

Global Gaps

**How Germany Is Externalizing Its Shortage
of Health Care Workers**



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Preface

Germany is experiencing an increasingly acute shortage of skilled workers in the healthcare sector, particularly in nursing. In response, German policymakers have identified the recruitment of foreign healthcare professionals as a key strategy to address these gaps. To this end, a growing number of bilateral agreements between the German Federal Employment Agency (Bundesagentur für Arbeit, BA) and partner countries referred to as Agreements on the Placement of Health Professionals have been established to provide a legal framework for structured recruitment and to facilitate labour migration.

These agreements frequently target low- and middle-income countries. However, their implications for the healthcare systems of source countries are often insufficiently considered. While the German healthcare system benefits from professionals trained abroad, their emigration can exacerbate existing shortages in their countries of origin. Structural economic inequalities enable Germany to recruit healthcare workers from countries that themselves face significant deficits in skilled personnel.

Despite Germany's comparatively high density of healthcare professionals, bilateral recruitment agreements have been concluded with countries such as Brazil and Colombia. Germany has approximately 45 doctors per 10,000 inhabitants, compared to 29 in Brazil and 26 in Colombia (1). Disparities are even more pronounced in nursing, with Germany employing around 120 nurses per 10,000 inhabitants, while Brazil has 37 and Colombia only 16 per 10,000 (2). Against this backdrop, such agreements pose considerable risks to national healthcare systems that already operate with substantially fewer human resources than Germany.

In addition, regional disparities within source countries are rarely adequately reflected in recruitment assessments. National-level statistics may mask severe shortages in specific regions, particularly rural and underserved areas. The recruitment of healthcare professionals from these regions can further undermine local healthcare provision and, in extreme cases, lead to its collapse. Furthermore, income disparities between countries contribute to secondary migration flows between neighbouring states, resulting in so-called recruitment chains. From a global perspective, these dynamics ultimately place the greatest burden on economically vulnerable countries with fragile healthcare systems. Such interconnected effects are largely disregarded in Germany's evaluation of potential partner

countries. Moreover, source countries often bear the financial costs of training professionals who subsequently migrate to destination countries such as Germany.

Bilateral recruitment agreements must not give rise to exploitative structures. They must be guided by clear ethical, social, and human rights-based standards. The adverse effects of active recruitment by third parties, including state institutions and private actors must be minimised, not only for individual healthcare workers but also for local populations and the healthcare systems of source countries.

Meaningful involvement of all relevant stakeholders in the negotiation of bilateral agreements is essential. The participation of local health authorities, trade unions, and civil society organisations is crucial to safeguarding fair working conditions and preventing harm to national healthcare systems. Informed decision-making requires comprehensive and disaggregated data on the number, distribution, and working conditions of healthcare professionals. Such data should not be sourced exclusively from governments or international organizations.

Furthermore, public investment in the education and training of healthcare professionals who later emigrate must be appropriately recognised and financially compensated. International recruitment should be accompanied by structural and capacity-building measures that address workforce losses, knowledge transfer, and the broader social consequences of migration, in accordance with the guiding principle of "do no harm."

This study examines the consequences of the emigration of healthcare professionals from Brazil and Colombia within the framework of bilateral agreements with Germany. It further identifies the conditions under which such agreements can be designed to ensure equitable benefits for all parties involved.

Julia Stoffner
Health Policy Advisor
Brot für die Welt

Introduction

This commissioned research examines the migration and international recruitment of health professionals from Colombia and Brazil, aiming to inform public policy in both source and destination countries. Across Latin America and the Caribbean, a shortage of 600,000 health professionals is projected by 2030 based on the World Health Organization (WHO) benchmark of 44.5 medical, nursing, and midwifery professionals per 10,000 inhabitants. Nurses, 56 percent of the health workforce and 89 percent women, remain especially vulnerable to low wages, precarious contracts, and migration pressures. Both Colombia and Brazil reflect these regional challenges: while Brazil has a larger workforce overall, its

regional inequalities and reliance on nurses mirror Colombia's gaps, which stand at around 36 doctors, nurses, and midwives per 10,000 people, below the WHO target. Against this backdrop, the Panamerican Health Organization (PAHO) and the WHO have called for ethical recruitment, fair treatment of migrant workers, and stronger cooperation. This work aims to generate actionable evidence to inform decision-making, shape public policies, and guide fair and effective bilateral agreements on health worker migration.

German Andres Alarcon Garavito
Juliana Ferreira de Santana



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Germany makes it easy for qualified health workers to find employment. This occasionally becomes a problem for their countries of origin.

Chapter 1

Overview of Brazil's and Colombia's Health Systems

Brazil

Created by the 1988 Constitution and regulated by Law 8080/1990, the Brazilian Unified Health System (SUS) is one of the world's largest universal public health systems. More than 70 percent of the population, over 85 percent in disadvantaged regions, relies exclusively on SUS for healthcare (3–6).

One of the most important programmes created by the SUS to reduce barriers and improve access to care was the Family Health Strategy (Estratégia de Saúde da Família, ESF). This primary care model was implemented in 1994 and deploys multidisciplinary teams to assist families in predefined areas, serving as the first contact with the health system, facilitating the assessment of local needs. Currently, over 60 percent of the total households in Brazil are covered by ESF. Although the strategy improved health outcomes, inequalities in healthcare utilisation persist, for example, access to specialised care resulting in long waiting times, and access to medicines (3, 7).

The SUS is also known for programmes that have gained international recognition. For example, the National Immunisation Programme (PNI) provides a comprehensive range of immunobiological products at no cost to the population. SUS also operates the largest publicly funded transplantation programme in the world. To meet the needs of the vast territory and its regional differences, SUS adopted a decentralised model, where the federal, state, and municipal governments share power and responsibilities over the health sector, including the funding, which originates from taxation and social security revenues (6, 8).

The government's participation in funding healthcare professional training varies. Data on costs per student at public universities is not available; however, the federal government has two programmes to democratise higher education by assisting with tuition costs for those enrolled in private institutions. The University for All Programme (Programa Universidade para todos – PROUNI) offers full and partial scholarships (50 percent of the tuition fee), whilst the Student Financing Programme (Fundo de Financiamento Estudantil – FIES) is a student loan programme that enables students to finance up to 100 percent their tuition fees.

