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Outbound Medical Tourism: The Case of Bangladesh

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Bangladesh is a least developed country and its health care management industry is miserably underdeveloped. Main reason behind underdevelopment of the health sector is inefficient human resources. Lack of efficient human skill in the health sector and level of corruption in this sector creates an explosive situation in Bangladesh. As such a good number of people per day is going to abroad for health treatment purpose. Research question of the study is whether people have been going other countries from Bangladesh due to inefficient human resources for treatment purposes? The study uses both primary and secondary sources. Studies prepared two questionnaires and respondents are 500 out of 611 questionnaires were distributed. On the basis of these questionnaires, the study does the statistical analysis. Time period of the study was from July 2011 to November 2011.Author observes that high costs, poor services, improper treatment and long waiting lists at home; new technology and skills in destination countries alongside reduced transport costs and Internet marketing have all played a pivotal role in the expansion of medical tourism from Bangladesh to abroad. Govt. hospitals and health centers are lacking basic health management skill. Private hospitals and nursing centers are also mostly engaged in earning super normal profit. But no systematic world class hospitals in ratio to population density have been established all over the Bangladesh.

Field of Research: Health Care Management, Outbound Medical Tourism, Inefficient human resources, Bangladesh

JEL Classifications: I11, I15, 015

1. Introduction

Bangladesh is a densely populated country. Health care ought to be one of the basic privileges of the community of the country. According to Bangladesh Economic Review 2010,990 person lives in per/sq. kilometer .Unfortunately medical treatment is not easily available in Bangladesh for which each year a section of patients of the country visit foreign countries for medical ground. http://www.novasans.com/blog/2011/06/defining-medical-tourism/ describes that medical tourism is a term involving people who travel to a different place to receive treatment for a disease, ailment, or condition, and who are seeking lower cost of care, higher quality of care, better access to care, or different care than they could receive at home. A huge number of patients are visiting outside the country each year for medical purposes.

Most important health care services are not right of entry uniformly and the marginalized people of rural as well as slum dwellers of the urban areas are treated in a highly discriminatory nature to access health care management. Even those who are lower middle class and middle class people, they do not also get proper treatment facilities. Moreover, maximum upper class people of the country do not trust health care supporting personnel including doctors, nurses. If there is no other alternative, in that case when seriously sick, the people of the country take treatment in the country.

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Mahmud (2008) argues that the consumption of health care and the pattern of use of various kinds of health services are influenced a great deal by how health care is provided and factors related to the service delivery system, as well as the affordability of health care. There is evidence of very poor standard of public health care and weak provider accountability, contributing to the low quality of the public health care delivery system in Bangladesh. Mahmud's observation is quite convincing as patients and their relatives are worst victim since they don't get proper treatment in the country.

Ali and Medhekar (2012) opine that in order to improve the Bangladesh healthcare system, the country has to face challenges from the growing global medical tourism in the neighbouring countries such as India, Thailand, Malaysia and Singapore. At the same time the Government of Bangladesh should take the opportunity to improve the Bangladesh health care provision to its low and middle income group citizens and provide quality of care at an affordable price.

Medical Tourism is one of the fastest growing healthcare industries. The world is in a healthcare crisis, given the ageing population, increasing cost and long waiting period patients from developed countries as well as from poor countries such as Bangladesh due to low quality or absence of health care are making choices and starting to travel to relatively better developing countries or developed countries such as India, China, Singapore, Thailand, South Korea, Malaysia, KSA, USA, UK, Australia, Japan and Germany etc. with the main objective of obtaining immediate health care, plastic surgery, organ replacement and reproductive – IVF procedures in search of health care which is of best quality and the most affordable medical care, combining with related tourism activity such eco-tourism and spiritual.

This research study intends to deal with outbound medical tourism to different countries from Bangladesh due to inefficient human resources in health care management industry on the basis of the primary survey findings which is not previously undertaken by maximum researchers'. This implies that this research intends to know the causative factors of outbound medical tourism. Huge amount of foreign exchanges have been out flowed from the country on the ground of medical tourism purposes.

As such motivation of undertaking this research work behind to identify reason for people are attracted to outbound tourism from the country to abroad for medical purposes.

2. An Overview of Medical Sector of Bangladesh

Currently Twenty- four public medical colleges and hospitals including Unani and Ayurvedic and Homeopathic medical colleges and hospitals were established in the country. In the private sector around fifty medical colleges and Hospitals. Besides there is one University was situated for medical treatment purposes. Recently some private medical hospitals with good qualities were established. But relatively their numbers are too scanty to meet the demands of a highly populated country. The world is in a healthcare crisis, given the ageing population, increasing cost and long waiting patients from developed countries as well as from poor countries such as Bangladesh. Low quality or absence of health care in these countries is making

choice for patients who have been travelling to abroad. The Bangladesh government has declared Health Policy but it remains inadequate and ineffective.

Health policies and strategies are not working properly. Actually health sector of Bangladesh faces lack of good facilities both skilled manpower and physical infrastructure, ineffective and inefficient treatment, corruption in the health management, high costs, politics among the health service providers, disparity in production of drugs i.e. high quality drugs and low quality drug, lack of inter sector cooperation, etc. Emergency preparation in the country is very much neglected, organizational behavior of the health system in maximum hospitals and health centers is very much old dated, managerial process is not updated, community action is not properly developed, limited health research and technologies, Population agenda and Reproductive Health including family program of Bangladesh is not effective one.

