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Nurse migration: a challenge for the profession and health-care systems

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Abstract
Introduction and questions of exploration In a first step this paper outlines the global context of and international influences on nurse migration. Liberalization of health markets is identified as a trigger point steering movements of nurses globally. Facts and figures concerning nurse migration are highlighted in a second section focusing on developments in the USA and UK, which are recruiting nurses from Europe and overseas on a large scale, and adding the latest European approaches and policies concerning this issue. Projections are presented that highlight growing demands for the next 2 decades. The third part explores the impact of nurse migration on nursing care and professional standards.
Methods The article is based on an extensive literature review and the analysis of quality issues in the nursing field.
Results The number of nurse migrations in the last decades show that the issue of nurse migration is already of high importance for many countries. This will be enhanced by future accelerated development of nursing shortages in many countries. Boosted global recruitment of nurses will be the consequence.The paper concludes that the recruitment of international nurses has not yet taken quality issues and indicators in health-care settings profoundly into consideration. Economical gains by not training nurses and recruiting them from abroad might have a severe impact on already existing problems concerning patient safety issues and nurse-sensitive outcomes in health-care settings.

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Introduction

Nurse migration is a phenomenon that has a long tradition. Florence Nightingale, known as one of the founding mothers of vocational nursing, spent time in Germany to train at the then famous nursing institution in Kaiserswerth. With the expansion of modern medical services, migration of medical staff became a more permanent phenomenon. Nurses and doctors working, for instance, in the colonies, were attracted by the developing industrial centers and followed job opportunities created in regions where the capacity for educating medical staff was not yet developed, such as the Arab countries.

Cycles of shortage and surplus of registered nurses have been experienced in many countries in the past decades, and in times of demand nurses have been recruited from abroad. The trends and effects of nurse migration that we observe today, however, have changed tremendously. The situation is much more serious and cannot be compared with the past: “Driven by growing and ageing populations, demand for health care and for nurses continues to grow, whilst projections point to actual reductions in the supply of available nurses in some developed and developing countries” (Buchan and Calman 2005, p 4). Moreover, today, nurse migration follows the logic and rules associated with the liberalization of markets and the global circulation of goods and services. Within this framework, some countries rely heavily on foreign nurses instead of building up a sufficient training capacity at home (Aiken and Cheung 2008). In many cases the source countries lose a high percentage of the nurses they trained to other

countries. The supply of health and nursing care in these countries is often inadequate to meet even the basic needs of their population (Aiken et al. 2004). As projections show, in future, the global shortage of nurses will have a deep impact on professional nursing, on nurse migration, on the provision of health care, and on sociocultural developments (Buchan and Calman 2005; Aiken et al. 2004; Institute of Medicine 2008; Commission of the European Communities 2008).

In a first step this paper outlines the global context and international influences of nurse migration. Facts and figures concerning nurse migration are highlighted in the second section. The third part explores the impact on nursing care and professional standards. The paper concludes with a summary and some statements addressing possible interests objectives and national and supranational policies are presented for discussion.

In order to deliver an in-depth exploration, this paper does not include the migration of physicians and other health professionals, even though there might be similar issues at stake. The paper concentrates instead on the nursing profession. However, it will leave out debates about "profession" and "professionalism" based on sociological categories and considerations. The terms "profession" and "professionalism" in nursing in this paper signify the claim of nurses worldwide to develop, control and legitimate their work in health care according to ethical standards (International Council of Nurses 2006) and defined quality standards, such as the global dissemination of the nursing process, as a baseline for nursing work (Habermann and Uys 2006) or the concept of evidence-based nursing as a new challenge in nursing (Rosswurm and Larabee 1999; ICN 1999).

