ORIGINAL ARTICLE

URBAN POOR: EVIDENCE OF BARRIERS IN ACCESSING PUBLIC CLINICS IN KUALA LUMPUR, MALAYSIA

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ABSTRACT

Having limited access to healthcare services could lead to poor health outcomes particularly for those of the lower-income group. People from the lower-income group is regularly reported to face problems in accessing healthcare, generally in the forms of personal, structural or financial constraints. This study focuses on analysing the barriers that hinder the urban poor in Kuala Lumpur from accessing public clinics, the most significant public primary healthcare provider in Malaysia. Respondents of this study were selected among the residents of 30 Projek Perumahan Rakyat (PPR) in Kuala Lumpur. A total of 585 respondents participated, 455 of them were public clinic users. The result suggests that financial and structural barriers prevent the urban poor from having access to public clinics. It is believed that revising current programmes to meet the growing healthcare needs of the people, the poor especially would be highly beneficial. Thus, this study contributed to a better understanding of the barriers faced by the urban poor in Kuala Lumpur to access public clinics.

Keywords: Public Clinics, Urban Poor, Barriers to Healthcare, Structural Barriers, Financial Barriers

INTRODUCTION

Accessibility to healthcare is one of the crucial benchmarks to measure the performance of a country. A country will not be considered as highly developed if it cannot fulfil people's basic needs, one of which is healthcare. As for Malaysia, every year, the government allocates millions of ringgit in the national budget for healthcare alone. Administered by the Ministry of Health, together with all related government agencies, they try to ensure that everyone in the country has access to healthcare services. Public clinics provide primary care, the first medical assistance that people normally search for before being referred to other levels of healthcare services if necessary[1]. To fulfil this function and the needs of the people, primary care facilities have to be widely distributed. In Malaysia, public clinic, better known as *Klinik Kesihatan* is the major primary care provider, fully subsidised by the government via taxation. It is estimated that 35.6% of public clinics in Malaysia are located in urban areas as compared to 64.4% in rural areas[2.] Even though the proportion is assumed to be very much comfortable when looking at the small geographical reach of urban areas, the density is higher in urban areas than in the rural areas (2.2 versus 1.1 clinics per 10,000 populations, respectively). The current scenario indicates that Malaysia is struggling with relative poverty, traditional poverty as well as urban poverty where health, food as well as socioeconomic issues become recurring problems for the poor[3,4].

Poverty and ill-health are consistently associated to one another and this two-way relationship could makes the poor, poorer. The urban poor had been commonly diagnosed with medical illnesses such as hypertension, diabetes and asthma[5.] Currently, the urban poor in Selangor are battling with various health problems that undeniably could reduce their quality of life[6]. A study which previously done by Wan Puteh et al[7] assures that being poor together with the presence of chronic medical illnesses contribute to low quality of life. In every dimension, the poor are easily exposed to various health challenges not only related to their inner health but also their physical function[8]. According to World Bank, a regular absence of access to healthcare facilities and social security may provide a route to urban poverty[9]. Many issues related to healthcare accessibility have been reported. For example, issues related to the quality of services, shortage of medication, transportation, location of the clinic, waiting time, and misinformation about the services[10-15] that could tarnish the reputation of healthcare services in this country. The issues are alarming as they suggest that despite the number of available clinics, the public still face problems accessing healthcare services in their areas and this could be one of the contributions of the growing urban population. Thus, the objective of this study is to investigate the barriers that prevent the urban poor from accessing public clinics in Kuala Lumpur.

Personal, Structural, and Financial Barriers

This study is applying the *Model of Monitoring Access* by Institute of Medicine (IOM). However, only the barriers part is used extensively. There are three major types of barriers to healthcare in the *Model of Monitoring Access*, namely; structural, personal, and financial barriers. These three barriers represent different issues. Despite that, these obstacles are inextricably intertwined. Some people may have experienced only one type of barrier, whereas some may face all these three challenges simultaneously throughout their health-seeking and health-treatment process. Financial barriers normally arise among the vulnerable population in accessing healthcare when they are either uninsured or underinsured[16]. Millman states that having insurance is the most essential component to getting access to healthcare. The focus of health insurance has always been the effort to finance the cost of care. However, for this study, financial barriers also include other cost related issues to gain access to healthcare services such as the cost of transportation. Consequently, financial barriers could certainly impaired people's accessibility to quality healthcare[17].