Daily Sun on 5th July, 2011 depicts that for the HNPSP (2003-11) development budget, the share of GOB is 38% and that of Development Partners is 62%. Out of the development budget, the share of the family planning, and maternal, child and reproductive health program is only 22% - 16% from GOB Development Budget and 25% from Project Aid. In the 2011-12 budget, only 5.4% has been allocated to the health sector - the annual per capita allocation in healthcare is only Tk. 590, i.e. a daily allocation of merely Tk. 1.62, not sufficient for attaining the MDG goals as well as Vision-2021 targets of the present government.

According to Financial Express (4th May, 2012) Health Minister AFM Ruhal Haque on 3rd May, 2012 called upon the local and foreign investors to set up industries for manufacturing medical and healthcare equipment and machineries in Bangladesh as the healthcare sector is booming here.

Financial Express 10th June 2012 observes that a section of unscrupulous hospital staff realizes money from helpless patients either for providing a trolley or allotment of a seat. In some hospitals, it is alleged, 'Dalals' allure patients to go to clinics on the assurance of receiving better treatment. A section of doctors and hospital staff who are associated with those particular clinics try to convince the patients for their own interest to earn extra money. Moreover, medicines supplied to those public hospitals find their way into the outside shops for sale. Such practices are not new. These are continuing for over the years unabated. The powerful groups among general staff having political connections are mainly responsible for this evil practice. Wrong treatment and bad behavior and greediness of doctors, nurses and ward boys and support staff have been crippling in this sector. Under government initiatives hospitals, health centers etc. a nexus of rampant corruptions have been created. Even maximum doctors are divided into two distinct political party affiliations. Moreover, investors and management of private sectors hospitals, nursing homes, diagnostic centers etc. Behave this sector as a “money making machine”. Though there is some good hospitals in private sector but they are too much expensive in relation to per capita income of the people. Sometimes these hospitals act like Stars of BCG matrix. Even some specialized doctors per month income is Bangladesh Tk.1 to 1.5 Crore through private practices. Health information system and prevention system is not good quality. Actually there are several reasons of these problems but the main reason behind this problem is lack of human resources. Receivers of the health services are not happy. Chronic disequilibria between

service providers and service receivers in the health sector prevail. However, the study mainly wants to identify the efficiency level of human resources of the health sector as they are very much vital.

http://expertscolumn.com/content/medical-and-health-sector-bangladesh-are-threat comments that not only in the rural area but also in the urban cities the people are not getting quality treatment. As there are few people in the whole country who can diagnosis the problem and can make the best treatment. People also gather to those doctors but because of the huge pressure doctors are not in a position to treat all the people who came to the doctor. The diagnostic centers are also not so quality who can make the report 100% correct. Though there are some good diagnostic centers who test the reports well but most of the diagnostic centers are not serious about their task and do not make their task with any importance.

Ara (2008) observes that the health care system in Bangladesh is operating within a complex political administrative environment. The politicized administrative structure which lies at the root of our mis-governance reflects governance failure in the health sector. She suggests that existing policies need to be reviewed and revised for improving accessibility, affordability and quality of services and for further improvements in affordability, quality and safety of drugs and rational use of drugs. New policies on public and private sectoral mix and financing of services need to be formulated, protection and preservation of the environment; more training institute for graduate and postgraduate study with proper practical facilities should be established, decentralization of management through devolution of authority and the adoption and maintenance of healthy lifestyles and the development of a comprehensive people oriented plan to improve and assure the quality of health services be provided.

Now below we shall see the present situation of the health sector in Table: 1

Table 1

Sl. No.	Present situation	2008-09
1	No. of Hospitals in Health sector	589
2.	No. of non-Govt. Hospitals (Numbers) Registered	2271
3.	No. of beds in Health sector	38171
4.	No. of beds in Private sector (Registered)	362444
5.	No. of registered Physicians (April 2009)	49994
6.	No. of Registered dental surgen (April 2009)	3451
7.	No. of govt. medical colleges	18
8.	No. of Private medical colleges	41
9.	No. of private dental colleges	11
10.	No. of private institute of Health Technology	39
11.	No. of Doctors under Health services	12382
12.	No. of registered nurses (as on April-2009)	23729
13.	No. of registered Mid-wives	22253
14.	No. of trained skilled birth attendance	5000
15.	Population per Physicians	2860
16.	Population per bed	1860
17.	Physician to Nurse Ratio	2.1
18.	Population per nurse	5720

(Source: Bangladesh Bureau of Statistics (2011), Statistical Pocket Book of Bangladesh p-375)

Aforesaid table: 1 indicates pitiable situation of the health sector of the country as doctor-patient ratio or nurse-patient ratio or physician per nurse ratio are very low. Even population per bed is also low.

Present study investigates the causative factor of outbound medical Tourism considering human resources as a vital factor to provide services to the patients.

3. Literature Review

Johnson (2000) comments that In health sector reform the role and core functions of the public sector shift from a primary focus on the direct provision of personal health services to a more clearly articulated normative role that combines health needs assessment and surveillance, policy making, regulatory, financing functions with the assurance of the delivery of quality persona l health services and population based services. This shift creates shifts in roles and functions for other organizations in the sector.

Hossen (2001) suggests that for better health care practices, partnership is required between sectors, institutions, communities, organized interest groups, and individuals to work in together in harmony and cooperation on the basis of the mutually agreed principles and objective.

