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Outmigration of Patients from Bangladesh

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Abstract *Every year large number of Bangladeshis visit foreign centers to receive health care services which are in many cases available within the country. This outflow of patients is a disturbing phenomenon for Bangladesh. This paper examines the magnitude and the reasons of imports of health services by Bangladeshis using cross-sectional descriptive type of study. The study reveals that patients migrate to foreign countries for the treatment of cancer, cardiac, kidney, liver, orthopedic, neurological, gynecological and obstetric, eye and ENT diseases. Pushing factors that compel patients to migrate to foreign countries were absence or lack of proper medical reception, proper emergency management, proper post operative care, doctors with better attitude, high tech-devices. Only 20% respondents believed that local doctors have lack of better knowledge. Lack of integrated medical facilities, lack of confidence in radiology and images, lack of confidence in laboratory reports and poor accessibility were the other factors pushing factors. Pulling factors, the attractive foreign health services, were more empathetic foreign doctors, giving reasonable time for patients, doctors with up-to-date medical knowledge, and considerate and caring doctors. Inconveniences faced by the patients in receiving foreign medical services were re-doing the same investigation, not welcoming a second medical opinion, exhausting patients physically and financially, language problem, wrong diagnosis and treatment and tiring and uncomfortable travelling, especially in case of children. Local doctors suggested that trends of out migration of patients can be stopped and even reversed by augmenting continued medical education and shunning politicizing the health service of the home country rather than bringing foreign specialist.*

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1. Introduction

The health status of developing countries of the world is miserable and unacceptable. A large segment of the population in developing countries is deprived to access to basic health care. The services delivered by the health care providers are not up-to the level of need and satisfaction of the clients.

In Bangladesh, the government is the largest single health service provider with 30% of health expenditure contribution. Other sources of health services are traditional and homeopathic services, private modern qualified and unqualified clinics and diagnostic services, NGOs and services by qualified and unqualified pharmacists (Ahmad 2003). Although the efforts of the Government of Bangladesh, NGOs and private service providers in the country's health sector have been rewarded with some success in primary health care, immunization and the child and maternal mortality, the public health facilities in Bangladesh function poorly. As a consequence majority of the patients seek medical services in both for-profit and not-for-profit private sectors. The quality and access to these services are far from satisfactory (Andaleeb, Siddiqui and Khandakar 2007; Ahmad 2003). The estimated client share of the government is also low. Even the poor has to depend largely on private sector providers (pharmacies) for curative treatment (Ahmad 2003). So many affluent people migrate to neighboring countries for simple diseases or routine check up and poor people also migrate for better management of complicated diseases with affordable cost.

1.1 Health service status of Bangladesh (Pushing factors for patients' migration)

There is a growing perception of increasing corruption in health service delivery including corruption in procurement, the registration of clinics, the provision of medicine, and the appointment, posting and promotion of medical professionals. Even after admission into government hospitals, extra payments are to be paid by the patients for treatment (Ahmad 2003).

Ashrafun and Uddin (2011) explored that 54.7 percent of the inpatients had to pay money to different people in the name of gift/tips after getting admitted in the hospital. The mean values of all hospital services variables such as nurses and boys/ayas (-care givers-) services and their behaviour, quality of food, toilet and bath room condition, doctors' behavior, and treatment indicate that inpatients were not enthused about hospital services and care that they received. The average waiting time for doctors after getting admitted in the hospital was 6.1 hours. On average, they have stayed 8.8 days in the hospital, and spent a handsome amount of money for treatment, with a mean of Taka 3020.00 (Ashrafun and Uddin 2011).

The dual involvement of same clinicians to public and private sectors leads clinicians to divert patients attending government hospitals to their private clinics from where they (clinicians) get incentives. In some cases, clinicians advertise for their private practice while working at the government hospital. Sometimes clinicians advise unnecessary or inappropriate investigations and prescribe over or inappropriate medicine to have incentives from diagnostic laboratories and pharmacies respectively. This malpractice raises the cost of treatment to the patient in Bangladesh (Ahmad 2003).

