Out migration of Health Professionals from Bangladesh: Prospects of Diaspora Formation for Homeland Development

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Abstract:

Skilled professional Diasporas can play a potentially valuable role in the transfer of financial and social capital to help enhance development in developing countries from which they originally out migrated. Their ability to do so effectively depends on a variety of factors which include: (i) the demographic characteristics of the Diaspora; (ii) the degree of inter-individual collaboration resulting in the formation of institutional frameworks/groups; (iii) the ability to identify specific targeted areas in which coherent, long term, sustainable transfer programs can be set up; and (iv) the receptiveness of the legal / political / bureaucratic environment in the source country to such exchanges either via return migrants or trans-nationals.

In this paper we will: (i) briefly review the ongoing theoretical debates of “brain drain” versus “brain gain or brain circulation” in the particular context of health professionals; (ii) provide a socio-demographic-economic profile of the Bangladeshi context; (iii) comment on policies restricting health professional out migration from Bangladesh and discuss alternative policy approaches to recover public investment in professional education; (iv) explore the size of health professional out-migration from Bangladesh and its impact on health service provision; (v) examine the impact of out migration as a spur for increasing the stock of health professionals in Bangladesh; (vi) discuss financial remittances from Bangladeshi out migrants both in general and in the particular case of health professionals; (vii) explore the opportunities and constraints vis a vis the transfer of financial and social capital from Bangladeshi health professionals focusing on the following issues: (a) demographic characteristics of the physician Diaspora; (b) Diaspora institution building along with case studies; (c) areas of potential resource transfer and associated challenges; (d) receptiveness of the Bangladeshi local environment to Diaspora initiatives; and (viii) conclude with (a) policy recommendations and (b) future directions.

Case studies will be used throughout as needed to illustrate various points of discussion, and health professional out migration will be placed in the context of the larger issue of professional out migration wherever suitable.
Introduction:

There is increasing appreciation that skilled professional Diasporas\(^1\) can play a potentially valuable role in the transfer of financial and social capital (e.g. financial resources, knowledge of advanced technology, professional, entrepreneurial and managerial skills, links to global networks) to help enhance development in developing countries from which they originally out migrated (Asian Development Bank, 2005; Bardak, 2005; Stilwell, 2003; Hunger U, 2002; Lowell and Findlay, 2001). Their ability to do so effectively depends on a variety of factors which include: (i) the demographic characteristics of the Diaspora; (ii) the degree of inter-individual collaboration resulting in the formation of institutional frameworks/groups; (iii) the ability to identify specific targeted areas in which coherent, long term, sustainable transfer programs can be set up; and (iv) the receptiveness of the legal / political / bureaucratic environment in the source country to such exchanges either via return migrants or trans-nationals\(^2\).

In this paper we will:

(i) briefly review the ongoing theoretical debates of “brain drain” versus “brain gain or brain circulation” in the particular context of health professionals.

(ii) provide a socio-demographic-economic profile of the Bangladeshi context.

(iii) comment on policies restricting health professional out migration from Bangladesh and discuss alternative policy approaches to recover public investment in professional education.

(iv) explore the size of health professional out-migration from Bangladesh and its impact on health service provision,

(v) examine the impact of out migration as a spur for increasing the stock of health professionals in Bangladesh

(vi) discuss financial remittances from Bangladeshi out migrants both in general and in the particular case of health professionals

(vii) explore the opportunities and constraints vis-a-vis the transfer of financial and social capital from Bangladeshi health professionals focusing on the following issues:

a. Demographic characteristics of the physician Diaspora
b. Diaspora institution building along with case studies
c. Areas of potential resource transfer and associated challenges

\(^1\) Diasporas have been defined as “transnational groups of immigrants living abroad but maintaining economic, political, social and emotional ties with their homeland and with other diasporic communities of the same origin” (Debruyne and Kuddus, 2005; Siddiqui, 2004).

\(^2\) Return migrants are those out migrants who permanently relocate to their country of origin. Trans-nationals are out migrants who move back and forth between country of origin and destination of out migration (Development Research Centre on Migration, Globalization and Poverty, 2005).
d. Receptiveness of the Bangladeshi local environment to Diaspora initiatives

(viii) conclude with (a) policy recommendations and (b) future directions.

Case studies will be used throughout as needed to illustrate various points of discussion, and health professional out migration will be placed in the context of the larger issue of professional out migration wherever suitable.

(i) Migration Theories: Brain Drain vs Gain

Historically professional out migration from developing countries to the developed world has been seen as a significantly negative phenomenon retarding homeland development and growth. This characterization has been summarized in the buzz phrase “brain drain”. The basic argument has been that the out migration of skilled professionals educated at public expense in developing countries results in a significant loss of return to public investment in professional education. This loss of return to developing countries can be characterized in terms of: (a) gaps in essential services in the developing world as a result of the out migration (Stilwell, 2003; USAID, 2001; Mutizwa-Mangiza, 1998); (b) de-motivation of those who are unable / unwilling to out migrate as they are faced with bigger workloads, and the knowledge of low salaries, poor working conditions and fewer opportunities of professional advancement compared to their peers who have out migrated (USAID, 2001; Mutizwa-Mangiza, 1998); (c) fiscal losses of future tax payments from high earning professionals who have out migrated (Rosenzweig, 2005; Desai, Kapur, Mchale, 2002); and (d) ultimately declines in overall economic growth rates due to the loss of human capital, particularly the best and the brightest who are most likely to generate economic growth. (Asian Development Bank, 2005; Rosenzweig, 2005; Stilwell et al, 2003; Lowell BL, Findlay AM, 2001).

Developing country policy responses to the notion of “brain drain” were for a long time (1970s and 80s) focused on preventing/severely restricting skilled professional out-migration from the developing world to the developed world, and or forcing would be emigrants to compensate developing country governments for the public expenditure on their education (Stilwell et al., 2003; Bundred and Levitt, 2000). These responses it is fair to say have been singularly unsuccessful in stemming the tide of professional out migration, and have been largely abandoned by most developing countries (Lowell BL, Findlay AM, 2001).

In more recent times, the notion of brain drain has been supplanted by a more nuanced view summarized by yet another set of catch phrases “brain gain—brain circulation”, whereby professional out migration from the developing to the developed world can potentially positively impact homeland growth and development, and may not require the permanent re-location of out migrants back to their source countries (Bardak, 2005; Hunger U, 2002; Lowell and Findlay, 2001; Beine et al, 1999; Mountford A, 1997). This new viewpoint is predicated on several important premises:

(i) Professional out migration (with health professionals being just a special case) cannot effectively be retarded by negative incentives (bans, bonds—financial penalty clauses

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3 Here the argument is that knowing peers who have out migrated and are benefiting from better working conditions/income/prestige is more de motivating than theoretical comparisons with foreign physicians.
etc) as long as income and professional opportunities are significantly better in the developed world.\(^4\)

(ii) Out migration of skilled professionals may not necessarily have a negative impact on the source country especially in situations where there is a surplus of professionals, an already existing inequitable distribution of professionals, and a relatively small proportion of country’s stock of professionals are out migrating (Bardak, 2005; Stilwell et al., 2003)

(iii) The prospect of enhanced earnings and professional opportunities through out migration can act as a very powerful driver to increase enrollments in specific high value professional educational programs, and as only a fraction of those enrolled eventually get to out migrate, the developing country ends up with substantially larger pool of professionals than it would otherwise. Moreover due to decreases in supply brought about by skilled out migration, average wages of skilled workers who are left behind may actually go up more than they would have in the absence of out migration (Asian Development Bank, 2005; Bardak, 2005; Lowell and Findlay, 2001; Beine et al, 1999; Mountford A, 1997).