Global context and international influences on nurse migration

The term globalization refers to the international circulation of financial and industrial products, goods and services (Razum et al. 2006). Many examples document the process: the power of multinational companies, risks and profits of global financial markets, communication channels like the worldwide web and the internationalization of policies and standardization of procedures. Health-care institutions, formerly controlled by communities or welfare organizations, are now part of the "health-care industry" and based on market rationality. The liberalization of markets has had an impact on all former nationally regulated health services. The General Agreement on Trade in Services (GATS) of the World Trade Organization will enhance this further, once it is agreed upon and put into action. Within the framework of globalization, companies operating worldwide that own hospitals and geriatric care homes are conquering local markets (Kingma 2006). One third of the nearly 3,500 German hospitals and rehabilitation centers are now owned by private companies. Some of these companies are listed on the stock market. Thirty-five percent of the old people's homes and 41% of the home care companies are privately owned in Germany (Friebe 2005). Searching the Internet, Friebe (2005) also found companies located in Germany and operating across Europe and around the globe, such as the Hospital Corporation of America (Great Britain, London, Switzerland, USA, Canada), Capio AB, a Swedish company that manages hospitals and nursing homes in Scandinavia, Great Britain, France and Spain, Asklepios, which owns hospitals in Germany and California, or the German Wittgensteiner Clinics (has purchased hospitals in the Czech Republic), to name just a few.

Further examples of the internationalization of national services are health insurance companies in Germany and the UK buying services from other countries. They also send patients to other countries when services do not meet the needs in some areas. Especially the National Health Service of Great Britain optimized care for the population by buying services abroad. Surgeries like hip replacement have been performed on British patients in large numbers in German hospitals (Carvel 2002). Outside Europe, for example, Indian hospitals are ready to offer heart surgery to European patients at an extraordinarily low price compared to the respective services at home (Medical Tourism India 2008), and Hungarian dentists treat German patients when German dentists are on strike or not willing to contract with health insurance companies because of low compensation. As a last example we would like to point to the growing market for care services rendered by lay women from Eastern Europe to private households in Western Europe. These care persons are often illegally working in their host countries. However, interventions are rare since it is generally accepted that without this hidden, illegal market, home care services for the elderly in many regions of Europe would break down. There is just not sufficient money available to pay for professionals in all fields of nursing, and many countries simply do not have enough professionals (Becker 2008).

Liberalization of service markets is one aspect that gives the migration of nurses a new dimension. Others are demographic and social developments that influence the worldwide demand for nurses. In many high-income countries we are experiencing a rapidly aging population and socio-cultural changes resulting in a growing number of single households and the loosening of formerly strong family networks (Habermann and Biedermann 2006; Institute of Medicine 2008). The women in the family, providing by far the largest amount of care worldwide, may have different preferences in the future and follow

professional careers where they are also needed, due to demographic changes. In many so-called developing countries the demography also predicts aging populations. China with its one-child policy and countries in Latin America and Asia will experience a population decrease in the near future (Habermann and Biedermann 2006). Since women are still the main provider of care worldwide, participants in a symposium initiated by the World Health Organization suggested that the responsibility for caring should be placed on the shoulders of men and women alike to meet future demands. (World Health Organization 2002). This would help to fill shortcomings in nursing within families as well as making professional nursing more attractive. However, so far there are no prospects for such a development.

A global service market also means that hiring nurses from other countries is seen as a rational choice by the recruiting institutions. Managers are paid for producing the best possible financial outcome, usually in a defined period of time. Financial calculations, profits or losses, are the main driving forces lying behind the decision-making process. Not training nurses domestically and, instead, hiring them from abroad increases profits. Clearly, a poor training quality of international staff and legal questions are important issues for health-care organizations in a competitive environment and might create barriers to hiring nurses. However, information about a connection between staff from abroad and the quality of care is not available. A literature review showed that recent studies dealing with a connection between the quality of nursing and staff did not include any aspect of employing international nurses (Habermann 2007).

