Is the concept of ethics misplaced in the migration of Indian trained dentists to Australia? The need for better international co-operation in dentistry

Authors: Madhan Balasubramanian and Stephanie Short
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Byline: Madhan. Balasubramanian, Stephanie. Short

The purpose of this article is to discuss the ethics involved in the migration of Indian trained dentists to Australia. It develops from interviews of senior oral health leaders in both the countries to provide evidence that ethics in migration is diluted in practice and to suggest that migratory procedures in both the countries should be reconsidered. There is also an urgent need for more organized bilateral communication and negotiation between the concerned organizations of both the countries (dental councils, immigration departments and research centers) in order to prevent the somewhat irreversible and intensive brain drain of top quality dentists from India to Australia. We would suggest as a starting point better monitoring of the migrants' academic and social background, the nature of the educational investment in India and the nature of the stay in Australia. This new information base could possibly lay the groundwork for more restrictive policies to be introduced both in Australia and India.

Over the years, the concept of ethics in the migration of health professionals has evolved into two major schools of thought. One school of thought holds that the international migration of personnel from low-income to high-income countries is unethical and harmful, and the other that this migration is beneficial to the "source" country. The purpose of this article is to discuss how conflicting views of these two schools of thought have contributed to the migratory practices for "internationally trained dentists". It develops from the case of Indian dentists migrating to Australia, and provides evidence to claim that ethics in migration is diluted in practice and calls for better international cooperation between concerned dental organizations of both source and recipient countries in order to prevent the somewhat irreversible intensive migration of top quality oral health professionals from India.

The Two Schools of Ethical Thought in Migration

The concept of ethics in migration emerged in the early 1960s to highlight educational investment loss in Britain, due to the migration of British-trained scientists and physicians to other developed countries (mainly, the USA and Canada). In due course, ethics became an even stronger case in discussing the migration of health personnel between developing and developed countries. The World Health Organization has regularly expressed concerns about the distribution of health professionals between developing and developed countries, and the effects of migration vis-a-vis this disparity. [sup][1],[2] Several international organizations and professional associations have also discussed the ethical problem, and as a result some ethical protocols have been put in place.

The dominant mode of thinking (as reflective of this ethical debate) is to restrict the migration of highly trained health professionals in order to avoid loss in investment, and preserve the scarce health personnel resources in developing countries. This school of thought placed emphasis on selective recruitment in recipient countries (based on the region of origin of health professionals) and capacity building in source countries (through better monitoring of health personnel).

Alongside this notion, a second school of thought was also fostered. This focused on the complexities involved in migration policies and benefits to the source country due to migration. [sup][3],[4] Migration was considered as mostly unavoidable due to several human rights problems. This school of thought also focused on financial investments and knowledge gain/sharing made by the emigrants to their home country. It could be argued that this mode of thought mainly takes a global development perspective, with more emphasis on long-term benefits and on the unavoidable nature of migration.

The Case of Indian Dentists Migrating to Australia

In a recent study on Indian dentists migrating to Australia, 15 key informants in the field of oral health (a mixture of senior academics, researchers and administrators), both from India and Australia, were interviewed. Each interview lasted around 45-60 minutes, and included questions on the nature, size, regulations and ethics of migration. Discussion on international cooperation formed a major part of the interview, with topics ranging from bilateral to multilateral (role of Commonwealth, World Dental Federation, World Health Organization). The results discussed explore only one aspect of a wider research study on Strengthening Dental Workforce Governance in the Commonwealth. Results on the role of the Commonwealth (and other international organisations) on dental workforce governance has been published elsewhere. [sup][5] Ethical approval for this research was obtained from the University of Queensland: MB05112008.

A key issue which emerged was the difference in how the migration was interpreted. While one group considered all migration as avoidable and unethical , the other group felt it was unavoidable and justified .

" As far as the norm is considered the distribution of dentists in India is definitely less. The distribution is so disproportionate that all the dentists want to live in posh urban localities. The large rural population remains unserved or underserved ".