With an exponential increase in the number of doctors, especially over the last decade, the category had 597,428 registered professionals in December 2024, and it is expected to reach 635,706 by the end of 2025, representing a density of 29.8 doctors per 10,000 people. The figure, however, varies between regions, with a higher density in urban and developed areas.

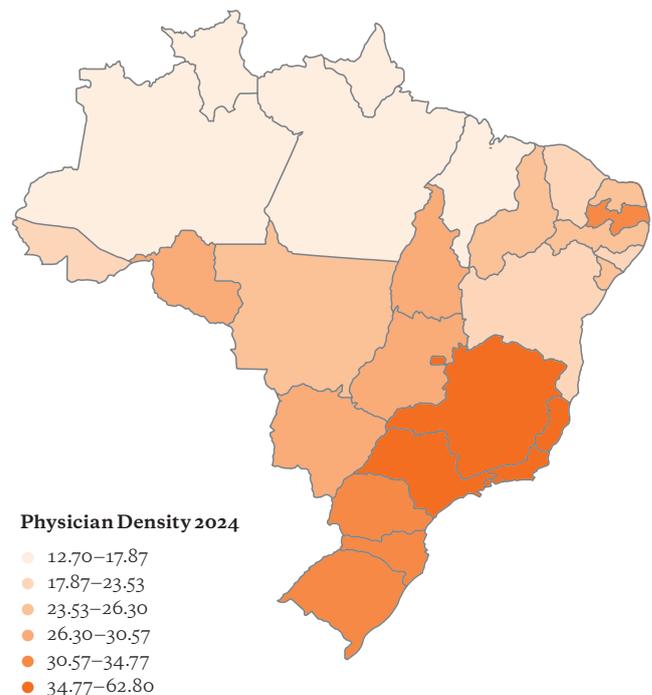


Figure 1: Physician density per 10,000 population by state
Source: Scheffer, 2025 (9)

Disparities are also present in the distribution of educational institutions, following similar trends. Most higher education institutions are now private, accounting for 79 percent of the total places in medical courses offered in the country (9, 10).

The nursing team is composed of three regulated professional categories: nurses, nursing technicians, and nursing assistants. They differ in their required education and scope of practice. Professional nurses complete a university training of five years and are qualified for higher complexity care, leadership, management and decision-making roles. Nursing technicians undertake about two years of training and provide intermediate complex-

ity care. Nursing assistants are allowed to provide basic care under supervision and receive approximately 15 months of training.

In 2025, the nursing workforce is large, over 799,000 registered nurses (37.4 per 10,000) (11), but only about half are effectively employed in the health system (12). Maldistribution is stark, with shortages in remote areas and oversupply in metropolitan regions.

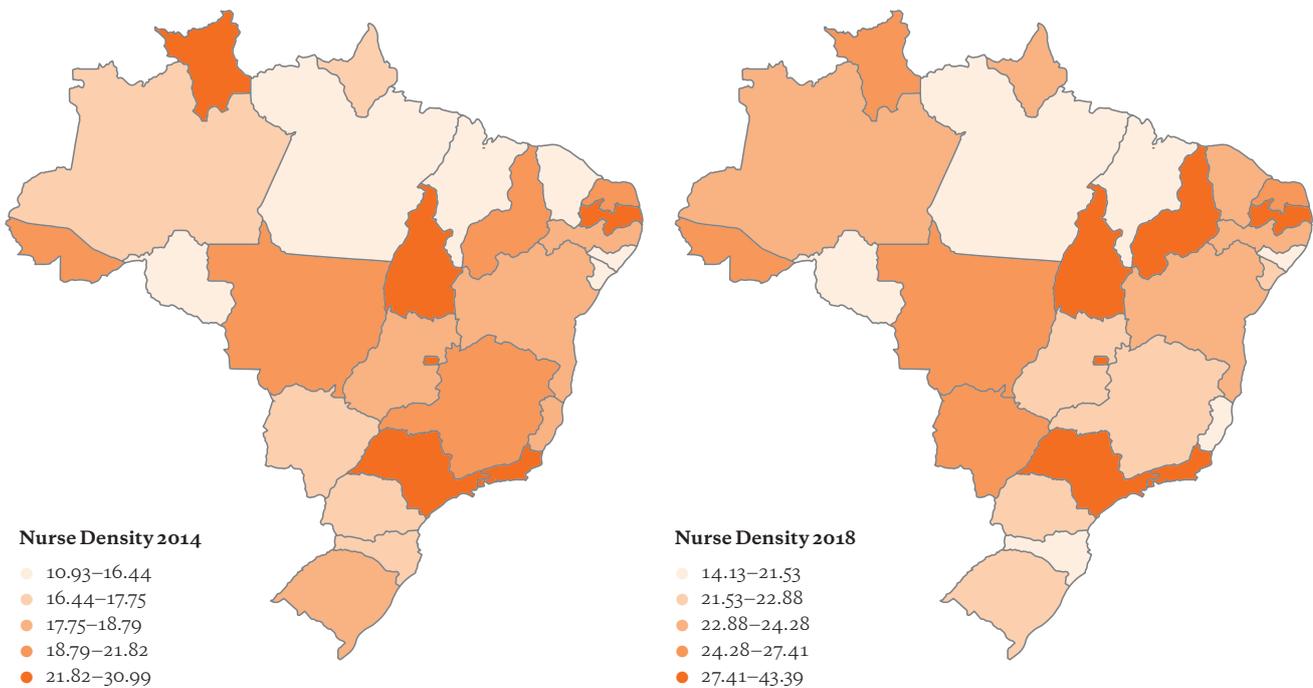


Figure 2: Nurse density per 10,000 population by state
 Source: PAHO, 2020 (13, 14)

The concentration of professionals in large urban centres is associated with signs of a saturated labour market, with growing numbers of qualified nurses competing for a relatively limited supply of stable positions. This situation is reflected in unemployment and underemployment, long working hours, precarious contracts and low

wages, conditions that authors describe as precarisation of nursing work (15–17). At the same time, there are still persistent difficulties in hiring and retaining nurses in some areas, where professionals often work with inadequate infrastructure and weak incentives to remain in the territory (15, 18, 19).

