INTERNATIONAL MIGRATION: BARRIERS AND OPPORTUNITIES FOR INDIAN HEALTH CARE PROFESSIONALS UNDER MODE IV OF GENERAL AGREEMENT ON TRADE & SERVICES (GATS)

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Abstract: Present paper highlights the issues surrounding trade in health services in India and other developing countries. As it is a well-established fact that in the modern era of globalization, the contribution of services to the global economy is increasing in comparison of the contribution of tangible goods. The paper gives an insight to the shortage of healthcare professionals in developed countries, which is the main cause of migration of health sector workforce from developing to developed countries. The economic impact of such migration on Indian economy has also been analysed in the paper. Today, heath sector is among the most rapidly growing service sectors in the world economy, which has been estimated at $4 trillion yearly in the OECD countries alone. As per the World Trade Report, 2008, the annual percentage change in the trade in commercial services was reported to be 18 percent while the annual percentage change in trade in merchandise goods was 15 percent. The sector has seen new and rapidly evolving forms of cross-border transactions, spurred by factors such as wide-ranging technology, demographic transition, increasing costs of medical care, skill up gradation, growing private sector participation, natural endowments etc. An effort has been made in the present paper to assess the various trade related barrier which are creating hurdle for free and transparent movement of healthcare professionals under Mode-IV of GATS. Besides, the paper shows that economic contribution of Indians working abroad in terms of remittances is more that of total FDI in the economy. The main object of the present paper is to assess barriers to trade in health services particularly in Mode–IV i.e. movement of natural persons abroad. The paper is based on secondary data collected from various sources like Reserve Bank of India (RBI), websites of various international agencies and Governments, data from Ministry of Health & Family Welfare, Government of India. Besides, data from World Health Report, 2006 was also used for preparation of present paper. It has been highlighted in the present paper that among the various categories of health care professionals, nurses are in acute shortage in developed countries mainly OECD member countries. This severe shortage has resulted in to recruiting nurses from countries like Philippines and India. However, there are a number of barriers for recruitment of healthcare professionals which mainly pertain to stringent requirements of qualification. Multiplicity of tests for practicing in destination country is another problem faced by these professionals. For example, in order to become a registered nurse in United States (US), a candidate has to go through minimum three tests- Commission on Graduates of Foreign Nursing Schools (CGFNS), National Licensure Exam (NCLEX) and mandatory language tests. Apart from this, the main problem is of recognition of home country's qualification in destination country. Lack of recognition of professional qualification remains a major obstacle for developing country professionals willing to

provide their services abroad. Therefore, Mutual Recognition Agreement (MRA) on qualification is the only solution for free movement of healthcare professionals because this agreement enables the qualification of professional service providers to be mutually recognized by signatory member countries. Therefore, it may be concluded that unnecessary quantitative as well qualitative restrictions on movement of healthcare professionals should be removed so that the availability and accessibility of global public goods and services towards universal access to health care may be promoted.

Keywords: FDI, GATS, Globalization, Mode-IV, RBI

INTRODUCTION

Globalization has created new opportunities for health care professionals in the present era. The health care professionals are migrating from developing nations to developed nations in search of enhanced career opportunities and economic well being. This process of migration further got more fuel when Organization of Economic Co-operation and Developed (OECD) countries started inviting such professionals from developing countries to fill the acute shortage of health manpower.

Globalization is the key feature of the world trade in the 21st century. Globalization of healthcare is also evident from the growing foreign equity participation in this sector and establishment of joint ventures, alliances and management tie-ups among health care establishments, resulting in the transfer of technology, skills and practices particularly in India.

The General Agreement on Trade in Services (GATS) signed as a part of World Trade Organization (WTO) agreement provides an opportunity to member countries to explore new market in health services by further liberalizing trade in services. Among other services such as financial, insurance, information technology etc., health too was brought under the ambit of GATS.

Services have recently become the most dynamic segment of international trade. Since 1980, world services trade has grown faster than merchandise flows. Defying certain wide-spread misconceptions, developing countries have strongly participated in this growth. Services account for a large share of production and employment in most of the countries. The share of services to the national GDP is higher in developed countries, where it averages 60-70 percent, while it is lower in developing and least developed countries. In India, the sector accounted for 49% of GDP in 2001-02. The world trade in services amounted to US$ 1.440 trillion in 2001, of which India's share was about 1.4% (Chanda, R. (2001).

