of comprehensive care with broad access. This is due to several achievements covering various comprehensive public health facilities, such as international access and the existence of budget security network for chronic diseases. Malaysia also has successfully portrayed its good image by providing public health programs, such as immunization, promotion and health education, health services at educational institutions, and communicable disease control program (Inside Malaysia, 2012). The Government puts 5% of the social sector development budget into public healthcare. With a rising and aging population, the Government wishes to improve the healthcare system including the refurbishment of existing hospitals, building and equipping new hospitals, expansion of the number of polyclinics, and improvements in training and expansion of telehealth. Over the last couple of years, the Government has increased its efforts to improve the healthcare system and attract more foreign investment. At present, the numbers and quality of the private hospitals in Malaysia have improved a lot. Both types of hospitals are equipped with the latest diagnostic and imaging facilities. As a result, presently the numbers of foreign patients are increasing in Malaysia for medical care. Recently, the Malaysian Government focuses on developing the health tourism industry (Idrus, n.d.).

According to the statistics of the Ministry of Health, Malaysia (Table 1), the total number of the attendance of foreign patients in the government hospitals, who used public health services in Kuala Lumpur and Selangor, significantly increased over time. In 2008, the attendance of foreign patients was 525,087, which was 483,751 in the previous year. It shows that the number of male patients were higher than the female patients. It might be because of the higher number of workers are male and staying here without their family. Within 4 years, total number of patients in both areas became almost double. The Ministry reported that 1.3 million foreign workers were registered in 2007 with Foreign Medical Examination Malaysia (FOMEMA) and had undergone medical examination. Indonesians made up 47% (635,445) of that total. The rest of the foreign workers were from other countries particularly Thailand, Bangladesh, and Pakistan. Sabah, Federal Territory of Kuala Lumpur and Selangor, recorded the highest proportions of foreign workers, with 24%, 7% and 6% respectively.

The evidence shows that the foreign workers get comparatively lower access to public health services though a very few studies mention the actual causes behind this. For example, Baglio, Saunders,

Table 1. Foreign Patients' Attendance to Public Hospitals in Kuala Lumpur (KL) and Selangor by Category of Age and Sex (2005–2009).

State/Year	<10 Years		10–19 Years		20–59 Years		>60 Years		Total (by sex)		Total
	M	F	M	F	M	F	M	F	M	F	
2005											
KL	490	375	331	325	9,621	9,297	681	570	11,123	10,569	21,690
Selangor	704	633	850	987	27,839	10,829	537	371	29,930	12,820	42,750
2006											
KL	684	578	561	408	10,227	10,012	446	357	11,918	11,355	23,273
Selangor	902	751	1,136	1,098	29,789	13,690	809	544	32,636	16,083	48,719
2007											
KL	740	558	560	458	13,626	10,917	325	320	15,251	12,253	27,504
Selangor	1,159	908	1,167	1,188	37,327	19,153	750	674	40,403	21,923	62,326
2008											
KL	1,041	880	835	662	18,654	14,381	624	584	21,154	16,507	37,661
Selangor	1,217	1,010	1,396	1,799	38,011	19,077	1,007	805	41,631	22,691	64,322
2009											
KL	1,319	1,034	818	860	19,615	15,340	740	511	22,492	17,745	40,237
Selangor	2,926	2,414	1,851	2,204	47,207	25,946	1,411	1,286	53,395	31,850	85,245

Source. Ministry of Health, Malaysia (2012).

Spinelli, and Osborn (2010) conducted a study on the migrant workers in Italy; Rahman (2012) with the Bangladeshi migrant workers working in the Gulf countries; Priebe et al. (2011) in the 16 European countries; Suresh, Simkhada, and Prescott (2011) with the Nepalese migrants working in three gulf countries; Therese, Xue, and Hong (2008) in China; and Woloshin, Bickell, Shwartz, Gany, and Welch (1995) in the United States. There has been no or little documentation of the health status, health care needs, and utilization patterns of migrant workers, the implications for public health care services and costs, as well as impact on diseases in Malaysia (Zain, 2002). Most of the studies (e.g., Kanapathy, 2006; Karim et al., 1999; Karim & Diah, 2015; Masitah et al., 2008) mentioned that the migrant workers are getting lower access to the public health facilities in the country than the locals. Karim and Diah (2015) conducted a study on the Bangladeshi migrant workers working in Malaysia and reported that due to the absence of clear agreements, they are not receiving proper medical support or health protection.

