Brain Drain and International Recruitment of Health Workers

Germany's Contribution to a Global Health Scandal

The Challenge

Qualified health personnel is scarce. Worldwide. According to the World Health Organisation (WHO), the world currently faces a gap of 17 million health workers, of whom 2.6 million are medical doctors and 9 million nurses and midwives. In absolute numbers, the majority of the shortfall in health workers is in densely populated Asia – 6.9 million in total. But the situation in Africa, where there is a lack of 4.9 million health workers, is even worse. The WHO estimates that achieving the Sustainable Development Goals requires a minimum of 44.5 health workers (here: medical doctors, nurses and midwives) per 10,000 people. In 83 African, Asian or Latin American countries, the rate is below 22.8 health workers per 10,000. According to the WHO, all these countries – almost half of all countries worldwide – are in a state of severe health workforce crisis. In these countries, even the most basic health care services are in short supply for large parts of the population (Campbell, et al. 2013: p. 17f). The WHO extrapolates the current health work force trends into the future and can show that the situation will not change much until 2030, with the exception of Africa: there, the situation is worsening.

Empirical research has found that there is a robust association between health work force density and mortality and, in particular, infant mortality. Scientists from the University of Harvard have calculated that one additional medical doctor per 1.000 people lowers the infant mortality rates by 15 percent in the short run, and by 45 percent in the long run (Farahani et al. 2009: p. 1922). In the countries of the global south, the poorer strata of the population tend to be served by nurses rather than by medical doctors. A study from Brazil shows that the density of nurses has a much bigger impact on neonatal mortality than the density of medical doctors (Sousa, et al. 2013).

Health Worker Shortage and Recruitment from Abroad

The scarcity of health workers is a global phenomenon, with some national characteristics and a long tradition of health worker migration and health worker recruitment from poorer to richer countries (brain drain). Health workforce migration, whether fuelled by official recruitment programs, by refugees from armed conflicts or poverty or by migration is not a new phenomenon. The health systems of the UK, the USA and Australia have, for large parts, relied on a foreign workforce since the 1970s. Nowadays, almost all western nations train fewer health workers than they need for their own supply, or are unable to retain their health workforce in the country. Therefore, most countries in the global north recruit their health workforce from abroad, either tacitly or openly, via official recruitment agencies.

The global brain drain of health workers today has become a systemic problem and constitutes a global political determinant of health, understood as being part of the "transnational norms, policies, and practices that arise from political interaction across all sectors that affect health" (Ottersen, et al. 2014).

A few countries in the global south have accepted the challenge. For example, the Philippines and Indonesia train more health workers than they need for their domestic health systems and thereby serve the global labour market. The rationale behind this policy is mainly the remittances sent back by the emigrants to their families back home. According to the World Bank, a total of 28 billion dollars in remittances is fuelling the Philippine economy per year (World Bank 2016: 5). But the system is reaching its limits. Recently, the Philippine government highlighted the issue in an internal report: the ever-rising demand for nurses and the licensing of masses of private nursing schools has led to a "low quality of education among health professionals in the country" (DoH 2013). And, despite the vast training capacities, health workers in the Philippine are also in scarce supply, particularly in many rural regions. And, it is often the best ones who leave their country (DoH 2013). Finally, the Philippine government is giving higher priority to the export of labour and to the remittances than to the health services for the domestic and, in particular, the rural population.

The issue of health workforce migration has been on the international health agenda for a decade now. The WHO has dedicated the World Health Report 2006 "Working Together for Health" to the issue and, thereby, triggered an intense international debate. In 2010, all WHO member states, including Germany, adopted the "WHO Global Code of Practice on the International Recruitment of Health Personnel" in the World Health Assembly. The Code of Practice primarily urges all countries to train enough health workers domestically for their own needs. Only if this is not possible under specific circumstances does the Code also establish rules for recruitment from abroad.