(iv) Financial remittances and investments from out migrants can potentially have a substantial positive impact on home land economic growth and balance of payments, and may counterbalance economic losses arising from the out migration (Asian Development Bank, 2005; Bardak, 2005)\(^5\).

(v) Last but not least, there is the potential for significant transfer of social capital (i.e. technical and managerial skills, market knowledge) from professional Diaspora communities to the homeland which can enhance economic growth and development (Asian Development Bank, 2005; Bardak, 2005; Singh, 2003; Hunger, 2002; Lowell and Findlay, 2001).

It is important to note that these transfers of financial and social capital from out migrants (who have enhanced their human capital by acquiring higher education and training abroad) involves both conventional “return migrants” who permanently re-locate back to their source country at some point and “trans-nationals” who shuttle back and forth between source and destination. In fact the activities of the trans-national group (termed “brain-circulation by some) may be much more important (given the very low rate of return migration of professionals\(^6\)) are considered to be a key factor in the burgeoning growth of the IT industry in India (Asian Development Bank, 2005; Wescott, 2005)

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\(^4\) Martinez and Martineau [1998] point out that the reality for many health workers in developing countries is to be "underpaid, poorly motivated and increasingly dissatisfied and sceptical"(Stilwell et al., 2001)

\(^5\) Remittances sent by migrant workers are estimated to exceed US$ 200 billion to Latin America, Africa, Asia and Europe (Asian Development Bank, 2005). They now significantly exceed official development aid and are the second largest source, behind foreign direct investment, of external funding for developing countries (Stilwell et al. 2003)

\(^6\) Return migration of professional migrants in terms of permanent re-location back to the source country is still very low to negligible for most developing countries and may require significant levels of economic development (as in South Korea) as a pre-condition (Bardak, 2005)
In view of the above theoretical framework, let us now explore the situation in the specific context of health professional out migration in Bangladesh.

(ii) Bangladeshi Socio-Demographic-Economic Context:

In order to give some context to our discussion of health professional migration and its potential impact on socio economic development in Bangladesh, it is useful to review briefly the socio-demographic/economic context in the country. Bangladesh is currently the eighth most populous country in the world and one of the most densely populated with a population of 140 million individuals in a land area of 144,000 sq kilometers. It remains one of the poorest, least developed countries in the world with a nominal per capita GNI of approximately US$ 370/year (ppp GNI= US$1980/year)\(^7\) and with 80% of the population living at under US$2 of income. GDP growth has averaged about 5%/ year in the last decade or so. (Bangladesh Bureau of Statistics, 2004; Siddiqui, 2003a,b).

Despite significant advances in public health in the last two decades, it continues to have reasonably high fertility (Total fertility rates of 3 children/woman; population growth rate of 1.5%/year), very high but falling maternal mortality (3 maternal deaths/1000 births) high but falling infant and child mortality (Infant Mortality Rate=66 deaths /1000 births; under five mortality rate of 89 deaths/1000 births) and medium range but steadily improving life expectancy (Life Expectancy=62 years for both men and women). These figures compare favorably to other countries in South Asia (similar to those in India and better than Pakistan or Nepal.) [Menken and Rahman, 2005; Bangladesh Bureau of Statistics, 2004]

Health services and infrastructure are poorly developed and concentrated in urban areas. For 140 million people there are currently 32, 498 physicians, 19,000 nurses, and 45,000 hospital beds. This translates into 1 physician for 4,000 people, 1 nurse for 7,368 people, and 1 hospital bed for 2,832 people. (Bangladesh Bureau of Statistics, 2004; Mabud, 2004).

Literacy rates are very low, averaging about 50%. However primary school and higher education enrollments are rapidly growing with gender parity in both\(^8\). Higher educational enrollment is one of the lowest in the world (approximately 700,000 students) with gross tertiary enrollment levels of about 4% (i.e. 4% of 18-24 year olds are currently in University) but is projected to rise tremendously over the next two decades (between 3-5 times). Bangladesh currently produces about 130,000 holders of Bachelor’s degrees and 44,000 masters graduates every year with a very small proportion (15%) in science and technical fields, and only 2.86% in engineering(3,689 graduates)—{Rahman, MO, 2005}

The total number of medical schools in Bangladesh are thirty two of which thirteen are government supported and nineteen are privately funded (most of recent vintage—in the last five years producing). Total annual output of physicians (holders of MBBS degrees) is about 2000

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\(^7\) As a frame of comparison PPP GNI for: India US$3,100 ; Pakistan US$2,160; Nepal: US$1,470; SriLanka, US$ 4,000 (2005, World Population Data Sheet of the Population Reference Bureau)

\(^8\) Primary School gross enrollment is near 100% with net enrollments about 75%. High school gross enrollments are about 70% with net enrollments about 50%.
(Bangladesh Bureau of Statistics, 2004; Mabud, 2004), with the government output being about 1300. Average annual output from 1971 (when Bangladesh was established as an independent country) to 1995 was about 1000. From then on it has steadily but slowly increased with an average over the last ten years of about 1500/year.

In summary Bangladesh is currently a poor country with a large population, high morbidity and mortality, a poorly developed health infrastructure with a relatively low output of skilled professionals. With regard to the latter however, projections suggest massive growth in the higher education sector over the next two decades fueled by steady economic growth (averaging 5-6%/year) and major improvements in educational enrollment over the last decade.

(iii) Restriction of professional out migration and alternative approaches to recovery of public investment in professional education:

Various governmental disincentive schemes (requirement of no objection certificates, signing of financial bonds) have not been particularly effective in retarding out migration of physicians and nurses from Bangladesh. In fact in recent decades (since 1990) the government has stepped away from this official dis-incentive approach recognizing their inability to enforce these regulations and or pay back schemes. It is not entirely clear why these restrictive policies have been unsuccessful. One possibility is that in developing countries like Bangladesh with poorly developed monitoring and enforcement institutional frameworks, physicians who are largely from the urban middle class and have significant political and bureaucratic clout are able to “game” the system and get around these official restrictions.