Nurse migrations: some facts and figures

The International Organization for Migration (2003 p. 8) defines migration "as movement of a person or a group of persons from one geographical unit to another across an administrative or political border, wishing to settle definitely or temporarily in a place other than their place of origin." Adaptation and, finally, integration into the new society follow migration. The time needed for the transformation from being an immigrant to being a truly integrated person depends on the framework in which migration takes place. The education level of the migrant and the 'success' of migration in terms of realizing one's objectives that initiated migration in the first place play an important role regarding the duration of the integration process (International Organization of Migration 2003). Sometimes integration will take several generations. The above-cited definition of the International Organization of Migration leaves this question open.

Migration is constitutive for modern societies. It supports nation-building processes as well as the accumulation of national wealth. The large number of refugees among the migrants makes it clear that migration is also a global indicator of unsolved tensions and conflicts, of racial and cultural suppression, and of natural disasters. Today, 1 out of 35 persons can be regarded as a migrant, that is, 175 million people or 2.9% of the world population. Between 1960 and 2000 the number of migrants doubled, and it is expected that this development will accelerate in the next decades (International Organization of Migration 2003). Migration today has a female face. Women are on the move, seeking opportunities for themselves and their families. A part of this female migration is nurses. Kingma (2006), a member of the International Council of Nurses, published some figures in her compilation "Nurses on the move":

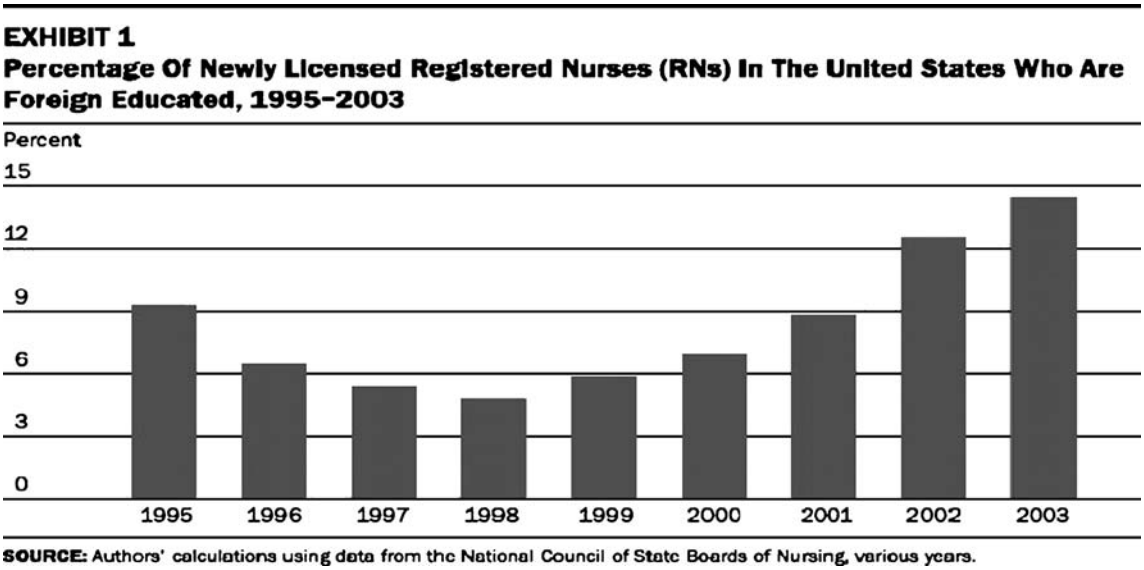
- in the Philippines, more than 250,000 nurses have left in the last decade. There, as well as in India, a surplus of nurses is trained for the international market.
- in 2001 more Zimbabwean nurses were registered in the UK than were trained in Zimbabwe in the same year.
- over 30% of all nurses working in Switzerland were trained abroad.
- in 2003 two thirds of the new entrants to the Irish register came from countries inside and outside the European Union (EU).

According to Kingma (2006), in some parts of the USA and the UK, 60–70% of the employed nurses are migrants. Aiken et al. (2004) report a total increase of the international workforce from 6% in 1998 to 14% in 2002 in the USA. Regarding the total employment of nurses in the USA, it is estimated in the publication of Aiken et al. (2004) that one third of the new job opportunities available were taken by nurses who had been trained abroad (Table 1).

