PILLARS OF HEALTH

Country report on health worker migration and mobility

Germany

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List of abbreviations

BA	Federal Employment Agency (Bundesagentur für Arbeit)
BMG	Federal Ministry of Health (Bundesministerium für Gesundheit)
BMWi	Federal Ministry of Economic Affairs (Bundesministerium für Wirtschaft)
CDU	Christian Democratic Union
DeFa	German Agency for International Healthcare Professionals (Deutsche Fachkäfteagentur für Gesundheits- und Pflegeberufe)
DGPH	German Society for Public Health (Deutsche Gesellschaft für Public Health)
DKF	German Competence Centre for International Healthcare Professionals (Deutsches Kompetenzzentrum für internationale Fachkräfte in den Gesundheits- und Pflegeberufen)
dpgg	German Platform for Global Health (Deutsche Platform für Globale Gesundheit)
DRG	Diagnosis-Related-Group-based Hospital Payment System
EPSU	European Federation of Public Services Unions
EU	European Union
FDP	Free Democratic Party
G-BA	Federal Joint Committee (Gemeinsamer Bundesausschuss)
GDP	Gross Domestic Product
GIZ	Gesellschaft für Internationale Zusammenarbeit
GSP	Global Skills Partnerships
HOSPEEM	European Hospital and Healthcare Employers' Association
ICU	Intensive Care Unit
LTC	Long Term Care
MENA	Middle East and North Africa
MP	Member of Parliament
ÖGD	Public Health Services (Öffentlicher Gesundheitsdienst)
PHI	Private Health Insurance
PPP	Purchasing Power Parities
RLS	Rosa Luxemburg Foundation (Rosa Luxemburg Stiftung)
SDG	Sustainable Development Goals
SHI	Social Health Insurance
SPD	Social Democratic Party of Germany

vdää	Association of democratic doctors (Verein demokratischer Ärzt*innen)
VENRO	Association of German Development and Humanitarian Aid NGOs (Verband Entwicklungspolitik und Humanitäre Hilfe deutscher Nichtregierungsorganisationen e.V.)
ver.di	United Services Trade-Union (Vereinte Dienstleistungsgewerkschaft)
WHO	World Health Organization

About Pillars of Health

Pillars of Health is an alliance of EU-based organisations that wants to contribute to an equitable geographic distribution of health workers across the European Union (EU), to ensure that all European citizens have equal access to health workers. In 2021, as part of the Pillars of Health project, lead partner organisation Wemos (the Netherlands) joined forces with the Center for Health Policies and Services (Romania), Media Education Centre (Serbia), and VU Athena (the Netherlands) to identify ways to address the negative effects of excessive health worker migration and recruitment. Together, we aim to influence policy-makers so they actively implement policies that mitigate the negative effects of health worker migration and mobility, and instead contribute to a strong and sustainable health workforce across the EU. Read more about Pillars of Health, and join us.

This country report is part of a series on health workforce migration and mobility in the focus areas of Pillars of Health:. Germany, France, Romania, Serbia and EU level.

This report was written by an independent German consultant: Heino Güldemann MPH.

Executive Summary

This report describes the health workforce and health system in Germany, the German recruitment of foreign health workers and their migration patterns, and the resulting brain drain of health workers in source countries. We also provide recommendations for a more sustainable answer to the German care crisis.

With more than 80 million inhabitants, Germany is a European giant. Its health workforce policy and cross-border recruitment have a significant influence on the surrounding countries. Therefore, Germany has extra good reason to adhere to ethical recruitment practices and to implement the principles stipulated in the World Health Organization (WHO) Code of Practice, particularly that *all Member States should strive to meet their health personnel needs with their own human resources for health [1]*. But what we see in practice is just the opposite: a ruined nursing profession with deplorable working conditions (see section 2.2.4) and as a result an

ever-growing German demand for the import of health workforce - particularly nurses - from abroad (see section 2.2.2).

Since 2013, the share of foreign nurses in the German nursing workforce increased from 5.8% up to 11%, and currently, an absolute number of 200,000 non-German nurses are working in the formal German health care system. 43% of these are coming from other EU Member States and 17.5% from the Western Balkan countries. Nowadays, 34,000 West Balkan nurses are working in Germany, which corresponds to a staggering 29.3% of the absolute number of 116,000 registered nurses in all Western Balkans countries together. The systematic brain drain of health workforce towards Germany is a European and a global health scandal: Germany's foreign health workforce recruitment activities hold a significant risk for source countries, as the source countries' populations are left behind with insufficient health workers needed to meet their health care needs due to the significant influx of health workers to Germany.

Recommendations

Based on this report's findings, we think the following measures are promising first steps to find a more sustainable answer to the German care crisis than the recruitment from abroad, and to mitigate the risks the current situation holds for the health systems of the source countries.

Recommendations for German civil society:

- A focal point with the task of advocating against the brain drain of health personnel needs to be permanently established.

Recommendations for the German government:

- The German government should adapt the legal framework of the self-governed German health system to better defend the interests of the nurses.
- The attractiveness of the nursing profession in Germany needs to be further improved.
- The German government needs to adapt the essential elements of the WHO Code of Practice and incorporate these into its national legislation.
- The German government needs to impose stricter regulation on private recruitment agencies to better protect the legal rights of migrating nurses and to do no harm.
- The costs of language training for recruited nurses should be borne by the recruiting agencies or the employers respectively. Claims for reimbursement against the trainees should be prohibited.

- The German government has the duty, at the very least towards the source countries, to improve data availability and data quality on the 24-hour home-based care sector.
- The German government should make use of its influence in the WHO and the EU to support the source countries to again open the debate about compensation payments for the training costs incurred.

Recommendations for the European Union:

- The EU should grant the authority needed to regulate and intervene in activities of cross-border recruitment to the Directorate-General for Health and Food Safety or another appropriate Directorate.

1. Introduction

With more than 80 million inhabitants, Germany is a European giant and an economic powerhouse. Hence, its health workforce policy and cross-border recruitment have a significant influence on the surrounding countries. Therefore, Germany has extra good reason to adhere to ethical recruitment practices and to implement the principles stipulated in the World Health Organization (WHO) Code of Practice, particularly that *all Member States should strive to meet their health personnel needs with their own human resources for health* [1, § 5.4].

But what we see in practice is just the opposite: a ruined nursing profession with deplorable working conditions (see section 2.2.4) and as a result an ever-growing German demand for the import of health workforce - particularly nurses - from abroad.

Up to 2012, Germany concentrated its recruitment efforts on the old and new EU Member States, but then it opened up its labour market for international nurses from third countries. While in 2013 the share of foreign nurses in the German nursing workforces was at 5.8% [2], this number doubled up to 11%, and an absolute number of 200,000 non-German nurses are working in the formal German health care system[1] [3]. 43% of these are coming from other EU Member States and 17.5% from the Western Balkan countries [3]. The rest is coming from East European non-EU countries, the Middle East, and from countries where the German government engages in active recruitment efforts, e.g. Tunisia, the Philippines, Vietnam, India, Indonesia or Mexico.

The most significant increase of the last five years was observed in nurses from the Western Balkans, where Germany intensified its recruitment efforts in 2016. Germany did so, despite the fact that the overall amount of nurses in this region is rather modest: according to the WHO National Health Workforce Accounts data base, Albania has 15,692 nurses (2020), Montenegro 3,118 (2020), Bosnia and Herzegovina 19,057 (2018), Serbia 53,881 (2016) and Northern Macedonia 7,884 (2015) [4]. Kosovo has 16,398 registered nurses (2019) [5]. Since Germany lowered the immigration thresholds for nurses, the numbers of immigrants tripled and nowadays

[1] Most likely this number can be doubled, when also taking into account the often informal home-based care sector and the foreign nurses employed by private households. Current estimations range from 300,000 – 700,000 foreign caretakers, the major part being women from East Europe, often equipped with a nursing diploma. But reliable numbers on the size and composition of the workforce in this sector are not available. For more details see chapter 2.3.3.

34,000 West Balkan nurses are working in Germany [3]. This corresponds to a staggering 29.3% of the absolute number of 116,000 registered nurses in the Western Balkans.
The systematic brain drain of health workforce towards Germany is a European and a global health scandal: Germany's foreign health workforce recruitment activities hold a significant risk for source countries, as the source countries' populations are left behind with insufficient health workers needed to meet their health care needs due to the significant influx of health workers to Germany.

