STUDY

Requested by the EMPL committee

European Parliament

Labour mobility and recognition in the regulated professions

Annex C - II

Italy: 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.

This document was provided by Policy Department A at the request of the European Parliament's Employment and Social Affairs Committee.

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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
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
INAPP	Institute for the Development of Vocational Training for Workers
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
MIGEP	National Federation of the Social and Health Professions
Mobility	This term refers to migration of EU-28 citizens within the EU
NAP	National Action Plan
OSS	Health auxiliary professional (*operatore socio-sanitario*)
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 - II

ITALY:
CASE STUDY

Italy

Authors: Dr. Flavia Pesce (IRS-Istituto per la Ricerca Sociale)

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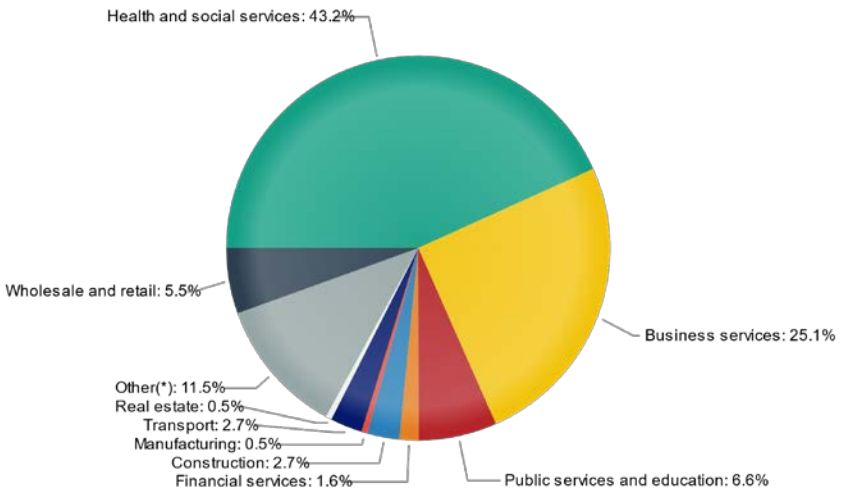
1. GENERAL NATIONAL CONTEXT FOR THE RECOGNITION OF PROFESSIONAL QUALIFICATIONS

1.1. General approach to Occupational Regulation

According to the Regulated Professions Database [1], as of March 2019, there are a total of 183 regulated professions in Italy. The vast majority (around 43 %) are professions in the health and social services sector (see Figure 1 below).

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



According to a 2015 EU wide survey [3], 19 % of the Italian labour force was considered to work in regulated professions. This was lower than the EU average (21 %). According to a more recent national study [4], in terms of employment, some **5.4 million Italians work in regulated occupations**, corresponding to 24 % of the overall labour force. Of this, 10 % are employed in those regulated professions enrolled in professional associations or 'Orders' and are therefore subject to stricter entry requirements and restrictions on market conduct.

Employment in regulated occupations has **increased steadily** over time, rising by **over 30 %** since the first half of the 1990s. This can be explained by an increase in the number of regulated professions, as well as an increase in the demand for professional services [5].

Italy is divided into 20 regions, five of which have autonomous status. **The regions have shared legislative competence in the field of education and exclusive competence in the field of**

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

[2] ibid.

[3] Koumenta, M. and Pagliero, M., Measuring Prevalence and Labour Market Impacts of Occupational Regulation in the EU, 2016.

[4] Mocetti, S., Rizzica. L. and Roma, G., Regulated occupations in Italy: Extent and labour market effects, 2018.

[5] ibid.

vocational education and training (VET), both for planning and for the management and delivery of the training offer through accredited structures[6].

Since January 2014, the European Policy Department, the administrations and the Institute for the Development of Vocational Training for Workers (INAPP, previously ISFOL) have worked together with the regions, which are **competent for the professional training required for some regulated professions and for the concurrent regulation of professions alongside the State**[7].

For **professions that come under the shared competence of the state and regions**, in accordance with Article 117 of the Constitution, the coordination with the regions serves a dual purpose. On the one hand, it enables them to exercise their remit in a transparent and collaborative manner, while on the other, it satisfies the need to identify, support and provide guidance to up-and-coming professional organisations within each region, avoiding both over-regulation and the dynamics of uncontrolled development[8].

Legislative Decree No 13/2013 defines the general rules and basic levels of the national skills certification system. It is implemented via approval of the relevant guidelines, following a proposal from the **National Technical Committee**, as provided for in Article 3 of the Decree[9]. A **technical body** assists the committee, and this includes **workers' trade unions and employers' organisations**[10].

With the Decree of 30 June 2015, the Ministry of Labour, in association with the regions, defined an **operational framework for the national recognition of regional qualifications** and the related competences, in the context of the national database of education and training qualifications and the professional qualifications referred to in Article 8 of Legislative Decree No 13/2013.

Over the years, the combined powers of the state and regions have offered opportunities for liaison and cooperation with regard to professions. For example, documents were adopted jointly at state/regional level (e.g. guidelines or agreements within the Joint Conference or Conference of State and Regions) relating to certain professionals defined by national legislation.

The definition of training, its content and duration, and the relevant implementing and organisational procedures fall under the exclusive competence of the regions and autonomous provinces. In recent years, ISFOL-INAPP, together with the Ministry of Labour and the regions, has analysed regional databases of professional qualifications[11] with a view to **linking regional professional training courses with national regulated professions**[12] **(the state having sole authority over the**

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6 Information on the European Commission website on administration and governance at central and/or regional level in Italy (available at: https://eacea.ec.europa.eu/national-policies/eurydice/content/administration-and-governance-central-andor-regional-level-39_it) further clarifies the competences of the different bodies involved.

7 Italian National Action Plan (NAP) for reforming professions, 2016. This clarifies that the coordination of this exercise was initially entrusted to the Autonomous Province of Trento, then to Lombardy Regional Authority and subsequently managed by Tuscany Regional Authority, with the aim of reflecting the importance of professions within the remit of the regions and autonomous provinces since the constitutional reform of 2001.

8 Italian National Action Plan (NAP) for reforming professions, 2016.

9 CEDEFOP, Italy, The national qualification repertory, available at: http://www.cedefop.europa.eu/sv/news-and-press/news/italy-national-qualification-repertory.

10 CEDEFOP, Italy, The national qualification repertory, available at: http://www.cedefop.europa.eu/sv/news-and-press/news/italy-national-qualification-repertory.

11 Following the work of the Professions Group which mainly focused on professionals and activities – both regulated and non-regulated such as: hairdressers, renewable energy system installers, restoration technicians, driving instructors and teachers, stewards, tourist guides, vendors of food and beverages, dental assistants and car mechanics. Italian National Action Plan for reforming professions, 2016.

12 On 15 February 2007, the Conference of Autonomous Regions and Provinces approved the Guide to defining agreements concerning regulated professions, which set out guidelines for the **national regulation of regulated professions**.

identification of professional qualifications) and examining whether there is a need to harmonise the various regional professional training courses. This harmonisation could then be the subject of a future agreement between the Ministry of Labour and the regions for individual professions[13].

Considerable variation exists in the form and content of regulations concerning qualifications, organisation of training and utilisation of these occupational profiles among the regions. This is the case, for example, for health auxiliary professions, such as the 'OSS' (*Operatore Socio Sanitario*, social health operator), which require only a regional vocational qualification yet show significant differences between the regions. According to the President of the National Federation of the Social and Health Professions (MIGEP), this is a significant problem limiting regional mobility and recognition of this qualification among those coming from abroad.

The European Policy Department, together with the Ministry of Labour and INAPP, is to conduct a thorough analysis[14] to **identify those qualifications that in some way obstruct access to regulated professions**. This work seeks to identify all professional qualifications in the national database that involve activities reserved for regulated professions, in which regional professional training courses could be considered to add value to the professional development of individuals. However, as indicated in the National Action Plan (NAP) prepared by Italy for the purposes of the mutual evaluation exercise, other than training courses devolved to the regions under state law, **under no circumstances may these represent a prerequisite for gaining access to the regulated profession in the region concerned**[15].

It is worth noting that the health professions have undergone substantial reform since the early 1990s, with the most significant changes seen in the nursing and midwifery professions, which have witnessed an enhancement of their professional role by the gradual shift from vocational to tertiary education (organised in the '3+2 system') during the 1990s[16]. Unlike all other health professions, medical professions (in Italy, this term relates solely to doctors) have undergone minor changes in the past 20 years: medical training is still gained through a six years' single-cycle university courses, followed by specialty courses, ranging from three years for general practitioners and family doctors to up to six years for some specialisations[17]. In December 2017, the world of health regulated professions and professional orders was reformed by the so-called *Lorenzin* Law. According to the Law[18], the current 'colleges' of health professions and their national federations were transformed into Orders of the same professions and their national federations. Thus, the orders of the nursing professions, obstetricians, technicians of medical radiology and technical sanitary professions of rehabilitation and prevention were added to the existing orders of doctors-surgeons, veterinarians and pharmacists. At the same time, the regulations concerning the internal functioning of the Orders, dating back to 1946, have been redesigned, with provisions introduced to improve their functionality, clarify their tasks (in particular, highlighting public importance and deontological function) and encourage internal

[13] Italian National Action Plan for reforming professions, 2016.

[14] Specifically the new national reference framework for regional qualifications (State/Regions agreement of 22 January 2015) in the context of the national database of educational and training qualifications and professional qualifications (as provided for in Article 8 of Legislative Decree No 13 of 16 January 2013). Italian National Action Plan for reforming professions, 2016.

[15] Italian National Action Plan for reforming professions, 2016.

[16] Luisa Saiani, La storia italiana della formazione infermieristica: la "lunga marcia" dalle scuole regionali ai corsi di laurea magistrale, Tutor - Università degli Studi di Verona, Vol. 16, N. 1, 2016: pp. 32-39.

