STUDY

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European Parliament

Labour mobility and recognition in the regulated professions

Annex C - IV

The Netherlands: case study

Policy Department for Economic, Scientific and Quality of Life Policies
Directorate-General for Internal Policies
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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)
CEFR	Common European Framework of Reference for Languages
CBGV	Commission for Foreign Healthcare Graduates (*Commissie buitenslands gediplomeerden volksgezondheid*)
CIBG	Central Point of Information Healthcare Professions
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
IAK	Integral Assessment Framework (*Integraal Afwegingskader*)
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
KNMG	Royal Dutch Medical Association (*Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst*)
Mobility	This term refers to migration of EU-28 citizens within the EU
NAP	National Action Plan
NUFFIC	Dutch organisation for internationalisation in education

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)
PQL	General Act on the Recognition of EU Professional Qualifications (*Algemene wet erkenning EU-beroepskwalificaties)*
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 - IV

THE NETHERLANDS: CASE STUDY

The Netherlands

Authors: Nienke Van Der Burgt with the support of Lorenz Adriaenssens
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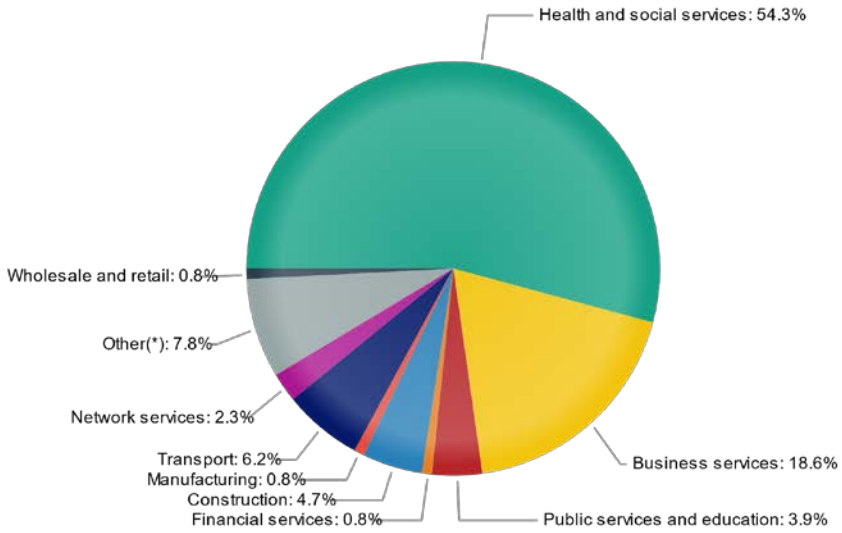
1. GENERAL NATIONAL CONTEXT FOR THE RECOGNITION OF PROFESSIONAL QUALIFICATIONS

1.1. General approach to Occupational Regulation

In March 2019, the Netherlands regulated **129 professions**[1], which is fewer **than in 2016**, when it regulated **147 professions**, covering **25 %** of the labour force (above the EU average of 21 %).

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



The Dutch **approach** towards occupational regulation is **liberal**[3]. As stated in the **National Regulated Professions Action Plan** (NAP): 'In the past the Netherlands has strived to **impose as few barriers as possible** to professionals to avoid setting up unnecessary barriers to entry'[4]. As a result of the 'European requirement, stipulated in the Professional Qualifications Directive, to screen, evaluate and modernise the requirements for regulated professions'[5] the Dutch Government has been **aiming to simplify** the requirements for regulated professionals and, where possible, abolish them. The Government's efforts towards this direction are described below in this document.

The healthcare sector is traditionally more regulated than others. This is due to public health considerations, which require the provision of high-quality services by qualified health professionals. In the Netherlands, the BIG Act (Act on Professions in Individual Healthcare)[6] provides a general legislative framework for the regulation and registration of health professions. The Ministry of Health,

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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#close. (accessed in February 2019).

2 ibid.

3 CEDEFOP, Working paper no 20: The role of qualifications in governing occupations and professions, (2013), Luxembourg, p. 48, available at: http://www.cedefop.europa.eu/files/6120_en.pdf.

4 National Regulated Professions Action Plan (NAP), p. 6, available at: http://ec.europa.eu/DocsRoom/documents/31943.

5 ibid, p. 1.

6 Act on Professions in Individual Healthcare (published in the official journal, Staatsblad 1993, 655), Wet op de beroepen in de individuele gezondheidszorg (BIG Act), available at: https://wetten.overheid.nl/BWBR0006251/2019-01-01.

Welfare and Sport, with the support of professional associations, however, are constantly working on the **modernisation** of the professional requirements in this sector. These efforts are described below.

The **competence** for occupational regulation, depending on the field and subject, is **spread across** different ministries and authorities[7]. Legislative measures are adopted specifically for each profession. Therefore, professional regulations are mainly laid down in the **specific sectoral legislation**.

In the **healthcare sector**, the Ministry of Health, Welfare and Sport is competent to establish professional regulations. This sector is mainly regulated by the **BIG Act** (Act on Professions in Individual Healthcare)[8].

The Netherlands has a deep-rooted culture of social dialogue which entails the **involvement of the professional stakeholders** in decision-making processes[9]. This is reflected in the fact that for certain aspects of professional regulation, the ministers responsible are **required** to involve the representative professional associations[10].

In the **healthcare sector**, the most important role of professional organisations is to contribute to the **definition and shaping of training requirements** for the health professions[11]. The BIG Act provides that consultation with the representative professional associations is required before a new regulation is enacted by the Minister[12]. This applies, for instance, to vocational training of medical specialists[13]. In addition to the consultation of the representative professional associations, other stakeholders, such as training institutes[14], are consulted on an ad hoc basis.

At the decision-making level, professional organisations also play an important role **in the shaping of the regulation of the profession**. For instance, when the Government issued the decree that gave a protected title to second level nurses (*verzorgende individuele gezondheidszorg*[15], the Government consulted the representatives of different organisations working in the field of nursing and care-work[16].

In principle, the registration of health professionals is done centrally by the Central Point of Information Healthcare Professions (CIBG) of the Ministry of Ministry of Health, Welfare and Sport, which manages the national register of professionals in the health sector (BIG register)[17]. However, the BIG Act allows for **competence for maintaining the register to be delegated to professional organisations**[18]. Such a delegation has taken place for general practice doctors, and the respective registry is maintained by the College of General Practice, Nursing Home Medicine and Medical Care for the People

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7 CEDEFOP, Working paper no 20: The role of qualifications in governing occupations and professions, (2013), Luxembourg, available at http://www.cedefop.europa.eu/files/6120_en.pdf, p. 46.

8 Act on Professions in Individual Healthcare (Wet op de beroepen in de individuele gezondheidszorg), published in the official journal, Staatsblad 1993, 655), BIG Act.

9 CEDEFOP, Working paper no 20: The role of qualifications in governing occupations and professions, (2013), Luxembourg, p. 9.

10 See for instance for the health professions, Article 91 BIG Act.

11 Information obtained in stakeholder consultation with the Royal Dutch Medical Association (KNMG), February 2019.

12 Article 91 in conjunction with Article 34 BIG Act.

13 NAP, p. 14.

14 Based on expert consultation with Dr. P.G.P. Herfs of the University of Utrecht, February 2019.

15 Decree on Careworker in Individual Healthcare (Besluit verzorgende in de individuele gezondheidszorg), published in the official journal, Staatsblad 1999, 463, Decree Careworker.

16 Explanatory note to the Decree on Careworker in the Individual Healthcare, published in the Official Journal, Staatsblad of 9 November 1999, Nota van Toelichting bij Besluit verzorgende in de individuele gezondheidszorg.

17 Explanatory note to the Decree on Careworker in the Individual Healthcare, published in the Official Journal, Staatsblad of 9 November 1999.

18 Article 14 BIG Act.

with Mental Disabilities[19]. Another example of delegation is that the Registration Commission of Medical Specialists (*Registratiecommissie Geneeskundig Specialisten*) of the Royal Dutch Medical Association (KNMG) maintains the register for the medical specialists[20].

Professional stakeholders are also involved in the process of recognition of foreign qualifications. Firstly, an expert commission, the Commission for Foreign Healthcare Graduates (CBGV) has been established which **advises the competent authority on the recognition and evaluation of foreign diplomas**[21]. The commission, composed of members of the relevant representative professional associations, gives specialist advice on whether foreign qualifications and diplomas could be considered as equivalent to the relevant Dutch qualifications or diplomas[22]. Secondly, for professions where the professional organisations are delegated to maintain the registration for certain specialists, the **professional organisation is also involved in the recognition process**[23]. For the medical specialists, this delegation results in a procedure in which both the **competent authority** and the KNMG are competent authorities for examining the qualifications of the applying practitioners[24].

