



Numero 3 / 2025

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Well, the nursing shortage has come about because there is a shortage of skilled workers, and this has developed over the years, it hasn't fallen from the sky. It has been a process. This is precisely why there is the hospital movement, the nursing movement, which wants to ensure that working conditions are so good that people are motivated to work in nursing again.

These were the words of Dana Lützkendorf, an intensive care nurse turned union organizer and one of the main forces behind the Hospital Movement that has been fighting for collective agreements for more nursing staff in hospitals across Germany for the past ten years. I met with Dana in the fall of 2023 at the Berlin headquarters of the United Services Trade Union (ver.di), which represents hospital nurses, to discuss the key challenges nurses in Germany have faced over recent decades.

The process Dana referred to in her quote is tied to health sector reforms since the 1990s, particularly in hospitals, where training positions were cut, staff numbers reduced, and hiring freezes imposed, resulting in steadily increasing workloads (Mohan 2018; Simon 2020). This trend intensified with the wave of hospital privatizations and the 2004 introduction of the Diagnosis-Related Groups (DRG) system, which replaced reimbursement hospitals receive from health insurance companies based on length of stay with fixed diagnosis-based payments (Fallpauschalen) (Busse et al., 2006; Heimeshoff et al. 2014).

While these reforms were officially introduced to increase the profitability of hospitals and reduce costs associated with rising national healthcare expenditure (Tiemann and Schreyögg 2012; Wilm et al. 2011), trade unions such as ver.di¹ and organized nursing staff saw them as opening up hospitals to the free market. They highlight that the DRG system incentivized early discharges, high patient turnover, and a focus on profitable treatments, while threatening unprofitable hospitals with closure (Pilny et al. 2025; Reifferscheid et al. 2015: e130). As a result, these cost-cutting pressures fell disproportionately on nursing staff, worsening working conditions and care quality (Leber and Vogt 2020; Lützkendorf 2025; Mohan 2018).

Mounting criticism led to partial reforms: in 2020 nursing costs were decoupled from DRG payments through a separate care budget (Pflegebudget) at hospitals and from 2025, a hybrid system was introduced that combined DRGs with so-called readiness payments (Vorhaltepauschalen) to keep essential but unprofitable hospitals open (Schmedders 2023: 216). Moreover, the state recently introduced the Nursing Staff Assessment Regulation

¹ <https://www.boeckler.de/de/pressemitteilungen-2675-personallucken-pflegeengpasse-privatisierungsdruck-28345.htm>

(Pflegepersonalbemessungsverordnung, PPBV), a legal regulation that provides a framework for calculating staffing requirements but does not impose sanctions if hospitals fail to meet them.² Critics argue that these changes have not reduced economic pressures or understaffing.³ Hospitals continue to struggle to recruit and retain nurses, many of whom leave the sector, work part-time, or retire early (Auffenberg et al. 2022; Care4Care Consortium 2024).

Research Site and Methods: TV-E Campaign at the Private Hospital

I address the issue of nursing shortages in Germany and possible solutions by examining the campaign for a company-level Collective Agreement “Relief” (Tarifvertrag Entlastung, TV-E) at the Private Hospital⁴ in Berlin between fall 2023 and summer 2024. Nurses, activists from the Hospital Movement, and organizers from ver.di led the campaign, applying Jane McAlevey’s workplace organizing strategy (McAlevey and Lawlor 2023), which centres on the direct participation of nurses in developing ward- and shift-specific demands, later negotiated between the union-led bargaining committee and hospital management.

I conducted ethnographic research on the campaign by attending ver.di’s regular weekly meetings with nursing staff they held near the Private Hospital, including workshops on organizing collective action, and accompanied ver.di union organizers as they helped nursing staff gather demands in their wards. I also held regular conversations and interviews with unionized and non-unionized nurses of different specializations and attended the short warning strike they organized towards the end of their campaign. Ethnography, as the study of social worlds through sustained engagement (Emerson et al. 1995), allowed me to build trust with nurses and organizers and to access the everyday dynamics of the campaign—insights that would have been difficult to obtain in the sensitive context of industrial action.

During the campaign, nurses collected their colleagues’ concerns and demands—ranging from general to intensive care, paediatrics, and psychiatry—and incorporated them into a proposed collective agreement. In this case, the TV-E focused on legally binding measures to alleviate understaffing by enforcing minimum nurse-to-patient ratios and sanctions through a system of “relief points,” which could be redeemed for additional paid leave or benefits when staffing falls short. The long-term goal of the agreement was to make understaffing more costly for employers than hiring additional staff⁵—while ensuring nurses themselves define what safe staffing looks like. Although the campaign was paused by ver.di after months of organizing due to legal and organizational hurdles, similar agreements have already been won in dozens of hospitals across Germany, underscoring the TV-E’s pioneering role in reshaping staffing policy.

