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International Migration of Health Professionals and the Marketization and Privatization of Health Education in India: From Push-Pull to Global Political Economy

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ABSTRACT

Health worker migration theories have tended to focus on labour market conditions as principal push or pull factors. The role of education systems in producing internationally oriented health workers has been less explored. In place of the traditional conceptual approaches to understanding health worker, especially nurse, migration, I advocate global political economy (GPE) as a perspective that can highlight how educational investment and global migration tendencies are increasing interlinked. The Indian case illustrates the globally oriented nature of health care training, and informs a broader understanding of both the process of health worker migration, and how it reflects wider marketization tendencies evident in India's education and health systems. The Indian case also demonstrates how the global orientation of education systems in source regions is increasingly central to comprehending the place of health workers in the global and Asian rise in migration. The paper concludes that Indian corporate health care training systems are increasingly aligned with the production of professionals orientated to globally integrated health human resource labour markets, and our conceptual analysis of such processes must effectively reflect these tendencies.

Keywords: India, Migration, Education, Nursing, Global political economy

INTRODUCTION

The current period of health care globalization demands we adopt a conceptual framework that recognizes global integration and interaction between health human resource (HHR) systems across different jurisdictions. Literature on HHR global migration has been conceptualized through various perspectives, including push-pull, brain drain, global care chain, post-colonial, and more recently through perspectives informed by global political economy (GPE) (Kalipeni et al., 2012; Ansah, 2002; Prescott and Nichter, 2014; McNeil-Walsh, 2004, Yeates, 2009a). Increasingly scholars are converging in their calls for research that recognizes and interprets global or transnational intersections between professional training, health systems and the migration of health professionals (Yeates, 2009b; Prescott and Nichter, 2014; Zabalequi, et al., 2006; Powell et al., 2012; Connell, 2014).

In order to contribute to this debate I examine the case of India to demonstrate how its health education systems are increasingly responsive to and shaped by international HHR circuits. I advocate for research that broadens migration analysis away from household and employment conditions (typically identified as the main 'push factors'), to the intersection of migration with education and training structures. This focus on education illustrates Powell et al.'s (2012, 256) wider observation that national skills formation policies respond to international goals and standards in order to compete, and that in effect; "Markets for individual investments in education and for skills among firms are increasingly transnational." More importantly focusing on the intersection of migration with education connects with wider debates on the changing role of education, which is increasingly constructed to serve: "the imperative to create hierarchically conditioned, globally oriented state subjects – i.e. individuals oriented to excel in

ever transforming situations of global competition, either as workers, managers or entrepreneurs (Mitchell, 2003, 388).

THEORIZING THE INTERNATIONAL MIGRATION OF NURSES

To begin I briefly provide an overview of how global political economy (GPE) is useful for understanding how current HHR global migration intersects with educational system change. I then provide a short overview of four other approaches to the migration of nurses (push-pull, brain drain, postcolonial and global care chain) to highlight how recent research on health worker migration is progressively detailing the emerging global and market oriented nature of the HHR training landscape.

I. Global political economy

While sometimes used interchangeably with international political economy, GPE is seen as less aligned with international relations and the discipline of Political Science, and rather is characterized as a more trans or multi-disciplinary approach (Palan, 2000 1-2). As with political-economy GPE examines public-private interaction in the allocation of resources (Ravenhill, 2014, 18), and focuses on the role of power (with reference to relational power and agenda setting) in state- non-state collaboration and co-operation. In addition, examining interactions between the state and the market, or the public and private sector, GPE also emphasizes interaction and integration between and across places and scales. 'Global' in this context does not refer to an apex scale of management, but rather the idea that 'national' processes are increasing comprised, altered and constrained by practices originating outside of the state (Betts, 2011). GPE's transdisciplinary nature is highly suited to the field of HHR migration, which is international in scope and engages multiple medical, policy and social science disciplines.

