

Nursing Shortage in India with special reference to International Migration of Nurses

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Abstract

In any health system, the health worker determines the nature and quality of services provided. Data demonstrate that most health systems across the globe face nursing shortages, varying across regions and rural-urban distribution. Although nursing services are an integral part of both preventive and curative aspects of India's health system, the nursing estimates of the country shows that India has been facing a shortage of nurses since independence. Studies show that professional, social and economic reasons are considered to be behind the nursing shortage in India. Similar reasons induce Indian nurses to look for migration opportunities in other countries. The high income countries have discovered India as a new source of well trained, English-speaking nurses to overcome their nursing shortages. This has resulted in mass migration of nurses from India, which in turn may lead to non-availability of standard quality health services especially to the poor section of the population in the country. Strong political commitment is required for improving the nursing situation in India.

Introduction

Human resources in health care are central to its functioning. They play a crucial role in determining the health status of the population as they contribute different skills and undertake various tasks in the health system. The scarcity of health workers negatively affects the quality and efficiency of services provided by a country's health system.

The data reveal a severe shortage of health workers in most parts of the world (JLI 2004).

Disparities in health worker distribution, irrespective of the country, are a major problem faced by health systems today. Countries with relatively higher needs of health care do not have enough employed health workers, whereas countries with relatively lower requirements of health workers are some of the biggest consumers of health services. The availability of health professionals in most of the countries does not match with the health needs of the population. Most of the countries across the globe are presently facing acute shortages of nurses and witness a maldistribution of health workers across states, rural and urban regions.

Nurses, along with other health care professionals, are involved in the direct delivery of health care to the population and therefore form an essential part of the health system. To overcome these shortages, the developed countries are undertaking active recruitment of foreign nurses. Most of the nurses migrating to the high income countries come from the developing countries (Buchan & Scholaski 2004). India is one of the major source countries providing nurses to the developed nations. The source country's health systems, especially the developing ones, face a severe loss of trained staff as the nurses migrate from both the public and private sector. A country with an already dismal health system suffers more when nurses migrate to other countries.

This paper attempts to explore the migration of nurses from India in the context of nursing shortages in the country. It looks at the relationship between the development of the nursing profession in India, shortage of nurses in the country and international migration of Indian nurses.

The paper consists of three sections. The first section looks at the history of nursing in India. It provides a snap shot on the development of nursing in pre- and post-independent India. The second section examines the shortage of nurses in the country and the reasons behind it. The third section

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explores the international migration of nurses from India. An attempt has been made to understand the migration and post-migration experiences of Indian nurses.

Secondary sources of information have been used for writing the paper. Indian government documents, reports prepared by various international organizations, newspaper reports, academic books and journal articles have largely provided the information. Human resource in health is an area of profound importance to India. The areas of nursing shortage and international nursing migration are largely under-researched, and this paper tries to understand an aspect of it.

History of Nursing in India

Historically, nursing in India had evolved under British rule. The British Medical Services, later known as the Indian Medical Services, were the first to develop nursing as a profession in India. The formal education of nurses started in India under various hospital-based training schools. It was mostly the women from among Anglo-Indians, Europeans and Indian Christians communities who formed the nursing workforce during British rule, and was considered a Christian profession.

The participation of Indians in nursing services was considered important by the British for arranging a workforce of Indian nurses who could provide care to the patients and take up necessary administrative and teaching responsibilities (GOI 1918). However, the British found out that it was difficult to train Indian nurses because they considered nursing work as menial. The caste and religious norms restricted Hindu and Muslim women from joining the nursing profession (The American Journal of Nursing 1907). The strong caste practices prevalent in India and low social status accorded to nursing profession impacted on the number of Indians taking up nursing (Noordyk 1921).

Under British rule, nursing training was organized and promoted as an educational field. The earliest efforts to regularize nursing education established nursing boards in different parts of India. These nursing boards conducted entrance examinations for nursing training (Gulani 2001).¹ The first examination was held in 1910 under

¹ The course was of three years duration with additional one year training in midwifery. The examinations were conducted in either English or Urdu in the North. In the South, regional languages were used as the medium for examination and training. The minimum educational qualification required for nursing candidates was 8th standard for European and Anglo Indian pupils and 4th grade in case of Indian applicants.

