# Barriers to Movement of Healthcare Professionals

## *A Case Study of India*

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# Barriers to Movement of Health Professionals
## *A Case Study of India*[*]

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# Executive Summary

Globalisation and resulting trade liberalisation in health services have caused an upsurge in international migration of health care professionals in recent years. Greater openness has created new opportunities for these professionals. In search of green pasture and enhanced career opportunities, health care professionals from developing countries have been migrating to other countries. This process got further impetus when Organisation for Economic Co-operation and Development (OECD) countries, while facing acute shortage of health care professionals, started recruiting such professionals from developing countries. Countries like the US and the UK even resorted to targeted recruitment of health care workers, particularly nurses from developing countries like Philippines and India.

The ageing of population in OECD countries and the resultant shortage of health care workers was seen as opportunities in countries like India and Philippines. While Philippines has traditionally been the main source country for supply of nurses, India is fast emerging as another important origin country to fulfill the rising global demand of nurses. And in supplying physicians, Indian trained International Medical Graduates (IMGs) tops the list in both – US and UK.

The General Agreement on Trade in Services (GATS) signed as a part of World Trade Organisation (WTO) agreement also provided an opportunity to member countries to explore new market in health services by further liberalising trade in services. Among other services, health too was brought under the ambit of GATS. It classified trade in services into four Modes: out of four Modes of service supply, Mode 4, which requires movement of health professionals, accounts for bulk of trade in health services. Since health care is a labour intensive activity requiring personal care of patients, the movement of either service provider or consumer is must. Consumption abroad (Mode 2) is, therefore, the second most important Mode through which trade in health services is taking place.

Migration of health care professionals from developing to developed countries has had negative impact on many Sub-Saharan African (SSA) countries. This gave birth to two competing schools of thoughts. While one school of thought accuse industrialised countries of sucking in labour from some of the poorest countries of the world that can ill afford to lose health care staff, the neo-liberals on the other hand feel that migration of health care professionals forms an integral and beneficial component of globalisation and the liberalisation of service sector.

Since this report is a case study of India, the objective is to identify barriers faced by Indian health professionals in select developed countries' markets. In other words, the emphasis would be more on neo-liberal perspective. However, the thoughts and findings of this study would in no way undermine the seriousness of the problems being faced by the poor African countries, who have witnessed large scale immigration of their health care staffs to developed countries.

As per the neo-liberal thought, migration of health care professionals brings double benefits for the home countries. While migrant workers are a source of remittances for their families and countries, the temporary outflow of physicians from developing countries may be beneficial in terms of upgrading of skills. Developed countries' technological advancement and better professional environment are major factors which induce people from developing countries to emigrate and expose themselves to qualitatively better work experiences.

**Historical and Contemporary Trend**

Health care professionals, comprising mainly of physicians and nurses, make up a small proportion of all migrating professionals. The international migration of health care workers is mainly taking place from North to North and from South to North. With regard to South-South migration, there are only a few instances that Indian doctors and nurses are migrating to Gulf countries. India and Pakistan from South Asia, Philippines from South-East Asia, South Africa, Nigeria and Ghana from Africa have been the major source countries of international migration of health care professionals. While Philippines and up to some extent India, are systematically trying to produce surplus nurses and medical doctors for export to developed countries, African countries are facing acute crisis in the domestic delivery of health services because of loss of health human resources to developed countries.

The migration of health care professionals from developing to developed countries started in 1960s. After the end of colonial era, many developing countries adhered to the concept of welfare state and began to expand their health services by training their nationals in the field of medical sciences. Though developed countries too started expanding their health services by that time, they lacked sufficient home trained health care professionals. This prompted the developed countries to recruit professionals from developing countries and thus widening the divide between developed and developing countries in terms of domestic health care services facilities.

Historically, international migration of physicians appears to be driven by a number of 'pull' factors such as opportunities for professional training, offers of higher wages, and better employment opportunities in the host country. 'Push' factors such as less attractive pay and working conditions, high unemployment rates, political instability and insecurity in the home country also play a major role. Physicians move abroad for training purposes – either to obtain additional professional qualifications or to gain experience with advanced medical techniques. Unlike physicians, the percentage of migrating nurses had been quite low in 1960s and 1970s. However, at present, nurses account for approximately 70 percent of the total migration of health care workers.

The recent migration of health care professionals is characterised by host countries giving greater emphasis on recruiting nurses than doctors. The rapidly ageing population is forcing countries to go for targeted recruitment of not only health care professionals but professionals in other sectors as well. For instance, the old-age dependency ratio (the number of people 65 and over relative to those between 15 and 64) in the European Union (EU 25 countries) is projected to double to 54 percent by 2050. It means the EU will move from having four persons of working age for every elderly citizen to only two. The ageing

of population has resulted in huge demand for nurses in OECD countries, giving opportunities to developing countries to supply such professionals. The local conditions in home countries have also acted as a catalyst in the outward movement of nurses from developing countries. Another important factor, which has influenced the contemporary migration of health care workers, is increasing realisation on the part of nations that trade in services has immense potential that needs to be exploited. This includes trade in health services.

**Migration of Indian Health Care Professionals**

Health care is one area where the Indian Diaspora has earned a niche. What is more remarkable is the fact that Indian professionals have proved their competence not only in developing countries but in highly industrialised countries like US and UK. In fact, Indian doctors have been the backbone of the UK's National Health Service for long. There are estimated 60,000 doctors of Indian origin working in the UK and some 35,000 in the US. Besides, India has bilateral agreements with six Middle East countries and some others for providing private and government doctors on short-term assignments.

In case of the US, India tops the list of 20 countries where IMGs received medical training. The presence of Indian trained doctors in UK and Canada is also significant. As many as 30 percent of doctors working for the National Health System (NHS) of the UK and Northern Ireland have obtained their primary qualifications from a country outside the EU. Out of this, 26 percent of doctors employed in the NHS are of Indian origin. The physicians of Indian origin have made significant contributions in building and sustaining the NHS. It was estimated that Indian doctors contribute £4.5 billion (US$8.9bn) to the UK's economy, taking into account the cost of training for approximately 20,600 Indian doctors on the UK register.

Of late, Indian nurses have also created a niche for themselves in developed countries health care services market. The presence of Indian nurses is not only confined to the English-speaking countries but they have registered their presence in a number of other developed countries as well. In Austria, for instance, Indian nurses are like pioneers, whose sizeable number in that country has led to the migration of their families. However, the US and the UK remained the main destinations of Indian nurses. In fact, in case of UK, India has surpassed Philippines in terms of annual registration of nurses. The US hospital, however, is still dominated by Filipino nurses. This could be because of stringent qualification requirements imposed by the US government and relatively longer wait for the US' visa.

**Trade in Health Services**

Trade in health services is minimal, particularly when compared to other traded services. However, since 1970s, there has been a growing trend of commercialisation of health care services across the world. Trade in health services can now grow rapidly as information and communication technology (ICT) makes it easier, for example, through e-health services and entry barriers for health care professionals are lowered. Health care was also included into the GATS classification of services, which seeks WTO member countries to make commitments on opening up of health sector.

The revolution in information technology (IT), which has had significant impact on almost all sectors of the economy, helped increase international trade in health services as well. Today, the health care sector is among the fastest growing sectors in the world economy. In fact, the sector was estimated to generate US$3tr per year in OECD countries and was expected to rise further to US$4tr by 2005. The international trade in health services has grown through all four Modes of service supply as defined by GATS. While the migration of health care professionals has been going on for the last several decades, the economic globalisation has spurred cross-border delivery of health services by electronic means and greater movement of medical tourists (patients). The liberalisation in foreign direct investment (FDI) policy by several countries has resulted in an increasing number of joint ventures and collaborative arrangements in health sector.

**Trade in Health Services: India As an Emerging Force**

In the last one decade, India has become a formidable force in trade in services. India's share in world export of commercial services has increased from 0.6 percent in 1990 to 2.7 percent in 2006. Besides IT, health care services is another area where India has made its presence felt in the global market. Traditionally, India has been exporting health services through movement of their health care professionals, mainly doctors and nurses. With the revolution in IT and faster mode of transportation, India has found new avenues in medical process outsourcing and health tourism, of enhancing its exporting its health services. While the trade in health services is rising globally, the data available on it is highly inadequate.

Medical process outsourcing includes medical transcription, medical billing, medical coding, medical insurance collections, health care website designing, health care staffing etc. The Health care marketplace is recognising India as the premier provider of outsourced services owing to its infrastructure, skill base and economic environment. Currently, medical transcription offshoring from India generates US$195mn in revenues; and is expected to reach US$647mn by 2010**.**

India is fast emerging as one of the most attractive destinations for medical tourism as at present the earnings from it is an all time high. With some of the most sought-after specialists in everything from cardiology, neuro-surgery, orthopaedics and eye surgery, India alone has increased its medical tourists by more than 30 percent per year for the past few years. India is just one of several countries that has recognised the incredible benefits from medical tourism, and is now making special efforts to make the country as appealing as possible to potential patients/tourists. Medical tourism in India is becoming such a major industry that some hospitals have now taken it, as far as working with tour operators to offer potential visitors, an all-inclusive health-tourist package, which includes the desired medical procedure, as well as things like hotel, air travel, and admission to various popular tourist attractions.

Exporting health services through cross border movement of health care professionals has been one of the most important means for India. Today, Indian doctors have become a powerful influence in the field of medicine across the world. Indian doctors and nurses go to the Middle East, North America, UK, Australia, Malaysia and Singapore. In fact, Indians

make up the largest non-Caucasian segment of the American medical community. Numbering over 38,000, physicians of Indian origin account for one in every 20 doctors practicing medicine in the US. However, because of non-availability of sectoral data, there is no estimate of India's trade in health services through Mode 4. Since India has become the top recipient of remittances in the world, this could be an indication how important is Mode 4 for India.

**Trade in Health Services: The Impact on Home Country**

The scaling up of international recruitment in developed countries comes against a backdrop of massive health worker shortages in developing countries. While the World Health Organisation (WHO) recommends a minimum of 100 nurses and 20 physicians per 100,000 people, many SSA countries, for example, have fewer than 50 nurses and 5 physicians per 100,000. In contrast, the average among OECD countries was approximately 222 physicians per 100,000 people in 2000. Thus for regions like Caribbean and SSA countries, the problem of health worker migration is a serious threat to their national health systems that is already reeling under the HIV/AIDS epidemic.

As regards the impact of migration of health care professionals on home country, the situation is something different in countries like India, China, and Philippines. These countries are able to produce more health care workers to take benefit of trade liberalisation in health services. For these countries, such flows have been part of an overall strategy of their labour export plan. The Philippines, India, and Cuba have intentionally invested in the training of health workers for export. Therefore, unlike SSA countries, who are facing severe shortage of health care professionals because of migration, the conditions of health sector in India is not as grave. Going by the WHO recommended minimum standards of 20 doctors and 100 nurses per 100,000 people, India does fulfill this standard in doctors but trailing far behind in case nurses availability. In 2004, there were 62 nurses and 51 doctors per 100,000 people available in India.

In case of India, the impact of health care professionals' migration on domestic economy could be measured through inflow of remittances and locals preference for medical and nursing professions. Although there is no sectoral break-up of data available on remittances received by India, the increase in overall inflow of remittances to India indicates that international migration has had a beneficial impact on Indian economy. Over the years, remittances from overseas Indians have emerged as a stable source of foreign exchange inflows for the country. The Reserve Bank of India (RBI) has reported that Indians living abroad transferred US$24.6bn to India in the fiscal year 2005-06, which made India the highest remittance receiving country in the world.

The contributions by migrants are not only through foreign currency remittances but also through other means. Seeing the growing demand for Indian health care professionals in developed countries, the country has already moved in the direction of offering world class education in health professions thus contributing actively to national development. Medical education infrastructures in the country have shown rapid growth during the last 15 years. The continued growth of medical and nursing colleges is an indication to the popularity of medicine and the belief nurtured by the common man that the combination of growth in the Indian economy and opportunities abroad will guarantee future medical employment.

The large scale migration of health care professionals from India has also had some negative impacts. This mass exodus of qualified nurses to Europe has hit nursing colleges across the country. Colleges are finding it difficult to fill vacancies, be it a principal's position, or that of a lecturer or a tutor. For instance, majority of the students passing out from premier institutions like L T Nursing College and Hinduja Nursing College Mumbai, and Rajkumari Amrit Kaur Nursing College, Delhi, migrate abroad after few years of initial training.

**Administrative and Procedural Barriers in Destination Countries**

Migration of skilled professionals including doctors, nurses and other paramedicals from India to other developed countries is not a new phenomenon. India has become one of the major source countries for highly skilled migrant workers that include health care professionals. This large source for labour movement has been despite the highly regulated structure of international health care services market.

The measures undertaken by the developed countries till date have offered little to the developing countries in terms of opening their markets or facilitating the administrative arrangements or providing national treatment in the area of Movement of Natural Persons. There are a number of visible and invisible barriers to the movement of health care professionals to the developed countries. In case of medical profession, developed countries enforce the most stringent qualification requirements.

In the US, barriers to entry have been maintained through a combination of medical school accreditation and mandatory state licensing of individual practitioners. While in Australia in 1990s, a wide range of measures, many of which existing even now were implemented to curb the entry of ever increasing number of doctors from developing countries. In practice, different types of barriers exist in different countries. As per the communication sent by India in November 2000 to the Council for Trade in Services Special Session, immigration and labour market policies of individual countries are the major barrier faced by Indian professionals abroad, among various other barriers. The constraints under this are in the form of strict eligibility conditions for application, processing of visas and work permits including limitations on the length of stay and transferability of employment in the overseas market. These constraints raise the direct and indirect costs of entering the foreign market, thereby eroding the cost advantage of foreign service suppliers.

**Health Services under GATS**

Health services are included under the GATS heading of 'professional services', which covers medical and dental services as well as the category of 'services provided by midwives, nurses, physiotherapists and paramedical personnel'. Health services have traditionally been subject to strong government involvement in many countries and this situation has changed far less rapidly than the role of governments in, for example, banking and telecommunications. While 90 percent of WTO members undertook some form of commitment on tourism services and about 70 percent included financial or telecommunication services in their Uruguay Round Schedules, less than 40 percent made commitments on health.

While the trade in health services has been on the rise, the commitments undertaken by WTO members under GATS is very shallow in nature. GATS seems to have had a limited impact so far on the migration of health care professionals. Out of 150 odd WTO members, only 29 countries have made commitments for trade in health services and that too are very limited in nature. Moreover, within the GATS framework, WTO members are free to pursue domestic policies in areas such as technical standards, licensing and qualifications to ensure the safety and quality of health care provision. This implies that a commitment to allow entry of foreign medical practitioners is still subject to meeting all domestic regulatory requirements. GATS only states that such requirements must be transparent and administered in objective and impartial manner.

For the health services sector, commitments under GATS are made separately for four Modes of supply: cross-border trade (Mode 1), consumption abroad (Mode 2), commercial presence (Mode 3), temporary movement of service suppliers (Mode 4). The commitments undertaken in the four sub-sectors by Australia, Canada, Japan, EU and the US, where Indian health care professionals see the opportunities to migrate, are very limited. Of the four sub-sectors, no other country has made commitments in more than one sub-sector except EU. Canada has not undertaken commitments in any of the four relevant sub-sectors. The EU's commitments are also not uniform across its members but vary from country to country.

Like most of the developing countries, India too was defensive during the Uruguay Round. However, India's negotiating stance on services has undergone a paradigm shift since then. In the ongoing services trade negotiations, India has been very offensive in seeking market access in developed countries, particularly under Mode 1 (cross border trade) covering the whole issue of business process outsourcing and Mode 4 ( temporary movement of natural persons).

This shift in India's stance in services trade negotiations can be attributed to significant increase in services exports from India. In a short span of little over one decade, India's share in world services exports has increased from 0.53 percent in 1993 to 2.7 percent in 2006. When the Doha Round of trade negotiations was launched in November 2001, India was the main proponent of market opening under Mode 4. In fact, a year before the launch of Doha Round, India made one of the most comprehensive submissions on temporary movement of natural persons to the WTO's Council of Trade in Services. The proposal provides not only concrete suggestions for areas of further liberalisation under Mode 4, but also details administrative procedures relating to Mode 4 visas and work permits and the recognition of qualifications.

In the current services negotiations, India has been spearheading the group of demandeurs on cross border services trade (Mode 1) and Mode 4. Though India remains one of the main demandeurs of liberalisation of services trade under Mode 4, in recent years there has been some indication of shifting of focus more towards Mode 1. This change has happened mainly because of increasing complexity with Mode 4 liberalisation as it touches upon immigration and visa issues, which are beyond the mandate of WTO. As regards health services, India has made request to major developed countries for opening up their health sector.

**Stakeholders' Perception**

The migration of doctors from India to developed countries, mainly the US and the UK, is not a new phenomenon. They have been migrating to developed countries for better training and higher medical degree since 1960s. While a majority of doctors prefer to stay there, some of them have come back. Since most of the doctors in India come from middle and higher income families, they find their own way to migrate. Contrary to this, nurses in India belong to lower or lower-middle class background. Therefore, they depend upon specialised recruitment agencies to help facilitate their migration.

The emergence of new opportunities globally for nursing professionals led to mushrooming of overseas placement agencies and private nursing colleges in India. The critical shortage of Registered Nurses (RNs) in the US has led to a boom in the recruitment of Indian nurses to America. A number of American hospitals are these days putting in requests with manpower consulting agencies and nursing schools across India for recruiting nurses. States Kerala and Tamil Nadu have established their own manpower export corporation to help the low-skilled professionals to migrate abroad. Though government agencies like nursing and medical councils do not seem to be encouraging health care professionals to go abroad, their role is crucial. These councils are involved in the negotiation of mutual recognition of medical qualifications, bilaterally as well as multilaterally. Non-recognition of qualification is one of the major barriers in free movement of professionals from developing to developed countries.

The stakeholders' perception survey has, therefore, targeted recruitment agencies, nursing colleges, nursing councils and state level manpower export corporations to gather their views on barriers, which Indian health care professionals face in developed countries' markets. Among the recruitment agencies only those were interviewed that are exclusively involved in overseas placement of health care professionals, mainly nurses. Recruitment agencies like All About Staffing (India) Private Limited, Fortis HealthStaff Limited, India International Technical Recruiters, Nurses Anytime, Modi Health etc., are working as agents of US and UK hospitals in India. Further, there is hardly any placement agency, which is involved in facilitating migration of doctors. Thus, most of the information collected through field survey relates to nursing professionals.

The major concerns, which emerged in stakeholders' perception survey, are following:

- Stringent qualification requirement is the most difficult barrier which Indian health care professionals face in developed countries market. Among developed countries US imposes the most cumbersome qualification requirement.
- It is mainly the tough qualification requirement, which delays the whole process of migration. For example, in case of US, for nurses it takes almost 3-4 years from the day of admission in recruitment agencies to the final placement.
- Visa is a problem but the process is considerably eased once a candidate clears all the necessary exams.
- Among the developed countries Ireland is the easiest place to go for nurses as it does not involve much time in granting visa. However, Ireland provides work visa only for a limited time period.

- The US definitely is the most preferred destination. Because of two factors – firstly, the large size of the market means a great number of opportunities and secondly the long-term family visa with possibility of upgradation into permanent residency, nursing professionals prefers the US.
- All the recruitment agencies are critical of nursing councils as they are not very supportive. Nursing councils are required to certify the degrees and other documents related to qualification. This is the mandatory clause imposed by hospitals in developed countries.
- Nursing councils and nursing colleges on the other hand expressed their views that they do not encourage their professionals to go abroad as it might impact negatively on domestic healthcare services.

**Policy Recommendations**

India has identified health care service as one of the key sectors where Indian professionals have competitive advantages in international market *vis-à-vis* other developing countries. Among the various categories of health care services, nurses are in greater demand in most of the OECD countries. The severe shortage of nurses in US and UK resulted in targeted recruitment by them from countries like Philippines and India. Since Filipino nurses have already been dominating the international market, OECD countries turned towards India as the new potential source of nurses' recruitment. India too has responded positively as trade in health services gets well with India's overall emphasis to boost its services trade.

In case of health care professionals, fulfilling stringent qualification requirement is the main barrier. Most of the stakeholders (overseas health care recruitment agencies) in India are of the view that once a candidate clear all the tests required for practicing nursing/medicine in a host country, visa is not a problem. The problem arises mainly because of multiplicity of tests. For example, in order to become a qualified nurse to get a job in the US hospital a candidate has to go through minimum three tests – Commission on Graduates of Foreign Nursing Schools (CGFNS), NCLEX-RN and mandatory language tests. As per information provided by stakeholders in India, majority of the nurses fail to qualify all the three tests in one attempt. This creates problem when a passing certificate of a particular test is valid for a shorter time period. If the remaining tests are not cleared within the stipulated time period, then a candidate may have to take the test again, which she has already cleared.

Thus, mutual recognition agreement (MRA) on qualification is the most critical for free movement of health care professionals. MRA enables the qualifications of professional services suppliers to be mutually recognised by signatory member countries, hence facilitating easier flow of professional services providers. The GATS allows members to deviate from the Most-Favoured Nation (MFN) requirement and set up bilateral or plurilateral MRAs. At present, developing country participation in MRAs is limited and concerns only the most dynamic among them. Lack of recognition of professional qualifications remains a major obstacle for developing country professionals willing to provide their services abroad. Thus, there is a need to devise some mechanisms and put in place effective participation in MRAs to facilitate developing country, as market forces will not by themselves provide a solution to the problem.

The ongoing GATS negotiations may provide an opportunity for developing mechanisms that would ensure that MRAs become effective tools for facilitating the international movement of professionals, including developing country professionals. Health services is perhaps relatively easier in which MRA could be signed among at least developed and larger developing countries as professional requirements and training courses do not vary much. In this context, GATS Article IV may be highly relevant for giving recognition to professional degrees and certificates of developing countries. The Article suggests that developed countries should make efforts aimed at facilitating the recognition of the academic and professional qualifications of developing country professionals, and developing country effective participation in MRAs.

Among trade barriers, the second most important measure is Economic Needs Tests (ENTs). Although, WTO members are not supposed to use ENTs to limit the number of natural persons, if at all members wish to continue to use such ENTs, they are supposed to cite and describe them in their schedules. Some members have indicated that ENTs or labour market tests are not applicable to certain categories of natural persons covered. However, because of the lack of transparency of their commitments or lack of available information on their national and sub-national regimes, it sometimes looks as if ENTs or labour market tests are indeed operating. In health service also some countries have relaxed it but one cannot be sure.

Developing countries have pointed out that ENTs or labour market tests constitute a Mode 4 barrier that needs to be addressed in the current negotiations, so that improved market access could result. The main reason behind its arbitrary and non-transparent application is lack of multilaterally agreed definition of ENTs under GATS. Research studies have shown that within the category of labour market tests, the most frequent factor is the availability of similar workers in the host country, or whether a foreign worker would be competing with or displacing a domestic worker.

The WTO members have suggested several ways to dealing with ENTs. Canada, for instance, proposed ENTs or labour market tests should either: a) not be applied to the categories of natural persons covered by a member's Mode 4 commitments; or b) if applied, should be included in the member's schedule of specific commitments. India, however, demands either its complete removal or substantial reduction. In case ENTs are substantially reduced, their application must be non-discriminatory. But above all, what is required urgently is to define ENTs, and laying down proper criteria and conditions for its application.

Another important barrier is visa procedure. Priority should be given to standardise visa and work permit regulations for professionals. Entry visas should be easily granted for medical professionals, with a short prescribed duration for procedural formalities. Within these procedural formalities, there is a need to ensure transparency and certainty particularly a transparent application processes, simplified renewal and transfer procedures, and recourse mechanisms to ascertain the status of an application and reasons for rejections. Further, quantitative restrictions on number of visas to be granted under temporary movement of professionals should not be there, just as there are to be no quantitative limitations on trade in goods.

Moreover, the fees, charges etc., applicable to residents and/or citizens with a view to provide social security nets or retirement benefits should not be made applicable on those foreign professionals who migrate to a foreign country only for a temporary period rather than for permanent residence or citizenship. Or if such charges are levied then these temporary professionals should be entitled to a refund of such contributions after their stay. A distinction between permanent and temporary movement of medical professionals is required so that procedures and requirements that apply to permanent movement do not hinder the commitments made for temporary movement. All the more, the conditions of entry and stay for temporary movement should be less stringent than for permanent immigration.

Apart from dealing with external barriers, there are some critical domestic issues which also need urgent attention of policy makers in India. At first, medical and nursing councils who are the nodal agencies responsible for regulation and maintenance of a uniform standard of training for doctors and nurses/midwives/auxiliary nurse-midwives respectively need to be more proactive. Since these councils prescribe the syllabi and regulations for various health care related professional degrees, it is important for them to make Indian professional and their technical degrees at par with international standard. This would help them in negotiating the bilateral/plurilateral/multilateral MRAs.

Another domestic issue is government active involvement in generating surplus health care manpower for export purpose. India has been able to substantially increase its annual flow of health care professionals but so far it has been largely private sector initiative. To produce surplus health care professionals is very crucial otherwise increase in migration of nurses and doctors would start adversely impacting the domestic health care facilities. India must pre-empt to make sure that in future as a result of greater outflow of health care professionals it should not land up in a situation where there would be a critical shortage of health care staff as being faced by many SSA countries today.

