STUDY

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Labour mobility and recognition in the regulated professions

Annex C I - Germany: case study

Policy Department for Economic, Scientific and Quality of Life Policies
Directorate-General for Internal Policies
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Labour mobility and recognition in the regulated professions

Annex C - I
Germany: case study

Abstract

This study analyses the impact on labour mobility and employment of the 2013 revision of the Professional Qualifications Directive (DIR 2005/36) and related EU initiatives. It analyses trends in mobility and recognition, focussing on the health sector and four country case studies - Germany, Italy, the Netherlands and Romania. It reports findings from consultations with stakeholders at EU and national level and highlights best practice.

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LIST OF ABBREVIATIONS AND DEFINITIONS

Active	Any person who is either employed or unemployed (EU Labour Force Survey (EU-LFS) definition)
BMBF	Federal Ministry of Education and Research (*Bundesministerium für Bildung und Forschung*)
BMWi	Federal Ministry for Economic Affairs and Energy's (*Bundesministerium für Wirtschaft und Energie)*
BQ Portal	Information portal for foreign professional qualifications
CEFR	Common European Framework of Reference for Languages
Employed	Any person who, during a reference week, worked for at least one hour, or had a job or business but was temporarily absent (EU-LFS definition)
EPC	European Professional Card
EU	European Union
EU-2	Bulgaria and Romania
EU-8	Poland, Czech Republic, Slovenia, Slovakia, Hungary, Lithuania, Latvia, Estonia
EU-28	This term refers to citizens of the 28 Member States of the European Union
EU-28	All current EU Member States
IMI-system	Internal Market Information System
Inflows	Inflows refers to the sum of all persons (of another nationality and/or previously living in another country) who moved to a certain country during a certain year
Mobility	This term refers to migration of EU-28 citizens within the EU
NAP	National Action Plan
PQD	Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005 on the recognition of professional qualifications (Professional Qualifications Directive)

Stocks

Stocks of mobile workers refers to the total number of EU citizens that live and work in an EU country other than their citizenship in a certain year; stocks of foreign-trained doctors and nurses refer to the total number of doctors or nurses working in a certain country in a certain year, who received training in another country. Stocks refer to a certain population at one specific date

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ANNEX C - I

GERMANY: CASE STUDY

Germany

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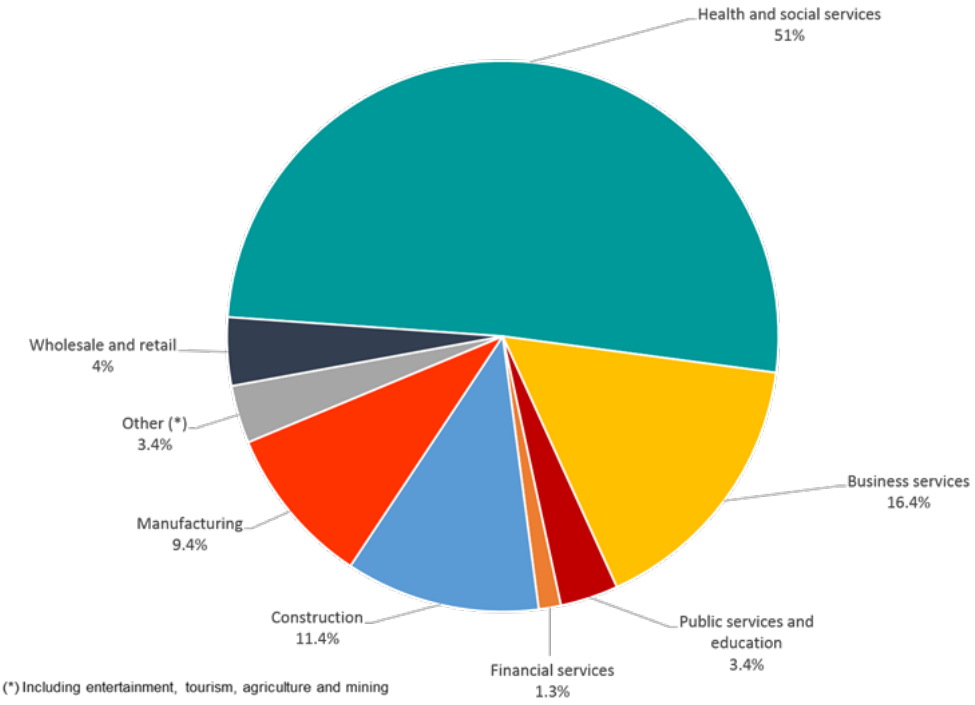
1. GENERAL NATIONAL CONTEXT FOR THE RECOGNITION OF PROFESSIONAL QUALIFICATIONS

1.1. General approach to Occupational Regulation

In January 2019, there were 149 regulated professions in Germany[1]. The vast majority of these (51 %) were professions in the health and social services sector (see graph below).

Figure 1: Distribution of regulated professions by economic sector in Germany[2]



In terms of the most dominant type of regulation, **protected titles without reserves of activities** (71 professions) and **reserves of activities** (70 professions) are the most common types of occupational regulation in Germany. The remaining professions are either regulated through a combination of **reserves of activities and protected title** (3 professions), or **no information** was provided for them (5 professions)[3]. Thus, the strictest regulation (reserves of activities and protected title), is used only exceptionally, and is applied to architects, paediatric/children's nurses and ski instructors.

An EU-wide survey on occupational regulation from 2015 showed that 33 % of the **German labour force** was working in a regulated profession – **the highest share in all EU Member States**[4]. In the Health and Social Work sector, 51 % of the labour force was licensed[5].

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1 Regulated professions database, available at: http://ec.europa.eu/growth/tools-databases/regprof/index.cfm?action=map&b_services=true (consulted in February 2019)

2 ibid.

3 ibid.

4 Koumenta, M. and Pagliero, M., 'Measuring Prevalence and Labour Market Impacts of Occupational Regulation in the EU', [2016] Ref. Ares(2016)6854283, pp. 28-31. Note that the Report on the survey uses the term 'licensed' for reserves of activity and 'certified' for protected titles, idem, pp. 9-10.

5 ibid, pp. 32-34.

The **regulatory framework** in Germany is set by the State. While the chambers and professional associations may submit their suggestions and opinions and act in an informational and advisory function[6], and even may be delegated tasks from the State authorities, they do not set the regulatory framework[7].

Data collected by the European Commission in 2016 with respect to seven liberal professions, painted a picture of a framework of occupational regulation in Germany that is **stricter** than the EU average[8]. This is in line with the fact that, in Germany, the link between training and education on the one hand and the resulting possibilities in terms of entry to the labour market on the other is particularly strong[9].

The German approach to examining the **justification for and proportionality of regulation** may be traced back to a Federal Constitutional Court decision in 1958, which established the so-called **'three-stage-theory'** according to which certain conditions must be fulfilled for the legislator to restrict occupational freedom[10]. The three stages roughly consist of: 1) amount of activity reserved for certain occupations – restrictions must be proportionate and promote the common good[11]; 2) certain entry requirements may be imposed before individuals may exercise an occupation, but these requirements must be strictly proportional – this forms the basis of licensing procedures[12]; 3) objective entry requirements such as professional quotas – for this stage to be acceptable, there must be an 'extraordinarily important public goods' which is being protected and for which the restriction is imperative[13]. Public health is an important aspect of notions of common and public good, and most health-related professions are therefore regulated in Germany[14].

The Federal Ministry for Economic Affairs and Energy's (*Bundesministerium für Wirtschaft und Energie* – BMWi) **transparency initiative of 2013**, launched under the revised Directive 2005/36/EC, provided an opportunity for federal and state authorities, as well as professional bodies and associations, to express their opinions and provide information to the BMWi on the appropriateness of the regulation of professions[15]. As a result of this process, changes to the laws on certain liberal professions are being considered in order to facilitate the pursuit of these professions[16], for example amending restrictions that require professionals to hold company shares or that prescribe certain forms of organisation of the profession. No plans for amendments to the laws regulating access to skilled trades[17] have been announced[18]. For the health professions specifically, some changes relating to the regulation of further training/education of doctors are planned, which would ensure that the specific requirements of different fields and scientific progress of the medical field are taken into account[19]. An overhaul of the training of nurses and carers, which would see uniform training for basic nursing being established, is also planned[20]. Therefore, whilst some modifications are happening, no major changes have been introduced or are planned as a result of the revised Professional Qualifications Directive (PQD).

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6 Information obtained from stakeholder consultations (competent authority for doctors, *Hesse*; *Physio-Deutschland*), February 2019.

7 Information obtained from stakeholder consultation (*Bundesärztekammer*), February 2019.

8 Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions on reform recommendations for regulation in professional services (2017), p. 66.

9 Donlevy, V. and others, 'Study on Obstacles to Recognition of Skills and Qualifications' [2016], European Commission, p. 43.

10 Haupt, A. and Witte, N., 'Occupational Licensing and the Wage Structure in Germany' [2016] Karlsruhe Institute of Technology, Institute of Sociology, p. 7.

11 ibid, p. 8.

12 ibid, p. 8.

13 ibid, p. 9.

14 ibid, p. 10.

15 National Action Plan for Germany, p. 1.

16 ibid, pp. 2-5.

The German recognition system and regulatory framework has garnered much international interest and is generally well-regarded[21]. The system has several **strong points**. The Federal Recognition Act adopted in 2012 (*Anerkennungsgesetz*) establishes, for the first time, a legal claim to the recognition procedure for individuals, and widens the scope of the previous legislation, for example providing clear rules on length of procedures and on taking account of practical experience in the assessment of equivalence[22]. Moreover, a number of advisory services have been established, which are free of charge and available in various languages, making it possible for professionals to access personal consultations throughout the process[23]. For example, the support initiative 'Integration through Qualification' ('*Integration durch Qualifizierung*' – IQ), also known as the IQ programme, established initial contact points which provide support and advice to those who are interested in having their professional qualifications recognised[24]. This government programme aims to facilitate migrants' labour market integration, by providing support to both individuals and institutions, for example through providing advice with respect to professional regulation and recognition of qualifications and helping companies and stakeholders from the public sector develop intercultural competence[25].

In relation to the health professions in particular, one of the strengths of the German system for doctors is the interaction between the **impartial competent authority**, which is responsible for deciding on the licensing of doctors in relation to basic medical training, and the specialised expertise of the chambers, who deal with specialist doctors and further education[26]. This is perceived as a strength, because it means that the chambers are not open to the accusation of (and indeed are incapable of) influencing the labour market[27]. With respect to physiotherapists, the German vocational training programme is considered to be a strength, because of its focus on practice. However, in terms of recognition, this often leads to foreign professionals with academic qualifications who would like to practice physiotherapy in Germany having to seek further qualifications in order to fulfil the requirements of recognition in Germany, thereby complicating the recognition of foreign qualifications in this field[28].

A **weakness** of the German system, particularly as concerns the health professions, has been the non-homogeneity of the implementation of the recognition procedure in the different federal states – the *Länder*[29]. Although some improvements have been made, for example with respect to the standardisation of examination contents, the design of adaptation courses and the form of the recognition certificates, differences remain, for instance, with respect to language requirements[30].

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17 The skilled trades in Germany encompass over 130 occupations, including occupations from the building and interior finishes trade, the electrical and metalworking trades, the woodcrafts and plastic trades, clothing, textiles and leather crafts and trades, food crafts and trades, health and body care trades, chemical cleaning sector and graphic design. https://www.zdh.de/en/occupations/.

18 National Action Plan for Germany, p. 5.

19 ibid, pp. 5-6.

20 ibid, pp. 5-6.

21 Bericht zum Anerkennungsgesetz 2017, available at https://www.bmbf.de/pub/Bericht_zum_Anerkennungsgesetz_2017.pdf, p. 10.

22 ibid, p. 10.

23 ibid.

24 ibid.

25 European Commission (2018), 'Study on the movement of skilled labour (Final report)', Annex 3 – Case Study: Germany, p. 175.

26 Information obtained in stakeholder consultations (competent authority for doctors, *Hesse*; *Bundesärztekammer*), February 2019.