2. Germany: country situation

2.1 General country profile and baseline data

Baseline data at a glance:

- Population size: 83,2 million inhabitants (42,2 million women, 41,1 million men) [6]
- Share of population above 65: 21.8% [7]
- Fertility rate: 1,5 births per woman
- World Bank classification: High income country
- GDP per capita (in Euro PPP): €36,951
- Gross national income per capita, PPP (current international $): $53,077
- Relative poverty rate[2]: 18.5% (women: 19.2%, men: 17.7%) [8]
- Annual economic growth rate (GDP) [9]:
    - 2017: 2.7%
    - 2018 & 2019: 1.1%
    - 2020: -4.6%
- Main GDP sector: Service Industry
- Unemployment rate (March 2022): 5.1% [10]
- Per capita current health expenditure (in Euro PPP): €4,505 [7]
- Share of health expenditure in GDP: 11.7%
- Domestic gov. health expenditure% of general gov. expenditure: 20% [11]
- Population covered in health finance:
    - 89% in social health insurance (SHI), [7]

[2] Defined as 60% of the median/average equivalent disposable household income. Data from 2020.

  - 11% in private health insurance (PHI) [7],
  - 0.7% not covered [12]
- Per capita health workforce numbers: 186,3 doctors, nurses, midwives / 10,000 [4]
  - Medical doctors: 44,5 / 10,000 [4]
  - Nurses and midwifes: 141,9 / 10,000 [4]
- UHC service average index (SDG 3.8.1): 85.8 [13]

The *Federal Republic of Germany* is located in Central Europe and with 83,2 million inhabitants (42,2 million women, 41,1 million men) it is the most populous country of the European Union. With 358 km^2 Germany has a population density of 233 persons / km^2 [6]. 16 million people are above 67, which is the current German retirement age. By 2035, this age-group will increase by 22% up to 20 million [14].

Germany is a federal, parliamentary, representative democratic republic. The Government is led by the chancellor, who is elected by the parliament. The party system has been dominated historically by the Christian Democratic Union (CDU) and the Social Democratic Party of Germany (SPD). Over the recent decades these two lost their sole status as so-called “Volksparteien” and substantial numbers of voters, which led to higher fragmentation in the political landscape: Currently six political parties are represented in the German parliament and three of them form the government coalition (SPD, the Greens, and the liberal FDP).
Germany is a federal state with 16 constituent states (Länder). These states are largely autonomous in regard to certain sectors as e.g. the education system and the public health services (Öffentlicher Gesundheitsdienst, ÖGD).

2.1.1 Population health status

Population health status at a glance:

- Life expectancy at birth: 81,1 years [7]
- Maternal mortality rate: 3,2 / 100,000 live births [15]
- Infant mortality rate: 3,1 per 1,000 live births [16]
- Main causes of death: ischaemic heart disease, stroke, and lung cancer [7]
- Risk factors [7]:
  - Smoking: 18%
  - Dietary risks, obesity: 19%

    - Alcohol, 10,6 litres per person per year, binge drinking[3]: 32%
- Covid-19 vaccination coverage (April 2022):
    - Fully vaccinated: 76%
    - With booster: 59%
- Influenza vaccination coverage, age group +60: 39% [7]
- Preventable mortality (age-standardised mortality rate): 156 /100,000 [7]
- Treatable mortality (age-standardised mortality rate): 85 / 100,000 [7]

The health status of the German population has improved over the last two decades, and life expectancy remains above the EU average despite the temporary reduction in 2020 caused by the Covid-19 pandemic. In 2020, Germany registered a life expectancy of 81,1 years – half a year above the EU average. The Covid-19 pandemic had less of an impact on life expectancy in Germany than in the EU as a whole: In Germany the value fell by 2,5 months in 2020 compared to an average of just over 8 months across the EU [7].

In 2019, two-thirds of the German population (66%) reported being in good health – less than the share in both the EU as a whole (69%) and most other western European countries, with little difference between men (66%) and women (65%) [7].

There is a large gap in self-reported health by income group: only about half of Germans in the lowest income group reported being in good health compared to 80% of those in the highest [7]. The median life expectancy at birth also differs largely according to income group: between 1995 and 2005, the differences for life expectancy at birth between the lowest and the highest income quintile are 10,8 years for men and 8,4 for women. The differences in life expectancy in good health are even larger: 14,3 years for men and 10,2 years for women [17].

The leading causes of death in Germany in 2019 were ischaemic heart disease, stroke, and lung cancer. In 2018, preventable mortality was lower than the EU average, but the rate (at 156 deaths per 100,000 population) was around 25% higher than in the five best performing countries. The leading causes of preventable mortality are lung cancer (22%), alcohol-related diseases (13%), ischaemic heart disease (12%) and chronic lower respiratory diseases (10%) [7].

[3] Binge drinking is defined here as consuming six or more alcoholic drinks on a single occasion for adults, and five or more alcoholic drinks for adolescents, at least once in a month.

Infant mortality decreased from 4,4 per 1,000 live births in 2000 to 3,1 in 2020 [16]. From 2005 until 2019 the maternal mortality ratio per 100,000 live births decreased from 3,8 to 3,2 [15].

2.1.2 What does Germany's health system look like?

Germany has the oldest social health insurance (SHI) system in the world. Its basic structure, which still widely shapes the contemporary system, was founded in 1883. Health insurance is compulsory, but people with a gross income above €5,363 / month or belonging to a particular professional group (e.g. civil servants or self-employed people) can opt out of the SHI system and enroll in (substitutive) private health insurance (PHI). Nowadays, about 89% of the population is covered by SHI and 11% by PHI. 0.7% are not covered at all of whom the majority is male, self- or unemployed [7].

The SHI contribution is 14.6% of the salary and it is to be paid by employers and employees in equal shares. But this percentage only applies to monthly incomes below €4,838. Above this threshold the absolute amount of the contribution is frozen and does not increase any further: for any higher salaries the contribution remains at €706 per month (14.6% of €4,838). Therefore, the German SHI is to be considered a regressive contribution scheme, in which the contribution share decreases for the better off. The fact that the better-off and some professions can opt out of the solidarity system is a topic of controversial debates in Germany (Bürgerversicherung). An SHI system with mandatory membership for the entire population and with a progressive - or at least proportional - contribution scheme would significantly increase health financing and relieve the burden for the lower population strata.

The German health system has a complex governance structure. It is labelled "self-governed" because the federal government only defines the legal framework, while regulatory details are specified in directives issued by the Federal Joint Committee (Gemeinsamer Bundesausschuss G-BA). The G-BA membership is mainly composed of representatives from SHI, physicians' associations and hospitals [7].

Nurses' associations are not present in the G-BA. In general, the German nursing and care sector plays a secondary role in the German health policy arena and is subjected to the better organised lobby groups of medical doctors, service providers / hospitals, SHI and the pharmaceutical industry [18].

In 2019, Germany devoted € 4,505 per capita (adjusted for differences in purchasing power) to health care – the highest level in the EU and 28% higher than the EU average. The country also spends the highest share of its GDP on health among EU Member States (11.7% in 2019, compared to the EU average of 9.9%). The bulk of health care spending is publicly funded: 84.6% of total health expenditure (including mandatory substitutive PHI) was public in 2019 [7].

Out-of-pocket (OOP) payments accounted for 12.7% of Germany's health expenditure in 2019 – below the EU average of 15.4%. About one-third of OOP expenditure is directed to Long Term Care (LTC, 35% in 2019). This relatively high share can be explained by the fact that SHI usually covers only around 50% of total costs for LTC delivered in institutions. After LTC, a sizeable share of OOP spending in Germany is on pharmaceuticals (20% of OOP spending, mostly for over-the-counter medicines), spectacles and hearing aids (16%) and dental care (13%) [7].

Germany has a very large hospital inpatient sector, with 7.9 hospital beds per 1,000 population – the highest in the EU and 50% more than the EU average (5.3 beds). Germany also has high numbers of physicians and nurses, with per population ratios and growth rates well above the EU average, particularly strong for hospital physicians [7].

Since 2004, the number of doctors in hospitals increased by 42%, while the number of nurses decreased. This is to be explained by the reform process of the health financing system over the last twenty years. Most prominently, in 2003 the reform of the hospital financing scheme took place: private as well as public hospitals are since been financed by case-based lump-sums based on diagnosis-related groups (DRG). The political intension behind this reform, was to put the hospitals in a position of economic competition against each other. As a consequence, the numbers of hospital physicians, who make the diagnosis and hence "sit at the cash box", rose significantly, as stated above. As the hospitals had to cut their budget to survive in the new competitive environment, nurses simply were the major cost position that the hospitals saved money upon. Hence, the number of nurses decreased significantly while the workload for individual nurses soared.

Despite this increase of hospital physicians, the general physician-to-bed ratio is still comparatively low in Germany, and the nurse-to-bed ratio is one of the lowest in the EU and as described above it declined since the DRG introduction in 2003. After all, in 2019 the new

Nursing Staff Empowerment Act was enacted in order to address the reductions in nursing staff and the resulting deterioration of working conditions. The act now excludes the costs for nursing personnel from the DRG-based payment system (and, thereby, from the economic competition between hospitals) and covers them separately. From 2020, the costs of nursing staff in acute care hospitals are fully covered by the sickness funds, while all other operating cost are covered by DRGs.

