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A Brief Review of Physiotherapy Migration in the Indian Communities

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Abstract – It is estimated that an additional 6.4 million allied health professionals are required to address India's health challenges. One of the largest of these professions is physiotherapy. Thousands of Indian physiotherapists have been working in the last decade to study and work abroad. 19 physiotherapists have been interviewed in this study from all over India. In accordance with constructionist grounded theory methods, data were collected and analysed. The results indicate that there are numerous political and clinical hierarchical challenges for the Indian health infrastructure in the Indian physiotherapy profession. Education in the profession has developed and the private clinical sector has grown, but the quality and standards across the sector are significantly different. In India, the profession has variable independence, is not regulated nationally, is poorly paid and leadership is split up. In Indian physiotherapy, the political, educational and clinical context affects physiotherapists' ability to exercise effectively to their professional satisfaction. Individual physiotherapists are frustrated at the job and traveling abroad, when they hear that the profession and practice of physiotherapy are different. As the disjuncture continues to influence these factors, and physiotherapy is seen as different and superior in other countries, Indian physiotherapists will continue to migrate to other countries and will make their return easier.

Key Words – Autonomy, Identity, India, Migration, Physiotherapy, Home Care Services, Exercise, Home Visits, Holistic Health

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INTRODUCTION

India is a country that's interesting. According to the World Health Organisation (WHO), public health expenditures amount to 30%, including expenditure on healing and preventive services, and are still increasing, by 1.295 billion people. The Community based rehabilitation (CBR) has been seen as a good option from costly rehabilitation based on institutions in India for many decades, although resource constraints in particular can be a challenge. Countrywide rehabilitation has taken place by qualified medical professionals in India such as trained stroke care workers, trained psychosis workers, speech language pathologies services for bowels, ophthalmologists trained blind community workers, trained handicapped workers, health workers for neuritis, However, 'as CBR cannot be described as a discreet procedure and the expected results are not standardized, it is difficult to see how effective it is.' Furthermore, it has been observed that research in the CBR is rarely published in low- and middle-income countries in which the need for rehabilitation of such a type may be anticipated to be greater. The institutions versus CBR in India have been compared with conflicting evidence. CBR is unique for each community, because local factors such as culture, community coping mechanisms, level of awareness, motivation and acceptance of a proposed treatment process could influence the result. Over the years, CBR models are generally those developed by local bodies, such as NGOs, and hospitals and replicated by a foreign model. There are numerous studies that focus on various community prevention strategies to reduce healthcare costs, in particular physiotherapy in various health conditions, as discussed by Peterson et al. In particular, it has been shown. Although it is known how important physiotherapy in CBR is, it can hardly be documented that physiotherapy is included in CBR.

In the years 2001-2002, the national disability rehabilitation program (India) was developed. While this program has been targeted for the communities with disabilities, it is not possible to emphasize the benefits of institution integration and CBR for various health conditions. In particular, physiotherapists in India could use this integration of health services to treat patients holistically because multidisciplinary approaches to Community issues are increasingly necessary. Documented evidence of the role or involvement of CBR physiotherapy is seldom, although physiotherapy could help communities in more than one way. Ward's first report tells us how preventive medicine in the

villages of India hasn't been given much priority and that preventive medicine is cheaper than curative treatments. Although this paper is over 40 years old, some of the gaps in community physiotherapy are still true. The impact of physiotherapy in community health programs in India is limited in documentation.

INDIA'S HEALTHCARE INDIA'S

1.2 billion people is a sixth of the world's population, but it contains a third of the world's poor.1Significantprogress towards achieving the Millennium Development Goals have been made, but health outcomes inequality remains. Over the last 25 years, governments have incentivized investment in the private health care industry, which has experienced exponential growth, but the resultant variable quality, provider-driven provision has not addressed the significant health challenges. Per capita, health expenditure grew from US$18.6 in 2000, to US$ 63.3 in 2015. In 2013 to 2014, the total spending on healthcare was 4.02% of gross domestic product (GDP), the government public sector making up 33% and the private sector 67%. Despite this investment, an additional 6.4 million allied health professionals are required to address India's significant healthcare needs.5Public health expenditure is, therefore, proposed to be increased from the existing 1.15% to 2.5% of GDP by 2025.

