STANOVNIŠTVO, 2026, 64(1), 91–110
https://doi.org/10.59954/stnv.768

Original research paper

Received: 27.01.2026
Revised: 27.03.2026
Accepted: 01.04.2026
First online: 29.04.2026

Whose Crisis, Whose Gain? The Socio-economic Consequences of Care Migration from Serbia to Germany

Dragana Stöckel*[1]
Marina Pantelić[1]

[1] Faculty of Political Sciences, University of Belgrade, Belgrade, Serbia

* Corresponding author
E-mail address: dragana.stoeckel@fpn.bg.ac.rs (D. Stöckel)
Address: Dragana Stöckel, Department of Social Policy and Social Work, Faculty of Political Sciences, University of Belgrade, Belgrade, Serbia

This article investigates the phenomenon of care migration by analyzing the socioeconomic impacts associated with the internationalization of care work, using Serbia and Germany as case studies. Over recent decades, various social, economic, and demographic transformations have significantly affected the availability of both paid and unpaid care work. Notable trends—including population aging driven by declining fertility rates and increased life expectancy, reductions in average household size, and rising female labor force participation—have fundamentally reshaped the organization and provision of care services. These shifts have exacerbated the persistent global care crisis and underscored the growing role of migrant care workers in care provision. Drawing on the concepts of "global care chains" and "crisis of care", this study analyzes the dynamics of care and migration, focusing on how policy and practice shape the integration of migrant care labor into transnational eldercare sector, with Serbia and Germany as illustrative cases. The article pursues three primary objectives: first, to assess care arrangements and the management of transnational care in both countries; second, to outline Germany's policy strategies aimed at balancing care demand and supply in eldercare provision; and third, to evaluate Serbia's responses to its care gaps within the national social policy framework. The findings indicate that Germany and Serbia face rising eldercare demand, but respond with unequal capacities. Germany expands services and recruits migrant workers, while Serbia relies on informal care amid workforce outflows. Embedded in global care chains, these strategies redistribute—rather than resolve—care deficits, reinforcing cross-national inequalities and long-term sustainability challenges.

Keywords: care migration, care work, global care chains, Serbia, Germany

1 Introduction

Care work represents a core component of individual and societal well-being and plays a critical role in sustaining a stable and resilient economy, making a substantial contribution to overall economic growth (World Health Organization [WHO], 2017, p. 14). Globally, the care sector employs approximately 381 million people—about 11.5% of total employment—and is characterized by a highly diverse workforce (International Labour Organisation [ILO], 2024). Ongoing demographic, socio-economic, and political changes within modern societies have far-reaching consequences for labor market configurations and the provision of care, thereby influencing the availability and composition of the care workforce. In particular, population ageing, higher dependency ratios, changing family structures, and greater female labor force participation, alongside expanding care requirements, are driving both care shortages and an increased reliance on migrant labor in the care sector across Europe and other economic contexts (WHO, 2017; Blower-Nassiri, 2023; ILO, 2024).

Population ageing already constitutes a major source of strain for long-term care systems and is anticipated to generate even greater pressure in the coming decades. This trend is particularly evident in Europe, where demographic ageing is driving a steady rise in long-term care demand, with the number of people requiring such care projected to increase from 30.8 million in 2019 to 38.1 million by 2050 (European Commission [EC], 2021). Many European countries have sought to address this issue by liberalizing labor mobility and recruiting a foreign care workforce, as a strategy to mitigate the "national care crisis" stemming from shortages in domestic labor and the limited capacity of families to provide adequate care.

Of the 169 million migrant workers around the world, a substantial proportion is employed in home-based care services—ranging from domestic work to long-term residential care—sectors that often remain underrecognized and insufficiently regulated (ILO, 2024). Within the European context, migrant care workers play a crucial role in sustaining health and social care provision (Eurodiaconia, 2024). Accurate data on the number of migrant care workers in Europe remains limited, as most countries can provide only rough estimates, with Austria being an exception (Sowa-Kofta et al., 2019). The free movement of workers and increased labor mobility have helped alleviate the care sector crisis at the European Union (EU) level by fostering transnational care chains, channeling labor from Central and Eastern Europe to the more affluent countries of Western Europe (Sowa-Kofta et al., 2019). However, despite these benefits, such migration—whether from within the EU or from third countries—can simultaneously weaken the care systems and care infrastructure of countries of origin, a phenomenon commonly referred to as "care drain". Despite its general social legitimacy, most countries do not have systematically developed policies to regulate the care migration phenomenon, with Austria and Italy representing exceptions. The rising reliance on migrant labor in the care sector poses complex challenges for the design, coordination, and effective implementation of relevant policies in the field. The nature of challenges varies between origin and destination countries. Destination countries must manage the recruitment and employment of migrant care workers, uphold care standards, and apply coherent immigration policies. Origin countries, on the other hand, struggle to preserve a sufficient care workforce capable of meeting the growing long-term care needs of their own ageing populations.

https://doi.org/10.59954/stnv.768

Although Serbia and Germany occupy the same end of the demographic spectrum, given the pronounced extent of the population ageing process in both countries, their institutional and policy strategies for addressing the structural labor deficit in the care sector diverge considerably. In Serbia, individuals aged 65 and over constitute approximately 22.6% of the population (Statistical Office of Republic of Serbia [SORS], 2025), while in Germany this share is around 23% (Statistisches Bundesamt [Destatis], 2026), indicating a comparable intensity of demographic ageing. Projections by the Federal Statistical Office (Destatis) suggest that population ageing will increase the number of individuals requiring long-term care in Germany by about 37%, from roughly 5 million in 2021 to nearly 6.8 million by 2055 (Destatis, 2023). In Serbia, according to the latest Health Survey of the Population (Statistical Office of Republic of Serbia, Institute of Public Health of Serbia "Dr Milan Jovanović Batut" & Ministry of Health [SORS et al.], 2021), 31.5% of older people have serious difficulties with household activities and 9.5% with personal care, while 37.0% and 44.8%, respectively, report unmet needs for assistance (SORS et al., 2021). At the same time, Serbia faces ongoing depopulation and sustained emigration of younger cohorts, reflected in the phenomenon of "care drain"—the substantial outflow of health and care workers abroad. These dynamics position Serbia as an important source of qualified care-sector labor for foreign markets, particularly for countries such as Germany, while the domestic care system(s) continue(s) to depend largely on informal support and limited institutional capacities.

