The Impact of Physician Emigration on Host Country and Health Care System

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Indian educational system had revolutionary change after Lord Macauley introduced structured education. Prior to that the system was essentially a Teacher-Taught (Guru-Kul) traditional system. As the medium of instructions was English, various branches of Science and Arts flourished. East India Company had its Headquarters in Calcutta and hence the four Medical Institutions were established in major cities such as Chennai (Madras) 1834-35, Calcutta 1838 and Mumbai (Bombay) 1845 way back in first half of 19th Century. The same trend continued and most of the Medical Education was in urban area, curative, hospital based with extended dispensary service. 72.22% of Indians still stay in rural areas according to 2001 census. It is since then that the Allopathic Medical Graduates are concentrated in urban area. Rural masses were serviced by the Ancient Indian System of Medicine "Ayurved", which was neglected during the British Rule. The first serious attempt to study the health care system was done by Sir Joseph Bore Committee in 1943 wherein the concept of Primary, Secondary and Tertiary Health Care and establishment of Primary Health Care Centres was suggested. This however was rejected after Independence. There were thirty Medical Colleges in cities prior to Independence.

The policy after independence was to produce "Basic doctors" i.e. Primary Health Care Physicians to cater to the rural community. The comprehensive care

envisaged Promotive, Preventive, Curative and Rehabilitative care. However, it was "Curative" medicine, which received a thrust and the two important aspects of Health Promotive and Preventive were relegated. The medical educational syllabus was on British model and continued the same way till date. The Medical Education being urbanized the graduates were trained in such a way that it was "BASIC SPRINGBOARD TO WEST'. As many as seven committees were appointed for upgradation of Medical Education and Health Policy after independence. The curriculum was upgraded with every new speciality and newer advances being incorporated. The number of modern medicine colleges (Allopathic) shot up from 30 to 221 as on today. The expected outcome was 70% Primary Health Care Physicians, 20% Specialists and 10% Super Specialists. However, the situation today is only 10% of Modern Medicine Graduates are Primary Health Care Physicians and the rest pursue the studies to become Specialists and Super Specialists. Modern Medicine has become "Top Heavy Bottom Light" Urban Based. It is Techno Intensive and Investigation Dependent. Since 1986, Health Universities were established in various States to encompass all the institutes of Health Sciences comprising of Modern Medicine, Dental, Ayurved, Homeopathy, Unani and Paramedical Sciences such as OT/PT, Nursing, Speech Therapy etc. This resulted in mushrooming of institutions particularly in four States in India Maharashtra, Karnataka, Andhra Pradesh and Tamilnadu, which account for 50% of the colleges. In early 1980s Privatisation of higher education was promoted by the Government. Though the first institute was started five decades ago the uncontrolled growth in last 20 years has not fulfilled the aims

of servicing the entire population as socio-economics and logistic needs were ignored. There is a great Urban/Rural divide. Urban serviced by Modern Medicine and Rural by other pathies such as Ayurved, Homeopathy and handful of unqualified doctors. A survey conducted in five Rural blocks (Tehsils) of a district in Maharashtra revealed that at the Primary Health Care level there were 29% Homeopaths, 22% Ayurved, 10% BEMS and only 11% MBBS in Government Service & 6% in private practice. It is thus evident that Urban Education results in Rural deprivation as the infrastructural facilities required by Modern Medicine are not available.

As an example the State of Maharashtra depicts the trends in India. Maharashtra has a population of 96.75 million peoples (2001 census) with 42.40 : 57.60 Urban-Rural ratio. The population of Maharashtra is more than Germany, France, UK and Australia. The Modern Medicine institutions in Maharashtra have increased from 4 to 37 after independence. There are in all 160 Health Sciences Institutions, 37 Modern Medicine, 23 Dental, 52 Ayurvedic, 43 Homeopathic and 6 Unani producing 9760 doctors per year. Already the doctor-patient population ratio in the State of Maharashtra has come down to :- (a) WHO Standard - 1 : 3500 (b) Modern Medicine - 1 : 1200 (c)All Pathies - 1 : 712. 80% of MBBS graduates opt for post graduation. About 10% joins Government service and remaining are looking for greener pastures in developed countries. It is evident that the Primary Health Care is in the hands of other pathies who incidentally prescribed Modern Medicine without