PHYSIOTHERAPY IN INDIA

The Indian Association of Physiotherapists (IAP) became a 1967 member of the World Confederation for Physical Therapists (WCPT), with the evolution of the world physiotherapy since then. Indian education in physiotherapy is high with a 4.5-year bachelor's degree and Masters and PhDs available after qualification. However the contextualisation of Indian learning needs and quality assurance across educational institutions are still important challenges. More evidence-based practice, more research and more commitment to ongoing training are requested from within the profession. The medical profession in India is the main focus for physiotherapy and prescribes specific physiotherapy treatments despite protests from physiotherapy. Doctors often supervise physiotherapists who see them as technicians and dispute whether physiotherapists in India should be able, without medical supervision, to practice independently.

In addition, physiotherapists are strongly opposed to using the title Dr. In physiotherapy itself, there was also discontent and conflict. In 2011 a contested election for IAP leadership resulted in a number of judicial actions. This dispute has been over recently, but it has been the case for more than six years that there have been two IAPs with different leaderships aimed at the same functions as representing the interests of some 30 000 physiotherapists in India; maintain a membership register; approve educational institutions for the delivery of physiotherapy courses and establish and guarantee ethical practice. The IAP membership of the WCPT was terminated in 2015 and has not been reinstated to date due to unpaid subscriptions. Indian physiotherapy aspires to recognised professional autonomy but has been hampered by a lack of professional regulation, despite rafts of government legislature over the years (see Table 1).

TABLE 1 Summary of the proposed Indian legislature affecting the regulation of physiotherapy

Year	Act and Key Implications
1992	Rehabilitation Council of India act—physiotherapists not included
1998	Notification to include physiotherapists in 1992 act—subsequently withdrawn
2007	Paramedical and Physiotherapy Central Councils Bill 2007—no interned autonomy
2008	Parliamentary standing committee report on the 2007 bill suggests amendments that infer physiotherapy autonomy
2009	National Council for Human Resources in Health 2009 Bill—disputes over the professional groupings and continuing medical dominance
2011	National Commission for human resources in health (NCHRH) 2011—physiotherapists grouped with "paramedical," no autonomy suggested.
October 2012	A parliamentary standing committee report rejects the 2011 bill.
December 2012	Union minister of health and family welfare report—recommends enhancing allied health professions roles and effectively autonomy.
2015	The allied and healthcare Professional's central council bill—draft for consultation. Aims to regulate over 50 types of allied and healthcare professionals and to set standards for their education and practices
February 2017	The allied and healthcare Professional's central council bill—draft amended and sent for interministerial consultations.

EDUCATING INDIA'S PHYSIOTHERAPISTS

The journey of the Indian physiotherapist begins with undergraduate studies, which lead to an understanding of who he/she is and what can be offered within a professional structure and context. Participants suggested that BA Physiotherapy education had evolved in India and was influenced by migrants who returned to India with different practices and ideas. Change was identified as hard to achieve and needed more: less content, less rote learning, more clinical reasoning, critical assessment, and the development of research skills. The quality changes of undergraduates physiotherapy education, explained by a rapid expansion in physiotherapy colleges and the associated poor regulation and lack of quality control, were significantly affected by all participants. All of the educators agreed that the curriculum may vary slightly, but that the standard and method of delivery may differ significantly.

There were mixed perspectives with commentaries on variable quality and methods of education in relation to the Indian master's degree in physiotherapy. The strength of the master's degree was the requirement for the entire course to practice and contextualize learning. Nevertheless, the balance between work and academic studies can be reduced to all hospital activities with minimum teaching, with secondary education. Others felt that the master was very theoretical. This apparent breakdown can be because exams are the primary method of assessment. The main criticism was that the bachelor's degree with very little new material repeated in a Physiotherapy degree in India with only a little more depth. The teachers have

recognized the problem of this repetition between academic levels. The students of aspiring masters were often advised by peers and teachers that they had to go abroad if they want to learn new skills and knowledge; but they had to stay in India if they wanted to establish networks.

