

# WORK → INT



Assessing and enhancing integration in workplaces

## RESEARCH REPORT

# WORKPLACE INTEGRATION OF MIGRANT HEALTH WORKERS IN GERMANY

**Qualitative findings on experiences in two Hamburg hospitals**

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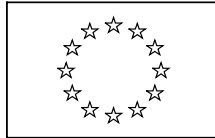
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## 1. Introduction

### 1.1 General design and research objectives

In the last decade, the healthcare sector in Europe has undergone growing labour shortages, which have been increasingly filled by international migrants, although with significant differences according to the various national contexts. Institutional and regulatory framework of the national health systems, highlighted shortages of national staff in the health sector, national policies aimed at filling them and at regulating the recognition of educational and professional titles of EU and non-EU migrant health workers (MHWs) and their access to the health labour market vary sensibly according to the different European countries (see Background national reports). As a result, non-EU and EU MHWs contribute to different segments of the health industry, with highly varying degrees of integration into this sector<sup>1</sup>, according to the different European contexts.

While most of the studies on the economic integration of migrants into the European labour market and its impact on the broader society has been mostly concentrated on the macro level, mainly using quantitative approaches, little empirical evidence is available on the micro-level, namely in workplaces. However, the contexts where the integration into the receiving economies and the interaction between immigrant minorities and native majorities take place and can be primarily tackled is within firms and specific workplaces.

Furthermore, the research available on the foreign labour force in European countries has been mainly focused on the supply side, i.e. on the analysis of the processes and outcomes of insertion of immigrant workers in European labour markets, while the perspective of the demand, i.e. of employers, but also the concurrent role of other relevant actors, such as trade unions, professional associations and other civil society organisations has been generally downplayed. The latter are key actors in the dynamics of labour market integration of migrant workers at different levels and their perspective and role need to be integrated more systematically in the study of migrants' integration in workplaces.

The WORK-INT project aims at contributing to the broader scientific debate on the labour market integration of migrants in the health sector in Europe, by adopting a research approach, which is *qualitative*, i.e. allowing in-depth insights on the phenomenon; *micro-level*, i.e. taking workplaces (hospitals) as a main context of analysis; and *multi-stakeholder*, where the role, the perspective and the professional and inter-personal relations are taken in consideration according to the different involved actors (employers, national, EU and non-EU employees, trade unions, professional associations, etc.).

The MHWs' integration at a workplace level was studied, in particular, as based on four main dimensions (Zincon 2009): the *systemic dimension* (health care firms' policies or specific measures concerning the recruitment and integration of MHWs and impact of MHWs on the competitiveness and efficiency of health care services); the *individual dimension* (subjective wellbeing, perception and degree of satisfaction of own integration within the workplace, etc.); the *relational dimension* (considering horizontal and vertical relations,

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<sup>1</sup> See Villosio 2015 for a comparative statistical analysis on Migrant Health Workers in the health sector in the 5 target European countries, based on Eurostat Labour Force Survey (EU-LFS) data.

i.e. with colleagues in equal and higher/lower positions); the *transnational dimension* (declined as the ties with the health workers' community in the country of origin and/or in other countries, the contribution to the origin country as a professional while abroad and the intentions to return as a health worker in the country of origin or to re-migrate elsewhere).<sup>2</sup>

The WORK-INT research is an EIF-EU Commission funded project aimed at assessing and analysing the integration of immigrant workers in private and public health structures (hospitals) in five European countries: Ireland, Germany, UK, Spain and Italy.<sup>3</sup>

As a first step, background reports were prepared in each target country, with the objective of providing an overview of: the institutional and regulatory framework of the health system in each target country; the shortages of national staff in the health sector and the national policies aimed at filling this gap; the active admission policies of non-EU MHWs; the policies regulating the recognition of educational and professional titles of EU and non-EU MHWs; the regulations concerning the access of MHWs to the health labour market in each country.<sup>4</sup>

As a second phase, a fieldwork research was undertaken in 5 medium-large European cities hosting large numbers of migrant workers: Dublin, Hamburg, Oxford, Madrid and Turin<sup>5</sup>. In each city two health structures (hospitals) were selected as case studies. Managers, human resource officers, non-EU/EU/national workers were interviewed using a common protocol of research, including common qualitative guides for interviews for national/foreign workers, managers and other stakeholders.

## 1.2 Migrant workers in the German healthcare sector

The German healthcare sector is characterized by a stable labour market, which was barely affected by the economic crisis in 2008. Unemployment in the sector is significantly lower than in the overall economy, with nurses and doctors exhibiting the lowest rates (Eckert 2011). The sector thus offers good employment opportunities for national and migrant workers. In fact, more and more foreign nationals work in the German healthcare sector since the 2000s. According to Microcensus data, their share increased from 4.7 per cent to 5.4 per cent from 2005 to 2012, when 150,000 foreign nationals were working in the healthcare sector (Kovacheva and Grewe 2015).<sup>6</sup> Even though the share of foreign nationals in the healthcare sector is still

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<sup>2</sup> For further details, please see Castagnone and Salis, 2015.

<sup>3</sup> For further information, see: [www.workint.eu](http://www.workint.eu)

<sup>4</sup> All reports from the WORK → INT project can be downloaded here: <http://www.work-int.eu/research-materials/>

<sup>5</sup> In each city, the study was undertaken by a local research institution, which is partner of the WORK-INT project: FIERI in Turin, COMPAS in London, Universidad Complutense de Madrid in Madrid, Hamburgisches WeltWirtschafts Institut in Hamburg, Trinity College of Dublin in Dublin. The project includes also a policy dialogue component, coordinated by the IOM Regional Office in Bruxelles.

<sup>6</sup> Data refer to health service occupations (*Gesundheitsdienstberufe*) that are directly related to the provision of health services such as doctors and nurses. So-called social occupations such as elderly care nurses and health crafts persons are not included.

below their share in the total working population (9.3 per cent in 2012), both absolute and relative numbers are on the rise, pointing to their increasing relevance for the health economy (Kovacheva and Grewe 2015). Moreover, the role of migrants becomes more visible when total employment of foreign born in the healthcare sector, including those with German citizenship, is considered.<sup>7</sup>

Despite rising numbers of migrant workers, the German healthcare sector suffers severe labour shortages. According to forecasts, the need for qualified labour will further increase in the future, particularly for doctors, general nurses and elderly care nurses. Migration of health professionals to Germany is debated as a measure for addressing the need. Beyond that, better integration of migrants is widely accepted as a measure with great potential to address labour shortages particularly in the long run (BMAS 2015). In line with this stance, the regulatory framework for migration and recognition of professional qualifications has been liberalised in the 2010s, with the aim of facilitating recruitment and employment of migrant professionals in the German healthcare sector. The Blue Card introduced as a new residence title in 2012 has created better options for migration of medical doctors and the inclusion of nurses in the so-called White List with shortage occupations in 2013 has improved the migration opportunities for healthcare occupations with vocational training.<sup>8</sup> The Recognition Act of 2012 enhanced the chances for recognition of foreign professional qualifications (Finotelli 2014).

Beside admission policies, firm-level policies and practices affect integration of migrant professionals in the workplace, but comparatively less attention has been paid to this topic. The report is aimed at contributing to this field of research, by exploring experiences with workplace integration of migrant doctors and nurses in hospitals. Hospitals were selected as workplaces employing most of the foreign health workers in Germany and having a broader occupational structure than other healthcare facilities such as medical practices or care homes.<sup>9</sup> Case studies in two hospitals in Hamburg were carried out between May and November 2014. Qualitative interviews were conducted inside the workplaces with migrant workers, mainly doctors and nurses, managers and works councils' representatives (*Personal- und Betriebsräte*), and outside the workplaces with relevant stakeholders such as policy makers, representatives from trade unions, professional associations and counselling centers at local and state level. During an expert workshop on 20 March 2015 research findings and policy implications were presented and discussed with relevant stakeholders.

The report presents results from the qualitative study in Hamburg. It starts with a description of the field work and the interviews carried out. As integration is influenced by individual action and systemic opportunities, workplace integration is studied at two levels, individual and systemic. Based on interviews with hospital managers and works councils' representatives, an appraisal of the systemic integration at the organisational

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<sup>7</sup> Although no statistics on workers in the healthcare sector by country of birth is available, it can be assumed that the number of naturalized persons employed in the sector is not negligible.

<sup>8</sup> In contrast to many countries where nurse education is completed at universities, nurse qualification in German is obtained in vocational training programmes.

<sup>9</sup> Data on employees subject to social security contributions show that in 2013, 46 per cent out of the 160,057 foreign employees in the healthcare sector were employed in hospitals compared to only 42 per cent among German nationals (Federal Employment Agency 2014a).



level in the two hospitals is given. For this purpose, the report explores the presence of migrant workers in the hospitals, recruitment policies and support measures targeting migrant workers and their perceived role for the workplace. Furthermore, interviews with migrant doctors and nurses give an insight into perceptions of individual workplace integration. The process of migration and access to practice the profession in terms of general labour market access, recognition of qualifications and job access is studied. After that, experiences at the workplace in terms of induction and adaptation, working conditions and relationships, and career plans are analysed. Finally, key lessons learnt from the case study about workplace integration of migrant health workers in Germany are summarised and implications for policy and practice for enhancing workplace integration are discussed.

## 2. Methodology

### 2.1 Field work

Various statistical sources present Hamburg as a multicultural city. The share of persons with migration background, foreign nationals and persons with own migration experience, are much higher than at federal level (see table 1). In 2013, 14.5 per cent of the population in Hamburg had a foreign nationality and 27.7 per cent had a migration background, meaning that the person or at least one of his or her parents migrated to Germany or has a foreign nationality. In contrast, 9.5 per cent of the total population in Germany was of foreign nationality and 19.7 per cent of a migration background. About two-thirds of the population with migration background has own migration experience, with Hamburg displaying a slightly higher share (67.5 per cent) than Germany (65.9 per cent).

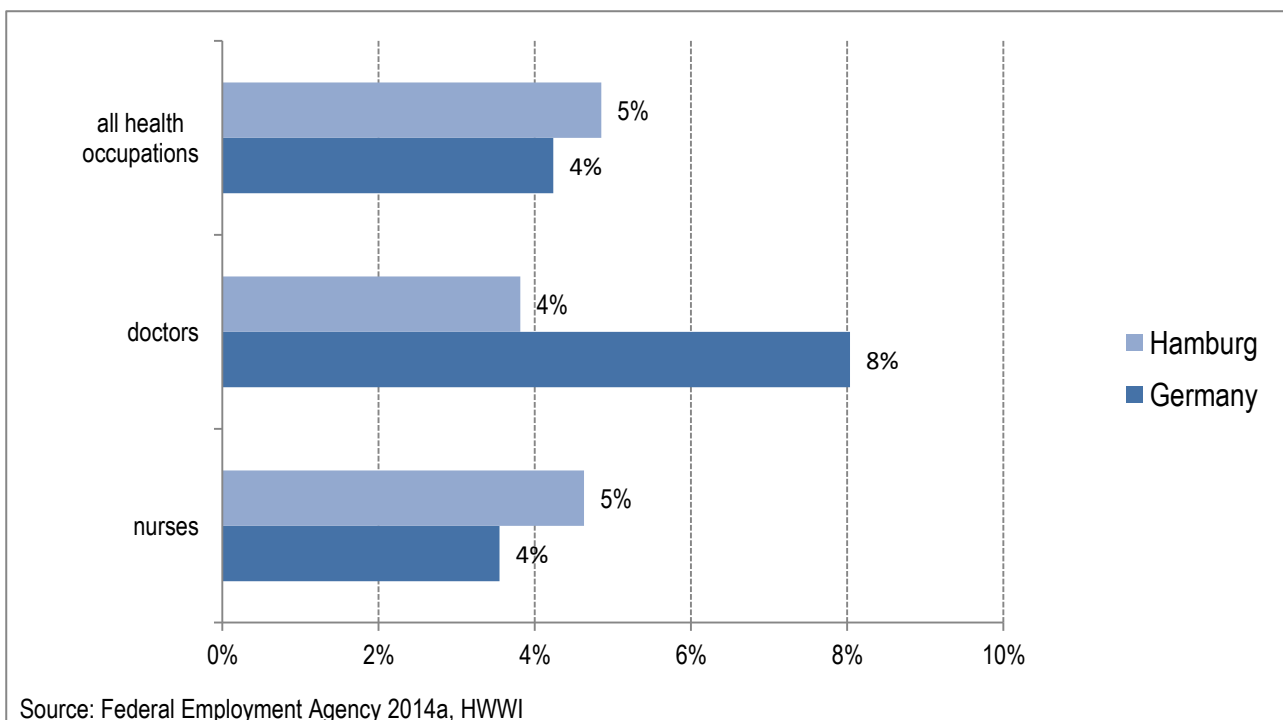
**Table 1 Migrant population in Germany and Hamburg in 2013**

	Germany	Hamburg
Total population	80,611,000	1,744,000
Foreign nationals	7,634,000	253,000
<i>In % of total population</i>	9.5 %	14.5 %
Persons with migration background	15,913,000	483,000
<i>In % of total population</i>	19.7 %	27.7 %
Persons with own migration experience	10,490,000	326,000
<i>In % of total population with migration background</i>	65.9 %	67.5 %

Source: Data on foreign nationality from Federal Statistical Office (2014a), data on population with migration background from Federal Statistical Office (2014b).

