GERMANY´S EMERGENCY PROGRAMME FOR CARERS: STRENGTHNING OCCUPATIONAL SAFETY AND STAFF RETENTION

Introduction

In 2018, Germany's Federal Ministry of Health (Bundesministerium für Gesundheit, BMG) described the situation of the nursing workforce as a 'dangerous spiral' characterised by increasing workloads, rising sickness absence, early departures from the profession, and further workload pressures on remaining staff. The Emergency Programme for Nursing and Older Adult Care (Sofortprogramm Kranken- und Altenpflege) was introduced as an initial fast-acting policy package to stabilise staffing and working conditions (Bundesministerium für Gesundheit, 2018c), with entry into force scheduled for 1 January 2019 (Bundesministerium für Gesundheit, 2018b). The programme was a direct result of BMG's Concerted Action on Care (Bundesministerium für Gesundheit, 2018a).[1]

This case study focuses on the programme component that sought to address health and safety in the residential care sector, thereby complementing the staffing and financing reforms included in the programme by targeting health protection and staff retention, as well as work-life compatibility – two structural drivers of workforce sustainability.

This case study is part of a broader research project aimed at providing an overview of research on occupational safety and health (OSH) in residential care work.[2] It was developed based on desk research (see relevant references in the text) and interviews with representatives of social partners in the health and social care sector at national level.

Description of the intervention

Background information and objectives

The Emergency Programme for Nursing and Older Adult Care, which BMG explicitly refers to as the Sofortprogramm, was subsequently implemented through legislative measures, notably the Nursing Staff Strengthening Act (Pflegepersonal-Stärkungsgesetz, PpSG). The general objective was to reverse the workload-attrition spiral through rapid, financially supported improvements in staffing and working conditions in hospital and long-term care (LTC) nursing. Above all, emphasis was placed on the rapid implementation of the planned interventions. The programme introduced the following interventions in the area of OSH: (1) staff retention through health protection measures, including increased and targeted workplace health promotion (WHP) resources for hospitals and care facilities, in recognition of the 'enormous' psychological and physical strain experienced by nursing staff. The aims of the programme were also embedded in the National Prevention Strategy, thus explicitly linking prevention policy to employability and reduced sickness absence in nursing; (2) staff retention and recruitment through work-family compatibility, which was implemented by introducing support measures to address non-standard hours (e.g. nights and weekends) and family responsibilities among the predominantly female workforce, thereby improving the attractiveness and sustainability of the profession.

The Sofortprogramm targeted employees who provide direct nursing care in hospitals (*Pflegestellen am Bett*) and in fully residential care facilities for older people (*vollstationäre Altenpflegeeinrichtungen*), primarily qualified nursing personnel. The programme also explicitly addressed the training pipeline,

[1] The Concerted Action on Care (Konzertierte Aktion Pflege) was followed by the Emergency Programme for Nursing and Older Adult Care and a series of further reforms: the Healthcare Provision and Care Improvement Act (GPVG), the Healthcare Development Act (GVWG), the Care Support and Relief Act (PUEG), the Act on the Expansion of Powers and Bureaucracy Reduction in Care (BEEP), etc.

[2] The full report — *Residential care workers: a comprehensive overview of occupational safety and health* — is available at https://osha.europa.eu/en/publications/residential-care-workers-comprehensive-overview-occupational-safety-and-health

including (paediatric) nurses and nursing assistance (*Krankenpflegehilfe*) trainees, for whom remuneration and reimbursement arrangements were specified.

Key actors included BMG (policy lead), statutory health insurers and their coordination structures (delivery and funding of WHP measures), hospitals and care providers (implementation), and social partners.

What has been done and how

In line with the programme's overarching goal of rapidly stabilising working conditions and staff retention in the nursing sector, the intervention described in this section focused on three complementary areas: first, strengthening staffing in hospitals and fully residential care homes through targeted financing mechanisms intended to expand nursing capacity; second, scaling up WHP measures in hospitals and LTC facilities by compelling statutory health insurers to fund and support preventive measures targeting physical and psychosocial strain; and, third, improving work-family compatibility through funded measures, especially for non-standard working hours and childcare needs, to make nursing jobs more sustainable and attractive.

Strengthening staffing in hospitals and care facilities

The programme's core component concerned increased funding for nurses in both hospitals and care facilities, including to address labour shortages. The rationale behind this policy priority was to ease demographic pressures on the health and care sectors in the context of persistent understaffing.

