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FACTORS AFFECTING THE SATISFACTION ON MALAYSIAN HEALTH CARE SERVICES BY BANGLADESHI MIGRANT WORKERS IN SARAWAK: A CROSS-SECTIONAL EMPIRICAL STUDY

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ABSTRACT

Providing good quality health care to all inhabitants including the foreign workers is one of the Government's health care objectives. However, information is very limited about the migrant worker's perceived satisfaction of health care. This study aimed to assess the level of satisfaction on health care services and factors affecting it in Sarawak, Malaysia. This cross-sectional study was conducted in three districts in Kuching Division, Sarawak. A total of 314 Bangladeshi workers were interviewed by face to face interview. The level of satisfaction was measured on Likert's scale adapted from previous studies. Data entry and analysis was done by IBM SPSS version 22.0. A p-value less than 0.05 was considered as statistically significant. The satisfaction on health care was assessed by four domains viz. technical quality, interpersonal communication, facilities and accessibility in the health care. A stepwise multinomial logistic regression analysis revealed that payment on a daily basis ($p<0.001$), health insurance in Sarawak and cultural behaviour appeared to be potential predictors of average level of satisfaction on health care. However, no variables were identified as the predictors of good level of satisfaction. The field note analysis revealed that the quality of healthcare is better in Malaysia compared to Bangladesh, but health care is more expensive in Malaysia. This study was conducted in a very small scale; thus, the results should not be generalized. However, the findings of this study could be used as a policy guideline to develop a migrant worker's friendly health care services in the country.

1. Introduction

Malaysia is known and recognized internationally for providing extensive and wide range of healthcare services to the population. Despite her remarkable achievements in delivering one of the best healthcare services and high health status, the healthcare cost remains low as compared to other developing countries (1). Malaysia spent 4.55% of its GDP to total expenditure on health in 2015 (2) which was way lower compare to other regional countries which provide equivalent quality of care. In Malaysia, both the public and private health sector provides parallel healthcare. The Ministry of health is the main provider in Malaysia, it is heavily subsidized by the government revenue. On the other hand, the private healthcare is mainly financed through out-of-pocket payments or by the social and private insurance. The government facilities are accessible by the local populations with a nominal fee of RM1 in most circumstances. The foreigners are also eligible for the public healthcare with additional fees imposed. Otherwise, the private healthcare is also accessible. For more than one decade, the foreigners have been burdened with expensive and skyrocketing medical charges. Currently it is not compulsory for the employers to provide medical benefits to the foreign workers (3). Besides that, foreign workers are covered under Workmen's Compensation Act 1952. Under the Foreign Workers' Scheme, employees contribute MYR 86 or less per month and those who earn MYR 500 and lower are eligible

to claim the injury benefits (4). Malaysia has 31.1 million population aged 1 year and above in between the period of 2015-2016. Two percent were migrants and about one-tenth of total migrants were international migrants (5). Almost two-thirds of foreign migrant workers came from Indonesia, and then followed by the Philippines, Bangladesh, Pakistan and Thailand and nearly two-thirds of these foreign workers were located in three main states in Malaysia viz. Sabah, Selangor and Johor. They were largely concentrated in the agriculture, plantation, construction and manufacturing sector (6).

Health is every human basic right. It is the main objective of the ministry of health that health should be accessible, equitable and affordable to all stream of population irrespective of citizenship. And it is the main goal of ministry of health to deliver the best quality of care to the patients. Patients' satisfaction is an important component in measuring quality of care (7). There are five main dimensions in measuring patients' level of satisfaction to health care; a) clinical effectiveness and outcomes, b) access to services, c) organization of care, d) humanity of care and e) environment (8). Socioeconomic factors and other health care provision also affect patients' satisfaction (9–11). Foreign workers generally are low-skilled with minimum education, thus earning lesser incomes compared to the local employers. These may attribute to their lower access to health care. Absence of medical insurance coupled with increasing medical expenses may result in lower satisfaction level in health outcomes (4). Various studies have evident that foreign workers has poorer satisfaction to level of health care in terms of quality of health care and access to health services (9,10,12). A systematic review on migrant patients' satisfaction with health care services in the developed countries revealed general lower levels of satisfaction among adult foreign workers using western health care services. Two significant determinants of satisfaction were identified, information or communication and non-tangible environment (13). A local study among Bangladeshi workers revealed that they received minimal medical support and no health insurance coverage in Malaysia. Therefore, they were rather apprehensive to obtain medical services from health clinics or hospitals especially for those foreign workers who did not possess proper legal documentations (14). The barriers to health care in terms of affordability, accessibility and other socioeconomic factors largely affect quality of care which is reflected in patients' satisfaction.

