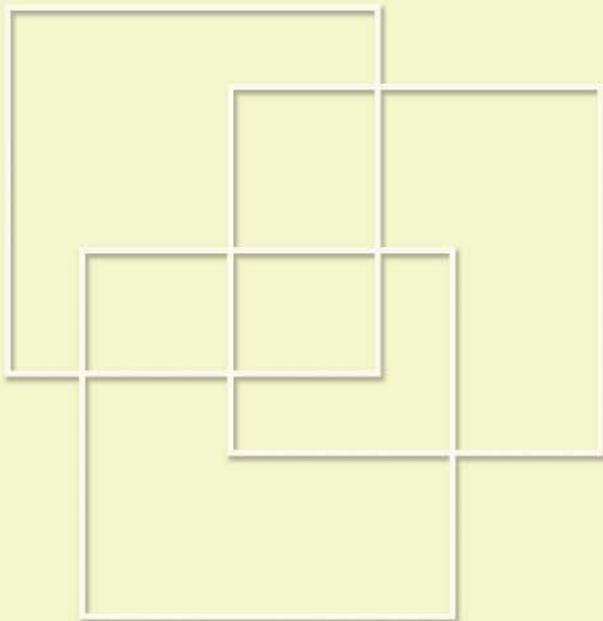


ILO Asia Pacific Working Paper Series

Employer's viewpoint on migration, retention and return of health-care workers: An Indian perspective

Federation of Indian Chambers of Commerce and
Industry - Deloitte Touche Tohmatsu India Pvt Ltd

August 2014



Promoting Decent Work Across Borders:
A Project for Migrant Health Professionals and Skilled Workers

Decent Work Team for South Asia and Country Office of India

ILO Asia-Pacific Working Paper Series

Employer's viewpoint on migration, retention
and return of health-care workers:
An Indian perspective

Federation of Indian Chambers of Commerce and
Industry - Deloitte Touche Tohmatsu India Pvt Ltd

A report prepared for the EU-ILO Project on
Decent Work Across Borders:
A Pilot Project for Migrant Health Professionals and Skilled Workers
New Delhi, India

Decent Work Team for South Asia and Country Office of India

Copyright © International Labour Organization 2014

Publications of the International Labour Office enjoy copyright under Protocol 2 of the Universal Copyright Convention. Nevertheless, short excerpts from them may be reproduced without authorization, on condition that the source is indicated. For rights of reproduction or translation, application should be made to ILO Publications (Rights and Permissions), International Labour Office, CH-1211 Geneva 22, Switzerland, or by email: pubdroit@ilo.org. The International Labour Office welcomes such applications.

Libraries, institutions and other users registered with reproduction rights organizations may make copies in accordance with the licences issued to them for this purpose. Visit www.ifro.org to find the reproduction rights organization in your country.

ILO Cataloguing in Publication Data

Employer's viewpoint on migration, retention and return of health-care workers: an Indian perspective: promoting decent work across borders: a pilot projects for migrant health professionals and skilled workers / International Labour Office, ILO DWT for South Asia and CO for India. - New Delhi: ILO, 2014

ILO Asia Pacific Working Paper Series; ISSN 2227-4391; 2227-4405

ILO DWT for South Asia and ILO Country Office for India
medical personnel / migrant worker / brain drain / skilled worker / labour migration / international migration / India

13.11.2

The designations employed in ILO publications, which are in conformity with United Nations practice, and the presentation of material therein do not imply the expression of any opinion whatsoever on the part of the International Labour Office concerning the legal status of any country, area or territory or of its authorities, or concerning the delimitation of its frontiers.

The responsibility for opinions expressed in signed articles, studies and other contributions rests solely with their authors, and publication does not constitute an endorsement by the International Labour Office of the opinions expressed in them.

Reference to names of firms and commercial products and processes does not imply their endorsement by the International Labour Office, and any failure to mention a particular firm, commercial product or process is not a sign of disapproval.

ILO publications and electronic products can be obtained through major booksellers or ILO local offices in many countries, or direct from ILO Publications, International Labour Office, CH-1211 Geneva 22, Switzerland. Catalogues or lists of new publications are available free of charge from the above address, or by email: pubvente@ilo.org

Visit our website: www.ilo.org/publns

Printed in India

Foreword

International migration of healthcare professionals is not a new phenomenon. However, migration flows of workers in this sector has increased significantly in recent years and India is among the leading countries of origin for doctors who migrate to work overseas.

The European Union has sought to address this issue by promoting the concept of circular migration. This basically means that within the context of the healthcare systems –countries of destination benefit from the opportunity to fill labour needs and skills gaps, and countries of origin benefit from skilled workers who return with further training and work experience, thus enriching the health care systems of both source and destination countries. The ILO recognizes that circular migration of skilled workers is one of the options to mitigate the impact of brain drain. However, one essential aspect underlying the potential success of any circular migration policy is the fact that it should be voluntary. As such, it calls for the understanding and development of incentives measures to entice migrants to come back to their home country before – if so desired – they emigrate again. India is among the few developing countries that are able to attract Indian doctors back to India, making circular migration for doctors a reality.

This report prepared in partnership with the Federation of Indian Chambers of Commerce and Industry (FICCI) through its knowledge partner Deloitte (Deloitte Touche Tohmatsu India Pvt Ltd.), presents a robust model for the acquisition and retention of doctors which is based on a comprehensive review of the existing drivers and strategies used by both private and public employers in India. It also provides recommendations for strengthening these strategies at different levels. This makes the document rich and useful for the healthcare industry, while deepening the understanding of the drivers of circular migration.

It is my hope that this publication will stimulate more debate among policy makers and feed into knowledge on issues of circular migration between origin and destination countries, and in particular for the management of human resources in health.

Tine Staermose
Director
ILO DWT for South Asia and CO for India

Table of contents

Foreword	iii
Table of content	v
Acknowledgements	vii
Executive summary	viii
Abbreviations	x
1. The Origins of the Study	1
1.1 Background and Context	1
1.2 Purpose and Scope	1
2. Approach	2
2.1 Data Collection	2
2.2 Data Analysis	4
2.3 Reporting - The Descriptive Model/Framework	4
2.4 Assumptions of the Methodology	5
2.5 Limitations of the Methodology	5
3. Introduction: the India Health-Care Story and Brain Drain	6
3.1 The India Health-Care Story	6
3.2 Brain Drain of Doctors from India	7
4. Acquisition Strategies	10
4.1 Incentives at the Workplace Level in the Private Sector	10
4.2 Incentives at the Workplace Level in the Public Sector	17
4.3 Acquisition Programmes at the State Level	20
4.4 Bi or Multi-Lateral Level Acquisition Policies	22
4.5 Improvement Opportunities	25
5. Retention Strategies	25
5.1 Workplace Level Retention Incentives in the Private Sector	25
5.2 Workplace Level Retention Incentives in the Public Sector	27
5.3 State Level Retention Programmes	29
5.4 Bi or Multi-Lateral Level Retention Policies	32
5.5 Improvement Opportunities	34
6. Solutions: Framework/Descriptive Model	34
6.1 Discussion Points: Arriving at the Framework/Descriptive Model	34
6.2 Framework/Descriptive Model	36
6.3 Decoding the Framework/Descriptive Model	38
6.4 Concluding Thoughts and Scope for Further Research	40

References	41
Annexure I: Technique Used to Shortlist Hospitals and Stakeholders	44
Annexure II: Primary Data Collection Instrument	46
Annexure III: Stakeholder List for Primary Research and Validation Event	48

Acknowledgements

India is emerging as one of the major countries of origin, transit and destination of migration of human capital and there is an imperative need to assess the impact of mobility on business community. It is equally important to address the issues of mobility so that the beneficial aspects of migration could be optimally utilized and geared towards economic development. The Task Force on Migration and Diaspora at FICCI is working in this direction with an objective to address economic and social dimensions of migration along with enhancing private sector engagement on migration issues, including migration policies, legal/regulatory frameworks, governance, recruitment and integrity in labour supply chains.

The growing demand for highly skilled professional health workers combined with recent trends in mobility of health professionals is a trend that requires empirical study & analysis. The impact is felt on health care systems of receiving and transit countries as well as countries from where mobility originates. Migration of skilled workers has been on the rise and this process inextricably links developing countries such as India to the advanced economies of the world.

The report “Employer’s viewpoint on migration, retention and return of health-care workers - an Indian perspective” is an analysis based on primary and secondary survey conducted by FICCI with Deloitte as the knowledge partner. The report highlights incentives at the workplace level, programmes at the State level, policies at the Bi and Multilateral levels to facilitate circular migration of Indian doctors between India and European countries. The report also includes descriptive model/framework which is made after the findings of primary research, secondary data and validation discussions.

We hope that all stakeholders will find the report useful and an interesting read. We also take this opportunity to thank “ILO” for leading this initiative and for their support.

Vinita Sethi
Assistant Secretary General
FICCI

Executive Summary

This report analyses incentives at the workplace level (across private sector and public sector organizations), programmes at the state level (across the state governments of India) and policies at the bi or multi-lateral levels (involving national level and bilateral or multi-lateral level national and international decisions) to facilitate the acquisition and retention (circular migration) of Indian doctors between India and European countries; thereby addressing the International Labour Organization's (ILO) Decent Work Across Borders (DWAB) Project on commissioning out policy research on the recruitment and employment of migrant health professionals from origin to European countries. The findings of the secondary data, primary research and validation discussions and recommendations to be directed to various stakeholders (the relevant ministries, employers and related bodies) in the form of a descriptive model/framework are captured in this report.

Strategies observed at workplace level in the private sector for the acquisition of doctors include providing a mix of staffing and incentive models to incoming doctors, having a specialist recruitment division to search for specialist doctors, creating specialization forums, reaching out to alumni groups and doctor fraternities and promoting the hospitals among candidates abroad by advertising in foreign journals, and conducting seminars abroad. Most of the well-established public hospitals attract talent with the promise of job security and accommodation facilities. The National Rural Health Mission (NRHM) and the Public-Private Partnership (PPP) are successful acquisition measures at the state level. Setting up of well-established public sector organizations like the All India Institute of Medical Sciences (AIIMS) in every state is also being planned. At the bi or multi-lateral level, the No Objection Certificate-related guidelines announced by the Health and Family Welfare Minister Ghulam Nabi Azad in 2012 and the World Health Organization (WHO) Global Code of Practice are observed policy measures.

Strategies observed at the workplace level in the private sector for retention of doctors include providing multiple incentives with minimum guarantee, creation of specialization-training divisions, centres of excellence and specialization forums, concentration on rewards, support in the form of marketing teams, counselling, and facilitating internal research opportunities. At the workplace level in public hospitals, enabling post-graduation followed by re-absorption, providing research grants, medical benefits and accommodation support are retention strategies. At state level, monthly financial incentives, rotational posting in difficult areas, workforce management policies and better residential infrastructure are retainers. At the bi or multi-lateral level, the World Medical Association's statement at its General Assembly meeting held in Finland in 2003 with respect to the Memorandum of Understanding (MOU) between the sending and receiving countries is a step towards a retention policy. Strategies include multiple channels of recruitment, establishing branding and connect mechanisms, concentrating on specialization and super specialization, having the right staffing and compensation mix, and the use of manpower agencies and specialist staffing agencies.

The proposed model provides solutions that include quick wins such as establishing the doctor database and manpower planning mechanism, and enhancing rewards and benefits for doctors at the national level. Redeployment of doctors based on the database to match supply and demand, and establishing district housing societies are quick wins at the state level. At the workplace level, employer branding followed by total rewards -- including learning and development opportunities -- are also beneficial. Evolving strategies include the redesign of policies concerning recognition of certifications, training, deployment and Human Resources in Health (HRH) in India. Bi or multi-lateral policy formulation including MOUs with host countries to facilitate circular migration and state-level partnership programmes are also evolving strategies. Enforcing Joint Commission International (JCI) standards

on state-level hospitals and workplace level incentives such as talent acquisition models for health-care and facility up-gradation in hospitals are also evolving strategies. Long-term strategies suggested in the model include parliamentary committees on a) gross domestic product (GDP) spend on health; b) educational and insurance reforms in health; and c) expanding pan India footprint of institutions such as the AIIMS. State level and workplace level long-term strategies include post-graduate schemes and adoption of/partnership with campuses, followed by a redesign of doctor key performance indicators, focusing on clinical outcomes.

This publication has been produced with the assistance of the European Union. The contents of this publication are the sole responsibility of the Federation of Indian Chambers of Commerce and Industry, consultant to the International Labour Organization and can in no way be taken to reflect the views of the European Union.

Abbreviations

AIIMS	All India Institute of Medical Sciences
ALOS	Average Length of Stay
ARPOB	Average Revenue per Occupied Bed
AYUSH	Ayurveda, Unani, Siddha and Homeopathy
BAMS	Bachelor of Ayurvedic Medicine and Surgery
BAPIO	British Association of Physicians of Indian Origin
BHMS	Bachelor of Homeopathic Medicine and Surgery
BUMS	Bachelor of Unani Medicine and Surgery
DHKI	District Health Knowledge Institute
DWAB	Decent Work Across Borders
ENCs	Exceptional Need Certificates
FICCI	Federation of Indian Chambers of Commerce and Industry
GDP	Gross Domestic Product
GSCs	Good Standing Certificates
HRH	Human Resources in Health
HSMP	Highly Skilled Migrant Programme
ILO	International Labour Organization
JCI	Joint Commission International
MBBS	Bachelor of Medicine, Bachelor of Surgery
MCI	Medical Council of India
MDGs	Millennium Development Goals
MOHFW	The Ministry of Health and Family Welfare, Government of India
MOIA	The Ministry of Overseas Indian Affairs
MOU	Memorandum of Understanding
NABH	National Accreditation Board for Hospitals and Healthcare
NCHRH	National Commission for Human Resources for Health
NGO	Non-Governmental Organization
NORI	No Obligation to Return to India
NRHM	National Rural Health Mission
PPPs	Public-Private Partnerships
SON	Statement of Need
TOR	Terms of Reference
WHO	World Health Organization

1. The Origins of the Study

1.1 Background and Context

The only United Nations (UN) agency with a constitutional mandate to protect migrant workers, the ILO has been dealing with labour migration issues since its inception in 1919 and has pioneered international conventions to guide migration policy and protection of migrant workers. The ILO strives to build an approach towards migration that is beneficial to migrant workers and their families, employers, and to the source countries from which they come and to those that they migrate to.

In 2011, the European Union (EU) granted the ILO funding to implement the DWAB Project, a pilot project for migrant health professionals and skilled workers that seeks to better understand schemes in line with circular migration of health professionals by engaging governments, trade unions, and employer organizations around three main objectives:

1. to strengthen mechanisms of policy dialogue among stakeholders;
2. to strengthen employment services for health-care professionals and skilled workers; and
3. to enhance labour market information system with regards to the migration of health-care professionals and skilled workers.

Through DWAB, the ILO seeks to facilitate an approach to migration that benefits the migrant workers, the source countries and the destination countries within a rights-based framework for labour migration management. The Philippines, India and Vietnam are the three countries in Asia with significant projected outflows of health professionals and skilled workers for foreign employment, and therefore DWAB focuses on these three countries. In addition, the migration of health-care workers from developing to developed nations has drawn significant attention and has become a pressing issue, primarily because of the economic and social effects it throws up.

The phenomenon that is being largely observed is that health-care workers from developing countries who migrate to developed countries are able to contribute to the health-care sector of the developed countries. However, the developing countries suffer in this steady movement of skilled professionals. This has led to interest on the part of both sending and receiving countries to develop voluntary policies that will help to facilitate the return of health-care workers to their own countries in order to support and strengthen the health workforce of their nation. A need has been felt to better manage international migration of health-care professionals to mitigate any negative impact on the achievement of health-related Millennium Development Goals (MDGs) in these countries.

1.2 Purpose and Scope

This study was sponsored by the ILO's DWAB Project, which was in turn sponsored by the EU and was implemented by the Federation of Indian Chambers of Commerce and Industry (FICCI), with Deloitte as the knowledge partner. FICCI, headquartered in New Delhi, India, is a non-government, not-for-profit association of business organizations in India. FICCI has a nationwide membership of over 1,500 corporates and over 500 chambers of commerce and business associations. Deloitte is the largest

professional services network in the world by revenue and by the number of professionals. Deloitte provides audit, tax, consulting, enterprise risk and financial advisory services with more than 200,000 professionals in over 150 countries.

The purpose of the study is to document and analyse the below mentioned three aspects to facilitate the acquisition and retention (circular migration) of Indian doctors between India and European countries, and thereby addressing DWAB on commissioning out policy research on the recruitment and employment of migrant health professionals from origin to European countries:

- 1) incentives at the workplace level (across private sector and public sector organizations);
- 2) programmes at the state level (across the state governments of India); and
- 3) policies at the bi or multi-lateral levels (involving national level and bilateral or multi-lateral level national and international decisions).

