MORE THAN JUST A BRAIN DRAIN – THE GREAT BRAIN ROBBERY

International poaching of nursing staff by the federal government

An analysis by the Rosa Luxemburg Foundation, Geneva Office

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1. Summary

The immigration of foreign health professionals is not a new phenomenon, nor is it a German speciality. For decades, well-trained doctors from the global South have been migrating to richer countries in the hope of better pay and living conditions. The rich North saves a lot of money on school and university education of the immigrant professionals and is able to compensate for long-term undesirable developments in its own health care system, at least for a while, by poaching important staff from abroad - although this of course massively exacerbates the shortage of skilled workers in the countries of origin.

This is currently evident in the nursing shortage in Germany (and not only there). This great shortage of nursing staff is homemade and a direct consequence of profit maximisation in the health sector. The privatisation of hospitals and the flat rate per case system have directly led to an extreme intensification of work in nursing, with poorer pay. Many nursing staff complain that good care is not possible and increasingly that even patient safety is at risk. As long as the work remains so stressful and there is so little money, fewer and fewer people in Germany are willing to work in health care or to seek training in this sector.

For some years now, the federal government has been reacting with a formula that is as simple as it is reprehensible: Well-trained professionals abroad are actively recruited for the health care system in Germany. In the past, people spoke of a ‘brain drain’, an outflow of knowledge or experience, when educated people migrated to richer countries out of individual choice. Today we need to talk much more about ‘brain robbery’ , because with the organised and well-funded poaching programmes of the federal government, other countries are actively and deliberately being robbed of their skilled workers.

The federal government's state-run poaching programmes currently list the following ten countries where nursing staff are actively being poached: Bosnia-Herzegovina, Brazil, Colombia, Dominican Republic, India, Indonesia, Mexico, Philippines, Tunisia and Vietnam.

Active recruitment abroad cannot and must never be a strategy to combat the nursing shortage. It simply will not work and has devastating effects on the health systems of the countries of origin. Instead, we need

- a long-term strategy for human resource development in the German health sector that addresses the main causes of the nursing shortage and does NOT involve strategic poaching abroad;
- instead of targeted poaching of skilled workers, a policy oriented towards freedom of movement and targeted measures by the federal government so that people who have already migrated to Germany or who have fled can work in the professions for which they are already trained or would like to be trained;
- an implementation of the WHO's demands for equitable global health workforce development, including halving dependence on foreign labour by 2030;
- a significant expansion of the list of countries of origin requiring special protection. In five of the ten German priority countries for recruitment, all activity must be stopped because these countries are below the critical threshold of 4.45 health workers per 1000 inhabitants: Dominican Republic, India, Indonesia, Tunisia, Vietnam.
- compensation for training services in the countries of origin;

state-organised or at least strictly controlled international mediation to protect workers from adhesion contracts.

2. Global health solidarity remains a mirage

This study focuses on the official programmes funded or run by German government agencies. There is, of course, also a great deal of individual migration as well as a large number of private intermediaries who use sometimes dubious methods to lure skilled workers from abroad to Germany. Correctiv published excellent research on this in November 2020.[1] According to Correctiv, more than 90% of foreign nursing staff are recruited by private intermediaries and not through government programmes.

In 2020, 13% of all nursing staff in Germany were of foreign nationality,[2] with the number of foreign nursing staff practically doubling in just a few years. [3] According to the Hans Böckler Foundation, it even increased sixfold between 2012 and 2017.[4] According to the Federal Agency for Civic Education, around 208,000 foreign nursing staff were working in Germany in 2021, 120,000 of them from third countries and 90,000 from EU member states. This means that every eighth nurse now comes from abroad, and for doctors it is even every seventh.[5]

On average, foreign health workers earn significantly less than German nationals. According to a study from 2020, the wage gap for skilled workers in nursing was 7.7 per cent, but only 0.5 per cent in elderly care. One reason for this could be that the foreign skilled workers are younger and subsequently have less work experience or seniority.[6]

An academic study on the Western Balkans published in May 2021 concluded that one in four Croatian nurses has emigrated to Germany in the past 10 years. For Bosnia-

[1] https://correctiv.org/top-stories/2020/11/25/wie-dubiose-vermittler-auslaendische-pflegekraefte-zur-ware-machen/

[2] https://de.statista.com/statistik/daten/studie/1029896/umfrage/auslaenderanteil-an-pflegekraeften-in-deutschland-nach-pflegeart/

[3] https://arbeitgeberverband-pflege.de/wp-content/uploads/2019/12/Wirksam_Ausgabe04_2019_Innenseiten_RZ_30-33_Halletz.pdf

[4] https://www.boeckler.de/de/boeckler-impuls-voneinander-lernen-braucht-zeit-4490.htm

[5] https://www.bpb.de/gesellschaft/migration/flucht/monatsrueckblick/345980/migrationspolitik-dezember-2021

[6] https://doku.iab.de/arbeitsmarktdaten/Entgelte_von_Pflegekraeften_2020.pdf

Herzegovina and Serbia, according to the study, official data is lacking, but the emigration share there is estimated to be similarly high.[7]

Against this background, the following Federal Government programmes and initiatives have been launched in the past ten years or so:

2.1 Triple Win

'When everyone's a winner' – is how the GIZ [German Society for International Cooperation] promotes Triple Win, a joint Federal Employment Agency and GIZ programme.[8] It was established in 2013 to recruit skilled health professionals, and since 2019 it has also been recruiting trainees in Vietnam.[9] By the end of 2021, over 4700 nursing staff had been placed in Germany[10] and over 200 employers had participated in the programme.[11] From Bosnia-Herzegovina, the Philippines and Tunisia, already trained skilled health professionals are placed, and they then undergo a recognition qualification in Germany, while 'young people with previous experience in health care' from Vietnam are recruited for health care training and later further employment (see below).[12]

To ensure better integration, each facility should accommodate at least three nursing staff. The gross monthly salary must be at least EUR 2,300 for a nurse without German recognition and EUR 2,800 after German recognition as a health care worker or nurse.[13]

Employers must pay GIZ a fee of EUR 7,900 per nurse placed, which also includes the costs of a language course up to level B1 prior to departure. Travel costs, as well as further language training up to level B2 and preparation for the knowledge test in Germany, must also be paid by the employer. The employer must also organise *'initial'* accommodation, of which the rent including utilities *'should'* not be more than one third of the net wage.[14]

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[7] T Jurić (2021) Medical brain drain from Western Balkan and Croatia to Germany and Austria – an approach to the digital demography. https://www.medrxiv.org/content/10.1101/2021.05.26.21257893v1.full.pdf

[8] https://www.giz.de/en/workingwithgiz/11666.html

[9] https://www.arbeitsagentur.de/vor-ort/zav/uber-triple-win/triple-win-das-projekt

[10] https://www.arbeitsagentur.de/vor-ort/zav/download/1533758277010.pdf

[11] https://www.arbeitsagentur.de/vor-ort/zav/download/1533716310198.pdf

[12] https://www.arbeitsagentur.de/vor-ort/zav/uber-triple-win/triple-win-das-projekt

[13] https://www.arbeitsagentur.de/vor-ort/zav/download/1533716310198.pdf

[14] https://www.arbeitsagentur.de/vor-ort/zav/download/1533716310198.pdf

What is interesting is the arbitrariness with which the urgency of this programme is invoked in the promotional material for Triple Win. At times it is stated that there will be a shortage of around 150,000 nursing staff in Germany by 2025,[15] at other times it is said to be 500,000 by 2030.[16]

2.2 Trainees from Vietnam

Trainees are recruited here, but they too must have at least two years of training in nursing[17] (College Nurse or Bachelor's degree).[18] They then take part in training that is shortened to two years at Vivantes.

The project began in 2013 with a memorandum of understanding between the German Ministry of Economics and the Vietnamese government. The Goethe-Institut offers a twelve-month language course in Hanoi and Ho Chi Minh City for nursing staff who are then able to complete specialist training in geriatric care in Germany. By the end of 2021, 710 Vietnamese nursing staff will have come to Germany.[19] At the end of 2019, Vivantes declared that the cooperation would now also be extended to include the area of health and nursing care.[20] According to its own information, Vivantes offers trainees furnished flats in Berlin so they can live there in shared flats.[21]

In 2015, a 'Memorandum of Understanding on the Basic Features of Fair Attraction of Workers for Training in Elderly Care' was signed by both Germany and Vietnam. There is hardly anything in the letter about 'fair' or ethical standards, but point 9 literally states: *'In the event of premature termination of the training relationship in Germany, the Vietnamese participant should bear the costs of repatriation insofar as they are responsible for the*

15 https://www.arbeitsagentur.de/vor-ort/zav/download/1533716310198.pdf

16 https://www.arbeitsagentur.de/vor-ort/zav/uber-triple-win/triple-win-das-projekt

17 https://www.goethe.de/ins/vn/de/sta/han/kur/pkd.html

18 https://hospiz.vivantes.de/news-details/news/fachkraeftegewinnung-vivantes-baut-ausbildungskooperation-mit-vietnam-aus/

19 https://www.goethe.de/ins/vn/de/sta/han/kur/pkd.html

20 https://hospiz.vivantes.de/news-details/news/fachkraeftegewinnung-vivantes-baut-ausbildungskooperation-mit-vietnam-aus/

21 https://hospiz.vivantes.de/news-details/news/fachkraeftegewinnung-vivantes-baut-ausbildungskooperation-mit-vietnam-aus/

termination[22]*.* This should be a powerful means of pressure by Vivantes on participants during the training. Anything but fair.

According to a 2015 study by the Bertelsmann Foundation, cooperation agreements have also been concluded between German and Vietnamese training institutions in order to 'carry out parts of German nursing training on site in Vietnam in the future'.[23]

2.3 Further placement agreements of the Federal Employment Agency

According to the Skilled Workers Immigration Act (FEG), the Federal Employment Agency (BA) may conclude so-called placement agreements with other countries. This then makes it easier for the respective agreed professions to enter Germany; for example, the recognition of foreign professional qualifications can also take place after entry.[24] The Triple Win Programme described above is based on placement agreements between the BA and the countries of Bosnia-Herzegovina, Tunisia and the Philippines.[25]

Under the Triple Win programme, two more such nursing staff placement arrangements were made in 2021, with Indonesia and the Indian state of Kerala. A deal with Mexico involved nursing staff as well as other professions. For Kerala, the first recruitments are planned for 2022, with the first arrivals and employment expected in 2023.[26] The Indian press is already talking about 'more than 10,000 nursing staff for Germany'….[27]

These BA placement agreements are remarkable in that India and Indonesia, of all countries, are now listed by the WHO as among the five countries with the greatest shortage of nursing staff worldwide. The WHO's 'World Nursing Report 2020' literally states: 'The countries with the largest number of shortages in 2018 included Bangladesh,