One important way of addressing the loss of return to publicly funded professional health education is to reduce substantially the subsidization of such education, and aim for full cost recovery. Acknowledging that it is politically and bureaucratically unfeasible to enforce public service commitments on medical/nursing graduates, and given that there is a huge demand for both physician and nursing education, a very limited number of educational opportunities, the private sector should be encouraged to expand vigorously in this area. This is already happening in Bangladesh with a rapid expansion of private medical colleges in the last decade (from 5 to 20 in the last five years). Nursing education however has not taken off in the private sector, but is poised to do so (see below for further details about nursing education—Aminuzzaman, 2005) Recently the expansion of private sector medical education has faced significant opposition on the alleged basis of ensuring quality of education and equity (allowing disadvantaged students appropriate access). The quality concerns are relatively easily addressed by licensing and educational curriculum standardization and monitoring (not easy but doable). The equity concerns can also be addressed to some degree by requiring private health educational institutions to set aside a specific proportion of seats for disadvantaged groups. Variants of these initiatives are already in place for private Universities (Rahman, MO, 2005)

(iv) Size of health professional out migration and impact on services in Bangladesh:

9 Bangladesh has not only very low output of professionals in an absolute sense but also relative to India. For example India with roughly 7.15 times the population of Bangladesh produces 20,000 physicians/year and 150,000 engineers/year. Proportionately this translates to India producing 1.4 times more physicians and 5.69 times more engineers.
There is an ongoing debate as to whether preventing out migration of health professionals will result in increased access to services in the source country. In regions like Africa, where a significant proportion of health professionals out migrate and a reasonably equitable prior distribution of professionals exist within the source country, one can make a good case that prevention of health professional out migration (however difficult it may be to achieve) would markedly prevent a major decline in access to health services (Mutizwa-Mangiza, 1998; USAID, 2001). This argument is much more tenuous in South Asia and the Philippines (Bardak, 2005; Stilwell et al., 2003; Beine, Docquier, Rapoport, 1999) where a relatively small proportion of the total output of health professionals out migrate (either due to inability to do so or lack of willingness) and the one’s who do are very concentrated in major urban areas and not in the under served rural sector. Of course there is the valid point that the best and the brightest are the ones most likely to out migrate. This most likely has an adverse impact on homeland medical research output but not necessarily in service provision.

Valid, reliable empirical data on out migration of any kind is hard to come by in developing countries, particularly for specific categories such as professionals who tend to emigrate unofficially (either under family reunification schemes, or as students or tourists) (Asian Development Bank, 2005; Stilwell et al., 2003). In the case of Bangladesh, it is estimated that between 1976 and 1999, about 3.24 million Bangladeshis migrated for overseas employment (135,000 per year on average with the annual flow increasing to about 200,000 in the last decade). Currently it is estimated that there are about a million Bangladeshi emigrants in industrialized countries worldwide who are essentially long term out migrants and can be thought of being part of the Bangladeshi Diaspora (Siddiqui, 2004). The overwhelming majority of Bangladeshi out migration is unskilled migration, and only about 4.6% constitute professional out migrants, i.e. 6,000--9000/year (Mian, 2003; Siddiqui, 2003a,b). Of the professional migrants, it is estimated that physicians constitute only about 300 per year on average or about 3-5% per year. This translates to about 1% of the total number of 32,498 physicians currently (as of 2001—Bangladesh Bureau of Statistics, 2004) practicing, but almost 20% of the average annual graduating cohort of 1500. It should be noted that this physician out migration figure is an approximation based on anecdotal conversations with medical students/recent graduates/health administrators. However it is consistent with physician output and registration data in Bangladesh and other data about Bangladeshi medical graduates from recipient countries, as shown below.

Anecdotal estimates suggest that the bulk of physicians (about 80%) out migrating from Bangladesh move via government recruitment to the Middle East, with a minority (20%) moving to the U.K. and North America. While we currently do not have statistics from the Middle East or the UK reliable statistics from the US (the primary desired destination of medical graduates) using data provided by the American Medical Association show that currently as of 2005, there are a total of just 1100 physicians who have graduated from a Bangladeshi Medical School. If we use a 35 year

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10 These estimates are essentially anecdotal and should be viewed with a fair degree of caution. They are almost certainly significant overestimates. In the case of the US these estimates report a Bangladeshi diaspora of 300,000-500,000 whereas the 2001 US census counts only about 100,00 residents of Bangladeshi origin. Note that the US census counts all those living in the household (irrespective of immigration status) and asks for their ethnic identity. Thus these 100,000 include 1st, 2nd, 3rd generation Bangladeshis.

11 All physicians in their medical license application have to state the medical school they graduated from.
window (starting from 1971 when Bangladesh became independent) this would mean that on average of only 33 physicians / year get licensed in the US. There are probably a few more who are waiting to get licensed (i.e. in the pipeline), probably in the order of a couple of hundred. Thus currently our estimate is that there is a total of about 1300 physicians of Bangladeshi origin currently in the US, which translates into 37 physicians/ year. While the figures for the UK are not available, if we assume that the rate of migration on a population basis is thrice that of the US, the UK being 1/5 the population of the US should receive about 3*37/5= 22 physicians/ year\(^\text{12}\). Thus the US and the UK would account for about 60 physicians a year from Bangladesh. Using the assumption that the US and UK account for 20% of the total out migration of Bangladeshi physicians, the total out migration per year can be estimated at about 5*60=300 physicians a year.

The small numbers of out migrating physicians to UK and North America is a function of the high costs of out migration both in terms of onerous licensing regulations (the need to pass very detailed comprehensive examinations with historically low pass rates, the requirement for English language fluency, and state by state variation in licensing requirements for the US) and the financial outlays involved in traveling to North America / UK and sustaining oneself while passing the licensing exams. More recently, in the last decade or so, there has been a significant decline in residency positions offered to foreign medical graduates as the US / UK are experiencing a relative glut of physicians\(^\text{13}\). The Middle East has also undergone significant changes in the last two decades with concerted efforts to reduce dependency on foreign medical graduates. This has exerted downward pressure on recruitment of medical graduates from Bangladesh and other developing countries.

It is worth noting however that Bangladeshi physician out migration is significantly smaller than the analogous Indian experience. Bangladesh currently produces approximately 2000 medical graduates/ year compared to India which produces about 20,000 graduates. However as of 2005, Bangladesh as noted above had only 1300 physicians in the US compared to about 40,000 of Indian origin. Adjusting for the 10 times greater output of physicians in India vs Bangladesh, this implies that Indian physicians have out migrated at four times the rate of their Bangladeshi peers. The reasons for this huge difference is not obvious but may be due to better information channels about migration due to a longer history of out migration, higher quality of medical education, better English language skills etc.