Therefore, this article examines the relationship between care work and migration through the theoretical lens of global care chains and care drain (Hochschild, 2000; Yeates, 2004, 2005, 2012). It focuses specifically on institutional and professional forms of eldercare in transnational contexts. Accordingly, it does not address informal caregiving, care provided within private households and family settings in destination countries, or the childcare, in order to foreground the organizational and regulatory dimensions, as well as formalized structures of care provision, given their distinct conditions of labor, regulation, and visibility. By doing so, the article pays particular attention to the ways in which policy frameworks and institutional practices shape the incorporation of migrant workers into transnational care regimes, with Serbia and Germany highlighted as illustrative case studies. Within this analytical framework, the article seeks to address the following research questions: (1) How do global care chains structure the migrant labor flows between Serbia and Germany? (2) Which policy instruments and practical mechanisms for integration of the migrant workforce into the care sector are currently in place in Germany?; and (3) What are the principal challenges and implications of the care drain for Serbia? In the following sections, the article first presents the conceptual underpinnings that guide the current analysis, introducing the notions of care crisis, care drain, and global care chains, with particular attention to their expanded analytical scope, followed by the methodological approach based on a comparative design and secondary data analysis. Thereafter, it examines demographic ageing and long-term care systems in Germany and Serbia, followed by an analysis of the migration dynamics and policy responses to the care labor shortages. Finally, the article interprets these developments through the lens of global care chains and concludes by discussing their implications for the redistribution of care and emerging transnational inequalities.

2 Conceptual framework

Against the backdrop of demographic ageing and increasing pressures on long-term care systems, the mismatch between care needs and labor supply extends beyond national contexts and is increasingly conceptualized as a "care crisis". As early as the 1990s, Hochschild (1995) pointed to a growing care crisis, emerging care deficits in economically advanced societies (Fischbach, 2025). Building on this, Nancy Fraser (2016) conceptualizes the crisis as a structural imbalance between care needs and their provision. These pressures have not remained confined within national borders but have contributed to the expansion of global care chains linking different welfare regimes, alongside the emergence of care drain in countries of origin. Since the early 2000s, this phenomenon has been increasingly theorized as "care drain," referring to the systemic disruption of care provision in sending countries and its broader social, familial, and community-level implications (Hochschild, 2000; Yeates, 2004, 2005, 2012; Lutz & Pallenga-Möllenbeck, 2012; Gheaus, 2013).

Rising demand for care workers reflects profound social and economic changes, including population aging, shifts in family structures, and the limited provision of public care services. At the same time, the increasing participation of women in paid employment, coupled with their historical role as primary caregivers, has created persistent care gaps. These gaps are increasingly filled by migrant women, illustrating the transnational redistribution of care responsibilities (Kofman & Raghuram, 2009). Migration within the care sector is highly gendered, predominantly undertaken by middle-aged women (Shahd, 2024), and often driven by economic pressures such as low wages, poor working conditions, and limited employment opportunities in their countries of origin (Sowa-Kofta et al., 2019). Beyond these economic drivers, care work also shapes and reinforces social hierarchies, particularly those associated with class and status (Yeates, 2005). Migration influences the provision and distribution of care, as care-related challenges may arise when individuals migrate as providers of care, migration results in the redistribution of care responsibilities left behind, migrants bring care responsibilities with them, or when they themselves experience ongoing or urgent care needs, particularly in later stages of life (Kofman & Raghuram, 2009, pp. 10–11).

Given its fundamental role in shaping both individual and societal well-being, care has increasingly been recognized as a central concept within welfare state research and social policy studies. Within social policy analysis, it is broadly understood as a form of labor, encompassing both the direct, physical tasks of "caring for" others and the emotional work involved in "caring about" others (Hooyman & Gonyea, 1995, cited in Yeates, 2004, p. 371). Accordingly, care comprises a wide range of activities, from intimate social and healthcare tasks to domestic work, whether paid or unpaid, across household and institutional settings, and involves a highly heterogeneous workforce characterized by diverse skills, professional statuses, and employment conditions (Yeates, 2004, 2005).

The concept of global care chains, first introduced by Hochschild (2000), provides a valuable framework for examining the intersection of care, migration, and globalization. It contributes to a deeper understanding of the global organization and redistribution of care, and of the mechanisms through which states govern the care economy via public policies and programs. By highlighting the processes of care migration and the internationalization of care

https://doi.org/10.59954/stnv.768

services, the concept underscores the pivotal role of transnational social reproductive labor in shaping development across diverse contexts. Although these chains generate benefits for both states and individuals, they also reproduce global inequalities and underscore the uneven distribution of care responsibilities.

Describing global care chains as "a series of personal links between people across the globe based on the paid or unpaid work of caring" (Hochschild, 2000, p. 131), Hochschild argues that women—predominantly from lower-income countries—migrate to provide care work such as childcare, eldercare, and domestic work for wealthier households in high-income countries. This process creates a care deficit within their own families and communities. As care work moves along the chains, its social and economic value progressively declines, often becoming unpaid at the lower end of the chain (Yeates, 2004, 2005). This unequal distribution of care sets the stage for Hochschild's concept of "emotional surplus value," which further explains how the benefits and burdens of care labor are distributed along the chains. By emphasizing the gendered, classed, and global dimensions of care labor, Hochschild demonstrates how global economic structures systematically exploit emotional labor and reproduce transnational inequalities.

While acknowledging the undoubted importance and innovative nature of Hochschild's concept of global care chains for understanding "the phenomena of migrant care workers, the globalization of families and households, and the internationalization of care services," Yeates (2004, 2005) stresses the need for its further development. She argues that the concept's early formulation was analytically limited, as it focused predominantly on "the transnational 'nanny trade', with international transfers of motherly labor and care labor provided in individualized, household contexts" (Yeates, 2005, p. 10). This emphasis effectively narrowed the analytical scope to domestic work and household-based childcare performed by migrant women. By confining the concept of the global care chains to such a narrow segment of workers, a broad spectrum of migrant care workers—whose labor takes place across diverse settings, involves multiple forms of care, and encompasses varied social groups—remains overlooked. It is on this basis that Yeates (2004, pp. 379–380; 2005, pp. 10–12) argues for an expansion of the conceptual boundaries of the global care chains in five principal directions.

First, Yeates critiques the global care chains framework for its predominant focus on "low-skilled" migrant workers, such as nannies and domestic laborers, arguing that research must also consider workers with diverse skills, given the growing significance of skilled labor in the global reproductive labor economy. She further contends that the framework's traditional emphasis on married mothers with dependent children is overly restrictive. Migrant care workers exhibit considerable variation in family status and household arrangements, with caregiving often extending to intergenerational and extended family obligations. This demonstrates that care operates as a system of reciprocal responsibilities beyond the nuclear family. Moreover, Yeates argues for broadening the concept of care to encompass health, educational, sexual, and religious services, alongside social care, highlighting both the multidimensional nature of care and its transnational scope. She also emphasizes the need to account for institutional settings, such as hospitals and schools, and to differentiate between public and private spheres, reflecting variations in skill, compensation, resources, organizational structures, and regulatory contexts. Finally, Yeates underscores the importance of historical analysis in

understanding the evolution of global care chains, revealing shifts in states' positions within these networks and capturing the sector's inherent heterogeneity (Yeates 2005, pp. 11–12).