The regulation of minimum staffing requirements is another attempt to increase the number of nurses practising in hospitals. Since February 2021, the maximum number of patients per nurse in intensive care units (ICUs) is set at 2 (during daytime, 3 by night); for geriatric care, it is 10 (during daytime, 20 by night). For the time being, these regulations for minimum staffing levels are limited to the divisions that hold the highest risks for patient safety, e.g. intensive or geriatric care, cardiology, and surgery [19].

2.1.3 Developments during the Covid-19 pandemic

The Covid-19 pandemic had a major impact on population health and mortality in Germany with over 127,500 Covid-19 deaths recorded between January 2020 and the end of March 2022 [20]. Measures taken to contain the pandemic also had an impact on the economy. German GDP fell by 5% in 2020. This is lower than the rate across the EU (6.2%). Germany had an effective initial response to the Covid-19 pandemic in early 2020. It was prepared relatively well for a public health emergency and had strong capacity in disease surveillance, detection, and testing. Germany's large laboratory capacity put the country in a good position to detect emerging diseases in good time. Pre-pandemic hospital and ICU capacity in Germany was the highest among EU countries, providing 602 acute hospitals beds and 33,4 ICU beds per 100 000 population in 2018. It is noteworthy that this "overcapacity" has often been a subject to criticism but turned out to be beneficial during the Covid-19 crisis. Germany increased its initial ICU capacity by 20% to 39,5 ICU beds per 100,000 population in April 2020, mostly by shifting capacities through postponing and cancelling planned and elective procedures. ICU beds occupied by Covid-19 patients remained far from saturation in overall numbers, but in hard-hit regions it had been necessary to refer Covid-19 patients into other regions.

Germany's 375 public health offices (Öffentlicher Gesundheitsdienst, ÖGD) are the agencies that are, among other things, responsible for monitoring infectious diseases at the regional and local level. In 2020, around 5,900 additional employees were deployed, primarily for contact tracing and testing and to control quarantining [7]. Historically the public health services played

a minor role in the (West) German[4] health care system, being dominated by private medical doctors and by hospitals. Moreover, these public health offices often struggled with their workloads due to lacking IT and digitalised processes [7]. A little but telling detail of the German public health system is, that many of these offices still used fax machines as a means to communicate infection numbers when Covid-19 struck. In mid-2021, the federal German Government released the Pact for the ÖGD to increase general staffing levels and digitalisation [21]. The Plan is backed by €4 billion until 2026 which is probably the single biggest political commitment to post-war public health structures in (West-)Germany. However, the federal states and communes in charge for the ÖGD still hesitate to agree to the new financing scheme from the central level as they fear interference into their jurisdiction.

As mentioned above, the physician-to-bed ratio is comparatively low, and the nurse-to-bed ratio is one of the lowest in the EU. To help hospitals with their staffing challenges and provide greater flexibility in the wake of the Covid-19 outbreak, the requirements for minimum nurse staffing levels in intensive care and geriatric care were temporarily suspended in 2020 [19]. In addition, a series of measures were employed to scale up workforce capacity during the first wave of the pandemic. These included asking part-time health professionals to work full-time and asking retired health professionals to return to clinical practice [7]. In general, the pandemic increased the already high pressure on the German nurses.

The report ‘’The Global Nursing Workforce and The Covid-19 Pandemic’’ [22] presents two surveys of German nurse long-term care managers, one in April 2020 (532 respondents), right after the arrival of Covid-19 in Germany, and one in December 2020 (301 respondents). The surveys document increasing levels of job dissatisfaction in the first Covid-19 year. The intention to quit the profession was reported often or very often by 12.8% of the respondents in survey one and 20.3% in survey two.

The same report summarises the developments in the Covid-19 pandemic in Germany as follows: It has been reported that “[t]he pandemic is accelerating a broad trend that has been building for some time,” with the Federal Labour Agency in Germany (Bundesagentur für Arbeit, BA) reporting that the average number of vacant positions for registered nurses in long-term care in 2019 was 15,000 and in acute care was 12,400; furthermore, they highlighted that it took 205 days to fill a position for a nurse in long-term care and 174 days for a nurse in a hospital. A

[4] In East Germany a comparatively strong public health system had been established and existed until 1990.

more recent report from Germany notes that “[a]t present, vacancies outnumber the amount of qualified job seekers on the job market. According to expert estimations, the nursing sector will need 150,000 new nurses by 2025. Demographic changes in the country will exacerbate this situation in the medium and long term” [22].

Since 15 March 2022, a Covid-19 vaccination is compulsory for employees in health facilities. This further strains the already stretched nursing labour market. By end of April 2022, the public health offices of the 20 biggest German cities (representing 16.252 million or 20% of the German population) reported 50,000 not fully vaccinated staff in health facilities. However, the lack of a fully vaccinated status did not yet lead to any layoffs so far, and until summer 2022 nobody has to face penalties. The consequences of and the deadlines for compulsory vaccination are still under debate for fear of losing critical numbers of health personnel. [23]

In January 2022, the Federal Employment Agency issued a press release which stated that during and despite the Covid-19 pandemic, the Federal Employment Agency (BA) managed to sign new bilateral agreements on the recruitment of nurses with India (Kerala), Indonesia and Mexico, and that the BA achieved an increase in the overall number of recruited workers (all sectors, not only health) from 2,500 in 2021 up to 3,200 in 2022 [24]. The fact that a German official body proudly promotes the agreements on health worker recruitment, from countries which have a health workforce density of a quarter or less from the German value, is somewhat irritating from an ethical perspective, particularly in the middle of a global pandemic. But it did not spark sharp reactions either. This frank press release is an indicator that in the German public debate of the care crisis, the recruiters do not have to worry about critique against the brain drain.

2.2 Health labour market

Table 1

WHO data on overall health personnel numbers by occupation in 2019/2020	
Medical doctors	372,000 (48% female)
Qualified nursing personnel	1,160,000 (84% female)
Midwifery personnel	25,000
Others	126,000
Total	**1,683,000**

The WHO number of nurses does not capture nurses working in elderly care and it is generally difficult to directly compare international staffing numbers in nursing, because, compared to the international standards, the nursing profession is organised slightly different in Germany (and Austria): nursing is not an academic profession and is not taught in universities. In Germany nursing is an apprenticeship. The total duration for qualified nurses is three years, and for nursing aides one year. Qualified nurses need to opt for one of three nursing sectors: clinical nursing, child nursing and elderly care. In Germany, the tasks the nurses are conducting include comparatively more caring activities, such as feeding and washing of patients, than in most other countries.

According to the more comprehensive data of the Federal Employment Agency, the total number of 1,72 million nurses were on pay roll in June 2020. This includes 1,1 million nurses in clinical nursing and 0.62 million nurses in elderly care. As the majority is working on part-time contracts, this number corresponds to 1,3 million full time equivalents [3]. In 2019, the overall number of nurses increased by 3.6% against the previous year [3].

A significant income gap exists between the nursing and elderly care sectors. While in nursing the average gross monthly salary for a full-time contract is at €3,539 the average value for elderly care is 15% lower at €3,034. These salaries correspond to a 3% increase for nursing compared to the previous year and a 5% increase for elderly care. [3]

Half of all German nurses are working in hospitals. Nurses by facility types are presented here [25]:

- Hospitals: 48.9%
- Residential long-term care: 27.1%
- Ambulatory health care: 23.7%
- Others: 0.3%

The age distribution by occupation reveals interesting details [25] (see figure 1 below).

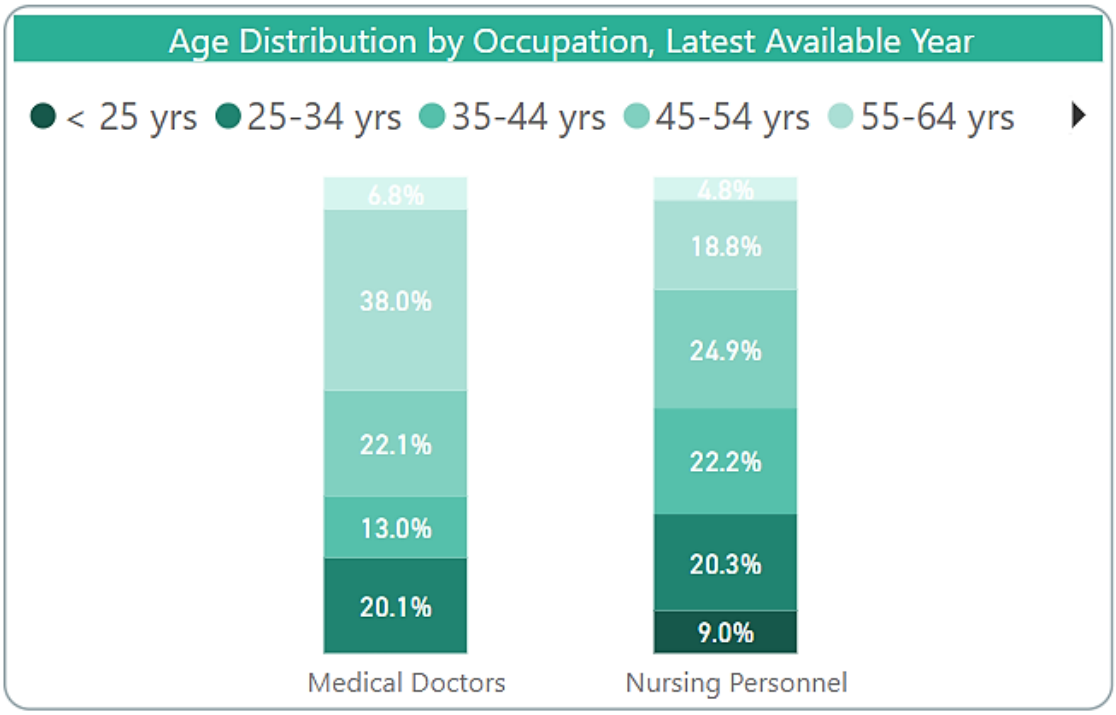

Figure 1: age distribution by occupation (latest available year)
Source: National Health Workforce Accounts Data Portal, Country Profile Germany [25] (data from 2019).