Secondly, structural barriers can be defined as the healthcare system's structure and facilities deficiency. This type of barrier is normally observed within healthcare facilities. Yet, it may also be found outside the compound. According to the Institute of Medicine, issues related to the location of healthcare facilities, transportation availability, overburdened of healthcare structure and limited number of healthcare facilities are the structural impediments to healthcare services. This barrier commonly relates to organisational workforce as well as complexity of the implementation side[18,19]. Additionally, structural barriers also comprise of issues like long waiting times and attitudinal problem of healthcare staff[20]. The other problem that should be mentioned here is the issue of discrimination by the healthcare staff[21]. Even when the medical cost is self-funded by individuals, the prevalence of these issues could limit people's access to healthcare.

Personal barriers are another type of challenges that could hamper patient's accessibility to healthcare services. Personal barriers are the personal hurdles experienced by individuals. For example, personal acceptability of the way the healthcare system is functioning, individual's attitude and awareness about healthcare services and the individual's cultural sentiment and belief about health[22]. Other than that, people's perception about getting treatment such as fear and their pre and post-recovery experiences such as shame, are also examples of personal barriers to healthcare. Ghimire and Van Teijlingen[23] and Hayrumyan et al[24] also added, people are concerned about their privacy and confidentiality, they afraid if the healthcare staff tell others about their health status and illness. Moreover, the acceptance of the family members as well as negative society stigmatisation on one's health are among the other problems associated to personal barriers[25,26]. It was also reported that too busy with household chores is one of the personal issues[27].

METHODS

Samples

For this study, the urban poor is defined as those who live in urban areas with a monthly household income of less than RM 4000. According to the Ministry of Housing and Local Government, a household with a total monthly income below RM 3860 is categorised as those who fall under the lowest 40% percentile of income or better known as the Bottom 40 (B40). The B40 group is consisting of the poor as well as the extremely poor. As for this study, the poor respondents were selected among PPR residents. PPR refers to *"Projek Perumahan Rakyat"*, a residential project for low-income and poor households initiated by the Ministry of Housing and Local Government. For households to be eligible to rent a PPR unit, the households must have a total monthly income of less than RM 3000. Therefore, all PPR residents are eligible to be our respondents as they are from the B40 group.

In Kuala Lumpur, there are 31 PPRs under the supervision and management of the Kuala Lumpur City Hall (DBKL) with 40,000 household population. However, in this study, we sampled our respondents from 30 PPRs only which comprised all main ethnic groups (Malay, Chinese and Indian). According to Krejcie and Morgan[28], 380 is minimum sample size needed for 40,000 population. The researchers decided to have 500 samples, taking into consideration the number of PPRs included. As Roscoe[29] stated, sample size in the range of 30 to 500 is consider appropriate for any research. All the 30 PPRs have different number of households. On that account, the number of sample for each PPR is determined by the total number of households in that particular PPR. By using stratified random sampling technique, every PPR would has its final sample size and the sample should includes all the three major ethnic groups. Eventually, a total of 585 households was selected because any PPRs that have less than 15 samples (after calculation with n = 500) were adding up to 15. Hence, no PPRs would have less than 15 samples. Furthermore, prior to allowing the residents to participate in the data collection process, they were first ask whether they are the actual residents and the head of units by showing the researchers, card of tenancy/ownership provided by Kuala Lumpur City Hall (as advised by the Kuala Lumpur City Hall's officer).

The units that have been approached and agreed to present the card were eligible to participate in the study. Lastly, the data collection process for this study was conducted before the COVID-19 pandemic hits Malaysia.