Therefore, the concept of global care chains constitutes a valuable analytical framework for examining migration patterns and the redistribution of care work between Serbia and Germany, with the migration of care workers from Serbia to Germany serving as a salient example of the complex dynamics inherent in these chains and their significant social, economic, and demographic implications. Building on Yeates' (2004, 2005, 2012) broadened conceptual framework of global care chains, this article critically examines the dynamics of care worker migration from Serbia to Germany, situating it within global care chains and highlighting how the interplay of labor demand, wage differentials, and recruitment networks shapes these migration patterns. It evaluates the policy instruments and practical mechanisms currently in place in Germany to facilitate the integration of migrant workers into the care sector, including regulatory frameworks for labor migration, recognition of professional qualifications, language and vocational training programs, and social inclusion measures. The article also considers the main consequences and ramifications of the "care drain" for Serbia as a country of origin, encompassing potential social consequences such as the disruption of family-based care arrangements, economic implications stemming from labor shortages, as well as demographic shifts driven by the emigration of a substantial segment of the working-age population. Finally, by providing a comprehensive understanding of the transnational organization of care labor, the article offers insights into how policy and practice can promote more sustainable and equitable migration flows, benefiting both sending and receiving countries.

4 Methodology

This article employs a qualitative comparative design to analyze eldercare systems and their links to migration dynamics in Germany and Serbia. These two cases were selected to reflect contrasting welfare and care regimes and their positions within global care chains, Germany as a high-income destination country with a highly institutionalized eldercare system, and Serbia as an upper-middle-income country characterized by a predominantly family-based eldercare system and significant outmigration of care workers. This contrast enables an exploration of both shared structural pressures—such as demographic ageing and care labor shortages—and divergent institutional responses.

The analysis method draws on secondary data and document analysis, including statistical sources (e.g., national statistical offices of both countries, Eurostat), strategic documents and relevant policy and legal frameworks. Statistical data from national and international sources are used for contextualization of demographic and labor market trends as well as the long-term care provision, while policy documents and legislative frameworks are analyzed for assessment of the institutional organization of the long-term care systems and migration policy measures aimed at addressing workforce shortages in both countries. The study is based on a theoretically informed, selective review of literature, focusing on key contributions to the concepts of care crisis, care drain, and global care chains, as well as selected relevant empirical studies on the long-term care and migration in Germany and Serbia. The temporal scope of the analysis covers the period from the early 2000s to the present; however, the

https://doi.org/10.59954/stnv.768

primary analytical focus is placed on the developments since 2012/2013, with a particular emphasis on the period following the COVID-19 pandemic, reflecting the acceleration of policy changes in migration and long-term care during this period.

5 Redistribution of care work between Serbia and Germany: care systems, migration, and policy responses

5.1 Population aging and long-term care systems

Despite their differing positions within the global economic hierarchy, both Germany and Serbia are experiencing pronounced demographic ageing, albeit driven by partially distinct dynamics and with varying implications for their care systems. Like other ageing societies, Germany is experiencing a continuous increase in the proportion of older and very old population groups, driven by low fertility rates and rising life expectancy. While the proportion of young people in Germany remains at a historically low level, with just over 8.3 million people aged 15 to 24 representing 10% of the total population (Destatis, 2025b), the share of people aged 67 and over is expected to increase from 20% in 2024 to 25%-27% by 2028. At the same time, the population aged 80 and over is expected to increase from around 6.1 million in 2024 to approximately 8.5–9.8 million by 2050 (Destatis, 2025a). The latest available data reveal that approximately 5.7 million people currently require care. Of these, more than a half (54.5% of the total) receive care exclusively from a family member, while a considerably smaller share (14.1) are fully cared for in institutions (Destatis, 2024). The future demand for long-term care in Germany is closely linked to the growth of the population aged 80 and over, as this age group has the highest likelihood of requiring care. For instance, in 2023, approximately one half of all the people aged 80 and above in Germany required care (Destatis, 2025a).

Unlike Germany, where population ageing is primarily associated with low fertility and increased longevity, in Serbia it is additionally reinforced by sustained emigration and overall population decline. The total population declined from approximately 7.2 million in 2011, to around 6.7 million in 2022 (Republički zavod za socijalnu zaštitu [RZSZ], 2023). These demographic trends are driven by a fertility rate below the replacement threshold, as well as a negative net migration balance, leading to an increasing share of the elderly population, with individuals aged 65 and over accounting for 22.0% of the total population (SORS, 2023). Consequently, demand for long-term care has increased substantially. According to the latest available data from the Health Survey of the Population of Serbia, slightly less than one-third of older people (31.5%) report serious difficulties in performing everyday household activities, while nearly one in ten (9.5%) experience difficulties with personal care activities; moreover, more than one-third of those with difficulties in household activities (37.0%), and almost a half of those with difficulties in personal care (44.8%) have unmet needs for assistance (SORS et al., 2021). However, in 2022, despite the existence of 297 residential care facilities (40 public and 257 private) accommodating approximately 14,370 older people, institutional long-term care capacity remained clearly inadequate, covering only 0.9% of the population aged 65 and over (SORS, 2023).

In both contexts, population ageing has generated a sustained increase in demand for care services. However, the capacity to respond to these needs differs significantly. Building on the demographic trends outlined above, Germany and Serbia exhibit both convergences and divergences in the organization and provision of long-term care, reflecting their distinct institutional arrangements and welfare regimes. Germany represents a highly institutionalized and regulated long-term care system, anchored in its long-established social insurance tradition, and maintains the world's oldest social health insurance (SHI) system (Güldemann, 2022). The long-term care insurance system, introduced in 1995 as one independent pillar of social insurance, requires all individuals, regardless of whether they are covered by statutory or private health insurance, to have long-term insurance. The system enables care recipients to choose how and by whom the care is provided, either through professional services or cash benefits for informal caregivers, to support independent living. Consequently, long-term care insurance, "following the subsidiarity principle typical for conservative corporatist welfare states" (Noack & Storath, 2022, p. 402), operates alongside family care traditions and an expanding formal care sector. Consistent with the principles of a conservative welfare regime, the introduction of cash benefits was intended to maintain the centrality of informal care within households, whereas in-kind benefits were designed to promote the growth of formal care provision (Shire & Nemoto, 2020, Götze & Rothgang, 2014, Gottschall 2023). This pattern—characterized by extensive informal care and limited formal provision—can be understood as a consequence of a conservative, familialistic care regime (Ariaans, 2021).

However, the growing number of people in need of long-term care, combined with the declining availability or willingness of family members to provide care, has steadily increased the demand for and persistent shortage of care workers, thereby reinforcing the role of migration as a key strategy for filling these gaps. Accordingly, long-term care in Germany is "characterized by a mixture of formal and informal care provision, and incorporation of migrant workers in both" (Gottschall, 2023). This hybrid model is further underpinned by high levels of public investment and an extensive service infrastructure. Germany has the highest share of GDP devoted to healthcare in the EU (12.27%). In 2023, €82.4 billion was spent on long-term care services, including ambulatory, inpatient, and semi-inpatient care, an increase of 6.3% compared with 2022, highlighting the significant financial pressure on the system.

