MIGRATION OF HEALTH CARE PROFESSIONALS FROM INDIA-A CASE STUDY OF NURSES

Centre for Trade and Development (Centad)
In Collaboration with
WHO India Office, New Delhi.
2009

MIGRATION OF HEALTH CARE PROFESSIONALS FROM INDIA-A CASE STUDY OF NURSES

Centre for Trade and Development (Centad)
In Collaboration with
WHO India Office, New Delhi.
2009

The final Technical Report is submitted for the fulfillment of the Study on the aspects of awareness generation and implementation of awareness generation programme of the WHO-Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property funded by World Health Organization (WHO).

Centad is an autonomous, not-for-profit institution that seeks to strengthen the abilities of governments and communities in South Asia to make economic globalisation work for development. Established in 2004, it strives towards evidence based policy research that, in turn, provides a platform for more informed policy-making at multilateral, regional and national levels.

Authors

Anns Issac, Research Consultant, Centad
Nirmalya Syam, Associate Fellow, Centad

Research Co-ordination

Santhosh M.R., Associate Fellow, Centad

Foreword

Centad has played a key role in bringing issue of trade and public health issues such as the patents regime, improvement in drug research and development (R &D), drug nomenclatures under the aegis of the access to medicines programme and discussed the issues holistically. This has been noted with acclaim in the associated networks. Public Health Programme works to secure access to essential medicines for the poor in South Asia particularly India. The study on migration was undertaken to mainstream the development debate on Mode 4 services and the developing countries deficiency in health workers. We stand in a crossroad where there is substantial shortage of health workers and these workers are not getting good deal for decent standard of living. Under these circumstances the nursing personnel find opportunities elsewhere where they can get better job satisfaction and income. In this context the study attempts to examine why there is staff shortage of health care professionals especially the nurses in India and the impacts it has on services like the emergency preparedness, quality of care, patient safety and access to needed health care services especially for vulnerable populations. The work included an extensive review of literature and secondary data analysis. These analyses were supplemented by the field survey undertaken in Delhi and Kerala. Another important role the study has played is to examine whether migration has been the only and/or main cause for an inefficient health care system in India. The study has suggested insightful policy recommendations to balance the migration issue with appropriate policy intervention. It is conceived that no country can put a complete ban on migration as everyone has a right to migrate for better living. However, the 'right to health' aspect of people cannot be overlooked as health care professionals are not just like any other 'tradable' material and can considered as essential services. Considering the requirements of the situation, the state can regulate` migration in order to bring a balance between the demands of professionals and countries. This study is a pioneering work since very few are available on the nursing profession, even the data unavailability on paramedical workers makes analysis extremely difficult. I take the privilege to thank the WHO Country office, the Ministry of Health and Family, Government of India for giving us this opportunity and all the partners who helped us in giving their valuable guidance and last but not least the Public Health Team of Centad for having completed the work especially Nirmalya and Anns for completing the assignment single handed. Any comments or feedback on the report is warmly welcome.

Linu Mathew Philip
Executive Director
Centad

Acknowledgements

The authors are immensely indebted to a number of resource persons who are contributed to the study in different forms varying from conceptualization of the problem to analysis and final report at different stages. Although it is not possible to acknowledge every one cooperated with the data collection process, several individuals and organisations deserve special mention. In particular, we would like to thank all the participants-nurses, nursing students, migrated nurses, returned migrants along with other senior staff for finding out time for sharing their experiences from their busy schedule. We are also thankful to the hospital authorities in Kerala and New Delhi, recruitment agencies and coaching institutes. Without their support and cooperation, this study would not have been possible.

The authors are extremely thankful to Mr. Sunil Nandaraj for his valuable suggestions throughout the course of study. We would like to acknowledge the contributions of Ms. Anagha Khot of WHO India Office, Mr. Gopakumar and Mr. Santhosh in the form of constructive criticism at various stages of the project. We also thank Dr. Dipankar Rao (PHFI) and Rashmi (IHD) and Dr. Bimla Kapoor (IGNOU) for their valuable inputs in the report. We are also thankful to Linu, Ranja, Roopam, Anurag and all other staff of Centre for Trade and Development for valuable suggestions. Special thanks are due to Jayashree and Raj for handling the accounting works promptly, Shaily and Sweety for administrative support.

We are also thankful to Directorate of Health Services and NRHM office, Trivandrum, Bureau of Immigration, New Delhi for the support to the project. Our special thanks are due to the library staff at Centre for Developmental Studies Library, National Institute of Health and Family Welfare, Jawaharlal Nehru University, National Medical Library and Centre for Women's Development Studies for their cooperation.

The authors would like to acknowledge the able guidance and support provided by WHO India Office to successful completion of the project. We hope and believe that the present study is able to do justice to the stated objectives within the limits of time and other resources and will create more discussions in the related field of knowledge. However, the views expressed are solely of authors and do not necessarily in anyway reflects the opinion of Centad and supporting organisation.

Anns Issac

Nirmalya Syam

Contents

Table of Contents

List of Tables

List of Figures

List of Boxes

Abbreviations

AIIMS	: All Indian Institute of Medical Sciences
ANM	: Auxiliary Nurse Midwife
B.Sc.	: Bachelor of Science
CBHI	: Central Bureau of Health Intelligence
CGFNS	: Commission on Graduates of foreign Nursing Schools
CHC	: Community Health Center
EU	: European Union
GATS	: General Agreement on trade in Services
GDP	: Gross Domestic Product
GOI	: Government of India
ICN	: International Council for Nurses
IELTS	: International English Language Testing System
INC	: Indian Nursing Council
MBA	: Master of Business Administration
MFN	: Most Favoured Nation
MoHFW	: Ministry of Health and Family Welfare
NCMH	: National Commission on Macroeconomics and Health
NHS	: National Health System
NRHM	: National Rural Health Mission
OECD	: Organisation for Economic Co-operation and Development
PHC	: Primary Health Center
RCN	: Royal College of Nursing
RQAN	: Return and Reintegration of Qualified African Nationals
UK	: United Kingdom
UNCTAD	: United Nations Conference on Trade and Development
US	: United States
USGAO	: United States General Accounting Office
WHO	: World Health Organisation
WTO	: World Trade Organisation

Executive Summary

The liberalization of trade in health services in many countries has facilitated an increase in international migration of health professionals from developing to developed countries. It is assumed that the economic gains from migration may translate into greater financial resources to be invested in improving the public health services in the country. Moreover, it is argued temporary migration can ensure that migrant health professionals return with improved skills which can be internalized and applied widely, thereby improving the quality of health services. In the context of the fact that India and other developing countries have been stridently seeking commitments from developing countries in Mode 4, this raises the issue whether the GATS regime is fundamentally incompatible with the public health problems that have surfaced due to migration of health professionals from these countries.

There is a dearth of health workforce in India and there is no visible initiative that addresses the problem born of outward migration of health workers. Indeed, the policy thrust is predominantly on encouraging such migration and there is no indication of any requirement to ensure the return of health care professionals or an adequate supply of workforce to counter this exodus. The neo-liberal opinion holds that the negative implications of migration can be counterbalanced through gains secured from migration; others argue that migration has an inherently negative implication on the availability of health professionals in developing countries. There is dearth of information in this area and foreseeing the less chance for decrease in migration, the study seeks to examine the factors that encourage migration of health professionals from India and its public health implications in the context of WTO agreement under GATS Mode 4. The study involves a case study on the migration of nurses from India.

The main objective of the study is to understand the factors governing migration of health care professionals from India and its implications for the health service system. The specific objectives are: (1) to study the trend in migration of health care professionals from India since 1990, (2) to understand the reasons for migration of health care professionals from India, (3) to analyse the implications of international policies associated with migration and (4) to explore the implications for migration on health service system in India.

Primary data was collected through a field study focussed on health care professionals in Kerala and New Delhi. Sampling techniques employed were purposive random sampling and snow ball sampling taken into consideration of the characteristics of the respondents

and feasibility of the study. The key informants identified are nursing students (Diploma/BSc.), nurses (Diploma/BSc.), migrated nurses and returned nurses, administrative authorities, tutors and doctors as well as senior nursing staff, recruitment agencies and coaching institutes, and patients. Informal discussions, in-depth interviews, focussed group discussions and survey method was adopted with various respondents to elicit information and all the participation was voluntary. Secondary data was collected from both published and unpublished documents which include census reports, journals and newspapers, books and theses, records from state health services system, Indian Nursing Council, CBHI etc will be used. Collected data were analyzed using qualitative and quantitative technique and the limitations of the study were identified and reported clearly.

With the help of field data and literature review related to migration of health care professionals globally, the study, analyses the arguments both favoring and opposing migration, expresses the concern for tackling the severe staff shortage in India, but at the same time emphasize the need for managing the push and pull factors effectively. One of the major arguments favoring migration is that it helps in reducing educated unemployment, but with reference to health professionals, migration cannot be regarded as a fall-out of the lack of employment opportunities in the domestic health care sector. It has to be admitted that the lack of satisfactory employment opportunities within the country is a major push factor behind migration of the health professionals. The trajectory of migration leads to an urban concentration of health care professionals in centers where it is easier to have a base from which to migrate and the consequent dearth in smaller towns and rural centers. The study shows that those who migrate are having minimum two years of experience in the home country. This also leads to a loss of experienced health professionals both in service and teaching in the domestic health sector. This freezes the level of skills available in the domestic health sector to the beginner's level, and increases the workload of the few experienced and overburdened professionals who remain in the country.

The field survey reveal that most of the remittance is spent on building big houses, buying land, purchasing luxury items including vehicles, repaying loans and for children's marriage etc. and it does not necessarily compensate for the brain drain. In addition, the returned migrants find it difficult to work in the home country as the setting do not recognize the advanced skill of the migrants, both in terms of facilities and remuneration. Currently there is no mechanism to ensure return of migrants and there is a complete unavailability of data on migration. It needs to be noted that migration of health professionals from India such as doctors and nurses has been happening without there being any GATS commitment binding developed countries to do so. Indeed, migration of health professionals from India has steadily increased. All that the developing countries are seeking in the GATS negotiations is to lock in this market for their migrant workforce for

the foreseeable future by removing all conditions which may limit market access for their professionals. But in this process, the interests of the people in the developing country should not be sidelined.

The study could not explore deep into the degree of association between migration and staff shortage currently in India, but it point towards the existence of an association. The study put forward the following suggestions in order to strike a balance between the rights of workers and 'right to health' issue of people in both home and host countries:

Ensure quality of training, introduction of courses and new institutions should be based on a need assessment giving priority to domestic demands,

Maintain proper data base of migrants,

Ensure ethical recruitment practices,

Ensure the security and welfare of the migrants in destination countries,

Incentives for return and ensure the use of skill by returned migrants,

Improve the condition of health service sector in India, provide opportunities for professional improvements and higher studies-promotion, improve status, recognition-awards for better performance,

Make arrangements for on the job training abroad and return,

Compulsory public service a necessary condition for migration, and incentives for rural area service.

Section I
Introduction

Background of the Study

The liberalization of trade in health services in many countries has facilitated an increase in international migration of health professionals from developing to developed countries. International migration of health professionals can be beneficial in the following ways: a) remittances from health professionals who migrate abroad can help nurture the economic growth of the home country; b) health professionals can acquire advanced skills by migrating abroad and bring back those skill sets and disseminate the same in their home country. From a public health perspective, one can think that the latter benefit may compensate for the temporary loss of health workers by enhancing the quality of health care in the long term. However, a sudden outflow of health professionals in the short run can lead to serious deficiencies in the domestic health sector of the home country, where public health institutions may not have adequate support staff to handle the voluminous work load. Migration of health professionals can reduce the quality of health services unless it is compensated for by the production of equally or better-skilled health professionals in the country. This is particularly significant for India where a large number of people are dependent on the public health service system. Moreover, since medical education including training of para-medics and nurses in India is subsidized, migration of these professionals effectively passes on the benefits of such subsidy to the foreign country and its health services consumers.

India is seeking market access commitments from developed countries for allowing Indian health professionals to migrate to these countries on a temporary basis under GATS[1] Mode 4 Negotiations. India was the largest source country of physicians for the US and the UK in the 1970s (Mejia et al., 1979). Indian trained doctors accounted for 18.3 per cent of the total foreign physician workforce in the UK in the year 2001 (OECD, 2006). India is the second largest source of foreign nurses who have qualified the US certification programme with about 6,962 nurses passing this requirement in 2004. It has been actively persuading the US to increase such facilities in the country. But there is little focus on the implications for the migration of health workforce on the home country.

[1] The General Agreement on Trade in Services (GATS) is a framework agreement for liberalizing trade in services. It establishes the first set of binding multilateral rules on trade in services. According to its preamble, GATS seeks: "… to establish a multilateral framework of principles and rules for trade in services with a view to expansion of such trade under conditions of transparency and progressive liberalization and as a means of promoting the economic growth of all trading partners and the development of developing countries; …. (GATS, Preamble)."

In India, the health service system is affected severely by the shortage of staff and other resources. While the WHO recommends a minimum of 100 nurses per 100,000 people, India had 62 nurses per 100,000 people in 2004. The National Commission on Macroeconomics and Health estimates that only 40 per cent of the nearly 1.4 million registered nurses are currently active in the country because of low recruitment, migration, attrition and drop-outs owing to poor working conditions (NCMH, 2005). There is a much higher density of qualified providers in urban areas than in rural areas. The other issue of import is the presence of unqualified and illegal private providers catering to the rural and urban poor (Gautham, 2006). Despite 229 medical colleges with an annual admission capacity of 25,600, nearly 700 primary health centres are without a doctor (Rural Health Statistics, 2005).

Despite such and other documented evidence of deficiencies in human resources afflicting the public health service system in India the policy thrust appears to encourage international migration and removes barriers to the same. There is no indication of any requirement to ensure the return of health care professionals or any policy to ensure an adequate supply of workforce to counter this exodus. The degree of migration is unlikely to decrease in the future because of increasing demand for health care professionals in many of the developed nations. The changing epidemiological profiles of developing countries characterised by the emergences of new diseases, the resurfacing of epidemics that had been previously controlled and the changing demographic patterns pose serious health challenges for their governments. These have to be tackled by the health workforce in an environment of meagre public resources and resultantly limited incentives that can be offered to retain health-workers. These asymmetries between host and source countries justify the need for interventions on this front. Within the context so outlined, this study seeks to examine the factors that encourage migration of health professionals from India and its public health implications. In order to examine the dynamics of migration of health professionals, a case study on the migration of nurses from India also has been conducted.

Objectives of the Study

Main Objective

To understand the factors governing migration of health care professionals from India and its implications for the health service system.

Specific Objectives

To study the trend in migration of health care professionals from India since 1990.

To understand the reasons for migration of health care professionals from India.

To analyse the implications of international policies associated with migration.

To explore the implications of migration on the health service system in India.

Methodology

The study utilizes both primary and secondary data. Primary data is collected through a field study focused on health care professionals in Kerala and New Delhi. Kerala state accounts for the majority of migration of health service professionals, especially nurses from India.This can have a significant impact on public health within the state because Kerala has a substantially aging population, which will depend increasingly on services from health professionals and nurses. Many of the premier nursing institutes in the country are located in Delhi and above all, Delhi is used as an intermediate platform for international migration. Four institutions from each state were selected. The selection of the institutions is done in a way that it ensures adequate representation of both public and private sectors. The institutions so selected were all well established ; the other criteria for selection included aspects such as a high bed strength, provision of both general and specialized services and the presence of training facilities attached to the institution. In the public sector, the selected institutions include medical college hospitals and district hospitals. The medical college hospitals are training centres for medical and paramedical professionals, besides which they offer that well-developed services that treat as critically ill and other difficult cases that cannot be treated in the peripheral hospitals. General hospitals or district hospitals are the nucleus of all the medical care provided in a district. In order to understand the nature and severity of migration, the survey was mainly focused on nurses. There are two categories of nurses in the hospitals viz., (1) diploma nurses who have undergone a three-year training in schools of nursing and are working as staff nurses in hospitals, and (2) B.Sc. nurses who go through a four year training programme in colleges of nursing and work mainly as tutors. The key informants included in the study are given below:

- Nursing students of both diploma and B.Sc. nursing.
- Nurses working in government and private institutions in Kerala and New Delhi.
- Emigrated nurses and returnees.
- Administrative authorities of institutions and government departments.
- Tutors, doctors and senior nursing staff.
- Recruitment agencies and coaching institutions for certification.
- Patients.