[17] Palese A., 'Rapporti con i corsi di laurea delle professioni sanitarie. Manifesto degli intenti della Società Italiana di Pedagogia Medica per il triennio 2010-2012', *Tutor*, 10, 2010, pp. 97-98.

[18] Legge 11 gennaio 2018, n. 3: https://www.gazzettaufficiale.it/eli/id/2018/1/31/18G00019/sq.

participation by members. Article 5 of the Law also recognises OSS social workers, sociologists and educators as health personnel rather than technicians.

- **Justification and proportionality of regulation**

No information was identified in relation to Italy's approach to examining the justification and proportionality of regulation. Official sources (Italian government website – Department for European Policies) [19] only indicates that 'each Member State is free to choose its regulatory professions and the conditions necessary for access to and pursuit of the profession, provided that the principles of non-discrimination, proportionality and necessity are respected'. It does not indicate whether Italy has developed an official mechanism to examine the justification and proportionality of regulation prior to adoption and over time.

For the purposes of the mutual evaluation exercise under Article 59 of Directive 2013/55/EU amending the previous Directive 2005/36/EC, Italy screened all national regulations relating to professions to assess whether such regulation is non-discriminatory, proportionate and based on an overriding reason of general interest[20]. Italy updated its regulated professions database internally and, with the coordination and cooperation of all authorities competent for the recognition of professional qualifications, **various stakeholders and social partners**, carried out an assessment of all national regulations relating to professions to ensure that they meet the criteria laid down by the EU [21]. The NAP was then prepared and submitted to the European Commission.

The NAP also **does not indicate the analytical framework** used to assess whether existing regulation is appropriate and proportionate. Although it mentions the reasons for regulation, it does not explain whether any less restrictive type of regulation was considered to achieve the same aim [22]. The NAP did not indicate the extent to which alternatives were considered to minimise the restrictiveness of regulation. The dominant type of regulation of occupations in Italy is by reserves of activities (162 professions), with few professions protected by a title (six professions). In practical terms, this means that the exercise of a specific professional activity is linked to a specific professional qualification, which is the most restrictive type of regulation.

Based on the NAP, it appears that the general approach to regulation did not change substantially after this evaluation. In the NAP, Italy defined three horizontal **lines of action**:

- the revision of training courses and adaptation of state exams for certain technical professions (engineers, technical consultants) to clarify the scope of reserved activities and competences;
- the establishment of a technical working group to identify minimum national standards for professions where training is devolved to the regions;
- identifying all professions regulated at regional level to assess if the regulation is justified and has added value [23].

[19] Department for European Policies, available at: http://www.politicheeuropee.gov.it/it/attivita/mercato-interno/riconoscimento-qualifiche-professionali/.

[20] Italian National Action Plan for reforming professions, 2016.

[21] Italian National Action Plan for reforming professions, 2016.

[22] ibid.

[23] European Commission, Communication on reform recommendations for regulation in professional services, available at: https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:52016SC0436&from=DE, p. 84.

In addition, the NAP contains specific measures for some professions, e.g. professions in the tourism sector 'although not always going into the direction of fewer barriers'[24] and beauticians.

The lack of public information about regulatory requirements, including how the justification and proportionality of regulation is assessed, **does not ensure sufficient transparency**. This makes it difficult to assess whether the mutual evaluation exercise fulfilled the expected objective.

1.2. Recognition of professional qualifications

In Italy, the recognition of professional qualifications is regulated by Legislative Decree No 206 of 6 November 2007, through which Italy transposed Directive 2005/36/EC. In Legislative Decree No 15 of 28 January 2016, Italy transposed Directive 2013/55/EU, updating the previous Directive 2005/36/EC and introducing new rules to facilitate the free movement of professionals within the EU.

To practice a regulated profession, the professional must obtain recognition of his or her qualification by the competent Italian authority. The following Italian authorities are competent to process applications and grant the recognition of professional qualifications[25]:

- Ministry of Culture and Tourism: professions in the tourism industry;
- Ministry of Education, University and Research: professions in the sector of architecture and teaching;
- Ministry of Health: health professions, grouped into seven main categories: medical professions (surgeons and physicians, psychologists, pharmacists, veterinaries); nursing and midwifery professions, rehabilitation professions (physiotherapists, speech therapists, etc.), technical health professions, health prevention professions, health auxiliary professions (OSS or nurse assistants);
- Ministry of Justice: stockbroker, agrotechnical graduate, social worker/junior social worker, actuary, junior actuary, lawyer, chartered accountant and accounting expert, agronomist doctor and forestry, agronomist and forestry doctor, zoonomist, agricultural biotechnologist, geologist, junior geologist, surveyor and surveyor, journalist, civil and environmental engineer, industrial engineer, information engineer, junior civil and environmental engineer, junior industrial engineer, junior information engineer, agricultural expert and graduate agricultural expert, industrial expert and graduate industrial expert, food technology technologist;
- Ministry of Economic Development: craft, trade and services sectors professions;
- Autonomous Province of Bolzano: craft, trade and services sectors professions – only for residents;
- Italian National Olympic Committee (CONI): sporting professions.

The competent national authorities for the recognition of professional qualifications are the national **authorities responsible for the specific policy area**, as mentioned above. For instance, the Ministry of Health is responsible for the recognition of foreign qualifications of health professionals.

[24] ibid, p. 85.

[25] Department for European Policies, available at: http://www.politicheeuropee.gov.it/it/attivita/mercato-interno/riconoscimento-qualifiche-professionali/professioni-regolamentate/.

The user guide for the recognition of professional qualifications (issued by the Italian Government – Department for European Policies[26]) does not refer to the role of professional associations in the recognition process. In the case of professions with self-governing bodies (the Orders), these bodies work together with the national competent authority (i.e. actions are discussed and agreed before being implemented), and professionals must become Order members to exercise their professions. However, they are not involved in the recognition process as such.

KEY FINDINGS

- In March 2019, a total of **183 professions** were regulated in Italy. This represents an **increase of over 30 %** since the first half of the 1990s.
- It is unclear whether there is a specific analytical framework in place to examine the justification and proportionality of regulation. There is **lack of transparency** in this regard.
- The mutual evaluation exercise does not seem to have had a significant impact on Italy's approach to regulation. The NAP indicated specific actions to be undertaken by Italy to modernise professional requirements, although these would not necessarily result in fewer barriers.
- Professional associations and other stakeholders are involved in the design of professional regulation. However, professional associations (Orders) have no role in the recognition of professional qualifications.

1.3. Type and Intensity of Regulation

The table below[27] shows the type and intensity of regulation applied to selected health professions in Italy. Doctors with basic training, general nurses and physiotherapists are regulated by **the strictest type of regulation**, i.e. reserves of activities and protection of the title. These reserves of activities are exclusive and cannot be shared with other medical professionals. To practice their profession, these professionals must also register with the Orders and are obliged to follow continuous professional development. All of the health professions must know Italian in order to practice, although the required language proficiency level is not specified.

For long-term care workers (OSS), whose profession is regulated in Italy, access is based on a regional vocational qualification. There is considerable variation in the regulation requirements between the regions. This is a significant problem, limiting both regional mobility and recognition of this qualification for those coming from abroad.

[26] *Presidenza del Consiglio dei Ministri, Dipartimento per le politiche europee, Guida all'utente Direttive relativa al riconoscimento delle qualifiche professionali*, available at: http://www.politicheeuropee.gov.it/media/1523/guida_utente_qualifprofess.pdf.

[27] The table was completed based on the information provided in the EU Regulated Professions Database. At times, that information is inaccurate or incomplete.

Table 1: Regulatory requirements for selected healthcare professions in Italy

Restrictiveness indicator	Medical doctors (with basic training)	General nurses	Physiotherapists	Long-term care workers (OSS in Italy)
Exclusive reserved activities	Yes	Yes	Yes	No
Protection of the title	Yes	Yes	Yes	No
Shared reserved activities (i.e. activities not limited to one profession)	No	No	No	N/A
Years of education and training	Six[28]	Three[29]	Three[30]	At least 1,000 hours (but with broad differences among the regions, which are in charge of vocational training)
Number of ways to obtain qualifications	One Tertiary education level (Master qualification)	One Tertiary education level (Bachelor qualification)	One Tertiary education level (Bachelor qualification)	One Vocational post-secondary
Mandatory traineeship	Yes	No	No	No
Obligation to have professional experience	No	No	No	Yes
Mandatory state exam	Yes	No	No	No
Continuous professional development obligations (mandatory)	Yes	Yes	Yes	No
Compulsory membership or registration in professional body	Yes	Yes	Yes	No
Limitation of licences (quantity restrictions)	N/A	No	No	No
Territorial validity of a licence	No	No	No	No, but the differences in terms of training hours between regions is a limitation on regional mobility
Age restriction	No	No	No	No

Knowledge of language (if yes, the level required)	Yes Level not specified	Yes Level not specified	Yes Level not specified	Yes Level not specified

KEY FINDINGS

- **High levels of regulation persist in the medical professions**, both for access and practice of professions. Less restrictive types of regulation (e.g. shared reserves of activities) are not considered.
- There is a clear difference between the first three professions (doctors, nurses and physiotherapists) and the fourth (long-term care workers, OSS). There are no reserved activities for this profession, nor is the title protected. Access to OSS is based on a **regional vocational qualification**, the requirements for which however vary between the regions. This is a **significant problem**, limiting regional mobility and the recognition of foreign qualifications.
- The non-medical professions (i.e. nurses and physiotherapists) have been through several changes with regard to training and the option to exercise the professions, introducing similar regulation as for the medical professions (these refer only to doctors in Italy). These reforms **increased the intensity of regulation regarding nurses and physiotherapists**.
- In 2017, OSS changed from a technical profession to a health profession, again **increasing the intensity of regulation.** There was an attempt to provide them with an Order but this has not yet been implemented[31].
- All of the health professions must know Italian in order to practice but the required language proficiency level is not specified. The provision on linguistic checks for OSS is a general one, rather than specific to particular regulatory or administrative acts.