The international migration of nurses has recently been conceptualized as a feminized labour export policy employed by Global South states to service flexibilized and globally integrated labour markets in the Global North (Valiani, 2012). The preeminent example of state-led nursing labour export is the Philippines, whose educational system was structured toward U.S. market demands under U.S. neo-colonialism (Choy, 2003). This global incorporation of certain national nursing labour markets is represented by Valiani as a new form of unequal exchange based upon "the re-intensified exploitation of female caring labour" (Valiani, 2012, 148). A GPE perspective informs Valiani's (2012) work in terms of assessing how U.S. market demands penetrate the Philippines health care training sector, with out-migration becomes the means of resource extraction. However, the increasing globalization of the health care sector in India problematizes a neat geographical distinction between 'core and periphery', since; "It is the advancement of health care in these countries that is, in effect, globalizing health care" (Crone, 2008, 117). Employing a North-South binary in terms of the directionality of HHR labour movements is also increasingly problematic because privatized healthcare has intensified service unevenness at all scales; local, regional and national (Smith et al., 2009; Reynolds et al., 2013).

International training has also contributed to reshaping the health sector. Levitt and Rajaram's (2013) research into different types of Indian health organizations suggests that the international experiences of health professionals are associated with neoliberal or market orientated forms of health care delivery. Levitt and Rajaram argue that the overseas educational experiences of professionals in the institutions they studied contributed to the adoption of neoliberal philosophy, further entrenching a market-responsive ethos (Levitt and Rajaram, 2013, 356). Levitt and Rajaram's (2013) research encourages a re-evaluation of the migratory process not as a binary balancing act between two separate national systems, but rather a circular process

where migration is both cause and consequence of increasing globalization and marketization in health care systems. Explicitly focusing on how power operates across multiple scales and sectors in the health-migration interface encourages researchers to attend to processes they may have implicitly recognized before, but not foregrounded in their analysis.

II. Push-pull

HHR migration has traditionally been seen through 'push-pull' migration, which tends to exhibit a dualist vision of migration where two separate systems are compared in terms of opportunity and then connected by migration (usually in a unidirectional manner). This approach is also evident in neoclassical gravity models which maintain that spatial difference generates migratory flows and propensities as part of an 'equilibrium recovering process' (Hart, 1975). However, after decades of Global South to North nurse migration (Organization for Economic Cooperation and Development, 2007) the inequalities between sending and receiving regions have not 'recovered equilibrium'. Traditional circuits remain, as new sources of oil wealth in the Middle East have created new and more diverse circuits of health professional migration. For example, in 2010 over 70% of the 12, 082 Filipino nurses who went overseas went to Saudi Arabia (Philippine Overseas Employment Administration, 2010). Migration, therefore, is not merely the accumulation of rational decision making units moving their respective systems toward some kind of equilibrium; rather migration is embedded within wider power and resource allocation structures. More recent analysis, while using the language of push-pull, has recognized that global political-economy factors shape HHR migratory flows (Kalipeni et al., 2012).

III. Brain drain

Resource reallocation and the interaction of states and markets in the health training process are also communicated in the concept of 'brain drain'. Originally used to characterize skilled professional migration to the USA in the 1950s (Ansah, 2002) brain drain was later used to reference medical professionals who moved from the Global South to service the Global North's health demands. By the 1990s this pattern of health professional migration was deemed a "perverse subsidy" (Mackintosh et al., 2006), that was impeding Global South healthcare systems from meeting their Millennium Development Goals (Willis-Shattuck et al., 2008). For example, Africa, with 25% of the global disease burden, retains only 3% of global health workers (Misau et al., 2010). Nevertheless, brain drain arguments have increasingly responded to changing patterns of professional migration by adopting the language of 'brain circulation'. Health professionals exploit the changing healthcare landscape and engage in expertise-building through international education and training. Such professionals may then operate as conduits to enhance international expertise and training capacity in their home countries (Hagander et al., 2013). From a GPE perspective skilled workers are important resources that countries compete for both as immigrants (Shachar 2006), and as return migrants (Levitt and Rajaram, 2013; CODEV-EPFL et al., 2013). Skilled health workers represent a resource that can be allocated through the relative power of state immigration and private corporate attraction policies. This model of *circulation,* determined by various intermediating state and market factors, is more attuned to the current reality of HHR migration.