Table 1: Items Included in the Questionnaire

Variables	Items	Sources
Access	• Services at the public clinics are available to us • We have easy access to the public clinics • Clinic location is convenient • The minimum fee charged at the public clinic is reasonable • The public clinic management system is pleasant • The service and character of the staff at public clinic is satisfactory	
Personal	• Not enough communication with the doctors • Doctors did not speak in the preferred language • Afraid to get treatment • Afraid if doctors and nurses tell others about the illnesses suffered • No one present to send off and accompany to the clinic • Too occupied with house chores • Worried about family, friends and community's perception if diagnosed with illnesses • Afraid to be diagnosed with illnesses • Other needs are more important • Feel that the health problem faced is not too serious and need no medical attention • Too busy with work • Feel ashamed to get treatment and to be treated • Side effect of medication • Difficult to find someone to look after family members while going to the clinic • Don't feel sick to go and consult the doctor • Treatment given by doctors of the opposite sex • Difficult to get leave • Prefer to use alternative/traditional medicines • No permission from the spouse • Do not want to get treatment when there is no cure • The public clinic staff did not encourage to perform any check-up • Do not know about the existence and availability of certain treatments in public clinics	Penchansky & Thomas (1981)[30], Millman (1993)[31], Carrillo et al (2001)[32], Mattson (2011)[33], Carillo et al (2011)[34], Rooy et al (2012)[35], Levesque et al (2013)[36], Loignon et al (2015)[37], Baart & Taaka (2017)[38], Agyemang-Duah et al (2019)[39], Zuurmond et al (2019)[40]
Structural	• Longer waiting time at the clinic • Too many patients in the public clinic • Did not receive treatment immediately • Long travel time to reach the public clinic • The staff nurse does not have comprehensive knowledge and is unskilled • The doctor does not have comprehensive knowledge and is unskilled • Doctor's unpleasant attitude • Nurse's unpleasant attitude • Difficult to get an appointment • Missed appointment because of the traffic • Unpleasant experience at the clinic counter • No transportation to go to the public clinic • The public clinic is too far • The clinic's condition is very much uncomfortable • No doctors in the clinic • Limited clinic operation times	
Financial	• Unable to pay the medical costs • Afraid cannot pay the consultation fees • Unable to pay someone to send to the clinic • Cannot afford the transportation costs • Possess medical insurance • Unable to pay someone to look after family members	

Instruments

As outlined by the Institute of Medicine, the three barriers discussed here are personal, structural, and financial barriers. Each barrier (predictor) comprises 22, 16 and 6 four-values-Likert-scale-items respectively. The dependent variable, accessibility to the public clinic was evaluated using 6 four-values-Likert-scale items. The scoring for four-values-Likert-scale items starts from 1 to 4 with 1: strongly disagree, 2: disagree, 3: agree and 4: strongly agree. All the items that represent the variables were extracted from different sources (see Table 1). Prior to the test, all the Likert-scale-items for the variables were computed to be the new dummy variables and the mean value scores were calculated.

The sets of questionnaires were distributed to 585 households among the 30 PPRs. Out of 585 household respondents, 455 were public clinic users. The data from these 455 users were then analysed. The data were analysed using Statistical Package in the Social Science Software (SPSS) version 22. Our hypothesis was that the present of barriers can prevent the urban poor from accessing public clinic. The test selected was multiple linear regression as follows:

Access = f (personal barriers, structural barriers, financial barriers)

Data Analysis

Factor analysis and reliability test were first to run. Table 2 shows the output of the Kaiser-Mayer-Olkin test and Bartlett's test of sphericity yielded from factor analysis. The KMO values for all the variables were at .6 and above, which is considered necessary for good factor analysis[41]. Meanwhile, Bartlett's test of sphericity indicates significant values at $p < .05$ for all the variables involved. Table 3 below points out the item loadings for every variable involved and each item has more than 0.30 loading value. According to Hair et al[42], the lowest acceptable loadings in the range of +/- 0.30 are considered to have met the minimal level interpretation of structure. Moreover, the reliability analysis was performed to assess the variables used in this study; access, personal, structural, and financial barriers. The result suggests the Cronbach Alpha values for access, personal, structural, and financial barriers to be .715, .772, .712 and .561 respectively (see Table 4). The Cronbach Alpha values higher than .500 are considered reliable and acceptable[43-45]. Hence, for all the items tested, the variables are reliable to be gauged in this study.

The other assumptions that should be properly investigated to perform multiple linear regression analysis are the issues of *outliers* and *multicollinearity*. As stated above, the three major predictors discussed are personal, structural, and financial barriers. According to the chi-square table, the *mahalanorbis* distance value which bigger than 16.22 indicates the existence of outliers. Here, the minimum *mahalanorbis* distance value was 0.086 and the maximum value was 14.9109[46]. This suggests that there were no outliers and hence, no cases were terminated. Other than that, the *multicollinearity* was tested to prevent inaccuracy in the regression model. Therefore, to know whether the value of *multicollinearity* is high or not, the *Tolerance* and *Variance Inflection Factor (VIF)* values in the linear regression analysis was referred. If the *Tolerance* value is lower than 0.1 and the VIF value is bigger than 10, it indicates that there is the presence of *multicollinearity*[47]. All the *Tolerance* and VIF values for this study are within the acceptable range. Table 5 shows the *Tolerance* and VIF values for the three predictors.