Despite the above, **certain aspects regarding professional regulation are exercised directly and exclusively** by the Government. This is particularly the case in relation to the enforcement of rules regulating professional conducts, which is done by a disciplinary board established by the Minister[25].

- **Justification and proportionality of regulation**

The framework for examining the justification and proportionality of professional regulation is embedded in the Integral Assessment Framework (*Integraal Afwegingskader* – IAK)[26]. The IAK **was developed in 2007**[27] and includes a set of tools and an approach for analysing legislation or regulation, in order to improve the regulatory and legislative quality[28]. The IAK is topic-neutral in the legislative process. It is composed of both binding requirements on the quality of governance as well as non-binding guidelines[29]. Typical characteristics of the Dutch IAK are that it **aims to reduce regulatory pressure** and that it **requires an assessment of whether Government intervention is necessary**[30]. This second objective could be seen in the context of the efforts the Netherlands makes in general to limit the involvement of the Government in economic activities.

The approach of the IAK has to be applied for the assessment of the **need for and the proportionality of new or existing professional regulation**. In this context the assessment takes place in two steps. In the first step, there is an examination of whether Government intervention **can be justified**.

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19 CEDEFOP, Working paper no 20: The role of qualifications in governing occupations and professions, (2013), Luxembourg, p. 57.

20 Information obtained in stakeholder consultation with the Royal Dutch Medical Association (KNMG), February 2019.

21 Article 41 BIG Act; Article 1(1) Regulations for specialists in medicine (Regeling specialisten geneeskunst).

22 Based on expert consultation with Dr. P.G.P. Herfs of the University of Utrecht, February 2019.

23 Information obtained in stakeholder consultation with the Royal Dutch Medical Association (KNMG), February 2019.

24 H. Schneider, A. Hoogenboom, L. Kortese, *Grenseffectenrapportage 2016: Erkenning van beroepskwalificaties*, (2016), available at https://cris.maastrichtuniversity.nl/ws/files/5677853/dossier2_nl_erkenning_beroepskwalificaties.pdf, p. 14 and 18.

25 Articles 47 and following BIG Act.

26 NAP, p. 3.

27 See Kenniscentrum Wetgeving en Juridische zaken, *Wat is het beste instrument?*, (2019), available at: https://www.kcwj.nl/kennisbank/integraal-afwegingskader-beleid-en-regelgeving/6-wat-het-beste-instrument.

28 Parliamentary Documents II 2009-2010, 31731 nr. 6, available at: https://zoek.officielebekendmakingen.nl/kst-31731-6.html.

29 Parliamentary Documents II 2009-2010, 31731 nr. 6, available at: https://zoek.officielebekendmakingen.nl/kst-31731-6.html.

30 ibid.

Government intervention is appropriate if public interests are at stake[31]. For instance, this is the case for the protection of public health[32]. In the following step the **proportionality** of new professional regulations is examined on the basis of defined public interests. Here the question that must be answered is whether the development of new regulation is the appropriate means for protecting the interests at stake. **It could be that alternative instruments provide a solution as satisfactory as regulation**[33]. The analysis has to include questions on whether certain activity could have major consequences for customers and if the skills of the professional can be easily determined by the customer[34]. The proportionality assessment should also extend to the integral analysis of the legality, effectiveness, efficiency and feasibility of implementing different potential regulatory instruments[35]. **According to the NAP, the approach of the IAK will also be applied in the modernisation of existing professional regulation**[36].

Resulting from the mutual evaluation exercise, the Netherlands was required to evaluate the extent to which its national professional qualifications system was proportionate and justifiable. By means of reference to documents from the 1990s, the NAP makes it clear that efforts in the Netherlands to deregulate and reduce reserved activities have been long-standing[37].

Since 2016, the Netherlands has deregulated a total of 18 professions. The NAP acknowledges 'that currently the greater part of national professional regulation does not cause serious barriers to access'[38], but it notes that some modernisation might be necessary for certain professions.

In the **healthcare sector**, these modernisation efforts were led by the Ministry of Health, Welfare and Sport. These efforts have led to three main outcomes. First, the responsibilities for certain professions will be reconfigured[39], which will **reduce the restrictions caused by reserved activities**. For instance, as a result of this reconfiguration, general practitioners will be allowed to carry out more activities, widening the scope of activities that general practitioners can perform and thereby ensuring that fewer activities will become reserved only for specialist doctors[40]. As a second outcome, the NAP addresses the issue of reform of the education system. By reducing the length of courses and increasing mobility between specialisations, the Netherlands aims to enhance **competency-oriented education**[41]. The last outcome of the modernisation efforts is an examination of whether the adjustment of the regulation of reserved activities is necessary to provide faster and more flexible responses to professional and technological developments[42]. In this light it was concluded that it was **better to regulate reserved activities by means of general executive measures** (AMvB) instead of legislative acts[43].

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31 Kenniscentrum Wetgeving en Juridische zaken, *Integraal afwegingskader voor beleid en regelgeving*, (2019), available at: https://www.kcwj.nl/kennisbank/integraal-afwegingskader-voor-beleid-en-regelgeving (accessed March 2019): NAP, p. 3.

32 NAP, p. 3.

33 ibid.

34 ibid, p. 4.

35 Kenniscentrum Wetgeving en Juridische zaken, *Wat is het beste instrument?*, (2019).

36 NAP, p. 3.

37 ibid, p. 6.

38 ibid.

39 NAP, p. 6.

40 ibid.

41 ibid.

42 ibid.

43 Parliamentary Documents II 2009-2010, 31731 nr. 6, available at: https://zoek.officielebekendmakingen.nl/kst-31731-6.html; NAP, p. 6.

Whilst the NAP was adopted to implement the Professional Qualifications Directive and in particular Article 59(3) that requires Member States to complete the mutual evaluation of their professional requirements[44], the approach taken by the NAP for modernising the national regulatory framework is not new. As explained above, the IAK approach was already established in 2007. Therefore, it can be concluded that the Netherlands is building on existing approaches while modernising its regulatory framework, but without major changes to the approach.

1.2. Recognition of professional qualifications

In the Netherlands, the Professional Qualifications Directive has been transposed by a **general law and various sectoral laws**. The general law, which sets out general rules for the recognition of foreign qualifications, regardless of the profession and sector concerned, is the General Act on the Recognition of EU Professional Qualifications [45] (PQL). For the sectoral regulation and recognition of health professions, the main legislative instrument is the BIG Act.

For the recognition of foreign qualifications in the health professions a distinction is made between the professions that fall under the system of **automatic recognition**[46] and the professions that fall under the general system of recognition. In the case of automatic recognition, **a direct application for recognition serves also as registration with the professional register** (BIG register). The BIG Act requires certain healthcare professionals to register in the **BIG register** in addition to having the necessary qualifications and diploma. This applies to nine professions (i.e. medical doctor, dentist, pharmacist, healthcare psychologist, psychotherapist, physiotherapist, midwife, nurse and physician assistant)[47] and all professionals qualified in the Netherlands or abroad. In order to protect patients, the list of registered professionals is accessible to the public.

If the health professional does not benefit from the system of automatic recognition, the **general system** of recognition applies[48]. In this case, the foreign professional has first to apply for recognition and only afterwards for registration in the BIG register. In this procedure, together with the documents of proof, the applicant has to submit an **application form (in Dutch)**[49, 50]. This submission has to take place by post.

The recognition of the professional qualifications also constitutes proof of the **professional's language proficiency** in cases where, for instance, primary or secondary education has been obtained in the Netherlands[51]. In other cases, language proficiency certificates need to be submitted with the application to register with the BIG register (that is, after the qualification has been recognised). However, when qualifications are recognised automatically, registration takes place simultaneously,

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44 NAP, p. 9.

45 General Act on the Recognition of EU Professional Qualifications (Algemene wet erkenning EU-beroepskwalificaties), published in the official journal, Staatsblad 2007, 530, available at: https://wetten.overheid.nl/BWBR0023066/2018-09-19/#Hoofdstuk1.

46 Article 21 Directive 2005/36/EC transposed by Article 41(1), letter (a) BIG Act.

47 Article 3 BIG Act.

48 Article 41(1), letter (b) and 45 BIG Act.

49 Article 2(6) Registration Order BIG; See also "Aanvraagformulier verklaring van vakbekwaamheid / erkenning beroepskwalificaties", CIBG website, available at: https://www.bigregister.nl/buitenlands-diploma/documenten/formulieren/2017/03/03/aanvraagformulier-erkenning-beroepskwalificaties-en-verklaring-vakbekwaamheid. (last accessed February 2019).

50 "Recognition of your professional qualifications", CIBG website, available at: https://english.bigregister.nl/foreign-diploma/procedures/recognition-professional-qualifications. (last accessed February 2019).

51 ibid.

therefore, in these cases the certificate needs to be submitted together with the application for recognition / registration.