In hospitals, the programme focused on making workforce expansion financially viable and enforceable by fully reimbursing every additional or expanded bedside nursing position (with no cap and no hospital co-payment), fully covering wage (tariff) increases to prevent cost savings 'at the expense of nursing', and strengthening incentives to increase training capacity. It also involved strengthening financing mechanisms, including the continuation and expansion of the hospital structural fund, and setting the direction for a structural reform: the transition towards a payment model that separates nursing personnel costs from diagnosis-related group[3] (DRG) payments through hospital-specific cost reimbursement.

In nursing facilities, the programme aimed to add about 13,000 additional nursing posts across all fully residential care homes via a simple size-based allocation and financing mechanism that avoids passing the costs of these new positions on to care recipients, funded through statutory health insurance contributions, with proportional participation from private insurance.

Workplace health promotion for nurses

Under the programme, WHP for nurses was designed as a binding financing and delivery obligation for statutory health insurers (Gesetzliche Krankenversicherung, GKV) to expand WHP, specifically in hospitals and LTC facilities. This reflected the high physical and psychosocial demands placed on nursing staff and other workers and recognised prevention spending as a lever for workforce retention. Specifically, it required GKV to mobilise at least EUR 70 million in additional annual spending for health promotion in these settings by increasing the statutory minimum prevention expenditure from EUR 2.10 to EUR 3.10 per insured person per year. In parallel, it called for the National Prevention Strategy to be complemented by shared objectives among stakeholders, aimed at maintaining employability and reducing sickness absence among nursing staff, thereby embedding nursing workforce sustainability within national prevention governance.

The delivery model was pragmatic: insurers funded and/or organised WHP interventions jointly with providers – typically covering measures such as stress prevention, ergonomic improvements and organisational adjustments – while regional coordination centres established under the Prevention Act were expected to provide stronger, more hands-on advisory support. This advisory infrastructure was intended to lower access barriers and improve implementation capacity, particularly among smaller providers and those with limited administrative resources, to ensure that preventive services were not concentrated solely in organisations with already strong management capacity.

[3] A hospital payment system whereby hospitals are paid a fixed lump-sum for each inpatient case, determined primarily by the patient's diagnosis, procedures and expected resource use. Therefore, revenue is linked to case volume and case mix rather than to the hospital's actual nursing staff costs for individual patients.

In residential LTC facilities, WHP funded or organised by statutory health insurers was typically implemented as a structured process rather than as one-off training, and combined changes to working conditions with behaviour-oriented interventions. The overarching idea was that insurers would help facilities identify the main health burdens in everyday care work through a needs and workload assessment, develop a package of measures with staff participation, and then support implementation and evaluation, often alongside other actors such as OSH, accident insurance and external specialists. The most typical examples of interventions were as follows:

- Stress prevention and psychosocial health: anti-stress courses, resilience and resource training, peer support formats, and improvements in work organisation and management.
- Ergonomics and physical workload: safer handling and transfer routines, better use of assistive devices and the redesign of workflows to reduce repetitive strain, often accompanied by short training modules and organisational follow-up.
- Organisational adjustments: reducing constant interruptions, improving break structures, clarifying responsibilities and strengthening cooperation routines across shifts, as well as leadership-related components ('health-oriented leadership'), since management practices strongly shape perceived workload and team climate.

Work-family compatibility measures

With regard to work-family compatibility measures, the programme recognised work-life balance as a key factor in the retention and recruitment of nursing staff, given the reality of shift work, night duties and weekend schedules in both hospitals and LTC facilities. The programme therefore included a time-limited, four-year financial incentive stimulus to help employers implement practical measures aimed at making nursing jobs more family friendly. The policy was explicitly designed to address the 'special childcare needs' arising outside standard childcare opening hours, a recurring barrier for nurses working irregular schedules, while also supporting broader organisational solutions to strengthen family-friendliness in hospitals and care facilities for older people more generally.

Two implementation strands emerged in practice: one in hospitals (2019-2024), which is not discussed further here, and one in LTC providers (2019-2030). In the latter, separate provider-level funding (embedded in the Social Security Code, SGB)[4] supports measures to improve the compatibility of 'care, family and work' and to facilitate the return of former staff, including those who left the profession after planned career breaks such as parental leave and may wish to re-enter. Current guidance indicates that the programme is due to run until 2030, with applications accepted until then (Bundesministerium für Gesundheit, 2025). Eligible measures include childcare and relief services, as well as training and organisational measures. Practical information portals outline annual caps (e.g. differentiated according to the facility workforce size) and co-financing rules.