Trade in Health Services (TiHS)

In modern world not only trade but services are also playing important role towards global economic development. Health being a service sector is attracting the foreign investment mainly in developing nations. The recent developments in this regard have been the initiation of health sector reforms in these countries and recognition of the influence of trade on efficient and equitable provisions of health services. The international trade in health services is increasing significantly and GATS has been instrumental in stimulating current thinking on the implications of globalization and opening up of trade in health services, posing new challenges and creating new opportunities for the health system as well as health professionals.

The trade in health services includes export via four modes of supply as outlined in GATS: (i) cross-border supply of health services (mode 1):- where the service is provided remotely from one country to another such as telemedicine via Internet or satellite, or international health insurance policies; (ii) consumption of health services abroad (mode 2):- where individuals use a service in another country, such as patients traveling to take advantage of foreign health care facilities, or medical students training abroad; (iii) foreign commercial presence (mode 3):- where a foreign company sets up operations within another country in order to deliver the service, such as hospitals, health clinics, insurance offices or water distribution operations; (iv) movement of natural persons (mode 4):-where individuals such as nurses, doctors or midwives travel to another country to supply a service there on temporary basis. It should be recalled, however, that modes of supply were developed for making GATS commitments and they are not concepts generally used by service providers. Many countries export services via several modes of supply simultaneously. However, the health sector is an exception to this where distinctions are relatively clear comparative to education sector.

It is important to bear in mind that the logic of liberalizing trade in goods and services may be intrinsically different from that of liberalizing trade in 'health' services. The reason being that market dynamics, specialization as presented by the concept of comparative advantage, and profit motives are the main concern of trade activities. When discussing health care services, the fact that markets fail in many instances, shifts the whole framework of analysis away from markets and towards what is called a 'public health' and 'public good' perspective. The public health perspective is mainly concerned with the achievement of non-market outcomes such as 'health for all', thus requiring a categorically different 'lens' when assessing the implications of

liberalizing trade in health services. Therefore, the public health perspective must be sustained at all times while preparing policies related to trade in health sector.

Thus it can be summarized that in the age of globalization Indian Public Health Sector has tremendous scope in trade in services in health sector but at the same time there is need to study the possible adverse effects of TiHS on public health sector in India. On the forefront of international business, Indian health industry can earn well in terms of it's comparative advantages particularly in health sector and there are prospective challenges and opportunities for Indian Economy in this rapidly growing sector.

METHODOLOGY

The main object of the present paper is to assess barriers to trade in health services particularly in mode 4 i.e. movement of natural persons abroad. The paper highlights the shortage of health professionals in developed countries which is the main cause of migration of health sector workforce from developing to developed countries. The economic impact of such migration on Indian economy has also been analysed in the paper. The paper is based on secondary data collected from various sources like RBI, website of various international agencies and governments, data from Ministry of Health & Family Welfare, government of India. Besides, data from World Health Report, 2006 was also used.

Migration of Health Care Professionals

The ageing population of OECD countries and resulting shortage of health professionals was seen as an opportunity for developing countries such as India, Thailand and Philippines. In a recent report of health systems, the OECD highlighted the increasing concerns about nursing shortages in many of it's 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 and Australia which projects a shortfall of 40,000 nurses by 2010. 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 demand of nurses.

With regards to Physicians, Indian trained International Medical Graduates (IMGs) top the list in US and UK. In absolute numbers, India was the largest source of country of Physicians in the 1970's (Mejia, A. 1978). Even today, Indian trained doctors continue to make up a substantial proportion of the stock of doctors in Canada, UK and USA (Khadria, 2004). In US, out of 2.3 million total Indian population, there are nearly 40,000 practicing doctors. In Canada, out of a total population of 700,000 people from India, there are 5,000 doctors. Similarly in UK, India ranks first among all the sources countries. Indian trained doctors account for 18.3 per cent of the total foreign physicians workforce in the UK in year 2001 (OECD, 2006).

Data from OECD countries shows that doctors and nurses trained abroad comprise a significant percentage of the total workforce in most of them, especially in English-speaking countries.

Global Shortage of Nurses: Major Pushing Factor for Cross-border Migration

The worldwide shortage of health manpower has been the main fueling force for recent upsurge in cross-border migration of health care professionals. The nurses account for almost 70 percent of the total cross-border migration of health care professionals. Although both the developed as well as developing countries are facing the shortage of health manpower but it the shortage in OECD countries which has caused migration of increased number of nurses from developing countries to developed countries. For instance the number of nurses in in the UK from non-EU countries grew from approximately 2,000 in 1994-95 to more than 15,000 in 2001-02. 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 source country, sent more than three times the number of nurses abroad in 2001 than in 1996, primarily to UK, Ireland and Saudi Arabia.