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[22] https://vietnam.diplo.de/blob/1240466/e9df543dbee4beb2555602cfac7a5213/150703-absichtserklaerung-altenpflege-d-data.pdf

[23] https://www.bertelsmann-stiftung.de/fileadmin/files/Projekte/28_Einwanderung_und_Vielfalt/Studie_IB_Internationale_Fachkraefterekrutierung_in_der_deutschen_Pflegebranche_2015.pdf Page 36

[24] https://www.arbeitsagentur.de/presse/2022-05-bundesagentur-rekrutiert-trotz-pandemie-mehr-fachkraefte-aus-dem-ausland

[25] https://www.make-it-in-germany.com/de/arbeiten-in-deutschland/gefragte-berufe/pflegekraefte

[26] https://www.arbeitsagentur.de/presse/2021-42-bundesagentur-fuer-arbeit-unterzeichnet-vermittlungsabsprache-mit-dem-indischen-bundesstaat-kerala

[27] https://indianexpress.com/article/india/kerala/kerala-nurses-recruitment-pinarayi-vijayan-german-agency-7652532/

India, Indonesia, Nigeria and Pakistan.'[28] The WHO 'National Health Workforce Accounts Data Portal' database [29]states very clearly in the country profile of Indonesia: *'An estimated shortage range of 200,000 to 300,000 nurses is projected for year 2030'*.[30] It is completely incomprehensible how the federal government can now reach a poaching agreement for nursing staff with this country of all countries.

The BA tries to justify the placement agreement with Kerala with the fact that in this state 'the number of nursing staff in relation to the number of inhabitants is above the national average and the limit mark of the World Health Organisation WHO'..[31] Of course, the fact that this will nevertheless deprive the Indian health system of skilled workers is not mentioned at all. Nor does the fact that, in an intra-India comparison, communist-ruled Kerala has one of the best health care systems with better care and more staff - an achievement that is now being torpedoed by poaching programmes from the global North.

Figures from the WHO indicate that there has been a private business model for training health workers for export in Kerala for several years. From 2005 to 2016, the number of nurse training places increased more than a hundredfold from 124 to 17,600 - the vast majority of them in private institutions.[32]

2.4 DeFa

In October 2019, the 'German Agency for Healthcare and Nursing Professionals' was founded[33] in Saarland, and subsidised by the federal government to the tune of EUR 4.7 million.[34] Pilot countries are Philippines, Mexico and Brazil.[35] In 2020, country offices have already been opened in Manila and Mexico, and another is planned in Brazil.[36]

[28] https://www.who.int/publications/i/item/9789240003279, Page 64

[29] https://apps.who.int/nhwaportal/Sown/Index

[30] https://apps.who.int/nhwaportal/Sown/Files?name=IDN

[31] https://www.arbeitsagentur.de/presse/2021-42-bundesagentur-fuer-arbeit-unterzeichnet-vermittlungsabsprache-mit-dem-indischen-bundesstaat-kerala

[32] https://www.who.int/hrh/HWF17002_Brochure.pdf?ua=1, Page 4

[33] https://www.defa-agentur.de/

[34] https://www.sueddeutsche.de/politik/pflege-fachkraeftemangel-pflegepersonal-1.4706507

[35] https://www.defa-agentur.de/de/leistungen

[36] https://www.euro.centre.org/downloads/detail/3885

The DeFa does not place skilled workers, but supports private recruitment in all official matters in Germany, from professional recognition to labour market admission and entry.[37] The DeFa's clients are personnel service agencies as well as hospitals and care facilities.[38]

The DeFa states that one of its tasks is to 'maintain international quality standards', especially the 'ethical-social quality' of recruitment abroad. The DeFa emphasises its 'high ethical standards' but without specifying them anywhere and writes succinctly that they are currently 'conceptualising' an accreditation of their 'standards'. They 'expect' their clients to 'commit' to the international ethical principles of overseas recruitment and make 'regular spot checks'.[39]

2.5 Fair Health Care Recruitment Germany

Under this name, there is both a Federal Government quality seal and funding programme. We will not go into further detail about the seal of quality here; the exact catalogue of requirements for the award of the seal is available online and is somewhat disillusioning.[40]

The funding programme was launched in June 2021 and relates to the recruitment of skilled health professionals from countries that are at least 3500 kilometres away from Germany.[41] A grant of EUR 6000 can be applied for each nurse; medical and nursing care facilities are supported.[42]

By the end of 2021, the professional recognition procedures of a total of 1,564 nurses had been supported, from the Philippines (881 nurses), Mexico (130), Brazil (148), Colombia (145), India (164) and Vietnam (53).[43] The website of the project executing organisation (Forschungszentrum Jülich) also mentions the Dominican Republic and Indonesia as possible countries of origin.[44]

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[37] https://www.defa-agentur.de/de/faq/

[38] https://www.defa-agentur.de/de/kunden/ Eine Liste der teilnehmenden Einrichtungen findet sich hier: https://www.defa-agentur.de/media/44njzu5n/information-zu-fapd-website-v2.pdf

[39] https://www.defa-agentur.de/de/leistungen

[40] https://www.faire-anwerbung-pflege-deutschland.de/

[41] This means that Turkey and Tunisia are not included, but Iraq and Egypt, for example, are.