In Serbia, long-term care is characterized by minimal state support, with the responsibility for eldercare largely falling on families, while care is formally organized within the social welfare system (cash benefits and institutional and non-institutional services), the health care system (palliative and in-home care), and the old-age and disability insurance system (allowance for support and care by informal caregivers).[1] While residential care for older adults in Serbia is managed exclusively by public or private entities, in-home support involves a broader spectrum of providers, including state institutions, NGOs, and the voluntary sector (Perišić & Pantelić, 2021). Both institutional care (residential care) and non-institutional services (in-home support and care, i.e., geronto-housewives) remain underdeveloped and spatially uneven, leading to unequal access to social rights. Prolonged waiting lists for residential care and the dependence of certain services on local government budgets render

[1] For more, see: Perišić (2021).

https://doi.org/10.59954/stnv.768

long-term care inaccessible for a substantial proportion of potential users. The marked fragmentation of the system and the absence of collaboration between the healthcare and social welfare sectors further undermine the quality, accessibility, and continuity of care provision. Simultaneously, a gradual commodification of care is occurring, driven by the expansion of the private sector, which operates according to market principles, but remains financially inaccessible to a significant portion of the population. In this context, access to high-quality care is strongly mediated by economic resources: wealthier individuals can secure enhanced support, while those with fewer resources remain largely dependent on family provision or minimal state-supported assistance. Such inequalities are embedded in an eldercare system that relies predominantly on the family, reflecting a feature of a familialistic care regime.

Within the context of deeply entrenched social and cultural norms, the burden of unpaid care work disproportionately falls on women (Perišić & Pantelić, 2021; Satarić & Perišić, 2017). This gender-asymmetric allocation of care responsibilities constitutes a central mechanism through which gendered and broader social inequalities are reproduced, while simultaneously contributing to the overburdening of family members and constraining the economic activity and social participation of female caregivers. Yet, this model is increasingly strained, as a growing number of older adults live in households without younger relatives available to provide care (Perišić, 2021). Nevertheless, similar to Germany, informal care remains the primary mode of support and relies dominantly on female family carers; however, this reliance is not embedded within a well-developed institutional framework, but rather reflects structural limitations in the availability, accessibility, and coordination of formal services. Furthermore, in contrast to Germany, Serbia's long-term care system operates under conditions of limited financial capacity and pronounced institutional fragmentation, accompanied by insufficient intersectoral coordination, which together produce gaps in addressing users' needs, as well as ambiguous allocation of responsibilities across different sectors. The total public expenditure on long-term care is estimated at approximately 0.5% of GDP, with cash benefits accounting for over 0.3% (Stanić, 2024, p. 158).

5.2 Migration and policy responses to care labor shortages: between compensation and destabilization

These demographic and systemic pressures not only intensify demand for long-term care, but also expose structural deficiencies in the care labor market, thereby increasingly positioning migration and policy strategies as key mechanisms for addressing workforce shortages.

Germany has responded to its care crisis through a multifaceted and increasingly differentiated policy framework, encompassing a range of complementary strategies rather than a single, unified approach. A set of diversified strategies, including the liberalization of immigration policies to recruit foreign healthcare workers, measures to enhance the attractiveness of care professions domestically, and reforms aimed at improving the recognition and standardization of foreign qualifications.

Nevertheless, it must be noted that rather than focusing on employment conditions and workplace issues, strategies to secure a qualified nursing workforce in Germany have increasingly emphasized the recruitment of care workers from abroad, implying that the care

crisis can, in principle, be mitigated through migration (Kordes, 2019; Kordes et al., 2020). Although since the 1990s, migration policy in Germany has increasingly been framed as a potential instrument for addressing demographic challenges (Schultz, 2016), concrete steps toward reforming of the immigration policy were only taken from the early 2000s onwards. The argument that migration could serve as a policy instrument to mitigate population ageing in Germany has repeatedly gained prominence during periods of major societal disruption, including phases of intensified migration, public health crises, and structural political change. In response, the recruitment of migrant workers in Germany has been facilitated by the gradual relaxation of migration policies.

The integration of nursing professionals into the German labor market is strongly shaped by legal frameworks. For EU, European Economic Area (EEA), and Swiss citizens, the right of residence and the EU Freedom of Movement Directive provide unrestricted labor market access, while the EU Professional Qualifications Directive ensures recognition of regulated qualifications, including nursing. In contrast, non-EU care workers face more restrictive entry conditions, requiring formal recognition of qualifications under German law, as well as proof of German language proficiency. Despite these general restrictions, the Recognition Act from 2012 (Anerkennungsgesetz) and specifically the Western Balkans Regulation[2] have lowered barriers for Albania, Bosnia and Herzegovina, Kosovo*, North Macedonia, Montenegro, and Serbia. Originally valid until 2023 and now extended indefinitely under the Skilled Immigration Act 2.0 (Fachkräfteeinwanderungsgesetz 2.0), these measures introduced significant legal changes to the labor migration framework for third-country nationals. As a result, the number of employees in the care sector from Western Balkan states has increased almost fivefold since 2015, the year before the regulation came into force, standing at 51,000 care workers (Statistik der Bundesagentur für Arbeit [Bundesagentur für Arbeit], 2025).

Alongside legislative changes, Germany has pursued various policy measures and programs to attract foreign care professionals as part of a broader strategy to alleviate chronic workforce shortages in long-term care, including targeted schemes such as the Western Balkans Regulation and bilateral recruitment programs. One of those measures is the recruitment program, the "Triple Win", initiated in 2013. It is run by the German Society for International Cooperation (GIZ) and the German Federal Employment Agency through bilateral agreements, aiming to attract qualified nurses to the local labor market. Initially launched with the Philippines and later extended to Bosnia and Herzegovina, Serbia, and Tunisia, the program has since expanded to include partner countries in Central and South America, as well as Southeast Asia (Bundesagentur für Arbeit, 2024). Advertised as a win for all three parties —care worker, employer, and country of origin—the program has been supporting German employers in the health and social care sector with the selection, recognition, and integration of foreign skilled workers. At the same time, these workers from countries with a surplus of skilled workers are being offered professional and personal prospects in Germany.

[2] The Western Balkans Regulation allows for up to 50,000 approvals per year, without requiring prior recognition of qualifications, but excludes regulated professions such as medical doctors, nurses, and similar. Certified nurses must use the regular Skilled Immigration Act, while unregulated positions, such as nursing assistants, can be filled under the regulation if a job offer is available. This framework has facilitated the migration of care workers from the Western Balkans to Germany.

https://doi.org/10.59954/stnv.768

Serbia participated in this program under the Agreement on the Mediation and Temporary Employment of Serbian Citizens in Germany, concluded between the German Federal Employment Agency and the Serbian National Employment Service. Between 2013 and September 2019, a total of 941 nurses migrated to Germany through the above-mentioned *Triple Win Program* alone (World Bank [WB], 2021). However, prior to the COVID-19 pandemic, the issue of workforce shortages had not yet been systematically addressed as a central policy concern in Serbia. Instead, participation in international recruitment schemes—such as the Triple Win program initiated by Germany—was largely framed as an employment and labor market measure, facilitating the outward mobility of healthcare workers rather than mitigating domestic shortages. At the same time, early signs of strain were already visible: Serbian hospitals had begun to experience noticeable personnel shortages, marking the first instances of broader public recognition of labor deficits in the health sector. For example, Radonjić and Bobić (2021) report that approximately 150 hospitals in Serbia were facing significant staffing shortages as early as 2018. The COVID-19 pandemic subsequently exposed and intensified these structural vulnerabilities. Between 2020 and 2022, the healthcare system was confronted with unprecedented pressures, including increased workloads, high infection rates among medical staff, extended working hours, and rising levels of burnout, all of which further contributed to staff attrition and migration intentions (WHO, 2024). In this context, Serbia withdrew from both the bilateral agreement and the Triple Win program in 2020, reflecting its growing domestic demand for healthcare workers at the onset of the pandemic.