²https://www.bundesgesundheitsministerium.de/fileadmin/Dateien/3_Downloads/Gesetze_und_Verordnungen/GuV/P/RefE_PPBV.pdf

³ <https://www.verdi.de/presse/pressemitteilungen/++co++dc8b23b4-8bfc-11ef-9f3e-7b1d0cc80d16;https://www.marburger-bund.de/bundesverband/pressemitteilung/krankenhausreform-grossversuch-mit-unabsehbaren-folgen>

⁴ The names of the hospital where the primary research took place, as well as those of the nurses, are anonymized to maintain confidentiality and protect participants’ privacy.

⁵ https://berliner-krankenhausbewegung.de/wp-content/uploads/2023/08/Flyer_TV-E.pdf

Ethical and Relational Dimensions of Nursing Work

The starting point of my ethnographic investigation was the observation that nursing work must be rethought through its ethical and relational dimensions, which are central to nurses' professional identity and directly tied to stressful working conditions. These dimensions also surface in the Hospital Movement's slogan:—*"We are saving you, who is saving us."* The sense of ethical responsibility towards patients and colleagues is a key reason why the nurses I spoke with so often "fill in" on their days off when there are not enough staff available and work overtime. To understand why this is the case, one must look at their perception of nursing work.

Ethical Responsibility towards Patients

"I save your life. That's all there is to it" (Dück and Garscha 2022: 39) are the words of Anja Voigt, an intensive care nurse and trade union organizer, from her interview for the Rosa Luxemburg Foundation, a think tank of the Left Party in Germany. She talks about not being able to take proper care of patients because her work has been reduced to quick and essential tasks due to staffing shortages. Dana Lützkendorf, who was also interviewed alongside Anja Voigt, described closeness and personal contact playing a central role in her work as *"she accompanies people on their difficult journey."* She contends that: *"It is always important to have time to sit by the [patients'] bedside, hold their hand or have a conversation with them. But...I don't have this time."*

Jenny, a paediatric intensive care nurse I interviewed, emphasized that time and empathy for patients are a core value for the nursing profession. Her belief in what constitutes "good care" was shared by the majority of nurses I spoke to: *"Good care means you have time for someone, and that's not possible if you have to look after too many patients in a limited amount of time."*

Most nurses emphasized that nursing is not just a set of technical skills and interventions required to care for patients, but that nursing work has a strong relational and ethical quality that they build with their patients. When I asked how their work differs from the work of doctors, most responded that they see the difference in the time they spend with their patients, which Kathy, another intensive care nurse, sums up nicely: *"I have real contact with the patients, whereas the doctors only spend 5 minutes with them at the regular check-up."* However, staff shortages are preventing the nurses to have enough time to take care of their patients in the way they would like to, while the severity of the understaffing has also led to situations where patients' lives were endangered. Vivi, a delivery nurse, recalled:

I saw that a child wasn't getting enough oxygen, and I was completely alone because all my colleagues and doctors were busy with an emergency in another room. I had to decide whether to join them because my name was being called and I was needed there, or to stay here.

Ethical Responsibility towards Colleagues

Nurses' ethical responsibilities extend beyond patient care to a strong sense of mutual solidarity toward colleagues. They feel compelled to prevent co-workers from carrying the burden of understaffed shifts, which often manifests in stepping in for sick colleagues and working overtime. As Wendy, a paediatric intensive care nurse, put it bluntly: *"You don't want to leave your colleagues and patients alone in such a shitty situation."* While the sense of inter-collegial responsibility has also been documented in other professions, such as among automotive industry workers, teachers, cocktail waitresses, etc. (Graham 1995; Hodson 1997; Laaser and Bolton 2017; 2020; Spradley and Mann 1975), it has a special significance in nursing given the direct responsibility for the well-being of patients (Theodosius 2008), which makes teamwork not only an organizational necessity but also an ethical responsibility.

Many of my interlocutors described their ward colleagues as a kind of work family, bound together by a strong sense of solidarity forged through shared experiences. Yet, as Vivi stressed, this responsibility has two sides, especially in the context of understaffing:

You have to imagine that we are always together. During the holidays, on weekends, when something bad happens; we are not just colleagues, we are also part of a family. This work family supports each other, but that also brings more stress for everyone.