[42] https://www.faire-pflege-deutschland.de/foerderprogramm

[43] https://www.defa-agentur.de/de/bmg-forderprogramm/

[44] https://www.ptj.de/projektfoerderung/faire-anwerbung-pflege-deutschland

The list of all participating institutions in Germany is also available online.[45]

In the BMG's guideline for this funding programme, reference is made to the fact that 'a further pull effect' for the Western Balkan states should be avoided, as the health systems there could soon be 'affected by a shortage of skilled health professionals' due to the poaching of health care professionals.[46] This probably explains the 3500 kilometre limit of this programme.

2.6 DKF

The 'German Competence Centre for International Professionals in the Health and Nursing Professions' is a BMG project that does not itself carry out recruitment, but is intended to develop content and structures for the recruitment of health care professionals. The DKF has, for example, developed and awards the seal of quality 'Faire Anwerbung Pflege' [Fair Nursing Recruitment]'.[47]

2.7 Make it in Germany

This is not a recruitment programme per se and not specifically for skilled health professionals, but an overarching information portal of the Federal Government to 'guide foreign professionals through the jungle of authorities'.[48]

2.8 Goethe-Institut Pro Pflege

Not only in Vietnam, but also in other countries, the Goethe-Institut offers special language courses for nurses, with an explicit reference to job opportunities in Germany.[49] There is even a special language test 'PRO Pflege' at the Goethe-Institut, which is equivalent to level B2.[50]

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45 https://www.defa-agentur.de/media/44njzu5n/information-zu-fapd-website-v2.pdf

46 https://www.bundesgesundheitsministerium.de/fileadmin/Dateien/3_Downloads/B/Bekanntmachungen/210629_Foerderbekanntmachung_Faire_Anwerbung_Pflege_Deutschland.pdf

47 https://dkf-kda.de/

48 https://www.sueddeutsche.de/politik/pflege-fachkraeftemangel-pflegepersonal-1.4706507

49 https://www.goethe.de/ins/in/en/sta/new/kur/spe/dfp.html#undefined

50 https://www.goethe.de/en/spr/kup/prf/prf/gpf.html

2.9 Summary: Target countries of the government programmes

The various official, state-supported or implemented programmes are currently directed at the following ten countries (in brackets are the programmes in which the respective country is included):

Bosnia-Herzegovina (Triple Win)
Tunisa (Triple Win)
Philippines (Triple Win, DeFa, 'Faire Anwerbung')
Vietnam (Triple Win, 'Faire Anwerbung')
India (BA51 für Kerala, 'Faire Anwerbung')
Indonesia (BA, 'Faire Anwerbung')
Mexico (BA, DeFa, 'Faire Anwerbung')
Brazil (DeFa, 'Faire Anwerbung')
Columbia ('Faire Anwerbung')
Dominican republic ('Faire Anwerbung')

In addition, there have been a number of ministerial trips to recruit health workers in recent years, but some of these appear to have been pure propaganda tours. For example, in July 2019, the then Minister of Health, Jens Spahn,[52] signed a 'cooperation in the field of health' declaration with the Kosovan Minister of Health, which, however, on closer inspection only provides for a pure exchange of information and expertise. Nevertheless, this trip was marketed in the German media as 'recruiting nursing staff' in Kosovo.[53]

[51] BA here means new Federal Employment Agency placement agreements from 2021, which are not yet mentioned in the Triple Win programme documents.

[52] https://www.bundesgesundheitsministerium.de/fileadmin/Dateien/3_Downloads/E/Erklaerungen/JD_Health_DEU_KOS.pdf

[53] Z.B. https://www.tagesschau.de/inland/spahn-pflegekraefte-kosovo-101.html

3. International Standards

There are a number of international agreements and guidelines for the international recruitment of professionals. The ILO (International Labour Organization), for example, adopted a corresponding document in 2016, the '*General principles and operational guidelines for fair recruitment*'.[54] A Code of Conduct for the recruitment of health care professionals from within and outside the EU was also agreed between the European Health Employers' Confederation (HOSPEEM) and the European Public Service Union (EPSU) back in 2008. It criticises the 'unnecessary burdens on health systems' caused by 'unethical poaching practices in the EU'.[55]

3.1 The WHO Code of Conduct

In 2010, WHO member states adopted a global code of practice on the international recruitment of health care personnel ('WHO Global Code of Practice on the International Recruitment of Health Personnel').[56] It is a voluntary code and not enforceable. It sets out some basic ethical criteria for the recruitment of health care personnel, especially with a view to the rights of workers and the situation in the countries of origin. For example, it calls for equal and good working conditions for migrant health workers. The following points are worth emphasising:

- It is emphasised that the Code must in no way restrict the freedom of individuals to migrate (paragraph 3.4).
- More developed countries are called upon to provide technical and financial support to poorer countries to strengthen their health systems and especially their capacity to train health workers (paragraph 3.3).
- All countries are encouraged to develop their own health care worker training system *'to reduce the need to poach migrant workers'* (paragraph 3.6).
- Countries should also facilitate circular migration so that the countries of origin are able to benefit as well (paragraph 3.8).
- Countries are explicitly requested to provide assistance to countries of origin in training health workers and to actively support their return to their home country (paragraph 5.2).