‘North India United Board of Examiners for Mission Hospitals’. Similarly in 1913, a nursing committee of the South India Medical Association conducted examination for a nursing training program. Later on, many government hospitals joined the various nursing boards in India to gain from the public nursing examinations conducted by these boards and to avail recognition given by them (Jaggi 2001).

Between the periods of 1920 to 1939, many nursing schools were set up in different parts of India with the objective of standardizing nursing training (Gulani 2001). Most of the provinces had been able to establish their own nursing schools by the time India obtained her independence.² The majority of them were however in South India.

Nursing service has been considered an integral part of both the ‘preventive and curative’ aspects of the country’s health system. The development of nursing in India during the post independent period can be traced historically from the reports prepared by various health committees, the Five Year Plans developed by the Planning Commission of India and other government sources.³ The estimates on nurses in the country are available from different government sources. The Indian Nursing Council, which was set up in 1950, provides nursing estimates of the country since its inception (Mathur & Manocha 1988).

The findings of the health committee reports give an account of the development of nursing education and training in India. The Shetty Committee recommended two grades of nurses, i.e. fully qualified nurses and midwives who have undergone training for three and half to four years, and the other one of Auxiliary Nurses and Midwives with a training of two years (GOI 1954). The Mudaliar committee suggested a nursing degree of four years training including six months in midwifery and six months in public health (GOI 1961). This was supported later by The High Power Committee on Nursing and Nursing Profession (GOI 1989). The nursing programmes offered at present are basic and post-basic B.Sc degree (nursing), General Nursing & Midwife (GNM) diploma, Auxiliary Nursing & Midwifery (ANM)

² The school for Hospital Administration in Delhi, which had started functioning in 1946, led to the introduction of four year training course at university level awarding a B.Sc honours degree (Jaggi 2001).

³ The health committee reports include Bhore Committee of 1946, Shetty Committee report (1954), Mudaliar Committee report (1962), National Health Policy (1982), Bajaj Committee report (1987) and High Power Committee report in 1989. The Planning Commission documents include the Five Year Plans.

diploma, M.Sc (nursing), M.Phil (nursing) and Phd (nursing) (Kumar 2005).

The estimates of registered nurses in India mainly include the GNM diploma and B.Sc degree holders. Based on the nursing estimates over the years, the government reports have recognized shortage of nurses in India and have discussed the reasons behind this shortfall. Lack of basic amenities in rural areas, shortage of accommodation, low professional and educational opportunities, poor working conditions, no gazette status for nurses, lack of equipment and supplies in work places, low salary, staffing norms, extra workload, time spent on non-nursing duties, security, incentives for promotion, lack of teaching staff, regulation of private nursing schools and health institutions etc had been cited as the major issues faced by the nursing workforce in India (GOI 1946, GOI 1954, GOI 1962, GOI 1989). However, most of the recommendations given by the various health committees had been recapitulated from previous reports.

Shortage of Nurses in the country

In India, the allocation of health workers is based on population sized norms (GOI 2006). The health needs of the population are not considered for apportionment of health workers in the country. The health indicators of the population in India bring forth the graveness of the health human resource shortage existing in the country. A comparison of health indicators of India with other developing countries shows that the mortality levels experienced in India remain quite high. In India, the IMR in 2004 was 62 per 1000 live births, and MMR in 2000 was 540 per 100000 live births. Sri Lanka, another developing country from the South-East Asian region, had an IMR of 12 per 1000 live births in 2004 and MMR of 92 per 100000 live births (WHO 2006 a). India's population constitutes 17 per cent of the world population, whereas it accounts for 20 per cent of global disease burden (GOI 2007).

The disparities in health status in India can be observed across the rural-urban regions and amongst the states. The differences in health status of the population of India reflect in part the disparities in terms of the availability and accessibility of health services.

Nurses represent the largest share, i.e. 38 per cent, of the total health workforce of India (Rao, Bhatnagar, Berman, Saran, & Raha 2008). The nurse to population ratio found in the country is suggestive of the shortage of nursing personnel existing in the country. The nurse to population ratio found in India stood at 0.80 nurse per 1000

population in 2004, which brings out the fact that not even one nurse is available to a population of 1000 in the country (WHO 2006 a). The distribution of nurses in India presents a picture of imbalance across states. The state with low mortality rates reported higher availability of nurses as compared to the states experiencing low health status. The rural-urban distribution of nurses showed that more nurses preferred working in the urban areas. However, the need for nursing services is more in the rural than the urban areas because of lower health status and higher mortality rates experienced by rural population. The nurses working in urban areas were nearly three times more in number than the nurses employed in the rural areas (Rao, Bhatnagar, Berman, Saran, & Raha 2008).