A recent study conducted by the Brazilian Ministry of Health indicates that, although there was a consistent increase in the number of nursing positions in the health system in the last decade, there is still a high turnover among these professionals (21).

Education capacity has expanded significantly. In 2023, Brazil had 1,298 nursing programmes, 86.9 percent in private institutions (10, 22). Although distance-learning programmes represented a small share of courses, they accounted for nearly half of all available enrolment slots, a trend that prompted new regulations in 2025 restricting health training to in-person delivery (23). Experts warn for the need of analyses regarding the vacancies offered in nursing programs, their terminal efficiency rate, and the job market (24).

Brazil has no national data system tracking the emigration of health professionals. Existing sources focus mainly on inflows, and only a small number of foreign nurses are registered in the country (21). Overall health worker density is around 67 per 10,000 people (above the WHO threshold), so Brazil is not included in the WHO Health Workforce Support and Safeguards List (25). Nonetheless, media reports and emerging studies indicate rising emigration, especially among nurses and doctors, with popular destinations including Canada, the United States, Germany and the United Kingdom (26–28).

Between 2022 and 2023, Brazil had a bilateral agreement with Germany to recruit nurses. While the agreement has been suspended, international recruitment still occurs through private agencies. Many of these companies liaise with private educational institutions in Brazil to recruit newly graduated nurses. It is also possible to see advertising on social media about the international recruitment of medical specialists.

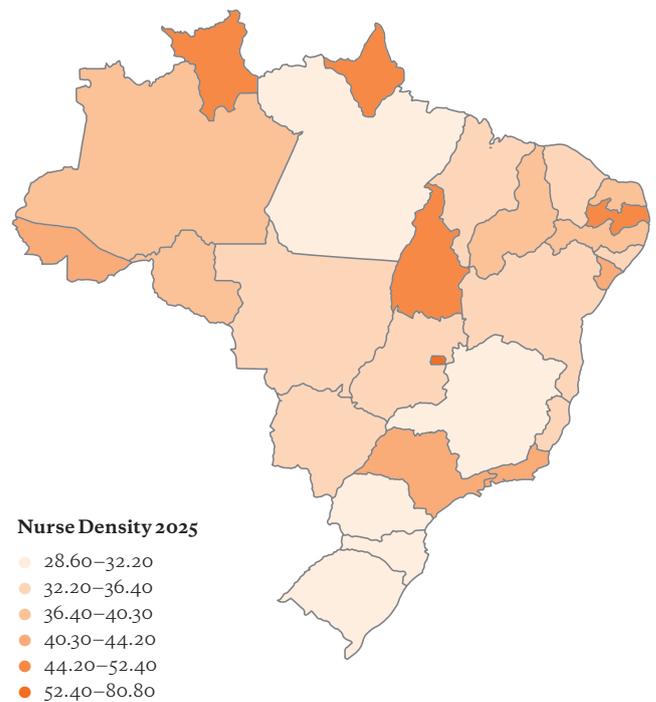


Figure 3: Nurse density per 10,000 population by state
 Source: Author's elaboration based on data from COFEN/CORENs and IBGE (11, 20)

Colombia

According to the Colombian Health Workforce Observatory (OTHS), the country has 989,863 healthcare workers (29), including 138,131 doctors (26.21 per 10,000 inhabitants) and 83,172 nurses (15.78 per 10,000 inhabitants) (see Table 1).

Indicator	Brazil	Colombia
Total population	213,4 m	53.1 m
Total number of nurses	799,337	83,172
Total number of doctors	597,428	138,131
Density of nurses (per 10,000 population)	37.5	15.7
Density of doctors (per 10,000 population)	29.8	26.2
Current health expenditure (% GDP)	9.14	8
Income level	Upper-middle	Upper-middle

Table 1: Main workforce indicators in Brazil and Colombia
 Sources: IBGE (2025) (20), COFEN (2025) (11), Scheffer (2025) (9), OTHS (2025) (29), & the World Bank (2025) (30, 31)

Moreover, Colombia's health workforce is extensive but unevenly distributed (see Figure 4).

There is no official registry for midwives, although traditional midwifery persists in rural areas. Colombia also depends heavily on technical and auxiliary staff, particularly nursing technicians, numbering 363,479 nationwide (68.98 per 10,000 inhabitants) (29). Nursing technicians play a central role but require supervision, reflecting a system built on task-shifting rather than sufficient numbers of fully trained professionals. Colombia hosts 425 assistant-level programmes, which help meet basic care needs but do not compensate for the low number of professional nurses (32).

Despite the scale, the combined density of doctors, nurses, and midwives remains below the WHO's target of 44.5 per 10,000 inhabitants (29), with Colombia at approximately 36 per 10,000, making it the fourth lowest in nursing density in the Americas (25). Urban centres have much higher workforce concentrations, while rural and dispersed populations remain underserved (25).