The central sentence with respect to the brain robbery problem can be found in paragraph 5.1: 'Member States should discourage active recruitment of health personnel from developing countries facing critical shortages of health workers.' It is a weak formulation, not a ban, but only an appeal to 'discourage', but the reference to countries with a 'critical

[54] https://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---migrant/documents/publication/wcms_536263.pdf

[55] https://www.epsu.org/article/epsu-hospeem-code-conduct-and-follow-ethical-cross-border-recruitment-and-retention-0

[56] https://www.who.int/hrh/migration/code/WHO_global_code_of_practice_EN.pdf

shortage' of health workers has an important meaning. Back in 2006, the WHO had defined 'critical shortage' in a report and identified 57 countries[57] to which this applies (see Figure 2).

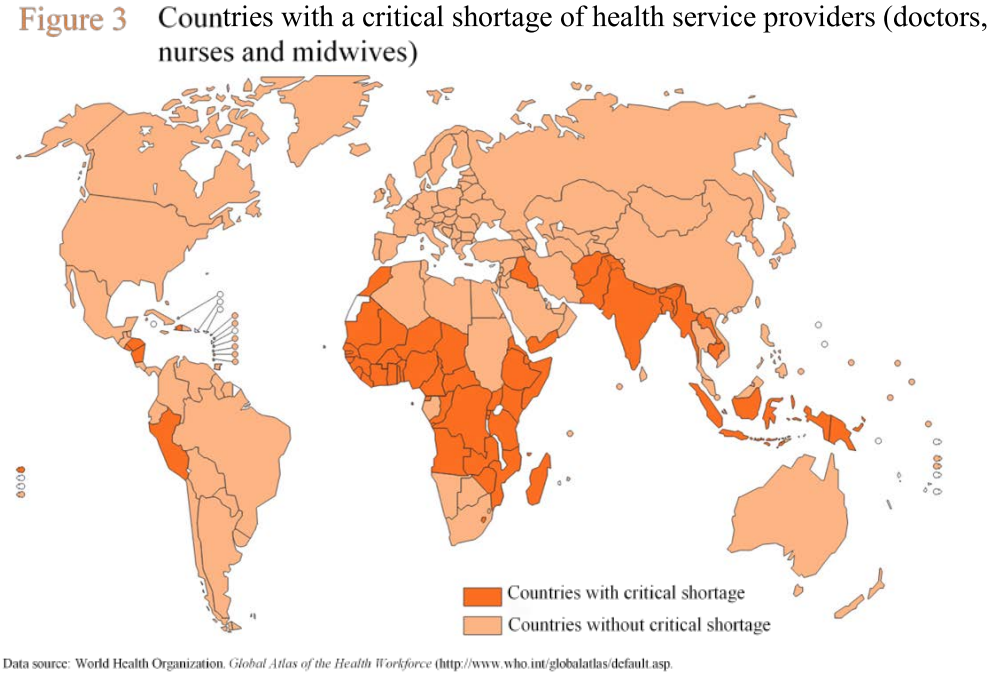

Figure 3: Countries with a critical shortage of health workers (from the World Health Report 2006)

3.2 What is a 'critical shortage'?

The basis for identifying countries with critical shortages was a threshold of 2.28 *'skilled health workers*' (doctors, nurses and midwives) per 1000 inhabitants in the 2006 World Health Report. This value was calculated using an important health indicator, namely the attendance of births by skilled health workers. The threshold taken was that at least 80% of the births should be professionally attended. From a variety of data from individual countries, it was then calculated that the limit of 80% is reached on average at a skilled worker density of 2.28/1000.

Of course, looking at just one indicator - birth attendance - is a very limited view of health care. For this reason, the WHO has further developed this methodology and, above all, adapted it to the United Nations SDGs (Sustainable Development Goals). In a comprehensive strategy paper 'Global strategy on human resources for health: Workforce 2030' from 2016, the WHO writes: *'The 2006 World Health Report broke new ground by developing an evidence-based model for health worker need (…) However, the model is clearly limited to one single health service (delivery by a skilled birth attendant). In*

[57] https://www.who.int/workforcealliance/countries/57crisiscountries.pdf

considering a new health workforce threshold, the focus must shift to reflect the broader range of services that are targeted by UHC and the SDGs.'

Following this logic, the WHO has taken twelve health indicators from the SDGs as a starting point in the strategy paper, including indicators from the family planning, diabetes, high blood pressure, tuberculosis, AIDS treatment and vaccination sectors. On this basis, a new threshold of 4.45 doctors, nurses and midwives per 1000 inhabitants was calculated.

This value, too, can of course only be a rough guide; it is explicitly limited to *'physicians, nurses and midwives'* and, above all, also dependent on the exact structure and organisation of a health system. But it makes clear that in 2006, the minimum supply was significantly underestimated and serves as the basis for the WHO's calculation of future skilled health worker needs in the 2016 strategy paper. For 2013, this resulted in a global undersupply of 17.3 million skilled workers.[58]

The WHO Code is regularly reviewed for relevance and effectiveness. The second round of review of the Code took place in 2019/2020, and the issue of 'critical health workforce shortage' played a particularly central role.[59] A WHO working group presented a paper with various calculation options. One of them envisaged using the two thresholds (2.28 and 4.45 per 1000) for measures of different depth of intervention.[60]

In 2020, the WHO then published a new *'Health Workforce Support and Safeguards List'*,[61] which is not based on either of these values and is also no longer oriented towards the concept of *'critical health workforce shortage'.* The list was reduced to 47 countries, which was then also included as a new list in the annex of the German Employment Ordinance (Section 38) shortly afterwards (see Table 2). From the outside, it is no longer possible to understand the logic with which the WHO chose this path and turned away from the SDGs as the most important point of orientation, and which forces were at work there.