adequate knowledge. The philosophy of increasing the Modern Medicine Colleges and flooding the society with doctors doesn't appear to change the Urban-Rural divide as provision of infrastructural facilities in rural area is likely to be a distant dream. 70% Rural population in India has poor affordability and cost intensive Modern Medicine is beyond their reach. Moreover, importance of Clinical Medicine is being ignored in Medical Education.

MIGRATION

A Professional desires to migrate due to following reasons:- (a) For Academic pursuit. (b) To Acquire Advanced Knowledge. (c) For Economic Prosperity. (d) To Enhance Social Standing. (e) For Easy Job Opportunity (f) Craze for Foreign Land. (g) Due to Socio Political Reasons. If one traces the history of physician migration from India there are three distinct eras. The first era is between 1900-1960 when essentially Medical Graduates went to UK to acquire FRCS or MRCP and professional experience. However, most of them returned back with British degrees, which enhanced their professional standing in India. Up to 1920 Indian Physicians with British degrees were denied faculty positions in Government run Medical Institutions. This was the reason for the birth of my Alma-mater Seth G. S. Medical College in Mumbai in 1925. The question of brain drain or economic gain really surfaced between the second era between 1960 and 1985. There was exodus to UK, USA, Canada and few to Australia. The primary aim was to acquire higher education, but the reality is many of them changed their specialities and pursued whatever they were offered.

It is a matter of investigation to find out how many migrant physicians with post graduates qualification in Medicine, Surgery, Gynaec & Obstetrics, Paediatric, Orthopaedics changed their speciality after migration. These Physicians have spent three years after MBBS to acquire post graduates degree and professional experience. Wasn't it waste of national funding for educating and training them! Such an investigation would prove that it was not knowledge but money, which mattered. These physicians no doubt played an important role in Health Care System of their chosen land. After 1985 the flow seems to have diminished obviously because the demand is dwindling. Certain reforms in UK and USA have resulted into this decline in migration. FMG's from other countries and from US/UK educated elsewhere are seeking jobs and competition has increased. Now the Physicians are primarily migrating to acquire advanced technologies rather than finding a job. Many physicians are opting for Fellowships of a shorter duration. It is time we conceive a plan for of bilateral short term training programmes which will benefit both the host and the recipient countries. In the last three decades the Urban Medical Centres are developing rapidly and most of the advances are available in India. Hence, a well trained Medical Professional aspires to return home.

MANPOWER EXPORT

If one considers Medical personal having manpower export potential then in order of better opportunity, it should be: - a) Nursing – highest demand b) OT/PT – Excellent opportunities & c) Physician – depend on need of recipient

country. Today's scenario is as far as Physicians are concerned, "demand" is diminishing and "the supply potential" in developing countries giving Western system of Medical Education is increasing. This demand and supply equation in market philosophy is not applicable to Human Professional Products. What are the likely consequences? Reverse flow from chosen land and surplus in host country will lead to congestion of medical graduates in Urban areas. Too many professionals in a society shall promote unhealthy competition, solicitation and malpractices. The migration of Modern Medicine Graduates to and fro is unlikely to alter the present state of Rural Health Care System in India. Rural masses will continue to be serviced by physicians from other pathies and the concentration of Modern Medical Graduates shall achieve enormous proportions primarily in Urban and Semi Urban areas. It is worthwhile pondering over an important question and that is planning of better Health Care Systems for deprived economically backward rural masses. It is high time that these Health Care Professionals from other pathies be empowered with sufficient knowledge of Modern Medicine to practice in a multidisciplinary manner. The concepts of bare foot doctors or village physicians need to be properly structured. Small proportion of Modern Medicine Physician Migration shall not affect or alter the present Health Care scenarios in INDIA.