According to the current legislative and policy frameworks, all foreign workers in Malaysia are accorded equal rights as local workers. Special guidelines were introduced in 1991 as part of the Policy on the Recruitment of Foreign Workers (Robertson, 2008). It outlined the responsibilities of the employers on aspects covering housing, health and other terms and conditions of employment (Kanapathy, 2006). From January 1, 2011, the Government of Malaysia declared that all new employers coming into Malaysia must have medical insurance. The employers must provide the same insurance for existing foreign workers, when renewing their work permits. The annual insurance premium for each foreign worker is RM120 (U.S. $38.8), and employers are free to engage any insurance company to provide the health coverage. In this context, the main argument is what are the underlying causes of the foreign workers' lower access to the public health services in Malaysia. Zain (2002) mentioned that the possible causes of this lower access in Malaysia are ignorance, lack of confidence, and problems with health care providers in Malaysia. A number of authors (Peabody et al., 1999; Radziah, Abdullah, & Rohani 2000; Yusof, 1996) mentioned that the accessibility to health services of the foreign workers is one of the main issues in the process of delivering health services. To consider the above discussion, this is a contemporary issue to know the status of the migrant workers' access of the public health services in Malaysia. The objective of this study was to know this issue based on their utilization pattern such as frequency of using health services, status of using services, choice and types of health institutions, and cost of health treatment.

Research question, objective, and method

Research question and objective

The principal research question of this study was "What was the status of the foreign workers' access to public health services in Malaysia based on their utilization pattern?" The main objective was to justify

this question and explore the status of utilization in terms of the frequency of using health services, choice and types of health institutions, and cost of health treatment.

Research approach and data collection methods

A quantitative survey approach was employed for this study, and data were collected through a structured interview schedule using a pretested questionnaire.

Sampling technique: Selection of hospitals and respondents

The foreign workers who used public hospitals in the Klang Valley area in Kuala Lumpur were selected as respondents for the study purposively. According to Kassim (1993), almost 50% of the foreign workers in Malaysia live and work in the Klang Valley. A total of six public hospitals (e.g., Kuala Lumpur Hospital, University Malaya Medical Centre, Tengku Ampuan Rahimah Hospital, Selayang Hospital, Sungai Buloh Hospital, and Ampang Hospital located in the Klang Valley) were selected through a simple random sampling. A total of 100 foreign workers were selected as respondents from each hospital through convenience sampling (Kim & Ham, 2012). Convenience sampling is a nonprobability sampling technique, where respondents are selected because of their convenient accessibility and proximity to the researcher. We think that it would be ideal to test the entire population, but in most cases, the population was just too large and it was impossible to include every individual. In addition, this sample technique is fast, inexpensive, and easy, and the respondents are readily available. Subsequently, the total sample size for the study was 600. The public health services for the foreign workers were examined based on their utilization pattern on such services.

Data collection instruments

We developed a structured interview schedule in the light of the study objectives. The questionnaire was in Bahasa Malaysia and English versions. We thought that the foreign workers could understand the English language in any form with the help of data collectors.

Ethical issues

We followed the ethical guidelines obtained from the Code of Research Ethics Committee of the University of Malaysia. A guarantee of confidentiality and anonymity were given to the authorities of six hospitals. We received verbal consent from all participants.

Data analysis techniques

The descriptive analytical approach was used for data analysis by using the Statistical Package for the Social Sciences (SPSS, version 9.0). To facilitate the data analysis, the frequencies and cross-tabulation analysis procedures were employed. The chi-square analysis was employed to determine the relationships between selected variables.

Results

Demographic and socioecomomic profile of the respondents

The characteristics of the respondents in the present study were examined according to their age, gender, marital status, occupational status, and income. The summary of the distribution of the respondent's characteristics is presented in Table 2.The highest number (70%) of the respondents' age ranged from 21 to 30 years, followed by 22% between 31 and 40, and the lowest below 2% were 40 years

and older. The ratio of male-to-female was 50%. More than one half (56%) of the participants were married, followed by 40% single, and 3% divorced. From the occupational distributions, it was found that the highest number of respondents were service holders (38%), followed by unskilled laborers (36%), 11% business, 11% housewife, and 2% professional, and 1% farming. A large number of the respondents' (66%) monthly income was RM501 to RM1000 (U.S. $175 to U.S. $350) per month.