While these migration dynamics have contributed to care drain in the countries of origin such as Serbia, Germany's response has not been limited to the liberalization of immigration policies; rather, it has been accompanied by the implementation of legislative reforms aimed at addressing the growing challenges in long-term care and stabilization of care system. These changes included the revision of the definition and categorization of care dependency,expansion of care recipient groups, and the introduction of measures to enhance service provision and support for those in need. At the same time, it became evident that reforms within the nursing and care professions were necessary to address persistent workforce shortages, improve working conditions, and enhance the overall attractiveness of the profession. For example, The Act on Nursing Professionals (Pflegeberufereformgesetz – PflBRefG) that came into force on 1 January 2020, restructured nursing education by integrating what had previously been healthcare, pediatric, and geriatric nursing into a single nursing profession, with the aim of modernizing training, enhancing its attractiveness, and strengthening the professional status of nursing. The reform also sought to increase flexibility across areas of practice and introduced financial incentives in the form of training allowances for trainees. Within this broader policy framework, Germany has also sought to enhance the attractiveness of care work through rising minimum wages, which have increased significantly in recent years. As of the latest adjustment on 1 July 2025, the statutory minimum gross hourly wage in the nursing sector is €16.10 for nursing assistants, €17.35 for qualified nursing assistants, and €20.50 for registered nurses (Bundesregirung, 2025). Beyond financial incentives, the federal government also seeks to strengthen the nursing profession by reducing bureaucratic burdens, thereby further improving the appeal of these occupations. These reforms have shown some effectiveness in addressing the challenges. According to the latest data of the Federal

Employment Agency (Bundesagentur für Arbeit) from 2023, just under 1.8 million nursing staff were employed in Germany, reflecting a continued upward trend, with an increase of 24,000 employees (+1.4%) compared to 2022 (Bundesagentur für Arbeit, 2025).

Such policy approach, however, is embedded in a broader structural asymmetry: while Germany has increasingly positioned itself as an active destination country seeking to attract foreign care workers, Serbia has long functioned as a country of emigration. Within the framework of care chains and care drain, the recruitment of foreign care workers in Germany can be understood as a market and policy-mediated strategy to compensate for the gaps in the domestic care regime, whereas the emigration of care workers from Serbia contributes to the erosion of the already fragile, family-based care arrangement. Outward labor migration of Serbian care workers emerges not merely as an individual mobility strategy, but as a central factor further destabilizing the domestic care system. The drivers of health workforce emigration from Serbia—and the broader dynamics of care drain—have varied over time but display strong structural continuity. Between 2004 and 2011, the emigration of healthcare professionals from Serbia was primarily driven by high unemployment and low wages in the domestic health sector (WB, 2021). Since then, migration has continued, with Germany emerging as a key destination, reflecting persistent labor market constraints, particularly for younger professionals, as well as broader dissatisfaction with working conditions (WB, 2021; Vučković et al., 2022). Recent studies further indicate various motivations, with physicians primarily seeking professional development opportunities, while nurses are more strongly driven by higher wages (Blagojević et al., 2023). In this regard, the outflow of care workers from Serbia reflects and reinforces the dynamics of transnational care labor redistribution, serving as a profound destabilizing factor for the Serbian care system(s), while at the same time serving as a compensatory mechanism for addressing the existing gaps in the German care sector.

5.3 Care systems through the lens of care chains

As a result of all those policy strategies, the German health and social care sector has become increasingly transnational. Nearly one in five care workers originates from abroad (18% in 2024, up from 6% in 2014) (Bundesagentur für Arbeit, 2025). In 2024, applications for recognizing foreign professional qualifications rose by 14% to approximately 55,300, with 88% originating from third countries (Böse et al., 2025). Regulated professions comprised 76% of all the submissions, driven almost entirely by healthcare. Care workers dominated the process with 22,400 applications (41%), followed by medical doctors at 10,900 (20%) (Böse et al., 2025). This trend underscores the growing reliance of the German health and social care system on international migration—particularly from third countries—to address structural workforce shortages, while also increasing the administrative and regulatory importance of recognition and qualification equivalence procedures. Since 2015, recruitment patterns reveal strong diversification of the origin countries, including sharp increases in workers from Syria and India (ten times as many employees), as well as the Philippines (18 times as many), highlighting the expanding role of complex migration arrangements and integration processes in sustaining Germany's care system (Bundesagentur für Arbeit, 2025). Beyond the pronounced transnationalization of the care work sector, Germany has also experienced

https://doi.org/10.59954/stnv.768

a growing reliance on physicians with foreign citizenship. According to the German Medical Association (Bundesärztekammer, 2025), the number of physicians increased by 2.1% in 2024 compared to the year before, reaching approximately 581,000.

While the physician density has increased substantially in Germany, rising by 17.9 physicians per 10,000 population, from 27.4 in 1991 to 45.3 in 2022, the physician density in Serbia increased modestly, rising by 3.9 physicians per 10,000 population, from 27.1 in 2003 to 31.0 in 2022. (WHO, 2025). By the year 2024, 1899 Serbian physicians were working in Germany (Bundesärztekammer, 2025). Beyond workforce shortages, physician migration generates considerable indirect fiscal losses for the countries of origin, particularly through unrecovered public investment in higher education and training. These costs can be illustrated by the current estimates of expenditure per medical graduate. According to the data from the German Federal Statistical Office (as of 16 March 2020), the most recent available figures on medical education costs date from 2017. In that year, the current expenditure (basic funding) per degree in human medicine or health sciences—excluding teacher training programs—amounted to €170,500 (Bundestag, 2020), with the projections going up to €250,000 (Agentur für Arbeit Würzburg, 2023). International recruitment of already qualified physicians allows Germany to substantially reduce domestic training expenditures, as the financial burden of education and professional formation has been borne by Serbia.

In response, Serbian government implemented salary increases (2019–2020) and established the Diaspora Office to encourage the return of health professionals, with limited but notable results (Ministarstvo zdravlja, 2025). Also, the Office for Cooperation with the Diaspora of the Ministry of Health was established at the end of 2024 to support Serbian medical professionals abroad by facilitating professional exchange, training opportunities, and providing guidance for employment in domestic healthcare institutions. According to the latest data, in its first year of operation, the Diaspora Office facilitated the return of over 200 healthcare professionals to Serbia (Ministarstvo zdravlja, 2025). While these initiatives have so far yielded limited results, they represent initial steps toward addressing the structural challenges of workforce attrition and mitigating the adverse effects of the ongoing care drain. Despite those measures, sustained emigration of health care professionals has intensified the already existing care deficits and put the care system(s) under strain. This reinforces family-based care arrangements, as care remains mostly within households, thereby hindering the move toward defamilialization, while services remain underdeveloped.