IV. Postcolonial

Critical assessments of how power informs the HHR training and migration agenda are evident in research framed by postcolonial approaches. The postcolonial lens offers deeper awareness of global interaction while challenging state-centric analysis of migration and health systems

(McNeil-Walsh, 2004). In the case of India, colonial practices are implicated in the nature of nurse training, which was heavily influenced by Christian missionaries as well as international agencies such as the Rockefeller Foundation, the World Health Organization, and the United Nations (Nair & Healey, 2006). A postcolonial framing encourages us to recognize how colonial control constitutes systems inter-relationally. For example Parvati Raghuram (2009, 29) unpacks the discourse of the National Health Service in the UK to reveal a 'national' system that has benefitted from the postcolonial incorporation of 'foreign' migrant health professionals. Colonialism is also evident in the circuits that Indian (especially Kerala) trained nurses were traditionally incorporated into; Anglo speaking sites of colonial-settlement. Nevertheless, English is today increasingly a corporate global language that is adopted by multinational health markets in the Middle East and elsewhere, thereby generating new forms of interaction. In addition, the historical territorialisation postcolonial approaches impose on our understanding of contemporary HHR migratory circuits can also limit our analysis, since in the case of India the UK no longer dominates health professional migration flows, rather the USA, the Middle East and other neighbouring Asian regions have become key markets for migrants (High Level Committee on the Indian Diaspora, 2001). While post-colonial relations retain significant influence in domestic health care delivery and training systems, India today forms part of an expansive market for HHR migration that is increasingly global.

V. Global Care Chain

Scholarly research on gendered migration (nursing among it) has increasingly been framed by approaches rooted in gender, globalization, and feminist political economy. These approaches have sought to examine how the 'care crisis' is globalized through international migration (Parreñas, 2000). Much of this work has been inspired by or parallels the global care chain

(GCC) concept, which initially focused on the experiences of domestic workers (Hochschild, 2000; Parreñas, 2000). GCC's powerful structural perspective identifies consistent similarities across various circuits of feminized migration, but this can limit analysis of migration circuits at the regional scale, and the complex inter-locking systems of formal and professional regulation they may be embedded into, such is the case with nursing. Yeates (2009a) has pushed GCC to incorporate nursing, and the resultant Global Nurse Care Chain (GNCC) concept is seen as highly effective in assessing institutional dimensions of nurse migration, but it arguably needs greater refinement. Prescott and Nichter (2014), for example, have recently called for more ethnographic research to enhance GNCC research, including in the area of nurse training and production in source regions. Yeates (2009b) has also pushed for greater analysis of health professional production in source regions.

This short overview of recent approaches to HHR migration suggest that scholarly work is increasingly aligning with broad GPE conceptualizations in that research is increasingly transdisciplinary in nature, recognises the interaction of states and markets in the production of health professionals, explores interactions and interdependencies between jurisdictions, and questions how power mediates these transnational systems of resource allocation. In the next section I engage this same approach to consider how India's nurse training is increasingly shaped by public and private investment that is embedded in, and responsive to, global labour markets. I start with an overview of research methods.

RESEARCH METHODS

This paper draws upon a program of transnational multi-sited research that began in Kerala, South India in 2008, and followed nurse migration trajectories from there to the United Arab Emirates, Australia and Canada. Research ethics permission was granted through Wilfrid