While the gamut of health professionals comprises of doctors, nurses, health workers and others, the scope of this study concerns acquisition and retention strategies only for Indian doctors with a minimum qualification of MBBS -- Bachelor of Medicine, Bachelor of Surgery, and does not include doctors with qualifications such as BHMS -- Bachelor of Homeopathic Medicine and Surgery, BAMS -- Bachelor of Ayurveda, Medicine and Surgery, and BUMS -- Bachelor of Unani Medicine and Surgery.

2. Approach

This section details the approach to this study outlining the methodology for collecting and analysing information on employer's viewpoint on migration, retention and return of doctors between Indian and European countries.

2.1 Data Collection

2.1.1 Secondary Research

Secondary research was conducted to review information available in the public domain from newspaper articles, websites, academic and professional research papers, and policy statements/announcements published by specialized national and international agencies (including both government and private) that are concerned with public health and migration. Information was collected from public domains with a view to focus on existing and proposed policies framework and public announcements across the three levels (workplace, state and bi or multi-lateral) concerning the enablement of circular migration of health-care professionals between India and select European countries.

The secondary data gathered was used to support the analysis of existing schemes and enhance knowledge of factors and key considerations that impact acquisition and retention in India of Indian doctors between India and European countries. The secondary research also helped in drafting discussion guides while meeting key stakeholders (hospital personnel, returnee doctors from European countries and ministry

officials). While the study focuses on European destinations as receiving countries, the secondary data also helped formulate strategies to tackle migration to developed countries outside Europe.

2.1.2 Primary Research

Relevant stakeholders for primary data collection were:

1. administrative heads, clinical heads and human resources heads of hospitals (i.e. the private and public employers of health professionals in India shortlisted for the purpose of the study);
2. doctors (consultants or employees) in the hospitals shortlisted for the purpose of the study who have returned to India from European destination countries; and
3. officials of the Ministry of Health and Family Welfare (MOHFW) and the Ministry of Overseas Indian Affairs (MOIA).

The primary research covered 23 stakeholders across all categories. The hospitals, from which the stakeholders were interviewed, were shortlisted using a technique elaborated in Annexure I, which also enlists the rationale applied in choosing the stakeholders for interview.

The discussion guides, which were validated prior to primary data collection using a pilot study conducted with industry experts and stakeholder representatives, have been explained in Annexure II. A mapping of the questionnaires to the themes explored in this report has also been detailed in Annexure II.

The secondary and primary research conducted to document and analyse incentives, programmes and policies required at the workplace level, state level and bi or multi-lateral level were followed by a validation event conducted at the FICCI office at Federation House, New Delhi. The aim of the validation event was to:

1. validate findings of the secondary and primary research; and
2. explore alternative incentives, policies and programmes (not covered by the research thus far) required to facilitate acquisition and retention of Indian doctors.

The validation event was attended by 16 professionals with participation from all categories of stakeholders.

2.1.3 Stakeholder List

A complete list of stakeholders who were interviewed for primary research and who attended the validation discussions is mentioned in Annexure III. The annexure also enlists number of stakeholders interacted with vis-à-vis the initially targeted number.

2.2 Data Analysis

Analysis of data on the employer's viewpoint on migration, retention and return of health professionals between India and European countries was executed as follows:

Secondary data was analysed to:

1. summarize the as-is state of existing incentives, policies and programmes at the workplace level adopted by private and public sector hospitals; and
2. summarize the as-is state of existing incentives, policies and programmes at the state level and bi or multi-lateral level established or proposed by the MOHFW, the MOIA and other related bodies to facilitate the acquisition and retention of Indian doctors.

Primary data from in-depth face-to-face interviews with select relevant stakeholders using the validated assessment tool was analysed:

1. to examine the effectiveness of practices pertaining to incentives, policies and programmes at the workplace level; and
2. to examine the effectiveness of practices pertaining to incentives, policies and programmes at the state level and bi or multi-lateral level.

Proceedings of the validation event were used:

1. to validate existing findings; and
2. to document improvement opportunities in incentives, policies and programmes at the three levels.

2.3 Reporting - The Descriptive Model/Framework

Recommendations to be directed to various stakeholders (the relevant ministries, employers and related bodies) in the form of a descriptive model/framework showing synergies between various incentives, policies and programmes identified through secondary research, primary research and the validation event are documented in this report.

2.4 Assumptions of the Methodology

1. the questionnaire-guide designed for ministry officials is meant to be used for discussion purposes alone;
2. stakeholders identified for our study for primary interviews do not include staffing agencies and medical colleges; and
3. the information gathered in the secondary research is through online/desk research.

2.5 Limitations of the Methodology

1. The scope of the study is limited to understanding the possibility of establishing policies and incentives in India to facilitate circular migration to and from European countries as mentioned in the Terms of Reference (TOR) and excludes any other interventions to counter brain drain.
2. This study does not cover personal level incentives to augment circular migration.
3. The schemes and solutions proposed in the study are based on primary and secondary research and validation discussions alone, and have not been previously tested. The study excludes the practical applicability of the same in a health-care setting/organization context.
4. The study focuses on documentation and analysis of incentives, policies and programmes for doctors across all demographics.
5. As per the TOR, the study was to cover dissemination of the proposed policies to trade unions. However, two key acts, namely the Industrial Disputes Act, 1947, and the Essential Services Maintenance Act, 1981, prohibit the formation of trade unions by doctors, thereby removing this aspect from the scope of the study.
6. The study is limited by the fact that there is no single source responsible for collating various health-care and/or migration trends in India and hence the secondary research presented is conjoined from multiple studies by different public and private bodies.

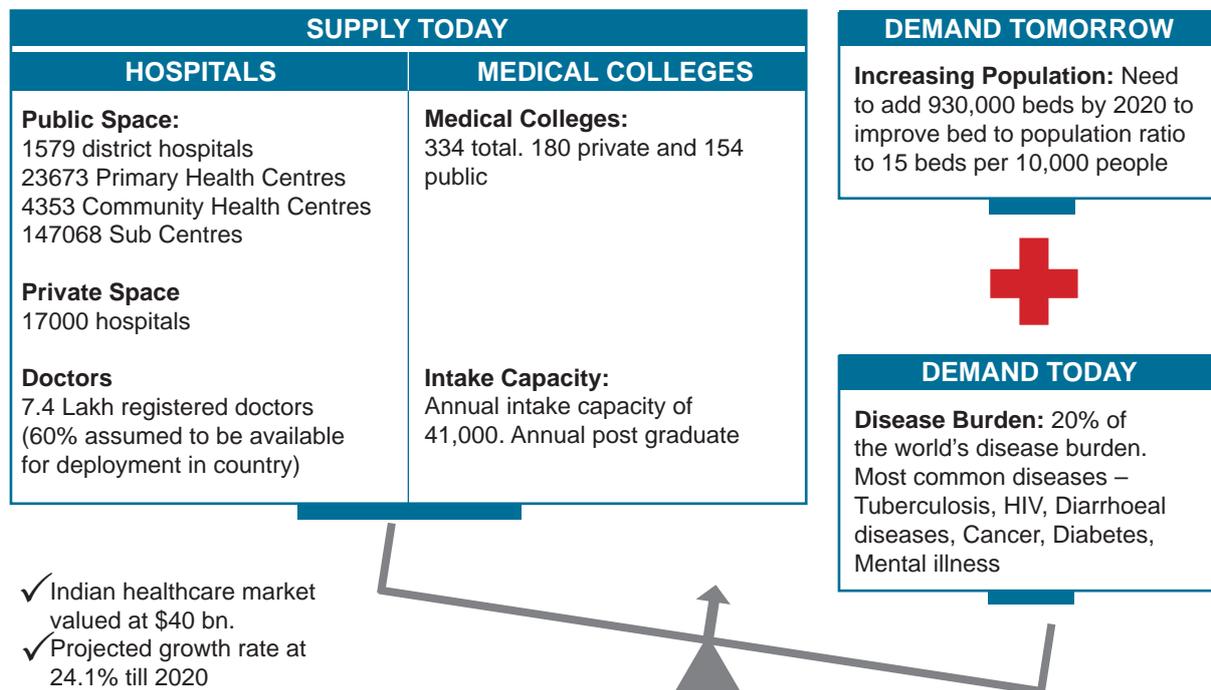
3. Introduction: The India Health-Care Story and Brain Drain

3.1 The India Health-Care Story

India accounts for more than one fifth of the world’s disease burden but for less than one tenth of the world’s hospital beds and doctors. The expenditure on health in India as a percentage of its GDP is lower than North and South America, Europe, Africa, the western Pacific region and the eastern Mediterranean regions. However, the private sector share of expenditure on health as a percentage of total expenditure is the highest among all regions. There is one doctor for every 1,700 people in India as against the stipulated 1:1,000 ratio. Sixty per cent of these doctors cater to India’s urban areas, which house only 26 per cent of the total population.

Data on healthcare in the public sector in India is published by the MOHFW, along with the Central Bureau of Health Intelligence (an agency under the Directorate General of Health Services) in the form of standard annual reports such as the National Health Profile and the Annual Report to the People on Health. However, data regarding private healthcare in India is not published by any designated body. The diagram below summarizes these official sources and relevant private reports to help understand the supply-demand scenario in the Indian health-care industry.

Figure 1: Supply and demand indicators in the Indian health care sector



Sources for the diagram: Annual Report to the People on Health: Government of India, Ministry of Health and Family Welfare, December 2011; National Health Profile 2012: Central Bureau of Health Intelligence; HSBC Global Research: India Hospitals 2012; Report by CII Working Groups on Health Insurance, December 2013; Gearing up for healthcare 3.0: CII Seventh India Health Summit, December 2010. Health Insurance

An analysis of the trends in the supply side of the equation indicate that there has been an improvement in the number of hospitals, beds, medical colleges, intake capacities and doctors for the years 2012 and 2013 -- indicating that while some efforts are paying dividends and need to be continued, other efforts must also be put in place to keep up with the accelerating demand.

3.2 Brain Drain of Doctors from India

In the later part of the twentieth century, a great number of Indian doctors travelled to places like the United States, the United Kingdom, Canada, and Australia in order to pursue residency training and practice positions. According to one study, the total number of graduates of Indian medical colleges practicing in these four countries had grown to a huge number in 2006 and stood at 59,095 - a workforce equivalent to 10.1 per cent of the 592,215 doctors registered by the Medical Council of India (MCI). This brain drain started with the movement of India's highly skilled professionals to European countries in the 1950s. The people who left comprised of doctors, engineers, scientists, teachers, architects and entrepreneurs. Beginning as a trickle in the 1950s, the skilled migration to the developed countries picked up after the mid 1960s, and became more prominent with the more recent migration of IT workers, and nurses in the 21st century, contributing inter alia to the concentration of skilled Indian migrants in the United Kingdom and other European countries, the United States, Canada, Australia and New Zealand.

3.2.1 Reasons

The motives for doctors leaving India and moving to developed nations such as those in Europe are many. Prominent among them are a) opportunity for post graduation; b) the socio-economic situation in India concerning infrastructure, pay and other issues; and c) the demand for doctors abroad.

Post-Graduation Opportunities

A key reason cited for doctor migration is the lack of post-graduation opportunities in the country. The low number of post-graduate seats for medical graduates in India translates into limited opportunities to pursue higher education amidst strong competition (The number of medical students who graduate every year is twice the number of post-graduate seats available, according to the Ministry of Health and Family Welfare's Annual Report to People on Health, 2011). In addition, admissions to private colleges are very expensive and the rampant corruption, as reported by sections of the media, with regard to allocation of seats, especially for preferred specializations, only worsens the situation.

A website on healthcare in India cites that there is a huge backlog of medical graduates waiting to get into a post-graduate course. With the increasing public awareness about health-care issues and the demand for specialists and super-specialists, there is an increasing need for more post-graduate institutes that can cater to the backlog which India faces today. So, another rather easy channel for doctors is to move out of the country to acquire specialist training from abroad. Sources estimate that some developed countries such as the United States have up to 1.5 times the number of post-graduate seats in medicine as India, thereby presenting more opportunities for Indian students to study abroad.

Independent research published in healthaffairs.org suggests that while the government system supports a number of hospitals in cities and larger towns, and also a nation-wide network of primary health centres, the former are crowded, unattractive, and stressed, and the latter are short of funds, equipment, medications, and personnel. The Primary Health Centre (PHC) is the basic structural and functional unit of the public health services in developing countries. PHCs were established to provide accessible, affordable and available primary health care to people, in accordance with the Alma Ata Declaration of 1978 by the member nations of the WHO. Currently, less than 5 per cent of doctors in PHCs make use of the housing provided. Educational facilities for their children are also a major concern for doctors during a rural posting. Some medical colleges in the country have mandated the requirement of a period of community service in return for receipt of medical education. Some government medical colleges have also made this criterion mandatory in order to be eligible to apply for post-graduate studies.

A large number of students go abroad or find other training or work opportunities without fulfilling the obligation. Although the graduating MBBS is sufficient to obtain registration and to practice in India, most medical graduates desire post-graduate training. Specialization is uniformly seen as desirable for reasons of competence, stature, and income. Many post-graduate programmes (especially those in private institutions) require a capitation fee of as much as \$50,000 for entrance into post-graduate studies. The dearth of positions contributes directly to migration of graduates towards medical specialization and super-specialization in other countries.

Socio-Economic Situation in India - Infrastructure and Pay

The report on the Indian mobility of health professionals by the Public Health Foundation of India dated April 2011 talks about corruption and government apathy towards medical policy and practice to facility-level issues like heavy workload, poor infrastructure, job insecurity, lack of proper case management systems or protocols, lack of opportunities for professional growth and the restrictive hierarchical system of not questioning senior practitioners.

Health centre infrastructure has been quoted as a key improvement area in another study conducted as a part of the National Conference on Bringing Evidence into Public Health Policy. In India, the infrastructure aspects outside the clinical system are also not encouraging. Power, education and connectivity remain low, as reflected by India's drop to 60th rank in the Global Competitive Index in 2013.

Low salaries paid to doctors in the public sector are highlighted in the form of strikes and protests, conducted by the Indian Medical Association and other doctor associations in India fighting against low wages. However, this problem is not restricted to the public sector alone. Insufficient incentives have also been cited as a key concern in the sector, as cited in the Central Bureau of Health Intelligence report of 2010.

3.2.2 Demand for Indian Doctor Skill Sets in Developed Countries

An article in the Harvard Business Review blog titled "India's Secret to Low-Cost Healthcare" has cited task shifting from Indian doctors to operational staff as a major reason for relatively high skill levels among Indian doctors. "The Indian hospitals transfer responsibility for routine tasks to lower-skilled workers, leaving expert doctors to handle only the most complicated procedures. Again, necessity is the mother of invention; since India is dealing with a chronic shortage of highly skilled doctors, hospitals

have had to maximize the duties they perform. By focusing only on the most technical part of an operation, doctors at these hospitals have become incredibly productive -- for example, performing up to five or six surgeries per hour instead of the one to two surgeries common in the United States,” the article states.

A recruitment agency placing Indian doctors abroad observes that doctors from India have been found to be equipped with innovative ideas, a skilled approach and an urge to learn that helps them gain a great stand nationally and internationally. This makes them the strength of medical industries in foreign countries like the United Kingdom, the United States, Canada and Australia. Additionally, India’s comparative advantage in health care is due to a large resource pool and competency in English.

3.2.3 The Psychology of Doctor Brain Drain from India

Author Saranya Nandakumar has captured the essence of the psychology of immigration in her book *What’s Up, Doc?* by listing the reasons for brain drain of doctors, as follows: (1) “The West Is Best Epidemic” - the long-standing belief of young doctors and their parents that training outside of India is superior and a mark of achievement; (2) “The Materialism Bug” - the expectation of bigger incomes and more material acquisition associated with life in the West; (3) “Specialization in Extremis” - the lure of high-tech training and “super” sub-specialisation perceived as prevalent in the West; (4) “Governmentitis” -- reaction to the structures and barriers of Indian governmental management of the education system and the corruption often associated with it; and (5) “Chaos phobia” - escaping the chaotic government and commercial systems in India in favour of what are perceived to be the more regularized and merit-based medical systems of the West.

3.2.4 Migration of Doctors from India to European Nations

Today, the countries across Europe are experiencing different stocks and inflows of Indian doctors. For instance, the United Kingdom, France and Portugal have larger and more significant Indian communities, while countries such as Austria and Finland have a small yet growing Indian community comprised of professionals (nurses, doctors, engineers, academics, scientists, and small and mid-level entrepreneurs). The size of the Indian communities in the countries of Eastern and Central Europe remain minimal, but growing most notably in Poland. As of 2008, India was the country of origin of 27,809 of the 68,836 registered doctors in the United Kingdom who earned their medical qualification outside the EU.

A study conducted by the Indian Institute of Management, Bangalore observes that India’s comparative advantage in health care is due to a large resource pool and competence in English. This study analysed recent trends and prospects for Indian health professionals in Denmark, Netherlands, Norway and Sweden by combining available data sources, personal communication with different migration boards, interview of two international recruiters and a migrant health professional. Additionally, it also looked at Indian R&D tie-ups in the sector with these countries, which have implications for the movement of health professionals. The data indicates that not much migration is happening in spite of the growing demands in these four locations. Though developments have occurred, a major hindrance to movement into these countries is still the language barrier and qualification recognition issues. The discussion in this study suggests that improving medical education, standards of practice and initiatives in India can have favourable effects on emigration and positive spill-over for the Indian health sector as a whole.

