

REACHING OUT WITH A HELPING HAND: A CASE STUDY OF A PRIVATE CORPORATE SOCIAL RESPONSIBILITY (CSR) INITIATIVE FOR PROVIDING EQUITABLE HEALTH CARE FOR MYANMAR MIGRANTS IN KUALA LUMPUR, MALAYSIA

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ABSTRACT:

Background: Following the turmoil in Myanmar decades ago, a large number of its citizens fled to neighbouring countries including Thailand, Malaysia and Singapore. In Malaysia, these 'illegal' migrants work in low-paying, often high-risk informal jobs and live in segregated, 'squatter' areas. They also have limited access to the welfare-based public healthcare system, having to pay high prices as 'non-citizens' or even higher prices for private healthcare services. This has resulted in poor health outcomes for Myanmar migrants, with high rates of communicable diseases, maternal and child morbidity and mortality. This study aimed to describe a Corporate Social Responsibility (CSR) initiative of a private hospital in Kuala Lumpur to provide equitable health care via a free, mobile primary care clinic for Myanmar migrants in Dengkil, Kuala Lumpur.

Methods: This paper is a descriptive-explanatory case study which constructs the processes involved in the planning and implementation of this CSR initiative as well as feedback from recipients of the initiative. Individual in-depth interviews were conducted with the hospital management to detail the thought processes involved in planning and implementation. Feedback from a sampled group of migrants was obtained via in-depth interviews on the benefits of this initiative to them.

Results: The CSR initiative was formulated as a free mobile primary care clinic conducted on-site at the settlement of the Myanmar migrants in Dengkil, Kuala Lumpur using volunteer doctors, trainee nurses from the hospital nursing college and logistic support from the hospital. The CSR initiative was designed and implemented as a 'win-win' situation in which both the hospital and migrant community gain social and economic benefits that have enabled this initiative to become a sustainable one, running over the past 4 years.

Conclusion: This case study highlights a new approach to health equity via participation of a private healthcare provider to engage in providing primary health care services to a migrant community. The success of this initiative and its sustainability is due to the fact that it is profitable to the hospital. Ensuring that the private healthcare sector can obtain tangible benefits from CSR activities will play a key role in ensuring they continue to engage in such initiatives over the long-term. This case provides an important example which could be emulated by other private healthcare providers to aid in shouldering the collective burden of healthcare provision to all people.

Keywords: Migrant health, Health equity, Refugee health, Myanmar, Health access

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INTRODUCTION

Myanmar, one of the youngest members of ASEAN, is an important country in Southeast Asia. Its long history and rich culture along with strategic location and abundance of national resources could

have enabled it to achieve a middle-income nation status alongside its other prosperous ASEAN

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neighbours decades ago [1]. Unfortunately, a prolonged period under military rule has left the country lagging both in terms of economic and social growth of its people until 2010 when it has returned to element of democratic rule. [1] One of the uniqueness of Myanmar has been the wide diversity of its population. There are 7 main ethnic groups in Myanmar, with the Burmese making up the majority (68%), followed by the Shan (9%) and the Karen (7%). The remaining groups (Rakhine, Chinese, Indian, Mon and other smaller ethnic groups) make up 16% when combined together [2]. During the time of military rule, repression of both the majority Burmese population who were demanding for return of democratic rule as well as of the various ethnic groups was actively carried out by the military [2]. As a result of this, thousands of Myanmar people fled their homes with nothing with the shirts on their backs, leaving to both neighbouring countries like Thailand, Malaysia as well as to other Western countries such as the United States. [2]As one of the recipient countries for this forced migration since the late 1980s Malaysia has absorbed these refugees who for the most part are placed there for a couple of years before they are resettled in a third country such as Australia or the US [3]. However there are many who have settled permanently in Malaysia, especially those who are Muslim such as the Rohingyas and the Christian Chin people who continue to face religious persecution in Myanmar [3]. As of year end 2014, there are some 140 000 refugees and asylum-seekers in Malaysia registered with UNHCR of which 50 000 are Chins, 40 000 Rohingyas, 12 000 Myanmar Muslims, 7500 Rakhinese and others. Thousands more remain undocumented [4]. The status of Myanmar refugees in Malaysia is very uncertain due to the fact that the country has not signed the 1951 Convention on the Status of Refugees or the 1967 Protocol and therefore does not recognize refugees formally [4]. Myanmar refugees are regarded as undocumented immigrants and cannot work or receive any form of government aid. As the country does not recognize them as refugees, they have to apply to the UNHCR and be granted status as 'refugees', a slow, long process with many delays. [4] Denied official status, Myanmar refugees have to work unofficially in restaurants, factories and building sites often for low pay and in poor working conditions [5]. Often they make only between RM 7,000-1,000 a month (around 7,000-10,000 baht) [5]. They are forced to be reliant on assistance from UNHCR and other NGOs for assistance to access even basic services such as healthcare [6]. Due to their 'illegal' status, Myanmar refugees cannot be