Box 1-1 Types of Nursing Programs: Terms & Conditions from admission at the Schools / Colleges of Nursing

No.	Nursing Programs	Eligibility Criteria	Training Duration	Examination	Registration
1	**Auxiliary Nurse & Midwife**	10 Pass	1 and 1/2 years	Nursing Examination Board	R.ANM
2	**General Nursing & Midwifery**	10+2 Class pass with aggregate of 40%	3 and 1/2 years	Nursing Examination Board	R.N & R.M
3	**B. Sc (Basic)**	10+2 Class Pass with 45% aggregate in PCBE	4 years	University	R.N & R.M
4	**B.Sc (Post Basic)**	**Regular**		University	Additional Qualification
		10+2 + GNM	2 years		
		Distance			
		10+2 GNM + 2year Exp.	3 years		
5	**M. Sc.**	B.Sc. Nursing / B.Sc. Hons. Nursing / Post Basic B.Sc. Nursing with minimum of 55% aggregate marks.	2 years	University	Additional Qualification
		one year of experience after Basic B.Sc. or Post Basic B.Sc. Nursing.			
6	**M. Phil**	M. Sc.	1 year (Full time)	University	Additional Qualification
			2 years (part time)		
7	**Ph D**	M. Sc./ M. Phil	3-5 years	University	Additional Qualification
8	**Post Basic Specialty Diploma Courses**	R.N & R.M	One Year	Board or University	Additional Qualifications
		one year of clinical experience			

Source: Indian Nursing Council (2009), *Types of Nursing Programmes*, available at http://www.indiannursingcouncil.org/types-nursing-programs.asp

The sample consisting of 60 nursing students, 100 nurses working in Kerala and New Delhi, and 60 migrated nurses was selected purposively Snow ball sampling was used to get access to migrated nurses and those who returned after migration. In addition to this, the researchers interacted with specialists in the field in order to obtain a multi-dimensional picture of the migration issue.

A pilot study was carried out in New Delhi in order to validate the tools for the primary survey. Wherever possible, group discussions with small groups of nursing students and nurses were carried out. Questionnaires were mailed to migrated nurses and telephonic interviews were conducted with many of them in order to ensure maximum participation. Information was elicited through informal discussions and in-depth interviews with various stakeholders. The tools include interview schedules, questionnaires and checklists targeted at differ1ent stakeholders with appropriate modifications. The semi-structured interviews were conducted with the aid of a checklist. A separate schedule was prepared for interviewing patients related to their perceptions on the quality of care they receive, the attitudes of health care professionals in general and nurses in particular towards them, difficulties that they face in accessing care, their socio-economic status and illness details.

The following themes have been covered broadly by the tools:

- Socio-economic and demographic details.
- Educational characteristics and motivations for taking up the profession.
- Intention and reasons for migration, process of migration including channels, benefits and costs associated with migration, trend and choices for migration.
- Working history, perceived quality of training facilities, wages and working condition.
- Opportunities for skill development in both parent country and destination country.
- Perception regarding status, autonomy and job satisfaction.
- Performance of nurses and intention to return.
- Shortage of staff.

Secondary data was collected from both published and unpublished documents which include journals, , books, dissertations and newspapers besides records from hospitals, clinics, district and state health services system, the Indian Nursing Council, medical colleges and nursing schools. The macro level statistical data has been collected from sources such as the Census of India, Economic Survey, data from MoHFW, NRHM and CBHI. The online sources were searched with the use of key words and phrases such as *migration of health professionals, brain drain, migration of doctors, migration of nurses, and migration of health resource persons*. The data collected from field survey is coded into excel and percentages are calculated for selected variables. For analysing qualitative data generated through interviews, colour coding technique is used.

Review of Literature

In the latter half of the past century, migration studies have produced a vast amount of literature; written from various conceptual, theoretical and methodological standpoints(King, Russell et.al, 2008). However we still lack a body of cumulative knowledge to explain the complexities of migration. The inability of the present body of knowledge to

"explain why some people become mobile, while most do not, and what this means for the societies where migrants come from, pass through and settle in" has been exposed by many researchers(Massey,1998). Massey in his paper argued that classical approach has entered into a crisis and is being challenged by new ideas and concepts and hypotheses. According to Castles, a conceptual framework for migration studies should take social transformation as its central category, in order to facilitate understanding of the complexity, interconnectedness, variability, contexuality and multi-level mediations of migratory processes in the context of rapid global change (Castles, 2008).

The use of the term 'migration" has itself come under question and arguments have been made in favour of the use of "mobility" instead as the former is thought to imply permanent movement. It is a well accepted fact that all highly-developed economies find themselves increasingly reliant on immigrant labour – at all skill levels. To many, migration is a *problem* that needs to be fixed by appropriate policies (Castles, 2008).

Migration can be categorized into different groups depending on spatial, temporal and professional dimensions: (1) Geographical – One country to another, and within the country from rural to urban, between states and/or small city to metropolitan area; (2) Temporary, permanent or transnational migration; and (3) One profession to another – for example, medical graduates opting for MBA and administrative services.

In the present study, we mainly concentrate on international migration of health care professionals. The phenomenon of the migration of high level manpower began to catch the attention of researchers only during 1960s (Margulies and Bloch, 1969; Mejia et al., 1979). Senewiratne (1975), through his study argues that there are many developed countries, such as the UK, the USA, Australia and New Zealand that rely on the supply of foreign trained doctors to maintain their health services and these doctors come especially from developing countries such as India, Philippines, Pakistan and Sri Lanka.

Since 1950s, doctors from overseas have formed a substantial proportion of medical manpower in the National Health Service in the UK (Smith, 1980). Doctors' migration to the UK reflects Britain's past historical and language ties with its former colonies. Smith made an extensive study on overseas doctors in the UK. According to him most of these doctors had their basic training in the country of origin but came to the UK to complete their training with the intention of returning after a few years. This pattern was made possible because basic qualifications granted by a large number of foreign medical colleges were recognized by the British authority. Although immigration has been subject to increasingly strict control from 1962 onwards, these personal security, higher standards of living, career development, possibility of high level specialization and aggressive recruitment marketing strategies (Maniple, 2004). Controls have never been extended to

qualified doctors (Smith, 1980). Most immigrant doctors to the UK came from the commonwealth countries; of who about half of them were from India (Mejia, 1979).

According to various researchers international migration of health workers appears to be driven by a number of pull factors such as the opportunities for professional training and better employment opportunities in the host country besides better salaries and perks. Push factors such as less attractive pay and working conditions, high unemployment rate, political instability and insecurity in the home country also pay a key role (Stilwell et al., 2004 (2004); Padilla, 2006). Poor remuneration, socio-economic and living conditions the lack of civic amenities such as schools for children, electricity, piped water, and telephone connections in remote areas discourage the retention of the health care professionals in these parts. Besides these the other reasons including professional isolation, heavy workload and lack of better career prospects encourage migration of health professionals. Temporary migration of professionals may be to acquire higher professional qualifications which are not available in the home country (Forcier, 2004). Thomas (1972) carried out a study on migration of physicians into the US. He argues that migration of physicians from the less developed countries to the developed countries was not only due to 'Pull Factors' from affluent countries. In fact there were 'Push Factors' in the donor countries (Thomas, 1972:170). The study says that push factors made it far more attractive for the physician to seek opportunities elsewhere than within his/her own country. For instance nurses in most developing countries report low levels of job satisfaction due to heavy workloads, long work hours, staff shortage, dissatisfaction with wages (compared to alternative career options) and a general move towards a more 'business' mindset (Aiken et al., 2002;Davis, 2003 Shields, 2004).

The direction of migration flows may also change over time. In the 1960s, many physicians working in developing countries originated from developed countries, but in the 1990s developing countries were estimated to supply about 56 per cent of all the migrating physicians (UNCTAD, 1998).Historical, administrative and legislative frameworks, training institutions, professional associations and regulation have influenced practices in former colonies and affected the migration of physicians for training and employment. This explains the significant migratory flows of physicians from India towards Australia, Canada, the US and the UK, and from North African and Middle Eastern countries to France. Indian physicians account for 9.6 per cent of foreign trained professionals in Canada (1998), 18.3 per cent for the UK (2001) and 19.5 per cent for the US in 2001 (Forcier et al., 2004). It is noteworthy here that countries like Philippines have a government approved programme for training nurses to cater to the needs of the developed countries (Aiken, Linda et.al, 2004).

Most of the literature has an anglo -centric framework. The severe shortage of health workers is a major health care issue for many of the western countries which work as a pull factor for professionals from outside. aging populations in these nations create an increasing demand for health care personnel (Shields, 2004). “Health professionals are the most precious health care resources, not money, beds or buildings. Shortage causes longer waits for surgery, can lead to delays in emergency care and deny patients a choice in who treats them. Shortages also cause stress among pressurized health workers and forces the health services to employ more temporary staff” (UKs King’s Fund, 2001). There is an ever increasing demand for health care professionals as aging of the population reduces the number of school leavers available to enter nurse training and as well as increases the number of nurses retiring each year (Buerhaus et al., 2000). For example, by 2010 approximately 40 per cent of the US nursing workforce will be over 50 years of age (USGAO, 2001). In the UK, 25 per cent of the nurses are expected to retire in the next five years (ICN, 2008).The level of educational achievement needed to enter nurse training has been increased in many countries in an attempt to increase the level of ‘professionalism’ in health care (Hardill and MacDonald, 2000). In developing countries such as India, there is a substantial increase in the demand for medical and paramedical courses during the last couple of decades (Percot and Rajan, 2007) whereas in developed nations, the demand is decreasing as has been pointed out in many studies.

Table 1-1

Countries receiving the most remittances, 2007

(estimates in US$ billion)

India	27.0
China	25.7
Mexico	25.0
Philippines	17.0
France	12.5

Sources: Development Prospects Group, World Bank

There are different views regarding migration of health professionals and its impact for the country of origin. Many studies focused on the remittance aspect of migration and compared the costs and benefits in monetary terms. Goldfarb argues that countries such as Cuba, India and Philippines produce more physicians than they need and send them abroad to benefit from remittance which helps the long-term development for the home country. The impact of emigration on the health care provision in the home country is limited as these countries have an adequate supply of physicians (Goldfarb et al., 1984). Temporary migration may benefit the source country through upgrading of skills, but permanent migration can harm the country since the cost on resources spent for educating the

professional and the cost of health care services that would have been gained if the physicians did not migrate are lost due to emigration (Forcier, 2004).

Stilwell points out that many of the 'exporting' countries are developing countries with weak health care systems and face severe staff shortage. Emigration causes brain drain in these countries and is likely to lead to deterioration in the working conditions of the physicians who stay back. It may affect access and quality of care, and impair the ability of the health care system to achieve health objectives of its population (Stilwell, 2003). The capacity of the parent country to provide quality training to new physicians and the research capacity of medical schools can also be affected by the migration of skilled professionals. In Nigeria and other countries in sub-Saharan Africa, most of the medical research institutions have collapsed because of massive emigration of highly skilled professionals (Ojo, 1990). On the other hand, the benefits to the host country include improved access to care and reduced medical care prices for consumers. Increased competition from physicians may raise the quality of service.

Box 1-2

Nursing Facts and Figures

- Research carried out in the South Pacific suggests that nurses are more likely to be remitters and remit a higher portion of their income than other migrants.
- The estimated cumulative value of remittances sent home by Tongan and Samoan nurses working in Australia is likely to surpass the costs associated with their initial training.
- Findings from a recent survey of international nurses working in London indicate that over half of respondents regularly send a portion of their earnings back to their home country.
- Approximately half of the respondents from the Philippines and South Africa indicated they were sending between 26% or more of their earnings home.
- The generation of remittance income is a major stimulus for countries that produce nurses for export, such as the Philippines, India, and China.
- Evidence suggests that remittances more than adequately make up for the economic losses associated with the migration of health professionals.
- Remittances have been associated with reductions in the poverty head count ratio in a number of low income countries, which are exporters of nurses — 11% in Uganda, 6% in Bangladesh, and 5% in Ghana.

Source: International Center of Nurse Migration. : Fact Sheet (2007)

The recognition of degrees across different countries controls the flow of migration. If the immigrant professionals have not gained adequate qualifications, it will hamper the quality of care in the host country. Many countries insist that the migrants undergo an equivalent examination to recognize their qualification. Professional associations employ the difference between practices and qualifications across different countries to exclude foreign professionals (Mossialos et al., 2001).

An analysis of national and international policies is required to understand the larger forces governing the migration of professionals across borders. Literature shows that in the US and the UK, migrant physicians are used as a supplement to the local labour in host countries. They are more willing to practice in certain organizational settings and certain geographical areas where the local physicians are unwilling to go. In the US, international medical graduates significantly contribute to care in rural areas (Bauer et al., 2002). . In the UK, general practitioners who have graduated from South-Asian medical schools (Bangladesh, India, Pakistan and Sri Lanka) are concentrated in the less attractive areas with large patient lists and relatively deprived populations (Taylor and Esmail, 1999). In Canada, policies requiring foreign physicians to practice in pre-specified areas have been legally challenged as a violation of basic human rights and have been judged against the Canadian Charter of Human Rights (Barer and Wood, 1997).

The literature on implications of such migration on the country of origin is very scarce. Maniple (2004) critically analyses the new policy adopted by the Ugandan government to facilitate 'export' of health professionals even though the country is facing severe health care crisis. He argues that it is a country that has taken measures to restrict the emigration of health workers, even short term migration in the late 1980s. However he describes the proposal that the administration came up with as self contradictory. He proposes that the possible forces behind such a proposal are the international economic order, local politics and reports of (in terms of remittance) success from other countries (Maniple, 2004). A study conducted in AIIMS, pointed out that graduates from high quality institutions account for a high proportion of emigrating physicians (Kaushik, 2008).

In recent years there has been an increased interest in the studies of migration due to GATS mode 4 negotiations. Under the GATS agreement, countries have the right to determine the extent to which they will make binding commitments for allowing market access to foreign firms and natural persons in various services sectors (WTO, 2005). GATS do not impose any general obligation on the members to grant market access in any service sector or sub-sector. Even where a member allows market access, it may do so subject to certain terms, limitations and conditions. These terms, limitations and conditions have raised many questions and have been a source of controversies. One of them is about the perceived benefits of GATS Mode 4 migration. There exists a great deal of uncertainty whether the job market entry through GATS Mode 4 will bring forth any positive outcomes to the developing countries (Wurcel, 2004, Jadhav, 2003).

GATS and Movement of Natural Persons

The scope of GATS in respect of movement of natural persons is determined by the terms of the GATS Annex C on Movement of Natural Persons. The Annex applies to measures

affecting natural persons of a WTO member state who either themselves supply a service in the territory of another member state, or to natural persons who provide such services in the territory of another member as employees of the service supplier of a member state. The Annex therefore applies to natural persons who migrate to another WTO member country to offer their services individually, or as intra-corporate transferees, contractual service suppliers or employees of Foreign Service suppliers. Natural persons of another member are deemed to supply their services in their individual capacity when there is a contract between the natural person and the consumer in the host country. Intra-corporate transfer happens when the natural person employed by a company in the home state is transferred to an office of the same company in another country. Commercial presence of the company is a pre-requisite for such migration. Contractual service suppliers are those natural persons who are employed by a service supplier company in their home country and sent to the host country to provide their services on behalf of the company they are employed in (WTO, 2005).

The GATS regime can be applicable to nurses who migrate as individuals or who migrate to provide services as contractual service suppliers. This means that once a country commits to allow the entry of natural persons from other countries to supply nursing services to a certain extent, such entry has to be provided to natural persons of all member states on an MFN (most favoured nation) basis (through same parameters for entry of natural persons from all members). However, members can still schedule in limitations to such access and limitations on national treatment to be provided to such migrant natural persons. Moreover, the Annex also states that the GATS regime shall not apply to measures affecting natural persons seeking access to the employment market of a member, nor shall it apply to measures regarding citizenship, residence or employment on a permanent basis. Members can also apply measures to regulate the entry and temporary stay of natural persons from other members in its territory. Thus, countries have the right to take measures to ensure that the entry of natural persons meets minimum qualifying benchmarks and is of temporary duration and also apply differential visa requirements (WTO, 2005).

The demand for health professionals from India and other developing countries in the developed nations suggests that there is significant potential for economic gains for the source countries if this demand can be locked in as market access commitments from developed countries under Mode 4 in the GATS negotiations. This economic ambition encourages a domestic policy environment that supports migration of health professionals from India. Indeed, various studies on trade in health services from India projects India as a formidable force on trade in health services through its position as a major exporter of health professionals such as doctors and nurses (CUTS, 2007). The impact of migration of its health professionals on India is generally cited as positive through a focus on the economic gains arising out of such migration in terms of increased inflow of remittances

and the generation of greater interest in the profession evidenced by a rise in the number of medical and nursing colleges in the country. It is also assumed that the economic gains from migration may translate into greater financial resources to be invested in improving the public health services in the country. Moreover, it is argued temporary migration can ensure that migrant health professionals return with improved skills which can then be internalized and applied widely, thereby improving the quality of health services.

Organisation of the Report

The first section gives an overview of the study, objectives, methodology, review of the related literature and a brief review of GATS (General Agreement on Trade in Services) and movement of natural persons.

The second section gives an account of the trend in migration of health care professionals since last decades through an analysis of available data

In the third section, we discuss the characteristics of migrants and the reason for migration through a case study of nurses.

The fourth section deals with the implications of migration on the health service system of the home country in the light of evidences drawn from field survey and secondary literature.

The fifth section discusses the major issues related to managing migration of health care professionals and staff shortage and the report concludes with recommendations.

Limitations of the Study

The non-availability of statistical information regarding the migration of health care professionals is a major constraint faced by the study. The attempts made by the researchers to collect data from different government offices related to migration, nursing school/college alumni records, hospital registries and recruitment agency records yielded little because of bureaucratic hurdles. Hence the analysis of trends in migration relies heavily on the information given by secondary literature which sometimes was dated and/or was based on small samples. Apart from this, the field survey conducted for the current project is limited to a small sample purposively selected from New Delhi and Kerala which gives an indicative picture of the current situation, however these results will have to be read with caution and may not be generalisable. The time and resource constraints limited the in exploration of various other inter-linkages revealed during the field survey.

