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Outbound Medical Tourism : The Case of Bangladesh

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Abstract *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 data. Two questionnaires were administred to gather primey data for the period from July 2011 to November 2011. Analysis reueals 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 Govt. hospitals and health centers 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 have been established in the country.*

***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. According to Bangladesh Economic Review 2010, 990 persons

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live in per/sq. kilometer. Unfortunately medical treatment is not easily available in Bangladesh for which each year a large nember 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 care, higher quality of care, better access to care, or different care than they could receive at home. A huge number of patients are govt. outside the country each year for medical purposes.

Most important health care services do not provide uniform right of entryand the marginalized people of rural as well as slum dwellers of the urban areas are treated in a highly discriminatory nature to access due health care lower middle class and middle class people 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, then when seriously sick, the people of the country take are forced to treatment in the country.

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 stps to enabls access to improved health care by 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 form patients from developed countries as well as from poor countries such as Bangladesh from whies more and impre patients traveling to relatively better developing countries or developed countries such as India, China, Singapore, Thailand, South Korea, Malaysia, KSA, USA, UK, Australia, Japan and Germany. 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 from Bangladesh due to inefficient human resources in health care management industry on the basis of a primary survey which not previously undertaken by researchers. This research intends to know the causative factors of outbound medical tourism. Huge amount of foreign exchanges have flowing out of the country from medical tourism purposes.

2. An Overview of Medical Sector of Bangladesh

Currently there are twenty-four public medical colleges and hospitals including Unani and Ayurvedic and Homeopathic medical colleges and hospitals in the country. In the private sector there are fifty medical colleges and Hospitals. Besides there is one University in the country. Recently some private medical hospitals with good quality were established. But 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 compeling patients to travell abroad. Bangladesh Government has declared Health Policy but it remains inadequate and ineffective.

Health policies and strategies are not working properly. Actually the health sector of Bangladesh faces lack of good facilities both skilled manpower and physical infrastructure, ineffective and inefficient treatment, corruption in health management, high costs, politics among the health service providers, production of insufficient high quality drugs 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 out dated, managerial process is not updated, community action is not properly developed, limited health research and technologies and the agenda of Reproductive Health including family planining program is not effective.

Daily Sun on 5th July, 2011 depicts that the HNPSP (2003-11) development budget, the share of GOB is 38% and that of Development Partners is 62%. 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 goal 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.

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 unabated for years. 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 this sector. Under government initiatives hospitals, helath centers etc. a nexus of rampant corruptions has been created an hospitals and health most doctors are divided into two distinct political party affiliations. Moreover, investors and management of private sectors hospitals, nursing homes, diagnostic centers etc. treat this sector as a "money making machine". Though there are some good hospitals in private sector 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 by income of Tk.1 to 1.5 crore through private practice. Health information system and prevention system are not of good quality. Actually there are several reasons of these problems but the main reason behind this problem is lack of human resources. Receivers the health services are not happy. Chronic disequilibria between service providers and service receivers in the health sector prevail. This study mainly wants to identify the efficiency level of human resources of the health sector as it is 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. There are not many pecinlist 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.

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 and the development of a comprehensive people oriented plan to improve and assure the quality of health services should be enscekped.

Table 1: The Present situation of the Health Sector

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*

Table 1 indicates the pitiable statr of theeountiys health sector. The doctor-patient ratio or nurse-patient ratio or physician per nurse ratio is very low. Even population per bed is also low.

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 personal health services and population based services.

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

Noe et al. (2003) comment that 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 and 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.

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 predict.

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 developing a proper remuneration system for the doctors of public sector within the country important so that the problem like brain drain, wastage of time energy and resources of public health sector could be solved.

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.

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 led 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) says that 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 the number of the 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 in efficiency 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.

A questionnaire was prepared and distributed to 611 persons randomly, out of which 500 persons responded. The sample size is low due to the fact that the time period limited and the cost in data collection was also high. Previously a scanty research work was done this subject but the persent study has tried to find out the reason behind outbound medical tourism. A field survey will also be done at the Gonoshasthaya Samajvittik Medical & Dental College under Ganashastya University. Time period of the study was from July 2011 to November 2011.

On the basis of these 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 intervi 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 is shown in 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).