Shortage of Nurses in USA

Supply of nurses in many high-income countries is failing to keep pace with increasing domestic demand. The table below highlights the projected demand, supply and shortage of registered nurses in USA. As shown the projected percentage shortage is continuously increasing. If not addressed and if present trend continues, the shortage is projected to grow to 29 percent by 2020.

Shortage of Nurses in Australia

In Australia, over the last one decade, there has been increased attention paid to nursing workforce planning both at state level and tertiary and national levels in recent years. This is 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 likey to continue unless action is taken to change the supply trends.

Table 1: Health Professionals Trained Abroad Working in OECD Countries

OECD Country	Doctors Trained Abroad		Nurses Trained Abroad	
	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
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
UK	69,813	33	65,000	10
Portugal	1,258	4	NA	NA
US	213331	27	99,456	5

Source: The World Health Report, 2006

Table 2: Shortage of Nurses in USA (Projection)

Year	Supply	Demand	Excess or Shortage	%age 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 Registered Nurses: 2000-2020, US Department of Health and Human Services, July 2002.

Table 3: Projection of Nursing Shortages in Australia

	2006	2007	2008	2009	2010
Surplus/Shortage(number)	-3243	-3000	-2316	-1701	-470
Surplus/Shortage as % of total nursing 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

Table 4: Share of India in the Physicians Workforce of Four Major Recipient Countries

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 2nd)	2,143 (4.0)
India (Rank 3rd)	**1,449 (2.1)**	New Zealand	1,742 (3.2)

Source: The New Zealand Journal of Medicine, October 27, 2005
Note: IMGs - International Medical Graduates

Table 5: Overseas-trained Nurses Registered per anum in UK (1998-99 to 204-05)

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	1209	1046	1342	940	1326	981
Australia	1335	1209	1046	1342	940	1326	981
Nigeria	179	208	347	432	524	511	466

Source: www.nmc-uk.org

However, Pretson (2006) finds that as a whole, the annual shortfall of 3243 (1.6 percent of workforce) is projected to reduce to 470 by 2010 as shown in table below:

Shortage of Nurses in UK

The UK government also forecasted the nursing shortage by 2011. According to the Health Service Journal, the department of health predicated a shortage of 14,000 nurses within a span of four years along with a shortage of 1200 General Practitioners and 1100 junior doctors.

Shortage of Nurses in Canada

The situation of shortfall of nursing workforce in Canada is not 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. As per the latest figure released by CIHI, the country's nursing workforce is growing older and new entries are very less in numbers into the profession. Nurses aged above 50 now account for 25 percent of those employed, while those aged under 29 represent only 10 percent of the total.

Migration of Indian Health Care Professionals

Healthcare is one important area where Indian diaspora has gained a name and fame for itself in the globe. The Indian health care professionals have prove their competence not only in the developing countries but also in highly developed countries like UK and USA. Indian doctors are the backbone of UK 's National Health Services. There are estimated 60,000 doctors of Indian origin in UK and some 35,000 in US. Besides, India has bilateral agreements with six Middle East countries and some others for providing private and government doctors on short term assignments (R. Chanda 2001).

Indian medical occupation occupies the highest position in the world renowned clinics like the Mayo Clinic and a number of other prestigious institutions in the US. The India's share in supply of trained physicians in select OECD countries is in double digits for instance in Canada it is 10.1 percent, in UK it is 18.3 percent in US it 19.5 percent in 2001.

Regarding nursing workforce, the number of registered nurses migrating to UK from India is increasing every year. The details are shown in table below:

Contribution to Indian Economy from Cross-border Migration

International trade in health services under GATS is opening many possibilities for increasing the economic contribution of the health sector to the national economy. Governments from both developed and developing countries are exploring different alternatives including the implementation of export strategies for health care delivery services and the liberalization of business and economic ownership for maximizing the national resource endowment and comparative advantages. This endeavor requires facing the challenge of reconciling trade objectives like foreign currency generation with those of availing their populations universal access to quality health care at an affordable cost with equitability.