Under the LTC strand of the programme (implemented through Section 8(7) SGB XI), eligible work-life balance measures are broadly defined as interventions that 'reduce the everyday conflicts between shift-based care work and family/caring responsibilities'. Examples of eligible measures include: expanding or adapting childcare to non-standard working hours such as early mornings, late evenings, nights, weekends, holidays and school holidays, including provider-run childcare solutions with non-standard hours; and support services for staff members who care for dependent relatives, where the costs are not already covered by LTC insurance benefits. On the organisational side, the following eligible measures are explicitly referenced: training and coaching for managers and staff to strengthen family-friendliness; professional consultancy to redesign working-time models and duty rosters, such as more reliable, health-oriented and participatory scheduling; the development of life-stage-oriented working-time models, the recruitment and re-onboarding of former care staff, and support for re-entry after parental or caregiving leave; and initiatives to improve internal communication and foster a more family-friendly organisational culture.

The LTC strand of the programme is accompanied by clear financial parameters. In practice, this means that providers can apply for grant funding subject to annual caps and co-financing requirements, which are designed to: (a) spread resources across many facilities; (b) encourage employer buy-in; and (c) keep the scheme administratively manageable, while allowing facilities to combine several small-scale interventions into a single annual package. Against that backdrop, the typical funding conditions are as

[4] More information is available at: https://www.sozialgesetzbuch-sgb.de/

follows: facilities with up to 25 care staff members can receive up to 70 % of eligible costs, capped at EUR 10,000 per calendar year, while facilities with 26 or more care staff members can receive up to 50 %, capped at EUR 7,500 per year. These caps apply to the total across multiple measures within a given year. Under certain conditions, unused amounts can be carried over to the following year if the state-level budget has not been fully utilised.

Results

1. **Workplace health promotion: spending and uptake signals**

   Statutory health insurance prevention reports (Bundesministerium für Gesundheit, 2025) show that, in 2024, insurers spent EUR 0.92 per insured person on WHP measures in hospitals and care facilities, while the relevant minimum expenditure for nursing settings in both sectors (reported as EUR 1.13 per insured person), was not fully utilised. This suggests that, although the programme strengthened and earmarked funding WHP, absorption and implementation capacity remained constrained – an important lesson for attractiveness measures that rely on cooperation between providers and insurers.

2. **Work-family compatibility in hospitals: documented low uptake and weak evidence base**

   A final 2025 report from GKV-Spitzenverband on the hospital programme (2019-2024) concluded the following (Bundesministerium für Gesundheit, 2025):

   - EUR 52.9 million in funding was agreed over the period, representing 12.6 % of the originally estimated EUR 420 million.
   - Only 35 % of the approved funding was verified as having been used for its intended purpose; for the remaining 65 %, no audited evidence of use was available, which suggests potential recoverability.
   - Annual hospital participation was relatively low, at roughly 16-18 %, before rising to 26 % in the final year. The report noted that unclear targets, the heterogeneity of measures, limited earmarking of funds, and data gaps prevented a credible assessment of effectiveness.
   - In terms of content, measures focused on childcare (the largest category) and flexible working-time models.

3. **Work-family compatibility in LTC: durable framework but limited reporting on consolidated outcomes**

   For LTC providers, national guidance confirms that funding remains available until 2030 and defines eligibility criteria for facility-level measures. While publicly available sources provide information on rules and eligibility, they offer less consolidated national reporting on uptake and outcomes than the hospital strand (where GKV issues formal reports) (Pflege-Netzwerk Deutschland, 2026).

Success factors and challenges

Success factors

Based on the results of the Sofortprogramm evaluation report prepared by BMG (Bundesministerium für Gesundheit, 2025) and interviews conducted with the representatives of national-level social partners, some conclusions were drawn.

The first success factor identified in the evaluation report was the clear definition of the problem and the political signal conveyed by the programme. The programme did not frame the nursing staff shortage as a purely technical issue; instead, it explicitly described a deteriorating cycle of increasing workload, sickness absence and departures from the profession, which reflected a loss of confidence in the system's ability to protect staff and maintain the quality of care. By positioning the package as an emergency programme, with a clear start date and tangible levers, policymakers aimed to create visible, near-term relief and restore credibility among frontline staff. The above challenges related to nursing occupations were also highlighted by trade unions, as stated by the representative of the Ver.di trade union. The recognition of these challenges and the direct approach taken to address them were assessed as relevant and necessary elements of the public policy.