Laurier's Research Ethics Board, and funding for the research was provided by various agencies. Research in India began while a visiting researcher at the Centre for Development Studies in Kerala in 2008-9, and Panjab University Chandigarh in Punjab in 2010-11. In Chandigarh I collaborated with faculty and students, who participated in ethics training prior to gathering interview and survey material (Bhutani et al. 2013). This paper draws upon some of this material, as well as secondary sources. The research process was inductive and adopted a form of 'transnational tracing' whereby research leads were followed or 'traced' from one site to another through intermediaries. As the research progressed one educational agent undergoing rapid expansion within Indian and overseas became an important network that was traced from India to Australia and Canada. This approach most closely corresponds with a network methodology, which locates ties (real and virtual) between networks and individuals that cross borders (Faist et al., 2013, 136). My research attempts to overcome the three main challenges of transnational analysis that Faist et al. (2013, 136) posit: methodological nationalism, essentialism and positionality. Methodological nationalism is where the nation-state is seen as the central container for all processes. My research was framed by regulatory processes in two states (Kerala and Punjab), but because it was multi-sited the regulatory context was always examined in terms of the interaction of these sub-national governments with other actors be they central or foreign governments or corporate interests. To counteract essentialism—where single aspects of identity are prioritised in a manner that suppresses awareness of intersectionality (Bastia, 2014) – multiple axes of identity were foregrounded through a research design sensitive to regional, religious, gender, class and caste differences. Researcher positionality was constantly and critically reflected upon through the routine interactions with research collaborators, practitioners and educators across the multiple transnational circuits explored.

INDIA: EDUCATION, MIGRATION, SKILLS AND GLOBAL ENGAGEMENT

The following section of the paper exam nurse migration and training, the privatization of health and health care training, health professional regulation and globalization, migration markets and the circulation of expertise, and globalized skills training and the circulation of expertise. Together they demonstrate how the health education system reproduces migratory tendencies, and that the global circulation of skills, expertise and private capital investment are increasingly a feature of India's HHR landscape.

I. Nursing training and migration in India

Unlike the active promotion of migration by the Philippine state (Rodriguez, 2010), the Government of India (GOI) maintains that it; "does not promote, it facilitates. Our mandate is to give the information and build the awareness of an intending migrant. Ultimately, it's the migrant's choice" (CARIM-India, 2013, 23). For the nursing occupation it is clear the choice is to seek out migration (Walton-Roberts, 2010; Connell, 2014). In India this is partly motivated by the poor status of nursing, which contrasts its more respected status elsewhere. Unsatisfactory working conditions, low pay, low staff to patient ratios and in some cases physical and verbal abuse (Buchan and Calman, 200; Nair, 2012) have made certain migratory hubs in India prime recruitment grounds (Gill, 2011). According to the Commission on Graduates of Foreign Nursing Schools, India was ranked 6th in the 1990s in terms of the number of registered nurse applicants applying for US visas, but from 2003 onwards it has ranked 2nd after the Philippines (Matsuno, 2009). India is the 3rd largest group of internationally educated nurses (IENs) in the USA (Health Resources and Services Administration, 2010), and in 2013 India was second, after

the Philippines, in terms of the number of international candidates writing the U.S.'s National Council Licensure Examination (NCLEX) (NCLEX 2014). Partly in response to overseas opportunities, the number of nursing schools and colleges is increasing in several Indian states to meet demand, which is increasingly emerging from regional and religious communities not traditionally associated with the profession (Walton-Roberts, forthcoming).

Despite the Indian government's stated position of emigration facilitation, rather than promotion, recent initiatives suggest an element of state-directed interest in supporting training and migration opportunities for nurses (Gill, 2011). Recent bilateral agreements have been signed between India and the UK covering the migration of nurses (Health Services Union, 2007), and India and Kuwait signed a Memorandum of understanding (MOU) to confirm the mutual recognition of medical skills and to promote medical tourism and exchange (Embassy of India in Kuwait, 2012). Public and private training investments are being made in order to meet domestic and overseas demand for nurses (Walton-Roberts, 2010; Khadria, 2007). State medical education officials are clear that their training programs must respond to international standards:

> We are just reacting to it, our motto is, the nurses who get training, whether in India or in Kerala they should get it at international standards… It is our responsibility to implement it at the level at which that they can compete, wherever they go. (Interview with Deputy Director of Nursing Education, Kerala, October 2008).

Education and training are essential sites where the private sector combines with state policy in reponse to overseas market demand (Mitchell, 2003). This is clearly evident in the nursing sector, where international mobility and training are increasingly seen as valuable assets. Connell

(2014, 77) notes this process in the Pacific Islands, where the out migration of health professionals is endemic:

> Teaching staff at … national nursing institutions not only did not discourage migration but judged their own success as teachers and the success of their students on whether they were able to practice in the more competitive medical environments of countries like Australia, the United States and the United Kingdom. The workplace and tertiary education culture and curriculum stressed that excellence was elsewhere.