Section II Trends in Migration of Health Care Professionals

The migration of skilled workers is not a new phenomenon, but what makes it different now is the volume and pace of migration along with the direction of flow witnessed over the last few decades. It is on the increase across a range of sectors (Findlay & Lowell, 2002). In the health sector, medical doctors, nurses and other health workers have always taken the opportunity to move across national borders in pursuit of new opportunities and better career prospects (Mejia et al., 1979). Health care professionals make up a small proportion of all migrating workers. But international recruitment and migration of health workers has been a growing feature of the global health agenda since the late 1990s (Buchan et al., 2003; Stilwell et al., 2003 & 2004) and appears to have the potential to undermine the attempts to achieve 'Health for All' by many of the developing countries. In this context, it is important to examine the characteristics of the mass movement of these highly skilled personnel across the globe in order to understand the possible threats and benefits it offers.

Box 2-1

Global Estimates and Trends of Migration

- In 2005, there were an estimated 191 million migrants worldwide, nearly half of them women.
- The total amount of remittances sent home by international migrants via formal channels in 2005 amounted to an estimated US $232 billion, with US $167 billion going to developing countries. This figure does not, however, take into account remittances passed through informal channels, which suggests the actual figure may be doubled, or by some estimates, tripled.
- Remittances are the second most important source of external funding for developing countries after foreign direct investment and ahead of overseas development assistance. The World Bank reports remittance flows to be twice the size of international foreign aid flows.
- Remittances of overseas Filipinos are expected to reach US $14.7 billion in 2007, up $1.9 billion from 2006. In many low-income countries, remittances represent a significant percentage of the gross domestic product (eg, 26.5% in Lesotho; 16.2% in Nicaragua; 5.8% in Burkina Faso).
- In Sri Lanka, remittances surpass earnings from tea export and exceed income gained through tourism in Morocco.
- US $1 in remittances generates US $2 in local economic activity.
- In 2004, the top five remittance-receiving countries were: India, China, Mexico, France and the Philippines.
- The United States, Saudi Arabia and Belgium were among the top three remittance-sending countries in 2001.
- Remittances are a lucrative income-generating activity for banks worldwide.

Source: International Center of Nurse Migration: Fact Sheet (2007)

The dynamics of migration is very complex, comprising issues of individual rights and choices, 'push and pull' factors, and approaches of different governments to manage human resources. There is no standardization of international documentation related to migration hence making inter- country comparisons difficult. There is also a lack of specific data on health professionals (Diallo, 2004). So the present study depends mainly on other micro and macro level studies – which are a few in number and specific to certain countries – along with data on related aspects from organizations including World Health Organization and Government publications. All types of health workers can migrate, but since the greater availability of data is for doctors and nurses only, the current analysis is limited to them.

The phenomenon of migration of high level manpower began to draw scholarly attention during 1960s. Historically speaking, emigration has been of three types: among developed countries, from developed to developing countries and from developing to developed countries (Ghosh, 2005). Mejia et al., (1979) classified countries as 'major donors' and 'major recipients' for convenience. However not all countries fall rigidly into any of these categories; for instance, countries such as Germany and the United Kingdom experience both inflow and outflow of workers (see Box 2.2).

Box 2-2

Classification of countries based on migration

Major donors	Major recipients	Both donors& recipients
India, Pakistan	US	UK
Sri Lanka, Philippines	UK	Germany
South Africa, Nigeria	Canada	Canada
Ghana, UK, Canada	Australia	
Germany, New Zealand	Germany	

Considering the net inflow of professionals, the developed countries are always at an advantage. In the United Kingdom, approximately a third of the total of 70,000 NHS hospital medical staff in the year 2002 was from other countries. Over 10,000 doctors immigrated to the UK in 2003 while 8,000 nurses moved out of the country during 2004-05. The major source countries are India, South Africa, Australia and the European Union. UK has an explicit international recruitment policy to assist in increasing NHS workforce. Table 2.1 provides the number of emigrated physicians and the top source countries for the same.

Table 2-1

Top Five Source Countries of Emigrating Physicians, 2000

(number of emigrated physicians - in thousands)

India	20.3
U.K.	12.2
Philippines	9.8
Germany	8.8
Italy	5.8

Sources: Docquier and Bhargava (2006); http://go.worldbank.org/P9Y9CG7DF0

According to Mejia et al., (1979), in 1972, about 6 per cent of the world's physicians (140,000) and 4 per cent of nurses (135,000) were located elsewhere than in their countries of origin. Over three-quarters of them were found in only three countries: in order of magnitude,

the United States of America, the United Kingdom and Canada. India, Pakistan, Philippines, South Africa, Nigeria and Ghana have been the major source of countries of international migration of health care professionals.

Global Demand for Health Care Professionals

There is a world-wide shortage of trained personnel in the field of health care. The demand for health care professionals has risen with increasing health care needs of aging populations. The shortage in health care professionals in developed countries can be owed to difficulties posed by high investment s required to train and produce them, the long training periods acting as disincentives to the younger generation in joining the profession and the retirement of old staff. O the other hand in developing countries, the shortage is related not only to production of sufficient numbers of trained personnel, but also their iniquitous distribution, delays in creation of sufficient posts, attrition and migration. Better facilities in the developed countries in contrast to the poor pay and working conditions at home attract health workers from developing countries to developed destinations. The major 'push and pull' factors often cited for migration are given in Box 2.3.

Box 2-3

Major push and pull factors

Push factors	Pull factors
Low pay (absolute and /or relative)	Higher pay, opportunities for remittance
Poor /dangerous working conditions	Better working conditions
Unemployment	Bette resourced health system
Lack of resources	Career opportunities,
Limited career opportunities	Provision for post-basic education
Limited educational opportunities	Higher standard of living
Impact of HIV/AIDS	Travel opportunities
Economic/political instability	Aid work, political stability

Source: Buchan et al., 2003.

The opportunities of migration created by the the demand in developed economies, contributes to the exacerbation of imbalances in health worker distribution in source countries. For instance, African countries are facing a severe crisis in health care delivery because of the loss of man power to developed countries. Data from OECD countries indicates that the health workers trained abroad constitute a significant percentage of the work force in most of them (see Table 2.2). The United States currently employs the greatest number of foreign-trained doctors and nurses, followed by the United Kingdom.

Table 2-2

Doctors and nurses trained abroad working in OECD countries

Country	Doctors		Nurses	
	Number	% of total	Number	% of Total
Australia	11,122	21	NA	NA
Canada	13,620	23	19,061	6
US	213,331	27	99,456	5
UK	69,813	33	65,000	10
Germany	17,318	6	26,284	3
Ireland	NA	NA	8,758	14
New Zealand	2,832	34	10,616	21

Source: World Health Report, 2006.

The changing demographic profile in the developed countries started giving priority for recruiting nurses rather than physicians. According to projections the old age dependency ratio in the European Union is expected to double to 54 per cent by 2050. The number of nurses in the UK from the non-EU countries grew nearly eight fold- from approximately 2,000 in 1994-95 to more than 15,000 in 2001-02. In the US, the percentage of nurses trained abroad more than doubled from 6 per cent in 1998 to 14 per cent in 2002. Migration of nurses from Philippines increased more than three times in 2001 compared to 1996.[2] Nurses account for approximately 70 per cent of the total migrating health care professionals (Kumar and Simi, 2003). The projected shortfall for nursing personnel in different developed countries clearly shows that the demand is going to increase further in the coming decades (Table 2.3).

Table 2-3

Shortage of Nurses in Selected Countries

Country	Projected Nurse Shortage
USA	275,000 RN FTE shortfall in 2010 808,000 RN FTE shortfall in 2020
England	108,000 additional RN FTEs needed by 2020
Wales	6,000 additional RNs needed by 2010
Scotland	12,000 additional RNs and midwives needed by 2007
Australia	Projected shortage of 40,000 nurses by 2010
New Zealand	RN shortages reported throughout health sector

Source: Jean Ann Seago (2009), *The Global Nursing Shortage and Nurse Migration* Center for Policy Analysis on Trade and Health.

Shortage of nurses in the US is projected to be 275,00 by 2010 and 808,000 by 2020 (Jean Ann Seago, 2009). At the end of the 1990s, the US had just over half of the world's highly

[2] Migration Policy Institute, 2004. The Global Tug of War for Health Care Workers, Migration Policy Institute, December 2004.

skilled migrants from the developing world (Carrington and Detragiache, 1999). Sub-Saharan African countries are facing acute staff shortage while the total number of nurses and mid-wives from Sub-Saharan Africa in OECD countries comprises 5 per cent of the source country work force (WHO, 2006). Given below is a table showing the distribution of physicians and nurses in major source and host countries. It is self evident that the major source countries have a low density of both nurse s and doctors in sharp contrast to all the host countries that enjoy a very high density of both categories of health workers.

Table 2-4

Distribution of Physicians and Nurses in Selected Countries

Countries		Physicians			Nurses		
		Number	**Density per 1000**	**Year**	**Number**	**Density per 1000**	**Year**
Source countries	South Africa	34829	0.77	2004	184459	4.08	2004
	Philippines	44287	0.58	2000	127595	1.69	2000
	Zimbabwe	2086	0.16	2004	9357	0.72	2004
	Nigeria	34923	0.28	2003	210306	1.7	2003
	India	645825	0.6	2005	865135	0.8	2004
Host countries	US	730801	2.56	2000	2669603	9.37	2000
	UK	133641	2.3	1997	704332	12.12	1997
	Ireland	11141	2.79	2004	60774	15.2	2004
	Canada	66583	2.14	2003	309576	9.95	2003
	Australia	47875	2.47	2001	187837	9.71	2001
	NZ	9027	2.37	2001	31128	8.16	2001

Source : Compiled from Annexe Table (4), The World Health Report 2006.

Health Care Professional Migration from India

From the limited secondary data sources, an attempt has been made to present a historical overview of migration of health care professionals from India. It is difficult to get a precise estimate of the number health care professionals who have migrated. There is no current mechanism to track overseas migration of medical professionals from India. The departments such as the Office of Protector General of Emigrants and the Bureau of Immigration who are in charge of collecting information about the people who are going abroad do not have any disaggregated information based on occupational qualification. In fact, those with professional qualifications are exempted from an emigration check from these offices.

A separate section on 'Indians Abroad' was included in the National Registry of Scientific and Technical Personnel of India in the year 1958 to gather information related to this matter.

Indian scientists, engineers, technologists and medical personnel going abroad for study, training or employment were encouraged to register in this section.

Table 2-5

Registered records of Indians abroad in the medicine field

Year	Indian medical personnel abroad
1959	187
1960	295
1961	403
1962	583
1963	850
1964	1,175
1965	1,575
1966	1,910
1967	2,135
1968	2,384
1969	2,670
1970	2,945
1971	3,218
1972	3,385
1973	3,582
1974	3,726
1975	3,855
Total	**34,878**

Source: Roy, 1975[3].

It is clear from Table 2.5 that there is an increasing trend in the out migration of medical personnel from 187 in 1959 to 3,855 in 1975.

Apart from the major 'push and pull' factors mentioned earlier, the choice of destination country is decided upon by taking into consideration many other factors, such as geographical proximity, shared language, customs, educational curricula and professional qualifications. Post colonial ties (including similar educational curricula and language) are also a major factor especially in some EU countries. The direction of flow of health workers in India is mainly to the US, the UK, Canada, Australia, Germany and the Middle East.

Ash and Mitchell (1968) found that every two out of three non-British doctors practicing in Britain during 1965 had come from developing countries, mainly India and Pakistan. About 700 doctors from India migrated to Britain during 1962-64[4]. India is the largest source country for physicians in the US and the UK and ranks second and third in the case of Australia and Canada respectively (see Table 2.5).

[3] Data available on that source is till 1975 only.

[4] R. Ash and H. D. Mitchell (1968), Doctor Migration 1962-64, British Medical Journal, March 2, pp.569-72

Table 2-6

Share of Indian physicians in the immigrant medical graduates in selected countries

Recipient country	Source country	No of IMGs (% of workforce)
US	India (**Rank 1)**	4.9
	Philippines	2.1
	Pakistan	1.2
UK	India (**Rank 1)**	10.9
	Ireland	2.1
	Pakistan	1.9
Canada	UK	4.0
	South Africa	2.6
	India (**Rank 3**)	2.1
Australia	UK	8.6
	India (**Rank 2**)	4.0
	New Zealand	3.2

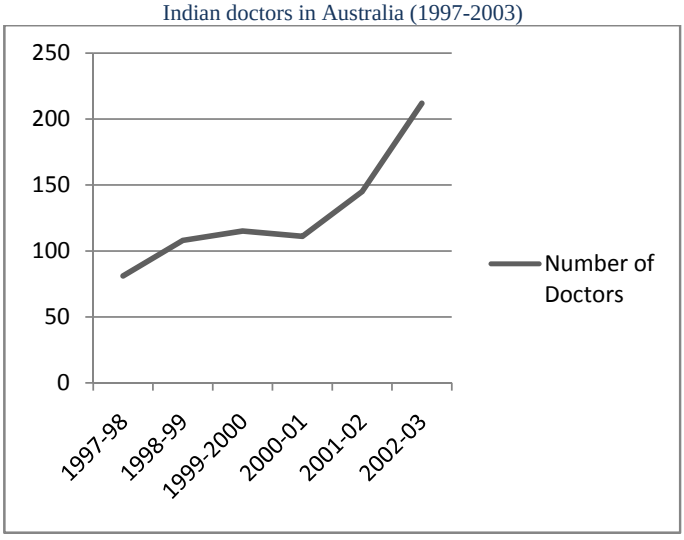
Source: Mullan, 2005.

There are an estimated 60,000 doctors of Indian origin working in the UK and around 35,000 in the US. Besides, India has bilateral agreements with six Middle Eastern countries and some others for recruiting private and government doctors on short term assignments (Chanda, 2001). About 3,000 Indian doctors migrated to the US during 1988-90 (Kanjanapan, 1995).

The rates of emigration have not increased but emigrating professionals are now finding newer destinations. For instance, the flow of Indian physicians to Australia has increased considerably from 81 in 1997-98 to 212 in 2002-03 (see Figure 2.1).

Figure 2-1

Indian doctors in Australia (1997-2003)



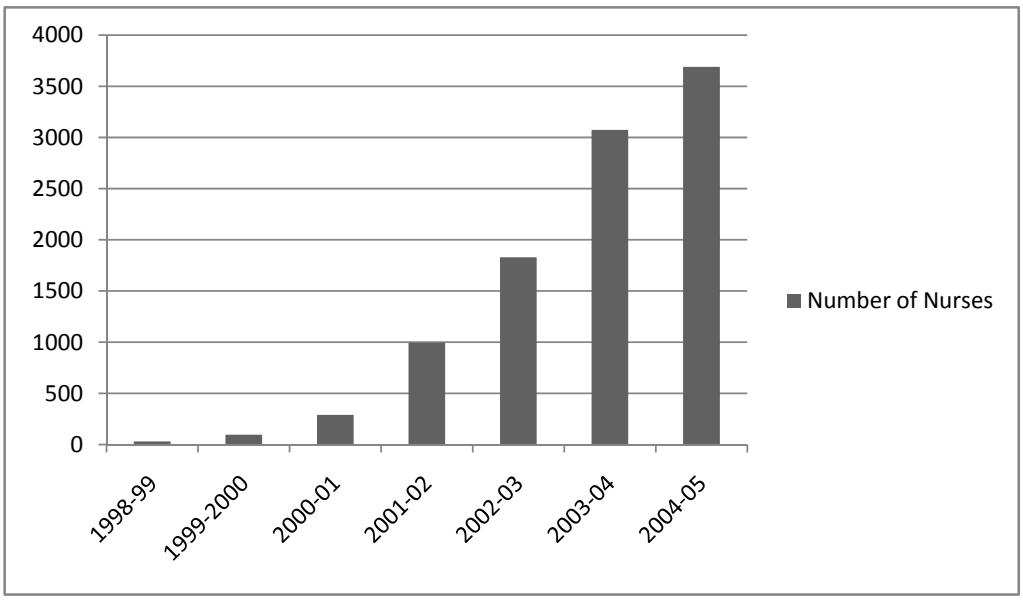
Source: Birrell, 2004.

The number of nurses taking CGFNS exam from India shows a rising trend as is evident from the data. In the period between 1990-95, there were 900 Indian candidates, and the number

rose to 1,981 during 1996-2000 and it was 24,242 in 2000-2006. The number of Indian nurses registered in the UK has been rising (see Figure 2.2). Moreover, India out-numbered Philippines in 2004-05; there were about 2,521 nurses from Philippines registered n 2004-05, as against 3690 from India.

Figure 2-2

Indian nurses registered in the UK: 1998-2005



Source: Bach, 2006.