Aiken et al. (2004) also published detailed figures from the main recruiting countries in Europe, mainly the UK, Ireland and Norway:

- in 2002 more nurses joined the UK register from overseas (16,155) than from training facilities within Britain (Table 2).
- between 1999 and 2002 the number of foreign-trained nurses based in and eligible for work in the UK more than doubled to 42,000 (Table 2).
- home sectors in the UK are highly dependent on foreign-trained nurses: One out of four nurses in London are from overseas, and some private health-care organizations employ as many as 60% nurses trained overseas. Nurses are recruited primarily from non-European countries in which the English language is spoken in academics, such as India, the Philippines, South Africa and Zimbabwe.

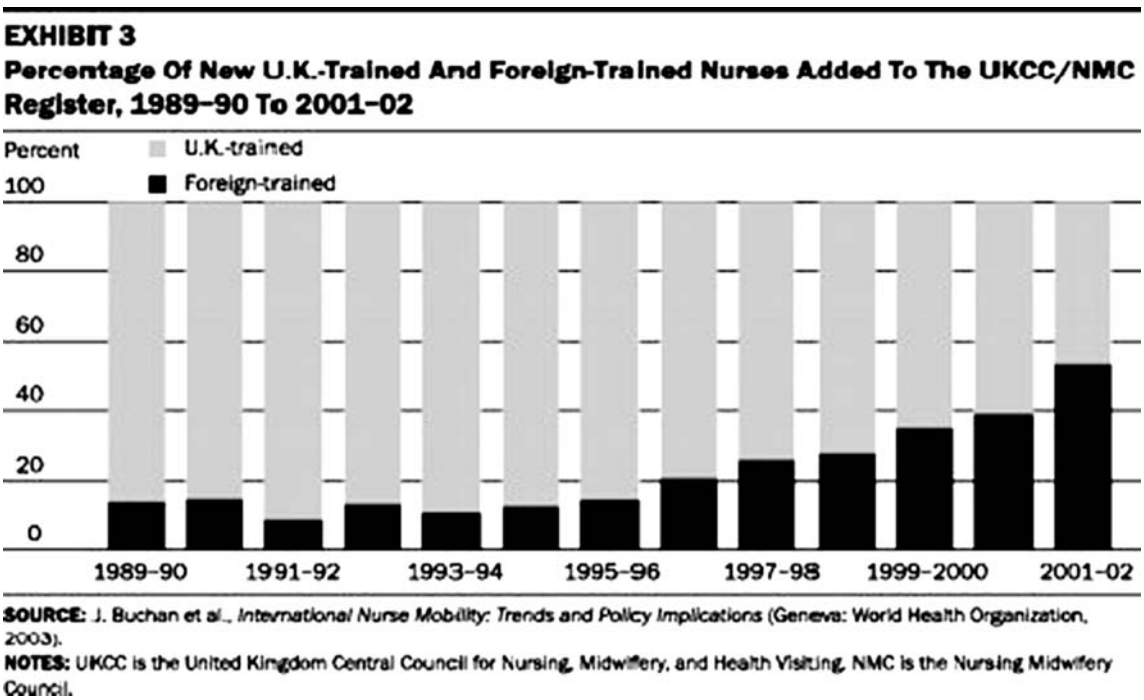
Table 1 Percentage of newly licensed registered nurses (RNs) in the US who were foreign educated, 1995–2003 Source: Aiken et al. 2004 p 72



According to Kingma (2006), more and more countries are coming into the focus of the recruiting countries. In 1990 the UK hired nurses from 71 countries and in 2001 from 95 countries. The USA recruits from a variety of countries and has established contracts with countries such as Jamaica in order to ease the migration of nurses from the region. In Jamaica between 1978 and 1985, 95 percent of the graduates in nursing chose to go abroad.