Given (a) the small numbers of physicians out migrating relative to the pool of existing physicians in the country, and (b) the fact that the overwhelming majority of those who out migrate are urban based it is hard to make a case that preventing such out migration will materially affect access to health services in Bangladesh (Stilwell et al., 2003). However from a quality perspective, there is no doubt that a relatively high proportion of the best and the brightest physicians are leaving the country. Over the last twenty five years (i.e. since 1980), Dhaka Medical College, the flagship medical school in the country has produced about 150/year* 25 years=3750 medical graduates. Anecdotal evidence from conversations with health administrators suggest that of this number about 50% are now abroad. Of the annual out migration of three hundred physicians per year, Dhaka

\(^{12}\) UK until recently because of recognition of basic medical credentials and equivalence of medical education systems was a much more receptive environment for physician out migration.

\(^{13}\) 20% of the current 650,000 US physicians are foreign medical graduates. Physician population ratios are at a historic high of 1 physician per 430 population
Medical College graduates account for about 25% (75/300). Of the sixty or so Bangladeshi physicians who out migrate every year to the US and the UK, knowledgeable individuals estimate that approximately 50% or 30/60 are from Dhaka Medical College. While this has an important impact on the quality of medical research and intellectual development at the top institutions in the country, it probably does not affect health service provision overall materially.

(v) Out migration as a spur to increasing professional educational enrollment:

While the prospect of enhanced earnings and professional development from out migration undoubtedly acts as a spur for increasing enrollment in medical schools, quantification of this effect is hard to come by. As medicine is even locally a high income generating profession, it is not clear how much additional demand is generated by the prospect of out migration. The real constraint is not one of inadequate demand but of low supply in terms of number of available medical school seats and the high cost of medical education.

The “out migration acting as a spur” argument however has much more validity in terms of nursing education. Traditionally nursing in Bangladesh has been viewed as a low paid, low prestige occupation attracting relatively few entrants. Unlike most countries where nurses outnumber physicians in ratios of 2-3 to 1, Bangladesh has an inverted pyramid with nursing/physician ratios close to 1:1 or even less than one. There are approximately 19,000 registered nurses in the country (13,000 in the public sector, 4000 in the private sector and or awaiting government posts and 2000 nurses have gone abroad) with an meager annual output of only 1000/year—(Aminuzzaman, S.M., 2004). The potential for nursing out migration is huge as there is a rapidly growing demand in Europe and North America for skilled and unskilled nurses due to burgeoning aging populations. Salaries for those with a BSc. in Nursing in the US are now approaching US$30,000/year, roughly 15 times current local salaries in Bangladesh. These high salaries could fruitfully act as a powerful spur to increasing nursing school enrolment, and draw higher quality students. In a recent study by Aminuzzaman, undergraduates who would normally not have considered nursing as a profession expressed eagerness to undergo such training provided there were out migration opportunities.

A vigorous expansion of health professional output by encouraging private sector higher educational initiatives should have a significant impact on raising the overall output of health professionals. If coupled with this expansion in capacity, we can improve quality of education to meet global standards there is the possibility of significant increases in targeted out migration of nurses and physicians and positive spill over effects in terms of raising local standards and stock of health professionals.

(vi) Financial remittances from out migrants:

It is estimated that for Bangladeshi out migrants as a whole, the flow of official remittances between 1996 and 2002 was about US dollar 23.7 billion (or about US$ 3.4 billion per year on average). This may in fact be a low estimate as there is a great deal of unofficial remittance with some analysts estimating that unofficial remittances are almost equal in share to official remittances. These remittances provide about 26% of annual foreign exchange earnings, finance 20 percent of the
import payments, and constitute about 30 percent of the national savings of the country. Official remittances account for about 5% of GDP in Bangladesh (Mian, 2003; Siddiqui, 2003a,b). The majority of this US$3 billion annual remittance comes from out migrants (temporary workers as opposed to Diaspora members) in the Middle East (40% come from Saudi Arabia alone) but the US Diaspora accounts for 14% of this flow.

Overall, remittances to Bangladesh (not unlike the situation in other developing countries) are most often used to finance daily consumption, followed by investments in real estate or home renovation, and payment of loans (often used to finance the original outmigration). Other uses include investments in education (Kuhn and Menken, 2002), health care and charity. A very small proportion is saved or invested in financing business ventures (De Bruyn and Kuddus, 2005). Some analysts have argued that these remittances may in fact have the perverse effect of increasing consumption, inequality, promoting inflation (as in the case of real estate prices) and may create dependency (Bardak, 2005; Newland, 2003). While remittances in Bangladesh clearly help improve the economic situation of the family of the out migrant, the large social/community impact is unclear (De Bruyn and Kuddus, 2005).

With regard to financial remittances from out migrating physicians, there is no real empirical data. In general out migrants who view themselves as eventually re-locating back tend to remit more than those who are planning to stay on in the destination country. As physician out migrants (especially those in North America) typically are not planning to return to Bangladesh (given their very high levels of income and opportunities for professional advancement), instead of remittances, a major means of transferring resources to Bangladesh is via family re-unification, i.e. bringing the extended family to North America from Bangladesh. When out migrant physicians do remit stereotypically they do so for investments in real estate or to help finance educational/professional aspirations of family members rather than in financing day to consumption. Anecdotally, in recent years there is an increasing phenomenon of return health professional migrants from the Middle East investing in state of the art diagnostic centres providing panoply of radiological and pathologic services to meet the needs of a growing urban middle class.

Although in recent years there have been some attempts made to attract financial investments from affluent Bangladeshi Diaspora members such as physicians, by and large due to a variety of factors (lack of trust in the government, overweening bureaucracy, lack of information about investment possibilities, and the lack of attractive investment climate where one can enjoy high returns) Diaspora physicians have probably not invested in productive business ventures in any significant way. (De Bruyn and Kuddus, 2005).

(vii) Opportunities and constraints vis a vis transfer of financial and social capital from health professional out migrants to enhance development in Bangladesh:

Although not much is happening currently, here exists the potential for significant transfer of financial and social capital (technical, entrepreneurial and managerial skills) from health professional Diasporas to their home countries and thus contribute to homeland growth and development. The actualization of this potential depends on a variety of factors including (a) the

14 Given that physicians generally come from relatively affluent middle to upper class families, financing consumption of residual family members is not necessary.
demographic characteristics of such groups; (b) the degree to which Diaspora professional organizations are able to bring together disparate, dispersed individual out migrants into a co-ordinated, coherent institutional framework for the purposes of resource transfers to the source country; (c) the ability to target areas where coherent sustainable transfers of technology/knowledge can be set up and (d) the receptiveness of the environment in Bangladesh to such exchanges. We are going to focus on the Bangladesh to US physician out migrant experience to explore these issues.

(vii-a) Demographic characteristics of the Bangladeshi physician Diaspora:

Physicians of Bangladeshi origin in the U.S. are spread throughout the country but with a concentration in large urban areas such as New York, Boston, Los Angeles, and Houston. On the basis of anecdotal reports, they are largely male (2/3), with an age range of 25-65 with most in the 35 to 50 age group. Most are in non-surgical specialties, partly reflecting difficulties in securing residency positions in the more lucrative surgical and or intervention oriented specialties. The vast majority are married with children. The average duration of stay in the United States is probably around 15 years, reflecting the more recent reduction of residency positions for foreign medical graduates.