In India international expertise is increasingly being positively connected with the potential for onward and circular migration in India, as one nursing education consultant emphasized:

> You start from here, you do a top up, you work, you specialize, you gain more experience [overseas], and in five or six years down the line, you come back to India—even if today you don't have it in your mind—because in India, there are so many opportunities…you see hospitals coming up all over the place. And they're looking for health care professionals who have the experience of international best practice. (Private nursing education recruiter, Chandigarh, India, July 2010).

Circulation thus becomes an important part of the occupational identity of health professionals, and opportunities are promoted in terms of global circulation for employment, but also expertise building. Private capital recognizes the opportunity to promote and attend to such demands.

II. Privatization of health and health training

Currently India's health care system is one of the most privatized in the world (Madhukar, 2008). The private sector accounts for 70% of health workers and deals with 80% of outpatients and

60% of admissions; 71% of health expenditures are out of pocket (Rao et al., 2011). The corporate health system contributes to marketizing healthcare and HHR training (Chakravarthi, 2010), and represents multiple intersections between domestic, diasporic and global capital: "The opportunity for profit in this sector has encouraged several large corporations and several non-resident Indians (NRIs) to invest money in setting up super specialty hospitals." (Hazarika, 2010, 248).

Health sector growth in several key markets across India is increasingly driven by medical tourism, which is projected to grow by 15% a year (Hazarika, 2010, 248). The dominance of the corporate health sector raises concern over the loss of Indian government control over health, about the limited improvements in quality of care for the majority of the population, how it might undermine the public sector, its high costs, and the lack of transparency and resistance to government oversight (Chakravarthi, 2010). Peters and Muraleedharan (2008, 2144) actually advocate for greater engagement with market based, consumer orientated, and collaborative approaches to health care in order to overcome what they see as the Indian government's failure to effectively regulate health care delivery. Such acceptance of market based health care in India raises questions about equity and access to services, but it also necessitates assessment of how such developments inform health care training and regulation.

Private health colleges have recorded substantial growth in India, for example, 88% of Auxiliary Nursing and Midwifery schools (the first nursing cadre regulated by the Indian Nursing College (INC)), are private, and in the four southern Indian states that are home to 63% of India's nursing colleges, 95% are private (Rao et al., 2011). According to Reynolds et al., (2013) the private sector in India is responsible for producing 95% of nurses. The rapid growth of private sector educational institutions has raised concern regarding the level of corruption in

regulation and licensing (Bhaumik, 2013b; Singh and Purohit, 2011). Private sector growth has also created a glut in the market of poorly trained candidates, with claims that 90 per cent of the colleges assessed by the National Assessment and Accreditation Council are of "middling or poor quality" and that the "unfettered growth of private higher education (especially in engineering, medical, dental, and nursing and management disciplines) combined with the international economic and political events created a surplus in the labor market in the recent years" (Singh and Purohit, 2011, 130). It is also suggested that private schools and colleges provide the corporate hospital sector with opportunities to promote institutional expansion, including the tendency to exploit student labour rather than hire staff nurses (Biju, 2013).

The increase in private colleges has also correlated with a growth in student debt: Indian banks recorded a 35 per cent increase in their student loans between 2004 and 2012, with unpaid educational loans more than double the amount of outstanding credit card customer debt (Unnikrishnan, 2012). Bachelors of Nursing program fees in private colleges range from INR. 60,000 (US $1,000) to INR. 200,000 (US$3,350) per year (Entrance exam.net, 2014). In a survey of returned nurse emigrants in Kerala, the majority indicated their education had cost between INR. 100,000 to 200,000 (US$2,000-4,000), with 30 per cent of female migrants interviewed indicating they had relied on bank loans to pay for education, and 44 per cent of those stating they were unable to repay the debt (Walton-Roberts and Rajan, 2013).