The findings (Table 2) show that the frequency of using health services differed significantly according to age, gender, marital status, occupational status, and total income. The highest of 70% of foreign workers were between ages 21 and 30 years, and the lowest 2% were 40 years and older. The highest of 73% and 52% of the age group (21 – 30 years) received health services occasionally (fewer than six times) and an average of (6 – 10 times), respectively. The gender did not vary significantly on the frequency of using health services except the average (6 – 10 times), where the female was found 61%. In occupational status, the serviceholders and unskilled laborers were found to be dominant, who had the highest numbers in all of the frequency of using health service. The lowest numbers were found among farming (1%) and professional (2%), which were also found the lowest among all three distributions of the frequency of health services. The unskilled foreign workers were found highest among occassonally and frequently groups, who were 38% and 40% respectively. The lowest income earners took the highest numbers of services in all three categories of the frequency of health services (Table 2).

The public health service pattern involves the aspect of frequency of use of public health services, choice of hospitals, type of service use, and health treatment cost imposed on the foreign workers. The findings show a large percentage of respondents (89%) used public health services occasionally

Table 2. Characteristics of the Respondents by Frequency of Using Health Services.

Characteristics of Respondents	Frequency of Using Health Services: Occasionally (>6 times) ($n = 531$)	Average (6 – 10 times) ($n = 54$)	Frequently (<10 times) ($n = 15$)	Total ($N = 600$)
Age				
>20 years	4.9	11.1	20.0	5.8
21 – 30 years	73.2	51.8	33.4	70.4
31 – 40 years	20.4	33.4	39.9	22.0
<40 years	1.5	3.7	6.7	1.8
Total	100	100	100	100
Gender				
Male	51.2	38.9	46.7	50.0
Female	48.8	61.1	53.3	50.0
Total	100	100	100	100
Marital status				
Single	41.8	35.2	13.3	40.4
Married	55.9	61.1	46.7	56.2
Divorced	2.3	3.7	40.1	3.4
Total	100	100	100	100
Occupations status in Malaysia				
Unskilled laborer	37.8	18.5	40.0	36.2
Service sector	36.7	57.3	26.7	38.3
Business	11.9	5.6	13.3	11.3
Farming	1.3	1.9	0.0	1.3
Professional	1.9	5.6	0.0	2.2
Housewife	10.4	11.1	20.0	10.7
Total	100	100	100	100
Total income				
>RM500	19.9	24.1	40.0	20.9
RM501 – RM1000	70.1	42.5	26.6	66.4
RM1001 – M1500	7.7	25.8	20.0	9.6
RM1501 – M2000	0.9	0.0	0.0	0.8
RM2001 – M2500	0.2	0.0	0.0	0.2
<RM2500	1.2	7.6	13.4	2.1
Total	100	100	100	100

Note. RM = Malaysian ringgit.

Table 3. Frequency of Receiving Treatment Annually.

Frequency to Hospital	Number	Percentage
Occasionally (>6 times)	531	88.5
Average (6–10 times)	54	9.0
Frequently (<10 times)	15	2.5
Total	600	100

(Table 3). It may be because of the high cost of the treatment facility that the foreign workers cannot afford. A small number of respondents (9%) used public health services for the average category, and a smaller percentage of respondents (3%) frequently used public health services. The findings show that most immigrants seldom used public health services when they were ill. Due to the high cost of hospital services, they only try to find health treatment when their illness became serious and required major treatment from the hospital.

Foreign workers' status of using health services

The health status influences the individual consumption pattern. Table 4 shows that a large number of respondents (94%) who "did not have a chronic disease" were involved in the study. They were getting medical treatment because of an injury or suffering from casual illness. However, a small number of respondents (7%) had illnesses such as asthma and diabetes. Data show that a large percentage (67%) of foreign workers who "did not have chronic disease" frequently, 91% average and 95% occasionally used the health services. Nevertheless, the number of respondents who frequently used public health services with diseases were also high (33%). The chi-square test shows a significant difference ($p < .05$) in the frequency of use of public health services between respondents with and without diseases (Table 4).