The nursing profession in India lacks high professional status, has low and unattractive salaries, gets inadequate recognition from the community for the services provided by them and has little incentives for quality performance (Gill 2009). The institutions responsible for nursing training lack the required physical and human resources. Most of these training institutes work as appendages to hospitals (Kumar 2005). Professional, social and economic reasons can be considered behind the nursing shortage in India. The rural job preference amongst nurses is shaped by factors such as living conditions, chances of sexual harassment at the workplace, personal and professional growth opportunities, intellectual stimulation, transportation, availability of jobs for the spouse and educational facilities for their children (Harnar & Lehman 1987). The nursing profession is given low social status because of the prevalent religious and societal traditions. Nursing work involves rendering services on a personal level to the patient and has chances of being exposed to bodily fluids and contaminations. The work undertaken by nurses still has social stigma attached to it (Nandi 1977). This can be cited as one of the main reasons behind the low perception held by the Indian society towards the nursing profession. The nurses are considered to be secondary in position as compared to other health professionals in India. There is a vast difference in the prestige and recognition accorded to doctors as compared to nurses (Gill 2009). The nursing profession continues to be neglected in India. Some of the causes behind this neglect are more emphasis on medical education, political influence by the medical community and less allocation of financial resources on health by the Indian government (Rao, Rao, Kumar, Chatterjee, & Sundararaman 2011).

The professional and financial incentives to

retain qualified nurses in the country are found to be inadequate. The attrition rate of nurses is highest among health personnel in the health care industry of India (*Business Line* 2004, *The Economic Times* 2008, *Business World* 2008). The scarcity of nurses in the country is leading the private health sector to fill its demand by employing untrained nurses or undertaking nurse poaching from other health institutions. Only 40 per cent of the total nursing workforce in the country is said to be active because of low recruitment, migration, attrition and drop-outs due to poor working conditions (GOI 2005). The public health institutions are facing the dual challenge of dealing with the existing shortage of nurses and the loss of trained nursing personnel to private health organizations and other countries.

International migration of nurses from India

India has been discovered as a new source country for recruiting well trained, English-speaking nurses by the high-income countries to overcome shortage of nurses faced by them. The migration of nurses from India can be traced from the decade of 1970's (Meija, Pizurki, & Royston 1979). Earlier, a few Indian nurses used to migrate because earning prospects were high. This helped them to send remittances back home, which were used for various purposes, e.g. building a new house, financing children's education and for a small business that the husband might start. But, in the post-1980's there was a shift to mass migration of nurses from India, most of them belonging to the state of Kerala (Nair & Percot 2007).

The recruitment of nurses from India is mainly targeted from a few geographical locations. There are three recruitment hubs in the country, i.e. Kochi, Bangalore and Delhi. These centers facilitate migration of nurses to other countries like the US, the UK, Ireland, Singapore, New Zealand, Australia and the Gulf nations (Khadria 2007).

The majority of the nursing workforce in the country is represented by Keralite Christians, who comprise a large section of the nurses migrating from India (Nair & Percot 2007). Nursing is taken up by women as part of their family strategy in which their education and migration constitute a vital part of the entire process. The majority of nurses in India come from lower-middle class families (Percot & Rajan 2007). It costs around a lakh of rupees for a nursing diploma (*The Hindu* 2001). Thus, the parents invest in the nurses' education, believing this will bear fruit once their child migrates (Nair & Percot 2007). The remittance sent back home by nurses is not only used for family purposes but a part of it is also saved for the dowry required for the nurse's

marriage. The remittances are instrumental in a way for raising the social status of the family. The money is generally used for buying jewellery and other consumable goods or for building a new concrete house. Migration to another country might give the Indian nurses an opportunity to live outside the prevailing strict family norms in India (Gill 2009).

Most of the women take up nursing profession because they have plans to work abroad. A nurse working abroad has better marriage prospects as she might be seen as a ticket for the groom to move abroad and to get employment there. The preferences held by groom's family for choosing the prospective bride among nurses in descending order are the nurses with a citizenship of the developed countries, nurses who are working abroad with a work permit, one who has applied abroad and finally the nurses who are working in India. Most of the migrant nurses go through arranged marriages. The migration opportunities available to nurses have lifted the social status accorded to nurses in India, especially among south Indian communities. However, the nurses from Kerala⁴ feel that the north Indian people still hold prejudices against the nursing profession (Gill 2009).