The INC stipulates nurses with a BSc qualification must have a salary of INR15,000 per month (US $252), but there are cases where nurses claim they are paid only INR 6,000 (US $100) a month in the private sector (Times of India, 2012). When compared to junior nursing wage rates in India, it is evident that the costs of private nursing programs reinforce the motivation to seek overseas employment. Research also suggests that student loans do not

increase access and equity in India; rather they generate finances for the higher education sector, often at the expense of disadvantaged groups (Tilak, 1997). The interaction of state and market in funding nursing education through student debt raises important questions about resource allocation and regulation.

III. Health professional regulation and globalization

One of the major regulatory weaknesses in India's health care system is in regards to professional regulation and certification, "professional associations organized by health providers…tend to act as self-interested trade guilds rather than as credible organizations for self-regulation" (Peters and Muraleedharan, 2008, 2139). Corruption in the private sector influences training quality, regulation and licensure, all of which are managed by the Indian Nursing Council and their state nursing councils (Bhaumik, 2013a). In 2007 the state government of Punjab ignored the fact that the INC denied to license to seven of their colleges, allowing them to enroll students nonetheless (Sethi, 2007). The lack of regulatory control of nursing programs is keenly felt by those nurses who are concerned about the reputational effect of increased private colleges and declining quality:

> In India … they got so many colleges and some colleges are not even registered. So they are simply making money and producing the nurses without knowledge. So if such kinds of nurses are coming to Canada … they are simply spoiling the name of India (Indian trained nurse in post-graduate training Canada, April 2011).

Recent efforts have focused on improving the status of nursing through curriculum reform, and the Central Health Ministry dedicated INR 3,190,000,000 (US $54.5 million) in the 11th plan to strengthen nursing education (Saeed, 2010). Throughout the 2000s there was

increasing pressure from private trusts and corporate groups interested in opening facilities to provide nursing diplomas and degrees. In 2008 the INC eased student entry criteria and relaxed the regulations controlling new nursing colleges and schools (Indian Nursing Council, 2008). In a 2010 interview with an official in the INC about these regulatory changes, she stated:

> The Government was worried, there is a need for more nurses. There is a policy not to prevent any nurse going out, so nurses can go out, there is no problem because they bring foreign exchange and every country is interested in that, so there is no move on the side of the government to stop them. But Government has told the councils to relax the norms for opening colleges, so that if anybody wants to open a college they should be able to open it…. we are only concerned about educational program, educational building, educational facility…. [and a] little bit of relaxation on staffing, and training (Indian Nursing Council official, November 2010, Delhi).

The need to train more nurses emerged as a combination of domestic health policies (such as the creation of the National Rural Health Missions (Sundararaman and Gupta, 2011)) and increasing demand from the private sector. Easing educational regulations in nursing was seen as an important means to manage these demands. State health officials I spoke to in Kerala and Punjab held the view that nurse emigration was not a problem:

> Nurses who are going overseas are basically from private institutions; whereas nurses from government institutions stay in India…we are producing enough nurses which are meeting our needs as well as rest of the world presently. (State Health Director, India April 2011).

The regulatory changes the INC passed in late 2008 were greeted positively by the private sector, but not by nursing groups and some state governments (Times of India, 2008). Following these changes stakeholders expressed concerns about the quality of training. This was especially evident in Karnataka, a state experienced rapid growth in nursing colleges and schools in the early 2000s (Anupama, 2002). Bengaluru in Karnataka developed into one of three recruitment hubs in the country for nurses seeking overseas opportunities (Tiwari et al., 2012). Since 2008, however, it has been commonplace to see the closure of substandard facilities that lack proper INC approval (Mohandas, 2008). As recently as September 2012, 348 nursing colleges in Maharashtra not affiliated with the INC were threatened with closure by the Maharashtra Medical Council (Gole, 2012). Data from the INC indicates fluctuations in the number of colleges registered, and the numbers for Karnataka are striking (see Figure 1).

Insert Figure 1 here

The degree of change in the number of colleges accredited by the INC from 2010 to 2013 is testament to the travails of managing private sector growth while maintaining quality. Quality training and accreditation have recently become a significant central government policy issue, and in regard to the health sector we see the full relevance of thinking about resource allocation in an increasingly globally regulated profession such as nursing.

