INDIA

EXECUTIVE SUMMARY

Source country perspectives on the migration of health personnel –
A report from the literature

Destination and Source Countries of
Health Worker Migration
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Source Country Perspectives on the migration of highly trained health personnel:
Causes, consequences and responses.
Executive Summary

Health human resources are of critical importance to health outcomes and the overall sustainability of health systems. However, the migration of highly skilled health professionals from ‘source’ developing countries to ‘destination’ developed/high-income nations raises significant concerns for its impacts on health systems and health outcomes. India is one of the ‘source’ countries whose HHR migrate to ‘destination’ countries, which include Canada, the U.S., the U.K., Australia and others.

India is the second most populous country in the world. With a population of 1.15 billion, it accounts for 17% of the world population and has a substantial proportion of the global burden of disease: it accounts for 18% of global deaths, a quarter of global child death, and a fifth of global maternal deaths. Despite its high economic growth rate and improved status as a low middle income country, in 2005 the government spent only 0.9% of its Gross Domestic Product (GDP) on health care expenditures, which placed government expenditure on health in India as the sixth lowest of any country in the world. Compared to other countries in the region, health gains in India over approximately the last decade are demonstrable but somewhat modest, and differentially distributed across the country. Shortages of HHR in India accounts for a significant proportion of the global shortage of HHR, and migration of HHR from India is a contributor to shortages. The most recent data for top emigration countries of physicians rank India in first place, with approximately 10% of physicians trained in the country having migrated. With the addition of other migrating health professionals, the migration of health human resources from India is sizeable, and the costs and human capital losses that this represents for India is significant.

Few studies have examined HHR flows and their consequences in detail and there has been an almost exclusive focus on the migration of medical and nursing practitioners and lack of consideration of other highly skilled health professionals. Research to date has also given less attention to the range of policy responses that decision-makers at different levels have either taken or can select to stem the tide of emigrating health professionals or address domestic issues of health human resources distribution, and shortages. This report, based on an extensive and systematic search of the Indian sourced literature in particular, is intended to uncover and provide description of these issues in the context of an international study of source country perspectives on the migration of health personnel.

Context and Overview of the Indian Health System

India has undergone considerable changes since the 1970s. The Indian economy has experienced rapid growth which has propelled it towards being currently one of the world’s largest economies, and ranking 10th for Gross Domestic Product in 2012. Globalization and rapid economic change have led to significant social change including the expansion of the middle class. India is also undergoing demographic transition (including increase in life expectancy and declines in both death and birth rates) which has been largely held responsible for urbanization, and an epidemiological transition, in which
Chronic diseases are rapidly replacing infectious diseases as the major cause of mortality. Indian health care incorporates allopathic (Western) medicine and traditional Indian medicine (including AYUSH Ayurveda, Yoga, Unani, Siddha, Naturopathy and Homoeopathy). Administration of health care at the national level is complex, and this complexity is repeated at every level of government, including the state and district (local) levels. At the district level, health care is divided into hospital and non-hospital care, and municipalities have their own organizational arrangements.

A major feature of the Indian health care system is an increasing involvement of the private sector in financing and delivering health care; in 2005, the government spent only 0.9% of its GDP on public health care expenditures, whilst the private health sector accounted for 4.2% of GDP. The majority of private spending is out of pocket (82%), and little private spending is through insurance schemes. Access to health care is also heavily influenced by one’s social class and geographical location, with rural areas being significantly underserved. Those that can afford to pay privately for health care, also access a greater share of health services resulting in highly inequitable distribution of health care resources. The Indian public sector is seriously understaffed: the nurse-to-population ratio is 80 nurses/100,000 population is extremely low compared to recommended global standards.

While it experiences severe understaffing and shortages, India is one of the largest exporters of all health professionals, and the world’s largest supplier of physicians. Emigration of Indian-trained nurses is also significant, with estimates ranging from 20-50%. Popular routes of migration for Indian HHR are to the UK and the USA, and more recently to the Middle East. There is also evidence of two-step migration from India via the Gulf States and onto the UK and the USA. While there is some research and data on Indian physician and nurse emigration, data are either lacking, inconsistent or non-existent, and the migration of other healthcare professionals, has received little attention.

In combination these factors mean that over 60 years after Independence, most Indian citizens remain without access to primary healthcare services.

Factors Influencing Migration

Closer inspection of the migration of health human resources suggest a number of factors that influence the individual health worker’s decision to migrate. These have been referred to as push, pull, stick and stay factors. Push and pull factors both drive emigration or outward migration, the former from the source country, and the latter from the destination countries. Push factors incorporate factors that include the socio-economic and cultural milieux of a source country society, as well as those that emanate from the health system itself.

At the macro (national) level, corruption and prejudice in the health care system, poor infrastructure and inequities between the public and private sector can impact the decision to migrate from India. At the regional level in India, push factors which can impact HHR at the individual level, include low
remuneration, unemployment, poor working conditions including low health worker to patient ratios, experience of bullying and/or violence in the workplace and limited opportunities for training and professional development, and poor living conditions. For example, for many new nursing graduates in India, it may take up to several years to find a domestic paid position. At the level of the individual, low status of HHR can also contribute to pushing HHR to migrate. Other push factors are framed positively, for example, students who train in high status medical and nursing schools in India are expected to migrate by their families and return their support through remittances. Indian health professionals are often trained ‘for export’, with medical and nursing curriculum focused on skills that will likely be more useful in Western countries than for the provision of care within India.