KEY FINDINGS

- In March 2019, the Netherlands regulated **129 professions**, which is fewer than in 2016, when it regulated 147 professions.
- The framework to examine the justification and proportionality of professional regulation is embedded in the **Integral Assessment Framework** (*Integraal Afwegingskader)*, developed in 2007.
- Due to the fact that the Netherlands builds on existing approaches while modernising its regulatory framework, the mutual evaluation exercise did not as such have a major effect on the regulatory approach.
- The Netherlands has **deregulated some professions** and is constantly working on modernising its regulatory framework by removing unnecessary restrictions and/or substituting them with less restrictive alternatives.
- Professional associations are involved both in the design of regulation as well as in the recognition of qualifications - directly or indirectly by providing advice.
- The use of a **uniform system of prior registration** of certain health professions could be identified as a good practice. It is simpler and clearer for candidate (foreign) practitioners to apply for recognition of their qualifications in the Netherlands. It also enhances patient safety as this register is accessible to the public.
- In the case of the automatic recognition of certain healthcare qualifications, registration with the professional register (BIG register) takes place at the same time as the granting of recognition.

1.3. Type and Intensity of Regulation

Compared to other EU countries[52], the regulation of health professions in the Netherlands is less strict. The number of **reserved activities** in the healthcare sector is limited and, where possible, **shared with other professions**. This is in line with the general approach in the Netherlands to use more protected titles instead of reserved activities[53].

In addition, for the professions analysed, the Netherlands **does not impose many additional requirements**. It does not require mandatory state exams, does not impose age restrictions or require prior professional experience. Furthermore, there is also no legal obligation for continuous professional development [54]. Continuous professional development can be required, for instance, to obtain professional indemnity insurance[55]. However, such insurance is not mandatory.

[52] Information on professional requirements in EU Member States can be found on the Regulated Professions Database.

[53] European Commission, Study to provide an Inventory of Reserves of Activities linked to professional qualifications requirements in 13 EU Member States & assessing their economic impact, (2012), available at: https://www.actuel-expert-comptable.fr/sites/default/files/20120214-reportcorr_en.pdf, p. 14.

[54] CEDEFOP, 2013, Working paper no 20: The role of qualifications in governing occupations and professions, Luxembourg, available at http://www.cedefop.europa.eu/files/6120_en.pdf, p. 94.

[55] CEDEFOP, 2013, Working paper no 20: The role of qualifications in governing occupations and professions, Luxembourg, p. 94.

For doctors in medicine, nurses and physiotherapists, there is the obligation to re-register in the BIG-register every five years[56]. In order to become re-registered, the professionals have to provide proof that they have exercised their profession during the five previous years or – if they cannot provide such proof – that they have undertaken professional training[57].

With regard to language skills, the Netherlands performs checks before allowing foreign professionals to practice. These checks were introduced with the implementation of the 2013 amendments to the Professional Qualifications Directive. Before this, the Netherlands did not check language skills, which caused problems in the field[58]. Nonetheless, the level of required proficiency is not high – mostly CEFR: B2. In the case of nurses of general care, it is even lower – CEFR: B1.

Table 1: Regulatory requirements for selected healthcare professions in the Netherlands

Restrictiveness indicator	Medical doctors (with basic training)	General nurses	Physiotherapists	Long-term care workers (second level nurse in particular)
Exclusive reserved activities	Yes	Yes	No	No
Protection of the title	Yes	Yes	Yes	Yes
Shared reserved activities (i.e. activities not limited to one profession)	Yes	Yes	N/A	N/A
Years of education and training	Five	Three	Four	Three
Number of ways to obtain qualifications	One	One	One	One
Mandatory traineeship	Yes	No	Yes	Yes
Obligation to have professional experience	No	No	No	No
Mandatory state exam	No	No	No	No
Continuous professional development obligations (mandatory)	No	No	No	No
Compulsory membership or registration in professional body	Yes	Yes	Yes	No
Limitation of licences (quantity restrictions)	N/A	No	No	No

[56] Article 8 BIG Act in conjunction with Article 2(2) Decree Periodic Registration BIG (Besluit periodieke registratie Wet BIG), published in the Official Journal Staatsblad 20016, 190.

[57] Article 8(6) BIG Act.

[58] P.G.P. Herfs, "Naar een veiliger BIG-register", Nederlands Tandartsenblad, of 13 February 2015 no. 2, p. 16; and asked on expert consultation with Dr. P.G.P. Herfs of the University of Utrecht, February 2019.

Territorial validity of a licence	No	No	No	No
Age restriction	No	No	No	No
Knowledge of language (if yes, the level required)	Yes CEFR: B2/C1	Yes CEFR: B1	Yes CEFR: B2	No
Other	Reregistration obligation every 5 years	Reregistration obligation every 5 years	Reregistration obligation every 5 years	N/A

Source: EU regulated professions database.

KEY FINDINGS

- Even though regulation of health professions is stricter compared to other professions, which is justified by public interest, the number of **reserved activities** in the healthcare sector is still limited and, where possible, **shared with other professions**.
- This is in line with the general approach in the Netherlands to use more protected titles instead of reserved activities[59].
- Moreover, for the professions analysed, the Netherlands **does not impose many additional requirements**. Hence, the regulation can be assessed as less intense compared to other EU countries.

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

The website www.business.gov.nl is the point of single contact for foreign practitioners. This website is clear and provides most of the necessary information on the recognition process, which helps facilitate the recognition of professional qualifications.

It is not possible to assess the extent to which the establishment of a point of single contact encourages foreign professionals to apply for recognition in the Netherlands. The general trend shows that the number of all decisions taken (which include the positive ones) has increased sharply between 2014 (84) and 2015 (889), and another increase was seen between 2015 and 2016 (2,653). After that there was a slight increase in 2017 (2,784)[60].

The website www.business.gov.nl (in English) provides, in a clear and easily accessible manner, information on how to become established as a professional in the Netherlands[61]. The website provides the list of professions regulated in the Netherlands and the relevant competent authorities, and short descriptions on the regulation and recognition of professions. It also explains, for certain professions, how the application process works. In addition, the website includes links to the

[59] European Commission, *Study to provide an Inventory of Reserves of Activities linked to professional qualifications requirements in 13 EU Member States & assessing their economic impact*, (2012), p. 14.

[60] Regulated professions database, available at: http://ec.europa.eu/growth/tools-databases/regprof/index.cfm?action=homepage. (accessed March 2019).

[61] "Professional qualifications and diplomas", Business.gov.nl-website: https://business.gov.nl/regulation/professional-qualifications/. (last accessed February 2019).

European Commission website, the European Professional Card website and the website of the national Assistance Centre - NUFFIC.

The Business.gov.nl-website provides links to the individual websites of the authorities competent for the recognition of foreign qualifications. Information on the applicable procedures, including deadlines and fees, and the documents which need to be submitted is **not provided on the Business.gov.nl-website**. Rather, this information is provided on the **websites of the specific competent authorities**. For instance, for the health professions, a link to the website of the English-language BIG register[62] is provided. On that website all the above-mentioned information on making an application for recognition is presented. The website of the BIG register lists the requirements necessary for recognition and it provides the addresses to which the documents are to be sent. However, the information on how the **procedure for application has to be started is less clear**. A link to the electronic procedure is provided[63], but the webpage on the electronic procedure is **only available in Dutch**[64].

According to the European Commission Digital Economy and Society Index (DESI), the Netherlands is ranked the fourth most advanced digital economy of the EU[65].

For the recognition of certain professions, it is possible to comply with the administrative procedures through **an online tool** provided by the BIG register[66]. Health professionals who want to apply for recognition can make an online request for recognition. However, the application for recognition is not fully electronic: as a last step the applicant has to send the application form and the required documents by post.

The website of the BIG register clearly indicates the costs for making a registration in the BIG register (a general cost of EUR 85). This amount is the same as for the registration by a person holding a Dutch qualification[67]. For this reason, it can be assumed that **costs do not form a substantial burden** in the course of the recognition process.

Language barriers are a general obstacle for mobility[68]. Insufficient language proficiency might also affect the administrative process of recognition. Firstly, this is the case where the recognition takes place under the general system of recognition. Here, the applicant is required to submit an application form. However, this form is only available in Dutch and also has to be completed in Dutch[69].

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62 "Costs and processing time", CIBG website, available at: https://english.bigregister.nl/registration/. (last accessed February 2019).

63 "Prepare for your registration", CIBG website, available at: https://english.bigregister.nl/registration/procedures/prepare. (last accessed February 2019).

64 "Inloggen", CIBG website: https://mijn.bigregister.nl/secure/login.aspx. (last accessed February 2019).

65 European Commission, 2018, *The Digital Economy and Society Index (DESI)*, available at: https://ec.europa.eu/digital-single-market/en/desi. (last accessed February 2019).