Whilst the medical doctors clearly show the German demographic transition and a large proportion of the generation of the strong age groups born between 1955 and 1968 (so-called baby boomers), the nurses do not show this pattern. Most likely because nurses often leave their jobs long before reaching retirement age.

2.2.1 Number of vacancies and jobseekers in health and care

In the clinical nursing in 2020, there were 47 registered, unemployed, and qualified nurses available for every 100 vacancies. In 2014, it was still 80 nurses per 100 vacancies. In elderly care, only 26 registered unemployed and qualified nurses were available for every 100 vacancies in 2020, but 38 in 2014. [3]

In clinical nursing, the average time span to fill a vacancy is 149 days (values for 2020) and in elderly care it is 186 days [26]. In 2016, the time span in nursing was still 124 days and in elderly care 153 days [27p. 9]. In Germany it becomes increasingly difficult to fill vacant positions in nursing and elderly care.

In 2020, an average of 36,200 nursing vacancies was registered with the Federal Employment Agency (15,500 in nursing, 20,700 in elderly care). The numbers of vacancies increased swiftly up to 2017 and stagnated up to 2019. From 2019 to 2020, the number of vacancies decreased by 4% in nursing and by 12% in elderly care. However, these are relatively low values compared to the overall decrease in vacancies across all professions, which was at 21% over the same period. The Federal Employment Agency argues that the observed decrease in nurse-vacancies should not be interpreted as an indicator for decreasing demand on the labour market, but is rather rooted in a generally low fluctuation of work-force during crisis periods. [3]

The overall unemployment rate across all professions is currently at 5.9%, while for qualified nurses the unemployment rate with 1.1% is virtually zero (nursing and elderly care) [3].
In nursing, 29% of the registered jobseekers (nurses and nursing aides) were non-German, while in elderly care it is 25%. The overall share of non-German nurses on the labour market is only 11%. In the group of unemployed nurses, their share is more than two times higher. Moreover, the data show that most of the foreign unemployed are nursing aides. It is to be assumed that many of them are temporarily unemployed, whilst undergoing the often lengthy process of the formal recognition process of their nursing diplomas. [3]

2.2.2 Germany’s growing demand for nurses

The German future demand for additional nurses has been calculated by several authors. Basically, all are referring to the expected demographic transition. These estimates are to be used with caution, but they give an idea in terms of the dimension of the problem: the lowest prediction calculates the additional demand in qualified nurses up to 2040 of 165,300 (according to different scenarios from 140,900 to 229,100) [28]. Other estimations in the middle ranks

calculate an additional demand of 270,000 nurses by 2035 [29], or a need of between 263,000 and 492,000 additional nurses by 2030 [30]. The highest estimate under discussion is 517,000 additional nurses by 2030 [31, p. 14]. Even by conservative estimates, Germany will need some 200,000 – 300,000 additional nurses over the coming 10 years.

2.2.3 Domestic supply and health work force planning in nursing

The German demand for health workforce and in particular for nurses from abroad is closely related to the low numbers of domestically trained nurses and low retention rates. In the German public this problem is widely acknowledged and usually referred to as the “care crisis” (Pflegenotstand). Despite manifold government initiatives in this field, the problem persists or even aggravated over the last decade.

Over the last decade, Germany has witnessed manifold political initiatives to strengthen the nursing sectors, amongst others a large communications campaign for a “training offensive” (Ausbildungsoffensive), promotion of occupational redeployment (Umschulungsförderung), and support for company measures to increase job retention (Unterstützung betrieblicher Maßnahmen zur Erhöhung des Berufsverbleibs). In 2018, the Federal Government had launched a "Concerted Action on Care" (Konzertierte Aktion Pflege, KAP) involving the line Ministries of Health, of Labour and Social Affairs, and of Family Affairs, Senior Citizens, Women and Youth. By 2020, the number of trainees as well as the overall number of health workforce in nursing increased and also the salaries increased at a faster pace than the average salary increases across Germany.

It also needs to be noted that salary increases make it less likely that hospitals are able to increase staffing levels simultaneously. More and better staffing in hospitals is a central request from organised nurses in labour disputes, in order to mitigate the workload and to improve working conditions.

In its final report, the KAP consequently suggests a further reliance on international recruitment to fill the gaps: “the goal of the KAP is to ensure good professional care primarily by nursing professionals from Germany and the European Union. Any additional demand is to be covered by nursing professionals from third countries.” [32, p. 133]

In January 2020, a new law reforming the nursing professions came into force. The formerly three distinct nursing professions (nursing, childcare, and elderly care) were integrated into one

single nursing profession. Thereby, the attractiveness of particularly the elderly care sector increased.

In 2019/2020, the number of new apprentices entering the formal nursing education (clinical nursing, child care, and elderly care) rose for the first time in 5 years by 8.2% and up to a total of 71,271 apprentices [33]. One year later, at the end of 2020 and after the integration of the nursing education into one singles scheme, the total number of new apprentices was only 53,610 [34]. Covid-19 certainly contributed to this slow start of the new scheme, which was far below expectations. However, the numbers of new apprentices are to be taken with caution, as 28% quit the apprenticeship before graduation [35]. This is amongst the highest values across all professions and yet another proxy-indicator for the sobering working conditions in the nursing sector.

The working conditions in elderly care were also in the centre of the negotiations between the employers and the trade unions in 2020 and 2021. A collective wage agreement for elderly care, the first of its kind in Germany, had been almost agreed upon, when the catholic German Caritas Association (Deutscher Caritas Verband), one of the biggest welfare organisations and the biggest employer in Germany, issued a veto. This move surprised most observers of the process and was harshly criticised in the German media. For the time being, no collective wage agreement for elderly care is in force or even in sight.

In June 2021, the German government issued a law to establish a database on regional and local health workforce monitoring [36]. The database is not yet operational but is projected to be launched soon. The expectation is that such a data base will provide valuable records for health workforce forecast and planning. Better late than never. However, the migrant status and the numbers of foreign-trained health professionals will most likely not be captured in the data base.

2.2.4 Root causes of the German care crisis

In the German public, often the demographic transition is seen as the main trigger behind the increasing demand for nursing services, but this is an erroneous or, at least, incomplete explanation. On the one hand, the generation of the larger age groups born between 1955 and 1968, the so-called baby boomers, only started to reach retirement age in 2020. Clearly this puts additional stress on the German health, care, and social security systems, but the German care crisis did not start in 2020. Instead, Germany has been suffering from a dramatic shortage

of nurses for decades already, and this has been the case at times, when the baby boomers were still in the labour market.

If demographic transition cannot explain the emergence of the care crisis, what other factors can be identified? Here we argue that the crisis is rather homemade and rooted in the general liberalisation of the German labour market and the health care and health financing reforms of the last two decades.

The reform process of the commercialisation and the commodification of the German health care system and particularly the reform of the hospital financing scheme and the introduction of DRGs took off in 2003: private as well as public hospitals are since being financed by case-based lump-sums. The political intention behind this is still to put the hospitals in a position of economic competition against each other. Since 2004, it can be observed that the case numbers and the numbers of hospital medical doctors rose. On the other hand, the number of nurses, which is the major cost position that the hospitals were able to save money on, decreased significantly in the same period. Consequently, this process was accompanied by increasing workloads and worsening working conditions for the remaining nurses over years. Moreover, the employers often cancelled valid collective wage agreements and replaced them with individual agreements, which came along with salary cuts.