27 Information obtained from stakeholder consultations (competent authority for doctors, *Hesse*), February 2019.

28 Information obtained from stakeholder consultation (*Physio-Deutschland*), February 2019.

29 Bericht zum Anerkennungsgesetz 2017, p. 12.

30 ibid.

The **implementation of changes at EU level** in national law was mainly achieved through the Professional Qualifications Assessment Act (*Berufsqualifikationsfeststellungsgesetz* - BQFG), which is established under Article 1 of the Federal Recognition Act, as well as the relevant *Länder* laws that followed in 2016 and 2017[31]. The main difference in the approach stemming from the implementation of the amended PQD is the introduction of the IMI-platform, which makes it easy to see which steps authorities must take, thereby streamlining the process (see also below)[32].

1.2. Recognition of professional qualifications

In Germany, professions can be regulated at federal level (as is the case for the four professions chosen for the current study: doctors with basic training, nurses of general care, physiotherapists and long-term carers) or at *Länder* level (for example, with respect to architects, engineers and teachers). At the federal level, the German Ministry of Education and Research is in charge of **professional regulation**. However, the **recognition procedure** itself is carried out at *Länder* level, by the competent authorities for each respective *Bundesland*. The 16 individual federal states are responsible for the establishment their respective **competent authorities**.

For many professions, the competent authority is the relevant **professional chamber** (for example, the Chamber of Industry and Commerce and the Chamber of Skilled Crafts (*Handwerkskammer*)[33]. For other professions, state authorities are responsible. For instance, the recognition of qualifications of doctors, nurses, physiotherapists and carers for the elderly in the *Länder* chosen for this study, *Hesse* and *Baden-Württemberg*, is carried out by state authorities. Nevertheless, certain responsibilities with respect to the recognition of foreign qualifications may still fall to the chambers. For example, if these competences have been delegated to them by the competent authority[34], they may assist with the alert mechanism, test the required language level of professionals, and for relevant professions, issue the European Professional Card. Therefore, their role is supportive.

With respect to the **recognition of foreign qualifications for doctors**, there is a dual system, in the sense that anything to do with the education and training of a **doctor of basic medicine**, including the contents of the studies as well as licensing after successful completion of studies, is dealt with by the **state authorities**, while further education and training after licensing is the responsibility of the chambers[35]. This means that when foreign doctors of basic medicine want their qualifications recognised, they first must seek a license from the state authority[36]. This recognition goes through the **automatic system** and applies to basic medical training. The chambers are not involved in this process. However, if a foreign doctor intends to work in Germany as a specialist doctor, as specialisations count as further education, the chambers for each *Land* take on the task of carrying out the recognition

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31 ibid, p. 21.

32 Information obtained from stakeholder consultations (competent authority for doctors, *Hesse*), February 2019.

33 Professional Qualifications Assessment Act from 6 December 2011, Federal Gazette I p. 2515, which was last amended through Article 150 of the Act from 29 March 2017, Federal Law Gazette I p. 626 (*Berufsqualifikationsfeststellungsgesetz vom 6. Dezember 2011 (BGBl. I S. 2515), das zuletzt durch Artikel 150 des Gesetzes vom 29. März 2017 (BGBl. I S. 626) geändert worden ist*), § 8.

34 See for example Act on Professional Associations, Professional Practice, Further Training and the Jurisdiction of Professional Regulatory Bodies for Doctors, Dentists, Veterinarians, Pharmacists, Psychological Psychotherapists and Psychotherapists for Children and Adolescents (Healing Professions Act) in the version promulgated on 7 February 2003, Federal Gazette I p. 66, 242, last amended by the Act of 3 May 2018, Federal Gazette I p. 82 (160) (*Gesetz über die Berufsvertretungen, die Berufsausübung, die Weiterbildung und die Berufsgerichtsbarkeit der Ärzte, Zahnärzte, Tierärzte, Apotheker, Psychologischen Psychotherapeuten und Kinder- und Jugendlichenpsychotherapeuten (Heilberufsgesetz) in der Fassung der Bekanntmachung vom 7. Februar 2003 (GVBl. I S. 66, 242), zuletzt geändert durch Gesetz vom 3. Mai 2018 (GVBl. I S. 82 (160))*, § 5.

35 Information obtained from stakeholder consultation (*Bundesärztekammer*), February 2019.

36 ibid.

procedure through the general system[37]. The chambers may also have certain other tasks delegated to them by the legislator. In *Hesse*, the *Landesärztekammer* supports the competent authority in relation to testing the language requirements of applicants as well as carrying out the assessment of equivalence[38].

A professional chamber for **physiotherapists** does not (yet) exist in Germany, but professional associations such as the German Association for Physiotherapy (*Deutscher Verband für Physiotherapie - Physio-Deutschland*) take on an advisory role with respect to regulation and recognition. *Physio-Deutschland* is the largest professional association of physiotherapists in Germany and the only one to be a member of the World Confederation for Physical Therapy (WCPT) and the European Region WCPT (ERWCPT). It advises requesting institutions, networks and physiotherapists from all over the world about professional recognition in Germany (among other things through its website) and informs physiotherapists with a German degree on working and obtaining recognition abroad[39]. Professional associations in the field of physiotherapy therefore have an informational and advisory function.

Staff shortages in recognition authorities, brought on by a sudden and continued rise in applications in recent years, for instance due to the arrival of a substantial number of refugees, have presented a challenge to the effective functioning of the recognition process in Germany[40]. Although, as a result, additional personnel have been made available to the Central Office for Foreign Education (ZAB) by the *Länder*, recognition authorities are still widely under-staffed[41]. The language skills of applicants also present a challenge to a successful recognition process[42]. This is for example the case when authorities already require proof from applicants regarding their language skills during the advisory stage or as part of the set of documents that they require from applicants during the application process[43].

KEY FINDINGS

- Germany has the highest share of labour force working in regulated professions in Europe.
- 51 % of the labour force in healthcare professions is licensed.
- The regulatory and administrative systems are well-regarded abroad, as Germany has introduced a general legal entitlement to professional recognition and made information and advice widely and easily available.
- Differences in the implementation between the *Länder* can cause problems particularly for health professionals (e.g. where different *Länder* have different ways to test language skills).
- Chambers and professional associations are often responsible for recognition, but in the health professions they play a predominantly advisory and supportive role.
- Major challenges to the effective functioning of the recognition process are staff shortages

37 ibid.

38 Information obtained from stakeholder consultations (competent authority for doctors, *Hesse*), February 2019.

39 Information obtained from stakeholder consultation (*Physio-Deutschland*), February 2019, available at: https://www.physio-deutschland.de/fachkreise/beruf-undbildung/recognition-recognition.html.

40 Bericht zum Anerkennungsgesetz 2017, available at: https://www.bmbf.de/pub/Bericht_zum_Anerkennungsgesetz_2017.pdf, p. 12.

41 ibid.

42 Bericht zum Anerkennungsgesetz 2015, available at: https://www.bmbf.de/upload_filestore/pub/Bericht_zum_Anerkennungsgesetz_2015.pdf, p. 162. Information obtained from stakeholder consultation (academic consultation), February 2019.

43 Bericht zum Anerkennungsgesetz 2015, p. 162.

and language barriers (e.g. increased numbers of applications lead to the authorities being overwhelmed and recognition processes being delayed).

1.3. Type and Intensity of Regulation

A 2016 study, which analysed the professional regulations framework of the EU Member States with respect to seven professions, reveals that the level of **intensity** of regulation in Germany is **relatively high** as compared to other EU Member States[44]. Looking at the four health professions, a relatively high level of intensity of regulation is confirmed, in particular for doctors. While the other three professions are regulated by protected titles, doctors are regulated by reserve of activities.

All of the professions require a mandatory state exam as well as continuous professional development, and there is only one pathway to obtaining the qualification, namely university studies for doctors and vocational post-secondary school education for nurses and carers for the elderly. For nurses, a further significant limitation is imposed by the fact that licences are subject to **territorial restrictions**. For physiotherapists, vocational post-secondary school education was the only way to enter this profession in the past, but nowadays the possibility of studying at university or doing a dual course which combines the vocational training with academic study, is increasingly provided[45]. Nevertheless, the title 'physiotherapist' is still protected and requires a state exam to be passed at the end of the vocational training or university studies [46]. Furthermore, Germany imposes certain exercise requirements, including mandatory indemnity insurance (all four professions), restrictions related to shareholding or voting rights (doctors) and restrictions on the corporate form or type of entity through which the profession may be exercised (doctors, nurses and physiotherapists).

It must also be noted that in some cases authorities ask applicants for **proof of an employment offer** when handing in their documents, despite this not being required by law[47].

Table 1: Regulatory requirements for selected healthcare professions in Germany

Restrictiveness indicator	Medical doctors (with basic training)	General nurses	Physiotherapists	Long-term care workers (carers for the elderly)
Exclusive reserved activities	Yes	No	No	No
Protection of the title	No	Yes	Yes	Yes
Shared reserved activities (i.e. activities not limited to one profession)	No	N/A	N/A	N/A

[44] Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions on reform recommendations for regulation in professional services (2017), p. 66.

[45] Brummer, M., Christ, A. and Kutzner, C., *Der Akademisierungsprozess der Physiotherapie im deutschsprachigen Raum: Ein Überblick über Prozesse, Hintergründe und Masterstudiengänge* (Akademische Verlagsgemeinschaft München, 2011) pp. 19-20.

[46] Brummer, M., Christ, A. and Kutzner, C., *Der Akademisierungsprozess der Physiotherapie im deutschsprachigen Raum: Ein Überblick über Prozesse, Hintergründe und Masterstudiengänge* (Akademische Verlagsgemeinschaft München, 2011) pp. 19-20.

[47] Bericht zum Anerkennungsgesetz 2017, pp. 42- 44.

Years of education and training	Six	Three	Three	Three
Number of ways to obtain qualifications	One	One	Three	One
Mandatory traineeship	Yes	No	No	No
Obligation to have professional experience	Yes	Yes	Yes	Yes
Mandatory state exam	Yes	Yes	Yes	Yes
Continuous professional development obligations (mandatory)	Yes	Yes	Yes	Yes
Compulsory membership or registration in professional body	Yes	No	No	No
Limitation of licences (quantity restrictions)	Yes	No	No	No
Territorial validity of a licence	No	Yes	No	No
Age restriction	No	No	No	No
Knowledge of language (if yes, the level required)	Yes (B2 general language skills + C1 specialist language skills)	Yes (B2)	Yes (B2)	Yes (B2)
Other	There are also requirements to have **professional indemnity insurance**, including in cases of cross-border workers, as well as restrictions concerning the corporate form/type of entity to be used to exercise the related activity.	There are also requirements to have **professional indemnity insurance**, as well as restrictions concerning the corporate form/type of entity to be used to exercise the related activity.	There are also requirements to have **professional indemnity insurance**, including in cases of cross-border workers, as well as restrictions concerning the corporate form/type of entity to be used to exercise the related activity.	There is also a requirement to have **professional indemnity insurance**.

Source: EU regulated professions database.

KEY FINDINGS

- The intensity of regulation of professions in Germany is **relatively high**, both generally speaking and with respect to health professions in particular.
- The majority of professions in Germany are either regulated through reserves of activities or protected titles.
- For health professions, there are often restrictions concerning the qualifications required or means of acquiring them (e.g. mandatory training or mandatory state exam).
- There are also frequently non-qualification restrictions (e.g. indemnity insurance and restrictions concerning the type of entity used to exercise the profession).