Most of the private hospitals in India offer an initial pay of Rs. 2500 to Rs. 3000 per month, whereas an Indian nurse can earn as much as Rs. 40,000 per month as a starting salary after migrating to the Gulf countries (*The Hindu* 2001, Percot 2006). A nurse who goes abroad, mainly saves for three purposes, i.e. for sending remittances back home, for dowry and for future savings. It is difficult for a nurse to have sufficient savings from her earnings in India. Thus, she realistically chooses a suitable option, i.e., migrating to other countries.

A nurse has two main options amongst the destination countries. An Indian nurse can migrate to the Gulf countries or they can take up employment in developed countries like the US, the UK, Ireland, etc. For working in the Gulf countries, a nurse needs a minimum experience of two years. There are no qualifying tests required for working in these countries. They have only to appear for an interview which can even be telephonic. A nurse needs to pass some qualifying tests as CGFNS, NCLEX, and IELTS for working in the developed countries.⁵ The nurses might have difficulties in

⁴ Kerala is a state in southern India

⁵NCLEX: National Council Licensure Examination, IELTS: International English Language Testing System, CGFNS: Commission on Graduate of Foreign Nursing Schools

passing the IELTS. The multiple choice question format and required curriculum poses difficulties for Indian nurses. Preparing for the tests can be expensive and can act as an additional financial burden for the nurse hoping to migrate. The nurses migrate to the Gulf countries mostly because of the easier employment criteria. It is also simpler and cheaper to migrate to Gulf nations as compared to the developed countries (George 2005, Gill 2009).

The recruitment agencies facilitating migration of nurses to Gulf countries claim a substantial amount as fees. The fees charged by these agencies can amount up to Rs. 1, 00, 000 or might be as much as three months of the nurse's salary abroad. The employers from Gulf countries also conduct direct recruitment drives in India. The nurse's friends, who are already working in Gulf countries, assist in her migratory process. They inform her about employment opportunities available in other countries through her friends and relatives working aboard. This transnational network of nurses helps in disseminating relevant employment information to nurses working in India. The Indian nurses migrating to other countries generally rely on their social network for adjusting to the new society of the destination countries (Gill 2009).

Among the Gulf countries, the preferred destinations are the United Arab Emirates, Qatar, Kuwait, Oman, and Bahrain as they offer better salary and good quality of life. Saudi Arabia and Yemen are the least preferred destination countries. The Indian nurses experience social and religious restrictions in Gulf nations, especially in Saudi Arabia. The Indian nurses employed in the Gulf have no opportunity of getting citizenship there, cannot own a house or business in the Gulf country and have few educational opportunities available for their children. The married women migrating to Gulf nations cannot avail a family visa; only men are allowed to bring their family to Gulf countries. Thus, the problems faced by Indian nurses in the Gulf countries provoke them to look for employment in the developed countries (Percot 2006).

Some Indian nurses use Gulf nations as a transit point for migrating to developed countries. They try to save from their earnings either to pay for the hefty fees charged by the recruitment agencies, which are catering to markets of the developed countries or in order to prepare for the qualifying tests (Gill 2009). The Indian nurses who have not cleared the Registered Nurses (RN) examination, another qualifying test for working in the US, might have to work as nurse's aide in the US hospitals located in urban areas. This work is considered emotionally and physically difficult by

Indian standard. They may face discrimination at the workplace and may not be provided with sufficient promotional opportunities (George 2005). Communication and language barriers are also to be surmounted. The migrants might hold themselves back from integrating in the society of the destination country, thus leading to alienation from the foreign culture (Troy, Wyness & McAuliffe 2007). Poor institutional accommodation, low salaries, high cost of living can be some of the other problems faced by Indian nurses in the developed countries (Garbayo & Maben 2009).

Migration is an on-going process with few chances of the nurses coming back to India. The government of India sees a positive factor in the increase of foreign opportunities for Indian nurse. The National Commission on Macroeconomics and Health mentions "*in fact, with the large number of opportunities opening up for employment in foreign countries, particularly for nurses, it would be to India's advantage to focus on expanding the number of colleges and nursing schools alongside efforts to ensure good quality to make them employable*" (GOI 2005, p. 63).

