Centre on Migration, Policy and Society

Working Paper No. 99
University of Oxford, 2012

Migrant Britain, sustainable Germany: Explaining differences in the international migration of health professionals

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WP-12-99

Abstract

There is a widespread assumption that demographic change will produce an increasing international migration of health professionals because of a growing demand for medical services in OECD countries. I challenge this argument and show that the ageing of societies is not necessarily accompanied by a growing demand for international recruitment. Based on the analysis of the German and the British cases I show that structural characteristics of national health sectors are more appropriate to explain patterns of migration. Apart from explicit migration policy I focus on two other arenas: the overall setting of health policy and procedures of recognition of qualifications.

Keywords

Migration of health professionals, doctors, nurses, German health sector, NHS, comparison, international recruitment, recognition of qualifications, corporatism

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Research interest and empirical background

The health sector is among the most important economic sectors in most OECD countries providing employment for about 10 per cent of national workforces. Among these health professionals are many migrant workers, who can be roughly differentiated into three categories: those already living in the country; those specifically recruited to fill vacancies; and those who migrated individually and were motivated by classic push and pull factors. However, in an international comparative perspective differences with respect to absolute numbers as well as to the distribution between the categories are huge. While in the UK about one out of three medical doctors is not British or not trained in the UK (Kelly/Morell/Sriskandarajah, 2005), in Germany this is true for only one out of seventeen (Bundesärztekammer, 2008b). This is intriguing given the widespread assumption which I would like to call the 'demographic nexus' – or even 'demographic axiom'. It suggests that ageing societies demand a growing amount of medical services. This growing demand will contribute to an increasing international migration and recruitment of health professionals. The many recently published studies on the migration of health care workers (OECD, 2007a; OECD, 2008; European Commission, 2006) testify to the increasing importance attached to this topic.

The main reasons for a supposed growing demand on the part of OECD countries are rapidly rising costs because of demographic change and medical technical progress. It is assumed that governmental actors tend to keep increasing costs at bay by avoiding higher investments in the expansion of training capacities. The training of a medical doctor is the most expensive training and takes about 12 years including specialist training. This long training period represents another reason for the expected growing demand for migrating doctors: Even if governmental actors decide to increase training capacities it will take too long to 'produce' home-grown doctors. In the area of nurses a supposed general unattractiveness of the profession makes it difficult to attract enough young professionals. In migration research nurses are regarded as one of the professional groups mostly in demand internationally (Iredale, 2001).

It seems that a growing demand in OECD countries is met by a vast supply of doctors and nurses from lower income or less developed countries who want to escape poor pay and working conditions. Hence, the causality implicit to the 'demographic axiom' seems persuasive and is hardly challenged in migration research as well as public debate.

But a first look at the huge differences between the number of foreign health professionals in different OECD countries suggests questioning this simple nexus. The demographic situation in all countries is similar but patterns of recruitment and migration differ significantly. A comparative analysis of international recruitment activities in six national health sectors (Germany, Italy, Netherlands, Portugal, Switzerland and the United Kingdom) showed that indeed five of these countries rely on international recruitment to face domestic labour shortages. However, the importance of international migration and recruitment is far from being proportional to the

demographic profile (Den Adel et al., 2004; more detailed Hoesch, 2009).[1] The situation in Italy and Greece directly contradicts the demographic axiom (OECD, 2009a). But *only* Germany did not show any serious interest in international recruitment activities during the study's sample period 2001-2004. On the other hand the United Kingdom had large scale international recruitment of health professionals between 1997 and 2006 (Den Adel et al., 2004; Hoesch, 2009). In 2001-2002 more than half of new registered nurses were overseas trained (NMC, 2005).

If one only regards the headlines and rhetoric of some stakeholders in recent years it seems that Germany follows the British experience. It has repeatedly been debating a looming shortage of doctors. Headlines such as "Recruiting as far as the Pacific" (Süddeutsche Zeitung, 2003), "Hospitals face staff crisis" (Balser, 2003) and "Mass retirement causes alarming shortages of doctors" (Meiritz, 2008) have appeared in the newspapers periodically and refer to a supposedly looming shortage.[2] In 2003 the two main doctors' professional associations published a much noticed statistical report called "Germany runs out of doctors" (Kassenärztliche Bunesvereinigung/Bundesärztekammer, 2003). While they argued, the soon-to-be retired doctors exceeded the number of new trained doctors, actual studies show, that the total number of registered doctors has continuously been increasing in the time period from 1991 until 2009 (Bundesärztekammer, 2010). Additionally in Germany the number of practising physician per 1000 population has always been above OECD average.

Interestingly enough interviews with these associations conducted by the author of this article revealed that despite these "looming shortage scenarios" international recruitment is not regarded as a strategy to fill vacancies. A totally different picture appears in the UK. There interviews showed that international recruitment represented a strategy to expand the NHS. Compared to the UK it seems that the strong issue of doctors' shortages in Germany does not fit the quantitative importance of migrant workers in the health sector and contradicts the demographic axiom.

This first look at the very different cases of Germany and the UK reveals that the demographic argument alone obviously is too simple to explain current and future migration and international recruitment of health professionals adequately. But what are the reasons? It is striking that the most different cases in terms of medical migration also represent the most different cases in terms of health systems. In Germany the statutory health insurance funded by contributions and shaped by a high degree of corporatism; in the UK the tax funded National Health Service is strongly influenced by governmental decisions. The present article begins with the idea that since similarities such as demographic change and medical technical progress are not able to explain differences in terms of migration we have to analyse the impact of structural differences between the two health

[1] The starting point of this comparative analysis was empirical data provided within the European research project "PEMINT" (The Political Economy of Migration in an Integrating Europe), funded by the European Commission within the Fifth Framework Programme. The author of this article was part of the research team. For details on research interests and findings of the project see Bommes et al., 2004)

[2] Translations by the author.

sectors, i.e. the impact of different funding and organisational structures and resulting different actors' constellations.

Hypotheses

In the following I will present my research hypotheses which are also supported by interview data which is presented later on as well as some ideas extracted from current approaches, namely Iredale (2001), Bach (2007) and Freeman (1995).

I assume that the demand for medical migrants does not inevitably accompany the ageing of western industrial societies. Whether severe labour shortages emerge or not and how they are dealt with strongly depends on the overall design of health policy, financial resources, workforce planning and the role that the relevant professional groups play within this overall setting.