Noe et al. (2003) comment that often human resource management functions that have been heavily involved in transactional activities for a long time tend to lack systems, processes, and skills for delivering state-of-the-art traditional activities are thoroughly unable to contribute in the transformational arena.

Hongoro and McPake (2004) argue that human resources are in very short supply in health systems in low and middle income countries compared with high income countries or with the skill requirements of a minimum package of health interventions. Equally serious concerns exist about the quality and productivity of the health workforce in low income countries. Among available strategies to address the problems, expansion of the numbers of doctors and nurses through training is highly constrained. This is a difficult issue involving the interplay of multiple factors and forces.

Mahmud (2004) depicts that in societies such as Bangladesh, the acceptance of inequality and tolerance of invisibility of the poor and the marginalised represent major barriers of the poor and the marginalised represent major barriers to the establishment of this virtuous cycle.

Huque and Bhuiyan (2005) argue that in the developing countries, the key elements of Health sector reforms are the promotion of the private sector, changes in the internal structure and operation of the public sector and changes in the financing of health care. Health sector reform is also an important policy agenda of Bangladesh. Young(2005) comments that as health systems operates in an environment of scarce resources, effective programs still need to be justified in terms of economic efficiency, which can be demonstrated by means of cost-effectiveness, cost-benefit, and cost-utility analysis. These types of economic evaluations all relate costs to consequences, but differ in how consequences are measured: as health effects, in monetary units, or in quality-adjusted life years, respectively.

Lee (2006) argues that Asian countries have a competitive advantage in the emerging healthcare industry. There are medical enterprises in countries such as India, Thailand, Singapore and Malaysia that have invested in attracting tourists for this specialist market.

Kabene, Orchard, Howard, Soriano and Leduc (2006) argue that proper management of human resources is critical in providing a high quality of health care. A refocus on human resources management in health care and more research are needed to develop new policies. Effective human resources management strategies are greatly needed to achieve better outcomes from and access to health care.

Kunitz (2007) observes that it is still accurate to say that while openness has not resulted in the benefits promised by the optimists, neither has it had deleterious consequences for the health of many populations that the pessimists predicts.

Lee and Spisto (2007) argue that as an international business, medical tourism is not too different from the subcontracting or the off-shoring of services. With higher costs and expertise, in the future, medical tourism is likely to be the new global trend for providing medical services.

Salahuddin and Nisar (2007) suggest that in Pakistan important areas for developing a proper remuneration system for the doctors of public sector within the country so that the problem like brain drain, wastage of time energy and resources of public health sector could be solved.

Cundiff (2008) argues that since the availability of many health care resources is correlated with the percent of health care spending that comes from government sources; many people would use this data to call for socialization medicine.

Nath (2010) depicts that urban health problems are complex and linked with socio-economic development issues. He also comments that to improve the health of the unnerved and undeserved people in urban areas, the health sector needs intensive and coordinated support and increased developmental action from the health-related sectors.

Tattara (2010) argues that Medical tourism in poor countries is strictly interlinked with the health privatization process and the ability to provide excellent treatment to some sectors of the population, not caring for the performance of the whole system.

ADB (accessed in the website -2011) observes for Vietnam is that the overall constraints in health human resources are poor skill levels, the mal-distribution of the workforce across rural and urban areas and across the public and private system, and low pay and poor incentives for workers. Policy and investment support for better quality pre- and in-service training will improve skills and service capacity and thus the effectiveness and technical efficiency of the health sector workforce in the medium to long term.

Kanchanachitra et al. (2011) depict that vital human resources for health are available to meet the needs of the populations that they serve, migration management and retention strategies need to be integrated into ongoing efforts to strengthen health systems in Southeast Asia. There is also a need for improved dialogue between the health and trade sectors on how to balance economic opportunities associated with trade in health services with domestic health needs and equity issues.

Islam and Akther (2011) observe that despite limited success in producing financial sustainability, quality and equity in government health services, user charges remain a vital strategy and a popular option for health care financing reforms.

Padmanabhan (2011) describes that from Greeks visiting Epidaurus to Romans immersing themselves in the healing waters of Bath to 19th century Europeans flocking to spa towns and sanatoria, people have traveled long distances hoping to restore their health for millennia. What is new is that, in spite of the existence of excellent local medical care in their countries of origin, many medical tourists residing in richer countries are simply unable to access what is right next door. The sphere of health care has been transformed by private, for-profit interests, where price and private insurance schemes reign and dictate who has access to treatment, surgery and medication and who does not.

Pocock and Phua (2011) examine that travelling overseas for medical care has historical roots, previously limited to elites from developing countries to developed

ones, when health care was inadequate or unavailable at home. Now however, the direction of medical travel is changing towards developing countries and globalization and increasing acceptance of health services as a market commodity have lead to a new trend; organized medical tourism for fee paying patients, regardless of citizenship, who shop for health services overseas using new information sources, new agents to connect them to providers, and inexpensive air travel to reach destination medical.

Snyder, Dharamsi, and Crooks (2011) argue that if medical tourists have a social responsibility to look to the efficient functioning of their own domestic health systems, then participation in medical tourism will extend this responsibility to the health systems of the destination countries to which they travel and develop new connections. Medical tourism for procedures that will serve to undermine health equity and the sustainability of the health system in destination countries is therefore a potential violation of the patient's social responsibility. Crucially, however, many of the worries about the negative impacts of medical tourism on destination countries are matters of conjecture rather than well-established fact.