The public health sector is plagued by uneven demand and poor quality services. The negative attitudes and behaviors of doctors and nurses are major hindrances to the utilization of public hospitals. The situation is further compounded by unavailability of drugs, and long travel and waiting times. These factors play a powerful role in shaping patients' negative attitudes and dissatisfaction with health care services. Unfortunately the quality of service is being ignored in the private health care sector as well. Some of its main drawbacks include lack of standard treatment protocols, qualified nurses and unnecessary diagnostic tests (Andaleeb, Siddiqui and Khandakar 2007; Ahmad 2003).

One of the reasons of deteriorating health service is migration of qualified doctors from the developing countries to developed countries. Doctors are migrating from developing countries to developed ones at large scale. The phenomenon of doctors' migration is also known as relocation of intellectual human capital from developing countries to developed countries. The trend is distressing the non-industrialized and developing countries where human potentials is re-arranged with unskilled manpower by relocation of highly educated and trained personnel to industrialized countries. Emigration of intellectuals from country of origin is often perceived as a great loss. Mostly poor countries are facing acute shortage of specialized manpower e.g., doctors, hence many public and private positions remain vacant. As a result, developmental targets prescribed in development vision and quality of health services are not achieved by the developing countries (Tahir, Kauser and Tahir 2011).

The above factors make the patients frustrated and compel affluent patients to go abroad for medical services. These low quality health services in own country act as pushing factors for the patients to go foreign countries to have better health services.

2. Popular Destinations for Treatment

Tourists. It arguably has the lowest cost and highest quality of all medical tourism destinations and English is widely spoken. Several hospitals are accredited by the Joint Commission International (JCI) and staffed by highly trained physicians. Prices can be obtained in advance and many hospitals bundle services into a package deal that includes the medical procedure and the cost of treating any complications. Hotel accommodations are extra, but hospitals often have hotel rooms or can offer discounts for hotels nearby (Herrick 2007). Bangladeshis come to India for treatment. Many of them arrive not for complicated procedures but for routine pathological tests. The more affluent medical tourists go to Singapore these days, but still an estimated 500.

The recent Government and Non-government Organization's report exposes that many Bangladeshis migrate to India through unauthorized or authorized ways as patients to receive free medical treatment from not only the Indian government hospitals but also private medical institutions. The government hospitals of India not only supply the medicines to the foreign nationals but also but also arrange for their food and lodging sometimes (Chatterjee). Nine out of 10 persons from Bangladesh seek for private hospitals in Kolkata, and the remainder goes to south India, mostly to Christian Medical College in Vellore, Tamil Nadu, where almost all doctors speak Bengali with Bangladeshi patients (Datta 2010). Bangladeshi patients are also available in the Indian Tripura States hospitals like Agartala Government Medical College Hospital, Sonamur Hospital, and other hospitals (Chatterjee). Around 50,000 Bangladeshis go to India every year for better medical treatment only. In a queue for visa to India, the purpose of more than 50% Bangladeshi nationals is medical treatment in India (Chatterjee). Cost and quality are obviously the most important factors patients consider in choosing specific destinations for treatment. But many patients also consider amenities commonly found in resorts and hotels (Herrick 2007).

Thailand, another popular destination for medical tourists from Bangladesh rivals India in price and quality. Thailand's large tourist industry has a better infrastructure and less noticeable poverty than India. Prices are not as low as in India, and Thai hospitals do not offer fixed pricing. However, food and lodging are less expensive than in India due to Thailand's competitive tourism industry. Bangkok's Bumrungrad International Hospital is a world-class private health care facility built for wealthy Thais, but foreigners comprise more than one-third of its patients (Herrick 2007).