The process of migration to the Gulf started during the 1970s, and there is an increasing movement of health professionals, especially nurses, to that region. There is no authentic estimate of the number of Indian health workers in the Middle Eastern Countries, but as per unofficial records, over 60,000 nurses are working there (Kumar and Simi, 2003). Most of the nurses are from Kerala. Though doctors are not present in large numbers in the Middle East, some countries have a substantial presence of Indian doctors. According to the Report of the High Level Committee on Indian Diaspora, there are about 2,000 Indian doctors in Oman (GOI, 2001).

Circular Migration

Migration is not just a one-way flow from origin to destination – health workers may leave one country to work in a second, and then either return to their home country, or move on to a third. For instance, Filipino nurses working in Ireland have been actively recruited in Australia (Marino, 2002). How much migration is temporary and / or permanent? We do not have any reliable information on this matter. Migration to Middle East is a temporary platform for migration to West for many of nurses (Percot, 2006). Table 2.7 shows the number of doctors of Indian origin in the US based country of last residence other than India. According to Mejia (1979), not all physicians of Indian origin went directly to the US. Of the 357 entering the US as immigrants in the year 1970, only 229 gave India as their country of last residence while 55 gave UK and 40 had been in Canada.

Migration for Higher Studies

There is a spectacular increase in the flow of foreign students into the OECD countries. The World Health Report (2008) observes that certain countries are developing specific policies to attract and retain highly skilled students, which is a strategy to combat health worker shortage. Table 2.7 describes the flow of Indian doctors going abroad, stating the purpose as higher studies/ training during 1995-1998.

Table 2-7

Distribution of Indian doctors trained abroad

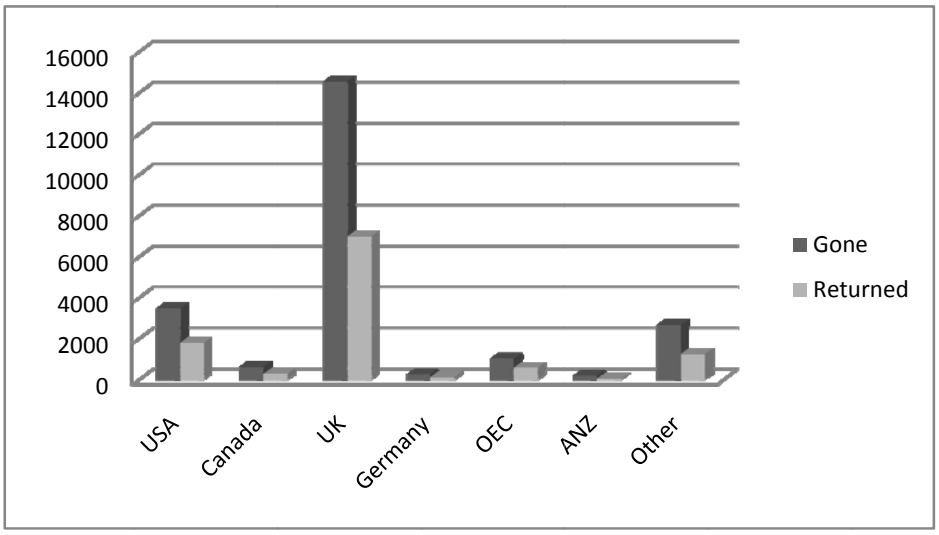
Country	1995		1996		1997		1998	
	Gone	Returned	Gone	Returned	Gone	Returned	Gone	Returned
USA	864	446	869	448	872	449	873	450
Canada	154	67	154	67	154	67	154	67
UK	3,624	1,741	3,634	1,747	3,644	1,752	3,648	1,754
Germany	65	27	65	27	65	27	65	27
OEC	253	141	254	142	255	143	256	144
ANZ	45	8	46	8	50	11	53	12
Other	662	312	663	312	668	315	669	316
Total	5,667	2,742	5,685	2,751	5,708	2,764	5,718	2,770

Source: Council for Scientific and Industrial Research. OEC - Oil Exporting Countries; ANZ-Australia and New Zealand.

Migration for higher studies is a case of temporary migration and acts as a launch pad for work related migration. Throughout these years, more than half of the total number of doctors who moved for educational purposes did not return to India. The UK attracted most of the doctors, followed by the USA (see Figure 2.3).

Figure 2-3

Flow of Indian doctors for training abroad (1995-98)



Source: Council for Scientific and Industrial Research (1996-1999).

Nearly 23,000 Indian medical graduates migrated to countries such as the US, the UK and Canada for higher studies during 1995-1998. More than half of them did not return to India after study.

Section III Case Study of Nursing Professionals

This section tries to explore the various reasons for migration of health care professionals from India. In order to understand the nature and severity of the problem, a systematic and comprehensive field survey has been conducted among nursing students, nurses and migrated nurses from India. In the hospital, nurses are among the most important providers of patient care. The present study is conducted in New Delhi and Kerala.The data presented here is based on the individual perceptions of the key respondents on matters of migration and working conditions in India and abroad. Interviews and discussions are conducted with selected respondents using semi-structured questionnaires and checklists in order to get relevant information. Responses from a total of 220 key respondents, spanning across different categories were sought in order to understand the major issues. The areas explored include the role of socio-demographic factors, perceived working conditions in India and abroad, channels for migration, migration preferences, opportunities for skill enhancement and return of migrants are discussed in detail.

Profile of the Respondents

The sample includes 60 nursing students, 100 nurses who are currently working in Kerala and New Delhi and 60 emigrated nurses from Kerala. The general characteristics of the respondents are given in Table 3.1.

Table 3-1

Profile of the respondents

Characteristic		Nursing students	Nurses	Migrated nurses
Age	19-22	60	-	-
	23-25	-	53	-
	26-30	-	38	26
	31-35	-	9	34
Sex	Male	8	4	5
	Female	52	96	55
Marital status	Single	60	63	9
	Married	-	37	51
Religion	Hindu	21	36	24
	Christian	33	57	33
	Muslim	6	7	3
Basic educational qualification	Pre-degree/Plus 2	60	90	54
	Bachelors not completed	-	7	6
	Bachelors completed	-	3	-
Professional qualification	Diploma nursing	48	100	52
	B.Sc. nursing	12	-	8

Table 3.1 reveals that nursing students (both diploma and BSc. engaging in their final years of training) fall under the age group 19-22. The majority of nurses under the study

who are working in India are in the age group of 23-25 and constitute around 53 per cent of the total nurses. Among the migrated nurses, 57 per cent are above the age of 30 while 43 per cent fall in the 26-30 age group. The meagre presence of males in the three categories shows that, nursing continues to be a female dominated profession. However males are also entering this profession owing to the promise of secure employment. In Kerala, 20 per cent of the seats are reserved for male candidates in nursing schools.

All the nursing students under this study are unmarried while about two thirds (63%) of the nurses and less than a fifth (15%) of the migrated nurses are single. More than half of all of those in the sample belong to the Christian community. This is followed by Hindu and Muslims respectively in all three categories.[5]

Owing to its professional nature and/or guaranteed employment status, most of the respondents have joined the course soon after they have completed their pre-degree (10+2). About 3 per cent of the respondents amongst the nurses category are holding bachelor's degree in another subject while 7 per cent have joined this course after discontinuing their bachelor's degree. The respondents with diploma nursing comprise 80 per cent and 87 per cent respectively of the nursing students and migrated nurses categories whereas the respondents with B.Sc. nursing comprise 20 per cent and 13 per cent respectively amongst the same categories. All the nurses interviewed in hospitals are diploma holders.

Based on the place of work, a total of 55 respondents both nurses and students are from New Delhi while the rest are from Kerala. Even though they are working in different institutions in New Delhi, all of them are from the state of Kerala. It is a well reported fact that a large majority of nurses all over India come from Kerala.

Motivation for Taking up the Nursing Profession

Table 3.2 displays the prime motivation for taking up this course as reported by the respondents. The most cited reason being the assured employment which comprises 58.3 per cent, 56 per cent and 37 per cent respectively amongst students, nurses and migrated nurse categories.

[5] The sharp community wise distribution of nurses is pointed out by many scholars. Even though the proportion of Christians in Kerala is only 20 per cent, among Malayalee nurses, 90 per cent are from Christian community. The reasons discussed include stigma (and/ or fear of impurity) attached with the nature of work such as close contact with body fluids, diseased bodies, male patients and doctors, work in odd hours prevented Hindus to enter the profession, the resistance of Muslims for women working outside the home, selection of Christians by early day missionaries for imparting training for nursing, etc. For more details, see Mohan, N. Shantha (1985): Status of Nurses in India, Uppal Publishing House, New Delhi.

Table 3-2

Motivations for taking up the profession

Reasons	Students	Nurses	Migrated nurses
Relatives/siblings in the same profession	6	12	8
To serve the society	-	2	4
Assured employment	35	56	22
To go abroad	19	22	4
No response	-	8	22
Total	**60**	**100**	**60**

The need to secure a job assumed greater significance over time irrespective of sex. Chandran[6] (32), who is working as a male nurse in the UK views his decision to be a male nurse as a right choice.

> "*When I joined the nursing school in Mysore, Karnataka, most of my friends and relatives laughed at me, saying that this is not a suitable profession for males. My friends, some of them opted for graduation courses while some went for technical diploma. But now, they all admire my decision. Very few of them are able to find out a comparatively satisfied level of earning while I have seen many countries and I am earning well too. Moreover, I recommended this profession to two of my cousins (males) also and now they are undergoing training*".

The second favoured reason cited is the opportunity to go abroad and about a third (32%) of the students, a fifth (22%) of the nurses and less than a tenth (7%) of those who have migrated express this opinion. In fact, nursing is considered a passport for migration.

Sheeba (24), coming from a lower middle class background and currently working in New Delhi, was not hesitant to reveal her plan to migrate to Philadelphia for work .

> "*It is my dream and nursing is a noble profession which provides a chance to go abroad and work, and visit many countries*".

. About 10 % of all the respondents said that they took up this profession because their relatives and/or siblings are in the same profession.. The availability of knowledge about opportunities and constraints in the profession facilitates the decision making regarding migration. Kerala has a long history of migration, especially to Gulf countries, hence there

[6] Names are changed in order to respect the privacy of the respondents.

is more information regarding the conditions abroad and the gap in knowledge between hearsay and ground reality is reducing.

Intention to Migrate

The majority of respondents – about three fourths said that they had the intention to migrate at some point in time or the other if they get an opportunity for that.

Table 3-3

Intention for migration

Intent to migrate	Students	Nurses
Yes	43	81
No	4	6
Not decided	12	5
No response	1	8
Total	**60**	**100**

Almost 72 per cent of the nursing students and 81 per cent of the nurses expressed the intention to migrate in the future. The surety of migration, as expressed by many of the respondents is influenced by the relatives and /or siblings in the same profession working abroad. Nair and Percot (2007) pointed out in their study that the process of migration starts in the family milieu involving the considerations of job opportunities and information networks. They argue that migration is a family strategy carried out by individual women[7]. Apart from economic motivations, family, societal and cultural factors influence the decision for migration. It is important to note that those who reported no intention for migration among nurses are in the age group of 30-35 and they added that if it could have been before their family formation, they would have migrated.

Reasons for Migration

The reasons for emigration reported by the three categories of respondents are given in Table 3.4.

[7] Nair, Sreelekha and Marie Percot (2007): Transcending Boundaries: Indian Nurses in Internal and International Migration, Occasional paper, Number 49, August 2007, p.2. Centre for Women's Development Studies, New Delhi.

Table 3-4
Reasons for migration

Reasons for migration	Students	Nurses	Migrated nurses
Better wages	18	53	38
Better working conditions	7	15	11
Inadequate wages in India	-	5	1
Poor working condition in India	-	2	2
No response	18	6	8
Total	43	81	60

The most important reason for emigration cited by the respondents was better wages. A substantial proportion reported better working conditions abroad. For 60 per cent of the migrated nurses, the most important reason was better wages while it is the major reason for 65 per cent of aspiring nursing migrants.

Most Preferred Destination

Table 3.5 shows the most preferred destination for work reported by the nursing students, nurses and migrated nurses. According to most of the respondents the USA is the most preferred destination. Accounting for 57, 43 and 48 per cent of the responses amongst students, nurses and migrant nurses' respectively.

Table 3-5
Most preferred destination

Destination countries	Nursing student	Nurses	Migrant nurses
USA	34	43	29
UK	18	32	18
Canada	4	4	6
Middle East	4	14	-
No response	-	7	7
Total	**60**	**100**	**60**

The United Kingdom ranked second with 30 per cent of students, 32 per cent of nurses and 30 per cent of migrated nurses preferring it over other destinations. About 10 per cent of migrated nurses preferred Canada while it came around 7 per cent among students and 4 per cent among nurses. The Middle East was the destination of choice is chosen by around 7 per cent of students and 14 per cent of nurses. Even though the working and living conditions are not very attractive, as reported by the respondents in personal interviews,

migration to Middle East is thought to be comparatively easier and facilitates future moves to Western countries. The favoured places in the Gulf were Dubai, Kuwait, Muscat and Qatar. Saudi Arabia has more vacancies for nurses, but their strict regulations and strictures regarding movement and dress make it the least preferred destination.

Renu (29) says,

> "*Middle eastern countries are very strict, particularly Saudi Arabia. There is a huge discrimination between migrants and the native population and also based on religion. Those who are in Saudi Arabia do not stay there for long, they try to come back as soon as they have saved some money or go to another place.*"

The sample has got migrated nurses working in Middle Eastern countries, but none of them reported Middle East as the most preferred destination (Table 3.5).

Table 3-6

Country of work- migrated nurses

Host country	Percentage
USA	22
UK	15
Canada	8
Ireland	5
Australia	2
Middle East	48
Total	100

Table 3.6 shows the details of migrated nurses in different countries, the highest being in the Middle East (48 per cent) followed by USA (22 per cent), UK (15 per cent), Canada (8 per cent), Ireland (5 per cent) and Australia (2 per cent), respectively.

It is worth mentioning that in several cases, migration does not end up with one destination; it continues, depending on the migrants' aspirations and resources.

Table 3-7

Transnational migration

Country of work	Percentage
First country	40
Second country	27
Third country	8
No response	25
Total	**100**

Duration of Service- Migrated Nurses

The minimum work experience prescribed by most of the emigrating countries is two years and so largely those people emigrated who had more than two years of work experience in India. Nearly 60 per cent of the migrated nurses have got four to five years of work experience in India. About 3 per cent have got six to seven years of experience while 30 per cent have two to three years. Majority of them worked outside their home state perceiving it as an advantage since that enabled them to develop better communication skills in English and improved their chances of staying well informed.

Table 3-8

Duration of service - migrated nurses

Duration of service	India (%)	Abroad (%)
Less than 2 years	-	5
2-3 years	30	8
4-5 years	60	27
6-7 years	3	45
More than 7 years	-	5
No response	7	10
Total	100	100

Regarding the duration of service abroad, 45 per cent of them have six to seven years while about 27 per cent have got four to five years and 5 per cent of them have been serving the host country for more than seven years. The majority of the nurses who are working in India have two to four years or less than that of experience.

Place of Study, Type of Training Institution and Additional Training

It is evident from the place of study of nurses and migrated nurses, the aspirants are willing to move to other states also for getting training . Neighbouring states such as Karnataka and Andhra Pradesh have a number of private nursing schools which cater to the needs of students from Kerala. About 64 per cent of the nurses and 70 per cent of the migrated nurses have got the nursing training from various institutions in Karnataka.

Table 3-9

Place of study

Place of study	Nurses (%)	Migrated nurses (%)
Kerala	14	10
Karnataka	64	70
Andhra	22	13
New Delhi	-	7
Total	100	100

All the respondents studied in self-financing institutions with high tuition fees. It can be argued that the cost of training also has a major role in the decision to migrate. The educational institution is selected by the majority with the aid of information from networks of friends and relatives. Most institutions grant entry only to students from a science background however some institutions, especially in Andhra, reportedly admit candidates from non-science backgrounds into the programme as well. These criteria also shaped the choice of nursing school. Almost 53 per cent of the migrated nurses are reported to have undertaken additional training to appear for tests like IELTS. While about a tenth didn't while another third did not respond to this question.

Table 3-10
Additional training

Training	Nurses (%)	Migrated nurses (%)
Yes	12	53
No	56	10
No response	32	37
Total	100	100

About 12 per cent of the nurses, who are currently working in India, are taking training for improving English language skills. The fee for such training ranges from Rs.5,000 to Rs.10,000 depending on the city, the coaching institution and needs of the candidate. Among the 56 per cent of the nurses who are at present not going for any training, 64 per cent have plans to go for it in future, 16 per cent are not decided while 20 per cent did not respond at all.

The large number of nurses in IELTS coaching institutes in Ernakulam shows the determination of the aspirants to succeed in their attempts to migrate. For many of them, it is not their first attempt at IELTS –

> "*we came here determined to score high on the exam. Our efforts will be rewarded by the foreign money that we will earn and the respect that we will get at home*".

Mini (30), mother of a four year old girl and a one year old son, says –

> "*my husband and in-laws are very cooperative in me going abroad for work. I have tried IELTS once earlier, but could not make through. In fact, now, they are taking the entire responsibility of my children since I have to qualify the exam this time at any cost*".