Assessing patients' level of satisfaction towards health care is crucial in maintaining good quality of care. Despite having impressive provision of health care with one of the cheapest health expenditures, Malaysia still faces challenges in managing and providing health care for foreign workers. Foreign workers have lower access to health care services in Malaysia as compared to the local citizens (14,3). Therefore, it is of substantial importance to further explore this issue, in terms of assessing foreign workers' level of satisfaction towards the provision of health care in Malaysia and its determinants. The contribution of this study would significantly guide the policy maker to realign the health system in terms of health care provision, not only to the local citizens but also to non-citizens. Considering this view, this study aimed to assess level of satisfaction on health care services in Sarawak, Malaysia by the foreign workers.

2. Material and Methods

2.1. Study design and sampling methods

The study was conducted among the Bangladeshi workers working in Sarawak, Malaysia. Only one Division with a large number of Bangladeshi workers were purposely chosen for data collection. All the workers in three districts viz. Kuching, Bau and Lundu were included as the sample size. The workers aged 18 years and above living in their primary place of residence were included in this study. A total of 401 sample size would be required to get the precise estimation of prevalence of current morbidity (15). However, only 314 workers

were successfully interviewed with a response rate of 87.2%.

2.2. Instruments and data collection

The data collection tools had several components viz. socio-demographic characteristics, morbidity pattern and care seeking behaviour, perception on health care delivery system, satisfaction of health care in the last one year either in government and private facilities, and cultural adaptation in Sarawak. In the present analysis, satisfaction on health care in Malaysia was analyzed. The data collection tool was developed into English. The content analysis was done by an expert followed by it was translated into Bengali, the mother tongue of the workers. Back translation was done to assess the consistency of the questions. The pre-test of data collection instruments was done among the Bangladeshi students speaking the same language. A minor change was made following pre-test. A key person was identified for easy access to their residence. No data was collected in their working place, so as not to disturbance their working hours. Most of the times, data was collected on Saturdays and Sundays. A university student speaking the same language was recruited for data collection. Data was collected by face-to-face interview. The project leader verified the data for accuracy and consistency. The project leader took the field note after informal discussion with the workers.

2.3. Operational Definition and variable of interest

For the assessment of satisfaction, a total of 27 item questions were asked. The items of questions had four domains namely, technical quality, interpersonal communications, facilities in the clinic or hospital and accessibility to the clinic or hospital. The questionnaire were adapted and modified from the previous studies (16–18).

Technical quality: Thirteen questions were asked for the assessment of satisfaction on technical qualities,. Each question was Likert's scores with "highly dissatisfied' to "highly satisfied". The item of question was satisfaction on physical examination, advice, medicine dispensing, diagnosis of disease, medicine prescription, etc. A high score indicates more satisfied. The Cronbach's alpha of the domain was 0.923.

Interpersonal communication: For the assessment of satisfaction on interpersonal communication, six item questions were asked such as behavior of doctors, nurses, pharmacist and medical assistants, clarity of information provided and help in taking decision about the treatment process. The assessment was the same as above with high score indicated more satisfied and low score indicated low satisfaction. The internal consistency of Cronbach's alpha was 0.846.