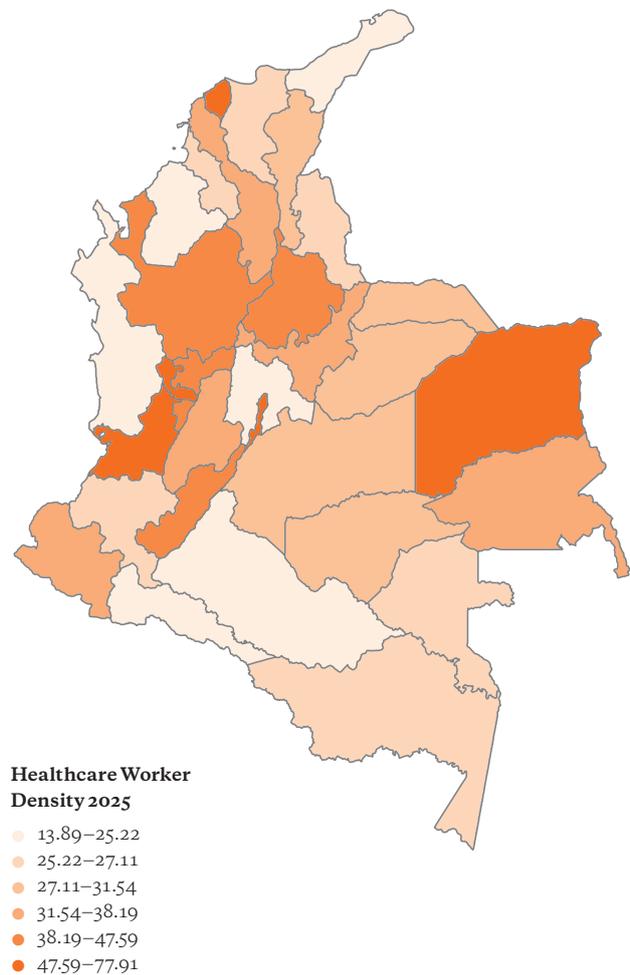


Figure 4: Healthcare worker density per 10,000 population by Department
 Source: OTHS (2025) (29)

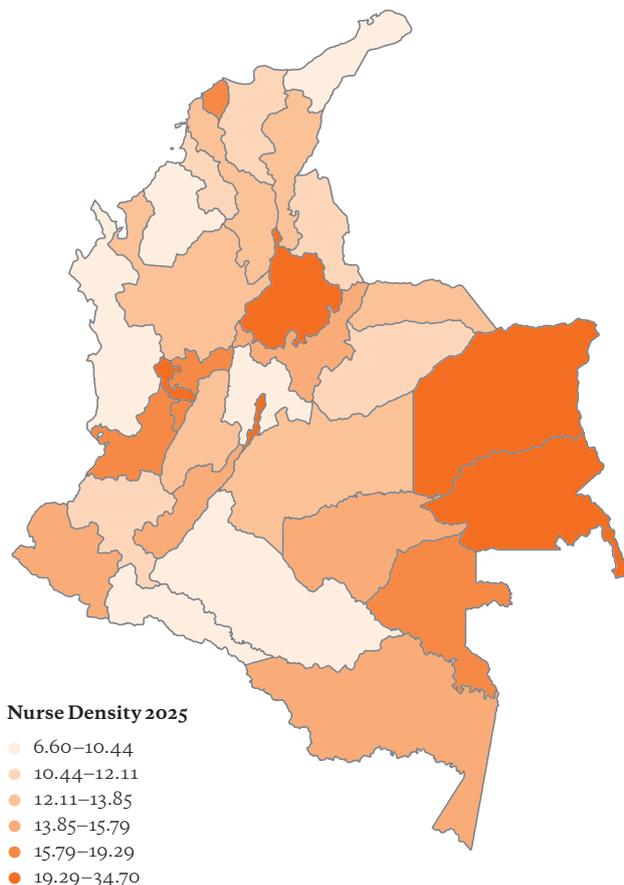


Figure 5: Nurse density per 10,000 population by department
 Source: OTHS (2025) (29)

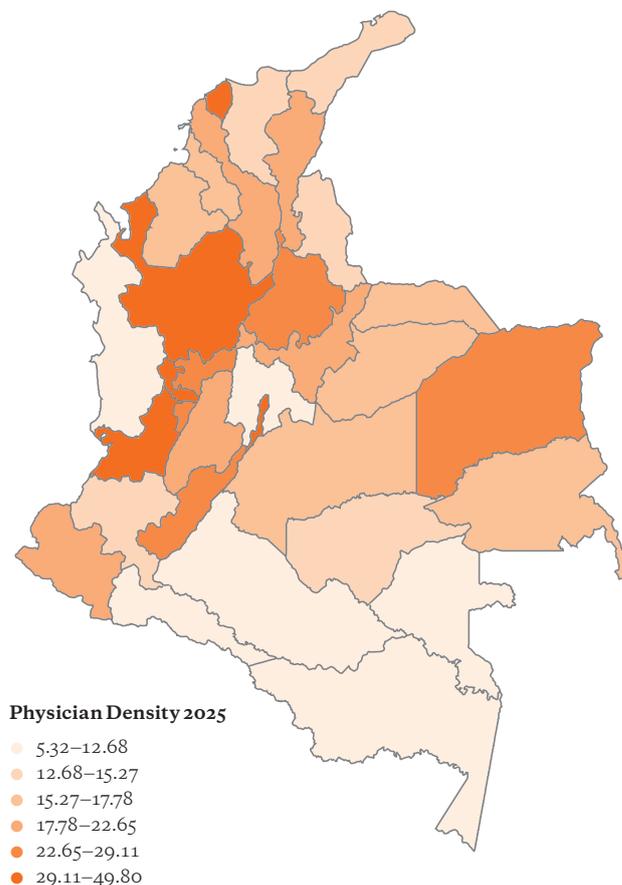


Figure 6: Physician density per 10,000 population by department
 Source: OTHS (2025) (29)

The health system displays important advancements in planning and public health. National strategies such as the 2024–2030 Plan for the Elimination of Communicable Diseases have improved surveillance, vaccination, and the management of high-burden conditions, including malaria, tuberculosis, HIV and hepatitis (33). Primary care has gained prominence through service integration and intersectoral efforts addressing water access, nutrition and other determinants (34). Colombia has also strengthened alignment with international partners through the WHO Country Cooperation Strategy 2024–2026 (35). Parallel labour reforms aim to address deteriorating working conditions and diversify employment arrangements (32). Nevertheless, structural weaknesses remain. Regional inequalities are entrenched (34), the workforce continues to face outsourcing and informal

employment, and remote areas struggle to attract specialised staff. Only 26 percent of physicians are specialists, far below OECD (Organisation for Economic Co-operation and Development) averages (32). Governance challenges, underfunding, and fragmented information systems compromise planning and monitoring efforts. External pressures such as climate change and antimicrobial resistance add further strain (33).