IV. Markets, migration, and the circulation of expertise

The largest and most internationally oriented Indian health corporations seek quality assurance from the Joint Commission International (JCI). The JCI Gold Seal of Approval® is the necessary foundation for health institutions that want to attract the best staff and international and elite domestic clients. Currently there are 19 JCI accredited institutions in India, of these 13 are

connected to organizations that are headed by individuals with overseas training, experience or residence. For example, six of India's JCI accredited facilities are part of Apollo Hospital Enterprises Ltd (AHEL), which holds a 30% market share in India, and was the largest health care group in Asia in 2010 (Chakravarthi 2010, 193). AHEL owns 11 nursing colleges and one medical school (Forbes 2014). Apollo is headed by Prathap Reddy, who completed his residency and held a research position in the U.S. prior to returning to India to develop his health care enterprise. Another four of the JCI accredited hospitals are part of the Fortis Healthcare chain, led by Chairman Malvinder Mohan Singh, and his brother Shivinder, both of whom studied in the U.S. at Duke University. Ahalia Foundation is Kerala's only JCI accredited hospital, and was launched by a Non-Resident Indian (diaspora) group of investors. One other JCI holder is Artemis Health Institute, which is home to several doctors who trained abroad, and the current chairman is a U.S. graduate.

The leaders and health professionals within these corporate hospitals are globally oriented, and many have trained and worked overseas. If Levitt and Rajaram's (2013) findings hold, then the international exposure of these key individuals through their education and migration reinforces the mantra of markets and management, and embeds it deeply into the Indian health sector and its concomitant impact on health professional training. Global financial input is evident in NRI investment with the potential to remake systems in line with 'best practices' that are born of the market even when altruistic (Levitt and Rajaram 2013).

The global market orientation of India's health delivery and training can be clearly evidenced with one example. Manipal Education and Medical Group (MEMG) is considered India's third largest healthcare group with a network of 15 hospitals and three primary clinics, and is considered a pioneer in the field of education and healthcare delivery. In India MEMG

manages 11 hospitals, including 8 teaching hospitals, and it has also established an off-shore medical school in Antigua, the American University of Antigua. MEMG's American University of Antigua recently benefited from a US $30 million loan from the International Finance Corporation (IFC, nd). IFC is part of the World Bank and is the largest multilateral investor in private education in emerging markets (IFC.org). This example of a World Bank financed Indian healthcare group developing an off shore medical training facility in the Caribbean to prepare international students to practice in the U.S. sums up the global ambitions and organization of Indian health professional training enterprises and their integration into global HHR migration circuits. This ambition for skills development and global competition has also been embraced by the GOI in terms of its recent skills development policy, and they have turned to the private sector to help them achieve it.

V. Skills training and labour export

The GOI recently created the National Skills Development Agency (NSDA) to harmonize and coordinate public and private sector efforts to meet the training targets of their 12th Plan. The NDSA has tasked the National Skills Development Corporation (NSDC), an autonomous public-private body, to oversee skill development programs in 21 sectors, including healthcare. The objective of the NSDC is to "contribute significantly (about 30 per cent) to the overall target of skilling / upskilling 500 million people in India by 2022, mainly by fostering private sector initiatives in skill development programmes and providing funding." (National Skill Development Corporation, nd). This pool of 500 million trained people by 2022 will target both domestic and international demand:

> The pool should be sufficient not only to meet the 'domestic requirements of a rapidly growing economy', but also 'cater to the skill deficits in other ageing economies, thereby effectively leveraging India's competitive advantage and harnessing the country's edge in having a higher proportion of the population comprising of young people'. (NSDC blog, 2010).

Healthcare investment combines with increased skills training, especially through Non-Resident Indian investment in corporate hospital chains such as Fortis and Apollo (Smith et al., 2009). The Indian government aims to capture more of such investment through the Overseas Indian Facilitation Centre (OIFC)—a not for profit government venture launched by the Ministry of Overseas Indian Affairs and the Confederation of Indian Industry. Mr Malvinder Mohan Singh, Group Chairman of Fortis Healthcare, is a member of the OIFC's Governing Council, and in an interview on investment opportunities he highlighted the health sector as a priority:

> I also remain bullish on medical devices, diagnostic services, hospital chains and wellness products and services, all of which will see an increased demand with the growing middle class in India. This decade will also mark an increased demand for medical colleges, nursing training facilities, geriatric care facilities and technologies that can enable fast scale up to allow access to quality care. (Overseas Indian Facilitation Centre, nd,).