4. Acquisition Strategies

A combination of multiple acquisition strategies is necessary to attract migrating doctors back to their home country and there is no specific written solution to this problem. Unique and context-specific methods are the need of the hour and vary drastically across the three levels that are a part of this study. While this study does not test results across demographic variants to find patterns, it has been widely admitted in interviews with stakeholders from private and public hospitals that the problem in attracting Indian doctors back from developed nations such as the United Kingdom and other European nations cannot be resolved by single, generic solutions. This section details the incentives, programmes and policies adopted at the workplace level (in the private sector and the public sector), the state level and the bi or multi-lateral level for attracting doctors back to India.

4.1 Incentives at the Workplace Level in the Private Sector

Secondary research reveals that private hospitals in India follow three staffing models to attract and cater to needs of incoming doctors with different necessities. The three models are briefly described below:

1. **Staffing Model** - In this model, the entire staff is on the rolls of the institution as employees. Doctors wanting to settle down to a steady long-term practice prefer this model. Doctors are paid a minimum-guarantee salary (which is independent of the surgeries or consultation done) for a longer period of time (such as 1.5 to two years from the start of their engagement with the respective hospital) when compared to the normal practices in the private sector

This model has another variant wherein the entire consultant medical staff is on the rolls of the institution in a retainer arrangement for a specified period of time. For incoming doctors preferring a specialist role for a limited period of time, this variant model acts as an attraction.

2. **Empanelled Model** - The empanelled model is for specialists who offer their service on fixed days of the month to patients in the hospitals. The hospital may deploy the entire medical staff in clinical disciplines on this model and keep the consultant medical staff in diagnostics and anaesthesiology on the staffing model.
3. **Mixed Model** - A mix of the staff and empanelled models for consultant medical staff is also used in order to be flexible to the different needs that incoming doctors may have.

As India's economy grows, Seattle-based Columbia Pacific Management, Inc. one of the trends being observed is that doctors who have left for foreign shores and are returning to India are lured back by the same things that pulled them away. A case in point is Columbia Asia, which is part of Seattle-based Columbia Pacific and operates hospitals across India. These hospitals claim that they demonstrate a high standard of both medicine and living. According to the hospital's website, 20 per cent of the company's doctors in India have received degrees from Western countries, and many others have trained or worked in the West. That number may go up as more doctors return home. In the meanwhile, such hospitals continue to build more branches in India, and as awareness spreads of the hospitals' claimed innovation and world class medical care, more doctors tend to return. This stresses the need for employer branding among hospitals.

While these practices are being followed in the hospitals surveyed, as confirmed in multiple interviews with doctors and administrators at private hospitals, other strategies also exist at the workplace level in private institutions and are governed by five key drivers.

4.1.1 Drivers

Primary research identifies five key drivers that govern acquisition strategies at workplace level in the private sector:

First, the large size of the diaspora of Indian doctors with no support in tracing location, status of practice, additional skills, specialization and education acquired, and other demographic/personal details of the doctors abroad has led hospitals to add multiple recruitment channels to their arsenal to cater to the varying coordinates of this diaspora. The channels include job advertisements in career pages, job sites, newspapers, magazines and medical journals abroad, partnering with recruitment agencies and tapping formal referral channels as well as informal references.

Second, the requirement of Indian private hospitals to have multiple specialties and super specialties and the corresponding need of incumbent doctors for pursuing specialization has ensured that hospitals set up or partner with “specialist recruitment cells”. Recruitment consultants provide a vital link between clients and candidates and attract candidates by drafting the job advertisement copy for use in a wide range of media, as well as by means of networking, headhunting and through references. They screen candidates, interview them, conduct background checks and match their skills to the clients’ requirements. Consultants also provide advice to both clients and candidates on salary levels, training requirements and career opportunities. Specialist recruitment consultants have knowledge of the industry as well as the specialization. It is a specialist recruiter’s role to understand one’s industry language (including technical terms), how one’s particular job works and where one’s skills would be most suited in potential employment. These teams and firms actively cultivate strong (and often exclusive) relationships with leading players in the industry and offer salary advice based on benchmarking within the industry.

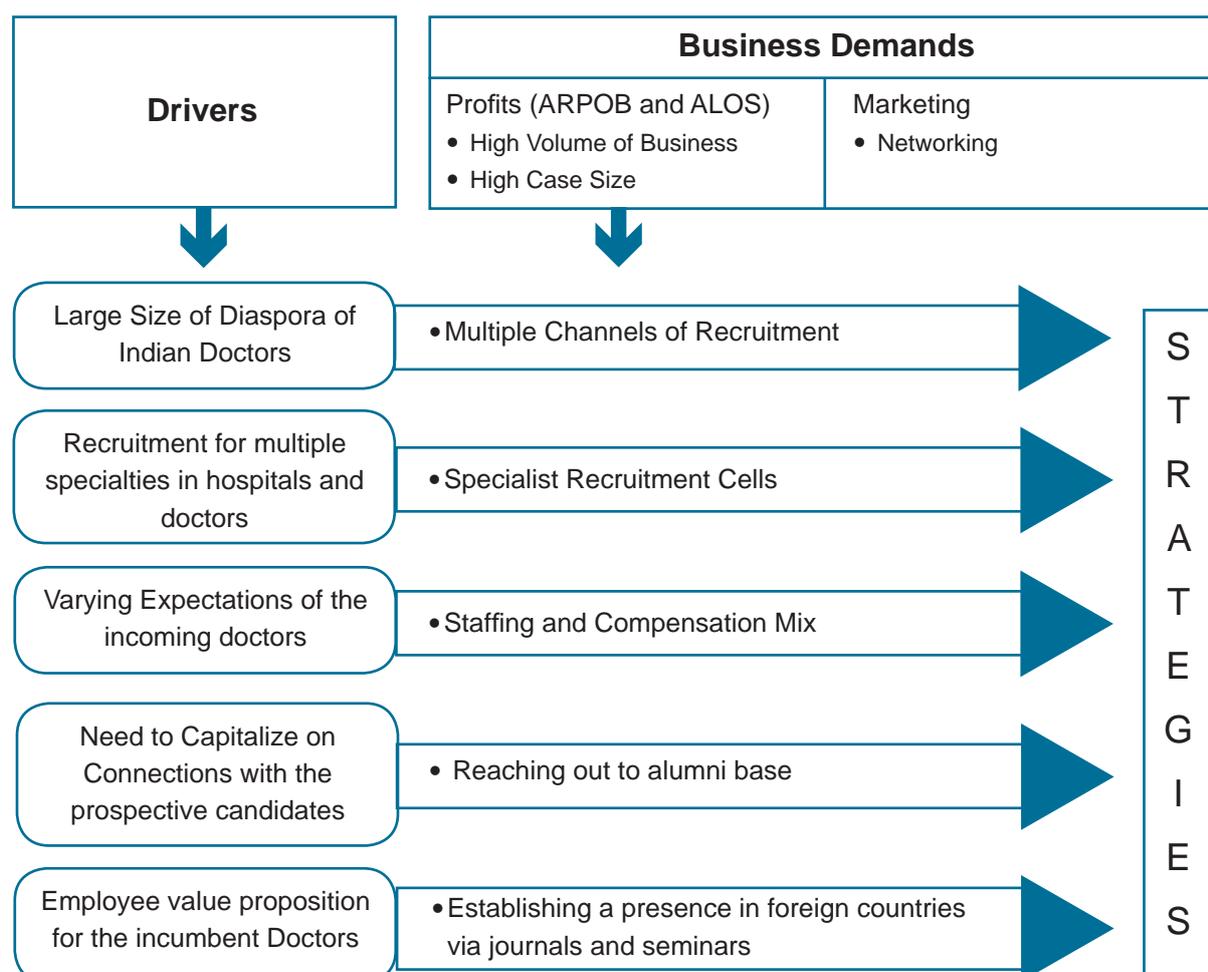
Third, the varying expectations of incoming doctors and HR personnel across demographic groups in terms of placement and compensation have driven the administration in private hospitals to introduce multiple staffing models, complemented with equally diverse compensation mix formulae. The expectations of doctors can vary from a) job security, steady monthly income, focus on designation and focus on research; to b) high income, income proportional to work and specific time limits to engagements. Some doctors can also have a mix of these expectations. These categories of expectations drive staffing and compensation strategies in private hospitals. This has been explained in the strategies section below.

The need to capitalize on connections with prospective candidates and employees is seen as the fourth key driver, leading hospitals to establish channels of reaching out to alumni networks and doctor fraternities abroad. This can include both personal and organizational connections and links with ex-colleagues, students and mentors.

Employer Value Proposition (EVP) - the value that an employee sees while engaging in written and unwritten rules of engagement with his or her employer, has also been found to play an important role in the decision making process of incoming doctors, encouraging hospitals to establish a presence abroad via journals and seminars, making it the fifth key driver for acquisition of doctors in private hospitals. EVP typically consists of five factors where organizations can make changes to provide value to their employees, namely: the organization (what the organization stands for); the people (when employees feel valued, encouraged and supported by management and colleagues); the work (challenging and meaningful work with a healthy work-life balance); the opportunities (learning, development and career progression opportunities in the organization); and the rewards (sufficient and appropriate recognition and reward for performance).

No institutionalized acquisition strategy was found in the hospitals to cater to softer drivers such as ageing parents, growing children, family businesses and the need of doctors to serve their home country. While the strategies are influenced by the drivers mentioned above, they are also reactive in nature catering to the business reality and needs of private hospitals. Figure 2 depicts the linkages between the business needs, drivers (from the incoming doctor perspective) and related strategies.

Figure 2: Acquisition of doctors at workplace level in private sector -- drivers and strategies



*ARPOB is Average Revenue per Occupied Bed and ALOS is Average Length of Stay

Interviews with returnee doctors in the private sector suggested that in addition to the above, two other aspects play a role in acquisition of doctors from European countries, though not directly. First, the perceived glass ceiling for doctors of Indian origin in European institutions can act favourably for Indian hospitals, while the prospective minimum visa-related hassles in these countries (with UK MPs demanding easier visa rules for the Highly Skilled Migrant Programme -- HSMP) and the ample job opportunities for doctors there can act against the interests of Indian hospitals looking to attract talent back to India. However, one of the administrative heads interviewed suggested that this was to change with visa renewal norms changing from relaxed to strict, more so for students, in countries such as the United Kingdom, which are now planning to hire most of their talent from the EU alone.

4.1.2 Strategies

Multiple Channels of Recruitment - Horses for Courses

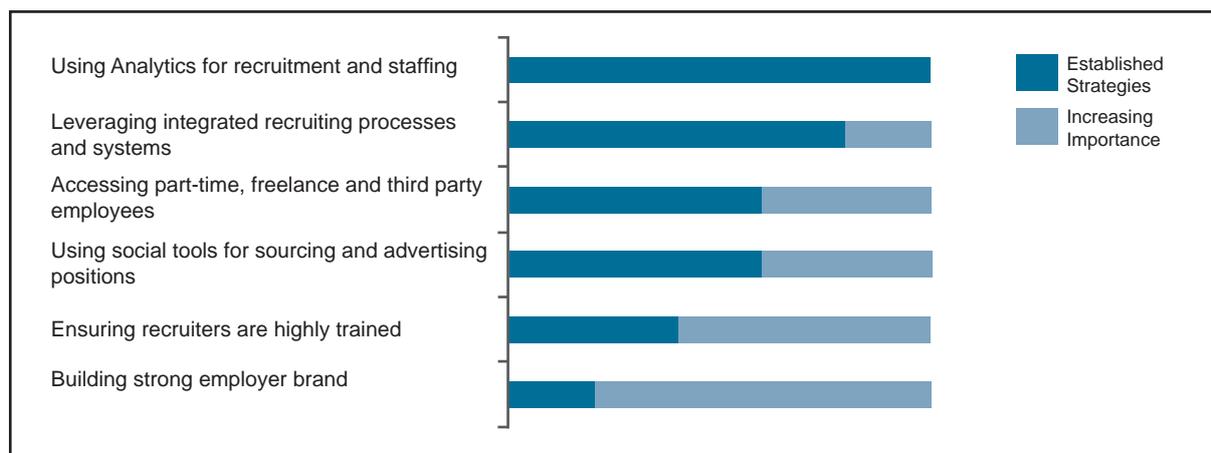
Nine of the 11 administrative heads of the private hospitals interviewed, established that a single channel of recruitment was not enough for recruitment of doctors residing abroad. These hospitals were found to employ a mix of recruitment tools and supporting elements to formulate acquisition strategies for doctors from European countries. The broad list of acquisition methods observed includes references (informal) and referrals (formal employee referral schemes -- an internal recruitment method employed by organizations to identify potential candidates through their existing employees.) In the case of formal referrals, the employer pays the referring employee a referral bonus. This approach is usually favoured when the costs of recruiting needs to be reduced. Other methods include job advertisements, job websites and social networking sites such as LinkedIn, Facebook and job sites such as Monster (UK). Focused recruitment drives for doctors abroad, including deployment of internal recruitment departments and teams working towards recruiting specialist doctors have also been observed. These recruitment cells were found to be established in two of the 11 private hospitals whose administrative heads were interviewed. While being diverse compared to the acquisition methods followed in public sector hospitals (explored later in this report), the methods followed by private sector hospitals are prevalent recruitment practices adopted widely by other leading industries such as information technology (IT)/ information technology enabled services (ITES), fast moving consumer goods (FMCG), and banking and financial services.

The aforementioned methods were also found to be supplemented with longer term talent management strategies such as employer branding and alumni connect programmes, and creation of specialty doctor forums observed in six of the 11 hospitals. These strategies are further discussed in the following parts of this section.

Branding and Connect - Image Matters

The importance of a strong employer brand as a crucial need for acquiring good talent is evident with most organizations concentrating on employer branding through various consumer media channels. Questions to administrative heads about focus areas for acquisition suggests that building a strong employer brand is increasingly seen as the strategy that hospitals focus most on to deploy in the private space. Figure 3 represents this trend.

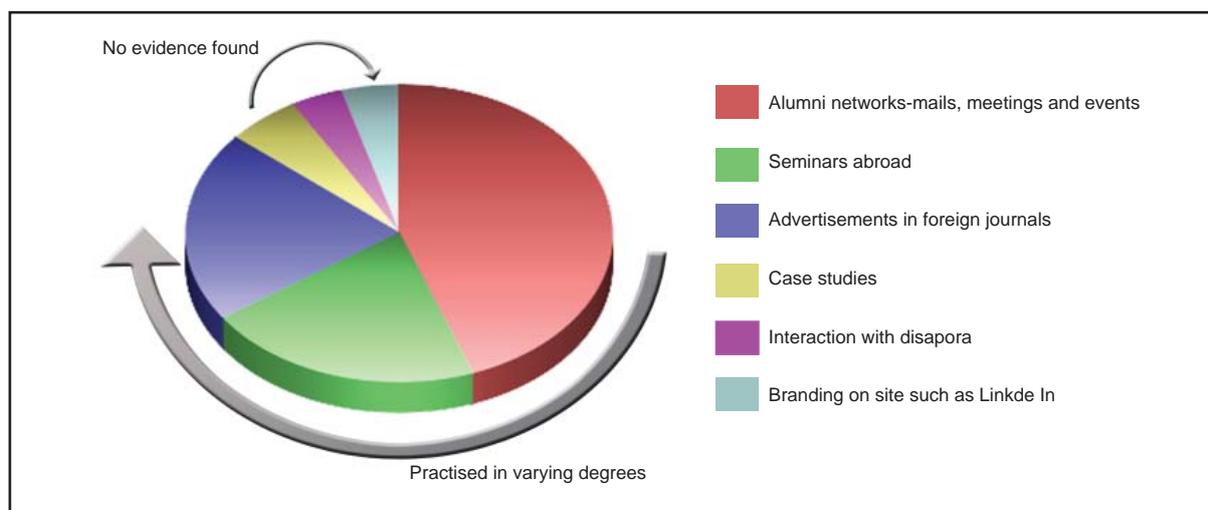
Figure 3: Increasing importance of building strong employer brand - hospitals in private sector



It has been observed that doctors who are educated and working in European countries are drawn primarily to the brand name of hospitals in India. One very important consideration among doctors has been found to be the global presence of hospitals they are targeting to join. The brand equity the hospital garners and the amount of recognition it receives have also found to positively influence attraction and retention. Hospitals with global footprints (established in at least one country other than India) have separate recruitment divisions to target doctors working abroad. Two of the administrative heads who were interviewed indicated that they visit European countries to conduct seminars once every year, allowing doctors considering moving back to India ample opportunities to have their queries answered. According to one of the marketing heads of a well-established hospital, some of the ways in which private hospitals attract talent back to India include initiatives by the leadership team to interact with Indian doctors in Europe when they visit European countries, especially the United Kingdom. During these interactions, they present trends that shape the Indian health-care setup, and improvements in infrastructure and career prospects, among other things.