Facilities: To assess the satisfaction on facilities in the hospital or clinic, 5 item questions were asked such as, housekeeping both in toilet and waiting area, diagnostic equipment's or facilities, and satisfaction on pathological test. The Cronbach's alpha for this domain was 0.661

Accessibility to the health care: For the assessment of accessibility to the health care three item questions were asked. These were distance from the residence to clinic or hospital, time require to reach the clinic or hospital and waiting time in the clinic or hospital. The reliability analysis showed the internal consistency with Cronbach's alpha was 0.723. The overall Cronbach's alpha was satisfactory 0.921.

2.4. Data entry and analysis

Microsoft Excel 2016 was used for data entry. Only completed and edited data were entered into the computer. IBM SPSS version 22.0 (19) was used for quantitative analysis. After cross-checking and validation of the data, a simple descriptive analysis was done. A composite mean score of each domain was calculated. However, the domain was converted into percentage for easy expression and analysis. Finally, a composite mean score of satisfaction was calculated. The total mean score was further categorized into four groups based on mean and one standard deviation around mean.

The lowest group was considered as poorly satisfied and highest category into highly satisfied and the middle two category as average satisfaction. Multinomial regression analysis was done with a view to determine the potential factors for satisfaction of health care. The result of analysis was presented in both graph and tables. A p-value less than 0.05 was considered as statistically significant.

2.5. Ethical issues

The research proposal was approved by the technical review committee of Faculty of Medicine and Health Sciences (FMHS) and Institute of Borneo Studies (IBS) of Universiti Malaysia Sarawak with minor correction. An Ethical approval was also obtained from the Ethics Committee of Universiti Malaysia Sarawak (UNIMAS). Before data collection, the workers were briefed about the objective of the study. Their voluntary participation was sought and assured for the data confidentiality. A written informed consent was obtained from the participant.

3. Results

3.1. Socio-demographic characteristics

Table 1 illustrates the socio-demographic characteristics of the workers. The mean (SD) age of the respondents was 35.9(7.3) years with the minimum age 24 years and maximum age 60 years. Out of 314 respondents, 98.1% were Muslim and the majority were married (84.7%). More than two-fifths (43.3%) had secondary level of education followed by primary level of education (33.8%). However, 15.6% had no formal education. Highest percentage of the workers were engaged in manufacturing job (43%) followed by construction (32.2%) and a variety of job according to the employer desire (22.9%). Majority of them (82.2%) of the workers works on a daily paid basis and only 17.8% had monthly salary. The median monthly income of the workers was MYR 923 with maximum MYR 2000 and minimum MYR 520. More than half of the workers had monthly income ranging from MYR 900 to 1300. Each worker had at least 4 members dependent on in his earning. The median duration of working in Malaysia was 10 years with maximum 21 years. More than three-fifths (62.4%) of the workers had 10 to 14-year work experience. A majority of the workers (94.6%) had no previous work experience abroad. It was noted that 84.1% were living in shared room. About two-thirds (63.4%) had health insurance in Sarawak. However, 25.5% had no health insurance. One-third (36.6%) of the workers reported that the employer did not bear any medical costs and two-fifths (41.1%) bear partial cost and another 22.3% bears all types of costs.

Figure 1 shows the mean percentage score of each domain of satisfaction. On an average, 76.34% were satisfied with the health care. However, they were highly satisfied with the facilities available in the clinic or hospital which accounted for 84.35%. All the domain score of satisfaction varies from 73.57% to 84.35%.

