



Investigating the Key Drivers of Bangladeshi Individuals Pursuing Medical Care Abroad

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ABSTRACT

Purpose: This study aimed to identify the primary causes that prompt most Bangladeshi individuals to seek medical care overseas.

Methodology: A standardized questionnaire was designed for this study, and data were collected from 160 participants. Data were collected using online and offline surveys. Descriptive and regression analyses were then performed. We conducted an ANOVA test, correlation analysis on independent variables (psychological factors, social factors, economic factors), paired t-test for hypothesis testing, and crosstab analysis on age, gender, and education using SPSS software.

Findings: This study revealed that Economic and social aspects are the primary factors driving Bangladeshi individuals to seek medical care overseas. Economic considerations have a more significant influence on Bangladeshi individuals' decisions to seek medical care abroad than social considerations.

Practical Implications: The findings of this study can aid policymakers and healthcare experts in the Bangladeshi government in recognizing areas that require renovation in the healthcare system, with the objective of discouraging the practice of outbound medical tourism.

Originality/Value: This research supports Bangladeshi stereotypes regarding overseas treatment, and will assist in addressing medical tourism issues in Bangladesh.

Limitations: This study may boost Bangladeshi medical businesses. However, inadequate disclosure and limited public data hindered this research. After the COVID-19 epidemic, medical tourism has increased. The current scenario may differ in coming years.

1. Introduction

Access to treatment is fundamental. Every government must guarantee this right to all citizens. The prevailing mistrust of Bangladesh's medical professionals and services among the general public is a noteworthy issue. Consequently, medical tourism is becoming increasingly popular. The primary and secondary goals of this study are to identify specific areas in the healthcare system that require modernization and to propose practical changes to prevent medical tourism.

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Patient satisfaction is a valuable metric for establishing quality standards for health care services. Concerns regarding the quality of healthcare services in Bangladesh have resulted in a lack of trust in healthcare practitioners, decreased use of public health facilities, and an increase in the number of people seeking treatment in overseas hospitals (Mohiuddin, 2020). Medical tourism has gained significant popularity throughout the country. In terms of financial gains and patient retention, Bangladesh has trailed other Asian nations in the medical sector. This issue is rooted in the fundamental framework of the country's medical education system. High costs and disdain for patient welfare are serious concerns. Furthermore, Bangladesh lacks specialised medical equipment. Several Asian countries, including China, India, Singapore, and Thailand, have been at the forefront of developing health tourism as a way to generate foreign exchange. They have employed various approaches and techniques to engage with patients. Bangladesh has potential, but it also trails these nations in this field (Alauddin et al., 2021).

According to statistics from the Bangladesh Outbound Tour Operators Forum, over 800,000 people from Bangladesh travel abroad each year to receive medical care, with India being their top choice. Other notable medical tourism destinations for Bangladeshis include Singapore, Thailand, and Malaysia (Jahan & Jahan, 2024). In 2022, the United States of America accounted for the largest number of international tourists visiting India, with a total of over 1,373 thousand visitors. By 2022, American visitors surpassed the number of tourists from other European and South Asian countries. In 2022, Bangladesh, the United States of America, and the United Kingdom were the top three countries in terms of tourist arrivals in India (India: Foreign Tourist Arrivals by Country of Origin 2022; Statista, 2023). Bangladesh was the second-largest source of tourists to India between 2020 and 2024, contributing 17.95% of all foreign visitors to the country according to the Indian Tourism Ministry. The number of visitors is increasing annually. Every day, an average of 1,000 Bangladeshis travels to India for medical treatment (8th International Health Tourism & Services Expo 2025, n.d.) Based on reports, over 85% of Bangladeshi patients seeking medical treatment abroad go to India, while approximately 10% choose Thailand. The remaining patients choose for Singapore, Malaysia, the UK, USA, and China ("Bangladeshi Patients Spent THB6. 7bn in Thailand in 2019," 2022) In the eight-month period from January to November 2022, the Indian High Commission in Dhaka granted Indian visas to nearly one million Bangladeshis, including 273,000 medical visas (Dey, 2023).

Bangladesh's neighbouring country, India, is a popular choice for medical care. Bangladesh accounted for a sizable share of medical tourists travelling to India in 2020 (54.3%), with Iraq (9%), Afghanistan (8%), the Maldives (6%), and a group of African nations (4.5%) following closely (R, 2021). Doctors' conduct is the primary factor influencing people's inclination to seek medical attention in India. Doctors in Bangladesh face much criticism for their seeming disregard for patients' needs. A few seasoned medical professionals in the city centre do not even give their patients five minutes. Due to shortcomings in Bangladesh's legal system, medical professionals and institutions could not be afraid of the consequences of their carelessness, which would cause patients to suffer rather than receive necessary treatment (Zakaria et al., 2023). Many Bangladeshis choose to receive medical care in India and spend a substantial amount of money each year. According to Pical's (2023) recent figures, there was an 83% surge in the number of medical tourists from Bangladesh visiting India between 2018 and 2021. Approximately 54% of foreign patients travelling to India for medical care come from Bangladesh. According to data from the Indian Tourism Ministry (Dhali, 2021), the number of Bangladeshis travelling to India for medical care is increasing.

Based on the reports and publications referenced in this paper, it is clear that India is Bangladeshis's preferred destination for medical treatment. In addition, a substantial number of Bangladeshis elect to undergo outbound medical treatment in the United Kingdom, the United States, China, Malaysia, Singapore, and Thailand.

Despite the Bangladeshi government devoting a substantial portion of its annual budget to healthcare, the allocation falls short of adequately addressing the demands of the local population. Surgical costs and a dearth of qualified and experienced healthcare personnel, in addition to the high cost of medical and diagnostic apparatus, represent substantial challenges for privately held organisations ("Why Bangladeshi Patients Prefer Outbound Medical Travel? An Analytical Study," 2021). The lack of adequate healthcare systems in developing countries such as Bangladesh forces affluent individuals to pursue contemporary medical care (Mahmud et al., 2021).