The director of a famous IELTS coaching institute at Cochin said –

> "*reading and writing are not major hurdles for our students, but speaking is a major problem. Patients can't understand Indian nurses' accent in the US and other destinations*"

The advertisement of many such institutes claim that the classes are taken by foreign trainers to improve accent. But in fact, they use the service of foreign tourists for a short period.

Channels for Migration

The nurses migrate in a step by step manner: first within India, mainly to metropolises, then to countries in the Persian Gulf and finally to Europe and America (Nair and Percot, 2007). After completion of training, New Delhi and Mumbai are two major attractions for aspiring migrants within India. The internal migration to these cities is through networks of friends and relatives. The shared linguistic and regional helps the new candidates as majority of the nursing professionals are from Kerala. Finding of jobs is never been a problem as there are lots of vacancies in the private sector, though many a time, the terms and conditions of work may not be so attractive. The experience gained however is useful to facilitate their eventual international migration.

Recruitment agencies play a very important role in enabling international migration. The work in metropolises has an added advantage as it exposes the nurses to well established recruiting agencies and training institutions which enable them for migration to a better hospital and/or country. Many of the big recruitment agencies in metropolises have tie-ups with big super specialty hospitals in the US and the UK.

Among the migrated nurses, in 46 cases, the channel reported is a recruitment agency. There is not much regulation for recruitment agencies in practice and instances of aspirants getting cheated by agencies are not unknown. For instance, last year, more than 350 overseas nursing job aspirants have been cheated by a Kochi-based overseas recruitment agency and it is alleged that the recruiting agency had swindled between Rs.5 lakh to Rs.7 lakh from 366 people promising placements in places like Netherlands, Finland and Belgium.[8]

Table 3-11

Channel for migration

Channel for migration	Number of migrated nurses	Percentage
Recruitment agency	46	77
Relatives/siblings	2	3
No response	12	20
Total	60	100

[8] For more details see The Hindu (2008), "Recruitment firm accused of cheating" available at http://www.thehindu.com/2009/02/06/stories/2009020654380600.htm

The commission for the agency varies from Rs. 25,000 to Rs. 50,000 apart from the cost for tickets and visa. Moreover, the agencies are taking a major share of the salary of the new migrant apart from charging a fee for their assistance. For example, in certain cases, nurses have to pay a commission equivalent to three months of their salary in the Gulf (Nair and Percot, 2007). According to official estimates, a total of 246 registered recruitment agencies existed in Kerala as of December 2008 (GOI, 2009)[9]. A study conducted by CUTS International (2007) collected data on nurses sent by selected recruitment agencies based in Delhi during 2003-2006 (see Box 3.1).

Box 3-1

Numbers of nurses send abroad by recruitment agencies

Sl.No.	Name of Recruitment agency	Year	Number of nurses
1	All about staffing	2004	284
		2005	340
		2006	490
2	AJ Placements		150 nurses/year
3	India International Technical Recruiters	2002-2006	1100 nurses total
4	RN India	2006	35
5	Max Health Staff	2003-Sept 2006	55

Source: CUTS International (2007).

The payments made to these agencies may be from one's own or parental savings and many of the aspirants often borrow money from friends and relatives. There are also direct recruitment drives in the bigger cities by the employers from foreign countries, especially from the Gulf.

Wages and Working Conditions

The private hospitals recruit a large number nurses. The conditions of work in private hospitals are tough. A large part of their time is spent on performing non-nursing duties. The staff nurses are expected to work beyond their shift timings without any break. A night shift lasts for 12 hours and the day shifts are of seven hours each. The hospitals are also understaffed with three staff nurses manning a ward of 80-90 patients as against the Indian Nursing Council's guidelines which stipulate that the nurse: patient ratio should be 1:3 and 1:1 for super specialty departments, two staff nurses for the operation theatre in each shift, one nursing personnel for 25 patients in general wards, one matron for 150 beds and so on.

[9] For more details, see www.moia.gov.in

Even government set-ups do not follow the INC norms despite the latter's efforts to have them followed.

Only the bigger hospitals provide hostel accommodation for nurses in the hospital premises itself. There is no provision for maternity benefits in many of the private hospitals and being pregnant often translates into a loss of job. Nurses have been demanding for rest and recreation facilities, transportation, reduction in workload and a safe working environment.

The pay scales vary widely across the public and private sector institutions and also within the private sector. They also vary by the type of hospital and its geographical location. The nurses who are working in the government hospitals get a fixed scale of pay and other allowances, while those who are working in the private hospitals draw comparatively meagre amounts as salary. Among the nurses interviewed those who are working in private hospitals are earning in the range of Rs.5,000-10,000 while a beginner in the state service gets around Rs.8,000 plus allowances.

The responses for the perceived workload in India and abroad for migrated nurses are given in Table 3.12. The workload in India is heavy, according to 67 per cent while for 20 per cent, it is too heavy. But at the same time, 80 per cent reported the workload abroad as heavy and another 7 per cent said it is too heavy.

Table 3-12

Perceived workload – migrated nurses

Workload	India (%)	Abroad (%)
Very heavy	20	7
Heavy	67	80
Manageable	-	10
No response	13	13
Total	100	100

Nearly 70 per cent of the migrated nurses reported satisfaction with the wages they are getting abroad while 23 per cent are moderately satisfied and 7 per cent did not respond. While preferring the West as destination, they are aware of the high cost of living in countries other than those of the Gulf. However, the standard of living *in toto* that they are

enjoying in the developed countries is projected as a major reason for continuing there. The aspiring migrants reported their perceived workload abroad as heavy, but within manageable limits. It is clear from their responses that, the migration abroad is a realistically chosen decision.

Perceived Status, Degree of Autonomy and Job Satisfaction

None of the respondents, be it nurses who are currently employed in India or those who migrated already, were satisfied with the status of their profession in India. They feel that their hard work and dedication goes unnoticed and unrecognized. There is much prejudice against the nursing profession since it is a semi professional occupation with nurses being considered inferior to the doctors. Though acknowledged for the element of service involved the profession is not considered as prestigious as that of medicine since their duties of care giving entail much greater manual handling of bodily fluids and wastes besides closer contact with patients. They do not have any degree of autonomy and all the decisions are taken by the doctors and many a time may be reprimanded or insulted in front of patients by doctors. The relatively low remuneration, the lower socio class that nurses generally belong to are other factors that shape the image of the profession (Mohan 1985).

Discussions with the older nurses who have been working for a while reveal that they have also faced exploitation and harassment. They have been made to work in very remote areas at odd hours and without any proper transportation or accommodation facilities. Those working in rural areas or those inhabited by the urban poor also might face the hostility of the community especially if they have been working on the family planning programme the activities of which people do not trust. The stereotype of nursing being a profession suitable to women also contributes to its inferior status especially since nurses are expected to be obedient and act in subordination to medical personnel- medicine being largely perceived as a male dominated profession.

Even though there exist a few associations for the rights of the nurses, majority of the nurses who are working in the private sector are unaware of them and there has been very little organised action to fight for better pay, benefits and working conditions in the private sector.

A comparison with the way their profession is perceived in the west and India reveals that majority of the migrated nurses are happy with the way nursing is perceived abroad. They also explain that with this enhanced mobility of nurses especially to countries of the First World the demand for them has increased considerably in the marriage market. The

matrimonial columns in local papers in Kerala reflect the preference for nurses as potential brides through advertisements announcing- 'nurses are preferred', 'nurses working abroad or willing to go abroad are preferred', or 'prefer B.Sc. nurses'.

> "*When I was getting married, some relatives of my husband asked him why he was marrying a nurse – that was the situation. But now the times have changed, people want to marry a nurse*", says Achamma (55).

Many of the migrated nurses expressed their happiness in becoming self-dependent and being able to negotiate greater space within the family.

> "*I am earning well, I can help my family and relatives, so I am getting respect. They (family) ask me for my opinion while taking decisions on matters such as education, marriage, financial issues, etc. I have gone abroad, so they value my suggestions more than others*", says Nisha (34).

Quality of Nursing Education and Skill Enhancement Opportunities

The training that the nursing students are getting while studying enables them to perform nothing more than the routine tasks. It is a widely accepted fact that there is a dearth of teachers with masters and/or doctoral degrees. National Commission on Macroeconomics and Health (2004) reports that the quality of nursing training is affected by an inadequate number of nurse teacher specialists, non-adherence of proper teacher-student ratio prescribed by the Indian Nursing Council, inadequate infra-structure, insufficient budget, lack of commitment and accountability among educators for clinical supervision and guidance, inadequate and improper clinical facilities and inadequate exposure to hands on experience for students. In 2004, it was found that 61.2 per cent of nursing schools/colleges in India were unsuitable for teaching (NCMH, 2005). But the Indian Nursing Council does not have any effective control over such institutions as they can seek the recognition of the respective state nursing councils.

It is worth mentioning here that none of the nurses working in India reported getting any special training or lectures apart from performing the routine work. There is no system whereby clinical nurse specialists can be produced in India (NCMH, 2005). The system has also been critiqued for its failure to incorporate mechanisms for continuing education for working nurses so as to improve and update their existing knowledge base and skills.

Table 3-13

Receiving/received any on the job training

Receiving/received any training abroad	Number of respondents	Percentage
Yes	18	30
No	22	37
No response	20	33
Total	60	100

Among the migrated nurses, only 30 per cent reported that they are getting any kind of on the job training; most of them are from the European countries where there is a planned effort from the authorities to impart specialized training to the nurses, keeping them updated with new technological advancements in the field. About 37 per cent of migrated nurses reported 'no' while 33 per cent did not give any response.

Intention to Return – Migrated Nurses

Migrated nurses can avail of the opportunity to settle down permanently in many of the host countries except in the case of the countries of the Middle East where the law there does not allow permanent stay to immigrants. But the migrant can re-emigrate to the same or a different country again.

The question on intention to return and work in the home country, created confusion among the respondents. In personal interviews, many of them reported that they are interested in coming back after several years of work abroad, but they would not like to work in India after their return.

Table 3-14

Intention to return and work in India

Intention to return and work in India	Percentage
Yes	3
No	55
Not decided	28
No response	14
Total	100

Only 3 percent of the respondents are willing to come back and work in the same profession in India, 28 percent are undecided about their future plans while 55 percent reported that they would have no intention of returning to work in India. They do not wish to come back to work in conditions that they had chosen to leave and that they view as inferior to their professional life in the West. Additionally they feel that returning to work here would not be as remunerative as their jobs abroad.

The migrants who had returned expressed similar views about working in India. Among the 15 returned migrants interviewed, only three of them are working now in India; two as nursing superintendents in multi-specialty private hospitals and another, as a nursing school principal in the public sector. The rest are not working and/or never worked after returning from abroad. All of them were working in the countries of the Middle East. The reasons for return of the migrants are varied. Some scholars have suggested the following reasons for migrant workers returning home (1) Fulfilling of pre-determined goals including accumulating a considerable income within a specified time; (2) Family compulsions and responsibilities that make the migrants to return early; (3) Termination of the contract, disease and /or old age; (4) Failure to find out an attractive or desirable (in terms of income and other variables) employment at destination and (5) Other reasons including political instability, ethnic conflict and economic depression. The reasons reported by the sample under study fall into first three categories. The three respondents who are currently working, have about 8-12 years of work experience outside India, are not satisfied by the wages and working environment, but the familial compulsions made them to return to India since the strict rules in Gulf countries regulate the migration of spouses and family. The knowledge and experience that they gained from working abroad helped them in handling their responsibilities more efficiently, but at the same time they are unsatisfied with the lack of resources in the Indian setting.

Section IV The Implications of Migration on Health Service System in India

Health workers are always in demand and they have shown a tendency to migrate in search for greener pastures. Migration may be temporary or permanent, voluntary or forced, stimulated by positive incentives in the destination country and/or negative incentives in the country of origin (Stilwell et al., 2003). This migration can have both pros and cons for different stakeholders depending on their relative status on movement chain and resources available in the country. For instance, it can be a solution to the staff shortages in some countries, and it can provide a means by which individual health workers can improve their skills, career opportunities and standard of living. At the same instant, it can also create additional problems of shortages in the health systems of some countries that are already understaffed. The effect of health professionals' migration on health system performance has therefore become more significant in recent international health policy debate (Chanda, 2002; Stilwell et al., 2003; Buchan et al., 2003; Buchan and Dovlo, 2004; Dumont and Meyer, 2004;).

In this section, the focus is on the implications of migration on the health care system from a source country perspective. Also, there is an attempt to understand the issues associated with migration in destination countries such as the kind of treatment that the immigrant workers are getting and recognition of degrees. Buchan (2007) discusses the opportunities and challenges for different stakeholders in migration of health workers (see Box 4.1).

Box 4-1

International recruitment of health workers: opportunities and challenges

Categories	Opportunities	Challenges
Destination countries	Solve skills/ staff shortages. A "quick fix".	How to be efficient and ethical in recruitment?
Source countries	Remittances Up skilled returners (if they return)	Outflow causes shortages with negative impact on delivery of care. Costs of "lost" education. Increased costs of recruitment of replacements. "Manage" migration?
Internationally mobile health workers	Improved pay, Career opportunities, Education.	Achieving equal treatment in destination country.
Static health workers	If worker oversupply Improved job and career opportunities	Increased workload as staff leaves. Lower morale.

Source: Buchan, 2007.

There are mainly two competing views regarding the impact of migration on source countries; one is 'brain drain' and another is 'brain gain'. Brain drain model argues that

developed countries are depleting the highly trained manpower of developing countries while the other model sees it as an integral and beneficial component of globalization and liberalization of service sector and helps the source country by remittance and skill up-gradation of personnel. The major arguments of both these viewpoints are discussed below.

The Movement of Highly Skilled Personnel Contributes to 'Brain Drain'

The migration of high level man power exacerbates the problems of an already weak and impoverished health sector in developing countries (Bach, 2003). In what ways does the migration of health workers influence the effectiveness of the health care system in India is not exactly known since we do not have any reliable estimate on the volume and type of migration. There are two main indicators of the relative importance of migration and international recruitment to a country; one is examining the inflow and/or outflow, and the second is to assess the actual stock of health workers in a country at a particular time (Buchan, 2007).

India is predominantly a sending country of doctors and nurses and an examination of time trends shows that the pace and volume of migration is continuing to increase. The movement is not only on well established routes but also to newer areas. In India, there is a huge gap in the requirement and availability of health personnel (see Tables 4.1 and 4.2). The shortage of skilled doctors/nurses has an adverse impact on service delivery.

Table 4-1

Health manpower in rural areas in India (government): Doctors – 2001 and 2004

Sr. No.	Category	Year	Required (R)	Sanctioned (S)	In Position (P)	Vacant (S-P) (%)	Shortfall (R-P) (%)
1	Doctors at PHCs	2001	22842	29689	25724	13.35	10.11
		2004	23109	24549	21974	10.91	3.80
2	Total specialists	2001	12172	6617	4124	35.49	61.27
		2004	12888	7061	3953	37.11	41.39
A	Paediatricians	2001	3043	1019	440	56.72	66.71
		2004	3222	1562	715	42.89	49.87
B	Physicians	2001	3043	1305	704	46.05	59.11
		2004	3222	1595	895	41.12	45.22
C	Obstetricians & gynaecologists	2001	3043	1498	780	47.93	55.83
		2004	3222	1867	1189	24.63	33.33
D	Surgeons	2001	3043	1518	781	48.55	55.80
		2004	3222	2037	1154	40.99	34.79

Source: Health Information of India 2003 and 2005, CBHI, Govt. of India.

About 50 per cent of sanctioned posts of specialists at various community health centres (CHCs) throughout India are vacant. Nearly 55.5 per cent of posts of surgeons, 55.83 per cent of obstetricians and gynaecologists, 59.11 per cent of physicians and 66.71 per cent of

paediatricians were vacant in 2001. About 5.6 per cent of the PHCs were without a doctor, about 40 per cent were without a lab technician and about 17 per cent were without a pharmacist. The number of doctors registered by different state councils is 6,68,131 during 2006. Moreover, the state-wide distribution of doctors was also highly skewed with Karnataka and Union Territories such as Delhi and Goa having a high ratio while others such as Haryana, Bihar and Uttar Pradesh being under-served. There are wide variations across different states and union territories regarding the availability of manpower in health service institutions (Table 4.2).

Table 4-2

Vacancy positions at PHCs & CHCs for health workers – selected states (as on March 2007)

States/UTs	ANM	Medical officer [PHC]	Specialist doctors	Pharmacists
All India	**14180**	**4920**	**5078**	**4814**
Kerala	36	*	309	43
New Delhi	9	8	0	2
Bihar	1653	228	176	550
Madhya Pradesh	1393	280	444	1204
West Bengal	456	111	68	273
Gujarat	203	39	240	550
Andhra Pradesh	623	283	278	72
Chhattisgarh	668	388	651	282
Himachal Pradesh	377	0	-	140
Jammu & Kashmir	376	25	134	0
Jharkhand	1177	1604	*	379
Karnataka	1512	196	152	463
Maharashtra	2655	609	1180	391
Orissa	353	0	-	56
Punjab	667	284	166	56
Uttarakhand	165	90	84	0
Uttar Pradesh	1756	-	697	-
Tamil Nadu	16	276	96	93

Source: Rural Health Statistics 2007.

*Surplus.