I assume that the position of professional organisations and their degree of power within the political process is the crucial level of analysis if we want to explain the different outcomes in terms of international migration. This is because in most countries' health sectors professional organisations, especially doctors' organisations, play a major role in designing and regulating medical training, controlling access to the labour market by issuing licences and recognising or rejecting foreign qualifications (Iredeale, 2001). However, despite this general feature huge differences between countries exist with respect to the actual assertiveness vis-à-vis governmental actors.

Furthermore it is too narrowly considered to analyse the international recruitment and migration of health professionals in an isolated way. Instead it has to be conceived of as an integral part of overall strategies of workforce planning and health policy. There are three political arenas within national politics, which are relevant in terms of outcomes of international migration: 1. Health policy and workforce planning; 2. Migration policy; 3. Recognition of qualification and issuing of licences.

While in arenas 1 and 3 professional groups might be equipped with great authority, the arena of migration policy, at least in the area of doctors, is far less important than in other labour market segments. Most countries facilitate temporary migration for the purpose of training.

I assume that professional organisations will follow their interests of securing the attractiveness of the profession in all three arenas. In arena 1 they will try to lobby for a sustainable workforce planning and securing the attractiveness of the profession in terms of pay and working conditions – if they succeed, arena 2 and 3 will never become relevant; if shortages emerge in arena 2 they may lobby for opening or closing specific immigration categories in accordance with the respective labour market situation; arena 3 may serve as a kind of *a posteriori* instrument of control. If outcomes in arena 2 cannot be influenced favourably, the recognition of qualifications and the issuing of licences will regulate access to the medical labour market.

In the present paper the focus is on arenas 1 and 3.

Current migration research on medical workers

Roughly speaking two types of approaches can be distinguished. Those concentrating more on describing, categorising and labelling empirically observable migration flows of medical workers, and those concentrating more on developing theoretical explanations of migratory flows and looking for links with existing theories.

Flows of medical migrants and supposed reasons

The more descriptive studies have four main assumptions in common regarding the reasons for the international migration of health professionals. The first assumption is that migratory flows of health care workers followed in the wake of expanding welfare states. When western industrial states expanded their health systems in the post-war period the migration of health care workers from low-income to high-income countries seemed to be the logical consequence. Expanding welfare states were not able to 'make' home-grown doctors and nurses fast enough to fulfil the growing demand. So they 'bought' additional staff from low-income countries with residual welfare regimes and health care stagnating at a low level (cf. Bach, 2003).

The implicit assumption here is the classical argumentation of push and pull factors referring to wage differentials as the driving force of migratory flows. Furthermore it is assumed, that training doctors is expensive and time consuming and might prompt countries to make use of international recruitment. Stephen Bach assumes that the importance of health professionals' migration to western industrial counties will rise soon because of

> "the well-known demographic profile of most OECD countries [...] alongside the marked reluctance or inability of most governments to train sufficient workers to meet the demand of their health sectors" (Bach, 2003: 9).

In the area of nurses a general lack of attractiveness of the profession and related problems of attracting enough young professionals are assumed (cf. Hoesch, 2009: 107; Buchan, 2002).

Against the background of these assumptions, the picture of migration patterns that is drawn by the more descriptive studies is not surprising. A general south-north-migration, which after the end of the cold war was compounded by an east-west-dimension – in each case structured by wage differentials and the developmental stage of national health sectors. Closely connected to this dynamic is a broad debate on 'brain drain' of health personnel. This problem of 'brain drain' has been relevant since the 1960s and has been debated in academia, media and among decision-makers equally. According to an initial survey conducted by the WHO in 1972 six percent of all doctors worldwide were residents elsewhere other than in their home countries. 86 per cent of these doctors were employed in only five countries: Australia, Canada, Germany, United Kingdom and United States (Mejia et al., 1979: 399-400).

Recent studies

More recent studies conducted by the European Migration Network (European Commission, 2006) and the OECD (OECD, 2007a; OECD, 2008) have taken into account the supposed growth of international migration of health professionals and tried to operate in a larger international context and in the wider context of current challenges of health policies. Apart from the consensus on the demographic nexus all surveys agreed on a point of criticism: the inadequate data, which makes a reliable international comparison difficult.

A wide strand of migration research is concerned with problems of labour market integration of health professionals. A number of studies focus on problems of 'brain waste' and downgrading of migrant workers in the health sector as well as problems of discrimination. The latter approach is often combined with a gender perspective due to the fact that in most OECD countries 80–95 per cent of nurses are female (Gupta/Diallo/Zurn/Dal Poz, 2003). It is therefore "one of the most prominent examples of gendered occupational segregation" (Bach, 2007: 383).

In this article I will briefly introduce three approaches, which do not deal exclusively with the migration of health personnel but rather with the migration of (high) skilled personnel in a more general way. They can be applied to the migration of health professionals in a productive way and have supported my research hypotheses. All three approaches have in common that they explain liberal or restrictive preferences with respect to foreign employment by analysing specific actor constellations and the influence actors have to follow their preferences.

Instructive approaches underpinning my hypotheses

Iredale (2001) provides an instructive approach with respect to the international migration of health professionals. While other approaches usually focus on explicit migration policy, Iredale analyses the way in which professional bodies and associations are able to admit or obstruct access to the labour market and thus have the capability to follow specific professional interests. The starting point is the fact that many professional organisations play an important role with respect to the regulation of training, the granting of professional licenses and the recognition of qualifications.

From such a perspective international migration of high skilled personnel can be viewed as a two-step flow. Firstly national frontiers have to be passed, secondly obstacles to access specific labour market segments have to be overcome. As to the first point, residence and work permits are the instruments of control, governmental actors are the gatekeepers; as to the second, recognition of qualification and the issuing of professional licenses are the levers to open or block, professional organisations are the gatekeepers.

Iredale shows that both the delegation of control from governmental to professional actors as well as the willingness to make use of it in a restrictive way differ between sectors and professional groups. While 'young' sectors such as the Information and Communication Technology show a high degree of internationalisation and "are relatively free of national or professional controls

[...] the medical and nursing professions are relatively nation and profession bound" (Iredale, 2001: 15).