The "Green Paper" of the Commission of the European Communities, published in 2008, documents the growing awareness of severe problems in recruiting sufficient staff for an aging population within Europe. Taking the lack of substantial data concerning the statistics of migrating health professionals, especially of nurses in some of the EU countries, into consideration, it has been suggested to establish a "mechanism" such as an "…observatory on the

Table 2 Percentage of new UK-trained and foreign nurses added to the OKCC/NMC register, 1989–90 to 2001–02 Source: Buchan et al. in Aiken et al. 2004, p 74



health work force which would assist Member States in planning future workforce capacity (...)" (2008 p. 8). This makes sense, since the monitoring of nurse migration flows in European countries is only possible by exploring the entry register of those countries that are operating the nurse workforce by a respective nursing register board. Germany, for instance, the largest of the potential "reciever" countries in the EU, does not monitor the migration background in official health personal statistics (Habermann et al. 2009), and the same is true for many other countries in the EU (Commission of the European Communities 2008). Reliable data are thus only available through single research or data-collecting projects as done at the moment by the OECD.

With regard to the mobility of health staff, the provision of language training courses is seen as another field of possible action. Clearly, the dangers of global recruitment for the EU population are seen. The paper refers to "an increased demand and competition for medical and nursing staff across the developed world" (2008 p.10) that attracts doctors and nurses to migrate to non-European countries like the USA.

Nurse migration push and pull factors

The reasons to migrate, the so-called push factors, lie in the living and working conditions of the home country. In contrast to these, pull factors are the attractions that recruiting countries offer. Studies have explored the importance of these factors for migrants in general (International Organization of Migration 2003) and for nurses in particular (International Council of Nurses 2002; Van Eyeck 2005). Some nurses migrate for adventure reasons, for career options or professional development. "Your profession is your passport"—being a nurse makes it easy to overcome immigration barriers. It opens possibilities for mobile persons.

Many nurses consider migration, however, because they seek personal safety, a higher income for themselves and their families, or personal freedom, and better working conditions. In many cases they leave their children and aging family members behind to give their children a good education by working abroad. Fewer nurses come from very poor countries (Kingma 2006). It seems that the intention to leave is more often articulated in countries like South Africa in which nurses have already experienced some professional development. Poor salaries for nurses in comparison with professions of a similar education level are observed worldwide. Differences in the purchasing power parities regarding the incomes of nurses in low-income, middle-income and wealthy nations like the USA, the UK or Germany are enormous.

The pull factor of supporting a family back home is one reason to migrate that is well documented by the remittances sent home every year. Statistically, the amounts sent back include all remittances, not only those of the nurses. But nurses contribute to the estimated 75–200 billion dollars remitted through formal bank accounts every year. In addition, according to Kingma (2006), private remittances double or triple these transfers. In some countries remittances represent a substantial percentage of the gross domestic product (Benin 4.5%, Nicaragua 16.2%, Lesotho 26.5%) (Kingma 2006 p. 6). However, there are indications that the push factors are more decisive because the decision to leave the family and personal networks behind is not an easy one to make and often means abandoning social and cultural obligations like caring for the elderly.

Rare and mainly qualitative studies have been undertaken to explore the situation of nurses who had migrated. The Royal College of Nursing (2002, 2005) found that those who fit easily into the dominant culture have fewer problems than those nurses who are easily recognized as foreigners due to, for instance, skin color or accent. The study resulted in the identification of an institutional racism hidden in structures and processes. Black nurses faced direct racism as well. Another study carried out in the UK found that nurses from abroad often felt unwelcome, not valued, discriminated against and urged to prove their knowledge (Alexis/Vydelingum 2005a cited in Adams and Kennedy 2006). With the focus on employment contracts and working conditions, Buchan (2003) found that nurses from abroad are often confronted with poor working conditions and disparaging treatment. He concluded that ethics-based regulations are needed to safeguard international workers in the nursing field.