Turner (2011) depicts that despite the rapid expansion of the medical tourism industry, few standards exist to ensure that these business organize high quality competent international health care. Standards should be established to ensure that clients of medical tourism companies make informed choices. Country of care needs to become an integral feature of cross-border care.

Vijay (Access in the website 2011) the Indian tourism industry is now promoting medical tourism as a novel hope for the Indian economy. Five-star hospitals are mushrooming around the nation and major investments by big corporate players are expected. The privatisation and 'corporatisation' of health care has created medical tourism where people from rich nations travel to Third World countries to obtain medical care, experience and enjoy the tourism attractions and use other resources. It is a 'magic lamp' for those countries to attract overseas patients and earn foreign exchange.

Waikar, Cappel, Tate (2011) argue that to promote medical tourism, the host country can undertake improvements in infrastructure, transportation, security etc. The host country government can look at not just the number of medical tourist visiting the city or the region but their net economic impact on the city or the region. Then, the “A-B-C analysis” approach in operations management can be employed to create category “A” category “B” and category “C” cities or regions with highest priority going to category “A” listing. Priorities established then can be used for allocation of resources for improving infrastructure, facilities, and tourist spots, and for improving security and safety of visiting medical tourists. The eventual goal should be to cover cities and regions in all three categories.

Aforesaid literature review indicates that most of the researchers’ have done work in other countries than Bangladesh. As a result numbers of these sort of research works in Bangladesh was very scanty. But health care and services are most important factor for the people. It is one of the basic needs. As such based on aforesaid literature review, we have undertaken following objectives and research methodology.

4. Objectives and Research Methodology

The study has been undertaken with following objectives:

i) To evaluate the overall efficiency of Personnel in Healthcare Management of Bangladesh;

ii) To examine reasons behind outbound medical tourism;

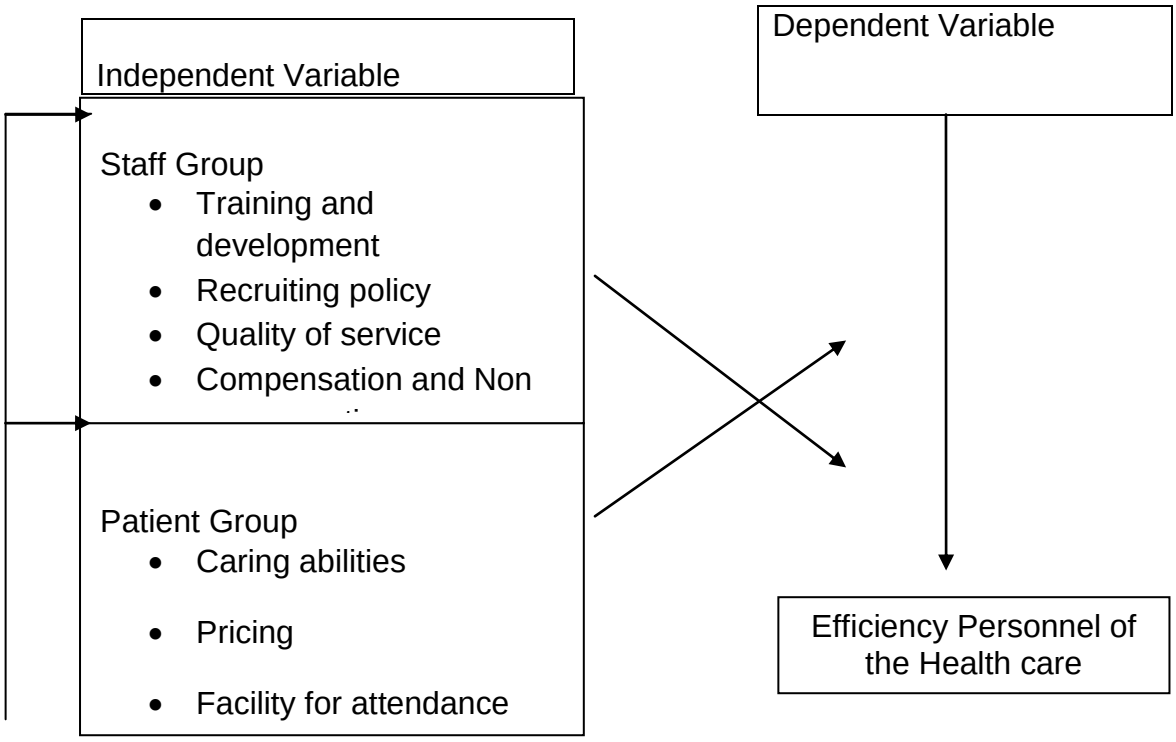
iii) To provide some policy implications for medical tourism sector of the country.

Research question of the study is whether patients are going to other countries from Bangladesh for lack of inefficiency of personnel in the country's Health care Management? The answer is, we assume, that healthcare services in Bangladesh are not efficient. The study collects data and information from both primary and secondary sources.

Two set of questionnaires were prepared and distributed among 611 persons randomly, out of which 500 were responded. The number of sample size is low due to the fact that time period is limited and huge cost in data collection is not possible. Previously a scanty research work is done in this purpose. But the study intended to find out the reason behind outbound medical tourism. A field survey was done at the Gonoshasthaya Samajvittik Medical & Dental College under Ganashastya University. Furthermore, discussion with some speicalised and junior doctors and nurses were done to investigate the matter. The study also used secondary sources. Exact sources have been mentioned. Time period of the study was from July 2011 to November 2011.