While professional actors quite often justify restrictive admission policies with the aim to preserve high quality standards, it is obvious that other interests - mainly keeping away too much competition - are also driving forces.

The second approach, which can be exploited for the purpose of this article, focuses on the migration of nurses. Concentrating on the regulation of nurse migration to the UK, Stephen Bach (2007) analyses the role that industrial relations play with respect to the labour market inclusion of foreign staff. Though Bach recognizes the important role that governmental actors have with respect to controlling labour migration he also emphasises the scope for action which still remains for social partners in implementing governmental targets:

> "Although the nation state has a dominant role in regulating migration, employers and trade unions interpret state policy and seek to shape it in a way that promotes theirs interests." (Bach, 2007: 394)

Bach states that the main reason for this is the strong influence of nurses' trade unions. In the British labour market nurses are among the professional groups with the highest level of organisation, membership rates estimated to be about 85 per cent.[3] As a consequence it can be assumed that trade unions and employers' organisations are important actors with respect to labour migration in the health sector.

Bach's view on the implementation side of the affair as well as on the influence of other than state actors, promises to be quite instructive for the comparative analysis of patterns of migration in different national health sectors. Yet it has to be taken into account that Bach's approach is strongly bound to the specific conditions in the British health sector. In Germany for example the situation is totally different: nurses are among the professional groups with the lowest degree of unionisation, with organisation rates estimated to be lower than 10 per cent (Hoesch, 2009: 108). Also in Germany not unions but professional associations are the main actors in the sector.

The third approach of interest is Gary Freeman's argumentation explaining the 'gap-hypothesis'. The term 'gap-hypothesis' describes an empirically measurable phenomenon (see Hollifield, 1986; Cornelius/Martin/Hollifield, 1994), which showed a discrepancy between restrictive rhetoric of governmental actors vis-à-vis migration on the one hand and relatively expansive migration policies on the other hand. How could this gap between rhetoric and policy outcomes be explained? One of the explanatory models focused on the specific interests of pressure groups vis-à-vis labour migration and their means to feed them into the political process (Freeman 1995). The main idea of this approach is the following. Employers have a particular interest in international recruitment because a generous supply of (foreign) labour prevents wages from increasing and unions

[3] This estimation stems from an interview with the Royal College of Nursing in 2007.

from gaining too much strength in negotiations. As a consequence employers' organisations vigorously lobby for liberal migration policies. Despite of the restrictive rhetoric they succeed because they are able to organise themselves in quite an effective manner. The reason for this is that migration produces concentrated benefits and diffuse costs.

Though Bach and Iredale assume that trade unions are important actors, I assume that at an international comparative level huge differences exist with respect to who the relevant actors are. Therefore I suggest first to clarify *who* the relevant actors in a given sector and institutionally setting actually are, which aims they pursue and which means they have at their disposal to follow these aims in which arena.

While Freeman focuses on explicit migration policy, Bach and Iredale choose a different perspective. Both are sceptical regarding the effectiveness of governmental decision-making and control and focus on interceding non-state actors. The effect is as follows: despite liberal migration policies the actual employment of migrants in certain sectors and labour market segments may be restricted. In such a broader perspective lobby activities of interest groups may occur at two stages: first lobbying for or against liberal migration policies; secondly lobbying for or against easy recognition of professional qualifications and interpreting governmental guidelines in a liberal or restrictive way.

Here the assets of Freeman's approach come into play. The underlying ideas of group theory and collective action give hints of who may be able to influence migration politics in its different stages according to particular interests: small groups rather than big ones (see also: Olson, 1965; 1974). According to this theory we can assume that doctors are better organised than nurses, and employers are better organised than both. The importance of this idea will become easily comprehensible in the further course of this article. It will be shown that in the UK big employers dominate the sector while in Germany despite the existence of big hospitals the overall shape of health policy is strongly influenced by self-employed doctors. Their interests are totally different from big employers' ones. While big employers lobby for international migration, small enterprises such as self-employed doctors can rather be expected to aim at fighting off too much external competition.

Data and Methodology

The present comparative analysis of migration in the British and the German health sectors is based on three sources of data:

First, official statistics concerning the employment of foreign staff in the British and the German health sector; secondly, the findings of twenty-four qualitative interviews with employers in the German and the British health sector, focusing on preferences and strategies vis-à-vis international recruitment and migration[4]; and thirdly semi-structured interviews with relevant actors

[4] This interview data stems from the PEMINT-research project, see footnote 1.

in the German and the British health sector, i.e. with Department of Health officials, representatives of professional organisations (nurses and doctors), trade unions, independent regulators, agencies etc.[5]

As to the first and the second sources, these quantitative and qualitative data only serve as the starting point of the analysis, providing the empirical puzzle as presented above. It has to be noted that a proper and immaculate comparison of stocks and flows of medical professionals is obstructed by different definitions of who a migrant is (for example either based on country of birth or country of qualification or nationality), different availability of data (for example in Germany no central professional registration for nurses exists – therefore no reliable data apart from micro census is available) and different ways of collecting and aggregating data in Germany at state level (Länder) and in the UK in England, Scotland, Wales and Northern Ireland after devolution. Nevertheless, for the purpose of this article the quality of the comparative data is sufficient. Despite a variation of definitions and methods of data collection the overall pattern of migration becomes obvious – huge differences with respect to the relevance of migration despite similar demographic challenges.

As to the third, these interviews with relevant actors in the respective health sectors represent the actual heart of the present analysis. Starting from my hypotheses and the above mentioned approaches of migration research the two health sectors are analysed and compared. Because of the different structures and institutional settings of the German and the British health sector the identification of relevant actors turns out differently. While in the German corporatist and federally organised health sector, interviews particularly focused on professional organisations and agencies at federal and state level, in the UK a stronger focus was laid on interviews with representatives of the Department of Health. Interviewees were asked to elaborate on the following issues. Assessment of their own position in the sector and the process of policy-making; overall assessment of present and future challenges of workforce planning; perception of the relevance of international migration and recruitment in the sector; aims and strategies with regard to workforce planning and/or migration; outlook.

The findings will be presented in three steps. In a first step basic funding and organisational structures of the two health sectors will be sketched, consequences for the overall design of health politics and health policy will be exposed. In a second step effects of specific funding and organisational structures on the development of the workforce will be shown. In a third step the respective relevance of international recruitment and migration in the two health sectors will be interpreted in the light of the preceding considerations on structural characteristics and actors' constellations.