1.4. Non-regulatory factors (such as access to information)

In Germany, **Points of Single Contact** have been established, both at the federal level and at state level. At the federal level, the Federal Institute for Vocational Education and Training (*Bundesinstitut für Berufsbildung* - BIBB) is the Point of Single Contact for the recognition of regulated professions. At state level, each *Land* has its own Point of Single Contact, through which various services can be accessed and procedures can be carried out, including the recognition of foreign qualifications. The website of the Point of Single Contact in *Hesse* (https://eah.hessen.de/english) is well-organised and has a clear layout. It is available in English and lists the different points of contact (there are three in *Hesse*). It is therefore easy to access the information required to start a recognition procedure. The website for *Baden-Württemberg* (https://www.service-bw.de/en) is more difficult to navigate. Although it is available in English, users have to use the search bar to find information on professional recognition, and then it depends on which search result users click as to whether they will find a lot of practical information or not. With the combination of the right search terms and the right choice of results, a lot of information is indeed available, for example, regarding the competent authority, required documents and costs. However, this information is not easily accessible. One of the stakeholders interviewed for *Baden-Württemberg* commented that the establishment of Points of Single Contact is likely to have had only a **marginal effect** on the recognition process in *Baden-Württemberg*[48].

Nevertheless, the **federal point of single contact website** (www.anerkennung-in-deutschland.de/html/en/) is very informative and provides information regarding contact points, competent authorities, language requirements, qualifications, and the procedure as such, and with respect to certain professions. All the information is available in English. There is also the BQ-portal (https://www.bq-portal.de/en), an information portal for foreign professional qualifications established on behalf of the BMWi, which provides a further platform for employers, state authorities and professionals with information on the regulation of professions. Despite this, one stakeholder commented, with respect to physiotherapists specifically, that the fact that the responsibility for the professional recognition of foreign physiotherapists lies with the state authority in the catchment area of the (future) primary residence means that at present, there are more than 20 authorities which are responsible, and this sometimes leads to confusion and difficulties for people searching for relevant information[49].

[48] Information obtained from stakeholder consultation (Point of Single Contact for *Baden-Württemberg*), February 2019.

[49] Information obtained from stakeholder consultation (*Physio-Deutschland*), February 2019.

At this stage, there is **no online system** for the recognition of professional qualifications applicable in all *Länder*. Some *Länder* have such a system, and in others, an online system is in the pipeline. For example, in *Hesse*, the project *Digitale Modellbehörden* aims to digitalise administration in *Hesse* in the coming years. The fact that no comprehensive online procedure exists across Germany corresponds with Germany's digitalisation index of 2018 which is just above the EU average of 54, with a score of 55.6. It has increased by 2.9 since 2017, placing Germany in the middle of the scoreboard for the EU Member States, at 14th out of 28[50]. As a matter of fact, the greatest shortcoming identified in the German system was the online interaction between the government and its citizens – an aspect which is important for the efficiency of processes such as recognition procedures. A general digitalisation of bureaucratic processes is planned in Germany for the future. This would entail a single system which applies to many different processes and while not specifically aimed at recognition, can be expected to cover recognition as well. Although there is currently no online procedure in operation, on the whole information regarding the recognition of foreign qualifications is relatively accessible in Germany, and the German system has been mentioned as an example of **'good practice'** in the literature[51].

The recognition procedure in Germany is **subject to a fee**, which is determined independently by the particular competent authority, i.e. the relevant chamber or state authority carrying out the procedure[52]. According to the information portal, the fees are between EUR 100 and 600 (EUR 10-400 for the EPC)[53], and in many cases must be borne by the applicant although in certain situations subsidies are available, for example through an employment agency or job centre[54]. This information is **not easy to find**, as it depends on a number of factors, including the *Land* and profession concerned. Studies carried out by the BIBB in 2015 showed recognition costs for the individual may constitute an obstacle[55]. In particular, this was identified as one of the reasons why people do not apply for recognition[56]. The 2017 Report on the Recognition Act[57] by the Federal Ministry of Education and Research, (*Bundesministerium für Bildung und Forschung* – BMBF) recognises that it is difficult to estimate to what extent the costs of the recognition procedure discourage people from submitting an application, but states that interviews with successful applicants suggest that procedural costs could indeed be an obstacle[58].

Contrary to this finding, one stakeholder commented that there is no evidence to suggest that administrative fees related to the recognition procedure itself hinder the recognition of qualifications for doctors, as it is possible to defer, reduce or waive fees in cases of hardship[59]. Organisations for migrants also often help with these costs (which is of relevance for third country nationals)[60]. The **costs associated with obtaining, certifying and translating evidence** are considered likely to be more

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50 Digital Economy and Society Index, available at https://ec.europa.eu/digital-single-market/en/scoreboard/germany.

51 Donlevy, V. and others, 'Study on Obstacles to Recognition of Skills and Qualifications' (2016), European Commission, pp. 106-107 and pp. 110-111.

52 Information portal of the German government, available at: https://www.anerkennung-in-deutschland.de/html/de/faq.php.

53 European Commission website, available at: https://europa.eu/youreurope/citizens/work/professional-qualifications/european-professional-card/index_en.htm.

54 Information portal of the German government.

55 Bericht zum Anerkennungsgesetz 2015, available at: https://www.bmbf.de/upload_filestore/pub/Bericht_zum_Anerkennungsgesetz_2015.pdf, p. 133 and 162.

56 ibid.

57 ibid.

58 ibid, p. 66.

59 Information obtained from stakeholder consultation (*Bundesärztekammer*), February 2019.

60 Information obtained from stakeholder consultations (competent authority for doctors, *Hesse*), February 2019.

significant[61]. **Compensatory measures** can often entail further high costs, e.g. examination fees, course fees, travel expenses, subsistence costs (during longer periods without earned income)[62]. For physiotherapists, the situation is similar. While the fees for recognition themselves are considered to be moderate and without major impact on those applying for recognition, the financial burden of having to provide for one's livelihood during the adaptation period in case of differences between the foreign qualification and the German requirements, which can take over a year, are considered to be significant[63]. Moreover, the cost of attending language courses can also be a significant financial burden for many[64].

Other practical obstacles hindering the recognition of foreign professional qualifications include, according to one stakeholder, the clarification of differences and similarities compared to the respective German reference occupations, which often presents the authorities responsible with serious challenges, both in terms of content and organisation. It is often necessary to obtain comments from other bodies, sometimes even from abroad[65]. Moreover, in nursing and other health care professions, there is a trade-off between patient protection and the desire for a rapid conclusion of procedures[66]. In relation to physiotherapists, apart from difficulties in finding the relevant information, language was mentioned as one of the major obstacles, with many foreign professionals struggling with German, and translations for certificates sometimes posing a difficulty in their home countries[67].

Another restriction which is independent from the regulatory regime concerns **non-regulated professions** in Germany. While there is no legal requirement to have one's qualifications recognised, it is generally understood that it is **beneficial to ask for an equivalence check**, because it ensures that an individual has an official confirmation that his/her qualification is equivalent to a German one and must be treated as such, and helps employers judge the professional's qualifications appropriately[68].

Therefore, whilst parts of the German system might be considered good practice, in particular as concerns access to information, in other aspects, the system is lacking, for example the absence of an online procedure and the high cost of completing the procedure.

Some **national level and *Länder*-level initiatives** have been introduced in recent years in order to streamline the process and address any shortcomings or challenges that might present obstacles to the recognition of foreign qualifications. For example, financing opportunities have been further developed both at federal and state levels which specifically aim to support persons excluded from receiving benefits pursuant to German Social Security Code[69]. Cost subsidies can be granted nationwide for a recognition procedure to help overcome hurdles, especially in view of the fact that the costs and benefits of recognition do not coincide, in that the costs often occur before the recognition process is completed and the applicant is able to exercise their profession in the relevant country[70]. There is great demand for these financial support systems, with several hundred applications

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61 Information obtained from stakeholder consultation (*Bundesärztekammer*), February 2019.

62 ibid.

63 Information obtained from stakeholder consultation (*Physio-Deutschland*), February 2019.

64 Information obtained from stakeholder consultations (competent authority for doctors, *Hesse*), February 2019.

65 Information obtained from stakeholder consultation (Point of Single Contact for *Baden-Württemberg*), February 2019.

66 ibid.

67 Information obtained from stakeholder consultation (*Physio-Deutschland*), February 2019.

68 Bericht zum Anerkennungsgesetz 2017, available at: https://www.bmbf.de/pub/Bericht_zum_Anerkennungsgesetz_2017.pdf, p. 63.

69 ibid, Section 5 'Costs and financing'.

70 ibid, p. 66.

having been submitted only months after the start of the programme[71]. Moreover, the IQ initiative also supports the recognition process by taking on additional costs, such as travel or childcare costs[72]. With respect to language barriers, the Federal Government has significantly expanded its offer of language courses for newly-arrived immigrants through a new occupation-related support programme, and the expansion of integration courses[73]. However, with respect to the health sector, the nationwide development of language courses continues to be hampered by the differing implementation of language requirements in the *Länder*. Further standardisation or consistent application of the already harmonised language requirements by the *Länder* authorities is required here[74].

Other initiatives may be launched by the competent authorities to address specific recognition obstacles. In *Hesse*, the competent authorities regularly roll out initiatives aimed at assisting foreign professionals to get their qualifications recognised and be able to work in their professions in Germany, such as, for example, through cooperating with organisations that support migrants (e.g. offering language courses)[75]. In respect to doctors, this has led to positive outcomes[76]. A single website was created (Point of Single Contact, see above) to make information easily accessible, and an online procedure is planned, which will allow foreign professionals to submit their applications for recognition online and thereby simplify the procedure further[77].

KEY FINDINGS

- Germany has put effective systems in place to ensure that professionals have adequate access to information, e.g. on how their profession is regulated and which authority is responsible for the recognition procedure.
- The federal websites for recognition (anerkennung-in-deutschland.de and bq-portal.de) in particular can be considered good practice.
- On the other hand, the accessibility of information with respect to the Points of Single Contact of the *Länder* depend on each individual *Land* and can lead to information being easily available for some (e.g. *Hesse*) but not for others (e.g. *Baden-Württemberg*).
- There is no nation-wide online application system - a universal online application system would simplify matters.
- Costs, language barriers and challenges in determining equivalence are considered as obstacles to the recognition procedure.
- Some of these obstacles, such as the financial burden of the process, are being tackled through national and state initiatives.

71 ibid, pp. 13-14.

72 ibid, pp. 13-14.

73 Bericht zum Anerkennungsgesetz 2017, p. 13.

74 ibid.

75 Information obtained from stakeholder consultations (competent authority for doctors, *Hesse*), February 2019.

76 ibid.

77 ibid.

1.5. Recognition rates and length in proceedings

Based on the EU Single Market Scoreboard, Germany scores **below average** in terms of **how quickly recognition decisions are taken**, and **average** in terms of the **share of positive recognition decisions**[78]. Based on 2017 data from national sources, in most professions, the share of those granted full equivalence varies from 40 % to 80 %. For instance, it is 72 % for doctors[79]. While this is a high percentage if compared to the recognition rates of other health professions in Germany (59 % for physiotherapists, 41 % for general care nurses, 20 % for geriatric nurses) as well as in comparison to other professions (e.g. 55 % for electronic technicians, 41 % for carpenters and 18 % for lawyers)[80], this number seems to be **below the EU average**. Generally, a higher response and recognition rate means it is easier and/or cheaper for professionals to have their qualifications recognised, but there can be several reasons for variations, which include:

- resources available for and dedicated to managing the applications;
- number of applicants;
- complexity of the regulation.

In Germany, the **duration of proceedings** presents one of the main challenges regarding the implementation of recognitions procedures. So far, reports have shown that the statutory deadline for the procedure is being met, although this may depend on the profession, the country where the foreign qualifications were obtained, and the nationality of the applicant[81]. However, the duration of proceedings is measured from the moment that all required documents have been handed in, meaning that only the administrative process from the point in time of a complete application is measured, with the duration of the entire process not being documented[82]. In particular, the experience of the individual professional going through this kind of procedure, including the stages of collecting information and asking for guidance etc., is not reflected in the data collected[83]. Other obstacles in the German system include the number of applicants and the limited resources of the authorities[84].