Resource allocation remains a significant obstacle for the Bangladeshi healthcare system, despite significant advancements. In the industry, there is a severe shortage of medical professionals such as physicians and nurses. The World Health Organization reports that Bangladesh has one of the lowest doctor-to-patient ratios in South Asia, at 5.26 per 10,000 individuals. The scarcity of medical personnel may place an undue burden on healthcare providers, particularly on those employed in public institutions. This can lead to instances of unprofessional conduct and decline in patient confidence (Hossain, 2023). Furthermore, pharmaceutical accessibility remains limited and price discrepancies persist between the public and private sectors. In the public sector, medication scarcity frequently necessitates patients to purchase their medications privately through personal funds. Due to the limited options for prepayment and risk aggregation, this is especially likely to lead to catastrophic expenditures and/or inadequate treatment for low-income households (Kasonde et al., 2019).

Bangladesh does not adhere to ethical standards when administering medical admission tests. This establishes a foundation for future inefficiency in the national medical system. In Bangladesh, undergraduate medical education faces several issues. There was insufficient clinical experience, ambiguous internship programs, competency-based training, or a carefully thought-out curriculum. Most recently graduated medical professionals have always upheld moral principles and stated that they would like the curriculum to include a required module on medical ethics and professionalism (Jahan & Flora, 2020).

These difficulties can be grouped into two categories, push and pull. Corruption, lack of medical expertise, unavailability of specialised treatment, high costs, and unethical practices are examples of push factors. Consistent with emerging medical tourism literature, the pull factors included experienced physicians and surgeons, high-quality nursing care (both before and after surgery), affordable surgical procedures, cutting-edge medical technology, treatment options, and secure medical facilities.

Research on Bangladeshi patient satisfaction in medical tourism is extensive, but few studies have explored the reasons for Bangladeshi participation in this activity. Moreover, none of the studies reviewed selected respondents entirely at random from among the native Bangladeshis. This study seeks to determine Bangladeshi's current overall impression of medical treatment overseas and identify the factors that influence this view. Our study provides decision makers with insights into the practical aspects of medical care. This study will assist in addressing medical tourism issues in Bangladesh.

2. Literature Review

2.1 Overall Industry Scenario

Medical tourism has become increasingly popular in Bangladesh. The inclination to seek medical treatment abroad is a prevalent trend. Asian nations, including India, Thailand, Malaysia, and Singapore, are popular choices for Bangladeshi citizens seeking medical care. The main factors contributing to this situation are inadequate healthcare services, exorbitant costs, and a lack of access to specialized medical treatments and facilities.

Human health is an inalienable quality, and the term "health" designates a state of whole emotional and physical well-being. The idea of travelling far and wide in search of better medical care is known as medical tourism. Many developing nations with the capacity and potential to meet these

expectations have become interested in the globalization of the healthcare industry and the recent surge in demand for affordable, high-quality treatment (Rabbi & Nekmahmud, 2021). Incompetent or dishonest medical professionals can murder or mistreat the patients. Reputable physicians also harm their reputation. Doctors treat patients poorly when charging exorbitant fees in private offices. Everyone is offended by commercial interest. This process violates ethical standards in medicine. The ethical standards of medicine are violated when doctors accept costly gifts from pharmaceutical companies or are paid by diagnostic centers to recommend treatment to patients. However, such acts do not seem to disturb anyone today (Issue-I 2019).

The infrastructure and environmental conditions of Bangladeshi healthcare facilities, including private clinics, are inadequate. Notwithstanding this, several private clinics have maintained a consistent commitment to hygiene and delivered exceptional quality. Sub-district public hospitals, such as UHC, have lagged behind in these locations. Moreover, out-of-pocket healthcare expenses that people pay for themselves sometimes constitute a large portion of the household budget, which could lead to catastrophic health expenditures (CHE). People frequently have to cut back on their total household consumption, take out loans, or ask for help from others in order to pay for these medical expenses (Sarker et al., 2023).

A staggering 84% increase in the number of Bangladeshis seeking medical treatment in India has made it their first choice of health care. According to Prashant Sharma, the head of the Indian Chamber of Commerce's health committee and managing director of Charnock Hospital, 2,470,000 medical tourists from Bangladesh visit India every year and spend a significant amount of money on Taka. Bangladeshi prefer India as their primary destination for medical treatment. According to India's tourism ministry, Bangladesh sends more than 2.5 million medical tourists to India every year, who collectively spend over \$500 million in the country. There is a growing inclination among Bangladeshis to seek medical care in surrounding countries annually (HOSSAIN, 2023).

Bangladesh's lack of technical advancement contributes to a major healthcare problem owing to its corruption and costly system. For the last 20 years, many Bangladeshis have travelled to neighbouring nations, such as India, Malaysia, Thailand, and Singapore, for medical care (HOSSAIN, 2023).

Over the last 10 years, allocation to the health sector in Bangladesh has been less than six percent of the entire national budget. Experts recommend that this percentage should be at least 15% to provide accessible quality services to everyone (Sujan, 2022). Since 1990, the government's healthcare budget in Bangladesh has exhibited a consistent upward trend. While per capita health expenditures have risen in Bangladesh, the proportion of the health sector budget in relation to the entire national budget has declined during the past four decades (Sultana et al., 2024). Compared to the projections in the eighth five-year plan, Bangladesh has allocated fewer resources to the education and health sectors. In contrast to the anticipated ADP allocation of 11.1 %, the health sector received 6.16% in this fiscal year. From fiscal 2020-21 to fiscal 2024-25, the eighth five-year plan is executed. The country is not prepared to provide benchmark quality and access to affordable public healthcare for everyone on the supply side. There are many medical schools and hospitals in Bangladesh, but the quality of their health services is low. The best doctors migrate to foreign countries to achieve better working conditions, medical facilities, and remuneration (Byron 2024).