American researchers found that nurses needed about 10 years to adjust completely to their new working environment (Adams and Kennedy 2006). In order to explore the experiences of international nurses further, the Commission on Graduates of Foreign Nursing Schools (CGFNS) conducted focus group interviews in several states. The research identified typical barriers preventing the integration of the recruited nurses. The CGFNS complemented their findings with positively evaluated strategies and instruments introduced by some organizations that recruit nurses. Support in the form of programs, networks and coaching for individual nurses was established to minimize turnover rates (Table 3). An in-depth evaluation, however, of such strategies and programs or a comparison between organizations has so far not been undertaken.

Since adaptation to a new work environment can take up to 10 years, employers who want to attract and retain nurses are asked to accompany the process over the years and to provide programs that are not only covering the first encounters of

Table 3 Barriers and strategies to support individual nurses. Source: Own compilation based on the article of Adams and Kennedy 2006

Barriers to the integration of nurses into the host country	Strategies to support individual nurses
Language and communication difficulties	Language courses focusing on medical language and local specifics
	Training in intercultural communication
	Gaining insights in multicultural contexts of the host country
Lack of access to appropriate information	In-depth and repeated information about all aspects of workplace and regional lifestyles
Lack of value and issues with de-skilling	Integration plan covering several years
Lack of cultural and religious services	Building up information about cultural and religious networks
Institutional racism	Diversity strategies as integrated management
	Repeated feedback talks with nurses addressing racial and cultural issues
Negative attitudes of health staff and patients	Diversity management—open and forward policies towards recruiting nurses from abroad
Lack of community and family support	Building up information about cultural and religious networks
	Support of family and cultural contacts

foreign nurses with their new work environment, but also support the adaptation process in the long run.

Nurse migration can also have a strong impact on the sending country, such as the uneven nurse-to-population ratio worldwide. Due to a lack of health workers, some low-income countries cannot implement their health policies; the World Health Report 2003 mentions this situation for instance in Botswana. The free antiretroviral therapy then made available by the government to all eligible citizens lacks consistent distribution because of a shortage of health workers. Lack of health workers has also been seen as one of the main obstacles to reaching the millennium goals of the UNO intended to reduce poverty and increase health (World Health Organization 2003). A special focus of attention must therefore be the source countries with a low- or medium-income background (Commission of the European Communities 2008). Some countries, such as India and the Philippines, cannot create enough jobs for nurses despite their domestic health-care needs. For decades they have trained nurses for markets overseas, establishing an additional market for private schools with an international orientation (Khadria 2007; Lorenzo et al. 2007).

Without the work of nurse migrants, health systems in many countries would not function. Projections suggest a demand of 3.5 million additional nurses in the US for the care of the babyboomer generation in 2030 (Aiken et al. 2004; Institute of Medicine 2008). In Australia, there are severe limitations to providing adequately for acute care needs (Kingma 2006). In both countries there are more nurses registered than are actually working. This 'hidden reservoir' of nurses seems to be the result of poor job conditions. Nurses' dissatisfaction in the USA seems to be associated with inadequate resources, insufficient time for patients, weak staff support and lack of a voice in the decision-making process. Nursing burnout "is driven less by the stresses inherent in caring for very ill people and more by organizational impediments to the delivery of an acceptable standard of nursing care, especially inadequate resources and poor administrative support" (Aiken et al. 2001, p 10).

Nurse migration—impact on nursing care and professional standards

Regarding the development of professional nursing, the demand for nurses worldwide can work in both directions. **First scenario:** Nurses' work could become even more unattractive than it is today, because international nurses are associated with problems of quality that would further downgrade the profession. Some developments indicate this: in Germany, as well as in the UK, international nurses and nurse assistants from abroad work especially in those areas that are less attractive to nurses: old age homes and home services (Friebe 2005; Kingma 2006; Royal College of Nursing 2005). A job hierarchy also exists. Migrants are rarely seen in senior or managerial positions. They work predominantly in direct care. Migrants are also not represented to the same extent in the training or academic education of nurses as they are in practical care. There are obvious impediments and barriers to their advancement, such as language abilities, lack of migrant-sensitive staff development and perceived traditional roles of migrants. Migrants are expected to do basic work and work nobody else wants to do. Nurses trained in the host country withdraw from areas with many migrants and look for jobs within or outside nursing that have more prestige. Difficulties in multicultural team settings are another indicator for the downgrading scenario. Productivity and creativity are