With respect to **low recognition rates**, stakeholders interviewed about doctors were surprised that the levels are so low. In *Hesse*, the competent authority for doctors reported that their own numbers showed a positive recognition rate of over 90 % for doctors from other EU Member States[85]. The Federal Chamber for Doctors also did not have an explanation, commenting that due to the automatic recognition procedure, EU doctors are usually recognised without any problems, and non-recognition is rare[86]. Moreover, the length of the recognition procedure was estimated to be four weeks at the most for doctors going through the automatic recognition process in *Hesse*, with some procedures taking as little as two weeks in the case of well-prepared applicants[87]. Longer procedures would have to be expected in relation to persons who obtained their degrees in a third country, as the general system

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78 Single Market Scoreboard on professional qualifications, available at http://ec.europa.eu/internal_market/scoreboard/performance_per_policy_area/professional_qualifications/index_en.htm.

79 BQ-Portal, Recognition statistics (2017), available at: https://www.bq-portal.de/en/Companies-and-recognition/Recognition-statistics.

80 ibid.

81 Bericht zum Anerkennungsgesetz 2017, p. 43.

82 ibid.

83 ibid.

84 ibid., pp. 42- 44.

85 Information obtained from stakeholder consultations (competent authority for doctors, *Hesse*), February 2019.

86 Information obtained from stakeholder consultation (*Bundesärztekammer*), February 2019.

87 Information obtained from stakeholder consultations (competent authority for doctors, *Hesse*), February 2019.

takes longer due to thorough checks having to be carried out[88]. Here, the sudden, sharp increase in applications in recent years due to the migrant crisis meant that there was a lack of personnel, which was initially not covered as the numbers were expected to fall again, which they did not[89]. While more personnel have now been employed to address the increase in applications, there is still a lack of resources and this affects the length of procedures[90].

In the area of health professions, some changes have been put in place to address challenges regarding personnel shortages or non-homogenous approaches by the different *Länder*, for example through the establishment of a **central authority for the assessment of equivalence** for health professions (*Gutachtenstelle für Gesundheitsberufe* – GfG), which provides for a uniform assessment procedure and supports the competent authorities[91].

One stakeholder commented that with respect to physiotherapists, **low recognition rates could due to** the fact that not all applicants continue with the recognition procedure once they are informed that they would have to go through certain **compensation measures**, which is frequently the case due to the practical nature of the German training for physiotherapists, as opposed to the more academic qualifications in other Member States[92]. Thus, this presents an obstacle for the recognition of foreign physiotherapists' qualifications in Germany. As for the length of the recognition process, it was suggested that the **IMI-system is not always used by authorities**, leading to delays in the recognition process[93]. Moreover, the time between the initial application and a first response from the authority was noted to be something that should be shortened, as well as the length of time that it takes for foreign professionals to complete their adaptation measures where required[94].

KEY FINDINGS

- Overall, German recognition procedures are slower than the EU average and present median rates of positive recognition outcomes.
- It is difficult to measure the total length of procedures as official data only counts the length of time from the moment all necessary documents have been submitted.
- For doctors, the relevant authorities and professional chambers considered the recognition rate to be high and the length of the process to be within the required time limit, or even quicker, due to automatic recognition.
- Good practice: Challenges in ensuring quick and homogenous assessment of equivalence in the health sector have been addressed through the creation of a central authority for the assessment of equivalence, which unifies this assessment and supports the competent authorities.
- For physiotherapists, low recognition rates could be due to many applicants terminating the process because they would have to go through adaptation measures. This highlights the difficulties that arise from Member States regulating professions in diverse ways.

88 ibid.

89 ibid.

90 ibid.

91 Bericht zum Anerkennungsgesetz 2017, p. 43.

92 Information obtained from stakeholder consultation (*Physio-Deutschland*), February 2019.

93 ibid.

94 ibid.

2. EFFECTS OF IMPLEMENTING THE MAIN 2013 PQD AMENDMENTS AIMED AT FACILITATING RECOGNITION OF PROFESSIONAL QUALIFICATIONS

2.1. European Professional Card (EPC)

In Germany, the European Professional Card is available for four professions, namely physiotherapists, general care nurses, pharmacists and mountain guides[95]. As a **home Member State**, numbers collected from 2016 showed that 234 applications for an EPC were submitted from Germany, 53 percent of which were approved, while in the following year, 202 applications were submitted from Germany, 63 % of which were approved[96]. Although there is a slight decrease in applications and a slight increase in positive decisions over this timeframe, there are no drastic discrepancies from one year to the next. Most persons applying from Germany as a home country applied to Austria, France and Italy[97].

As a **host Member State**, the number of applications received by Germany from other EU Member States did not differ substantially between 2016 (131) and 2017 (137)[98]. This number is quite low in comparison to the UK or France for example. The majority (47 percent) of EU applicants for an EPC to work in Germany were from Poland and Italy over both years[99]. More than half of the applications received by Germany concerned the occupations of **physiotherapist and nurse**, with the numbers for both being relatively steady between 2016 and 2017, except for a slight increase in applications for physiotherapists (45 in 2016 and 59 in 2017 for physiotherapists and 53 in 2016 and 49 in 2017 for nurses)[100]. Strikingly, **the number of EPCs issued in comparison to the applications made is quite low**, with only 32 EPCs issued in 2016 and 40 in 2017[101]. The rate of EPCs issued for physiotherapists has remained low throughout both years, with only a slight increase in 2017 (eight in 2016 and 14 in 2017), whereas a sharp increase in EPCs issued for nurses is visible, from 7 in 2016 to 20 in 2017[102]. The numbers for the other professions have been stable, with very few applications being made for mountain guides (5 in 2016 and 3 in 2017) and only moderate numbers for pharmacists (28 in 2016 and 26 in 2017)[103].

Although the low rates of EPCs issued might be due to the delay between applications being made in one year and the eventual decision being made in the next, the discrepancy between applications and issuance is still noteworthy. Another interesting statistic is the fact that the number of EPC applications that were refused rose from two in 2016 to ten in 2017. While refusals of applications from nurses remained steady, refusals for physiotherapists and pharmacists increased from one to three (physiotherapists) and four (pharmacists)[104].

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95 Note that mountain guides are regulated only in Bavaria.

96 Statistics on EPC applications, available at: http://ec.europa.eu/internal_market/imi-net/_docs/statistics/2017/12/epc-applications-issued.pdf.

97 ibid.

98 ibid.

99 ibid

100 ibid.

101 ibid.

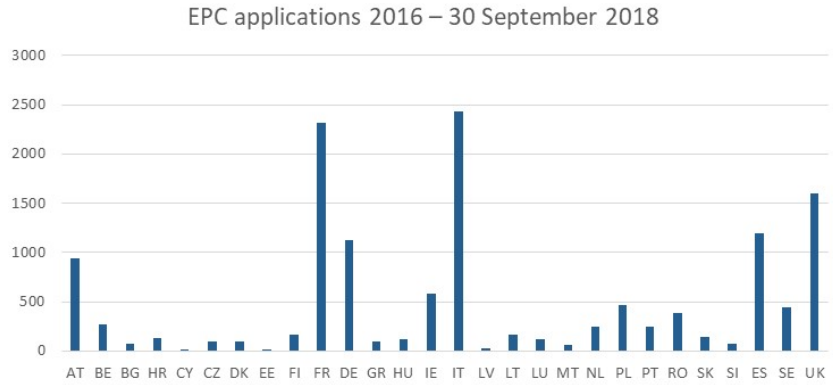
102 ibid.

103 ibid.

104 Statistics on EPC applications, http://ec.europa.eu/internal_market/imi-net/_docs/statistics/2017/12/epc-applications-issued.pdf.

Overall, Germany has received slightly more than 1,000 EPC applications as host and as home country between January 2016 and September 2018. This is much less than Italy and France, but it is still among the five countries with the largest numbers of EPC applications (see Figure 2 below).

Figure 2: Member States concerned by EPC applications



The European Commission's data available at:
http://ec.europa.eu/internal_market/imi-net/statistics/index_en.htm.
(consulted in March 2019)

Considering that data is only available for two years, and the numbers are relatively low overall, it is not possible to draw conclusions about the extent to which the EPC has been useful in facilitating the recognition of foreign qualifications. However, if the numbers available from the EPC are compared to numbers available with respect to positive recognition decisions in 2016 and 2017, the numbers for nurses show that compared with the total number of positive decisions taken with respect to recognition of qualifications for nurses taken in 2016 and 2017, the number of EPCs issued for nurses during that time constitutes only a small fragment of the overall numbers[105]. It can therefore be assumed that professionals in this field prefer to go through the regular recognition channels, rather than applying for the EPC. For physiotherapists, the data for 2016 and 2017 is missing, and therefore similar observations cannot be made.

Some observations were also made by consulted stakeholders, which might further explain why applications for the EPC in nursing make up such a small fraction of overall recognition decisions for this profession. According to the competent authority for nurses and carers in *Hesse*, only three recognition procedures have to date been applied for using an EPC, with those applicants coming from Italy, the Netherlands and Sweden[106]. For the concerned qualifications, the automatic procedure applied in any case, so the **EPC was not considered to add much**[107]. Moreover, it was stated that even where the EPC is used, applicants must still prove their language skills, and their appropriate health and ability to carry out the profession, meaning that the only advantage lies in the guarantee for the applicant that the outcome of the recognition procedure will be positive without the need for any adaptation measures[108]. Another stakeholder commented that in general, the existence of the EPC was not sufficiently well-known among the population and among groups of professions[109].

[105] See section 3 below.

[106] Information obtained from stakeholder consultations (competent authority for nurses and carers, *Hesse*), February 2019.

[107] ibid.

[108] ibid.

[109] Information obtained from stakeholder consultations (academic consult), March 2019.

KEY FINDINGS

- The number of EPC applications in Germany from European professionals is relatively low.
- The numbers of professionals from Germany using the EPC are quite low.
- The highest numbers of applications come from nurses and physiotherapists.
- Applications for EPCs make up a small fraction of overall positive recognition decisions in Germany for nurses.
- Where it is used, it has only a limited effect on facilitating the recognition procedure and does not add much for automatic recognition.
- In some cases, like in *Hesse*, the EPC may be subject to a fee, adding to the financial burden of applicants.

2.2. Partial access to professional activities

In Germany, applicants who have the required professional qualifications to carry out a certain profession in their country of origin, but in Germany the qualifications only cover part of a profession, now have the possibility to exercise the part of the profession for which they have the relevant qualification[110]. This partial access to the profession is provided for where the differences in training could only be compensated by a compensatory measure corresponding to the total duration of training in the host Member State[111]. In Germany, partial access to employment was already provided for in the Crafts Code (*Handwerksordnung*). While partial access is now expressly regulated in the respective specialist laws for certain health professions in Germany regulated by federal law (in accordance with Directive 2013/55/EU), it does not apply to those health professions whose training content has already been harmonised at European level (pharmacists, doctors, dentists, midwives and nurses)[112]. Data on recognition decisions for qualifications from Germany shows that there were very few cases of partial access being requested and being granted or denied. Among the decisions on establishment, negative partial access was reported for three cases in 2017 and for six cases in 2016 only; positive partial access was reported for 27 cases in 2016 and for three cases in 2015. No decisions including partial access for temporary mobility were reported.

KEY FINDINGS

- Partial access is possible in Germany, including for certain health professions.
- There were very few partial access decisions in Germany between 2015 and 2017.

2.3. Temporary service provision

With respect to temporary service provision, the numbers of decisions made in Germany in 2011 (723, 70 positive) and 2012 (545, 35 positive) with regards to EU professionals show that the use of this regime was rather moderate in those years[113]. During 2011, nine of the decisions were made with respect to doctors, eight with respect to geriatric care nurses and four with respect to

[110] Bericht zum Anerkennungsgesetz 2017, p. 21.

[111] ibid.