[5] Some of the interviewees were sceptical concerning direct quotation. That is why references to interviewees sometimes are rather vague, e.g. "a representative of a regional medical chamber".

Findings: interdependencies between sector structures and international recruitment and migration of health professionals in Germany and the UK

Funding and organisational structures and resulting actors' constellations

Health services in the British health sector are tax funded. Almost three quarters of NHS funds are raised by taxation whereas around one fifth derives from national insurance contributions (Department of Health, 2003). The National Health Service, introduced in 1948 and based on the ideas of the 'Beveridge Plan', provides universal coverage for all citizens and denizens.[6] Broadly speaking the organisational structure can be described as hierarchic with a strong impact of governmental control, from a German perspective it even represents a quasi-state sector (Mayntz/Scharpf, 1995: 26).

Health services in Germany by contrast are mainly financed by social security contributions. Funding is not part of the overall state budget and therefore difficult to control by governmental politics. The shape of the German health sector is mainly determined by the shape of the statutory health insurance ("Gesetzliche Krankenversicherung", GKV), originally introduced in 1883 within Bismarck's landmark package of social security laws. Today it encompasses about 90 per cent of the German population (Rosenbrock/Gerlinger, 2006).

In the comparative analysis of welfare states, the Bismarck type on the one hand and the Beveridge type on the other hand represent two opposed role models of welfare distribution with respect to modes of funding and organisation and eligibility for benefits (e.g. Schmid, 2002). Approaches from the field of comparative health systems analysis confirm the distinct role model character of these two health systems. Among the three classical types "Private insurance", "Statutory social insurance" and "State-generated National Health Service" Germany can be ascribed to the second, the UK to the third category (Gellner/Schön, 2002).

But what exactly are the *effects* of these different modes of funding and organisation? Roughly speaking they are twofold, namely economical and political, and materialize in different forms of incentives for individual as well as collective actors.

Economic effects of taxes vs. contributions

At macro level the main difference is the limitedness vs. limitlessness of financial resources. Taxes are part of the overall state budget. Therefore they are limited *a priori* and compete with other policies for scarce resources. Contributions, by contrast, are earmarked for a specific purpose and are levied independently from and in addition to taxes. In statutory health insurance systems the level of contributions is determined not by governmental actors but by the statutory health insurance companies.[7] In tax-funded systems governmental actors decide whether to increase health

[6] For details see Lowe (2005).

[7] Since January 2009 contributions are determined centrally by the Department of Health. However, insurances are still allowed to raise additional contributions.

expenditure or to restrict it. However, since tax increases are generally unpopular and might jeopardize a re-election, governmental actors usually try to avoid increases. By contrast in social security systems funding and investments are to a considerable extent detached from political and economic cycles. If costs for health services and investments increase, health insurances are able to react by increasing contributions as well – regardless of political considerations such as chances for re-election. These effects of different modes of funding become more visible if we regard health expenditure as a share of the gross domestic product. While Germany has always spent far more than OECD average and has been among the four most expensive health systems in the world, the UK has always spent less than the OECD average (OECD 2009b).

At meso level the distinct modes of funding can be held responsible for the existence or absence of an additional tier of non-state actors in Germany and the UK: the statutory health insurance agencies. Within the corporatist structures of the German health sector they represent strong actors following their own interests. They control the level of contributions individually and are free to increase them if necessary.

Governmental actors in Germany have delegated large areas of competences to corporatist actors among which the organisations of GKV and the KV (Kassenärztliche Vereinigung – the interest organisation of independent physicians) represent the most important ones, strongly shaping health policy outcomes in Germany. They are furnished with a great deal of authority not only in the area of informing health policy and regulating quality standards but also in allocating funding and defining the GKV benefits catalogue listing all medical services to which insured persons are automatically entitled. Relations between the responsible central organisations of GKV and KV can be described as monopolistic and far from fostering competition.

At micro level, the main actors are the individual patients on the demand side and the individual medical doctors on the supply side. The main incentive shaping individual behaviour is money, i.e. on the demand side a cost-benefit-analysis with respect to suggested treatments, on the supply side a cost-benefit-analysis with respect to the amount of work and related remuneration. Since all GPs in Germany and also many consultants are independent practitioners they are in the first place entrepreneurs and accordingly aim at increasing income return. On the demand side individual patients did not have any reason to object to suggested treatments because a growing use of services did not directly affect contributions (cf. Oberender/Fleischmann 2002).

By contrast, these kinds of incentives and risks of supply-induced demand cannot be found in the British NHS. Many doctors – and all consultants – are employed in hospitals and paid salaries. The incentives for the rationally acting individual doctor would be to reduce services in order to work less for the same money. Despite many recent reforms (see Ham 2009) with respect to funding and remuneration these basic mechanisms are still active. Right from the beginning of the NHS the state has had a strong grip on doctors' wages:

> "In paying hospitals centrally a given budget and paying doctors a fixed capitation sum for each patient each year, Bevan [then Minister of Health, KH] unwittingly built into the NHS a powerful mechanism by which the Treasury could control the costs of health care far more effectively than in any other western country" (Glennerster, 1995: 51).

Furthermore and despite the recently growing importance of the private sector the state has always been the most important purchaser of medical services and therefore is in a position to reduce prices (Breyer/Zweifel/Kifmann, 2005: 438).

Political effects of taxes vs. contributions

The proportion of public money in total health care expenditure is often used as an indicator for the level of state penetration and therewith for the relevance of governmental control in the health sector (Alber, 1989; 1998). Since the state pays the bill it is more legitimised to intervene in the sector, define aims and perform the necessary structural changes than in insurance-based systems where the larger part of funding escapes from governmental control. This direct control in tax-funded systems corresponds with organisational structures that are significantly more homogenous and hierarchic than in insurance systems (Wendt, 2003: 19). These latter systems usually lack political controllability. The state has legally transferred instruments of control to corporatist actors. While insurers and suppliers are charged with negotiating the terms of funding and organising health care provision, governmental policy only sets the legal framework for self-government. In comparative health systems research the chances of reform are regarded as small in social insurance based systems and big in tax funded public health services (Gellner /Schön, 2002).