Bangladesh has a shortage of quality, trustworthy healthcare services and organisations to meet demand. Given the expanding middle class, the supply gap between the poor and affluent care is large. Despite this growth, most private hospitals and clinics provide substandard care. More than 40% of private hospitals, clinics, blood banks, and diagnostic institutions remain unregistered by the government. Furthermore, most people in Bangladesh are displeased with the state of hygiene in their medical facilities. People in Bangladesh avoid hospitals for a variety of reasons, including inadequate hygiene management, filthy floors, overcrowding, noise, "hostile behavior by nurses and doctors," and escalating medical expenses. Additionally, the air is foul-smelling and overcrowded, with a persistent odour (Mohiuddin, 2020).

Bangladesh has lost \$3.5 billion in revenue, because 700,000 people seek medical care overseas annually. The average annual medical cost per person in Thailand, India, Malaysia, and Singapore is \$5,000 or Taka 550,000 in the local currency (Zakaria et al., 2023). The judicial system in Bangladesh is ineffective, leading to physicians and hospitals not being held accountable for their carelessness, which causes patients to suffer rather than receive the appropriate treatment. Political leaders and physicians seeking medical treatment overseas undermine public faith in local health care professionals (Zakaria et al., 2023).

2.2 Psychological Factors

Several psychological factors influence Bangladeshi citizens seeking medical care in another country. Perceiving better treatment in other nations, lack of faith in local healthcare providers, and experiencing a lack of empathy among local physicians and nurses are key psychological variables. Each of these factors plays a crucial role in influencing a patient's choice to seek medical care overseas.

In Bangladesh, physicians' principal responsibilities are multifaceted. A senior physician assumed the dual responsibilities of a clinical school instructor, hospital superintendent, and private consultant. A notable percentage of medical professionals were classified as either clinical or private. In addition, clinicians have competing interests because they are salaried or receive commissions from diagnostic centres. Indirectly, physicians aid pharmaceutical companies in product marketing through the prescription of said products to patients, for which they receive a commission from the companies in exchange for the expenses incurred.^{15,16} This discipline in the medical field leads to such complications and disrupts the patient-physician relationship (Ahmed, 2021).

Healthcare provision in Bangladesh is substandard in both public and private sectors. Insufficient evaluation of the quality of care provided by providers, inadequate application of skills, and limited professional knowledge are the prevalent issues. There is no formal arbitration authority in Bangladesh for complaints lodged by health care providers. Complaints and disputes are resolved autonomously by hospital or clinical authorities in the absence of involvement from government bodies or legal entities. Furthermore, neither human rights review bodies nor specialised mental health authorities inspect mental health facilities (Nuri et al. 2019).

Bangladeshi people widely mistrust the healthcare system because of resource scarcity and systemic failures. This mistrust is exacerbated by the fact that medical professionals are hesitant to treat patients because of inadequate protective equipment. Despite having a moral obligation to treat and serve patients, physicians are obligated to safeguard their families. This predicament exposes healthcare professionals to circumstances that can induce moral distress (Hossain 2020).

H1: *Psychological factors drive Bangladeshi people to seek medical care overseas.*

2.3 Social Factors

The study of Bangladeshis seeking medical treatment abroad is significantly affected by various social factors. The critical determinants of social factors are inaccurate diagnoses, substandard performance by local physicians and nurses, and a lack of comprehensive medical services. These factors significantly affect Bangladeshis propensity to seek medical treatment abroad.

Serious allegations concern the public and private healthcare systems in Bangladesh regarding improper disease treatment, which has resulted in patient fatalities, injuries, or disabilities. Daily newspapers disseminate news from virtually every district in the nation. Although not a novel occurrence, widespread complaints have been reported. This suggests that incorrect treatment is pervasive and recurring, with no apparent resolution in sight ("Wrong Treatment or Negligence", n.d.).

There were occasions when it became evident that the physicians had neglected treatment. Such occurrences at Mugda Hospital, Dhaka, included operating on the right leg of a man rather than his

fractured left leg and operating on the gallbladder of one Parvez based on the test results of another Parvin. The BMDC has received approximately 200 complaints in the past five years regarding patient fatalities caused by improper treatment and negligence (Sun, 2024).

Undergraduate medical students are required to study many fields simultaneously, because of the comprehensive nature of the program. The present medical academic curriculum offers information in a restricted way and fails to provide students with the abilities needed to comprehensively examine, assess, and approach patient health. The rapid expansion of numerous public and private medical colleges in Bangladesh, along with a notable lack of skilled personnel, has led to apprehensions regarding the consistency of the country's medical education system. There are also concerns about the quality and oversight of medical colleges, whether public or private (Report, 2021)

Every patient often expects a high-quality treatment. Death and lasting disabilities may result from misdiagnoses. This may occur through several means, such as inaccurate diagnosis and delayed administration of appropriate therapy. Several factors contribute to misdiagnosis. Some misdiagnoses originate from human errors, whereas others stem from malfunctioning equipment.

However, most diagnostic institutions and hospitals in Bangladesh lack accreditation. However, they do not guarantee a quality level. In accordance with the accreditation system, institutional resources undergo periodic evaluations to maintain service quality based on the established requirements. St. Accreditation is a tool used to enhance quality, and is not a goal.

H2: Societal factors positively influence Bangladeshi citizens seeking medical care overseas.

2.4 Economic Factors

Several economic, psychological, and social factors influence Bangladeshi people abroad to seek medical treatment. The primary reasons for this are unnecessary medical testing, the unavailability of special treatment, and medical mismanagement. This study aimed to determine the influencing rate of these factors for Bangladeshi people to go abroad for medical treatment.

The multifaceted economic consequences of medical tourism in Bangladesh provide insight into the possible benefits and drawbacks associated with this growing trend. An outlay of foreign currency by Bangladeshi people surpassing \$2 billion annually for medical treatment abroad represents a substantial amount of funds that could have been invested in the domestic economy. The considerable disbursement of capital underscores the potential economic ramifications that could ensue from neglecting to allocate these funds to regional healthcare and related sectors (Jahan & Jahan, 2024).