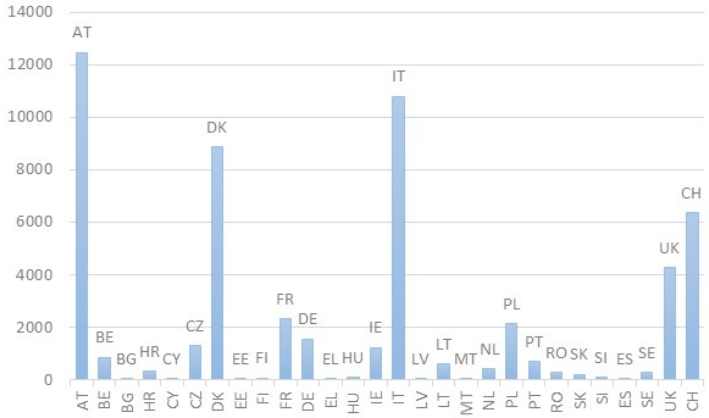
[112] ibid.

[113] Regulated professions database, available at http://ec.europa.eu/growth/tools-databases/regprof/index.cfm?action=homepage.

physiotherapists[114]. In 2012, 26 of the 545 decisions made concerned physiotherapists, 14 concerned nurses and four concerned doctors[115]. While there is very little to no data for 2013 and 2014, the three decisions recorded for 2013 all concerned geriatric care nurses – they were all positive[116]. 209 decisions were recorded overall for 2015, all of which concerned neutral decisions[117]. Of these, none concerned the health professions. So far, no data is available for 2016 and 2017, so no inferences can be drawn yet concerning the contribution of the PQD amendments to a potential greater use of the temporary service provision regime.

Compared to other Member States, Germany has had a rather moderate number of decisions on temporary service provisions in the period 2008 – 2018, as can be seen in figure 3 below. Note that the low number might also be due to missing entries into the database.

Figure 3: Temporary mobility in the EU, all decisions 2008-2018, by host country[118]



Source: European Regulated Professions Database, available at: http://ec.europa.eu/growth/tools-databases/regprof/.
(extracted in January 2019)

One stakeholder commented that one of the major issues with temporary service provision lies in different understandings of what 'temporary service provision' means, in particular as concerns the term 'temporary'[119]. There is a lack of guidance on this which leads to very different conceptualisations of this term[120]. Moreover, another hindrance relates to the language skills of temporary service providers. By the time it is established that there may be problems with their knowledge of German, temporary workers have already left again[121]. Generally, good preparation is key for this kind of service provision to be successful, for example in hospitals, when a specialist doctor is brought in specifically to cover one specialisation, for instance to teach a certain set of skills or to fill a gap for a certain amount of time, this is usually done with a lot of preparation and as a result, works well[122].

[114] Regulated professions database, available at http://ec.europa.eu/growth/tools-databases/regprof/index.cfm?action=homepage.

[115] ibid.

[116] Regulated professions database, available at http://ec.europa.eu/growth/tools-databases/regprof/index.cfm?action=homepage. No data is available for Germany for 2014.

[117] Regulated professions database, available at http://ec.europa.eu/growth/tools-databases/regprof/index.cfm?action=homepage.

[118] European Regulated Professions Database, available at: http://ec.europa.eu/growth/tools-databases/regprof/

[119] Information obtained from stakeholder consultations (competent authority for doctors, *Hesse*), February 2019.

[120] ibid.

[121] ibid.

[122] ibid.

Another stakeholder commented with respect to nurses and carers in *Hesse*, that so far only two requests for temporary service provision had been made[123].

KEY FINDINGS

- Difficulties arise from the different conceptualisation of the term 'temporary'.
- Language skills can be another challenge, where issues may be caught too late in the case of workers staying only for a short period.
- Good preparation is key to making temporary provision of services a success.
- The temporary services regime has been used **only moderately** in Germany so far. Due to missing data, no conclusions can yet be drawn regarding the impact of the PQD amendments on the use of this regime.

2.4. IMI-SYSTEM: exchange of information and the Alert Mechanism

The IMI system is frequently used in Germany, with 879 requests concerning the PQD being sent by Germany in 2017 for all professions – the second highest number for that year after the UK[124]. In terms of receiving requests, Germany received 776 requests related to professional qualifications through the IMI system in 2017. This is a relatively high number, with only three other Member States receiving more requests (Spain 1100; Poland 1503; Romania 1451)[125]. The Single Market Scoreboard shows that Germany has been relatively fast in answering requests, with an average of nine days in 2017, and that Germany has improved in its performance using the IMI-system in 2017[126]. Its performance in this area is now considered to be very good[127].

According to the national stakeholders consulted, the IMI system is considered to be one of **the success stories of the European wide recognition system**[128]. It is judged to be a **real breakthrough** and said that it substantially facilitates the exchange of information[129]. The system is considered to be of great assistance to national authorities[130]. In terms of problems, one issue that was mentioned is the number of pre-prepared questions one has to go through before having the opportunity to write a free question[131]. The user interface is considered to be somewhat complicated and difficult to grasp for someone who is new or uses the system only sporadically[132]. There is a lack of training being provided for those who actually use the system, or if these trainings exist, this is not communicated effectively[133]. **More training units for the IMI-system could help to ensure that the system works smoothly and is used by all relevant authorities**.

123 Information obtained from stakeholder consultations (competent authority for nurses and carers, *Hesse*), February 2019.

124 Single Market Scoreboard, available at http://ec.europa.eu/internal_market/imi-net/_docs/statistics/2017/12/imi-requests.pdf.

125 ibid.

126 Single Market Scoreboard, available at: http://ec.europa.eu/internal_market/scoreboard/performance_by_member_state/germany/index_en.htm#maincontentSec4.

127 ibid.

128 Information obtained from stakeholder consultation, competent authority for doctors (*Bundesärztekammer*), *Hesse*, February 2019.

129 Information obtained from stakeholder consultation; competent authority for doctors, (*Bundesärztekammer*), *Hesse*, February 2019.

130 Information obtained from stakeholder consultation, competent authority for doctors, (*Bundesärztekammer*), *Hesse*, February 2019.

131 ibid.

132 Information obtained from stakeholder consultations (competent authority for doctors, *Hesse*), February 2019.

133 ibid.

Moreover, one stakeholder stated that where users enter a free question, it is not translated well, and so it is difficult to get the message across about what exactly one is looking for to the corresponding person in the other EU country[134]. What would be helpful is a way of contacting people directly in such cases[135]. Another issue, which is more relevant for the national level rather than the EU level, is that to begin with, professional associations and chambers had to work hard to be included in the system[136]. **If all authorities working on recognition procedures are not included in the system, it loses its value**[137].

A similar comment was also made in relation to physiotherapists, where the main professional association suggested that while the introduction of the IMI-system has modernised cross-border administrative cooperation, the system relies on the use of public authorities[138]. The **system is therefore only useful if all authorities are using it**. Doubts were expressed about whether this is the case, at least as concerns authorities relevant for the recognition of physiotherapists in Germany, mainly because the length of recognition procedures seems to suggest otherwise[139].

With respect to the alert mechanism, although the idea behind the alert mechanism is generally considered to be good, the main issue that was identified by several stakeholders is that Member States have differing practices when it comes to alerts (e.g. the UK issuing 14,653 between 2016 and 2017, compared to 143 alerts from Germany in the same period). Practice offers differs, in the case of doctors, as regards the kinds of behaviours that result in the revocation of a doctor's licence to practise[140]. Some Member States issue a great number of alerts per year, for example because they include the surrender of a licence at the end of a doctor's career, whereas other Member States may issue very few alerts[141]. Another factor is the type of behaviour that is punished with the revocation of a licence in some countries but not in others[142]. In Germany, this is considered a last step that is considered quite extreme, whereas in other countries this may happen more regularly[143].

One stakeholder commented that because there is such a **flood of alerts**, it is impossible to have any oversight over them, so usually this is dealt with by checking applicants' names against the alerts by means of a search function, which may lead, however, to alerts on a person being missed, either because there are too many alerts to go through or because the spelling of the name differs and the search is therefore inaccurate[144]. In case of a breach of professional duties by persons carrying out certain professions (such as doctors, lawyers, dentists, veterinarians, pharmacists, psychotherapists, architects and engineers), including any breaches in connection with the recognition of qualifications, the **professional court** (*Berufsgericht*) is responsible for hearing these cases and making a decision - provided that the matter does not fall under the criminal legal system. Otherwise, state authorities may also enforce fees independently, as provided for by the administrative enforcement law, and general

134 Information obtained from stakeholder consultation (*Bundesärztekammer*), February 2019.

135 ibid.

136 ibid.

137 Information obtained from stakeholder consultation (*Bundesärztekammer*), February 2019.

138 Information obtained from stakeholder consultation (*Physio-Deutschland*), February 2019.

139 ibid.

140 Information obtained from stakeholder consultation (*Bundesärztekammer*; competent authority for doctors, *Hesse*), February 2019.

141 Information obtained from stakeholder consultation (*Bundesärztekammer*), February 2019.

142 ibid.

143 ibid.

144 European Commission Website, available at: https://ec.europa.eu/docsroom/documents/28671/attachments/2/translations/en/renditions/native.

administrative law applies[145].

With respect to doctors, one stakeholder explained that where the alert mechanism has been utilised by another Member State and a doctor has been flagged, German authorities carefully analyse the reasons for the alert before deciding what to do, as sometimes alerts are issued on the basis of someone's age or other reasons that may not be sufficient reason to deny a licence in Germany[146].

In some cases, it is decided that a licence cannot be granted and whenever necessary, the chambers are notified[147].

KEY FINDINGS

- The IMI-system is generally a success and is being used in Germany.
- To ensure optimal functioning of the IMI-system, it is important that all relevant authorities use the system, and that training for users is readily available.
- The interface could be further simplified and it is important that the translation of the 'free questions' is of a high standard.
- As regards the alert mechanism, it might be useful to draw up some common guidelines on when the alert mechanism should be used, to ensure a more homogenous application of the system throughout the EU.

2.5. Sectoral amendments

No information has been identified on the impacts or related issues of the sectoral amendments in relation to the minimum training requirements and language rules on the recognition of qualifications for health professions.

[145] Professional Qualifications Assessment Act, § 16.

[146] Information obtained from stakeholder consultations (competent authority for doctors, *Hesse*), February 2019.

[147] ibid.

3. TRENDS IN RECOGNITION OF QUALIFICATIONS AND MOBILITY IN THE HEALTH SECTOR

3.1. Germany as a host country

Germany has become the most important destination country of EU movers of working age over the past decade. The annual inflows of citizens of other Member States into Germany doubled between 2009 (105,000) and 2016 (321,000). While Germany was still in third place in terms of absolute numbers of inflows in 2009 (after the UK and Italy), it had moved to first place by 2016[148]. In comparison to the size of its population, Germany has a rather moderate number of working EU movers, with the largest nationalities represented in 2016 being the Polish (0.9 % of the total population), Italians (0.7 %) and Romanians (0.5 %)[149]. The top three occupations among migrant workers from EU countries in Germany in 2016 were professionals, craft and related trades workers and service workers and market sales workers[150]. Interestingly, only the latter category presented a labour shortage. Most medium to high skilled EU-28 workers in Germany in 2016 were employed in manufacturing or wholesale and retail trade, while health-related professions came in in third place, reflecting a general shortage of labour across the health sector[151].

The total numbers of recognition decisions for establishment (across all professions) also showed an increase between 2008 and 2016 – but numbers were already very high in 2011 (around 9,000), then seem to have dropped and then increased to the same level in 2016 (around 9,000). Health professionals make up a large part of the recognition decisions and rank at the top among all professions. In recent years, they have become even more significant than before. During the period 2015 to 2017, 47 % of all recognition decisions for establishment were for nurses and 22 % for doctors of medicine. Other big professional groups were engineers (6 %) and secondary school teachers (4 %). On the other hand, in the period 2008-2012, secondary school teachers made up a much larger group (32 %), although doctors of medicine still ranked in first place (33 %) and nurses made up 10 % and physiotherapists 5 % of all recognition decisions[152].

Teaching professionals and personal care workers were identified as occupations where there are shortages through Labour Force Survey indicators, meaning that there is a high ratio of new hires to employed persons and that there is an indicated lack of labour force in this occupation. Furthermore, in 2016, public employment services did report shortages for medical doctors and associate professionals in the health sector in (medical and pharmaceutical technicians, nursing and midwifery associate professionals and other health associate professionals)[153].

