The migration of health professionals from high-disease burdened, poor and middle-income 'Source' countries to low-disease burdened, rich 'Destination' countries has been discussed at international forum for some years now, culminating in the May 2010 WHO Global Code of Practice on the International Recruitment of Health Personnel. The serious plight of countries in the Caribbean and sub-Saharan Africa has been highlighted both in the official discussions and in the mass media. However, conditions prevailing in India are quite different from those in many other 'Source' countries. India therefore needs to work out its own approach to address the migration issue.

Literature Review
Global Code of Practice on the International Recruitment of Health Personnel, 63rd World Health Assembly (WHO, May 2010) seeks to encourage countries to “mitigate the negative effects and maximise the positive effects of migration on the health systems of the source countries” without “limiting the freedom of health personnel, in accordance with applicable laws, to migrate to countries that wish to admit and employ them”. Most significantly, the Code states, “Member States should discourage active recruitment of health personnel from developing countries facing critical shortages of health workers.” Till the end of 2013, just 44 percent of Member States had reported the status of monitoring of the Code to WHO. The unfortunate part is that of the six WHO regions, only the European region had a satisfactory response rate (43 of 53 countries). Generally the response rate was good among the Destination countries; leading destination countries like USA, UK etc. had notified their National Authorities. The significant Destination countries which had not done so were Australia, New Zealand and the UAE. Among the Source countries, India was the most important country not to have notified the WHO. Also missing was South Africa, which is both a Source as well as a Destination country.

In the Middle Eastern countries not a single country reported progress in this area. Both Europe and the USA reported progress in the vital area of providing equality of treatment to migrant health workers. However, the Middle East, which is a very important Destination region for Indian nurses, had a poor record in this respect. The points arising from the symposium, 'Destination and Source Countries of Health Worker Migration Projects' held in September 2013, in which the author participated, followed by interviews with 15 key informants, is presented here.

Objectives
The study was conducted to provide an Indian perspective on the out-migration of Health Professionals in terms of its social context and its effects on the Health System.

Methodology
The author conducted interviews with 15 key informants. The break-up of the key informants was as follows:
- 6 were nurses, of whom 4 were serving or retired office-bearers of All India Nursing Bodies and 2 were Principals of Nursing Colleges;
- 4 were Medical Doctors, of whom 2 were Medical
Superintendents in hospitals of New Delhi and 3 were representatives of the Doctors’ Associations;

- 1 each was (a) a member of the Indian Pharmaceutical Congress Association (b) a member of the Physiotherapy Forum of India (c) an employee of a key recruiting agency and (d) a Senior Health Specialist working in the Public Health Foundation of India.

Results and Discussion

The minority view among the Key Informants was that migration was harmful for the Indian health system since it would mean the loss of persons trained in India without any substantial or meaningful compensation to the Indian health system from the recipient countries.

The vast majority of the key informants expressed a diametrically opposite view: that in the light of the fact that the number of health professionals being trained every year was quite large, it was unlikely that migration would ever form a significant percentage of the total number of health professionals graduating each year; in any case, if emigration ever showed signs of bringing about actual shortages in the availability of health professionals, there was ample scope for increasing the number of training institutes. In the meantime, the health authorities were actively promoting the opening of new medical, nursing and para-medical colleges. As such, according to this view, in India migration of health professionals was unlikely to seriously damage the health system.

The rural-urban dimension

As the respondent from the Public Health Foundation of India remarked, “Even if all the Doctors and nurses who have migrated, were to return, it would not solve the health care problem. One reason is that the rural-urban disparity would still remain, since health personnel prefer to work in urban areas because life is better in the cities.”

Private sector - public sector dimension

The responses of the Key Informants indicated that there was a basic difference between Senior Doctors and other Health Professionals in regard to the issue of migration. Salaries of senior doctors are higher in the private sector than in the public sector, thus encouraging many senior doctors to shift to the private sector. On the other hand, for junior doctors and all categories of other health professionals, both senior and junior, salaries are higher in the public sector and encourage them to shift to the public sector, wherever possible.

Current International Migration Scene

According to nearly all the respondents, despite the fall in outward migration following the outbreak of the economic crisis, many health professionals were still very keen to migrate.

Reasons for moving and staying

Many reasons were put forward:

- The ‘higher pay scales’ and ‘better quality of life abroad’ were cited as major reasons for migration.
- Opportunity for ‘professional growth’ and the ‘acquisition of new skills’ was mentioned as another factor.
- Frustration with an ‘unresponsive health administration’ was cited.
- The need to accumulate ‘money to pay for dowry’ was suggested as a factor in the case of nurses.
- Need to ‘repay heavy costs of private professional education’ was another reason given.

Among the factors responsible for some people not wishing to migrate, the following were suggested:

- Unwillingness to ‘live like second class citizens’ abroad.
- Desire to ‘serve Indian people’.
- ‘Patriotism’.