Bangladeshis delayed medical treatment until emergencies. Government data show that inflation in July climbed from 5.36% in 2022 to 7.48 %. Other government data found that Bangladeshi healthcare spending per capita jumped by 60% from BDT 2,862 to BDT 4,578. The Health Economics branch of the Ministry of Health and Family Welfare revealed that Dhaka spent the highest per capita in 2020 at BDT 7,039. Mymensingh had the lowest health expenditures (BDT 2,060 in the sixth Bangladesh National Health Accounts Report. In 2020, Bangladeshis spent a BDT of 77,734 crore on healthcare, up from 58,442 in 2015. The survey revealed that 69% of health expenditures were funded by people in 2020, up five years earlier. The 2015 out-of-pocket payments were BDT 29,985 crores, and 53 and 274 crores in 2020. The study found that 64.6% went to medicine, 11.7% went to diagnostics, and 10% went to hospitals (Zishan, 2023).

Corruption, bad priority setting, and poor execution prohibit most of the yearly healthcare budget from reaching target individuals. This combined effect is a serious concern regarding access to care. Owing to funding issues, many community clinics are idle, whereas public medical colleges and district hospitals are overloaded and fail. This encourages people, especially low-income groups, to utilise subsidised government facilities to employ private healthcare providers, straining their resources. Every year, 700,000 people spend the Taka 350 crore on international healthcare. Patients flying abroad pay an average of Taka 5.5 lakh, although intricate and lengthy surgeries may cost more. The

treatment costs in Singapore may be 10-15 times higher than those in Bangladesh and 2-3 times higher than those in India. Even wealthy people may find international therapy expensive (Shamim, 2024).

For the past two decades, Bangladesh has allocated less than 1% of its GDP to health, the lowest percentage among the 46 least developed countries. As a result, families are compelled to exceed their financial means to afford treatment for non-communicable diseases that necessitate prolonged hospitalisation and care (Tajmim, 2022).

In early 2023, the sixth Bangladesh National Health Accounts showed that most Bangladeshis will pay more than two-thirds of their healthcare costs. According to the Bangladesh National Health Accounts from 1997 to 2020, out-of-pocket expenditures increased from 62% in 2012 to 68.5 percent in 2020, which is alarming. Given the existing healthcare expenditure scenario, the government promises to reduce out-of-pocket healthcare costs by 32% by 2032 (KHAN, 2023).

As stated by the World Health Organization, health spending is deemed catastrophic if medical costs exceed 40% of a family's income, after accounting for food expenses. Recently, 26% of Bangladeshi households have allocated a substantial portion of their budget to hospitalisation expenses. Cancer accounted for 50% of the CHE cases, with liver disease (49.2%) and paralysis (43.6%). The incidence of Catastrophic Health Expenditure (CHE) during hospitalisation has increased from 14.2% of the total household consumption expenditure (THCE) in 2010 to 24.6% in 2016 and 26.1% in 2021. Increasing hospital expenses for serious illnesses such as cancer causes financial strain on families owing to inadequate health funding in the national budget and limited insurance coverage (Sheikh et al., 2022).

A considerable proportion of patients from Bangladesh are unwilling to accept substandard health care. Therefore, they travel overseas to clinics. The domestic medical services of the nation have yet to achieve global benchmarks. Serious patients are frequently mistreated because of the lack of qualified physicians to administer appropriate treatment. Foreign medical facilities can fulfil the needs of critical patients.

H3: *Economic reasons contribute to a higher percentage of Bangladeshi individuals seeking medical care overseas.*

2.5 Theoretical Framework:

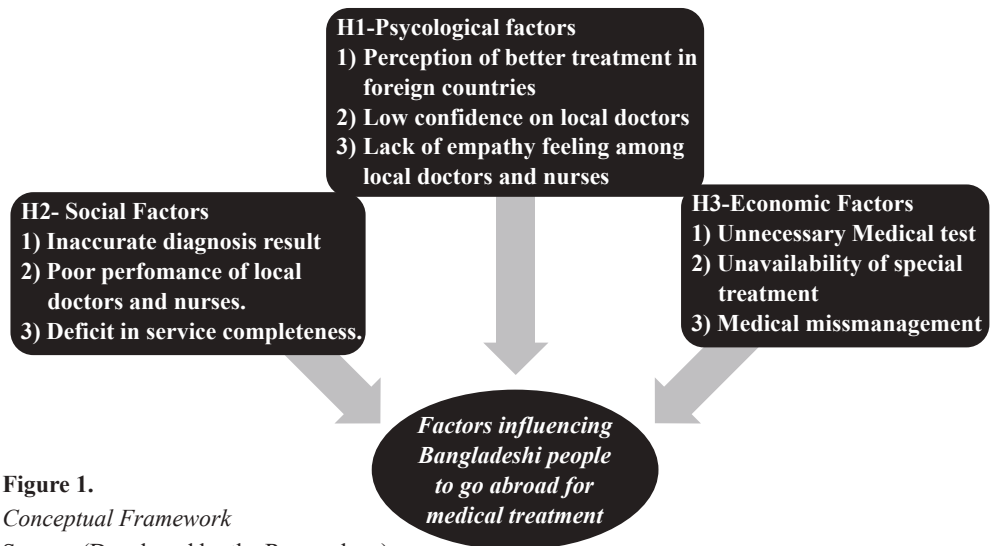


Figure 1.

Conceptual Framework

Source: (Developed by the Researchers).

We divided the reasons why Bangladeshis visit other countries for medical care into three distinct factors. Psychological factors affect how Bangladeshis think and feel about their country's health care system. Social factors underscore the social gap in the services offered by currently established healthcare facilities in Bangladesh. Economic factors represent the general perception of Bangladeshi individuals about the cost-effectiveness of seeking medical treatment from hospitals and doctors in Bangladesh compared to overseas medical treatment.