With regard to size, as noted above, the numbers of first generation Bangladeshi physicians who have graduated from Bangladeshi medical schools but are practicing in the US is quite small (about 1300 individuals), and will grow at a fairly steady but slow rate of an additional 30-50 physicians/year, given current constraints in terms of visa regulations, and reductions in residency positions. It is important to note that these calculations do not take into account those Bangladeshis who have moved to the US as children, and have graduated from medical schools in the US. Given that the bulk of the migration from Bangladesh to the US took place in the last twenty five years, and that one needs to be at least 25 years old to graduate from Medical School in the US, this group is likely to be very small currently but may grow in the future. In addition from both a practical and theoretical perspective the eventual Bangladeshi Diaspora should include 2nd and possibly 3rd generation Bangladeshis (i.e. those who have been born in the US, but have at least one parent /grandparent who is Bangladeshi) as well as these individuals may have special ties to the birthplace of their parents even if they were not born there. The total size of the Bangladeshi physician Diaspora thus depends on the current number of physicians in the US who graduated from Bangladeshi medical schools, new Bangladeshi physician out migrants every year, and subsequent cohorts of 2nd and 3rd generation Bangladeshi-Americans who graduate from US medical schools. Thus there is some potential for relatively healthy growth of the Bangladeshi physician Diaspora, although empirical estimates to difficult to quantify.

(vii-b) Diaspora Institution Building:

Bangladeshi physician Diaspora institution building in the US is fraught with many pitfalls. First physicians tend to be very busy and have little time for participating in community groups unless there are specific payoffs in terms of access to medically related information with regard to CMEs, licensing requirements etc. Second, the relatively wide geographical dispersion of Bangladeshi origin physicians across the US makes it difficult to maintain contact. Third medical
specialization makes it difficult to form general purpose organizations, as each physician identifies primarily with his or her own specialty and there is relatively little common ground across specialties. Fourth variation in place of origin within the home country may make it difficult to forge a common agenda. Fifth, the desire to assimilate into the mainstream culture may act as somewhat of a hindrance to participating in Diaspora organizations, particularly for 2nd and 3rd generation immigrants. The Bangladesh Medical Association of North America (BMANA) is a specific Diaspora organization which has tried to bring together physicians of Bangladeshi origin for the last twenty five years. Its successes and challenges are probably reflective of the general experience of physician Diaspora organizations. A brief summary of the organization is given in Box 1.

(vii-c) areas of potential resource transfer from Diaspora to Homeland/ with associated challenges:

In conversations with the current president of BMANA (Dr. Ehsanur Rahman, a cardiologist based in Delaware), it is clear that BMANA and its members are interested in helping with development in Bangladesh’s health sector. In fact on an individual level, various members have been participating over the years in sporadic educational and service activities. The major constraint in institutionalizing and co-ordinating this response is the lack of clarity as to what range of activities would be most beneficial to enhance health sector development in Bangladesh. The obvious choices are transfer of knowledge and training in terms of cutting edge advances in medical specialties, the provision of subsidized/pro-bono specialized clinical services, and the donation of medical equipment and journals. The advantages of these kinds of resource transfers are that:

(a) the provision of pro-bono specialized medical services (plastic surgery, advanced cardiac interventions) allows some needy Bangladeshis (albeit a small number) to benefit from advanced medical services which would otherwise not be available to them.
(b) the donation of books, journals, medical equipment helps upgrade the quality of medical educational institutions and hospitals/clinics.
(c) Seminars/workshops by expatriate experts allow local Bangladeshi physicians to be exposed to the latest advances in their specialties and to upgrade their skills without having to travel abroad which are both logistically and financially expensive.
(d) these activities allow for skill transfer at much lower costs than otherwise possible as Diaspora physicians are much more likely to subsidize their costs than non Diaspora physicians.
Box 1. BANGLADESH MEDICAL ASSOCIATION OF NORTH AMERICA:

www.mbana.org

**Total Membership**: 300

**Current Regional Chapters**: 14: (New York, Michigan, Mid Atlantic, Carolina, Philadelphia, California, Kentucky, Missouri, Chicago, Alabama, Florida, Boston, Ohio, Connecticut)

**Mission**: to promote fellowship, provide educational / professional development for Bangladeshi physicians in the US, and facilitate development of the health sector in Bangladesh

Message from BMANA president on the occasion of the 25th anniversary: “Our challenge is to reach out to all the members and formulate an effective platform to launch activities to improve health care in Bangladesh and jointly face the challenges in health care in USA.”

**Activities**: regular annual meetings in different cities of the US. These meetings host educational / professional development activities (e.g. CME; dissemination of research posters & papers, information on visa, licensing, mal-practice issues, job placement) and publicize member efforts to transfer resources to enhance development in the Bangladesh health sector.

**Resource transfer activities**: sponsoring journals to Medical Colleges in Bangladesh, Telemedicine projects (both Free and for fees), CME programs for Bangladesh, mentoring young graduates, donations for books, computers and other materials, research funds or research collaboration with Bangladeshi institutions, donation for disaster fund (personal or national), procurement and donation of medical equipment, arranging training for visiting Bangladeshi Physicians, donation to humanitarian agencies in Bangladesh for their projects in education and welfare, and Member Welfare fund.

Dr. Mohammad Badruzzaman recently conducted a Post graduate course in histopathology, a cytopathology course in Bangladesh. Dr. Dhiraj Shah gave lectures at the annual convention of the Neurologists in Bangladesh. He also performed free vascular surgery including carotid bypass in several hospitals in Dhaka. Dr. Rafiq Ahmed has established two EP labs and is now training cardiologists in Bangladesh. Dr. Sitara and Dr. Abid Rahman took a cardiology team from USA and performed procedures at NICVD in Bangladesh. Dr. Showkat Hussain is now in Bangladesh. He brought many dialysis grafts and catheters and is performing, as well as providing training in, vascular surgery procedures in a few centers in Bangladesh. Drs. Ziauddin Ahmed and Mohammad M. Zaman received a travel grant from IDSA to do a 3 day seminar on Infection control in Bangladesh. The seminar was very successful. An infection control center has been established at the Ibrahim Medical College. Dr. Ekramul Kabir of KY is arranging a vocational program in rural areas and Dr. Ehsan Haq of CT has arranged a cleft lip surgery camp in Bangladesh.
(e) these exchanges build professional networks between local Bangladeshi and Diaspora Bangladeshi physicians which allow for sustainable exchanges of information and may help with out migration as well.

(f) last but not least these interactions provide Diaspora physicians a productive way to keep in touch with Bangladesh (psychologically very important) and channel their enthusiasm about homeland development.