[58] WHO 2016: Global Strategy on Human Resources for Health: Workforce 2030. Annex I. Page 44. https://apps.who.int/iris/bitstream/handle/10665/250368/9789241511131-eng.pdf

[59] Expert Advisory Group's 2nd Review of Code Relevance and Effectiveness. https://www.who.int/publications/m/item/eag-2nd-review-of-code-relevance-and-effectiveness

[60] https://cdn.who.int/media/docs/default-source/health-workforce/eag2/2nd-code-review-eag-working-group-paper-1-options-paper.pdf?sfvrsn=f8fe620c_2

[61] https://cdn.who.int/media/docs/default-source/health-workforce/hwf-support-and-safeguards-list8jan.pdf?sfvrsn=1a16bc6f_5#:~:text=The%202020%20Health%20Workforce%20Support,the%20World%20Health%20Assembly%20every

Recruitment in and employment service from the following countries for jobs in health and care professions may only be carried out by the Federal Employment Agency (Annex to Section 38 BeschV):

1. Afghanistan (Islamic Republic of Afghanistan),
2. Angola (Republic of),
3. Equatorial Guinea (Republic of),
4. Ethiopia (Federal Democratic Republic of),
5. Bangladesh (People's Republic of),
6. Benin (Republic of),
7. Burkina Faso,
8. Burundi (Republic of),
9. Ivory Coast (Republic of),
10. Djibouti (Republic of),
11. Eritrea (State of Eritrea),
12. Gabon (Gabonese Republic),
13. Gambia (Republic of),
14. Ghana (Republic of),
15. Guinea (Republic of),
16. Guinea-Bissau (Republic of),
17. Haiti (Republic of),
18. Yemen (Republic of),
19. Cameroon (Republic of),
20. Kiribati (Republic of),
26. Malawi (Republic of),
27. Mali (Republic of),
28. Mauritania (Islamic Republic of Mauritania),
29 Micronesia (Federated States of Micronesia),
30. Mozambique (Republic of),
31. Nepal (Kingdom of Nepal),
32. Niger (Republic of),
33. Nigeria (Federal Republic of),
34. Pakistan (Islamic Republic of Pakistan),
35. Papua New Guinea (Independent State of Papua New Guinea),
36. Solomon Islands,
37. Senegal (Republic of),
38. Sierra Leone (Republic of),
39. Somalia (Democratic Republic of Somalia),
40. Sudan (Republic of),
41. South Sudan (Republic of),
42. Tanzania (United Republic of Tanzania),
43. Togo (Republic of),
44. Chad (Republic of),

Table 2: Countries from which skilled health workers may not be recruited.[62]

3.3 Health care situation in German recruitment countries

Current figures on the health care situation in individual countries are provided by both the WHO database 'National Health Workforce Accounts Data Portal' [63]and the 'World

[62] From a BA leaflet on the employment of foreign workers. https://www.arbeitsagentur.de/datei/merkblatt-7-auslaendischean_ba015382.pdf

[63] https://apps.who.int/nhwaportal/Sown/Index

Development Indicators',[64] a World Bank database. In both, the nursing staff, midwives and doctors per 1000 inhabitants can be queried by country.

These two databases were used to determine the health care situation in the ten countries that are currently the focus of German state recruitment programmes (see above). Table 3 shows some differences between the two data sources, but ultimately they are quite comparable.

All ten countries are above the old threshold of 2.3/1000 inhabitants, although in some cases only just. The five countries that are below the new threshold of 4.45/1000 are highlighted in red.

	World Bank	WHO
Bosnia-Herzegovina	Not spec.	7.9
Brazil	11.9	9.7
Dom. Republic	2.8	2.9
India	2.4	3.3
Indonesia	2.4	4.3
Columbia	Not spec.	5.2
Mexico	8.0	7.4
Tunisia	3.8	3.8
Vietnam	2.3	2.3
Philippines	5.5	6.0

Table 3: Number of doctors, nurses and midwives per 1000 inhabitants in the countries that are being specifically targeted by German recruitment programmes.[65]

64 https://databank.worldbank.org/reports.aspx?source=2&series=SH.MED.PHYS.ZS&country=#

65 World bank: World Development Indicators, calculated for 2017 or 2018 depending on data availability, and total of 'physicians' and 'nurses and midwives'. Accessed in January 2022. https://databank.worldbank.org/reports.aspx?source=2&series=SH.MED.PHYS.ZS&country=#

WHO: The Global Health Observatory. Data retrieved from the most recent years available, mainly 2018 and 2019, and the total of 'medical doctors' and 'nursing and midwifery personnel'. Accessed in January 2022. https://www.who.int/data/gho/data/themes/topics/health-workforce

4. The problem is called capitalism: Working conditions in the health care sector

It is undisputed that there is currently a massive shortage of skilled workers in the geriatric and nursing care sector in Germany. The Federal Employment Agency expects that around 150,000 additional nursing staff will be needed by 2025.[66] A study by the Bertelsmann Foundation has calculated a supply gap of 492,000 jobs in a worst-case scenario for 2030.[67] This situation has been exacerbated by the Corona pandemic. After two years of continuous workload, there is already a massive exodus from the nursing profession, and this will become much worse in the near future. In December 2020, the 'German Professional Association for Nursing Professions' (DBfK) carried out a survey of nursing staff throughout Germany. 32.1 percent said they had often thought of leaving the nursing profession during the year.[68]

The federal government and private hospital operators like to try to blame this on demographic change. In fact, the main reason behind all this is the maximisation of profits in the health care sector: As a result of the privatisation of many hospitals and the introduction of the flat rate per case system, the cost pressure on each individual department has steadily increased, and work has become more and more concentrated and paid less and less. The lack of attractiveness of the nursing profession can be traced directly back to the neoliberal atrocities of the last 20 years.