As a background report for Germany prepared for the WORK->INT project revealed, contrary to the overall trend at federal level, the healthcare sector in the 1.7 million inhabitant city of Hamburg currently does not face shortages of doctors, but shows signs of shortages in nursing (Kovacheva and Grewe 2015). It is assumed that competition for jobs in non-shortage occupations, such as doctors in Hamburg, is strong, thus reducing the chances of foreign-trained persons to find a job. In line with this expectation, data on employees subject to social security contributions showed that in 2011, the share of foreign doctors in Hamburg was much lower than at federal level and amounted to 4 per cent as opposed to 8 per cent for Germany (see figure 1). By contrast, the share of foreign nationals in nursing occupations in the city state was slightly higher than at federal level.

**Figure 1 Share of foreign nationals in employees subject to social security contributions in 2011, by occupation**



In 2014, there are 52 hospitals in Hamburg. The share of private commercial hospitals is much higher in Hamburg than at federal level: 71 per cent versus 35 per cent. 24 per cent of Hamburg’s hospitals are non-profit and only 6 per cent public (Federal Statistical Office 2014c). About 31,000 persons are working in hospitals in Hamburg in 2013 (Federal Statistical Office 2014c). With 17 per cent, the share of medical staff was higher in Hamburg than at the federal level of 14 per cent. Two hospitals were selected for the case study:

a public hospital, the University Medical Center Hamburg-Eppendorf, and a private hospital cluster of eight hospitals spread over the city, Asklepios.<sup>10</sup> With 9,400 workers in the public hospital and about 13,000 workers in the private hospital group, they are the biggest hospitals in Hamburg and a high incidence of migrant workers can be expected.<sup>11</sup>

Following the common interview guideline of the project, a German version of the guideline was prepared. Being interested in workplace integration as a process, migrant workers were asked about their experiences with migration, access to practice the profession in terms of general labour market access, recognition of qualification and job access, experience in the workplace in terms of adaptation in the initial phase of employment, working conditions and relationships, and career plans related to retention in the workplace and migration intentions. Managers and works councils' representatives were asked about presence and perceived role of migrant workers as well as policies and measures related to recruitment, utilization and retention of migration workers. Stakeholders outside the hospitals were interviewed with the aim of learning more about the healthcare sector in general and specific obstacles of integration of migrant workers in the workplace in particular.

Access to the field was organised by contacting general managers in both hospitals and asking for permission to do field work. Works council' representatives and managers were contacted directly, whereas the vast majority of the migrant workers were accessed with the help of managers. Managers provided contacts of potential interviewees, who were then contacted individually by the research team and asked whether they wanted to participate in the study. The willingness to participate was high. Only few refused to participate. Two interviews that were used as test interviews for the interview guideline were organised *via* private networks.

Most interviews were conducted face-to-face with the exception of some expert interviews on the phone. The interviewees could choose the place of the interview. Most interviews were held in the workplace of the interviewees, only few in the office of the research team and two at the home of the interviewees. Interviews were between 45 minutes and 2.30 hours long and were recorded.

Except from interviews with external stakeholders, all interviews carried out in hospitals were anonymised. Protocols of all interviews were prepared and selected quotes were literally transcribed. In the report, interviews are referred to by a code, including an abbreviation of the respective occupation and the number of interview: doctors (DOC1, DOC2 etc.), nurses (NUR, NUR2, etc.), researchers (RES1, RES2, etc.), managers (MAN1, MAN2, etc.), works councils (CON1, CON2, etc.) and external stakeholders (EXT1, EXT2, etc.).<sup>12</sup>

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<sup>10</sup> Field work was done in three out of eight hospitals.

<sup>11</sup> It was originally envisaged to compare experiences of private and public institutions with workplace integration of migrant workers. As the case studies show no particular differences that can be attributed to the legal form of the hospital, the results are presented for the hospitals in general. When aspects refer only to one of the hospitals, we refer to this individual hospital explicitly.

<sup>12</sup> See list of interviews in Appendix.

## 2.2 Sample description

After a long phase of establishing and negotiating contacts with managers in charge, the interviews were organized in a short period of time. Between May and November 2014, 48 interviews were carried out: 21 in the university hospital, 18 in the private hospital and nine with representatives of trade unions, professional associations, local policy makers and counselling centers outside the hospitals (see table 2).<sup>13</sup> In the hospitals, seven interviews with managers, who represent different departments within the hospitals (general managers, human resource managers (HR managers) or managers in charge of special groups such as guest researchers and guest doctors and trainees) and four interviews with representatives of the works councils representing employees in the hospitals, were carried out.<sup>14</sup> Twenty-eight migrant workers were interviewed: half of them in academic (doctors and researchers) and the other half in non-academic occupations (nursing professionals and medical assistants).

As initially envisaged, most of the interviewed migrants were doctors and nurses. During the field work, two further occupational groups were included in the sample. By getting access to interviewees indirectly through managers, contacts to some medical assistants were established and interviews correspondingly conducted. As medical assistants obtain their qualification in vocational training programmes as nurses, medical assistants and nurses were grouped for the further analysis. Furthermore, due to the high share of migrant workers holding research positions in the university hospital, researchers were also included in the sample.

**Table 2. General overview of interviews**

Interviews by occupation	University hospital	Private hospital	Total number
Doctors	5	5	10
Researchers	4	0	4
Nurses	3	9	12
Medical assistants	2	0	2
<i>Total number of interviews with migrant workers</i>	<i>14</i>	<i>14</i>	<i>28</i>
Managers*	4	3	7
Works councils' representatives*	3	1	4
<i>Total number of interviews in hospitals</i>	<i>21</i>	<i>18</i>	<i>39</i>
External stakeholders	-	-	9
<i>Total number of interviews</i>			<i>48</i>

Source: Field work in Hamburg, own compilation.

\* The interview was conducted with two persons in charge, but is counted as one interview in the table.

<sup>13</sup> We thank all persons who supported our study: the managers who made the access to the hospitals possible, all employees and external experts who shared their experiences and visions with the team. We thank also Dita Vogel and our project colleagues for helpful comments and suggestions.

<sup>14</sup> The works council (*Betriebsrat*) is an elected body of employee representatives in private enterprises that has legally prescribed rights of co-determination, information and consultation. The works council in public services is called *Personalrat* and corresponds to the function of the works council in private enterprises.

Considering the main demographic characteristics of migrants (see table 3), the sample is dominated by women (60 per cent). Whereas the group of doctors was gender-balanced, women prevailed among nurses. The average age of the interviewees at the time of interview was 40 years. At the year of migration, the age of interviewees averaged 26 years. Migrants in an academic occupation moved to Germany on an average age of 29 years whereas those in a non-academic occupation moved younger, with 23 years. With regard to the year of entry, five migrants came to Germany before 1990, seven between 1990 and 2000 and 16 after 2000. Six interviewees are recent migrants who migrated in the last three years.

**Table 3. Main characteristics of migrant interviews**

Gender			Age			Year of migration		
	Abs.*	In %		Abs.	In %		Abs.	In %
Male	11	39%	<34	8	29%	<2000	12	43%
Female	17	61%	35-44	10	36%	2000-2010	10	36%
Total	28	100%	>45	10	36%	>2011	6	21%
Country of birth			Nationality			Foreign qualification in the field of healthcare		
	Abs.	In %		Abs.	In %		Abs.	In %
Germany	1	4%	German	13	46%	Doctors/Researchers	12	86%
EU	9	32%	EU	9	32%	Nurses/ Medical assistants	9	64%
Non-EU	18	64%	Non-EU	6	21%	In % of all interviewees	22	79%

Source: Field work in Hamburg, own compilation.

\* Abbreviation: absolute number.

As own migration experience was the main prerequisite for interviewing, all interviewees were persons who moved to Germany as adults. We, therefore, refer to them as migrants irrespective of their nationality. Interviewees originate from 22 different countries: six EU member states (Bulgaria, Greece, Italy, Poland, Portugal and Spain) and 16 non-EU countries (Afghanistan, Argentina, Armenia, Australia, Bosnia-Herzegovina, China, India, Indonesia, Iran, Macedonia, Russia, South Korea, Syria, Tunisia, Turkey and Ukraine). One interviewee was born in Germany but grew up in the country of birth of her parents and returned aged 22 to Germany, thus fulfilling the criterion for an own migration experience. Almost half of the interviewed migrants are German nationals (13). Slightly more than half are foreign nationals (15): nine nationals of EU member states and six nationals of non-EU countries.

With regard to the origin of their qualifications, most interviewees obtained their qualification abroad and moved to Germany as qualified workers in the healthcare field or related fields as biology. A difference was found between doctors and nurses. Whereas almost all doctors but two migrated with a university degree in medicine, four nurses and one medical assistant migrated without relevant qualification and did vocational training in Germany. Remarkably, five persons who already possessed foreign qualification obtained

qualification in the healthcare field also in Germany. Except from two persons pursuing vocational training in nursing and a doctor carrying out internship training, all interviewees had already completed their training and were hospital employees at the time of interview.

### 3. Systemic integration in the workplace

Based on statistical data on foreign employees in the two hospitals and interviews with managers and works councils' representatives, the process of systemic integration in the workplace is analysed. At firm level, the following aspects give insights into the systemic integration of migrant health workers: their presence in the hospitals, recruitment policies and support measures targeting foreign-trained workers and the perceived role of migrant employees for the workplace.

#### 3.1 Presence of migrant workers

The University Medical Center Hamburg-Eppendorf is one of 35 university hospitals in Germany. As a university hospital, it is the teaching hospital of the University of Hamburg and a hospital offering a broad range of medical services for patients. It is a public body and comprises 14 departments divided in more than 80 clinics and institutes. In the 2000s, several subsidiary companies with limited liability were established and services outsourced, for instance, cleaning, gastronomy and logistics, and medical services in specialty fields as cardiology and prostate cancer. The hospital has a capacity of 1,345 beds in the core university hospital, 196 beds in the university heart centre and 58 beds in the prostate cancer centre. Workers in the public body and the private subsidiary companies are represented by different works councils. Furthermore, as a particularity of a university hospital, there are two separate works councils in the public body for the academic staff (e.g. doctors and researchers) and for the non-academic staff (e.g. nurses).

In 2013, the university hospital was staffed by 9,440 employees in both the public body and its subsidiary companies (UKE 2014). 1,550 foreign nationals in 2014 corresponded to 16 per cent of the workforce.<sup>15</sup> No data by individual nationalities was available, but a hospital manager pointed out a large group of persons of Turkish and Afghan origin (MAN2). With regard to their occupations, foreign nationals are mostly represented in medico-technical professions (20 per cent of all foreign nationals), cleaning and related domestic services (19 per cent) and other occupations such as researcher (30 per cent). Seven per cent of the foreign nationals are medical doctors and 12 per cent nurses, with 3 per cent of them being highly specialized nurses. Only 3 per cent work in the administration.<sup>16</sup>

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<sup>15</sup> This is an authors' calculation. Data on foreign nationals for 2014 stem from a special evaluation of internal statistics provided by a HR manager. The total number of workers in 2013 of 9,440 in 2013 stems from an official report of the hospital and includes all workers in the public hospital and its subsidiary companies (UKE 2014).

<sup>16</sup> The share of foreign nationals in individual occupations could not be calculated due to missing data.

The private hospital group Asklepios comprises eight independent hospitals in the city state of Hamburg, with a capacity of more than 5,100 beds.<sup>17</sup> Being part of the former state hospital company *Landesbetrieb Krankenhäuser*, these hospitals were public until 2004. After their privatisation, nowadays, 74.9 per cent are private and 25.1 per cent are still public. Besides the eight hospitals providing medical services, several other private enterprises belonging to the hospital group provide further medical and non-medical services as cleaning services and clinical research. Each hospital is independent and has extensive financial autonomy and own management and personnel structures. In each hospital, workers are represented by a works council.

12,800 workers were employed in the private hospital group in 2012.<sup>18</sup> Seven per cent of them were foreign nationals, and an approximately equal share consisted of naturalized immigrants so that, in total, 14 per cent of the workers were born outside Germany. With 62 per cent of the foreign workers, non-EU nationals outnumbered EU nationals. The five most represented nationalities were Turkey, Poland, Portugal, Italy and Austria. Data by country of birth including naturalized persons point to an even higher share of persons born in a non-EU country (69 per cent). The first five countries of birth were Poland, Turkey, Russia, Kazakhstan and Bosnia-Herzegovina.<sup>19</sup>

With regard to main occupations, the highest share of foreign nationals was found among non-medical occupations (16 per cent of the employees), followed by other medical occupations such as nurses (five per cent) and doctors (four per cent). Data by country of birth provided a similar picture: foreign born were 23 per cent of the employees in non-medical occupations were, 13 per cent of those in other medical occupations and 12 per cent of the doctors.

Asked about the presence of migrant workers in the hospitals, general managers in both the private and the public hospitals emphasised repeatedly the good labour supply in the healthcare sector in Hamburg and stated that the presence of migrant workers is not associated with labour shortages which have to be met (MAN2, MAN5). They further argued that labour shortages in the healthcare sector differ among German states and Hamburg is less affected compared to other German states.<sup>20</sup> The privileged situation in Hamburg is attributed to the attractiveness of the city and the good reputation of the hospitals with their specialized infrastructure and multiple career opportunities.

According to a hospital manager, most migrant workers take up employment in the hospital after several years of residence in Germany and only a few recent migrants, who migrated for labour purposes, are hired (MAN5). Also among trainees, there are more persons who were born or grew up in Germany than those with personal

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<sup>17</sup> Authors' calculation of bed capacity is based on administrative data from Behörde für Gesundheit und Verbraucherschutz (2014).

<sup>18</sup> Data on employees were provided by a hospital manager.

<sup>19</sup> Shares by nationality and country of birth show a more comprehended picture of the presence of migrant workers in the workplace and thus the advantages of evaluation by both features. The diverging ranking of countries by nationality and country of birth could be explained by different naturalisation behaviour of migrants from individual countries.