Pull factors include employment in destination countries as a result of HHR shortages, for example; and at the individual level, HHR may be attracted by the promise of better remuneration and safer living conditions. Well-trained and English speaking Indian health professionals offer an attractive target for recruitment by many developed countries, and which can offer them greater opportunities for career development and continuing education. Foreign immigration policies, for example, those of the US and the UK, that are designed to ease the HHR migrant’s transfer and adjustment can also act as a pull, as do family members abroad and diaspora networks.

Stick factors are those that discourage mobility and emigration in general and increase health worker retention, such as good working conditions, job satisfaction and family ties or they may be negative such as barriers to obtaining visas and lack of financing for migration. Stay factors are reasons why emigrated health professionals remain in a destination country and weaken chances of migrant return. As Indians form the world’s second largest diaspora, stay factors are clearly not insignificant.

**Implications of Migration and Policy Responses**

There are direct and indirect impacts of health worker migration at several levels. Implications at the global level include worker migration flows and the ethics of HHR recruitment. Ethical recruitment is essentially the responsibility of the destination country, but several Indian studies have shown that healthcare professionals who were recruited and migrated from India, often experience lower levels of wages than domestic workers, and lack of respect in the workplace. Some HHR were misled by recruitment agencies. At the national and system level implications of migration include the financial costs and losses of migration, negative impacts on infrastructure maintenance or development, including loss of experienced faculty for health professional education in India, and career development, and impacts on health indicators and health outcomes. Remittances are seen as positive effects of Indian HHR migration although India does not collect taxation with regard to remittances, with the exception of a service tax on currency exchange. These monies, whilst benefiting individuals and families, do not benefit the country or the country’s health care system.
At the regional and local levels, migration of HHR has implications for increased workloads for remaining staff and for human resources management which include staffing considerations such as filling vacancies. While, health worker migration is not responsible by itself for low health worker-to-patient ratios, extensive HHR planning and resources are needed to meet a recommended nurse to patient ratio of 1:500. When HHR migrate from underserved rural and remote areas, where staffing and other resources are extremely limited, the impacts are often profound.

India is in the process of developing and implementing policies at each level and through several different approaches to address system shortcomings and HHR shortages and, by implication, health worker migration. At the global level, India has worked with a number of international organizations, including the IOM, the WHO, the ICN, and other international NGOs on migration, ethical recruitment and other aspects of HHR migration including study of nurse faculty migration. India has also worked to establish agreements with some destination countries concerning HHR. However, there is little evidence of much activity, development or results at this level in the literature, including little to no efforts that substantially encourage return migration or ease re-settlement of health workers on return.

Policy activity addressing system shortcomings and HHR shortages and, by implication, minimizing the effects and push factors of health worker migration, takes place at the national level. The National Rural Health Mission (NRHM) is perhaps the most important initiative moving towards increasing access to health care for rural and remote Indian citizens. The creation of new cadres of health workers, such as the Accredited Social Health Activist and the lay-worker Mitanin (friends), form one component. However, system design with its dependence on a national system may be improved by decentralization, and benefit the NRHM. In medical education, India has implemented a mandatory community service fulfillment for medical graduates: however, whether this has impact on graduates’ migration decisions has not been assessed, and for helping to address rural shortages of HHR, the strategy has been largely unsuccessful to date. Another solution to HHR shortages is mid-level cadre development, for example, a new 3-year training program for a new cadre of non-physician clinicians has been introduced in Chhattisgarh and Assam that focuses on training rural medical practitioners with skills in primary health care. This policy has raised more questions concerning quality of health care provision than actual solutions to some very difficult challenges of staffing rural regions, or offering the conditions in which potential migrants would want to stay. Concerns about quality of medical and nursing education are being addressed in some cases by the formation of collaborations with international schools of renown, although if improved social prestige or quality is an outcome of these collaborations, these are more likely to support migration than forestalling it. Significantly, resources that can be allocated towards improving the health system generally, remain poor. Although statements have been made about increasing the proportion of GDP on health spending, the percentage of GDP spending on health remains low and significantly lower than international targets.

There is however evidence in the literature of government policies and departments that are somewhat contrary to policies that directly or indirectly discourage ‘pushing’ potential migrants. These policies and departments support the export of labour and overseas non-resident Indians (NRIs), providing no support to the retention of Indian HHR, and helping to support overseas NRIs. Although there is some
evidence that medical tourism is encouraging some return migration with corporate (private) hospitals employing skilled and experienced ‘returning’ Indians, the numbers suggested are very small. Medical tourism does appear to have potential for providing employment opportunities to HHR, however benefits to the Indian public are difficult to discern.

At the individual level, incentive schemes, such as the non-practicing allowance, and wage increases have been implemented to mitigate migration of health professionals. The non-practicing allowance is an incentive which compensates for physicians’ financial ‘losses’ from not being allowed to practice private medicine while they are in the public service. There is little evidence in the policy literature of other schemes designed to improve retention of HHR at the individual level, although there is good evidence that HHR are educated and raised in a culture that increasingly and actively supports migration. In general, India has tended to overlook human resource management and there has been poor data collection at different levels throughout the country. Although there is ample evidence of ideas, interventions and strategies for improving health in India, it is difficult to find demonstration of improvements in the literature.

Conclusions

India faces a myriad of challenges with regard to health system strengthening and improving basic access to primary health care in an equitable manner. The size of the population, the social and health disparities accompanied by demographic and epidemiological transitions that face this low middle-income developing country, and the pronounced disparities in access to health care, form the context in which a highly bureaucratized health system administration at different levels, struggles to coordinate limited resources, including health human resources. HHR migration is one of many factors that can contribute to HHR shortages, but retaining HHR is a lesser consideration for India’s attention.