Choice of hospitals

Every individual, local citizen and foreigner, has a choice to receive treatment in hospitals offered by the government or private sectors. The findings show that a large percentage of respondents (61%) received health treatment from the government hospitals (Table 5). The rest of them used private hospitals (25%) and panel clinics (14%) to get treatment for their illness. Data show that 60% frequently, 76% average, and 60% occasionally chose public hospitals for their health treatment. Nevertheless, a good number of respondents (33%) who frequently use public health services received services from private hospitals. Panel clinics were also visited by the respondents, especially those who occasionally used public health services for their illnesses. These services were only used by a number of them frequently (7%) and average (4%). The chi-square test shows no significant difference ($p < .05$) in the frequency of use of public health services among respondents who chose public hospitals, private hospitals, and panel clinics for their treatment (Table 5). From this finding, we can assume that the choice of hospitals was made based on options offered on services. This means that the consumers could choose the type of service or service provider that met their needs. More competition in the market system creates wider and more varied choices. More choices also can maximize consumer satisfaction.

Table 4. Health Status of Respondents.

	Frequency of Using Health Services					
Health Status	Occasionally (>6 times) ($n = 531$)	Average (6–10 times) ($n = 54$)	Frequently (<10 times) ($n = 15$)	Total ($N = 600$)	Value of χ^2	*df*
Diseased	5.5	9.3	33.3	6.5	19.390*	2
Without chronic disease	94.5	90.7	66.7	93.5		
Total	100	100	100	100		

*$p < .05$.

Table 5. Choice of Hospitals by Respondents.

Type of Hospital	Frequency of Using Health Services: Occasionally (>6 times) ($n = 531$)	Average (6–10 times) ($n = 54$)	Frequently (<10 times) ($n = 15$)	Total ($N = 600$)	Value of χ^2	*df*
Government	59.9	75.9	60.0	61.4	8.085	4
Private	25.0	20.4	33.3	24.8		
Panel clinics[a]	15.1	3.7	6.7	13.8		
Total	100	100	100	100		

[a]Panel size is the number of unique individual patients under the care of a specific provider.

Types of health services by frequency of using

The study shows that there are four clinical services with the highest use among the respondents were the general medical (39%), orthopedics (27%), obstetrics and gynecology (27%), and day-care service (26%) (Table 6). Data show that the highest 53% used frequently, 50% average, and 38% occasionally in general medicine category. 33% respondents used the day-care services. Twenty-seven percent used the orthopedic services that are linked to their occupation. This is because most respondents work as laborers who were exposed to risk of injury and accidents in the workplace. The use of obstetrics & gynecology services involves female respondents for delivery services which were found among the most frequently used service. Data show that 27% used this service and 26% used day-care service. According to the findings, the support services were found less favorable services in health treatment where pharmacy service was used by highest number of respondents (11%), followed by public health (9%).

Cost of health treatments

The findings show that majority of the respondents (32%) spent less than RM 200 for each health treatment (Table 7). Nevertheless, a small number of respondents (18%) spent more than RM 1000 for each health treatment. More than one half of the respondents who frequently used (53%) allocated around RM200 to RM400 for each health treatment. The same amount was also spent by the majority of the respondents who used public health services "average" (32%) when seeking treatment. The majority of the respondents (33%) who occasionally used public health services spent less than RM 200 for each treatment. The chi-square test shows that there was no significant difference ($p < .05$) in the frequency of use of public health services and the total payment each time for treatment (Table 7). This

Table 6. Types of Health Services Received by the Respondents.