66 "inloggen, CIBG website, available at: https://mijn.bigregister.nl/. (last accessed March 2019)

67 "Costs and processing time", CIBG website, available at: https://english.bigregister.nl/registration/procedures/costs. (last accessed February 2019).

68 Fries-Tersch, E., Tugran, T., Rossi, L., Bradley, H., *2017 annual report on intra-EU labour mobility'*, (2018), p. 88.

69 "Aanvraagformulier verklaring van vakbekwaamheid / erkenning beroepskwalificaties": https://www.bigregister.nl/buitenlands-diploma/documenten/formulieren/2017/03/03/aanvraagformulier-erkenning-

Secondly, according to a comparative study conducted by the Maastricht University[70], the fact that the documents submitted could be in languages which have to be translated could substantially complicate the administration of the recognition process. There are the practical complications for the competent authorities of providing translations of the documents[71]. The time needed for translation could lead to an extension of the duration of the whole administrative process of recognition. On the other hand, the competent authorities could ask for the practitioner to provide translations of the documents to be submitted which would lead to additional costs for the practitioner. However, in the case of the Netherlands, there is need for nuance, since the Dutch competent authorities generally accept documents in three languages other than Dutch (English, French and German)[72].

This study conducted by the Maastricht University pointed out that the fact that different authorities have competence for recognising qualifications could cause **confusion for the practitioner**. This is, for instance, the case for medical specialists, for whom the recognition procedure is a two-step procedure, in which two authorities play a role (CIBG and KNMG)[73]. In comparison with Belgium, where only one instance decides on the recognition, the Dutch procedure with the involvement of different instances makes the recognition procedure more complicated[74]. A less complicated recognition procedure for medical specialists could be more favourable for the mobility of professionals[75].

KEY FINDINGS

- The **clear and understandable information provided in English** on the website of the single contact point (general), the assistance centre and of the BIG register (health professions) has been identified as good practice.
- For certain professions it is possible to comply with the administrative recognition procedures through an **online tool** provided by the BIG register.
- The Business.gov.nl-website gives users an opportunity to give feedback about their user experience on the site and the level of helpfulness.
- Insufficient language proficiency may present an obstacle to the process of recognition. For instance, the application form for recognition of qualifications may only be available in Dutch.
- Costs for the recognition of qualifications are not considered an obstacle; however, some associated costs might be, such as the need to translate documents.
- The fact that for the medical specialists, two authorities are involved in the recognition procedure could cause confusion for practitioners.

beroepskwalificaties-en-verklaring-vakbekwaamheid
(last accessed February 2019).

70 H. Schneider, A. Hoogenboom, L. Kortese, *Grenseffectenrapportage 2016: Erkenning van beroepskwalificaties*, (2016), available at: https://cris.maastrichtuniversity.nl/ws/files/5677853/dossier2_nl_erkenning_beroepskwalificaties.pdf.

71 idem, p. 13.

72 H. Schneider, A. Hoogenboom, L. Kortese, Grenseffectenrapportage 2016: Erkenning van beroepskwalificaties, (2016), p. 16 and 36.

73 idem, p. 14.

74 idem.

75 Based on a comparative study on the cross-border movement of professionals between the Netherlands, Belgium and the German state of North-Rhine-Westphalia, in which a score is given on certain aspects of the recognition procedure. The Netherlands received a score of 75/100, where Belgium, for which there is only one authority, the score is 100/100. See H. Schneider, A. Hoogenboom, L. Kortese, *Grenseffectenrapportage 2016: Erkenning van beroepskwalificaties*, (2016), p. 18 and 23.

1.5. Recognition rates and length in proceedings

The recognition rate in the Netherlands in the years 2009, 2010, 2015 (for other years data are not available) was 81 %, which is **lower than the EU average**[76].

Under the general system, the time for the procedure for recognition of professional qualifications is a maximum of three months, which may be extended by one month[77]. If a foreign practitioner falls under the system of automatic recognition, he or she is only required (like a Dutch practitioner) to make a direct application for registration in the BIG register. The duration for such an application under the system of automatic recognition is maximum three months[78]. In comparison, the same *registration* procedure for a practitioner who possesses an equivalent Dutch diploma is only eight weeks[79]. Under Directive 2005/36/EC, the competent authority is required to complete the procedure of examining an application for authorisation to practice a regulated profession within three months[80]. When a practitioner applies to the BIG register (Article 3 professions) for recognition under automatic recognition, this application also counts for the registration in the BIG register. Thus, once the practitioner is recognised, he or she does not need to do an additional registration step[81].

The Netherlands has transposed the processing times for the application as required by the Directive. In practice, the Dutch processing times are similar to the ones in Belgium and the German state of North-Rhine-Westphalia[82]. **According to information provided by the stakeholders, these time limits are generally respected**[83]. In practice, the average time length of the procedure for automatic recognition is eight weeks[84]. For the procedure under the general system, the time length is fifteen weeks[85].

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76 Single Market Scoreboard: Professional Qualifications", European Commission Website: http://ec.europa.eu/internal_market/scoreboard/performance_per_policy_area/professional_qualifications/index_en.htm. (last accessed February 2019).

77 Article 19(2) PQL; see also "Recognition of your professional qualifications", CIBG website: https://english.bigregister.nl/foreign-diploma/procedures/recognition-professional-qualifications. (last accessed February 2019).

78 Article 19(2) PQL; see also "Direct enrolment in the BIG-register (automatic recognition)", CIBG website: https://english.bigregister.nl/foreign-diploma/procedures/direct-enrolment. (last accessed February 2019).

79 "Doorlooptijd en kosten", CIBG website: https://www.bigregister.nl/registratie/nederlands-diploma-registreren/doorlooptijd-en-kosten. (last accessed February 2019).

80 Article 51(2) Directive 2005/36/EC.

81 See above.

82 Based on a comparative study on the cross-border movement of professionals between the Netherlands, Belgium and the German state of North-Rhine-Westphalia, which a score is given on certain aspects of the recognition procedure. The Netherlands received a score of 75/100, where Belgium, for which there is only one authority, the score is 100/100. See H. Schneider, A. Hoogenboom, L. Kortese, *Grenseffectenrapportage 2016: Erkenning van beroepskwalificaties*, (2016), p. 15, 22 and 26.

83 Information obtained in stakeholder consultation with the Society of Dutch Nurses (V&VN) and with Ministry of Public Health, Welfare and Sport, February 2019.

84 Information obtained in stakeholder consultation with the Ministry of Public Health, Welfare and Sport, February 2019.

85 Information obtained in stakeholder consultation with the Ministry of Public Health, Welfare and Sport, February 2019.

KEY FINDINGS

- The processing time of applications for recognition, as set out in the Dutch legislation, corresponds with the time limits provided for in the Directive. These time limits seem to be **generally respected in practice**.
- Taking into account that in practice the duration of the procedure is shorter than provided under the Directive, this could be considered good practice.
- In this regard, it should be noted that in the case of health professions for instance, the recognition of qualifications also ensures the required registration in the BIG register. This one-stop shop procedure saves time for the professionals in accessing the labour market by preventing additional administrative burdens.

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

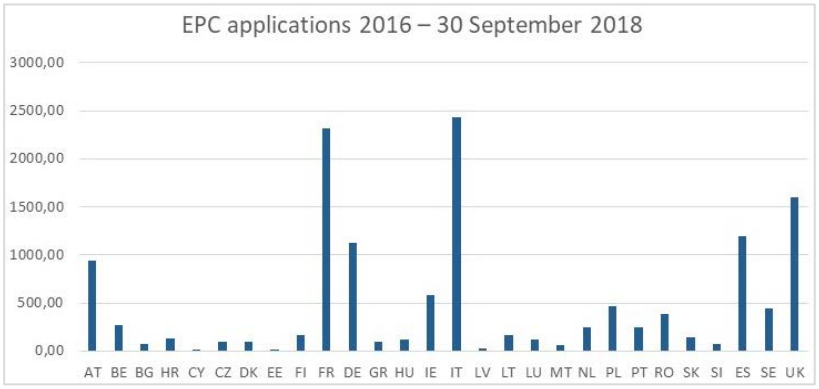
2.1. European Professional Card (EPC)

In the Netherlands **as a host Member State** the European Professional Card (EPC) is available with respect to the following regulated professions: physiotherapists, general care nurses and pharmacists[86]. The professions of mountain guides[87] and real estate agents[88] are not notified by the Netherlands as regulated professions.

The Netherlands **also accepts applications in the role of the home Member State** for the temporary provision of services (excluding professions that have public health or safety implications). These applications may concern all five professions for which the EPC is available, regardless of whether or not these professions are regulated in the Netherlands[89]. The application for an EPC has to be made via the European Commission's website.

The data[90] show that in the period from January 2016 to September 2018, the Netherlands dealt with **247 EPC applications** as home and host Member State[91] (see Figure 2 below). This is a relatively low number of applications when compared to other Member States.