The constraints are that:

(a) successful transfer of knowledge about professional practice requires a significant investment of time—this typically can not be taught in a one week workshop. Sustainable programs in skill transfer would require Diaspora Bangladeshi physicians/surgeons with requisite advanced skills to come on sabbatical/leave for six months to a year. This poses problems with regard to getting permission from one’s home institution for such long absences which cannot be just viewed in the context of vacation time.

(b) opportunity cost—salaries in the US are several times higher than in Bangladesh, thus the physician who donates several months of time stands to lose out significantly in terms of income. This is despite the willingness of Diaspora physicians to subsidize their costs due to emotional links to their homeland.

With current advances in web technology (email, web conferencing, telemedicine), many skill transfer activities and some consultation can be carried out long distance without Diaspora physicians actually having to travel. In the private University sector some of this is already happening with regard to courses being taught over the web to US and Bangladeshi audiences.

Diaspora professional organizations can help facilitate and co-ordinate these skill transfer/pro-bono service provision/medical equipment-journal donations programs by acting as brokers, matching willing teachers/consultants with needy students/patients/institutions. They can provide one-stop shopping whereby local Bangladeshi institutions (medical schools/hospitals) can register their preferences for specific skill transfer courses/programs and appropriately skilled Diaspora physicians can in turn register their willingness, and availability to teach in these programs. Medical equipment and journal donations can also be more effectively organized with Diaspora professional organizations arranging for volume discounts by acting as mediators between US pharmaceutical/medical equipment manufacturers and needy hospitals/local NGOs in Bangladesh. Current web technology makes it very possible to do this matching or brokerage service but it requires quite strong commitment on the part of Diaspora organizations to spend the resources to sustain such programs which at the minimum would require current up dated databases of US professionals and institutions matched to needs in Bangladesh. Some of this in a small scale is already being done by organizations like BMANA. There are good examples from other sectors.

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15 South Africa has effectively used web technology to mobilize its professional diaspora in the form of a virtual network called SANSA (Bardak, 2005)
(Environmental Science and Policy) where web technology has been effectively utilized to forge Diaspora-homeland connections in the service of specific public policy goals (see BOX 2).

Aside from the options mentioned above, other areas in which Diaspora health professional groups can get involved in impacting development in the health sector in Bangladesh include:

i. Telemedicine projects which facilitate expert consultation;
ii. Setting up of state of the art hospitals, diagnostic centres with international collaboration;
iii. Out sourcing of medical transcription services from the US to Bangladesh taking advantage of low cost transcribers with English Language Skills;
iv. Out sourcing of reading of radiological data (X-ray, MRI, CT scans) etc. from the US to Bangladesh again taking into account differences in salaries of radiologists in the two settings.

Telemedicine projects have been started in a small way in Bangladesh but have a huge potential for further expansion. Web technology now makes it possible to arrange for sophisticated medical consultation between Bangladeshi physicians and experts in the US and Europe. Given the lack of specialized medical services in Bangladesh, a significant number of patients are forced to travel abroad at considerable financial and logistic costs to seek medical advice/care. Telemedicine could help considerably in rationalizing this health care seeking and restricting it to surgical interventions.

In a natural extension of the telemedicine concept, in the last five years there has been an explosion of interest in setting up international standard hospitals in Bangladesh offering a full range of diagnostic and curative services typically in collaboration with major hospital management companies abroad. For example the Apollo Group in India has set up a state of the art hospital within the last year with local Bangladeshi partnership. They have hired mostly expatriate US trained Bangladeshi physicians along with a significant contingent of Indian trained physicians. The management is largely US/Indian. At least four other major international hospital groups (Malaysian, Singapore, Thailand and US investors) are setting up hospitals due to come on line within two years. This interest caters to the huge unmet demand for medical services among the middle and upper middle class in large urban centres in Bangladesh which is currently being serviced by people travelling to India, Thailand, Singapore and Malaysia. The market is potentially very large and expansion in this sector is likely to be very rapid.
BOX 2: The Bangladesh Environment Network

In the 1990s, the Bangladeshi environment was being degraded at an alarming rate while the scope of government interventions was very limited. Some individuals realized the necessity of a strong social movement for environmental protection, and BEN was founded in 1998 “to unite and mobilize non-resident Bangladeshis and other members of the international community who are willing to work together with pro-environment forces in Bangladesh and thus help the country protect her environment.”

Since its inception, BEN has grown significantly to become a truly global organization. Its membership consists of individuals from all parts of the world, but a majority of the membership resides in the US, where the organization was initiated and is headquartered. Other than the US, there are members from Australia, Canada, Japan, Sweden, the UK and some other countries. Many resident Bangladeshis are also part of the cyber network. The membership is constituted of professionals coming from various disciplines and even non-professionals, and provides the diversity of knowledge and perspective required in dealing with environmental issues.

BEN has been a unique organization because of its orientation and innovative activities. Very few of BEN members have actually met each other physically, the interactions and discussions being carried out primarily through the discussion website and e-mail. Apart from discussions, BEN has a wide range of activities, including provision of technical help, dissemination of information on environmental issues through publications and website, establishing international contacts who can potentially help, advocacy of government officials, organizing events and projects in collaboration with environmental organizations in Bangladesh, and overall promoting an environmental movement among the masses.

BEN is distinctive in a lot of ways, most important of which is its self-reliance in finances. The organization does not accept funds from the government or other donors, allowing it to remain independent and to maintain critical stands against detrimental decisions of the government. BEN has virtually no overhead costs, and is sustained easily by monetary or in-kind contributions of its members. Work done by the members is entirely voluntary.

Other unique features of BEN include an open membership, non-hierarchal structure and consensus style of decision making. It is one of the first of its kind, and also the first Bangladeshi organization to link Diaspora with resident Bangladeshis to work towards a common goal.
The major developmental advantages of this phenomenon of international joint venture hospitals are that it (a) saves a substantial amount of foreign exchange which is currently being used to finance overseas medical treatment; (b) by bringing in international standard hospital services it raises the expectation bar and helps improve local hospital services; (c) it provides an avenue to attract back (for both short and long term contracts) the best and the brightest Diaspora physicians with salary packages which are quite competitive and can not be matched by the public sector; (d) by providing international standard health care services (especially emergency services) for children and adults, it helps address a major constraint (lack of adequate health care) that acts as a hindrance to return-migration.

With regard to outsourcing of medical transcription, there is a huge potential market. The constraints are the relatively small pool of fluent English speakers who have the capability of comprehending medical terminology in Bangladesh. Quality is of the essence in medical transcription and there is a very low tolerance for error given the potential malpractice implications. The quality issue can be gotten around by using physicians to proof read the transcribed notes. The lack of a history of doing similar kinds of work makes it difficult to break into this market and compete with regional competitors such as India which has a well established track record in call centres and data entry.

In terms of more sophisticated outsourcing of radiological tests, the major constraints are having a pool of international standard low cost radiologists. Bangladesh is very far from achieving this status but the lucrative ness of this market may act as a spur to increase enrolment in medical school particularly in radiological specialties. It is worth noting that in recent years, very sophisticated radiological infrastructure (MRIs, CT scanning) has proliferated in the major cities.