formally employed and even for those who work, they are not covered by health insurance, despite working in often dangerous conditions in high risk [6]. For many of them who are often young couples with small children, access to healthcare is a difficult, expensive option which is resorted to only during times of severe injury or illness [6]. The Malaysian healthcare system consists of separate public and private health sectors. The public sector is a tax-based welfare system, provides healthcare at almost free (RM1) for citizens at point-of-access and highly subsidized inpatient coverage while the private sector consists of private primary care clinics and specialized private hospitals funded by private health insurance or Out-of-Pocket (OOP) [7]. Myanmar refugees have the option of seeking treatment in both public and private facilities but they are charged about 15 times more compared than Malaysian citizens in public, with bills running into thousands of ringgit if they are admitted for surgery or complex procedures. Even normal deliveries are charged more than RM 1,000 [8]. Accessibility to medical treatment even in the public sector for Myanmar refugees are worsened as not only are the charges high but also failure to pay may result in arrest and detention in an immigration detention camp, police lock-up or prison [8]. Technically, there is a discount of 50 % on fees for UNHCR registered refugees but even with these discounts this is still a huge burden on the refugees' small incomes [9]. Not surprisingly, Myanmar refugees have had to resort to aid from various NGOs including *Medecins Sans Frontieres* (which has recently stopped operating in Malaysia) [6], A Call to Serve (ACTS) [10] and Tzu Chi Foundation [11] in order to access healthcare services especially at the primary care level. One such provider of free primary care medical services for Myanmar refugees is Assunta Hospital, a private community hospital based in Kuala Lumpur [12]. As part of its Corporate Social Responsibility Initiative, this hospital provides free mobile clinics at various venues, including at a village for Myanmar migrants in Dengkil, a district town about 45 minutes away from Kuala Lumpur. The clinic has been operating at this venue over the past four years (since 2011). This case study aims to describe this Corporate Social Responsibility (CSR) initiative as an example of good citizenship by a corporate entity in shouldering the social burden in terms of community healthcare.

METHODS

This case study used qualitative methods; namely semi-structured individual in-depth interviews

with members of the hospital management as well as with Myanmar migrants in the Dengkil area in which the hospital runs its mobile clinic initiative. The study was conducted over two months in March-April 2015. In-depth interviews were used as the method of choice to extract information as they offered leeway for the interviewee to give a complete overview as per their own understanding of the issue being discussed while still in a structured format [13]. Members of the hospital management were i) Chief Executive Officer and ii) Chief Medical Services Officer. Questions posed to them were clustered around 3 themes: 1) What were the thought processes involved in planning this CSR initiative by the hospital management? 2) What were the processes involved in its implementation? 3) What are the benefits and drawbacks from the programme to the hospital? From the village, 5 adults of different age groups and gender were chosen as representatives of the village population based on gender and age. They were asked general sociodemographic questions as well as specific questions on the impact of the mobile clinic on their community. Questions asked included: How they had been accessing medical care prior to the mobile clinic programme? What benefits have they been getting since the start of the mobile clinic programme? How much money do they save from having a mobile clinic service? Questions and answers were translated by the community headman, who is an English-graduate teacher and is principal of the community school. Interviews were recorded electronically and transcribed verbatim. An inductive approach was used to thematically analyse transcripts [14]. Two members of the study team (MM, TT) read and re-read the transcripts independently before identifying and highlighting significant ideas and opinions which were then arranged into groups. Variations in ideas were discussed between the two members and a consensus reached if disagreements arose. Findings were categorized into themes and sub-themes that are presented in the results.