UNDER DOCTORS ORDERS

Participants described two types of workplace. Firstly, "non-self-sufficient" where the practice learned in training was difficult to implement. Practice was based on referrals by prescriptive doctors which often demonstrated an incompetence in physiotherapy. Exercises or electrical methods would be 'given' according to the diagnosis of the patient. The diagnosis was defined by the doctor. Some attributed this practice to qualified senior graduates whose lack of knowledge meant that they adhered to conventional treatments. Hierarchical structures ensuring that no dialog is encouraged, young physiotherapists should not question or express their own opinion. The leadership and protocol should be followed in accordance with senior employees. These departments have been called "parochial," with no "change incentives." "In those hospitals that are paid less good physios from good schools will not work, so the standard of physical activity in those hospitals remains low" (Lalit).

These departments were not intended to employ masters who were to work in academic institutions. In the "non-autonomous" departments, the participants were not satisfied, did not feel respected and did not feel certain to engage the physicians in debate. The second is that the working culture was more progressive in the "semi-autonomous" departments, department leaders were more qualified, proactive, and staff development was encouraged. Physical therapists could talk to physicians to suggest alternative, better forms of treatment. They could also discuss this. After seeing the results, the doctors just prescribed "pain control" when they referred to a next case, leaving the physiotherapist to decide the method. Thus, the clinics have evolved into "semi-autonomous," working methods and improved job satisfaction. This mutual respect between physicians and physiotherapists has been achieved through knowledge and effective communication of physiotherapy, good clinical practice. Often in large corporate hospitals or in academic institutions, these departments are associated. They employed master graduates because they were more expert, more critical and more innovative.

CONCLUSION

A number of examples have been identified during this study of excellence, innovation and development of Indian physiotherapy. This included educational institutions that seek to pedagogically develop departments that embrace current developments and promote self-government. There was a story throughout the interviews that illuminated an emerging and vibrant community that strives in India to develop the practice of physiotherapy. In contrast, the interviews also depicted a more adverse picture of physiotherapy in India; a variety of standards of education, minimum management of quality, differing clinical standards and narrow clinical contexts in which rehabilitation is dominated by hierarchy and doctor prescription. The profession is struggling to position itself as autonomous and regulated professional organisations, given its political complexity. There have been reports of physiotherapists in ongoing conflict and negotiation with the medical hierarchy it serves. There were reports of people in the profession who felt underpaid, underestimated and disrespectful while striving for professional self-sufficiency. There was a desire for a common goal, but a lack of coherent leadership or agreement on how to achieve an autonomous and respected profession. This more sinister account led to an empowered and disenchanted generation of physiotherapists who migrate to the rest of the world to seek a better life and profession.

As Indian physiotherapy leaders and Indian health leaders see the future in view of the governments proposed investment in Indian medicine, it is important and timely to articulate this complex narrative. This will provide the opportunity to reflect on the messages contained in the narrative and find solutions in order to address the challenges posed by indian physiotherapists. This story suggests that improving satisfaction in the workplaces is essential to reduces migration outflow by improving self-sufficiency, increased pay and respect through self-employment. India cannot afford a single-way migration from abroad to lose its talented physiotherapy workers.

REFERENCES

1. Hartley S, Finkenflugel H, Kuipers P, Thomas M (2009). Community-based rehabilitation: opportunity and challenge. Lancet.; 374(9704): pp. 1803-4. DOI: 10.1016/ S0140-6736(09)62036-5.

2. HN R, George R, Eapen EP, Pulimood SA, Gnanamuthu C, Jacob M, et. al. (2004). A comparison of economic aspects of hospitalization versus ambulatory care in the management of neuritis occurring in lepra reaction. Int J Lepr Other Mycobact Dis.; 72(4): pp. 448-56. DOI: 10.1489/1544-581X(2004)722.0.CO;2.