Interviews reveal that engaging alumni of hospitals is a key step in establishing and furthering a “connect” with doctors in developed nations. The use of campaigning, promoting the workplace and using modern recruitment tools have been suggested as methods of acquisition of talent back to India. Two of the administrative heads who interact closely with recruitment teams in the hospitals authenticated that social media like LinkedIn play a major factor in identifying the doctors who are willing to return back to their home country. The official website is used for posting jobs and alumni events are conducted to attract doctors who are looking for an opportunity to return. Advertisements in the British Medical Journal are another way by which hospitals seek to attract talent from abroad. Administrative heads suggested that staffing agencies also play a role in branding hospitals that are new or are undeveloped setups by spreading favourable word of mouth information. Figure 4 provides a perspective on the “branding and connect” strategies adopted, and the ones not adopted in private sector hospitals in India today. The evidence mentioned in Figure 4 is based on the information received during the primary interviews only.

Figure 4: Branding and connect gaps -- hospitals in private sector



Specialization and Super Specialization - Niche Recruiting

Specializations are a two-way advantage as far as acquisition of doctors from abroad is concerned. While displaying the hospital’s specialty functions to the prospective candidates, a niche recruiting model in hospitals also calls out to the candidates’ need for establishing himself or herself in a specialized field. As mentioned earlier in this section, specialist recruitment cells are established in hospitals to source doctors with specializations and super-specializations looking to practice the same in India.

Three administrative heads of private hospitals agreed that in order to attract doctors they are trying to build a strong pool of specializations that would encourage doctors to come back and practice in India. According to a senior executive in a leading private hospital, preferred clinical specialties that attract Indian doctors largely vary, but the ones to top the list are orthopaedics and anaesthesiology.

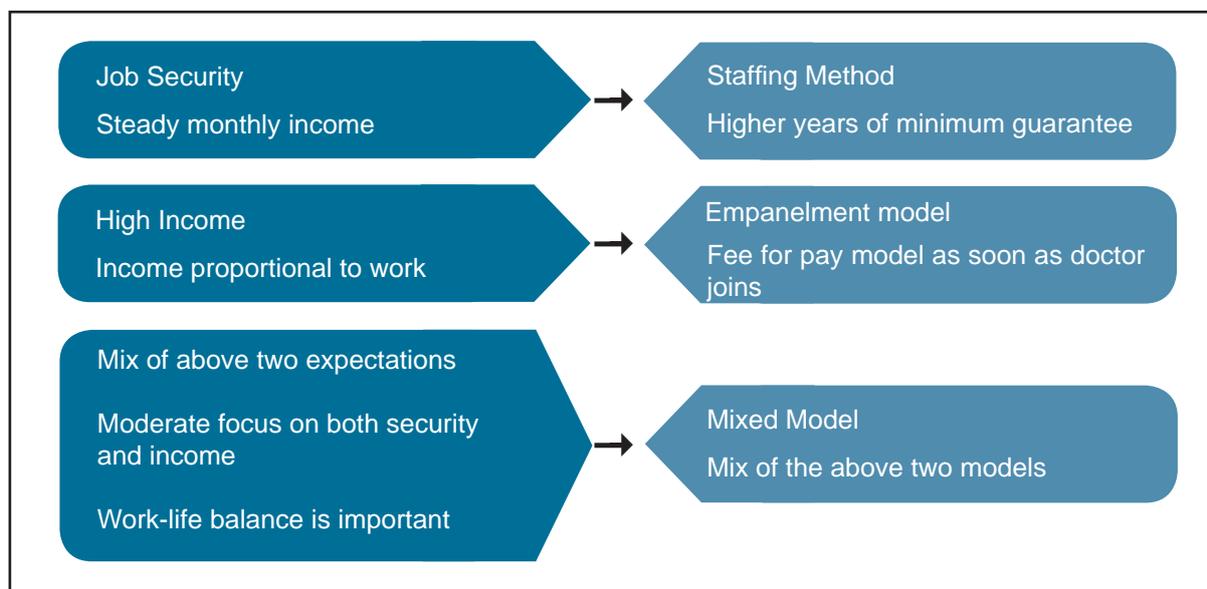
Primary research also found that doctors who do return before retirement prefer to work in the private sector rather than the public sector as the pay is higher (average pay in private hospitals is estimated twice the average in public sector hospitals) and the facilities are better. Some of the established private players in the health-care industry continuously invest the income generated from clinical specialties in cutting-edge technology, infrastructure and equipment, and these are the natural places of work to which Europe-educated doctors would return to. However, this is contradicted by administrative heads in public sector hospitals who suggest that the natural choice for a doctor returning to India is the public sector (though no evidence has been found for this contradicting claim).

Staffing and Compensation Mix - the Right Placement

In our primary research, the importance of both the staffing model as well as clinical infrastructure in acquiring doctors from abroad was established. Six of the eight administrative heads interviewed stressed on how the staffing model is a key consideration looked for by doctors before choosing to return. Discussions revealed that one of India’s leading hospital chains (with a global footprint) successfully employs the “fee for service” model, where doctors enter into an agreement to earn and share professional fees towards hours spent on clinical practice. In other words, the doctors in a “fee for service” model tend to earn more with more hours spent on clinical practice. This is a direct relationship

between the hours spent by the doctor on clinical practice to his or her earnings. Doctors under this model have no fixed or standard pay. This, yet again, can contribute effectively towards attracting and providing incentives for doctors to come back to India, and thereby help in catering to their needs and preferences (as explained in Figure 5 below):

Figure 5: Expectations of incumbent doctors vis-à-vis staffing/compensation mix -- private sector



Use of Manpower Agencies and Specialist Staffing Agencies

Primary research explored the use and effectiveness of manpower agencies in attracting doctors back to India. Interviews revealed that apart from a limited number of firms (market leaders such as Adecco, Randstad and ManpowerGroup), which focus on recruiting specialists and super specialists, hospitals mostly stick to the other four strategies mentioned above and make minimum use of the agency route owing to high recruitment costs.

4.1.3 Effectiveness

The acquisition strategies being adopted to attract doctors back to India have been successful in the private sector. It was seen in one of the hospitals where interviews were conducted that over the last three years, nearly 250 returnee doctors have been recruited pan India across clinical specialties. This was said to be a large number in comparison to historic data. Other hospitals also mentioned that they have met with success and spoke about the incentive and staffing mix as one of the reasons for success. Specialization is also said to have played an important role in this success.

Four administrative heads said that their hospitals have successfully acquired doctors by establishing a “connect” on a personal basis with doctor fraternities across the world. It was also observed that among those hospitals happy with the success of the acquisition initiatives, the ones with global footprints made the maximum impact, stressing the importance of a national/global presence and brand.

4.2 Incentives at the Workplace Level in the Public Sector

While it is observed that public sector hospitals have very few acquisition initiatives when compared to the private sector hospitals (as depicted in Figure 6), the drivers for public sector level acquisition initiatives are vastly different.

Acquisition measures being followed by public hospitals to acquire doctors include the promise of post-graduation reservation schemes. The Post-Graduation Reservation Scheme is a strategy adopted by several states to make rural service attractive for medical graduates by reserving post-graduate (PG) seats in medical colleges for doctors serving in the public sector. This scheme in Andhra Pradesh has played a role in attracting medical graduates to government service and rural posts over the last few years. Increased competition due to the rapid expansion of undergraduate medical education has made the scheme more attractive than before. While it is difficult to establish causality, the available evidence suggests that the scheme has contributed to fewer vacancies in medical officer and specialist posts. By aligning its requirement for medical officers at primary health centres with the high demand among medical graduates for PG seats, the government of Andhra Pradesh has been able to fill vacancies at the primary health centres level as well as increase the pool of specialists available in public sector hospitals. However, whether this strategy has worked with returnee doctors is yet to be examined.

Other known practices are in reputed public institutions with renowned colleges such as AIIMS that attract talent from their own pool of graduating medical students as specified in their mission statement. This can also be looked at as a retention technique in public sector hospitals. The AIIMS are a group of autonomous public medical colleges of higher education. AIIMS New Delhi, the fore-runner parent excellence institution, was established in 1956. The institute has comprehensive facilities for teaching, research and patient care. As provided in the Act, AIIMS conducts teaching programmes in medical and para-medical courses, both at under-graduate and post-graduate levels and awards its own degrees. Teaching and research are conducted in 42 disciplines. In the field of medical research, AIIMS has more than 600 research publications by its faculty and researchers in a year. AIIMS also runs a College of Nursing and trains students for nursing post-certificate degrees.

The stakeholders interviewed as a part of the primary research did validate these measures, which were arrived at from the secondary data. However, a different set of drivers have emerged from their discussions, as discussed below.

4.2.1 Drivers

Four of the five administrative heads interviewed in the public sector agree that the top three reasons why doctors in developed countries such as the United Kingdom return to public sector hospitals in India are 1) the urge to serve the nation; 2) past association with premier public sector institutes; and 3) the lure of job security and accommodation provided for, by the institution.

4.2.2 Strategies

No institutionalized approach was observed to meet the three drivers in public sector hospitals. As one of the administrative heads of a public sector hospital pointed out, a good number of doctors return from abroad to work in the private sector as facilities there are good, opportunities exist and they are able to earn the desired money. The same cannot be said of public sector hospitals in India. This opinion is present among other stakeholders of both the private and the public sector.

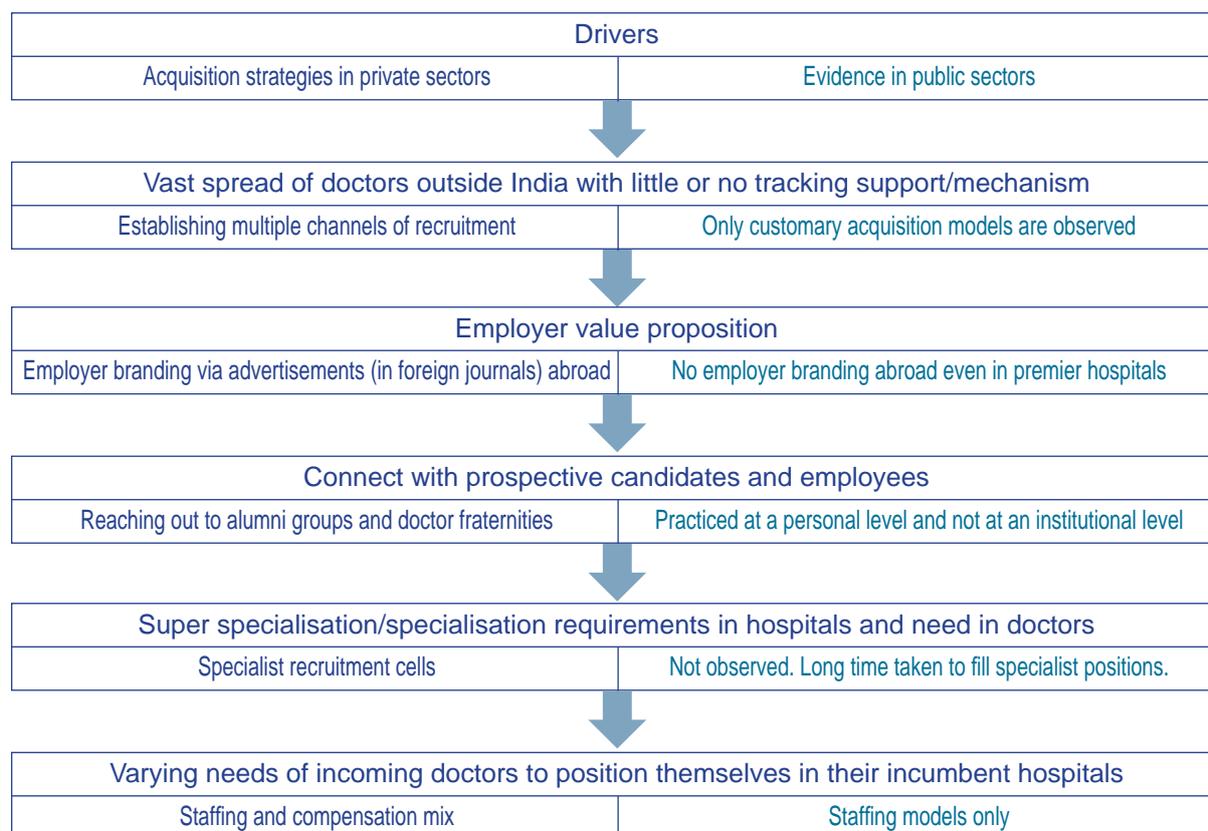
Doctors in public sector hospitals feel that many doctors return to public hospitals in India once they reach the age of retirement. It is at this time that they can enjoy the best of both worlds -- they have earned well in all their years abroad and now they would like to lead a comfortable life among family members in India. However, no specific mechanism exists to establish this in any of the public sector hospitals.

Interviews revealed that a recent instance of a premier public sector hospital in India started its kidney transplant service after a long wait of five years for a nephrologist. This highlights the need for urgent up-gradation of specialization facilities in public sector hospitals. As a doctor mentioned in the interviews, there are more Indian-born nephrologists working in the United Kingdom today than in India itself. Most administrators interviewed pinned the percentage of posts of specialists (surgeons, doctors, paediatricians, and gynaecologists) at the community health centres vacant at the rate of a whopping 80 per cent.

Similarly, primary interviews suggest that there is an acute shortage of gastroenterologists, diabetologists, neurologists, neurosurgeons, rheumatologists and psychiatrists in public sector hospitals. Public sector doctors feel that the salaries offered to them by private super-specialty hospitals are higher and cannot be matched by government hospitals. Administrators we spoke to expressed that the range of average salaries earned by doctors in the private sector in India is Rs. 20-30 lakhs while it is Rs. 12-15 lakhs in the public hospitals. These are approximate figures.

In addition to the above, job titles such as “programme directors” for returnee specialists was deemed a successful attraction strategy in the public sector.

Figure 6: Drivers and strategies in public sector (as compared to the private sector)



4.2.3. Effectiveness

Public sector hospitals have not been able to establish processes to attract talent from abroad. The evidence of talent already attracted is more from a personal “connect” -- referring to one-on-one contact between doctors from different hospitals, regions, sectors, specializations and internal drivers, which the public sector has not been able to capitalize on. If this can be capitalized, better establishment of public hospitals can be observed. It can be made a standard or a mandatory practice depending upon the situation and criteria of that hospital.

As represented in Figure 6, only the usually used acquisition models such as advertisements in newspapers have been observed. Other acquisition models like branding with the use of networking websites are not seen. There is no employer branding abroad, even in premier hospitals. Alumni connections are not institutionalized and specialist positions take a long time to fill, thereby hinting at no existence of specialist recruitment cells for the public sector. Only the staffing model option exists for incumbent doctors, and this minimizes the flexibility offered elsewhere in the private sector.

4.3 Acquisition Programmes at the State Level

While there have been several schemes introduced by different state governments in India that affect acquisition of doctors directly and indirectly, most of them are in early stages of implementation. A review of schemes implemented by certain states and their corresponding challenges in implementation are examined in this section.

The NRHM, launched by the Government of India in 2005, promoted various state and national initiatives to address the issue of attracting doctors. Under India's federal constitution, the states are responsible for implementing the health system with financial support from the national government. Before 2005, the most common strategy was compulsory rural service bonds and mandatory rural service for preferential admission into post-graduate programmes. Initiatives under the NRHM include an increase in sanctioned posts for public health facilities, incentives, workforce management policies, locality-specific recruitment and the creation of a new service cadre specifically for public sector employment. As a result, the NRHM has added more than 80,000 skilled health workers to the public health workforce since inception. However, allegations of misuse of the Uttar Pradesh NRHM funds and the related murders of five executives have cast a shadow of doubt over the furtherance of the scheme (as reported in the *New Indian Express*, 17 February 2012).

To lessen the urban-rural divide of doctors available, the state governments have also focused on developing the PPP model. A PPP is a government service or private business venture that is funded and operated through a partnership of government and one or more private sector companies. Apart from PPP, these schemes are sometimes referred to as P3. PPP involves a contract between a public sector authority and a private party, in which the private party provides a public service or project and assumes substantial financial, technical and operational risk in the project. The benefits of working under the PPP model apply to doctors returning from abroad as well.

The critical success factors for PPP are political commitment and introduction of requisite regulations, policy and legal framework for operating PPP models, strong control mechanisms for efficient oversight (including dispute resolution procedures), risk apportionment through careful design of the contract, and incentivized private sector with an "acceptable rate of return". The aspects such as clearly specified, realistic and shared goals; clearly delineated and agreed roles and responsibilities; distinct benefits for all parties; the perception of transparency; active maintenance of the partnership; equality of participation; and meeting agreed obligations attract doctors. This gives the doctors in the public sector the much-needed exposure to private medical practice. This promise of a re-energized working environment in a state-run medical setup can help attract doctors back to the public sector.

Some of the PPP projects in India include Karnataka Karuna Trust, Yashaswini Scheme, Tamil Nadu Mobile health services, Andhra Pradesh Aarogyasri, Andhra Pradesh Diagnostic Services for 4 Medical Colleges, West Bengal Mobile health services, Madhya Pradesh Community outreach programme, Rajasthan Contracting in public hospitals and Gujarat Chiranjeevi Project.