Governmental control of the sector

Among OECD countries the UK represents the country with the highest proportion of tax funding as share of total health expenditure (OECD, 2007b). 87 per cent of total health expenditure is provided by taxes granted by general government opposed to only about 12 per cent in Germany. A further 65 per cent in Germany is provided by GKV insurance contributions. OECD data sums it up to 77 per cent public share, including both social insurance and general government funding. Even in other countries with tax funded public health services the public share of total health expenditure is smaller than in the UK (OECD, 2007b). According to Albers' line of argument this means a very strong governmental grip on British health policy compared to corporatist German health politics.

In the German health sector, apart from the authority to allocate funds, intermediary bodies such as GKV institutions and doctors' professional associations are able to influence legislation particularly in the preliminary stages (Wendt, 2003: 110) as well as in implementation (Rosenbrock/Gerlinger, 2006). Though there are other groups excluded from corporatist negotiations (e.g. patients), I will focus on the unequal representation of the professional groups of

doctors and nurses because it becomes relevant with respect to the development and composition of the medical workforce and the relevance and use of international recruitment and migration.[8]

The role of non-governmental actors in Germany

In Germany medical doctors enjoy a double 100 per cent level of organisation. All licensed doctors are compulsory members of a chamber, all self-employed doctors contracting with GKV insurances are compulsory members of a regional KV organisation. Both organisations have far-reaching authority and privileges within self-government and corporatism. Due to compulsory membership fees these organisations are well-equipped with financial resources. Furthermore, they enjoy the privileged status of a public body while at the same time being strongly committed to members' interests. Additionally, well-organised independent interest organisations exist such as the 'Marburger Bund' representing hospital doctors and the 'Hartmann Bund', representing self-employed doctors. This double representation of doctors by public bodies and independent organisations has secured them a strong influence in health politics for decades (Bandelow, 2005: 87). On the contrary, the level of organisation of nurses is estimated to be lower than 10 per cent in both unions and professional organisations (Hoesch, 2009: 212). The reasons for this disparity are manifold, but the most important are corporatism and path dependency. Although the lack of representation of nurses is recognized today and steps towards a professionalization of organisation and a voluntary registration are made, governmental actors are not really bent on creating another actor in a policy field too often stuck between too many stakeholder groups.

A major side effect of this lack of organisation is the lack of data. Apart from micro-census it is almost impossible to find reliable data on professional nurses in Germany (Hoesch, 2009: 213-214). On the other hand doctors have meticulous data at their disposal, which is automatically collected from all compulsory members. They do not only have at their disposal statistics but also claim the prerogative of interpretation.

The role of non-governmental actors in the UK

In the UK the situation is quite different: the distribution of power among non-governmental actors is relatively balanced, the Department of Health is the dominant actor and decides which interest organisations to consult with respect to a given project. Some authors argue that the British health sector can be described as corporatist because of the strong position of the British Medical Association from the beginning of the NHS (e.g. Ham, 2004: 129; Cawson, 1982: 37), but if one applies tight criteria for corporatism such as compulsory membership (Lehmbruch 1974, Schmitter 1974) the British health sector does not qualify for the label 'corporatist'. Membership in the BMA as well as other organisations is by choice. It is true, however, that the level of organisation is high: about 65 % (interview information) of doctors are BMA members. The BMA is both trade union and

[8] For details on asymmetries between different groups of health professionals in Germany and the UK see Döhler (1997).

professional organisation at the same time. The diverse Royal Colleges represent the interests of the different groups of medical specialists. Membership again is voluntary. The General Medical Council (GMC) acts as an independent regulator. It is responsible e.g. for the development of medical curricula and medical training, problems of ethical behaviour and the recognition of qualification.

On the part of the nurses the 'Royal College of Nursing' is the most important organisation, acting as professional organisation as well as trade union. In recent years nurses have succeeded in continuously ameliorating their position vis-à-vis doctors in political negotiations and also in everyday work. About 85 per cent of nurses are members of the 'Royal College of Nursing' or the trade union UNISON. In the UK professional nurses are obliged to register with the 'Nursing and Midwifery Council' acting as the independent regulator in the field of nursing. Therefore plenty of data exists on nurses and other care professionals in the UK. In the UK the nursing profession is based on university training. Quite different in Germany: there nurses are trained within vocational training. This lack of academic training in Germany further contributes to the inferior position of nurses' compared to doctors' organisations in Germany.

Effects on the composition and development of the workforce

There is a close interdependency between the organisational and economical framework of a health sector on the one hand and the stock and development of the medical workforce on the other. The composition of the workforce at a given point in time can be regarded as the product of factors such as funding of medical services, professional prestige, prospect of future pay, working conditions, training conditions and training capacities. It is worth remarking that these factors become effective only after a time lag of at least six to twelve years on the part of doctors and at least three to five years on the part of nurses because of the length of training (Hoesch, 2003).

In Germany the composition of the workforce reflects the privileged position of doctors – especially self-employed GPs and consultants – in terms of pay, interest representation and prestige. Because of the growing attractiveness of the medical profession since the mid 1960s the number of doctors related to population was growing. Today not only the number of doctors related to population but also the number of doctors related to nurses is striking: In Germany it was 100:174 in the late 1990s compared to 100:314 in the UK (Döhler, 1997: 16).[9]

In the late 1980s and early 1990s the growing number of doctors culminated in a public debate on oversupply of doctors labelled with the pejorative term "glut of doctors". While from the doctors associations' perspective oversupply initially did not represent a threat to the maintenance of their financial interests this changed dramatically in the aftermath of the 1992 reform. Due to the introduction of capped budget and a maximum number of doctors in the ambulant sector, doctors suddenly had to face the financial consequences of competition. They lobbied successfully for a

[9] More recent – and comparable data – are not available because of problems of aggregation.

reduction of training capacities (Schacher, 1996: 100). In 1992 access to medical schools was reduced by 22 per cent (Schacher, 1996: VII).

In the UK the composition of the medical workforce reflects the limited financial resources, the rather balanced distribution of power among different professional groups as well as the power of the executive. Briefly speaking, the number of doctors in the UK has always been significantly lower not only than in Germany, but also than in many other OECD countries. As described above tax funding, strong governmental control and a lack of incentives that could have made for an expansion of medical supply prevented the workforce from growing 'German-style'.