Recently, the authoritative *Nursing Report 2021* [28] identified the root causes for the lack of nurses in the low quality of work and the resulting job-dissatisfaction. Particularly, low wages, shift work, time-pressure, high workloads, and a lack of opportunities for professional advancement were mentioned. To cope with the situation, many active nurses opt for part-time contracts. The share of nurses on part-time contracts in the inpatient and outpatient care in Germany recently rose above 70% [28, p. 175 f.]. Across all nurses this value was slightly below 60% in 2018, with 62% for women (who represent 82% of all nurses) and 38% for men. These values are far above average, as e.g. for men the part-time share across all professions is 12% [3]. Another survey [28, p. 175 f.] reveals that half of all nurses opted for part-time contracts in order to cope with the unmanageable workloads.

In 2020, the ever more dramatic situation in nursing led to the first deviation from the neo-liberal reform model and a major adaptation of the DRG-based hospital financing scheme: a specific and earmarked nursing care budget has been established to finance personnel costs in nursing

independently from the DRG-system. Hospital remuneration is being changed to a combination of flat rates per case and remuneration of nursing staff costs.

As a result of the health care reforms of the last two decades, we now see highly profitable private hospitals, on the one hand, and, on the other hand, a damaged profile of the nursing profession with barely manageable working conditions. Jacobs et al. highlight that in addition, the German economy is currently facing a shrinking working population and that increasing the attractiveness of the nursing profession and recruiting skilled workers from abroad may help to attract more staff, but that these measures will still not be enough to satisfy the growing German demand for nurses. The authors argue that, in addition, it is rather needed to reduce the necessary staffing levels without reducing the quality of care. However, they do not elaborate in detail how this may be achieved. [28]

The working conditions of nurses in Germany have deteriorated to such a degree that countless domestic nurses have quit their jobs partially by opting for part-time work or in full. Some go to work in Switzerland, some pursue additional studies to enter hospital management, while others are working in completely different sectors. The widespread feelings of professional dissatisfaction are still present. Numbers on the nurses who quit the job are not available in Germany, but this topic has been discussed further above regarding the high and still increasing rates of nurses working in part-time. The modest improvements achieved in the nursing sector in recent years and described in section 2.2.3 did not revert the trend. Given the projected demand for additional nurses, the current political commitment for more attractive job conditions is clearly not sufficient.

In Germany, the nursing profession has lost its former appeal. The political countermeasures still lack commitment and impact. Meanwhile, government bodies and employers are desperately looking for workforce from abroad, inside and outside the EU, who might still accept the prevailing conditions.

2.3 Health worker migration and mobility

According to data from different sources, Germany employs a large and growing share of foreign-born and foreign-trained health workers. In 2018, the Federal Ministry of Health reported the consolidated stock of foreign-born health personnel in 2017 to the WHO in the National Reporting Instrument, WHO Code of Practice [37, 2018] (see table 2).

Table 2. Stock of health workers in 2017, as reported to WHO Code of Practice (2018)

	Total	National-born	%	Foreign-born	%
Medical doctors	244,747	210,204	85.89%	34,433	14.07%
Nurses[5]	836,143	722,647	86.43%	63,233	7.56%
Midwives	11,288	10,626	94.14%	660	5.85%
Dentists[5]	94,098	59,450	63.18%	10,100	10.73%
Pharmacists	39,715	37,743	95.03%	1,956	4.93%

According to Buchan et al., in 2020, Germany employed an absolute number of 71,000 foreign-trained nurses and is on rank three after the US (197,000) and the UK (100,000) [22].

The Federal Employment Agency estimates that the total number of non-German clinical nurses (according to nationality) grew from 53,000 in 2016 to 84,000 in 2021. This corresponds to an increase of the non-German share of the entire nursing workforce from 6% to 11% [3].
The obvious differences between the datasets cannot be solved completely but for a large part they result from different definitions of foreign-born and foreign-trained nurses[6]. The details will be further discussed in section 2.3.2.

The general trend over the years is clear: the foreign share in the German nursing workforce is rapidly growing, both in absolute numbers and in percentages.

[5] Please note that the numbers for nurses and dentists do not add up to 100 % and should be used with caution.

[6] And sometimes the data are just rubbish, even in the usually rather authoritative WHO data base National Health Workforce Accounts: The NHWA data base as well as the NHWA country profile for Germany are reporting a share of 100 % of foreign-born physicians among all physicians practicing in Germany. This is obviously erroneous and indeed a pity. After investing so many resources in such a great database, dearest WHO, please don't mess it up on the very last mile.

2.3.1 Migration patterns of foreign medical doctors

Williams et al. [38] analysed European migration patterns of physicians on basis of the data of the 2019 joint OECD/EUROSTAT/WHO Europe questionnaire on healthcare statistics, and were able to identify the source regions of the foreign-trained physicians in Germany (see table 3 below).

Table 3: Stock of foreign-trained physicians in Germany by source region (2018)

Source region	Share
EU Member States before May 2004 + EEA countries (Austria, Belgium, Denmark, Finland, France, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden, United Kingdom + Iceland, Liechtenstein, Norway, Switzerland, and Turkey.)	20.4%
EU Member States that joined after May 2004 (Bulgaria, Croatia. Cyprus, Czechia, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Romania, Slovakia, and Slovenia.)	28.2%
Non-EU third countries in the WHO Europe Region (Albania, Andorra, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Georgia, Israel, Kazakhstan, Kyrgyzstan, Monaco, Montenegro, North Macedonia, Republic of Moldova, Russian Federation, San Marino, Serbia, Tajikistan, Turkmenistan, Ukraine, and Uzbekistan)	21.2%
Non-European low- and lower-middle-income states	16.0%
Non-European upper-middle-income states	10.1%
Non-European high-income states	2.4%
Not classified	1.9%

Almost 50% of the foreign-trained doctors in Germany come from within the EU, and the largest share comes from the new EU Member States in eastern and south-eastern Europe. The largest non-EU share comes from European third countries followed by low and lower middle-

income countries outside Europe. Immigration from non-European upper-middle- and high-income countries is comparatively low.

When comparing these data across Europe (data not shown in the table), it is most striking that Germany employs 20 times more foreign-trained physicians immigrating from European third countries than the other of the listed major European destination countries. While Germany employs 8,884 physicians from European third countries, the other major destination countries (Austria, Belgium, France, Ireland, Norway, Switzerland, UK) employ just 461 physicians per country on average [38, table 1, own calculation].

What emerges most clearly is that the medical brain drain from the Western Balkans and far eastern Europe has one major destination: Germany. This can partly be explained by the German Western Balkan Provision: since 2016 and up to 2023, the threshold to access the German labour market is significantly reduced for immigrating health workers from Albania, Bosnia and Herzegovina, Kosovo, Northern Macedonia, Montenegro and Serbia [3, 39].

2.3.2 Migration patterns of foreign nurses

The overall share of foreign-trained nurses in Germany is at 8.9% [25, 2019], and for foreign-born nurses at 16,9% [25, 2018]. Within the EU, the German share of foreign born nurses is the second highest after Ireland.

Detailed studies on the migration patterns of nurses are rare and raw data virtually unavailable. In the following we present the data found in two reports: first, a special evaluation of the accreditation data of the Federal Employment Agency (BA) for the study “Integration of foreign nurses” by Pütz et al. from 2019 [27] and, second, the data published by the BA in the “Labour Market in the nursing sector” from 2021 [3].

Pütz et al. analysed the migration patterns of nurses from the most important source countries between 2012 and 2017. These were the first five years of the official German recruitment efforts. The absolute number of immigrating nurses rose from below 1,000 up to more than 6,000 nurses per year in this period, but the ranking of most relevant source countries changed remarkably:

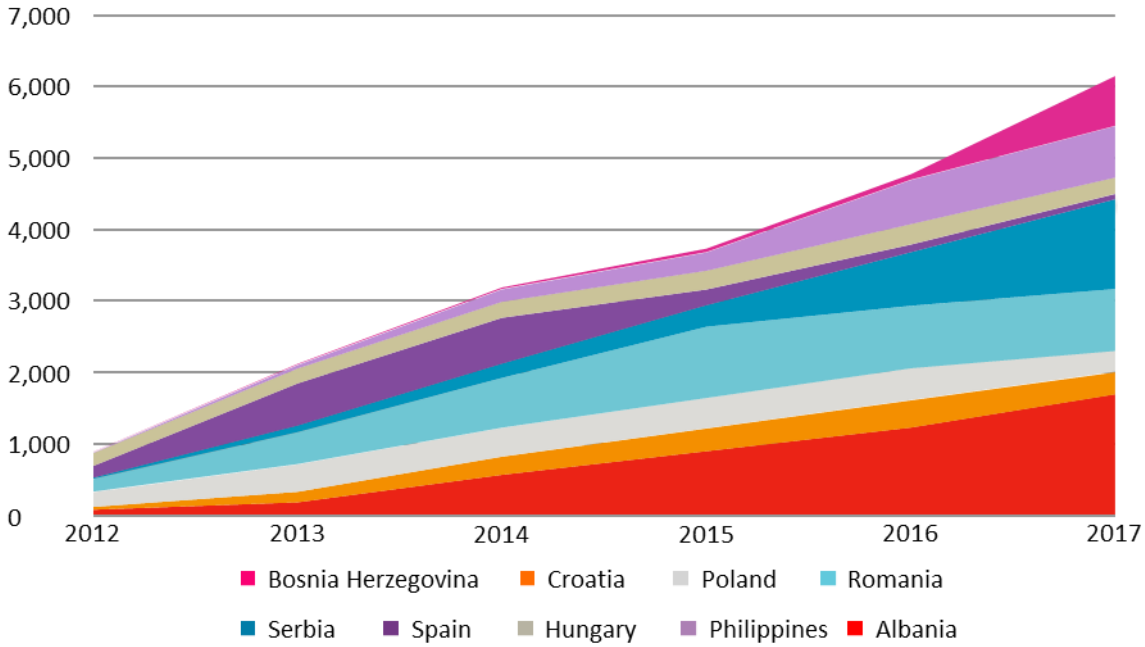

Figure 2: The five most frequent source countries of foreign trained nurses in all recognition procedures in Germany, 2012-2017 [translated from Pütz et al., 27]