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148 Eurostat Immigration Data [migr_imm1ctz]

149 European Commission (2018), 'Study on the movement of skilled labour (Final report)', Annex 3 – Case Study: Germany, p. 159.

150 ibid.

151 ibid.

152 DG Grow, Regulated professions database, Overall Statistics for persons moving abroad (establishment).

153 European Commission (2017), 'Bottleneck occupations 2016. A comparison of shortage and surplus occupations based on analyses of data from the European Public Employment Services and Labour Force Surveys', prepared by John McGrath and Jasmina Behan: https://publications.europa.eu/en/publication-detail/-/publication/28a5c10c-48fc-11e8-be1d-01aa75ed71a1/language-en.

These shortages and resulting labour demand are among the pull factors that make Germany the most important country of destination for health professionals[154] and associate health professionals[155] from other EU countries – 31 % of mobile health (associate) professionals across the EU resided in Germany in 2016. Germany is also the third largest destination country of mobile personal care workers[156] (after Italy and the UK), hosting 8 % of them in 2016[157]. As in other professions, the number of EU movers working in Germany as health (associate) professionals or as personal care workers has increased significantly in recent years – between 2012 and 2017 the figures almost doubled[158].

The principal **countries of origin** of mobile health (associate) professionals in 2016 were Poland, Croatia, Italy and Romania[159], and the main country of origin of mobile personal care workers was by far Poland[160]. Data on doctors trained in another EU Member State, however, show that in 2015 the most important countries of training were Romania, Greece and Austria[161]. While Greece and Austria have remained important countries of origin for foreign-trained doctors working in Germany[162], more recently, Romania has become the most represented country, with the number of doctors trained in Romania working in Germany increasing sevenfold between 2005 and 2015[163]. In the nursing and care professions (including physiotherapy), data from *Hesse* shows that since 2014, the majority of people from the EU applying for recognition in this particular *Bundesland* came from Romania[164].

Looking at **developments over time** shows that some events seemed to have influenced mobility in the past:

Data on doctors trained in another EU country allows us to look further back in time and shows that their numbers increased constantly between 2000 and 2016[165]. This data shows the strong impact of the Eastern enlargement in 2004, which marked the strongest year-on-year increase in annual inflows (+114 % on 2003) of that whole period[166]. Furthermore, the total opening of the labour market to EU-8 citizens in 2011 seems to have also played a role, since annual inflows also increased significantly in 2010 (+33 %) and 2011 (+34 %). The opening of the labour market to EU-2 citizens in 2014 might have further affected inflows of health professionals. Data on health (associate) professionals of another EU nationality show, compared to other years in the period 2013-2017 particularly strong increases in 2015 for specialist medical practitioners (+40 %), nurses/midwives (+23 %) and personal care workers (+41 %), and in 2016 for generalist medical practitioners (+37 %)[167]. Stakeholders confirmed that especially inflows of nurses from the new Member States have increased in recent years[168]. General trends of inflows from Romania and Bulgaria as well as Poland and other EU-8 Member States (SI, SK, CZ, LT) to Germany clearly show much stronger increases in 2011 and 2014 compared to other years, respectively – the two years when Germany opened its labour market completely to EU-2 and EU-8 citizens[169].

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[154] Measured in the Labour Force Survey according to ISCO-2D code 220; this includes: medical doctors, nursing and midwifery professionals, traditional and complementary medicine professionals, paramedical practitioners, veterinarians, other health professionals.

[155] Measured in the Labour Force Survey ISCO-2D code 320; this includes: medical and pharmaceutical technicians, nursing and midwifery associate professionals, traditional and complementary medicine associate professionals, veterinary technicians and assistants, other health associate professionals.

[156] ISCO-3D code 532: Personal care workers in health services provide personal care and assistance with mobility and activities of daily living to patients and elderly, convalescent and disabled people in health care and residential settings.

[157] European Commission (2018), 2017 Annual Report on intra-EU labour mobility, chapter 2.4.2, prepared by Fries-Tersch, E., Tugran, T., Rossi, L. , Figure 46.

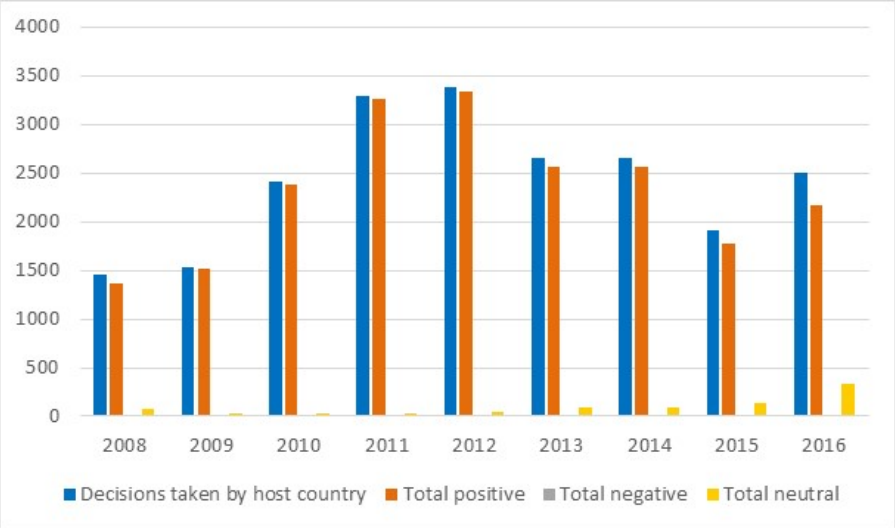
[158] EU-LFS 2018, data provided by Eurostat.

[159] European Commission (2018), 2017 Annual Report on intra-EU labour mobility, chapter 2.4.2, prepared by Fries-Tersch, E., Tugran, T., Rossi, L. , Figure 51.

[160] ibid., Figure 52.

The general trend in the number of **decisions on recognition of qualifications** taken by Germany on recognition of doctors' qualifications from other EU Member States shows growth to a peak in 2012, followed by decline to 2015 (Figure 4 below)[170]. The latest figures from 2016 show an uptick[171]. Given that the share of positive decisions has, with one exception, remained above 90 %, the number of positive decisions follows the trend of the number of decisions as a whole. The exception is in the latest figures from 2016, when the share of positive decisions dropped to 87 %, still higher than the Netherlands in the same year (76 %)[172]. At the start of the period, the vast majority of positive decisions were based on the automatic sectoral professions system (96-100 %)[173]. For the final two years of the period, this had fallen to approximately half of positive decisions; the other half was based on the automatic general system[174].

Figure 4: Decisions taken by Germany on doctors in basic medicine



Source: DG GROW, Regulated Professions Database, Overall Statistics for Professionals moving abroad (establishment). (extracted in January 2019)
Data for 2010, 2013 and 2014 estimated.

161 Information obtained from stakeholder consultation (*Bundesärztekammer*), February 2019.

162 OECD statistics on health workforce migration, available at: https://stats.oecd.org/Index.aspx?DataSetCode=HEALTH_WFMI (extracted in January 2019).

163 ibid.

164 Information obtained from stakeholder consultations (competent authority for nurses and carers, *Hesse*), February 2019.

165 OECD statistics on health workforce migration, available at: https://stats.oecd.org/Index.aspx?DataSetCode=HEALTH_WFMI (extracted in January 2019).

166 OECD statistics on health workforce migration, available at: https://stats.oecd.org/Index.aspx?DataSetCode=HEALTH_WFMI (extracted in January 2019).

167 EU Labour Force Survey 2017, available at: https://ec.europa.eu/eurostat/web/microdata/european-union-labour-force-survey.

168 Information obtained in stakeholder consultation (academic consultation), February 2019. The interviewee stated that the number of migrants from the new Member States was particularly high.

169 European Commission (2017), 2016 Annual Report on intra-EU Labour Mobility, prepared by Fries-Tersch, E., Tugran, T. and Bradley, H., p. 88.

170 Regulated professions database, available at: http://ec.europa.eu/growth/tools-databases/regprof/index.cfm?action=homepage.

171 It should be noted that figures for 2010, 2013 and 2014 were not available and so have been estimated by calculating an average of the adjacent years, where data was available.

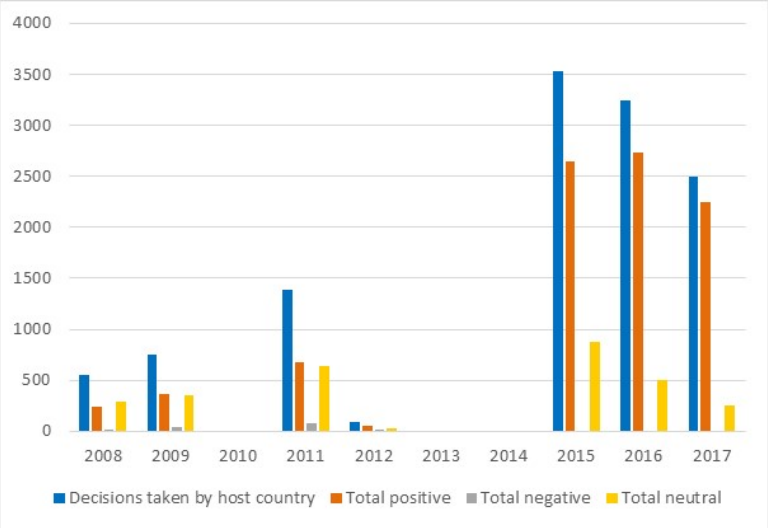
172 Regulated professions database, available at: http://ec.europa.eu/growth/tools-databases/regprof/index.cfm?action=homepage.

173 ibid.

174 ibid.

With regard to general care nurses, whilst data is missing for 2010, 2013 and 2014, the number of decisions increased dramatically between the start of the period in 2008 to its peak in 2015 (Figure 5 below)[175]. The latest figures show that the number of decisions decreased compared to the peak in 2015[176]. The percentage of positive decisions has increased over time, from 44 % at the start of the period to 90 % in 2017[177]. Throughout the period, nearly all positive decisions were taken under the automatic sectoral system[178]. Germany has most often used the automatic sectoral system of recognition for positive decisions. This went from four in ten positive decisions in 2008 to six in ten positive decisions in 2017. Over this period, it has also used the automatic general system and the aptitude test and the adaptation period[179].

Figure 5: Decisions taken by Germany on general care nurses



Source: DG GROW, Regulated Professions Database, Overall Statistics for Professionals moving abroad (establishment). (extracted in January 2019)
Data for 2010, 2013 and 2014 unavailable.

Data for physiotherapists from other EU countries in Germany is only available from 2008 to 2012, and none was available for 2010. The limited data available shows that for physiotherapists, the share of positive decisions hovered at around 60 % (from 56 % to 64 %) (Figure 6, below). Few negative decisions were made, but the share of neutral decisions was high compared to other professions. They were mostly due to a longer time being taken to take a decision. Other cases were delayed due to the physiotherapist undergoing an adaptation period[180].

[175] Regulated professions database, available at: http://ec.europa.eu/growth/tools-databases/regprof/index.cfm?action=homepage.

[176] ibid.

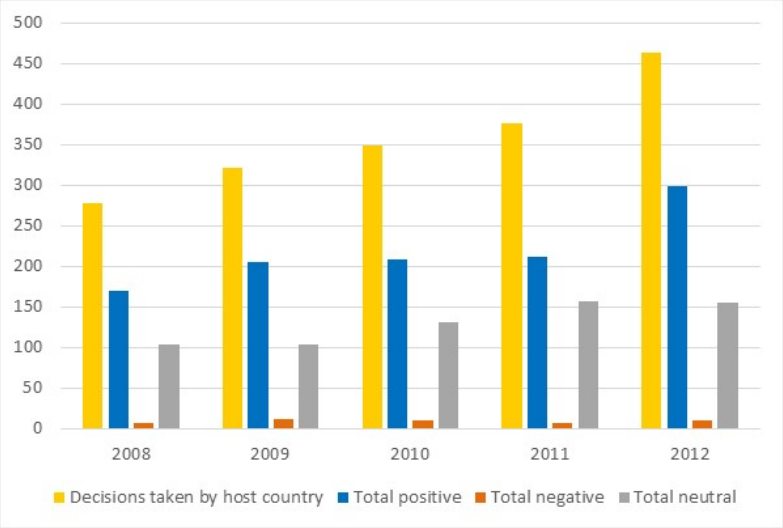
[177] ibid.