Private capital, health corporations and health professional training are at the centre of an emerging market sector targeting international, Indian and diasporic interests (Pandey et al., 2004). Add to this the fact that health workers, managers, leaders, instructors and increasingly patients have overseas exposure and experiences. The overseas training of medical professionals

can reinforce the tendency toward marketization and capital restructuring in the health sector, but the private investment in education that accompanies these developments has raised concern over quality and access. It has been noted that the privatization of India's education system in the 1990s marked a shift from "half baked socialism to half baked capitalism, with the benefits of neither" (Kapur and Mehta, 2004, 13). For example, incentives in the form of taxation have led to the creation of a multitude of 'philanthropic' educational trusts, the majority of which generate funds not through endowments but by charging fees. Kapur and Mehta (2004) argue these public-private arrangements result in the educational sector being trapped between state under-investment coupled with overregulation, limiting the effective mobilization of private capital. Commentators have argued this latest NSDA agenda will continue to fall short due to "overly ambitious targets, wasteful duplication and bureaucratic turf battles" (Agrawal, 2013, 58).

CONCLUSION

While a number of different conceptual approaches to HHR migration are used, I have argued that researchers are increasingly attentive to sectorial (public-private) and spatial (local-global) intersections and circulations in terms of the interpenetration of migration and education. The role of public and private regulation in the area of health professional training is increasingly examined in light of global migration circuits that reproduce tendencies toward markets and management. This global circulation of expertise is likely to continue as medical tourism in India grows. The number of Indian trained physicians practicing in the UK, US, Canada and Australia is equivalent to 10% of all physicians in India (Crone, 2008, 121),therefore there is a substantial labour pool ready to circulate across health systems to train and deliver services should market conditions continue to encourage it. Diaspora capital is also drawn in through the GOI's overseas facilitation centres, injecting mantras and models from privatized market systems.

Emphasizing research that connects regional, national, and global processes can aid in understanding how privatized and marketized tendencies emerge and are reproduced. In terms of HHR migration, sensitivity to GPE broadens scholarly inquiry beyond the scale of the migrant, the household and national institutions by foregrounding sectoral (public/private/hybrid) and scalar (regional/national/global) interactions to reveal emergent networked structuring processes that shape HHR training and migration. It demonstrates how education systems in the source region are increasingly relevant to our understanding of the global and Asian rise of migration and the place of health workers in that migration. In the case of India I have argued that privatized training and health care systems are inspired and reproduced in part by global health professional migration circuits. As Connell (2014, 80), makes plain: "Acquiring education and training in the health sector is tantamount to acquiring cultural migratory capital. In many places it may be the most effective means of acquiring a 'passport'."

Private nursing college growth in India is oriented toward the global market, and this is evidenced by student intentions to seek overseas opportunities and the increasing imbalance between educational costs and domestic salaries in India's public and private health systems. . Nursing educational sector deregulation advances private sector interests, and in the case of the NSDC, the private sector has been formally incorporated into the GOI's policy architecture. The integration of India's HHR training into global health migration systems is clearly illustrated through the international orientation of health professional training, the responsiveness of government regulators to facilitate private investment in the sector, and the ongoing globalization and marketization of the health training sector, including the valorization of international expertise and international 'best practices'.

The paper emphasizes the necessity of understanding the global migration of health professionals and the domestic training and professional regulation systems that produce them, and how they are increasingly shaped by the global political economy of public-private interaction within a globally orientated health care system. While the role of national governments is still vital to assess, in the case of India current skills training policy architecture has become so embedded in public/private interpenetration that lines of responsibility and demarcation between the two are increasingly difficult to disentangle. To this end GPE helps foreground the processes central to the deepening relationship between governments and the (globalised) private sector.

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