Colombia trains its health workforce through two complementary subsystems: higher education (professional degrees, specialities, postgraduate programmes) and the Training for Work and Human Development system (which trains auxiliaries). Nursing education is pivotal, with 65 faculties and schools (22 public, 43 private) (36). While this constitutes the national formal infrastructure, it appears modest compared to regional peers, where

the number of nursing schools often reaches into the hundreds. For example, in 2019 was reported that there were more than 1,244 courses and programmes in nursing (undergraduate) in Colombia (37). Programme length varies (eight semesters: 29 programmes; nine: 14 programmes; ten: 22 programmes). Yet distribution is uneven: Amazonas and Orinoquía, both in the Amazonian region, have no nursing faculties, forcing reliance on technical training (10). Although the health education landscape has tripled since the 1990s (38), regional inequalities persist, student interest is low, and only 1.5 percent of 15-year-olds express interest in nursing (39) (a level similar to trends observed in OECD countries), mainly due to the perceived heavy workload, difficult working conditions and low pay (40).

International benchmarks suggest Colombia would need to increase graduates by 8–12 percent annually to double its workforce within a decade, particularly in nursing (41). Importantly, there are no publicly available consolidated national data on public expenditure for training, limiting transparency and planning.

Migration of health professionals is increasingly visible but poorly tracked. The WHO estimates 15 percent of health and care workers globally practice outside their country of birth (42), with high-income countries hosting almost half the world's nurses (46 percent) despite representing just 17 percent of the population (42). Colombia does not systematically report indicators on outflows or maintain registries of migrating doctors or nurses. Available figures show that seven percent of Colombian physicians and less than two percent of nurses were trained abroad (25). Outward migration is rising sharply: formal requests from Colombian nurses for international placement increased from four in 2014 to 507 in 2021 (43). Drivers include inadequate pay, precarious contracts, and dissatisfaction, yet migrating nurses often face less favourable conditions abroad (44). This reflects global patterns in which wealthy countries recruit from countries like Colombia to offset their own underinvestment (44).

Colombia has responded with policies such as the National Nursing Policy and Action Plan 2022–2031 to improve training quality and create incentives for underserved regions (36). However, these policies do not explicitly address international migration, and without reliable national data, the country risks “brain drain”, which has

been defined as the extraction of skilled professionals who are allowed to migrate abroad in search of better opportunities, and unequal distribution of personnel (45).

The discourse on migration and international recruitment reflects tension between domestic shortages and global demand. Despite a nurse density of only 1.3 per 1,000 inhabitants, far below the international recommendation of 10 per 1,000 (46), Colombia has entered agreements with Germany's Federal Employment Agency through the National Learning Service (SENA in Spanish) to promote labour mobility (46). Private recruitment agencies also facilitate migration, offering German language training (often up to B2) and job placement, typically binding workers to a two-year minimum stay abroad (47). The Colombian Association of Nursing Faculties (ACOFAEN) and academic leaders have warned that such outward migration aggravates shortages and risks turning state investments into a subsidy for foreign labour markets (48). Also, previous research has highlighted that bilateral agreements rarely deliver promised knowledge transfer or investment (39, 49).

Migration is also appealing to students: final-year undergraduates report plans to emigrate even before entering the workforce, with Germany, Spain, Canada, and the United States as top destinations (50). There is also growing interest in “south-to-south” migration within Latin America (50). While the WHO Global Code of Practice (42) highlights risks of draining human resources, Colombia is not on the WHO 2023 Health Workforce Support and Safeguards List (51), even though its nurse deficit is critical in comparison with regional and OECD indicators (52). This might be due to the limitations of the list as a standalone tool, as it does not consider other relevant factors such as the deficit against regional or developmental benchmarks, internal maldistribution or future precarity.

Colombian nursing leaders from ACOFAEN have argued that international mobility can be positive but also exposes professionals to vulnerabilities abroad, where they may face less favourable conditions than local staff (48). For this reason, they have urged governments to improve training capacity, working conditions, and retention policies to prevent further depletion of human resources (48).

Chapter 2

Policies on Health Care Worker Recruitment and Emigration

Brazil

To better understand the complexities of the topic, two interviews were conducted: one with representatives of the Federal Nursing Council (COFEN), the autonomous agency regulating nursing practice in Brazil, and another with a representative of the Secretariat for Workforce Management and Health Education (SGTES), which oversees remuneration and workforce planning. These interviews provided insight into the policy logic behind recent bilateral agreements and the broader political environment in which they were negotiated.

The representatives of COFEN actively participated in the development of the bilateral agreement with Germany, and the representative of SGTES works directly with remuneration policies and health workforce planning.

To contextualise the bilateral agreement with Germany, it is useful to note that Brazil has previously engaged in targeted international recruitment, particularly through the “Mais Médicos” (More Doctors Programme) launched in 2013. Professionals recruited to work on the programme include Brazilians (who have concluded their medical degree in Brazil or abroad), as well as international doctors, demonstrating Brazil’s willingness to use international recruitment as a strategy to fill shortages in underserved areas (53). Between 2013 and 2018, PAHO established technical cooperation with the Brazilian government, facilitating agreements between Brazil and Cuba. According to the Brazilian Ministry of Health, in 2018, the participation of Cuban doctors accounted for 60 percent of the total participants in the programme (54). The programme substantially improved primary care access and health indicators, and for several years relied heavily on Cuban physicians through an agreement facilitated by PAHO. Its end in 2018 (55) underscored the vulnerability of recruitment policies to political cycles and diplomatic tensions. Further studies have shown that the programme brought a huge improvement in the coverage of primary care, as well as health indicators (56, 57).

Although the Brazilian government had, until recently, maintained an agreement for recruiting international doctors, in June 2022, Germany’s Federal Employment Agency (Bundesagentur für Arbeit, BA) and COFEN signed a bilateral agreement to recruit Brazilian nurses (58). According to its representatives, COFEN was appointed by the then-ministries of Foreign Affairs,

Labour and Employment, and Health, under Bolsonaro’s administration, as the body to negotiate the matter. Before signing the agreement, the organisation had the expectation that it would establish regulations and ensure better hiring conditions for nurses than those offered by private recruitment agencies.