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## Acronyms

| | |
|---|---|
| AAMT | American Association for Medical Transcription |
| AIIMS | All India Institute of Medical Sciences |
| AMA | American Medical Association |
| AMC | Australian Medical Council |
| ANM | Auxiliary Nurse Midwife |
| ANMC | Australian Nursing & Midwifery Council |
| AON | Area of Need |
| BDS | Bachelor of Dental Surgery |
| CGFNS | Commission on Graduates of Foreign Nursing Schools |
| CNATS | Canadian Nurses Association Testing Service |
| CRNE | Canadian Registered Nurses Examination |
| CVS | Certification Verification Service |
| ECFMG | Educational Commission for Foreign Medical Graduates |
| ENT | Economic Needs Tests |
| ERAS | Electronic Residency Application Service |
| EVSP | Exchange Visitor Sponsorship Program |
| FTAs | Free Trade Agreements |
| GATS | General Agreement on Trade in Services |
| GDP | Gross Domestic Product |
| GNM | General Nursing and Midwifery |
| IELTS | International English Language Testing System |
| IENs | Internationally Educated Nurses |
| IMG | International Medical Graduates |
| INC | Indian Nursing Council |
| IT | Information Technology |
| LMCC | Licensure of the Medical Council of Canada |
| LPNs | Licensed practical nurses |
| MCCEE | Medical Council of Canada Evaluating Examination |
| MCCQE | Medical Council of Canada Qualifying Examination |
| MDS | Masters of Dental Surgery |
| MFN | Most Favoured Nation |
| MRA | Mutual Recognition Agreements |
| NASSCOM | National Association of Software and Services Companies |
| NBME | National Board of Medical Examiners |
| NCLEX | National Licensure Exam |
| NCSBN | National Council of State Boards of Nursing |
| NHS | National Health System |
| NRMP | National Resident Matching Program |
| NVC | National Visa Center |
| OECD | Organisation for Economic Co-operation and Development |
| OFLC | Office of Foreign Labor Certification |
| OTD | Overseas Trained Doctor |

| | |
|---|---|
| PLAB | Professional and Linguistic Assessment Board |
| PMQ | Primary Medical Qualification |
| RBI | Reserve Bank of India |
| RNs | Registered Nurses |
| SEVIS | Student and Exchange Visitor Information System |
| SSA | Sub-Saharan African |
| TOEFL | Test of English as a Foreign Language |
| TOEIC | Test of English in International Communications |
| TSE | Test of Spoken English |
| TWE | Test of Written English |
| UNCTAD | United Nations Conference on Trade and Development |
| UNDP | United Nations Development Programme |
| USMLE | United States Medical Licensing Examination |
| WHO | World Health Organisation |
| WTO | World Trade Organisation |

# Barriers to Movement of Health Professionals

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## Section I. Introduction

The cross-border migration of health-care professionals is not a recent phenomenon and its root goes back to several decades. However, the globalisation and resulting trade liberalisation in health services have caused a renewed upsurge in international migration of health care professionals in recent years. In fact, greater openness has created new opportunities for these professionals. In search of green pasture and enhanced career opportunities the health care professionals migrate to other countries. This process got further impetus when OECD countries, while facing acute shortage of health professionals, started recruiting them from developing countries. Countries like the US and the UK even resorted to targeted recruitment of health care workers, particularly nurses from larger developing countries like Philippines and India.

The ageing of population in OECD countries and resulting shortage of health care workers was seen as opportunities for countries like India and Philippines. In a recent report on health systems, the OECD highlighted increasing concerns about nursing shortages in many of its member countries. Some recent examples of OECD country assessments of nursing shortages include Canada, where the shortfall of nurses was quantified at around 78,000 nurses by 2011,[1] and Australia, which projects a shortage of 40,000 nurses by 2010[2]. While Philippines has traditionally been the main source country of supply of nurses, India is fast emerging as another important country of origin to fulfill the rising global demand for nurses. This is evident by mushrooming of specialised recruitment agencies, dealing exclusively with international migration of nurses and rise in the number of private nursing colleges in India. Most of these recruitment agencies are an affiliate of big super-specialty hospitals of the US and the UK.

With regard to physicians, Indian trained IMGs tops the list in both US and the UK. In absolute numbers, India was the largest source country of physicians in the1970s (Mejia et al. 1976). Even today, Indian-trained doctors continue to make up a substantial proportion of the stock of doctors in Canada, UK, and US (Khadria, 2004). In US, out of 2.3 million total Indian populations, there are about 40,000 practicing doctors. In Canada, out of a total population of 700,000 people from India, there are 5,000 doctors.[3] Similarly, in the UK, India ranks first among all the source countries. India-trained doctors account for 18.3 percent of the total foreign physician workforce in the UK in year 2001 (OECD, 2006).

GATS, signed as a part of WTO agreement, also provided an opportunity to member countries to explore new market in health services by further liberalising trade in services. Among other services, health too was brought under the ambit of GATS. It classified trade

[1] Canadian Nurses Association, 2004
[2] Australian Health Ministers Conference 2004
[3] http://www.saag.org/%5Cpapers21%5Cpaper2060.html

in services into four Modes[4]. Out of four Modes of service supply, Mode 4, which requires movement of health professionals accounts for bulk of trade in health services. Since health care is a labour intensive activity requiring personal care of patients, the movement of either service provider or consumer is must. Consumption abroad (Mode 2) is the second most important Mode through which the trade in health services is taking place.

The migration of a large number of health care workers from developing to developed countries is, however, not free from controversy. The loss of scarce health care workers of developed countries has become a matter of great concern for SSA countries, as this outflow severely affected their domestic health services. Many countries in SSA countries are implementing ambitious plan on HIV/AIDS. The shortage of health care workers is widely recognised as a major barrier to reaching out to those patients who urgently need antiretroviral (ARV) drugs, crucial for treatment of HIV/AIDS. Access to drugs is a necessary condition, but will not be enough to save millions of lives at risk unless priority is also given to ensure the necessary personnel to provide such treatment.

For the purpose of this study, the focus is directed on movement of health professionals, especially from developing to developed countries. Regarding the impact of migration of health care professionals from developing countries, there are two competing school of thoughts. One view accuses industrialised countries of sucking in labour from the poorest countries of the world that can ill afford to lose health care staff (Bach, 2003). Contrary to this, the neo-liberals feel that migration of healthcare professionals forms an integral and beneficial component of globalisation and the liberalisation of service sector.

Since this report is a case study of India, the objective is to identify barriers faced by Indian health care professionals in select developed countries' markets. India along with Philippines and some other larger developing countries has been the main target of developed countries in their aggressive recruitment of overseas health care workers. In other words, the emphasis would be more on neo-liberal perspective. However, the thoughts and findings of this study would in no ways undermine the seriousness of the problems being faced by the poor African countries that have witnessed large scale emigration of their health care staffs to developed countries.

As per the neo-liberal thought, migration of health care professionals brings double benefits for the home countries. While migrant health workers are a source of remittances for their families and countries, the temporary outflow of physicians from developing countries may be beneficial in terms of skill upgradation. Developed countries' technological advancement and better professional environment are major factors which induce people from developing countries to emigrate and expose themselves to qualitatively better working experiences.

This paper is organised thus. Section II explains the objective, methodology and limitation of the study. Section III presents a historical and cotemporary account of migration of health care professionals. Section IV analyses the trend of migration of Indian health care workers. Section V tries to assess the magnitude of international trade in services, though

[4] GATS four modes of services supply; Mode 1 – Cross Border Trade; Mode 2 – Consumption Abroad; Mode 3 – Commercial Presence; Mode 4 – Temporary Movement of Natural Persons

there is a serious crunch of data on it. Section VI discusses how India is fast emerging an important global player in trade in health services. Section VII deals with one of the most critical and controversial issues – the impact of migration on health system of the home country. Section VIII traces the major destination countries where Indian health professionals are migrating. Section IX gives an account of the major procedural requirements which health care professionals need to follow before getting a job in major developed countries. Section X discusses major barriers other than legitimate procedures, which Indian health care workers face in developed countries' market. Section XI presents the progress in the WTO under GATS in liberalising trade in services. Section XII analyses the findings of stakeholder perception survey. Finally, Section XIII sums up the study with policy recommendations.

## Section II. Objective, Methodology and Limitation of the Study

The study aims to achieve two main objectives: first, the research is intended to examine the policy, administrative and implementation mechanisms employed by various host countries' governments at the national, bilateral and regional level to manage temporary migration of independent overseas health service providers. The study analyses the domestic regulations of various countries viz: US, UK, Canada, and Australia, to shed light on issues that have detrimental effect on the movement of Indian health service providers, aiming to simultaneously focus on experiences acquired by Indian professionals to draw lessons that can facilitate in managing the temporary movement effectively. The study has not covered Gulf countries, though it is one of the favoured destinations of Indian health care professionals. This is mainly because of two reasons: first, unlike developed countries Indian health care professionals do not face any kind of stringent barriers in Gulf countries; and second, the information about the process and regulations of these countries are not easily available.

The second objective is to identify how the procedures applied by host countries act as barriers for Indian independent health service providers (namely, medical and dental service providers and services provided by nurses) under Mode 4 of GATS and appropriately gives recommendation to strategise to ensure access of Indian health professionals to opportunities for employment abroad through authorised channels. The study intends to highlight how the ongoing GATS negotiations can be used to generate a stronger liberalising momentum in health sector. Further, the study also presents an account of GATS contribution in the liberalisation of international trade in services and India's stance on health services trade liberalisation in the ongoing services negotiations under the aegis of Doha Round.

The study is largely based on secondary literature and data. The migration data has been taken from the various reports of WHO, International Organisation of Migration, OECD, and Government of India. The study begins with critical evaluation of the current policy, administrative and implementation mechanisms employed by various governments at the national, bilateral and regional level to manage temporary migration of independent health service providers. Along side, the study examines the approach adopted by the various countries (favoured destinations) as regards their commitments on health services *vis-à-vis* potential for trade in services under GATS negotiations.

As a part of the research study a stakeholder perception survey was conducted in select cities of India. This was a qualitative survey. The following set of stakeholders has been interviewed:

- Recruitment agencies dealing exclusively with healthcare professionals;
- Regulatory authorities/Government Agencies including state level agencies;
- Health professionals from nursing colleges;
- Councils; and
- Other experts and practitioners in the field

One of the main hurdles is the lack of credible data on trade in health services. In the absence of a comprehensive and internationally comparable data, it is always difficult to properly analyse the trend in health services and its social and economic impacts on home country. Most of the data available is anecdotal in nature. No doubt services have always been difficult to quantify in terms of volumes as well as values due to their invisible, non-storable and intangible nature. But this problem is more severe in the case of social sectors such as health where data is simply not available at a disaggregated level.

In India, the RBI provides Balance of Payments (BoP) data on services trade. But the BoP only covers traditional sectors like transport, travel, and insurance services, rest all clubbed together under heterogeneous category of "other services". There is no separate category called health services. While there has been some estimate available on earnings from health tourism and medical outsourcing, there is hardly any figure available on trade in health services through Mode 4. It is worthwhile to mention here that unlike overall trade in services, the trade in health services is dominated by cross border movement of health care professionals. Again, there is no sectoral break-up available of earnings from remittances.

## Section III. International Migration of Health Professionals: Historical and Contemporary Trend

Health care professionals, comprising mainly of physicians and nurses, make up a small proportion of all migrating professionals. The international migration of health care workers is mainly taking place from North to North and from South to North. As regards South-South migration, there are only a few instances such as Indian doctors and nurses migrating to Gulf countries. India and Pakistan from South Asia, Philippines from South-East Asia, South Africa, Nigeria and Ghana from Africa have been the major source countries of international migration of health care professionals. While India and the Philippines are systematically trying to produce surplus nurses and medical doctors for export to developed countries, African countries are facing acute crisis in the domestic delivery of health services because of loss of health human resources to developed countries.

### III.1 Historical Perspective

The migration of health care professionals from developing to developed countries started from 1960s. After the end of colonial era, many developing countries adhered to the concept of welfare state and began to expand their health services by training their nationals in the field of medical sciences. Though developed countries too started expanding their health services by that time, they lacked sufficient home trained health care professionals. This prompted them to recruit professionals from developing countries and thus widening the divide between developed and developing countries in terms of domestic healthcare services facilities. Mejia and Pizurki (1976) in their study commissioned by the WHO in 1970s looked at the global stocks and flows of physicians and nurses and showed this growing disparity between developed and developing countries (see Table 1).

**Table 1: Physician Flows in 1972**

| Countries | Stock | Inflow | Outflow | Change |
|---|---|---|---|---|
| Developed | 1,746,000 | 118,000 | 52,300 | 65,700 |
| Developing | 615,300 | 14,300 | 67,100 | -52,800 |
| Totals | 2,361,300 | 261,000 | 119,400 | |

*Source: Mejia and Pizurki, 1976*

In 1960s and 1970s, the physician flows accounted for about 16 percent of the global stock of physicians on the move. They were mainly migrating to the US and the UK from Canada, Germany, Ireland, India, Iran, Pakistan, Sri Lanka, the Philippines, Korea and Latin America. Historically, international migration of physicians appears to be driven by a number of 'pull' factors such as opportunities for professional training, offers of higher wages, and better employment opportunities in the host country. 'Push' factors such as less attractive pay and working conditions, high unemployment rates, political instability and insecurity in the home country also play a role. Physicians move abroad for training purposes – either to obtain the additional professional qualifications or to gain experience with advanced medical techniques.

Migration for training purposes accounts for a substantial number of foreign-trained physicians in a country. Overseas physicians who were attending postgraduate training in England made up 39.6 percent of all overseas physicians in the National Health Service in 1995, 36.2 percent in 2000 and 37.3 percent in 2001. IMGs, who came to the US to attend postgraduate training, comprised 11.9 percent of all IMGs in 1980, 12.1 percent in 1990, 15.1 percent in 1995 and 13.1 percent in 2000. Similarly, training opportunities may account for a significant proportion of emigrating physicians. In 2001, the number of physicians who were registered in Switzerland, but were living abroad to attend postgraduate training and to practice was 555 and 629, respectively (Forcier et al 2004).

Unlike physicians the percentage of migrating nurses was quite low in 1960s and 1970s. However, today nurses account for approximately 70 percent of the total migration of healthcare workers. In the 1970s it was estimated that about 135,000 nurses (or four percent of the world total) were outside their country of birth or training, 92 percent of these were in Europe, North America and the developed countries of the West Pacific. In 1970 more Filipino nurses were registered in the US and Canada than in the Philippines. The migration of nurses was more multidirectional than that of physicians. This is mainly

because better job opportunity is the key factor which influences international migration of nurses. Major countries of origin were Canada, Egypt, New Zealand, the Philippines, and the UK and major destinations were Canada, US, UK, Germany and Australia. For instance, of the foreign nurses newly registered in the US in 1972, over 49 percent were from the Philippines, over 21 percent from Canada and the UK together and over 14 percent from India, Korea, Thailand and the Caribbean together (Mejia, 1978).

### III.2 Contemporary Migration

While the shortage of health care workers remained in OECD countries, some of these countries are adopting the ethical practices in recruitment of professionals from developing countries at the same time. As a result, there has been temporary fall in the recruitment of health care professionals from developing countries, particularly SSA countries. This has happened because international recruitment has generated controversy in 1997 when Nelson Mandela crticised the UK government for recruiting nurses from South Africa. In reaction to this criticism, the UK's department of health issued guidelines to all NHS employers in November 1999 that stated: "It is essential that all NHS employers do not actively recruit from developing countries which are experiencing nursing shortages of their own (Bach, 2003). Later, the Commonwealth Secretariat also released its code of practice for the international recruitment of health workers which calls for balancing the needs of developed countries with minimising the adverse effects on the health care of the exporting countries.[5]

However, there has been no let up in migration of health care workers from developing to developed countries. In OECD countries, the percentage of health and other community services worker in total foreign-born employment was ranging from as low as 2.4 percent in Greece to 20.7 percent in Norway in the year 2003-04.[6] Data from OECD countries indicate that doctors and nurses trained abroad comprise a significant percentage of the total workforce in most of them, but especially in English-speaking countries (see Table 2). It also appears that doctors trained in SSA countries and working in OECD countries represent close to one quarter (23 percent) of the current doctor workforce in home countries, which goes as high as 37 percent in South Africa. Contrary to this, nurses and midwives trained in SSA countries and working in OECD countries represent one twentieth (five percent) of the current home country workforce. However, in a few countries such as Zimbabwe, this ratio is as high as 34 percent.[7]

**Table 2: Doctors and Nurses Trained Abroad Working in OECD Countries**

| | Doctors Trained Abroad | | Nurses Trained Abroad | |
|---|---|---|---|---|
| **OECD Country** | **Number** | **% of Total** | **Number** | **% of Total** |
| Australia | 11,122 | 21 | NA | NA |
| Canada | 13,620 | 23 | 19,061 | 6 |
| Finland | 1,003 | 9 | 140 | 0 |

[5] Commonwealth Code of Practice for the International Recruitment of Health Workers and Companion Document to the Commonwealth Code of Practice for the International Recruitment of Health Workers, Commonwealth Secretariat, London, May 2003

[6] International Migration Outlook, Annual Edition, 2006 Edition, OECD

[7] The World Health Report 2006, WHO

| | | | | |
|---|---|---|---|---|
| France | 11,269 | 6 | NA | NA |
| Germany | 17,318 | 6 | 26,284 | 3 |
| Ireland | NA | NA | 8,758 | 14 |
| New Zealand | 2,832 | 34 | 10,616 | 21 |
| Portugal | 1,258 | 4 | NA | NA |
| UK | 69,813 | 33 | 65,000 | 10 |
| US | 213,331 | 27 | 99,456 | 5 |

*Source: The World Health Report 2006, WHO*

The recent migration of health care professionals is characterised by host countries giving greater emphasis on recruiting nurses than doctors. The rapidly ageing population is forcing countries to go for targeted recruitment of not only healthcare professionals but professionals in other sectors as well. For instance, the old-age dependency ratio (the number of people 65 and over relative to those between 15 and 64) in the EU-25 countries is projected to double to 54 percent by 2050. It means the EU will move from having four persons of working age for every elderly citizen to only two.[8] The ageing of population has resulted in huge demand of nurses in OECD countries, giving opportunities to developing countries to supply nurses (see Table 3). The local conditions in home countries have also acted as a catalyst in the outward movement of nurses from developing countries (see Table 4).

**Table 3: Destination Countries: Total No. of Nurses and Sources of International Recruitment, 2001**

| Country | No. of Nurses | Source Country of Recruitment |
|---|---|---|
| Australia | 149,202 | UK, New Zealand |
| Ireland | 61,629 | UK, Philippines, South Africa |
| Norway | 45,133 | Scandinavian countries, Germany, Philippines |
| UK | 640,000 (580,000) | Philippines, South Africa, Australia |
| US | 2,238,800 | Philippines, Canada, S. Africa and Nigeria |

*Source: OECD Health Data CD-ROM, 2001 as given in report, "International Nurse Mobility: Trends and Policy Implications, WHO, International Council of Nurses and Royal College of Nursing, 2003*

**Table 4: Main Push and Pull Factors in International Nursing Recruitment**

| Push Factors | Pull Factors |
|---|---|
| • Low pay (absolute and/or relative)<br>• Poor working conditions<br>• Lack of resources to work effectively<br>• Limited career opportunities<br>• Limited educational opportunities<br>• Impact of HIV/AIDS<br>• Unstable/dangerous work environment<br>• Economic instability | • Higher pay (remittances opportunities)<br>• Better working conditions<br>• Better resourced health systems<br>• Career opportunities<br>• Provision of post-basic education<br>• Political stability<br>• Travel opportunities<br>• Aid work |

*Source: "International Nurse Mobility: Trends and Policy Implications", WHO, International Council of Nurses and Royal College of Nursing, 2003*

[8] "Can Europe Afford to Grow Old", Finance and Development, International Monetary Fund, September 2006.

Another important factor, which has influenced the contemporary migration of health care workers, is increasing realisation on the part of nations that trade in services has immense potential that needs to be exploited. This includes trade in health services. In 1960s and 1970s, it used to be an individual efforts and initiatives of migrants. There was hardly any active support either from government or private agencies. Today, those who wish to migrate are not only being helped by agencies of home country but they get crucial support from the employer and government of host countries. While host countries prefer immigrants in those sectors where there is a shortage of workers [health, information technology (IT) etc.], poor developing countries mainly wants to see their low and semi skilled labour migrate.

### III.3 Global Shortage of Nurses: Fueling the Cross-border Migration of Health Care Professionals

The world-wide shortage of nurses has been the main driving force of recent upsurge in cross-border migration of health care professionals. The shortage at its simplest is a lack of adequate numbers of skilled practicing nurses, as seen now in most nations of the world. Although both developed and developing countries are facing the acute shortage of nurses, it is the shortage in OECD countries that has caused increasing numbers of nurses from developing countries migrating to developed countries. For instance, the number of nurses in the UK from non-EU countries grew from approximately 2,000 in 1994-1995 to more than 15,000 in 2001-2002. Similarly, in the US, the percentage of nurses trained abroad increased from 6 percent in 1998 to 14 percent in 2002. Even the Philippines, a traditional sending country, sent more than three times the number of nurses abroad in 2001 than in 1996, primarily to the UK, Ireland, and Saudi Arabia.[9]

One of the main reasons of this shortage is that women now have far greater range of career choices than in the past and men are still not entering nursing in significant numbers. For instance, in US men comprise only about 6 percent of working US nurses. At the same time, the nursing workforce is rapidly aging, and too few new nurses are being trained. Other cited reasons are poor relations with physicians, including lack of physician respect, physician disruptive behavior and major communication failures, continue to be a problem for nurses, especially where nurses' status is lower.[10] In the recent years, countries like US, Australia and Canada have taken some initiatives to raise the interest of local people in nursing profession but these have not been sufficient to end the shortage.

#### III.3.1 Shortage of Nurses in US

The growing trend in migration of healthcare professionals is mainly because of incidence of world-wide shortage of nurses. Nurses accounts for almost 70 percent of the total cross border migration of health care professionals. Supply of nurses in many high-income countries is failing to keep pace with increasing domestic demand. For instance, in 2000, the national supply of full-time equivalent RNs in the US was estimated at 1.89 million

[9] "The Global Tug-of-War for Health Care Workers", Migration Policy Institute, December 2004
[10] "What is Nursing Shortage and Why Does to Exist?", The Centre for Nursing Advocacy, US

while the corresponding demand was estimated at two million, a shortage of 110,000 or 6 percent.

Based on what is known about trends in the supply of RNs and their anticipated demand, the shortage is expected to grow relatively slowly until 2010, by which time it will have reached 12 percent. At that point demand will begin to exceed supply at an accelerated rate and by 2015 the shortage, a relatively modest 6 percent in the year 2000, will have almost quadrupled to 20 percent. If not addressed, and if current trends continue, the shortage is projected to grow to 29 percent by 2020 (see Table 5).

**Table 5: Shortage of Nurses in the USA (Projection)**

| | Supply | Demand | Excess or Shortage | Percentage Shortage |
|---|---|---|---|---|
| 2000 | 1,889,243 | 1,999,950 | -110,707 | -6% |
| 2005 | 2,012,444 | 2,161,831 | -149,387 | -7% |
| 2010 | 2,069,369 | 2,344,584 | -275,215 | -12% |
| 2015 | 2,055,491 | 2,562,554 | -507,063 | -20% |
| 2020 | 2,001,998 | 2,810,414 | -808,416 | -29% |

*Source: Projected Supply, Demand, and Shortage of RNs: 2000-2020, US Department of Health and Human Services, July 2002*

III.3.2 Shortage of Nurses in Australia

In Australia over the last one decade, there has been increased attention paid to nurse workforce planning both at state and territory and national levels in recent years. This is in response to increasing incidence of nursing workforce shortages. The findings of the AIHW Nursing Labour Force 2001 report (AIHW 2003) support the proposition that the shortage of nurses is likely to continue unless action is taken to change the supply trends. However, Preston (2006) finds that as a whole, the annual shortfall of 3243 (1.6 percentof the workforce) is projected to reduce to 470 by 2010 (see Table 6).

**Table 6: Projection of Nursing Shortages in Australia**

| | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|---|
| Surplus/Shortage (number) | -3243 | -3000 | -2316 | -1701 | -470 |
| Surplus/Shortage as % of total RN workforce | -1.6% | -1.5% | -1.1% | -0.8% | -0.2% |
| Supply as % of Demand | 66.6 | 71.0 | 77.6 | 83.3 | 95.4% |

III.3.3 Shortage of Nurses in the UK

"Our NHS – today and tomorrow" - a Royal College of Nursing commentary on the current state of the NHS, shows the true extent of the nurse numbers problem characterising the NHS:

- there is a retirement time-bomb in UK healthcare i.e. there is an ageing nurse population and it is estimated that 180,000 nurses are set to retire in the next 10 years, which means that we will need even more nurses, rather than fewer, in the years to come.

- the underlying shortage of nurses is masked by the reliance of the health service on the unpaid work nurses carry out beyond their contracted hours (i.e. 60 percent of nurses work an average additional 6 hours per week).
- the headline increase in nurse numbers in recent years has been accompanied by an increase in nurse workloads as the number of patients treated has risen, but it has not resulted in significant increases in staffing levels in NHS wards (i.e. there was no change in the overall nurse patient ratio on NHS wards for 2005 when compared to 2001).

UK Government also forecast a nursing shortage by 2011. According to the Health Service Journal (HSJ) a leaked Department of Health document predicts a shortage of 14,000 nurses within four years – along with a shortage of 1,200 GPs and 1,100 junior doctors.