With regards to impact of migration of health manpower on home country, the situation varies from country to country even within developing nations like China, India and Philippines. These countries have become able to produce more health professionals to take benfit of trade liberalization in health sector. The Philippines, India and Cuba have intentionally invested in the training of health workers for export. In India, as per the standard of WHO which recommended 20 doctors and 100 nurses per 100,000 population, the position of doctors is as per standard but trailing in case of nurses availability. In 2004 there were 62 nurses and 51 doctors per 100,000 population available in India.

The best way to judge the economic contribution of migrated professionals to any economy is the inflow of remittances. Although there is no sectoral break-up of data available on remittances received by India however the increase in overall inflow of remittances to India indicates that international migration has a beneficial impact on Indian economy. Over the years remittances from overseas Indians have emerged as a stabe source of foreign exchange inflows for the country. The RBI has reported that Indians living abroad transferred $24.6 bn to India in the fiscal year 2005-06. 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 percent. These are called ' private transfers' from overseas Indians. According to RBI data, the 'private transfers' rose from US$2.1bn in 1990-91 to US$24bn in 2004-05. On the other hand FDI in 2005-06 was only US$7.69bn.

The contribution by migrants is not only through foreign currency transfers/ remittances but also through other means. Assessing the growing demand of health professionals in developed countries, the country has already started moving in the direction of offering qualitative education in health profession thus contributing actively to national income.

Table 6: Private Transfers from Overseas Indians and Inward FDI (US $bn)

Year	Private Transfers	FDI
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 RBI Handbook, 2006
Note:* Partially Revised

** Preliminary Estimates

Medical education infrastructure in the country has shown rapid growth during the last 15 years. In the year 1991-92 there were only 146 medical colleges, 77 dental colleges in the country but number has increased to 266 medical colleges and 268 dental colleges in 2007-08. Similarly infrastructure in nursing and para-medical field has also been strengthened. As per Indian Nursing Council and Pharmacy Council of India, 2006, there are 1597 institutions in the country providing General Nursing Midwives courses, 312 institutions are providing AMN courses, 461 are providing dental Hygienist courses, 97 are providing laboratory technician courses and 102 are providing Health Worker (male) under M.P.W. courses (Government of India 2007). Thus it is evident that the country is investing a lot in building the resources in health sector especially medical education. Nevertheless, this 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.

However, the mass scale migration of health professionals from India also has some negative impact. This mass exodus has created vacant faculty positions in the medical and nursing colleges. Therefore, any attempt to assess whether the objectives of health and trade are compatible, must be considered in the light of three main policy objectives of public health: equitable access to health care, qualitative health care and efficient use of resources. (a) Equitable access can be defined as "equal utilization of health services for the same need" combined with vertical equity, which means that the users contribute according to their economic capacity. (b) Quality refers to the standard of health care provided by the system. (c) Efficiency is related to the optimum allocation of resources.

An optimum combination of the above factors and due respect for the primary objectives of health would generate positive externalities with multiplier and spillover effects that would support the social and economic sustainability of trade in health services from a development perspective.

Table 7: Opportunities and Challenges of GATS in Public Health under Four Modes of Services

Movement of health care providers (mode 4)	
Opportunities	**Challenges**
Can help promote the exchange of clinical knowledge among professionals and raise the standards of health care in the home country, provided these service providers return to the home country The home country may gain as a result of remittances and transfers by providers working abroad From the point of view of health professionals, mode 4 is welfare enhancing as it provides them with the opportunity to earn more wages and widen their knowledge and skills Mode 4 provides and important means to meet shortages of health care providers	If the outflows of health service providers are of a permanent nature, or in other words there is a brain-drain of health professionals, this will have adverse implications for equity, quality and availability of health services for the source country

Any export strategy for the health services must be founded on the principle of recognizing that the primary obligation of governments is to provide universal coverage of health care to their local communities. The development of an export strategy is secondary to this obligation. According to this premise, development of any sustainable export strategy should be conceived as a mean of strengthening the National Health System through the following opportunities: (a) Generating fresh financial resources from external demand to overcome or reduce the fiscal deficit created by the need to grant universal health coverage; (b) Improving equity, efficiency, and quality standards in the delivery of health care; and (c) Upgrading the health infrastructure of hospitals and other complementary structures, as well as technologies and skills.

Barriers to Indian Healthcare Professionals for Movement under Mode IV of GATS

A number of barriers are specific to health sector and some of them can be termed as ” soft” or “ invisible” barriers. These barriers may vary from destination country to country. The table 8 highlights some barriers relating to mode-wise trade in health services.