On the basis of the questionnaires, regression analyses were conducted. We use SPSS to determine descriptive study data accurately and regression analysis. Moreover, the study also did some qualitative judgments and interviewed at field level survey. In our study the dependent variable is Efficiency of Personnel in healthcare management, while independent variables are Staff Group (includes Training and development; Recruiting policy; Quality of services; Compensation and Non compensation), and Patient Group (includes Good services, Caring abilities, Pricing). This paper, therefore, finds some objects for staff group such as training and development, quality of service, recruiting policy work as an independent variable and good service, caring abilities and pricing work as an independent variable of patient group for Efficiency Personnel of the Health care Management to provide better medical services in the country. The model can be shown below in Figure: 1.

Figure 1



From the service providers we choose Staff Group. Staff group consists of *Training and development (*Staff_T_D)*, Recruitment Policy* (Staff_Recruit)*, Quality Service (*Staff_qua_ser), Compensation and Non compensation (Staff_comp_ncomp).

For the demander side we choose patient group. Patient group consists of facility for attendance (Patient_Atce); Caring abilities (Patient_Cari_abi), Pricing (Patient_Price).

5. Hypothesis Testing

Ho: Overall efficiency of Personnel in Bangladesh Health care management does not prevail which leads to increase outbound medical tourism from Bangladesh.

Ha: Overall efficiency of Personnel in Bangladesh Health care management prevails which isn't related to increase medical tourism from Bangladesh.

6. Analysis of Findings (Quantitative)

Result of descriptive statistics has been given below:

Table 2: Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
Staff_T_D	500	1.75	5.00	3.5975	.72399
Staff_comp_ncomp	500	1.00	5.00	4.1150	.95241
Staff_qua_ser	500	1.25	5.00	3.9765	.84676
Staff_Recruit	500	1.50	5.00	3.6305	.59143
Patient_Atce	500	1.75	5.00	3.8670	.70821
Patient_Cari_abi	500	1.50	5.00	3.6280	.66029
Patient_Price	500	1.25	5.00	3.8530	.85666

In Table: 1, mean value of all the Independent and Dependent Variables between 3.60 to 4.2 so it indicates sampling people agree with our most of the questionnaire on health care sector, and the Standard deviation indicates that the data points are far from the mean because sampling group of people has different thoughts. If it is small standard deviation than it indicates they are clustered closely around the mean.

7. Reliability

Table 3: Case Processing Summary

		N	%
Cases	Valid	500	81.8
	Excluded(a)	111	18.2
	Total	611	100.0

a List wise deletion based on all variables in the procedure.

Here the Reliability test indicates the Independent variables are highly related to the underlying dependent variable.

In Table: 3 *List* wise deletion based on all variables in the procedure.

Here the Reliability test indicates the Independent variables are highly related to the underlying dependent variable.

Table 4: Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.757	.730	8

In table: 3, Cronbach's alpha is a coefficient of reliability. It is commonly used as a measure of the internal consistency or reliability of a psychometric test score for a sample of examinees. Here Cronbach Alpha value is more than 0.7 which is an acceptable value for internal consistency or reliability of the test

8. Regression Analysis

Table 5: Model Summary

R Square	Adjusted R Square	Std. Error of the Estimate	F-Stat.
.6267	.6160	.68367	38.17364

F –statistics is significant at 1% level. Difference between R square and adjusted R square is quite okay. Adjusted R-squared is 0.616, which indicates that the equation provides a moderate fit.

Table 6: Estimated Results of the Regression Equation

VARIABLE	COEFFICIENT	T-STATISTICS	PROB.
C	3.427461	7.975067	0.0000
Staff_T_D	0.724549	6.253381	0.0004
Staff_comp_ncomp	0.810758	8.569812	0.0000
Staff_qua_ser	-5.362317	-2.801366	0.0105
Staff_Recruit	1.410225	1.2712044	0.0847
Patient_Atce	0.675582	1.883297	0.0841
Patient_Cari_abi	0.460879	3.592275	0.0012
Patient_Price	0.512611	5.012241	0.0001

In the regression equation, all the variables are significant. Staff Compensation and Non compensation is significant at 1% level. Staff quality services are also significant at 1% level. Staff training and development is also significant at 1% level. Recruitment Policy is significant at 10% level of significance.

On the other hand in case of patient pricing and caring abilities are significant at 1% level of significance. Facility for patients attendance is significant at 10% level.

However, from the service providers we choose Staff Group. Staff group consists of *Training and development (*Staff_T_D)*, Recruitment Policy* (Staff_Recruit)*, Quality Service (*Staff_qua_ser), Compensation and Non compensation (Staff_comp_ncomp). For the demander side we choose patient group. Patient group consists of Facility for Attendance (Patient_Atce); Caring abilities (Patient_Cari_abi), Pricing (Patient_Price).

9. Observations of Quantitative Analysis

The study observed that null hypothesis is acceptable. As such overall efficiency of Personnel in Bangladesh Healthcare Management does not prevail .This deficiency creates medical tourism from Bangladesh to abroad and huge amount of foreign exchange outflow from the country to the abroad.

The author observes that medical tourism arises due lack of efficient and effective health care system, doctor-nurses, brothers, biotechnologists and ward boys were

not providing desirable services to the patients and allegations against diagnostic centers caused failure of faith in local hospitals. Another interesting findings of the study is that most of the diagnostic centers and lab tests are charging high which is relatively one-third in India in any good Institute as reported by the respondents. Reason behind low price in India is that there is no system of giving percentage or bribe. Moreover, reasons for problems of attendances are also working as one of the causative factor to travel outside the country.

