

International Nurse Recruitment in India

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Objective. This paper describes the practice of international recruitment of Indian nurses in the model of a “business process outsourcing” of comprehensive training-cum-recruitment-cum-placement for popular destinations like the United Kingdom and United States through an agency system that has acquired growing intensity in India.

Findings. Despite the extremely low nurse to population ratio in India, hospital managers in India are not concerned about the growing exodus of nurses to other countries. In fact, they are actively joining forces with profitable commercial ventures that operate as both training and recruiting agencies. Most of this activity is concentrated in Delhi, Bangalore, and Kochi.

Conclusions. Gaps in data on nursing education, employment, and migration, as well as nonstandardization of definitions of “registered nurse,” impair the analysis of international migration of nurses from India, making it difficult to assess the impact of migration on vacancy rates. One thing is clear, however, the chain of commercial interests that facilitate nurse migration is increasingly well organized and profitable, making the future growth of this business a certainty.

Key Words. India, nurse exodus, recruitment agency, push and pull factors, policy

India is an overpopulated large country with the potential to supply English-speaking workers in many different fields to developed countries (GCIM 2005; Khadria 1999, 2005; NCAER 2005). As the demand for nurses rises worldwide, commercial recruiters have become increasingly interested in the potential for exporting nurses from India to these countries. While India does have a large potential labor pool that could be trained as nurses, at present India does not have enough professional nurses to meet its own domestic health services needs (Khadria 2004). This paper provides an overview of nursing education and migration in India, as well as a description of the current environment for international recruitment of nurses in India.

GENERAL DATA ON INDIA

The U.S. Population Reference Bureau (PRB 2004) estimates India's population to have been 1.086 billion in 2004, with a per capita income estimate for India at US\$2,650. Life expectancy is 61 for males and 63 for females. The crude birth rate was 25 per 1,000 population in 2002, down from 40 in 1951 (UNDP 2005; Government of India 2001).

The number of hospitals (private and public) was over 38,000 in 2004, although these aggregate figures do not reflect the regional variations that are usually large within the country. The total number of hospital beds was reported to be 915,000 in 2004.

Data on health care workforce vary across sources though not by wide margins. Whereas the recommended international norm for nurse-physician ratio is between 2:1 and 3:1 (i.e., between 2.0 and 3.0), according to *World Health Statistics 2005*, for India, in 2003, it was a lower ratio—of 1.3—derived from the index of health care workforce per 10,000 population: 7.9 nurses and midwives, and 5.9 physicians (WHO 2005). Assuming that these may not have been radically different in the immediately preceding or succeeding year, any one number in a particular year would provide a rough approximation of the other figure, if one were to attempt constructing limited time-series data. For example, the Government of India stock figure of 625,000 modern allopathic doctors in 2002 would provide an approximate estimate of 812,500 nurses and midwives in that year, and similarly, a stock figure of over 1.3 million of registered nursing personnel (GNM, ANM, and HV and HS together) in 2004. It may, however, remain questionable whether there were actual increases of 50 percent each in the number of these health care worker categories over a short span of just 2 years (2002–2004), or these were due to nonstandardized problems of underestimation in the first year or a double counting in the second year. What is also important to note in this context is that the Indian data for doctors and nurses are net of attrition due to retirement, migration, and death, but one could not be sure if the practices of data collection have been consistent from year to year.

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NURSING EDUCATION

There are a range of nurse categories in India. Entry-level eligibility for nursing education is a pass in the Senior Secondary School Leaving Certificate Examination or equivalent 12-year schooling, preferably with physics, chemistry, and biology as chosen subjects, and a minimum age of 17 years. Post-secondary programs include both a 4-year Bachelor of Science in Nursing degree (B.Sc.(N)) and 3-year General Nursing and Midwifery (GNM) diploma, the latter being the minimum requirement for an entry-level job of a staff nurse. Auxiliary Nurse Midwife (ANM), and Health Visitor (HV) and Health Supervisor (HS) are assisting nurses at a lower level of expertise.

Table 1 shows the stocks of registered nursing personnel in India. As of 2004, there were 865,135 GNMs, the 3-year diploma holders, and 506,924 ANMs, and 50,393 HV and HS. No complete or reliable data are available on the B.Sc.(N) degree holders.