III.3.4 Shortage of Nurses in Canada

The situation in Canada is no different from other OECD countries. According to Canadian Institute for Health Information (CIHI), the nurse-to-population ratio went from 1:122 in 1992 to 1:131 in 1997. The Ontario province alone lost nearly 10 percent of its nursing workforce i.e. 8346 nurses between 1992 and 1997. It was the sharpest decline in Canada, and resulted in a nurse-to-population ratio of 1:145 people in 1997, compared with 1:123 in 1992. Many nurses were forced to work casually; half of Canada's 227 000 RNs still work on a part-time or casual basis.[11]

The latest (1998) figures – released by the CIHI, the Canadian Nurses Association (CNA), and Statistics Canada (a federal government agency) – show that the country's nursing workforce is growing older and that the number entering it (especially young people) continues to drop. Of the 227 651 RNs employed in nursing in 1998, 57 966 were aged over 50 years compared with 48 838 in 1993, a 19 percent increase. Over the same period those aged under 29 declined by 32 percent (from 33 429 to 22 778). Nurses aged over 50 now account for 25 percent of those employed, while those aged under 29 represent only 10 percent of the total.[12]

CAN warned of its dire consequences widely. The most comprehensive national study, published by the CNA, predicts a shortage in Canada (except Quebec) of between 59 000 and 113 000 by 2011. Today, the average RN is 47 years old; most nurses retire at age 55. By 2011, more than 100 000 of Canada's 227 000 RNs will have retired or left the profession.[13]

On top of everything else, there are record-low numbers of new graduates - only 10 percent of practicing nurses are now under age 29. The CNA anticipates only 5200 new nurses will graduate from Canada's 70 university and college schools of nursing in 2000 - about half of what is needed to meet demand. In the 1970s, about 10 000 nurses graduated annually.[14]

[11] See http://www.cmaj.ca/cgi/content/full/161/1/67
[12] "Canada faces nurse shortage", See http://findarticles.com/p/articles/mi_m0999/is_7241_320/ai_61995020
[13] Ibid
[14] Ibid

## Section IV. Migration of Indian Health Care Professionals

### IV.1 Migration to Developed Countries

Healthcare is one area where the Indian diaspora has earned a name for itself. What is most remarkable is that they have proved their competence not only in developing countries but in highly industrialised countries like US and the UK. Indian doctors are the backbone of the UK's National Health Service. There are estimated 60,000 doctors of Indian origin[15] in the UK and some 35,000 in the US. Besides, India has bilateral agreements with six Middle East countries and some others for providing private and government doctors on short-term assignments (Chanda, 2001). According to Mullan (2005) study, India has sent the most physicians to recipient countries (59,523), followed by the Philippines (18,303) and Pakistan (12,813). The study identifies US, UK, Canada and Australia as four major recipient countries (see Table 7).

**Table 7: IMGs[16] in the Physician Workforces of the Four Major Recipient Countries: The Share of India**

| **US** | | **UK** | |
|---|---|---|---|
| Source Country | No. of IMGs (% of workforce) | Source Country | No. of IMGs (% of workforce) |
| **India (Rank 1)** | 40,838 (4.9) | **India (Rank 1)** | 15,093 (10.9) |
| Philippines | 17,873 (2.1) | Ireland | 2,845 (2.1) |
| Pakistan | 9,667 (1.2) | Pakistan | 2,693 (1.9) |
| **Canada** | | **Australia** | |
| Source Country | No. of IMGs (% of workforce) | Source Country | No. of IMGs (% of workforce) |
| UK | 2,735 (4.0) | UK | 4,664 (8.6) |
| South Africa | 1,754 (2.6) | **India (Rank 2)** | 2,143 (4.0) |
| **India (Rank 3)** | 1,449 (2.1) | New Zealand | 1,742 (3.2) |

*Source: The New England Journal of Medicine, October 27, 2005*

Indian medical professionals occupy the highest positions in world renowned clinics like the Mayo Clinic and a number of other prestigious institutions in the US. For instance, Dr. Ranawat who performed two knee surgeries on the former Indian Prime Minister Atal Bihari Vajpayee has distinguished himself as one of the top knee surgeons in the world. There are many NRI doctors of such competence and standing in almost every branch of medicine. Indian doctors and nurses are an integral part of the healthcare delivery system in several Commonwealth countries. A number of Indian doctors are also serving in the Armed Forces of the English-speaking countries (GOI, 2001).

In case of the US India tops the list of 20 countries where IMGs received medical training. The following list (see Table 8) ranks the top 20 countries where the largest numbers of US' IMGs are trained. These data do not represent citizenship or ethnic origin. They only

[15] This includes people of Indian origin (PIO), who may not necessarily be an Indian citizen.
[16] In US IMGs also include US citizens who have gone abroad for medical education and returned to the country to practice

represent the location of the medical school where the US practicing physician obtained their medical degree.

**Table 8: Top 20 Countries Where US IMGs Received Medical Training**

| Rank | Country | IMGs Received Medical Training (in Percentage) |
|---|---|---|
| 1. | India | 24% (44,585) |
| 2. | Philippines | 10.6% (19,656) |
| 3. | Mexico | 6.7% (12,448) |
| 4. | Pakistan | 5.7% (10,689) |
| 5. | Dominican Republic | 3.8% (7,147) |
| 6. | Russia | 2.9% (5,343) |
| 7. | Grenada | 2.8% (5,1496) |
| 8. | Egypt | 2.6% (4,884) |
| 9. | Italy | 2.5% (4,755) |
| 10. | South Korea | 2.5% (4,676) |
| 11. | China | 2.4% (4,523) |
| 12. | Iran | 2.3% (4,355) |
| 13. | Spain | 2.3% (4,332) |
| 14. | Germany | 2.3% (4,269) |
| 15. | Dominica | 2.1% (4,050) |
| 16. | Syria | 1.8% (3,491) |
| 17. | Israel | 1.6% (3,098) |
| 18. | Colombia | 1.6% (3,095) |
| 19. | England | 1.6% (3,071) |
| 20. | Lebanon | 1.5% (,2871) |

*Source: 2005 American Medical Association Membership Fact Book*

The presence of Indian trained doctors in the UK and the Canada is also significant (see Table 9). As many as 30 percent of doctors working for the NHS of the UK and Northern Ireland (UK) have obtained their primary qualifications from a country outside the EU.[17] Out of this 26 percent of doctors employed in the NHS are of Indian origin[18]. The Physicians of Indian origin have made significant contributions in building and sustaining the NHS of the UK. It was estimated that Indian doctors contribute £4.5 billion (US$8.9bn) to the UK's economy, taking into account the cost of training for approximately 20,600 Indian doctors on the UK register.[19]

[17] Non-European Union doctors in the National Health Service: why, when and how do they come to the United Kingdom of Great Britain and Northern Ireland? See URL http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1817649

[18] The Indian Origin implies people who have origins in the countries of the Indian sub-continent including India, Pakistan, Bangladesh, Sri Lanka and Nepal.

[19] India-UK Bilateral Relations, High Commission of India, London. See URL http://www.hcilondon.net/bilateral-relations.html

**Table 9: Supply of Foreign (-trained) Physicians in Select OECD Member Countries**

| Country | Foreign-trained Physicians (in %) | India's Share (in %) |
|---|---|---|
| Canada (1998) | 20 | 9.6 |
| United Kingdom (2001) | 12.6 | 18.3 |
| United States (2001) | 27 | 19.5 |

*Source: EUROSTAT Labour Force Survey*

Of late, Indian nurses have also created a niche for themselves in developed countries health care services market. The presence of Indian nurses is not only confined to the English-speaking countries but they have registered their presence in a number of countries in other developed countries as well. In Austria, for instance, Indian nurses are like pioneers, whose sizeable number in that country has led to the migration of their families as well. However, the US and the UK remained the main destinations of Indian nurses (see Table 10 & 11). In fact, in case of UK, India has surpassed Philippines in terms of annual registration of nurses (see Figure 1). The US hospital, however, is still dominated by Philippines nurses. This could be because of stringent qualification requirements imposed by the US and relatively longer wait for the US visa.

**Table 10: Overseas-trained Nurses Registered per annum in the UK 1998-2004-05**

| Country | 1998-99 | 1999-00 | 2000-01 | 2001-02 | 2002-03 | 2003-04 | 2004-05 |
|---|---|---|---|---|---|---|---|
| Philippines | 52 | 1052 | 3396 | 7235 | 5594 | 4338 | 2521 |
| India | 30 | 96 | 289 | 994 | 1833 | 3073 | 3690 |
| S. Africa | 599 | 1460 | 1086 | 2114 | 1480 | 1689 | 933 |
| Australia | 1335 | 1209 | 1046 | 1342 | 940 | 1326 | 981 |
| Nigeria | 179 | 208 | 347 | 432 | 524 | 511 | 466 |

*Source: Nursing and Midwifery Council (NMC). www.nmc-uk.org*

**Figure 1: Trends of Nurses Supply to UK by Select Developing Countries**

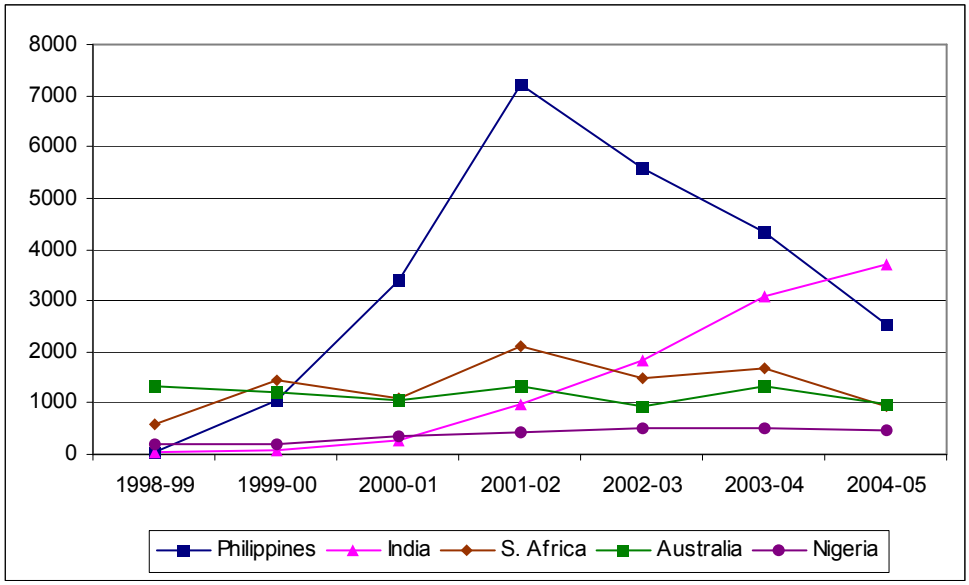


**Table 11: Foreign Educated Nurses in USA (in Percentage)**

| Country | 2000 | 2004 |
|---|---|---|
| Philippines | 43 | 50.2 |
| Canada | 16 | 20.2 |
| UK | 8 | 8.4 |
| Nigeria | | 2.3 |
| Ireland | | 1.5 |
| India | 10 | 1.3 |

*Source: Health Resources and Services Administration, US Department of Health and Human Services.*

## IV.2 Migration to Developing Countries

Within developing countries till recently Persian Gulf countries have been the major destination of Indian medical professionals, particularly nurses. In fact until year 2000, the bulk of Indian nurses were going to Gulf countries. Only in the last few years, the Indian nurses have started looking Westward – the US, UK, Ireland became the choice destination. As regards doctors, since higher education and research are the main reasons of their migration, western countries from the very beginning have been the most preferred destination of Indian doctors. Nevertheless, under the bilateral arrangements between India and governments of Gulf countries, India doctors do get hired by these countries.

There is a huge population of Indians in the Middle East, especially in the oil rich monarchies neighbouring the Persian Gulf. Most moved to the Gulf after the oil boom of early 1970s to work as labourers and for clerical jobs. One of the major reasons Indians still like to work in the Gulf is because of the tax-free income it provides and its proximity to India. Although there is no authentic figure on the number of Indian doctors and nurses in Gulf region, as per unofficial records over 60,000 RNs work in the Gulf countries. Most of these nurses are from the Southern states of Kerala. While doctors are not in large number in Gulf region, some countries do have substantial presence of Indian doctors. In Oman, for instance, there are about 2000 Indian doctors.[20]

The process of migration of Indian nurses to Gulf started in mid-1970s, when Gulf countries constructed large number of new hospitals. For India nurses, especially from Kerala, it was an unexpected opportunity to earn good wages. That trend continued for next two decades as thousands of young girls, predominantly Christians from Kerala; fill up the nursing schools all over India with the intention of migrating after graduation. Hence, the nursing diploma is obviously considered as a passport opening the world not only to the nurse herself, but also to her relatives. Families encourage this female migration since it is very consciously regarded as a privileged opportunity to increase social mobility. The migration opportunity has consequently changed the status of nurses, which used to be rather low in India. However, the trend is now changing as migration to the Gulf is considered as an intermediate step before further migration to the West (Percot, 2005). More and more nurses are returning back to India with the aim of going to West for much more economic benefits and opportunity to work in technologically more advanced working set up.

[20] Report of the High Level Committee on Indian Diaspora, 2001, Government of India

## Section V. Trade in Health Services

Health services were always looked at from human perspective as it has direct bearing on the national human development. Since life expectancy is one of three important indicators of United Nations Development Programme's (UNDP's) human development index, government's role becomes crucial in its delivery, particularly to the poorest section of the society. Trade in health services is, therefore, minimal, particularly when compared to other traded services. However, since 1970s, there has been a growing trend of commercialisation of health care services across the world. Trade in health services can now grow rapidly as information and communication technology makes it easier. Healthcare was also included into the GATS classification of services, which seeks from WTO member countries to make commitments on opening up of health sector.

Health services include medical, dental, nursing and paramedical services, hospital, social and other human health services. These are among the most rapidly growing industries in the world economy. Direct exports of related services include shipment of laboratory samples, diagnosis, second opinions and consultations via traditional postal channels as well as via electronic means. China offers on-line diagnostic services to patients in Taiwan Province of China and some South East-Asian countries. In India, radiologists interpret computer tomography scans for hospitals in the US. Medical samples go for diagnosis to Mexico from Central America, and some medical facilities have their medical records or patient interviews digitally transcribed in Bangladesh, India, Pakistan, the Philippines and Zimbabwe (UNCTAD 2004).

The revolution in information technology, which has had significant impact on almost all sectors of the economy, helped increase international trade in health services as well. According to Chanda (2001), health care sector was estimated to generate US$3tr per year in OECD countries and was expected to rise further to US$4tr by 2005. OECD Health Data 2007 also notes that a growing share of the economy is devoted to health across OECD countries. Per capita health spending increased by more than 80 percent in real terms between 1990 and 2005 on average in OECD countries, outpacing the 37 percent growth in Gross Domestic Product (GDP) per capita. In 1970, health spending accounted for just 5 percent of GDP. By 1990, this share had increased to nearly 7 percent. Today, it has climbed to 9 percent. One in four OECD countries now spends more than 10 percent of its income on health. With a 15.3 percent share in 2005, the US leads by a wide margin, followed by Switzerland (11.6 percent), France (11.1 percent) and Germany (10.7 percent).

The international trade in health services has grown through all four modes of service supply as defined by GATS. While the migration of healthcare professionals has been going on for the last several decades, the economic globalisation has spurred cross-border delivery of health services by electronic means and greater movement of medical tourists (patients). The liberalisation in FDI policy by several countries has resulted in an increasing number of joint ventures and collaborative arrangements in health sector.

Since trade in health services has not been conventional, there is a serious dearth of credible data on it. Thus, unlike travel and transport services, the two most commonly known services sector, there is no reporting and collection of systematic data on trade in health services. The poor availability of data is also because trade in health services is

modest at present. Another important reason behind the lack of authentic data on trade in health services is that a large part of trade takes place through movement of healthcare professionals. Remittances received by home country are the only indicator through which this trade flow can be measured. But neither at the global level nor at any country level there is any sector-wise data on remittances. Since potential for trade in health services has expanded rapidly in recent years, quite a few studies have attempted to make some rough estimates on trade in health by using GATS classification of four modes of service supply.

### V.1 Cross-border Trade in Health Services (Mode 1)

Cross-border delivery of health services includes shipment of laboratory samples, diagnosis, and clinical consultation via traditional mail channels, as well as electronic delivery of health services, such as diagnosis, second opinions, and consultations. A range of services beginning from the admission to post-discharge of a patient including medical coding, billing, medical transcription, claims generation, patient follow-up, etc., are referred to as revenue cycle management. More than half of the US hospitals are directly or indirectly offshoring various components of health care services, offshore vendors can now expect more end-to-end work, according to a recent report by Pune-based market research firm ValueNotes[21].

In this era of globalisation, like every other sector health care industry too facing challenges ranging from cost curtailment, lack of stability, compliance of standards, to an uncertain future. All these factors have a significant impact on the profit margins of health care service provider organisations. They are reshaping themselves to meet these challenges. But not all of them can actually devote their entire efforts to managing their day-to-day administrative operations. They face significant difficulties associated with hiring, training and retaining qualified office personnel. These complexities are growing and pulling organisations away from their core function of providing quality care to patient. Hence, healthcare organisations are taking a step back to reflect on their core competency and outsource those components, which have supporting role. Outsourcing is and will become increasingly important as organisations channel their resources and energies into the provision of professional services, which need to be continually developed, to keep up with current trends and service requirements.

Outsourcing Health Care Services is a hugely popular practice today. A Gartner Study predicts that over 60 percent of health care companies will outsource more than 50 percent of their IT operations by 2007. The medical outsourcing market is expected to grow through 2010, from US$10.7bn in 2005 to US$19bn in 2010 at a compound annual growth rate of 12.2 percent. In its report, "The Worldwide Electronics Manufacturing Services Market, Third Edition," Electronic Trend Publications examines the growth of the medical outsourcing market.

[21] The US Medical Transcription Industry: Perspective on Outsourcing and Offshoring, ValueNotes

## V.2 Medical Tourism (Mode 2)

The term medical tourism has emerged from the practice of citizens of highly industrialised nations such as the US, Canada, UK, Western Europe, and the wealthier nations of the Middle East travelling to other countries around the globe to receive a variety of medical and health care services, mainly due to the outrageous and continually rising costs of the same services and procedures in their own countries. In addition, these people also take on the role of tourists, vacationing and taking advantage of all the major sites and attractions that these nations have to offer, in conjunction with receiving medical treatment. The medical tourism industry has already grown into more than a US$20bn industry, with the majority of this money going directly into the economies and health care systems of these host nations.

A wide variety of factors have led to this sudden rise in medical tourism, not so common a few years back. In addition to the rising costs of health care in countries like the US and UK, the increasing ease and affordability of international travel via air, as well as the rapid advancement of medical technologies in lesser-developed nations all around the world have all contributed to the growth in medical tourism. Also, more and more people are looking for places where they can not only receive more affordable health care, but also enjoy a fun and relaxing vacation at the same time.

As the trend of medical tourism continues to grow, many nations around the world are beginning to promote special services and attractions aimed specifically at those people that are most likely to be interested in medical tourism. The attraction toward places that are also major tourist destinations is one reason why places like India, Thailand, Malaysia, Singapore, the East Indies, Mexico, and South America are so popular for medical tourism. Not only do these nations provide a high level of quality medical care at significantly lower rates, but they also offer an abundant number of touring, site-seeing, shopping, dining, and relaxation options as well.

Asia's burgeoning medical tourism industry, expected to be worth at least US$4bn by 2012 against the current size of half a billion dollars a year. It is being estimated that the Asia alone would be attracting more than 1.3 million tourists a year to its key locations – Thailand, Singapore, India, South Korea and Malaysia. Research findings show that a medical tourist spends average US$362 a day, compared with the average traveller's spending of US$144. Medical tourism is big growing pie as opportunities are projected to grow all the time.[22]

**Table 12: Medical Tourism: Projected Gains**

| Country | Gains Forecast |
|---|---|
| India | India's medical tourism business is growing a 30 percent per year and is forecast to generate at least US$2.2bn a year by 2012 |
| Singapore | Singapore is targeting to attract one million foreign patients annually and push the GDP contribution from this sector above US$1.6bn |

[22] Medical Tourism, Asia's Growth Industry, HOTELMARKETING.COM, 2006

| | |
|---|---|
| Malaysia | Malaysia expects medical tourism receipts to be in the region of US$590mn by 2012. |

*Source: hotelmarketing.com*

Other hot spots medical tourism such as the West Indies, Africa, the Middle East, and Mexico are also jumping on the band-wagon, offering a number of special facilities and other incentives for those medical tourists that choose to visit their respective countries. Many of these nations, including India, have also launched full-scale marketing, advertising, and promotional campaigns to help showcase their health care offerings and attract prospective patients.

Medical tourism has become a major issue in places like the US, Canada, and UK where a rapidly increasing number of people are now looking elsewhere for procedures as simple as corrective eye surgery. The question arises why would anyone want to take the time and effort to travel overseas to receive such a simple procedure, which only takes about 5 minutes an eye to perform in US? According to recent research, for the same price as a week long vacation for two in Hawaii that includes airfare and lodging, a couple can travel to the beautiful city of Kerala on India's southeast coast for a spectacular vacation that would include airfare, lodging, personal tour guide/concierge, *and* LASIK corrective eye surgery for two.

The medical tourism industry is also seeing a significant rise in a number of major surgeries and procedures. The average cost of private heart surgery in the US is US$50,000. That same operation with comparable rates of success and complications costs only US$10,000 in the most state-of-the-art hospital in big cities of India. While a bone marrow transplant costs US$250,000 in the US, the same treatment costs only US$25,000 in India. Similarly, a metal-free dental bridge worth US$5,500 in the US costs US$500 in India, a knee replacement in Thailand with six days of physical therapy costs about one-fifth of what it would in the US, and LASIK eye surgery worth US$3,700 in the US is available in many other countries for only US$730. Cosmetic surgery savings are even greater: A full facelift that would cost US$20,000 in the US runs about US$1,250 in South Africa (Hutchinson, 2005).

Large price disparities such as these exist across the board for many other medical and surgical procedures. Also, due to the extremely favorable currency exchange rates for medical tourists around the world, the additional costs associated with accommodations, food, shopping, etc. can be far more appealing as well.

### V.3 Temporary Movement of Healthcare Professionals (Mode 4)

This area of international service trade is becoming increasingly important to the countries in South. Since health services sector is labour-intensive and largely based on universal scientific knowledge, many qualified health professionals migrate to seek better living standards, career opportunities, and higher remuneration which they cannot get in their home countries. Moreover, there are shortages of health personnel in many countries, particularly in rich industrialised countries. Hence, the migration of health personnel could

alleviate the shortage in the more developed countries and bring economic benefit to source countries in terms of remittances and enhancement of skill of their health professionals.

Many countries have experienced both an inflow and an outflow of health personnel. Physicians and nurses from the Philippines, India and Thailand migrate to the US, UK and other OECD countries to work and earn better living. Remittances sent by immigrants back home is the only indicator of measuring trade in services under Mode 4. Since there is no sectoral break-up of remittances receipt, it is always difficult to make even any rough estimate of trade in services through temporary movement of health care professionals. As there has been a steady growth in the number of doctors and nurses, who are residing outside their home country, naturally their contribution in global remittances must have increased.

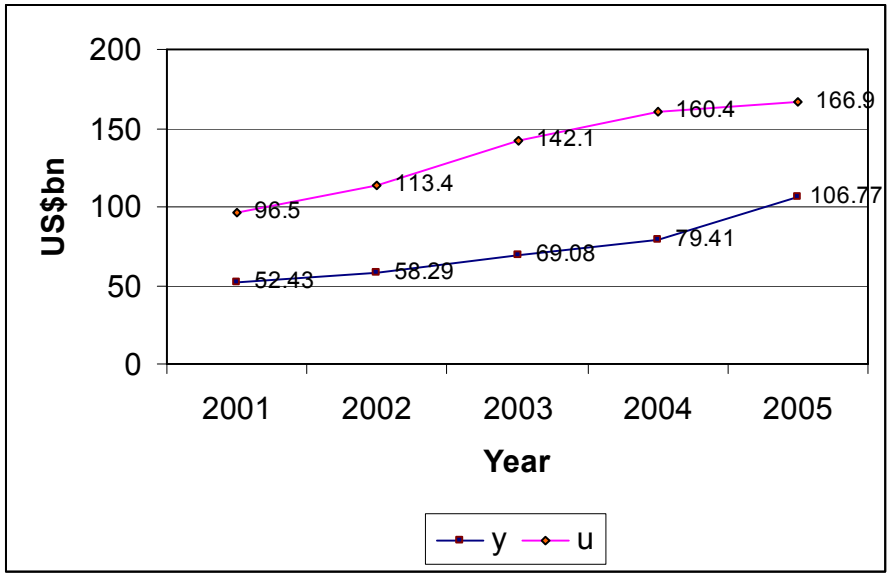
According to the World Bank's Global Economic Prospects 2006 report, worldwide total flow of remittances is more than twice that of Official Development Assistance (ODA). Of the total remittances more than 70 percent goes to developing countries (see Table 13). For many poor countries remittances as a percentage of GDP is quite high.

**Table 13: Remittances and ODA (In US$Billion)**

| Year | Official Development Assistance | Remittances | |
|---|---|---|---|
| | | Developing Countries | World |
| 2001 | 52.43 | 96.5 | 147.1 |
| 2002 | 58.29 | 113.4 | 166.2 |
| 2003 | 69.08 | 142.1 | 200.2 |
| 2004 | 79.41 | 160.4 | 225.8 |
| 2005 | 106.77 | 166.9 | 232.3 |

*Source: Compiled from OECD DAC and World Bank Data*

**Figure 2: Remittances to Developing Countries and ODA**




* Y – ODA, U – Remittances

## Section VI. Trade in Health Services: India an Emerging Force

In the last one decade, India has become a formidable force in trade in services. India's share in world export of commercial services has increased from 0.6 percent in 1990 to 2.38 percent in 2005 (WTO, 2006). In the year 2005, India ranked 11th among the world top exporters of commercial services, with only China and Hong Kong (China) from developing country were ahead of it. It is no secret that this impressive growth in services export from India has been achieved because of the massive growth of Indian software industry. Over the last one decade the relative share of traditional sectors such as travel and transportation in total services exports has fallen drastically, while the share of software exports increased from 19 percent in 1995 to 40 percent in 2005-06. In dollar terms, software exports have expanded from US$1.8bn in 1997-98 to US$23bn in 2005-06, accounting for more than half of 'other commercial services'[23] exports (NASSCOM, 2006).

Besides IT, health care services is another area where Indian professionals have made their presence felt in the global market. Traditionally, India has been exporting health services through movement of their healthcare professionals, mainly doctors and nurses. With the revolution in IT and faster mode of transportation, India has found new avenues in medical process outsourcing and health tourism, of enhancing its exporting its health services. While the trade in health services is rising globally, the data available on it is highly inadequate.