<sup>20</sup> Two indicators are considered in the assessment of labour shortages: the job vacancy duration and the number of unemployed workers in relation to the number vacant positions (job vacancy-unemployment ratio). Relevant data on vacant positions and unemployment are collected by the Federal Employment Agency at state level and published in reports (Federal Employment Agency 2014b).

migration experience as adults (MAN4, MAN6). Correspondingly, direct migration of foreign-trained workers plays rather a subordinate role for the hospitals and many migrant workers possess German qualification that distinguishes them from foreign-trained migrants, who need recognition of their professional qualification.

Statistical indications of the presence of migrant workers in individual occupations are reflected in the interviews. On the question about relevance of migrant workers for individual occupations, managers and works councils' representatives in the private and public hospital stated that migrants work often in low-skilled areas such as cleaning, logistics and gastronomy rather than in skilled occupations as doctors and nurses (MAN3, MAN5, CON1). The share of migrant workers in nursing is assessed as minor for both hospitals (MAN2, MAN5, CON1, CON3), although their number is slightly increasing in the last years (MAN5). Given the highly international nature of the field (MAN1, MAN3, CON1), migrant workers are strongly represented in the field of research. No data on migrant researchers was available, but managers indicated that their share is relatively high (MAN1, CON1). For researchers, English skills are much more relevant than German skills and they are often employed in third-party funded positions (MAN1).

Doctors and nurses are mostly directly recruited by the hospitals, but temporary work also plays a role (MAN5, CON3). In order to handle unforeseen personnel bottlenecks on individual wards, employees are exchanged within the hospital structures or workers are recruited with the help of external temporary work agencies. This applies particularly to nursing with the aim of covering short-term labour shortages (MAN5).

Apart from temporary work, at both hospitals, many migrant workers stay on a short-term basis, for instance, as guest researchers, guest doctors or for job shadowing (MAN1, MAN2, MAN7). About 50 guest researchers are annually present in the university hospital. The majority of guest researchers are doctors that had already practiced medicine in their home countries, but also other professions such as biologists, chemists and psychologists are represented. They are financed by a scholarship or by their sending institution and stay between four weeks and three years. Permanent employment in the hospital is basically not intended (MAN1). According to a manager in charge of guest researchers, they do not face severe problems related to residence status in Germany as international researchers enjoy good migration opportunities granted by law (MAN1).<sup>21</sup>

Migration as a guest doctor is assessed to be much more difficult than as a guest researcher, as the former need recognition of the licence to practise medicine in order to work with patients (MAN3). Guest doctors stay up to three years, mostly to do a part of their specialty training or to obtain their full specialization. Since guest doctors are not paid by the hospitals, they have to get a scholarship for their visit in Germany (MAN3, CON4). According to a regulation of the Chamber of Physicians in Hamburg, hospitals in the Hamburg region are allowed to include one guest doctor per department (MAN7, CON4). Usually, about 50 guest doctors are present at the university hospital. Besides visits of guest doctors, migrants stay at hospitals for job shadowing (*Hospitation*). In one of the private hospitals, more foreign doctors come for job shadowing than as guest

<sup>21</sup> The admission and residence of researchers from non-EU countries is regulated in Council Directive 2005/71/EC of 12 October 2005 and correspondingly implemented in national law (§20 of the German Residence Law). The residence permit for researchers entitles to take up employment in research for which no work permit and no consent of the Federal Employment Agency are required (HRK 2013).



doctors, in particular from China (MAN7). This could be explained by the lack of a cap on the number of doctors in job shadowing.

### 3.2 Recruitment policies

Recruitment of new staff is highly personalised in the private as well as in the public hospital. Head doctors or nurses who lead a department decide which job applicant is selected for an employment or training programme. The HR department takes care of the administrative formalities such as job advertisement, contract preparation and check of required documents. The employment of a new worker and amendments in the working conditions, e.g. wage classification, has to be approved by the works council.

According to managers and works council' representatives, recruitment of migrant workers takes place mostly through initiative applications or general job advertisement (MAN2, MAN5, CON2). Managers emphasised repeatedly the current labour situation in the healthcare sector in Hamburg as good from an employer's point of view and stressed this as an explanation for the lack of structured concepts for international recruitment in the hospitals (MAN2, MAN5). Works councils' representatives also pointed out that the hospitals are at the very beginning of approaching the topic of international recruitment (CON3, CON4).

Although vacancies can be currently filled with applicants from the German labour market, shortages become visible in the declining number of applicants per vacancy (MAN5) and partly less qualified applicants than in the past (CON1, CON3). Shortages have occurred in the field of nursing, particularly for specialized nurses in intensive, surgery and anaesthesia care (MAN2, MAN3, MAN5, MAN7). From the perspective of managers, potential worsening of the labour situation in Hamburg is considered to affect the hospitals in the future and increase the need for international recruitment (MAN3, MAN5).

Despite the lack of systematic international recruitment, experience with recruitment for the purpose of work or training has been gathered on a small scale. Different experiences were found in the two hospitals. Whereas the private hospital has recruited trainees in nursing abroad and recently started active recruitment of foreign-trained nurses for work, the public hospital has not displayed comparable initiatives and has focused on the international exchange of guest doctors and guest researchers that takes place often in the framework of international cooperation. In the private hospital, active recruitment for nursing training took place in the framework of two pilot projects. In 2011, a project started with Italy and in 2012, a project was launched with Tunisia in the framework of a transition partnership between the Federal Republic of Germany and the Republic of Tunisia. In 2014, facing labour shortages in nursing, one hospital of the private hospital group initiated cooperation for recruitment of nurses abroad with two partners: a private recruitment agency with a focus on Spain and Portugal and the Federal Employment Agency, with a focus on Serbia, Bosnia-Herzegovina and the Philippines (MAN7). This is considered a measure for filling vacancies in the short run (MAN5).

Motivated by the importance of international networks, the university hospital promotes the exchange of researchers and doctors, and hosts regularly guest doctors and researchers on a temporary basis. It has established international cooperation for exchange of guest doctors with countries such as Saudi Arabia, Yemen and Macedonia. Cooperating partners are universities, hospitals or embassies of the sending countries (MAN3). Cooperation for exchange of guest researchers is based usually on a Letter of Intent or a Memorandum of Understanding (MAN1). Further activities are planned to strengthen the international profile of the university hospital as a strategy for attracting international workers. For instance, campaigns abroad such as a visit of a career expo in England are envisaged (MAN1). The hospital's website was redesigned and information about the hospital and living conditions in Hamburg is provided by an administrative clerk in charge of international workers.

In the interviews, managers reflected on the recruitment of foreign-trained workers and assessed it as more complicated than that of German graduates and migrants trained in Germany. Due to the lack of reliable partners for recruitment, particularly the selection of suitable foreign-trained workers is not an easy task for hospital managers (MAN5). Managers in both hospitals receive frequent offers from private recruitment agencies (MAN4, MAN5), but mistrust their competences and seriousness (MAN5, MAN7). A HR manager from the private hospital especially welcomes the support of state agencies in international recruitment, thus avoiding "black sheeps" that are present in the business of private recruitment (MAN7).

Administrative formalities such as residence and work permit and recognition of qualifications hamper the employment of migrant workers, for instance, as they could postpone the starting date of the job (MAN3, MAN5, MAN7). A HR manager openly admitted that he would prefer a worker who could be easily employed:

*"They [migrant workers] are often confronted with the problem that they have to pass a complex procedure concerning the residence permit as well as the recognition of their training. If you are not operating coordinately, it is extremely burdensome and difficult. [...] That is why I am glad that we do it very very seldom. First of all, we have enough applications in the field of doctors. That is why we take the easy ones and the ones that know the German language."* (MAN7)

Beside the burden of formal recognition of qualifications, a manager pointed to difficulties to assess the skills of someone who had worked in another healthcare system and had gathered experiences abroad, for example, in the case of different working culture (MAN5). In order to assess an applicant, it is seen as an advantage to get to know the applicant personally:

*"It is easier to have an applicant, who is living in Bremen. He could come for one day, can introduce himself, attend the clinic and have a look, a kind of making a one-day work trial"*. (MAN5)

### 3.3 Support measures in the workplace

Hospital policies are aimed at attracting, utilising and retaining workers in the workplace, irrespective of their nationality. Good working conditions are considered as essential and general actions for improving working conditions in the hospitals have been taken (MAN2, MAN5). Actions refer to providing more secure jobs (e.g. through permanent labour contracts), improving work-life balance (e.g. flexible working time arrangements, more possibilities for part-time work), increasing compatibility of family and work (e.g. establishment of kindergarten in the workplace), and improvement of the health of workers (health management in the workplace).

Furthermore, hospital policies are influenced by the principles of equality and diversity. The principle of equal treatment is highly valued in both hospitals (CON1, CON2, CON3, MAN2) and – according to managers – universally practiced (MAN2). Both hospitals are also committed to diversity in the workplace and joined the Corporate Charter of Diversity for Germany in 2008 (private hospital) and 2013 (university hospital), which is aimed at creating working environment free of prejudice in the workplace. No structured diversity management concepts but single diversity-oriented measures for individual groups of employees have been implemented, with foreign nationals being just one of these groups.

For new workers, support is provided in the initial stage of employment. Adaptation to the new workplace is facilitated by orientation days with introductory events and orientation guidelines with useful information for the workplace. A mentoring system operates in both hospitals, so that a mentoring colleague is assigned to each new employee in the team. Incorporation of a new employee takes place in the individual team, where tensions may occur (CON2, CON3). Active support in the initial phase in the team appears challenging in practice due to high work intensity (CON4). Hospital wards have been restructured and staff fluctuation has increased, which makes team building and incorporation of new workers more difficult than in the past (CON4). Hence, incorporation of migrant workers “with their own problems” is partly perceived as an additional burden to the teams (CON4), in particular the incorporation of temporary migrant workers as guest doctors (CON2).

Arguing that team building and supervision are a core management task of persons in leading positions on the wards (MAN7), further qualification courses are provided to head doctors and nurses. Such courses are devoted to different topics such as team management, conflict management and intercultural education. In the private hospital, intercultural training will be organised for administrative clerks who take care of migrants in an upcoming recruitment pilot projects.

A low level of special support for migrant workers was identified in both hospitals. In general, migrants are not perceived as a special target group for personnel policies and pass the same adaptation processes as all other employees. More structured migrant-oriented support is provided to special migrant groups such as foreign nurses coming in the framework of pilot programmes, and guest doctors and researchers. In the private hospital, structured support measures were adopted for participants in the two pilot projects with Italy and Tunisia. Recruited in groups, the trainees in nursing attended language courses and got support with

housing (MAN6). In the project with Tunisia, courses on German culture and support in everyday life were organized by an external provider who was in charge of mentoring the group. In the case of the Italian group, a peer programme with German trainees for provision of ongoing advice was organised at school but the offer was not sufficiently used by the Italian trainees (MAN6). In the practical part of the training, language difficulties and cultural differences related to dress codes and gender roles were perceived as challenging (MAN6, MAN7). Comparing both pilot projects, a manager stressed that group-specific support measures are required:

*“Italians in particular needed assistance with language acquisition but were doing fine in everyday life. For the Tunisians, support in everyday life was important. But it has to be taken into account that foreign trainees are not supported too much and can keep self-responsibility, independence and dignity.” (MAN6)*

In the university hospital, administrative clerks in charge of guest doctors and guest researchers assist them with handling administrative formalities inside and outside the workplace. Information is provided about administrative formalities such as obtainment of a work and residence permit and recognition of qualification. Language courses have been systematically organised mainly for guest doctors. More general language courses for migrant employees with insufficient German knowledge were recently introduced (MAN2).<sup>22</sup>

Besides these group-related measures, individual support is provided on a case-by-case basis, for instance, covering costs for language courses or assistance in the search for housing. Given the tense situation at the housing market in Hamburg, support in the search for housing is useful, as both managers and representatives of the works councils emphasised (MAN7, CON4). But also more general support, particularly related to opportunities for family reunification and labour market participation of family members, is needed. In this regard, the website Dual Career Network Germany used frequently by guest researchers is given as a good example for a supportive measure (MAN1).<sup>23</sup>

In addition to supportive measures for migrant employees, the university hospital carried out two projects for nurses whose foreign qualifications were not yet recognised. Adaptation measures to prove the equivalence of their knowledge were offered at the hospital.<sup>24</sup> A manager described the rationale behind the project:

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<sup>22</sup> During a stakeholder workshop in the framework of the WORK->INT project on 20 March 2015, a representative of the university education academy (*Universitäre Bildungsakademie*), which is the institution of the university hospital for training and continuing education, mentioned that a pilot project for language training of employees with insufficient German knowledge was recently launched. He described the project as innovative and being in a test phase. It is aimed at language training of employees by taking their individual needs into account through an online learning tool that was created. About 50 employees will take part in the programme annually.

<sup>23</sup> <http://www.dcmd.org>

<sup>24</sup> For nurses, in case of substantial differences between the qualifications and the corresponding German qualifications, migrants have the opportunity to undergo adaptation measures to prove the equivalence of their knowledge. That could either be an examination (*Kenntnisprüfung*) or a compensation measure (*Anpassungslehrgang*). For doctors, if there are substantial differences between the foreign qualifications and the corresponding German qualifications, migrant doctors have the opportunity to take a test to prove the equivalence of their professional knowledge (*Kenntnisprüfung*), [www.anerkennung-in-deutschland.de](http://www.anerkennung-in-deutschland.de).