Germany Fuelling the Brain Drain

In Germany, health workers and, in particular, nurses are also scarce. But, compared to the global south, on a rather comfortable level: Germany has 39 medical doctors and 115 nurses and midwives per 10,000 people (Statistisches Bundesamt 2014). However, the lack of nurses, often referred to as *Pflegenotstand* (in German), constitutes a serious challenge and will be further heightened in the near future. According to a study conducted by the Rheinisch-Westfälisches Institut für Wirtschaftsforschung and mandated by the Federal Ministry of Economic Affairs, a further 145,000 to 320,000 nurses will be needed by 2030 in Germany (Braeseke, et al. 2015: 65). The Federal Ministry of Health anticipates that, depending on the scenario and source, the additional requirements will range between 110,000 and 200,000 nurses (BMG 2016) by 2025. According to a survey by ver.di, German hospitals currently lack 162,000 workers, 70,000 of whom are nurses (ver.di 2016). Regardless of how one looks at this situation, Germany will need several 100,000 health workers in future, and this constitutes a serious threat for the health systems of the source countries. On the one hand, this is already affecting the health systems in Poland or Romania, the biggest source countries at the moment, and, on the other hand, countries such as Bosnia-Herzegovina, Serbia, Tunisia or Vietnam, where the German government is in the initial active recruitment programme stage.

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. The interdependence between increasing life expectancy and rising demand for care and nursing services is not as clear as intuitively assumed. In Germany, the evidence rather points to the Compression of Morbidity Theory, which means that increasing life expectancy is rather achieved by the extension of phases in good health. But, this is true for the higher income groups in particular. In Germany, high-income earners, on average, live 10 years longer than low-income earners (women: 8.4 years, men: 10.8 years). The difference in respect of life expectancy in good health is even higher: almost 14 years on average, with 13.3 years for women and 14.3 years for men (Lampert & Kroll: 2014: 3). Therefore, the impact of increased life expectancy on the health system rather depends on the degree of social inequality and is, by far, not simply determined by the average lifespan. The second challenge comes from the generation of so-called baby boomers from the strong age groups born between 1955 and 1968. In 2020, the first of these will reach retirement, and this will clearly put additional stress on the German health system, the elderly care services and the social security systems.

However, Germany is already suffering from a dramatic shortage of nurses, which cannot simply be explained by the baby boomers, as they are still in the labour market. The causes of this so-called *"Pflegenotstand"* are homemade and rooted in the health policy reforms of the last two decades. These reforms have been driven by market-based principles. Thus, since 2007, private as well as public hospitals have been financed by case-based lump sums based on diagnosis-related groups (DRG). But, at the same time, the rigid formalities and tight financing corridors (e.g. the Landeskrankenhauspläne) are preventing the establishment of market-conform salary scales, i.e. salary levels which would bring the demand and the supply of labour into balance. Instead, 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, insurance agencies and the pharmaceutical industry.

As a result of these health care reforms, we now see highly profitable private hospitals, on the one hand, and, on the other hand, the nursing profession suffering from continuously worsening working conditions. The working conditions of nurses in Germany have deteriorated to such a degree that countless domestic nurses have now quit their jobs. The shrinking salaries – often achieved via the cancellation of collective regional labour agreements – go hand in hand with increasing workloads and additional bureaucratic tasks. In Germany, nursing has lost so much of its former appeal. Thus, employers and the federal government are desperately looking for labour from abroad, assuming that migrants will be more willing to accept a deterioration in the working conditions.

Since 2012, the German government has engaged in the active recruitment of the health workforce and, in particular, of nurses from abroad. Ironically, this has happened just two years after Germany voted for the adoption of the WHO Code of Practice for the International Recruitment of Health Personnel. The activities of the Federal Government are targeting countries in the East and the South. Nurses from the Philippines, Vietnam, Serbia and Bosnia-Herzegovina are being recruited by the Deutsche Gesellschaft für

Technische Zusammenarbeit (giz) and, in China, the recruitment is organised in direct cooperation with the Employers' Association for Nursing (Arbeitgeberverband Pflege, AGVP). Further recruitment activities are taking place through the European-Employment-Services (EURES) and job-fares in the crisis-shaken EU countries of Spain, Italy, Greece and in the EU countries of Eastern Europe.