Indian Dental Academic

The avoidable and unethical group purported claims in relation to the underlying health care scenario of the source country (India), highlighting the growing need of dentists in rural and remote areas, and greater prevalence of oral disease. In addition, some of them also stressed on the resources spent in training dental personnel. One key Indian oral health administrator went to the extent of asking, " One doctor costs around 1.7 crore rupees. And why should he be allowed to go now? " On reciprocity issues, a senior Indian academic indicates, " One possibility is to give the Indian government the investment made on the student ". These were also considered appropriate by some of the Australian interviewees. The dominant mode of thought was that migration was detrimental, and at best should be prevented or at least compensated.

" Fairness is a relative concept… Countries work according to the notion of competitive advantage, and it is to Australia's advantage - if they can't produce them (dentists) to the amount required - they should buy them as cheaply as they can from other countries ".

Australian Social Scientist

In contrast, the unavoidable and justified group expressed doubts on the concept of fairness. Migration was considered as unavoidable, with supporting arguments on the demand and supply of dentists in the source and recipient countries. A senior Indian researcher suggested, " Migration is a human rights issue and you cannot stop any one from migrating ". An Australian academic also claimed, " They do in fact make substantial financial contribution to their families in their own countries ". It was suggested that in the long term, migration leads to significant investment and development in the source country.

Conflicting Views and the Ethical Paradox

For decades, the migration of dentists into Australia was considered as mainly one from developed countries. [sup][6] The entry of internationally trained dentists not directly registrable in Australia is through a national examination system. These procedures were implemented to select dentists of an acceptable quality to suit the underlying health system concerns. The examinations are perceived to be of very high standard, and are often revised to maintain effective selection of international graduates. To some extent, these reasons have partially contributed to the limited number of entrants through this pathway. The quality of these examinations permits only the top or more experienced oral health professionals to migrate. However, these numbers have substantially risen by at least fivefold between 2003 and 2006. [sup][7] The underlying context for this increase is the growing demand for dental care in Australia.

The Indian dental education system consists of around 290 dental schools, and produces around 15,000 graduates each year, [sup][8] with an annual output almost the size of Australia (in the number of dentists). However, the dentist to population ratio in India is very low compared to Australia, and there are significant disparities in the rural and urban distribution of dentists. [sup][9] The dental health care system has often found it difficult to direct the vast dental workforce resources into visible gains in oral health status. [sup][10] As more than three-quarters of the Indian population live in rural areas, the majority are still unserved or underserved. Migration poses a serious problem to India. While on one side there is paucity of data on the nature and size of such migration, on the other side differences in state/territory educational systems, and freedom of movement concerns have considerably lessened the possibility of the Indian government to consider restrictive measures. This places India in a highly vulnerable position to lose the educational investment made on dental graduates.

The accepted notion that migration of dentists into Australia is mainly one from developed countries is gradually fading. The tough examination and licensing procedures imposed on Indian trained dentists restricts only the best to migrate. The successful graduates are encouraged toward permanent residency in Australia. Such migrants, though few in number, could very well be leaders in the field and constitute a significant loss to the source country. In addition, the massive growth in the number of dental graduates and inadequate migratory restrictions in India has contributed to the increasing number of dentists seeking to travel overseas.

Conflicting views from senior oral health professionals reflect the fact that both the countries are unable to maintain ethical migratory practices. As the two schools of thought are universally prevalent, it is hard to suggest that either country has a dominant view. This difference could have a historical link, with underlying health care concerns contributing toward the development. In addition, international laws on human rights could have also influenced current migration policies. Therefore, there is some scope to suggest that the ethics involved in current migratory procedures in both countries need to be reconsidered.

On Reflection

The case of Indian dentists migrating to Australia is a good example to suggest how conflicting views between two groups have contributed to the ethical paradox, resulting in the dilution of ethics and causing the migration of top quality leaders from India. In the context of globalization, there is a need for more organized bilateral communication and negotiation between the concerned organizations of both the countries (dental councils, immigration departments and research centers). It would be beneficial to work together to curtail the somewhat irreversible and intensive brain drain of top quality dentists from India to Australia. We would suggest as a starting point better monitoring of the migrants' academic and social background, the nature of the educational investment in India and the nature of the stay in Australia. This new information base could possibly lay the groundwork for more restrictive policies to be introduced both in Australia and India.

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