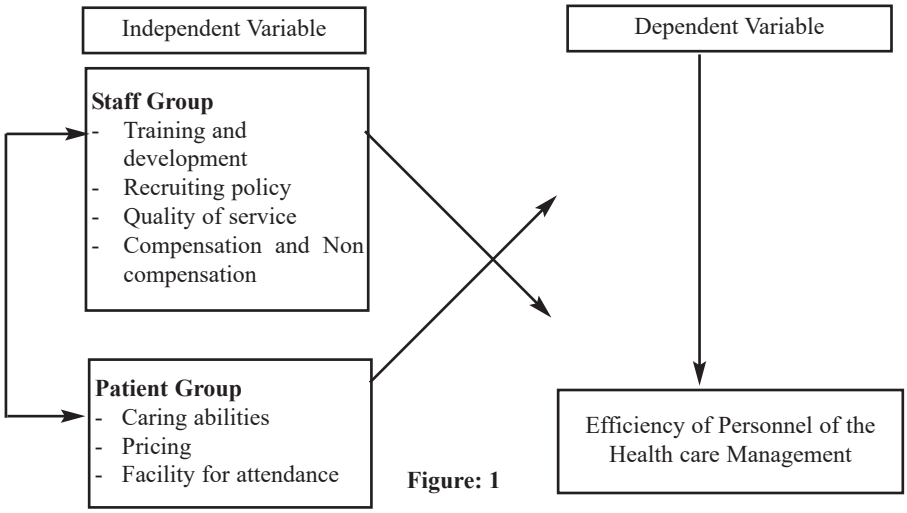

Figure: 1

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:

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

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

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

Reliability test persented in Table 3 indicate the Independent variables are highly related to the underlying dependent variable.

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.

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

Table 4: Reliability Statistics

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

8. Regression Analysis

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.

In the regression equation, all the variables are significant. Staff Compensation

Table 5: Model Summary

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

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.

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

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

9. Quantitative Analysis

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

It is observed that out bound medical tourism rose 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 of faith in local hospitals. Another interesting findings of the study is that most of the diagnostic centers and lab tests are charging high

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*

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, problems of attendances are also working as one of the causative factors 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.

Depending on income and nature of diseases, patients visit different countries. As such huge amount of fund flows out of the country. Depending on financial ability as well as connectivity and visa facility, patients along with attendance go to various counties like USA, Canada, Australia, UK, Thailand, South Korea, Malaysia, Saudi Arabia, Singapore and India. However, lower middle class and middle class patients have been going to India for treatment purposes. Table 7 data on outward remittance on medical ground to India and also total remittance from Bangladesh from the year 1986-87 to 2008-09:

Unofficially march more amount flows out from Bangladesh for health leadment. All the respondents informed that they did not declare the amount in order 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. In our survey of 500 patients most respondents told us that nurses, brothers and ward boys act like mussel. It is evident the study that in most cases nurses, brothers and ward boys in do not care doctors and avoid providing good services in different govt. medical hospitals and health centers. Moreover, most doctors' in govt. hospitals are engaged in politics supporting actively the two big political parties for getting good posting as well as other facilities in the regime of the party in power and also getting shelter for rampant corruption. They even forget to do welfare of the patients. There is no accountability 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 either. Rather they charges huge

amount of money without ensuring good treatment and quality services. Quality of medicine is also a problem for Bangladesh. Patients complained that that due to the absence proper monitoring some companies are produeing lower quality medicine and doctors bribe from low graded medicine companies to prescribed these lower quality medicines.

Patients also commented that they found with utter surprise that the number of diagnostic centers Bangladesh is 2/3 times higher in India. When we verified it from 5 good diagnostic centers situated at Dhaka City and Chittagong City they told that they have to pay 25-45% commission to the Doctor who refered them to the patient. Moreover, it is alleged specialised doctors are used to see 80-200 patients on an average per day. As a result they cannot give much time to the paticnts. Moreover, monthly income of a few specialized doctor is from Bangladesh Taka 1 crore to 1.5 crore. Another complain from the patients is that a lot of pathological reports in Bangladesh differs from those of quality diagnostic centers abroad.

Private medical colleges charge admission fee for studying MBBS from 0.9 to 1 Million Bangladesh Taka and when a person finishes his/ her MBBS degree he/she has to pay 3-6 Million Taka. So when a student becomes doctor a his/her attitude is to raise income at any cost. Moreover, admission criteria are not up to the mark. The eviteri doe not favour students who come from “O” level and “A” level but help those who come from Bengali medium schools. 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 the number of specialised doctors is small. Furthermore, patients allege that in Bangladesh in rare cases 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 from different corners of the country to the Dhaka city for medical purpose suffer from residense problem as well as security and safety problem. There are middlemen in the govt. hospitals that suck poor patients’ money. Bangladeshi patients travell to India for medical tourism not receive 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 hamper treatment. Even one ex director general of Health services was allegedly involved in occupying a garage through using muscel power and

cartel with some persons at Dhanmondi residential area of Dhaka under the banner of the apartment society. If unethical practice is done a person who served as a Director General of health services and who is still working as a Professor of a Govt. Medical college then what sort of treatment one can expect from such doctors?