seen as important advantages of such teams. However, to date, research could not convincingly clarify under which conditions multicultural teams work effectively (Habermann 2003). Especially in health-care settings it has to be asked what constitutes a negative outcome with regard to multicultural teams and how it does come about. Is it a sign of a too extreme diversity when for instance most team members have a different mother tongue? Are language and cultural barriers hindering the little chats among good colleagues? Do poor working conditions and/or an insufficient intercultural management cause team members to lash out against each other? It seems that multicultural diversity has its limits where the productivity of nursing teams is concerned and that some of the team members should be representatives of the local population and be able to support newcomers to adapt to and integrate into the new culture (Ertl 2002).

Sceptical voices point also to the fact that the motives to become a nurse are no longer those that used to form professional attitudes. If becoming a nurse means escaping the living conditions in the home country, then the attitude and ethical commitment to the profession might become more and more unimportant. Nurses are then seen as clever business women selling their skills at the best price on the global market.

High demands for scarce goods result in high prices. Demand and supply set the price. Some hope this basic rule in economics might support nurses in gaining significance and influence in societies that have a growing demand for them. This, however, gets overruled by global migration policies in many fields of services and production, and probably cannot be applied to the nursing field. If nurses from one country are too expensive, opportunities arise for the nurses of another country. Thus, China's workforce comes into the focus of American companies that act as employment agencies (Xu 2007). The issue and its strategic meaning remain unclear not only for regional nursing associations, but obviously also for the global organizations monitoring the migration processes like the World Health Organization, International Council of Nurses and International Labor Organization. It is astonishing that global nurse migration is rarely addressed by these organizations as a chance to gain more influence for this profession in *global* health policies; even so, there is awareness to strengthen and support regional and national developments in nursing and midwifery (WHO et al. 2007).

Second scenario: Positive developments created by the migration of nurses are associated with learning possibilities, positive impacts on socio-cultural norms and on the field of intercultural nursing. "If you come back from a journey you have things to tell to others." This is an old German saying that is certainly true for nurses with migration experience. Self-confidence, broadened knowledge and skills can be gained through a working experience in another country. Even a mediocre working environment supports learning by sharpening sensitivities about the quality of nursing and learned attitudes and beliefs brought from the home country.

In many countries, nurse migration has constituted an important push factor for the advancement of the nursing profession. In India, for instance, nursing had been a totally unattractive profession for high castes like the Brahmins since nursing meant getting in touch with egesta. That was unthinkable for a Brahmin woman. Dealing with egesta was left for the so-called untouchables. The first nurses educated by the British colonialists originated from this population group. Only when Europe and the USA started recruiting nurses on a large scale from India in the 1950s, nurses became eligible on the marriage market for high castes and the stigma faded. A nurse in the family secured access to more income and to the western world. As a consequence, nursing started to be an acceptable profession for Brahmins (Somjee 1991). Taking the strong traditions of the Indian society into account as well as the cemented barriers among castes at that time, nurse recruitment from abroad and their migration had a tremendous effect on society. Today, India is still one of the countries in which more nurses are educated than the regional labor market absorbs, and its nurses are recruited by high-income countries. Well-educated nurses can expect to be an asset on the marriage market. Nursing is a profession that opens possibilities in a culture that does not easily acknowledge the value of women.

An international workforce can support multicultural patients and persons in need of care. Diverse language skills and a shared experience of migration open communication possibilities. However, detailed knowledge about such settings would be helpful to identify factors and environments for success.