The sections below on initiatives and situations in various states are not necessarily related to or directed at acquisition of doctors, but have potential to indirectly drive acquisition by virtue of the clinical and non-clinical atmosphere that these initiatives create, thereby facilitating the return of doctors.

National Capital Region: With big “medcities” being introduced in the Delhi-National Capital Region and aggressive corporate expansions, most reputed doctors from the public sector were found to be shifting to private hospitals, or from one private establishment to another, and so on, leading to an imbalance in the distribution of human resources between public and private sector. The Delhi government, as a part of its Central Government Health Scheme (CGHS), has made it mandatory for all hospitals empanelled or enrolled with the scheme hospitals to get National Accreditation Board of Hospitals (NABH) authorization. However, seven prominent government hospitals that have applied for NABH accreditation have already failed to qualify for it, thereby getting excluded from Quality Council of India’s (QCI) list of accredited hospitals. Accreditation is a major part of establishing an employer brand and attracting doctors from abroad.

The NABH is a constituent board of QCI, set up to establish and operate accreditation programmes for health-care organisations. The board, while being supported by all stakeholders including industry, consumers, and government, has fully functional autonomy in its operation. The CGHS was started under the MOHFW in 1954 with the objective of providing comprehensive medical care facilities to Central Government employees, pensioners and their dependents residing in CGHS-covered cities. Subsequent CGHS services were extended to other cities and states such as Allahabad, Lucknow and Kanpur.

Tamil Nadu: Successive governments in Tamil Nadu have ensured that there is an increase in the number of medical colleges in the state. Senior academicians and officials feel that this is also one way by which to reduce the spiralling costs of healthcare by means of augmenting talent supply. Indirectly, these also provide opportunities to doctors abroad to get involved with the medical colleges in the capacity of experts, thereby providing them a chance to return to India.

Karnataka: The Karnataka government plans to bring in private doctors to work in rural hospitals on a daily basis, by handsomely paying freelance doctors for their services. The state has felt an urgent need for qualified medical professionals from private hospitals who can raise the quality of service in rural areas, and has consequently embarked upon this initiative of increased payments. In the case of doctors practicing abroad, such incentives at a state level have the capacity to initiate doctor movements to their native districts.

Andhra Pradesh: In Andhra Pradesh, the government announced that those students who served in rural areas for one or two years after completing their under-graduate studies would be able to get a seat for graduate medical training by falling into the reservation quota created for such a purpose. The idea was to try and bring a reduction in the number of vacancies at both the PHC and Community Health Centre (CHC) levels. Candidates who had served in a rural posting were found to have a better chance of getting a post-graduate seat than general candidates. This opportunity to pursue post-graduation in the state can act as a pull factor in attracting doctors back to the country. However, problems such as the mismatch of the demand and supply of certain types of specialist doctors, poor academic performance of in-service candidates, as well as quality of services, were yet to be resolved. The PG bond is also an issue where the students need to sign a bond in order to pursue the post-graduation course, which would automatically tag them to specific hospitals where they have to work for a specific period.

Kerala: Kerala is looking at branding health and tourism together and has witnessed increased presence of accredited hospitals in the recent past to attract doctors back to the state. Steps taken by Kerala

state to promote Ayurveda, Unani, Siddha and Homeopathy (AYUSH) through medical tourism were deemed a successful method to attract doctors back to India and to promote tourism and health together.

Jharkhand: An official interviewed in Jharkhand resonates with the idea that the public sector is behind the private sector in terms of pay, promotions and career paths -- thereby hampering acquisition opportunities. Policy paralysis is also said to have impacted improvements in acquisition methods in the state. The feeling is that processes are long drawn and complicated, and that there are little or no HR policies. Rural postings are very poor in terms of housing conditions and education facilities for children. Jharkhand especially is a Naxalite infested area, and not much is done in terms of safety. The Naxalites are considered to be far-left radical communists who extend support to Maoist political sentiment and ideology. For the last few years, they have been on the rise -- mostly though displaced tribal natives who are fighting against exploitation by major Indian corporations, as well as local officials who are believed to be corrupt.

In interviews with a highly placed official at AIIMS, it was confirmed that there would be the setting-up of well-established public sector organizations like AIIMS in every state. There were also plans to set up such institutions in two-tier cities like Jodhpur, Raipur, Patna, Rishikesh and Bhopal. This can act as an acquisition strategy, as doctors abroad will be attracted to the brand that institutions like AIIMS have created for themselves. Establishing such institutions in multiple states will now give an opportunity to doctors to return to their home state as well.

As observed, the focus in all-state level schemes has been in attracting doctors to the rural regions. Many doctors, however, are not keen to work in these areas primarily because of the housing facilities that are provided to them by the government at the PHC level. Considering the immense investments and special skills needed to overcome infrastructure and human resource hurdles, there is no doubt that public-private partnerships and private initiatives are needed to complement government efforts in addressing the dual goals of building health-care infrastructure and building skills, as well as increasing the number of health-care personnel.

Envisaged needs to tackle acquisition problems, emerging from primary research, include the need for high quality accreditation of medical colleges across all states, monitored at state government levels, and reservation of PG seats in medical colleges for doctors serving in the public sector, across all states. The need for rationalization of pay structures in states with poor health indices (Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh) also emerged.

4.4 Bi or Multi-Lateral Level Acquisition Policies

Discussions with officials of the MOHFW, a key stakeholder of health-care systems in the country, focused on the three major challenges plaguing healthcare in India, namely:

- 1) communicable diseases;
- 2) non communicable diseases; and
- 3) shortage of HRH in India

As confirmed by the MOHFW, as on date, over 40 per cent of registered doctors are unaccounted for, and only 60 per cent is assumed to be available for deployment within the country. Given the lack of data on the availability of HRH, it is unsure whether they are still practicing, working abroad or even dead.

The talent supply situation is further compounded by the skewed distribution of HRH in urban and rural areas. Secondary research on healthcare in India had highlighted that close to 60 per cent of doctors in India work in urban areas, while 74 per cent of the country's population resides in rural areas.

The case of policies on migration of health-care professionals in India and the Philippines present a contrasting picture. While India is grappling with reactive measures to counter brain drain, the Philippines has utilised people who migrated to their maximum advantage, or has leveraged the migration of the country's health-care professionals.

In India, the MOHFW's Ghulam Nabi Azad in 2012 stressed that a doctor who fails to return to India after studies abroad (United States) will not be allowed to practice medicine in the United States as the Indian government would revoke its No Objection Certificate. The No Obligation to Return to India (NORI) certificate (as the name implies, is a certificate given to Indians migrating abroad freeing them from any obligation to return to the nation) would not be issued by the MOHFW for these doctors under any circumstance and applications for extension of Statement of Need (SON)/Exceptional Need Certificates (ENCs) shall be processed only by the MOHFW (these certificates are crucial in order to pursue higher studies in other countries).

According to the terms, a doctor who fails to return after completing his or her studies in the United States will not be allowed to practice medicine there, because the Indian government would revoke its No Objection Certificate. According to an editorial in *The Hindu* that appeared on 26 April 2012, a government bond cannot by itself solve India's human resource crisis. "A well thought-out plan to make suitable rural service a pre-requisite to be eligible for higher studies may yield some benefit," the editorial said.

In contrast, five key suggestions in various stages of approval and implementation are believed to repair the Philippines' health-care professionals demand to supply gap:

- 1) setting up the institution of a national network on HRH for policy review and programme development;
- 2) exploration of bi and multi-lateral negotiations with destination countries for recruitment conditions to improve domestic nursing training, education, compensation and scholarships;
- 3) for each nurse recruited, the cost of post-graduate hospital training being remitted to the hospital from which the nurse has been recruited, allowing the hospital to then train another nurse. The cost of post graduate hospital training that a nurse pays for recruitment is remitted to the hospital by the visiting country. This remitted amount is used to train another nurse;
- 4) six-month leave to nurses in foreign countries to return and train local hospital nurses; and
- 5) graduates from state-funded nursing schools to serve locally for the number of year's equivalent to their years of study.

In keeping with the practice in the Philippines for setting up the institution of a national network on HRH for policy review and programme development, the need was felt during interviews with ministry officials to establish an accurate and real-time health-care personnel information system to track Indian doctors studying and working in European countries. Primary research also revealed that acquisition is blocked at a bi or multi-lateral level in certain cases due to India's refusal to recognize foreign clinical certifications. A need to take policy-level decisions on an increase in the number of post-graduation seats and including creation of sub-specialization and super-specialization courses was also established as a concern area during the interviews.

In the international space, according to the WHO International Code of practice on the international recruitment of health personnel, governments recruiting from other Commonwealth countries should consider how to reciprocate for the advantages gained by doing so. This could include:

1. programmes to reciprocate for the recruitment of a country's health workers through the transfer of technology, skills and technical and financial assistance to the country concerned; and
2. training programmes to enable those who return to do so with enriched value arrangements to facilitate the return of those recruited (subject to application of the non-discrimination principle and to the rights of the workers concerned in accordance with immigration and other laws).

Another practice at the national level is the virtual education facility by MOHFW for Indians completing under-graduation in medicine in the United States, the United Kingdom, Canada, Australia and New Zealand to help them succeed in the screening test (which they need to pass in order to take up practice in India). Like a traditional classroom, the virtual classroom is a scheduled teacher-led tutoring session, where the students can interact and learn with fellow classmates, but the interaction with the teacher and students from other centres is through the internet. Hence, if and when the screening test can be taken up by the Indians graduating from abroad virtually, it is efficient and cost effective, reduces geographical barriers and is very simple. This sees similarities to e-Med Private Medical Services, an online medical site based in the United Kingdom, staffed and owned by doctors. It is notable for being the first web portal to offer consultation, diagnosis, referral and prescription services via email and Skype video conferencing to remote patients without the time or proximity to visit a doctor.

As an acquisition strategy, the MOIA organizes:

- a) a half-day session on health in Pravasi Bharatiya Divas (celebrated in India in January each year to mark the contribution of the overseas Indian community to the development of India), wherein opportunities in India are displayed to doctor diaspora;
- b) one-month assignments signed up with doctors (who are practicing abroad) for work in India as voluntary service; and
- c) an MOU with American Association of Physicians of Indian Origin (AAPI) and other such associations for them to be included in the working group to improve primary health in India.

4.5 Improvement Opportunities

At the bi and multi-lateral level, the creation of a global medical task force with a global accreditation model to address the issue of doctor shortage and urban-rural disparity in medical services across countries, complemented by virtual training and teaching mechanisms (via didactic online lectures) across the global community are being seen as improvement opportunities in acquisition practices. MOUs with British Association of Physicians of Indian Origin (BAPIO) and associations from other countries as well for their members to be included in the health-care activities in India, establishment of reach-out mechanisms to tap on doctors' needs to serve one's own country, and encouraging social entrepreneurship through awareness events and support activities can also be considered as an attraction strategy.

At the state level, possible steps to improve the overall ambience of Indian hospitals and experience of returnee doctors working in these hospitals in order to attract doctors back to India include provision of the following:

- a) international (JCI) accreditation of all hospitals run by the states;
- b) district level doctor societies with houses, schools for children and support for other lifestyle aspects; and
- c) facilities for doctors in line with civil servants.

At the workplace level, segment wise attraction policies will help. Helping the doctors find two to three years of working stints in hospitals abroad and attracting them back to their home country is a strategy that can be institutionalized. Improving the quality of health-care administrators (by recruiting administrators from reputed management institutes and providing them training on health-care management) is another improvement area.

5. Retention Strategies

Multiple strategies are deployed by employers in the workplace (private and public sector hospitals), through state and bi or multi-lateral levels to retain doctors in India. A host of advantages are offered, catering to varying needs of doctors ranging from monetary to learning, and growth to esteem. This section details retention strategies at each of the three levels.

5.1 Workplace Level Retention Incentives in the Private Sector

Private hospitals deploy a mix of strategies such as paying fixed salaries (which refers to the sum of basic monthly salary and fixed monthly allowances - similar to the practice in the public sector) or retainer-ship amounts, with either an incentive plan and/or sharing of revenues over and above the fixed components. The "fee-for-service" (FFS) model is also followed. This is a payment model where doctor services are unbundled and paid for separately. This gives an incentive for doctors to spend more hours attending to patients as their income is dependent on the quantity of care. A retainer amount on the other hand refers to a fixed monthly salary given to the doctors for their services.

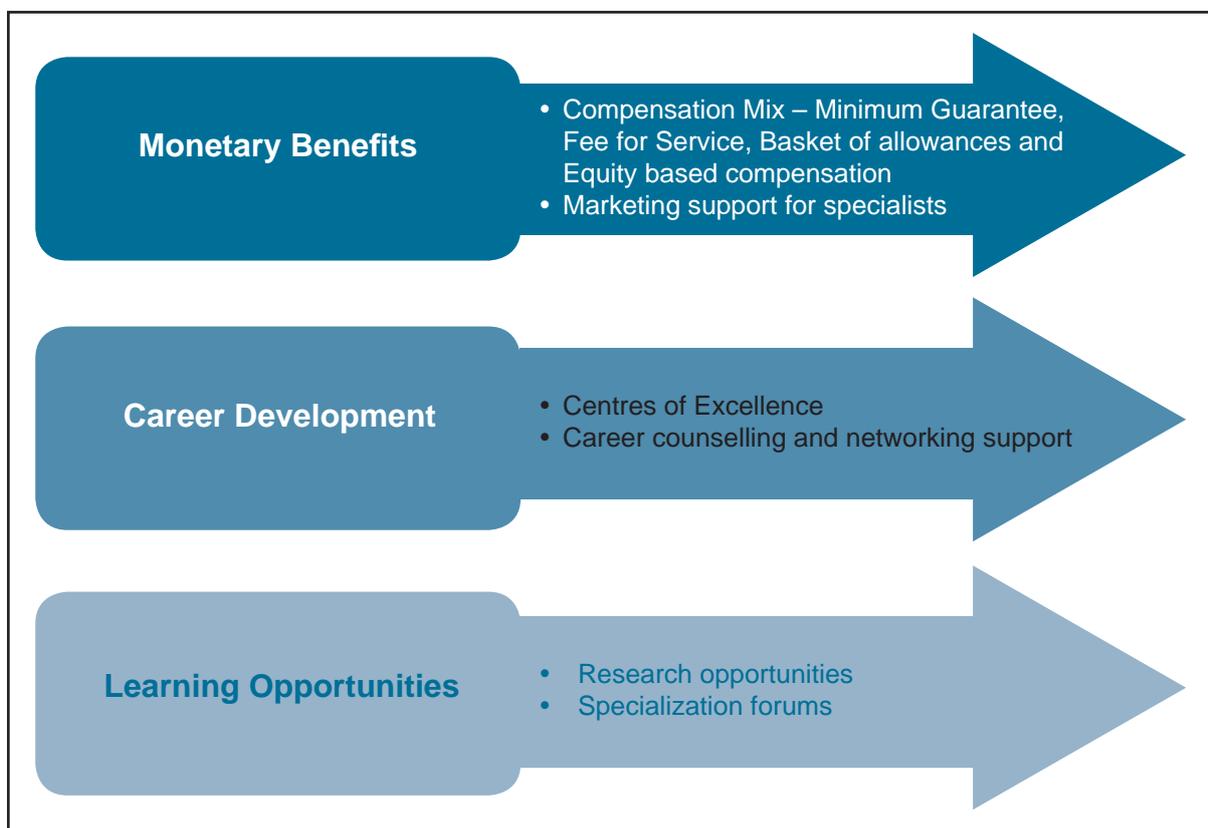
Both monetary and non-monetary schemes such as career advancement opportunities and performance management systems (measuring organizational performance, departmental performance and individual performance) are employed. This linkage or performance measurement to organizational, departmental and individual performance helps make the performance management systems of the hospitals rational, objective and fair, and thereby helps in the retention of doctors.

5.1.2 Drivers

Primary research identifies three drivers for Indian doctors to look for opportunities abroad. These drivers are the ones for which the private sector hospitals have developed countering strategies (represented in Figure 7). Doctors in India find the monetary benefits offered in European countries and the United States attractive. To counter this, private sector hospitals have come up with a compensation mix that consists of options between minimum guarantee payment and fee for service-based payment, and includes a basket of allowances.

Career development opportunities in European countries also attract doctors from private hospitals in India. The hospitals have responded by creating centres of excellence for doctors wherein doctors are provided with an opportunity to head teams practicing particular specializations. The incentive for doctors here is to gain recognition and subject authority. Support to further enhance networking within and outside the hospital, along with career counselling, are retention methodologies being practiced. Learning opportunities abroad, especially in the United States and the United Kingdom have historically attracted doctors. Internal research opportunities and specialization forums can be used to counter this trend.

Figure 7: Retention of doctors at workplace level in private sector -- drivers and strategies



5.1.3 Strategies

Some of the detailed strategies to retain doctors in private hospitals in India are examined in this section. Providing guaranteed money (up to periods such as one or two years) with a guaranteed sum payable to the doctors even if doctors/hospitals terminate the contract, along with an opportunity to form a group (initiated by the Chairman) for clinical specialties, was highlighted as a good practice in private sector hospitals by one of the returnee doctors who was interviewed.