Although the ILO (International Labour Standards) guidelines were used for the construction of the agreement, the WHO Code of Practice for International Recruitment of Health Personnel was not applied. When questioned on the matter, COFEN representatives stated that the agreement’s purpose was not to redirect nurses, but solely to announce the job offers, and therefore, the use of the Code would not be applicable. It was underscored that the organisation was not involved in the selection process of the professionals who migrated. Furthermore, COFEN emphasised that the agreement was signed between two autonomous public entities and not between governmental ministries.

Interviewees also described how precarious employment, low wages, and the need for multiple jobs are major drivers of nurse migration, which is consistent with existing literature (59–61). Yet the agreement itself did not address these structural issues; instead, it created a pathway that risked reinforcing them, as nurses accepted migration largely as a response to domestic labour market instability (62, 63).

“We expect that we will have conditions in Brazil that encourage professionals to stay here, and those who wish to leave – because some do – will do so not because of poor conditions, but because they have greater expectations elsewhere.”

(COFEN representative)

Union organisations such as the National Federation of Nurses (FNE), the National Confederation of Health Workers (CNTS), the Union of Psychologists in the State of São Paulo (SINPSI SP), the National Federation of Psychologists (FENAPSI), and the National Confederation of Social Security Workers (CNTSS) issued a strong critique of the bilateral agreement between COFEN and Germany (64). They argued that it lacked essential labour



Facing a shortage of skilled healthcare workers, Brazil is turning to international recruitment to fill gaps.

protections, failed to guarantee recognition of qualifications, and risked imposing financial costs on nurses, especially if revalidation was unsuccessful (64). Importantly, these unions challenged narratives of a “surplus” of Brazilian nurses, emphasising instead persistent regional inequities in workforce distribution. Their critique also highlighted that COFEN’s negotiation without consultation from unions or health ministries weakened worker protection (64).

The perception of the agreement changed over time, especially after the transition of governments. During Bolsonaro’s administration, the government appointed COFEN to act as the organisation responsible for the discussion of the terms and conditions with Germany’s Federal Employment Agency, while the new government under Lula’s power showed more interest in protecting the

national workforce and reaching a mutually beneficial agreement. In a press conference with the President in December 2023, the labour minister stated that Germany had not complied with some of the points agreed upon in the memorandum regarding the recruitment of the Brazilian nurses, and that an official letter was filed reporting the issue. He also reiterated the importance of protecting the healthcare workforce. He mentioned points to be discussed with the German government, such as the guarantees about family, efforts to promote cultural adaptation and more involvement of federations and trade unions (65).

The agreement was suspended in November 2023, but the Brazilian government has the intention to create an interministerial group to discuss the matter further and to develop ethical recruitment, avoiding brain drain and working towards mutual benefit (66).

Colombia

Two key informant interviews were conducted with a former senior government official from the Direction of Human Resources in Health at the Ministry of Health, with a background spanning academia, professional associations, and policy design, and a union leader and academic, senior representative from the National Association of Nurses of Colombia (ANEC), with extensive



Two Colombian midwives assist a mother during childbirth. In Colombia, there are not even any statistics on how many midwives are practising.

experience in nurse advocacy, nursing policies, and university teaching. Together, these interviews capture both policy-level and grassroots/union perspectives on health worker migration and international recruitment.

Both interviewees stressed that Colombia lacks a coherent national policy on international recruitment of health professionals. Despite the high volume of migration, particularly of nurses, no clear bilateral framework exists to govern recruitment or ensure reciprocity.

Instead, agreements are fragmented and largely negotiated through the Ministry of Foreign Affairs rather than the Ministry of Health, with little or no consultation of nursing associations such as ANEC. For example, the recent bilateral agreement with Germany was signed by the Ministry of Foreign Affairs without input from professional associations, even though it facilitates recruitment agencies' operations in Colombia.

ANEC's official position is not to support migration but also to defend the right of professionals to seek better opportunities abroad. The association has written to embassies and government officials to express concern about the exodus of nurses, but reports receiving little response from the national government.

“International recruitment in Colombia resembles a form of trafficking; agencies promise conditions that are not fulfilled once nurses arrive... We have noted these per our colleagues who have moved to countries such as Germany.”

(ANEC leader)

Both interviews emphasise that some local governments and universities actively encourage migration, for example, through training programmes or direct recruitment campaigns, despite significant shortages of nurses within their own regions. This is viewed as undermining national health workforce needs and as an instance of “state-supported out-migration”. Consequently, interviewees indicated that Colombia's current approach is permissive and unregulated, leaving recruitment mainly to private actors and foreign agencies.

Chapter 3

Effects of International Recruitment of Healthcare Workers

Brazil

Brazil lacks official data on the number of healthcare workers emigrating to other countries; however, a study conducted by the Ministry of Foreign Affairs indicates that in 2022, approximately 4.9 million Brazilians were living abroad, with higher figures in North America and Europe (67).

During an interview with representatives of COFEN, it was noted that, although COFEN does not maintain official data on nursing migration, its representative reported a consistent increase in the phenomenon: whereas a few years ago requests for documentation for immigration at the regional nursing councils were sporadic, there are reports that today they occur every week.

Although data on the number of doctors and nurses leaving the country is scarce, the upward trend in healthcare personnel migration is evident, and international recruitment also occurs through private agencies.

Interviewees noted that it is not yet possible to observe negative impacts from the migration of nurses on the healthcare services, largely due to the high number of nursing schools and registered professionals.

This interpretation, however, accounts only for total numbers and fails to acknowledge the documented maldistribution of nurses across regions and the difficulties in attracting and retaining nurses in disadvantaged and remote areas of the country.

Representatives from SGTES recognise these inequalities and point out that producing official data for the distribution of nurses in remote vs. urban areas is not easy. Database from COFEN, for example, is organised mainly by state and by professional registration, not by the place where the nurse works or whether the job is rural or urban, making it difficult to see clearly where the gaps really are on the ground.

Under these conditions, the emigration of nurses can directly aggravate shortages in regions that are already underserved. Even when those who leave come from saturated urban labour markets, such as the Southeast region, they represent professionals who could, in principle, be mobilised to fill gaps in other parts of the country.