### VI.1 Mode 1: Cross Border Trade in Health Services

Medical process outsourcing includes medical transcription, medical billing, medical coding, medical insurance collections, healthcare website designing, healthcare staffing etc. Currently, medical transcription offshoring from India generates US$195mn in revenues; and is expected to reach US$647mn by 2010**.** Today, the US$195mn strong industry is silently supplying to the US$12bn medical transcription industry in the US (ValueNotes, 2006).

According to the latest Market Intelligence Service report of National Association of Software and Services Companies (NASSCOM), with at least 120-150 companies engaged in medical transcription in India, the sector is clocking an annual revenue aggregate of about US$220-240mn. And this figure, analysts say, will witness a meteoric rise in the coming years, given factors such as increasing healthcare costs in the US, its ageing

[23] *Other commercial services* corresponds to the following components defined in BPM5:
(i) communications services (telecommunications, postal and courier services); (ii) construction services; (iii) insurance services; (iv) financial services; (v) *computer and information services* (including news agency services); (vi) *royalties and licence fees*, covering payments and receipts for the use of intangible non-financial assets and proprietary rights, such as patents, copyrights, trademarks, industrial processes, and franchises; (vii) *other business services*, comprising trade-related services, operational leasing (rentals), and miscellaneous business, professional and technical services such as legal, accounting, management consulting, public relations services, advertising, market research and public opinion polling, research and development services, architectural, engineering, and other technical services, agricultural, mining and on-site processing; and (viii) *personal, cultural, and recreational services* including audiovisual services.

population, and increasing regulatory emphasis on digitisation of medical records and documentation.

Medical transcription activity — which by definition refers to conversion of doctor or physician interactions with their patients, including patient history, medical diagnosis from oral or written exchanges into a digitised format — hit the Indian shores way back in the 1990s, when large US-based service providers made a beeline for the country to leverage the cost advantage achievable through the offshore outsourcing model.

Outsourcing medical transcription allowed physicians to not only devote more time to attending patients but also paved the way for standards in the documentation and management of medical records. According to the American Association for Medical Transcription (AAMT), the global medical transcription pie is estimated to be anywhere between US$12bn and US$20bn, with the US being the largest market. Only 50-60 percent of the US transcription market gets outsourced from hospitals and clinics, and of that amount approximately 10 percent is offshored to countries such as India and the Philippines.

According to Indian Medical Transcription Industry Association, at present India's share is roughly over US$200mn. This means, as an industry, we are capturing less than two percent of the overall size of the US market, but it also shows there is a tremendous opportunity waiting to be tapped.

Medical billing outsourcing services include doctor billing, insurance claims filing, patient collections, accounting, and generating reports for physician practices, diagnostic service groups, and hospitals. Medical billing services are witnessing an unprecedented growth, throughout the world and especially in India, which has become the primary destination for quality medical billing outsourcing services. Current estimate of medical billing outsourcing market is approximately US$1bn.

The health care marketplace is recognising India as the premier provider of outsourced services owing to its infrastructure, skill base and economic environment. Mckinsey and Co. predicts a US$17bn outsourcing industry in India by 2008. A recent study by management consultants AT Kearney “Where to Locate – Selecting a country for Offshore Business Processing” rated countries on three parameters – Cost, Environment and People. India got the highest composite score in this study and came out as the top destination by choice for American companies. It is now positioning itself to become the “back-office to the world”.

### VI.2 Mode 2: Medical Tourism

India is fast emerging as one of the most attractive destinations for medical tourism as at present the earnings from it is an all time high. With some of the most sought-after specialists in cardiology, neuro-surgery, orthopedics and eye surgery, India alone has increased the arrival of medical tourists by more than 30 percent per year for the past few years. India is just one of several countries that has recognised the incredible benefits from medical tourism, and is now making special efforts to make the country as appealing as possible to potential patients/tourists. Medical tourism in India is becoming such a major

industry, some hospitals have now taken it as far as working with tour operators to offer potential visitors an all-inclusive health-tourist package, which would include the desired medical procedure, as well as things like hotel, air travel, and admission to various popular tourist attractions.

The Indian health care market is Rs 15 billion (US$368mn) and growing at over 30 percent every year. Indian private hospitals are increasingly finding a mention in the travel itineraries of foreigners, with the trend of medical tourism catching up in the country. If industry estimates are to be believed, the size of the medical tourism industry stands at Rs 12-15 billion (US$295-368).

A recent CII-McKinsey study on Indian healthcare says medical tourism alone can contribute Rs 50-100 billion (US$1.2-2.4bn) additional revenue for tertiary hospitals by 2012, and will account for 3-5 percent of the total healthcare delivery market. Compared to countries like the UK or the US, procedures like heart bypass surgery or angioplasty come at a fraction of the cost in India, even though the quality of doctors and medical equipment is comparable to the best in the world.

A heart bypass surgery in India costs US$6,500, while in the US it costs between US$30,000 and US$80,000 (see Table 14). This is a huge, untapped market, not just for therapeutic medical tourism like ayurveda, but also for curative treatment. India can lead the world in medical and health tourism since we have a tremendous advantage with a large pool of skilled manpower and technological edge. One million health tourists per annum could contribute up to US$5bn of tourism revenue to the Indian economy.

India could earn more than US$1bn annually and create 40 million new jobs by sub-contracting work from the British National Health Services. Apollo and Escort Hospitals in India can carry out operations at a fraction of what they would cost in the US and the UK. Medical tourism is likely to be the next major foreign exchange earner for India as an increasing number of patients, unwilling to accept long queues in Europe or high costs in the US, are traveling to the country to undergo surgery.

**Table 14: Cost Comparison of Medical Services**

| **Procedure** | **Cost (US$)** | | | |
|---|---|---|---|---|
| | **US** | **Thailand** | **India** | **UK** |
| Heart Surgery | 40,000 | 7,500 | 6000 | 23,000 |
| Bone Marrow Transplant | 2,50,000 | — - | 26,000 | 1,50,000 |
| Liver Transplant | 3,00,000 | — - | 69,000 | 2,00,000 |
| Knee Replacement | 20,000 | 8,000 | 6,000 | 12,000 |
| Cosmetic Surgery | 20,000 | 3,500 | 2,000 | 10,000 |

*Source: Escorts Heart Institute and Research Centre Limited, New Delhi*

Seeing the vast potential to earn foreign exchange through this sector, the government of India introduced some new policies. India's National Health Policy 2002, for example, says:

"To capitalise on the comparative cost advantage enjoyed by domestic health facilities in the secondary and tertiary sector, the policy will encourage the supply of services to patients of foreign origin on payment. The rendering of such services on payment in foreign exchange will be treated as 'deemed exports' and will be made eligible for all fiscal incentives extended to export earnings".

Recently, in an effort to make India a global hub for medicare, the government of India introduced a medical visa for foreigners seeking specialty treatment for extended periods. The new medical visa will be open to residents of all countries including Pakistan, Bangladesh, China and Sri Lanka, those availing of the medical visa - with a validity of one year that can be extended for another year. Until now, such patients had to enter the country on a tourist visa, valid for barely six months and subject to extension by the Union Home Ministry alone, causing them tremendous inconvenience in case an extended treatment was needed.

### VI.3 Mode 4: Movement of Health Care Professionals from India

Cross border migration of health care professionals is one of the most important means through which India has been exporting its health services. Today, Indian doctors have become a powerful influence in the field of medicine across the world. Indian doctors and nurses go to the Middle East, North America, UK, Australia, Malaysia and Singapore. Indians make up the largest non-Caucasian segment of the American medical community. Numbering over 38,000, physicians of Indian origin account for one in every 20 doctors practicing medicine in the US. Another 12,000 Indians and Indian-Americans are medical students and residents – doctors in specialty training – in teaching hospitals across the country. And Indians make up roughly 20 percent of the "IMGs" – or foreign trained doctors operating in the US.

According to the American Nurses Association, 3.5 per cent of US nurses are foreign born, over 100,000 in 2004. Out of which half are from Philippines, and 1.3 percent have an Indian diploma. Four years ago, just 30 Indian nurses were registered to work in the UK. Today, more than 2,000 have registered. For the NHS, India is one of the main countries from where it can poach health workers. Britain imports nurses because it does not have enough, and because India, according to its government, has more than 8 million today, against 3.8 million 10 years ago. The country also has an edge over many other developing nations; English is widely spoken and it has a "youth bulge", with more than half the population under 30.

## Section VII. Trade in Health Services: The Impact on Home Country

Neo-liberal economic thought argues that labour movement of all types from lower to higher-wage countries results in optimal allocation of labour resources, which allows maximum global production. Whatever be the skepticism and respective standpoint of recipient and sending countries, theoretically and empirically it has been proved that international migration does result in economic benefits for both the groups. This is not to undermine the associated cost of migration in terms of brain drain, loss of jobs for locals in

host countries etc. However, what is important is the net increase in global economic welfare, which definitely comes through freer movement of labour.

Contrary to the neo-liberal views, according to the neoclassical models of economic development, the outflow of any labour, unskilled or skilled, has adverse effects on the development of the home country. It slows down the GDP growth rate. The more recent economic theory, the endogenous growth theory, also predicts that emigration of highly skilled workers reduces economic growth rates. Such theories are on the basis that professional migrants are net fiscal contributors and their going away for that reason represents a fiscal loss for those left behind. In addition, skilled and unskilled labours complement one another in the production process (World Bank, 2005). Hence, a paucity of skilled labour and abundant unskilled labour due to migration, usually as is the case in developing countries, would pose a substantial negative impact on unskilled workers' productivity and wages thus leading to higher inequality in the home country.

All the more, when it is related to the migration of health professionals the scaling up of international recruitment in developed countries comes against a backdrop of massive health worker shortages in developing countries. While the WHO recommends a minimum of 100 nurses and 20 physicians per 100,000 people, many SSA countries, for example, have fewer than 50 nurses and 5 physicians per 100,000 (see Table 15). In contrast, the average among OECD countries was approximately 222 physicians per 100,000 people in 2000. Thus for regions like Caribbean and SSA countries, the problem of health worker migration is a serious threat to their national health systems that is already staggering from the HIV/AIDS epidemic.[24] According to a *Medecins Sans Frontieres* report released recently, the shortage of health workers in Southern African countries is undermining access to antiretroviral drugs in the region.[25]

**Table 15: Physicians and Nurses (Per 100,000 Populations) in African Countries, 2004**

| Country | Doctors per 100,000 Population | Nurses per 100,000 Population |
|---|---|---|
| WHO Min. Standard | 20 | 100 |
| Malawi | 1.1 | 20.6 |
| Rwanda | 1.9 | 21.0 |
| Tanzania | 2.3 | 36.6 |
| Mozambique | 2.4 | 20.5 |
| Niger | 3.3 | 23.1 |
| Somalia | 4.0 | 19.0 |
| Mali | 4.4 | 12.6 |
| Uganda | 4.7 | 5.4 |
| Lesotho | 5.4 | 60.1 |
| Zimbabwe | 5.7 | 54.2 |
| Benin | 5.8 | 20.4 |

[24] Migration and the Global Shortage of Health Care Professionals: Advancing U.S. Domestic and Foreign Policy, 2006 Health in Foreign Policy Forum, February 2006

[25] Confronting the Healthcare Worker Crisis to Expand Access to HIV/AIDS Treatment: MSF Experience in Southern Africa, *Medecins Sans Frontieres,* May 2007

| | | |
|---|---|---|
| Zambia | 6.9 | 113.1 |
| Senegal | 7.5 | 22.1 |
| Ghana | 9.0 | 64.0 |
| Kenya | 13.2 | 90.1 |
| Nigeria | 26.9 | 66.1 |

*Source: Compiled with data from www.globalhealthfacts.org*

International migration flows have also exacerbated rural health shortages, as vacancies in urban areas left by migrating workers are filled by those leaving rural tracts. For example, in South Africa, rural areas account for 46 percent of the population, but only 12 percent of doctors and 19 percent of nurses. These internal disparities have also been noted in countries whose governments support the emigration of health care personnel, such as India.

**VII.1 Situation in India**

As regards the impact of migration of healthcare professionals on home country, the situation is something different in countries like India, China, and Philippines. They are able to produce more healthcare workers to take benefit of trade liberalisation in health services. For these countries, such flows have been part of an overall strategy of their labor export plan. The Philippines, India, and Cuba have intentionally invested in the training of health workers for export. Therefore, unlike SSA countries, who are facing severe shortage of healthcare professionals because of migration, the conditions of health sector in India is not as grave. Going by the WHO recommended minimum standards of 20 doctors and 100 nurses per 100,000 people, India does fulfill this standard in doctors but trailing far behind in case nurses availability. In 2004 there were 62 nurses and 51 doctors per 100,000 people available in India.[26]

In case of India, the impact of health care professionals' migration on domestic economy could be measures through inflow of remittances and locals preference for medical and nursing professions. Although there is no sectoral break-up of data available on remittances received by India, the increase in overall inflow of remittances to India indicates that international migration has had a beneficial impact on Indian economy. Over the years, remittances from overseas Indians have emerged as a stable source of foreign exchange inflows for the country. The RBI has reported that Indians living abroad transferred $24.6 billion to India in the fiscal year 2005-2006. This made India the highest remittance receiving country in the world. India's share in total global remittances of US$225.8bn in 2004 was almost 10 per cent.[27] The RBI (India's Central Bank) calls it "private transfers" from overseas Indians. According to RBI data, the "private transfers" rose from US$2.1bn in 1990-91 to a whopping US$24bn in 2005-06. It is worth mentioning that FDI in 2005-06 was only US$7.69bn (see Table 16).

[26] WHO Global Health Atlas, available at http://globalatlas.who.int/

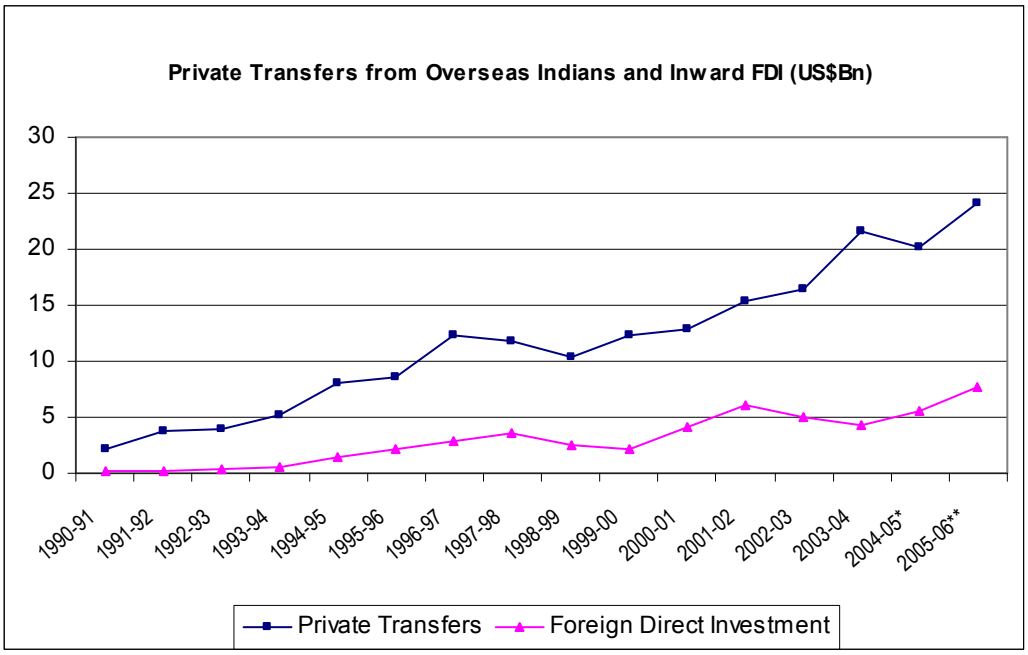
[27] Indian Budget 2005-2006, accessible at <http://indiabudget.nic.in/es2005-06/chapt2006/chap63.pdf>

**Table 16: Private Transfers from Overseas Indians and Inward FDI (US$bn)**

| Year | Private Transfers | Foreign Direct Investment |
|---|---|---|
| 1990-91 | 2.06 | 0.09 |
| 1991-92 | 3.78 | 0.12 |
| 1992-93 | 3.85 | 0.31 |
| 1993-94 | 5.26 | 0.58 |
| 1994-95 | 8.09 | 1.34 |
| 1995-96 | 8.50 | 2.14 |
| 1996-97 | 12.36 | 2.84 |
| 1997-98 | 11.83 | 3.56 |
| 1998-99 | 10.28 | 2.48 |
| 1999-00 | 12.25 | 2.16 |
| 2000-01 | 12.85 | 4.03 |
| 2001-02 | 15.39 | 6.12 |
| 2002-03 | 16.38 | 5.03 |
| 2003-04 | 21.60 | 4.32 |
| 2004-05* | 20.25 | 5.58 |
| 2005-06** | 24.09 | 7.69 |

*Source: Compiled from Handbook of Statistics on Indian Economy, 2006, RBI*
*Note: * Partially Revised*
*** Preliminary Estimates*

**Figure 3: Private Transfers from Overseas Indians and Inward of FDI**




The contributions by migrants are not only through foreign currency remittances but also through other means. Seeing the growing demand for Indian health professionals in developed countries, the country has already moved in the direction of offering world-class education in health professions thus contributing actively to national development. Medical education infrastructure in the country have shown rapid growth during the last 15 years.

The country has 242 medical colleges, 205 Bachelor of Dental Surgery (BDS) colleges and 67 Masters of Dental Surgery (MDS) colleges in 2005-06, up from 181 in 2001.[28] The admissions to medical colleges increased from 11,800 admissions per year in 1990 to 24,000 in 2005. This continued growth of medical colleges is an indication to the popularity of medicine and the belief nurtured by the common man that the combination of growth in the Indian economy and opportunities abroad will guarantee future medical employment.

Likewise, according to the Indian Nursing Council (INC), there are currently 271 Auxiliary Nurse Midwife (ANM) schools, 1312 institutions offering the General Nursing and Midwifery (GNM) diploma, 580 colleges offering bachelor degrees in nursing, and 77 institutions offering masters degrees in nursing (INC, 2006).[29] In keeping with the rising demand in developed countries, the government-aided as well as private Indian universities churn out 30,000 nurses a year. In India, the number of nurses graduating every year is almost three times the pace of the 1990s.[30]

Thus it is evident that the country is investing huge resources on medical education and to an extent one could claim that this is due to the influence of the migrants to provide quality training to new physicians and to promote the research capacity of medical schools. Nevertheless, this huge investment would not become futile as only a few skilled people migrate at a time, and those migrated still contribute to the development of knowledge and remittances to country (Dalmia, 2006).

Another important way through which migrants contribute to their home countries is through return migration. A study by OECD (2002) sums up that the migrant workers return to their home country with new technological and entrepreneurial skills obtained abroad, and very often have money to invest or useful contacts in the international science and technology fields. For Instance, most of the doctors in Apollo and Escorts hospitals in India are trained or specialised in UK, US and Australia. They serve as visiting scholars, create virtual networks and shape the direction of scholarly environment and capacity building in various fields of science, technology, cultural exchange, business, etc. Indians who have immigrated to countries like the US and Britain have been active in the growing not only in medical field but also in sectors like software industry and other professional fields.

The large scale migration of healthcare professionals from India also has had some negative impact. This mass exodus of qualified nurses to Europe has hit nursing colleges across the country. Colleges are finding it difficult to fill vacancies, be it a principal's position, or a lecturer's or a tutor's. For instance, majority of the students passing out from premier institutions like L T Nursing College and Hinduja Nursing College Mumbai, and Rajkumari Amrit Kaur Nursing College, Delhi, migrate abroad after few years of initial training. In the year 2002-03 around 50 students graduated from LT College of nursing, with two-year hands on training as a staff nurse, after which almost everyone has flown abroad. The problem is more severe in Southern parts of the country from where a major

[28] Ministry of Health and Family Welfare and Planning Commission, Government of India
[29] Figures taken from <http://cbhidghs.nic.in/CBHI%20Book/chapter6.pdf>
[30] See http://www.atimes.com/atimes/South_Asia/GJ08Df01.html

portion of migration takes place. Even at All India Institute of Medical Sciences (AIIMS) nursing college, there are posts lying vacant.[31]

Holy Family, a New Delhi based mission hospital, has over the last few years witnessed mass scale exodus of nurses, often on 24 hour's notice. Between, January 2004 and June 2005, 260 nurses resigned from Holy Family Hospital, 189 of them to take jobs outside India in the Gulf countries, the US, Ireland, and the UK. The remaining seventy-one initially took jobs in government or private hospitals in Delhi and other parts of India but subsequently flew westward. The hospital was thereby deprived of not just the nurses but also the experience they acquired. To date, the hospital has been unable to find suitable replacements despite offering very high salaries. It is clear from looking at Holy Family's losses that the West is picking up the cream of India's experienced nurse workforce. [32]

The report of the Comptroller & Auditor General has repeatedly indicted how the emigration of AIIMS medical graduates is impacting adversely on the quality of healthcare services delivered by India's leading medical institution (see Box 1). According to Adkoli (2006), from AIIMS 56 percent of the doctors went abroad between 1956 and 1980. About 75 percent of graduates from AIIMS are continuing their education in the West.

**Box 1: AIIMS Doing a Bad Job**

India's leading public hospital and medical education centre has failed to provide high quality medical services to its patients, a government audit report has said. A shortage of doctors and infrastructure deficiencies at the AIIMS, New Delhi, is depriving patients of quality time in diagnosis and medical care, the report by India's auditor general said.

An outpatient at the institute on average gets four to nine minutes of attention from a doctor, while the waiting time for surgery ranges from two to 34 months, it said. And at least three patients terminally ill with cancer are turned away each day for lack of healthcare facilities. The outpatient department, originally designed to cater for 500 patients a day, now receives nearly 6,000 each day.

The report also said the institute failed to nurture trained medical professionals and stop the 'brain drain'. The government subsidises medical education at the institute, but 49 per cent of a sample of 390 doctors who had trained there had emigrated. Health policy analysts say that the situation at the institute merely exemplifies the deterioration of health care services in the government sector.

*Source: Indian Journal of Medical Ethics, October-December 2001-9(4); http://www.ijme.in/094fp132.html*

[31] http://www.expresshealthcaremgmt.com/20031215/focus01.shtml
[32] "India Is Losing Its Nurses to the West", See http://findarticles.com/p/articles/mi_qa3859/is_200511/ai_nl5745214/print

## Section VIII. Migration of Indian Health Professionals: Major Destinations

India being an extremely large country with a huge population and an enormous potential to supply English speaking health professionals to many developed countries stands to gain a lot particularly when their demand rises worldwide. In recent years, health care institutions in prosperous countries have discovered India as a new source country for recruiting well-trained, English-speaking nurses and physicians. Today, Indian doctors have become a powerful influence in medicine across the world - from US, UK, Australia and Canada etc. To be precise, the total number of graduates of Indian medical colleges now practicing (2005) in these four countries is 59,095 – a workforce equivalent to 10.1 percent of the 592,215 physicians registered by the Medical Council of India (Mullan, 2005).

### VIII.1 Migration of Indian Health Professionals to US

Indians are the largest overseas trained health care workers segment of the American medical community. Numbering over 50,000 physicians, they are the largest group of physicians after native-born American doctors. One Indian doctor is available in the US for every 1325 Americans in contrast with one Indian doctor in India for over 2400 Indians. Moreover these Indian origin doctors account for one in every 20 doctors practicing medicine in the US.

**Box 2: Some Facts Regarding IMGs in US**

- In 2005, out of 794,893 physicians, 185,234 IMGs received medical degrees from 127 different countries, accounting for 23.3 percent of the total physician count.
- IMGs make up approximately 23 percent of the US physician population.
- The heaviest concentration of IMGs is in New Jersey (39.6 percent of doctors); New York (38.6 percent); Florida (33.6 percent); and Illinois (32.3 percent).
- The largest national group is from India (24 percent of total).
- Among the top four primary specialties, the IMG population represents 30.8 percent of total physicians in internal medicine; 29.9 percent in anesthesiology; 29.8 percent in psychiatry; and 28.6 percent in pediatrics.
- The total physician population increased by 350,386 between 1970 and 1994 (or 104.9 percent), while IMGs accounted for over one fourth (27.8 percent) of this increase by gaining 97,359 physicians.
- In this 24-year period, non-IMGs grew by 91.4 percent, while IMGs increased by 170.2 percent.
- In 1980, IMGs accounted for 20.9 percent of the total physician count of 467,679, while that percent climbed to 22.6 percent of the total count of 684,414 physicians in 1994.

*Source: American Medical Association www.ama-assn.org*

Ironically, the US still faces a physician shortage in some regions and specialties medical establishment because of which the AMA is still more relying on the IMGs who can help meet the needs of a growing and aging population (Raymer, 2004). Also in the US, 44 percent of IMG's provide primary care when compared to that of 33 percent of US medical graduates, since US graduates choose the more high paying specialties (see Table 17). This demand for IMGs is being driven in part by demographic changes, particularly the rapid aging of the US population. The US Census Bureau projects that the number of people above the age group of 65 years and older will grow by 53 percent by 2020.[33] By 2030, there will be some 70 million senior citizens in the US. Significantly, older people utilise medical services at a much higher rate than younger people.

**Table 17: IMG Physicians Provide the Bulk of Primary Care in US**

| Category of Medical Care | Percentage of Physicians |
|---|---|
| Internal Medicine | 30.3% (57,490) |
| Psychiatry | 29.5% (14,576) |
| Anesthesiology | 29.0% (12,006) |
| Pediatrics | 28.7% (18,782) |
| Other | 22.7% (7,472) |
| General/Family Practice | 17.6% (19,628) |
| Obstetrics/Gynecology | 16.8% (7,472) |
| General Surgery | 14.2% (17,621) |

*Source: American Association of Physicians of Indian Origin (AAPI) Journal, April 05, Vol 19, No 1*

Likewise, overseas trained nurses are playing an increasing important role in the provision of nursing care in the US. The 2004 survey estimates that 3.5 percent of the RNs practicing in the US (100,791) received their basic nursing education outside the US and the five States estimated to have the largest number of foreign educated RNs were: California (25.5 percent), Florida (9.6 percent), New York (9.3 percent), Texas (6.7 percent), and New Jersey (6.1 percent).