Table 1 also shows the number of institutes that provide training and education in the field of nursing, by qualification types and levels of diplomas and degrees. There are more than 1,000 recognized nurse training centers in India, mostly attached to teaching hospitals, which together admit nearly 10,000 students every year. Many nurses receive training through military hospitals, although to qualify, the women trainees must be unmarried, divorced, legally separated, or widows. Those selected to the 4-year B.Sc. and 3-year Probationary Nursing courses execute a bond to serve in the Military Nursing Services (MNS) for 5 and 4 years, respectively, as they are fully sponsored by the government. Recently some private institutions have launched 4-year programs, but most B.Sc.-level nurses are still graduates of government schools.

Amongst higher level courses in nursing that have been started in the country in more recent times are Master of Philosophy (M.Phil.) in Nursing—1 year for full time and 2 years duration for part time; a Diploma course in Nursing Education and Administration—of 10-month duration; Ph.D. in Nursing; Clinical Specialization in Master of Nursing; Clinical Specialization in Community Health Nursing, etc. No data are available on the numbers of these advanced graduates, although given the recent launch of such programs, they are likely to be still quite low.

Each state or a group of states has its own organization for the registration of nurses called the State Nursing Council. After the successful completion of training, a nurse must register her name with the state's Nursing Council to be eligible for employment as a registered nurse. It is the Indian

Table 1: Nursing Education Institutes and Registered GNM, ANM, and HV/HS in India, by State Nursing Councils, up to March 31, 2004

Registering State Council	Total Number of INC-Recognized Nursing Education Institutes in India, by Course Level						Registered Nurses		
	GNM	ANM	DNEA	B.Sc (N)	P.B.B.Sc (N)	M.Sc (N)	GNM	ANM	HV/HS
India (total for all states)	769	236	6	165	30	29	865,135	506,924	50,393
Andhra Pradesh	103	31		27			84,306	94,395	2,480
Assam	15	9		2			10,321	12,589	
Bihar	13	23					8,883	7,501	511
Chattisgarh	2						179	93	
Delhi	15	1					2,594	355	
Gujarat	20	2		2			85,796	35,840	1,352
Haryana	13	9					15,821	13,112	694
Himachal Pradesh	5	1					7,920	9,087	411
Jharkhand							10	15	
Karnataka	170	4		56	14	12	54,762	47,407	6,836
Kerala	78	14	1	5	1		71,589	27,612	7,797
Mahakoshal	19	8	2	8	1	1	92,331	25,344	998
Maharashtra	50	16	1	11	4	2	81,983	25,690	551
Mizoram	4	2		1			1,301	1,441	
Orissa	7	15		1	1		46,090	30,213	110
Punjab	67	28	1	10	4	3	43,470	17,389	2,584
Rajasthan	49	8		1			35,482	22,239	850
Tamil Nadu	55	8		37	4	8	159,525	52,819	11,083
Tripura	3						641	969	79
UP and Uttra'al	28	30					17,479	26,956	2,789
West Bengal	26	20		2		2	44,652	55,858	11,294
MIB	4	4	1						
SIB	18	3		2	1	1			
AFMS									

Notes: Assam includes Arunachal, Manipur, Meghalaya, and Nagaland; Maharashtra includes Goa; Punjab includes J&K; Tamil Nadu includes A&N Islands and Pondicherry; West Bengal includes Sikkim.

ANM, Auxiliary Nurse Midwives; GNM, General Nursing Midwives; HV, Health Visitor; HS, Health Supervisor; DNEA, Diploma in Nursing Education and Administration; B.Sc (N), Bachelor of Science in Nursing; M.Sc (N), Master of Science in Nursing; P.B. B.Sc. (N), Post-Basic Bachelor of Science in Nursing; MIB, Mid-India Board; SIB, South India Board; AFMC, Armed Forces Medical Services are only educational and examining bodies, not registering bodies.

Source: Government of India (2004a, 2004b, 2005). Courtesy, Advisor (Nursing), Ministry of Health & Family Welfare, Government of India.

Nursing Council, a federal autonomous statutory body constituted under the Indian Nursing Council Act, 1947, which is responsible for regulation and maintenance of a uniform standard of education and training for Nurses and Midwives, ANMs and HVs throughout the country. The Council prescribes the syllabus and regulations for various nursing courses.