Moreover, the programme's ring-fenced financing approach can be considered a success factor. Rather than relying primarily on non-binding appeals to employers, the programme defined funding streams and minimum expenditure obligations to make WHP and family-compatibility measures financially actionable. This structure was intended to reduce the risk that 'attractiveness' objectives would remain merely aspirational and to ensure that resources were available regardless of local budget pressures.

Moreover, the attempt to embed the health of the nursing workforce within national prevention governance was an important feature of the programme. By linking nursing employability and sickness absence reduction to the National Prevention Strategy and existing prevention infrastructure, including regional coordination mechanisms, the programme increased the likelihood of cross-actor alignment and sustained attention beyond a single legislative cycle. In principle, this should improve coherence and strengthen multistakeholder accountability for workforce health outcomes.

Challenges

In terms of implementation, the most immediate constraint was low uptake and limited absorption capacity. Prevention reports indicate that the minimum expenditure allocated to WHP in hospitals and care facilities was not fully utilised, which suggests that availability of funding did not automatically translate into the implementation of measures. Similarly, the final report on hospital work-family compatibility funding highlighted low participation rates and limited utilisation of allocated funding, which points to practical barriers such as administrative burdens, unclear incentives and uneven organisational capacity across providers. The above conclusions were also confirmed by interviewees representing both employers' organisations and trade unions.

A second challenge was limited evaluability, which significantly constrained the ability to demonstrate the impact on the workforce. The hospital programme report explicitly noted that unclear goal-setting, heterogeneous measures, incomplete data and insufficient reporting routines made it difficult to credibly assess whether the funded interventions had improved staff retention, reduced sickness absence or supported recruitment.

These challenges contributed to a broader risk of 'programme design without implementation leverage', as assessed by the trade union representative. When eligibility criteria are broad, implementation is decentralised, and reporting and audit requirements are insufficient to ensure consistent evidence, spending may occur without generating measurable improvements in workforce outcomes. Under such circumstances, even well-funded measures to enhance attractiveness may have limited impact on indicators such as staff turnover, sickness absence and return-to-work rates, precisely because the policy does not provide sufficient oversight of implementation quality, targeting and documentation.

Transferability

One of the key advantages of the Emergency Programme for Nursing and Older Adult Care is its transferability, although it would need to be adapted to national financing and governance structures.

In practice, several elements appear particularly well suited for transfer. First, countries could introduce earmarked funding for prevention and WHP in nursing workplaces by establishing minimum expenditure requirements or ring-fenced budgets for WHP in high-strain sectors, such as healthcare and LTC, linked to measurable objectives, including reductions in musculoskeletal and psychosocial risks, the prevention of stress and lower sickness absence through organisational measures and training. This could be complemented by coordination or technical assistance units to support providers, especially smaller facilities, in accessing funds and implementing measures.

Second, the programme's approach to targeted funding for childcare and flexible working arrangements compatible with shift work is readily replicable through mechanisms such as grant schemes, tax credits and social insurance co-financing to support changes in working time arrangements, participatory scheduling, 24/7 childcare provision, emergency childcare, caregiver support services and flexible scheduling systems.

Third, another transferable component is the integration of workforce health into national prevention strategies and the alignment of workforce retention and prevention policies to reduce fragmentation and improve cross-ministerial coordination.

For transfer within the EU, several preconditions and design considerations should be taken into account. First, it is essential to define outcomes from the outset. Germany's hospital strand illustrates

that, without clear targets and minimum standards, programmes may be underutilised and difficult to evaluate. At the same time, policymakers should seek to minimise administrative burdens while strengthening accountability by combining simple application processes with consistent, timely reporting and audit requirements. Transferability also depends on ensuring supply-side feasibility. For example, childcare funding is effective only if sufficient childcare capacity, including providers, staffing and opening hours, already exists or can be commissioned. Finally, it is crucial to embed evaluation from the outset by requiring the collection of baseline and follow-up indicators through mechanisms such as work-related risk assessments to systematically capture organisational working conditions and implemented changes. These should be accompanied by indicators such as sickness absence, staff turnover, holiday duration and return-to-work rates following leave, complemented by qualitative feedback from staff.

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