Singapore, Yet another destination for heath servies, has modern, high-quality hospitals. Prices are higher than in Thailand or India but are much lower than in the United States (Herrick 2007). The more affluent medical tourists go to Singapore for treatment (Datta 2010). Patients who are not familiar with specific medical facilities abroad can coordinate their treatment through medical travel intermediaries. These services work like specialized travel agents. They investigate health care providers to ensure quality and screen customers to assess those who are physically well enough to travel. They often have doctors and nurses on staff to assess the medical efficacy of procedures and help patients select physicians and hospitals (Herrick 2007).

3. Objective of the study

General objective of this study is to generate reliable information on the magnitude and the reasons of imports of health services by Bangladesh from abroad.

Specific objective are:

1. To identify major reasons why people go abroad for medical treatment
2. To identify the shortcomings of the existing health care services of Bangladesh
3. To suggest the ways to overcome these shortcomings
4. To identify the feasibility of averting such outward migration of patients by establishing health institution within the country capable to deliver quality services within affordable cost.

4. Methodology

Is is a cross-sectional descriptive type of study carried out at Dhaka, Bangladesh by Health 21, a center for 'Health Care Management' in collaboration with 'the daily Star' a daily English news paper published from Bangladesh. The study was carried out in two temporal phases with same questionnaire. The 1st phase was conducted during January to December 2005 and the 2nd phase during Mid April 2008 to December 2009. The samples were selected from the patients who travelled abroad exclusively for health care needs, from doctors who treated these patients and from health services management experts of Bangladesh, Australia, India and UK.

Sample size of the study is 200 patients and 25 doctors. Patients were selected purposively from acquaintances and those attending doctors' clinics. Data were

collected through field survey mainly among the respondents of Bangladesh and two foreign countries: India and Thailand where patients usually like to migrate to seek better medical services. Data on use of health care services by Bangladeshis in different foreign health care centers was collected through visiting those centers in India and Thailand known to be popular with Bangladeshi patients and interviewing with the clinicians, medical agents, hospital authorities and medical personnel of those health care centers. Interview was carried out in front of doctors clinics, their respective offices and clinics**.** A limited number of respondents were interviewed from West Bengal and Tamil Nadu (3) and Bangkok (3) during 1st phase and couple of respondents was interviewed from Kolkata during 2nd phase.

Data collection tool: Data was collected by administering a pretested structured questionnaire. Two sets of questionnaires were administered, one set for patients attended foreign clinic for medical services and another set of open ended questionnaire for Bangladeshi doctors to obtain data regarding their perception and possibility of import substitution.