While India's aggregate nurse-to-population ratios is one of the lowest amongst source countries, lower even than Nigeria, shortages in rural areas are the most urgent. In rural areas in 2001, there were 32,723 funded nurse positions, while the number of needed positions estimated by the Indian government was 44,143. Of these funded positions, 27,336 were filled, with 5,495 remaining vacant due to shortages (Government of India 2004a).

RECRUITMENT HUBS IN INDIA

In recent years, health care institutions in prosperous countries have discovered India as a new source country for recruiting well-trained, English-speaking nurses. Much of this recruitment is targeted in a few geographic areas and some of the best hospitals in India are reportedly experiencing mass resignation and exodus of nurses to hospitals abroad (CHAUS 2005). At the same time, Indian hospitals have engaged in "business process outsourcing" (BPO) to take advantage of this phenomenon. They recruit and train Indian nurses and prepare them to take the foreign nurse examinations.

New Delhi in north India, and Bangalore and Kochi in the south have emerged as the three main recruiting hubs. Delhi-based agencies tend to focus on the U.S. market, while those in Kochi and Bangalore are mainly facilitating migration of nurses to other destinations like the Gulf countries, Australia, New Zealand, Singapore, Ireland, and the United Kingdom. The licensing and visa processes to these different countries vary markedly and require significant knowledge of the system. For example, waiting period for migrating to the United Kingdom has been as short as 6 months, whereas for the United States it is up to 2 years. Of note, however, is that in Delhi, over half the migrating nurses are also originally from the south of the country.

Based on media reports on the two southern hubs and the number of nurses taking the CGFNS examinations, our best estimate for Bangalore was that between 5,000 and 6,000 nurses have left in the last 2 years, while from Kochi they numbered between 3,000 and 4,000. In Delhi in north India, we estimated that 10,000 have migrated.¹

Indian recruiting agencies that partner with the U.S. recruiters have mushroomed in Delhi since 2003. The largest ones are the Max HealthStaff,

Western International University (Mody Private group), Escorts Heart Institute, the Apollo Hospitals, and Jaipur Golden Hospital. According to our interviews, those hospitals that are well-known for catering to Indian patients from outside Delhi, invest an average of US\$4,700–7,000 in training a nurse, and earn as much as US\$47,000 once one is placed abroad. In some states, even the government has now started taking interest in facilitating international migration of nurses. Such is the case of Overseas Manpower Corporation Limited, an entity created by the Government of Tamil Nadu.

In the 1990s, India's ranking in terms of the number of registered nurse applicants aspiring for the U.S. licensure was sixth after the Philippines, Canada, South Africa, Nigeria, and Korea. By 2004, however, it had jumped to second position, next only to the Philippines, in large part due to the expansion of CGFNS examination centers in India (CGFNS 2004). According to CGFNS, in 2004–2005 a record of 10,000 Indian nurses were in the process of applying to migrate to the United States through the help of recruiting agencies in Delhi. The CEO of one agency we interviewed told us that their own goal was to export 100,000 Indian nurses to the United States by the year of 2010.

CONCLUSIONS

India is faced with the double challenge of producing more nurses for emigration and at the same time filling vacancies within India. Currently, there is virtually no discussion of the difficulties this dual challenge poses. Interviews with the top management of two different government-sector hospitals, as well as with officials from the Ministry of Overseas Indian Affairs, the Advisor (Nursing) to the Ministry of Health & Family Welfare,² and the Registrars of the Delhi Nursing Council and the Indian Nursing Council revealed that none of these groups were seriously concerned about problems that could arise from the international recruitment of nurses in India. This somewhat neutral position is overshadowed by enormous enthusiasm on the part of the private commercial agencies that engage in BPO, including in nurse supply and are rapidly effecting change in the country.

It is the author's view that if the massive growth in recruitment activities continued, then there is a serious risk of selective depletion of the most qualified nurses in the country. In order to inform public policy in this area, it is critically important that data on nurse production, employment, retention, and migration be tracked and analyzed by the Indian government.

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NOTES

1. These estimates are collated from the media reports and the interviews of various stakeholders carried out for this study, and CGFNS (2004).
2. Some of these interviews were conducted in July–October 2005, although the major survey was carried out in early 2005.

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