Initially the recruitment of international RNs was focused from countries like Canada and UK, but now it's from countries like Philippines, India and other developing countries from Asia and Africa. In April 2006, American officials with the Health Resources and Services Administration (HRSA) released projections that the nation's nursing shortage would grow to more than one million nurses by the year 2020. In the report titled 'What is Behind HRSA's Projected Supply, Demand, and Shortage of RNs ?' analysts show that all 50 states in US will experience a shortage of nurses to varying degrees by the year 2015.[34]

The US has traditionally depended on nurses from the Philippines and a few other countries, but of late preference has been shown for nurses from India as they are highly trained, hard working and have excellent English language skills. The US began to look at India for nurses when the flow from Canada, Ireland and the Philippines dried up. Among various social and economic reasons, financial incentive is the most tempting factor. Nurses in the US earn US$30 an hour, while in India the average salary of nurses is about

[33] An Analysis of the Emerging Physician Shortage in the United States, Oct. 2004, Accessible at <www.healthleadersmedia.com/print.cfm?content_id=59315&parent=103>

[34] Refer <http://bhpr.hrsa.gov/healthworkforce/reports/behindrnprojections/index.htm>

6000 rupees (US$120) a month. Indian nurses working in the US are paid on par with their American counterparts. It means they take home around US$3000 plus a month.[35]

### VIII.2 Migration of Indian Health Professionals to UK

The UK is another major destination country for Indian doctors and nurses and has been active in the international recruitment of health professionals. But recent evidence highlights a marked fall in international nurses entering the UK register in the last two years, as a result of reduced demand due to NHS funding deficits and due to tightened regulations on entry to the UK. Above all, the outflow of nurses from the UK to other countries, as measured by NMC verifications, has risen in recent years. In other words, the UK recruits nurses from developing countries, and loses nurses to developed countries like Australia, New Zealand, Canada, the US and Ireland.

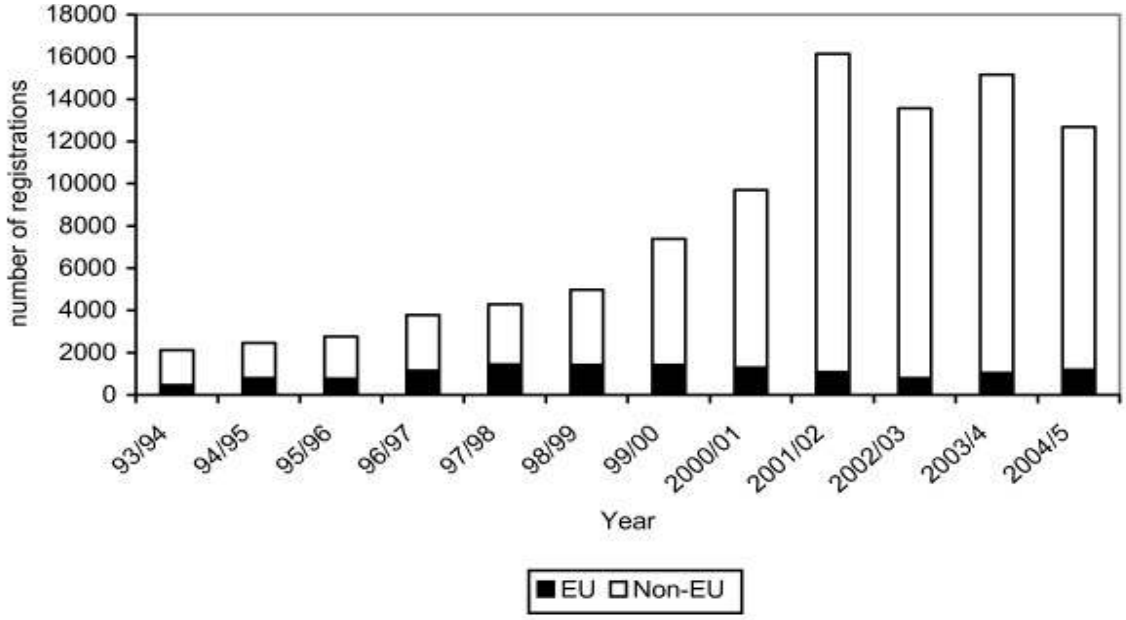
However, overseas trained nurses in UK have accounted for a substantial proportion of the 660,000 nurses on the register at March 2005. Most of the growth in inflow of nurses to the UK has been from countries outside the EU, particularly from India, Philippines, South Africa and Australia. However Philippine is no longer the primary source country as the numbers from India exceeds those from the Philippines (NMC, 2005) (see Table 18).

**Table 18: Nurses from India & Philippines Registered Per Annum in UK 1998-2005**

| Country | 1998/99 | 1999/2000 | 2000/01 | 2001/02 | 2002/03 | 2003/04 | 2004/05 |
|---|---|---|---|---|---|---|---|
| India | 30 | 96 | 289 | 994 | 1830 | 3073 | 3690 |
| Philippine | 52 | 1052 | 3396 | 7235 | 5593 | 4338 | 2521 |

*Source: www.wider.unu.edu/publications/rps/rps2006/rp2006-82.pdf*

**Figure 4: Admissions to UK Nurse Register from EU/Non-EU Countries, 1993/94 – 2004/05**



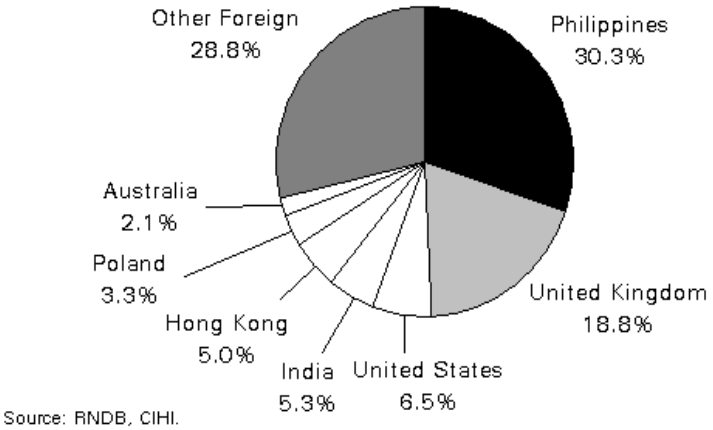

*Source: www.rcn.org.uk/publications/pdf/worlds_apart_labour_market_interim_report.pdf*

[35] "Indian Nurses' American Dream", BBC News

### VIII.3 Migration of Indian Health Professionals to Canada

Canada is experiencing both doctors and nursing shortage and this is projected to worsen dramatically over the next 15 to 20 years. In 2002, about 230,957 RNs were employed in nursing in Canada. Of this number, 6.9 percent of RNs employed in nursing (15,847) graduated from a foreign nursing program (CIHI, 2002). While a total of 986 were practicing Licensed practical nurses (LPNs) trained abroad, out of the 5,132 registered practical nurses (RPNs) employed in psychiatric nursing in Canada in 2002, 385 or 7.5 percent were foreign graduates. Hence there is strong evidence that a substantial number of internationally educated nurses (IENs) are applying for licensure in Canada. This number has increased in the past few years, undoubtedly due in part to active recruitment by Canadian employers.

**Figure. 5: Percentage of Foreign Nursing Graduates by Country of Graduation, Canada, 2005**




Likewise, Canada also depends rather heavily on foreign-trained physicians to staff its health system. Currently about 25 percent of practicing physicians in Canada are foreign-trained. While the immigration of health and other professionals to Canada is not new, the number of physicians coming from developing countries which themselves are facing severe health human resource shortages is rapidly increasing. At present the major source countries are UK followed by South Africa and India.

**Table 19: Active Physicians from India of MD Graduation, Canada, 1994-2007**

| | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| India | 86 | 93 | 109 | 106 | 103 | 102 | 104 | 106 | 116 | 125 | 134 | 145 | 145 | 152 |
| India (Goa) | 1215 | 1221 | 1197 | 1198 | 1191 | 1190 | 1185 | 1181 | 1183 | 1199 | 1207 | 1197 | 1232 | 1242 |

*Source: <www.cma.ca/multimedia/CMA/Content_Images/Inside_cma/Statistics/10PhysByCountry.pdf>*

It is been estimated that the number of doctors per capita in Canada will decline by 2015 without more foreign-trained doctors. Hence the country need to employ IMGs, as well as nurses and nurse practitioners, to expand the volume of service delivered.

### VIII.4 Migration of Indian Health Professionals to Australia

Like other develped countries, Australia too is facing the problem of shortage of doctors and nurses, particularly in remote areas. In order to address this by 2007 an additional 725 appropriately qualified overseas trained doctors will be working in Australia under the overseas trained doctor initiatives.[36] Since the late 1990s Australian employers have been recruiting an increasing number of overseas-trained doctors to hospital located in the "area of need" (AON) at general practice positions. This rapid increase in the recruitment of overseas-trained doctors in Australia's medical workforce is a consequence of a government decision taken in the early 1980s to cap the number of entrants to Australian medical schools.

In 1997–98, most overseas trained doctors arriving under temporary resident visas were from the United Kingdom and Ireland, and by 2002–03 this had dropped to under 50 percent; overseas trained doctors now come from a greater diversity of countries including India. (see Tables 20 & 21)

**Table 20: Medical Professionals Arriving Under Visa Subclass 422[37]**

| Country of birth | 1997–98 | 1998–98 | 1999–00 | 2000–01 | 2001–02 | 2002–03 |
|---|---|---|---|---|---|---|
| India | 32 | 31 | 37 | 49 | 67 | 123 |
| United Kingdom and Ireland | 572 | 634 | 463 | 552 | 538 | 476 |

*Source: www.mja.com.au/public/issues/181_11_061204/bir10706_fm.html*

**Table 21: Medical Professionals Arriving as Occupational Trainees Under Visa Subclass 442**

| Country of birth | 1997–98 | 1998–99 | 1999–00 | 2000–01 | 2001–02 | 2002–03 |
|---|---|---|---|---|---|---|
| India | 49 | 77 | 78 | 62 | 78 | 89 |
| United Kingdom and Ireland | 444 | 173 | 321 | 338 | 221 | 251 |

*Source: <www.mja.com.au/public/issues/181_11_061204/bir10706_fm.html>*

## Section IX. Major Procedural Requirements in Destination Country

Regulations have multiple objectives as it seeks to monitor and control the number of migrants and their quality and at the same time facilitates migration. These regulations are largely enacted on a unilateral basis as an important component of domestic policy measures. However, in some case the domestic regulations are framed through bilateral, regional and multilateral cooperation agreements. They include visa and work permit regimes, and other quantitative restrictions on the deployment of foreign workers by firm, industry and occupation. The extent of regulation also varies across countries and occupations. A broad array of regulatory interventions is used to regulate professions.

[36] *Overseas-Trained Doctor Initiatives: the Benefits.* Accessible at <http://www.health.gov.au/internet/wcms/publishing.nsf/Content/factsheet-overseas_trained_doctors >

[37] Visa Subclass 422 also known as the medical practitioner visa allows foreign nationals, who are medical practitioners, to work in Australia for a sponsoring employer for three (3) months to four (4) years.

Table 22 provides a summary of the most commonly used forms of professional regulations (Deighton-Smith, Harris and Pearson, 2001).

**Table 22: Examples of Professional and Occupational Regulations**

| Type of restriction | Explanation |
|---|---|
| Entry qualifications | Various types of academic and experience qualifications are needed to become a professional. |
| Registration Requirements | Even if a person has the appropriate qualifications, they must hold a license to practice. |
| Reservation of Title | Only persons with the appropriate qualifications and/or on the register may use the professional title. |
| Reservation of Practice | Certain areas of practice are not allowed to be performed by persons other than certified practitioners. |
| Disciplinary Processes | Professionals may be asked to explain their actions if their conduct is questioned, and may be disciplined or prevented from practicing. |
| Conduct of Business | Some professions have rules that prescribe ways in which the professional may or may not conduct their business affairs. Common restrictions include ownership, profit sharing and advertising. |
| Business Licensing | Businesses must be licensed before they are able to sell their services. |

*Source: Rex Deighton-Smith, Ben Harris and Kate Pearson, Reforming the Regulation of the Professions, Staff Discussion Paper, National Competition Council, Australia, May 2001*

Professional associations do play an important role in the regulation of foreign supply of professionals and their role are more pervasive in case of healthcare professionals when compared to other occupations. And within this profession their role are more crucial and prominent while dealing with doctors than for nurses and other paramedicals. One prime factor for this strict regulation is the direct link between the provision of health services and human health and well-being. But despite this stringent regulation, migration of healthcare professionals across national borders continues to grow, both on a permanent and increasingly on a temporary, contract basis.

The reasons are inadequate remuneration in the migrant's home country, plus the desire to work in a more conductive working environment, or to work in a technically better managed health system. Short supply of doctors and nurses relative to the demand in the host countries is the primary reason for recruiting foreign professionals. Thus migration in this sector would continue until developed countries (usually the host countries) address the underlying causes of medical professional's shortages and until developing countries (usually the migrant's home country) address conditions that cause medical professionals to leave.

However, there are some regulatory measures that curtail this international movement of health professionals. This includes the strict and complex procedures for obtaining visa and other requirements such as labour market tests that justify the need for employment of a foreign professional and problems arising from the lack of recognition of professional training and experience obtained in a foreign country. Other than such policy related

hurdles, obstacles such as language barriers, cultural difference and social disruption are needed to be dealt with by an aspiring professional.

Besides, the aspirants are required to register/license with the local Medical Council or Nursing Board who are involved in the pre-employment confirmation of the applicant's qualifications and skills.[38] This procedure consists of holding required qualifications from a recognised medical school/university with specified period of training. However, this registration/license is only valid within the jurisdiction of the granting body. Hence medical practitioners who wish to practice in other countries have to go through the process of having their qualifications recognised by the relevant body in the host country.

## IX.1 Major Procedural Requirements in the US

### IX.1.1 Doctors

For many years the US was a closed destination for most "foreign medical graduates" (FMG)[39]. From 1976 to 1991, federal immigration laws barred foreign-born physicians from obtaining temporary working "H-1B" visa in order to perform direct patient care. A physician under H-1B status was permitted only to teach or conduct research in the US for a public or non-profit private educational or research institution or agency. However, in 1991, Congress amended US laws to allow FMGs to qualify for temporary visas to enter in order to qualify for medical residencies and fellowships and to perform patient care.

The Immigration Act of 1990 comprehensively revised the H-1B visa category. The amended law allowed certain FMGs to obtain H-1B status in order to render patient care. The legislation which was part of Miscellaneous Technical Immigration and Naturalisation Amendments of 1991 (MTINA), allows FMGs to obtain H-1B status by the following two methods:

1. Pursuant to an invitation from a public or nonprofit private educational or research institution or agency to teach or conduct research;

or

2. Pursuant to an offer of employment as a physician if the foreign doctor has passed the Federation Licensing Examination (FLEX) or its equivalent as determined by the US Department of Health and human Services

and

3. S/he is competent in oral and written English, or is a graduate of a medical school accredited by the US Department of Education.

The US Immigration and Naturalisation Service (INS) is the nodal agency responsible for implementation of the new law. The INS issued regulations in 1992, which provide that a FMG seeking H-1B status must:

[38] Chris Manning and Alexandra Sidorenko, *The Regulation of Professional Migration in ASEAN*, accessible at <http://rspas.anu.edu.au/economics/publish/papers/wp2006/wp-econ-2006-08.pdf>

[39] FMG is defined as "an individual who has graduated from a medical school, located not within the United States, and s/he is qualified to practice medicine in a foreign countr." FMGs are also called "international medical graduate".

1. have a license or other authorisation required by the state of intended employment to practice medicine if the physician will perform direct care and the state requires the license or authorisation;

and

2. have a full and unrestricted license to practice medicine in a foreign country;

or

3. have graduated from a medical school in the US or a foreign country.

The 1992 regulations further provide that the petitioning employer establish that the FMG

1. is coming to the US primarily to teach or conduct research, or both, for a public or a nonprofit private educational or research institution or agency, and that no patient care will be performed, except that which is incidental to the teaching or resaerch;

or

2. has passed the FLEX, or an equivalent examination as determined by US Department of Health and Human Service, which grants recognition to National Board of Medical Examiners (NBME) and the US Medical Licensing Examination (USMLE);

and

3. is competent in English or is a graduate of a medical school accredited by the US Department of Education. In order to demonstrate competence in English, the FMG must qualify the English proficiency test conducted by the Educational Commission for Foreign Medical Graduates (ECFMG).

Foreign Medical Graduates (FMGs) also have the option of pursuing advanced medical training in the US for periods normally not to exceed seven years under ECFMG Exchange Visitor visa (J-1) programme.[40] The small percentage of FMGs who are accepted must agree that upon completion of their training in the US they will return home for two years before they are eligible to return to the US as either an immigrant ("green card"), or H-1B non-immigrant. This J-1 programme has resulted in significant healthcare improvements in the home countries of these exchange visitor physicians.

However, under current law, a J-1 FMG can receive a waiver of the two-year home residency requirement in several ways:

- the waiver is requested by an interested government agency (IGA) or state department of health;
- the FMG's return would cause extreme hardship to a US citizen or Legal Permanent Resident (LPR) spouse or child; or
- the FMG fears persecution in the home country based on race, religion, or political opinion

Most J-1 waiver requests are submitted by an IGA and forwarded to the Department of State (DoS) for a recommendation. If DoS recommends the waiver, it is forwarded to US

[40] "Foreign Medical Graduates: A Brief Overview of the J-1 Visa Waiver Programme", CRS Report for Congress, January 26, 2007

Citizenship and Immigration Service (USCIS) in the Department of Homeland Security (DHS) for final approval. Upon final approval by the USCIS, the physician's status is converted to that of an H-1B professional specialty worker.[41]

IX.1.2 Nurses

Nursing profession in America offers both challenges and opportunities to those nurses who are educated outside the country and willing to migrate to the US, which fast emerging as the number one choice for IENs seeking to practice outside the borders of their home country. However, their adjustment to the US system can be affected by several factors such as the health care system of the nurse's home country, language competence, knowledge of medications and their administration and most importantly familiarity with technology.

Nurses who decide to immigrate cannot just apply for US employment as there are many steps to the immigration process. The following conditions/requirement needs to be fulfilled for a foreign registered nurse (RN) to be employed in the US:[42]

The RN must have:
a. A diploma from a nursing school in her country;
b. An RN license in her country;
c. A full and unrestricted license to practice professional nursing in the state of intended employment, and/or a certification issued by the Commission on Graduates of Foreign Nursing Schools (CGFNS), or evidence that she has passed the national licensure exam (NCLEX) but cannot obtain a license because she lacks a social security number.

Unless the nurse was educated in an English-speaking country (US, Australia, New Zealand, Ireland, UK or Canada - all provinces except Quebec), she must achieve a certain minimum score on tests in written and spoken English administered by Test of English as a Foreign Language (TOEFL), (International English Language Testing Service (IELTS) or (Test of English in International Communications (TOEIC).

Passing scores for RNs on English exams are as follows:

> IELTS: Academic Module or the General Training Module 6.5, Overall Band Score, 7.0 Speaking
> TOEFL: Paper-Based 540; TOEFL Computer-Based 207; Test of Written English (TWE) 4.0; Test of Spoken English (TSE) 50.
> TOEIC: 725; plus TWE: 4.0 and TSE: 50

Although some states require that foreign nurses pass the CGFNS examination before taking the state RN licensing (NCLEX) examination, the number of such states is on the decline. This is because, as of January 2005, it became possible to take the NCLEX abroad in (1) Hong Kong; (2) London, England; or (3) Seoul, Korea. On January 24, 2006, the National Council of State Boards of Nursing (NCSBN) announced that within the next year, it will be possible to take the NCLEX in Australia, India, Japan, Mexico, Canada, Germany and Taiwan as well as the three locations named above. In pursuant to this, since

[41] Ibid
[42] *Immigration of Registered Nurses,* accessible at <www.shusterman.com/rn.html>

January 2006, NCLEX-RN exam is being conducted at five major cities of India, viz., Bangalore, Chennai, Delhi, Hyderabad and Mumbai. Passing NCLEX-RN exam is a daunting task for nurses educated outside of North America, since they are much more familiar with essay type examinations than multiple choice tests. Only after securing state licensure, the international nurse can begin US employment (Davis, 2004).

The immigration process begins when an employer submits an immigrant visa petition to the service center of the US Citizenship and Immigration Services having jurisdiction over the nurse's place of intended employment. Once approved the visa petition is forwarded to the National Visa Center (NVC) after which the nurse (or her attorney) receives a "fee bill" asking for all government processing fees to be paid in advance of processing her application and those of her immediate family members. After the fees are paid, the NVC forwards to the nurse or her attorney the biographical information forms that need to be completed by her and her family members, and a list of documents which must be submitted.

The RN, or her attorney, sends the signed and completed forms and documents to the NVC which then schedules an appointment for an Immigrant Visa for the RN and her family at the US Consulate or Embassy where they will have their interviews for permanent residence.

A registered nurse seeking employment in the US also needs to get a Visa Screen Certificate. As per US Immigration law, it is mandatory that healthcare professionals, other than physicians, complete a screening program in order to qualify for certain occupational visas. Visa Screen, a program offered by The International Commission on Healthcare Professions (ICHP), a division of CGFNS, enables healthcare professionals to meet this requirement by verifying and evaluating their credentials to ensure that they meet the government's minimum eligibility standards. CGFNS is named in Federal law as a qualified provider of such a screening program. The Visa Screen Certificate is issued directly to the applicant who successfully completed all of the requirements of the program. The applicant then presents it to a consular office or attorney general (when applicable) as part of a visa application.[43]

Generally, the process of obtaining permanent residence may take between 12 to 18 months assuming that the immigrant visa quota from the RN's country of birth is not backlogged.

## IX.2 UK

### IX.2.1 Doctors

Foreign doctors from outside the European Union must be registered with the UK General Medical Council (GMC) in order to practice medicine in the UK. In order to obtain limited registration, the doctor is required to pass the examinations as set out by the Professional and Linguistic Assessment Board (PLAB).[44]

[43] See http://www.21stcenturynurse.com/nursing_in_the_usa.htm
[44] *Doctors not from EU countries.* Accessible at <www.workpermit.com/uk/medical_practitioners/doctors.htm>

The test is in two parts:

- Part 1 tests the knowledge on clinical management and includes science as applied to clinical problems.
- Part 2 tests the clinical and communication skills. It is designed so that an examiner can observe the candidate putting these skills into practice.

A candidate cannot enter Part 2 until he/she have passed Part 1. Also Part 2 must be taken within three years of passing Part 1. However a candidate will generally have to wait for four to six months between applying for and securing a place for the Part 2 examination.

Before a physician can take the test, he must already have the following qualifications and experience:

- S/he must have a primary medical qualification (PMQ) for limited registration as listed in the WHO Directory of Medical Schools.
- S/he must be proficient in the English language. This would be demonstrated by obtaining the relevant scores in the IELTS test (a minimum of 7 as an overall score).
- S/he must have at least 12 months' postgraduate clinical experience in a teaching hospital, or another hospital approved by the medical registration authorities in the appropriate country.

Recent graduates who have never worked in a hospital either in the UK or overseas are only eligible for limited registration at the level of Junior House Officer. In addition, the graduate will be required to sit in both parts of the PLAB examination as part of initial 12 months training. However, if the candidate has already completed 12 months post-graduate training in a hospital either in the UK or overseas, and have passed the PLAB examinations, then S/he will be eligible for entry to an NHS hospital at the level of Senior House Officer (SHO).

IX.2.2 Nurses

Overseas nurses must be registered with the UK Nursing and Midwifery Council (NMC) in order to practice nursing in the UK. For registration, they are required to fulfill certain requirements.

1. Candidate must already have an acceptable nursing qualification. Here are a few examples of the kind of 'first level' qualifications that the NMC can accept:
    - Registered Nurse
    - Registered Midwife
    - State Registered Nurse

2. In order to be considered for registration, applicants must comply with the following minimum education and training requirements and post registration experience:

    - The programme of education and training must have been of three years or 4600 hours in length, all of which must have been relevant to nursing. Any additional general areas of study will not be considered as part of a nursing programme.

- This programme must have been carried out at a post-secondary school level of education. Also the programme must have demonstrated a balance of theoretical and practical aspect of nursing training.

- The instructions must contain minimum of one third theoretical training and not less than one half clinical/practical training. Further, the theoretical and clinical/practical training must have been in the following areas:
    - General and specialist medicine
    - General and specialist surgery
    - Child care and pediatrics
    - Maternity care (Obstetrics)
    - Mental Health and Psychiatry
    - Care of the elderly (Geriatrics)
    - Community (Home) Nursing.

- Must have undertaken at least six months of continuous post-registration experience within the last five years

- Must have a reasonable command over English language. This would be demonstrated by obtaining the relevant scores in the IELTS test (a minimum of 7 as an overall score).[45]
    - At least 7.0 in the listening and reading sections.
    - At least 7.0 in the writing and speaking sections.
    - An overall average score of 7 (out of a possible 9).

3. Once all the above requirements are satisfied, then the aspirants get eligible to apply for visa that would allow her to enter the UK and work as a nurse.

**IX.3 Australia**

IX.3.1 Doctors

Overseas doctors are usually sponsored for a period of 4 years to work in areas of high demand, such as rural and remote areas. Medical Practitioner visa is a temporary visa to allow Australian employers to employ overseas doctors to work in Australia. The term 'medical practitioner' covers radiologists, doctors, or specialists in any medical field. However, this visa is not meant for nurses or other paramedical professions, who should look at the Temporary Business Visa.

Typically, an overseas trained doctor wishing to work in Australia must meet the basic requirements listed below:[46]

- Satisfy Australian Medical Council (AMC) English language proficiency requirements.