The 'Krankenhaus statt Fabrik' alliance (Hospitals instead of Factories) has detailed how this works in a nutshell: 'More than 60% of a hospital's costs are personnel costs. Reducing them is one of the most important adjusting screws of any management. The DRG system encourages staff reductions, because personnel costs, e.g. for nursing, are included in the calculation bases, but the staffing plan that should be used for nursing is not specified. Although the number of cases treated has increased year by year, 6.3% of nursing posts have been cut; the workload has increased by 30%. In no other country in Europe are more patients cared for by just one nurse'.[69]

In addition, the fee-per-case system also exacerbates the overload on the wards - especially the intensive care units - via a second lever: There has been an increase in certain operations, even if they are not medically necessary, simply because they bring a

[66] https://www.arbeitsagentur.de/vor-ort/zav/uber-triple-win/triple-win-das-projekt

[67] https://www.bertelsmann-stiftung.de/fileadmin/files/BSt/Publikationen/GrauePublikationen/GP_Themenreport_Pflege_2030.pdf

[68] https://www.dbfk.de/media/docs/download/Allgemein/Broschuere_Pflege-im-2.-Lockdown_Auswertung_Feb2021.pdf. Page 19

[69] https://www.krankenhaus-statt-fabrik.de/index.php?get=download&cfilename=BRwTBQoFUFcdf1waXEE2JhMcFwgOH1RBV2YCUwsCNgMEAAUGEkRBV1Q%3D

higher profit. This overload of profit-seeking - in addition to exhaustion itself - is also a reason for many health care workers to quit their jobs.

The German Platform for Global Health has summarised the impact of the neoliberal reforms of the last decades very well in its highly recommended statement, pointing out that *'on the one hand, private hospitals are recording double-digit profit margins, something that did not exist at all 20 years ago, and on the other hand, there is a noticeable shortage of skilled workers and the professional image of nursing has suffered significantly. After all, the working conditions in nursing have deteriorated in this country to such an extent that countless numbers of local nurses are turning their backs on their profession. For years, poor and, in many cases, declining pay, which is often linked to employers' fleeing from area collective agreements to in-house collective agreements, has been accompanied by increasing work intensification and a growing burden of documentation. The nursing profession in Germany has become so unattractive that the federal government and employers are looking for workers on the world market who are willing to work in nursing under the increasingly poor income and working conditions in this country'.*[70]

Verdi has also spoken out accordingly, although they also see poaching abroad as part of a possible solution: 'Without more staff, decent pay and good working and training conditions, it is not possible to address the skills shortage - recruitment can only be one part of a whole bunch of necessary measures.'[71]

This also explains why the federal government relies so heavily on recruitment abroad, especially in the nursing sector, and spends millions of taxpayers' money on it: The profits of the private sponsors of hospitals and care facilities must not be reduced, which is why young people from Vietnam or Colombia are preferred to be brought to Germany to fill the gaps. Especially since they are on average even 7.7% cheaper than German skilled health workers.[72]

All those who want to come here to work in health care are welcome. It is not migration that is wrong, but targeted poaching. Germany must put itself back in a position where it trains and retains the skilled health workers it needs itself.

[70] https://gesundheit-soziales.verdi.de/++file++58342bab7713b84060162e51/download/dpgg_paper_brain-drain_web.pdf

[71] https://www.bundestag.de/resource/blob/711338/666defffdad752029dba2eb17e965a90/19_14_0199-5-_ver-di-_Pflege-data.pdf

[72] https://doku.iab.de/arbeitsmarktdaten/Entgelte_von_Pflegekraeften_2020.pdf

5. Demands

5.1 A strategy for long-term health care workforce development

If working conditions in the health care sector are the problem, then they must be improved. Better pay and less stress are the main prerequisites for being able to recruit nursing staff at all. For good reasons, the WHO Code of Practice states that each country should '*take effective measures to train and retain health workers (...) based on an evidence-based health workforce strategy'.*

There is not much evidence of such a long-term, sustainable strategy at the federal government. The new federal government must abandon its focus on poaching skilled health workers from abroad as soon as possible and now develop a fundamentally new strategy together with all political and trade union interest groups in order to significantly increase the attractiveness of the nursing profession. A study from Bremen concluded that over 60 per cent of former nursing staff would be willing to return to nursing if the conditions were right. The main points mentioned were recognition, more time for good care, needs-oriented staffing levels, collective bargaining agreements and a higher basic salary, especially for younger staff.[73]

This is exactly where the demands of the recent labour disputes in hospitals in Germany come in, where the workers are demanding, not only better pay, but above all, collective bargaining agreements.

5.2 A policy oriented towards freedom of movement

For the new federal government, the 'modernisation' of immigration policy it has announced means above all labour immigration: 'In addition to the existing immigration law, we will establish a second pillar with the introduction of an opportunity card based on a points system to enable workers to gain controlled access to the German labour market in order to find a job. We will extend the Blue Card in national law to non-academic professions.'