3. Methodology

This study is exploratory in nature, in terms of its aims. This research used a Random Sampling approach for sample selection. The survey questionnaire assesses the psychological, economic, and sociological aspects that influence Bangladeshi individuals seeking medical care overseas. We used six statistical procedures for data analysis to ensure precise study results: Cronbach's alpha, descriptive frequencies, crosstabs, Paired T test, regression model, and correlation. To determine whether the sample size was viable, we used descriptive analysis based on gender and the statistical sample size determination approach.

3.1 Data Collection

Primary data were collected through a structured questionnaire that was completed by approximately 160 respondents, both online and offline.

By 2024, almost 700,000 Bangladeshis are expected to go abroad each year to receive medical treatment. After calculating the margin of error, we used it to support the size of our sample.

$$\text{Margin of error} = \left(z \times \frac{\sigma}{\sqrt{n}} \right) \% = \left(1.28 \times \frac{500}{\sqrt{160}} \right) \% = 5\%$$

n = sample size, σ = population standard deviation, z = z-score

For 80% confidence level z score is 1.28

$$\text{Sample size} = \frac{\frac{z^2 \times p(1-p)}{e^2}}{1 + \left(\frac{z^2 \times p(1-p)}{e^2 N} \right)} = 164$$

N = population size, e = Margin of error (percentage in decimal form), z = z-score, p = Percentage Value (as a decimal).

Only 160 of the 250 native Bangladeshis who answered the survey completed it. Since the number of people travelling overseas for medical care is approximate, we used 160 respondents rather than 164.

To obtain a comprehensive understanding of medical tourism in compared to local healthcare facilities, respondents are randomly selected from the middle class, upper middle class and higher class population of Bangladesh. Selection criteria was based on only Bangladeshi national from the middle class, upper middle class and higher class citizens. Survey was conducted in both online and offline approach. The initial location for the offline survey was Dhaka, the capital city of Bangladesh. In addition to the offline survey, an online survey was implemented in districts other than Dhaka City to broaden the survey and ascertain the stereotypical opinions of Bangladeshis regarding medical tourism.

The first section of the questionnaire focused on gathering the demographic information. The second section consisted of multiple-choice questions regarding the factors influencing Bangladeshi individuals seeking medical treatment abroad, as well as questions about their personal perceptions and knowledge of local and foreign medical services.

3.2 Data Analysis

The acquired data were evaluated using various tools and methodologies to achieve the goals of the study. These consist of Cronbach's alpha, descriptive frequencies, crosstabs, paired t-tests, regression models, and correlations. We used approximately six statistical methods for data analysis to ensure precise study outcomes. Researchers have long been interested in medical tourism. Medical tourism refers to the practice of individuals visiting other nations to receive medical treatment. Medical tourism relies on several factors, including psychological reasons, such as seeing better treatment abroad, lack of faith in local healthcare providers, and lack of empathy from local physicians and nurses. Social variables included incorrect diagnoses and poor performance of local medical professionals. Economic reasons include excessive medical testing, lack of access to specialized treatments, and medical mismanagement. The data for all independent variables were assessed using Cronbach's alpha reliability test. This test assesses the dependability of the survey.

Descriptive frequencies were used to determine the demographic variables. We used crosstabs to determine the correlations between the demographic factors and the dependent variable. We used a Paired T-test to determine the validity of our proposed hypothesis. We used a regression model to determine independent factors that were significantly associated with the dependent variable. We also conducted a correlation analysis to determine the link between the independent variables.

4. Analysis and Discussion

4.1 Demographic Factor Analysis

Demographic variables are human traits used to gather and analyze data from the general population. Prior to the investigation, we identified some demographic parameters from the standpoint of Bangladesh, including gender, age, income, and profession. Demographic statistics were evaluated using the following frequency table.

4.1.1 Gender

Table 1.

Gender Analysis of Respondents.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	87	54.4	54.4	54.4
	Female	73	45.6	45.6	100.0
	Total	160	100.0	100.0	

Source: Author Calculation

45.63% of respondents were female and 54.38% were male, as shown in the survey distribution table.

4.1.2 Age

Table 2.

Age Analysis of Respondents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	20 year or below	7	4.4	4.4	4.4
	21-30 year	47	29.4	29.4	33.8
	31-40 year	56	35.0	35.0	68.8
	41-50 year	34	21.3	21.3	90.0
	Above 50 year	16	10.0	10.0	
Total		160	100.0	100.0	100.0

Source: Authors Calculation

Age: This table shows the distribution of the survey respondents' ages. It also reveals that the largest section comprises people aged 31-40 years. The sample size of the survey was 160. Of the participants, 4.4% were under 20 years old, 29.4% were between 21 and 30 years old, 35.0% were between 31 and 40 years old, 21.3% were between 41 and 50 years old, and 10.0% were above 50 years old.

4.1.3 Marital Status

Table 3.
Marital Status of Respondents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Single	57	35.6	35.6	35.6
	Married	103	64.4	64.4	100.0
	Total	160	100.0	100.0	

Source: Authors Calculation

The data displayed the marital status of the respondents: 35.6% were single and 64.4% were married.

4.1.4 Educational Level

Table 4.
Educational Level of Respondents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	SSC	24	15.0	15.0	15.0
	HSC	55	34.4	34.4	49.4
	Diploma Certificate	2	1.3	1.3	50.6
	Bachelor Degree	60	37.5	37.5	88.1
	Master Degree	14	8.8	8.8	96.9
	Professional Degree	2	1.3	1.3	98.1
	Other	3	1.9	1.9	100.0
	Total	160	100.0	100.0	

Source: Authors Calculation

This Statistics shows the educational level of the respondents, where 15.0% completed SSC, 34.38% completed HSC, 1.25% completed Diploma, 37.50% achieved a bachelor's degree, 8.75% had a master's degree, 1.88% completed professional courses, and 1.24% completed with others.

4.1.5 Monthly Income

Table 5.
Monthly Income

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0 to 20000 TK.	8	5.0	5.0	5.0
	21000 to 40000 TK.	23	14.4	14.4	19.4
	41000 to 60000 TK.	43	26.9	26.9	46.3
	61000 to 80000 TK.	48	30.0	30.0	76.3
	Above 80000 TK.	38	23.8	23.8	100.0
	Total	160	100.0	100.0	

Source: Authors Calculation.