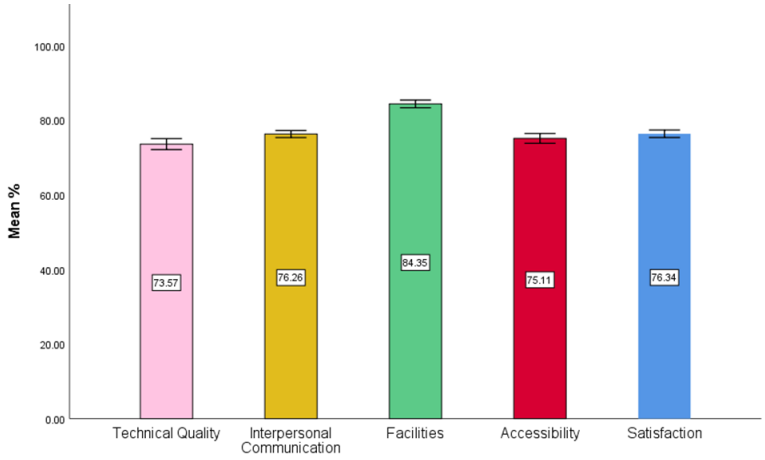

Figure 1 Domain-wise mean percentage score of satisfaction on health care

Table 1: Socio-demographic characteristics of the migrant workers

Variables	Characteristics	Frequency	Percent/Mean
Age in years (Mean, SD)		314	35.9(7.3)
Religion	Islam	308	98.1
	Hinduism	6	1.9
Marital status	Single	48	15.3
	Married	266	84.7
Level of education	No formal education	49	15.6
	Primary	106	33.8
	Secondary	136	43.3
	Higher secondary	23	7.3
Nature of job	Farming	6	1.9
	Construction	101	32.2
	Manufacturing	135	43.0
	Others	72	22.9
Type of salary payment	Daily	258	82.2
	Monthly	56	17.8
Median Monthly income (RM)		314	923.0
Number of dependant (Median)		314	4.0
Duration of work in Malaysia (Yrs)		314	10.0
Working experience other than Malaysia	Yes	17	5.4
	No	297	94.6
Living condition	Shared room	264	84.1
	Single room	50	15.9
Ever take sick leave	Yes	58	18.5
	No	256	81.5
Health insurance in Sarawak	Yes	199	63.4
	No	80	25.5
	No idea	35	11.1
Whether company bear treatment cost	Never	115	36.6
	Partial	129	41.1
	All types of cost	70	22.3

3.2. Level of satisfaction

The score of satisfaction was categorized into three level, viz. poorly satisfied which accounted for 9.6% and average satisfaction (79.3%) and highly satisfied 11.1% (Figure 2).

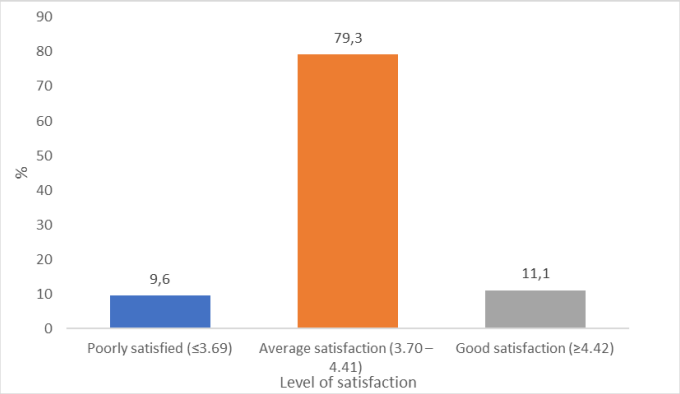

Figure 2 Percentage distribution of level of satisfaction

3.3. Factors affecting the satisfaction on health care in Sarawak, Malaysia: stepwise multinomial logistic regression analysis

To determine the factors affecting the satisfaction on health care services in Malaysia, a step-wise multinomial logistic regression analysis was done in which the level of satisfaction was dependent variables. The poorly satisfied was considered as reference category. Initially, there were six categorical variables such as marital status, level of education, type of payment, health insurance in Sarawak, living condition and whether employer bear treatment cost and the six continuous variables such as age in years, monthly salary, duration of works in Sarawak and three domains of cultural adaptation such as adaptation of local language, cultural behavior and knowledge on local culture. There was a well fitted model based on 12 variables. The model fitting information revealed that likelihood ratio test was chi-square (df)= 236.835(8); p=0.000. Goodness of fit with Pearson (df) = 654.562 (618); p=0.149 and Deviance (df) = 236.146 (618); p=0.1.00. indicated good fitted model with homogeneity. Pseudo R-Square analysis revealed that Cox and Snell = 0.425; Nagelkerke=0.583, i.e. 42.5% and 58.3% explained the variability of the independent variables respectively. The classification table shows that 84.7% of the cases correctly classified the level of satisfaction.