Instead of the targeted poaching of skilled workers and the orientation of immigration policy towards utility criteria, the possibilities of individual migration as well as the living and working conditions of people living here without a German passport must be improved. Facilitated naturalisation, dual citizenship, good training and working conditions as well as adequate pay for all are important steps towards this. Qualifications, and educational and professional degrees of people who have migrated or fled to Germany must be more strongly recognised. And at the same time, people without a German passport need the security that their stay is not dependent on the goodwill of their employer. This is only possible with residence and work permits, which are independent of duration of

[73] https://gesundheitohneprofite.noblogs.org/post/2021/02/06/bremer-studie-zur-ruckkehr-in-den-pflegeberuf/

employment and employment contract. And: They need the same social protection as everyone else.

5.3 Halve dependence on foreign skilled workers

This is a WHO requirement from 2016 in the WHO strategy paper 'Workforce 2030'. There, a clear milestone for the year 2030 was formulated for the recruitment of skilled health workers: *'All countries are making progress towards halving their dependency on foreign-trained health professionals, implementing the WHO Global Code of Practice*.' [74]

Germany is developing in just the opposite direction; in recent years there has been a massive increase in the immigration of skilled health workers. In essence, this point goes hand in hand with the first requirement. Only if the nursing profession in Germany becomes attractive again in the long term can the dependence on foreign skilled workers also be reduced.

5.4 Redefine countries of origin in need of special protection

The WHO's new 2020 *'Health Workforce Support and Safeguards List'* reduced the list of countries of origin requiring special protection to 47. Given the methodology developed by the WHO in 2016 based on the SDGs, this is the wrong way to go. If the German government takes the SDGs and their indicators seriously, it should not poach skilled health workers from countries that fall below the critical level of 4.45 skilled workers per 1000 inhabitants. Based on this threshold, the Federal Government should draw up a new list and make it legally binding as an annex to Section 38 of the Employment Regulation.

On this basis, all recruitment in the Dominican Republic, India, Indonesia, Tunisia and Vietnam must be stopped, because these countries are below the critical threshold of 4.45 skilled health workers per 1000 inhabitants.

This would also be in line with the WHO 'Workforce 2030' strategy paper, which explicitly recommends not directly recruiting from countries with the lowest share of skilled health workers ('*not hiring directly from countries with the lowest health care worker–to-population ratios'*).[75]

5.5 Compensation for countries of origin

Educating a person in a health care profession costs a lot of money, first for schooling and then studying or training in nursing. These are investments made by the countries of origin, which in the end are left empty-handed. It would be right and necessary for the German

[74] WHO 2016: Global Strategy on Human Resources for Health: Workforce 2030. https://apps.who.int/iris/bitstream/handle/10665/250368/9789241511131-eng.pdf,

[75] WHO 2016: Global Strategy on Human Resources for Health: Workforce 2030. https://apps.who.int/iris/bitstream/handle/10665/250368/9789241511131-eng.pdf,

government to compensate the countries of origin for the poaching of skilled health workers - and to lobby at the WHO level for such compensation to become the global standard.

The form of such compensation would have to be decided on a case-by-case basis and with the involvement of those affected in the countries of origin. For example, it could be an obligation for the federal government to develop appropriate training capacities and/or support the health care system of the respective country.

To illustrate the scale of this: In Kenya, the training of a nurse, including preceding schooling, costs 43,180 US dollars.[76] According to a 2012 study, poorer countries lose around 500 million US dollars annually due to the emigration of skilled health workers. Since 1951, for example, the UK has saved the equivalent of 168 million US dollars - just by immigrating skilled health workers from Ghana.[77] According to the Nepalese Ministry of Health, Nepal trains 4000 medical graduates a year, but 3000 of them leave the country to look for work elsewhere.[78]

5.6 Protecting the recruited - putting a stop to dubious private intermediaries

In November 2020, Correctiv published research showing that many private intermediaries recruit skilled workers to Germany, often leaving the entire risk with the migrants.[79] In some cases, they have to sign adhesion contracts in which they commit to staying with the employer for at least five years, otherwise they would have to pay back up to EUR 15,000 in recruitment costs. In the Ärzteblatt, a labour lawyer very accurately described this as ‘modern bonded labour’.[80] Similar adhesion contracts were also documented by the ‘German Platform for Global Health’ using the example of Spanish care workers who were threatened with a payment of several thousand euros for the costs of the language course if they quit before 18 months had elapsed.[81] Very special problems arise in home care for the elderly, with sometimes terrible working conditions. This is why, for example, the Polish

[76] JM Kirigia (2006) The cost of health professionals’ brain drain in Kenya. BMC Health Services Research 6:89. https://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-6-89

[77] https://www.sciencedirect.com/science/article/abs/pii/S016885101200111X

[78] https://www.devex.com/news/who-seeks-equitable-answer-to-health-worker-shortage-94966

[79] https://correctiv.org/top-stories/2020/11/25/wie-dubiose-vermittler-auslaendische-pflegekraefte-zur-ware-machen/

[80] https://www.aerzteblatt.de/nachrichten/118678/Auslaendische-Pflegekraefte-Hinweise-auf-Knebelvertraege

[81] https://gesundheit-soziales.verdi.de/++file++58342bab7713b84060162e51/download/dpgg_paper_brain-drain_web.pdf

trade union federation OPZZ set up a counselling service for Polish female nurses in Germany in 2019.[82]

In order to better protect the skilled workers placed, poaching should in principle only take place within the framework of intergovernmental agreements and via the Public Employment Service.

[82] https://www.dgb-bildungswerk.de/migration/kein-arbeitsvertrag-kein-eigenes-zimmer