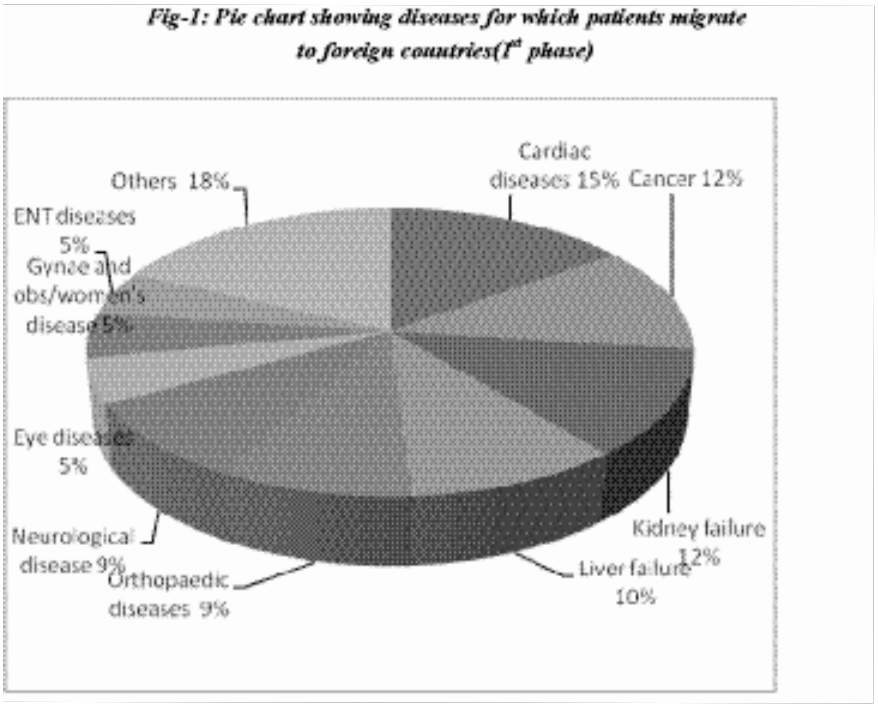
5. Results

Interview was undertaken among 200 patients. 194 of them were interviewed at Dhaka. 2/3rds were males and 1/3rd female. The mean age of the patients was 49 years with a range of 29-57 years. The mean age of the interviewed physicians (n=25) was 43 years with a range of 28-57 years. Among the participant physicians 18 were males and 7 were females, 15 worked in government hospitals, 8 in private hospital and 2 in medical university.

The first phase of the study revealed that about 12,000 patients migrated in India and 10,000 in Thailand during the 1st phase of the study period (in the year 2005). 1st phase (2005) and 2nd phase (2009) of the study revealed that 81% and 86% of the patients migrated respectively through tourist visa**.**

Diseases for which patients migrate to foreign countries

According to the first phase of the study (2005), diseases for which patients migrate to foreign countries were cardiac (15%), cancer (12%), kidney failure (12%), liver failure (10%), orthopedic diseases (9%), neurological disease (9%), gynecological and obstetric disease (5%), eye disease (5%), ENT diseases (5%) and other disease (18%) (Figure-1)



According to the second phase of the study (2009), diseases for which patients migrate to foreign countries were cardiac (10%), cancer and cancer related different illness (18%), kidney diseases (15%), liver diseases (12%), and neurological disease (11%) (Figure -2).

The study found that 39% of the patients came to know about foreign medical care through friends and relatives, 23% through social gathering or other patients, 21% through agents and local doctors and 17% through own decision (Figure-3).

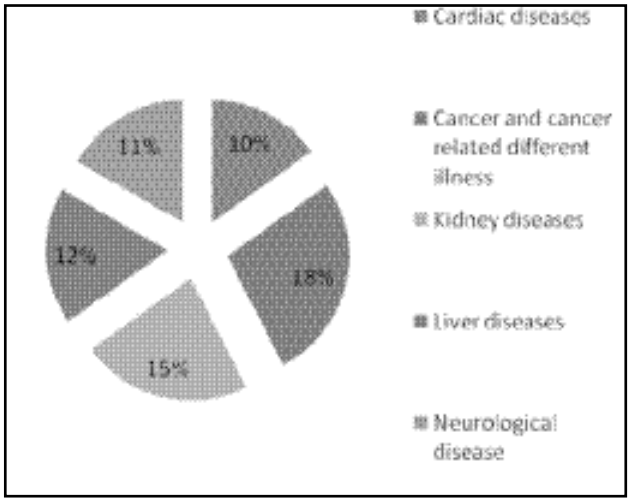
Causes of Patients' migration; Patients' of point view

Pushing forces: Absence or lack of facilities in Bangladesh

According to the response of the 1st phase of the study, the pushing forces acting on patients' migration to foreign countries were absence or lack of following facilities: proper medical reception (75%), proper emergency management (90%), proper post operative care (69%), doctors with better attitude (65%), high tech-devices (35%). Only 20% respondents believed that local doctors have lack of better knowledge (Table I).