Scope for encouraging return migration

Many Key informants suggested that India should encourage the return of health personnel from foreign countries. However, some of them pointed out that such schemes already existed on paper but there had been immense problems in its implementation. The equipment and procedures in India were very different from those in the OECD countries and returnees had found it difficult to adjust here; some returnees found the new Private Hospitals geared to the Medical Tourism sector to be excessively profit-oriented. As for nurses, it was pointed out that maximum age bar in public sector meant that better paying Government sector jobs were not available to returnees.

There are reports that with post-2007 world-wide recession there has been a significant drop in the outflow of health professionals from India. Historical evidence suggests that major economic events such as the Great Depression of the 1930s had a tremendous impact on migration patterns for decades thereafter. The ongoing troubles of the world economy may possibly create a similar disruption in migration patterns. However, it is likely that within a few years
the old flows may resume and perhaps even increase, reason being, the share of older age-groups in the population is rising in such countries as USA and UK. Consequently more and more trained health professionals would be needed to look after the health needs of these older people. As for supply side, there is ample evidence from micro studies that many Indian health professionals, both young students as well as those with extensive working experience, are keen on migrating abroad.

The Indian situation needs to be understood in the context of very low per capita availability of trained health personnel. But the health personnel who graduate every year are not being fully utilised to provide health services to the people who are in real need, and most of them are absorbed in low-wage urban establishments geared to provide services to the fee-paying customers. Further, India has one of the most highly privatised health delivery systems in the world. In 2008-09, total health expenditure as a share of GDP was just 4.13 percent, making only 1.10 percent of public expenditure.

It is only expected that a mainly profit-oriented health sector would not be able to provide services to patients who cannot pay for them. On the other hand, for multiple socio-political reasons India is unable to make the public sector health system answerable to the people it is supposed to serve. The end result is that while the private sector caters to the rich and middle class, the public sector is in a terrible bureaucratic mess.

Although a very large number of Indian doctors have migrated to foreign countries the implications are not the same as in some of the smaller countries. This point was made some years ago by Mullan when he showed that the “Emigration Factor” (i.e. ratio of Indian Doctors based in foreign countries to the total number of Indian Doctors both at home and abroad) was 10.6 for India, far lower than for countries like Jamaica, Haiti, Ghana and South Africa and somewhat lower than its neighbours like Srilanka and Pakistan.

We should have proper understanding of the social context in which health professionals migrate from India to different countries. In India the issues arising out of the migration of nurses and other health professionals are quite different from the issues coming up in the Caribbean and sub-Saharan Africa. The very severe nature of the problems coming up in the Caribbean and sub-Saharan Africa has created an impression that the out-migration of health personnel needs to be curbed everywhere. This is not true for India.

There is a basic difference between the migration stream of nurses to the Western countries (mainly USA and UK) and the migration stream to the Middle East. Different policies are appropriate in respect of each of these streams. The first stream being in the nature of a permanent out-migration, there is need for ensuring some kind of bilateral understanding with the Destination countries such that they help to strengthen the nursing education system in India. The second stream being circular in nature, India is assured of a reasonable flow of remittances from these nurses; health policy must concentrate on ensuring that the returning nurses are usefully employed in the Indian health care system.

As far as Nurses are concerned, there is not enough information. However, it is possible to have rough estimates:

- There are no estimates of the annual migration of Indian nurses to the Middle East. However, this migration is essentially circular migration. The permanent loss of trained health professionals arises only in the case of migration to the OECD countries and that too, not in all cases. The two major destinations are USA and UK.
- The maximum annual enrolment of Indian nurses in UK was 3690 (in 2004-05).
- The maximum annual enrolment of Indian nurses in USA was 3458 (average between 2004 and 2008).
- The current annual capacity in BSc Nursing and Diploma courses is 1,89,469 seats.
- Even if migration levels go back to the maximum levels, the migration to USA plus UK would not exceed 4 percent of the annual seating capacity.

In recent years, partly as a result of the scope for nurse out-migration particularly to the USA, UK and Australia, there has been a very rapid expansion of the Nursing Education system. For example the number of Institutions recognised by the Indian Nursing Council for imparting the GNM course increased from 684 in 2004 to 2670 in 2012. Simultaneously the number of institutions recognised for BSc Nursing increased from 187 in 2004 to 1578 in 2012. When a system expands very fast there is always a danger that quality may not be maintained. The professional bodies in the nursing field must take care that this does not happen.

In some countries like Philippines which have been training nurses primarily for out-migration there has been a focus on training for the medical care environment found in the West. In India, as argued above, it is unlikely that the share of out-migrants in
the annual output of nursing students will ever exceed even 5 percent, and therefore it is necessary to maintain a balance between training for Indian conditions and training for the conditions that prevail in foreign countries.

Conclusion

Since India produces a large number of health professionals every year, it is unlikely that in the foreseeable future the number of emigrants would be large enough to significantly alter the availability of skilled health personnel. The international migration of health professionals by itself does not reduce the availability of health services to ordinary Indians and there is therefore no real case for restricting migration. With growth in INC-recognised institutions (for BSc Nursing 1578 in 2012), there is risk of quality degradation. The authorities must take care that this does not happen.

References


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- Chief Editor

Advice to the Contributors

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