RESULTS

Assunta Hospital and the Mobile Clinic Initiative

Assunta Hospital is a private not-for-profit hospital in Petaling Jaya, a suburb of Kuala Lumpur. Founded in 1954 by the Franciscan Missionaries of Mary (FMM), the hospital is a tertiary centre with 350 beds and more than 100 multi-speciality consultants. Besides providing conventional clinical services to paying patients, the management of the hospital is engaged in other charitable healthcare activities. Under its not-for-profit philosophy, 70%

of profits are reinvested in hospital expansion activities while 30% are channeled to a Social Welfare Fund providing subsidised medical care to poor patients [15]. As part of its charitable activities, the management initiated a mobile clinic initiative to provide primary care services for lower socioeconomic areas over the past 5 years. Interestingly, the mobile clinic is an almost self-funding program, building on two major innovations. The first is the use of about-to-expire medication. The hospital has a policy of not using medication that has less than 6 months to expiry for its patients, and these medications are usually disposed of upon reaching this date. Instead, medications for acute conditions such as fever, stomach ache and antibiotics are used for the mobile clinic. Through this, patients in these lower socioeconomic areas are able to obtain quality medication for free which they use immediately. The hospital manages to make a financial gain as well. This is because the amount of money that is previously disposed as wastage is now claimable as income tax deductions under the Corporate Social Responsibility scheme for companies in Malaysia. In addition to this, the staff of the mobile clinic mainly comprise of doctors, nurses and other volunteers. Attached to the hospital is a nursing training college, the Tun Tan Cheng Lock Nursing College. Nurses are trained here to obtain a diploma in nursing, and one of their training components involve community nursing. Instead of paying lecturers additional monies for training student nurses in these components, community nursing modules are incorporated into the mobile clinic programme, with nursing lecturers accompanying the student nurses as staff at the mobile clinic. Through this the hospital manages to save costs from employing a full staff contingent at the mobile clinics while at the same time providing training for their student nurses. Thus this community initiative becomes both profitable and sustainable for the hospital to continue as it has done over these years. The current mobile clinic operates two or three times a week to different fixed venues all over Kuala Lumpur. Each venue is visited on the same date every month. Currently there are 10 venues for the mobile clinic. All of venues are low socioeconomic residential areas. The mobile clinic is headed by a volunteer medical officer, public volunteers, student nurses from the nursing college, staff nurses and nursing instructors. All equipment and medicine is transported via a van purchased for this purpose with a designated driver. Clinic attendance is around 40-70 patients on average per visit ranging from newborns to elderly patients.

Dengkil Myanmar Mobile Clinic

As some of the board members were themselves actively involved in other social work, it was highlighted to them that members of the Myanmar migrant community were direly in need of primary care services as well. Myanmar migrants were both poor and had no direct access to public medical services due to security and financial concerns. A ground visit was organized by the hospital management to the Dengkil Myanmar village to scope out the conditions there.

“We had been running Mobile Clinic services to the poor segment of the Malaysian community. However they lived in flats, which although were dirty and run-down had piped water and electricity. We were shocked to find them living in wooden shacks, some using palm leaves as roofs.” – Dr A

“There were so many children who were sick. One was even coughing out blood. Many pregnant mothers had not seen a doctor for their pregnancy since it was too expensive. We were horrified at the situation there. I could not believe I was in Malaysia.” – Mr B

In view of these conditions, the management felt that a mobile clinic was needed at this venue and proceeded to begin operations there. The mobile clinic is monthly run on a Saturday morning and lasts for 5 hours. All patients are seen and treated by a medical officer and medicine is dispensed free-of-charge. Patients with untreatable complications are referred to tertiary centres and some even to Assunta Hospital itself for further treatment.

Benefits and drawbacks of the Dengkil Mobile Clinic to the hospital?