The acute shortage of trained nursing staff has affected hospitals, both private and public in urban areas, and the primary health care system in rural areas badly.

Table 4-3

Health manpower in rural areas in India (government): 2001 and 2004

Sr. No.	Category	Year	Required (R)	Sanctioned (S)	In Position (P)	Vacant (S-P) (%)	Shortfall (R-P) (%)
1	Multipurpose worker (F)/ANM	2001	160153	148151	137407	7.26	14.20
		2004	165764	146852	138906	5.43)	6.75
2	Health worker (M)	2001	137311	84750	71053	16.16	48.72
		2004	142655	83339	60756	27.13	47.14
3	Health assistant (F)	2001	22842	23032	19855	14.14	17.02
		2004	23109	22379	19773	12.64	13.83
4	Health assistant (M)	2001	22842	23569	19927	15.45	23.86
		2004	23109	26869	20086	25.24	22.22
5	Nurse midwife	2001	44143	32723	27336	16.79	47.21
		2004	45663	33347	29139	13.04	27.86
6	Laboratory technician	2001	25885	15544	13262	15.23	48.91
		2004	26331	14755	12553	14.96	24.09
7	Government pharmacists	2001	25885	22972	21118	10.74	25.79
		2004	26331	19930	17741	11.02	7.09
8	Extension educator	2001	-	6743	5708	15.34	-
		2004	-	4167	2873	31.03	-

Source: Health Information of India 2003 and 2005, CBHI, Govt. of India.

The iniquitous distribution of health personnel and facilities in India has been well documented by several authors. Both facilities and personnel are concentrated in urban areas as compared to the villages. In 1998, there was a requirement for 2,913 doctors in rural areas, but the availability was only 1,262. But at the same time, 5,718 doctors migrated for higher studies and among them 2,948 did not return. The gap between the required personnel and sanctioned posts has always been very wide.

Moreover, medical education is subsidized to a great extent in developing countries and thus there is a huge investment in training skilled personnel such as doctors and nurses. It can take three to five years to train a nurse, and 15 to 20 to train an experienced senior physician (Buchan, 2007). Hence the recruitment of these personnel from in effect means that the developing countries are subsiding the training costs for the developed nations of the First World. Hence, while tapping into the opportunities that the demand for health professionals in the developed world offers for source countries like India there must be a realization that the benefits of subsidized training of health professionals are being passed on to the developed countries while depriving domestic patients. There is a need to draw bilateral agreements on migration of health professionals stipulating the quantum of

compensation due to the sending country in relation to the number of health professionals being taken by the receiving country.

A problem which calls for intervention is the shortage of teachers in medical colleges which is at present estimated at about 2,000 and is likely to increase further (3rd Five Year Plan). Migration is many a time, projected as not a disease but a symptom of a poorly developed health services system. Apart from out migration which is out flow of health workers from the country, within the country there is major flow from health care system into other sectors including non-practice of skilled personnel.

Brain Drain Can Be Compensated By Remittance

There are many studies done on the remittance of migrant workers. In many countries, the remittances represent a sizable share of GDP and almost always exceed foreign aid. The remittance from overseas Indians has emerged as a stable source of foreign exchange inflows for the country, according to some scholars. The Reserve Bank of India has reported that Indians living abroad transferred US $24.6 billion to their home country during 2005-06, which made India the highest remittance receiving country in the world.

In proportion to their salary, how much are they really able to send back home is a major question posed by many of the studies on remittance. Though the volume of remittances flowing into India from migrant workers including health professionals has increased steadily, most of this money is spent on building big houses, buying land, purchasing luxury items including vehicles, repaying loans and for children's marriage. Thus, the remittance from the migrant health professionals does not necessarily compensate for brain drain in terms of greater financial support for the public health care services. It is unlikely that these remittances are even utilized to recover the amount of public money spent on the training and education of the health care professionals through education subsidies.

Furthermore, it is argued that, the contribution of skilled workers in remittance is comparatively lesser than that of semi-skilled or unskilled workers. Reasons stated are: (1) Unskilled and semi-skilled workers are not able to take their family along with them to the host country and so they send a major amount from their earnings to support family. Migration to the Middle East is an example. (2) Skilled workers migrate mainly to more developed countries in the West and many times, they are allowed to and/or able to take the family to the host country. In such cases, the remittance sent home is much lesser.

Migration Helps in Reducing Unemployment

The advocates of neo-liberal policies argue that migration helps in reducing the unemployment in the developing country as developing countries are producing more than they can employ. It is highlighted with the examples of educated unemployment in countries such as India. Furthermore, some authors suggest that such courses should be designed and promoted for enabling migration. Two critical questions stem out from this kind of argument, and these are:

(i) Who is migrating?

The people who are migrating are in employment in the home country i.e., it is not the unemployed who are migrating out. And those who studied from premier institutions in the country are showing more tendencies to migrate. In short, the country is losing its well trained, skilled and experienced human resources.

(ii) How much it is possible/easy to fill the vacancy created by the migration of an experienced worker by an inexperienced worker? How much does the quality suffer until the new person gains experience?

We can see the huge disparity between the sanctioned and vacant posts in government institutions in rural area (refer Table 4.1 and 4.2). This shortfall may be due to less attractive wages, a stagnant career in the public sector, unwillingness to serve in the rural areas with less equipped settings, more wages and opportunities in private sector and improper human resource planning; we do not have any exact data to attribute the share of migration in this. But it is possible to draw a logical link between international migration of skilled professionals and the corresponding void created in the domestic service system which acts as a pull factor to attract professionals from rural and remote areas to urban and multi-specialty institutions. The vacancy created in the less attractive places are either filled by less experienced personnel or left vacant. Unfortunately, this burden falls in to public health care sector where majority of the common people seek care.

(iii) Workload and morale of those who stay back

Emigration has a strong impact on the employment pattern of the people who stay back in the home country. The absence of a professional adds to the workload of the existing worker who is already overburdened. The Bhore Committee (1946) and Mudaliyar Committee (1961) had recommended the desirable doctor-population ratio in order to ensure the availability of care to all people, but the targets have still not been met. For instance, the WHO recommends 100 nurses per 10,000 people, while the current ratio

in India is 62 per 10,000 people. Apart from this, it has an adverse influence on the motivation of the non-migrating worker which will reflect in the rendering of service.

Medical education infrastructure in the country has shown rapid growth during the last two decades and is projected as a positive development by many. The emergence of new opportunities globally for nursing led to mushrooming of nursing schools and recruitment agencies in India. There has been a proliferation of nursing schools and colleges; but the quality has been affected. In order to match the growing demand, government has now decided to relax the rules for starting new institutions for training nurses. Experts raised concerns regarding ensuring the quality of training. But the most important fact is that the demand for such courses is not related to health needs of the community, instead it is driven by market principles.

The growing disparity between the volume and type of health professionals in the home country and the rising demand for medical/paramedical courses needs more interrogation to analyse the role of market. The increase in seats is not a wise decision as more number of medical graduates pass out; their demand is for starting post-graduate courses increases. The training itself is commensurate with private demands, for international market. This resultantly affects the availability of nursing personnel suitably trained to provide basic services and meet the needs of populations in rural areas. A study from Philippines shows that due to the growing opportunities for migration and employment, even doctors are opting for the nursing profession (Lorenzo, 2002).

Brain Gain

The knowledge and experience gained by the professional abroad would be beneficial for the development of the country by sharing and exchanging the knowledge gained.

Ellerman (2003) argues that return migration is capable of generating significant benefits for the country of origin. The professional networks that are expanding without borders can help in updating the home country's knowledge base. The returned migrants having acquired higher technical skills and experience abroad can be used for enhancing the source country's health service system. Some authors suggested creation of temporary worker programmes with short durations of stay abroad and mechanisms that facilitate return in order to reap the benefits of skill improvement of migrated workers by the source country (Martin, 2003). Migration is many a time, not a short term phenomenon. For example, nearly 23,000 Indian medical graduates migrated to countries such as the US, the UK and Canada for higher studies. More than half of them did not return India after study. Till now no mechanism has been developed to ensure that temporary workers actually return home.

It is argued that migration of health professionals can be most beneficial if it is temporary as mandated under GATS. The assumption is that temporary migration will necessarily ensure the return of migrant professionals with improved skills, who can then be utilized more efficiently in the domestic health sector. However, the evidence from the field survey points to a very low (almost negligible) rate of return of migrant nurses. In fact, migration is an end in itself and is followed as a career goal from the outset. The major factor behind migration is not skill enhancement, but economic gains. In fact, a majority of Indian nurses migrate to the Gulf and use it as a base for further migration towards the West. There is no general intention of returning to India. In a few cases where nurses have returned it has been triggered by various personal reasons. In many cases, where migration of a nurse has enabled the migration of the entire family, the personal incentives for returning are further diminished. Moreover, even those who have returned do not prefer going back to work in the health sector, or at least at the same level. There is no evidence of any initiative to address the issue of how the migrant workforce is utilized in the host country and on how to ensure the return of the workforce, though there is a recognition that temporary circular migration can translate into developmental gains.

The level of skill up-gradation of migrated professional depends on the extent of opportunities that they are getting in destination countries. The factors that hinder the utilization of their expertise are not only the low level of technology in use in the source country but also the appropriateness of the skills that they acquired from abroad for the home country. Even if they are willing to work in India after returning, their preferences for location and type of institution matter a lot. Moreover, the people who are migrating are not unemployed before migration. They were in employment and in many cases from premier institutions in the country.

Social and Psychological Costs of Migration

Migration poses many challenges for migrating individuals as well; difficulties in adaptation to the new culture, new language and many times, racial and gender discriminations along with absence of proper social support systems. Strenuous working conditions, lack of equal rights and separation from the family adds to the problems of adjusting to a new environment. Migration is not only for economic gains, but the quality of living is an equally important factor in selecting a destination. Most of the Gulf countries have rules that strictly regulate the migration of spouses and family. Migration also contributes to problems on the familial front and has been seen to be associated with problems such as alcoholism, drug abuse, adjustment problems for children both left behind and those moving abroad among others (WHO, 2006). In case of doctors, most of them are from comparatively higher socio-economic background than the nursing personnel and they migrate on their own as against the nurses' migration that is mainly aided by recruitment agencies often riddled with problems of breach of contract.

Status of Migrant Health Professional

The status of migrant worker in a destination country is depended up on a number of intertwined issues. The entry level problems started with delay in processing work permit applications and recruitment practices. Recognition of professional qualifications and work experience by the host country is always a burning problem.[10] Many of them are not able to take up the work that they are trained in, in the destination country. It is reported that immigrant nurses are often made to work as care assistants in many developed countries. The personnel from developing countries are channelled to remote areas in many of the destination countries. Equitable treatment for international migrants and proper utilization of their skills need to be ensured.

Many times, the host country changes its policies towards migrants depending on the availability of foreign personnel. For example, Britain introduced the Highly Skilled Migrant Programme visa scheme in 2002 in order to deal with the staff shortage in key areas but changed the rules in 2006 when there was an influx of migrants. The changed rules were applied retrospectively which severely affected the highly skilled workers, mainly from India who had to requalify under a new point based system. But the Indian migrants won the legal battle with the British Government[11].

The question on ethical recruitment practices has been much debated in World Health Assembly (WHO, 2004). Various types of bilateral and multilateral recruitment agreements are being developed by some recruiting countries, and there are other local and national approaches aimed at encouraging mutual benefit, where the source country is not only a loser in the process (Buchan, 2003). In the European Union, Mode 4 commitments with respect of nursing services are subject to different kinds of limitations in different EU countries. For instance, In Denmark, nursing services under Mode 4 are allowed under GATS for a specific function for a maximum period of 18 months and national treatment is accorded in matters of obtaining authorization from the National Health Board only if residency requirements are met. In Great Britain, Mode 4 entry for nursing services is conditioned to nationality requirements. In some countries, Mode 4 access is permitted subject to the satisfaction of economic needs tests or labour market tests, i.e., subject to the existence of vacancies and shortages which cannot be addressed nationally. Countries such as India are experiencing a net outflow of health care professionals while many countries in the West including UK and Germany, there is a net inflow.

Policy Interventions

There is a general consensus among most scholars that migration of health professionals from developing countries tends to have a negative impact on the availability of health professionals in their domestic health sectors (Buchan, 2008; Stilwell, 2004). However,

[10] In the GATS negotiations pertaining to migration of health professionals, the thrust has been on seeking the removal of barriers to migration such as non-recognition of professional degrees, the criteria of economic needs test and visa restrictions.

[11] For more details, see Sarkar, Dipankar (2008) “Thousands of Indian Migrants Celebrates Legal Victory”.

there is considerable disagreement among scholars on the extent of this negative impact. While the stated objective of the GATS is to achieve progressive liberalization of trade in services, not only for promoting economic growth of the trading partners of member states, but also for the benefit development of the poorer source countries (GATS, Preamble). The word development in this context must be construed in a broader sense going beyond an 'economic' understanding of the term. Thus, the GATS negotiations on Mode 4 migration of nurses and other health professionals from developing countries must also address issues of the negative impact of migration on the quality of health services delivered in the developing countries.

While seeking to secure market access in Mode 4, the government should also strive to ensure that systems are put in place to tap the full benefits that may be derived from migration in such a manner that it effectively translates into improved human resources scenarios in the domestic health sector as well. In addition to seeking removal of barriers to migration in developed countries under GATS Mode 4, the negotiations should also strive to ensure that migration is temporary and leads to return migration. In this regard, the GATS negotiations on Mode 4 may be of significance by guaranteeing stability to the migrant health professional in terms of a sufficiently long duration of stay which will not only be financially rewarding and generate sufficient and satisfactory levels of saving, but also lead to substantial improvements in skill levels.

There is a strong need for policy interventions in the national and international level in order to bring about a balance between the demands of both the 'source' and 'destination' countries, without affecting the quality of health care delivery in both. Concentration on the GATS negotiations alone will not suffice. The government should also take appropriate measures to ensure that return migration actually takes place. This implies a two step strategy: 1) Ensuring return of the migrant worker back to the country; 2) Ensuring their return to the profession (see Box 4.2).

Box 4-2

Creating incentives for return migration

The following measures may be taken to encourage return migration:

1. Developing programmes to support the earnings/savings target of the health worker; and
2. Creating livelihood prospects upon return (Michelle Klein Solomon, 2008). For example, the Return and Reintegration of Qualified African Nationals (RQAN) programme being used by 11 African countries identifies vacancies in various sectors where highly skilled personnel are needed in co-operation with various public and private enterprises and also selects the candidate on the basis of guidelines (Kategekwa, 2008).
3. Reimbursing expenses incurred on account of return migration. For example, in Argentina, the National Commission for the Return of Argentineans Living Abroad provides payment for moving and establishment costs and family travel costs to encourage return migration (Kategekwa, 2008). The RQAN programme also pays for expenses relating to return migration, including settling-in expenses.
4. Developing programmes to raise the respect and recognition for health care workers, particularly nurses, midwives and so on. Raising social awareness is an integral part of the solution.

Buchan (2007) proposes that some level of intervention is essential either to moderate flows via some type of frame work or code, or to attempt to manage the migration process so that it is closer to a 'win-win' situation (see Box 4.3).

Box 4-3

Examples of potential policy interventions in international recruitment

Level		Characteristics/ examples
Organizational	'Twinning'	Hospital in 'source' and 'destination' country developed links, based on staff exchanges, staff support and flow of resources to source country.
	Staff exchange	Structured temporary move of staff to another organization, based on career and personal development opportunities/organizational development.
	Educational support	Educators and/or educational resources and/or funding in temporary move from 'destination' to 'source' organization.
National	Government-to government bilateral agreement	'Destination' country develops agreement with 'source' country to underwrite costs of training additional staff, and/or to recruit staff for a fixed period, linked to training and development prior to staff returning to 'source' country, or to recruit 'surplus' staff in 'source' country.
	Ethical recruitment code	'Destination' country introduces code that places restrictions on employers, in terms of which source countries can be targeted, and/or length of stay. Coverage, content and compliance issues all need to be clear and explicit.
	Compensation	Much discussed, but not much evidence in practice. Destination country pays compensation, in cash or in form of other resources, to source country. Possibly some type of sliding scale of compensation related to length of stay and/or cost of training, or cost of employment in destination country possibly 'brokered' via international agency?
	Managed migration (can also be regional)	Country (or region) with outflow of staff initiates programme to stem unplanned out-migration, partially by attempting to reduce impact of push factors, and partially by supporting other organizational or national interventions that encourage planned migration.
	Train for export (can be a subset of managed migration)	Government or private sector makes explicit decision to develop training infrastructure to train health professionals for export market- to generate remittances, or up-front fees.
Inter-National	International code	As above, but covering a range of countries. Its relevance will depend on content, coverage and compliance, the Commonwealth Code is an example.

Source: Buchan and Perfilieva, 2006.

The effectiveness of the framework or code of practice, whichever it be rests on the content, coverage and compliance on the part of stakeholders (Buchan, 2007). There is a clear need to improve the availability of data which is essential in monitoring the trend in migration and providing a basis for policy formulation.