Figure 2: Member States concerned by EPC applications[92]



In terms of the number of EPC applications received, the profession of physiotherapists stands out. In 2016, the Netherlands received 25 EPC applications as a **host Member State**. 2017 showed a slight decrease with 23 applications in total. This was a considerably higher number than for other

86 Commission Staff Working Document – Assessment of stakeholders' experience with the European Professional Car and the Alert Mechanism procedures, SWD(2018) 90 final.

87 idem, p. 12.

88 idem, p. 16.

89 "Europese Beroepskaart", available at: https://www.nuffic.nl/onderwerpen/beschermd-beroep-binnen-de-eu/. (last accessed on 28 February 2019).

90 European Commission data, available at: http://ec.europa.eu/internal_market/imi-net/_docs/statistics/2017/12/epc-applications-issued.pdf.

91 European Commission data, available at: http://ec.europa.eu/internal_market/imi-net/statistics/index_en.html. (accessed March 2019).

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

professions (pharmacists: 11 in 2016 and 9 in 2017; general care nurses: 15 in 2016 and 16 in 2017)[93].

The professions of physiotherapists and nurses stand out in terms of the number of EPCs issued (Table 2 below)[94]. The data below cover all the EPCs issued involving the Netherlands as the host and home Member State (a total of 75 in 2016 and 2017).

Table 2: EPC applications and EPCs issued in the Netherlands as host country[95] (2016 and 2017)

Profession	EPC applications	EPCs issued
Mountain guides	0	0
General nurses	31	15
Pharmacists	20	4
Physiotherapists	34	3
Real estate agents	0	0

Table 3: EPC applications and EPCs issued in the Netherlands as home country[96] (2016 and 2017)

Profession	EPC applications	EPCs issued
Mountain guides	3	0
General nurses	24	18
Pharmacists	2	2
Physiotherapists	60	31
Real estate agents	29	2

It is, however, not possible to draw any conclusions about the extent to which the EPC has facilitated the recognition of qualifications, given the novelty of the instrument (data are only available for two years). Moreover, the interviewed stakeholders indicate that they did not identify any

93 Statistics on EPC applications, available at: http://ec.europa.eu/internal_market/imi-net/_docs/statistics/2017/12/epc-applications-issued.pdf, pp. 8-13. (last accessed on 25 February 2019).

94 Statistics on EPC applications, available at: http://ec.europa.eu/internal_market/imi-net/_docs/statistics/2017/12/epc-applications-issued.pdf, pp. 8-13. (last accessed on 25 February 2019).

95 EPCs for the temporary provision of services (excluding professions that have public health or safety implications) are issued by the home Member State.

96 EPCs for the temporary provision of services (excluding professions that have public health or safety implications) are issued by the home Member State.

specific obstacles for the wider use of the EPC[97].

Some observations can be made comparing the number of EPCs issued (thus the number of positive decisions) with the number of positive recognition decisions taken overall (thus EPCs and recognition decisions issued through other procedures). In absolute terms the number of EPCs issued for general care nurses constitutes only a small segment of the positive recognition decisions overall. Namely, 15 EPCs against 209 positive decisions in 2016 and 2017[98]. This suggests that general care nurses **preferred the traditional way of recognition as opposed to the EPC**. A similar observation could be made with respect to physiotherapists. It is noted though that the full sample of positive recognition decisions for physiotherapists is much smaller than in the case of nurses, which might result from the fact that general care nurses constitute a more mobile profession.

The stakeholders interviewed (the national competent authority responsible for the implementation of the EPC for general care nurses, pharmacists and physiotherapists) expressed some concerns regarding the administrative arrangements around the issuance of the EPC. In particular, the stakeholder referred to some **difficulties in cooperation of the competent authorities of the host and home Member States**. According to the Dutch authority, the issuance of the EPC can become complicated in cases where the home Member State fails to fulfil its administrative obligations[99].

With respect to the EPC applications by physiotherapists, the Netherlands noted that in their experience home Member States often transmit applications without validating all the documents submitted by the applicants. This results in cases where the Netherlands also (as the host Member State) ends up asking the applicants for missing documents, which ultimately adds to the length of the recognition procedure. Another problem which was signalled by the interviewed stakeholder is the failure, on the side of the home Member States, to respond to requests filed by the Netherlands. This omission leads to a situation where applications remain invalidated or incomplete and are thus rejected[100].

Due to these issues, while evaluating the EPC system the Dutch authority gave very low scores to questions that concerned the cooperation between the competent authorities. As an example, to the question whether the EPC has facilitated communication with other Member States, the authority provided a score of 0, which was the lowest score. The Dutch authority also flagged some complications regarding the use of the EPC repository. They noted that from their point of view the filing process is too labour intensive.

As a final point, the Dutch authority mentioned that the process of issuing EPCs is **free of charge in the Netherlands**. In response to the 2017 survey, however, authorities were considering a change in this respect and thus referred to the possible introduction of fees.

Presumably due to the aforementioned reasons, the Dutch authority also noted that compared to the traditional recognition procedure, the **EPC system is not considerably faster**. The duration of the recognition procedure under the EPC system is on average ten weeks, where under the general recognition procedure it lasts on average fifteen weeks. According to the stakeholder interviewed the shorter duration of the procedure is not of great benefit for the health professionals[101].

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97 Information obtained in stakeholder consultation with the Ministry of Public Health, Welfare and Sport, February 2019.

98 European Commission data, available at: http://ec.europa.eu/growth/tools-databases/regprof/index.cfm.

99 Information obtained in stakeholder consultation with the Ministry of Public Health, Welfare and Sport, February 2019.

100 Information obtained in stakeholder consultation with the Ministry of Public Health, Welfare and Sport, February 2019.

101 Information obtained in stakeholder consultation with the Ministry of Public Health, Welfare and Sport, February 2019.

The survey also captured the views of one professional association (Dutch Association of Real Estate Brokers and Valuers). Their responses, which mainly concerned the Netherlands in the role of the home Member State, focused on the real estate agents' profession. The association expressed concerns regarding the availability of information on the EPC and the user-friendliness of the application process. In particular, they referred to the fact that registration is hindered by the shortcomings of the online platform which on occasion does not seem to operate. **It was their view that the EPC fails to meet its objective of removing administrative barriers**.

KEY FINDINGS

- The number of EPC applications that the Netherlands deals with in the role of the host and home Member State has been **relatively low**.
- Stakeholder interviews identified **occasional issues** with using the EPC platform, including the application filing process being too labour intensive.
- The Dutch authorities have been very **critical of cooperation between the competent authorities**. Competent authorities from other Member States often transmit incomplete applications and do not respond to requests filed by the Netherlands, thereby adding to the length of the recognition procedure, or even rejection of the application.
- Due to the issues, the consulted authorities expressed the view that the EPC system is **not considerably faster** than the traditional recognition process.
- In the view of one stakeholder, the EPC **fails to meet its objective** of removing administrative barriers.

2.2. Partial access to professional activities

Compared to the total number of partial access granted in the EU (data accessed in the Regulated Professions Database in March 2019), the number of cases of partial access granted by the Netherlands is **relatively high**. In total in the EU there were 214 cases of partial access granted to provide temporary and occasional services, and 299 for establishment. In the Netherlands, a total of 201 were granted for temporary mobility (thus, representing almost all cases in the EU), and only three for establishment.

It should be noted that the Dutch government had been critical regarding partial access. In the course of the EU council negotiations on the 2013 amendments to the PQD, the Dutch government considered it not opportune to introduce a system of partial access, which in practice would gradually expand to full access to the profession. The Netherlands favoured the possibility for the Member States to impose compensation measures on the professional in order to gain full access[102]. This approach appears to be reflected in that the Netherlands grants **partial access predominantly for temporary mobility**, and not for establishment. In 2016 and 2017, the Netherlands granted 201 positive decisions for partial access for the provision of temporary services (across all professions), whereas since 2015, the number of positive decisions for partial access for the purpose of establishment was only 3[103].

In the context of health professions, there are no decisions on partial access[104]. The reason for this,

[102] Kortese, L.S.J., MCEL *Master Working Paper 2016/1: Assessing the Coherence of Mechanisms for the Recognition of Qualifications: Discerning Dimensions to a Multilevel Challenge*, (2016), Maastricht, p. 47.

[103] DG GROW, Regulated Professions Database.

[104] Information obtained in stakeholder consultation with the Ministry of Public Health, Welfare and Sport, February 2019.

according to the Ministry of Public Health, Welfare and Sport, is that the competent authority follows the practice of either allowing full access or imposing compensation measures[105].