This study has obtained ethical clearance from the University Malaya Research Ethics Committee (Reference Number: UM.TNC2/UMREC-588). All the respondents that participated gave their informed consent prior to their inclusion in this study and they were also clear about the aim of this study.

RESULTS

Table 6 illustrates the socio-demographic characteristics of the public clinic users participated in this study. 66% of the respondents were female. 55% of the users were aged between 41 to 60 years old, followed by respondents aged 61 years old and above (23%). The majority of the respondents were Malays (59%). The ethnicity breakdown of the respondents was determined before data collection. The respondents were mostly married (63%) and 26% of them reported that their spouses have passed away. Other than that, a small number of them (8.6%) were divorced and only 3% of them were single respondents. The number of respondents with primary and secondary education was almost similar (39.1% vs. 38.9%) and only 2% of the respondents had tertiary education. The remaining 20% of them had no formal education. In terms of occupation, 46% of them were unemployed, whereas 24.2% were self-employed and 22.9% of them work in the private sector. 48.8% of the respondents' household income was in the range between RM 1000 and RM 2000, 24.2% had a household income between RM 2001 and RM 3000, whereas the remaining 23.5% had a monthly household income of less than RM 1000. Most of the respondents (67.9%) had 1 to 5 family members, while about 30.8% had 6 to 10 family members. The remaining 1.3% had more than 10 family members in their households.

Table 2: The Kaiser-Mayer-Olkin and Bartlett's Test of Sphericity Values from Factor Analysis

Variables	KMO	Bartlett's Test of Sphericity
Access	.713	.000
Personal	.708	.000
Structural	.727	.000
Financial	.600	.000

Table 3: Items Loadings from Factor Analysis

Variables	Items	Factor Loading
Access	Services at the public clinics are available to us	.745
	We have easy access to the public clinics	.701
	Clinic location is convenient	.671
	The minimum fee charged at the public clinic is reasonable	.645
	The public clinic management system is pleasant	.615
	The service and character of the staff at public clinic is satisfactory	.556
Personal	Not enough communication with the doctors	.790
	Doctors did not speak in the preferred language	.750
	Afraid to get treatment	.625
	Afraid if doctors and nurses tell others about the illnesses suffered	.591
	No one present to send off and accompany to the clinic	.589
	Too occupied with house chores	.584
	Worried about family, friends and community's perception if diagnosed with illnesses	.579
	Afraid to be diagnosed with illnesses	.561
	Other needs are more important	.545
	Feel that the health problem faced is not too serious and need no medical attention	.533
	Too busy with work	.503
	Feel ashamed to get treatment and to be treated	.487
	Side effect of medication	.464
	Difficult to find someone to look after family members while going to the clinic	.455
	Don't feel sick to go and consult the doctor	.450
	Treatment given by doctors of the opposite sex	.444
	Difficult to get leave	.411
	Prefer to use alternative/traditional medicines	.402
	No permission from the spouse	.370
	Do not want to get treatment when there is no cure	.364
	The public clinic staff did not encourage to perform any check-up	.335
	Do not know about the existence and availability of certain treatments in public clinics	.330
Structural	Longer waiting time at the clinic	.896
	Too many patients in the public clinic	.881
	Did not receive treatment immediately	.854
	Long travel time to reach the public clinic	.629
	The staff nurse does not have comprehensive knowledge and is unskilled	.626
	The doctor does not have comprehensive knowledge and is unskilled	.597
	Doctor's unpleasant attitude	.543
	Nurse's unpleasant attitude	.535
	Difficult to get an appointment	.503
	Missed appointment because of the traffic	.494
	Unpleasant experience at the clinic counter	.461
	No transportation to go to the public clinic	.459
	The public clinic is too far	.419
	The clinic's condition is very much uncomfortable	.394
	No doctors in the clinic	.380
	Limited clinic operation times	.341
Financial	Unable to pay the medical costs	.928
	Afraid cannot pay the consultation fees	.917
	Unable to pay someone to send to the clinic	.880
	Cannot afford the transportation costs	.866
	Possess medical insurance	.659
	Unable to pay someone to look after family members	.448

Table 4: Cronbach Alpha Values

Variables	Number of Items	Cronbach Alpha Values
Access	6	.715
Personal Barriers	22	.772
Structural Barriers	16	.710
Financial Barriers	6	.561

Table 5: Tolerance and Variance Inflection Factor (VIF) Values

Variables	Tolerance	VIF
Personal Barriers	.585	1.710
Structural Barriers	.584	1.714
Financial Barriers	.996	1.004