High costs, poor services and long waiting lists at home; innovative technologies and expertise's in target countries alongside reduced transport costs and Internet based communication have all played a pivotal role in the expansion of medical tourism from Bangladesh to abroad.

10. Qualitative Analysis

High costs, poor services and long waiting lists at home; new technology and skills in destination countries alongside reduced transport costs and Internet marketing have all played a pivotal role in the expansion of medical tourism from Bangladesh to abroad.

Depending on income and nature of diseases, patients visit different countries. As such huge amount of fund is out flowed from the country. Depending on financial situation as well as connectivity and visa facility patients along with attendance has been going various country including USA, Canada, Australia, UK, Thailand, South Korea, Malaysia, Saudi Arabia, Singapore and India etc. However, lower middle class and middle class patients have been going to India for treatment purposes. Here we have given data of outward remittance on medical ground in India and also total remittance out flowed from Bangladesh from the year 1986-87 to 2008-09:

Table 7

OUTWARD REMITTANCE TO INDIA		
		Million US$
Year	**Total Remittance**	**Medical**
1986 -87	18.93	0.03
1987-88	19.05	0.02
1988-89	18.58	0.02
1989-90	24.4	0.01
1990-91	19.36	0.01
1991-92	19.1	0.03
1992-93	20.08	0.05
1993-94	27.77	0.17
1994-95	33.01	0.23
1995-96	25.69	0.24
1996-97	37.1	0.29
1997-98	32.29	0.44
1998-99	25.96	0.17
1999-2000	33.06	0.21
2000-01	34.3	0.38
2001-02	16.06	0.2
2002-03	17.21	0.29
2003-04	18.88	0.28
2004-05	22	0.26
2005-06	17.04	0.23
2006-07	19.61	0.13
2007-08	28.07	0.24
2008-09	81.89	0.39
Source: Statistics Department, Bangladesh Bank, 2010		

But unofficially more amount was out flowed from Bangladesh due to health ground. All the respondents' informed that they did not declare the amount due to avoid tax or harassments. In special cases they go to bank for remitting fund on health ground. The growth of medical tourism is an important export sector in India .India's National Health Policy which declared that treatment of foreign patients is legally an "export" and deemed "eligible for all fiscal incentives extended to export earnings. This helps to ensure good quality of medical treatment in India. Most of the Bangladeshis are going there as they are getting relatively better treatment at an affordable cost which is not feasible in Bangladesh. For this study when we did our survey among 500 patients they told us that the most important thing is that nurses, brothers and ward boys act like mussel power than the Doctors. It is evident from the study that in most cases nurses, brothers and ward boys do not care doctors and mostly avoided to provide good services in different Govt. medical colleges and health centers.

Moreover, most of doctors' in govt. hospitals are engaged in politics supporting actively main two big political parties for getting good posting as well as other facilities in the regime of the party which in power and also getting shelter for rampant corruption and lack of transparencies. They even forget to do welfare of the patients. There is no accountability or fairness for wrong treatment in the country as observed by the respondents' comment.

In private medical colleges, specialised hospitals, health centers and nursing homes/ centers services are not at all satisfactory. Rather they charges huge amount of money without ensuring good treatment and assurance of quality services. Quality of medicine is also a problem for Bangladesh. Patients complained that some companies' medicines are being prepared International standard but in case of lack of proper monitoring some companies are preparing lower quality of medicine and doctors' taking bribe from low graded medicine companies prescribed lower quality medicines.

Patients also commented that they found with utter surprise that the rate of good diagnostic centers of Bangladesh is relatively so high than in India that it is 2/3 times higher in Bangladesh. When we verify it from 5 good diagnostic centers situated at Dhaka City and Chittagong City they told with indemnity that they have to pay 25-45% commission to the Doctor who refereed them to the patient. Moreover, allegation is brought that maximum specialised doctors are habituated to see 80-200 patients on an average per day. As a result they cannot give much time in Bangladesh. Moreover, monthly income of a few specialized doctor is from Bangladesh Taka 1 crore to 1.5 crore. Another complain form the patients were lot of pathological reports in Bangladesh differs from the report of quality diagnostic center of abroad which prevents them to get quality treatment in Bangladesh.

Patients also complained that they are afraid about their attendance as law and order situation of the country is not good and there is no proper or alternative arrangement for residing of attendance.

Though Bangladesh has world class pharmaceutical companies but there are also some lower grades pharmaceutical companies and both engage in unfair competition. As a resultant factor sometimes they cannot get good quality medicine.

Private medical colleges charges admission fee for studying MBBS from 0.9 to 1 Million Bangladesh Taka and when a person finish his/ her MBBS degree he/she has to pay 3-6 Million Taka. In a country where per capita income is USD 848 (Source: Speech of National Budget of Bangladesh for 2012-13 by Finance Minister on 7th June, 2012 as reported by Daily Sun on 8th June, 2012)per year so when a student becomes doctor his/her attitude is to raise income at any cost. Moreover, admission criteria are not up to the mark. It does not in favour of students who are doing "O" level and "A" level rather help those who are coming from Bengali medium school. This prevents to get good quality students. As such those passed with Physics, Chemistry, Biology and Math with "B" grade at "O" level and any three aforesaid subjects at "A" level with "B" grade should get preference to get admitted in MBBS program of Bangladesh.