Challenges of nurse migration: safe patient care and care according to professional standards

Nursing is seen as a "portable profession." This means that knowledge and basic skills in nursing can be applied worldwide. Global organizations like the World Health Organization and the International Council of Nurses have disseminated professional concepts like "the nursing process" as a baseline for systematic and not intuitive nursing work (Habermann and Uys 2006) as well as global ethical guidelines like the Code of Ethics (ICN 2006) and recently the concept of evidence, which means research-based nursing (Rosswurm and Larabee 1999; ICN 1999). Medical technology does not vary too much in the global context, allowing specialized nursing staff like nurses for intensive care units to adapt to a new working environment within a

Table 4 Self-sufficiency and sustainability. Source: Own compilation based on the International Council of Nursing 2008

Positive impacts	Negative impacts
• Increased employment opportunities for nurses in the country	• Reduced opportunities for foreign employment
• Increased educational opportunities for students interested in nursing	• Limited professional and personal growth of nurses
• Creation of better nursing conditions for nurses	• Reduced brain gain in terms of nurses bringing 'best practices' and innovations
• Strengthening the health-care system	• Reduced opportunity for culturally appropriate patient care provided by a diverse group of foreign nurses
• Monetary and non-monetary gains for nurses	

reasonable time. As mentioned before, research findings focusing on nursing errors and failures in nursing in the USA and the UK showed that foreign nurses are very rarely seen as an issue. Also, the current high profile research in the USA focusing on nurse-sensitive outcomes of care (Van den Heede et al. 2007; Alexander 2007) in relation to (under-) staffing did not look into the issue of foreign nurses (Lang et al. 2004; Aiken et al. 2002). This is astonishing, taking into account the great numbers of foreign nurses working in hospitals in the USA and UK. It must be assumed that differences in education levels, language abilities and maladjustment to the cultural context can constitute a challenge to the safety of patients and to the quality of care. Internationally agreed upon, more sophisticated selection procedures of recruiting countries and an ongoing evaluation of health outcomes with regard to internationalization of the workforce should be implemented to minimize hazards caused by newly immigrated staff.

Some conclusions

Article 13(2) of the Universal Declaration of Human Rights adopted in 1948 by the United Nations gives everyone the right to leave their home country. Free migration therefore must be guaranteed, also for nurses. However, nurse migration is a phenomenon that needs internationally valid rules and regulations. With other globally operating organizations, such as the World Health Organization and the International Labor Organization, the International Center on Nurse Migration of the International Council of Nurses published several reports and fact sheets to identify deficits and resources in the development of the health-care field that enhance or respectively limit nurse migration (International Council of Nurses 2008). Three important aspects of this ongoing discussion are listed as follows:

- Countries are asked to address their nursing shortages by focusing on self-sufficiency, described as "a sustainable stock of domestic nurses to meet service requirements" (International Council of Nurses 2008, p 1). Adequate measures could be increasing student enrollment and reducing student attrition.
- Compensation might be requested from the recruiting countries.
- Since in many countries there are more nurses registered than actually working, the retention of nurses on the job is of high importance. This means establishing satisfying and safe working conditions.

Potentially positive and negative impacts of future policies focusing on self-sufficiency and sustainability of the health workforce are summed up in Table 4.

The concept of self-sufficiency and sustainability (outlined in Table 4, left side) is clear and could support countries that have a high percentage of their nurses recruited. However, it remains unclear how this policy could be transferred into international practice. The concept demands planning at the mid-range level and contradicts the concept of liberalization of health markets. As indicated before, in the framework of such markets, local and regional policies are right to reduce the number of nursing schools and neglect educational standards when this seems to be an economically sound decision. For the same reason, compensation funds for low-income countries seem not to be applicable in global policies in the near future.

Therefore, it seems wise to focus in future research on health quality outcomes. Potential costs for national health economies due to an unqualified mix of staffing should be highlighted. Strategies, based on economical considerations in a liberated health market must be answered by profoundly exploring the potential economic costs involved.

Conflict of interest The authors disclose any relevant association that might pose a conflict of interest.

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