According to the management, the Dengkil Myanmar village is their furthest mobile clinic site, situated some 35 kilometres away from the hospital, as compared to their other sites, which are on average only 10 kilometres away. This causes an increase in logistics and manpower costs to operate the clinic compared to other sites. In addition, as the clinic serves only migrants, some amount of negative feedback has also been reported due to biased views from Malaysians on the need to provide free medical services to a migrant population. Thus there are many drawbacks both in terms of financial costs and public views on the Dengkil mobile clinic. However, the hospital has

still continued the programme for thus long.

“The hospital policy has always been to serve the poorest of the poor, and nowhere is this more evident than among the migrants especially from Myanmar. We are thus not concerned with the grouses from some of the disgruntled public as they may have a lack of awareness.” – Mr B

“On average, when we pool the costs together for all the clinics, the additional amount that needs to be spent on the Dengkil mobile clinic is only a small additional sum. However we feel that it has a big impact on the community there and thus we continue to run this service. In fact, realizing this need among migrant communities from our Dengkil experience, we now have started another mobile clinic for migrants at another location as well.” – Dr A

Myanmar Dengkil Village

Dengkil is a small town located in the state of Selangor. It is located nearby the new national administrative capital Putrajaya and has thus grown rapidly in the past two decades. Prior to this Dengkil was mainly farmland with palm oil estates, rubber estates and some mixed agriculture. There are still some rubber and palm oil estates and mixed farmland surrounding the 1 kilometre town area. The Myanmar village has around 100 Myanmar families. Most of them are of Chin origin and have settled here for around 15 years. Their population numbers close to 1,000 people as most are extended families. They live in the area in and surrounding an abandoned palm oil farm in ramshackle wooden houses constructed by themselves. They have managed to negotiate with the land owner to get permission to stay on this land and for each constructed house must pay RM 100 (1000 baht) for water, electricity and rent monthly. Most of the families work as odd-job workers in surrounding plantations, or as workers in restaurants, workshops and other businesses around Dengkil town. Most of them are from the younger generation in their 20s and 30s but also with some old people. Most of them are Christians and they have a small church inside the village which is also their community centre and school.

Feedback from the Myanmar residents of Dengkil

a) Changes in health-seeking behavior

Health-seeking behavior amongst the Myanmar migrant community in Dengkil itself has changed in

the years following the inception of the mobile clinic.

“First, try to take some traditional medicine – herbs, some ointments –many of us have brought from Myanmar and also some Myanmar shops in KL which have some medicine – it is very cheap and curing. Second if cannot then we try to buy medicine from the pharmacy/medicine shop in Dengkil. Third we go to the private doctor in private clinic in Dengkil but sometimes only and only when very sick because very expensive – per visit almost RM 50. Fourth sometimes when very very ill or ask to go by the doctor then only to government hospital – very expensive, far and always have some problems with immigration or police” – Mr C, 31 year old Myanmar resident,*

Currently they are able to plan for the mobile clinic visit. Pregnant mothers are followed up on schedule monthly as well as children especially for immunization programmes. Residents with chronic diseases are able to obtain medication monthly. Stocks of medicine for basic ailments are kept in stock with the schoolteacher who then gives it to those who need it acutely for their illnesses. Thus they now use mainstream medication and see a doctor regularly for their health problems (monthly at the mobile clinic).

b) Changes in health status

Most of the residents of this village are young families with an average of 3-4 children per household. Two of their largest areas of need in healthcare provision is in maternal and child health, with many pregnant women and small children who are undernourished and often ill due to the unhygienic conditions in which they live. There were many who suffered from treatable diseases such as anemia, malnutrition, bronchial asthma as well as chronic conditions such as diabetes and tuberculosis which made them ill, unable to work and poorer as a result. Due to the monthly mobile clinic, regular treatment and free medication is available to them and has, overall, decreased the rates of occurrence of many acute diseases and enabled good control of chronic ones.