During their first term of office (1997-2001) the New Labour government decided soon to fulfil their pre-election promise and to "save" the NHS. They regarded massive increases in budget and workforce as salvation. In 2000 'The NHS Plan' was published. It named staff shortages as a major challenge and the announced additional employment of 7,500 consultants, 2,000 general practitioners (GP), 20,000 nurses and 6,500 other therapists (Secretary of State for Health, 2000; Ham, 2004: 63). Except for consultants the targets set by the plan were already achieved and even exceeded in 2004. Furthermore training capacities in medical schools were increased by 55 per cent between 1999 and 2004 (King's Fund, 2006a). All this was possible only because of massive increases in budget. Between 1997/98 and 2007/08 the NHS budget increased from 34.7 billion to 90.2 billion (Department of Health, 2004b; Mellor, 2006).

Apart from higher investments into the NHS another structural decision concerning the allocation of tasks between doctors, nurses and other medical and care professionals had major implications for the future composition of the workforce. The New Labour Government and the Department of Health pursued a strategy of shifting areas of tasks and responsibilities 'downwards' i.e. boosting and extending the role of nurses relative to doctors and strengthening primary care and community nurses relative to specialised services in hospitals (interview information Department of Health, Royal College of Nursing; also Buchan/Calman, 2005). The underlying idea is cost saving. Nurses are less expensive than doctors with respect to wages and training; primary and outpatient care is less expensive than specialised care in hospitals and community nurses are less expensive than ward and specialised nurses. While nurses first profited from this strategy in the meantime they observe sceptically a further shift from trained nurses to care assistants. In this context the suspicion was expressed that a further 'de-skilling' is also meant to facilitate international recruitment and to increase the pool of potentially available employees (interview information in 2007).

Though this shift of responsibilities took place slowly, it can be regarded as an alternative strategy to cope with cost explosion and demographic change. In Germany, by contrast, a comparable strategy appears to be rather improbable because of the described imbalance of power.

Relevance of migration and its perception by relevant actors in the British and the German health sectors

The relevance of migration and international recruitment in Germany and the UK is quite different. While public debate on labour shortages and international recruitment of health professionals is significant in both health sectors the empirically measurable situations drift apart. High physicians' density per population and low share of foreign staff in Germany is opposed to low density of physicians per population and high share of foreign staff in the UK.

Why do situations and actors' strategies vis-à-vis workforce development and international migration differ so remarkably? In the following this question will be answered taking into account preceding considerations on the importance of institutional frameworks and actors' constellations.

United Kingdom

Relevance of migration and related perceptions and strategies

In the UK the most relevant actor is the state. The outstanding recruitment between 1997 and 2006 can be attributed to two major decisions of the government: 1. The adoption of the NHS Plan, scheduling a massive increase in health professionals within ten years; 2. the corresponding massive increases in budget. It was quite obvious that the huge numbers of additional staff outlined in the NHS Plan could not be "home-made" alone, considering the length of training.

Information on whether the Department of Health initiated international recruitment quite from the beginning or started to direct it in later stages differ. While DoH interviewees stressed the important role that the DoH played at the centre of the whole process of international recruitment, interviewees of nursing organisations expressed the view that at first NHS trusts started recruiting internationally on their own because they saw no alternative to fulfil workforce targets of the NHS Plan. Thus at least over time the DoH evolved as the central organiser of international recruitment activities. What does this mean?

The main activities of the DoH were in three areas: 1. Establishing and institutionalising contacts with potential supplier countries; 2. Providing guidelines for NHS employers concerning the specific procedure of international recruitment; 3. Removing unnecessary barriers to international recruitment.

As to the first, the DoH played a major role in making first contacts with possible supplier countries at governmental level. About twenty countries that seemed to qualify for international recruitment were selected. Recruitment was facilitated by public campaigns, conferences and trade fairs – all organised by the British DoH in the supplier country.

As to the second, the DoH provided practical guidelines to NHS Trusts recruiting individually and observed recruitment activities to identify best practices. In this context the so-called "Code of

Practice" (DoH, 2001; 2004) is remarkable. It listed a number of countries which were not allowed to be recruited from for fear of 'brain drain'.

As to the third, there is a widespread acceptance of the employment of foreign nationals in the NHS. This can also be attributed to the longstanding tradition of exchanges with Commonwealth countries in the course of medical training. It has been quite common for doctors from India or Pakistan to spend some years of specialist training in the UK. For this group even a special immigration category existed until April 2006, the "International Medical Graduate" (IMG), allowing doctors in specialist training to stay in the UK even without work or residence permit. However, this IMG category was closed in 2006 because of higher outputs of British medical schools caused by the increases in training capacities (Boseley, 2006).

This also puts the whole recruitment campaign as well as increases in budget and staff into a different perspective. Workforce development seems to follow a boom-and-bust logic which is stimulated by the rationale of political actors to anticipate voters' preferences as described above. Only if the expected political cost of *not* investing in the NHS exceeds prioritising low taxes funding will be increased as well as the number of health professionals, training places and migrant workers. Therefore the workforce development is closely connected to political cycles – only disturbed by time lag effects.

> "And so there has been a sense of boom and bust for international doctors that for a period of time we welcome them to the UK and we positively encourage them. And then [...] we suddenly shut the door and say 'No, we are changing the requirements', we don't want them anymore and we are training enough UK doctors." (interview BMA, 2007)

With respect to international recruitment and migration the positions of BMA and RCN are differentiated and ambivalent. On the one hand both organisations criticise the boom-and-bust logic and call for a more self-sufficient, sustainable and long-term workforce planning. On the other hand they appreciate the important role that migrant workers play in the NHS and refer to the long-standing tradition of exchanges in the course of training. Vis-à-vis recruitment activities the main criticism is expressed on recruiting from countries at the risk of brain drain and the many loopholes that still continue to exist despite a "Code of Practice". At the same time they recognise the individual rights to leave their home countries to make for a better life.

The positions of the BMA and the RCN show that in general these organisations aim at sustainable workforce development, self-sufficiency and also the improvement of pay and working conditions to attract young professionals. But the institutional setting of the NHS usually does not allow these aims to become realised. In fact it produces a boom-and-bust logic. Because of this and because there has always been migration and migrant workers add up to a significant and visible part of workforce stocks it is appreciated and people are used to it. Furthermore migrant doctors and

nurses represent a significant share of the members of professional interest organisations and therefore just cannot be neglected.