Analysis revealed that type of payment, health insurance in Sarawak and cultural behaviour appeared to be statistically significant predictors of satisfaction on health care services. It was found that 9.19 (95% CI: 2.68,31.54) times likely to be

Table 2 Factors affecting the satisfaction on health care in Sarawak, Malaysia: Step-wise multinomial regression analysis

Variables	*Average satisfaction*			*Good satisfaction*		
	β	*SE*	*Adj. OR (95% CI)*	*β*	*SE*	*Adj. OR (95% CI)*
Type of payment						
Daily	2.22***	0.63	9.19(2.68,31.54)	-0.18	0.61	0.84(0.25,2.76)
Monthly (Ref)	-	-	-	-	-	-
Health Insurance						
Yes	1.74**	0.77	5.68(1.26,25.70)	-0.63	0.75	0.54(0.12,2.32)
No	1.36	0.84	3.89(0.75,20.04)	-0.07	0.66	0.94(0.26,3.41)
No idea (Ref)	-	-	-	-	-	-
Cultural behavior	-0.13***	0.03	0.88(0.83,0.93)	0.01	0.02	1.01(0.97,1.04)
Intercept	2.09**	0.83		0.19	0.66	
N	314					
Goodness of fit	654.562 (618); p>0.05					
Model chi-square test	236.835(8), p<0.001					

**p<0.05; **p<0.01; ***p<0.001*
Adj. OR = Adjusted Odds ratio
CI= Confidence interval

average satisfied if they had an agreement on daily rate of payment compared to monthly salary agreement. They were also 5.68 (95% CI: 1.26,25.70) times likely to be average satisfied if they had health insurance in Sarawak compared to no idea about having health insurance. However, there was negative correlation with level of satisfaction ($p<0.05$), for local cultural matters.

4. Discussion

Our study revealed that type of payment, health insurance and cultural behaviour were the significant predictors of satisfaction on health care services among Bangladeshi migrant workers in Sarawak. Type of payment appeared to be the strongest determinant of satisfaction. Other important variables such as age, marital status, level of education, monthly salary, living condition, duration of working in Sarawak, whether employer bear treatment cost, adaptation of local language and knowledge on local culture does not significantly associated with satisfaction of health care.

Type of payment appeared to be the significant predictor for satisfaction of health care among Bangladeshi migrant workers in Sarawak. The payment could be either on daily or monthly basis. In this study, more than four-fifths of the workers were paid on daily basis as opposed to only 17.8% on monthly basis. This difference was probably due to the nature of work that the workers were engaged in where most were in construction and manufacturing sector. These were generally done by a labourer or unskilled workers (20). A high proportion of workers who were paid on daily payment probably explain that they were 9.19 times more likely to have average satisfaction on health care compared to their counterpart with monthly salary payment. This could be probably due to the advantages of daily payment itself that allows the workers to get their pay instantly (20) and may have less difficulties in the case of medical emergencies. Thus they have a better utilization and satisfaction of health care compared to workers with monthly payment who may have to wait till the end of the month to get their pay.

Health insurance is considered as a mechanism of achieving universal health coverage (21). The provision of health insurance in the health system associated with the reduction of financial burden of the insured when they are accessing and utilizing the health care services, affects their satisfaction with the services. With a rising health care cost, health insurance play an important role to counteract the effect and providing an affordable financial health care assistance, thus avoiding catastrophic health expenditures. Although Malaysia has introduced “Skim Perlindungan Insurans Kesihatan Pekerja Asing” (Hospitalization and Surgical Scheme for Foreign Workers), the mandatory private medical coverage scheme for all foreign workers back in 2011 (22), however, still a number of workers without health insurance as found in this study. Unlike local people, migrants in Malaysia including Sarawak are not subsidized when they are accessing the government health care facilities. Indeed, they have to pay a higher treatment fee, for instance, RM 15 (US$ 4.50) and RM 60 (US$ 18), compared to local RM 1 (US$ 0.30) and RM 5 (US$ 1.50) for a general outpatient treatment and specialist consultation respectively (23). This led to the option of seeking private health care for better treatment with similar cost. Informal discussion with the workers reported that

“we believe that the health care delivery in public facilities are good, but too expensive. It hampers our daily earning due to long waiting time in the public hospital. There is no scope of bargaining, whereas, in private hospital or clinic we can visit after duty and pay less”.