Types and Sources of Health	Occasionally (>6 times; $n = 531$) Yes	No	Average (6–10 times; $n = 54$) Yes	No	Frequently (<10 times; $n = 15$) Yes	No	Total ($N = 600$) Yes	No
Clinical services								
General medicine	37.9	62.1	50.0	50.0	53.3	46.7	39.3	60.7
General surgery	13.9	86.1	14.8	85.2	6.7	93.3	13.8	86.2
Orthopedic	28.2	71.8	16.7	83.3	6.7	93.3	26.7	73.3
Psychiatry	0.2	99.8	0.0	100.0	0.0	100.0	0.2	99.8
Emergency	4.9	95.1	22.2	77.8	20.0	80.0	6.8	93.2
Pediatric	3.2	96.8	5.6	94.4	13.3	86.7	3.7	96.3
Obstetrics & gynecology	25.8	74.2	35.2	64.8	20.0	80.0	26.5	73.5
Day-care treatment	24.3	75.7	42.6	57.4	33.3	66.7	26.2	73.8
Support services								
Health education	1.3	98.7	5.6	94.4	6.7	93.3	1.8	98.2
Physiotherapy	0.8	99.2	3.7	96.3	0.0	100.0	1.0	99.0
Public health	6.6	93.4	27.8	72.2	26.7	73.3	9.0	91.0
Pharmacy	10.7	89.3	14.8	85.2	20.0	80.0	11.3	88.7
Medical social work	0.4	99.6	1.9	98.1	0.0	100.0	0.5	99.5

Table 7. Cost of Health Services.

Treatment Cost	Frequency of Using Health Services				Value of χ^2	*df*
	Occasionally ($>$6 times) (*n* = 531)	Average (6–10 times) (*n* = 54)	Frequently ($<$10 times) (*n* = 15)	Total (*N* = 600)		
Treatment fee						
$<$ RM200	33.3	22.2	13.3	31.8	17.276	10
RM201–400	271.0	31.5	53.3	28.2		
RM401–600	6.8	7.4	6.7	6.8		
RM601–800	5.1	3.7	6.7	5.0		
RM801–1000	9.0	22.2	6.7	10.2		
$>$RM1000	18.7	13.0	13.3	18.0		
Total	100	100	100	100		
Source of funding for treatment						
Employer	21.3	25.9	0.0	21.2	4.765	2
Self	78.7	74.1	100.0	78.8		
Total	100	100	100	100		

Note. RM = Malaysian ringgit.

means that the respondents who used the public health services were not influenced by treatment of cost.

The findings show that a large number of respondents (79%) spent their own money for their health treatment (Table 7). Only 21% stated that their treatment costs were supported by their employers. Data shows that 100% of the respondents used health service frequently, 74% average, and 79% occasionally. A small number of the respondents' (average 26% and occasionally 21%) health cost was supported by their employers. The chi-square test shows that there was no significant difference ($p < .05$) in frequency of use of public health services between those supported by their employers and those who bear their own costs.

Discussion

The study presented the findings on the status of the foreign workers' access to the public health services in Malaysia. The main objective of this study was to know the utilization pattern of these services on the frequency of using health services, status of using services, choice and types of health institutions, and cost of health treatment. The main limitation of this study was the lack generalization as this study collected data from a small number of respondents from Klang Valley area in Kuala Lumpur, Malaysia, based on purposive sampling. In addition, the focus and objective of this study only covers the status of the utilization pattern. The further study should be on their health rights, workplace safety, decent work practice, and psychological factors that might have significance implication on the foreign workers' health services as most of them are often placed in hazardous jobs for which they suffer from illnesses, serious abuse, and exploitation at workplaces (Karim & Diah, 2015).

We found that two thirds of the foreign workers' average monthly income was between RM 501 to RM 1000 (U.S. $175 to U.S. $350) and most (89%) received treatment fewer than six times a year, and a majority (94%) went to hospital for health services without chronic diseases. Two thirds of the total foreign workers went to the government hospital, 76% were six to 10 times a year, and 39% for general medicine. The highest 32% spent below RM 200 (U.S. $70) each treatment, and the highest 79% spent their own money for their health services. We could realize from these findings that most of the foreign workers' access to the public health services was very poor. The evidence shows that the foreign workers was considered as the minority or marginalized group that prevented them from enjoying equal health facilities and health benefits. This marginalized group could be linked to social exclusion, whereby the foreign workers were separated and given a lower status in accessing public health services. The denying of health services is a form of violation of their universal basic human rights. There are certain restrictions and preconditions that prevent them from getting equal health facilities. In this regard,

we can consider the opinion of Netto (2014), who mentioned that it is already discriminatory enough that hospital charges for the foreigners in Malaysia are higher than the locals. He reported that the Government in Malaysia has now restricted the health facilities from this discriminatory practice including medicines for the foreign workers.