“I have asthma. My son (1 year old) and my daughter (4 years old) also have asthma. Every day we must use inhaler (metered-dose long acting beta agonist and corticosteroid). For three of us it is too expensive. So we all used to just use one and share. I know it was

*not working properly and not of correct dosage. We used to cough and be sick so much all the time. Since the past 3 years we come and take medicine in the clinic. Now we have no cough at all” – Ms D *, 26 year old Myanmar resident*

c) Household economic expenditure

A general survey of the households had an average income of RM800 to 1000 per month (8000-10000baht), with 5-6 people per household. They could ill-afford to spend even moderate sums on medical illnesses. Living in such poor conditions, the villagers and their families suffer from frequent bouts of acute illnesses such as gastroenteritis, viral fevers and respiratory infections. Frequent episodes of illnesses which need to be treated cut into their monthly incomes. This financial strain in worsened in many long-term condition. For example, buying the required amount of vitamin supplementation such as iron tablets for anemic mothers is also expensive and an additional strain on these families as well. The regular availability of services at the clinic has not only reduced household economic expenditure monthly for these villagers but also aid them in generating some savings, which are then available for other uses.

“Almost every month 1 or 2 children get sick. Any many don't get better. We give them some medicine that we have (traditional medicine) or sometimes buy (from pharmacy). If become very sick then we take to (private) doctor. He charge(s) us at least RM50 (500 baht). We have to spend sometimes RM 150 (1500 baht) one month when everyone is sick (at home). Now we really have a lot of help because have doctor and have medicine from the clinic. We save so much money.” – Mr E, 31 year old Myanmar resident.*

DISCUSSION

The term Corporate Social Responsibility (CSR) has increasingly become an integral aspect of the business model of organisations today. The term has been associated with welfare and charitable programmes engaged in by private sector organisations. However it more accurately refers to how an organization can meet its formative objectives while at the same time satisfying stakeholders' interests in the field in which it operates [16]. The International Bioethics Committee of UNESCO on Social Responsibility and Health envisions corporate social responsibility in the healthcare sector as providing access to

quality healthcare as a right to all, engaged in by both the private and public sector equally [17]. This may seem to be somewhat in conflict with the private business model, where profit-making is the end while healthcare delivery is perceived as the means to do so. Private providers however, have to be seen to engage in a fine balance between delivering healthcare and making a profit, since it is important that their benevolent caring external image be maintained in order to obtain further profits. Hardwig theorises that the private hospital can indeed straddle these two seemingly conflicting objectives via engagement in active and passive CSR policies [18]. Active CSR policies include implementing ethical codes of conduct, promoting reverse discrimination policies, increasing accountability of management decisions and performance indicators; and actively engaging in environmental and community programs [18]. Passive CSR policies include fair employment policies, protecting interests of all stakeholders, respect of human rights, abstaining from environmental damage and abiding to the law [18]. Social responsibility initiatives can only be carried out and sustained via dedicated corporate governance and focused corporate strategy [16].

In this case study, it is clear that the founding values of the not-for-profit Assunta Hospital has enabled it to embark on an active CSR policy specifically in terms of promoting a reverse discrimination policy by providing access to healthcare to a dispossessed minority group i.e Myanmar migrants. The sustainability of this CSR strategy has been due largely to its economic competitiveness, in which the hospital continues to profit financially by strategizing on its available resources (medicine, nursing students) and utilizing them to provide a service (the mobile clinic) while obtaining financial benefits (income tax deduction).

The ability to highlight this CSR initiative and its impact on a migrant community is the reason why the case study design was chosen. Detailing the unique mechanism and strategy in undertaking this in descriptive- explanatory form provides a complete picture as to the construction of thought processes, planning and implementation of this program.

LIMITATIONS

Limitations of the findings from this case-study was that it was unable to determine whether maximum variability sampling had been carried out or theoretical saturation achieved. However this is a known weaknesses of the case study design. Although the benefits of this service to the

community have been detailed in narrative form in terms of both socio-economic and health. The true quantitative effects of the initiative need to be evaluated via specifically designed and conducted studies utilising proper sampling technique and design.

Nevertheless the importance of this case study remains. This is because it highlights a unique approach to health equity with the participation of a private healthcare provider in providing primary health care services to a migrant community. The success of this initiative and its sustainability is in no small part due to its profitability and the 'win-win' situation for the hospital management. Ensuring that the private healthcare sector can obtain tangible benefits from CSR activities will play a key role in ensuring they continue to engage in such initiatives over long-term. This case provides an important example which could be emulated by other private healthcare providers to aid in shouldering the collective burden of healthcare provision to all peoples.

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