When asked whether they felt ethically obliged to step in, my interlocutors consistently answered yes. Leaving colleagues to work understaffed shifts created what many described as a *guilty conscience*, or in Vivi's words: *"You want to help. Even though it's not really your fault, you feel guilty in that moment, so you usually feel like you're the bad one because you say no."* On the other hand, Danny, a nurse in the psychosomatic ward, explained that this guilt came also from the knowledge that one could easily end up in the same situation: *"You feel guilty towards the other nurse being there alone and you know that it's bad when you're working alone."*

Another significant consequence caused by understaffing was the normalization of excessive overtime work. *"If the emergency call comes ten minutes before the end of your shift, you can't just leave the colleague and the patient alone,"* Marlene explained. However, my interlocutors distinguished between such emergency overtime, which they accepted as part of the profession, and the overtime caused by chronic understaffing, which was the result of unfinished tasks and a guilty conscience about burdening colleagues in the next shift. Kathy sums this up: *"You always end up staying an extra half hour or an extra hour because you don't have time to do everything you had to do, and you don't want all that unfinished work to be passed on to your colleagues on the next shift."*

Emergency Service Agreement and Warning Strike at the Private Hospital

Irina, a senior nurse in the palliative care unit, pointed out that this mutual solidarity among nursing staff and their ethical responsibility toward patients was regularly misused by hospital management as an excuse not to hire new nurses: *"They know that we will manage somehow and not let our patients down, even if we are understaffed."* This dynamic has also complicated strike mobilizations in the healthcare sector, which until recently were relatively rare in Germany. Before a strike can take place, unions and employers typically negotiate an emergency service agreement that

guarantees a minimum number of nurses on duty to safeguard patient care. While such agreements are not legally required, in practice they are almost always concluded. As Dana Lützkendorf explained in a short text for the Hospital Movement (Lützkendorf 2022: 24): *“Hospital management has often used the ethos of the nursing profession and the sense of responsibility towards patients to discourage nurses from participating in strikes.”*

This in fact happened at the Private Hospital. As the nurses announced a warning strike, the hospital management took the matter to the labour court on the grounds that the emergency service staffing was not sufficiently covered, although an agreement had been reached a week beforehand. The labour court ruled in favour of the management a day before the strike. A higher number of nurses had to be registered as emergency staff and no wards could be closed during the strike. However, ver.di quickly appealed against the judgment and the nurses carried out a warning strike lasting several days.

On the second day of the strike, a demonstration was organized in front of the hospital. When I arrived there, the square was already filled with more than 200 striking nurses and several hundred supporters. As I listened to the speeches of union organizers and nurses who stood on the back of the truck equipped with loudspeakers, an intensive care nurse caught my attention with her speech:

“The hospital management is telling us that we can't strike as the wards can't be closed because the emergency service staffing has not been met. That's not true, because we've negotiated this with them over the last few days. Now they are acting as if they are looking after the patients and we are not. But we are! They are the ones who only care about money! I can only tell them that working below the level of emergency staff is already part of our everyday work!”

Conclusion

So, what can we learn about the ethical and relational qualities of nursing care for the regulation of this type of labour? In light of current debates on how to address chronic staff shortages in Germany (Auffenberg et al. 2022; Penter et al. 2023; Schmedding et al. 2025), my argument is that a legal mechanism to ensure minimum staffing levels in hospitals is essential. Nurses depend on teamwork and sufficient time for patients to fulfil their professional identity. At present, however, many struggle to guarantee even safe care for patients while simultaneously compensating for absent co-workers. This generates intense emotional strain, deteriorating working conditions, and ultimately attrition, which further deepens the staffing crisis and jeopardizes patient care.

Wages are a crucial factor for recruitment and retention (Care4Care Consortium 2025: 297; Roth et al. 2022),⁶ but they alone cannot break the vicious cycle in which understaffing worsens working conditions, leading to increased levels of sick leave among nurses (Gohar et al. 2020; Petersen et al. 2022). Professionalization through higher education can increase job satisfaction by expanding autonomy (Schmedding et al. 2025: 8), but this has limits in nursing, which relies above all on teamwork. Similarly, proposals to reduce overall working hours could improve

⁶ Nurse salaries have increased in recent years and, in some cases, now exceed the German national average—for example, among nursing professionals with three years of vocational training (Care4Care Consortium 2024: 285).

quality of life (Care4Care Consortium 2025: 12-13), but risk merely redistributing workloads unless staffing levels rise. Recent legal tools like Nursing Staff Assessment Regulation or the PPBV are important steps, but they exclude nurses from defining appropriate ratios and lack sanction mechanisms to ensure compliance.

Against this backdrop, campaigns for the Collective Agreement “Relief” (Tarifvertrag Entlastung, TV-E) under the Hospital Movement have shown the power of nurse-led organizing. These campaigns not only strengthened unionization and collective voice but also created binding mechanisms to sanction hospitals that failed to meet agreed staffing levels. They stand as best-practice examples of how nurses themselves can define fair staffing and negotiate conditions that make safe care possible.⁷

However, campaigns for the TV-E are not always won. This underscores the limits of workplace action alone. Adequate staffing must be secured through enforceable legislation combined with strong workplace organization. This requires both further reform of the DRG system and the immediate introduction of sanction mechanisms within the PPBV framework, reinforced by collective agreements that go beyond legislative minimums. Without these countermeasures against the on-going marketization of hospitals, neither safe patient care nor long-term nurse retention will be achievable.

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⁷ During my fieldwork on the campaign in the Private Hospital, nurses and organizers reported that several dozen nurses had joined ver.di in the course of the mobilization.

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