Migration and Indian doctors

Sanjay Dalmia
SpR, General and Colorectal Surgery, West Midlands, UK

For correspondence:
Sanjay Dalmia, 37 Winterton Way, Bicton Heath, Shrewsbury, Shropshire SY3 5PA, United Kingdom. E-mail: dalmiasanjay@hotmail.com

ABSTRACT

There has always been a trend in India for doctors to go abroad. They go to developing countries for an international exposure and training in their job. Doctors as well as their countries of origin do benefit from this exposure. A large number of doctors however settle abroad and never return to their country of origin. I have tried to do an in depth analysis of numbers, socioeconomic factors, opportunities and various other factors affecting this. Comforts of western lifestyle and insecurities of living away from their country of origin has to be balanced for this migrant group.

Key words: Migration, Indian, Doctors

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Traditionally doctors from India have been going to many developed countries for many years. Causes may be variable in individual cases but commonly they are: Higher qualification, skills and training, financial, political, tourism and social. Most of the doctors commonly go to developed countries like the United States (US), United Kingdom (UK), Canada, Australia etc. There are many facets to this issue and commonly debates occur whether it is good or bad for the involved parties i.e. country of origin, country of working, doctors themselves etc.

STATISTICS

Data on the countries of origin, based on countries of medical education, of international medical graduates practicing in the US, the UK, Canada and Australia were obtained from sources in the respective countries and analyzed separately and in aggregate. International medical graduates constitute between 23 and 28% of physicians in the US, the UK, Canada and Australia and lower-income countries supply between 40 and 75% of these international medical graduates. India, the Philippines and Pakistan are the leading sources of international medical graduates. Emigration factor is the relative number of physicians lost due to emigration. Nine of the 20 countries with the highest emigration factors are in sub-Saharan Africa or the Caribbean. Reliance on international medical graduates in the US, the UK, Canada and Australia is reducing the supply of physicians in many lower-income countries. As per the 1989 figures about 11,000 university graduates leave India every year for advanced study and/or work. About a quarter of these will remain abroad permanently. Factors promoting migration include 1) unemployment, 2) immigration rules, 3) colonial links, 4) financial incentives and material benefits, 5) pursuit of higher education, 6) improvement of working conditions and facilities, 7) avoidance of excessive bureaucratic procedures and 8) compensation for the mismatch between Indian education and employment. An article from 1976 showed migration level going up to 40% or more. Those who are denied the opportunity of a postgraduate training in their own country have a higher possibility of emigrating. The US, with 5% of the world's population, employs 11% of the globe's physicians. This gap is filled by international medical graduates, most of whom will attain citizenship or permanent residence and remain in the US to practice medicine. Demand in affluent countries pulls healthcare workers from poor countries as low salaries, limited career prospects, poor working environments, family aspirations and political insecurity push them out. The beneficiaries are the importing countries and, of course, the migrants themselves. In Canada recently 680 International Medical Graduates (IMG) qualified for training but there were only 80 re-entry positions. The CMA General Council considers IMGs as a part of the short-term solution. Currently, 24% of Canada's doctors are IMGs. Maintaining cultural and religious values, as well as relationships to their respective
With each country they do not expect excessive support from the community they appreciated the cultures of welcoming or embracing differences.[4] In the UK, the recent exodus of a significant number of hospital doctors into general practice has shifted the balance without actually solving the manpower crisis in the NHS. IMGs are a remarkably successful professional group in the UK making up to 30% of the NHS work force. Their very success and media publicity about general practice and consultant shortages, has led to a large influx of inexperienced doctors seeking training opportunities in competitive specialties in UK. In 2003 a record 15,549 doctors joined the medical register of which 9336 doctors were non-European economic area citizens. The number of candidates sitting PLAB part 1 and part 2 in 2003 rose by 267% and 283% respectively compared with 2001. Changes to Department of Health, Home Office and deanery regulations with expansion of medical schools, implementation of European Working Time Directive, Modernizing Medical Careers and the future role of the Postgraduate Medical Education and Training Board, will have an important impact on IMGs’ training. Dissemination of realistic information about postgraduate training opportunities is important as the NHS for some time will continue to rely on IMGs. A recent survey analyzing origin and ethnicity of UK consultants showed that the total number of consultants appointed before 1992, 15% had trained abroad; of those appointed in 1992-2001, 24% had trained abroad. The percentage of consultants who had trained abroad and were non-white was significantly high in geriatric medicine, genitourinary medicine, pediatrics, old age psychiatry and learning disability. UK-trained non-white doctors had specialty destinations similar to those of UK-trained white doctors. The percentage of UK medical graduates who are non-white has increased substantially from about 2% in 1974 and will approach 30% by 2005. White men now comprise little more than a quarter of all UK medical students. White and non-white UK graduates make similar choices of specialty. Specialist medical practice in the NHS has been heavily dependent on doctors who have trained abroad, particularly in specialties where posts have been hard to fill. By contrast, UK-trained doctors from ethnic minorities are not over-represented in the less popular specialties. Ethnic minorities are well represented in UK medical school intakes; and white men, but not white women, are now substantially under-represented.[6]