Taken together, these developments illustrate how different care regimes are increasingly interconnected through transnational labor mobility, reflecting Yeates's expanded conceptualization of global care chains. Firstly, the Serbia – Germany case demonstrates complex, evolving care chains spanning diverse sectors, skill levels, and institutional frameworks, thereby highlighting the asymmetric consequences of transnational labor mobility. The care regimes of both countries are linked through a causal nexus, where policy shifts in one country trigger corresponding labor market responses in the other. Furthermore, this analysis challenges the narrow focus on domestic, low-skilled care, revealing a more nuanced landscape of mobility that includes both highly skilled physicians and mid-skilled nursing staff integrated into formal institutions, such as hospitals, and long-term care (LTC) facilities and community/ambulatory services in Germany. Moving beyond the "precarious informal

workers", as suggested by Yeates (2005), is essential for deeper understanding of the systemic shocks in countries of origin, such as Serbia, where the outflow undermines the domestic care infrastructure across multiple sectors.

Secondly, the analysis indicates that eldercare systems in both countries rely heavily on informal (family-based) care, while the coverage of older adults in residential facilities remains very limited. Migration disrupts these domestic arrangements as caregivers emigrate, the care gaps in the country of origin intensifies, while family care in the destination country is increasingly supplemented by migrant labor. This demonstrates that care chains operate across several settings, including state and non-state care work environments. Linked to this is a clear sectoral differentiation, particularly in Germany, which exhibits a dual structure characterized by the division between formal and informal sectors, as well as distinctions between private/public and regulated/unregulated care.

Finally, the care outflow from Serbia to Germany points to important temporal dynamics within the global care chains. However, given the limited time span covered in this analysis, it is not possible to draw firm conclusions regarding their long-term evolution. While Germany has progressively moved toward a hybrid system that incorporates foreign labor to address workforce shortages, Serbia continues to be characterized by a predominantly familialistic model of care provision. At the same time, demographic ageing, combined with ongoing emigration—largely driven by wage differentials and working conditions—suggests that the workforce deficits in the Serbian care sector are likely to intensify, further reinforcing its position as a labor-sending node within transnational care chains. However, these positions are not fixed. Emerging labor shortages—already evident across several sectors of the Serbian economy—alongside increasing instances of labor import, indicate that Serbia may gradually assume a more complex role within global care chains, potentially becoming not only a sending but also a receiving country. This is particularly likely in the care sector, given the existing shortages of healthcare and care workers, coupled with the ongoing population ageing and rising care needs. This underscores the dynamic and relational nature of care chains, in which countries' positions shift over time in response to evolving demographic pressures, labor market conditions, and policy strategies.

Thus, this analysis demonstrates that care regimes are not static. However, each of the countries examined maintains a relatively fixed position along the global care chain axis. Specifically, Germany has solidified its role as a primary destination country for care labor, whereas Serbia occupies the labor-supplying periphery.

6 Conclusions and limitations

Although positioned differently within the global economic hierarchy (WB, 2026), both Germany and Serbia are confronted with similar structural trends driven by population ageing, resulting in an increasing demand for eldercare provision and mounting pressure on health and long-term care systems. In response to these shared challenges, both countries have implemented measures aimed at addressing the growing care deficit, albeit from markedly different starting points and with divergent capacities. Germany, as a high-income economy, has pursued a multi-dimensional strategy combining the expansion of care services,

https://doi.org/10.59954/stnv.768

improvements in working conditions, and the systematic recruitment of foreign care workers. Serbia, an upper-middle-income economy, by contrast, has largely relied on informal (family-based) care, while only more recently beginning to recognize and address the workforce shortages, particularly in the context of the COVID-19 pandemic.

Despite these differing approaches, both systems continue to depend heavily on informal care, predominantly provided by women, highlighting persistent structural limitations in the organization of eldercare. From the care regime perspective, Germany's response can be understood as a gradual recalibration of its conservative model, combining elements of partial defamilialization, marketization, and transnationalization. By contrast, Serbia continues to exhibit the characteristics of a strongly familialistic care regime, where limited institutional capacity and insufficient policy responses leave families as the primary providers of care, even as demographic ageing and migration increasingly undermine this model.

At the same time, migration has emerged as a key mechanism of shaping the care provision in both contexts. While Germany actively incorporates migrant labor to sustain its care system, Serbia experiences a continuous outflow of healthcare and care workers, contributing to care drain and exacerbating the existing shortages. This dynamic not only weakens the capacity of the Serbian care system(s), but also reinforces inequalities in access to care, as limited resources and workforce constraints restrict the scope and quality of services. Against this backdrop, Serbia has only recently begun to acknowledge the workforce shortages, introducing measures such as wage increases and return-oriented migration strategies targeting its diaspora. However, unlike Germany, it has not systematically developed broader migration policies aimed at attracting foreign labor, or substantially improving the working conditions within the care sector.

These interconnected developments can be most effectively understood through the lens of global care chains, reflecting the diversity, complexity, and institutional embeddedness of contemporary care labor. In this regard, Germany's increasing reliance on migrant care workers is directly linked to the outflow of labor from countries such as Serbia, where the emigration of both highly skilled professionals (physicians) and mid-skilled workers (nurses and care workers) contributes to care drain and further weakens the already constrained systems of eldercare, while at the same time placing additional pressure on families caring for their elderly members. This dynamic extends beyond domestic or low-skilled care work, encompassing formal institutional settings such as hospitals and long-term care facilities, as well as informal and semi-formal arrangements, including live-in care. At the same time, migration is embedded in broader transnational family structures, where care responsibilities are redistributed across extended and intergenerational networks, rather than confined to nuclear households.

Concerning this, care deficits are not resolved but just reallocated across borders, reflecting structural asymmetries in resources, labor markets, and welfare state capacities, which are themselves subject to change over time and may lead to shifting distributions of care deficits, depending on the strategies countries are able to employ. Germany's multi-dimensional strategy—combining migration, service expansion, and reforms of the care profession—relies in part on external labor, while Serbia's limited policy responses and continued reliance on informal care render it particularly vulnerable to the loss of care capacity. The Serbia–Germany case thus illustrates how eldercare systems are embedded in asymmetric

and evolving global care chains, in which national strategies interact to reproduce inequalities in both care provision and labor distribution.

The dependence on migrant labor as a structural feature of care provision raises concerns regarding its long-term viability, particularly considering the globally increasing life expectancy and converging care demands. Consequently, the recruitment of foreign workers should be conceptualized as only one component of a broader policy mix, requiring the simultaneous development of internally grounded strategies aligned with national labor market conditions, demographic trajectories, and professionalization of care work.

This study is subject to several limitations. First, the analysis is based on secondary data and document analysis, which may be constrained by the comparability due to different applied methodologies, availability, and timeliness of the existing statistical and policy sources across the two country contexts, especially in the domain of comparability of indicators related to long-term care provision and labor market dynamics. This challenge is further compounded by the uneven availability and quality of data between the two countries: while Germany provides relatively detailed and systematic statistics on different profiles of healthcare workforce, Serbia lacks comprehensive and up-to-date data on the emigration of nurses, physicians, and care workers, thereby limiting the precision of comparative insights and potentially leading to an underestimation of the extent of care drain.