*“We have good expertise in further education and we see further education of migrants as our integration mission as a public company. (...) In view of the great number of migrants who brought qualification in nursing from abroad, I think it is meaningful to activate this group of persons with migration background.” (MAN2)*

The first project launched in 2012 was a shortened vocational training for nurses whose foreign qualifications were not or were only partly recognised.<sup>25</sup> With the aim of preparing them for the recognition examination, a shortened vocational training was organised at the education academy of the university hospital. It lasted 22 months in contrast to the standard vocational training as general nurse of 36 months. The main difficulties in the project were limited language skills of the participants (MAN4). 25 participants attended the course, mainly women and persons from non-EU countries, but a mere eight out of 20 participants passed the final examination. A manager involved in the project stated the main reason in her view:

*“They had to face the requirements of the nursing exam. There the gap became visible again: They did not understand enough spoken language.” (MAN4)*

The second project initiated in 2013 was a long-term internship at the education academy of the university hospital. It constituted a compensation measure for foreign-trained nurses whose qualifications were not recognised. It was a one-year course with six separate modules with the aim of obtaining a recognised qualification in nursing. Two courses with six participants per course took place in the hospital. A manager involved in the project addressed the challenges faced:

*“The participants need this one year urgently, particularly to learn basic care and the nursing philosophy. There were difficulties. It is not only related to the culture in a clinic. It is a fundamental cultural issue”. (MAN4)*

Apart from individual support measures, works councils provide more generally support to employees in the workplace. They represent the interest of employees and have co-determination rights related to employment of workers and general working conditions, and provide support to employees in case of conflicts with the employer or in the team. One of the main tasks of works councils are to promote the integration of foreign workers and the further understanding between them and their German colleagues, as well to request activities to combat racism and xenophobia.<sup>26</sup>

Works councils usually react to problems concerning the integration of migrant workers but seldom act proactively (CON3, CON4). They took action only in few cases of discrimination because of migration background (CON1, CON3). As a works council's representative observed during his work, problems of

<sup>25</sup> The project was funded by the European Social Fund (ESF). Two similar courses took place in two other hospitals in Hamburg in 2008 and 2010. The course in 2008 was organised in cooperation with one of the private hospitals where the field work was done (Universitäre Bildungsakademie 2014).

<sup>26</sup> § 80 Works Constitution Act (*Betriebsverfassungsgesetz*).

migrant workers in the hospitals are the same as of non-migrant workers and are rarely related to their migration background (CON1, CON2)<sup>27</sup>:

*“When someone faces problems and contacts us, we support him or her. [...] But I can’t remember any case that somebody contacted us with problems that he or she has due to migration or to the fact that he or she is not born in Germany”. (CON2)*

### 3.4 Perceived role of migrant workers

Migrant workers are predominantly perceived as an asset to the workplace. In both hospitals, qualification is a main prerequisite for employment and migration background is considered to have a subordinate role. As a manager of the university hospital stated, *“Migrant workers cover the need for personnel.”* (MAN6) Migrant workers are perceived predominantly as workers holding the required qualification and are thus employed because of their professional skills. Cultural and social enrichment is viewed rather as a positive side effect of their presence in the workplace.

Migrant workers who obtained their qualification abroad could bring new skills and approaches learnt in the countries of origin. If a doctor comes to the hospital as an experienced specialist doctor, the transfer of knowledge is a gain for the workplace (CON2). Migrants are often well qualified and highly motivated, as was reported for international researchers:

*“International researchers are extremely keen to work, almost at the edge of self-exploitation. [...] They bring new approaches, for instance, other laboratory techniques and series of test.” (MAN1)*

With regard to cultural aspects of employment of migrants, it is highlighted that people of different background enrich working process by new perspectives and that culturally-mixed teams work more productively (CON2). People of different cultural background contribute to the cultural diversity within the hospital that could also improve the working atmosphere with bringing more tolerance and understanding for otherness (MAN6). For instance, the communication skills of workers from Southern European countries are appreciated as warm-hearted. A case of a Spanish nurse was described who was warmly accepted by patients because of her friendly communication (MAN7), which was attributed to her cultural background. Besides advantages of multicultural teams, challenges were also mentioned and attributed to language difficulties, different mentalities and understandings of gender roles and dress codes, and different work tasks and hierarchies at the new workplace.

The issue of access to patients with increasingly diverse background was emphasised by managers as highly relevant. It is an advantage if the structure of the German society is mirrored in the employees’ structure

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<sup>27</sup> This view is shared by a representative of the trade union *ver.di* from the local office in Hamburg (EXT5).

(MAN5). Furthermore, migrant workers bring language skills and understanding of other cultures (MAN2, MAN5). For instance, it is easier, when a nurse of Turkish origin takes care of an 80-years-old Turkish patient who does not speak German. The variety of languages is an advantage as migrant workers could help out as informal interpreters for patients with the same first language (MAN2, MAN5, MAN7). In view of the increasing diversity of patients, migrants could not only provide healthcare to persons with migration background already in Germany but also attract private patients from abroad for treatment at the hospital (MAN2).<sup>28</sup>

## 4. Individual integration in the workplace

Results from the field work show experiences of migrant health workers with their workplace integration in Germany. The following aspects give insights into the individual integration in the workplace, as perceived by migrant workers: experience with migration, access to practice the profession in terms of general labour market access, recognition of qualification and access to the current job, workplace experience related to adaptation, working conditions and relationships at the workplace, and career plans.

### 4.1 Migration

#### Motives for migration

With regard to migration, differences were found between doctors and nurses. Doctors migrated predominantly as qualified persons. Except from two doctors who studied medicine in Germany, all of the interviewed doctors obtained their degree in medicine abroad and accessed the German healthcare sector upon arrival. Doctors moved mostly individually and professional motives for migration dominated. Academics came to do a PhD (DOC1, DOC2), specialty training (DOC9, DOC4, DOC5) or research (DOC3, RES3, RES4). Others came for family reasons, following their partners who were already working in Germany (DOC7, RES1, RES2). A doctor from South Asia came for political reasons in the early 1990s.

Out of fourteen nurses, only five migrated as already qualified nurses (NUR5, NUR7, NUR8, NUR10, NUR11). They came in periods with shortages in nursing in Germany: a nurse assistant from South Korea in the 1970s, a nurse from former Yugoslavia in the 1990s, two nursing trainees from Tunisia and Italy in the framework of pilot projects in the 2010s and a Spanish nurse in 2012. The majority of nurses did vocational training in nursing in Germany. Three migrants migrated without professional qualification after school (NUR2, NUR3, NUR6), four were trained in related healthcare occupations abroad (a midwife, a medical-technical assistant, a biologist and a physiotherapist) and two had work experience in non-related occupations (NUR4, NUR14). In terms of motives for migration, professional motives dominated among nurses who migrated as qualified

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<sup>28</sup> It is assumed that patients from abroad usually do not possess a German healthcare insurance and receive medical services as private patients.

nurses (NUR7, NUR10, NUR11). Some left the country of origin because of a bad labour market situation in the country of origin (NUR10, NUR13) or general insecurity after a political crisis (NUR14, NUR13). Nurses who obtained their vocational training in Germany declared various reasons for migration: political (NUR2, NUR6), family (NUR1, NUR3, NUR5), educational (NUR12, NUR4, NUR13, NUR14) or personal (NUR9).

### Choice of destination

Due to a lower language barrier, English-speaking countries were usually declared as more desirable than Germany (DOC2, DOC4, DOC5, NUR10, NUR12). Good reputation was a chief motive for academics to choose Germany as a destination. The reputation of the specialty training (DOC4, DOC5) or the medical research (DOC1, DOC3, RES4) and the availability of scholarships played an important role for the choice of Germany (RES4, DOC2, DOC3). The choice of Germany was also related to the presence of relatives or friends in the country, as several interviewees stated. Previous experience in Germany also positively influenced the migration decision. For instance, a Greek doctor and a Russian researcher who did an internship in the past opted for migration to Germany later to do specialty training and respectively research.

As regard the choice of Hamburg, the city was often the first choice for doctors who pointed to the good reputation of the hospitals or the head of the team they were going to work with (DOC3, DOC4). Besides good opportunities for career development, Hamburg was named as an attractive city to live (DOC10, NUR10). Some interviewees had worked in other German cities before and followed their superior who moved to a Hamburg hospital (DOC1, DOC5, NUR4).

Academics highly value international experience. In particular international experience during studies was highlighted as an advantage, as people can see whether living abroad suits them and they have time to learn the language (DOC6). The majority of academics had lived in other countries for professional reasons: in the US, the UK, Japan, Greece, France and Poland. Except from a nurse who lived in France, nurses rarely had professional experience abroad.

External stakeholders shed further light on the choice of Germany as a destination. According to a representative of the trade union *ver.di*, foreign health professionals opt for other destinations than Germany mostly due to a low level of attractiveness of the sector in international comparison (EXT6):

*“Indeed, the migration flows are passing over Germany. We need a debate on how we could valorise healthcare work in Germany and how we could design it.” (EXT6)<sup>29</sup>*

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<sup>29</sup> A report of the Federal Statistical Office about the role of migrants for nursing in 2010 revealed that compared to the overall economy, the healthcare sector does not benefit overproportionally from labour migration. 7.6 per cent of the workers in nursing occupations in 2010 were labour migrants as opposed to 8.3 per cent in the overall economy (Afentakis and Maier 2014). Decreasing labour migration in nursing occupations is observed over time. Whereas on average 6,000 labour migrants who worked in nursing occupations came annually in the time frame 1988-1995, in the time frame 2005-2009 only 2,000 labour migrants migrated to Germany annually and were employed in nursing occupations in 2010 (Afentakis and Maier 2014).



A representative of the trade union *ver.di* from the local office in Hamburg referred to cases of nurses who left Hamburg and migrated to the Switzerland or Scandinavia, where they enjoy better payment, less workload, better quality of work and higher life satisfaction (EXT5).

## 4.2 Access to practice the profession

### 4.2.1 General labour market access

Labour market access differs between EU and non-EU nationals. As EU nationals enjoy free movement within the EU and thus no permission for residence and work in Germany is required, the obtainment of residence and work permits is a topic predominantly for non-EU nationals.

#### Obtainment of residence and work permits

Handling of administrative formalities such as an obtainment of residence and work permits caused problems for some of the non-EU migrants. The procedure for a granting or for steadily renewing permits was perceived as non-transparent and burdensome. A lack of transparency in the obtainment of residence status was criticised by non-EU migrants coming in the 1990s (NUR6, NUR7). An Eastern European doctor who studied medicine at a German university in the 1990s found it burdensome to renew her residence and work permit several times over many years, during her specialty training and further employment as a senior and head doctor. For an Asian migrant who obtained her degree in medicine in another EU country and moved to Germany for specialty training, migration as a non-EU citizen within the EU was not as easy as expected. She thus decided to naturalize in the EU member state, where she is eligible for naturalization, in order to minimise administrative formalities in Germany and to have better career opportunities within the EU. A doctor from an Arab country perceived the obtainment of a work permit based on the Blue Card regulations as difficult. His application for a work permit was rejected as his income was lower than stipulated in the law. After two rejections, his boss increased the wage and he obtained a work permit enabling him to practice his profession.

Migrants reported negatively about administrative clerks in charge of administrative procedures as non-knowledgeable and lacking English skills:

*“Whenever you are going to renew your visa, the persons there, they don’t speak English. It is absolutely true. And that was my first experience in Germany. (...) I don’t understand the concept. It’s like they are getting trained not to help you. (...) I really think that they are not contributing to integration at all. You are feeling really like an Ausländer (foreigner).” (DOC3)*

The general stance of administration towards foreigners was criticised as inappropriate. Assistance with paperwork and the legal regulations in general is needed (DOC3, NUR7, NUR12):

*“When you don’t have anybody who gives you a leg up, you have no chance. You are running from agency to agency and nobody can help you. Some of them are able to speak English with you. But when they recognize that you cannot speak German, they speak with you in a different manner. [...] You have to know your rights and claim your rights.” (NUR12)*

In some cases, the lack of a work permit prevented migrants from pursuing their profession in Germany or to do training in Germany. A doctor from South Asia was excluded from the German labour market for several years, as he resided with a toleration status and as asylum seeker. A female doctor from non-EU country who came as a family member of a Green Card holder was not allowed to work between 2002 and 2007. In 2013, when her husband obtained a Blue Card and the family re-migrated to Germany, she got a permission to work in Germany. A woman from a non-EU country who came in the early 1980s for political reasons had to postpone her training as medical assistant as she did not possess a work permit.

#### **4.2.2 Recognition of qualification**

As regulated professions, state admission to practise the profession in Germany is required for both doctors and nurses. Doctors need a full or temporary licence to practice whereas nurses need a state licence to practice as a general nurse.<sup>30</sup> These licences are granted in the course of procedure for recognition of professional qualifications. EU graduates enjoy more favourable recognition regulations than non-EU graduates. Whereas an automatic recognition for EU graduates is granted by the EU Recognition directive from 2005 (Directive 2005/36/EC), an individual assessment of equivalence of foreign qualifications with German standards takes place for non-EU graduates.

Recognition of professional qualifications was a main topic in the interviews. Migrants trained in EU member states highlighted that they benefited from the automatic recognition of qualifications and easily obtained it, as in the case of doctors from Greece and Austria, as well as nurses from Spain and Portugal. Non-EU migrants complained about unclear administrative procedures they had to deal with. In the 2000s, a work permit was a prerequisite for a licence to practise and *vice versa* that caused difficulties in the obtainment of a work permit and a licence to practise (DOC1, DOC2).