Thus, by health insurance, provides a sense of security as it could reduce the financial burden which in turn will affect the satisfaction level of health care. This was shown in this study where those who have health insurance were 5.68 times

likely to be satisfied compared to those who have no idea about having health insurance. This was supported by other finding which showed that those with health insurance were associated with better satisfaction compared to those without (24–27). Thus, health insurance appeared to be a vital mechanism to increase the quality in the health care services as measured by the level of satisfaction by the clients.

Cultural behaviour was postulated as one of the predictors of satisfaction of health care among Bangladeshi migrant workers. However, our study found that there was negative correlation with level of satisfaction, indicating that local cultural issues were not a good predictor of satisfaction on health care. Similarly, adaptation of local language and knowledge on local culture were not associated with satisfaction on health care among the Bangladeshi migrant workers. This may be supported by the fact that more than three-fifths of the workers had 10 to 14-year work experience in Sarawak. Although the three domains of cultural adaptation do not significantly influence the satisfaction, in accessing and utilizing the health services provided by the local health care provider, some of the migrant workers may face some intercultural situation including discrimination and racism due to differences in race and cultural background (28). Patients tend to be poorly satisfied and less comfortable when they engaged with doctor from a different race and cultural background. The provider might get influenced by the cultural differences and cause cultural mistrust (29), hence may affect the doctor-patient relationship and the decision-making process. This would lead to misdiagnosis and maltreatment and further lead to distrust and poor satisfaction among this group of patients.

One of the limitations of this study was the small sample size. This might be due to a small number of Bangladeshi migrants' workers in the selected sampling site. Small sample size could reduce the statistical power, thus may affect the conclusion in this study. Another limitation was that all the samples were purposively selected which may not ensure the representativeness of the Bangladeshi migrants' workers and thus lead to bias to some extent. Furthermore, the study population that limited to only one division which also may not represent the Bangladeshi migrants' workers and limit the generalizability of the results.

5. Conclusion

This study found that type of payment and health insurance and cultural behaviour appeared to be predictors of health care satisfaction among Bangladeshi workers in Sarawak. The type of payment may have been regulated under the jurisdiction of the employer, however, the provision of health insurance by employer to the worker should be enforced. The private insurance card should be kept by the workers to ease the registration at any health care facilities. Future research could be done to migrant workers from other countries and comparison could be made among different nationalities to ascertain the satisfaction as well as the associated factors. Additionally, attempt to stratify the satisfaction based on the level of health care (primary and hospital) can be made.

Abbreviations

UNIMAS: Universiti Malaysia Sarawak

SD: Standard Deviation

IBS: Institute of Borneo Studies

FMHS: Faculty of Medicine and Health Sciences

MYR: Malaysian Ringgit

Declarations

Ethics approval and consent participate

The Ethics approval was taken from the Ethics Committee of Universiti Malaysia Sarawak (UNIMAS) [(UNIMAS/NC-21.02/03-02(13)]. A written informed consent was taken before an interview.

Consent to publish

Approval was taken for publication with strict confidentiality and not to disclose the identity of the participants.

Availability of data and materials

The datasets used for analysis of the current study has been kept confidential and not available publicly.

Competing interests

The authors declare that they have no competing interests.

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Author's Contribution

MMR conceptualized, designed, analysed and drafted the manuscript. MTA conceptualized the study, sourced for funding, participated in the design of the study and edit, draft and revise the manuscript. RS, ZT CAP and ZJ participated in conceptualization of the study and have participated in revising the manuscript. DJ and WJ help in drafting the manuscript. All authors read and approved the final manuscript.

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