Second, the analysis is restricted to institutional and formal care provision, thereby excluding a substantial segment of care that takes place within private households and informal settings. In particular, informal caregiving provided by family members, as well as care delivered by undeclared or non-formally employed caregivers, remain outside the scope of this study. Given the central role of such forms of care—especially in familialistic care regimes—this constitutes an important limitation of the analysis. Finally, the temporal scope may not fully capture longer-term historical trajectories, or the long-term effects of recent policy changes, which are still unfolding.

Data availability statement

Data are available from the authors upon request.

Coauthor contributions

Dragana Stöckel: Conceptualization, Formal analysis, Investigation, Data curation, Writing – original draft, Writing – review & editing

Marina Pantelić: Conceptualization, Formal analysis, Methodology, Investigation, Writing – original draft, Writing – review & editing

Acknowledgments

This paper was supported by the Ministry of Science, Technological Development and Innovation of the Republic of Serbia, pursuant to the Agreement on the implementation and financing of scientific research work of teaching staff at higher education institutions for 2026, No. 451-03-34/2026-03 of January 29, 2026.

https://doi.org/10.59954/stnv.768

References

Agentur für Arbeit Würzburg. (2023). *Studium der Humanmedizin: Wege und Alternativen [Studying human medicine: paths and alternatives]*. https://www.arbeitsagentur.de/vor-ort/datei/humanmedizin_ba198292.pdf

Ariaans, M. (2021). *Professionalization of the Long-Term-Care Workforce in Germany – The Role of Policies and Organized Actors*. https://madoc.bib.uni-mannheim.de/61784/1/20220322_Dissertation_Ariaans.pdf

Blagojević, M., Krasulja, N., Ilić, D., & Milošević, D. (2023). The analysis of brain circulation of health care professionals in Serbia, Croatia and Slovenia. *BizInfo Blace*, *14*(1), 59–67. https://doi.org/10.5937/bizinfo2301059V

Blower-Nassiri, J. (2023). *A gendered analysis of migration trends in Europe's social care sector*. International Organization for Migration. https://publications.iom.int/system/files/pdf/pub2023-065-l-a-gendered-analysis.pdf

Bundesagentur für Arbeit. (2024). *Programm Triple Win [Triple Win program]*. https://www.arbeitsagentur.de/vor-ort/zav/projects-programs/health-and-care/triple-win

Bundesregierung. (2025). *Mindestlöhne in der Altenpflege sollen steigen*. https://www.bundesregierung.de/breg-de/service/newsletter-und-abos/bundesregierung-aktuell/ausgabe-43-2025-november-28-2396126?view=renderNewsletterHtml

Bundesärztekammer. (2025). *Ergebnisse der Ärztestatistik zum 31.12.2024 [Results of the physician statistics as of December 31, 2024]*. https://www.bundesaerztekammer.de/baek/ueber-uns/aerztestatistik/2024

Böse, C., Schmitz, N., & Zorner, J. (2025). *Auswertung der amtlichen Statistik zum Anerkennungsgesetz des Bundes für 2024: Ergebnisse des BIBB-Anerkennungsmonitorings*. Bundesinstitut für Berufsbildung. https://res.bibb.de/vet-repository_783880

Deutscher Bundestag. (2020). *Einzelfragen zu den Kosten eines Medizinstudiums*. https://www.bundestag.de/resource/blob/702380/4582a586f8639efa3edf4a949b112c1f/WD-8-020-20-pdf-data.pdf

Eurodiaconia. (2024). *Report on migrant care workers: Towards fair working conditions and inclusion of migrants in the EU care workforce*. https://eurodiaconia.org/wp-content/uploads/2025/04/Migrant-Care-Workers-Report.pdf

European Commission. (2021). *The 2021 ageing report: Economic and budgetary projections for the EU member states (2019–2070) (Institutional Paper 148)*. Publications Office of the European Union. https://economy-finance.ec.europa.eu/publications/2021-ageing-report-economic-and-budgetary-projections-eu-member-states-2019-2070_en

Fischbach, S. (2025). Social sustainability and the crisis of care: Western European 'care extractivism' in South East Europe. In K. Hermans, I. Stamm, A.-L. Matthies, & S. Elsen (Eds.), *Ecosocial Work and Sustainability Transitions: Theories, Methodologies and Practices* (pp. 164–180). Policy Press. https://doi.org/10.51952/9781447376118.ch009

Fraser, N. (2016). Contradictions of Capital and Care. *New Left Review 2*, 99–117. https://doi.org/10.64590/nt2

Gheaus, A. (2013). Care drain: Who should provide for the children left behind?. *Critical Review of International Social and Political Philosophy*, *16*(1), 1–23. https://doi.org/10.1080/13698230.2011.572425

Gottschall, K. (2023). The interaction of gender regimes and long-term care provision across Europe: Ambivalent intersections of gender, class and ethnicity. *Women's Studies International Forum*, *98*, 1–9. https://doi.org/10.1016/j.wsif.2023.102745

Götze, R., & Rothgang, H. (2014). Fiscal and social policy: Financing long-term care in Germany. In K. P. Companje (Ed.), *Financing high medical risks* (pp. 63–100). Amsterdam University Press.

Güldemann, H. (2022). *Pillars of health: Country report on health worker migration and mobility, Germany*. https://cstor.eu/pillarsofhealth/2022/09/b3b4063d-pillars-of-health_country-report-on-health-worker-migration-and-mobility_germany.pdf

Hochschild, A. R. (1995). The culture of politics: Traditional, postmodern, cold-modern, and warm-modern ideals of care. *Social Politics: International Studies in Gender, State & Society*, *2*(3), 331–346. https://doi.org/10.1093/sp/2.3.331

Hochschild, A. R. (2000). Global care chains and emotional surplus value. In W. Hutton & A. Giddens (Eds.), *On the edge: Living with global capitalism* (pp. 130–146). Jonathan Cape.

International Labour Organization. (2024). *Migrant workers in the care economy*. https://www.ilo.org/publications/migrant-workers-care-economy

Kofman, E., & Raghuram, P. (2009). *The Implications of Migration for Gender and Care Regimes in the South*. United Nations Research Institute for Social Development.

Kordes, J. (2019). Anwerbeprogramme in der Pflege: Migrationspolitiken als räumliche Bearbeitungsweise der Krise sozialer Reproduktion. *Prokla*, *49*, 551–567.