Moreover, numbers of specialised doctors are few. Furthermore, patients alleged that in Bangladesh in rare cases though actions may be taken against doctors but no action has ever been taken against nurses, brothers, ward boys for their negligence of duties. There is a nexus of corruption in the health sector.

Patients who come different corners of the country to the Dhaka city for medical tourism purpose it is evident that they suffers from residing problem especially attendance of the patient as well as security and safety problem. There is a middleman in the govt. hospitals that suck poor patients' money. Bangladeshi patients are travelling to India for medical tourism covering demand and supply side factors after analyzing the data it is observed that most of the cases they did not receive there basic medical treatment in Bangladesh. Criminalization and corruption among some doctors are such that they even do different sorts of business and active politics which greatly hampers treatment. Even one ex director general of Health services allegedly involved in occupying garage through using mussel power and cartel with some persons for illegal possessions at Dhanmondi Residential Area of Dhaka under the banner of the apartment society. If unethical practice is done by a person who served as a Director General of health services and who is still working as a Professor of a Govt. Medical college at Sylhet then what sort of treatment one can expect from these sort of doctors? Lack of ethical and immoral behavior of maximum doctors and nurses in Bangladesh create not congenial atmosphere to provide good treatment for the patients.

According to a report published in Bengali Daily Kalayer Khanta (30th April, 2011) as per World health organization's guidelines the ratio of doctor and nurse should be 1:3. But in Govt. hospitals of Bangladesh where number of registered doctors are 12359 but number of nurses are only 14338.Moreover, in govt. hospitals total number of posts of nurses are 16,969 while 2020 posts are still vacant. In the private sector, total numbers of registered physicians are 51,993 and numbers of registered dentists are 3913. But in private sector total number of registered nurses is 26899. There is a huge deficit in nurses in Bangladesh. As such patients are not getting proper services.

This study through field survey also observed that Ganashastya University has a medical college and also gives training to the nurses. But in most cases they do not issue certificate to the nurses and as such after learning 3-4 months, most of the student nurses whom they call worker left the organization and work in different private clinics. Gonoshasthaya Samajvittik Medical & Dental College does not normally appoint any ward boys, which creates tremendous hindrance for getting well services especially male patient or overweight female patients. Gonoshasthaya Samajvittik Medical & Dental College's pay structure is very low and as such their retention of qualified doctors, nurses or workers are very poor. Management of Ganashastya hospital actually depends on whims and caprices of one man-its founder Zafrullah Chowdhury. He is busy with collecting fund from abroad and misuse of fund mostly for his personal gain. Though the hospital tries to provide services to poor people in different areas through its hospitals and health centers but treatment and health related services are very poor. This is due to fact that lack of adequate doctors, nurses and management problems are encountering to provide better services rather their services are some times worst then remote govt. health centers or govt. hospitals. From the field study it is observed that Gonoshasthaya Samajvittik Medical & Dental College needs proper managerial skill, efficiency and

effectiveness, core competent human resources and compensation packages for their doctor, nurse and other staff.

Govt. of Bangladesh has recently declared Health Policy. But it needs to be holistic nature. Only giving more emphasis on Doctors duty is not sufficient as related other services such as nurses, brothers, biotechnologists and ward boys and moreover hospital management is weak in Bangladesh. As such huge amount of fund is out flowed from the country for treatment purpose.

Bangladesh Institute of Research and Rehabilitation in Diabetes, Endocrine and Metabolic Disorders (BIRDEM) is working for long time but their standard is degrading day by day. Bangabandhu Sheikh Mujib Medical University (BSMMU) is the only medical University of the country but it is not providing up to the mark of international standard benchmarking services. This author observed personally in BSMMU in the year 2005, during my father's treatment for around 40 days how nurses are gossiping with young doctors in the intensive care unit of cardiovascular dept. None is there to take action against them. Individualistic attitude and personal gain is the key factor for doctors and nurses and specialized doctors neglect the patients.

Recently Some good Hospitals have been established like Apollo, Square, United, Lab Aid, Popular, Sikder Medical college hospital etc. are situated in Dhaka city. But relatively there numbers of good hospitals and diagnostic centers are too scanty then the highly densely populated country likes Bangladesh where according to UNICEF reports (2010) 16.4 crore people lives and is a low income country. Some good private hospitals also established in Chittagong, Sirajgong etc. From the study it is evident that Govt. hospitals are lacking basic health management skill. Private hospitals and nursing centers are also mostly engaged in earning super normal profit. But no systematic world class hospitals in ratio to population density have been established all over the Bangladesh.

11. Concluding Remarks and Policy Implications

The government may put emphasis to develop health sector of Bangladesh. As such they should establish joint venture medical college in collaboration with foreign medical institutes/colleges. Moreover, private entrepreneurs can invest in this sector as it stills remains an unexplored market. Besides number of doctors, quality and dutiful nurses, brothers, biotechnologists and ward boys need to be increased and management should be improved. Health care management can be improved through strategic formulation and implementation of the government policy. Career path of young doctors should be properly redesigned. Moreover, social prestige of nurses in the society should be upgraded. Corruption in the govt. hospitals as well as private hospitals should be removed. False and immoral doctors should get proper punishment. Quality maintenance of drugs should be ensured. Diagnostic center should stop bribing processes. Cross boarder hospitals and Medical colleges may be set up under joint venture.