#### *The Recognition Act of 2012*

Until 2012, non-EU doctors were considerably disadvantaged in Germany as they were only entitled to a temporary license to practice. Since temporary licenses were only issued for one German state and a limited

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<sup>30</sup> All doctors in Germany need to obtain a licence to practice their profession. There are two types of licence: temporary (*Berufserlaubnis*) and full (*Approbation*). Until 2012, non-EU nationals were entitled only to a temporary licence to practise that provided them with limited rights. The temporary license was issued for a single German federal state (*Land*) for a limited period of time and did not allow self-employment. With the Recognition Act as of 2012, non-EU nationals were allowed to apply for a full licence to practise and a temporary licence is issued rather in exceptional cases. For further information see the National Background Report Germany (Kovacheva and Grewe 2015) published in the framework of WORK->INT project.

period of time, foreign doctors perceived heavy burdens and a lack of mobility in Germany. Even as a German graduate, a Polish doctor had to renew repeatedly her temporary licence and to apply for a new licence, when she moved from one to another German state. This was costly and time-consuming. She pointed out the positive impact of Poland's EU accession on her labour prospects because as an EU citizen, she was allowed to apply for a full license. A doctor from Syria, who worked in other German state, also faced limited labour mobility because of his temporary licence to practise. It took him a year to obtain a new licence before he could start a new job in Hamburg.

The Recognition Act of 2012 introduced several improvements, as external stakeholders emphasised.<sup>31</sup> It abolished the legal difference between EU and non-EU nationals and entitled non-EU doctors to a procedure for a full licence to practise the profession. A striking situation existed before the Recognition Act. *“In the past it was odd that a person was allowed to do specialty training in Germany but could not obtain a general licence to practise.”* (EXT3)

Improved recognition opportunities led to increasing number of applications of qualifications in the field of healthcare. According to the manager of the counselling center for recognition in Hamburg, one fifth of the seeking advice persons have a healthcare profession (EXT3). Rising inquiries from foreign-trained doctors are observed also by the head of the international affairs department of the professional association of employed doctors *Marburger Bund* that provides advice to foreign doctors (EXT7).

Despite improvements, negative experiences with the recognition procedure were reported by interviewees who applied for recognition after 2012. Migrants encountered a lack of standardisation and transparency as well as a high amount of paperwork:

*“It was not fair in my view, because you need to pay, and every time you are going there, it is an extra paper that you need to find...They [persons in charge] have absolutely different perspectives about the requirements they ask you. [...] They don't have a clear idea.”* (DOC3)

A doctor with experience in the US compared the German recognition regulations with those in the US and wished to have the opportunity to take a practical exam instead of the paperwork, as is the case in the US (DOC3). But he assessed his chances to pass the German exam successfully as low as it corresponds to the exam German students passed in the last year of medical education and he obtained his diploma 14 years ago.

The recognition procedure was described as highly dependent on the individual decision of the person in charge (DOC3, DOC5). As no standardised procedure for assessment of the equivalence of the university

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<sup>31</sup> As part of the German policy on dealing with labour shortages, a Recognition Act came into force in April 2012 by which several changes in the recognition of foreign qualifications were enacted. The Recognition Act includes the Professional Qualifications Assessment Act (*Berufsqualifikationsfeststellungsgesetz - BQFG*) under the responsibility of the Federal Ministry of Education and Research (BMBF) as well as provisions for the recognition of vocational qualifications in around 60 federal laws and regulations governing professions, such as healthcare professions (Medical Practitioners' Code, Nursing Act) and master craftsmen (Craft Trades Law), see more on [www.bmbf.de](http://www.bmbf.de) and (Kovacheva and Grewe 2015).

diploma is in force, two persons from the same country, city and university can receive different decisions on their application, as the case of a Syrian doctor showed. His diploma was not recognised and he had to do an exam for evaluation of equivalence of his qualification.<sup>32</sup> He successfully filed an objection, after having referred to graduates from his university who obtained recognition without an exam.<sup>33</sup> The procedure was partly perceived as unjust as the exam regulations are not equal for all countries, as an Afghan doctor argued. He passed the examination in 2012, but felt not fairly treated as his examination was three hours in length carried out at the university hospital whereas the examination for other nationalities such as Russian usually takes only an hour and takes place in the Chamber of Physicians.

External stakeholders also reported that obstacles to recognition of qualifications remain even after the Recognition Act. A lack of “standardization, transparency and legal certainty” is a main obstacle to recognition (EXT7). *“In each federal state the same conditions should apply for recognition, but this is not the case.”* (EXT2) The reason is that recognition is regulated at federal level but implemented by the individual federal states, leading to differences in terms of requirements such as requested documents and thus to different recognition decisions (EXT2, EXT7). For instance, language requirements for doctors vary from state to state. To address this issue, the Health Ministers of the *Länder* decided at their annual conference in 2014 on common language requirements for doctors, by setting a B2 level for general language and a C1 level for job-related language. A written and oral language exam for job-related language skills is foreseen (Wichmann 2014).

An obstacle particularly for potential migrants remains the lack of possibility to access the chances of success of an application (EXT7). More transparency and consistency in decisions on recognition cases is needed, as the representative of the *Marburger Bund* argued:

*“If you obtained your diploma at university XY in country XY in year XY, and we already have assessed five similar cases and found that in all cases diplomas are equivalent/ not equivalent, then you have to apply but your chances for recognition are relatively good/ relatively bad.”*  
(EXT7)

### Coping strategies related to recognition

Various coping strategies were developed by the migrants related to recognition. Some interviewees started working at positions, for which no recognised professional qualification was required – as guest doctor (DOC5), researcher (DOC3), PhD students (DOC1, DOC2), nursing assistants (NUR7, NUR8) – and applied for recognition on the job. Other migrants participated in training courses in order to prepare for the examination. Two doctors attended a preparatory course for doctors with the financial support of the employment agency (DOC8, DOC10). Both positively evaluated the programme that contained three-month

<sup>32</sup> In the case of partly recognition of qualifications, doctors have the possibility to do an exam to prove the equivalence of their qualification (*Kenntnisprüfung*).

<sup>33</sup> The doctor stated that his brother who is a doctor too migrated to Hamburg in 2014 and is allowed to work for up to two years with a temporary licence to practise, a transition period, in which he can obtain a permanent licence in order to further work.

job-specific language training, six-month traineeship and three-month preparation for the examination. External stakeholders also stressed that preparatory courses for assessment of equivalence and adaptation period (*Anpassungslehrgang*) are often expensive and time-consuming.<sup>34</sup> The adaptation period for nurses takes up to three years (EXT2, EXT3), that is as long as full vocational training in nursing lasts. Financial support offered by the employment agency is possible but often not applicable to newly arrived immigrants (EXT3). Hamburg plays a “pioneering role” offering a scholarship for migrants who aim at recognition of their qualification (EXT2, EXT3). The scholarship programme of the State Agency for Work, Social Issues, Family and Integration (BASFI) provides a scholarship for a period up to 18 months and one-time grant for covering fees for language courses, preparatory courses or tests.<sup>35</sup>

A lack of recognition kept some migrants from pursuing their profession and motivated them to do further training in the field of healthcare. No recognition of her diploma as psychologist kept a doctor’s wife from taking up a regular job (DOC3). A midwife who failed in the examination for equivalence for midwifery decided to do vocational training in nursing (NUR1). Other interviewees did not apply for recognition of their foreign qualification at all and deliberately changed their profession in Germany. A medical-technical assistant did vocational training in nursing that she could not do in the country of origin for limited training capacities (NUR12). A physiotherapist with a Bachelor degree decided to study medicine as she did not have opportunities for further development in her profession, which is a vocational training in Germany (DOC7).

A lack of recognition led in some cases to professional downgrading, as the case of a non-EU doctor exemplified. Her diploma in biology as well as training as bacteriological doctor was not recognized, due to the fact that this medical degree does not exist in Germany: “*Basically, I was a person with a profession and suddenly, I became a person without a profession.*” (DOC9) She started working as a nursing assistant in a nursing home and after that did vocational training in nursing. Working below her level of qualification caused frustration: “*After six years of study and five years of professional experience as a doctor, it was frustrating to work as assistant in a nursing home.*” In 2013, after the Recognition Act came into force, her teaching degree in biology was recognised as first state examination and she considers doing the second state examination, which would allow her to work as a teacher.

#### Overqualification during recognition procedure

During the recognition procedure some migrants were employed below their level of qualification. Migrant nurses from non-EU countries worked as nursing assistants with a corresponding lower wage, as a nurse from the former Yugoslavia and a nurse from Bosnia-Herzegovina reported. External stakeholders referred to cases

<sup>34</sup> A twelve-month preparatory course for doctors in Hamburg cost about 10,000 euro, a six-month preparatory course for nurses about 3,500 euro. For occupations with a low number of persons interested in the course, e.g. physiotherapists, preparatory courses or adaptation periods are not sufficiently offered (EXT3).

<sup>35</sup> The scholarship is a monthly subsistence allowance in the amount of maximum 670 euro. One-time grant of up to 12,000 euro can be received for covering fees. Half of the scholarship has to be paid back (<http://www.hamburg.de/wirtschaft/anererkennung-abschluesse/>).

of qualified nurses working as assistants for a long period of time until they achieve B2 language level, which is required for the recognition of qualification (EXT8).

Senior doctors whose specialty training was not recognised were also affected by overqualification. Senior doctors from Armenia, Argentina and Macedonia had to do specialty training in Germany and to work as assistant doctors. The manager of the counselling center for recognition in Hamburg explained that recognition of specialities of doctors causes difficulties. Specialities are not fully recognised when they are shorter than the training in Germany or obtained during the general medicine studies (EXT3).

Nevertheless, most interviewees accepted a temporary period of employment below their level of qualification and appreciated further training in this period. A doctor from Armenia and a nurse from former Yugoslavia stated that they appreciated the internship before starting a regular job in order to catch up on German standards and German language. *“It should be this way. If I do not accept this I can stay at home.”* (DOC10) An external stakeholder confirmed this view by arguing that nurses who attended a preparatory courses are often *“better prepared for the job”*, particularly in preparing nursing documentation, than those nurses whose qualification was automatically recognised (EXT3).

### 4.2.3 Job access

#### Job channels

In line with results from the interviews with managers, both interviewed doctors and nurses found their first job in Germany predominantly through an initiative application or as a reaction to a specific job advertisement. Doctors who came for professional motives applied individually from abroad (DOC1, DOC2, DOC3, DOC4, DOC5) whereas in the case of nurses, direct recruitment also played a role: A nurse from South Korea was recruited in the framework of a bilateral agreement between Germany and South Korea in the 1970s, a nurse from former Yugoslavia came through a recruitment agency with nine further nurses in the 1990s and a nurse from Spain was recruited by a private recruitment agency in 2012. Temporary work agencies operating inside Germany channelled some interviewees into their first job. Two nurses (NUR1, NUR3) and a doctor (DOC8) found a job in a hospital *via* temporary work agencies.

Professional networks seem to be important, in particular for changing the workplace. A senior doctor moved to a hospital in Hamburg through a recommendation of a colleague (DOC6). A doctor (DOC5) and a nurse (NUR4) changed to another hospital as their bosses changed the workplace. An assistant doctor changed the hospital of his specialty training through personal contacts (DOC9). Although he got a job *via* personal contacts, he criticised the practice and argued that it is therefore hard for foreigners to get access particularly to big hospitals and university hospitals (DOC9). Difficulties to find a job in research were faced by a

researcher who migrated in the early 1980s. However, she underlined that this affects not only foreigners and women as it is often stated, but characterises the German labour market for researchers in general (RES3).

### Hospitals as a preferred workplace

Self-employment is usually not an option for migrant doctors who recently migrated as a recognised specialty is a legal requirement for self-employment in Germany (Kovacheva and Grewe 2015). Hospitals are often the first workplace for migrant doctors as they are big facilities and offer many specialty training positions. For an assistant doctor, the chances to get a training post in a hospital were much better than in a medical practice, where nobody knows him and would not employ him (DOC5). Some interviewees consider hospitals as superior workplaces (DOC8), especially as they offer good training opportunities (DOC9).

In contrast to doctors whose first job in Germany was often in a hospital, the interviewed nurses reported about labour market experience in other facilities such as care homes or medical practices before changing to a hospital (NUR2, NUR10, NUR9).<sup>36</sup> Nevertheless, working in a hospital is favoured also by nurses, as work tasks better correspond to their qualification obtained abroad (NUR9, NUR10) and are more diversified (NUR2). Hospitals are experienced as technically better equipped than other facilities and are thus associated with reduced physical workload (NUR10).

### Perceived chances for a job access

The interviews indicated that migrant doctors perceive their chances to get the preferred position as lower than those of natives. Two types of reasoning seem to account for this situation: strong competition for jobs in certain German cities, and mistrust and prejudice against foreign-qualified workers. Competition for jobs is considered severe in German cities such as Hamburg, Berlin and Munich. Interviewees described that they are very attractive for German graduates too, so that migrant doctors have lower chances to get a job there (DOC7, DOC9). A young doctor who moved to Germany for his specialty training could not find a position in a big city for a long time:

*“You should have studied here in order to get a position in these cities. (...) I intended to do vocational training in a hospital with high reputation in order to enjoy good training but in the reality, you are first here to fill gaps and not to follow your own ambitions.” (DOC9)*

Better chances of migrant doctors are seen in regions that are affected by severe labour shortages. An assistant doctor remarked that it is easier to get specialty training in small cities or in the Ruhr area where clinics facing substantial labour shortages employ migrant doctors even without German knowledge (DOC9).

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<sup>36</sup> This corresponds with findings from other research, showing that migrant nurses are often employed in elderly care homes or home services, areas that are less attractive to national staff (Friebe 2006: 17).