[178] ibid.

[179] ibid.

[180] Regulated professions database, available at: http://ec.europa.eu/growth/tools-databases/regprof/index.cfm?action=homepage.

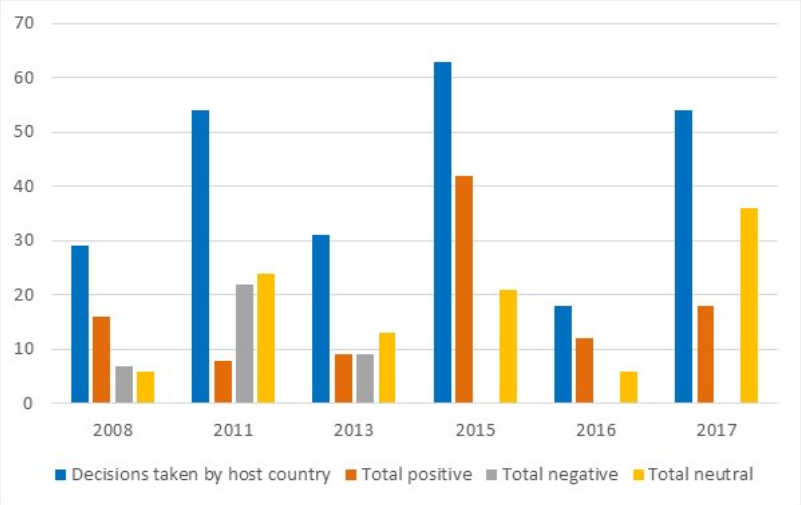
Figure 6: Decisions taken by Germany on physiotherapists



Source: DG GROW, Regulated Professions Database, Overall Statistics for Professionals moving abroad (establishment). (extracted in February 2019)
Figures for 2010 are estimated, as no data was available. No data was available after 2012.

Numbers on decisions on long-term care workers [181] are available for the specifically regulated profession of carers for the elderly, but figures are low. With only 60 decisions, 2015 marked a peak (Figure 7, below)[182]. The share of positive decisions has varied significantly: in 2015 and 2016 it was 67 %, whereas in 2017 this dropped to 33 %. It is not clear what the reason for the dip after 2015 is. The share of neutral decisions in 2017 was 66 % with all of those cases still being examined, suggesting that the waiting time for decisions was particularly long in 2017[183].

Figure 7: Decisions taken by Germany on long-term care workers (carers for the elderly)



Source: DG GROW, Regulated Professions Database, Overall Statistics for Professionals moving abroad (establishment). (extracted in January 2019)
No data was available for 2009, 2010, 2012 and 2014.

[181] This only concerns the specifically regulated profession of carers for the elderly in Germany.

[182] Regulated professions database, available at http://ec.europa.eu/growth/tools-databases/regprof/index.cfm?action=homepage.

[183] ibid.

The increase in EU-migrant health professionals in Germany corresponds to the emerging shortage of health professionals, with the lack of carers for the elderly coupled with high old-age dependency (31 %) being considered a significant problem[184]. The change in the demographics of the German population leading to a higher demand for healthcare is considered to be one reason for this shortage[185]. The general shortage of doctors is moreover considered to be due to the costs of the studies, a higher demand for health services due to the ageing of the population, as well as a change in lifestyle among doctors, who now also insist on work-life balance[186]. This has also been influenced by the change in German society over the last decades. In the past, women traditionally stayed at home and took care of the household and children. In line with changes in society, 70 % of doctors are now women, and the traditional gender roles where a doctor can work 60 to 80-hour weeks and his wife can keep the household and family going are becoming extinct[187]. Physiotherapists are also among the professions experiencing shortages[188], and there is a large personnel shortage in nursing. In particular, nursing care for the elderly is affected by the shortage of skilled workers in all federal states[189]. The rising need for health professionals is being addressed through various policy initiatives aiming to fill the gap of skilled workers in these sectors, for example by means of transnational cooperation projects such as the one that is in place between Germany and Poland, which concerns vocational and educational training for nurses that includes the development of curricula and the exchange of personnel and students[190].

3.2. Germany as a country of origin

With only 0.1 % of Germans between 15 and 64 years of age emigrating in 2015, it is clear that the emigration of skilled Germans is not a serious issue for Germany[191]. The main reasons for Germans emigrating to other countries are unemployment, with concrete job offers in another EU Member State, higher wages, and better working conditions[192]. For **doctors**, data shows that for the period 2008 to 2017, the UK was the most popular EU country of destination for doctors trained in Germany (see Figure 8, below). France follows, with Belgium the third most popular over the period[193].

[184] European Commission (2018), 'Study on the movement of skilled labour (Final report)', Annex 3 – Case Study: Germany, p. 169.

[185] ibid.

[186] Information obtained from stakeholder consultation (*Bundesärztekammer*), February 2019. Note that another stakeholder, commented that the shortage of doctors in Germany is not the subject of general consensus, with some considering it to be an issue of distribution rather than a proper shortage. Accordingly, while there are far too few doctors in rural areas, some (metropolitan) areas even experience an surplus of doctors. Information obtained from stakeholder consultations (competent authority for doctors, *Hesse*), February 2019.

[187] Information obtained from stakeholder consultation (*Bundesärztekammer*), February 2019.

[188] Information obtained from stakeholder consultation (*Physio-Deutschland*), February 2019.

[189] Bundesagentur für Arbeit, Fachkräfteengpassanalyse, Dezember 2018, available at: https://statistik.arbeitsagentur.de/Navigation/Footer/Top-Produkte/Fachkraefteengpassanalyse-Nav.html. Information obtained from stakeholder consultation (academic consultation), February 2019.

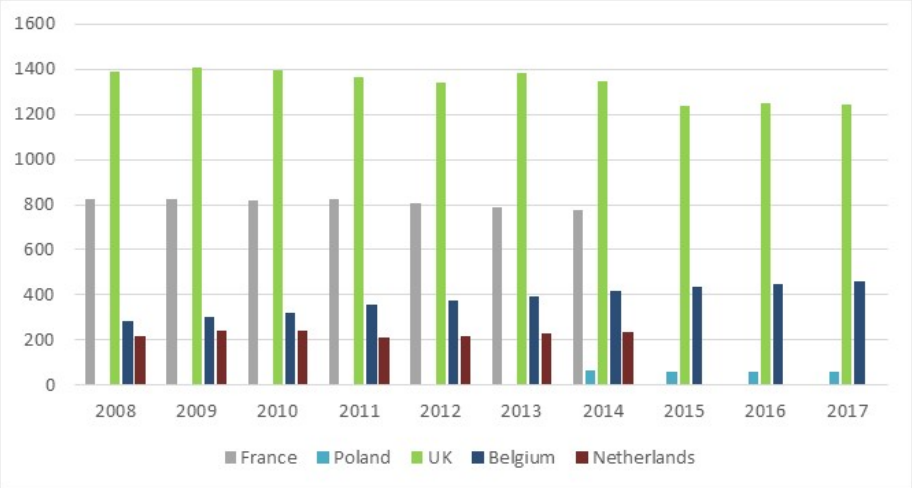
[190] European Commission (2018), 'Study on the movement of skilled labour (Final report)', Annex 3 – Case Study: Germany, p. 169.

[191] ibid , p. 161.

[192] ibid., p. 161.

[193] OECD statistics, available at: https://stats.oecd.org/Index.aspx?DataSetCode=HEALTH_WFMI (extracted in January 2019).

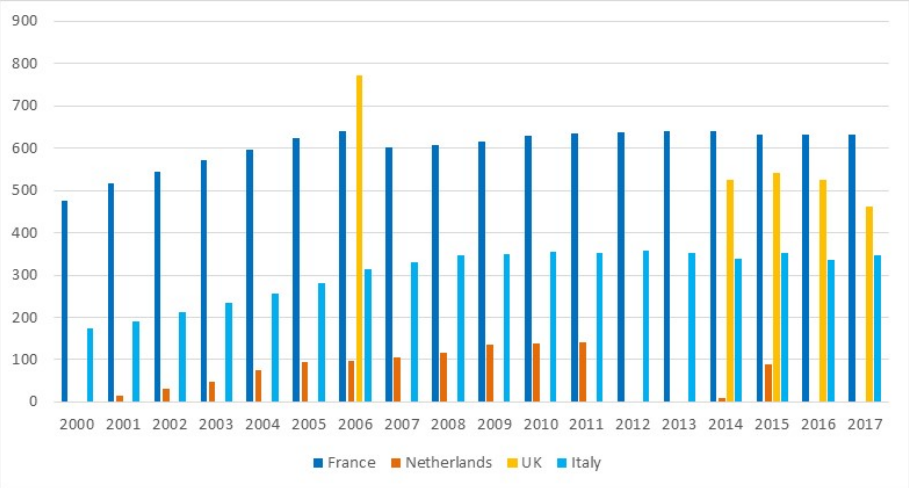
Figure 8: German-trained doctors by country of destination



Source: OECD statistics on health workforce migration, available at: https://stats.oecd.org/Index.aspx?DataSetCode=HEALTH_WFMI. (extracted in January 2019).

Over the period 2000 to 2017, the most popular country of destination for **nurses** trained in Germany has consistently been France, where numbers of German-trained nurses have been steady since the mid-2000s (see Figure 9, below)[194]. Numbers in Italy have also been steady during the same period, at a little over half of the figure in France. It appears that there are also significant numbers of German nurses in the UK: for the years where data is available, numbers are slightly lower than for France[195].

Figure 9: German-trained nurses by popular countries of destination, 2000-2017



Source: OECD statistics on health workforce migration, available at: https://stats.oecd.org/Index.aspx?DataSetCode=HEALTH_WFMI. (extracted in January 2019).
Data for the UK was only available for 2006 and 2014-2017. Data for the Netherlands was not available for 2012-2013 and 2016-2017.

[194] OECD statistics, available at: https://stats.oecd.org/Index.aspx?DataSetCode=HEALTH_WFMI (extracted in January 2019).

[195] ibid.

As regards the recognition of German qualifications in the health sector in other EU Member States, the total number of decisions taken by other EU Member States on **doctors** qualified in Germany has varied considerably during the period 2008 to 2017. There is a dip in 2011 in the number of decisions, before the number gradually builds again up to 2016. The rate of positive decisions remains high, although it has dropped gradually from 96 % in 2008 to 89 % in 2016. Most decisions are taken based on the automatic sectoral recognition regime[196].

For **general care nurses** qualified in Germany, the number of decisions in other EU Member States has remained fairly stable since 2011, at 300-400 decisions per year. This follows a significant drop from 2008, when over 1000 decisions were made. The share of positive decisions on these applications has remained above 95 % for the period 2008-2015, before dropping to 85 % in 2016. Nearly all positive decisions were made through the automatic sectoral professions' system or the automatic general system throughout the period[197].

The number of decisions in other EU Member States on **physiotherapists** qualified in Germany decreased from 2008 to 2012 and appears to have stabilised since then[198]. The exception is 2014, when the number of decisions almost doubled, before reducing again in 2015 to a level similar to 2013. The share of positive decisions has stayed at a high level throughout the period, only dropping below 90 % in 2010. Nearly all decisions are made using the automatic general system for recognition[199].

In total numbers, Germany is the fourth most popular country of origin of health (associate) professionals[200] working in another EU country, following Romania, Poland and Italy[201]. However, the numbers are low when compared to the total workforce of health (associate) professionals in Germany – they only make up 1 %, one of the lowest shares in the EU[202]. A similar observation can be made for personal care workers[203] with German qualifications: Germany is among the top six as sending country in total numbers, but the share from the overall workforce of personal care workers in Germany is low[204].