Whilst the exponential increase of nursing schools has not solved the regional workforce disparities, mainly due to a lack of proper planning, it has also raised concerns about the quality of training, particularly for those

programmes offered through online modality. At the same time, international recruitment tends to draw away the most qualified professionals, as stated in one interview:

“What we are usually sending abroad is a more qualified workforce that can succeed in these selection processes. So, we tend to export what we have best.”

(SGTES representative)

The inadequate nursing staffing in healthcare institutions, characterised by a high nurse-to-patient ratio, was a recurring topic in the interviews. The disproportional composition of the nursing team was also mentioned. In fact, nurses account for only a quarter of the total nursing personnel, with the largest proportion (over two million professionals) being nursing technicians, highlighting the system's fragility. The migration of these qualified professionals would negatively impact the ecosystem even further.

Moreover, the migration of these professionals represents a permanent loss of publicly financed training investments and results in substantial opportunity costs for the health system.

Colombia

Interviewees described a double loss: (a) depletion of an already scarce and unevenly distributed nursing workforce, and (b) loss of public investment in training highly qualified professionals. Around 5,500 nurses graduate annually, yet many emigrate soon after graduation or mid-career, often leaving underserved areas completely without professional staff.

“There are municipalities in Cundinamarca (the region where Bogota is located) where there is not a single professional nurse.”

(ANEC leader)

Working conditions were repeatedly cited as the main driver of migration: outsourcing, low salaries, precarious contracts, and lack of recognition compared with those of doctors. This generates “desesperanza” (hopelessness) and leads to migration as a survival strategy rather than a career choice.

“Nurses migrate heavily indebted, seeking dignity and a fair wage.”

(ANEC leader)

Both interviewees emphasised the risks and costs borne by migrants, such as large debts to cover migration expenses and the possibility of unequal treatment abroad, including longer working hours or lower pay compared with local staff. Family separation and psychosocial stress were also mentioned.

At the system level, migration weakens the capacity of hospitals and universities to maintain experienced staff, erodes continuity of care, and may exacerbate reliance on auxiliary nurses rather than professionals, especially in rural and dispersed areas. This undermines Colombia’s stated move towards a preventive and community-oriented health model.



In Colombia, only 26 percent of physicians are specialists.

Chapter 4

Wider Lessons and Recommendations

Brazil

Considering that Brazil lacks consistent and reliable data on healthcare personnel migrating to other countries, the SGTES representative suggested that the starting point for Brazil would be to improve data collection on the workforce and identify possible surpluses or deficits. Brazil is taking steps towards this. The Ministry of Health is developing a healthcare workforce census (68), as well as a report on the nursing demography. The data will be used for the development of a 10-year workforce plan. In July 2025, Brazil, in partnership with PAHO, held the International Forum on Human Resources for Health in the Americas. The discussion resulted in a regional consensus on ethical and sustainable healthcare personnel migration management and is expected to inform a future roadmap on the topic (69).

Regarding the suggestions for future collaborations, all the interviewees expressed their interest in compensation from the destination country:

“What counterpart does the recruiting country offer to a nation [...] economically weaker than them and that has invested in its workforce?”

(SGTES representative)

The COFEN representative adds: “I believe the main recommendation for a future agreement for countries that need this workforce is to invest in the training of people from the countries they consider recruiting. [...] the importance lies in the training and the agreements between governments themselves, to prevent any impression of exploitation, from either side.”

Although Germany seeks to recruit nurses only in countries with a reported surplus of these professionals and frames this under the Triple Win Strategy, the benefits provided for the source countries (mainly remittances and brain circulation) do not seem to compensate for their losses (55).

“The German government, from the beginning, told us they were concerned about understanding the impact. So, I believe these agreements between governments are important as well. Therefore, investment in training and ensuring that working conditions there will be adequately maintained.”

(COFEN representative)

The WHO Global Code of Practice recommends that destination countries support source countries via measures such as training partnerships and technology transfer (70). In the context of a country, such as Brazil, where the training for healthcare professionals is highly financed through public funds, and the government invests in the development and retention of the healthcare force, despite the financial constraints, the compensation for this investment needs to go further. It is also paramount for the development and success of a mutually beneficial agreement to promote stakeholder engagement and foster constructive discussions to better understand the needs and priorities of both source and destination countries.

Colombia

Both interviewees converged on the urgent need for a national and interministerial strategy that coordinates the Ministries of Health, Foreign Affairs, Education and Labour to address health workforce retention and international recruitment. They emphasised that without a unified policy, Colombia is effectively “training for export” rather than building domestic capacity.

“Fragmentation of the sector, including healthcare professionals' unions, prevents this from becoming a political priority.”

(Former government official)

A key recommendation was to negotiate genuine bilateral agreements with destination countries. These agreements should not only regulate recruitment numbers but also include enforceable assurances for working conditions abroad, recognition of qualifications, and monitoring systems to safeguard workers' rights. Interviewees also emphasised the need for financial compensation from receiving countries.

“Germany and any country that recruits healthcare workers should pay a tax to finance more training slots in public universities.”

(Former government official)

The ANEC leader also supported this statement. This “training tax” would allow Colombia to reinvest in its health workforce and ensure that public investment in professional education benefits the national health system rather than subsidising richer nations.

Another lesson concerns the strengthening of unions and professional associations. Both interviewees contrasted Colombia's weak and fragmented union culture with Brazil's mandatory unionisation and more robust institutional leverage. The ANEC leader noted that Colombia's health professionals face persecution and socio-economic barriers to organising, which undermines their ability to influence policy and negotiate fairer terms. Building collective power, they argued, is critical to elevating the migration issue on the political agenda.

Finally, both called for improvements to domestic working conditions and education to make migration a genuine choice rather than an act of desperation. This includes ending outsourcing, raising salaries, creating a special labour regime for the health sector, meaning a tailored set of employment rules, protections, and benefits that recognise the sector's specific workload, risks, and training requirements, and revising university curricula so that nurses graduate with the skills to defend their labour rights and negotiate ethical conditions before migrating.

“Without changing the labour system for healthcare workers, Colombia will continue to 'train for export' rather than build domestic capacity.”