In November 2013, German immigration laws were changed in order to allow nurses to access the German labour market. 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, at least in West Germany. With respect to the WHO Code of Practice, the active recruitment of nurses abroad is restricted to those countries not suffering a severe health workforce shortage themselves. It is jarring and incoherent that this restriction only applies to nurses, but not to medical doctors.

According to the current laws, the active recruitment of a nurse from a crisis country, such as India or Kenya, may cost the employer, or the recruitment agency, a fine of up to EUR 30,000. However, the freedom of individual migration is not restricted to an Indian or Kenyan nurse. The prohibition only refers to active recruitment. This may sound inconsequential, but is in compliance with the WHO Code of Practice. Paragraph 3.4 states that "nothing in this Code should be interpreted as limiting the freedom of health personnel, in accordance with applicable laws, to migrate to countries that wish to admit and employ them" (WHO 2010, § 3.4). With regard to the current debate about work permits for refugees, this also means that the WHO Code of Practice is not hindering faster access to the German labour market.

Experiences of Foreign Nurses on the German Labour Market

Often, the nurses from within and outside Europe enter the German labour market with high expectations. But, ultimately, they find themselves working in a sector which has already been vacated by many of their domestic colleagues. As a result, an employer recruiting nurses from abroad also needs to find strategies to retain them. In terms of human resources management, this is highly challenging and requires e.g. concepts of diversity management, which are still under developed in the health sector.

Some employers also rely on unfair business practices to retain their newly-recruited nurses. The Company for Intensive Care (Gesellschaft für Intensivpflege mbH, GIP) has issued adhesion contracts, which have forced nurses to stay for at least 18 months. Should a nurse resign prematurely, he or she is obliged to pay back several thousand euros for their initial language training – despite the language training being subsidised by EU funds and by programmes run by the Federal Government. This raises a suspicion of subsidy fraud. The German trade union for service providers, ver.di, made these "modern forms of debt bondage" (Kreysler 2014) public, which ultimately resulted in the GIP cancelling its recruitment program from abroad. Another example of the failed attempt to recruit nurses from abroad can be seen in the private Asklepios hospitals in Hamburg. This project recruited nurses from Tunisia, but collapsed in 2013, because the employer claimed compensation to the tune of EUR 19,000 from each nurse for the costs incurred (Berger 2013).

These stories show the importance of public or legal control in this sector. Compliance with legal and ethical standards needs to be assured against private purely economic interests to lower costs. Nevertheless, the Federal Ministry of Economic Affairs – a major player in the current debate – claims that the first pilots for recruitment via public entities, such as the GIZ, comes at a very high cost. Harald Kuhne, the Director of the Central Department, suggests that the private sector should take control of the initiative instead (Güllemann 2014). Such statements raise fears that ethical standards are vanishing as regards recruitment from abroad. Moreover, further cycles of shrinking salaries, the violation of labour rights and the deterioration of working conditions are to be expected.

Another important aspect of the health workforce migration is the question of cross-border compensation for the cost of training. Open access for qualified health workers to the labour markets in the north is shifting costs for training to the source countries. This, in turn, is leading to economic distortions, which should be mitigated by compensation in the form of transfers from the destination countries to the training systems of the source countries. When the WHO Code of Practice was discussed, southern countries and civil society organisations campaigned for such compensation however, without success. Instead, the WHO Code of Practice suggests extending technical assistance. This mainly serves the interests of the development industry. The issue of compensation needs to

be returned to the international health agenda in the interest of all parties concerned (apart from the development industry).

In summary, the recent German attempts to recruit more nurses from abroad have put the nursing profession and their working conditions under further pressure. Consequently, instead of being resolved, the current root problems of the nursing sector are being aggravated and pushed into a downward spiral.

Action or Reaction?