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

The Single Point of Contact is the website of the Ministry of Economic Development, where a brief section (in English) provides information on the establishment of services which require a professional qualification. The website also provides information about and/or useful links to:

[28] It takes six years (after the high school diploma) to achieve a Bachelor's degree in medicine. After the conclusion of their studies, graduates in medicine must pass a licensing exam (*Esame di Stato*) as a precondition for their enrolment in locally based professional registers. Then, there is the mandatory enrolment in the Order, without which a doctor is not authorised to operate in the health sector. Subsequently, they must complete their education with further studies, as no doctor can really practice without a specialisation. Access to a specialisation course (2-5 years) is controlled by a national exam. Finally, a specialisation diploma is issued.

[29] It takes three years (after the high school diploma) to achieve a Bachelor's degree in nursing. During the three years, a mandatory traineeship is completed. Once the Bachelor's degree has been obtained, the nurse has the opportunity to continue his or her studies and choose to pursue a Master's degree to specialise in a particular area. To exercise the profession, the nurse must be admitted to a register, held by the Provincial Orders (former colleges), coordinated by the National Federation of Nursing Professions Orders.

[30] It takes three years (after the high school diploma) to achieve a Bachelor's degree in physiotherapy. During the three years a mandatory traineeship is completed. On completion of a Bachelor's degree, the physiotherapist may undertake a further Master's degree to specialise in a particular area. The *Lorenzin* Law on health professions (approved by the Senate in December 2017 and entered into force with Law No 3 of 11 January 2018) established a register for each of the regulated but not ordered health professions, including the Register of Physiotherapists.

[31] In 2018, an amendment in the Budget Law introduced a derogation for those people who had been employed for at least 36 months in the previous 10 years doing similar activities. This would allow also people that could have lower level of qualifications (as requested in the past), but with professional experience, to exercise the health profession of OSS.

- The list of regulated professions and competent authorities (list of all competent Ministries and regions for different professions and links to their websites);
- The process of recognition of professional qualifications, with information on relevant EU and Italian legislation;
- Information of the freedom of establishment;
- Information on the cross-border provision of services;
- Information on language requirements;
- The list of professions for which a European Professional Card (EPC) is available;
- How to appeal against decisions of competent authorities;
- The assistance centre.

However, most of this information is **only in Italian**.

More information on regulated professions can be found on the website of the **Italian Assistance Centre** for professional qualifications of the Department for European Policies[32]. The Assistance Centre provides citizens with the necessary information on the recognition of professional qualifications, and, where appropriate, assists citizens who need recognition of professional qualifications. Unfortunately, again, this website is **only in Italian**.

With regard to the documents required from EU citizens who intend to settle in Italy, additional information is provided in the guidelines published on the Italian government website – Department for European Policies[33]. However, this guide is **only in Italian**.

There is an option to submit questions and/or requests to a general email address: centroassistenzaqualifiche@politicheeuropee.it or to call a number, which is **not toll free**.

The fact that most of documentation and information are provided only in Italian and that the contact centre can be contacted only through a generic email address or a non-toll-free number contributes to making the system **complicated and not easy accessible**.

There is **no way of completing these administrative procedures online**. The website only lists the necessary documents and procedures, and provides links to legislation and competent authorities. This information again is **only in Italian**. The fact that online procedures are not available reflects Italy's ranking in 25th place according to the digitalisation index (DESI) for Europe[34].

There is no evidence that **fees and cost** are a major obstacle. The Department for European Policies states that applications must be accompanied by a tax stamp of EUR 16[35].

By contrast, the **Italian language proficiency requirement is a major obstacle**. As indicated above, most information provided to applicants is in Italian and all of the preliminary applications for

[32] Department for European Policies, available at: http://www.politicheeuropee.gov.it/it/attivita/mercato-interno/riconoscimento-qualifiche-professionali/centro-di-assistenza/.

[33] Department for European Policies, available at: http://www.politicheeuropee.gov.it/media/1523/guida_utente_qualifprofess.pdf.

[34] European Commission, Digital Economy and Society Index (DESI), available at: https://ec.europa.eu/digital-single-market/en/scoreboard/italy.

[35] Department for European Policies, available at: http://www.lavoro.gov.it/temi-e-priorita/ammortizzatori-sociali/focus-on/riconoscimento-delle-qualifiche/Pagine/default.aspx.

professional recognition and any compensatory measures always take place in Italian, regardless of the specific regulated profession.

KEY FINDINGS

- There are three major barriers to recognition of professional qualifications in Italy:
  - **Significant language barriers** in accessing clear and detailed information on the conditions for recognition (e.g. documentation requirements, fees);
  - **Insufficient guidance** for applicants during the recognition process;
  - The **lack of an online application procedure**.
- No information was identified on national level initiatives to facilitate the recognition of foreign professional qualifications held by EU citizens.

1.5. Recognition rates and length of proceedings

Based on the EU Single Market Scoreboard, Italy scores well **below average** in terms of positive decisions and quick positive decisions taken. Possible causes may be a recognition system characterised by a **lack of general guidance and underdevelopment of recognition structures** (e.g. specialised centres and services for support)[36].

While the inefficiencies described above substantially affect the free movement of professionals, the extent to which the length of the recognition procedure represents an obstacle to mobility and employment of professionals is unclear. A lack of input from stakeholders or clear information from national sources makes it impossible to provide a definite answer here.

KEY FINDINGS

- The **absence of clear guidance** for professionals seeking recognition represents a serious issue.
- The 2016 Study on obstacles to recognition of skills and qualifications pointed out that EU policy makers could consider creating a single EU web portal to centralise information on recognition policies, practices and decisions across the EU and in EEA countries. This would include a clear overview of the recognition practices in each Member State/EEA country, relevant laws/frameworks, the main actors and available mechanisms for recognition for different types of qualification (national/EU/third country), skills and informal/non-formal learning[37].

[36] European Commission, Study on Obstacles to Recognition of Skills and Qualifications, Final Report, 2016, available at: https://ec.europa.eu/social/main.jsp?catId=738&langId=en&pubId=7939&type=2&furtherPubs=yes.

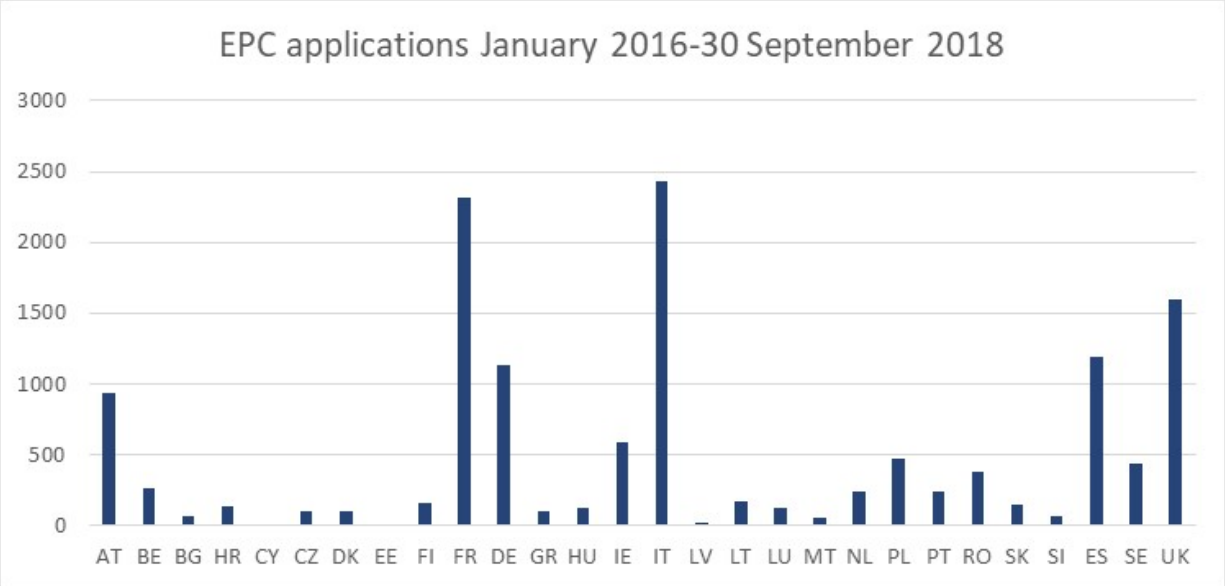
[37] ibid.

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

2.1. European Professional Card (EPC)

Data on the EPCs in respect of Italy as a home and host Member State show that it has dealt with the **highest number of applications** in the EU (see Figure 2 below), i.e. **2,432 applications** of the 6,828 in total in the period from January 2016 to September 2018[38].

Figure 2: Member States concerned by EPC applications[39]



In relation to the EPCs issued, Italy is **second** only to France, being involved in the **granting** of **1,353 EPCs**. The word 'involved' is used here to reflect Member States' status as both host Member States (issuing the EPC) and home Member States (making sure the professional's application is complete before it is transferred to the host Member State, as well as issuing the card for the provision of temporary services for professions without health and safety implications)[40].

There is a significant difference between the numbers of applications submitted and EPCs eventually issued. In its assessment of stakeholders' experiences regarding the EPC, the European Commission noted that only 11 % of applications were rejected or refused, with others 'either withdrawn by the professional or closed by the system when the professional did not pursue the application and did not react to the authorities' queries about missing documentation or fees'[41].

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

39 ibid.

40 European Commission, Assessment of stakeholders' experience with the European Professional Card and the alert mechanism procedures, available at: https://ec.europa.eu/growth/single-market/services/free-movement-professionals/european-professional-card_en.