(Former government official and ANEC leader)

Chapter 5

Conclusion

A key limitation in this comparative analysis is the uneven availability of information between the two countries. Whereas Brazil's experiences, particularly through Mais Médicos and COFEN's negotiations with Germany, generated some degree of public documentation, Colombia's agreement with Germany remains far less transparent. This limited visibility appears to stem from the absence of formal consultation processes, restricted public access to documents, and a general lack of communication by the institutions involved. Consequently, the Colombian case contains less detail, not because the issue is less significant, but because the agreement was implemented with minimal transparency and virtually no publicly available material. This scarcity of information is itself a major finding: opaque processes undermine accountability, constrain the capacity to monitor impacts, and weaken the evidence base on which policymakers rely.

Across both countries, the comparison reveals two markedly different approaches shaped by institutional capacity, political context, and the involvement of key stakeholders. Brazil's trajectory reflects more structured programmes and the visible participation of professional councils like COFEN, which negotiated directly with German authorities and contributed to framing recruitment conditions. Colombia, in contrast, has followed a more reactive and fragmented path, with professional associations entirely excluded from negotiations and private recruitment agencies playing a dominant role. Brazil's tradition of unionisation and stronger public training infrastructure confer leverage in negotiating safeguards, whereas Colombia's reliance on private intermediaries reduces oversight and increases the vulnerability of health workers to precarious conditions, limited support, and uneven monitoring. These differences show how institu-



Many regions of Colombia lack healthcare professionals.

tional strength and social dialogue can determine whether international recruitment operates within an ethical, regulated framework or one that intensifies existing labour inequalities. This comparison also highlights a crucial policy lesson: without consultation, compensation, and strong domestic protections, international recruitment can deepen inequalities in source countries.

Additionally, the absence of Brazil and Colombia from the WHO Safeguard List should not be interpreted as evidence that their health systems are resilient or sufficiently staffed. Instead, it highlights the limitations of global indicators in capturing complex challenges such as fiscal austerity, professional insecurity, internal maldistribution, and the escalating recruitment pressures exerted by high-income countries dealing with their own workforce shortages. Both countries, therefore, remain in a structurally precarious situation with regard to the long-term sustainability of their health workforce.

A central cross-cutting finding is the near-complete lack of comprehensive, transparent, or consistent data. There is no unified system documenting: 1. the content and terms of the bilateral agreements with Germany; 2. the true magnitude of nurse emigration flows; or 3. the direct and indirect effects of these recruitment processes on national health systems. The absence of such information is not only a technical gap but a structural barrier that prevents proper evaluation, obscures potential risks, and blocks the development of evidence-based policy responses. This also represents an important gap in the existing academic and policy literature.

The available evidence from both Brazil and Colombia underscores a stark and uncomfortable reality: destination countries are not simply attracting talent but effectively extracting scarce, publicly trained health professionals from health systems that are already under strain. This sustained loss exacerbates geographic inequities, weakens public investment, and undermines health sovereignty. Interviews conducted as part of this work reveal a shared sense of urgency: without coordinated national strategies, transparent international agreements, and enforceable protections for migrant health workers, international recruitment risks becoming a form of institutionalised extraction benefiting high-income countries at the expense of source countries.

Both WHO guidelines and the experts consulted emphasise that destination countries bear a significant responsibility to ensure ethical recruitment practices, guarantee fair treatment of migrant workers, and provide compensation to source countries whose resources and training systems they rely on. Financial transfers to expand training capacity, investments in retention policies, bilateral support for workforce planning, and mechanisms that facilitate circular or temporary migration should not be optional. They are essential components of a fair and sustainable global health workforce. Only through such measures can health worker migration evolve from a model of brain drain into a mutually beneficial exchange that reinforces, rather than depletes, health systems on both sides.

These findings also point to clear recommendations. First, there is a pressing need for rigorous, systematic research on the impacts of international recruitment, particularly the recruitment currently taking place between high-income countries such as Germany and Latin American countries. Understanding how these processes affect service delivery, workforce distribution, and long-term health system resilience is indispensable for developing effective national and international policies. Second, both Brazil and Colombia should establish transparent, centralised systems for tracking bilateral agreements, recruitment processes, and emigration flows. Without this, neither governments nor international organisations can accurately assess risks, safeguard workers, or plan for sustainable workforce development. Finally, any future agreements must include consultation with professional associations, clear accountability mechanisms, and enforceable protections to ensure that recruitment contributes to shared global health goals rather than intensifying existing inequalities.

Abbreviations

ACOFAEN	The Colombian Association of Nursing Faculties (Asociación Colombiana de Facultades de Enfermería)
CNTS	the National Confederation of Health Workers (Confederação Nacional dos Trabalhadores na Saúde)
CNTSS	National Confederation of Social Security Workers (Central Única dos Trabalhadores)
COFEN	Federal Nursing Council (Conselho Federal de Enfermagem)
CORENs	Regional Councils of Nursing (Conselho Regional de Enfermagem)
ESF	Family Health Strategy (Estratégia de Saúde da Família).
FENAPSI	National Federation of Psychologists (Federação Nacional dos Psicólogos)
FIES	Student Financing Programme (Fundo de Financiamento Estudantil)
FNE	National Federation of Nurses (Federação Nacional dos Enfermeiros)
IBGE	Brazilian Institute of Geography and Statistics (Instituto Brasileiro de Geografia e Estatística)
ILO	International Labour Standards
OECD	Organisation for Economic Co-operation and Development
OTHS	Colombian Health Workforce Observatory (Observatorio de Talento Humano en Salud)
PAHO	Panamerican Health Organisation
PNI	National Immunisation Programme (Programa Nacional de Imunização)
PROUNI	The University for All Programme (Programa Universidade Para Todos)
SENA	The National Learning Service (Servicio Nacional de Aprendizaje)
SGTES	Workforce Management and Health Education (Secretaria de Gestão do Trabalho e da Educação na Saúde)
SINPSISP	the Union of Psychologists in the State of São Paulo (Sindicato dos Psicólogos do Estado de São Paulo)
SUS	Unified Health System – Brazilian Public Health System (Sistema Único de Saúde)
WHO	World Health Organisation

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