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 the number of registered doctors is 12359, the number of nurses is 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 number of registered physicians is 51,993 and then of registered dentists is 3913, but the 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 the organization and work in different private clinics. Gonoshasthaya Samajvittik Medical & Dental College does not normally appoint any ward boys, which creates tremendous hindrance to getting good services especially for male patients 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 is very poor. Though the hospital tries to provide services to poor people in different areas through its health centers the treatment and health related services are very poor worse than remote govt. health centers or govt. hospitals. From the field study it is observed that Gonoshasthaya Samajvittik Medical & Dental College needs proper managerial skill and compensation packages for their doctor, nurse and other staff.

Govt. of Bangladesh has recently declared a Health Policy. But it needs to be holistic nature. Only giving more emphasis on Doctors duty is not sufficient as other related services such as nurses, brothers, biotechnologists and ward boys and moreover hospital management are weak in Bangladesh. As such huge amounts of money flow out of 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 decarging 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 his father's treatment for around 40 days how nurses were gossiping with young doctors in the intensive care unit of the cardiovascular department. None is there to take action against them. Individualistic attitude and personal gain is the key factor for doctors and nurses and specialst doctors neglect the patients.

Recently some good Hospitals have been established like Apollo, Square, United, Lab Aid, Popular, Sikder Medical college hospital etc in Dhaka city. But the number of good hospitals and diagnostic centers are too scanty to the highly densely populated country like Bangladesh where according to UNICEF report (2010) 16.4 crore people Live. Some good private hospitals were also established in Chittagong, Sirajgong etc. From the study it is evident that public 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 population density have been established in Bangladesh.

11. Concluding remarks and Policy Implications

The government may put emphasis on the development of the health sector of Bangladesh. It may encourage establishing joint venture medical colleges in collaboration with foreign medical institutes/colleges. Moreover, private entrepreneurs can invest in this sector as it still remains an unexplored market. Besides, the 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 government policy. Career path of young doctors should be properly redesigned. Moreover, social prestige of nurses in the society should be upgraded. Corruption in government as well as private hospitals should be removed. False doctors should get proper punishment. Quality maintenance of drugs should be ensured. Diagnostic centers should stop bribing processes.

Hongoro and McPake (2004) observation that human resources are in very short supply in health systems is 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 as part of Vision 2021.

Turner's (2011) caution about maintenance of standards should be perused with care in order ensure that patients and their associates get proper information of

medical tourism for taking appropriate choices. There are no other alternatives but to maintain quality assurance in this sector.

Outbound medical tourism arises due to lack of efficient and effective health care system. In this connection Hossen (2001) suggestions for better health care practices, partnership between public and private sector may be arranged.

Private Universities except Gonoshasthaya Samajvittik Medical & Dental College under Ganyo Shasthya university of the country should come forward to open different sorts of education related to Medical science courses. Some private universities have opened only Master in Public health course. Even physiotherapy course cannot be given permission to open or continue in private medical Collages by the Health ministry.

Not only decreasing outbound medical tourism but also increasing inbound medical tourism in Bangladesh may be a part of Vision 2021 by the government of Bangladesh when the country will observe fifty years of independence of the country. 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 ensured as a top priority, in mid and long term planning. Contingency planning for developing health care industry should be properly implemented. This will help save valuable foreign exchange through decreasing outflow of foreign exchanges due to outbound tourism. Moreover in the inflow of foreign exchange earnings from inbound medical tourism in the country will help accelerate growth of national income of the country.

References

1. ADB 2011, "Economic Analysis Health Human resource sector development program", (RRPVIE 40354-01), http://www.adb.org/Documents/ RRPs/VIE/ 40354/40354-01-vie-ea.pdf (access on 23rd June the website, 2011)
2. Ali, MM and Medhekar, A 2012, "A Cross-Border Trade in Healthcare services: Bangladesh to India, *Presidency University Journal*, Vol. 1, No. 1, January.
3. Ara, F 2008), "Key Issues to Health Governance in Bangladesh", Paper to be presented at the International Conference on '*Challenges of Governance in South Asia*' in Kathmandu, Nepal, December 15-16.
4. Bangladesh Bureau of Statistics (2011), Statistical Pocket Book of Bangladesh p-375
5. Cundiff, KR 2008, "Life Expectancy, Health care, and economics", *Southwest review of International Business,* Vol. 19, No. 1, March, pp. 145-149.
6. Daily Kalayer Khanta 2011, 30th April
7. Financial Express (Bangladesh) 2012, 4th May
8. Financial Express (Bangladesh) 2012, 10th June
9. Haque, R and Bhuiyan, S M 2005, "Recent Debates on Heath Sector reforms: Some reflection on Key policy issues", *Social Science Review, The Dhaka university Studies*, Part-D, Vol. 22, No. 1, June, pp. 131-146