41 European Commission, Assessment of stakeholders' experience with the European Professional Card and the alert mechanism procedures, available at: https://ec.europa.eu/growth/single-market/services/free-movement-professionals/european-professional-card_en.

Based on the data on specific professions (covering 2016 and 2017)[42], in Italy, the profession of **mountain guide** is notable both for the numbers of applications submitted as a host country (over 75 %) and EPCs issued (83 %) (Table 2). In most cases, these related to **temporary and occasional provision of services** in the Italian Alps[43].

Table 2: EPC applications submitted and EPCs issued by Italy as a host country (2016 and 2017)[44]

Profession	EPC applications submitted	EPCs issued
Mountain guides	507	207
General nurses	38	12
Pharmacists	16	7
Physiotherapists	74	5
Real estate agents	34	17

The biggest professional group in terms of submitting an EPC application to leave Italy (for the years 2016 and 2017) was physiotherapists (37 %), although only 25 % of those were issued. The second biggest group was nurses (27 %).

Table 3: EPC applications submitted and EPCs issued by Italy as a home country (2016 and 2017)[45]

Profession	EPC applications submitted	EPCs issued
Mountain guides	133	96
General nurses	201	39
Pharmacists	138	42
Physiotherapists	280	69
Real estate agents	2	13

Although the EPC is intended to save time and costs, Italian authorities report that **most applicants continue to prefer the traditional paper-based procedure**[46]. The reasons for this are not known but could be linked to insufficient awareness of the EPC as a new instrument, difficulties using the EPC online platform (asking applicants to select the applicable recognition regime, which requires good

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

[43] Information available on the website of the Italian government (Department for European Policies), available at: http://www.politicheeuropee.gov.it/en/communication/news/european-professional-card-2017-state-of-play/.

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

[45] ibid.

[46] Information available on the website of the Italian government (Department for European Policies), available at: http://www.politicheeuropee.gov.it/en/communication/news/european-professional-card-2017-state-of-play/.

knowledge of complex legal requirements), and insufficient transparency of documentary requirements and/or fees.

In a 2017 survey to assess the functioning of the EPC[47], the Italian authority responsible for issuing EPCs to nurses, pharmacists and physiotherapists noted that the EPC functions very well overall but does **not contribute to enhancing transparency in respect of national document requirements and fees**, either for professionals or national competent authorities, and does not help to overcome language barriers.

In conclusion, the overall number of EPCs issued is **not yet sufficiently significant to facilitate mobility and employment** of EU citizens. However, it has benefited one specific group of professionals (mountain guides) and clearly contributed to their mobility to and from Italy. In terms of the Italian labour market, however, with surplus occupations in the tourism industry and shortages of highly skilled professionals in ICT, engineering, healthcare and teaching[48], two actions would be useful:

- understanding the reasons why the EPC is not more widely used by those health professionals for whom it is available;
- considering extending the EPC to other professions (i.e. those with labour shortages).

From the simulation exercise on the EU website[49], it appears that Italy **does not charge fees** for the EPC, either as a host or home Member State. This can be considered good practice in that it limits costs for applicants in the recognition procedure.

KEY FINDINGS

- Italy experiences the **highest numbers** of EPC applications in the EU.
- Overall, the number of issued EPCs is **not significant enough** to facilitate mobility and employment.
- The EPC has **benefited one specific group of professionals** (mountain guides) and has clearly contributed to their mobility to and from Italy. This profession is notable for both the number of submitted applications (over 40 %) and EPCs issued (70 %).
- The EPC has **not been widely used in professions experiencing labour shortages**, such as general nurses.
- The issues hindering wider use of the EPC are not clear but could be linked to insufficient awareness of the EPC, difficulties using the EPC online platform and insufficient transparency of documentation requirements and/or fees.

[47] European Commission, Survey on the first year of the European Professional Card, Anonymous and non-anonymous responses to the survey, 2017, available at: http://ec.europa.eu/growth/content/take-part-our-survey-first-year-european-professional-card-0_en.

[48] CEDEFOP, Skills mismatches in Italy, available at: https://skillspanorama.cedefop.europa.eu/en/analytical_highlights/italy-mismatch-priority-occupations#_stem_occupations__6.

[49] European Commission, European Professional Card, available at: https://europa.eu/youreurope/citizens/work/professional-qualifications/european-professional-card/index_en.htm.

2.2. Partial access to professional activities

The introduction of partial access **has not led to greater mobility and employment in Italy**. Partial access has been requested and granted in very few cases, mainly relating to professions in the **tourism industry**.

According to the Regulated Professions Database[50], there were **only three cases** of (positive) partial access granted for establishment in 2017. In the years before, no decisions with partial access were recorded (data for 2018 are not available). All three partial access cases concerned recognition of qualifications of **ski instructors qualified in Romania**. For temporary provision of services, partial access was granted in **eight cases**, all concerning **mountain guides** from Austria.

Partial access to a profession is possible in Italy, thus it is not among the Member States with infringement proceedings pending[51]. However, it is **up to the applicant to seek partial access**[52]. The PQD does not oblige Member States to offer the applicant partial access to a profession instead of rejecting his or her application for full recognition. Professionals must thus be aware of the option of partial access, as well as of the differences in the regulatory regimes, to be certain that he or she has better chances of obtaining partial than full access. The limited number of applications for partial access seems to suggest that this option is not well known to applicants.

KEY FINDINGS

- Partial access to professional activities has been granted in 11 cases in Italy. A possible reason for the **limited number** of cases may be insufficient awareness among applicants of the existence of this option and the conditions enabling access.

2.3. Temporary service provision

Italy places **second** among the top five countries where mobile professionals provide services on a temporary and occasional basis (along with Austria, Denmark, Switzerland and the UK). The most mobile professions are in the **tourism industry** (ski instructors, tourist and mountain guides), as are health professionals providing temporary services (doctors, dentists, veterinarians)[53].

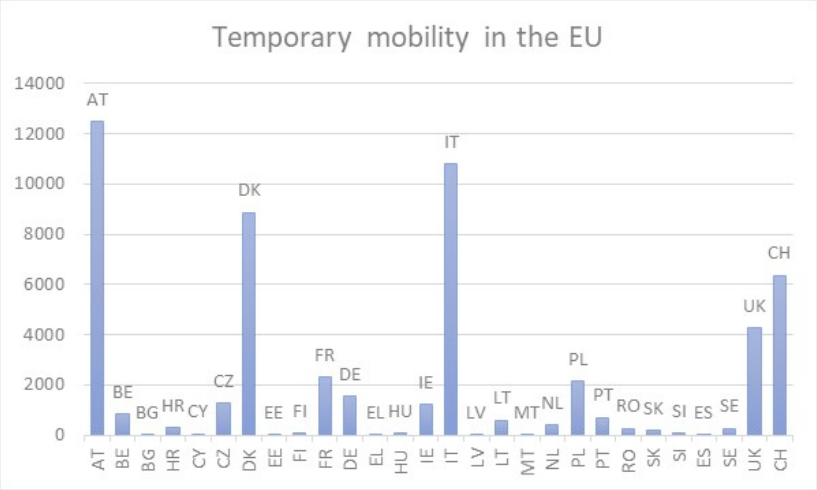
[50] European Regulated Professions Database, available at: http://ec.europa.eu/growth/tools-databases/regprof/.

[51] European Commission, Press release, available at: http://europa.eu/rapid/press-release_IP-19-1479_en.htm.

[52] Article 4f PQD.

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

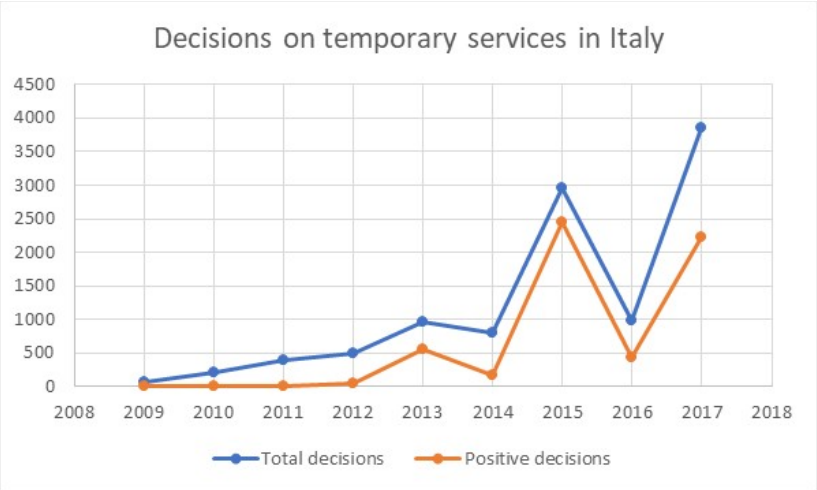
Figure 3: Temporary mobility in the EU



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

The data in the Regulated Professions Database show an overall **upward trend** from 2009 to 2017 in the number of declarations introduced and decisions taken for professions with health and safety implications (the host Member State can check qualifications in such cases) (see Figure 4 below).

Figure 4: Declarations / decisions on temporary services in Italy between 2009 and 2017[54]



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

Based on the positive trend and the **significantly higher temporary mobility** compared to other EU Member States, it can be concluded that temporary provision of services facilitates mobility of EU citizens to Italy.

However, it is **not possible to establish a clear a link with the 2013 PQD amendments**, which came into force in 2016. As shown in Figure 4 above, there is a dip in the number of declarations and decisions on temporary services in 2016 (for reasons unknown), and the number of **positive decisions actually decreased** in 2017 compared to 2015. This can be explained by the fact that in 2017 the overwhelming

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

majority of declarations were submitted by foreign ski instructors. Given the health and safety implications, Italian authorities can check their qualifications and reject their applications. This represents the risk emphasised by the Commission in its 2011 evaluation of the Directive, i.e. that prior checks may unduly restrict the scope of the temporary provision of services regime 'to the detriment of professionals who should benefit from lighter procedures'[55].