The central monitoring instrument of the WHO Code of Practice is the tri-annual reporting by member states. In May 2016, the World Health Assembly held the member states accountable for the second cycle of code implementation (2013 - 2015). Germany's response to the central question as to whether "your country strives to meet its health personnel needs with its domestically trained health personnel" (WHO 2016) comes with a reference to the statutory minimum wage for nurses, but without including any further details. In the reporting period, the statutory minimum wage for nurses in West Germany was between EUR 9.00 and 9.40, and, in the East, between EUR 8.00 and 8.65. This is only slightly higher and partly lower than the general statutory minimum salary of EUR 8.50, which also covers unskilled labour. Nevertheless, the Federal Government reports the minimum wage as a central measure for training and retaining more domestically-trained nurses. (WHO 2016: 4, 10)

The second measure that the report mentions is a campaign for enhanced qualifications, with the third one being more flexible and family-friendly working hours in the nursing sector (ibid.). Given that the attractiveness of the nursing profession is under heavy pressure in Germany, these measures are a mere kludge and cannot be taken as serious. Any effective strategy aimed at combating the nursing shortage initially needs to take into account the salary level and, secondly, the working conditions. This needs to be improved in order to allow nurses to deliver a proper job instead of just managing the day-to-day routine chaos. Trade unions and organised nurses are engaged in the struggle for better working conditions. For years, the ver.di trade union has stipulated mandatory safe and effective staffing levels for in-patient care. Recently, the nursing personnel of the Berlin-based hospital Charité was able to negotiate a collective agreement to include such safe and effective staffing levels, but – and this cannot be emphasised strongly enough – only after years of having pursued a fierce labour dispute. In doing so, the Charité has already become a role model for labour disputes in other hospitals.

These, and other examples illustrate: if the working conditions of nurses are to be increasingly determined by a health system based on competition and profits, the nurses start to organise and to fight for themselves. However, deteriorating working standards and shrinking salaries are still negatively impacting on the attractiveness of the nursing profession and, in particular, on the meaningful and satisfying aspects that it formerly possessed.

Call for Action

The German Platform for Global Health calls upon the Federal Government to engage in increasing the attractiveness of the training 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 nursing. Decent work in nursing is not only a necessity for the nurses and their patients, but, in the long run, they are a valuable contribution towards combating the brain drain of health workers and strengthening health systems in the countries of the global south. We call upon the Federal Government:

a) to adapt the legal framework of the self-governed German health system in order to give the interests of nurses and other medical professions more influence and more weight in the relevant boards and committees.

b) The concerned ministries should elaborate and implement sustainable strategies for human resources development in close cooperation with the special interests groups and trade unions representing nurses. These strategies should aim at increasing the attractiveness of the nursing profession and work places in Germany in order to mitigate the need for the cross-border recruitment of health workers.

c) 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.

d] Germany needs to adapt the essential elements of the WHO Code of Practice and incorporate these into its national legislation. In particular, this refers to:

- measures for sustainable human resources development in health, with particular focus on needs-based minimum staffing levels for health personnel in nursing.

- The existing ban on the active recruitment of nurses from one of the 57 crisis countries should be extended to other health professions, and to medical doctors in particular.

e] We call upon the Federal Government to use its influence at the international level and, particularly within the WHO, to campaign for the reimbursement of the training costs incurred by the source countries providing health personnel.

f] The recruitment of nurses from abroad should only occur within the framework of bilateral agreements and through the ZAV (Zentrale Auslands- und Fachvermittlung) or through certified agents. We welcome the bilateral agreement for the recruitment of nurses which the Federal Government has signed with the Philippines, and we suggest using this agreement as a model for other countries (Ramm & Güllemann 2013).

g] 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.

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German Platform on Global Health

In 2011, several German civil society health care actors formed a platform for global health with the objective to raise public awareness for the close links between global and local health-influencing factors in view of the increasing internationalisation of living conditions and, to pool existing efforts and to participate in the German decision-taking process. The platform, which is composed of trade union members, social organisations, development and migration policy organisations, scientists as well as social projects and movements, does not consider itself a new health or development lobby group but an interdisciplinary initiative that aims at bringing the social conditions for health more sharply into the focus of national and international discussions about health. Moreover, the platform wants to strengthen national and international initiatives and help to overcome the still existing discrepancy between domestic and global health policy.

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Individual health is largely determined by social conditions. Consequently, health needs to be part in all policies. We dedicate this series to Rudolf Virchow, a famous German physician and politician of the 19th century and an early promoter of the social determinants of health. According to Virchow "policies are nothing but medicine on large scale".

Unterstützer:

- **GandHI**
- **ippnw**
- **medico international**
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