   http://expertscolumn.com/content/medical-and-health-sector-bangladesh-are-threat (accessed on 14th March,2012) http://www.novasans. com/blog/ 2011/06/ (accessed on 25th October 2011)
10. Hongoro C, McPake B *2004,* "How to bridge the gap in human resources for health", *The Lancet* , Vol. 364, pp. 1451–56
12. Hossen, MA 2001, "Beliefs and Practices relating to health care in Developing countries", *Social Science Review, The Dhaka university Studies*, Part-D, Vol. 22, No.1, June, pp. 247.-256.
13. Islam, A and Akhter, S 2011, "Introducing User charges in Government Health facilities in Bangladesh: Policy and Implementation", Social *Science Review, The Dhaka university Studies*, Part-D, Vol. 28, No. 1, June, pp. 43-56.
14. Johnson, S 2000, "Building Capacity In Human Resources Management For Health Sector Reform And The Organizations And Institutions Comprising The Sector", the LAC Health Sector Reform Initiative by the Family Planning Management Development Project (FPMD), a project of Management Sciences for Health (MSH) in Boston, Massachusetts.
15. Kabene, SM, Orchard, C, Howard, JM, Soriano, MA and Leduc, R 2006, "The importance of human resources management in health care: a global context, http://www.ncbi.nlm.nih.gov/pubmed/16872531 Kanchanachitra, DC et al. 2011,"
16. Kunitz,SJ 2007, *The Health of Populations-General Theories and Particular Realties*, Oxford University Press, Inc. New York, pp.135-185

17. Lee, C 2006, Medical tourism, an innovative opportunity for entrepreneurs, *Journal of Asia Entrepreneurship and Sustainability*, Volume III, Issue 1, pp. 110-123

18. Lee, C, Spisto, M 2007, "Medical Tourism, the Future of Health Services", 12-ICIT 9-11/4/07 in RoC Going for Gold ~ Best Practices in Ed. & Public Paper No. 07,p.1-7

19. Mahmud, S 2008, "Health care provision and Consumption in Bangladesh" in "Emerging issues in Bangladesh Economy- A review of Bangladesh's Development 2005-06', Rehman Sobhan (Series Editor), Center for Policy Dialogue and The University press Limited, pp. 323-359.

20. Vijay NM 2011, "Medical tourism - Subsidising health care for developed countries"; http://www.twnside.org.sg/title2/resurgence/207-208/cover9.doc *(accessed in web 2011)*

21. Noe, RN et al. 2003, *Human Resource Management-Changing a competitive advantage*, McGraw-Hill-Irwing, Boston, 4th edition, pp. 656-663

22. Padmanabhan, A, 2011, A Study of the Phenomenon of Medical Tourism with in the Context of the General Agreement of Trade in Services (GATS), SSRN-id1941709, pp.1-21,

23. Pocock, NS and Phua, KH 2011," Medical tourism and policy implications for health systems: a conceptual framework from a comparative study of Thailand, Singapore and Malaysia", *Globalization and Health*, pp.1-12

24. Salahuddin,T ad Nisar, MY 2007, "Comparing incentives and productive efficiency in Government health services: A suggestion document for Government of Pakistan, 9th South Asian Management forum, Proceedings organized by North South University, Dhaka and South Asian association for regional cooperation, 24-25 February, pp. 447-453.

25. Snyder, J, Dharamsi, S and Crooks, VA 2011, "Fly-By medical care: Conceptualizing the global and local social responsibilities of medical tourists and physician voluntourists", *Globalization and Health*, http://www.globaliza tionandhealth.com/content/7/1/6

26. Tattara, G 2010, "Medical tourism and domestic population health". Working Papers, Department of Economics, C A ' Foscari University of Venice No. 0 2 /WP/2010, pp.1-16

27. Turner, L 2011, "Quality in health care and globalization of health services: accreditation and regulatory oversight of medical tourism companies." *International Journal for Quality in Health Care,* December, Vol. 23, pp. 1-7

28. Waikar, AM, Cappel, SD, Tate US 2011," Challenges and Opportunities for Developing Countries from Medical Tourism", *Journal of Business and Economics*, Volume: 2, No. 5, pp. 325-331

29. Young, T. Kue 2005, *Population Health-Concepts and Methods*, Oxford University Oress, Inc., New York, 2nd edition, pp.296-323