We discovered that 79% of the foreign workers are not entitled to get health benefits (e.g., work injury), which is mentioned in the Foreign Worker's Scheme. The Economic Transportation Programme (2013) mentioned that approximately 3.1 million foreign workers employed in low-technology and labor-intensive industries in Malaysia are uninsured or underinsured, resulting in a substantial amount of unpaid hospitalization bills at public hospitals. Karim and Diah (2015) mentioned that there is a lack of health facilities among Bangladeshi foreign workers in Malaysia due to the absence of any precise specification in the agreements. They reported that most of them are fully devoid of having any Medicare facilities from their respective place of employment and working farms as 87% of these workers clearly claimed that they did not receive any medical support or health protection and privileges in times of necessity and crisis. Baglio et al. (2010) conducted a comparative study between Italian local citizens and the immigrant workers who were from developing countries and found a significant deprivation of the health facilities among these migrant workers. This finding can also be compared with Lee et al. (2014). They found that the foreign workers among the males in Singapore has lower access to public health services. They identified possible delays in access in a vulnerable group of workers who were lower income, inadequate knowledge about healthcare insurance plans, and the presence of a sizeable minority who would not seek care when presented with potentially serious health problems.

However, the conditions set up by the government should be changed. There are a number of difficulties that the terms and conditions impose on the foreign workers. They have to show their Visa or identification during registration. This means that an illegal foreign worker would find it difficult to receive public health treatment. In this regard, Irsyad (2014) commented that the illegal immigrants are the threat to Malaysian health services. We would argue that these indirect restrictions are a form of hidden stigma against foreign workers. Our finding can be compared with the study of Peabody et al. (1999). Peabody et al. mentioned that the stigma against foreign workers and minorities happen elsewhere, especially in developed countries like the United States of America. This stigma imposed on the minorities and foreign workers leads to inequality in health. For example, African Americans suffer from twice the mortality rate, thrice the number of deaths during childbirth, 10 times more likely to get cancer, and twice more likely to suffer from diabetes compared to other Americans. However, social inclusion should be strengthened for reducing isolation.

Conclusions

The study findings showed that the foreign workers' access to public health services is extremely low. We found that most of the foreign workers went to the public hospitals for general medicine and found it inexpensive as 79% of them spent their own money for their health services. We have also seen that their low financial condition on one hand, and social exclusion and marginalization on the other isolated them from proper access to the public health services. In Malaysia, the contribution of the foreign workers to the infrastructural development and national economic growth is huge. Health is a basic human right, and this is among the most important factors in ensuring their continued productivity and contribution to the nation's development. Therefore, they should not be excluded from health services by the government or private sectors.

The findings of this study would be an important guideline for the Malaysian Government. The Government is now implementing two long-term development plans (e.g., the 10th Malaysian Plan and the Vision 2020), where the public health service has been mentioned as a significant sector. Under the 10th Malaysian Plan (2011 – 15), the healthcare is identified as one of the 12 National Key Economic Areas (NKEA). The contributions and investments in this area are expected to help the country to become a high-income nation by the year 2020. Within the healthcare, six entry-point projects (EPPs)

and two business opportunities have been identified as key drivers of the growth: private health insurance for the foreign workers, improvements in clinical research, exporting generic medicines, health tourism, and telemedicine (Economic Planning Unit, 2010). On the other hand, the objective of the Vision 2020 is to be a united nation with a confident Malaysian society infused by strong moral and ethical values, living in a society that is democratic, liberal, tolerant, caring, economically just and equitable, progressive and prosperous, and in full possession of an economy that is competitive, dynamic, robust, and resilient. The health sector has also been included in four thrusts in this Vision 2020, which attempts to improve the standard and sustainability of quality of life. To achieve this quality of life, the Government wants to confirm the transformation toward a more efficient and effective health system in ensuring universal access to healthcare, health awareness and healthy lifestyle, and empowerment of individual and community to be responsible for their health (Mohamad, 1991). This study finding would be a useful guideline to promote an inclusive and successful health care policy in Malaysia.

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