3.3. Potential impacts of the PQD on mobility of health professionals

With the German labour market being heavily formalised, the recognition of certificates can pose a substantial challenge for migrant workers, which can cause them to be forced into working in jobs for which they are overqualified[205]. As a response to this, and to the PQD, Germany adopted the Professional Qualifications Assessment Act, establishing the right to have one's qualifications assessed. The law aimed at ensuring that the potential of skilled migrant workers was used more effectively in Germany, to prevent overqualification of migrant workers, to attract foreign skilled workers and to promote their integration into the German labour market and society, by simplifying administrative processes and promoting automatic recognition[206]. The Act is considered to have improved the situation in the German labour market for skilled immigrants, as well as making it easier for businesses to identify suitable workers, thereby contributing to the closing of the skilled labour gap[207].

A simplified recognition procedure can positively influence mobility, as was determined by the 2017

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196 Regulated professions database, available at: http://ec.europa.eu/growth/tools-databases/regprof/index.cfm?action=homepage.

197 ibid.

198 Regulated professions database, available at: http://ec.europa.eu/growth/tools-databases/regprof/index.cfm?action=homepage.

199 ibid.

200 For definitions, see ISCO Codes 220 and 320, available at: http://www.ilo.org/public/english/bureau/stat/isco/.

201 European Commission (2018), 2017 Annual Report on intra-EU labour mobility, chapter 2.4.2, prepared by Fries-Tersch, E., Tugran, T., Rossi, L., Annex Table 60.

report of the BMBF, which concluded that according to its evaluations, the different recognition options were very well accepted[208]. Between 2012 and 2015, the number of applications for recognition almost doubled[209], corresponding to an increase in stocks of movers generally (chapter 3.1). The numbers for applications in the health sector are particularly high, in particular with respect to those professions where recognition is possible through the automatic system (doctors and nurses), which together account for 60 % of all applications[210]. According to the BMBF's evaluation, recognition is shown to be an advantage for integration into the German labour market[211]. This understanding was echoed by one stakeholder, who considered recognition to be by far the most important criterion in comparison to other issues affecting labour mobility[212].

As regards overqualification, doctors with foreign qualifications do not usually work below their qualifications in Germany[213].

If one looks at the figures for foreign nursing staff from the new EU Member States in occupations of nursing care for the elderly that are subject to social insurance contributions, it can be seen that they primarily work in the low-skilled segment ("helpers" instead of "specialists in nursing care for the elderly"), since they have no nursing training, or at least none that is recognised in Germany[214]. In addition, migrant nursing staff (above all from the new EU Member States) are often employed in Germany as contract workers or as part of the secondment of nursing staff from foreign companies[215]. It is, however, difficult to assess whether migrants who work as unskilled workers (helpers) do so because they have difficulties getting their qualifications recognised[216].

3.4. Potential impact of mobility on labour supply in the health sector

As EU workers benefit from free movement in the EU, larger scale policy initiatives in Germany are more commonly addressed to non-EU migrants, although for health professions, such initiatives do exist (e.g. the Germany-Poland VET programme for nurses mentioned above)[217]. However, initiatives aimed broadly at all skilled-labour migrants frequently also benefit EU-nationals (for example the IQ-initiative[218] mentioned previously, or the 'Make it in Germany' programme[219], both of which are

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202 ibid, Figure 56.

203 For definitions, see ISCO Code 530, available at: http://www.ilo.org/public/english/bureau/stat/isco/.

204 EU Labour Force Survey 2017, available at: https://ec.europa.eu/eurostat/web/microdata/european-union-labour-force-survey.

205 European Commission (2018), 'Study on the movement of skilled labour (Final report)', Annex 3 – Case Study: Germany, p. 173.

206 ibid.

207 ibid.

208 Bericht zum Anerkennungsgesetz 2017, p. 43, available at https://www.bmbf.de/pub/Bericht_zum_Anerkennungsgesetz_2017.pdf, p. 35.

209 ibid.

210 ibid.

211 ibid.

212 Information obtained in stakeholder consultation (Point of single contact for *Baden-Württemberg*), February 2019.

213 Information obtained in stakeholder consultation (*Bundesärztekammer*), February 2019.

214 Information obtained in stakeholder consultation (academic consultation), February 2019. More concrete information on the types of qualifications these workers have could not be found at this stage.

215 Information obtained in stakeholder consultation (academic consult), February 2019.

216 Information obtained in stakeholder consultation (academic consult), February 2019.

217 European Commission (2018), 'Study on the movement of skilled labour (Final report)', Annex 3 – Case Study: Germany, p. 172.

218 IQ Network Integration through qualification (Netzwerk Integration durch Qualizierung), http://www.netzwerk-iq.de/ (accessed 29 March 2019).

219 German Federal Government *(Die Bundesregierung),* Portal of the Federal Government for Professionals from Abroad *(Das Portal der Bundesregierung für Fachkräfte aus dem Ausland)*, http://www.make-it-in-germany.com/ (accessed 29 March 2019).

targeted at skilled migrants)[220]. These and other initiatives have been introduced to address skilled labour shortages across the professions, and to add to the 'welcoming culture' (*Willkommenskultur*) that is being promoted to attract and retain foreign skilled workers, students and entrepreneurs[221].

In spite of simplified occupational mobility within the EU, the highest number of applications for recognition of qualifications in the field of care (2014) come from people who have not completed their training in the EU but in third countries[222]. This is related to the "Triple Win" programme for recruiting foreign nursing staff run by the International Placement Services (*Zentrale Auslands - und Fachvermittlung* - ZAV), the Federal Employment Agency (*Bundesagentur für Arbeit*) and the German Association for International Cooperation (*Deutschen Gesellschaft für Internationale Zusammenarbeit* - GIZ)[223]. Since the start of the programme in 2013, more than 2,000 nursing professionals from Serbia, Bosnia and Herzegovina, the Philippines and Tunisia have been placed at clinics and nursing facilities in Germany[224]. One reason for the higher emphasis on non-EU migrants can be glimpsed from the federal government's comments on its recently introduced draft of an Immigration of Skilled Workers Act[225]. This Act intends, among other things, to speed up the recognition procedures by shortening processing times and changing the form requirements with regard to the documents to be submitted, and is once again aimed at non-EU professionals. In the introduction chapter, the problems at hand and objectives of the law are explained, and it is specifically stated that although German and EU-workers are the primary sources through which the gaps in the labour market should be closed, it is anticipated that EU-internal labour migration will not be sufficient to fill German labour shortages in the long run[226].

The assumption that EU movers alone are unlikely to fill the labour shortage in the health sector is also shown by concrete data, for example, on 'personal care workers'[227]. This occupation has been identified as an occupation with a shortage in Germany. Furthermore, the share of unemployed to new hires is quite low, indicating that there is an absolute shortage of labour force in these occupations. Additionally, the share of movers in these occupations is also lower than the average share of movers across all occupations. This indicates that although mobility has been increasing, it cannot quite compensate for the demand for personal care workers[228]. This and other reports of shortages (see chapter 2.1) in the health sector show that although mobility of health professionals to Germany has been increasing, it cannot meet the entire demand.

KEY FINDINGS

- Germany is the most popular destination country of EU movers, but viewed in terms of its size, their share out of the total population is small.
- Most medium to high skilled EU-28 workers in Germany in 2016 were employed in manufacturing or wholesale and retail trade, while health-related professions came in

220 European Commission (2018), 'Study on the movement of skilled labour (Final report)', Annex 3 – Case Study: Germany, p. 172.

221 ibid.

222 Information obtained from stakeholder consultation (academic consult), February 2019.

223 ibid.

224 ibid.

225 Available at: https://www.bmi.bund.de/SharedDocs/gesetzgebungsverfahren/DE/fachkraefteeinwanderung.html.

226 Draft Immigration of skilled workers Act (as at 26 November 2018), available at: https://www.bmi.bund.de/SharedDocs/gesetzgebungsverfahren/DE/fachkraefteeinwanderung.html.

227 The data refers to personal care workers in the health sector and other sectors (ISCO 2D level).

228 European Commission (2019), 2018 Annual Report on intra-EU labour mobility, p.104, prepared by Fries-Tersch, E., Tugran, T., Jones, M, Markowska, A.

third place, reflecting a general shortage of labour across the health sector.

- Germany is the most popular country of destination for health professionals and associate health professionals from other EU countries – 31 % of mobile health (associate) professionals across the EU resided in Germany in 2016.
- The most common countries of origin of mobile medical doctors, physiotherapists and nurses and midwives in Germany are Poland, Croatia, Italy and Romania.
- The number of doctors with another EU citizenship working in Germany strongly increased between 2012 and 2017, from around 15,000 in 2012 to 23,000 in 2017.
- Comparably strong increases can also be seen with regard to nurses and midwives (38,000 in 2012 to 58,000 in 2017) and physiotherapists (6,000 in 2016 to 7,000 in 2017).
- The general trend in the number of decisions taken by Germany on recognition of doctors' qualifications from other EU Member States shows growth to a peak in 2012, followed by decline to 2015, with the number of positive decisions following this trend.
- For general care nurses, the number of decisions increased dramatically between the start of the period in 2008 to its peak in 2015, with the percentage of positive decisions increasing over time, from 44 % at the start of the period to 90 %.
- The limited data available shows that for the profession of physiotherapist, the share of positive decisions hovered at around 60 %.
- For long-term care workers, the number of long-term care workers in Germany trained in other EU countries is quite low, with only 60 decisions made in the peak year of 2015.
- The number of EU-migrant health professionals in Germany is in line with the emerging shortage of health professionals.
- Emigration is not a problem in Germany, with only 0.1 % of Germans of working age emigrating in 2015.
- The UK is the biggest host country for German doctors who emigrate, while France is the preferred destination for nurses.
- Recognition rates for doctors with German qualifications in other EU countries have remained high between 2008 and 2016, although positive decision rates have dropped from 96 % in 2008 to 89 % in 2016.
- Recognition rates for general care nurses with German qualifications in other EU countries have remained stable since 2011, while positive decisions stayed at 95 % between 2008 and 2015, but dropped to 85 % in 2016.
- The introduction of the Professional Qualifications Assessment Act (BQFG) has improved the situation for skilled immigrants in Germany. Mobility appears to have been influenced by the simplification of the recognition procedure, with recognition numbers almost doubling since 2012.
- Overqualification is not considered an issue with respect to doctors, but with respect to general care nurses, especially for the elderly, foreign workers often work in low-skilled jobs.

- Initiatives have been put in place in Germany to attract skilled foreign workers. These are often aimed at third country nationals, but EU-migrants also benefit from many of them.
- The largest number of applications for recognition comes from non-EU workers, despite simplified recognition procedures for EU nationals. This is due to the fact that it is believed that EU workers alone cannot fill the labour shortages in the sector and therefore recruitment policies for third country nationals have been put in place (see point above).

LIST OF STAKEHOLDERS CONSULTED

Table 1: Stakeholders consulted for the case study on Germany

	Stakeholder	Category
Federal Level	Bundesärztekammmer	Professional organisation (doctors)
Federal Level	Deutscher Verband für Physiotherapie	Professional organisation (physiotherapists)
Federal Level	Academic	Academic (research in transnational service provision in long-term care between Western and Eastern Europe)
Federal Level	Academic	Academic (research on mobility in the health sector)
Baden-Württemberg (state level)	Service Portal	Point of Single Contact
Hessen (state level)	Hessisches Landesprüfungs- und Untersuchungsamt im Gesundheitswesen	Competent Authority (doctors)
Hessen (state level)	Regierungspräsidium Darmstadt	Competent Authority (nurses and carers, physiotherapists and carers for the elderly)

This study analyses the impact on labour mobility and employment of the 2013 revision of the Professional Qualifications Directive (DIR 2005/36) and related EU initiatives. It analyses trends in mobility and recognition, focussing on the health sector and four country case studies - Germany, Italy, the Netherlands and Romania. It reports findings from consultations with stakeholders at EU and national level and highlights best practice.
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