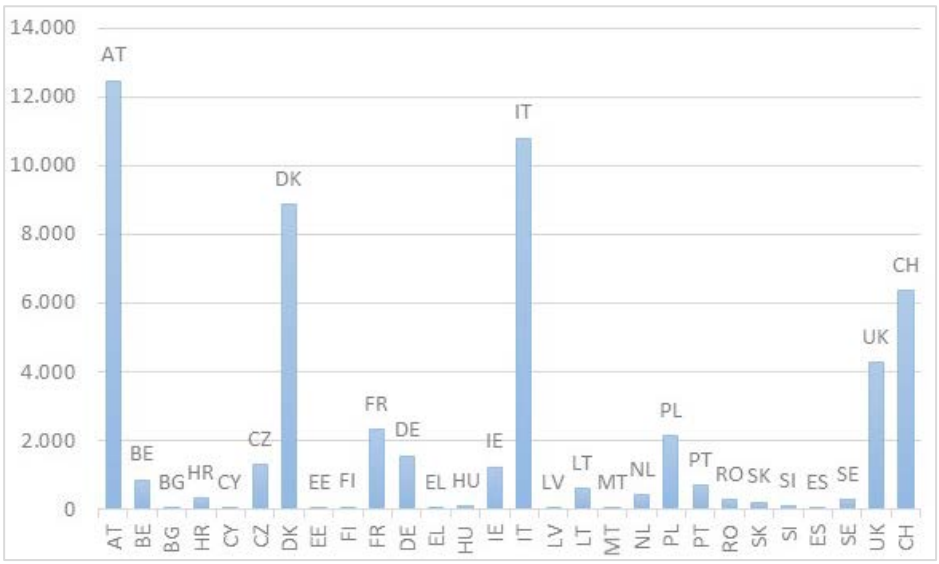
KEY FINDINGS

- In the negotiations on the revised PQD, the Dutch government was critical with regard to partial access due to the risk that in practice, partial access might give the professional full access to the whole profession.
- This appears to be reflected in the fact that the Netherlands grants partial access predominantly for temporary mobility, and not for establishment. In fact, partial access granted by the Netherlands for temporary mobility represents almost all cases of such access in the EU.

2.3. Temporary service provision

With regard to the numbers of professionals that made use of the regime of temporary service provision, in the EU Regulated Professions Database, only data for the years 2016-2017 is available. Due to this limited period for which data is available, it is not possible to provide information on the impacts of the 2013 amendments to the PQD on the number of professionals that provided temporary services. In the period 2016-2017, for all regulated professions 413 decisions were made on the provision of services. The professions for which most decisions were made were the professions related to mobile offshore services (190 decisions). Also, many decisions related to professions in the education sector (158). The number of decisions concerning health professionals is limited to nine in the period mentioned [106]. Figure 3 below provides more recent data and therefore slightly differs from the period analysed above.

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



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

[105] ibid.

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

According the stakeholder interviewed at the Ministry of Public Health, Welfare and Sport, the amended rules on the temporary service provision have only recently been implemented. At the beginning of 2019, the competent authorities are still assessing the use of it and opportunities provided by the revised rules[107].

KEY FINDINGS

- It is not possible to assess the impact of the 2013 amendments to the PQD on the provision of services because data is only available for 2016 and 2017. Due to this, it is also not possible to identify the overall trend since the introduction of this regime by Directive 2005/36/EC. This is a **significant issue** as it does not provide full picture of the how often the regime is applied in the Netherlands.

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

The **IMI-system is widely used** by the competent authorities **in the Netherlands**. In 2018[108] (first three quarters) the Dutch authorities (with respect to all professions, thus not specifically in relation to health professions) sent 794 requests to other Member State authorities in total through the IMI-system. The majority of these requests (722) concerned the Professional Qualifications Directive. In comparison to the number of requests sent by other Member States, the Netherlands has a high score. Only three Member States (i.e. Austria, Belgium and the United Kingdom) have sent more requests through the IMI than the Netherlands.

During the first three quarters of 2018, the Netherlands received 260 requests from other Member States through the IMI-system. This number does not seem to be exceptional compared to the number of requests received by other Member States (e.g. Romania received 1,689 requests). Out of the 260 requests, 180 concerned the Professional Qualifications Directive.

The Single Market Scoreboard[109] also provides some data regarding the use of the IMI-system (in general, thus not in connection with the Professional Qualifications Directive exclusively) by the Netherlands. These datasets focus on the performance of the Netherlands in relation to the use of the said system. They suggest that the Netherlands has been performing moderately (relatively steadily over the years), compared to other Member States. **This source notes that the Dutch system could be further improved by enhancing the timely acceptance of requests and the timely provision of responses to these requests**.

Statistical data on the use of the alert mechanism is only available from 2017. Of the 41 alerts, most concerned doctors (15 related to doctors with basic training and one to a general practitioner) and other health professionals (16 alerts in total, out of which four concerned dental practitioners, seven other professions that have patient safety implications, one a pharmacist, two physiotherapists/kinesiotherapists, two psychotherapists).

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[107] Information obtained in stakeholder consultation with the Ministry of Public Health, Welfare and Sport, February 2019.

[108] Requests sent and received in 2018, available at: http://ec.europa.eu/internal_market/imi-net/statistics/index_en.htm#maincontentSec2. (last accessed on 26 February 2019).

[109] Single Market Scoreboard, available at: http://ec.europa.eu/internal_market/scoreboard/performance_by_member_state/netherlands/index_en.htm#maincontentSec11. (last accessed on 26 February 2019).

There is no literature explaining these numbers. However, some stakeholders, by responding to the 'Survey on the first year of the European Professional Card' expressed their views on the functioning of the alert mechanism.

The National IMI coordinator/National coordinator for the recognition of professional qualifications provided **positive feedback** while being asked about the following:

- the contribution of the alert mechanism to enhancing cooperation between the national authorities;
- ensuring the safe mobility of professionals within Europe;
- creating a rapid warning mechanism between the national competent authorities;
- providing the necessary data protection safeguards;
- contributing to the objective of overcoming language barriers; providing a reliable and secure means of communication; strengthening mutual trust amongst national competent authorities; allowing national authorities to search amongst all the valid alerts they have sent or received.

The national competent authority responsible for the implementation of the alert mechanism procedures (e.g. a national competent authority responsible for sending or receiving alerts or a coordinating authority in this context) also gave a **positive evaluation** of the alert mechanism. It is noted though that as opposed to the IMI coordinator this competent authority could not respond to the question about the extent to which the alert mechanism has contributed to the safe mobility of professionals within Europe.

The BIG register also provided feedback regarding the alert mechanism. This feedback was similar to the one given by the authority responsible for the implementation of the alert mechanism.

Based on the above it can be concluded that, overall, the Dutch authorities perceive the alert mechanism as a positive and useful mechanism. In other words, the alert mechanism seems to facilitate the work of the competent authorities and thus it is assumed that at least, to a certain extent, it facilitates the recognition of professional qualifications.

In addition to the above, the research has revealed potential good practice, related to the transparency of the BIG register. The BIG register provides a publicly available list of registered health professionals[110]. The BIG register includes information on the registered professional, such as his or her name, professional title[111], **as well as information on professional sanctions**[112].

[110] Article 11 BIG Act.

[111] Article 3(2) BIG Act.

[112] Article 9 BIG Act.

KEY FINDINGS

- The alert mechanism is perceived as a useful tool in the Netherlands. No issues have been identified that hinder the application of the alert mechanism in practice.
- The BIG register could be considered good practice given its transparent nature. This register is **publicly available** and provides information on the list of registered professionals, as well as information on **sanctions imposed against professionals**.

2.5. Sectoral amendments

Based on the information provided by the Ministry of Public Health, Welfare and Sport, the sectoral amendments by Directive 2013/55/EU have no, or only a marginal, effect on the recognition of qualifications as the introduced changes are minor[113].

Since the 2013 amendments to the PQD, the Netherlands imposes tests of professionals' language knowledge in order to ensure patient safety[114, 115]. The Ministry of Public Health said that professionals see the introduction of a language test as a barrier to accessing the labour market[116]. However, the Ministry does not have evidence of how the introduction of a language test has affected mobility[117].

KEY FINDINGS

- According to stakeholders, the sectoral amendments with regard to training requirements have no or only marginal impact on facilitating the recognition of qualifications.
- Stakeholders are aware that the language checks introduced are seen by applicants as a barrier, but there is no proof so far whether or not it has affected the mobility of professionals.

[113] Information obtained in stakeholder consultation with the Ministry of Public Health, Welfare and Sport, March 2019.

[114] Article 53 Directive 2005/36/EG amended by Article 49b Directive 2013/55/EU.

[115] Based on expert consultation with Dr. P.G.P. Herfs of the University of Utrecht, February 2019.

[116] Information obtained in stakeholder consultation with the Ministry of Public Health, Welfare and Sport, March 2019.

[117] ibid.