The result of the second phase of the study is almost similar. According to the 2nd phase of the study, the pushing forces were absence or lack of proper medical

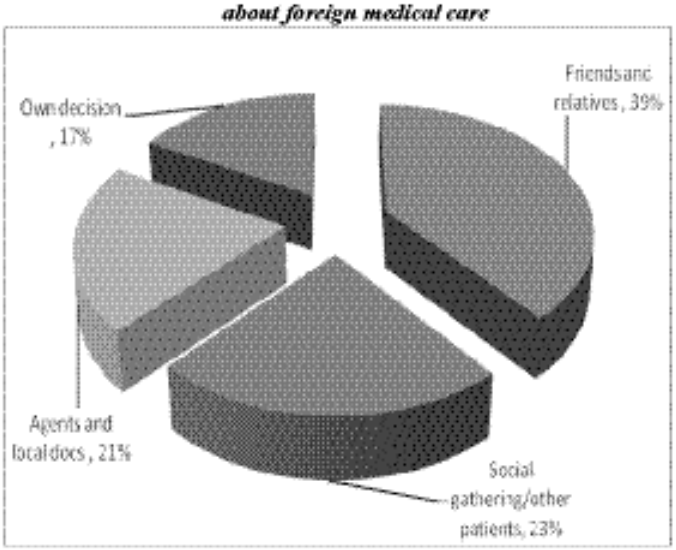
Fig 2: Pie chart showing diseases for which patients migrate to foreign countries(2nd phase)



Source: of information about foreign medical care

reception (70%), proper emergency management (90%), proper post operative care (75%), doctors with better attitude (75%), high tech-devices (25%). Only 18% respondents believed that local doctors have lack of better knowledge (Table I).

Fig-3: Pie chart showing Source of information about foreign medical care



Pushing forces: Quality of available facilities in Bangladesh

According to the respondents of 1st phase of the study, the pushing forces were lack of integrated medical facilities (10%), lack of confidence in radiology and images (29%), lack of confidence in laboratory reports (42%) and poor accessibility (lack of proper medical attention when needed) (70%) (Table I).

Table I : Causes of Patients' migration; Patients' of point of view *(n – 200)*

Causes of Patients' migration; Patients' of point of view	% of response	
	1st phase	2nd phase
Pushing forces: Absence or lack of facilities in Bangladesh		
• Proper medical reception	75%	70%
• Proper emergency management	90%	90%
• Proper post operative care	69%	75%
• Doctors with better attitude	65%	75%
• Doctors with better knowledge	20%	18%
• High tech-devices	35%	25%
Pushing forces: Quality of available facilities in Bangladesh		
• Lack of integrated medical facilities	10%	10%
• Lack of confidence in radiology and images	29%	31%
• Lack of confidence in laboratory reports	42%	39%
• Poor accessibility (lack of proper medical attention when needed)	70%	--
Pulling forces: Qualities of foreign doctors		
• More empathetic	94%	84%
• Give reasonable time for patients	88%	80%
• Up-to-date medical knowledge	74%	64%
• Treated as an intelligent person	32%	--
• Considerate and caring	74%	--
• Respect by emotion	94%	--
• Same treatment but environment was superb	38%	--
• Treated scientifically, nicely and happy with treatment	58%	--

Similar findings were revealed by the second phase of the study, the pushing forces were lack of integrated medical facilities (10%), lack of confidence in radiology and images (31%) and lack of confidence in laboratory reports (39%)(Table I).

Pulling forces: Qualities of foreign doctors

1st phase of the study revealed the following quality of foreign doctors acted as pulling forces on patients' migration: doctors were more empathetic (94%), give reasonable time for patients (88%), have up-to-date medical knowledge (74%), treat patients intelligently (32%) and considerate and caring (74%) and respect by emotion (94%). Fifty-eight percent respondents believed that they were treated scientifically, nicely and they were happy with treatment. 38% believed that same treatment was given in foreign country but the environment was superb (Table I).

2nd phase of the study similarly revealed that foreign doctors were more empathetic (84%), gave reasonable time for patients (80%) and doctors have up-to-date medical knowledge (64%) (Table I).