There is another feature of the British health sector which seems to be in line with Freeman's argumentation and is another cause for the large scale international recruitment: big employers play a major role. In contrast to the German health sector where the small businesses of self-employed GPs and consultants dominate the shape of the whole sector, in the UK all consultants are employed in hospitals. Hospitals and big NHS trusts are huge employers and at the same time enterprises close to the state. The logic at work described by Freeman (1995) – employers lobbying for migration in order to profit from lower or stable wages – in the British NHS seems to be facilitated because NHS trusts in fact are not only enterprises. The DoH itself follows an employers' logic – also because of budget limitations it aims at keeping wages stable.

Recognition of qualifications

Another important actor is the General Medical Council, an independent regulatory body responsible for the recognition of qualifications of doctors (Dowling, 2006). Unlike the scattered structure of German regulatory bodies, the British GMC represents a central contact point for all doctors. The recognition of qualifications is regulated in a consistent way. According to interview information the GMC grants first registration to about 12, 000 doctors every year. About 45 per cent originate from British medical schools, about 55, sometimes 60 per cent from overseas medical schools.

Compared to Germany the procedure of recognition of qualification is quite transparent. On its website the GMC provides information on all international qualifications recognised by the GMC. If a potential migrant worker disposes of a recognised qualification then a two-tier procedure of qualification follows, the PLAB-I and PLAB-II tests ("Professional and Linguistic Assessment Board tests", interview information GMC, DoH, BMA). A successful completion of PLAB II does not guarantee a job offer.

The recognition of consultant qualifications is a good example for the narrow scope of action of professional organisations as well as the dominant role of the state. According to DoH interview information the difficulties in recruiting enough consultants at international level could be attributed to a lack of equivalence of foreign specialist training to UK standards. The British specialist training takes seven years compared to an international average of five to six years. The DoH solved the problem by recognising work experience as equivalent to the missing years of specialist training.

This shows that at stage three of possible interventions against migration - hampering or smoothing the recognition of qualification – professional bodies neither have direct influence on centrally organised independent regulators nor follow a direct and unambiguous strategy against recognition because of the tradition of international exchange. All in all the independent regulators –

also the 'Nurses and Midwifery Council' (NMC) and the 'Health Professions Council' (HPC) – cooperate smoothly with the DoH (interview information DoH).

Germany

Relevance of migration and related perceptions and strategies

In Germany the most relevant actor is the state – in theory. In reality most relevant actors are corporatist ones, i.e. mainly doctors' associations. While hospitals and their organisations are not corporatist actors in a narrow sense, organised interests of self-employed doctors dominate relations with governmental actors. Because of the dominant role of self-employed doctors the perception of and dealing with migration on the part of ambulant sector actors is crucial. In this context it is remarkable that the share of foreign doctors in hospitals is much higher than in self-employed practices. Between 1996 and 2007 the distribution of foreign doctors was as follows: about 25 per cent self-employed, about 45 to 50 per cent in hospitals and about 20 to 30 per cent unemployed or in other than medical jobs. Exact data is not available.[10]

Furthermore in Germany we find the special case of a strong east-west divide following reunification. Due to socio-economic reasons employment in the medical profession both in hospitals and self-employed is less attractive in Eastern Germany. Therefore over- and undersupply still coexist and even aggravate. It is mostly Eastern German regions suffering from shortages, while in Western German metropolitan areas the level of supply of practices amounts to about 150 per cent of originally scheduled (Neubacher, 2008: 34-35). Accordingly, preferences regarding international recruitment and migration differ significantly on the part of Eastern and Western German organisations.

In interviews representatives of Western German doctors' associations revealed perceptions, interests and strategies totally in tune with professional logics of action as described above. They regard international migration and recruitment as a temporary solution only. Their main aim, which they pursue vigorously, is to retain the stock and to attract young professionals by securing attractive pay, working and training conditions. Because of the scope of action provided by corporatist governance they have usually pursued their aims quite successfully. The case of the "looming shortages" pronounced in 2002/2003 is quite instructive. A major reason for this allegedly looming shortage was the reduction of training capacities in 1991 of about 22 per cent at the instigation of doctors' associations (see above). Because of the length of training the effects of this reduction became visible only about 10 to 12 years later. In interviews representatives never referred to this reduction of training places, but pleaded for better pay, working and training conditions – and

[10] Official statistics provided by Bundesärztekammer and Kassenärztliche Bundesvereinigung does not designate the number of foreign doctors in the different sectors in a consistent and ongoing way. In some annual reports not figures are presented, but expressions like "about a quarter" or "similar to the preceding year", see e.g. Kassenärztliche Bundesvereinigung/Bundesärztekammer (2003).

succeeded. In 2001/2002 the unpopular house officer year, compulsory for graduated young doctors, was abolished after strong lobbying of doctors' organisations. At the same time doctors' income increased above average. Even despite a strongly objected reform of professional pay, income is still increasing above the average of other professions (Bosem, 2010).

Furthermore it is remarkable that doctors associations mainly referred to a "looming shortage" of doctors, announced to become active soon because of the increasing average age of doctors and expected retirement. At the same time density of doctors per population is further increasing. It can be assumed that the reference to imminent shortages serves to improve bargaining positions. The total number of practising doctors in Germany increased from 244,238 in 1991 to 297,893 in 2001 to 342,063 in 2011 (Bundesärztekammer, 2008b, 2012).

Representatives of doctors associations said that more liberal immigration rules are not needed because most doctors who come to fill a temporary gap are in training and therefore enjoy privileged immigration channels. At consultant level German immigration law allows the granting of a work and residence permit if a public interest and the lack of a German or EU applicant can be attested.[11] The trading director of a rural hospital said that nine times out of ten they finally succeed in complying with immigration law requirements. However, bureaucratic procedures often are exhausting and time-consuming.

Recognition of qualifications

In contrast to the UK where the GMC provides unitary guidelines, in Germany 29 government agencies at state level are responsible for the recognition of qualifications and the issuing of a provisional license (Hoesch, 2009: 254). Added to this are 17 medical chambers responsible for the recognition of specialist training and 17 regional KVs responsible for the contracting of KV doctors. Requirements vary between regions and discretionary powers of the regulators are huge.