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

3.1. The Netherlands as a host country

In 2016, the Netherlands was the fifth most popular country of destination of EU movers of working age among the Member States (in total numbers of annual inflows). Between 2009 and 2016, the annual inflows of other EU citizens of working age had increased by 46 % (from 36,000 to 53,000)[118]. The upward trend in numbers of decisions on recognition of professional qualifications for establishment reflects this development: the total number of decisions (across all regulated professions) increased from 1,000 in 2009 to 2,500 in 2017[119]. Data on decisions for temporary service provisions is only available for 2016 and 2017, therefore no trend can be identified.

Among those applying for recognition for the purpose of establishment, the most frequent professions in the period 2015-2017[120] were secondary and primary school teachers (which together make up roughly 30 % of all those applying for recognition of qualifications), childcare workers (14 %) and professions in the health sector, especially doctors of medicine (15 % of total), dentists (8 %), nurses (5 %), veterinary surgeons (3 %) and midwives (3 %). Another sizeable professional group asking for recognition of qualifications are pesticide sprayers/crop protection contractors (5 %). Both secondary school teachers and several health professions (medical doctors, nursing and midwifery professionals and other health professionals and associate professionals) were mentioned in 2016 by public employment services as occupations experiencing shortages [121].

The picture was quite different 10 years previously (2008-2010) when professions in the health sectors outranked others: doctors, dentists, nurses, midwives and veterinary surgeons were the five most frequent in terms of recognition decisions and together made up 66 % of all decisions. In that period, no decisions for teachers or childcare workers were granted[122].

Despite their quantitative weight in recognition decisions, reliance on health professionals or care workers from other EU Member States is generally low in the Netherlands: in 2016, the number of health professionals with other EU nationalities made up only 1 % of the total workforce of these occupations in the Netherlands[123] which is lower than the EU average (3 %). Nevertheless, the numbers of doctors and nurses with another EU nationality and/or trained in another EU Member State did increase over the past decade.

The **numbers of doctors** working in the Netherlands *who were trained in another EU Member State* generally **increased between 2001 and 2015**, the years for when data was available. During this time there was a fairly steady year-on-year increase of 4 % to 12 %. The major exception to this was a decrease in numbers in 2012 when they dropped 17 % compared to the previous year[124]. Inflows of

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[118] Source: Eurostat Immigration Data [migr_imm1ctz].

[119] Source: DG GROW, Regulated Professions Database, 'Professionals moving abroad (establishment) – Overall statistics'; Note that figures recorded are extremely low for the years 2011-2014; this may be due to a recording or reporting error and can therefore not be interpreted in any way.

[120] Data for the years 2011-2014 is unusually low and therefore seems unreliable and is not interpreted here.

[121] 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.

[122] Source: DG GROW, Regulated Professions Database, 'Professionals moving abroad (establishment) – Overall statistics'.

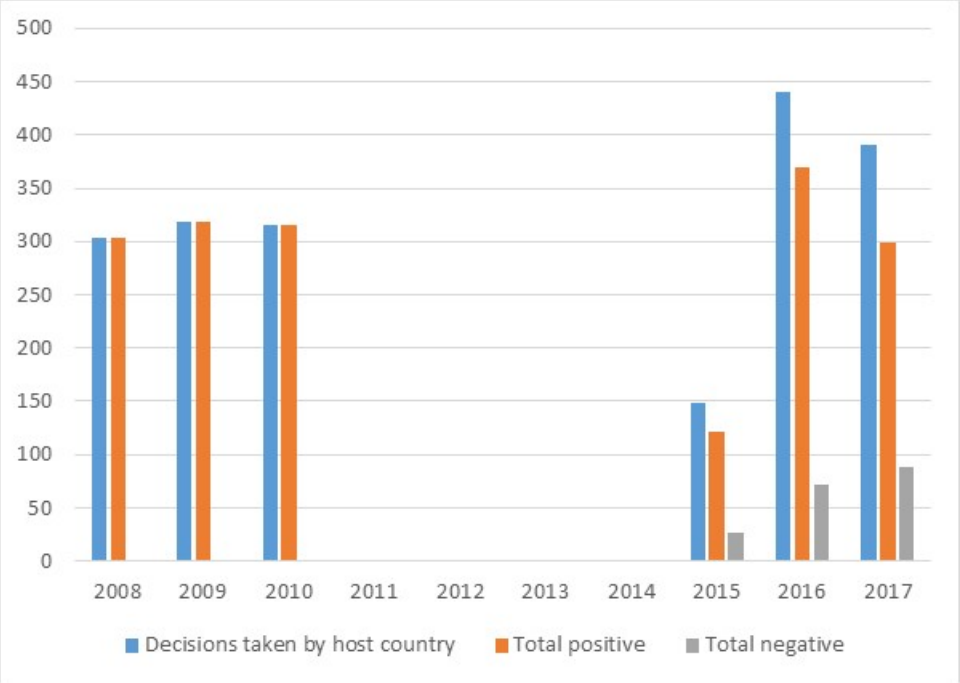
[123] European Commission (2018), 2017 Annual Report on intra-EU labour mobility, chapter 2.4.2, prepared by Fries-Tersch, E., Tugran, T., Rossi, L., table 59.

[124] DG GROW, Regulated professions database – statistics on recognition decisions for establishment.

doctors trained in other EU Member States saw peaks in 2010 and 2012 before dropping by more than half in 2013. Most recent figures for 2015 indicate a recovery but are still below 2010 and 2012 figures. The number of doctors trained in another EU Member State as a share of the total number of doctors closely follows the pattern of the numbers of foreign-trained doctors.

The trend in recognition decisions for doctors with qualifications from other EU countries is unclear, as no data is available for the years 2011 to 2014. Nevertheless, there was a large increase in 2016, and the overall number of decisions in 2016 and 2017 (around 400 per year) was larger than in 2008-2010 (around 300 per year). However, the **share of positive decisions was a lot lower** in 2016 and 2017 than in 2008-2010, resulting in the fact that the total number of positive decisions was not so different in 2008-2010 and 2016-2017.

Figure 4: Decisions by Netherlands on doctors in basic medicine from other EU Member States



Source: DG GROW, Regulated Professions Database, Overall Statistics for Professionals moving abroad (establishment). (extracted in January 2019)

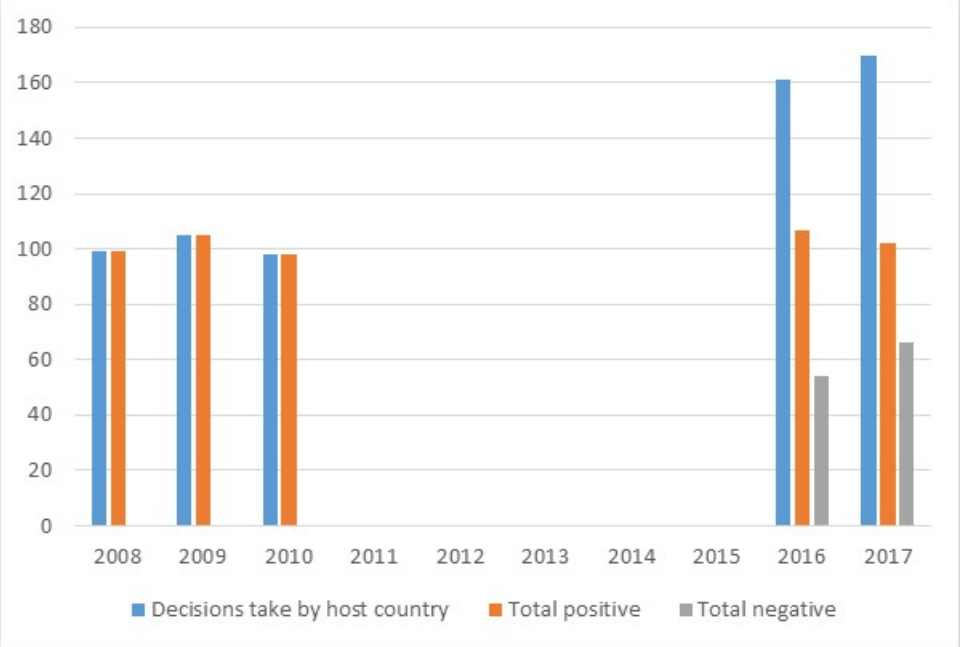
Data for 2011, 2012, 2013 and 2014 not available.

Overall the **stocks of nurses** trained in another EU Member State show an **increase between 2001 and 2015**. The **annual inflow of nurses** trained in another EU Member State shows little general trend but has **remained between 30 to 55 for most of the period 2001-2015**. As with the stocks, there is a drop in inflows in 2012 and 2013, but this could again be explained by the lack of data for these years. Viewed as a percentage of the total number of nurses in the Netherlands, the number of nurses trained in another EU Member State is very small, remaining below 0.2 % apart from in 2015, when it rose to 0.3 %.