Despite equal level of formal qualification, chances of migrants to get a job were assessed as lower than of German graduates because of mistrust against their foreign qualification. Although she applied for several internships and had the required B2 language level, a non-EU doctor could not find an internship. Not before starting a preparatory course for doctors she got a position in a hospital with the support of the course provider (DOC10). According to a senior doctor, migrants are generally perceived as less qualified than German graduates, thus having lower chances to be hired (DOC7). She thus recommended giving a chance to foreign doctors to do internship or job shadowing, so that their qualification level can be assessed on the job:

*“If migrant doctors are good, they have to be supported. [...] At least, we should give a chance. We should not say that nobody is enough qualified. There is a large margin.” (DOC7)*

Another senior doctor also stressed the need to give a chance to migrant workers by offering them a job (DOC6). She described the success story of a Romanian doctor. Despite his language problems at the beginning, she employed him as an assistant and over time, he proved his outstanding skills as a doctor and improved his German skills (DOC6). Young migrant doctors shared similar views regarding the relevance of having a chance to take up a job at the beginning of their stay in Germany. An assistant doctor explained that he found his first job as the boss employed him first as an intern for some months and after that as assistant doctor (DOC9). A doctor felt lucky to start internship in a medical practice after she graduated at a German university as she had a child and had low chances for a regular job. Later on, she changed to a hospital to do her specialty training and remained for more than 15 years (DOC7).

### **4.3 Workplace experience**

#### **4.3.1 Language and communication**

##### Job-related language

The biggest challenges at the beginning of employment are related to language skills. Communication problems were reported particularly by doctors and nurses whereas fewer problems were reported by researchers who often used English as a working language (DOC3, RES1). For example, some migrants had difficulties to understand conversations (DOC5, DOC9), were embarrassed by asking several times (DOC9, DOC10) or were afraid of answering the phone (RES3). Besides challenges faced in speaking, writing in German caused problems, particularly the preparation of documentation (NUR5, NUR8, NUR10, DOC2, DOC4), even after several years working in Germany (NUR8).

Job-related language appears to be even more challenging than everyday language. Medical terminology was identified as country-specific. The case of a doctor who graduated in Germany and returned to the country of origin to do internship further exemplifies the problem. Even as a native speaker, she had to learn the specific terminology in medicine in her home country (DOC6). Good job-related language skills are inevitable for



fulfilling the work tasks properly, as a doctor argued. *“It is important to know what a knife, a scalpel in German is, what different types of pain are.”* (DOC5)

Insufficient language skills caused indisposition and were perceived as an obstacle for showing professional skills. Because of her insufficient language skills, an interviewee was feeling as *“mind-handicapped”* (DOC10). A nursing trainee described it in this way:

*“If you cannot say something, you are ashamed of yourself; then you cannot integrate. If a colleague gives you a task and you do not understand him, it is bad. It is really a bad feeling. Sometimes you have doubts if you are in the right job or not.”* (NUR13)

An assistant doctor argued that sufficient language skills are a necessary prerequisite to prove professional expertise: *“If there is a doctor without German language skills and even if he or she is the best doctor, it is barely possible to show his or her knowledge.”* (DOC9) Although the importance of good language skills for practicing the profession is widely accepted, the perception of language skills as a sign of professional qualification is criticised. An assistant doctor who studied in a German-speaking country before and assessed her German at a very good level was surprised when colleagues attributed misunderstandings in the workplace to gaps in her language skills (DOC4). *“It is considered as a weakness of my professional competences as I need more time to formulate or write documentation.”* (DOC4)

### Language training

Language training was emphasised by most of the interviewees as crucial for successful workplace integration. The need for job-related language courses was stressed by migrant health professionals: *“Even if somebody makes C1 or C2 level, it is not much use as you learn things you do not need in your field of work.”* (DOC5) Several interviewees underlined that they invested extra time and money for improving their language skills, either off the job or before starting the job. Language courses were considered expensive and time consuming. Attending a language course for a longer period of time without having a job is not always possible for financial reasons, as a nurse argued: *“Not everybody could afford to visit a German course and do sightseeing for one year.”* (NUR5) As a reward, incentives for people who learn German on their own initiative and pass the exam could be offered by employers, as a researcher suggested (RES1).

Only in individual cases, language courses were financed by the employer or in one case by a church. Trainees in nursing who came in the framework of pilot projects to the private hospital were offered a language course. A nursing trainee criticises the six-month intensive language course she attended as all trainees from the same country attended the same course and did not practise German a lot. She thus recommended mixed courses in terms of nationalities, so that participants have more opportunities to practise German (NUR14). Likewise, vocational training in courses with mixed nationalities was emphasised as meaningful (NUR13). Special language courses for migrant workers were offered to guest workers in the public hospital. They were highlighted as a positive initiative of the employer, even though the course is not for free (DOC5).

Several migrants reported about the need of learning language on the job. A nursing trainee explained that he learnt a lot during the intensive six-month language course before vocational training. However, at the very first day in the clinic, he realised that his German was not sufficient and he had to invest much more time in learning the language, particularly the colloquial language (NUR13). A head doctor made a similar observation on guest doctors. Despite the intensive language courses, they could barely be deployed in clinics in the first year of their stay and need more language training (DOC7).

Communicating in German on the job helps a lot for improving job-related language, as a doctor who works predominantly with native speakers highlighted (DOC10). Aimed at improving their German knowledge fast, some interviewees asked their bosses to speak with them in German from the very beginning (DOC5, DOC8). Likewise, a researcher regretted having used English as working language in the workplace as it thus took her much longer to learn German (RES2).

### 4.3.2 Adaptation to a new workplace

Besides language skills, interviewees further referred to an adjustment to the new workplace with its working processes and culture as a challenge in the early stage of employment. They show high acceptance of the necessity to catch up and to adapt to German and workplace-related customs, but ask for more acceptance on the side of the employer and the team for the time it needs. A recent migrant who came to Germany in 2012 stressed acceptance and adaptation as a prerequisite to integrate in the workplace:

*“First of all, acceptance. [...] If you do not accept, you cannot succeed. You have to accept, to learn and to discover a new culture; and to adjust. [...] The most important thing here is the contact with other people. In this way you can learn and discover new things.” (NUR13)*

A doctor admitted that he missed practical experiences during his studies in his country of origin and hadn't worked with modern technologies but was keen on catching up on German standards. He described the difficulties in adapting to the workplace at the beginning: *“Honestly, I did not do good job. My boss expected from me having the same level as a German doctor [...] I can manage it but I need time. It is not that simple”* (DOC8). In some cases, migrants felt better qualified than their German colleagues. For instance, a non-EU dentist emphasised his practical experience with patients during his education in the home country that, in his view, was more extensive than of German graduates (DOC5). A head nurse highlighted the excellent knowledge of a foreign colleague in the field of anatomy (DOC6).

Expectations by the superior and colleagues to meet the German standards immediately after starting the job were perceived as burdensome. A migrant doctor was upset by a German colleague who severely criticised the quality of his patient report and expressed his expectations to conform to German standards in this way: *“You are in Germany. You are the Ausländer (foreigner). You have to adjust.”* (DOC3) He wished for more

understanding and argued: “A German doctor who moves to Hamburg is also new and need time to adjust.” (DOC3)<sup>37</sup>

Regarding working culture, cultural differences may hamper workplace integration, as the project manager who supported a pilot project for recruitment for a hospital in Hamburg experienced (EXT1). He thus recommended provision of relevant information about the working culture in Germany to potential candidates before migration and more inter-cultural trainings in the workplace:

*“Migrants have to be informed already in their country of origin. The reality in Germany, the German labour market and the German working culture have to be explained. This information has to be adjusted for the culture of the individual country of origin of the workers.” (EXT1)*

### Induction and mentoring

Support in settling in the new workplace in terms of working processes and culture is appreciated by many migrants. Three types of support in the initial stage of employment were mentioned by the interviewees: structured induction programmes, informal support by colleagues, and support by a mentor. In general, hospitals departments provide an induction phase for new employees, irrespective of the nationality (NUR3, NUR5, NUR7, DOC4). The content of induction programmes differs from hospital to hospital and even from ward to ward. Periods vary between one and four weeks (NUR3). A head nurse gave the example of a written guide for new employees with information about the hospital and the corresponding field of work (NUR7).

Migrant workers highlighted several times support they got from the superior and colleagues. The superior provided crucial support in obtaining a work permit (DOC5, NUR2), helped migrants smoothly settling in the new workplace (DOC5), was “friendly and treated foreigners well” (DOC9), was motivating and challenging (RES2). Colleagues helped a lot in the adaptation period, for instance, in paperwork and documentation as well as with administrative steps (DOC1, DOC2, DOC3, DOC4, RES1).

A colleague was assigned to some interviewees as a counterpart at the workplace (NUR5, DOC4). Support by such a mentor, who is meant to be a more personal supervision by a colleague, was perceived as very helpful at the beginning of employment (DOC1, NUR7, NUR9, NUR13, NUR14). Support over a longer period of time by the mentor was also appreciated (NUR9). Two nursing trainees shared their different experience with a mentor system for trainees at their workplaces (NUR13, NUR14). Whereas one of the trainees was unsatisfied, pointing out that the mentors in charge were usually not motivated to assist (NUR13), the other highlighted the confidence she was gaining through her mentor (NUR14).

Mentoring was perceived to be successful when the ward was well staffed (NUR3, DOC4) and both mentor and mentee were given additional time (DOC4). An assistant doctor at a clinic for private patients argued: “At

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<sup>37</sup> This finding is in line with the literature showing a deficit-based discourse about the skills of migrant health workers in Germany, as revealed in Friebe (2006). The main deficiencies of migrant health workers are related to their language skills, ability to work in a team and nursing philosophy (*Pflegeverständnis*) (Friebe 2006).

*university hospitals you are thrown in at the deep end, but at my clinic they are almost overstaffed that enables good induction of new workers.” (DOC4) A head nurse that migrated in a group of recruited nurses in the 1990s and was accompanied by a mentor admitted: “I can imagine that I was a burden at the beginning. [...] Today I wouldn’t have time to take somebody with me, to accompany someone for three or four months.” (NUR9)*

### 4.3.3 Working conditions

In terms of working conditions, the contractual situation, working hours and the matching between required and attained qualifications are main indicators for job quality and stability (OECD 2012: 111 ff.). According to a representative of the trade union *ver.di*, migrant health workers basically encounter the same working conditions as their German colleagues and face similar problems, whereas problems with discrimination or because of foreign nationality are assessed as rare (EXT6). The working conditions for doctors and nurses are assessed differently by the representative of the German Nurses Association (EXT4). According to her, in international comparison, Germany attracts doctors with good working conditions whereas it fails in the case of nurses because of unattractive working conditions in this occupation (EXT4).

In general, external stakeholders assess the working conditions in the German healthcare sector as being non-competitive compared to countries like Switzerland, USA or Sweden (EXT6). High mental and physical workload due to staff savings, low wages, overtime, inflexibility in balancing family and work life and missing offers for further training and career development were given as barriers to attract and bind health professionals, both national and foreign. Some measures for improvement of working conditions in the sector are suggested by the representative of the trade union *ver.di*: higher wages, more flexible working hours, better health management in the workplace and work assignment corresponding to the different phases of life (EXT6).

#### Working contract

The contractual situation among interviewees varies widely depending on their occupation and stage of career. Contracts seem to be corresponding to established patterns in the healthcare sector. Migrant workers in the early stage of their career, as doctors in specialty training and nurses in training, were mostly employed temporarily for the duration of their training (DOC1, DOC2, DOC4, DOC9). Head doctors and nurses mostly had permanent posts (DOC6, DOC7, NUR7, NUR8, NUR11). Interviewees in research were employed on a temporary basis and had to apply for funding in order to secure their job (RES2, RES3, RES4). Interestingly, most qualified nurses had a permanent contract whereas only few doctors were permanently employed. This is explained by the specific labour situation in the healthcare sector. As nursing has become a shortage occupation in Hamburg, increasingly permanent labour contracts have been offered to nurses as a strategy to retain them in the workplace (NUR4).

Few complaints were raised by the interviewees related to their contractual situation. Having a contract in German language was one of the few issues mentioned as burdensome. *“My work contract was in German, which was completely useless for me [...] I didn't feel comfortable signing a contract that I couldn't read”* (RES1). Whereas no complains about the content of the contract were raised by interviewees, some grey areas were identified by external stakeholders. For instance, work experiences gathered by migrant doctors in the countries of origin are often not taken into account that leads to a lower wage classification in Germany, not corresponding to their level of professional qualification and experience (EXT7). Migrant nurses are employed as nursing assistants for a long period of time, as they receive lower wages, until they reach the required B2 language level for recognition of their qualification and (EXT4). Binding nurses to the workplace for several years by oppressive contracts with the argument that a lot has been invested in their language and qualification was also criticised (EXT4, EXT6, EXT8).

With regard to wages, almost no problems were reported in the interviews and migrants seem to be paid corresponding to the wage agreements in force.<sup>38</sup> There was a single case of a researcher who was paid below her qualification for 18 months as she was grouped at a lower level than her PhD qualification requires. After she asked her superior, her wage was promptly corrected (RES1). There are cases of migrants who worked unpaid during internship (DOC10) or were not allowed to earn money as a guest doctor (DOC5). In some cases, this was perceived burdensome. For instance, according to an interviewee, there are guest doctors who do not finish their visit because of financial difficulties (DOC5). By and large, interviewees seem to be satisfied with their wage although the wish for higher wages was expressed by some nurses. A high level of dissatisfaction with the wages was not found in the study but this could be due to the process of interviewing where this aspect was not broadly discussed.<sup>39</sup>

### Working time

Working time is associated with more concerns. Both doctors and nurses complained about overtime. Differences among hospitals appear not to be substantial, except from university hospitals where the need to combine medical practice, research and teaching is more distinct. Differences were often attributed to different occupational levels. Whereas overtime by senior doctors is paid with extra money or holidays, assistant doctors get no compensation (DOC2). An assistant doctor said to be employed for 40 hours, but to work 70-80 hours weekly. For him, it was a clash between expectations about working time and free time before migration and reality in Germany (DOC1). A doctor with experience in the US compared the fixed working time from 9 am to 6 pm in the US, by emphasising that he was aware of what was expecting him in Germany (DOC2). A nurse stressed that making extra hours was paid but she would prefer to rest (NUR10).