The table above represents the income distribution of our respondents: 5 percent respondents earned Tk 0 to Tk 20,000, 14.4 percent earned between Tk21000 and Tk 40000, 26.9 percent earned between Tk 41000 and Tk 60000, 30.0 percent earn betweenTk 61000 and Tk 80000, and 23.8 percent earned more thanTk 80000.

4.2 Cross Tabulation

Cross-tabulation is a technique used to examine the relationship between two variables. The display is a cross-tabulation that illustrates the correlation between income and occupation. We aimed to investigate the relationship between education and gender, how they affect one another, and how they affect Bangladeshi people's choice to pursue medical treatment abroad.

4.2.1 Educational Level * Gender Cross tabulation

Table 6.

Educational Level and Gender Cross tabulation of Respondents.

Count		Gender		Total
		Male	Female	
Education	SSC	5	19	24
	HSC	28	27	55
	Diploma Certificate	2	0	2
	Bachelor Degree	40	20	60
	Master Degree	10	4	14
	Professional Degree	0	2	2
	Other	2	1	3
Total		87	73	160

Source: Authors Calculation

4.3 Factor Analysis

4.3.1 Co-relation Matrix

Correlation matrices were calculated based on the squared multiple correlations between a variable and the other variables. The Correlation Matrix displays the relationships between psychological, social, and economic elements.

Table 7.

Correlation Matrix

		P1	P2	P3	S1	S2	S3	E1	E2	E3
Correlation	P1	1.000	.389	.228	.129	.296	.064	.118	.117	.329
	P2	.389	1.000	.378	.186	.409	.137	.209	.230	.272
	P3	.228	.378	1.000	.318	.384	.233	.429	.204	.520
	S1	.129	.186	.318	1.000	.385	.281	.377	.323	.287
	S2	.296	.409	.384	.385	1.000	.186	.445	.275	.465
	S3	.064	.137	.233	.281	.186	1.000	.158	.184	.203
	E1	.118	.209	.429	.377	.445	.158	1.000	.435	.536
	E2	.117	.230	.204	.323	.275	.184	.435	1.000	.443
	E3	.329	.272	.520	.287	.465	.203	.536	.443	1.000

a. Determinant = .104

Source: Authors Calculated

4.3.2 KMO & Bartlett's Test

The KMO and Bartlett's tests are important for assessing sample adequacy. KMO evaluates whether the sample size of respondents is sufficient for the study. The KMO values range from 0 to 1. Bartlett's test assesses the statistical significance of replies. To establish the significance level, it is necessary to adhere to a standard for accurate findings, which is determined by comparing it with an alpha value of .05. If the p-value was less than 0.05, the null hypothesis was rejected; if it was greater than 0.05, the null hypothesis was accepted.

Table 8.
KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		0.791
Bartlett's Test of Sphericity	Approx. Chi-Square	351.022
	df	36
	Sig.	0.000

Source: Authors Calculated

The hypotheses are as follows:

H0: *The overall number of responses was insufficient for this study.*

H1: *Sufficient respondents were gathered for this study.*

The significance level of .000 was set at less than the alpha value. Hence, the alternative hypothesis is supported, suggesting that the respondent groups (parents and teens) are statistically significant and 79% appropriate for the research, according to the KMO measure of Sampling Adequacy. We may proceed with our research by holding responder meetings.

4.3.3 Communalities

This is the maximum change in each element, which can be explained by the variables. The Extraction value in the table indicates questions that were not linked to the research. The maximum range of the extraction value was 1. It is preferable to have a value that is extremely close to 1 and higher.

Table 9.
Extraction Method: Principal Component Analysis.

	Initial	Extraction
P1	1.000	.656
P2	1.000	.604
P3	1.000	.484
S1	1.000	.460
S2	1.000	.534
S3	1.000	.239
E1	1.000	.598
E2	1.000	.454
E3	1.000	.591

Source: Authors Calculation

In the communalities table, all component extraction values are below 1. In this step, components with values less than 0.5 were not deleted. Instead, they were identified as problematic and set aside for more extensive study.

4.3.4 Cronbach's Alpha Test

Cronbach's alpha was used to determine the reliability of an instrument by comparing the covariance or shared variance of its elements with the total variance. The underlying concept is that a substantial degree of covariance should be present among the items regarding variance, if the instrument is deemed reliable. The calculation of Cronbach's alpha was equivalent to averaging all conceivable split-half reliability. The most widely used statistical software application is capable of calculating the Cronbach's alpha. It is frequently beneficial to analyze the change in Cronbach's alpha that occurs when a specific item is removed. If removing an item significantly increases Cronbach's alpha, it is possible that the item no longer belongs to the measure.

Table 10.

Case Processing Summary

		N	%
Cases	Valid	160	100.0
	Excludeda	0	.0
	Total	160	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.728	17

The study's estimated reliability statistics for the (17) items yielded a Cronbach's alpha value of 0.728, which signifies internal consistency among the items. Given that the value is positive and greater than 0.5, the scale exhibits exemplary internal consistency.

4.3.5 Total Variance Explained

The number of variables anticipated in our study was determined by explaining total variation. The total column in the explained variance provides the eigenvalue; half of the variance column shows the ratio of variance explained by each component of all variables, and the cumulative preferred column indicates the proportion of variance explained by the first nine components compared to the total variance.

Table 11.

Total Variance Explained

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	3.449	38.317	38.317	3.449	3.449	38.317	2.614	29.047	29.047
2	1.172	13.018	51.335	1.172	1.172	51.335	2.006	22.288	51.335
3	.937	10.414	61.750						
4	.763	8.482	70.231						
5	.724	8.040	78.272						

6	647	7.185	85.457
7	.560	6.221	91.677
8	.427	4.748	96.425
9	.322	3.575	100.000

Extraction Method: Principal Component Analysis.