The role of professional Diaspora groups in jumpstarting these potentially lucrative channels of international collaboration and investment lie in their facilitating functions. For example in the case of the new hospitals, BMANA has facilitated recruitment of expatriate Bangladeshi physicians by allowing local hospitals to use their meetings and email databases to publicize employment opportunities. Anecdotally it is often the case that Diaspora Bangladeshi physicians in their frequent visits and exchanges with local Bangladeshis are able to gauge the possibilities of the market demand and capitalize on it by providing a bridge between international investors and local collaborators. The challenge is to transform these often sporadic individual initiatives into a more organized systemic effort which can effectively utilize Diaspora talents and resources.

**(vii-d) receptiveness of the Bangladeshi local environment to Diaspora initiatives**

So far we have discussed in detail the role of Diaspora professional organizations in facilitating resource transfers to enhance homeland development. However to make this transfer successful and sustainable a key element is the receptiveness of the environment in Bangladesh with regard to, the general enthusiasm and eagerness in seeking Diaspora help, the minimization of legal/bureaucratic hurdles, and the provision of appropriate co-ordination, and adequate technical infrastructure.

It is worth exploring the potential role of government policies. Many have advocated systematic government initiatives to enhance Diaspora involvement in homeland development,
as in the case of the People’s Republic of China. While the jury is still out, it is not completely clear that the Chinese model of specific targeted governmental involvement in actively promoting Diaspora exchanges (in the form of policies, concrete programs focusing on specific short term profitable projects with clear deliverables, websites) is necessarily that important. What appears to be crucial is the clearing of bureaucratic and legal hindrances which make it difficult for Diaspora professionals to interact effectively with local partners (both government and non-government), and the adoption of a long term perspective without concrete project driven deliverables necessarily as the objective (Asian Development Bank, 2005).

In the context of Bangladesh, it would perhaps be fair to say that there is relatively little understanding or appreciation in the public sector of how Diaspora professionals can help with the growth and development of the health system in any co-ordinated way. Due to the lack of competitive pressure, the public sector hospitals which provide care for free or at significantly subsidized rates, and thus have a captive patient audience, have very little incentive to provide modern up to date services for which they would have to go to the Diaspora to get the requisite personnel. Moreover civil service rules prevent lateral entry and make it difficult for government medical colleges / hospitals to recruit highly qualified physicians at a level commensurate with their qualifications. The few exchanges that have taken place between Diaspora health professionals and local Bangladesh government institutions have been ad hoc, sporadic, very short term and entirely on the initiative of Diaspora professionals (individuals offering pro-bono consulting / educational and clinical services).

More recently the increasing appreciation that non-resident Bangladeshi professionals can potentially be a source of significant financial remittances has awakened government interest in trying to channel these by offering all Diaspora professionals certain tax privileges, and investment benefits. With regard to bureaucratic / legal hurdles vis-a–vis visa regulations, work permits, some progress is being made in this regard but more so due to pressure from the private sector [De Bruyn and Kuddus, 2005]

In the last decade, the rapid expansion of private medical colleges (serving the huge unmet demand for medical education) and the increased interest in setting up international standard hospitals in order to capture a part of the lucrative segment of the population which is seeking medical care services abroad, has spurred a small but growing number of local institutions to seek Diaspora physicians with specialized skills for both short and long term contracts. This phenomenon is still in its infancy but is likely to expand as the private market for health services and health education is potentially huge and the current supply is very limited. The advent of the private sector into health services /education, with their greater access to resource mobilization (from cost recovery), their freedom from existing civil service recruitment rules allow for a much greater degree of flexibility in terms of designing financial and professional development packages that will be attractive to Diaspora professionals.

There is good precedence for the likely evolution of this phenomenon in the rapid expansion of private (non-medical) higher Education in Bangladesh. The first private University in Bangladesh opened in 1993. Up to 5 years ago there were only ten private Universities. Now there are close to sixty. Because of the competitiveness of the market, private universities are actively trying to recruit Diaspora University Professors with attractive financial and professional development packages.
They are able to do this because they have access to significant financial resources (much greater than the public sector institutions due to cost recovery from student fees) and because are freed from onerous bureaucratic encumbrances. Thus they can follow international merit based norms in terms of hiring and promotion, and can design work environments that are challenging and attractive to Diaspora faculty (Rahman, MO, 2005).

The private University experience in Bangladesh provides some interesting pointers as to opportunities and challenges in mobilizing Diaspora health professionals, which are consistent with experiences elsewhere as well (Development Research Centre on Migration, Globalization and Poverty, 2005; ; Stilwell et al., 2003; Stilwell, 2001). These include the following:

1. As recovery of publicly supported health professional educational expenditure has not been particularly successful (either in terms of monetary paybacks or requirements of public service), efforts should be made to increase cost recovery for health professional education by raising fees and allowing the private sector to expand.

2. Diaspora professionals want the flexibility of both short and long term contracts. While some will actively consider permanently re-locating, others due to personal /family obligations are more interested in shorter duration sojourns. Institutions that have the managerial flexibility to accommodate both kinds of involvement are likely to be more attractive to Diaspora professionals.

3. Diaspora professionals are willing to return even at financial packages which are significantly lower than their current salaries in the developed world. Purchasing power parity calculations anecdotally suggest that for the North American Diaspora, maintaining the same life style would require 40-50% of US salaries. Because of other non-monetary advantages, and other sources of income (savings etc) professionals would most likely accept salary ranges which are lower say about 30% of US salaries.\footnote{Writing from Nairobi Loefler (2000)suggests that doctors "use their qualifications as a passport to freedom, intellectual and emotional fulfillment and professional satisfaction", and it is not only economic motives that "push" physicians to migrate” (Stilwell et al., 2001). Presumably the decision to return is also governed by similar concerns.}

4. The work environment is the key feature that figures in return migration calculations. Here providing an international environment where hiring, promotions, evaluations are based on transparent merit based criteria (not typically true in the public sector institutions) will make a huge difference (Development Research Centre on Migration, Globalization and Poverty, 2005).

5. The lack of a critical mass of equivalently educated peers to collaborate with in research and professional practice is a concern for many physicians. Here current internet technology (web and email) which allows for relatively seamless access to current information, and international collaboration minimizes this intellectual isolation.
6. Infrastructure limitations except in very specialized cases are not a major constraint. The private sector is able to mobilize significant resources to provide adequate infrastructure for research and teaching.