Between 2012 and 2017, the German immigration pattern of foreign-trained nurses completely shifted from EU-internal migration between Member States towards third country migration from outside the EU. Up to 2014, Bosnia Herzegovina was the only non-EU Member State that appeared in the ranking of the five most important source countries (together with Croatia, Poland, Romania, and Spain). In 2015, Serbia joined the list as well, followed by the Philippines in 2017 and Albania in 2017. At the end of the study period, Romania was the last remaining EU Member State in the group of the top five source countries. [27]

The sharp increases of immigrating nurses visible for Bosnia Herzegovina, Serbia, the Philippines, and Albania can partly be explained by the endorsement of bilateral agreements on nurse migration between Germany and the respective states. Serbia and the Philippines signed in 2013 and Bosnia Herzegovina in 2014. In July 2018, Germany's former Minister for Health Jens Spahn announced that Germany shifts its recruitment focus towards Albania, Kosovo[7] and other Balkan countries [40]. Kosovo signed a bilateral agreement in July 2019 [41].

[7] This designation is used here as it is used by the German government and does not imply any opinion on the status of the Kosovo from the side of the authors.

According to the BA [3] in 2021, a total number of 194,000 non-German nurses (clinical nurses: 103,000; elderly care nurses: 91,000) worked in Germany. 43% of these are coming from other EU Member States and 17.5% from the Western Balkan countries. In more detail: from 2016 – 2021 the share of non-German nationals in clinical nursing increased from 5% to 9% and up to a total number of 103,000; in elderly care, the share increased from 8% to 15% and up to a total of 91,000 nurses. These numbers add up to a total number of 194,000 non-German nationals in a nursing profession. The share of nurses coming from EU countries increased over the last five years by 58%, from an absolute number of 53,000 to 84,000 (nursing: +16,000; elderly care: +15,000). The numbers for nurses from the non-EU-countries in the Western Balkans, a prominent target of the German recruitment efforts, tripled in the same period up to a total of 34,000, which corresponds to a share of 17.5% (nursing: +13,000 up to 19,000; elderly care: +10,000 up to 14,000). The main home countries of non-German nurses remained the same over these five years: Poland, Bosnia Herzegovina, Turkey, Croatia, and Romania. But the share of the Western Balkan countries is rapidly increasing since 2016. [3]

Please note that the numbers and the list of most relevant source countries differs from one study to the other: Pütz et al. analysed the numbers of newly accredited foreign nursing diplomas (foreign-trained), while the BA referred to the number of all non-German nationals.

2.3.3 24-hour live-in care

The 24-hour live-in care sector in Germany is huge, predominantly run by women from East Europe, and barely visible. The sector is not part of the formal German health system and the workforce employed in 24-hour care is not necessarily qualified health workforce. However, a case study of the German health worker migration patterns would barely be complete without an outline of the live-in care sector.

Since there is no official register for home-based care and because part of it takes place in the informal sector, it is very difficult to quantify this employment sector. However, estimates range from around 300,000 [42] to around 700,000 [43] migrant care workers working in German private homes. According to the Foundation Patient Protection, only one-third of the live-in care workers in Germany have a formal labour agreement, while two-thirds are working without a written contract [44]. The Federal Association for Home Based Care estimates the share of illegal employment in the 24-hour care sector even higher at 90% [43].

According to Steiner et al., the strong growth in the number of intermediary agencies is also evidence of the increasing relevance of migrant care work in this sector. While Stiftung Warentest identified about 60 cross-border intermediary agencies in 2009, the number was already 266 seven years later [42]. At the end of 2017 Steiner et al. identified 337 agencies that advertised 24-h-care in Germany.

The recruitment agencies are operating in a barely regulated grey zone. Despite the prevalent legal uncertainty, the German state so far has been acting in complicity through lack of regulation and lack of controls. According to Steiner et al., the secondment of care workers from EU Member States is the dominant model in over 70% of the agencies surveyed. The placement of a self-employed care worker is another common variant. Both models circumvent German regulations on working hours and on minimum wages. [45]

In how far these models are bound to statutory working hours or minimum wages is currently being intensely debated in Germany: in a ground-breaking judgement, Germany's federal labour court ruled in June 2021 that formally seconded foreign workers, who care for senior citizens in their homes, are entitled to the statutory minimum wage, not only for the working hours but also for the stand-by time (file reference 5 AZR 505/20). Self-employed caretakers are not covered in the judgement.

This judgment is questioning a widespread and well-established system of home-based elderly care, which so far has been based on the systematic bypassing of German labour laws. And the judgement is not at all negligible: if we assume 400,000 concerned 24-hour caretakers and roughly calculate the difference of the currently paid salaries (conservative estimate €2,500) against the ones after the application of the statutory minimum wage (estimated cost per month: €9,500), the additional cost will be at €31 billion per year. Consequently, many of the families currently employing caretakers for home-based care would probably opt for seniors' home instead, if these new rules should be applied strictly.

In the *coalition treaty,* the new German government formulated the clear aim for the next term that "*We will design a legally secure basis for 24-hour care in the family environment*" [46, own translation]. How exactly this will be done, is still to be seen, but most probably the established practice will persist. Either on a black market or re-labelled as self-employed 24-hour care.

2.3.4 Relevant initiatives in the context of health worker migration

Since 2012, the German government started to prepare for the active recruitment of nurses from within and from outside the EU. In order to facilitate immigration of nurses, the German immigration laws were changed. In November 2013, the German labour market was opened for foreign nurses. This represents a paradigm shift in German immigration policy, as the immigration of non-academic workers (nursing is a non-academic training course in Germany) was banned in 1972 in the Federal Republic of Germany.

The early recruitment activities of the German government from 2012 – 2016 have been targeted towards nurses in the East and the South from within and outside the EU. Nurses from Serbia, Bosnia Herzegovina, the Philippines, and Vietnam were initially recruited by the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) within the so-called Triple Win Programme.

Germany recruited nurses from within the EU via the MobiPro-EU-Programme, via the European-Employment-Services (EURES) and job fairs. First targets were the EU countries of Spain, Italy, and Greece during the peak-years of the Euro crisis in 2012-2016. Since these countries consolidate economically, the influx from nurses declines. Instead, Germany concentrated its European efforts on eastern Europe and the Western Balkans.

These early recruitment programmes, and particularly the Triple Win programme to recruit Vietnamese nurses mandated by the Federal Ministry of Economic Affairs, were ambitious, well-financed and expensive - and as is known today, too expensive to be sustainable [47]. Looking back, one gets the impression that these projects were devised as door openers and to prepare the field for cheaper private recruitment agencies, who are successively taking over the field. According to Ulrich Dietz, Head of the MoH *Department for Health Personnel from Abroad, Migration and Integration* (Referat Z 24) , nowadays roughly 75% of the immigrating health personnel are being recruited via private agencies, 15% via governmental recruitment programmes and the rest is coming on individual initiative [48]. The predominant role of private recruiters is also confirmed by GIZ interviews stating that many of the employees from abroad are not coming via GIZ or the Triple Win programme, but via private recruiters [49, p. 8, footnote 11].

The practices of private recruitment agencies are often close to or beyond the legally permitted and the ethically appropriate. The article *Nurses for Sale* [50] published by *correctiv*, a group of

investigative journalists, sheds light on the prevailing methods in this sector. Amongst others, *correctiv* shows that hospitals as well as agents are transferring the financial risks of cross-border recruitment "*entirely onto the nurses by requiring them to sign one-sided contracts which force the nurses themselves to shoulder the upfront costs (…) involving costs of about 15,000 euros*." Often the hospitals and the agents use contracts, which are "*in clear violation of German labour law. Nurses committed themselves to pay back costs of about 15,000 euros if they quit their jobs before a period of five years (…) Christiane Brors, a law professor at Oldenburg University, thinks the clause is invalid: 'This is modern debt bondage'*." [50]

Nobody knows how many of these recruitment agencies are currently operating in Germany or how many nurses they are actually recruiting. Instead of imposing strict regulations in this sensitive field, the German government subsidises private recruitment efforts and offers a voluntary quality seal for ethical compliance which the agencies can apply for, if they want to (see section 2.3.4.7).