Section V Conclusion and Policy Recommendations

The analysis in the previous sections of this study clearly shows that the international migration of nurses and other health care professionals is on the rise and is at a rate disproportionately higher than the rate of return of such professionals to India. This is very much in keeping with a general global trend of increased migration of health professionals from developing to developed countries. This has created impediments in the ability of the health care system in the country to deliver vital services to the people. There is no visible initiative that addresses the problem born of outward migration of health workers for the grossly understaffed health services sector in India. Rather, there is greater interest in negotiating market access commitments from developed countries under the WTO-GATS framework for enabling Indian professionals to deliver their services in the developed countries. This section presents the concluding arguments of the study and puts forward policy recommendations in order to manage migration without compromising the 'right to work' of health care professionals issue and the people's 'right to health'.

Health professionals from India are perceived to be major beneficiaries of such market access commitments from developed countries. Analyzing the impact of migration of health professionals on the home country with reference to India, a recent study points out that the international flow of health workers from India has been a part of the overall strategy of the labour export plan of the country, similar to strategies followed by China and the Philippines (CUTS, 2007). It needs to be noted here that most of the migration of natural persons, particularly of health professionals from India such as doctors and nurses has been happening without there being any GATS commitment binding developed countries to do so. Indeed, migration of health professionals from India has steadily increased. All that the developing countries are seeking in the GATS negotiations is to lock in this market for their migrant workforce for the foreseeable future by removing all conditions which may limit market access for their professionals. This is based on the assumption that inflow of remittances from migrant professionals leads to economic gains and compensates for brain drain, this also helps tackle the problem of unemployment, brain drain is also compensated in the long run through the return of the migrant professionals after enhancement of their skill levels which can be internalized.

The impact of migration of its health professionals on India is generally cited as positive through a focus on the economic gains arising out of such migration in terms of increased inflow of remittances and the generation of greater interest in the profession evidenced by a rise in the number of medical and nursing colleges in the country. It is also assumed that the economic gains from migration may translate into greater financial resources to be invested in improving the public health services in the country. Moreover, it is argued that temporary migration can ensure that migrant health professionals return with improved

skills which can then be internalized and applied widely, thereby improving the quality of health services. Accordingly, in the GATS negotiations pertaining to migration of health professionals, the thrust has been on seeking the removal of barriers to migration such as non-recognition of professional degrees, the criteria of economic needs test and visa restrictions. Binding GATS commitments from developing countries allowing entry of migrant health professionals from India can certainly cement for the future of significant economic gains emanating from migration for the country. However, this needs to be balanced with the social pay offs in terms of reduced human resources for health care in the country and its impact on access to health care for the general masses in the country.

As the previous sections of the study pointed out, many of the assumptions on which this extremely positive outlook towards migration of health professionals is based do not exist in reality. While it is true that health professionals migrate because of the promise of lucrative economic gains, this does not translate to optimal utilization of remittances for improvements in the public health system. Though the volume of remittances flowing into India from migrant workers including health professionals has steadily increased, most of this money is spent on building big houses, buying land, purchasing luxury items including vehicles, repaying loans and for children's marriage. Thus, the remittance from the migrant health professionals does not necessarily compensate for brain drain in terms of greater financial support for the public health care services. It is unlikely that these remittances are even utilized to recover the amount of public money spent on the training and education of the health care professionals through subsidies for education.

With reference to health professionals, migration cannot be regarded as a fall-out of the lack of employment opportunities in the domestic health care sector. The supply of health professionals is far short of the demand in the Indian health sector. In fact, the study has shown that most nurses migrate abroad after attaining the required two years of experience in the domestic health sector. Thus, it is the employed health professionals who are migrating. This not only leads to an urban concentration of nurses in centers where it is easier to have a base from which to migrate (and the consequent dearth of nurses in smaller towns and rural centers), it also leads to a loss of experienced health professionals in the domestic health sector. This freezes the level of skills available in the domestic health sector to the beginner's level, and increases the workload of the few experienced and overburdened professionals who remain in the country.

However, it has to be admitted that the lack of satisfactory employment opportunities within the country is a major push factor behind migration of the health professionals after attaining two years of experience, as pointed out in this study. The response to this should ideally be in the form of policies and schemes that improve the working conditions, including pay as well as raise the social status of the health professionals, particularly nurses. There is also a need to improve the standard of domestic education in nursing

services. It is interesting to note that while the demand for nursing courses in India have grown steadily, there is still a wide gap in terms of the adequate supply of nurses in the domestic health sector. The norms for starting new institutions for training of nurses have been relaxed to create a readily available migrant workforce of health professionals to tap the services market in developed countries, rather than ensuring that high quality standards are adhered to for developing well-trained health workers for responding to the demands of the domestic health sector.

It is also argued that migration of health professionals can be most beneficial if it is temporary as mandated under GATS. The assumption is that temporary migration will necessarily ensure the return of migrant professionals with improved skills, who can then be utilized more efficiently in the domestic health sector. However, the evidence from the field survey points to a very low (almost negligible) rate of return of migrant nurses. In fact, migration is an end in itself and is followed as a career goal from the outset. The major factor behind migration is not skill enhancement, but economic gains. In fact, a majority of Indian nurses migrate to the Gulf and use that it as a base for further migration towards the West. In a few cases where nurses have returned it has been triggered by various personal reasons. In many cases, where migration of a nurse has enabled the migration of the entire family, the personal incentives for returning are further diminished. Moreover, even those who have returned do not prefer going back to work in the health sector, not at least at the same level. There is no evidence of any initiative to address the issue of how the migrant workforce is utilized in the host country and on how to ensure the return of the workforce, though there is a recognition that temporary circular migration can translate into developmental gains.

There is general consensus among most scholars that migration of health professionals from developing countries tends to have a negative impact on the availability of health professionals in their domestic health sectors. However, there is considerable disagreement among scholars on the extent of this negative impact. While the stated objective of GATS is to achieve progressive liberalization of trade in services, not only for promoting the economic growth of the trading partners of member states, but also for the development of developing countries (GATS, Preamble). The word development in this context must be construed in a broader sense going beyond an ‘economic’ understanding of the term. Thus, the GATS negotiations on Mode 4 migration of nurses and other health professionals from developing countries must also address issues of the negative impact of migration on the quality of health services delivered in the developing countries. This is because all governments have an obligation under international human rights law to ensure that the people are given real opportunities to acquire the highest standards of health. In respect of international migration health professionals, this international legal obligation entails responsibilities on the part of governments of sending as well as receiving countries.

Therefore, there is a need for devising policy responses to the problems induced by migration of health professionals in the domestic health sector.

Policy Recommendations

On a closer examination of the institutions under study and the general reflection from the literature, the study find that there is a shortage of experienced personnel in the field which affected mostly the vulnerable sections of the population (such as the remote areas, poor people, etc). Specific attention should be given to analyse the 'shortage of staff' phenomenon in the light of all available hypotheses including lack of increment in the number of professionals along with increase in population before drawing out any final causal relationship with migration. The discussions with various stakeholders threw light into further research problems and gave an understanding of some of the factors that may require consideration for making policies for monitoring and governing migration. The recommendations span across a range of issues including improvement in the domestic health service system and proper planning of education to negotiation with destination countries for balancing migration which are summarized below (Box 5.1).

- There is a rapid growth of training institutions, especially for nursing in the private sector in India. This trend should be analysed with caution since the intention behind such institutions are, many a time, merely profit making, and their growth is a response to the high demand for secure employment with assured upward mobility through a chance to migrate internationally. Hence the quality of the training imparted in these institutions has to be monitored and there should be proper verification of the institutions prior to granting them approval.

- Moreover, the allotting of new institutions and increasing seats should be based on the need of the country (and not to be based merely on need of the foreign country). The policies adopted by the destination countries are entirely based on their interest, i.e., relaxing the rules when they need more health care personnel. So, the 'production' of personnel in developing countries such as India based on 'demand' from abroad will not be a sound approach to earn foreign exchange and combat unemployment.

- One of the most important issues is to maintain a proper data base of migrants from the country. At present, India does not have any reliable information regarding the volume and characteristics of migrants.

- Regulate recruitment agencies in order to avoid exploitation of the migrating personnel and to ensure fair practices in the recruitment process. The government should

maintain a database of all authorized recruitment agencies for health professionals in accordance with Article 9.5 of the Draft WHO Code of Practice on the International Recruitment of Health Personnel.

- Ensure the security and welfare of the migrants in destination countries. This includes not only the provision of information regarding the working environment and culture in the destination country, but also negotiate with the major recipient countries to ensure a fair treatment for the migrants, in terms of wages and working condition, status and so on.

- Career opportunities for health professionals should be improved in order to enable them to progress to their desired levels of responsibility in their careers. There is a need for better opportunities for promotion. This is particularly true for nurses whose lack of career progression possibilities acts as a push factor behind migration[12]. Recognize their hard work and contribution to the society provide rewards for better performance and raise the status of profession, especially nurses, by generating awareness in the public. Strengthen the role of professional associations and increase their participation.

- It is particularly important to address the domestic push factors that encourage migration. To this end the working conditions in the public and private health services need to be improved. Prevent exploitation of professionals in the private sector hospitals. The wage and incentives need to be revised based on a systematic examination of the current situation.

- Improved training and skill development of health professionals in the country without requiring them to leave the profession is a must. The state can support higher training costs of health professionals by sending them abroad conditional on return to serve in areas where their services will be required in the country. A period of service in a remote area may be made a requirement for eligibility for such support. Financial incentives for discouraging migration too can be considered in certain circumstances. For example, the ICN has pointed out that in one island nation, students who complete their education and remain in the country do not have to pay any interest on their educational loans. However, if they migrate, interest accrues on their loans.

[12] In an attempt to manage the shortage of trained personnel, the government has now decided to upgrade several government nursing schools into colleges such as the one at Lady Hardinge Medical College in Delhi. New plans have been set aside to train not only nurses but also nurse practitioners who will fill the gap of doctors in rural areas.

- Make public sector service compulsory for migration and/or higher studies, not only from government run institutions but also from private sector institutions[13]. Provide incentives for rural and remote area services. Not only on monetary terms, but also in terms of giving priority for higher studies, promotion, etc., this will attract health care professionals to work in such areas with lesser apprehension.

- Provide incentives for return and ensure the effective use of the skills of returned migrants. To encourage return migration, the receiving country and sending country may enter into an agreement requiring a part of the remuneration of the migrant worker to be deposited in an account in the sending country which can be accessed only upon return to the country. To ensure that migrant workers are able to work at the desired level of their professional competence and utilize their improved skills, proper technological facilities should be provided to make use of those skills.

Box 5-1

Policy Recommendations

- **Ensure quality of training and need based courses.**
- **Maintain proper data base of migrants.**
- **Ethical recruitment practices.**
- **Incentives for return and ensure the use of skill by the returned migrants.**
- **Improve the condition of health service sector in India.**
- **Ensure the security and welfare of the migrants in destination countries.**
- **Provide opportunities for professional improvements and higher studies-promotion.**
- **Improve status, recognition-awards for better performance.**
- **On the job training abroad-bilateral agreements.**
- **Compulsory public service a necessary condition for migration.**
- **Incentives for rural area service.**

The study reveals the pressing need for tackling the issue of staff shortage and migration of health care professionals from India. There are many push and pull factors that accelerate

[13] Health professionals interested in migrating after benefitting from the subsidized education in the country may be required by law to serve in the public sector, including in the rural centers, for a stipulated number of years. For instance, to counter the massive outflow of health workers, Thailand made it mandatory for students to sign contracts with public universities requiring them to serve the public for three years after their graduation, and about two-thirds of these graduates were required to serve in rural districts, leading to a significant improvement in the health facilities in rural areas. See Kategekwa (2008).

the migration of health care personnel from India. The lack of staff has substantial impacts on emergency preparedness, quality of care, patient safety and access to needed health care services especially for vulnerable populations. But we also have to look into the policies of the State to conclude whether migration is the only and/or main cause for an inefficient health care system in India. No country can put a complete ban on migration as everyone has a right to migrate for better living. But at the same time, people's 'right to health' also cannot be overlooked as health care professionals are not just like any other 'tradable' material. Considering the requirements of the situation, the State can regulate migration in order to bring a balance between the demands of professionals and the needs of populations.

Bibliography

Abidi, Nigar Fatima. (1983). Women Doctors and Nurses in India: A Study in Sociology of Professions, Jawaharlal Nehru University, New Delhi, Unpublished Doctoral thesis.

Adams, O and Kinnon C. (1998). A Public Health Perspective, in UNCTAD-WHO Joint Publication, International Trade in Health Services: A Development Perspective, UNCTAD/ITCD/TSB/5 – WHO/TFHE/98.1, Geneva.

Adkoli, B V. (2006). Migration of Health Workers: Perspectives from Bangladesh, India, Nepal, Pakistan and Sri Lanka, *Regional Health Forum*, 10(1), pp.49-58.

Aiken, L.H et al. (2002). Hospital Nurse Staffing and Patient Mortality, nurse Burnout and Job Dissatisfaction, *JAMA*, No.288, pp.*1987*-93

Aiken, Linda H, James Buchan, Julie Sochalski, Barbara Nichols, Mary Powell (2004), "Trends In International Nurse Migration" *Health Affairs* ~ Vo l u m e 2 3 , Nu m b e r 3.

Ananthakrishnan, N. (2007). 20(1). Acute Shortage of Teachers in Medical Colleges: Existing Problems and Possible Solutions, *The National Medical Journal of India*, pp.25-29.

Ash, R. and Mitchell, H D. (1968). Doctor Migration 1962-64, *British Medical Journal*, March 2, pp.569-72.

Astor, A et al. (2005). Physician Migration: Views from Professionals in Colombia, Nigeria, India, Pakistan and the Philippines, *Social Science and Medicine*, 12(61). pp.2492-500.

Bach, S. (2003). International Migration of Health Workers: Labour and Social Issues, Sectoral Activities Programme Working Paper, International Labour Office, Geneva. http://www.ilo.org/public/english/dialogue/sector/papers/health/wp209.pdf.

Bach, S. (2006). International Mobility of Health Professionals-Brain Drain or Brain Exchange? UNU WIDER. (www.wider.unu.edu/publications/rps/rps2006/rp2006-82.pdf.)

Ball, Rochelle E. 2004. Divergent Development, Racialised Rights: Globalised Labour Markets and the Trade of Nurses: The Case of the Philippines, *Women's Studies International Forum*, 27(2), June-July, 2004. pp.119-33.

Barer, M L and Wood, L. 1997. Common Problems, Different Solutions: Learning From International Approaches to Improving Medical Services Access for Underserved Populations, *Dalhousie Law Journal*, Vol 20, pp.321-58.

Bauer T, Gil E and Gang I (2002). Herd effects or migration networks? The Location

Choice of Mexican Immigrants in the US. Internet Documents in Economics Access Service database, Institute for the Study of Labor, Discussion Paper *551* (http://ideas.repec.org/p/iza/izadps/dp551.html).

Birrell, J Robert (2004). Australian Policy on Overseas Trained Doctors, MJA 2004; 181(11/12). pp. 635-639. www.mja.com.au/public/issues/181_11_061204/bir10706_fm.html.

Biswas, Chandrima. (2000). Nursing in India and its Changing Status as a Profession, Jawaharlal Nehru University, New Delhi, Unpublished Doctoral thesis.

Blouin, C et al. (2006). International Trade in Health Services and the GATS: Current Issues and Debates, The World Bank, Washington, D.C.

Buchan J and Dovlo D (2004). International recruitment of health workers to the UK, Department for International Development, London.

Buchan, et al. (2003). International Nurse Mobility: Trends and Policy Implications, World Health Organisation, Geneva.

Buchan, J and Perfilieva, G. (2006). Health Worker Migration in the European Region: Country Case Studies and Policy Implications, WHO Regional Office for Europe, Copenhagen. (http://www.euro.who.int/document/e88366.pdf.)

Buchan, J. 2007. Health Worker Migration in Europe, - Assessing the Policy Options, *Euro Health*, LSE Health, London, Vol 13, No 1. pp.6-8.

Buchan, James. (2008). Health Systems and Policy Analysis – How can the migration of health service professionals be managed so as to reduce any negative effects on supply?World Health Organization, on behalf of the European Observatory on Health Systems and Policies 2008.

Buerhaus,P. et.al. (2000). Implications of an Aging Registered Nurse Workforce, *JAMA*, June, pp.2948-54

Carrington, J.W and Detragiache (1999). How Extensive is the Brain Drain? *Finance and Development*, IOM, Vol.36, No.2 (http://www.imf.org/external/pubs/ft/fandd/1999/06/carringt.htm)

Chanda, R. (2001). Trade in Health Services, CMH Working Paper Series, Paper No.WG 4:5, Commission on Macroeconomics and Health.

Chanda, R. (2002). Trade in Health Services, *Bulletin of World Health Organisation,* Vol. 80. pp.158-63.

Chiha, Y. A., and C. R. Link. (2003). The Shortage of Registered Nurses and Some New Estimates of the Effects of Wages on Registered Nurses Labor Supply: A Look at the Past and a Preview of the 21st Century, *Health Policy*, Vol.64, No.3, pp. 349-75.

Clark, P F et al. (2006). The Globalization of the Labour Market for Health Care Professionals, *International Labour Review*, Vol 145, No 1, pp.37-64.