Some migrants were concerned about dense workload in the workplace. A doctor declared to work overtime in order to finish her work somehow and particularly emphasised the high level of documentation required to do

<sup>38</sup> There are collective wage agreements for doctors and nurses. Different agreements are in force for the three types of hospitals: private for profit, public and non-profit hospitals run by churches.

<sup>39</sup> A qualitative study among 30 migrant health workers showed that only a minority was satisfied with the payment (Mihali *et al.* 2012).

as a doctor (DOC6). Nurses stressed the tight personnel situation in the clinic as increasing the workload and physical strain (NUR3, NUR10, NUR12).<sup>40</sup> Shift work was perceived as an obstacle to work-life balance by both doctors and nurses (DOC9, NUR5, NUR8). Some nurses opted for part-time work as a coping strategy with the dense workload, whereas doctors rarely worked part-time.<sup>41</sup>

### Match between qualification and job assignment

For most of the interviewees, there is a match between qualification required for the job and acquired qualification, except the case of migrants whose professional qualification was not formally recognised. For instance, specialized doctors had to work at assistant posts or nursing professionals had to work as nursing assistants. Employment in the hospitals usually takes place in correspondence with the formal recognition of qualification.

However, some job tasks caused dissatisfaction or surprise among some interviewees. Some assistant doctors complained about assignment to a clinic without taking their preferences for wards into account (DOC9). Guest doctors were disappointed as they were not allowed doing certain tasks such as visitations after a surgery, thus missing relevant professional experience (DOC5). Taking blood samples or doing injections – in Germany the responsibility of doctors – were given as examples for tasks on nurses' hands in the country of origin (DOC10). A Polish head doctor who failed to recruit a Polish colleague from abroad for her team in Germany attributed this partly to untypical tasks of doctors in Germany he was not willing to do. Furthermore, the distribution of tasks between doctors and nurses appears as a problem area. A head doctor was astonished at the narrow bundle of tasks attributed to nurses in Hamburg compared to her previous workplace: *"It is a pity for the nurses"* (DOC6).

Some nurses qualified abroad are dissatisfied with a lower level of tasks assigned to them in comparison with the countries of origin.<sup>42</sup> Particularly basic care was emphasised as an untypical task to have to get used to (NUR8, NUR9, NUR10). Basic care was partly perceived as inappropriate, but eventually accepted as part of the German system. Some of the migrant nurses who migrated to Germany as trained nurses had university degree in nursing (NUR5, NUR10). As a result, some foreign-trained nurses are perceived as better qualified than German nurses, as a head doctor assessed for nurses from Russia where nursing is five-year university education (DOC6).

Also in view of external stakeholders, differing occupational profiles in Germany and the country of origin cause dissatisfaction of migrant nurses with the working conditions in Germany and hamper their workplace

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<sup>40</sup> A survey among works' councils carried out in hospitals across Germany found that more personnel is needed in the wards in order to do work of high quality. The personnel gap is calculated at 19.3 per cent for Hamburg and at 19.6 per cent for Germany (EXT5).

<sup>41</sup> This finding is in line with Microcensus data, showing rather low relevance of part-time employment for doctors. In 2010, only 14 per cent of 373,100 working doctors had part-time jobs (Demary and Koppel 2013).

<sup>42</sup> Nursing qualification in Germany is obtained in vocational training programmes whereas in many countries it is university education. Thus nurses who obtained training abroad are often university graduates compared to apprentices in Germany. Basic care belongs to the tasks of a nurse in Germany whereas in many countries is assigned to nursing assistants.

integration in the long run. This applies particularly to nurses who obtained academic education in nursing abroad and have to get used to untypical tasks (EXT4, EXT8, EXT9). The representative of the German Nurses Association emphasised the need to adapt German nursing training to international standards in order to make it more competitive, by introducing academic education in nursing with corresponding tasks (EXT4). She referred to several cases of Spanish nurses who came for work to Germany and left the country because they were unsatisfied with the tasks:

*“As last year primarily Spanish nurses were recruited, we could then read in internet forums how appalled the nurses were, when basic care tasks were assigned to them. (...) They were not used to this as in their countries of origin this is done by nursing assistants. And they perceived this as an imposition for someone with a Bachelor degree to do such work. Many could not accept this and returned indignant or emigrated to another country” (EXT4)*

#### 4.3.4 Relationships at the workplace

Good relationships in the workplace are crucial for workplace integration, as one interviewee summarised: *“The most important part of integration is social work”* (DOC3). Both positive and negative experiences with colleagues and superiors in the workplace were described.

##### Working in multicultural teams

Some interviewees are not working in multicultural teams and emphasised being the only foreigner in the team that can be a disadvantage. A researcher experienced mistrust by colleagues that she explained by the fact that she was the only foreigner in the team: *“The other 10 to 20 percent were afraid of me, because I spoke English. I defiantly felt like an outsider. But I expected that. [...] I was the only Non-German”* (RES1). Several interviewees referred to positive experience with working with different nationalities at the current workplace in Germany or in other countries (RES1, RES2) and expressed preferences to work in a multicultural team (RES1, RES2, NUR8, NUR10). Multicultural teams are considered as an asset for the working atmosphere and working process. They are associated with *“openness, different perspectives”* (DOC7); *“different way of working and approaches to solve problems”* (RES2); *“other way of thinking, not entangled in his or her visions.”* (DOC6)

The presence of other foreigners in a team is perceived as supportive for integration at the new workplace and as a positive contribution to good working atmosphere. An interviewee reported about concrete support for career development by colleagues with migration background (DOC4). A nurse from Spain explained: *“I prefer working multicultural and with foreigners. They know your situation better, because they had experienced the same.”* (NUR10). Drawing a comparison to a multicultural neighbourhood, a nurse from Bosnia-Herzegovina stated:

*“If I could buy a house, I would buy it where it is multicultural. It is about acceptance. [...] I can be 100 percent German, but I also can be somehow different. And when you have like-minded people too, relaxation comes fast.” (NUR8)*

### Challenges in multicultural teams

Conflicts in the workplace are mostly attributed to individual characteristics rather than to different cultural background of colleagues. Several interviewees stated that they had occasionally conflicts with colleagues, but the source of conflict was individual and not migrant-specific. A head doctor argued in the same line, by sharing her experience with managing a multicultural team: *“Integration depends on the personal characteristics; the question is to bond the team together, to bond different personalities together.” (DOC7)*

Tensions in the team are often related to hierarchical structures that is more a general than a migrant-specific phenomenon in the German healthcare sector. Teams seem to be perceived as intra-professional as nurses and doctors rarely refer to the other profession when speaking of their team. In intra-professional teams, tensions were attributed to daily work processes as decision on individual medical cases and hierarchical issues. Further conflicts occur among persons at different levels of career. For instance, assistant doctors described conflicts with head doctors (DOC1, DOC2) and nurses mentioned conflicts with head nurses (NUR1). In inter-professional teams including different professions, particularly tensions between doctors and nurses were stated. Some doctors described difficulties in communication with nurses (DOC5) and *vice versa* (NUR12). A head doctor explained tensions between nurses and doctors as a specific phenomenon of the city, by arguing that there is much more hierarchy in Hamburg than in other German states where she had previously worked: *“We were all on duty nurses and doctors; all in the same pot; in Hamburg it is much more hierarchical.” (DOC6)*

In some cases, tensions at the workplace were attributed to mistrust and prejudice against the foreign qualifications or the country of origin. Interviewees encountered mistrust against their professional skills not only by colleagues but also by patients. *“The disrespect on the part of nurses and patients can unfortunately not be denied.” (DOC4)*. For instance, a patient took a migrant doctor of Asian origin for the cleaner or patients did not accept treatment by a migrant doctor or nurse and insisted on being treated by a German worker. Migrants show understanding of mistrust by patients (DOC9, NUR5). A Portuguese nurse accepted mistrust as being something natural in stress situations, sharing her experiences with parents at the emergency department: *“When you are coming with your child and suddenly a foreign nurse appears, you have naturally doubts about the competence” (NUR5)*.

Mistrust against his professional skills obtained abroad on the side of colleagues was criticised by a doctor from a South Asia in this way:

*“When someone comes here, at first people do not believe that he or she is good (...). It is not easy for us. As a doctor who studied abroad, one has fewer chances than others although we are*



*equal on paper. When I have a licence to practise it means that I'm just as people who studied here." (DOC5)*

A head doctor gave a similar example of a highly qualified colleague from South America who was mistrusted as “*latino*” with regard to his qualifications, when he started in the hospital, and only with the passage of time, his outstanding professional skills were acknowledged by the colleagues (DOC6). A Chinese researcher, for instance, has been facing prejudice against her country of origin on a daily basis. An Indian doctor and a Portuguese nurse felt discriminated in a job interview, when their background was given as a reason for not employing them. As a male nurse coming from Central Asia, an interviewee was perceived as “*an exotic species*” in the workplace and felt rather a reserved attitude of the colleagues towards him (NUR6). Similar experiences described a nurse from an Arab country:

*“Yes, I look differently. And some people – as I found out – possibly had bad experiences with Arabs or with Afghans. And that's why you sometimes feel prejudice. It is just a feeling.” (NUR13)*

Distance in the communication with non-migrant colleagues was experienced by some interviewees. A researcher from Southern Europe who experienced distance on part of a German colleague could not understand the reason until she asked her openly. The source of tensions was described in this way:

*“Not because we are from other countries, it is just for the background. [...] Just for the way to deal with something. Just this is different. Because I am Italian. I am open. I would like to speak very openly. It is the cultural thing on the back of us.” (RES2)*

Openness of both colleagues and migrants are perceived as a key to good relationships in the team (NUR4, DOC3). A young doctor felt uncertainty at the beginning at the workplace as he was not used to the way of interacting and communicating in Germany. “*Does he or she like me? (...) Is he direct? Is he not direct? The way how people interact is simply completely different.*” (DOC9) He further argued that it helps to become acquainted with the German culture of communication: “*One should not become angry when Germans address directly something they do not like. One should not think they would criticise because you are a foreigner*”. (DOC9)

Equality in multicultural teams is highlighted as a further prerequisite for good relationships in the team. A Spanish nurse argued that both foreign-trained and German-trained colleagues consider themselves as equal in the team:

*“I don't feel that I can do better with a university degree or that my colleagues know more than me. Important is the experience. Like everywhere. I do not know what they are learning here at the vocational training. I feel myself in the same position and I think it is the same for my colleagues.”*

A researcher viewed positively that she is appreciated and equally treated in the workplace despite her foreign origin (RES3):

*“I’m neither preferred nor worse treated. There is equal treatment. There is neither discrimination nor prejudice. If someone is good, he does advance”. (RES3)*

A doctor argued that equality is practised in the team and emphasised the role of team management for this:

*“Nobody in the wards thinks that as a German, he or she is better than the other colleagues. If it would be the case, the head doctor would intervene. If someone develops such feelings, he or she would be dismissed.” (DOC8)*

Intercultural sensitisation at workplaces is emphasised as a way for reducing inequality and a poster campaign at a former workplace under the slogan *“We all working together”* was given as a good example (NUR8).

### Off-jobs relationships

Socialising outside the workplace appears as an issue in many interviews. Mixed experiences with off-job relationships are found. Whereas some migrants feel well integrated in the team and emphasised that they have social relationships with colleagues also outside the workplace, other interviewees felt isolated particularly at the beginning of employment. This is not attributed to being a foreigner but to German culture of separating work and social life. A young doctor from Eastern Europe referred to a cultural shock as colleagues were not taking interest beyond working relationships (DOC1). A young researcher missed the culture of having a drink with the colleagues after work together: *“You work and you work and then you go home. And that’s it. You don’t mix up the two.” (RES1)*

Broader social integration outside the workplace was partly stated as a challenge and adaptation to *“daily life in Germany”* as difficult (DOC3). Some interviewees had difficulties to establish social contacts outside the workplace (DOC1, DOC8, NUR10) or to find housing in Hamburg (DOC4, DOC5). Migrants with family members already living in the city reported about helpful assistance by family networks (NUR12, NUR5, NUR2). Migrants that had worked and lived in smaller German cities before and moved to Hamburg appreciated the more diverse possibilities to meet people, visit cultural events, make use of wider choice of language courses and jobs for partners (DOC9, DOC10, NUR9, NUR10).