In Germany, a new government was elected in autumn 2021, but the general line of action regarding the recruitment from abroad will be maintained and even intensified. In the coalition treaty (chapter *nursing*), the government committed itself to "*simplify and accelerate the needed recruitment of foreign skilled workers and the recognition of vocational qualifications acquired abroad"* [46, p. 82, own translation].

In order to illustrate the risk that the German recruitment activities hold for source countries, one needs to compare the German demand of 200,000 – 300,0000 additional nurses over the next decade with the situation in the source countries targeted by the German recruitment activities. Particularly worrying is the situation in the Western Balkans, where Bosnia Herzegovina has a total domestic stock of 19,000 nurses [25], Albania of 16,000 nurses [25], and Kosovo of 16,000 nurses [5].

More than 200 nurses from Bosnia Herzegovina took up their work in the Heidelberg University Hospital over the last years. From the German perspective, this can be interpreted as an achievement: the recruitment process was governed by a bilateral agreement, in the hospital dedicated trade union representatives are watching over legal matters and an effective integration of the migrant nurses, retention rates are very high (> 90%), and the hospital gets the direly needed workforce [48]. On the other hand, the 200 Bosnian nurses employed in a single German hospital constitute 1% of the entire domestic nursing workforce back home in

Bosnia Herzegovina [25]. The most relevant German initiatives for cross-border health worker recruitment are presented here below in more detail.

2.3.4.1 WHO Global Code of Practice on the International Recruitment of Health Personnel

Since 2013 and in line with the WHO Code of Practice, the active recruitment of doctors and nurses from countries with highly insufficient health personnel is prohibited in Germany and may cost a private recruitment agency a fine of up to €30,000 [51]. Germany was one of the very first countries to transfer this provision from the Code of Practice into domestic laws. From 2013 until 2020 this regulation banned recruitment from the 57 crisis countries listed in the World Health Report 2006 [52, p. 12]. Since 2020, this negative list was replaced by an updated list agreed upon by the World Health Assembly in November 2020 [53]. Due to a controversial change in the methodology, this new list only contains 47 countries. Thereby, countries such as India and Indonesia are slightly above the thresholds and not any longer listed. Germany has put this new list into effect and immediately started active bilateral and private recruitment activities in both countries.

Germany regularly fulfils its commitment for three-annual reporting to the WHO secretariat as stipulated in the Code of Practice, but the level of detail and informative value decrease from cycle to cycle.

Article 8.3 of the Code stipulates that “Member States are encouraged to consult, as appropriate, with all stakeholders (…) in decision-making processes” [1]. From 2012, the Federal Ministry of Health maintained regular meetings with stakeholders (Working group health workers from developing countries) to discuss the implications of the Code but did stop this activity in 2016. With the growing numbers of immigrating health workers, this working group should be reactivated.

Article 5.2 clearly stipulates that “all Member States should strive to meet their health personnel needs with their own human resources for health” [1]. Germany has set up several initiatives regarding the increase of domestic care workers (see section 2.2.3), but their intensity falls back behind the energy invested in the recruitment from abroad. In general, one can state that in the early years after the adoption of the Code of Practice, a small number of interested and engaged staff in line ministries promoted the Code, but that this energy has been fading since 2016, since Germany rather invests ever-growing efforts and finances in cross-border

recruitment activities.

2.3.4.2. Bilateral agreements on the recruitment of health workers

Under German law, the Federal Employment Agency (Bundesagentur für Arbeit, BA) has the mandate to sign bilateral agreements on the recruitment of migrant workers (Vermittlungsabsprachen) with other countries. Currently ten such bilateral agreements are in force:

- Bosnia-Herzegovina (Triple Win, signed in 2014)
- Brazil (DeFa, “Fair Recruitment”, signed in 2021)
- Columbia (“Fair Recruitment”, signed in 2021)
- Dominican Republic (“Fair Recruitment”)
- India, Kerala (Triple Win, BA, “Fair Recruitment”, signed in 2021)
- Indonesia (Triple Win, BA, “Fair Recruitment”, signed in 2021)
- Mexico (BA, DeFa, “Fair Recruitment”, signed in 2019)
- Philippines (Triple Win, DeFa, “Fair Recruitment”, signed in 2013)
- Tunisia (Triple Win, signed in 2013)
- Vietnam (“Fair Recruitment”, Ministry of Economic Affairs, signed in 2012)

Serbia originally also signed a bilateral agreement with Germany in 2013 under the Triple Win programme but suspended it unilaterally in February 2020 due to its own demand for nurses. Between 2016 and 2019, a total of 679 nurses had left Serbia for Germany under the programme. Another example of the attempts of source countries to limit the outflow of health workers is Romania. In 2018, the Romanian government raised doctors’ salaries by over a double to stem emigration after it had lost more than 25,000 doctors in one decade [54]. And in April 2020, during the onset of the Covid-19 pandemic, the Romanian government banned the emigration of medical doctors [55].

In combination with these bilateral agreements Germany also runs several programmes, in order to effectively organise their implementation (see below).

2.3.4.3 Triple Win programme

The German Triple Win programme started in 2012 and is a governmental initiative to recruit nurses from third countries outside the EU, and is carried out by the German official development agency Gesellschaft für Internationale Zusammenarbeit (GIZ). Formally these activities are framed by a bilateral agreement between source and destination country. The

name emphasizes that three parties, i.e. the migrants, the source and the destination country, win in such an agreement. However, the euphemism leaves out the rural populations in underserved rural areas of the source countries, who most likely lose.

From 2013 until 2021, 4,700 nurses were recruited under the programme, mostly from Bosnia Herzegovina, the Philippines, Tunisia and up to February 2020 also from Serbia [56].
An employer has to employ at least 3 nurses and pay €7,900 per head for the services to GIZ. This also includes a language training up to level B2 already in the nurses' home country. In addition, the employer pays for travel, further language training after arrival, and the recognition of training certificates. [57]

The following countries are currently in the Triple Win programme: Bosnia Herzegovina, India (Kerala), Indonesia, Tunisia, and the Philippines.

2.3.4.4 Vietnamese trainees for nursing and elderly care

In 2012, the Federal Ministry of Economic Affairs started the pilot project "Elderly care training of Vietnamese workers" on the basis of a joint declaration of intent with the Vietnamese Ministry of Labour, Invalids and Social Affairs. The project was also carried out through GIZ, though, formally it was not part of the Triple Win programme. The objective of the pilot phase was to recruit 200 Vietnamese migrant workers and to train them for two years in Germany in elderly care, which is one of the three formal nursing curriculums. In 2015, a second bilateral joint declaration was signed and the project was extended [58]. Since 2016, it also recruits trainees for nursing and not only elderly care [59]. By the end of 2021, 710 Vietnamese nurses had migrated to Germany under this programme [60], which is still a negligible number compared to a Vietnamese stock of 107,000 nurses [4, data from 2016]. It is to be noted that under this programme, Germany recruits Vietnamese nurses with a diploma or a university degree, who then undergo a second 2-year training, according to the German standards, to become geriatric nurses.

2.3.4.5 The Western Balkans Regulation

In 2016, Germany endorsed the Western Balkan Regulation, which facilitates access to the German labour market for nationals from Albania, Bosnia and Herzegovina, Kosovo, Northern Macedonia, Montenegro, and Serbia. The regulation is not limited to health workers but basically grants access to skilled workers, who can prove to have a work contract on offer in

Germany. Originally the Regulation was intended to expire in December 2020, but it has been prolonged until December 2023. [39]
Between 2016 and 2020, the number of nurses from these six countries working in Germany tripled up to a total number of 34,000. In comparison: the absolute number of domestically registered nurses in these six countries together adds up to 116,000 [3]. The loss due to brain drain is enormous, and the first Balkan countries already try to stem the outflow. In early 2020, Serbia started to prosecute private recruitment agencies working in Serbia without formal accreditation [61] and unilaterally cancelled the Triple Win agreement with the German government [62]. However, the effectiveness of this latter move is questionable, as the numbers of nurses recruited under Triple Win are far lower than the number of nurses migrating under the Western Balkan Regulation. And the latter regulation remains in force.

The German prolongation of the Western Balkan Regulation took place in late 2020, in a year when the staggering numbers of nurses emigrating from the Balkans were already known and when Serbia had already taken action to limit the scope of the brain drain. The chronology of events helps to answer the question, whether the German government is not aware of the effects of the brain drain in source countries or if they simply don't care. They simply don't care.