[45] *Overseas Nurses Registration*, accessible at <www.nmc-uk.org/aArticle.aspx?ArticleID=1653>
[46] *Checklist for overseas trained doctors*, Department of Health and Aging, Australian Government, accessible at <www.health.gov.au/internet/otd/publishing.nsf/Content/work-General-guide>

- *General practitioners* (GPs/family physicians) must pass the AMC exam consisting of theory and clinical components. Before commencing work as general practitioner (family physician) in Australia the physician need to have his general practice qualifications and experience assessed by the Royal Australian College of General Practitioners. *Hospital non-specialists* must meet the specific registration requirements of the relevant State or Territory Medical Board for an AON position. *Specialists* must apply to the relevant Specialist Medical College for recognition as a specialist via the AMC.

- Apply for a visa and pass required character/police and medical checks. Doctors can apply for either a temporary or permanent visa.
  *Permanent Visa*: For immigration purposes, doctors seeking permanent residency in Australia must hold full medical registration. The department will accept one of the following certificates issued by the State or Territory Medical Board as evidence of full registration:
    - full/unconditional/general medical registration
    - conditional specialist registration - this registration allows you to practise only in your particular speciality, with no further training or supervision requirements.

  *Temporary Visa*: Doctors who do not yet hold full medical registration in Australia can be employed and sponsored as a temporary resident while they are in the process of meeting the requirements to obtain full medical registration.

- Identify an appropriate job. (Most overseas trained doctors will initially have to work in an AON position).

- Apply to the relevant State/Territory Medical Board for medical registration.

- Obtain medical indemnity cover in Australia.

IX.3.2 Nurses

The International Section of the Australian Nursing & Midwifery Council (ANMC) is an assessing authority for the Australian Department of Immigration and Citizenship (DIAC). The ANMC conducts an assessment of RNs and Midwives who intend to migrate to Australia under the *General Skilled Migration* category. The ANMC has been authorised by DIAC to undertake these assessments. Through this process the ANMC determines whether nurses and midwives are suitable for migration or they are required to undertake further education in order to be eligible for migration in the stated skill category.

Below mentioned are the guidelines developed by the ANC for the process of assessment of the educational qualifications and work experience of overseas-educated nurses and midwives:[47]

[47] *ANC Guidelines for the Assessment of the Qualifications of Overseas-Educated Nurses and Midwives for Migration Purposes*, Australian Nursing and Midwifery Council, June 2003. Accessible at <www.anmc.org.au/docs/Professional_Standards_Criteria.pdf>

1. Applicants possess a certificate, diploma or degree in nursing issued by the educational institution where the course in nursing was undertaken.

2. Applicants possess documentation giving evidence of registration issued by the jurisdiction where the nursing course was completed.

3. Applicants have completed an educational programme required for registration as a nurse, and which has been positively assessed by the Australian nurse regulatory authorities as necessary requirements for registration, including competence.

4. Applicants are registered in the country of most recent practice and the relevant regulatory authority verifies this. Dates of employment and professional competence are confirmed by recent employers.

5. Applicants provide documentary evidence of full name, previous surnames if applicable, date and place of birth and gender.

6. Applicants are successful in an acceptable English language test endorsed by the ANC. There are two tests that can be taken. These are:
   - IELTS Academic Test: Nurses and midwives must achieve a minimum of 6.5 in each of the sections and receive a minimum overall band score of 7.
   - Occupational English Test (OET) for Nurses. Nurses and midwives must achieve a B pass or higher in all four sections of the OET test.

7. Once application, supporting documents and assessment fees has been received, the ANMC assessment process can commence. The ANMC on completion of the assessment process inform the applicant the outcome. The applicant will receive a letter of determination advising either:
   - The applicant's skills have been assessed as suitable for migration for the nominated occupation of registered nurse or midwife.
   - Information will be provided about how to apply for registration with the Australian Nurse Regulatory Authorities.
   - Information will be provided indicating any variations in requirements by individual nurse regulatory authorities.

or

   - The applicant's skills have been assessed as not suitable for migration for the nominated occupation of registered nurse or midwife. Reasons are given as to why the applicant is not suitable based on the standards and criteria.
   - Advice will be given regarding the actions, if any, the applicant must take in order to meet the requirements to be suitable for migration.
   - Information will be provided about how to apply for registration with the Australian Nurse Regulatory Authorities.
   - Information will be provided indicating any variations in requirements by individual nurse regulatory authorities.

or

   - The applicant has been assessed and current registration in Australia or New Zealand is confirmed.

## IX.4 Canada

IX.4.1 Doctors

In Canada, to apply for Licensure of the Medical Council of Canada (LMCC), a graduate must have passed both Medical Council of Canada Qualifying Examination (MCCQE Parts I & II). However as a pre-requisite to appear for the MCCQE Part I, an International medical graduate must pass the Medical Council of Canada Evaluating Examination (MCCEE).[48]

An IMG, for the purpose of eligibility for the MCCEE, must have completed all didactic and practical requirements to obtain the final qualification of Doctor of Medicine or equivalent qualification and be in receipt of the final medical diploma from the university that granted medical degree. The medical diploma must entitle the candidate, with appropriate postgraduate training, to be licensed to practice as a physician in his/her country.[49] The university granting the degree must be listed in either the WHO World Directory of Medical Schools: http://www.who.int/hrh/wdms/en/ or the FAIMER International Medical Education Directory: http://imed.ecfmg.org

Passing the relevant examination (MCCEE) does not necessarily mean that the applicants are eligible for a license to practice medicine. In most provinces, graduates of foreign medical schools are required to have two to six years of postgraduate medical training at a Canadian university and must pass the appropriate certification examinations of the College of Family Physicians of Canada or the Royal College of Physicians and Surgeons of Canada. For the same, thirteen accredited Canadian postgraduate medical training programs participate in the Canadian Resident Matching Service. This service matches prospective physicians to a training program. However, not all medical schools participating in the matching service accept graduates of foreign medical schools into their postgraduate medical training programs. Applications from graduates of medical schools from outside Canada are processed according to the policies established by each institution.

But to register with the matching service, one must have passed the MCCEE within five years prior to starting a residency. Since the results of the exams are made available to Canadian Resident Matching Service, more recent candidates to the MCCEE may also register with Canadian Resident Matching Service if the exam results will be available before the match is performed.

Once deemed eligible for licensure, the next step is immigration approval. There are two steps in this. First the job has to be approved as being an eligible position for a foreigner by Human Resources Canada. Human Resources then issue an approval number which allows the foreign doctor to apply for a visa with Immigration. Once the visa is obtained, a formal application for license is to be made.

48 <www.xusom.edu.pa/Accreditations.shtml>

49 *Information Pamphlet on the Medical Council of Canada Evaluating Examination (MCCEE) - 2005*, Medical Council of Canada, accessible at < http://www.mcc.ca/pdf/2005ee/EE_Pamphlet%202005.pdf>

IX.4.2 Nurses

To qualify for registration in Canada, an international nurse must complete a nursing program comparable to one in Canada, demonstrate fluency in English, provide evidence of recent practice and achieve a passing score on the Canadian RNs Examination (CRNE). If there is an offer of employment, the international nurse is allowed to practice on an interim (temporary) permit before the Canadian Examination. However, applicants must be advised that Canadian employers prefer international nurses who have already passed the CRNE.

The basic requirements for Nurse Work Visa Programme:

- Completion of a Nursing Education program of minimum 3 years (4 years required in Ontario).
- A minimum of 5 years postgraduate experience, preferably in ICU, CCU, OR, ER or L&D.
- Good character - based on references, no record of outstanding criminal charges or convictions relevant to the practice of Nursing.
- Fitness to engage in the practice of Nursing - based on satisfactory employment references, registration in good standing in other jurisdictions and no health problems that impair ability to practice.
- Fluency in English; if native language is not English, passing scores at: TOEFL Paper=550/Computer=213 and TSE=50; or Academic IELTS: At least 7 in Speaking and 6.5 for Writing, Listening and Reading.

In some cases, the following categories of international nurses might be able to obtain a waiver for the English test:

- applicants who have worked as a RNs for at least 12 consecutive months in a Hospital where English was the language of communication.
- applicants have completed a nursing education program in English.
- applicants who are registered and have practiced nursing in the last five years in a country where official language is English.

CGFNS/NCLEX tests are not mandatory or required in order to obtain registration in Canada. If an applicant does not feel ready for the Nurse Work Visa Program, she might consider the live-in caregiver program as a first step towards nursing career in Canada. This program requires completion of a nursing program of minimum 2 years; RNs, LPNs and RMs (registered midwives) are eligible to apply.[50]

[50] <www.newsolutionscanada.com/nurse/work/requirements.html>

## Section X. Indian Health Professionals Facing Administrative and Procedural Barriers in Destination Country

Migration of skilled professionals including doctors, nurses and other paramedical professionals from India to developed countries is not a new phenomenon. India has become one of the major source countries for highly skilled migrant workers. This large outflow of health care workers from India has been despite the highly regulated structure of international health care services market. During recent years the regulations and procedures for monitoring and controlling the number of professional migrants particularly within the health sector has undergone significant changes. While there is greater demand of health care professionals, especially nurses, the recent changes have made it more difficult, time consuming and confusing for health care workers to obtain visas to work in developed countries.

Well developed transparent guidelines and programmes will benefit both the home and countries. This would enable the employers in the recruitment process and the aspirant professionals in knowing what they can expect while applying. Winters et al (2002) have already estimated that an increase in developed countries' quotas on the inward movements of both skilled and unskilled temporary workers equivalent to 3 percent of their work forces would generate an increase in world welfare of over US$150bn a year. Hence the elimination of impediments would generate gains not just for India and other exporting countries but also for the importing countries as estimates suggest that there are huge returns to even relatively small movements of labour. So if regulated and managed properly without any unjustified barriers both the source and host countries can reap huge benefits.

However, the measures undertaken by the developed countries till date have offered little to the developing countries in terms of opening their markets or facilitating the administrative arrangements or providing national treatment in the area of Movement of Natural Persons. There are a number of visible and invisible barriers to the movement of professionals and others to these developed countries. In case of medical profession the most developed countries enforce stringent qualification requirements.

For instance, in US as in other countries, barriers to entry have been maintained through a combination of medical school accreditation and mandatory state licensing of individual practitioners (Abhaya & Sukhan, 2006). While in Australia in 1990's, a wide range of measures, many of which existing even now were implemented to curb the entry of ever increasing number of doctors trained abroad. Thus different types of barriers exist in different countries. These include:[51]

- Entry restrictions for certain sectors/categories of natural persons.
- Restrictions on duration of stay of natural persons.
- Conditions for entry and other related requirements.
- Economic needs test, labour market tests, management needs test etc.

[51] *Need for Greater Market Access for Movement of Professionals,* India and the WTO - Monthly Newsletter, Ministry of Commerce, Govt. of India, VOL. 1 NO. 6, June 1999.

- Quantitative restrictions by way of number, fixed proportion of total employment, fixed proportion of total wages etc.
- Restriction on capital transfers.
- Prohibition against foreigners obtaining local qualifications.
- Tax discrimination.
- Requirement of Government approval.
- Requirement of work permits/residency/citizenship.
- Non-recognition of professional qualification by importing country.
- Domestic regulations concerning registration, licensing, certification, recognition and accreditation, and also residence, nationality or citizenship requirements
- Restriction by way of minimum investment requirements.

As per the communication send by India in November 2000 to the Council for Trade in Services Special Session[52], immigration and labour market policies of individual countries is the major barrier faced by Indian professionals abroad among various other barriers. The constraints under this are in the form of strict eligibility conditions for application, processing of visas and work permits including limitations on the length of stay and transferability of employment in the overseas market. These constraints raises the direct and indirect costs of entering the foreign market, thereby eroding the cost advantage of foreign service suppliers.

## X.1 Wage Parity Requirement

Wage parity is a restrictive eligibility condition which negates the cost based advantage of developing countries in exporting labour-intensive services. Wage parity is a pre-condition for labor market test in many OECD countries. For instance, in US the foreign labour certification can be obtained in cases where it can be demonstrated that there are insufficient qualified US workers available and willing to perform the work at wages that meet or exceed the prevailing wage paid for that occupation in the area of intended employment.

If the host country government does not insist on wage parity requirement then it is a win-win situation for both employer and overseas workers. For instance replacing 20 registry nurses in US with foreign nurses could save US$1.8million. In US as the nursing shortage becomes more severe, many medical centers are turning to travel nurses and/or local registry nurses to meet their growing demand. The analysis given in Table 23 demonstrates how these methods are far more costly than developing an effective international nurse recruitment programme. Wage parity requirement is an important part of the labour certification process in many countries and constitutes an administrative hurdle delaying issuance of work permits and visas. Also there are constraints in the form of quantitative limits on visas in important developed countries for movement of professionals.

[52] *Proposed Liberalisation of Movement of Professionals under General Agreement on Trade in Services (GATS)*, Communication from India, Council for Trade in Services Special Session, S/CSS/W/12, 24 November 2000

**Table 23: Cost Advantage in International Recruitment of Nurses for US**

| | Expense | Travel Nurse | Registry Nurse | International Recruited Nurse |
|---|---|---|---|---|
| Rate/Salary/Hr | | $50.00 | $55.00 | $22.00 |
| EE Benefits | | | | 8 |
| Agency Fee | | | | 3.85 |
| Immigration | | | | 0.75 |
| Relocation Package | | | | 2 |
| Total Hourly | | $50.00 | $55.00 | $36.60 |
| Total Daily | | $400.00 | $440.00 | $292.80 |
| Total Annual | | $104,000 | $114,400 | $76,128 |
| First Year Savings | $27,872 | to | $38,272 per nurse | |
| Second Year Savings | $41,600 | to | $52,000 per nurse | |
| Replacing 20 Nurses Saves | | $1,389,440 to $1,805,440 | | |

*Source: Modi Healthcare*

## X.2 Economic Needs Tests

Barriers do exist in the form of Economic Needs Tests (ENT), Local Market Tests and Management Needs Tests to ascertain the need for entry as well as the number to be allowed to enter.[53] The ENTs are artificial barriers preventing free movement of labour. Further, the conditions on which they are based have not been clearly specified or defined in GATS, leaving complete discretion in their application, thereby reducing the predictability and certainty of the commitment. Use of such discretionary ENTs is widespread and in only three out of a total of 54 cases have criteria been specified in the GATS schedule.

In fact, ENTs have been identified as barrier to market access under Article XVI of the GATS. However, legal provisions are absent in the GATS to challenge any rejection on the basis of the ENTs. Though ENTs are scheduled with respect to all GATS modes of supply of services, mode 4 is the one most frequently subjected to tests, whether the service concerned is supplied under mode 4 or in conjunction with mode 3. Thus, the application of ENTs remains a major trade barrier to the cross border movement of independent professionals as service suppliers. Transparency is a prerequisite to being able to assess existing trading opportunities, but ENTs make this process less predictable, unstable and more burdensome. The main issue is how to reduce the degree of subjectivity associated with use of ENTs by host countries.

The measures scheduled by Members that are identified as ENTs, either explicitly or by similar language - e.g. "labour market tests", "needs test", "authorisation…subject to

[53] *Ibid*

evidence of economic need" - do not necessarily involve the identical measures. Many measures are subject to ambiguity as to their objective and effect. Some seem to aim to restrict the entry of foreign service suppliers, by making their entry conditional upon an existing inadequacy of similar local skills. Assuming that references to local markets and suppliers translate for the most part to mean national suppliers and markets, in these circumstances, the ENTS appears to be that for foreign suppliers, due to an unavailability or insufficiency in the domestic market.

Based on Schedules of Specific Commitments on Services of 134 WTO Member countries in 1999, it appears that only commercial-presence-related categories of persons are excluded from the application of the ENTs. In that respect, all trade in services based on mode 4 could potentially face ENTs which have not been explicitly spelled out in commitments but may be contained in the national legislation. Of 134 WTO members, 67 have used ENTs to regulate trade flows in one or more modes and all or selected services sectors. ENTs have qualified commitments on market access in all sectors in a few countries, but others may also apply them since no mechanism exists in GATS to limit the scope of their application. Some countries have identified categories of persons that are likely to be subject to needs tests in their horizontal commitments, but this does not mean that these and other countries would not apply needs tests to categories of persons not included in the schedules of commitments (UNCTAD, 1999).

The policy justification behind this measure may be that it would be socially and economically "undesirable" to allow foreign suppliers to enter the market when there are local suppliers who could meet demand. Countries are applying ENTs in different names. For instance, while the US calls it “Foreign Labour Certification”, in Australia an employer has to take “AON” approval before recruitment of overseas workers. In case of Canada, it is “Labour Market Opinion”. However, in UK, since healthcare sector is under the category of shortage occupation, labour market test is done without advertising the vacancy. It will take longer if the position is advertised and have not yet met the advertising requirements for the work permit application.[54]

In EU, ENTs are applied individually by the member countries. As per the EU Schedule of Commitments (1999) in WTO, Germany, Italy, Belgium, and Sweden try to restrict entry of independent health professionals through ENTs. Medical, dental and mid-wife services are subject to ENTs in Germany. The criterion is shortage of doctors and dentists in the given region. In Italy, services provided by nurses, physiotherapists and paramedical personnel are conditional upon ENTs and the decision is subject to regional vacancies and shortages. In Sweden, ENTs are applied to the services of doctors and dentists and other health professionals. This is necessary to decide the number of private practices to be subsidised through the social security system (UNCTAD, 1999).

### X.2.1 “Foreign Labour Certification” of US

The Office of Foreign Labor Certification (OFLC)[55] under the Immigration and Nationality Act provides labor certifications to employers seeking to bring foreign workers into the US.

[54] UK Home Office
[55] See http://www.foreignlaborcert.doleta.gov/

Certification may be obtained in cases where it can be demonstrated that there are insufficient qualified U.S. workers available and willing to perform the work at wages that meet or exceed the prevailing wage paid for the occupation in the area of intended employment. Foreign labor certification programs are designed to ensure that the admission of foreign workers into the United States on a permanent or temporary basis will not adversely affect the job opportunities, wages, and working conditions of US workers.

The requirement of FLC varies from one visa category to another. It also depends upon the profession. For healthcare professionals (doctors and nurses) who seek temporary employment under H-1B category, their employer only needs to get approval under Labour Condition Application (LCA) of the US Department of Labour (see Box 3). The Labour Certification is required only when a US employer tries to obtain permanent residence ("green card") status for a foreign born physician or nurse. In that case the employer will have to demonstrate that it is unable to locate a suitable local US professional to fill the position.

However, the procedure varies from state to state. An employer is typically required to place a job advertisement in an appropriate national journal. The advertisement must describe both the employment offered in terms of the job duties and the salary, which may not be less than the prevailing wage and the qualifications required to perform the job. The name of the employer need not be mentioned in the advertisement. After reviewing the resumes received and interviewing any applicants who profess to be qualified for the position, the employer must demonstrate to the Labour Department that there are no US Physicians or nurses ready, able and qualified to perform the job.

**Box 3: The Labour Condition Application**

The LCA requires that an employer attest that:

- The working conditions will not adversely affect those of US health care professionals similarly employed
- There is no strike or lockout of physicians/nurses at the facility
- The employer has given notice of the filing of an LCA to its employees either by serving the bargaining representative of the physicians/nurses, or if there is no bargaining representative, by posting two notices that an LCA has been filed. The notice must advise that complaints regarding he LCA may be made to the wage and Hour Division of the US Department of Labour. A copy of the LCA must be given to he physician/nurse.

*Source: Medical Practice in the USA, Guidelines for Foreign-Born Physicians, Law Offices of Carl Shusterman. See http://www.shusterman.com/medguide.html*

H-1B route is mainly used by physicians to get employment in the US. Nurses, who are in greater demand globally and especially in the US, have other options too. Earlier in 1999, The US government through the Nursing Relief for Disadvantaged Areas Act of 1999 (NRDAA) allowed qualifying hospitals to employ temporary foreign workers (non-immigrants) as RNs for up to three years under H-1C visas. Only 500 H-1C visas could be issued each year during the four year period of the H-1C programme (2000-2004). The sponsoring employer paid a filing fee of $250 for each application filed with the Labour department. H-1C nurses were admitted for a period of three years as the law did not

provide for an extension of that time frame. This temporary visa programme expired at the end of September 20, 2004.

After the expiry of this Act, nurses are generally recruited through either H-1B or EB3 visa categories. However, unlike physicians, the employer of nurses has advantage in getting the Foreign Labour Certification. Nursing profession is now under Schedule 'A' List for which Labour department has already declared that there is shortage of professionals in the local market (see Box 4). This makes the task of employer much easier in getting the necessary Labour certification as it has not to go through the laborious and time-consuming process of giving advertisement in national journal, which has to be followed by interview of local candidates.

**Box 4: Schedule 'A' Occupations**

Schedule A is a list of occupations, for which the Department has determined there are not sufficient U.S. workers who are able, willing, qualified and available. In addition, Schedule A establishes that the employment of aliens in such occupations will not adversely affect the wages and working conditions of U.S. workers similarly employed. The occupations listed under Schedule A include:

- Physical Therapists
- Professional Nurses
- Sciences or arts (except performing arts)
- Performing arts

*Source: US Department of Labour. See http://www.foreignlaborcert.doleta.gov/perm.cfm*

X.2.2 "AON" Approval in Australia

In Australia employers who have been unable to find an Australian trained doctor to fill a position can consider employing an overseas trained doctor (OTD). However, before attempting to recruit an OTD, the concerned employer needs to apply for the position to be recognised as an unmet AON position.[56]

An AON is any location in which there is a lack of specific medical practitioners or where there are medical positions that remain unfilled even after recruitment efforts have taken place over a period of time. AON applies to both public and private sector positions. They are determined by the State and Territory Governments. Methods of defining them vary. Most OTDs are required to work in an AON when they first come to Australia, so the employer will need to apply for AON approval before offering a position to an OTD. AON approval must be obtained by the employer---not an OTD.

Applications for AON approval should be made by the employer to the relevant State or Territory Health Department. This makes the task complicated as that there are some differences in the definition and administration of the AON process between the States and Territories.

[56] See http://www.doctorconnect.gov.au/internet/otd/Publishing.nsf/Content/employ-AON-approval

As regards nurses, they are currently in high demand in Australia. There are excellent career opportunities with permanent and temporary work available in Australia. Most visa applications for nurses receive priority processing. In Australia overseas nurses have the options of getting either sponsored by the employer or relatives. Even they could seek employment wothout a sponsorer. However, if a nurse opts for Employer Nomination Scheme, the employer will have to prove before recruitment of overseas nurses that it has a training strategy for existing Australian employees. In case if it is a newly established usiness, the employer must show that it has training plan for future training of Australian employees.[57]

X.2.3 "Labour Market Opinion" in Canada

Besides the standard immigration screening (for national security, health, criminality and bona fides) to determine if a visa for admission can be issued, a foreign professional seeking to work temporarily in Canada or the relevant Canadian employer or client, essentially face two, main regulatory requirements: assessments for a) a labour market opinion and b) a work permit. What Canada's commitments on temporary entry in international trade agreements basically do is exempt specific categories of business people from one or both of these requirements. For example, the labour market opinion does not apply to any of the categories of service suppliers covered by Canada's existing mode 4 commitments (business visitors, intra-company transferees, and several professionals). Canada has made this commitment more explicit in its initial offer on Mode 4 by citing whether or not a labour market test or a work permit applies.[58]

However, overseas healthcare professionals are not exempted from the labour market test as the sector's name is not listed in specific categories of job. For labour market opinion a written confirmation from Human Resources and Social Development Canada (HRSDC) is required that a foreign worker can fill the job. This confirmation is called a positive labour market opinion. In most cases, it is up to your employer to get that written confirmation.[59]

## X.3 Lack of Mutual Recognition of Qualifications

The lack of recognition of professional qualifications and licensing requirements is also adversely affecting the ability of professionals to supply services in developed county markets. The non-recognition of qualification may either prevent market access for the foreign service providers causing a rejection of the work permit or visa application, or may limit his scope for work to specific activities once he enters the overseas market, preventing him from practicing.

Several international trade agreements contain provisions for mutual recognition of professional services. Article VII of the GATS permits bilateral and regional recognition agreements, although such agreements represent a departure from the MFN principle. Under the GATS, recognition can also be conferred unilaterally or through a harmonisation

[57] See http://www.immi.gov.au/skilled/skilled-workers/ens/eligibility-employer.htm
[58] Mode 4 Commitments and Economic Needs Tests, Communication from Canada to Council for Trade in Services Special Session, WTO Document TN/S/W/46; S/CSC/W/47, 21 June 2005
[59] See http://www.cic.gc.ca/english/work/apply-who-eligible.asp

of rules. However the parties to such an arrangement must give other members of the WTO an opportunity to reach a similar agreement, and no recognition agreement may be applied in a discriminatory or trade restricting manner. The WTO has adopted voluntary, non-binding guidelines for the negotiation of Mutual Recognition Agreements for the accounting profession, which could be useful for other professions.

The provisions of Article VII of GATS remain largely unused. Article VII provides for MRAs and provides opportunity to Members to participate in negotiations to such Agreements. However, developing countries have normally been kept outside the ambit of such MRAs, they being limited to developed countries. So far none of the developed countries have signed any MRA on health services with any of the developing countries. This greatly reduced the scope for qualifications being recognised, leading to complete discretion of the host countries.

The qualification requirements further get complicated in a large federal country like US and Canada, where it is mandatory for the candidates to qualify both federal and state level eligibility tests. In the absence of a single licensing and regulatory body in US, overseas health care professionals are required to meet recognition requirements of individual provincial and state authorities, each with their separate medical licensing boards and having very different standards. The situation in Canada is also more or less similar as licensing requirements vary across provinces (Chanda, 2001).

In such a situation when an aspiring candidate has to confront with multiplicity of qualification and licensing requirements, MRAs would also be of not much use. For instance, all medical schools of Canada are accredited by the US but even then Canadian medical graduates face problem in getting work permit. Graduates of Canadian Medical Schools are in a favoured position as compared with most IMGs in the US. They are not considered to be IMGs since the US Department of Education through its Licensing Commission on Medical Education (LCME) has accredited all US and Canadian medical schools. This exempts Canadians from having to complete residencies in the US, from obtaining exchange visitor status, and from the two-year foreign residency requirement.