Retention strategies in two of the hospitals whose administrative heads were interviewed include building an atmosphere that encourages research and super-specialization for doctors, and having a healthy mix of fixed pay (or minimum guarantee) and fees for service models. As one of the chief executives who was interviewed mentioned, the doctors do not have a specific one or two year timeline for their minimum guarantee salaries to be paid (as explained in the section on attraction strategies), thereby helping doctors to settle down and concentrate on their work without being worried about income. This also reduces the typical frustration that doctors face as a result of a 100 per cent fee for the service model, which curbs time for research and eventually drives the doctors to look for more balanced opportunities abroad.

At least four of the hospitals where interviews were conducted follow a retention policy of hiring doctors as consultants and protecting their base salary for a fixed period. The hospitals also help publicise the consultant doctors' skills in known networks of professionals and patients, and thereby help in acquiring goodwill among doctors. Once the doctor is established and is a star performer, he is promoted to co-head "centre of excellence", and would be the head of the specialization/practice/unit, thereby providing him/her with a clear career growth plan. Hospitals also spoke of cultural adjustments and counselling to help retain doctors once they join, and prevent them from leaving for the developed countries again. Some hospitals also mention this support system to attract doctors to India. One of the administrative heads interviewed said that doctors are provided with a facility team, which helps them out in their personal/social areas.

5.1.4 Effectiveness

The retention schemes have met with moderate success in the private sector, with hospitals finding them satisfactory. One of the hospitals reported that retention schemes have helped a lot and contributed to retention of around 80 per cent to 85 per cent of doctors, year-on-year within the organization. Other hospitals have also felt that the schemes have impacted retention positively. A 100 per cent fee for service models has been ineffective in retention due to the frustration that doctors face, with less time for research or other interests.

5.2 Workplace Level Retention Incentives in the Public Sector

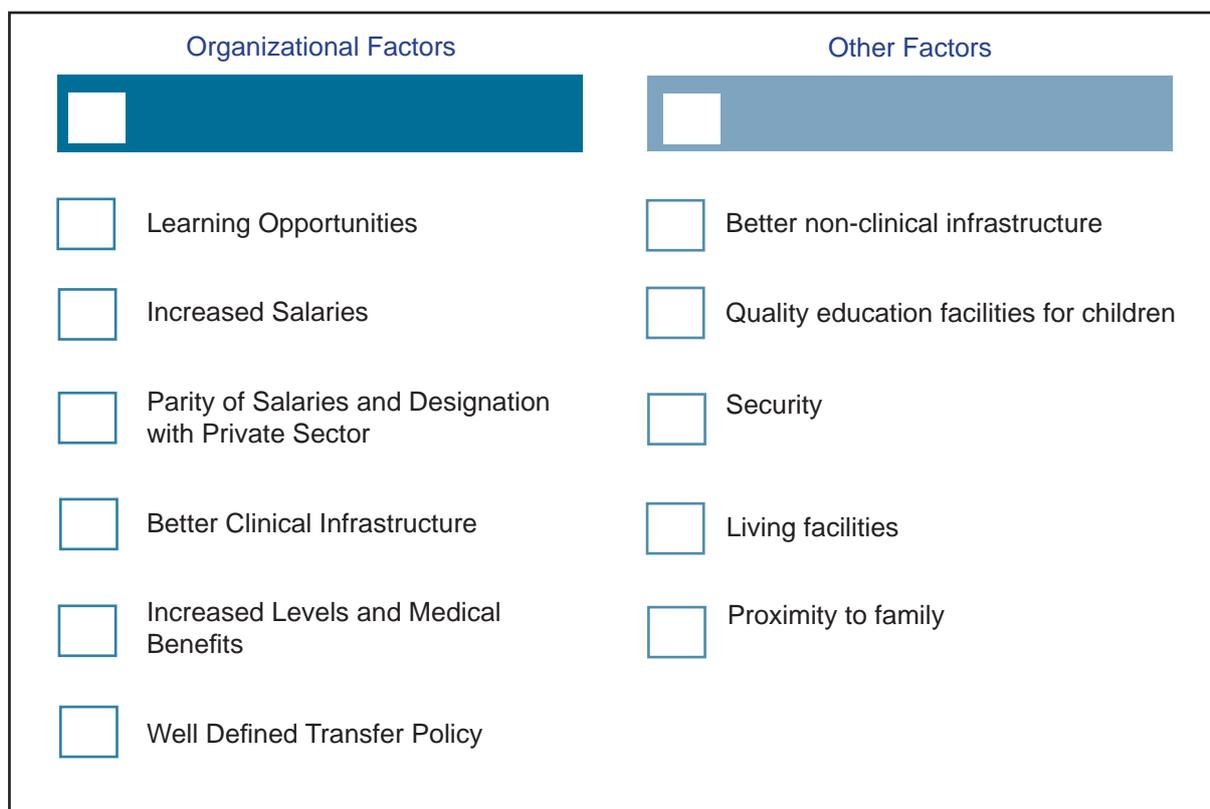
To retain doctors, especially in rural regions, hospitals have met success by increasing incentives. Recent developments in Himachal Pradesh indicate that various incentives such as hardship posting incentive, incentives for additional hours spent, etc. help retain doctors.

Heads of top private hospitals, according to a report in Times of India, state that the salaries for the corresponding posts in their hospitals is relatively higher than public hospitals, but the doctors do not get advantages such as subsidized accommodation, job security, research grants and medical benefits that are offered in good public sector hospitals. On the contrary, some interviews also suggest that it is not just salary but the inadequate clinical infrastructure that forces doctors to leave government institutions -- an aspect that needs improvement and is a possible solution to retaining doctors in public institutions.

Primary research asserts that the retention strategies in the public sector must address two sets of expectations -- organizational and other factors. These form the drivers for retention strategies in the public sector.

5.2.1 Drivers

Figure 8: Public sector retention drivers -- doctor expectations



5.2.2 Strategies

Interviews with doctors and administrative heads in the public sector reveal that the current retention strategies in the public sector address four of the above mentioned drivers, namely:

- 1) learning opportunities -- post graduate and research opportunities;
- 2) living facilities -- accommodation support in premier public sector hospitals;
- 3) medical benefits -- as mentioned in Figure 8, can include benefits like insurance and accident coverage for self and family; and
- 4) high-ranking positions with commensurately increased pay and benefits for senior practitioners.

One of the retention practices that is followed and can be adopted by all public sector hospitals, according to administrative heads, is the funding of post-graduation or super specialization courses for interested doctors, followed by their re-absorption back into the hospitals.

Most of the public sector hospital administrative heads answered in the positive that subsidized accommodation, research grants and medical benefits are retainers. Recruiting students of the medical colleges associated directly with the hospitals (such as AIIMS) by engaging them as employees on completion of their graduate education is in itself a retention strategy, though indirect.

5.2.3 Effectiveness

The stakeholders interviewed were of the opinion that the retention schemes have met with good success in established public sector hospitals, but have yet to percolate down to other public sector hospitals. For example, while AIIMS is a public sector hospital that has gained recognition for its practices, these same practices need to be implemented and followed in other public hospitals, too. While the availability of high ranking positions with commensurately increased pay and benefits for senior practitioners is a factor favouring retention, it is applicable only for doctors who put in a considerable number of years in public institutions.

5.3 State Level Retention Programmes

Before the NRHM was established, state governments covered all human resource costs except for the auxiliary nurse-midwife category. Now about 80 per cent of total health expenditure is borne by the states, and of this, about 70 per cent goes towards salaries. From 2007 onwards, state governments introduced a range of measures with financial support from the federal government to address the problem of retention in rural postings.

5.3.1 Monetary compensation

The pay scales in each state for the respective grade government employees apply to doctors as well. However, since 2007, monthly financial incentives in addition to salaries have been widely introduced across all the states for doctors, nurses and midwives working in remote areas. There is a wide diversity between states in categorizing “difficult” areas. States have used criteria such as distance from urban areas, geographical terrain such as hilly, desert or forested areas, access by roads and public transport, availability of housing and tribal areas or extremist insurgencies to categorize the same. The hardship incentives depend on the cadre of the employee and on the way each state grades difficult areas.

5.3.2 Workforce management policies

Recent experiences from Tamil Nadu and Karnataka states have shown that a major impact on worker morale can be achieved by providing rotational postings in difficult areas and ensuring that everyone spends some years there, after which they could choose to be posted to another area. The NRHM is trying to encourage states to adopt workforce management policies that ensure transparent transfer and placement for doctors and nurses and better residential infrastructure for all health personnel. Although this is apparently an easily achievable reform, in practice it often proves to be the most difficult, given its linkages to basic issues of governance.

5.3.3 Alternative strategies

Almost all states have been addressing specialist shortages by providing doctors with short-term, 18–24 week training courses in emergency obstetric care, including caesarean sections and anaesthesia. Two states, Assam and Chhattisgarh, have created a cadre of rural medical practitioners with three years’ training to exclusively work in primary health care in rural areas. Assam has insisted on local selection and conditional licensing to work only in rural areas and in the public sector. From the point of view of doctors, while this satiates the need for career growth to an extent, it can’t be viewed as a retention strategy.

The need for multi-skilling is being met by training and deploying doctors taught in the indigenous streams of medicine to work as medical officers in primary health centres. This has been used extensively in some states. About 700,000 female community health workers called ASHA (accredited social health activists) are trained to provide basic, first-contact healthcare and to encourage families to seek pregnancy and child health services. The pioneering effort for this was the “Mitandin” programme in Chhattisgarh. The first evaluations of this programme are promising, but they also point to the need for much more investment to be made in this cadre for a greater outcome.

The state of Maharashtra is now producing surplus MBBS doctors. The government of Maharashtra has, therefore, decided to scrap the service bond to serve the rural sector -- which was being signed by all students in government medical college. Earlier, falling short of doctors, especially in rural areas, the state made it mandatory for all fresh MBBS graduates to work for a year in the interiors of the state. But the plans of the government failed to improve medical services in rural areas. Then, the state government made it compulsory for students to sign a bond of Rs. 1 lakh to be admitted for the MBBS course. But that too failed, as the administration found that over 80 per cent of the MBBS graduates paid

the bond money to skip the rural stint. This is not in practice anymore. This can be seen as an indirect method to retain doctors from practicing abroad.

These alternate strategies don't necessarily help retain doctors from going abroad, but can be viewed as a long-term measure to set right the health-care workforce supply chain and career-level pyramid in India.

Despite the efforts of the government and incentives offered, medical students or doctors do not show interest in working in rural areas. The reasons for these are many. Surveys of rural health-care facilities have revealed poor infrastructure, non-availability of medicines and equipment, and even the basic clinical infrastructure. The government in Andhra Pradesh has understood now that in order to retain doctors, basic technology and infrastructure need to be in place. Necessary infrastructure should be in place and hardship allowance also should be provided for really remote/tribal areas.

As much as there is talk of doctors leaving the public sector for the private sector or abroad, possible reasons why they leave might be because of dissatisfaction with some element of their current practice. These may include reasons like low or unsatisfactory salary, the number of patients treated, and the expectation of the kind of injuries or health problems not matching with the existing health problems and injuries in that particular region. In simple terms, when the doctors do not get maximum satisfaction with the work carried out, they prefer moving out and working at private sector hospitals or abroad. Professionals interviewed from the ministry and public sector hospitals like AIIMS and the Employees' State Insurance Corporation have mentioned that if the following factors be carried out in the public sector, there would be a reduced number of doctors leaving the practice: compensation parity with the private sector, strong communication with management, encouragement to provide input into decision and policy making, and adequate appreciation and recognition.

Overall, already known solutions like increasing salary are in need but not sufficient in recruiting or retaining doctors in the public health sector. There is need for a package of incentives, as several factors influence where doctors choose to work. Elements of this package should include an increase in salary, enhanced opportunities for post-graduate education, better equipped and supplied health facilities, improved living conditions, and clear transfer policies. As indicated earlier in the example of Andhra Pradesh, employment bonds do not necessarily encourage retention.

Ministry officials and administrative heads of public sector hospitals opined that creation of subsidized housing for health professionals at district levels, (instead of primary health centre levels), thereby allowing doctors to travel from districts (40-60 kilometre radius) to villages, is a viable retention option. PPPs driving the creation of sub-specialization and super-specialization post-graduation courses in medical colleges (especially in states with poor health indices), was a solution that emerged from discussions during the course of primary research.

Finally, as acquisition and retention are not wholly separate entities, it should be realized that the activities and steps taken to bolster the effectiveness of one should bolster the effectiveness of the other. They do not exist in isolation, and policy makers would do well to remember that strong acquisition measures result in strong retention measures, and vice-versa.

5.4 Bi or Multi-Lateral Level Retention Policies

An effort towards establishing a governing body for human resources in India was through the National Commission for Human Resources in Health bill. The President of India, in an address to the Joint Session of Parliament on 4 June 2009, announced the government's intention to set up a National Commission for Human Resources for Health (NCHRH) as an overarching regulatory body for the health sector to reform the current framework, and enhance supply of skilled personnel. The proposal was discussed with all stakeholders including state governments and experts in the field. On the basis of comments received from states and other stakeholders, a draft cabinet note and bill was prepared and submitted in the Cabinet Secretariat in March 2011. Subsequently the same bill was revised on the basis of the inputs received from the Departments of Higher Education and the Legal Affairs and Legislative Department. However, the bill is yet to be passed. Among other things, this bill could be the solution to the current lack of control on HRH statistics in India. Among other things, this bill could be the solution to the current lack of control on HRH statistics in India, which indirectly can help retention.

The Minister of Health and Family Welfare in India, in his answer to a series of questions from parliamentarians on migration of Indian doctors abroad and its solutions, stated that "the government is aware that large numbers of doctors, nurses and other health professionals migrate to other countries either for pursuing higher studies or for employment. However, no specific information regarding numbers of Indian doctors, nurses and health professionals working abroad is available with the MOHFW. The doctors, registered with the MCI, who go abroad for pursuing courses or for employment, need to obtain Good Standing Certificates (GSCs) from the MCI. In order to arrest this trend in respect of doctors working under government sector, the following steps have been taken by the central government: the pay and allowances of doctors have been enhanced considerably after implementation of the 6th Central Pay Commission; the age of superannuation for faculty of medical institutions has been enhanced to 65 years; assured promotion scheme for faculty of central government institutions has been revised to make it more beneficial; and various allowances available to faculty like non-practicing allowance, conveyance allowance, learning resource allowance, etc. have been enhanced considerably.

The National Health Policy of 2002 was reviewed thoroughly by a high-level expert group that as a part of its suggestion on health manpower, presented the following action points to the planning commission:

1. reorient health-care provision to focus significantly on primary healthcare;
2. strengthen district hospitals;
3. ensure adequate numbers of trained health-care providers and technical health-care workers at different levels by:
 - a. giving primacy to the provision of primary health care; and
 - b. increasing HRH density to achieve WHO norms of at least 23 health workers (doctors, nurses, and midwives) for a population of 10,000; and
4. establish district health knowledge institutes (DHKIs).

Some of the action points mentioned above can have a direct impact on retention of doctors in India. At an international level, the World Medical Association at its General Assembly meeting held in Helsinki, Finland in September 2003, adopted a statement declaring that every country should do its

utmost to educate adequate numbers of doctors, taking into account its needs and resources. No country should rely on immigration from other countries to meet its needs. Countries wishing to recruit doctors from another country should only do so through an MOU between the concerned countries.

Another suggestion that has been made in a study on doctor migration from India is that of the host country compensating the developing country for the loss incurred, on account of the cost of training and value of health-care service that is being deprived. Though quantifying such loss is a difficult task, gross measures can be taken to work out modalities that strengthen the health systems of the source countries. Establishing long-term partnerships including funding and training to strengthen research, clinical training and teaching infrastructure of institutions in the developing countries could be a good step forward.

In a different but related research, Fitzhugh Mullan summarizes three policy options for recipient nations with regard to migration of health-care workers:

1. Practicing the idea of self-sufficiency in recipient nations might take some time to accomplish but this might be a key focus area. It would decrease the demand for doctors from abroad and thereby allow India and other countries to focus their medical education strategies on domestic health-care needs and minimize investments in training doctors who are destined for other medical economies. The fact that large numbers of doctors in the United States, the United Kingdom, Australia, and Canada that come from abroad suggest long-standing patterns of underinvestment in medical education in those countries. This has prompted the United Kingdom, Australia, and Canada to increase their numbers of medical graduates. The focus needs to be on “self-sufficiency.” This would involve education policy aimed at training a physician workforce close to the size of the demand for doctors in practice.
2. Consideration should be given to the sponsorship of special study opportunities for Indian doctors in recipient nations that feature leadership training focused on transferring medical leadership skills for the purpose of return to India. This initiative would be funded by the recipient nations as part of a programme of recognition of Indian doctors’ past contributions to recipient nations. The programme would be developed with bilateral input, be for a specified period, and be offered on a competitive basis to people who already are associated with clinical or academic institutions in India.
3. A separate and parallel programme of exchange consultations, with a similar rationale and funding, might be developed in areas deemed important by India and the recipient countries. Areas that might be appropriate for consideration for Indian doctors coming to the West might include hospital administration, quality improvement strategies, research administration, and primary care. Areas for Western doctors going to India might include infectious diseases, complementary and alternative medicine, health and development, and IT and health.⁹

During interviews, the existence of an MOU between the United Kingdom and the NRHM was explored. Interviewees opined that the United Kingdom has made it abundantly clear that they will support the activities of the NRHM and will not attract those doctors who work for the NRHM.