It is worthy to mention here that the Philippines is the largest supplier of nurses in the world, and the foremost example of managed migration of nursing workforce (Abella 1997). This country is losing trained nursing personnel much faster than it is possible to replace them. The majority of the Filipino nurses, 84.75 per cent, are reported to be working abroad. Many regions of the Philippines are facing severe a shortage of nurses (Lorenzo, Galvez-Tan, Icamina & Javier 2007). It was reported by the Philippine Hospital Association (PHA) that in a time span of two years, 200 hospitals have been closed and around 800 hospitals are partly closed due to mass migration of nurses from the country (Philippine Hospital Association 2005). Therefore, migration of nurses in the county is affecting the availability of nurses in Philippines.

There is a growing trend among the Filipino doctors, pharmacists, physical therapists, dentists to get re-trained as nurses in order to take advantage of the high migration nursing opportunities available outside the country. It was reported that around 2000 doctors became nurse medics in 2001. This number increased to approximately 3000 of nurse medics by the year 2003 (JLI 2004). It adds to the existing shortage of health workers in the country and affects the health system adversely. In spite of having managed migration, the movement of health workers from the Philippines is leading to a fall in the quality of health services provided in

the country. If India undertakes planned migration of nurses then it might lead to further shortage of nurses in the country. There are lessons to be learnt from the Filipino experience of nursing migration.

The migration of health workers from India leads to the non-availability of standard quality health services to the poor section of the population as most of them depend on the public health system, particularly in the states which provide low incentives to health workers. The biggest challenge faced by the public health system is the shortage of skilled health human power in the country. There is an acute scarcity of nurses in the country. Most of nurses who migrate abroad are highly experienced. Thus, loss of qualified staff can severely impact the functioning of health systems in the country. Migration of skilled health personnel from developing countries, especially in sub-Saharan Africa has led to virtual collapse of health systems in the region. Consequences of international migration in extreme cases have been measured in lives lost (WHO 2006 b).

The impact of migration should be understood from the source country perspective, for example appointment of two specialists from a South African Health Unit by a Canadian employer led to closure of that unit in South Africa (Martineau & Decker 2002). Ghana witnessed the migration of 382 nursing personnel in 1999, which was equivalent to 100 per cent of the annual output of the country's nursing schools (Padarath, Chamberlain, McCoy, Ntuli, Rowson, & Loewenson 2003). Thus, the health professionals migrating may not constitute a high proportion of the health workforce for the destination country, but loss of the health workers can represent a significant proportion of HRH of the source countries. Nursing migration can further augment the existing nursing shortage in the country.

Conclusion

Overcoming global shortage of nurses is one of the priority areas of International Council of Nurses (ICN 2007). The nursing shortage faced in developed countries is leading to large scale movement of nurses from the developing to the developed nations. ICN acknowledges the right of nurses to migrate. However it condemns the practice of recruiting nurses by the country where the authorities have not been able to carry out requisite human resource planning or addressed the reasons behind the shortage of nurses. It is imperative that nursing should be considered as an integral part of HRH (Human Resources in Health).

Strong political commitment is required for improving the nursing situation in India. Good

working conditions must be provided so that nursing workforce can be developed and deployed in the health services fulfilling the recommended staffing norms. Nurses should be considered as active members of the health team, in terms of not only providing services, but also as a part of the decision making processes, so that it is possible for her to participate in providing holistic and comprehensive health care to the patient.

The nursing education programme in India should be strengthened. The Indian Nursing Council should be vested with requisite powers, so that it can work with in tandem with the State Nursing Councils for the purpose of regulating and maintaining standard in nursing education and training. The government should take initiatives to create and empower leaders from the nursing fraternity itself. Moreover, there should be efforts to provide adequate infrastructure, remuneration and working conditions to the nurses. Efforts should be made by the government to retain qualified nursing personnel in the country.

Reducing movement of nursing personnel outside the country must form one of the priority areas of the government. The nurses choose migration as a realistic option arising out the circumstances existing in the country. Adequate incentives, both financial and otherwise, need to be provided in order to retain health staff. Addressing the issues and problems faced by the nursing fraternity will help not only to in reducing migration of nurses from the country but also to some extent it will help in reducing the nursing shortages faced in the country.

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