Secondly, in over 40 US states, Canadian-licensed physicians are exempted from having to take US examinations in order to obtain medical licenses. These states consider the LMCC examination to be equivalent to the FLEX. However, the US Department of Health and Human Services has refused to designate any foreign medical examinations, including the LMCC, as equivalent to the FLEX. This is unfortunate since it places the federal government at loggerheads with 80 percent of the state licensing boards which recognise the LMCC as equivalent to the FLEX and prevents. It prevents many qualified Canadian physicians from obtaining temporary working status in the US.[60]

In recent years another incidence, which has been noticed, particularly in the UK, that fulfilling qualification requirements too does not ensure jobs for Indian doctors. In UK, Indian doctors who even after passing the mandatory PLAB Test are getting unfair treatment. Since there is a perception that UK needs large number of doctors, the number of

[60] Medical Practice in the USA, Guidelines for Foreign-Born Physicians, Law offices of Carl Shusterman, Los Angeles, USA

doctors taking PLAB test has steadily increased over last few years. As per the British Association of Physicians of Indian Origin (BAPIO), last year about 3000 doctors passed the test. Majority of them come from Indian Subcontinent. Each of these doctors spends a large sum of money to travel to UK, pay the GMC fees and attend courses. Having then passed the exam one would expect that the doctor- starved NHS will welcome them with open arms. However unfortunately the truth is that these doctors suffer several months struggle even to find a clinical attachment while few lucky ones will obtain a job. Each of them has to write hundreds of applications for clinical attachments/jobs. The Immigration office is severe on those who do not find a job and these may be forced to leave the country. There does not seem to be any coordination between GMC, Home Office, DOH and COPMeD.[61]

### X.4 Social Security Contributions

The developing countries' professionals are also being subjected to payment of social security contributions in the host country though usually they are not eligible to get the benefits from such contributions since their period of stay is invariably lower than the minimum period required for such benefits to flow to them. All these limitations largely results in the rise in costs of entry and operation for India medical professionals aspiring to work abroad.

For instance, an Indian medical graduate need to invest a huge amount in order to start at least a temporary practice in the US. There are large costs at every step of the accreditation process starting from the qualifying exams to registering for the national resident match and attaining a state license. The total costs are summarised in Table 24.

**Table 24: Total estimated costs in US for a Foreign Medical Graduate from India**

| Step | Cost |
|---|---|
| USMLE I | $695 + $130 |
| USMLE II | $695 + $145 |
| USMLE III | $695 |
| Clinical Skills Assessment | $1200 |
| Extension of Eligibility Period (USMLE I & II) | $50 per exam |
| USMLE III Rescheduling Fee | $0 - $400 (depending on date of cancellation) |
| USMLE Transcript | $50 per request form (up to ten transcripts) |
| ECFMG Exam Chart | $50 per request form (up to three copies) |
| ECFMG CSA History Chart | $50 per request form (up to ten copies) |
| Score Recheck (USMLE I, II & III) | $55 per exam |
| Electronic Residency Application Service (ERAS) Token | $75 |

[61] "Unfair Deal for Doctors Passing PLAB Test", BAPIO Memorandum to GMC

| | |
|---|---|
| Exchange Visitor Sponsorship Program (EVSP) Application for J-1 Visa Sponsorship | $200 An additional $100 fee, payable to the Department of Homeland Security, is required of initial applicants for J-1 sponsorship. |
| Certification Verification Service (CVS) Verification to State Medical Licensing Authority | $25 |
| TOEFL | US $130 |
| National Resident Matching Program (NRMP) | US $40 |
| State Licensing | $240 |
| Interviews | $1000 + travel to the US (two trips if H-visa sought - one for USMLE 3, one for CSA with interviews) |

*Source: Compiled from various sources*

## X.5 Visa Procedures

Apart from these estimated costs shown above, additional costs would also be incurred as fees in visa applications and other related process thus making it a costly and distant dream for many Indian doctors to start practice in countries like US. For nurses the major barrier is the issuance of appropriate visa, particularly in the US. H-1C visas reserved for RN's are difficult to obtain due to the burden of evidence placed on the employers. Only hospitals in underserved areas that have received attestation from the Department of Labour (DOL) are able to file and till date only a few hospitals in the country have succeeded in being certified to accept H-1C nurses. Moreover the H-1C visa has expired in 2004. These hospitals must show that certain percentages of patients are entitled to Medicare and Medicaid and that the hospital has taken steps to recruit RNs who are U.S. citizens or permanent residents.

Meanwhile, the H1-B visa requires a bachelor's degree for employment and is largely unavailable to foreign educated nurses. In India as of December 2000, there existed only 84 nursing educational institutions, which were providing bachelor's degree in nursing as against 739 institutions giving degree in diploma in GNM.[62] It is quite natural that majority of the nurses from India are diploma holder. Although many US hospitals have filed labour certifications with the Department of Labour to allow the utilisation of H1B visas, the Immigration and Naturalisation Service (INS) has been reported to deny the majority of requests by foreign-educated nurses in this category (Ganguly, 2005). H-1B visas are only available to highly specialised nurses or those in high level supervisory or administrative roles.

[62] The Trained Nurses Association of India, 2001

## X.6 Licensing Requirement

In spite of obtaining an appropriate visa to enter the US, difficulties do arise due to state license requirements, wherein each state has its own Board of Nursing. Thus every nurse must meet additional state requirements and take the NCLEX as established by the State Board of Nursing. Similarly in Canada, licensing requirements vary across provinces. Relevant provincial ministries must agree on the need for the professional service provider. RNs require provincial licenses to practice before they can enter Canada. There are some state boards of nursing that will accept the Canadian Nurses Association Testing Service (CNATS) or the CRNE. There are also a few state boards of nursing that will directly endorse foreign educated nurses who have never taken the NCLEX.

Moreover many states require re-verification of the nurse credentials before they can sit for the exam, even if the nurse is CFGNS certified. For instance, state of New York use the CGFNS as their approved credentials evaluation service-provider. The CGFNS charges the nurses a fee of $265 to do a third verification of the credentials previously twice verified by them, thus imposing additional costs and wastage of time for aspirant nurses.

## X.7 Increasing Security Concerns

In the aftermath of the 9/11 terrorist attacks, the US became increasingly hostile toward immigration as the terrorists who perpetrated the attacks exploited glaring security holes in the US' immigration system. As a result border security became both an immediate and long-term concern for the US government. President Bush ordered consular offices to tighten their rules for all visa applicants. The Bush administration also debarred US Trade Representative (USTR) from negotiating visa issue as part of services negotiation in the WTO. The US is now performing extensive background checks on potential immigrants that include a tamperproof visa containing biometric data such as facial screens or thumbprints to prevent impostors from gaining entry.

Post 9/11, the US immigration implemented yet another system called SEVIS (Student Exchange Visitor Information System) to monitor foreign students more closely. SEVIS is the US Department of Homeland Security's web-based data collection and monitoring system. Although under development since 1996, its implementation was prioritized after September 11, 2001 with passage of the US PATRIOT ACT (Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism Act). SEVIS records the same information that the US government has always collected from international visitors to the US, but SEVIS collects that information electronically from a number of sources at the time that any action occurs.[63]

Effective from September 1, 2004, US Department of Homeland Security (DHS) requires the collection of a one-time Student and Exchange Visitor Information System (SEVIS) fee of US$100 for all new F-1 and J-1 applicants. The purpose of the SEVIS fee is to fund

[63] See http://www.lmu.edu/PageFactory.aspx?PageID=26511

operation of the Student and Exchange Visitor Program Office, which has oversight over SEVIS, a federally mandated tracking system for F, M and J visa holders.[64]

This new law has created further roadblocks for FMGs in getting jobs in the US. In all, about 1000 foreign doctors come to the US each year for work under the various J-1 visa waiver[65] programmes. Following 9/11 incident, however, the J-1 programme administered by the US Department of Agriculture and which had brought about in about 1000 doctors per year was abandoned. The new programme in place of the existing one, run by the US Department of Health and Human Services (HHS) has failed to fill that federal void. The HHS has approved just 61 J-1 visas since the programme began in 2003.[66]

The September 11, 2001, terror attacks in US, followed by a series of bombings in Madrid, London have made the immigration process for overseas professionals more arduous and expensive. While the 9/11 attacks made the process more complex and difficult, the FMGs fear that the attempted terror attacks in UK in June 2007 – allegedly carried out by foreign doctors – will irreparably undermine the confidence of host countries in foreign medical graduates.

## Section XI. Health Services under GATS

GATS commits WTO members to successive rounds of negotiations "with a view to achieving a progressively higher level of liberalisation" in their service sectors. To achieve this, the WTO members adopted "request" and "offer" approach of opening up of various sub-sectors. GATS allow Member countries to assume legally-binding commitments concerning their use or renunciation of trade-related measures in individual service sectors. These commitments are laid down in country schedules, one for each member. Further, there is wide scope to adjust schedules to domestic policy objectives and constraints.

Health services are also included under the GATS heading of 'professional services', which covers medical and dental services as well as the category of 'services provided by midwives, nurses, physiotherapists and paramedical personnel'. Health services have traditionally been subject to strong government involvement in many countries and this situation has changed far less rapidly than the role of governments in, for example, banking and telecommunications. While 90 percent of WTO Members undertook some form of commitment on tourism services and about 70 percent included financial or telecommunication services in their Uruguay Round Schedules, less than 40 percent made commitments on health (Adlung and Carzaniga).

When GATS was adopted in 1994, few developing countries were aware of the challenges it would bring. Very few government departments other than trade and finance ministries were involved in the negotiations. As a result, several countries committed all or part of their health services to GATS liberalisation without the knowledge of their health

[64] Ibid
[65] Allow foreign doctors to work in underserved areas for three to five years, with the incentive of eventually securing permanent residency in the US.
[66] "Foreign Doctors finding it Difficult to Get Work in US", The Times of India, 20 July 2007, http://timesofindia.indiatimes.com/articleshow/msid-2219559,prtpage-1.cms

ministries. In fact, many countries have deliberately withheld their health services from GATS liberalisation in recognition of the great uncertainty surrounding what a GATS commitment might mean for health care. It is only now, in the current round of GATS negotiations, that health services may again come under threat of liberalisation.

While the trade in health services has been on the rise, the commitments undertaken by WTO members under GATS is very shallow in nature. GATS seems to have had a limited impact so far on the migration of healthcare professionals. Out of 150 odd WTO members, only 29 countries have made commitments for trade in health services and that too are very limited in nature (Forcier et al, 2004). Moreover, within the GATS framework, WTO members are free to pursue domestic policies in areas such as technical standards, licensing and qualifications to ensure the safety and quality of healthcare provision. This implies that a commitment to allow entry of foreign medical practitioners is still subject to meeting all domestic regulatory requirements. GATS states only that such requirements must be transparent and administered in objective and impartial manner.

For the health services sector, commitments under GATS are made separately for four modes of supply: cross-border trade (Mode 1), consumption abroad (Mode 2), commercial presence (Mode 3), temporary movement of service suppliers (Mode 4). Table 25 shows the commitments undertaken in the four sub-sectors by Australia, Canada, Japan, EU and the US, where Indian healthcare professionals see the opportunities to migrate. Of the four sub-sectors except the EU no other country has made commitments in more than one sub-sector. Canada has not undertaken commitments in any of the four relevant sub-sectors. The EU's commitments are also not uniform across its members but vary from country to country.

As regards commitments undertaken by all WTO members in health services, of the four sub-sectors, medical and dental services are the most heavily committed (54 Members), followed by hospital services (44 Members) and services provided by nurses, midwives etc. (29). Overall, this pattern suggests that it is politically easier or more economically attractive for governments to liberalise capital-intensive sectors than labour-intensive activities (Adlung and Carzaniga, 2002).

## Table 25: GATS Commitments of Select Developed Country Members on Health Services

| 1) Mode 1; 2) Mode 2; 3) Mode 3; 4) Mode 4 | | | |
|---|---|---|---|
| **Country** | **Sector or Sub-sector** | **Limitations on Market Access** | **Limitations on National Treatment** |
| **Australia** | Not undertaken any commitment in a) Medical and Dental Services; b) Nurses, Midwives, etc. and c) Hospital Services | | |
| | d)Other human health services[67] | 1)Unbound<br>2)None<br>3)None<br>4)Unbound except as indicated under horizontal commitments | 1)Unbound<br>2)None<br>3)None<br>4) Unbound except as indicated in the horizontal section.<br>Permanent residency requirement for chiropodists (South Australia).<br>Permanent residency requirement for podiatrists (Western Australia). |
| Canada | NOT UNDERTAKEN COMMITMENTS IN ANY OF THE FOUR SUB-SECTORS | | |
| EU (12)[68] | a) Medical and Dental Services, Midwives | 1)Unbound<br>2)None<br>3) D: Access restricted to natural persons only. Economic needs test for medical doctors and dentists who are authorized to treat members of public insurance schemes. The criterion is shortage of doctors and dentists in the given region.<br>E: Access restricted to natural persons only.<br>I, P: Access is restricted to natural persons only. Professional association (no incorporation) among natural persons permitted.<br>IRL: Access through partnership or natural persons only.<br>UK: Establishment for doctors under the National Health Service is subject to medical manpower planning.<br>F: Provision through SEL (anonyme, à responsabilité limitée ou en commandite par actions) or SCP only.<br>4) Unbound except as indicated in the | 1)Unbound<br>2)None<br>3)None<br>4)Unbound except as indicated in the horizontal section and subject to the following specific limitations:<br>DK: Residence requirement in order to obtain necessary individual authorization from the National Board of Health.<br>I: Residence requirement. |

[67] Covers podiatry and chiropody services. Includes podiatry services carried out in health clinics, residential health facilities other than hospitals, as well as in own consulting rooms, patients' homes or elsewhere.

[68] The following abbreviations are used to indicate the Member States of EU: B – Belgium; D – Germany; DK – Denmark; E – Spain ; F – France; GR – Greece; I – Italy; IRL – Ireland; L – Luxembourg; NL - The Netherlands; P – Portugal; UK - United Kingdom

| | | | |
|---|---|---|---|
| | | horizontal section and subject to the following specific limitations:<br>DK: Limited authorization to fulfil a specific function can be given for maximum 18 months.<br>GR, P: Condition of nationality.<br>F: Condition of nationality. However, access is possible within annually established quotas.<br>D: Condition of nationality for doctors and dentists which can be waived on an exceptional basis in cases of public health interest. A zero quota for midwives. | |
| | b) Nurses, Physiotherapists and Paramedical Personnel etc. | 1)Unbound<br>2)None<br>3)E, P: Nurses - access restricted to natural persons.<br>I : Nurses - access restricted to natural persons. Professional associations (no incorporation) among natural persons permitted.<br>F: Provision through a SEL (anonyme, à responsabilité limitée, ou en commandite par actions) or SCP only.<br>4)Unbound except as indicated in the horizontal section and subject to the following specific limitations:<br>DK: Limited authorization to fulfil a specific function can be given for maximum 18 months.<br>GR, P: Condition of nationality.<br>I: Subject to economic needs test: decision is subject to regional vacancies and shortages. | 1)Unbound<br>2)None<br>3)None<br>4)Unbound except as indicated in the horizontal section and subject to the following specific limitations:<br>DK: Residence requirement in order to obtain necessary individual authorization from the National Board of Health. |

| | | | |
|---|---|---|---|
| | c) Hospital Services | 1)Unbound<br>2)None<br>3)B: The number of beds and use of heavy medical equipment is limited on the basis of a health plan. The needs test is in function of the degree of specialisation, their capacity and equipment. The criteria are fixed, arithmetical rules or formulae designed to calculate the needs in function of the population, age scale, death rate and geographical spread.<br>F, I, L: The number of beds authorised is limited by a health services plan established on the basis of needs.<br>F, I, L, P: Equipment of heavy material is limited by a health services plan established on the basis of needs.<br>I: Private health and sanitary services need authorization by local health authorities. Criteria are based on a ratio in function of population.<br>NL: Quantitative economic needs test fixed by a health plan allowing for a maximum number of beds related to the population of each health region.<br>E: Prior authorisation is required by the "Comunidades Autónomas" based on an economic needs test taking into account the population and already existing health services in the given health regions.<br>4)Unbound except as indicated in the horizontal section and subject to the following specific limitations:<br>F: Access to management functions is subject to prior authorisation. In granting the authorisation conditions such as professional experience and skills, availability of local managers and degree of specialisation required, are taken into consideration.<br>GR: Condition of nationality for public hospitals. | 1)Unbound<br>2)None<br>3)None<br>4)Unbound except as indicated in the horizontal section |
| | Not undertaken any commitments in d) Other human health services | | |
| Japan | Not undertaken any commitments in a) Medical and Dental Services; b) Nurses, Midwives, etc. and d) Other human health services | | |

| | | | |
|---|---|---|---|
| | c) Hospital Services | 1) Unbound<br>2) None<br>3)Unbound except that there is no limitation on the participation of foreign capital<br>4)Unbound | 1)Unbound*<br>2)None<br>3)Unbound except that there is no limitation on the participation of foreign capital<br>As indicated in HORIZONTAL COMMITMENTS<br>4)Unbound |
| USA | Not undertaken any commitments in a) Medical and Dental Services; b) Nurses, Midwives, etc. and d) Other human health services | | |
| | c) Hospital Services | 1) Unbound*<br>2) None<br>3) Establishment of hospitals or other health care facilities, procurement of specific types of medical equipment, or provision of specific types of medical procedures may be subject to needs-based quantitative limits.<br><br>In New York, corporate ownership of an operating corporation for, and limited partnerships as operators of, hospitals, nursing homes (including long term health care centres) or diagnostic and treatment centres is prohibited. If the operator has any members which are not natural persons or is a corporation whose shares of stock are owned by another corporation, a New York corporation must be established as the operator of a licenced home care services agency and a certified home health agency.<br><br>In Michigan and New York Health Maintenance Organisations must be incorporated in those states.<br><br>4)Unbound except as indicated in the horizontal section | 1) Unbound*<br>2)Federal or state government reimbursement of medical expenses is limited to licensed, certified facilities in the US or in a specific US state<br>3) None<br>4) None |

*Source: WTO*

## XI.1 India and GATS

Like most of the developing countries India too was defensive during the Uruguay Round of trade negotiation on services. However, India's negotiating stance on services has undergone a paradigm shift since then. In the ongoing services trade negotiations, India has been very offensive in seeking market access in developed countries, particularly under Mode 1 (Cross Border Trade) covering the whole issue of business process outsourcing and Mode 4, dealing with temporary movement of natural persons. Of late, India has realised its strength under other two Modes as well. While India has become one of leading destinations of medical tourism (Mode 2 – Consumption Abroad), outward investments

from India are increasingly rising. Indians have built hospitals in Bangladesh, Sri Lanka, and Middle East countries.

This shift in India's stance in services trade negotiations can be attributed to significant increase in services exports from India. In a short span of little over one decade, India's share in world services exports has increased from 0.53 percent in 1993 to 2.7 percent in 2006 (WTO, 2007). This massive jump in export has happened because of India's huge comparative advantage in "IT enabled services" (business process outsourcing) and increase in remittances. Remittances by overseas Indians, as reflected in private transfers in the balance of payments, have touched a new high of US$8,145 million during the quarter ended December 2006. This is the highest-ever received by the country in any single quarter. Remittances for the entire calendar year 2006 touched US$26.9 billion.[69]

When the Doha round of trade negotiation was launched in November 2001, India was the main proponent of market opening under Mode 4. In fact a year before the launch of Doha round, India made one of the most comprehensive submissions on temporary movement of natural persons to the WTO's Council of Trade in Services. The proposal provides not only concrete suggestions for areas of further liberalisation in Mode 4, but also detailed administrative procedures relating to Mode 4 visas and work permits and the recognition of qualifications. It is motivated by the view that there is a huge imbalance between current commitments on Mode 3, commercial presence, and those on Mode 4, natural persons (Winters, 2005).

In the current services negotiations, India has been spearheading the group of demandeurs on cross border services trade (Mode 1) and Mode 4. Though India remains one of the main demandeurs of liberalisation of services trade under Mode 4, in recent years there has been some indication of shifting of focus more towards Mode 1. This change has happened mainly because of increasing complexity with Mode 4 liberalisation as it touches upon immigration and visa issues, which are beyond the mandate of WTO. As regards health services, Table 26 lists India's request to major developed countries for opening up their health sector.

**Table 26: India's initial request list to USA, EC, and Japan on Health Services**

| ***Country*** | ***Medical and dental services.*** | ***Services provided by midwives, nurses, physiotherapists & paramedical*** | ***Hospital Services*** | ***Additional Commitments*** |
|---|---|---|---|---|
| USA | *Market Access:*<br><u>Mode 2:</u><br>Take full commitments & Schedule "None"<br><u>Mode 4:</u><br>Take full commitments & Schedule "None" in | *Market Access:*<br><u>Mode 2:</u><br>Take full commitments & Schedule "None"<br><u>Mode 4:</u><br>Seek full commitment in respect of services | *Market Access:*<br><u>Mode 4:</u><br>Take full commitments & Schedule "None" in respect of services provided by Medical doctors, Dentists, Dieticians | To recognize the qualifications of Indian Medical and Dental Service Professionals and nurses. |

[69] "Diaspora Sends More Money than Before", The Economic Times, April 13, 2007

| | | | | |
|---|---|---|---|---|
| | respect of services provided by Medical doctors, Dentists, Dieticians & Nutritionists, Dental Assistants: Remove the limitation under which Individual Medical Doctors are allowed to enter US only for purposes of studies or training and not for rendering professional services.<br><br>*National Treatment:*<br><u>Mode 2:</u><br>Take full commitments & Schedule "None"<br><u>Mode 4:</u><br>Take full commitments & Schedule "None" | provided by Midwives, nurses, physiotherapists and paramedical personnel: Nursing and Midwifery professionals, physiotherapists and related Associate professionals Speech Therapists.<br><br>*National Treatment:*<br><u>Mode 2:</u><br>Take full commitments & Schedule "None"<br><u>Mode 4:</u><br>Take full commitments & Schedule "None" | & Nutritionists, Dental Assistants; Midwives, nurses, physiotherapists and paramedical personnel: Nursing and Midwifery professionals physiotherapists and related Associate professionals, Speech Therapists. Remove the limitation under which Individual Medical Doctors are allowed to enter US only for purposes of studies or training and not for rendering professional services.<br><br>*National Treatment:*<br><u>Mode 4:</u><br>Take full commitments & Schedule "None" | |
| EC | *Market Access:*<br><u>Mode 4:</u><br>Seek specific commitments in respect of services provided by Medical doctors, Dentists, and Dieticians & Nutritionists, Dental Assistants.<br><br>• Remove requirement of residency and Nationality.<br><br>• Remove quantitative restrictions so as to enable health professionals to enter and deliver | *Market Access:*<br><u>Mode 4:</u><br>Take full commitments & Schedule "None" in respect of services provided by Medical doctors, Dentists, and Dieticians & Nutritionists, Dental Assistants.<br><br>• Remove requirement of residency and Nationality.<br><br>• Remove quantitative restrictions so as to enable health professionals to enter and deliver | *Market Access:*<br><u>Mode 4:</u><br>Take full commitments & Schedule "None" in respect of services provided by Medical doctors, Dentists, and Dieticians & Nutritionists, Dental Assistants; Midwives, nurses, physiotherapists and paramedical personnel: Nursing and Midwifery professionals physiotherapists and related Associate professionals Speech Therapists .<br><br>• Remove the | To recognize the qualifications of Indian Medical and Dental Service Professionals and nurses. |

| | | | | |
|---|---|---|---|---|
| | health services on demand.<br><br>*National Treatment:*<br>Mode 4:<br>Take full commitments & Schedule "None".<br><br>• Remove Residency Requirement. | health services on demand.<br><br>• Remove Economic Needs Test.<br><br>*National Treatment:*<br>Mode 4:<br>Take full commitments & Schedule "None"<br><br>• Remove Residency Requirement. | requirement of nationality.<br><br>• Remove Local Market Tests and ENTs.<br><br>*National Treatment:*<br>Mode 4:<br>Take full commitments & Schedule "None" | |
| Japan | *Market Access:*<br>Mode 2:<br>Take full commitments & Schedule "None"<br><br>Mode 4:<br>Take full commitments & Schedule "None" in respect of services provided by Medical doctors, Dentists, and Dieticians & Nutritionists, Dental Assistants<br><br>*National Treatment:*<br>Mode 2:<br>Take full commitments & Schedule "None"<br><br>Mode 4:<br>Take full commitments & Schedule "None" | *Market Access:*<br>Mode 2:<br>Take full commitments & Schedule "None"<br><br>Mode 4:<br>Take full commitments & Schedule "None" in respect of services provided by midwives, nurses, physiotherapists and paramedical personnel<br><br>*National Treatment:*<br>Mode 2:<br>Take full commitments & Schedule "None"<br><br>Mode 4:<br>Take full commitments & Schedule "None" | *Market Access:*<br>Mode 1:<br>Take full commitments & Schedule "None"<br><br>Mode 3:<br>Take full commitments & Schedule "None" through<br><br>• Remove ownership of hospitals to national license physicians.<br><br>• Remove prohibition on investor owned hospitals.<br><br>Mode 4:<br>Take full commitments & Schedule "None" in respect of services provided by Medical doctors, Dentists, and Dieticians & Nutritionists, Dental Assistants; and services provided by midwives, nurses, physiotherapists and paramedical | To recognize the qualifications of Indian Medical and Dental Service Professionals and nurses. |

| | | | | |
|---|---|---|---|---|
| | | | personnel<br><br>*National Treatment:*<br><u>Mode 1:</u><br>Take full commitments & Schedule "None"<br><br><u>Mode 3:</u><br>Take full commitments & Schedule "None"<br><br><u>Mode 4:</u><br>Take full commitments & Schedule "None" | |
| Canada | *Not Mentioned* | *Not Mentioned* | *Not Mentioned* | *Not Mentioned* |
| Australia | *Not Mentioned* | *Not Mentioned* | *Not Mentioned* | *Not Mentioned* |
| Switzerland | *Not Mentioned* | *Not Mentioned* | *Not Mentioned* | *Not Mentioned* |

*Source: WTO*

## Section XII Stakeholders' Perception

After software professionals, it is the turn of the health care workers to tap the rich prospects in many developed countries, where hospitals are feeling the pinch of the shortage of such professionals, particularly nurses. Many research studies, newspapers stories and even government agencies have raised and highlighted the issue of shortage of nurses in OECD countries. This led to targeted recruitment of nurses by some of the developed countries from developing countries like Philippines, South Africa and India. Since Philippines has been exporting nurses to developing for many years, India is more preferred source country as it is relatively a new entrant into this field. India, although, has been supplying nurses to Gulf countries.