3. Alim M, Lindley R, Felix C, Gandhi DB, Verma SJ, Tugnawat DK, et. al. (2016). Family-led rehabilitation after stroke in India: the ATTEND trial, study protocol for a

randomized controlled trial. Trials.; 17: pp. 13. DOI: 10.1186/s13063-015-1129-8.

4. Pandian JD, Felix C, Kaur P, Sharma D, Julia L, Toor G, et. al. (2015). Family-Led RehabiliTaTion aftEr Stroke in INDia: the ATTEND pilot study. Int J Stroke.; 10(4): pp. 609-14. DOI: 10.1111/ijs.12475.

5. Chatterjee S, Pillai A, Jain S, Cohen A, Patel V (2009). Outcomes of people with psychotic disorders in a community-based rehabilitation programme in rural India. Br J Psychiatry; 195(5): pp. 433-9. DOI: 10.1192/bjp.bp.108.057596.

6. D'Antonio LL, Nagarajan R. (2003). Use of a consensus building approach to plan speech services for children with cleft palate in India. Folia Phoniatr Logop.; 55(6): pp. 306-13.

7. Vijayakumar V, Datta D, Karthika A, Thulasiraj RD, Nirmalan PK (2003). Utilization of community-based rehabilitation services for incurably blind persons in a rural population of southern India. Indian J Ophthalmol.; 51(3): pp. 273-7.

8. Mauro V, Biggeri M, Grilli L (2015). Does community-based rehabilitation enhance the multidimensional well-being of deprived persons with disabilities? a multilevel impact evaluation. World Dev.; 76: pp. 190-202. DOI: 10.1016/j. worlddev.2015.07.004

9. Mauro V, Biggeri M, Deepak S, Trani JF (2014). The effectiveness of community-based rehabilitation programmes: an impact evaluation of a quasi-randomised trial.J Epidemiol Community Health.; 68(11): pp. 1102-8. DOI: 10.1136/jech2013-203728.

10. Biggeri M, Deepak S, Mauro V, Trani JF, Kumar J, Ramasamy P (2014). Do community-based rehabilitation programmes promote the participation of persons with disabilities? A case control study from Mandya District, in India. Disabil Rehabil.; 36(18): pp. 1508-17. doi: 10.3109/09638288.2013.823244.

11. Dias A, Dewey ME, D'Souza J, Dhume R, Motghare DD, Shaji KS, et. al. (2008). The effectiveness of a home care program for supporting caregivers of persons with dementia in developing countries: a randomised controlled trial from Goa, India. PloS One.; 3(6): pp. e2333. DOI: 10.1371/ journal.pone.0002333.

12. Daniel A, Manigandan C (2005). Efficacy of leisure intervention groups and their impact on quality of life among people with spinal cord injury. Int J Rehabil Res.; 28(1): pp. 43-8.

13. Chatterjee S, Patel V, Chatterjee A, Weiss HA (2003). Evaluation of a community-based rehabilitation model for chronic schizophrenia in rural India. Br J Psychiatry.; 182: pp. 57- 62.

14. Xavier D, Gupta R, Kamath D, Sigamani A, Devereaux PJ, George N, et. al. (2016). Community health worker-based intervention for adherence to drugs and lifestyle change after acute coronary syndrome: a multicentre, open, randomised controlled trial. Lancet Diabetes Endocrinol.; 4(3): pp. 244-53. DOI: 10.1016/S2213-8587(15)00480-5.

15. Paul BJ, Rahim AA, Bina T, Thekkekara RJ (2013). Prevalence and factors related to rheumatic musculoskeletal disorders in rural south India: WHO-ILAR-COPCORD-BJD India Calicut study. Int J Rheum Dis.; 16(4): pp. 392-7. DOI: 10.1111/1756-185X.12105.

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