Commonwealth Secretariat (2003). Commonwealth Code of Practice for the International Recruitment of Health Workers, London. (http://www.thecommonwealth.org/shared_asp_files/uploadedfiles/{7BDD970B- 53AE-441D-81DB-1B64C37E992A}_CommonwealthCodeofPractice.pdf)

CUTS (Centre for International Trade, Economics & Environment). (2007). "Barriers to Movement of Health care Professionals: A Case Study of India", CUTS Centre for International Trade, Economics & Environment in collaboration with WTO Cell, Ministry of Health & Family Welfare, Government of India and WHO India Country Office, New Delhi.

Davis, Deirdre (2003). Nursing burnout and Patient Safety, *JAMA*, Vo.289, No.5

Dayrit, Manuel et al. (2008). WHO Code of Practice on the International Recruitment of Health Personnel, Bulletin of World Health Organisation, October 2008, Vol.86, No.10

De Haan, A. 1999. Livelihood and Poverty: The Role of Migration – A Critical Review of the Migration Literature, *Journal of Development Studies*, 1999, 36(2). pp.1-47.

Department of Health. (2004). Code of Practice for the International Recruitment of Health Care Professionals, London. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4097730.

Diallo K (2004). Data on the Migration of Health-care Workers: Sources, Uses, and Challenges, *Bulletin of World Health Organ,* 2004 Aug, 82(8), pp.601-7.

Diaspora, Ministry of External Affairs, India.

Dubois, C A, McKee, M and Nolte, E (eds). (2005). Human Resources for Health in Europe, Open University Press, Buckingham.

Dumont J, and Meyer J (2004). The International Mobility of Health Professionals: An Evaluation and Analysis Based on the Case of South Africa, in Trends in international migration. Paris, Organisation for Economic Co-operation and Development.

Dussault, G and Dubois, C A. (2003). Human Resources for Health Policies: a Critical Component in Health Policies, *Human Resources for Health*. Vol 1, pp.1-16.

Ellerman, David (2003). Policy Research on Migration and Development, World Bank Policy Research Working Paper No. 3117.

Forcier, Melanie B et al. (2004). Impact, Regulation and Health Policy Implications of Physician Migration in OECD Countries, *Human Resources for Health*, 2(12). http://www.human-resources-health.com/content/2/1/12.

Fortney, Judith A. (1970). International Migration of Professionals, *Population Studies*, 24 (2), July, 1970, pp.217-232. http://www.jstor.org/stable/2172655.

Ganguly, D. (2005). Barriers to Movement of Natural Persons: A Study of Federal, State, and Sector Specific Restrictions to Mode 4 in the United States of America, ICRIER Working Paper No 169, New Delhi.

Gautham, M. (2006). Quality of Care for Reproductive Tract Morbidities by Rural Private Practitioners in north India, Unpublished PhD thesis, London School of Hygiene and Tropical Medicine, UK.

Ghosh, B. (2005). Economic Effects of International Migration: A Synoptic overview, Chapter 8 in World Migration 2005: Costs and Benefits of International Migration, IOM.

Goldfarb, R. et al. (1984). Can Remittances Compensate for Manpower Outflows: The case of Philippine Physicians, *Journal of Developmental Economics*, No. 15.

Gopakumar, K M and Syam, N. (2006). Health Services Liberalization in India, in Rupa Chanda (ed.), Trade in Services & India: Prospects and Challenges, Wiley India.

Government of India (1946). Bhore Committee Report

Government of India (1962). Mudaliar Committee Report

Government of India (2001). Report of the High Level Commission on the Indian

Government of India (2003). Health Information of India, Central Bureau of Health Intelligence, MoHFW, New Delhi.

Government of India (2005). Health Information of India, Central Bureau of Health Intelligence, MoHFW, New Delhi.

Government of India (2005). Rural Health Statistics, New Delhi.

Government of India (2008). Health Information of India, Central Bureau of Health Intelligence, MoHFW, New Delhi.

Grubel, H and Scott, A. (1977). The Brain Drain: Determinants, Measurement and Welfare Effects, Wilfrid Laurier University Press, Waterloo.

Hardill, Irene. (2000). Skilled International Migration: The Experience of Nurses in the UK, *Regional Studies*, 34(7), Oct., 2000, pp.681-92.

Hernandez, P et al. (2006). Measuring Expenditure for the Health Workforce: Challenges and Evidence, World Health Organization, Geneva. (Background paper for *The world Health Report 2006*). http://www.who.int/hrh/documetns/en.

Hongoro, Charles and Barbara, McPake. (2004). How to Bridge the Gap in Human Resources for Health? *The Lancet*, Vol 364. pp.1451-56.

ILO. (2005). ILO Joint Meeting on Social Dialogue in the Health Services, ILO, Geneva.

International Council for Nurses (2008). Guidelines: Incentives for Health Professional, ICN, Geneva.

International Council of Nurses et al. (2008). "Guidelines: Incentives for Health Professionals", International Council of Nurses, International Pharmaceutical Federation, World Dental Federation, World Medical Association, International Hospital Federation, World Confederation for Physical Therapy.

International Council of Nurses. (2008). "Return Migration of Nurses" ICNM Office of the Secretariat, 3600 Market Street, Suite 400, Philadelphia.

Iredale, Robyn. (2000). Migration Policies for the Highly Skilled in the Asia-Pacific Region, International Migration Review, The Center for Migration Studies of New York, Inc. 34 (3), pp.882-906. http://www.jstor.org/stable/2675948.

Joint Learning Initiative. (2004). Human Resources for Health: Overcoming the Crisis, Harvard University Press.

Joy Kategekwa (2008). Liberalization of Trade in Health Services: Balancing Mode 4 Interests with Obligations to Provide Universal Access to Basic Services, South Centre Research Paper 16.

Kanjanapan, W. (1995). The Immigration of Asian professionals to the United States: 1988-1990, *International Migration Review*, Vol.29, pp.7–32

Kaushik, Manas et al. (2008). High-end Physician Migration from India, *Bulletin of the World Health Organization*, January 2008, 86 (1). pp.40-45.

Khadria, B. (2004). Perspectives on Migration of Health Workers from India to Overseas Markets: Brain Drain or Export? IOM's International Dialogue on Migration, Seminar on Health and Migration, 9-11 June 2004. http://www.iom.int/documents/official.

Kingma M (2006). Nurses on the Move: Migration and the Global Health Care

Economy,Cornell University Press, Ithaca.

Kingma, M. (2001). Nursing Migration: Global Treasure Hunt or Disaster in the Making? *Nursing Inquiry*, 2001, 8(4). pp.205-212.

Krajewski, M. (2003). Public Services and Trade Liberalization: Mapping the Legal Framework, *Journal of International Economic Law*, Vol 6, no 2.

Liese, Bernhard et al. (2003). The Human Resources Crisis in Health Services in Sub-Saharan Africa, World Bank. (www.wds.worldbank.org/servlet/WDSContentServer/WDSP/IB/2003/10/...20031031161656/additional/310436360_20050276022409)

Lorenzo, F (2002). Nurse supply and demand in the Philippines, University of the Philippines, Institute of Health Policy and Development Studies, Manila.

Lowell L & Findlay A (2002). Migration of Highly Skilled Persons from Developing Countries: Impact and Policy Responses, International Labour Office, Geneva, 44.

Madhavan, M. (1985). Indian Emigrants: Numbers, Characteristics, and Economic Impact, *Population and Development Review*, Population Council, Vol 11, No 3. pp.457-481. http://www.jstor.org/stable/1973248.

Maniple, E. (2004). Export Health Worker? For Uganda an Indecent Proposal, *Health Policy and Development*, 2(3).

Manuel, Dayrit et al. (2008). "WHO Code of Practice on the International Recruitment of Health Personnel", Bulletin of the World Health Organization, October 2008, 86 (10).

Margulies H and Bloch L.S. (1969). Foreign Medical Graduates in the United States, Cambridge, Harvard University Press.

Marino, M. (2002). Foreign Nurses Hired as Shortage Bites, *The Age*, 15 December.

Martin, P. (2003). Highly Skilled Labour migration: Sharing the Benefits, ILO, international Institue of Labour Studies, Geneva.

Mejia, A et al. (1979). Physician and Nurse Migration: Analysis and Policy Implications, World Health Organisation, Geneva.

Mejia, A. and H. Pizurki (1976). World Migration of Health Manpower, WHO Chronicle 30.

Migration News India: Remittances, High-Tech. ttp://migration.ucdavis.edu.

Ministry of Health & Family Welfare. (2005). Situational Analysis of Public Health

Nursing Personnel in India, Academy of Nursing Studies, Hyderabad.

Mohan, Shantha, N. (1985). Status of Nurses in India, Uppal Publishing House, New Delhi.

MoHFW (2005). National Commission on Macroeconomics and Health, Government of India, New Delhi.

Mowafi, Hani et al. (2007). Facing the Challenges in Human Resources for Humanitarian Health, *Prehospital and Disaster Medicine,* 22(5). pp.351-59. http://pdm.medicine.wisc.edu/22-5%20PDFs/mowafi.pdf.

Mullan, F. (2006). Doctors for the World: Indian Physician Emigration, *Health Affairs,* Vol 25. pp.380-93.

Nair, Sreelekha and Marie Percot (2007). Transcending Boundaries: Indian Nurses in Internal and International Migration, Centre for Women's Development Studies, New Delhi.

Nair, Sreelekha. (2007). Rethinking Citizenship, Community and Rights: The Case of Nurses from Kerala in Delhi, *Indian Journal of Gender Studies*, Sage Publications, New Delhi, 14(1), Jan-Apr. 2007. pp.137-56.

Narasimhan, V et al. (2004). Responding to the Global Human Resource Crisis, *Lancet*, Vol 363. pp.1469-72.

OECD (2006). The Supply of Physician Services in OECD Countries, OECD Health Working Papers No.21, Directorate for Employment, Labour and Social Affairs Group on Health, Paris.

Ojo, Ko. (1990). International Migration of Health Manpower in Sub-Saharan Africa, *Social Sciences and Medicine*, Vol 31, pp.631-37.

Padilla, Paul. (2006). Nurse Migration and Nursing Shortage, Imprint, 53 (3), April-May 2006, National Student Nurses Association, New York. pp-18-24. http://www.nsna.org/pubs/imprint/AprMay06/IMP_APRIL06_TOC.pdf)

Percot, M (2005). Indian Nurses in the Gulf: Two Generations of Female Migration, Paper presented a*t* the Sixth Mediterranean Social and Political Research Meeting of the Mediterranean Prog*r*amme of the Robert Schuman Centre for Advanced Studies at the European Universit*y* Institute, Montecatini Terme, March 2005.

Percot, Marie and Irudaya Rajan, S. (2007). Female Emigration from India: A Case Study of Nurses, *Economic & Political Weekly*, 42 (4), Jan-Feb 2007, pp.318-25.

Percot, Marie. (2006). Indian Nurses in the Gulf: Two Generations of Female Migration, South Asia Research, Sage Publications, New Delhi, 26 (1), Feb 2006, pp.41-62.

Phillips, V. L. (1995). Nurses' Labor Supply: Participation, Hours of Work, and Discontinuities in the Supply Function, *Journal of Health Economics*, vol. 14, No. 5, pp. 567-82.

Pudney, Stephen & Michael Shields (2000). Gender, Race, Pay and Promotion in the British Nursing Profession: Estimation of a Generalized Ordered Profit Model, *Journal of Applied Econometrics*, John Wiley & Sons, Ltd., vol. 15, no.4, pp. 367-399.

Rice, T. (1998). The Economics of Health Reconsidered, Health Administration Press, Chicago.

Roy, S K. (1975). Indian Scientific and Technical Personnel Abroad, *Nature*, May 22, Vol 255.

Russell King, Ronald Skeldon and Julie Vullnetari (2008), "Internal and International Migration: Bridging the Theoretical Divide", Paper prepared for the IMISCOE 'Theories of Migration and Social Change Conference', St. Anne's College, Oxford, 1-3 July 2008

Sarkar, Dipankar (2008) "Thousands of Indian Migrants Celebrates Legal Victory", The Indian News, April 8, 2008 (URL: http://www.thaindian.com/newsportal/world-news/thousands-of-indian-migrants-celebrate-legal-victory_10035746.html)

Satpathy, S K and Venkatesh, S. (2006). Human Resources for Health in India's National Rural Health Mission: Dimension and Challenges, *Regional Health Forum*, 10(1). pp.29-37.

Sein, Than U. (2006). Health Volunteers: Third Workforce for Health for All Movement, *Regional Health Forum*, WHO SEARO, New Delhi, 10(1).

Senewiratne B (1975). Emigration of Doctors: a Problem for the Developing and the Developed Countries, Part I, *British Medical Journal*, 1(5958), pp.618-20.

Shields, Michael A. (2004). Addressing Nurse Shortages: What can Policy Makers Learn from the Econometric Evidence on Nurse Labour Supply? *Economic Journal*, 114 (449), Nov 2004. pp.F164-498.

Smith, D.J. (1980). Overseas doctors in the National Health Service, Policy Studies Institute, London.

Solomon, Klein Michelle (2008). Setting the Scene: Understanding Return Migration, Power point presented at Conference on Managing Return Migration at Switzerland on April 21.

Stark, O. (2004). Rethinking the Brain Drain, *World Development*, Vol. 32. pp.15-22.

Stilwell B et al. (2003). Developing Evidence Based Ethical Policies on the Migration of Health Workers: Conceptual and Practical Challenges, *Human Resources for Health*, pp.1-8.

Stilwell, B et al. (2004). Migration of Health Care Workers from Developing Countries: Strategic Approaches to its Management, *Bull World Health Organ* 2004; Vol. 82. pp.595-600.

Taylor, D H Jr and Esmail, A. (1999). Retrospective Analysis of Census Data on General Practitioners who Qualified in South Asia: Who will Replace them as they Retire? *BMJ*, No 318, pp.306-10.

Thomas, Dublin D. (1972). The *migration of physicians* to the *United States, New England Journal of Medicine,* Vol. 286, No. 16, pp. 870-876.

U.S. General Accounting Office (2001). Record, Linkage and Privacy: Issues In Creating New Federal Research and Statistical Information.

UK King's Fund (2001). www.kingsfund.org.uk

UNCTAD Secretariat (1998). International Trade in Health Services: Difficulties and Opportunities for Developing Countries, in Zarrilli, S.; Kinnon, C. (eds.) International Trade in Health Services: A Development Perspective.

Vujicic, M et al. (2004). The Role of Wages in the Migration of Health Care Professionals from Developing Countries, *Human Resources for Health*, 2(3).

WHO. (2002). Report of Working Group 5 of the Commission on Macroeconomics and Health, World Health Organisation, Geneva.

WHO. (2005). IOM International Dialogue on Migration, Health and Migration: Bridging the Gap, IOM, WHO Publication No 6.

WHO. (2005). Resolution on "International Migration of Health Personnel: A Challenge for Health Systems in Developing Countries", WHA57.19.

WHO. (2006). Health Worker Migration in European Region-Country Case Studies and Policy Implications, World Health Organisation.

WHO. (2007). "Follow-Up Action on Selected Resolutions/Decisions of the Last Three Years: International Migration of Health Personnel: A Challenge for Health Systems in Developing Countries", Regional Committee Provisional Agenda Item 16.6 Sixtieth Session SEA/RC60/25 Thimpu, Bhutan 31 August – 3 September 2007, 20 August 2007.

WHO. (2008). "International Recruitment of Health Personnel: Draft Global Code of Practice", Executive Board EB124/13 124th Session 4 December 2008 Provisional Agenda Item 4.10.

Wickramasekara. (2002). Asian Labour Migration: Issues and Challenges in an Era of Globalization, International Migration Papers 57, ILO, Geneva.

World Health Organisation (2006). The World Health Report 2006 – Working Together For Health, World Health Organization, Geneva (http://www.who.int/whr/2006/en/, accessed on15 April 2008).

World Health Organisation. (2004). Global Atlas of the Health Workforce. http://www.who.int/globalatlas.

World Health Organisation. (2007). Not Enough Here… Too Many There…: Health Workforce in India, WHO, India.

World Health Organization (2008). The World Health Report 2008 – Primary Health Care: Now More Than Ever, WHO, Geneva.

World Health Organization. (2004). Challenge Posed by the International Migration of Health Personnel, WHO Resolution WHA57.19 (2004), Geneva. http://www.who.int/gb/ebwha/pdf_files/WHA57/A57_R19-en.pdf.

World Health Organization. (2006). International Migration of Health Personnel: A Challenge for Health Systems in Developing Countries, Report by the Secretariat, Geneva, Document No. A 59018.

Xhafa, Edlira. (2006). Sustaining Strategies Addressing the Human Resources for Health Crisis through Union Participation, Unpublished Master Thesis, University of Kassel and the Berlin School of Economics, Germany. http://www.gurn.info/topic/health/master_xhafa.pdf.

Xu, Y and Zhang, J. (2005). One Size Doesn't Fit All: Ethics of International Nurse Recruitment from the Conceptual Frameworks of Stakeholder Interests, *Nursing Ethics*, 72(6), 571-581.

Centad
Centre for Trade & Development

A1/304 Safdarjung Enclave
New Delhi