However, the migration of doctors from India to developed countries, mainly the US and the UK, is not a new phenomenon. They have been migrating to developed countries for better training and higher medical degree since 1960s. While a majority of doctors prefer to stay there, some of them have come back. Since most of the doctors in India come from middle and higher income families, they find their own way to migrate. Contrary to this nurses in India belong to lower or lower-middle class background. Therefore, they depend upon some agencies to help facilitate their migration.

The emergence of new opportunities globally for nursing professionals led to mushrooming of overseas placement agencies, and private nursing colleges in India. The critical shortage of RNs in the US has led to a boom in the recruitment of Indian nurses to America. A

number of American hospitals are these days putting in requests with manpower consulting agencies and nursing schools across India for recruiting nurses. State governments like Kerala and Tamilnadu have established their own manpower export corporation to help the low-skilled professionals to migrate abroad. Government agencies like Nursing and Medical councils do not seem to be encouraging healthcare professionals to go abroad but their role is crucial. These councils are involved in the negotiation of mutual recognition of medical qualifications, bilaterally as well as multilaterally. Non-recognition of qualification is one of the major barriers in free movement of professionals from developing to developed countries.

**Table 27: Number of Nurses sent abroad by the Recruitment agencies**

| S. No. | Recruitment Agency | Year | Number of Nurses Send Abroad |
|---|---|---|---|
| 1 | All About Staffing | 2004 | 284 |
| | | 2005 | 340 |
| | | 2006 | 490 |
| 2 | AJ Placements | | 150 Nurses a year |
| 3 | India International Technical Recruiters | 2002-2006 | 1100 nurses within a period of 4 years (800 – Ireland ; 300 – US) |
| 4 | RN India | 2006 | 15 from Delhi office |
| | | 2006 | 20 from Cochin office |
| 5 | MAX Health Staff | 2003 – Sep 2006 | 55 nurses |
| 6 | Fortis Health Staff Ltd | | Nil |

*Source: Based on information supplied by individual recruitment agencies*

The stakeholders' perception survey has, therefore, targeted – recruitment agencies, nursing colleges, nursing councils, state level manpower export corporations to gather their views on barriers, which our healthcare professionals face in developed countries' markets. Among the recruitment agencies only those were interviewed who are exclusively involved in overseas placement of healthcare professionals, mainly nurses. Recruitment agencies like All About Staffing (India) Private Limited, Fortis HealthStaff Limited, India International Technical Recruiters, Nurses Anytime, Modi Health etc. are working as agents of US and UK hospitals in India. Very recently, O'Grady Peyton[70] has opened a new corporate office in Bangalore. So nurses in India can now deal directly with the US' number one nurse recruitment company. Further, there is hardly any placement agency, which is involved in migration of doctors. Thus, most of the information collected through field survey relates to nursing professions.

[70]O'Grady Peyton International is the international division of AMN Healthcare and with over 24 years experience, is the largest and most experienced travel nurse company in the US. Since 1981, O'Grady Peyton has placed thousands of nurses from around the world in leading healthcare facilities across the United States through its Nursing US Programmr.

## XII.1 Qualifications

In the absence of multilateral/bilateral MRAs on qualification, the qualification requirements imposed by the host countries are the major hurdle in the way of nurses finding jobs in developed countries' hospitals. Among developed countries Indian nurses mainly go to US, UK, Ireland, Australia and Canada. According to recruitment agencies, the US has the most stringent qualification requirements for nurses. However, in case of US the nurses get long term work permit under H-1B or EB3 category, which is likely to be converted into permanent residency after six years. While Ireland has relatively more flexible qualification requirements, the UK has its own yardsticks to assess the training quality of nurses acquired in their home country.

Most Indian nurses are used to working in the Gulf countries and thus are not familiar with the rigorous examinations of the US. It is difficult to pass these tests at one go. Migrating to the US is not at all an easy task even for a qualified nurse. Most boards of nursing require a foreign nurse graduate to qualify CGFNS certificate. CGFNS Qualifying Examination is required from graduates of nursing schools located outside the United States of America who are interested in practicing as RNs in the U.S. The CGFNS Qualifying Examination is a test of the candidates' nursing knowledge and their understanding and use of English language. They will be awarded a CGFNS certificate when they have passed both the nursing section and the English language section of the examination.

To be allowed to work as a registered nurse, persons must have a license. The license is issued by the Board of Nursing in the particular state in which the person is to work. For that candidates have to pass the state licensing examination. The CGFNS certification programme is designed specifically for first-level, general nurses educated and licensed outside the US who wish to assess their chances of passing the U.S. registered nurse licensing exam, the NCLEX - RN® examination, and attaining licensure to practice as RNs within the US.

Nursing school exams are significantly different from the NCLEX, or National Council Licensure Examination. In nursing school, exams are knowledge-based. Candidates are tested on the facts that they know. The NCLEX is application-based and they are tested on how to take the facts that they know and use them in actual situations. Earlier, it was required that NCLEX- RN examination must be taken in the United States only but now this test is conducted outside US also. Thus, technically a candidate could take this exam directly without first clearing the CGFNS. However, many US States[71] still put a condition that foreign nurses to pass the CGFNS examination before taking the NCLEX-RN. However, once a nurse get the CGFNS certificate, the chances of passing the NCLEX-RN exam and get a license to work as a registered nurse become high. About 88-92 percent of those nurses who have secured the CGFNS certificate has passed the NCLEX-RN exams.

[71] The following states require foreign nurses to pass the CGFNS examination before taking the NCLEX-RN: Alabama, Alaska, Arizona, Arkansas, Colorado, Connecticut, District of Columbia, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, North Carolina, North Dakota, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Vermont, Virginia, Washington, West Virginia and Wyoming.

Once a candidate secures the CGFNS certificate, the employer will also have a greater confidence on her working skills. There is every possibility of getting better pay.

Most of the recruitment agencies who are an affiliate of US hospitals apply very stringent screening process while selecting candidates for training. For instance, in Modi Healthcare, a leading nurses recruitment agency of India, only one in ten nurses who attend screening test finally qualify for admission into their programme.

No direct examination is required for foreign-trained nurses to practice in the United Kingdom; instead, the NMC assesses nurses' overall credentials, including evidence of proficiency in English, and ascertains that an employer has agreed to provide employment for the period of the work permit. The absence of an exam might make it easier for foreign-trained nurses to eventually practice as a qualified nurse in the UK than in the US.

**Box 5: Steps to be Followed in Becoming a Registered Nurse in the US**

Pre-Screening & sign up with Recruitment Agencies
↓
IELTS Training & Exam
↓
CGFNS/direct NCLEX training and exam
↓
Job offer from US
↓
Visa Screen Certification
↓
NCLEX-RN Training and Exam
↓
Consulate Interview for green card
↓
Fly to US
↓
Post Arrival support
↓
Start working in US

**Table 28: Qualifications Requirement for Overseas Nurses in the US, UK and Ireland**

| Country | Qualifications |
|---|---|
| USA | • Background of nursing – GNM (General Nursing and Midwifery) is the minimum qualifications, which is a 3 ½ year diploma course.<br>• Current nursing license with one 1 year working experience in home country.<br>• IELTS – English language exam<br>• NCLEX – National Council Licensure Examination<br>• CGFNS – Commission on Graduates of Foreign Nursing Schools |
| UK | • Background of nursing – GNM (General Nursing and Midwifery) is the minimum qualifications, which is a 3 ½ year diploma course.<br>• Minimum 18 months working experience. |

| | |
|---|---|
| | • A NMC (earlier known as UKCC) decision letter<br>• IELTS – English language exam |
| Ireland | • Background of nursing – GNM (General Nursing and Midwifery) is the minimum qualifications, which is a 3 ½ year diploma course.<br>• TOEFL/IELTS – English language exam |

*Source: Based on information collected from recruitment agencies*

## XII.2 English Language

The spoken English was the most difficult part as most of the nurses in India come from low income family, having their education in vernacular language. While the nurses are definitely competent in terms of nursing skills, learning to speak in English is the hard part of it as most of them come with no training in the language. In India, recruitment agencies have been scouting for candidates from various metros in India - Chandigarh, Vellore, Mumbai and Mangalore - it is from the hospitals of Bangalore that it found the candidates fulfilling the requirement of excellent spoken English. It is very essential to communicate with the patients very clearly and despite good qualification and skills, nurses from many cities in India lack the fluency.

IELTS is, therefore, an essential requirement for those nurses who aspiring to work UK, Australia, New Zealand and Canada. US have started accepting IELTS as the language proficiency test for nurses who wish to work in the country. According to recruitment agencies, who prepare aspiring nurses for international English language test, most of the candidates require more than a year of preparation. Even after that they fail to pass the exam in one go.

What is more problematic is that the scores that a nurse achieves in both CGFNS qualifying exam and TOEFL are valid for only two years in case of the US. The time required for processing the US visa ranges from minimum 1-2 years. Hence, for nurses it is necessary to complete all the formalities and join in a job before this validity ceases. Other wise, she will have to appear for the exams again, which is expensive and time taking.

**Table 29: English Language Test for Nurses**

| | US | UK |
|---|---|---|
| **Requirement in English Language Test** | TOEFL with a score of 540 and higher on the hand written exam or 207 and higher on the computerised exam .& .TWE with a score of 4.0 and higher & TSE with a score of 50 and higher<br>OR<br>TOEIC with a score of 725 and higher & TWE with a score of 4.0 and higher & TSE with a score of 50 and higher<br>OR<br>IELTS with an overall score of 6.5 and a spoken band score of 7.0 (Academic Module) | NMC require a minimum score of 5.5 in each module with an average score of not less than 6.5 at the IELTS. |

*Source: Based on information provided by recruitment agencies*

## XII.3 Visa

Nursing is now the fastest route to the Green Card for an Indian in the US. Consultants say these days it is easy for the Indian nurse to get a green card compared to a software engineer. The US Department of Labor abolished the time consuming process of getting a labour certification[72] for foreign nursing professional to migrate to the US. The usual procedure for an immigrant visa meant that the applicant had to go through a labour certification procedure. But the acute shortage of nursing professionals forced the Department of Labour to do away with the procedure. As a result, RNs have been put on the Schedule A, which put them on a fast track to a US Green Card.

Employment Based Third Preference Immigrant Visas (EB-3 or Green Card) is the Visa commonly given to nurses. It usually takes 9-12 months to get an EB-3 visa, if a candidate has CGFNS certification. The EB-3 Application requires:

- Labour certification by the employer
- Visa petition by the employer
- Visa application by the nurse

Since labour certification requirement has been abolished, nurses are required to submit only two documents. However, the US Directorate of the Citizenship and Immigration Service issued a regulation making it mandatory for immigrating health workers to get the Visa Screen certificate, which tests an applicant's education, experience, training and English vis-à-vis that of US health care workers. The recruitment agencies in India feel that the new visa rule will considerably delay the migration of hundreds of nurses and other healthcare professionals from India to the US. It also spoils the chances of nurses who want to work in the US only on temporary basis, either for three years or for a maximum of six years.

In order to receive a Visa Screen Certificate to, a candidate has to demonstrate that her education is equivalent to a nursing education in the US and that her written and spoken English skills are at an acceptable level. A Visa Screen Certificate is presented to a consular office, or in the case of adjustment of status, to the Attorney General as part of the visa application.

..

[72] Office of Foreign Labour Certification (OFLC) provides labor certifications to employers seeking to bring foreign workers into the US. Certification may be obtained in cases where it can be demonstrated that there are insufficient qualified US workers available and willing to perform the work at wages that meet or exceed the prevailing wage paid for the occupation in the area of intended employment. Foreign labour certification programs are designed to ensure that the admission of foreign workers into the US on a permanent or temporary basis will not adversely affect the job opportunities, wages, and working conditions of US workers.

### XII.4 Role of Nursing Councils

In India, the main function of Nursing Council is to establish and monitor a uniform standard of nursing education for nurses, midwife, Auxiliary Nurse-Midwives and health visitors by doing inspection of the institutions. Both Nursing and Medical councils are the nodal government agencies to deal with Mutual Recognition of Qualification with their foreign counterparts. Foreign hospitals also require that the certificates of educational qualification of nurses and doctors must be certified by these councils before they are recruited.
However, recruitment agencies are of the view that Nursing Council in India not effectively coordinating with the nurses who aspire to go abroad for work. They make inordinate delay in filling out forms and verifying mark sheets that need to be send to the concern hospital abroad who has recruited the candidate. This delay to send the requisite details by the Council makes the entire process time consuming.

## Section XIII. Policy Recommendations

India has identified healthcare service as one of the key sectors where Indian professionals have competitive advantage in international market vis-à-vis other developing countries. Among the various categories of healthcare services, nurses are in greater demand in most of the OECD countries. The severe shortage of nurses in US and UK resulted in targeted recruitment by them from countries like Philippines and India. Since Filipino nurses have already been dominating the international market, OECD countries turned towards India as the new potential source of nurses' recruitment. India too has responded positively as trade in health services gels well with India's overall emphasis to boost its services trade.

Unlike telecommunication and financial services where foreign direct investment (Commercial presence) is the dominant mode of international trade, healthcare services trade is dominated by movement of independent professionals, both temporary and permanent. Since healthcare is a labour intensive activity, it requires movement of either service provider or patients. That is why medical tourism is also getting popular.

In the current negotiation under Doha Round, India has been spearheading the group on Mode 4, which seeks greater commitment from developed countries for their independent professionals. In the year 2000, India made one of the most comprehensive submissions on Mode 4, identifying several barriers like ENTs, wage parity requirement, non-recognition of qualification and cumbersome visa procedures, which come in the way of free movement of independent professionals including healthcare professionals. After the WTO Hong Kong Ministerial conference in December 2005, WTO members adopted a new plurilateral way of making requests and offers, in addition to the existing bilateral one. Following this, India on behalf of the several interested members[73] made a collective request on Mode 4, calling for removal of wage-parity and ENTs as pre-condition of entry.[74]

[73] Argentina, Brazil, Chile, China, Colombia, Dominican Republic, Egypt, Guatemala, India, Mexico, Morocco, Pakistan, Peru, Thailand, and Uruguay.
[74] Collective Requests on Mode 4 – Movement of Natural Persons from Permanent Mission of India to the WTO, 2006

However, in case of healthcare professionals, to fulfill stringent qualification requirement is the main barrier. Most of the stakeholders (overseas health care recruitment agencies) in India are of the view that once a candidate clear all the tests required for practicing nursing/medicine in a host country, visa is not a problem. The problem arises mainly because of multiplicity of tests. For example, in order to become a qualified nurse to get a job in the US hospital a candidate has to go through minimum three tests – CGFNS, NCLEX and mandatory language tests. As per information provided by stakeholders in India, majority of the nurses fail to qualify all the three tests in one attempt. This creates problem when a passing certificate of a particular test is valid for a shorter time period. If the remaining tests are not cleared within the stipulated time period, then a candidate may have to take the test again, which she has already cleared.

Thus, MRA on qualification is the most critical for free movement of healthcare professionals. MRA enables the qualifications of professional services suppliers to be mutually recognised by signatory member countries, hence facilitating easier flow of professional services providers. The GATS allows Members to deviate from the MFN requirement and set up bilateral or plurilateral MRAs. However, if those agreements, instead of being trade-creating become mainly trade distorting, and if they become instruments that facilitate trade only or mainly among developed countries, their overall objective may be missed. At present developing country participation in MRAs is limited and concerns only the most dynamic among them. Lack of recognition of professional qualifications remains a major obstacle for developing country professionals willing to provide their services abroad (UNCTAD, 2005).

There is a need to devise some mechanisms and put in place to facilitate developing country effective participation in MRAs: market forces will not by themselves provide a solution to the problem. The ongoing GATS negotiations and countries' engagements in bilateral/regional free trade agreements (FTAs) provide an opportunity for developing mechanisms that would ensure that MRAs become effective tools for facilitating the international movement of professionals, including developing country professionals. Health services is perhaps relatively easier in which MRA could be signed among at least developed and larger developing countries as professional requirements and training courses do not vary much. In this context, GATS Article IV may be highly relevant for giving recognition to professional degrees and certificates of developing countries. The article suggests that developed countries should make efforts aimed at facilitating the recognition of the academic and professional qualifications of developing country professionals, and developing country effective participation in MRAs.

### XIII.1 Feasibility of MRAs with Major Countries for India

At present India does not have much experience in negotiating MRAs. So far India has signed only five FTAs but except in case of Singapore, services is not a part of agreement. Though the talks have started with Singapore on MRAs in health services, but at the moment it is stuck on the number of educational institutions to be recognised on mutual basis. India, being a large country in comparison to Singapore, would definitely like to

have larger number of its medical/nursing/dental institutions to be considered for mutual recognition of qualification.

Given the growing importance of the US, UK, Canada and Australia as destination markets for healthcare service providers, India would definitely like to have MRAs on qualification with these countries. Since stringent qualification requirements imposed by host countries have become major barriers in the free movement of healthcare professionals, MRAs with them would considerably ease the complex procedures and thereby reduce the time in the migration of professionals. However, there is a real practical problem in negotiating MRAs, particularly with large federal countries like US, Australia and Canada. These countries have regulating agencies functioning at federal and state levels, resulting in multiplicity of qualification and licensing requirements.

The situation in EU is peculiar as the 27-member regional trading block has power to negotiate free trade agreement but no mandate to negotiate MRAs with country outside the block. It means in the upcoming EU-India FTA despite Services being a part of negotiating agenda, MRAs cannot be negotiated. In other words, for MRAs, India will have to go bilateral with as many EU members as it wishes to negotiate. It means the choice boils down to a few select countries like UK and Ireland, where India is already the leading supplier of doctors and nurses. Hence, the EU-India FTA is unlikely to improve upon the present situation in terms of providing Indian health care professionals better market access to EU countries.

The US is very crucial for India as far as MRA on medical qualification is concerned. While the US is the world largest market of healthcare service, Indian health professionals too consider US as the most attractive destination. Of late many big US-based hospitals have made India as the target country for recruitment healthcare professionals, particularly nurses. However, it is the US where the qualification requirements are more stringent, causing much delay in issuance of visa and work permit. The importance of India as source country of nurses is also evident from the fact that there are five examination centres of NCLEX-RN in India as against only one in Philippines.

As per the GATS Article VII, WTO member nations have the option to go either way – bilateral/regional/multilateral – for MRAs. It would be worthwhile to see US' approach on MRAs on medical qualification in its bilateral trade agreements. For quite some time the US is on FTA signing spree. Since the launch of Doha round in 2001, the US has signed as many as seven FTAs with countries ranging from Australia in the down South to Chile in Southern America. These FTAs are in addition to NAFTA and FTA with Israel. Besides, there are eight other FTAs in pipeline, which would soon be operational. In most of these FTAs, there is a mandate under "Cross Border Trade in Services" chapter to initiate negotiation on MRAs.[75] But, in none of the case, there is any progress so far on MRAs.

Now looking at the feasibility of MRA between Indo-US on medical qualification, can it be possible in the absence of bilateral FTA between the two countries? If Singapore, Australia

[75] Article 11.9 of US-Chile FTA Text, Annex 8 C of US-Singapore Text, and Article 10.9 of US-Australia Text provide mandate to both the parties to initiate negotiation on MRAs for various professional qualifications.

and Chile, which have FTAs with USA, could not make any progress on MRAs, how can India do it? Does this mean that for negotiating MRAs with the USA, India first require to sign FTA with it? Theoretically, the answer may be no but practically FTA with USA would be one step forward in this direction. Besides the FTA would double the mandate (in addition to Article VII of GATS) to both US and India to go for bilateral MRAs. However, the FTA between India and the US in the near future does not seem feasible.

Though, debates are going on for Indo-US FTA, there seems to be not enough political support for it in India at least. Moreover, the present US' FTA framework pushes for social clause like labour standards and seeks WTO plus commitments under TRIPs, which India would not like to see in any trade agreement. There were also talks of Indo-US FTA on services trade, but the US seems to be not very enthusiastic about it.

It is not the absence of bilateral FTA, there are other problems too which are adding complexity in negotiating MRAs. For instance, US, Canada and Australia are large federal country, where there are state level regulatory authorities in addition to federal regulatory authority. Often, an independent healthcare professional has to satisfy the qualification and licensing requirements of both federal and state level regulating agencies. This practice is most common in the US. In such a situation, MRAs with federal government would serve the purpose much. And negotiating MRAs with 50-odd states of US is next to impossible.

Another problem is technological and knowledge gap arises due to variations in health care systems. The US health care system, for instance, relies heavily on technology for diagnostic, preventive and palliative care. Contrary to this, in India, the government medical and nursing institutions, from where maximum number of students acquires their degrees, are not well equipped with advanced technology. Further, the Western medicine relies heavily on drugs to treat patient illness, many of which are not use in developing countries. Therefore, the more similar the health care system, the easier it would be to negotiate MRAs.

### XIII.2 Tackling Economic Needs Tests

Among trade barriers, the second most important measure is ENTs. According to WTO, UNCTAD and OECD analyses, GATS Article XVI:2(d)[76] and the Scheduling Guidelines set out the rules on ENTs with respect to Mode 4. Members are not supposed to use ENTs to limit the number of natural persons; however, if members wish to continue to use such ENTs, they are supposed to cite and describe them in their schedules. Some members have indicated that ENTs or labour market tests are not applicable to certain categories of natural persons covered. However, because of the lack of transparency of their commitments or lack of available information on their national and sub-national regimes, it sometimes looks

[76] Article XVI:2(d) says: In sectors where market-access commitments are undertaken, the measures which a Member shall not maintain or adopt either on the basis of a regional subdivision or on the basis of its entire territory, unless otherwise specified in its Schedule, are defined as: […] limitations on the total number of natural persons that may be employed in a particular service sector or that a service supplier may employ and who are necessary for, and directly related to, the supply of a specific service in the form of numerical quotas or the requirement of an economic needs test [...]".

as if ENTs or labour market tests are indeed operating. In health service also some countries have relaxed it but one cannot be sure.

Developing countries have pointed out that ENTs or labour market tests constitute a Mode 4 barrier that needs to be addressed in the current negotiations, so that improved market access could result. The main reason behind its arbitrary and non-transparent application is lack of multilaterally agreed definition of ENTs under GATS. Research studies have shown that within the category of labour market tests, the most frequent factor is the availability of similar workers in the host country, or whether a foreign worker would be competing with or displacing a domestic worker.

WTO members have suggested several ways to dealing with ENTs. Canada, for instance, proposed ENTs or labour market tests should either a) not be applied to the categories of natural persons covered by a Member's mode 4 commitments or b) if applied, should be included in the Member's schedule of specific commitments.[77] India, however, demands either its complete removal or substantial reduction. In case ENTs are substantially reduced, their application must be non-discriminatory. But above all, what is required urgently is to define ENTs, and laying down proper criteria and conditions for its application. India also wanted wage-parity requirement should not be a pre-condition for ENTs as it is in many developed countries.

### XIII.3 Visa Procedures

Another important barrier is visa procedure. Priority should be given to standardise visa and work permit regulations for professionals. Entry visas should be easily granted for medical professionals, with a short prescribed duration for procedural formalities. Within these procedural formalities, there is a need to ensure transparency and certainty particularly a transparent application processes, simplified renewal and transfer procedures, and recourse mechanisms to ascertain the status of an application and reasons for rejections. Further, quantitative restrictions on number of visas to be granted under temporary movement of professionals should not be there, just as there are no quantitative limitations on trade in goods.

### XIII.4 Miscellaneous Issues

Moreover, the fees, charges etc., applicable to residents and/or citizens with a view to provide social security nets or retirement benefits should not be made applicable on those foreign professionals who migrate to a foreign country only for a temporary period rather than for permanent residence or citizenship. Or if collected these temporary professionals should be entitled to a refund of such contributions after their stay. A distinction between permanent and temporary movement of medical professionals is required so that procedures and requirements that apply to permanent movement do not hinder the commitments made for temporary movement. All the more the conditions of entry and stay for temporary movement should be less stringent than for permanent immigration.

[77] Communications from Canada, TN/S/W/46, S/CSC/W/47**,** 21 June 2005

Apart from dealing with external barriers, there are some critical domestic issues which also need urgent attention of policy makers in India. At first medical and nursing councils who are the nodal agencies responsible for regulation and maintenance of a uniform standard of training for doctors and Nurses/Midwives/Auxiliary Nurse-Midwives respectively, need to be more proactive. Since these Councils prescribe the syllabi and regulations for various health care related professional degrees, it is important for them to make Indian professional and technical degrees at par with international standard. This would help them in negotiating the bilateral/plurilateral/multilateral MRAs.

Another domestic issue is government active involvement in generating surplus healthcare manpower for export purpose. India has been able to substantially increase its annual flow of healthcare professionals but so far it has been largely private sector initiative. To produce surplus healthcare professionals is very crucial otherwise increase in migration of nurses and doctors would start adversely impacting on domestic health care facilities. We must pre-empt to make sure that in future as a result of greater outflow of our healthcare professionals, India should not land up in a situation where there would be a critical shortage of healthcare staff as being faced by many SSA countries today.

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