KEY FINDINGS

- Italy is **second** among the top five countries where mobile professionals provide services on temporary and occasional basis.
- The most mobile professions were in the tourism industry (ski instructors, tourist and mountain guides), as well as health professionals (doctors, dentists, veterinarians).
- Data provide **mixed results** in terms of the impact on mobility of the option to provide temporary services. Data show an overall an upward trend since 2009 in the number of declarations introduced and decisions taken, but the positive decisions in 2017 had decreased compared to 2015.
- The impacts of the revised PQD provisions on the provision of temporary services remain unclear.

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

According to the EU scoreboard[56], around 250 authorities in Italy use the internal market information IMI-system. Most requests sent and received in the IMI-system concern **professional qualifications**, thus its use can strengthen and simplify administrative cooperation and facilitate recognition of professional qualifications. However, it is **not possible to detail** the extent to which the exchange of information in the IMI-system effectively facilitates recognition of professional qualifications. In response to the 2017 survey[57], Italian authorities noted that communication with the relevant authorities is **satisfactory overall**. Similarly, in relation to the alert system, the survey responses indicated some issues with the functionalities of the alert mechanism, but an overall satisfaction with the experience of the mechanism. Due to the insufficient responses from the Italian stakeholders consulted for the study, the current issues in using the IMI-system from the perspective of Italian authorities are unknown.

KEY FINDINGS

- Insufficient feedback from stakeholders means that current issues in using the IMI-system for exchange of information and the alert mechanism are not known.

[55] European Commission, Evaluation of the Professional Qualifications Directive, 2011, p. 69.

[56] EU scoreboard, available at: http://ec.europa.eu/internal_market/imi-net/statistics/index_en.htm#t_0_1.

[57] Survey results, available at: https://ec.europa.eu/growth/content/take-part-our-survey-first-year-european-professional-card-0.

2.5. Sectoral amendments

From desk research and stakeholder consultation it was not possible to identify the extent to which the sectoral amendments to the minimum training requirements have facilitated recognition. However, for professionals qualified in Italy, some new entry routes have been added (e.g. based on acquired rights of professionals trained in Italy in the period after 31 December 1983 and before 1 January 1991), which may potentially facilitate more mobility of professionals.

Language requirements for health professions do not pose challenges for the applicants during the recognition process. However, a certain level of proficiency needs to be proven to **access the profession**. The level of required knowledge is **not clear** from publicly available information, making it difficult to judge whether the language requirements are proportional. From the point of view of an applicant, however, this creates uncertainty as to the level required and the means of proving proficiency. There is no information on whether Italy provides publicly funded languages courses for foreign professionals.

According to the national Order of nurses (FNOPI) (in their written answers to the questionnaire), the language requirements present a strong obstacle to mobility, particularly for professionals trained in Italy who wish to work abroad. In fact, very high proficiency levels of knowledge are required in other Member States, which not everyone can reach, and in any case are surely higher than those required by Italy for the access of nurses from abroad.

KEY FINDINGS

- No information is available on the impact of the revised minimum training requirements on the recognition process. However, new routes (e.g. recognition of acquired rights) for Italian professionals to have their qualifications recognised can facilitate mobility.
- Language requirements are not clear for health professions, leading to uncertainty for professionals with respect to the level of proficiency in Italian required to access the profession. This may discourage professionals from starting the recognition process. According to the stakeholders consulted, however, the required language proficiency level in Italy is lower than that of other Member States.

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

3.1. Italy as a host country

Italy is one of the most important destination countries for EU movers, although inflows have considerably decreased since the beginning of the economic crisis in 2008. In 2016, annual inflows of EU movers of working age were only half (51,000) those in 2009 (110,000). Nevertheless, Italy still received the **seventh highest number of movers** across the EU[58].

Despite this strong decrease in inflows, the numbers of decisions on recognition **doubled** between 2009 and 2017 (from 2,000 to 4,000). There was a significant dip in 2011, when decisions decreased to 1,000 before increasing again. Notably, the **share of negative decisions** increased substantially between 2013 and 2017 (13 %-17 %) compared to prior years, when negative decisions were below 10 %. This is quite high compared to the EU average of a 5 % rejection rate both for the time span 2008-2013 and 2014-2017[59]. Health professionals from other EU Member States have been among the biggest professional groups seeking recognition of qualifications, although the total numbers changed over time (see below). In the **2008-2012** period, almost **40 % of all recognition decisions were for nurses and 10 % for medical doctors,** making up the two largest professional groups, followed by lawyers (8 %). Dental practitioners and physiotherapists ranked fourth and fifth. In the **2013-2017 period, secondary school teachers were the largest group** (21 %), while the number of dental practitioners became more significant than nurses and doctors[60]. Of those groups, only nurses were reported by the Public Employment Service as an occupation experiencing shortages in 2016[61].

According to the Ministry of Health (in its written answers to the questions submitted for this study), the presence of EU movers in the Italian health sector has increased considerably in the past decade, although the crisis is still inducing substantial changes in this labour market sector. According to MIGEP, migrant health workers are concentrated in particular among nursing professions and lower-level health auxiliary occupations (OSS), while the numbers of foreign doctors employed in Italy remains low.

According to the EU-LFS data (stocks of mobile health professionals (health professionals from other EU countries)), Italy is an important country of destination for health professionals from other EU Member States (with another EU nationality). In 2016, it hosted 20 % of all mobile health professionals and health associate professionals [62] in the EU, being the **third most important country of destination** after Germany (31 %) and the UK (22 %)[63]. However, in terms of reliance [64] on health professionals from other EU nationalities, Italy is well below the EU average (3 % at EU level, and below

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58 Eurostat Immigration Data [migr_imm1ctz].

59 DG GROW, Regulated Professions Database, Overall Statistics for Professionals moving abroad (establishment).

60 ibid.

61 European Commission, 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 J. McGrath and J. Behan, available at: https://publications.europa.eu/en/publication-detail/-/publication/28a5c10c-48fc-11e8-be1d-01aa75ed71a1/language-en.

62 Mobile health (associate) professionals are those of an EU nationality residing in a Member State different than their citizenship. For definitions of health professionals (ISCO 2D = 220) and health associate professionals (ISCO 2D = 320), see ISCO coding definitions in the Annex to the report.

63 European Commission, 2017 Annual Report on intra-EU labour mobility, Chapter 2.4.2, 2018, prepared by E. Fries-Tersch, T. Tugran and L. Rossi.

64 Reliance is the share of foreign health workers compared to the native health workers.

1 % for Italy), while for health associate professionals, it is slightly below the EU average (3 % at EU level, slightly more than 2 % for Italy)[65].

The vast majority of the mobile health (associate) professionals in Italy are nursing associate professionals[66], with around 18,000 **nurses** in Italy of another EU nationality in 2017. These made up roughly 4 % of all nurses in Italy. The number of mobile health professionals (more specifically, specialist medical practitioners) was only 1,500[67] in 2017, making up roughly 1 % of all health professionals. According to the Ministry of Health, this may be linked to the fact that the number of places available for enrolment in nursing degree courses in Italy increased and the demand for nurses from abroad (that was consistent until 2011-2012) tended to decline[68].

Italy is even more important when it comes to **personal care workers in health services**[69] from other EU Member States (with another EU nationality). In 2016, Italy hosted 44 % of all such mobile care workers, being by far the principal country of destination (followed by the UK, with 23 %). In 2017, there were around 119,000 personal care workers in Italy with another EU nationality. Of those, 7,000 were healthcare assistants (working in health or care institutions) and 112,000 were home-based personal care workers. Mobile EU personal care workers made up 18 % of all personal care workers in Italy in 2017 and 17 % in 2016[70]. This makes Italy the EU Member State with the largest reliance on personal care workers from other EU countries (followed by Luxembourg, with 16 %, Austria, with 9 % and Germany, with 6 %). Reliance on personal care workers from third countries in Italy is even higher, at 24 %[71].

When looking at data on recognition of professional qualifications on the Regulated Professions Database – statistics on recognition decisions for establishment, the following key trends are noted:

Doctors in basic medicine from other EU countries:

The total number of decisions increased since 2009, with a slight dip in 2015.

Compared to the EU average, the **shares of positive decisions have been quite low in Italy since 2012, ranging from 67 % to 83 %** (at EU level, the shares of positive decisions for doctors from another EU country were 89 % or higher throughout 2011-2017). This is due to a rather large share of 'neutral' (i.e. ongoing) decisions and also the fact that shares of negative decisions have been quite high, above 10 % in the years 2010-2012, 2015 and 2017. As a comparison, the shares of negative decisions for doctors for all EU host countries varied between 1 % and 3 % in the period 2011-2017.

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65 European Commission, 2017 Annual Report on intra-EU labour mobility, Chapter 2.4.2, 2018, prepared by E. Fries-Tersch, T. Tugran and L. Rossi.

66 In Italy, there are only numbers for nursing associate professionals (also in the data for those of Italian citizenship), and only blanks for nursing professionals, thus it appears that all nurses are coded under 'nursing associate professionals'.