Table 6: Socio-Demographic Profile

Socio-Demographic Profile of Public Clinic Users	Prevalence, N = 455	
	Number	Percentage
Gender		
Male	155	34.1
Female	300	65.9
Age		
21 – 40 years old	100	22.0
41 – 60 years old	251	55.2
61 years old and above	104	22.9
Ethnicity		
Malay	269	59.1
Chinese	102	22.4
Indian	84	18.5
Marital Status		
Single	13	2.9
Married	285	62.6
Divorced	39	8.6
The spouse has passed away	118	25.9
Education		
No education	91	20.0
Primary	178	39.1
Secondary	177	38.9
Higher education	9	2.0
Occupation		
Self-employed	110	24.2
Government servants	7	1.5
Private employee	104	22.9
Retiree	8	1.8
Others	17	3.7
Unemployed	209	45.9
Household Income		
Less than RM 1000	107	23.5
RM 1000 – RM 2000	222	48.8
RM 2001 – RM 3000	110	24.2
RM 3001 – RM 4000	16	3.5
Number of Family Members		
1 – 5	309	67.9
6 – 10	140	30.8
10 and above	6	1.3
Total	455	100.0

Furthermore, the regression (see Table 7) shows that, out of the three types of barriers presented in this study, only two barriers were significantly associated with the urban poor's accessibility to public clinics; structural barriers and financial barriers. In detail, the urban poor who encountered structural barriers (beta = -.90, p = 000) faced more troubles to access public clinics followed by those who experienced financial barriers (beta = -.10, p = 0.00). This study rejects the null hypothesis.

Table 7: Barriers Associated with Access to Public Clinics; Multiple Linear Regression

Variables	Accessibility		
	β	SE	Sig.
Personal barriers	-.065	.061	.282
Structural barriers	-.901	.069	.000*
Financial barriers	-.102	.032	.001*

*p-value is significant at 0.05

DISCUSSION

The findings of this research are similar to previous studies[48-50] particularly for those who earn a lower income, access to public clinics is limited compared to their counterpart. This study suggests that structural and financial barriers are major obstacles that hinder the urban poor from having full access to public clinics in Kuala Lumpur. Previous studies indicate that access to healthcare is deteriorating as a result of structural barriers. Research has shown that having no personal transportation exacerbates the situation[51,52]. Speaking about that, transportation problem is one of the issues that represents structural barriers. It has undeniable impact on people who are poor and who have diseases[53]. People with lower socio-economic status experience more transportation problems because they do not own private vehicles. Additionally, issue related to other socio-demographic factors also may contribute to severe structural problems[54]. Taking public transportation, especially for the poor elderly may be challenging. For this group of people, walking towards the nearest bus stand and waiting for the bus to come are quite a hassle. Appiah et al[55] also pointed out similar problem in their study, the poor elderly in Ghana especially women having serious transportation issues to healthcare. Studies indicate that transportation problems make patients miss their scheduled appointments and force them to reschedule[56,57]. In this study for instance, an inconsistent bus arrival time is also a contributor to transportation issues. The urban poor in Kuala Lumpur is considered largely rely on public transportation to go to public clinics such as, buses and trains. Moreover, every PPR has different travelling distance and times to public clinics. Some clinics are within 2 kilometres from their home while others are further than 10 kilometres. Despite the clinics that are only 2 kilometres away, travelling time could be longer due to no transport and road traffic. Positively or negatively, it cannot be denied that travelling distance and time to healthcare providers can influence access to healthcare particularly for the poor[58]. In addition, some PPRs are located in congested areas that do not have easy access to public transports. Therefore, people prefer to use their own vehicles to get to public clinics. Another structural barrier is organisational structure of the healthcare services. Hoffman et al[59] and Aspen et al[60] highlight the overburdened structure and system of healthcare facilities. Longer waiting times for appointments are also frustrating for patients, as they will miss work. Freed et al[61] pointed out that some patients have to wait all day due to understaffed problem in medical facilities. Fixed appointments also do not reduce the long waiting times when numerous people come at an allocated time.