The 1st phase of the study revealed the following inconvenience in receiving foreign medical services; re-do the same investigation (90%), did not welcome a

Table II: Inconveniences for patients in receiving foreign medical service; Patients' of point of view (n = 200)

Causes of inconvenience in receiving foreign medical service; patients' of point of view	% of response 1st phase	2nd phase
Patients' harassment in abroad		
• Re do the same investigation	90%	78%
• Did not welcome a second medical opinion	73%	90%
• Exhaust patients physically and financially	84%	85%
• Could do little about language problem	82%	--
• Wrong diagnosis and treatment	16%	--
• Tiring and uncomfortable travelling, specially in case of children	84%	--
Cost of treatment		
• Very expensive	79%	92%
• 25-75% expenses could be saved as same treatment was available in Bangladesh	38%	36%

second medical opinion (73%), exhaust patients physically and financially (84%), could do little about language problem (82%), wrong diagnosis and treatment (82%) and tiring and uncomfortable travelling, specially in case of children (84%) (Table II).

The 2nd phase of the study showed almost similar figures. The inconveniences observed in receiving foreign medical services were the following: re-do the same investigation (78%), did not welcome a second medical opinion (90%) and exhaust patients physically and financially (85%) (Table II).

Table-III: Cost of treatment (n=200)

Items	Cost (Taka)	
	1st phase	2nd phase
Average overall cost (Including airfare/accommodation-food/ treatment/misc accompanied by at least 1 person where surgery or invasive procedure was not included)	145,000	250,000
If surgery or invasive procedure needed	2,50,000-9,00,000	3,00,000-10,00,000

Average overall cost was 145,000 taka revealed in 1st phase and 250,000 taka in 2nd phase. Cost of treatment increased by 60% by 4 years. If surgery or invasive procedure needed, the cost was 2,50,000-9,00,000 taka revealed in 1st phase and 3,00,000-10,00,000 taka revealed in 2nd phase, the cost was somewhat static

Table IV: Local doctors' suggestion regarding patients' migration (n=25)

Local doctors' suggestion: Trend could be contained, eventually reversed by	% of response	
	1st phase	2nd phase
• Bringing in selected foreign specialist	93%	43%
• Augmenting CME	85%	95%
• Shunning politicizing the health service	61%	79%
• Post referral system	50%	--
• Liberalization of rules for FMS in few disciplines	31%	--
• Government can take the lead in bringing FMS in specific disciplines	93%	--
• No proper policies regarding private practice	13%	--

between two phases of the study (Table III). Abbreviation: CME, Continued Medical Education; FMS, Foreign Medical Staff In the 1st phase of the study local doctors suggested that trends of out migration of patients could be contained and eventually reversed by bringing in selected foreign specialist (93%), augmenting continued medical education (CME) (85%), shunning politicizing the health service (61%), post referral system (50%), liberalization of rules for FMS in few disciplines (31%), government can take the lead in bringing FMS in specific disciplines (93%) and no proper policies regarding private practice (13%)(Table IV).

In the 2nd phase of the study local doctors suggested that trends of out migration of patients could be contained and eventually reversed by bringing in selected foreign specialist (43%), augmenting continued medical education (CME) (95%) and shunning politicizing the health service (79%) (Table IV).

6. Discussion

In the 1st phase of the study, 200 middle aged patients who had experience of visiting foreign countries for medical services were interviewed; among them 194 were recruited from Dhaka. The male: female ratio of the patients was 2:1. We also interviewed 25 physicians who dealt with patients who migrated to foreign countries for medical services. Among the participant physicians 15 worked in government hospitals, 8 in private hospital and 2 in medical university.

The first phase of the study revealed that about 12,000 patients migrated in India and 10,000 in Thailand during the year 2005. This number of patients is quite lower than the number described by Rahman (2000) who described that around 50,000 Bangladeshis go to India every year for better medical treatment (Chatterjee; Rahman 2000). A lot of patients cross the border through unauthorized way creating a great difference between the documented and actual number of patients crossing the border. Chatterjee described that in a queue for visa to India, the purpose of more than 50% Bangladeshi nationals is medical treatment in India (Chatterjee). 1st phase (2005) and 2nd phase (2009) of the study revealed that 81% and 86% of the patients migrated respectively through tourist visa**.**