67 This figure is of low reliability.

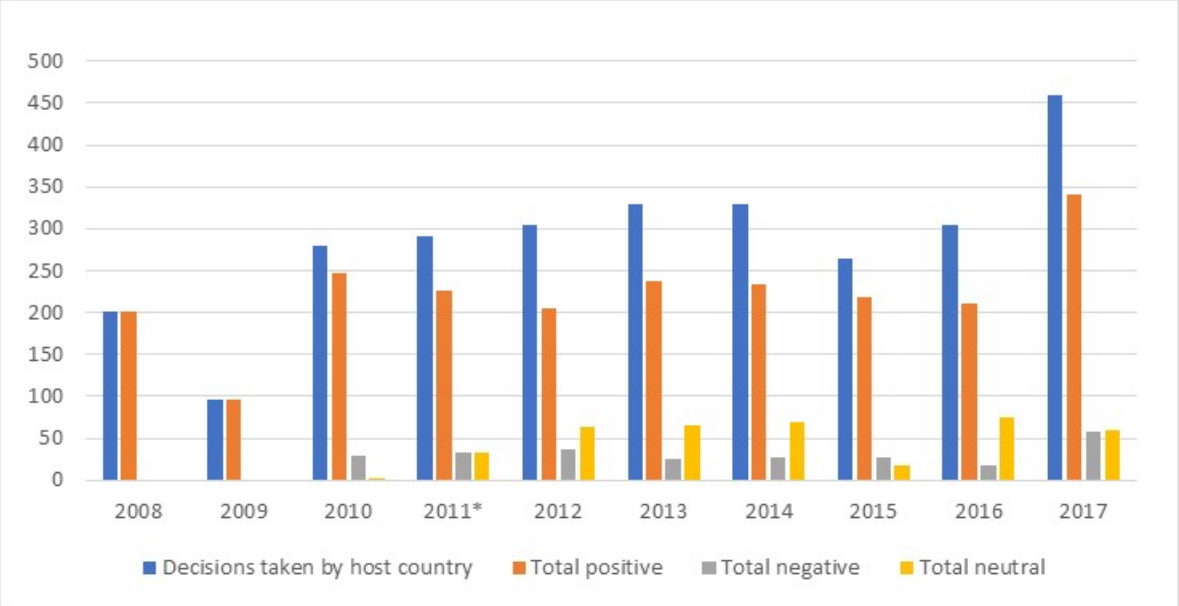
68 The Ministry of Health, by a specific regulatory provision (Article 6ter of Legislative Decree 502 of 1992), carries out a specific activity for determining the training needs of the health professions regulated in Italy on the basis of a methodology and forecasting model developed during a pilot project carried out in the context of a Community initiative, the Joint Action on Health Workforce Planning and Forecasting.

69 ISCO code 532 and the definition in the coding document.

70 EU-LFS, 2017, Milieu Consulting calculations.

71 European Commission, 2017 Annual Report on intra-EU labour mobility, Chapter 2.4.2, 2018, Annex, Table 59, prepared by E. Fries-Tersch, T. Tugran and L. Rossi.

Figure 5: Decisions on medical doctors from other EU Member States by Italy



Source: DG GROW, Regulated Professions Database, Overall Statistics for Professionals moving abroad (establishment). Data for 2011 was missing and was thus estimated as an average of 2010 and 2012.

General nurses from other EU countries:

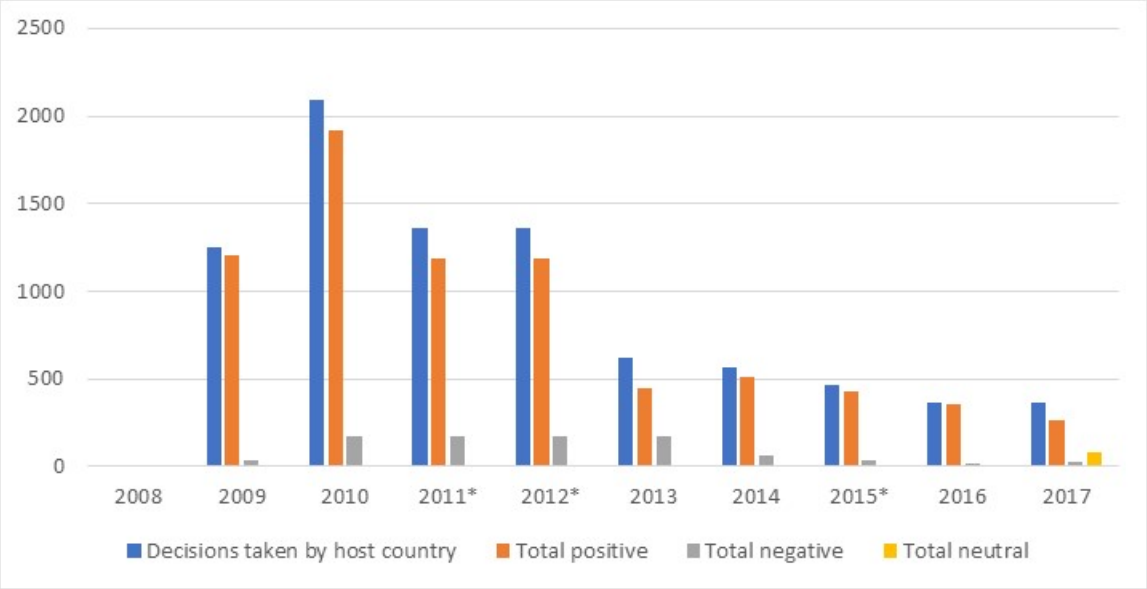
Fewer nurses are coming from other EU countries in recent years. Since 2011, when there were 2,000 decisions for nurses, the numbers have decreased consistently to 266 in 2017.

This might be explained by the fact that public employment in the healthcare sector has been subject to substantial restrictions in the past decade due to policies of cost-containment implemented by national and regional health authorities. Turnover of medical and nursing staff in public health structures has been strongly limited.

There was a clear increase in the share of positive decisions between 2013 and 2016 (73 %-95 %)[72]. This may be related to the fact that the shares of positive decisions taken under the automatic recognition regime (for sectoral professions) increased a lot in the period 2013 to 2016 (73 % or higher) compared to the period 2009-2010 (17 % and 18 %).

[72] Many of the 2017 decisions are still outstanding, thus it is not possible to determine whether or not this trend continues.

Figure 6: Decisions on general nurses from other EU Member States by Italy

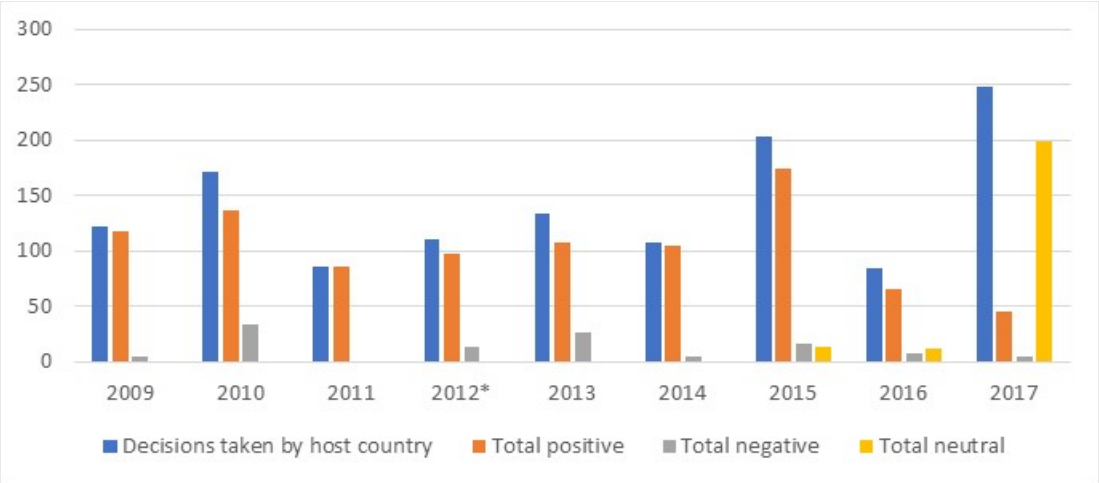


Source: DG GROW, Regulated Professions Database, Overall Statistics for Professionals moving abroad (establishment). Data for 2011, 2012 and 2015 was missing and was thus estimated as an average of the closest years.

Physiotherapists from other EU countries:

The total number of decisions decreased between 2010 and 2011 before increasing more or less steadily (except for a large drop in 2016) until 2017. The share of positive decisions varied, but dropped between 2014 (96 %) and 2016 (76 %). The share of positive decisions without compensation measures from all positive decisions increased strongly between 2014 (72 %) and 2015 (90 %), but then dropped again slightly in 2016 (86 %).

Figure 7: Decisions on physiotherapists from other EU Member States by Italy



Source: DG GROW, Regulated Professions Database, Overall Statistics for Professionals moving abroad (establishment). Data for 2012 was missing and was thus estimated as an average of the closest years.

Data on foreign-trained nurses also confirm the slow-down of immigration of nurses from other EU Member States[73]. Inflows showed an extremely strong year-on-year increase between 2001 and 2003 (between +100 % and +300 %) and continued, at a slower rate, between 2004 and 2006. The years 2007 to 2015 were marked by year-on-year decreases in the inflows of nurses trained in another EU country, 2016 showed an increase of 30 %, but 2017 showed a decrease again.

Among EU movers working in Italy as health professionals and health associate professionals, an overwhelming majority come from Romania. In 2016, around 60 % of all health (associate) professionals were Romanian, followed by around 20 % Polish and 8 % Greek nationals. Among EU movers working as personal care workers, Romanians form an even larger share, at almost 90 %. Polish and Bulgarian citizens each made up around 5 % of mobile personal care workers[74].

While Poland and Germany were the most important countries of origin of foreign-trained nurses in Italy (for both stocks and inflows) in the year 2000, as of 2004, Romania became the most important country of origin by far, followed by Poland. However, when looking at inflows in 2017, Germany has overtaken Poland as a country of origin (although Romania remains firmly in first place)[75].

3.2. Italy as a country of origin

Italy is one of the **main countries of origin** of EU movers. In 2017, Italians were the third largest group of (economically active) EU citizens living in another EU Member State[76]. The numbers of persons seeking recognition of a qualification obtained in Italy in another EU Member State increased substantially in recent years, more than doubling between 2013 and 2015/2016 (from 2,600 to 5,700)[77].