Kordes, J., Pütz, R., & Rand, S. (2020). Analyzing migration management: On the recruitment of nurses to Germany. *Social Sciences*, *9*(2), 19. https://doi.org/10.3390/socsci9020019

Lutz, H., & Palenga-Mollenbeck, E. (2012). Care workers, care drain, and care chains: Reflections on care, migration, and citizenship. *Social Politics*, *19*(1), 15–37. https://doi.org/10.1093/sp/jxr026

Ministarstvo zdravlja. (2025). *Povratak naših medicinara: Više od 200 njih se vratilo za godinu dana rada kancelarije za dijasporu*. https://www.zdravlje.gov.rs/vest/460423/nastavlja-se-povratak-nasih-medicinara

Noack, K., & Storath, G. M. (2022). Migrantische Arbeitskräfte in der formellen Altenpflege in Deutschland und Schweden. *WSI-Mitteilungen*, *75*(5), 401–406. https://doi.org/10.5771/0342-300X-2022-5-401

Perišić, N. (2021). *Long-term care in the Republic of Serbia*. CRC 1342 Global Dynamics of Social Policy. https://doi.org/10.26092/elib/1500

Perišić, N., & Pantelić, M. (2021). Care Triangle or Care Diamond? The Case of Childcare and Eldercare in Serbia. *Revija Za Socijalnu Politiku*, *28*(3), 323–345. https://doi.org/10.3935/rsp.v28i3.1805

Radonjić, O., & Bobić, M. (2021). Brain drain losses: A case study of Serbia. *International Migration*, *59*(1), 5–20. https://doi.org/10.1111/imig.12710

Republički zavod za socijalnu zaštitu. (2023). *Izveštaj o radu ustanova za smeštaj odraslih i starijih za 2022. godinu*. https://www.zavodsz.gov.rs/media/2575/izvestaj-o-radu-ustanova-za-starije-2022.pdf

Satarić, N., & Perišić, N. (2017). *Prigušena svetla grada – Studija o položaju i potrebama staračkih domaćinstava Novog Beograda*. Amity.

Schultz, S. (2016). Die zukünftige Nation: Demografisierung von Migrationspolitik und neue Konjunkturen des Rassismus. *Movements: Journal for Critical Migration and Border Regime Studies*, *2*(1). http://movements-journal.org/issues/03.rassismus/06.schultz--die.zukuenftige.nation.html

Shahd, A. (2024). The global care chain: Analyzing the increasing feminization of care work across borders. *Social Sciences*, *13*(3), 74–80. https://doi.org/10.11648/j.ss.20241303.14

Shire, K., & Nemoto, K. (2020). The origins and transformations of conservative gender regimes in Germany and Japan. *Social Politics*, *27*(3), 432–448. https://doi.org/10.1093/sp/jxaa017

Sowa-Kofta, A., Rodrigues, R., Lamura, G., Sopadzhiyan, A., Wittenberg, R., Bauer, G., Doetter, L. F., Ilinca, S., Marczak, J., Piersinaru, A., & Rothgang, H. (2019). Long-term care and migrant care work: Addressing workforce shortages while raising policy questions. *Eurohealth*, *25*(4), 15–18.

Stanić, K. (2024). Dugotrajna nega starih u Srbiji. In V. Kostić (Ed.), *Budućnost starenja : zbornik radova sa naučnog skupa održanog 1. i 2. decembra 2022. godine* (pp. 151–171). SANU.

Statistical Office of Republic of Serbia. (2023). *Estimated Population, 2022*. https://publikacije.stat.gov.rs/G2023/HtmlE/G20231179.html

Statistical Office of Republic of Serbia. (2025). *Regions of the Republic of Serbia*. https://publikacije.stat.gov.rs/G2025/PdfE/G202526001.pdf

https://doi.org/10.59954/stnv.768

Statistical Office of Republic of Serbia, Institute of Public Health of Serbia "Dr Milan Jovanović Batut", & Ministry of Health. (2021). *The 2019 Serbian National Health Survey*. Statistical Office of Republic of Serbia. https://publikacije.stat.gov.rs/G2021/PdfE/G20216003.pdf

Statistik der Bundesagentur für Arbeit. (2025). *Berichte: Blickpunkt Arbeitsmarkt – Arbeitsmarktsituation im Pflegebereich*. https://statistik.arbeitsagentur.de/DE/Statischer-Content/Statistiken/Themen-im-Fokus/Berufe/Generische-Publikationen/Altenpflege.pdf

Statistisches Bundesamt. (2023). *Long-term care projection: 1.8 million more people in need of long-term care expected until 2055*. https://www.destatis.de/EN/Press/2023/03/PE23_124_12.html

Statistisches Bundesamt. (2024). *Pflegebedürftige nach Versorgungsart, Geschlecht und Pflegegrade*. https://www.destatis.de/DE/Themen/Gesellschaft-Umwelt/Gesundheit/Pflege/Tabellen/pflegebeduerftige-pflegestufe.html

Statistisches Bundesamt. (2025a). *Bereits 2035 wird in Deutschland ein Viertel der Bevölkerung 67 Jahre und älter sein*. https://www.destatis.de/DE/Presse/Pressemitteilungen/2025/12/PD25_446_12.html

Statistisches Bundesamt. (2025b). *Tag der Jugend: Anteil junger Menschen von 15 bis 24 Jahren bleibt mit 10,0 % auf historisch niedrigem Niveau*. https://www.destatis.de/DE/Presse/Pressemitteilungen/Zahl-der-Woche/2025/PD25_32_p002.html

Statistisches Bundesamt. (2026). *Ältere Menschen. Die Bevölkerungsgruppe der älteren Menschen ab 65 Jahren [Older people: The population group of people aged 65 and over]*. https://www.destatis.de/DE/Themen/Querschnitt/Demografischer-Wandel/Aeltere-Menschen/bevoelkerung-ab-65-j.html

Vučković, M., Dimitrijević, M., & Panić, R. (2022). *Istraživanje o odlasku lekara iz Srbije na rad u inostranstvo*. Centar za politike emancipacije. https://cpe.org.rs/wp-content/uploads/2023/06/Istrazivanje-o-odlasku-lekara-iz-Srbije-CPE-SLFS-2022-web.pdf

World Bank. (2021). *Health workforce mobility from Croatia, Serbia and North Macedonia to Germany*. https://documents1.worldbank.org/curated/en/489881614056529442/pdf/Main-Report.pdf

World Bank. (2026). *World Bank Country and Lending Groups. Country Classification*. https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups

World Health Organization. (2017). *Women on the move: migration, care work and health*. https://www.who.int/publications/i/item/9789241513142

World Health Organization. (2024). *Protecting health and care workers' mental health and well-being: Technical Consultation Meeting*. https://www.who.int/news/item/25-04-2024-202404_protecthw_mentalhealth

World Health Organization. (2025). *Density of doctors (physicians) per 10 000 population*. https://data.who.int/indicators/i/CCCEBB2/217795A

Yeates, N. (2004). Global care chains: Critical reflections and lines of enquiry. *International Feminist Journal of Politics*, *6*(3), 369–391. https://doi.org/10.1080/1461674042000235573

Yeates, N. (2005). *Global care chains: A critical introduction*. Global Commission on International Migration. https://www.refworld.org/reference/research/gcim/2005/35223

Yeates, N. (2012). Global care chains: A state-of-the-art review and future directions in care transnationalization research. *Global Networks*, *12*(2), 135–154. https://doi.org/10.1111/j.1471-0374.2012.00344.x

How to cite

Stöckel, D., & Pantelić, M. (2026). Whose Crisis, Whose Gain? The Socio-economic Consequences of Care Migration from Serbia to Germany. *Stanovništvo*, 64(1), 91–110. https://doi.org/10.59954/stnv.768