7. Concerns about educational opportunities for children are a major issue. Here again, at least in the major urban areas, fairly high standard private high schools exist. University education is still a problem, but getting better every year with the rapid privatization of the higher education sector. (Stilwell, 2003; Van Lerberghe, 2002, Stilwell, 2001; Mutizwa-Mangiza, 1998)

8. The lack of access to international standard health care services, particularly for emergencies has long been a cited deterrent preventing re-location of Diaspora professionals. This gap is now being filled with the recent setting up of several international standard hospitals in the capital city (Stilwell, 2003; Van Lerberghe, 2002, Stilwell, 2001; Mutizwa-Mangiza, 1998)

9. Last but not least, uncertainty about the political situation, basic personal security can be a major factor in the decision making of Diaspora professionals about re-location. Bangladesh has made good progress in this regard but there is still a lot to be done (Stilwell, 2003; Van Lerberghe, 2002, Stilwell, 2001; Mutizwa-Mangiza, 1998)

(viii-a) Policy Recommendations:

The following set of policy initiatives can be a good starting point for increasing the size of the health professional Diaspora, recovering some of the costs of publicly financed education of out migrating health professionals and enhancing health professional Diaspora-homeland interactions in the service of growth and development of the health sector in Bangladesh (Sorensen, 2004; IOM, 2003):

1. The government should move towards significantly reducing the subsidy for professional health education and allow vigorous private sector expansion, with appropriate safeguards for quality and equity concerns.

2. Concerted efforts should be made to raise the quality of health professionals in Bangladesh so that they can meet global standards. Particular attention needs to be given to raising English language skills, and standardizing curricula (Alimuzzaman, 2005)

3. In order to attract Diaspora professionals back either in the short or long term, local Bangladeshi institutions (in the private and government sector) need to create nurturing work environments similar to those in the developed world in terms of autonomy, transparency and minimization of bureaucracy. This may be more important than financial incentives (Development Research Centre on Migration, Globalization and Poverty, 2005).

4. Diaspora health professional organizations and local Bangladeshi institutions should collaborate in developing sophisticated web based database systems which allow matching of needs and gaps with professionals who can fill those needs. Although some government driven
initiatives in Africa exist\textsuperscript{17}, a more sustainable model if for such activities is for it to be commercially viable, because only then is it likely to continuously updated and current. A number of successful models in the private sector human resource realm already exist and should be emulated. To help level the playing field, subsidization of access to non-profit organizations can be thought of.

5. Removal / minimization of legal, political, bureaucratic hurdles which make it difficult for Diaspora health professionals to invest, provide services and collaborate with local Bangladeshis partners, and for a small but significant few to actually return back to the source country. These include:

- Easing of visa regulations to facilitate easy travel back and forth from Bangladesh\textsuperscript{18}.
- Allowing dual citizenship/voting rights which increase the likelihood of Diaspora professionals investing in and spending time in Bangladesh\textsuperscript{19}.
- Promoting more user friendly consulates / embassies/ airport arrivals
- Providing one-stop shopping for taking care of legal/financial issues with regard to Diaspora Bangladesh interactions\textsuperscript{20}.
- Allowing physicians with valid licenses in their current country to practice in Bangladesh, subject to rapid review.
- Relaxing civil service rules which prevent lateral hires of highly qualified Diaspora medical professionals in public sector institutions

6. Providing financial incentives for Diaspora health professionals to invest

- A variety of tax incentives to promote investment in underserved health care sectors such as nursing and allied health professional training etc should be considered. Efforts should be made to widely publicize available incentives.
- Providing tax free status to equipment used for humanitarian medical purposes

\textsuperscript{17} In Africa, IOM has started doing this by “circulating a questionnaire through Diaspora communities, health-related organizations, Embassies, higher education institutions, professional associations, hospitals, etc. and documenting the records in a database” (IOM, 2003). The database can be viewed by country of origin, country of residence, or by professional qualifications of candidates.

\textsuperscript{18} Bangladesh already provides NO VISA required stamps for originally Bangladeshi citizens who have emigrated.

\textsuperscript{19} This is already possible for citizens of US, Canada, UK, Australia and other selected countries. This list should be expanded. Absentee voting should be allowed.

\textsuperscript{20} Bangladesh has established a separate Ministry of Expatriate Welfare and Employment (MEWOE) but it lacks logistic and financial capacity (De Bruyn and Kuddus, 2005).
7. Publicly acknowledging and recognizing the contributions of Diaspora health professionals through forums, workshops, “Diaspora Days” with support from the highest administrative, political levels can help motivate Diaspora professionals to solidify linkages with Bangladesh.

One thing that must be reiterated here is that, although Diaspora involvement can be definitely facilitated by favorable government policies, interactions with the government sector is not the only and not even the primary means of such facilitation. Connections with NGOs, researchers, private entrepreneurs and social pioneers from the home country can also be useful channels that could be fruitful if properly utilized (IOM, 2005). This is particularly important in Bangladesh where there is a fast growing, socially and politically conscious civil society, and the NGO sector is very large and has been a pioneer in many health system initiatives.

(viii-b) Future Directions

Over the last decade or so, there has been an evolution in our thinking about out migration of health professionals from the developing world to the developed world. We have gone from a position of lamenting it to if not actually welcoming it, seeing it as having a potentially positive impact on homeland development. This transformation is shaped by our acknowledgement that: (a) health professional out migration is difficult to control effectively; and (b) there exists the possibility of significant transfer of financial and social capital from a large group of trans-nationals and the smaller group of return migrants which can have a significant positive impact on health sector development in the source country.

In order to actualize and optimize this potential for transfer of financial and social capital from the health professional Diaspora to Bangladesh, we need to transform the current sporadic, scattered individual initiatives into a more systematic framework which will contribute to sustainable growth and development in Bangladesh. This transformation requires changes both abroad and at home. As discussed in detail above, Diaspora professional organizations abroad have to (a) expand their membership base significantly so that they have access to a critical mass of health professionals who can be a potential source of transferring resources back home; (b) use appropriate internet based technology to identify members with appropriate skill sets and availability and match them with Bangladeshi institutional partners who have specific needs and gaps. On the Bangladeshi side what is required is (i) strategies to significantly increase the number and quality of health professionals in the country with the intent of increasing the size of the health professional Diaspora (ii) a clear articulation of gaps and needs where Diaspora professional skills can possibly help coupled with the active solicitation and recruitment of Diaspora professionals by both government and non-governmental institutions; (iii) the provision of positive incentives financial or otherwise to induce Diaspora resource transfer, and (iv) the removal of bureaucratic and legal hurdles that constrain effective Diaspora/Bangladeshi co-operation and collaboration.

21 India has instituted regular up of ‘Pravasi Bharatiya Divas’ or Non-Resident Indians (NRI) Day, to recognize the positive impact of the Diaspora
References


Bardak, U. (2005), “Migration trends in MEDA and a discussion on the links between migration and educational systems”, Briefing note for the ETF


IOM (2005), “Mainstreaming migration into development policy agendas”, published by Migration Policy, Research and Communications Department (MPRC), International Organization for Migration (IOM), Geneva, 2005


Newland, K (2003); “Migration as a factor in Development and Poverty Reduction”, Migration Policy Institute