Italy is also an important **source country of health professionals**. In 2016, Italians made up 9 % of EU movers working as health (associate) professionals in another EU country, the third largest group after Romanians (14 %) and Polish (12 %)[78]. In total numbers, this corresponds to around 33,000 health professionals or health associate professionals of Italian nationality working in another EU Member State[79]. The number of Italian health (associate) professionals working in other EU Member States increased almost continuously between 2011 (around 15,000) and 2016 (33,000), as did their share of all Italian health (associate) professionals[80]. In the same realm, the number of requests made by Italian health professionals (doctors, pharmacists, nurses, physiotherapists, psychologists and dentists) to work abroad has increased by 30 % in the past five years. During the same period, the labour demand from other countries for Italian health professionals has also increased by 40 %[81].

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[73] Organisation for Economic Co-operation and Development (OECD), Dataset on Health Workforce Migration; Data on foreign-trained doctors is not available by country of training, thus figures for doctors trained in other EU countries cannot be estimated.

[74] European Commission, 2017 Annual Report on intra-EU labour mobility, Chapter 2.4.2, Figures 51 and 52, 2018, prepared by E. Fries-Tersch, T. Tugran and L. Rossi.

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

[76] European Commission, 2018 Annual Report on intra-EU labour mobility, Chapter 3.4.2, prepared by E. Fries-Tersch, T. Tugran, A. Markowska and M. Jones, 2019.

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

[78] European Commission, 2017 Annual Report on intra-EU labour mobility, Chapter 2.4.2, 2018, prepared by E. Fries-Tersch, T. Tugran and L. Rossi, p. 123.

[79] European Commission, 2017 Annual Report on intra-EU labour mobility, Chapter 2.4.2, Figure 56 and Annex Table 60, 2018, prepared by E. Fries-Tersch, T. Tugran and L. Rossi.

[80] European Commission, 2017 Annual Report on intra-EU labour mobility, Chapter 2.4.2, Figure 58 and Annex Figure 75, 2018, prepared by E. Fries-Tersch, T. Tugran and L. Rossi.

[81] *Ordine delle Professioni Infermieristiche della provincial di Bologna*, 2 August 2017, available at: https://www.ordineinfermieribologna.it/2017/in-italia-oltre-60mila-professionisti-sanitari-stranieri.html.

In the period 2008 to 2013, doctors were the largest group (35 %) seeking recognition of qualifications from Italy. In the period 2014 to 2017, that changed somewhat, with nurses becoming the most important group (39 %), with doctors in second place (18 %)[82].

For personal care workers, Italy is a less important source country (partly because almost 50 % of mobile personal care workers EU-wide come from Romania alone), but it is among the five largest source countries. In 2016, around 3 % of all EU movers working as personal care workers in another EU Member State were Italian. In total numbers, this represented 7,200 Italian personal care workers in 2016, which is around 2 % of all Italian personal care workers, including those working in Italy[83].

The trend of Italian personal care workers in other EU Member States has been flat since 2011, with their share of all Italian personal care workers remaining at around 2 % throughout the 2011-2016 period[84].

Data on recognition of professional qualifications from the Regulated Professions Database – statistics on recognition decisions for establishment, show the following key trends:

Doctors in basic medicine qualified in Italy:

The total number of decisions by other EU countries on doctors qualified in Italy decreased slightly between 2008 (around 800) and 2011 (around 600), then dropped in 2012 (around 300) and then increased strongly in 2013 (1,000) and 2014 (1,200), before dropping again in 2015 (800) and 2016 (800).

The share of positive decisions on doctors qualified in Italy shows no clear trend over time and varied between 86 % (in 2009 and 2010) and 97 % (in 2012). In recent years (between 2013 and 2017), the share remained around 90 %.

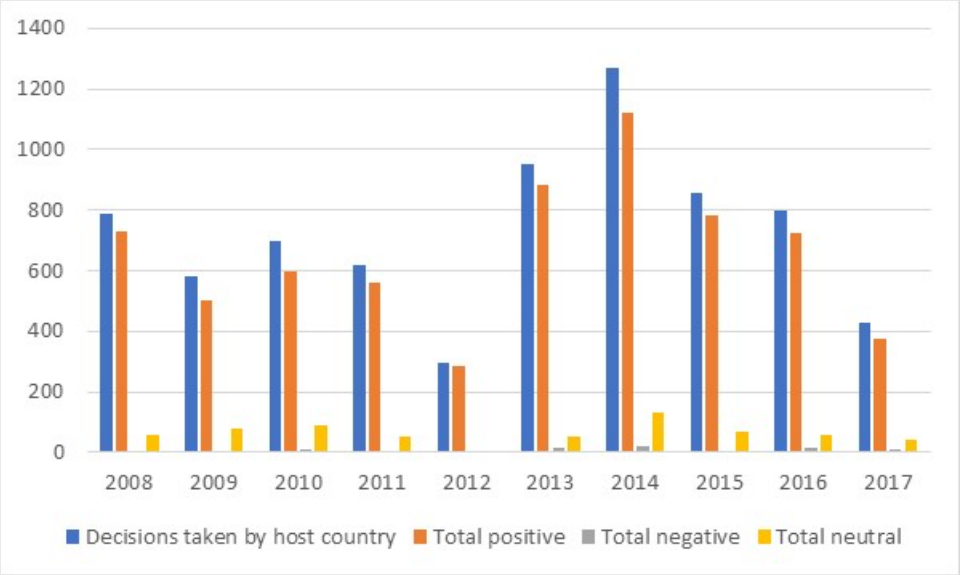
Most decisions are taken based on the automatic recognition regime. However, their share dropped in 2015, from almost 100 % between 2011 and 2014, to around 90 % in 2015 and 2016, and rising to 98 % again in 2017.

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

[83] European Commission, 2017 Annual Report on intra-EU labour mobility, Chapter 2.4.2, Figure 57 and Annex Table 60, 2018, prepared by E. Fries-Tersch, T. Tugran and L. Rossi.

[84] European Commission, 2017 Annual Report on intra-EU labour mobility, Chapter 2.4.2, Figure 59, 2018, prepared by E. Fries-Tersch, T. Tugran and L. Rossi.

Figure 8: Decisions on doctors qualified in Italy by other EU Member States



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

General nurses qualified in Italy:

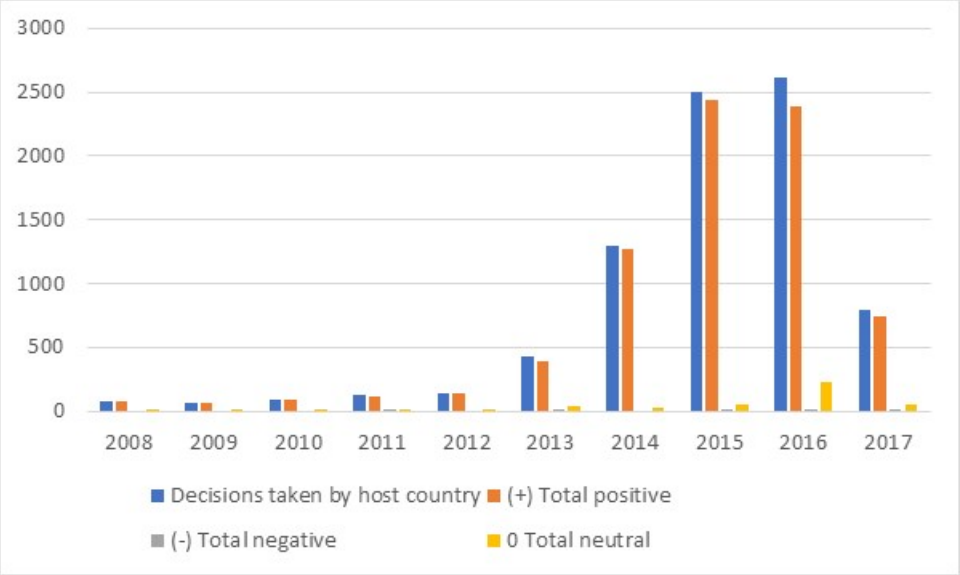
The number of decisions in other EU Member States on general nurses qualified in Italy was quite low between 2008 and 2013 (between 0 and 500), but then sharply increased in 2014 (to 1,300) and then further increased in 2015 and 2016 (to around 2,500 for both years), before dropping to 790 in 2017.

The share of positive decisions on these applications does not show a clear trend in time. In the peak years, 2015 and 2016, it varied between 98 % (in 2015) and 91 % (2016). The lowest recognition rate was in 2011 (89 %).

Over 90 % of positive decisions are taken under the automatic recognition regime, which also show no clear trend over time. Shares of decisions taken under the automatic regime were already quite high before 2013, at between 93 % in 2010 and 99 % in 2008, and 94 % in 2012.

Similarly, the numbers of decisions which required compensation measures do not seem to have been influenced by the amendments, as trend figures show. The large majority of decisions taken under the general system do not provide for compensation measures. These shares were between 89 % and 96 % in the period 2013-2017, but 100 % in 2011 and 2012.