Source: Authors Calculation

The total variance explained table should ideally include nine variables; however, we initially chose two variables with eigenvalues larger than 1. Hence, we regard these variables as influencing 51% of Bangladeshi individuals seeking medical care overseas.

4.3.6 Component Matrix

Each component in the matrix is paired with only one variable. If this does not occur, there must be an issue. The purpose of the component matrix is to identify problematic components and remove them from the questionnaire.

Table 12.
Component Matrix

	Component	
	1	2
P1	.448	.675
P2	.566	.533
P3	.692	.077
S1	.590	-.334
S2	.719	.126
S3	.385	-.302
E1	.710	-.308
E2	.585	-.335
E3	.768	-.026

Extraction Method: Principal Component Analysis.

a. 2 components extracted.

Source: Authors Calculation

We used a component matrix to identify problematic variables in our questionnaire, setting the suppression value at an absolute threshold below 0.45. All the components were dispersed in a scattered manner. In many circumstances, one component is assigned to two variables. This scenario is referred to as a cross-loading procedure. We were unable to determine which components to retain and which were removed from our study questionnaire in the component matrix table. We address this issue using a different statistical method known as the Rotated Component Matrix.

4.3.7 Rotated Component Matrix

The Rotated Component Matrix was used to remove troublesome components from the questionnaire. This technique is performed using the varimax approach. Repeatedly rotating the entire component matrix table leads to a definitive conclusion. The primary objective of this type of rotation is to remove the most troublesome elements and retain the most crucial elements that can effectively represent the entire phenomenon. We identified pairings of variables that helped explain our dependent variable after applying the rotation component matrix.

Table 13.
Rotated Component Matrix

	Component	
	1	2
P1	-.052	.808
P2	.128	.767
P3	.504	.480
S1	.672	.091
S2	.496	.536
S3	.489	-.007
E1	.751	.184
E2	.668	.088
E3	.628	.444

Extraction Method: Principal Component Analysis.

Rotation Method: Varimax with Kaiser Normalization.^A

a. Rotation converged in 3 iterations.

Source: Authors Calculation

From the rotated component matrix above, we found P1, P2, P3, S1, S2, S3, E1, E2, E3 items which belongs-

P1: Better medical treatment abroad has an impact on Bangladeshi people's psychology of going abroad for medical treatment.

P2: Inexpert Bangladeshi doctors influence Bangladeshi people to travel abroad for medical treatment.

P3: The absence of proper empathy in Bangladeshi doctors and nurses' minds influences Bangladeshi people to go abroad for medical treatment.

S1: Inaccurate diagnosis results of Bangladeshi medical institutions have an impact on Bangladeshi people going abroad for medical treatment.

S2: The poor performance of Bangladeshi doctors and nurses influences Bangladeshi people to go abroad for medical treatment.

S3: Severe service deficits in Bangladeshi hospitals influence Bangladeshi people to travel abroad for medical treatment.

E1: Irrelevant and unnecessary medical tests given by Bangladeshi Doctors have an impact on Bangladeshi people going abroad for medical treatment.

E2: The unavailability of specialised medical equipment in Bangladeshi hospitals influences Bangladeshi people to go abroad for medical treatment.

E3: Medical mismanagement in Bangladeshi hospitals influences Bangladeshi people to travel abroad for medical treatment.

These components were included in the questionnaire.

4.3.8 Regression Analysis

Regression Analysis is a statistical process for estimating relationships among variables. Regression Analysis encourages one to see how the standard estimation of the variable changes when any of the free factors fluctuate. It incorporates numerous procedures to demonstrate and investigate several factors. Here, we used Linear Regression to conduct a statistical study.

4.3.9 Linear Regression

Linear regression is a fundamental type of regression often used in predictive analyses.

Do the independent factors effectively predict the dependent variable?

Which independent factors have substantial predictive effects on the dependent variable?

Table 14.
Variables Entered/Removed^a

Model	Variables Entered	Variables Removed	Method
1	Economical, Psychological, Social ^b		Enter

a. Dependent Variable: MedicalTourism

b. All requested variables entered.

Source: Authors Calculation

The above table indicates that the three independent factors identified were present prior to conducting the poll.

Table 15.
Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.485 ^a	.235	.220	.50827

a. Predictors: (Constant), Economical, Psychological, Social

b. Dependent Variable: Medical Tourism

Source: Authors Calculation

The summary table of the model indicates the regression line's capacity to explain the overall variance of the dependent variable. This determines whether the independent variable can predict the dependent variable. The model summary included R, R Square, modified R Square, and Std. Estimation error

4.3.10 R Square

The R-squared statistic quantifies the goodness of fit of the model to the data and the proportion of data variability accounted for by the model. It has a value that ranges from zero to one. A value close to 0 indicates a poor explanation of the variation in the dependent variable, whereas a value of approximately 1 signifies a strong explanation of the variance and an accurate prediction of observations.

The R Square value is missing from the model summary table.235 signifies that psychological, social, and economic variables account for 24% of the overall variation, representing the R-Square benchmark. The remaining 76% of patients were affected by unconsidered elements in our study. These elements and variables will be considered in future research.

4.3.10.1 Adjusted R Square

The adjusted R-square was similar to the R-square, with an adjustment to account for the number of predictors in the model. Here, the adjusted value is .220 which is slightly reduced from .235 because it is adjusted after justifying the errors.

4.3.10.2 Standard Error of the Estimate

The standard error of the estimate quantifies the spread or variability of the predictions in a regression model. A small standard error of the estimate implies that the observed values are closely clustered

around the regression line, whereas a high standard error suggests that the observed values are further dispersed from the regression line. A lower standard error of the estimate indicated a better chance of the best match. The standard error of the estimate in this model summary was 0.50827.

4.3.11 ANOVA

An ANOVA is a statistical test that assesses whether a null hypothesis should be accepted or rejected. Our theory is as follows:

H0: Independent variables lack the ability to explain this variable fully.

H1: Independent variables can be clarified through exploration.

Table 16.