Apart from structural barriers, the urban poor also face financial barriers to access public clinics. A study done by Halwindi et al[62] in Zambia found that, people stopped seeking healthcare treatment from healthcare providers due to financial problems. According to Wong et al[63], those denied from healthcare services in Hong Kong are those with financial issues as they were unable to seek treatment due to unbearable costs. Similarly, a study conducted in Oregon, the United States, also found that low-income parents often could not afford their children's healthcare expenses[64]. Limited funding to pay for the care is also one major hurdle that shackle vulnerable populations in Ghana[65]. Equally, Akeju et al[66] even stated, an additional cost like the cost of transportation may causes headache to people. In Timor-Leste, the poor would rather stay at home and avoid seeking treatment even they are sick due to transportation difficulty. Nevertheless, when they have to and getting treatment can no longer be avoided, they would turn to expensive private vehicle arrangements to reach health facilities and this involves an extra cost[67]. One particular trait that distinguishes Malaysian healthcare services from others, especially the United States is that the Malaysian government subsidises its public healthcare services. American citizens are usually covered medically through private healthcare insurance and public health programmes like Medicare and Medicaid, however a large number of the population are still uninsured due to the high cost of insurance

and healthcare services. Public clinics in Malaysia are fully funded, where Malaysian citizens only need to pay MYR 1 for registration purposes. This amount includes consultation fees and medication. However, this study confirms that financial barriers are still an issue even if fees that need to be paid in public clinics are kept at the minimum because many patients especially the urban poor cannot afford to pay additional costs associated with using care. When some countries discuss about the possession of insurance and money to finance medical care, Malaysian public clinic users deal with the other expenses to get access to the services such as the cost of transportation and the cost of having someone to look after their family members or dependents when they go to the clinic. In addition, as an equal comparison on how Malaysian healthcare system works, to name one, United Kingdom is the closest example. Prior to independence in 1957, Malaysia was previously under the British colonisation. As a result, the fundamental of Malaysian healthcare system is in accordance to the British healthcare system model and definitely over time many improvements have been made to cater the people's needs. Healthcare (primary and specialist care) in the UK is almost free at the point of use, centrally administered by National Health Services (NHS). Nevertheless, research shows the prevalence of unmet healthcare needs among the poor in the UK was due to longer waiting time at the healthcare facilities, distance to reach as well as escalating cost[68.] Long waits for appointments could end up making people buying the medicine over the counter even though they could get it for free. The UK government is struggling with the growing healthcare demands and yet it strives to deliver quality and affordable services to its people. Therefore, a comprehensive understanding of barriers faced by the urban poor in accessing public clinics is very significant for policymakers and healthcare providers to provide the government with useful information and a clearer picture of the problems that hinder people from accessing healthcare. As a result, the right actions can be taken to deal with the problems.

CONCLUSION

Public clinics are believed to be easily accessible to the general public regardless of their socioeconomic status. It could be a voluntary choice for the rich and a valuable need for the poor, where everyone in society can use the healthcare services available in their areas. This study aims to identify the barriers that curb the urban poor in Kuala Lumpur from accessing public clinics. The study indicates structural and financial barriers are the major challenges the urban poor face. Specifically, this group of urban poor is experiencing higher structural barriers followed by financial barriers. Many of them had

no other medical options to rely on, therefore they used the free services rendered by public clinics as their main source of health treatment. It is understandable because the majority (57.8%) of the urban poor were diagnosed with chronic diseases. However, the presence of these barriers made the process to seek medical help a little bit complex. They had to cope with structural issues associated with the availability of transportation, the distance of the clinic which is far from home, the travelling and waiting times for transportation and getting treatment. In addition, they also have to deal with a larger number of patients in the clinic, the understaffed problem and the clinic's limited operating hours. Financially, the urban poor also have to bear the transportation cost to go to the clinic. Those who are less fortunate need to pay to cater for any public or private vehicles as they do not own personal vehicles. Married people also need to set aside some money for someone to look after their family members while they are out. Moreover, although 88% of this vulnerable group were aware of the existence of private facilities in their areas, they still could not use them as they could not afford to pay for their services. As this study discusses the barriers faced by the urban poor, the findings could enlighten authorities to assess the issues seriously. Realising the importance of healthcare accessibility, the Ministry of Health as the provider, together with the Malaysian government could benefit from the findings of this study as it provides fresh insight into what the urban poor are experiencing. Thus, revising the current programmes or policies that have been implemented to meet the needs of the people would be highly beneficial. The limitation of this study is that it focuses on public clinic users only. Future studies should focus on the non-users or patients of private clinics as well. Other than that, this kind of study could be executed to other urban areas in Malaysia. So that, people can obtain better understanding with regard to urban poor' accessibility to healthcare.

Conflict of interest
The authors declare no potential conflict of interest.

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