This is in line with the findings of the secondary research referring to the statement adopted by the aforementioned World Medical Association at its General Assembly meeting in Helsinki.

Additionally, intervention by the MOHFW in foreign trade agreements with developed countries -- stressing on India's inability to part with any health-care professionals except dentists and physiotherapists, is a current practice at the bi or multi-lateral levels.

5.5 Improvement Opportunities

- 1) At the bi or multi-lateral level, steps to increase health insurance penetration in the country that will impact reduction of dependency on doctors for "business development" will help. Standardization of HRH practices and polices across states and government-run hospitals (from a best practice point of view) to avoid disparity in key aspects of health governance across states is one of the retention strategies that can be used. Establishing a body to track returnee doctors and support them to avoid repeat brain drain and negative word-of-mouth about practicing medicine in India will also help. To this, the establishment of teaching banks across states for doctors and specialists who wish to contribute, and recognizing them as teachers and making them available by establishing virtual networks is necessary. Relooking at regulations of MCI on medical training that is currently restricted to medical colleges and ensuring that infrastructure due diligence is in place in any state before hospitals such as AIIMS are established, are other retention strategies suggested.
- 2) At the state level, tapping on doctors' needs to serve their own state by reaching out to them, reviewing and improving NRHM fund utilization and increasing PG seats in each state will help retain doctors.
- 3) At the workplace level, segment-wise retention policies, enhanced compensation packages in the public sector, eliminating business development from doctors' responsibilities and improving clinical infrastructure are improvement opportunities.

6. Solutions: Framework/Descriptive Model

This research asserts that a working model can be drawn out of the current practices in acquisition and retention of doctors only by institutionalizing efforts across all levels and stakeholders. There exists a synergy between efforts in acquisition and retention at the workplace level, the state level and the bi or multi-lateral level. The framework/descriptive model draws from the secondary research, primary research and validation discussions to arrive at a systemic solution to the problem in hand. This section covers the discussion points used to arrive at the framework/descriptive model and the details of the model.

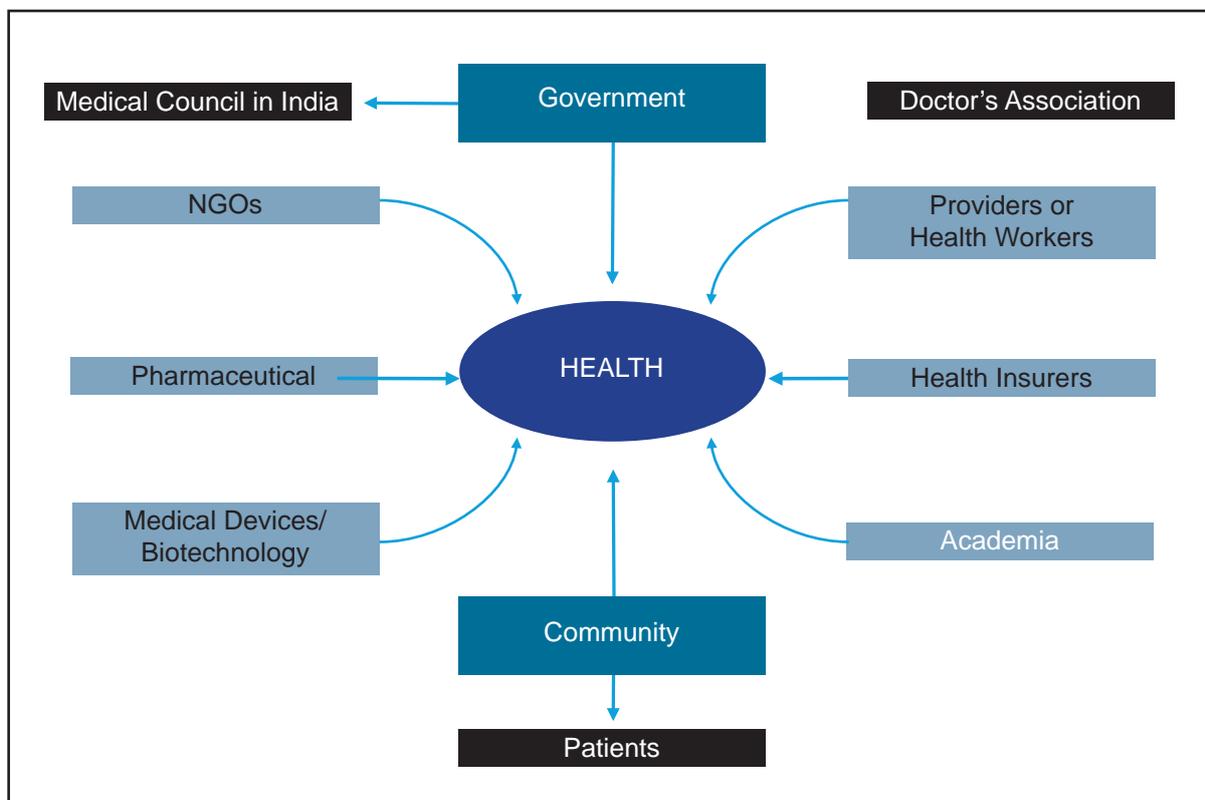
6.1 Discussion Points: Arriving at the Framework/Descriptive Model

6.1.1 The role of multiple stakeholders

Figure 9 below summarizes the role of multiple stakeholders in enhancing the overall health-care system in India. This is an important factor that helps arrive at the construct of the model and deliberates the

stakeholders, who must be involved in the model in order to efficiently manage the acquisition and retention practices for doctors at the three levels. In particular, the role of the government, health-care providers, health insurers and academia has been explored in the model.

Figure 9: Stakeholders in the health-care system



6.1.2 Key Impact Areas

Six broad and over-arching areas of focus that will have the highest impact on the acquisition and retention strategies for doctors have emerged from the research. These focus areas have been referred to by a majority of the stakeholders as necessary action points in multiple stages of the research.

1. Medical education
2. Health insurance
3. HRH policies
4. International relations
5. Doctor tracking
6. Doctor engagement

The action that needs to be taken in these six focus areas and how they translate across the three levels (workplace, state and bi or multi-lateral) are explored in the subsequent section that details the model.

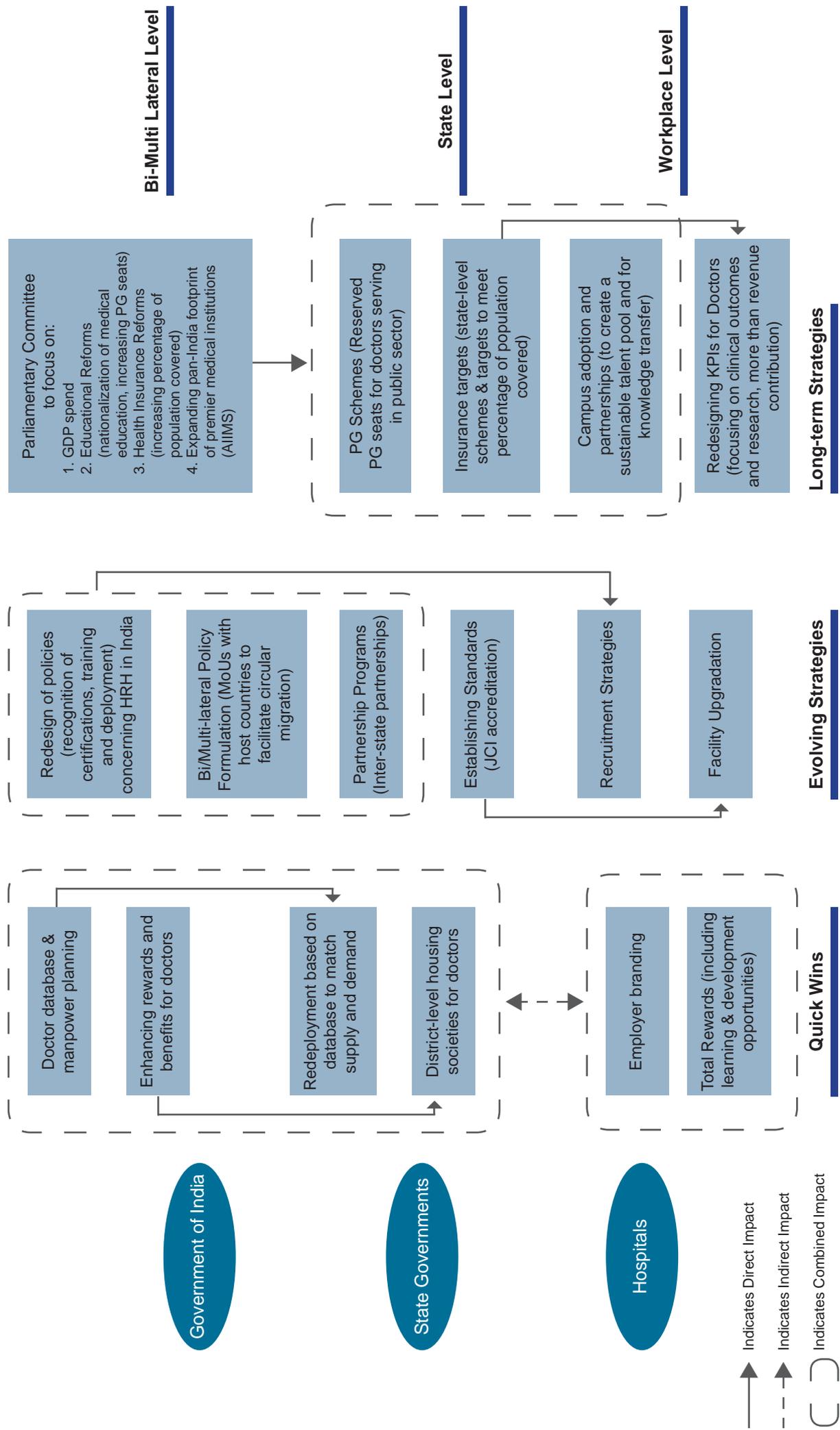
6.2 Framework/Descriptive Model

The framework positions the strategies discussed above, across the three levels of operations (bi or multi-lateral level, state level and workplace level) and further divides them into three categories:

1. Quick Wins: Urgent and pressing impact areas with immediate gains.
2. Evolving Strategies: Impact areas that need continuous attention and review and that will increasingly evolve along with the gains.
3. Long-term Strategies: Impact areas that demand revolutionary changes in the system and will have a long-term impact.

On the left-hand side, the bodies responsible for the strategies at each level are mentioned. Two forms of inter-linkages between these strategies at the three levels exist -- direct and indirect impact represented by solid and dashed lines respectively. Cases where a combination of strategies impact or are impacted by other strategies have been represented by dashed rectangles.

Figure 10: Framework/Descriptive Model



6.3 Decoding the Framework/Descriptive Model

6.3.1 Quick Wins

At the national level, there is an immediate and pressing need to establish a tracking mechanism for doctors' databases in India, followed by accurate manpower planning to meet the future demand and to meet prescribed WHO standards. Currently, the number and names of doctors registered with the MCI is available for access but there is no mechanism capturing changes in the doctors' coordinates (within and outside India) such as status of them practicing, their specialization, geography of current deployment, and this data is unavailable. The doctor database mechanism has far-reaching consequences both from a need and an engagement point of view. While the know-how of doctor statistics is the starting point to solve all doctor-shortage related issues, the data also helps engage specialists by reaching out to them as and when necessary. This therefore directly affects the state level strategies of redeployment based on the database to match supply and demand.

Equally important immediate targets at the national level are enhancing the rewards and benefits for doctors. As mentioned by the Minister for Health and Family Welfare, a host of benefit measures for central government employees ranging from pay increase to promotion and extension of superannuation age have already begun. A directly related strategy to enhancing benefits, widely suggested to be an urgent need across the nation by all stakeholders of this research, is the district-level housing societies for doctors. One of the keys to solving the severe doctor shortage crisis in rural areas is providing good and acceptable housing and living standards to doctors who work in these areas. Here, the decentralized governance structure of the country (divided into districts) needs to be synergized with health-care personnel benefits. Subsidized housing for health professionals at district levels, (instead of primary health centre levels), thereby allowing health professionals to travel from districts to villages is a widely suggested idea.

Together, the four strategies, namely doctor database and manpower planning, enhancing rewards and benefits for doctors (which could include an entire gamut of compensation and benefits-based changes including aspects that concern work-life balance, women-friendly policies, tax holidays in public sector, etc.), redeployment of doctors based on supply and demand, and district-level housing societies are indirectly impacted and indirectly impact the suggested workplace level strategies of employer branding and total rewards. While employer branding refers to the hospitals' efforts to display their key differentiators as an employer of good talent, total rewards concern all the monetary and non-monetary benefits received by doctors in these hospitals, which help them be satisfied and engaged employees.

6.3.2 Evolving Strategies

Policies on recognition of certifications both from India and abroad, training licenses and deployment concerning HRH in India and bi or multi-lateral policy formulations with regards to MOUs with host countries and Indian associations in these countries (such as AAPI and BAPIO) to facilitate circular migration are currently either in a state of paralysis or moving very slowly in India. Hence, there exists a need to relook at these two critical policy mechanisms with a sustained effort and help develop tools to continuously evolve these policies in line with the changing times. Development of policies on retention and migration of health-care professionals can also be looked at under the gamut of HRH policies.

Partnerships to redeploy doctors and health-care personnel need not be only global in nature. There is also a need for inter-state partnerships in this regards to together meet the nation's demand supply cavity. Together these three evolving strategies directly impact recruitment strategies at a workplace level by creating a policy atmosphere to facilitate the attraction of doctors from abroad.

In parallel, work needs to be done on establishing standards in clinical, non-clinical infrastructure and (currently plagued with issues including red-tape as discussed earlier in the report) medical practices as such to attract doctors back to India and to retain them in the country. State level strategies of establishing international standards, such as JCI accreditation to hospitals and the consequent facility up-gradation drives at the workplace level in individual hospitals, are most needed to solve the attraction-retention puzzle.

Long-term Strategies

In addition to quick wins and evolving strategies, there is a definite need to fix a few issues hurting Indian healthcare from the roots. Four particular issues are:

- 1) the low national expenditure on healthcare;
- 2) the low number of medical colleges providing graduation and post-graduation courses;
- 3) the low penetration of health insurance in the country; and
- 4) the lack of any chain of premier government-run medical institutions across the country.

These are long-term issues that need resolution in order to have a sustainable health-care mechanism in the country.

To begin with, a parliamentary committee (comprising of officials from the MOHFW, MCI and the MOIA) must be set up to examine these issues and suggest concrete changes in the system, including possibilities of nationalization of medical education and increasing PG seats. These will directly impact state-level strategies of reserving PG seats for doctors serving in the public sector and schemes and targets to meet a minimum percentage of population covered by health insurance in the state. Workplace level campus adoption and partnerships that refer to opportunities like internships that a college can provide to graduates in any hospitals practicing or specialising in any branch of medicine (to create a sustainable talent pool and knowledge transfer mechanisms which includes employment opportunities etc.), will also be impacted directly by the findings and recommendations of the said parliamentary committee.

Health insurance penetration will further change the face of performance indicators for doctors, marking a paradigm shift of focus from revenue contribution to clinical outcomes and research. This has immense potential to both retain and attract doctors as majority stakeholders of the research identified with revenue contribution as an impediment to establishing a fulfilling career in the country.

6.4 Concluding Thoughts and Scope for Further Research

At each level -- the workplace, the state and bi or multi-lateral, a clear demarcation exists for the stakeholders to play roles relevant to their scope and span. A successful effort to enable a working model for seamless acquisition and retention of Indian doctors from host countries can only be complete if synergies across these three levels are established clearly and all three strategies -- long term, evolving, and quick wins are acted on in tandem. The model described in this section needs to be applied to the rest of health-care personnel such as nurses, AYUSH professionals, health officers and allied workers after detailed research and modifications to suit those categories of workforce. Research also needs to be commissioned on pending health-care related bills such as the NCHRH.

“The health of nations is more important than the wealth of nations” said American philosopher Will Durant. The time has come to energize efforts in this direction.

References

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

All India Institute of Medical Science. *Introduction*. Available at: <http://www.aiims.edu/aiims/about-aiims/aboutaiimsintro.htm>

Bakhru, G. 2012. *India's Hospitals: India's health gap*, HSBC Global Research

Bhattacharjee, A. *Migration of Indian Health Professionals to Selected European Nations: The Case of Denmark, Netherlands, Norway, Sweden*. CARIM-India RR 2013/07, Robert Schuman Centre for Advanced Studies

Bhojani, U. et al. 2012. *Bringing Evidence into Public Health Policy (EPHP) 2012: Strengthening health systems to achieve universal health coverage* in BMC Proceedings 2012, Volume 6 Suppl. 5. Available at: <http://www.biomedcentral.com/bmcproc/supplements/6/S5>

Butler, P. 2008. "How Migrants Helped Make the NHS" available at: <http://www.theguardian.com/society/2008/jun/18/nhs60.nhs2>

CARIM-India and EU: Developing a Knowledge Base for Policymaking on India, 2013.