Hongoro and McPake (2004) observation that human resources are in very short supply in health systems is equally applicable in Bangladesh. As such there is no other alternative but to take holistic approach to develop this sector. Medical tourism in Bangladesh may be developed for which it can be taken as a part of Vision 2021

which year will be fifty years of Independence of Bangladesh. This will aid to save valuable foreign exchange rather through increase foreign exchange earnings by developing expansionary scope of International Business and help to raise national income of the country. Policy makers of the country can follow the Lee's (2006) observation to transform Bangladesh as an emerging healthcare industry.

Turner's (2011) caution about maintenance of standards should be established in the health care industry of Bangladesh to ensure that patients and their associates get proper information of medical tourism for taking appropriate choices. As such Bangladesh needs proper directives for arranging health care management. A long term vision, mission, goals and objectives in this sector should work. There are no other alternatives but to have maintained quality assurance in this sector. From our quantitative observation we also found that from the point of view of service providers Training and development, Recruitment Policy Quality Service Compensation and Non compensation of staff group is very much important .On the other hand for the demander side -facility for attendance, caring abilities, pricing of services to the patients are very important.

Outbound medical tourism arises due to lack of efficient and effective health care system, doctor-nurses, brothers, biotechnologists and ward boys were not providing desirable services to the patients and allegations against diagnostic centers caused failure of faith in local hospitals. High costs, poor services and long waiting lists at home; new technology and skills in destination countries alongside reduced transport costs and internet marketing have all played a pivotal role in the expansion of medical tourism from Bangladesh to abroad. Depending on income and nature of diseases, patients visit different countries. As such huge amount of fund is out flowed from the country. In this connection Hossen (2001) suggestions for better health care practices, partnership between public and private sector may be arranged. The government of Bangladesh may put emphasis to develop health sector of Bangladesh. As such they should establish joint venture medical college in collaboration with foreign medical institutes/colleges. Govt. should allow cross border educational institute in Bangladesh. More emphasis should be given to set up high quality cross border educational institutes in medical science area under joint venture from USA, Australia, Canada, UK, Japan, Germany, France etc. Otherwise imbalance as well as low grade education will prevail in the medical educational atmosphere of the country. Director General of Health services (DGHS) office is full of corruption and nepotism. Govt. especially Health and family welfare ministry indulges DGHS.

Private Universities except Gonoshasthaya Samajvittik Medical & Dental College under GanyoShasthya university of the country should also come forward to open different sorts of education related to Medical science courses. Other private universities mostly open only Master in Public health course. Even physiotherapy course cannot now give permission to open or continue under private medical Universities by the Health ministry. This sort of hindrance should be waived jointly by the education ministry and health ministry.

Moreover, private and foreign entrepreneurs can invest in this health care management sector as it stills remains an unexplored market. Besides number of doctors, quality and dutiful nurses, brothers and ward boys need to be increased and management should be improved. Health management can be improved through

strategic formulation and implementation of the government policy. There is no other alternative but to take holistic approach to develop this sector. Kanchanachitra et al. (2011) argument to arrange a dialogue between the health and trade sectors to balance economic opportunities associated with trade in health services with domestic health needs and equity issues in Bangladesh is being required. This will need socio-political, legal, environmental and cultural consciousness in the country to create core competent human resources through arranging strategic alliances and strategic partnership not only within the country but also outside the country. Under public-private partnership arrangement manufacturing medical and healthcare equipment and machineries may be prepared in the country.

Not only decreasing outbound medical tourism but also increasing inbound medical tourism in Bangladesh may be developed for which it can be taken as a part of Vision 2021 by the government of Bangladesh when the country will observe fifty years of Independence of Bangladesh. Govt. expenditure in the health sector should be raised to achieve millennium development goal. Inbound Medical tourism should be declared as a thrust export sector in Bangladesh and availability of all sorts of medical care at a low cost and maintaining quality assurance must be arranged as a top priority basis under operational, mid and long term planning. Contingency planning for developing health care industry should be properly implemented. This will aid to save valuable foreign exchanges through decreasing outflow of foreign exchanges from outbound tourism .Moreover, inflow of foreign exchange earnings from inbound medical tourism in the country can be arranged by developing expansionary scope of international business and can assist to accelerate growth of national income of the country.

12. Limitations of the Study and Further Agenda for Research

The study was done based on 500 respondents only. If the sample size and time period of the study is more than 500 and five moths respectively then it will definitely give more real scenario of pathetic situation of the health systems of the country as well as further better findings and understanding of the reasons behind negligence of duty in health sector and rise of outbound tourism from Bangladesh. Best thing is to conduct the research based on total sixty-four districts of the country. Separate questionnaires such as for patients, attendance of patients, doctors, nurses and authority of hospitals/centers may be prepared and survey can be conducted taking large number of sample size.

Due to time shortage and lack of fund prevents this study to do research with a smaller sample size. Anticipate that in future researchers will do this research work with more sample size and sample must represent different ages, gender and covers total sixty-four districts of the country. Moreover, different govt. and private hospitals, nursing and health centers ought to be directly investigated.

Huge cost will be involved in the research work. If aforesaid sorts of research work is undertaken by any related govt. agencies or private organizations or any donor agencies then more information are likely to be obtained. On the basis of the findings if proper strategies are being taken to develop capacity building through a holistic approach then in the health sector of the country will be in a superior condition. From the outcome of a holistic approach with implementation of contingency planning of

developing inbound medical tourism sector instead of outbound medical tourism sector may be feasible.

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