SOCIOECONOMICS

Migration of doctors, though universal, is high in India and a may be a cause of concern to the government and the educationist.[5] Responsibilities at the global level of source and recipient country are reviewed. It is concluded that that the situation is more complex than perceived. The challenge is to advance human health while protecting health workers’ rights to seek gainful employment. The first responsibility for action belongs with each country to “train, retain and sustain” its workforces through national plans that improve salaries and working conditions, revitalise education and mobilize paraprofessional and community workers whose services are demonstrably more cost-effective and who are less likely to emigrate. Better information is needed to monitor migration flows; source countries need to improve staff attraction and retention strategies; and recipient countries need to ensure that they do not become a permanent drain on health professionals from the developing countries.[6] In light of the increasing globalization of the health sector, ways in which health services can be traded needs examining. The trade modes include cross-border delivery of health services via physical and electronic means, movement of consumers, professionals and capital. An examination of trade in health services for equity, efficiency, quality and access to healthcare indicates that health services trade has brought mixed benefits. There should be policy measurement to reduce the adverse consequences and facilitate the gains. Brain drain does include policy measurement and priority area. Increasing investment in the health sector and prioritizing this and promoting linkages between private and public healthcare services to ensure equality of health delivery. Data collection, measures and studies on health services trade all need to be improved to assess the magnitude and implications of this. The potential costs and benefits of trade in health services are shaped by the underlying structural conditions and existing policy and infrastructure in the health sector. Thus appropriate policies and safeguard measures are required to take advantage of globalization in health services.[9]

ADVANTAGES

There is a common perception that migration of these doctors to high-income countries is a loss to the country of origin. However, it is debatable as a shortage of doctors in India is really in the rural area and most of these doctors who are migrating abroad were unlikely to settle in rural areas. On the other hand, doctors from India with a stint abroad have often benefited by the international exposure and this has helped in the advancement of medical facilities in India. According to a recent article in the New England Journal of Medicine, the emigration factor of India is much lower than many African countries. Unemployed or badly struggling educated professionals are a bigger drain than emigrated ones. There has been substantial immigration of physicians to developed countries from lower-income countries. Although the recipient nations and the immigrating physicians benefit from this migration, less developed countries lose important health capabilities as a result of the loss of physicians. Even when migration is not a certainty, a brain drain may increase average productivity and equality in the source economy. Temporary possibility of emigration may permanently increase the average level of productivity of an economy.[10] Asians emerge as a dominant group in the immigration of all professionals. There is a demand for foreign
Migration of doctors abroad has both advantages and disadvantages for India as a country and certainly the doctor himself. The recipient country benefits from skill, labor and multiculturalism. Controlled migration and a substantial contribution by these doctors back to their country of origin in various ways may turn this Brain Drain into Brain Gain.

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