According to the first phase of our study (2005), diseases for which patients migrate to foreign countries were cardiac (15%), cancer (12%), kidney failure (12%), liver failure (10%), orthopedic diseases (9%), neurological disease (9%), gynecological and obstetric disease (5%), eye disease (5%), ENT diseases (5%) and other disease (18%) (Figure-1) and according to the second phase of the study (2009), diseases for which patients migrate to foreign countries were cardiac

(10%), cancer and cancer related different illness (18%), kidney diseases (15%), liver diseases (12%), and neurological disease (11%) (Figure -2). There was no substantial difference between disease profiles between the two study periods. Our findings were not supported by the findings of Banik et al (2010). They also stated that patients coming to India were for cardiac (49/190), cancer (45/190), orthopaedic (21/190) and kidney-related (22/190). However, the proportion of different disease they found in their study was not similar to our findings. It may be due the fact that they surveyed among 190 patients who visited India for medical services from different SAARC countries (Banik et al 2010). On the other hand we recruited patients of Bangladesh only.

The study found that 39% of the patients came to know about foreign medical care through friends and relatives, 23% through social gathering or other patients, 21% through agents and local doctors and 17% through own decision (Figure-3). Herrick (2007) also described that patients who are not familiar with specific medical facilities abroad can coordinate their treatment through medical travel intermediaries. They often have doctors and nurses to help patients select physicians and hospitals abroad (Herrick 2007).

According to the response of our study, the pushing factors that compel patients to migrate to foreign countries were absence or lack of proper medical reception (75%), proper emergency management (90%), proper post operative care (69%), doctors with better attitude (65%), high tech-devices (35%). The result of the second phase of the study is almost similar. According to the 2nd phase of the study, the pushing forces were absence or lack of proper medical reception (70%), proper emergency management (90%), proper post operative care (75%), doctors with better attitude (75%), high tech-devices (25%). All these factors are related to both hospital authority and physicians. However, only 20% respondents in the first phase and 18% respondents in the second phase believed that local doctors have lack of better knowledge (Table I). In our study, the pushing forces were lack of integrated medical facilities (10%), lack of confidence in radiology and images (29%), lack of confidence in laboratory reports (42%) and poor accessibility (lack of proper medical attention when needed) (70%)(Table I).

Our findings are in line with the findings of Banik et al (2010), Ahmad (2003), Ashrafun and Uddin (2011), Andaleeb, Siddiqui and Khandakar (2007) and Tahir, Kauser and Tahir (2011).

Banik et al (2010) found that the local doctors advise patients to go abroad for better treatment in view of insufficient facilities and expertise in the home country (Banik et al 2010).

Ahmad (2003) stated that people in Bangladesh experience different types of barriers to the access to health care such as distance, long waiting hours, expenses related to medical advice and medicine, misbehavior of health workers etc (Ahmad 2003).

Ashrafun and Uddin (2011) described that services of nurses and boys/ayas and their behaviour, quality of food, toilet and bath room condition, doctors' behavior, and treatment indicate that inpatients were not satisfied with the hospital services and care that they received. On average, they have stayed 8.8 days in the hospital, and spent a handsome amount of money for treatment, with a mean of Taka 3020.00 (Ashrafun and Uddin 2011).

Andaleeb, Siddiqui and Khandakar (2007) stated that the public health sector is plagued by uneven demand and poor quality services. The negative attitudes and behaviors of doctors and nurses are major hindrances to the utilization of public hospitals. The situation is further compounded by unavailability of drugs, and long travel and waiting times. These factors play a powerful role in shaping patients' negative attitudes and dissatisfaction with health care services. The quality of service is being ignored in the private health care sector as well. Some of its main drawbacks include lack of standard treatment protocols, qualified nurses and unnecessary diagnostic tests (Andaleeb, Siddiqui and Khandakar 2007).