ANOVA^a

Model	Regression	Sum of Squares	df	Mean Square	F	Sig.
1	Residual	12.365	3	4.122	15.955	.000 ^b
	Total	40.301	156	.258		
		52.666	159			

a. Dependent Variable: Medical Tourism

b. Predictors: (Constant), Economical, Psychological, Social

Source: Authors Calculation

The decision about the hypothesis is based on the p-value (significance level) compared to the alpha value of 0.05. ANOVA justifies the p-value based on certain criteria.

If $P < \alpha$, H0 is rejected.

If $P > \alpha$, then H0 is accepted.

The significance level from the ANOVA table was .000, indicating a statistical significance below the threshold of .05. As the null hypothesis is rejected, we adopt the alternative hypothesis that the independent variables have the explanatory potential to predict the dependent variable

4.3.12 Coefficient

Table 17.

Coefficient

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	2.014	.299		6.729	.000
	Psychological	-.041	.070	-.048	-.591	.555
	Social	.260	.081	.276	3.194	.002
	Economical	.235	.067	.303	3.523	.001

a. Dependent Variable: Medical Tourism

Source: Authors Calculation

The coefficient establishes a precise link between the independent and dependent variables. This precisely delineates the degree to which a certain factor may affect the dependent variable.

In the response letter, you can see each update as per your comment.

By examining the coefficients, we can identify the variables that significantly influence the factors that drive Bangladeshi individuals to seek medical care overseas. The significance level dictates the specific variables included in the study. The results were analyzed as follows:

Hypothesis for all variables

H0: Psychological, economic, and social factors have no impact on the factors that influence Bangladeshi people to travel abroad for medical treatment.

H1: Psychological, economic, and social factors influence Bangladeshi travel abroad for medical treatment.

The significance level for the psychological component was .555, which was above the alpha value of .05. For the economic and social variables, the significance levels are .001 and .002, both below .05.

Psychological: sig. value .451 > .05; H0 accepted

Economical: sig. value .001 < .05; H0 rejected

Social: sig. value .002 < .05; H0 rejected

Thus, we only examined economic and social factors, as this led to the rejection of the null hypothesis, indicating that our alternative hypothesis is valid. Economic and societal variables have a greater influence on motivating Bangladeshi individuals to seek medical care overseas.

4.3.13 Beta Value

The Beta value reveals whether social or economic reasons have a greater influence on motivating Bangladeshi individuals to seek medical care overseas. This describes the likelihood of rejecting the null hypothesis when it is incorrect. A higher beta value results in a stronger influence on the dependent variable.

Here, Beta value of Social 0.276 < Beta value 0.303 of Economical

Economic considerations have a higher beta value than social components. Economic issues have a greater effect on Bangladeshi individuals' decision to seek medical care overseas.

5. Theoretical and Managerial Implications

Social factors exert a lesser impact on Bangladeshi citizens' decisions to pursue medical treatment abroad than economic factors. In accordance with our findings, we recommend the following courses of action.

Ensuring the elimination of erroneous diagnostic outcomes is of utmost importance for instilling trust and assurance in Bangladeshi communities. Consequently, it is imperative to provide advanced training to Bangladeshi doctors and nurses in order to develop their skills. Reduce the lack of services at hospitals in Bangladesh. Therefore, it is best to stop the performance of pointless medical tests. The legal firm must shift its focus. Medical establishments in Bangladesh should install specialized medical equipment. Thus, cooperation between the public and commercial sectors is crucial. Therefore, it is imperative to eliminate medical mismanagement.

Medical institutes and universities are scarcer than in other rising and industrialized nations. Medical education has more technical issues than in other areas. Quality of medical education is more important than the number of colleges. Bangladeshi hospitals lack people, equipment, and infrastructure. The government should focus on medical education to improve the quality of medicine over time.

Bangladeshi doctors and nurses are not compassionate. Patients in Bangladesh frequently complain that doctors and nurses do not respond on a daily basis. However, this must be addressed. There should be more training for nurses and doctors on how to interact with patients. Moreover, the government should keep an eye on doctors who do not give their patients sufficient time.

Minimizing unnecessary medical testing and inaccurate diagnostic outcomes is crucial. To carry out these responsibilities, it is important to ensure the quality assurance of the existing medical diagnostic equipment. Medical institutions that use obsolete medical diagnostic equipment should be subject to fines to establish their responsibilities. In this situation, it is imperative to have cooperation between the administration and law enforcement agencies.

Nevertheless, the conditions of the pharmaceutical industry require further enhancement. Numerous local pharmacy establishments have accumulated expired medication. Military personnel should be dispatched to capture the unethical enterprises. Local businesses frequently face higher expenses for prescriptions than actual expenditure. Such difficulties can be prevented by establishing and enforcing stringent legislation.

In Bangladesh, physicians and nurses exhibit below-average performances. Both the quality of service and expertise, as well as the lack of concern for patients, are clearly apparent in this situation. Regular surveillance of healthcare personnel while they care for patients and deliver services can promptly address any problem by reporting wrongdoing to the authorities of the medical facility.

Medical executives require training in order to avoid mismanagement. Therefore, businesses and governments should collaborate to address this issue. Developing and implementing effective marketing tactics while continuously monitoring government and legal institutions may lessen this issue. Patients receive comprehensive medical treatment only when the government, law enforcement, medical departments, private healthcare, and pharmaceutical companies work together.

6. Conclusion

We describe the determinants that influence individuals from Bangladesh to pursue overseas medical care. We initially identified the independent variables that affected Bangladeshis' decisions to seek medical treatment overseas. The study found that social and economic factors are the predominant determinants influencing Bangladeshi citizens' decisions to seek medical treatment abroad.

This study emphasizes the impact of social and economic factors on the dependent variable. The objective of our research is to provide a modest societal contribution in the hope that it will aid in deliberations on the eradication of this grave issue. Our endeavors will be considered successes solely at this juncture. Bangladesh must develop a globally competitive healthcare system to better serve its population and bolster the domestic healthcare sector.

Declarations

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