There is no data on recognition decisions for nurses from other EU countries for the years 2011-2015, so a trend is difficult to detect. The number of decisions stayed very stable for the first three years of the period studied (2008-2010). The latest figures show that the number of decisions had increased significantly by 2016 and 2017 compared to the last data available, from 2010. As with doctors, all decisions taken between 2008 and 2010 were positive. For 2016 and 2017 the percentage of positive

decisions dropped to 66 % then 60 %. Between 95 % and 100 % were taken under the automatic recognition regime.

Figure 5: Decisions by Netherlands on general care nurses from other EU Member States



Source: DG GROW, Regulated Professions Database, Overall Statistics for Professionals moving abroad (establishment). (extracted in January 2019)

Numbers of **physiotherapists** qualified in the Netherlands are only available for 2016 and 2017 and they were very low (around 30 in both years)[125].

Data on **personal care workers in health services** with another EU nationality working in the Netherlands (based on the Labour Force Survey) was at 1,700 in 2012 and then slightly increased to 1,900 in 2015 and to 3,300 in 2016, before decreasing again to 1,900 in 2017[126]. Numbers on the share of mobile personal care workers out of the total workforce are not available.

The most common **countries of origin for foreign-trained doctors** working in the Netherlands has remained Belgium and Germany throughout the period 2002-2015. The next most common countries after this were Poland being replaced by Romania in the most recent figures, and the UK being replaced by Italy.

The situation for nurses is similar, with the most common **countries of origin for nurses** in the Netherlands being Germany and Belgium for the period from 2001 to 2015. Together they account for at least 60 % of nurses trained in other EU countries during this period. The next most common countries of origin are Poland and the UK, although numbers remain below 50 for both countries throughout the period.

The reason why Belgium and Germany are the main countries of origin can be explained by the fact that both countries have a border with the Netherlands. Furthermore, language could also be a factor

[125] Source: DG GROW, Regulated Professions Database, Overall Statistics for Professionals moving abroad (establishment).

[126] EU-LFS, 2017; figures are of low reliability.

in explaining this, since Dutch is also spoken in Belgium[127].

Financial reasons (higher wages) could probably be one of the grounds for the popularity of the Netherlands as a host country for other countries, especially Poland[128].

A further reason that could explain the trends could be private initiatives of employers in the health sector. During stakeholder consultation, it was mentioned that in some regions (i.e. Amsterdam) hospitals and other employers in the health sector actively recruit nurses and other health workers in EU Member States such as Spain and Italy[129].

3.2. The Netherlands as a country of origin

The total number of decisions taken by other EU Member States on doctors in basic medicine qualified in the Netherlands has generally increased during the period of 2008 to 2017. A decline can be seen in 2012 in the number of decisions, before it gradually builds again up to 2016. The rate of positive decisions is relatively high. Since 2013 it has stayed between 83 % and 88 %[130].

It is difficult to discern a trend in the number of decisions in other EU Member States on general care nurses qualified in the Netherlands during the period of 2008 to 2017. The first four years of the period show similar numbers of around 100 decisions per year, before a very large drop in 2012 and then a very large increase in 2014. The number then appears to have gradually decreased in 2015 and 2016. The share of positive decisions on these applications also shows no clear trend. During the period (2008 to 2017), the percentage of positive decisions ranges from a low of 71 % in 2013 to a high of 96 % in 2012. Over 90 % of positive decisions were taken under the automatic sectoral recognition regime in all years except for 2009 and 2010[131].

The number of decisions in other EU Member States on physiotherapists qualified in the Netherlands generally decreased over the period 2008 to 2017. In 2009 and 2011 there were over 200 decisions made; by 2015 this had dropped to just over 50 decisions. The percentage of positive decisions during this period also declined in more recent years, dropping below 80 % for the first time in 2015[132].

In 2016, the most popular country of destination for Dutch doctors by far was Belgium, with stocks of around 1,100 doctors. The second was Germany, with stocks of around 600, and third the UK, with around 400 doctors[133]. The popularity of Germany and Belgium for Dutch doctors could also be explained by the fact that those countries have a shared border with the Netherlands. Language could explain why Belgium is a popular destination for Dutch doctors. The generally high-level of competence in English in the Netherlands could also be a reason for the popularity of the UK.

In general, persons living in the Netherlands are quite positive about their educational and training qualifications being recognised in other EU Member States. According to Eurobarometer data, 67 % of the Dutch population believe that their qualifications would be recognised, which is more than at EU level (58 %)[134].

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127 Wismar, M. et al. (2011), 'Health Professional Mobility and Health Systems', available at: http://www.euro.who.int/__data/assets/pdf_file/0017/152324/Health-Professional-Mobility-Health-Systems.pdf?ua=1, p. 148.

128 Wismar, M. et al. (2011), 'Health Professional Mobility and Health Systems', p. 148.

129 Information obtained in stakeholder consultation with the Society of Dutch Nurses (V&VN), February 2019.

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

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

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

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

134 Eurobarometer 2014, 'European area of skills and qualifications'.

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

The competent authority could not provide a response to the question on the extent to which the 2013 PQD amendments facilitated recognition and mobility to the Netherlands[135].

No evidence could be found on the extent of over-qualification among movers compared to nationals, nor on potential obstacles to accessing suitable jobs among overqualified movers. On the contrary, one stakeholder mentioned that, for nurses, it seems more the case that mobile workers are less qualified than Dutch workers who have, under the Directive, the same level of diploma[136].

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

As mentioned above, the Netherlands has to deal with labour shortages of health personnel. This is particularly the case for nurses. The reasons for such shortages could be the increasing demand for professionals because of the ageing population, which is in particular the case in the less urbanised regions[137].

No information on national initiatives undertaken in order to retain workers in the country or to attract health professionals from abroad could be identified. However, on the regional level, some employers have taken initiatives to attract foreign workers in health care (mostly nurses)[138].

No evidence could be found that would prove that international_mobility had a large effect on the labour supply in the health sector. It is true that in less urbanised areas (Friesland, Groningen and Zeeland) there is a shortage of medical professionals[139]. Nevertheless, a correlation with international labour mobility could not be found.

KEY FINDINGS

- **In 2016,** the **Netherlands was the fifth most popular destination for labour mobility**. This development is also reflected in the numbers of decisions on recognition of professional qualifications for establishment. Between 2009 and 2017 the total number of decisions (across all regulated professions) increased from 1,000 to 2,500.
- **Reliance on health professionals or care workers** from other EU Member States is **generally low** in the Netherlands. Yet, the numbers of doctors and nurses with another EU nationality and/or trained in another EU Member State did increase over the past decade. Despite the **labour shortages of health personnel,** no initiatives were undertaken in order to retain workers in the country or to attract health professionals from abroad.
- In general, **data on recognition decisions is rather low**. The number of recognition decisions for doctors increased in 2016 and 2017 (around 400) compared to 2008-2010 (around 300). **However, the share of positive decisions decreased in 2016 and 2017.** For nurses, the numbers of positive decisions show an increase between 2001 and 2015. No numbers were available for after 2015. Numbers of physiotherapists qualified in the Netherlands in 2016 and 2017 were very low. For second level nurses with another

[135] Information obtained in stakeholder consultation with the Ministry of Public Health, Welfare and Sport, February 2019.

[136] Information obtained in stakeholder consultation with the Society of Dutch Nurses (V&VN), February 2019.

[137] Information obtained in stakeholder consultation with the Society of Dutch Nurses (V&VN), February 2019.

[138] Ibid.

[139] Based on expert consultation with Dr. P.G.P. Herfs of the University of Utrecht, February 2019.

EU nationality working in the Netherlands, the numbers slightly increased to 1,900 in 2015 and to 3,300 in 2016, before decreasing again to 1,900 in 2017.

- The most common countries of origin for doctors and nurses in the Netherlands have remained Germany and Belgium, which border the Netherlands and have similar languages. Other important countries of origin are Poland and the UK.
- The Netherlands also became a more popular country of origin for mobile doctors, with numbers of decisions taken by other EU Member States on doctors in basic medicine qualified in the Netherlands generally increasing during the period 2008 to 2017. In 2016, the most popular country of destination for Dutch doctors by far was Belgium, the second was Germany, followed by the UK.
- No evidence could be found that would prove that international mobility had a large effect on the labour supply in the health sector in the Netherlands.

LIST OF STAKEHOLDERS CONSULTED

Table 1: Stakeholders consulted for the case study on the Netherlands

Stakeholder	Category
CIBG (Ministry of Health)	Competent Authority (health)
CBGV (Ministry of Health)	Commission responsible for assessing professional qualifications (health)
Royal Dutch Medical Association (KNMG)	Professional organisation (doctors in medicine)
Nurses and Care Workers Association	Professional organisation (nurses and long-term carers)
Academic	Academic (research experience in the topic of integration of foreign doctors in the Netherlands)

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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