It appears that mode 4 (movement of natural persons) attracts the most number of barriers compared to trade in other modes of services. As for any service, so also for health services, ensuring quality of services is a prime concern both for service provider and service receiver that is why these barriers are there to maintain a particular level of quality. However, it should be properly assessed that these barriers may not create hurdle for movement of natural persons who really deserve to be migrated.

Table 8: Barriers to Indian Healthcare Professionals for Movement under Mode IV of GATS

Mode of Supply	Barriers	Type of Barrier
Mode 1: Cross-border supply	▪ Restriction on electronic transmission of consultancy services	
Mode 2: Consumption abroad	▪ Restriction on travel abroad for availing service	Invisible
Mode 3: Commercial Presence	▪ Insistence of local partner ▪ Insistence that provider be accredited in home country ▪ Limitations on FDI by health providers ▪ Difficulty in approval of joint venture ▪ Restriction on capital transfers. ▪ Restriction by way of minimum investment requirements.	Invisible
Mode 4: Movement of Natural Persons	▪ Visa entry restrictions (work permits/ residency/ citizenship) ▪ Non-recognition of professional qualification by importing countries. ▪ Registration for a license to practice even if the person has appropriate qualification ▪ Restriction on duration of stay ▪ Economic Needs Test, labor market tests, management needs tests etc. ▪ Tax discrimination. ▪ Quantitative restrictions by way of numbers, fixed proportion of total employment, fixed proportion of total wages etc.	Invisible

CONCLUSION AND POLICY RECOMMENDATIONS

Countries across the globe have witnessed a spectacular growth in international trade in services and health is one of those services covered under GATS. Indian has identified healthcare services as one the key sector where Indian professionals have comparative advantage in international market vis-à-vis other developing countries. As highlighted in the present paper, among the various categories of health care professionals, nurses are in acute shortage in developed countries mainly OECD member countries. This severe shortage has resulted in to recruiting nurses from countries like Philippines and India.

In other sectors such as telecommunication, finance, insurance etc. foreign direct investment (commercial presence) is the dominated mode of international trade but in healthcare services trade is dominated mainly by movement of independent professionals, both temporary and permanent. In view of this medical tourism industry is also mushrooming in India. However, in case of healthcare professionals the main barrier is the stringent requirements of qualification. Multiplicity of tests for practicing in

destination country is the main problem faced by these professionals. For example, in order to become a registered nurse in US, a candidate has to go through minimum three tests- Commission on Graduates of Foreign Nursing Schools (CGFNS), National Licensure Exam (NCLEX) and mandatory language tests. Apart from this the main problem is of recognition of home country's qualification in destination country. Lack of recognition of professional qualification remains a major obstacle for developing country professionals willing to provide their services abroad (UNCTAD, 2005). Therefore, Mutual Recognition Agreement (MRA) on qualification is the only solution for free movement of healthcare professionals because this agreement enables the qualification of professional service providers to be mutually recognized by signatory member countries.

In view of above the following is recommended: (a) International regulations and institutions should promote global public goods and services towards universal access to health care; (b) Growth and development in this sector needs to be equitable and sustainable which requires policy coherence among trade, development and non-economic (social / cultural) policies; (c) Access and affordability of health care services, especially for developing countries, should be integrated fully in negotiations on trade in services under WTO; (d) A comprehensive multistake-holder approach, including cooperation and monitoring mechanisms, along with the participations of all the relevant agencies involved in health policy formulation and health services, is key to the adoption of a sustainable and informed approach to health services negotiations. (e) GATS does not oblige any country to liberalize its health services. Liberalization needs to be based on a through impact assessment of potential costs and benefits (Cost Benefit Analysis) for the health systems and policies. (f) Special attention is needed to increase the transfer of financial and technical resources and capacity-building measures (training and development) to ensure the development of developing countries, particularly the LDCs and particularly in respect to building competitive services sectors, including the health sector and building the capacity of health workers; (g) Ensuring commercially meaningful commitments in Mode 4, e.g. streamlined visa, licensing and work permit requirements; separating temporary stay from permanent migration in visa regimes by creating a Services Provider Visa; improving transparency and facilitating recognition of qualifications, is required; (h) Strong mechanisms should be put forward to alleviate/discourage brain drain from developing countries to developed countries.

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