2.3.4.6 DeFa

DeFa stands for German Agency for International Healthcare Professionals (Deutsche Fachkäfteagentur für Gesundheits- und Pflegeberufe) and was founded in October 2019. It is located in the state of Saarland and financed by the Federal Ministry of Health. According to its self-presentation *DeFa guides hospitals, care facilities and personal service agencies through the application process* [for immigrating health workers] *(…) The focus of our work is to support and accelerate the necessary application procedures. (…) Our partners include the German Competence Center for International Professionals in Health and Health Care (DKF).* [63] The DeFa also claims to adhere to an *ethical framework for recruitment* but without any further specification about what this might mean. From observers on the side of trade unions such an organisation is welcomed in principle, but the current state of the DeFa is described as ineffective and characterised by a lack of know-how.

2.3.4.7 DKF - quality seal "Fair Recruitment Nursing Germany"

DKF stands for German Competence Centre for International Healthcare Professionals (Deutsches Kompetenzzentrum für internationale Fachkräfte in den Gesundheits- und Pflegeberufen). Founded in 2019, it is financed by the Federal Ministry of Health. The aim of the

competence centre is to participate in the development and implementation of recruitment activities for health workers from abroad. Amongst others, the DKF developed the quality seal “Fair Recruitment Nursing Germany.“ According to DKF, the quality seal is intended to document minimum standards for employers or private agencies active in cross-border recruitment of health professionals from outside the EU, including the standards set in the WHO Code of Practice and good practices of social integration. From NGO side, the seal is criticised because the screening process does not include the repartition and density of health personnel in the countries of origin.

The application for the quality seal is voluntary but related to specific advantages: since July 2021 and currently up to December 2023, employers who hold the quality seal are entitled to apply for a €6,000 compensation of their recruitment costs for up to 40 recruits per year. The programme is called *Fair Recruitment Nursing Germany*. Interestingly no compensations are paid for recruitments from countries within a 3,500 km radius around Germany, which comprises Europe and the MENA region, as shown in figure 3 [64]. According to the programme’s website, the intention behind this restriction, and behind the entire programme, is to reduce the pressure of the brain drain on nearby countries and in particular on the Western Balkans: “*A large part of the recruited nursing professionals comes from the Western Balkan countries and a decline in available staff is now noticeable in these countries. In order to prevent a further worsening of the situation, the Federal Ministry of Health (BMG) has launched the support programme "Fair Recruitment of Nurses in Germany*"[65, own translation]. Or in other words: after picking the low hanging fruits, the German government subsidises the employers to reach higher up.

Figure 3: 3,500 km diameter around Germany

2.3.4.8 Global Skills Partnerships

The Global Skills Partnerships (GSP) approach suggests shifting the professional qualification and skills training for the future migrants to specific training institutions in the source countries. The approach is rather being discussed on the global agenda than in Germany. So far the German government does not implement any GSP training and recruitment programmes in the health sector [49].

The Friedrich Ebert Stiftung recently published a working paper, which discusses the implications of a potential application of GSPs in the German recruitment activities of health workers. In summary, the authors caution potential implementers to use this tool, if at all, with care and warn that GSPs are no appropriate tool to contribute to sustainable health system strengthening or to mitigate global inequalities in health care [66].

2.3.4.9 Make it in Germany

“Make it in Germany" is the name of a government-run website under the responsibility of the Federal Ministry of Economic Affairs and posts information about application procedures and job opportunities in Germany [67]. It is available in German, English, French and Spanish. Aside from the information for jobseekers from abroad, it also offers an online repository of detailed current vacancies. By end of March 2022, a total number of 4,000 German job vacancies was listed for health professionals, out of which 1,400 were for nurses and 1,300 for medical doctors.

2.3.4.10 Goethe Institut

The Goethe Institut participates in the recruitment efforts for nurses: on the one hand, it advertises the nursing recruitment programmes on its website [60] and, more importantly, it offers language courses and exams, which are specifically designed for health care workers. Under the label “Goethe-Test PRO Pflege certification”, the participants can train and prove their language skills for medical professions up to the B2 level in order to “prepare for a training course in medical or non-clinical nursing in Germany” and to “demonstrate their specialist language skills at an advanced language level with the Goethe-Test PRO Pflege certification” [68]. The B2 level is required for the formal recognition of foreign nursing diplomas in Germany.

2.4 The national political and legal framework regarding health workforce migration and mobility

The field of cross-border health worker recruitment is a wide one and characterised by few centralised and manifold decentralised structures.

Within the German government, the Federal Ministry of Health is the strongest player. The Department 424 is responsible for Health Workers from Abroad (Fachkräfte Ausland) and is currently chaired by Ulrich Dietz. This is a highly influential department which devised many of the specific German recruitment systems previously mentioned (DeFa, quality seal DKF Fair recruitment).

The Department Z 23 is responsible for Global Health and is the main German actor vis-à-vis the WHO and regularly participating in the World Health Assembly. Z 23 is also the designated German authority for the implementation of the WHO Code of Practice for the International Recruitment of Health Personnel. The department is currently chaired by Dagmar Reichenbach. The Ministry of Development's Global Health Department is not yet a heard voice in the field of health worker recruitment. It is to be assessed with tact and diplomacy, in which sense it might be instrumental to voice a critique of the brain drain.

The Ministry of Economic Affairs was amongst the very early actors in organising the brain drain and kickstarted the recruitment of nurses from Vietnam together with the GIZ already in 2012. However, since then most of the activities have been taken over by the Ministry of Health.
The GIZ is Germany's government-owned main implementor of technical cooperation in development work. In the field of health worker recruitment, GIZ has taken a position clearly in favour of active recruitment practices. GIZ devised and implements the *Triple Win programme* as well as *Make it Germany*.

The Federal Employment Agency (BA) exerts a strong influence on the recruitment activities as it is the body to fine-tune and implement the changes that opened up and are still widening access to the German labour market for health workers from abroad. The BA also has the best databases on the numbers of immigrating health workers, though it does not publish them systematically.

3. Recommendations

The remedies against the global health scandal described in this report are well-known and intensively discussed in the German public.

The Federal Government should engage in increasing the attractiveness of the training for and the working conditions of nurses in Germany. All nurses, whether from inside or from outside Germany should, again, see long-lasting and positive perspectives in the nursing profession. Decent work in nursing is not only a necessity for the nurses and their patients in Germany, but, in the long run, would be a valuable contribution towards combating the brain drain of health workers and strengthening the health systems in the source countries.

We recommend that the following measures are promising first steps in order to find a more sustainable answer to the German care crisis and to mitigate the risks the current situation holds for the health systems of the source countries.

Recommendations for German civil society:

- On the side of German civil society organisations and NGOs, a focal point with the task of advocating against the brain drain of health personnel needs to be permanently established and entrenched in the relevant networks.

Recommendations for the German government:

- The German government should adapt the legal framework of the self-governed German health system in order to give the interests of the nurses more influence and more weight in the relevant boards and committees.
- The working conditions of nurses are suffering from market-oriented competition among hospitals. The system of hospital financing through diagnosis related groups (DRG) requires a fundamental transformation which gives more value to care work. The attractiveness of the nursing profession in Germany needs to be further improved and minimum working standards should be guaranteed in the care labour market in Germany.
- The German government needs to adapt the essential elements of the WHO Code of Practice and incorporate these into its national legislation. This refers to:
    - Effective measures for sustainable human resources forecast and planning in health.

    - The development of standards for needs-based minimum staffing levels for nurses.
    - The existing ban on the active recruitment of nurses from one of the 47 crisis countries should be extended to all countries below the SDG-related threshold of 4,41 doctors, nurses and midwifes per 1,000 population [69].
    - More intense control of the practices of private recruitment agencies is needed to inhibit unethical recruitment techniques as debt-bondage and kick-backs.
    - The Federal Ministry of Health should reactivate the Working group health workers from developing countries to regularly discuss the implications of the WHO Code with all stakeholders.
- The German government needs to impose stricter regulation on private recruitment agencies to better protect the legal rights of migrating nurses and to do no harm.
- Sufficient German language skills are a mandatory condition for recognising the skills of nurses in Germany. As a result, the costs of language training should be borne by the recruiting agencies or the employers respectively. The costs of language training should be given the same legal status as the general costs of education and claims for reimbursement against the trainees should be prohibited.
- Significant numbers of mainly eastern European women (often qualified nurses) are working in 24-hour home-based care. Data on the scope of the sector, size and qualification of the workforce are not available. The German government has the duty, not at least vis-à-vis the source countries, to improve data availability and data quality on this sector.
- The German government should use its influence in the WHO and the EU to support the source countries to again open the debate about compensation payments for the training costs incurred.

Recommendations for the European Union:

- Within the EU, the question of cross-border migration of health personnel should not any longer be dealt with by individual countries. According to the principle of subsidiary, the EU and in particular the Directorate-General for Health and Food Safety (or other appropriate Directorate) should contract the authority to regulate and intervene in activities of cross-border recruitment, whilst not restricting the individual mobility of health workers.

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