Some migrants struggled with unacceptance as being part of the society as the statement of a migrant worker show who was asked by their colleagues whether she is expecting to go back to her home country:

*“I felt like, I am expected not to stay. And a couple of people make a little comment, like you are a guest here. And they mean in a nice way: Like you are very welcome, you are a guest. But I don’t feel like I am a guest. I work here. I have a contract here. I feel like I am part of the German – I am not German – but I am part of the German society.” (RES1)*

## 4.4 Career plans

### Retention in the workplace

Career plans of migrants vary depending on their stage of career and occupation. Retention in the workplace was mostly related to satisfaction with working conditions. Long working hours and shift work could negatively affect the work-life balance and were often stated as a burden (DOC1, DOC9, NUR5, NUR8) or a reason to leave (DOC1). Nurses complained about dense workload and physical strain (NUR3, NUR10, NUR12), and wished higher wages although nurses are seen as well paid in comparison to other vocational occupations in Germany (NUR7, NUR8). A head nurse that began to work in Germany in the 1990s observed increasing workload and low wages not only as an obstacle to keep staff, but also to attract nurses from other countries:

*“[In the past], as a foreign nurse, it was possible to work more relaxed. Today it is more demanding. There are performance pressures. A foreign nurse always thinks, when you have to work hard you should get a lot of money. And that is no more the case. [...] If I tell fellow-countrymen that from 1,400 euro they have to spend 600 euro for renting a flat, they would wave aside. The Balkan [as a recruitment region] is over.” (NUR8)*

The opportunity for permanent positions affects the intention to remain in the workplace. Whereas most nurses had permanent contracts, temporary contracts affect mostly doctors in the early stage of career development. Some assistant doctors stated that they would stay in the workplace if they are offered a permanent contract (DOC8, DOC3). However, due to the time restrictions for working on a temporary basis, assistant doctors at university hospitals often have to change the workplace (DOC4).<sup>43</sup> In fact, offering a permanent contract has been used as a retention strategy by hospital managers, as was the case with a doctor (DOC1) and a researcher (RES3). Better working conditions were offered to a doctor, when she wanted to leave the workplace (DOC7).

Considerations about remaining in the workplace are often related to opportunities for career development. Better training and a higher position were the main factors for doctors for changing the workplace. For instance, as an assistant doctor was not satisfied with the quality of specialty training, he changed the workplace three times before finishing his specialisation (DOC9). A head doctor who assessed his chances for a chief position in his current workplace as little was already looking for a new job where he could influence working processes to a large extent according to his own visions (DOC2).

Nurses often miss academic opportunities for career development in Germany that they have in the countries of origin (NUR5) or that further specialisation is not actively supported in the workplace (NUR1, NUR5, NUR10, NUR12). Many nurses consider starting or had already started further training or studies in the field of

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<sup>43</sup> According to the Academic Fix-Term Contract Law (*Wissenschaftszeitvertragsgesetz*).

care management or medicine (NUR1, NUR3, NUR4, NUR10, NUR12, NUR14). As nursing is considered as a highly demanding profession, with immense physical strain, that could not be practised up to retirement, academic education is considered as a strategy for securing employment in the future. Some interviewees – both doctors and nurses – consider self-employment as an option that offers more flexibility and better work-life balance (DOC1, DOC7, NUR6, NUR8). Concerns about self-employment are related to financing and attracting patients as migrant doctor (DOC4, DOC9) and to a lack of secure employment (NUR5).

### Staying in Germany

Satisfaction with the job, quality of life and family reasons affect the intention to remain in Germany. Intention to remain in Germany was expressed by most of the interviews. Few indicated further migration as very likely. Quality of life in Germany motivated some interviewees to remain (RES1, NUR5) but for others it was a reason for emigration (DOC4). Some interviewees remained in Germany because of the family (DOC2, NUR8, NUR12, RES3) and better prospects for children in terms of education or security (DOC6, DOC10, RES3). Others plan to migrate in order to follow their partners (RES1, DOC3) or started to think of remigration after getting divorced (RES3, DOC4). Bad career opportunities of the partner in Germany whose professional qualification was not recognised motivate a doctor to return to the country of origin (DOC3).

Plans to go abroad were often linked to career opportunities. Bad economic situation in the countries of origin keeps some migrants from returning, as Spanish and Portuguese nurses stated. An Italian researcher held the view that she could go back to the US, where she had already worked, but not to return to the country of origin due to the lack of career prospects:

*“I knew that I didn’t want to go back to Italy. That was sure, because in Italy the situation was too difficult. To do research in Italy is nearly impossible. There is no funding. [...] I knew that the situation is too unstable.”*

Going abroad is considered as an opportunity to follow career paths that are considered barely possible in Germany. For instance, a doctor would like to work both in a hospital and a private practice (DOC5) and another wishes better opportunities to combine research and clinical work (DOC4). Some nurses mentioned the opportunity to start their own care business in the countries of origin (NUR4, NUR5). However, emigration options are assessed differently by nurses and doctors. Whereas returning doctors with German specialty training are considered having a good reputation in countries of origin (RES3), nurses who did vocational training in Germany are afraid of non-recognition of their professional skills abroad (NUR12, NUR13, NUR14). Also a representative of the trade union *ver.di* criticised the practice to recruit for training as the German vocational training is often not recognised in the countries of origin and may hamper reintegration in the home labour market (EXT6).

Dissatisfaction with the occupational profile in Germany can lead to emigration, as was reported about migrant nurses who had left Germany as they were not willing to do basic care (NUR10, NUR13). Different

professional qualifications across countries were considered as an obstacle to migration, as a nurse from Bosnia and Herzegovina indicated:

*“We are speaking about Europe. I am from Bosnia. It is not yet part of the EU. I am thirty kilometres away from the EU. What measures can be undertaken to make the European market more flexible? [...] the qualifications. It is unacceptable that you have professional training in Germany and in Croatia and Spain it is different. That has to become identical so that you have the same chances. Then you can say I am going to Czech Republic tomorrow or to Germany or to England. We don't want to be bound for 100 years to one workplace. We want to be flexible. Back and forth. We don't have borders but somehow are concentrating on borders.” (NUR8)*

Professional contacts in the country of origin were emphasised as important for knowledge exchange and career development. Being involved in professional networks in Germany and in other countries as well as knowing German structures and the German language is perceived as an advantage for the job prospects (RES3, DOC3). The international professional network is strengthened by conference visits and academic presentations in the country of origin (DOC3, DOC4, DOC7, RES1). Contacts with colleagues internationally are kept by inviting superiors to conferences abroad or to do surgeries in the country of origin (DOC3, DOC4, DOC5). This is usually done on a private basis and missing support of the employing hospital was partly criticised. Some doctors already initiated or aim at establishing bilateral cooperation between their workplace and institutions in the country of origin (DOC2, DOC3). A doctor who has temporary contract in Germany perceives such cooperation as an option for further career development: *“Basically, because I'm concerned about my future, I want to continue with this connection.”* (DOC3)

## 5. Discussion: key lessons and implications

The case of the city of Hamburg can be characterized by relatively attractive healthcare labour market with good infrastructure and career opportunities. It suffers so far no general labour shortages for doctors but increasing pressure in the nursing profession. Therefore, shares of foreign health workers are relatively low compared to other German regions, particularly among doctors. Whereas hospitals in other German regions already recruit staff actively abroad, Hamburg hospitals still mainly rely on their favourable labour market position within Germany, but prepare for the future with experiments and pilot programmes. Policies concerning workplace integration of migrant health professions are at the very beginning, particularly at firm level. The study showed the importance of successful workplace integration and identified three fields of actions for better workplace integration.

### Job-related language skills

A key challenge for migrant health workers irrespective of nationality and occupation is the requirement to communicate with colleagues and patients in German and prepare much documentation. Not only general language but particularly job-related language skills turned out to be demanding at workplaces. Missing job-related language knowledge diminishes the full valorisation of migrant workers' skills in the early stage of employment and in consequence, reduces the acceptance by colleagues in the team. Many health workers had received substantial amounts of language training but face high language requirements in terms of technical and colloquial medical language only on the job.

Therefore, specific learning opportunities should be explored on several levels, particularly opportunities that can be combined with work in hospitals. At firm level, language facilitators who accompany newcomers during part of their working day and support individual learning strategies in highly specialized departments can be helpful. Language facilitators should be familiar with the specific job and workplace features, therefore, an assignment of employees associated with the workplace is pertinent, for instance as a retention measure for persons on parental leave or in early retirement, by offering them part-time work. At national level, additional job-related language courses can be funded by state institutions that can be organised according to local needs. At EU level, an online multilingual learning platform for health professionals, sponsored for example by the EU, can allow to gain and improve technical and colloquial medical language even before migration and continuously on the job.

### Adaptation to a new workplace

Partly due to missing language skills and practical experience in the country and the specific workplace, migrant health workers often need additional time for their job tasks and help with a number of work-related and non-work related issues at the beginning of employment. All interviewees emphasised that the supervisors and colleagues played a major role in the adaptation at the beginning of their employment. Mostly informal support was offered, but a more intense support by an experienced colleague or a mentor in the workplace was seen as advantage. It can facilitate the adaptation to new working processes and culture and lead to the full utilization of migrants' skills in the workplace.

Mentoring by colleagues during their working time is experienced as insufficient because of increasing performance pressures and workload in hospitals, as repeatedly addressed in the interviews. Mentoring systems can show satisfactory results when both newcomers and mentoring colleagues are given extra time and resources for this task. But also improvement of working conditions in hospitals in general can help, by giving migrant workers more time for individual adjustment to German conditions.

### Working in multicultural teams

Working in multicultural teams is predominantly considered as enrichment. However, whereas internationality is more common and highly valued in research teams at the hospitals, practicing migrant doctors and nurses experience prejudices by colleagues and even more by patients. Although their qualifications are fully recognised at this stage, migrant workers particularly mentioned prejudices against professional skills as not being perceived as equal to German qualifications.

Intercultural sensitisation and information about foreign qualifications can be helpful for creating good working atmosphere. Intercultural training for employees, especially for doctors and nurses in leading positions, as well as public campaigns in the workplace can reduce prejudice and contribute to intercultural understanding. For instance, a poster campaign stressing the value of foreign professional qualifications can increase their acceptance on the part of colleagues and patients.

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## Appendix: List of interviews

### A) Interviewed migrant workers in academic occupations

Interview code	Gender	Age	Occupation	Region of birth	Region of training
DOC1	M	36	Doctor	EU	EU
DOC2	M	42	Doctor	Non-EU	Non-EU
DOC3	M	38	Doctor	Non-EU	Non-EU
DOC4	F	33	Doctor	Non-EU	EU
DOC5	M	38	Doctor	Non-EU	Non-EU
DOC6	F	49	Doctor	EU	Germany
DOC7	F	52	Doctor	Non-EU	Non-EU *
DOC8	M	47	Doctor	Non-EU	Non-EU
DOC9	M	32	Doctor	EU	EU
DOC10	F	42	Doctor in internship	Non-EU	Non-EU
RES1	F	28	Researcher	Non-EU	Non-EU
RES2	F	37	Researcher	EU	EU
RES3	F	56	Researcher	Non-EU	Non-EU
RES4	M	27	Researcher	Non-EU	Non-EU

\* Second training in healthcare in Germany

### B) Interviewed migrant workers in non-academic occupations

Interview code	Gender	Age	Occupation	Region of birth	Region of training
NUR1	f	38	Medical assistant	Non-EU	Non-EU*
NUR2	f	50	Medical assistant	Non-EU	Germany
NUR3	f	46	Nurse	EU	Germany
NUR4	f	37	Nurse	Non-EU	Germany
NUR5	f	33	Nurse	EU	EU
NUR6	m	40	Nurse	Non-EU	Germany
NUR7	m	49	Nurse	Non-EU	Non-EU
NUR8	m	45	Nurse	Non-EU	Non-EU
NUR9	f	40	Nurse	Non-EU	Non-EU*

NUR10	f	27	Nurse	EU	EU
NUR11	f	62	Nurse	Non-EU	Non-EU
NUR12	f	43	Nurse	EU	EU*
NUR13	m	26	Nursing trainee	Non-EU	Non-EU*
NUR14	f	29	Nursing trainee	EU	Germany

\* Second training in healthcare in Germany

### C) Interviewed managers

Interviewcode	Position	Organisation	Date
MAN1	Manager in charge of guest researchers	University hospital	20.06.2014
MAN2	General manager	University hospital	22.07.2014
MAN3	HR manager	University hospital	13.10.2014
MAN4	Two managers in charge of nurse training and further education	University education academy, University hospital	09.09.2014
MAN5	General manager	Private hospital	11.09.2014
MAN6	Manager in charge of nurse training	Education centre for healthcare occupations, private hospital	02.09.2014
MAN7	HR manager	Private hospital	12.09.2014

### D) Interviewed representatives of works councils

Interview code	Position	Organisation	Date
CON1	Representative of works council for the non-academic staff	University hospital	25.07.2014
CON2	Representative of works council for the academic staff	University hospital	12.08.2014
CON3	Two representatives of works council of a subsidiary	University hospital	11.09.2014
CON4	Representative of works council	Private hospital	24.11.2014

**E) Interviewed experts outside the hospitals**

<b>Interview code</b>	<b>Name</b>	<b>Organisation/ Project</b>	<b>Date</b>
EXT1	Jan Stephan Hillebrand	Manager of pilot project for recruitment of nursing trainees from Tunisia, Hamburg	03.06.2014
EXT2	Daria Braun	Initial contact point for information and referral in support of the Recognition Act, Otto Benecke Stiftung, Berlin	06.06.2014
EXT3	Michael Gwosdz	Initial contact point for information and referral in support of the Recognition Act, Zentrale Anlaufstelle Anerkennung, Diakonie, Hamburg	23.06.2014
EXT4	Johanna Knüppel	German Nurses Association, Deutscher Berufsverband für Pflegeberufe, <i>DBfK</i> , Berlin	18.07.2014
EXT5	Michael Stock	Trade union <i>ver.di</i> , Hamburg	23.07.2014
EXT6	Margret Steffen	Trade union <i>ver.di</i> , Berlin	24.07.2014
EXT7	Ruth Wichmann	Professional association of employed doctors <i>Marburger Bund</i> , Berlin	15.09.2014
EXT8	Sylwia Timm	Advisory center for the care sector, Project Fair Mobility, Berlin	21.11.2014
EXT9	Andreas Brandes	Gesundheitswirtschaft Hamburg GWHH, subsidiary of the Free Hanseatic City of Hamburg and the Hamburg Chamber of Trade	06.01.2015