(Tahir, Kauser and Tahir (2011) explained that one of the reasons of deteriorating health service is migration of qualified doctors from the developing countries to developed countries. The trend is distressing the non-industrialized and developing countries where human potentials is re-arranged with unskilled manpower by relocation of highly educated and trained personnel to industrialized countries. Mostly poor countries are facing acute shortage of specialized manpower e.g., doctors, hence many public and private positions remain vacant. As a result, the targets in the developmental of quality of health services are not achieved by the developing countries (Tahir, Kauser and Tahir 2011).

Our study revealed that the foreign doctors were more empathetic (94%), gave reasonable time for patients (88%), had up-to-date medical knowledge (74%), treated patients intelligently (32%) and were considerate and caring (74%). Fifty-eight percent respondents believed that they were treated scientifically and they were happy with treatment. 38% believed that same treatment was given in foreign country but the environment was superb (Table I).

These observations were supported by Banik et al (2010), Herrick (2007) and Mudur (2004).

Banik et al (2010) revealed that a vast majority of patients reported that they came to India because of its inexpensive and high quality doctors (Banik et al 2010). Today's India offers World Class Medical Facilities, comparable with any of the western countries. India has state of the art Hospitals and the best qualified doctors with the best infrastructure, the best possible medical facilities, accompanied with the most competitive prices (Newdelhitravel.co.in 2011).

Herrick (2007) explained that prices for treatment are lower in foreign hospitals for a number of reasons including lower labor costs, less or not at all involvement of third parties (insurance and government), package pricing with price transparency etc (Herrick 2007).

Mudur (2004) described that different states of India took severe steps to attract patients from foreign countries. The western Indian state of Maharashtra has set up a Council for Medical Tourism to promote the state as a health destination for foreign patients (Mudur 2004).

The present study revealed the following inconveniences faced by the patients in receiving foreign medical services; re-do the same investigation (90%), do not welcome a second medical opinion (73%), exhaust patients physically and financially (84%), could do little about language problem (82%), wrong diagnosis and treatment (82%) and tiring and uncomfortable travelling, specially in case of children (84%).

Cost of treatment increased by 60% by 4 years. In cases where surgery or invasive procedure needed, the cost was somewhat static between two phases of the study (Table III).

It is worth noting that there was a remarkable change in opinion of local doctors in bringing selected foreign specialist between 1st and 2nd phase of the present study. Most of the local doctors were no longer suggesting for bringing selected foreign specialist (93% vs 43%), rather they were more in favor of augmenting continued medical education (CME) (85 vs 95% in 1st and 2nd phase respectively) and shunning politicizing the health service (61% vs 79%) (Table IV). The suggestion of the local doctors was supported by opinion of Forcier, Simoens and Giuffrida (2004). They explained that physician migration can only offer temporary solutions and act as a short-term buffer. Instead, countries need to focus on how they can create an adequate supply by implementing policies affecting education and training, levels and methods of remuneration, retention and retirement of domestic physicians (Forcier, Simoens and Giuffrida 2004).

7. Conclusion

The present study identifies that patients migrate to foreign countries for the treatment of cancer, cardiac, kidney, liver, orthopedic, neurological, gynecological and obstetric, eye and ENT diseases. Factors that compel patients to migrate to foreign countries are absence or lack of proper medical reception, proper emergency management, proper post operative care, doctors with better attitude and high tech-devices. Lack of integrated medical facilities, lack of confidence in radiology and images, lack of confidence in laboratory reports and poor accessibility are the other factors causing patients to migrate foreign countries. Attracting factors of foreign health services are more empathetic foreign doctors, giving reasonable time for patients, up-to-date medical knowledge of physicians, and considerate and caring doctors. Inconveniences faced by the patients receiving foreign medical services are re-doing the same investigation, not welcoming a second medical opinion, exhausting patients physically and financially, language problem, wrong diagnosis and treatment and tiring and uncomfortable travelling specially in case of children. Local doctors suggested that trends of out migration of patients can be stopped by augmenting continued medical education and shunning politicizing the health service of the home country rather than bringing foreign specialist.

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