Columbia Asia. 2010. "Columbia Asia Attracts Indian Doctors Back Home" available at <http://www.columbiaasia.com/doctors.html>

Dayrit, M. et al. 2008. *WHO code of practice on the international recruitment of health personnel* in Bulletin of the World Health Organization Volume 86. Available at: <http://www.who.int/bulletin/volumes/86/10/08-058578/en/>

Express News Service. 2012 "HP Govt. Hikes Incentives for Doctors in Tribal Areas" available at <http://archive.indianexpress.com/news/hp-govt-hikes-incentives-for-doctors-in-tribal-areas/972249/>

Fargues, P. et al. 2009. *EU-India Mobility Cooperation: A Strategic Asset and a Field of Opportunities*. Scientific Working Group on EU-India Mobility Cooperation. Available at: http://issuu.com/observatoriodiasporas/docs/eu-india_migrationpolicypaper-nov09

Government of India; Ministry of Health and Family Welfare. 2011. *Annual Report to the People on Health*

Government of India; Ministry of Health and Family Welfare. 2013 *Instructions for Candidates applying for Statement of Need (SON) certificate or Exceptional Need Certificate (ENC) for joining training program/ course in medical specialties in medical institutions out of India*

Government of India, Ministry of Health and Family Welfare, Lok Sabha Questions. 2012. Unstarred Question No. 438. Available at: <http://164.100.47.132/lssnew/psearch/qresult15.aspx?qref=131314>

Govindarajan, V; Ramamurti, R. 2013. “India’s Secret to Low Health Care” available at: <http://blogs.hbr.org/2013/10/indias-secret-to-low-cost-health-care/>

Graci’a-Pe’rez, M.A., et al. 2007. *Physicians’ Migration in Europe: An Overview of the Current Situation* in BMC Health Services Research 2007 7:201. Available at: <http://www.biomedcentral.com/content/pdf/1472-6963-7-201.pdf>

Gudwani, A., et al. 2012 *India Healthcare: Inspiring possibilities, challenging journey*, Healthcare Services and Systems, McKinsey & Company. Available at: [http://www.mckinsey.com/McKinsey/Of-fices/India_healthcare Inspiring possibilities and challenging journey Executive Summary.pdf](http://www.mckinsey.com/McKinsey/Of-fices/India_healthcare_Inspiring_possibilities_and_challenging_journey_Executive_Summary.pdf)

Hazarika, I., et al. 2011. *India: Mobility of Health Professionals* in Public Health Foundation of India

Jha, D.N. 2014. “AIIMS spends Rs. 20 lakh on doctors in a year: Study” available at: <http://timesofindia.indiatimes.com/india/aiims-spends-rs-20-lakh-on-doctors-in-a-year-study/articleshow/30131348.cms>

Kindo, L. 2011. “Will The Exodus Of Indian Doctors Continue?”. Available at: <http://www.medicalisland.net/featured/will-the-exodus-of-indian-doctors-continue>

Khadria, B. 2002. *India: Skilled Migration to Developed Countries: Study on India* in International Migration Papers 49, International Migration Program. Available at: http://ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---migrant/documents/publication/wcms_201778.pdf

Kumar, U.A. 2013. “India has just one doctor for every 1700 people” in *The New Indian Express*. Available at: <http://www.newindianexpress.com/magazine/India-has-just-one-doctor-for-every-1700-people/2013/09/22/article1792010.ece>

Kumar, A. 2010. *National Health Profile 2010* 6th Issue in Central Bureau of Health Intelligence

Medical recruitment agency. 2010. “Why Indian Doctors Are In Demand for Overseas Recruitment” available at: <http://www.medicalrecruitmentagency.com/blog/why-indian-doctors-are-in-demand-for-overseas-recruitment/>

Mishra, R.A. 2013. “India’s ranking on global competitiveness index drops to 60” available at <http://www.livemint.Com/politics/1bg1dagfgywoe7hbuwtcul/Global-Competitiveness-Indias-Slide-Continues.html>

Mullan, F. 2006. “Doctors For The World: Indian Physician Emigration” available at: <http://Content.Healthaffairs.Org/Content/25/2/380.Full>

Nandakumar, S. 2004. *What’s Up Doc.* (Parity Paperback)

PTI. 2012. “Nationwide Strike of Doctors Called by Indian Medical Association Today” available at: <http://www.ndtv.com/article/india/nationwide-strike-of-doctors-called-by-indian-medical-association-today-235491>

Rao, K.D., et al.2012. *So many, yet few: Human resources for health in India* in Human Resources for Health 2012 10:19. <http://www.human-resources-health.com/content/pdf/1478-4491-10-19.pdf>

Rao, K.D.; Ramani, S. 2013. *What works, where, and how well? Lessons from a comparative assessment of current rural retention strategies for doctors in India* in Human Resources Technical Paper II, Public Health Foundation of India.

Shroff, Z.C., et al. 2013. *Attracting Doctors to Rural Areas: A Case Study of the Post-Graduate Seat Reservation Scheme in Andhra Pradesh* in Indian J community med V38 (1). Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/pmc3612293/>

Shukla, S. “Paying For Performance” available at <http://healthcare.financialexpress.com/200808/healthcarelife01.shtml>

Silicon India. 2013. “Indian Medical Students Flee Abroad” available at <http://Www.Siliconindia.Com/News/General/Indian-Medical-Students-Flee-Abroad-Due-To-Scarcity-Of-Pg-Seats-Nid-153196-Cid-1.Html>

Sundararaman, T; Gupta, G. 2011. *Indian Approaches to Retaining Skilled Health Workers in Rural Areas* in Bull World Health Organ 89:73-77. Available at: <http://www.who.int/bulletin/volumes/89/1/09-070862.pdf>

Thakur, J.S. 2011. *Key Recommendations of High-Level Expert Group Report on Universal Health Coverage for India* in Indian J Community Med v36 (Suppl. 1). Available at : <http://www.ncbi.nlm.nih.gov/pmc/articles/pmc3354908/>

The Hindu. 2012. “A Bond That Is No Panacea” available at: <http://www.thehindu.com/opinion/editorial/a-bond-that-is-no-panacea/article3353729.ece>

Annexure I: Technique Used to Shortlist Hospitals and Stakeholders

Short-listing of Hospitals

Given the lack of a single source of information on health-care trends in India and trends on migration of health-care professionals between India and select European countries, the locations where primary interviews would be conducted were selected in order to ensure pan-India coverage of private and public employers of health professionals in India.

The list of hospitals was arrived at from the MOHFW and the MCI, and was restricted to the following five locations: National Capital Region (NCR), Mumbai, Chennai, Kolkata and Bangalore. The hospitals shortlisted from this list were arrived at on the basis of convenient sampling, which includes hospitals that have a relationship with FICCI and Deloitte, and were further shortlisted by deploying at least two of the four below filters, verified from sources mentioned in the table below:

Key criteria to arrive at a short list of hospitals	Filters	Verified from
Number of beds	Hospitals having more than 150 beds	Capitaline database* and company websites
Clinical specialties	Minimum single specialty hospitals (among major clinical specialties in India, but not limited to cardiology, oncology, neurology, paediatrics and gastroenterology)	Capitaline database*, annual reports from company websites and company websites
Accreditation	JCI (Joint Commission International)/NABH (National Accreditation Board for Hospitals and Hospitals) accreditation, as applicable	JCI and NABH accreditation lists
International presence	Presence in at least one country other than India	Company websites

Based on the guidelines established above, a total of 65 hospitals were identified across five locations in order to conduct interviews with the stakeholders, with a minimum of seven hospitals in each of the locations. The number of hospitals is 65 in order to ensure that at least 30 interviews can be conducted with stakeholders (including the stakeholders participating in the validation event).

Short-listing Stakeholders

To examine the effectiveness of practices at the workplace level, primary interviews were held with doctors only if they had returned from European countries to the hospitals shortlisted using the filters mentioned above.

To examine the effectiveness of practices pertaining to incentives, policies and programmes at the state level and bi or multi-lateral (cooperation) level, primary interviews were held with officials from the MOHFW and the MOIA.

The targeted total number of interviews (with all stakeholders) was fixed at approximately 30 (this being a statistically significant number) for the identified five locations, inclusive of the participants in the validation event. This target was further split into:

- 1) 20 hospitals -- administrative heads, clinical heads, HR heads or professionals;
- 2) Eight doctors; and
- 3) Three ministry officials.

Assumption of the Sampling Methodology

- The term health-care worker in this study is limited only to doctors across clinical specialties with a minimum qualification of MBBS and excludes BHMS, BAMS, BUMS and all health-care workers related to AYUSH practice.

Limitations of the Sampling Methodology

- The sample size for interviews with key stakeholders for the study is limited to 30 interviews.
- The first list of hospitals, which is further validated using defined filters, is arrived on the basis of convenient sampling that includes hospitals that have a relationship with FICCI and Deloitte.
- The study does not focus on migration problems in individual states and attempts to cover the problem from a sending country perspective (national view point).

Annexure II: Primary Data Collection Instrument

Questionnaires

- 1) Questionnaire for doctors
- 2) Questionnaire for hospital personnel
- 3) Discussion guide for ministry officials

Thematic Analysis of Interviews

Questionnaire A: Questionnaire for doctors

S1 No.	Questions	Themes
1.	Are there certain specializations that are not as well-developed in India as they are abroad?	Drivers vis-à-vis strategies for acquisition and retention
2.	What are some of the factors that motivate doctors to go abroad?	
3.	Are Indian doctors hired? If yes, how many have been hired recently (last 2-3 years)? Would they constitute a significant percentage of the total workforce?	
4.	Do you think return migration of health professionals has increased over the past years? If increased/decreased, why?	
5.	What has been the success rate in attracting Indian doctors back to India?	
6.	What are your thoughts on efforts we need to take as a country to attract talent?	
7.	Which city, according to you, attracts the most number of returning doctors?	
8.	What are your thoughts on efforts we need to take as a country to attract talent?	Acquisition of doctors
9.	In cases where doctors plan to migrate, are retention plans adopted? If yes, what are they?	Retention of doctors
10.	Are there any benefits provided/ strategies adopted to facilitate circular migration? If yes, can the strategies be categorized into social acceptance, monetary, esteem, opportunities for research and learning?	
11.	Are there staff retention policy/schemes in the hospital? If yes, what are the policies adopted? Was the policy evolved over time? What are the challenges faced in implementing them?	

S1 No.	Questions	Themes
12.	How much of an effect do the schemes and policies facilitate circular migration?	
13.	Are there tie-ups with any foreign hospital/university that will allow Indian doctors to be trained in India?	

Questionnaire for Ministry officials

International migration among healthcare professionals is not a new phenomenon, but migration flows of workers in this sector have increased significantly in recent years. While migrant health care workers from developing countries are contributing to the health care sector of developed countries, the migration of professionals and skilled workers from developing countries is perceived to negatively affect the development potentials of the countries of origin. This phenomenon has been referred to as the “brain drain”. The international migration of health care professionals directly impacts the achievement of health-related Millennium Development Goals (MDGs), which relies upon strong and sufficiently staffed national health care systems. As a consequence, sending and receiving countries have shown interest in developing voluntary policies to facilitate the return of healthcare professionals to their source country with the aim to support their resuming active participation in the health workforce of their home country. One of the underlying assumptions is that health workers will return to their country of origin. However, there is a need to understand and document what would bring health professionals back to their country of origin; the incentives that are present for them to return and to retain them when they are back. In order to collect specific data on each practice/ process, in-depth interviews are conducted with selected audience using a purpose built assessment tool to be developed by the Deloitte and validated by the FICCI / ILO.

S1 No.	Questions
1.	Could you provide us insights / statistics of doctors returning to India in the last 2-3 years? (what cities have they moved to, clinical specialties)
2.	What is the effectiveness of national policies in India to facilitate circular migration?
3.	What challenges do we face as country in implementing the policies / schemes that facilitate circular migration?
4.	What are your thoughts on efforts we need to take as a country to facilitate circular migration (strengthening areas like building our education system, specialization etc.?)
5.	According to you, how could stakeholders contribute to circular migration / retention of Indian doctors?

Annexure III: Stakeholder List for Primary Research and Validation Event

Distribution

The distribution of stakeholders for primary research and validation event across stakeholder categories vis-à-vis targeted numbers are mentioned below:

S1 No.	Type of Stakeholder	Target No. of stakeholders to be interacted with	Actual No. of stakeholders interacted
1	Returnee doctors	8	8
2	Administrative and HR heads	20	24
3	Ministry officials	3	3

The distribution of stakeholders for primary research and validation event across public sector, private sector and ministry officials is mentioned below:

S1 No.	Type of Stakeholder	No. of stakeholders to be interacted with
1	Public sector	12
2	Private sector	20
3	Ministry officials	3

The distribution of stakeholders across primary research and validation event is mentioned below:

S1 No.	Type of Stakeholder	No. of stakeholders to be interacted with
1	Interacted with during primary research	19
2	Interacted with during validation event	13
3	Both	3

The complete list of stakeholders interacted with during the primary research as well as the validation event is mentioned in the table below:

S. No	Name	Designation and organization
1	Dr Navneet Kumar Dhamija	Dy. Commissioner (Training & Telemedicine), Ministry of Health & Family Welfare, Govt. of India
2	Dr Sumant Mishra	Chief of Health Services, Government of Jharkhand
3	Dr Naresh Chawla	Former President, Delhi Medical Association
4	Dr B. Premkumar	Senior VP -- Medical, Apollo Hospitals Enterprise Ltd and former Dean -- Madras Medical College
5	Chandra Shekar	Executive Director, Global Hospitals
6	Father Pinto	Director, Holy Family Hospital
7	Ganesh Selvaraj	Senior GM and Head HR, Manipal Health Enterprises
8	Joy Chakraborty	Senior Manager – Operations, Hinduja Hospital
9	Dr Praneet Kumar	CEO, BLK Hospitals
10	Ranjan B Pandey	Head -- Corporate HR, Fortis Healthcare Ltd
11	Russell Rozario	Head HR, Metropolis India
12	Dr Shubnam Singh	Dean -- Nursing, Allied Health, & Wellness Programmes, Max Healthcare
14	Kirubasagar Balachandar	DGM (HR) Corporate - Narayana Hrudayalaya
15	Dr S. Warsi	Holy Family Hospital
16	Dr Arun Agarwal	Chairman, Delhi Medical Council & former Dean, Maulana Azad College
17	Dr MC Singhal	Sr. Vice President, Delhi Medical Association Head of Department, Pulmonary Medicine, ESI Hospital, Rohini
18	Dr Narottam Puri	National Accreditation Board for Hospitals & Healthcare Providers & Medical Advisor -- Fortis Healthcare Ltd.
19	Dr Sanjay. K. Arya	Registrar, AIIMS
20	K.D. Rao	Sr. Public Health Specialist, Public Health Foundation of India
21	P.B. Mani	Regional Director-South, ESIC

S. No	Name	Designation and organization
22	Dr Ashok Goel	Head -- Joint Replacement, Balaji Action Medical Institute
23	Dr Ramakanth Agarwal	AIIMS
24	Sumit Grover	Manager -- Capacity Building (HR) -- Indraprastha Apollo
25	Dr Vivek Gupta	Senior Consultant -- Interventional Cardiology - Indraprastha Apollo
26	Dr (Professor) Man Mohan Mehndiratta	President Indian Academy of Neurology 2012-2013, President Indian Academy of Neurology 2012-2013, Professor & HOD (Neurology), Janakpuri Super Specialty Hospital
27	Dr Rakesh Mathur	Medical Director, Chairman -- Radiology & Imaging Radiology, Saket City Hospital
28	Dr Nipun Chaudhary	Academic Head, Indraprastha Apollo
29	Dr Daljit Singh	Professor -- Neurosurgery, G B PANT Hospital
30	Noyal Thomas	Director (DS), Ministry of Indian Overseas Affairs
31	Dr Devi Shetty	Founder and Chairman, Narayana Hrudayalaya Group of Hospitals
32	Kavita	Assistant Manager (HR); Metropolis Healthcare
33	Dr Harsh Bhardwaj	Resident, Neurology, Department of Neurology, IHBAS
34	Dr Payal Sharma	Deputy Medical Superintendent, Rajiv Gandhi Cancer Hospital
35	Dr Ruchi Singhal	Consultant -- Gynaecology, RMC Polyclinic
36	Focus group discussion	Returnee doctors from Saket City Hospitals

ILO DWT for South Asia and Country Office for India
Core 4B, 3rd Floor
India Habitat Centre
Lodhi Road
New Delhi-110003
India
Tel:+91 11 4750 9200
Fax:+91 11 2460 2111
Website:www.ilo.org/india
Email:delhi@ilo.org

DECENT WORK

A better world starts here.

ISSN 2227-4391; 2227-4405