Though there is a common list helping to assess non-EU qualifications and being up-dated on an annual basis by the committee of the state examination offices it is not binding. If the qualification of an applicant is not recognised as being equivalent to a German one, the applicant is able to pass a so-called 'year of adaptation' in a hospital which is completed by an examination equivalent to the German medical exam. Length and organisation vary at state level. The recognition of qualifications and the issuing of a provisional license also depend on administrative discretion and regionally differing norms. Though doctors associations cannot influence procedures in the area of a general registration and provisional license directly, they have indirect impact on the procedures and conditions of governmental agencies via lobbying and consultations.

In the field of recognition of specialist training and the admission to KV practices, doctors' associations are directly responsible. Specialist training has to be recognised by one of the 17 regional medical chambers which are also responsible for the regulation of specialist training of German

[11] For details on requirements and procedures see Derst/Heß/von Loeffelholz (2006: 18).

consultants. Again regional differences and discretionary powers are large. However, most insurmountable requirements are imposed by professional regulations concerning the opening of a KV practice. Apart from the successful recognition of specialist qualification a so-called 'full licence' – opposed to the 'temporary licence' usually issued to migrant doctors – has to be obtained. It is adequate to label requirements for a 'full licence' as 'instruments of exclusion': According to § 3 *Bundesärzteordnung* (Federal regulation of the medical profession) a full licence will only be granted to German or EU citizens or if preconditions for a particular case are fulfilled. Usually this means that the applicant has to have had a provisional licence for a considerable time and has to have been employed as a medical doctor in Germany for a couple of years (Kassenärztliche Bundesvereinigung/Bundesärztekammer, 2003: 124-125).

Interviews showed that regulators in Eastern Germany appeared to be more liberal and flexible than in Western Germany. It can be assumed that the widespread experience of severe labour shortages has produced an administrative routine rather lubricating immigration. It seems that in some Eastern German regions severely struck by emigration of the young and highly skilled the strategy of "skill mix" – shifting tasks and responsibilities between different medical professions – has been started hesitantly and born out of necessity. For instance there are nurses and doctors assistants who are allowed to do house visits in regions particularly struck by labour shortages (Hardenberg, 2008) – an approach still unthinkable in Western Germany. In a way Eastern Germany seems to represent a kind of experimental laboratory for new approaches. These new ideas can be put into practice and implemented against resistance because of the mere necessity. Another reason might be more flexible structures and less gridlocked positions of vested interests because the corporatist system was introduced only after German reunification. Health care in GDR times was organised within a state system.

Conclusion

This is an article on migration although large parts of it do not deal directly with migration. The detour into the ranges of comparative health systems research was necessary to show that the demand for international migration and recruitment is less determined by demographic reasons but more by institutional ones. The very different cases, Germany and the UK, virtually falsify the demographic nexus at least in its simplicity, with Germany ageing faster than the UK and not recruiting significantly and the UK ageing slower and massively recruiting at international level. Though the demographic change in OECD countries probably will contribute to an overall growing demand for health professionals in the future, it is too narrowly considered to assume massive international recruitment and migration as inevitable. The German and the British cases showed that governmental and non-governmental actors develop specific strategies to deal with problems of workforce development. Exogenous factors such as demographic change, expensive medical training and cost explosions may cause a certain inclination to release health systems and public budgets by

international recruitment. However, it depends on *endogenous* factors such as organisational structure of the sector and relevant features of the overall political system whether this inclination actually turns into a comprehensive human resources strategy. It makes sense to assume that professional interest groups in the first place follow self-sufficiency with respect to workforce planning. The organisational logic of action is determined by members' interests such as securing attractive pay and working conditions and keeping at bay too much competition. The analysis of the German and the British cases showed that in Germany professional organisations are furnished with a great deal of authority, enabling them to pursue their interests successfully. Self-sufficiency is the name of the game, while international recruitment is regarded as a temporary solution only. Though international recruitment occurs, it is rather restricted to specific geographic regions and does not represent an extensive problem.

In the UK, by contrast, empirically measurable shortages can be found – at least with respect to OECD averages. International recruitment represents a favoured and accepted strategy to meet these problems. The logic at work is that of big employers close to the state. The tax funding forces governmental actors as well as employers to pursue austere cost containment. This financial constraint not only affects recurrent campaigns of international recruitment but also alternative strategies such as shifting tasks from doctors to nurses and from nurses to care assistants. This latter example shows that international migration and recruitment cannot be analysed properly in an isolated way but has to be viewed in the context of stakeholders' interests, workforce development and human resources strategies. Accordingly, in Germany we do not find comparable strategies.

The analysis of migration in the two national health sectors has brought to light some intriguing observations with respect to health policy in general. It has become obvious that debates on necessary reforms follow particular national paths and are astonishingly immune to new ideas from other countries. While in Germany new and promising models such as skill mix will probably not be considered in the near future, in the UK the dominant pattern is boom-and-bust in accordance with political cycles.

From a system theory angle, in Germany health policy represents a rather autonomous sub-system, difficult to control by governmental action. The rationales behind actions are two-fold: first, an economic one which in the case of the self-employed GPs' and consultants' 'small enterprises' means increasing turnover and benefits by selling more; secondly a 'hippocratic' one which again means supplying sufficient services without rationing. In the UK, by contrast, health policy rather represents an integral part of the overall political system. Relevant actors are governmental ones and the rationale behind their actions is to secure (re-)election and/or avoid being voted out. Thus funding and workforce development is closely connected to political cycles and therefore particularly prone to boom and bust – and international recruitment.

This analysis of the German and the British cases have shown that the mere demographic argument is not adequate to explain the huge differences with respect to the relevance of

international recruitment and migration of health professionals in a given health sector. Yet the high or low relevance of migration can better be explained by analysing the overall structures of a sector and the scopes of action they provide for governmental and non-governmental actors. This widening of the analytical framework could support future research on the demand for international recruitment and migration in given national health sectors. A starting point for further research could be the more general assumption that tax-funded systems tend to be affected by under-investment, boom-and-bust and international recruitment, while social security systems tend to be affected by oversupply of medical staff – especially doctors – and self-sufficiency.

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