Figure 9: Decisions on nurses qualified in Italy by other EU Member States



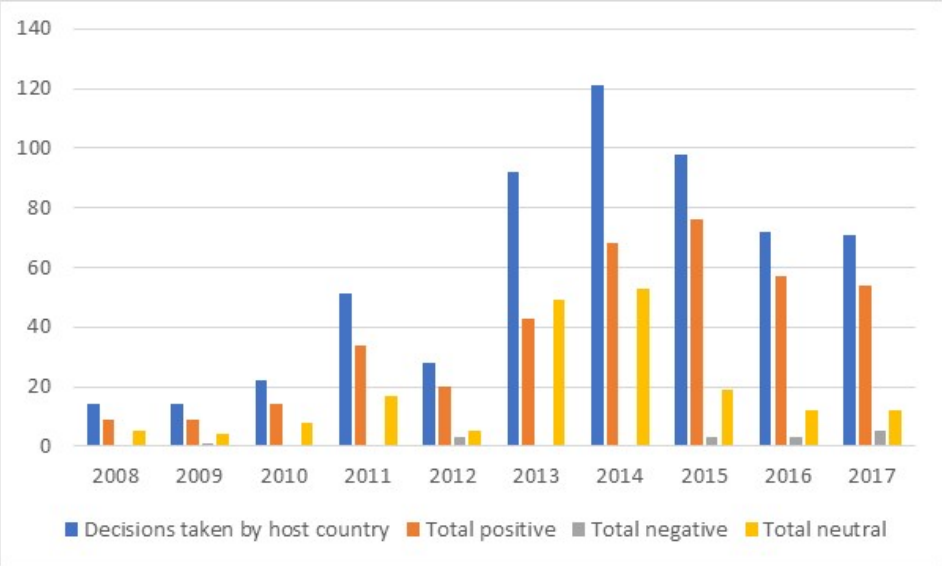
Source: DG GROW, Regulated Professions Database, Overall Statistics for Professionals moving abroad (establishment).

Physiotherapists qualified in Italy:

The number of decisions in other EU Member States on physiotherapists qualified in Italy was low in 2008-2010 (below 10), then increased to around 50 in 2011, before sharply increasing to almost 100 in 2013, and then further to 120 in 2014. In 2015-2017, the number decreased slightly, remaining above 60.

What is striking compared to the other two health professions is that the **shares of positive decisions have been quite low.** Although they increased in the years 2015-2017 (possibly related to the EPC), they were still at just below 80 %. Before that, the share of positive decisions varied between 47 % in 2013 and 71 % in 2012.

Figure 10: Decisions on physiotherapists qualified in Italy by other EU Member States



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

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

According to Eurobarometer data[85], around 3 % of Italians have unsuccessfully tried to work in another EU Member State, a figure that is slightly lower than the EU average (4 %). However, Italy ranks quite low in the share of people who think that their qualifications from education or training would be recognised in another EU Member State, with only 42 % believing this (compared to 56 % on average across the EU) and 28 % believing their qualifications would not be recognised (23 % EU average).

No evidence could be found on whether the amendments to the PQD had an impact on labour mobility to Italy.

EU-LFS data indicate that the lack of recognition of qualifications might be related to overqualification among EU movers. In Italy, 30 % of employed EU movers of working age feel overqualified for the job they are doing[86]. The lack of recognition of qualifications is reported most frequently as the main obstacle to getting a suitable job among EU movers who believe they are overqualified for the job they do. Lack of recognition of qualifications is mentioned as the main barrier by 22 %, which is a large share compared to other countries, but also compared to other barriers in Italy, where 10 % mention origin, religion or social background (also high compared to other Member States), 9 % mention lack of language skills, 9 % mention citizenship or residence permits, and the rest mention either 'other barriers' (2 %) or 'no barrier' (48 %)[87].

Overqualification also seems to be related to the decline in recruitment in the (public) health sector, and the lack of rules in the private sector. According to the national Order of nurses[88] (FNOPI), in order to practice, a nurse must register with Orders (according to numerous laws, including the latest and most recent Law 3/2018). In this sense, the Orders protect the competence and professionalism of their members and prevent its improper use. One danger remains when nurses are employed in the private sector, where they may accept work in areas for which they are overqualified rather than risk losing their jobs. This is closely linked to the recruitment block that limits turnover and/or entry into the public health service. It thus creates scope for private structures or outsourced cooperatives, which may downgrade the professional qualification by retaining professions on low wages and without the possibility of career development, while continuing to charge service users normal rates. This issue underpins FNOPI's successful insistence that the nursing profession should be included among those provided for by the law on equal compensation.

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

The Italian health labour market has been traditionally characterised by a surplus of doctors and a shortage of nursing staff.

According to FNOPI (in its written answers to the study questionnaire), the shortcomings are almost the same in all of the main health professions tasked with diagnosis, care and assistance, with the problem most acute among doctors and nurses. For nurses, in particular, the shortage is at least 51-53 thousand units, given the necessary ratio to doctors (3:1) and international indicators (WHO and OECD). It is frequently noted that Italy has an insufficient ratio of professional nurses to citizens. According to

[85] Eurobarometer, European area of skills and qualifications, 2014.

[86] European Commission, 2017 Annual Report on intra-EU labour mobility, Chapter 2.4.2, Figure 35, 2018, prepared by E. Fries-Tersch, T. Tugran and L. Rossi.

[87] ibid., Figure 38.

[88] FNOPI, written answers to the questionnaire.

international studies estimating effects on mortality, the optimal nurse-patient ratio in the public health service is 1:6, yet in Italy it ranges from 1:8 (Friuli Venezia Giulia) to 1:17 (Campania). The difference is linked first of all to the enduring recruitment block that for years has prevented those regions with the greatest economic deficits from hiring personnel. To comply with the EU Directive on Working Time[89] alone would require an increase of about 18,000-20,000 nurses in hospital facilities, while to meet the changing epidemiological needs (aging of the population, increase in chronic illness and non-self-sufficiency, etc., which presuppose increases in home assistance) at least 30,000-33,000 new nurses would be required.

However, according to an EU study[90], there are important differences in how policy makers have responded to recruitment and retention challenges. No policy intervention in this field has been reported for Italy (confirmed by FNOPI in its written answers to the questionnaire). The lack of a retention strategy means that the 'flight' of nurses – and doctors – abroad is a key sign that the system needs reorganisation. Professionals are trained at a high cost and to a very high standard, with recruitment campaigns from other countries specifically hiring highly skilled young professionals from Italy. FNOPI is trying to put in place a mechanism that would allow these young people to return to Italy and thus recover professionals of high professional value.

According to the Ministry of Health (in its written answers to the questionnaire), Italy aims for 'self-sufficiency', i.e. a sufficient number of professionals are trained to adequately satisfy the health demands of the population. In this regard, Italy has also adhered to the WHO 'Global Code of Conduct for the International Recruitment of Health Personnel', which has introduced ethical principles applicable to the international recruitment of health personnel, with the aim of strengthening the health systems of countries in development, countries with economies in transition and small island states. Similarly, **Italy does not put in place specific 'active recruitment' initiatives to attract health workers from countries with weaker economies**.

Before the crisis and its negative effects on national health funding (i.e. from the early 1990s until 2008), serious shortages were identified in nursing staff. The reforms in nursing education programmes and the skill-mix changes implemented within the health workforce aimed to enhance the attractiveness of these professions for the domestic workforce. Law 42/99, Law 251/2000, Law 43/2006 and the Code of Ethics established the end of the concept of nursing care as a mere auxiliary role in relation to the medical profession[91]. The evolution in the exercise of the profession went hand-in-hand with a parallel process of reform of nurse training (Ministerial Decree 509/99). This training now consists of different levels of university study, with nurses increasingly prepared and competent, allowing them to contribute to effective improvements in the field of clinical practice, care and personal care[92].

The situation has now changed slightly, with the numbers of professional nurses increasing substantially in the past decade, mainly due to an increase of nationals completing their education and enrolling on the official registers for nurses. It seems that the shortage of nursing staff has been progressively absorbed, due to the investments made in education and training in the past decade, but also to reduced labour demand in the health sector brought about by public budget cuts.

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89 Italy by art. 14 of Law 161/2014 has recognized the EU Directive 88/2003 CE on working time.

90 Directorate-General for Health and Food Safety, Recruitment and Retention of the Health Workforce, 2015.

91 Online newspaper registered at the tribunal of Rimini, available at: https://www.nurse24.it/infermiere/professione/la-professione-infermieristica.html.

92 Online newspaper registered at the tribunal of Rimini, available at: https://www.nurse24.it/infermiere/professione/la-professione-infermieristica.html.

With regard to medical professions, a gap can also be observed between the number of graduates leaving medical school each year and the numbers of places available in specialty schools.

The phenomenon of emigration of both native and foreign-born young doctors and medical graduates is a recent one, which might explain why Italy has never had a strategy to recruit doctors from abroad. Rather, national health authorities called for increasing investments in medical education and training, i.e. raising the number of students admitted to postgraduate specialty programmes. In addition, strategies to tackle territorial unbalances in the distribution of medical staff (by developing incentives for geographical mobility of doctors within the national territory) were also envisaged as solution to local shortages. At present, the recruitment of foreign doctors from abroad is not envisaged as an option.

According to MIGEP, migrant health workers (including third country nationals) are concentrated in the nursing professions and lower-level health auxiliary occupations (OSS), while the numbers of foreign doctors employed in Italy remain low.

KEY FINDINGS

- Italy is one of the main destination countries of EU movers but has seen a strong decrease in inflows since 2009.
- Decisions on recognitions of qualifications increased since 2009 and health professionals, especially doctors, nurses and dentists have been among the four biggest professional groups in numbers of decisions.
- Decisions on nurses decreased dramatically since 2010 (by -75 %), most likely due to cuts in public budget for such positions and/or because of improved opportunities in training and education within Italy itself.
- The share of negative decisions seems rather high compared to the EU average. The rejection rate across all professions even increased since 2013 (17 %, compared to 8 % EU average). This is also the case for decisions on doctors, where rejection rates have been around 10 percentage points higher than the EU average in recent years. The share of neutral/ongoing decisions is quite high. Both (high negative and neutral decisions) might be linked to the gaps identified in Chapters 1 and 2 (barriers in access to information for applicants, e.g. language).
- Italy has also been an important country of origin for movers working in other Member States, with figures increasing strongly in recent years.
- Doctors were by far the largest group (35 %) seeking recognition of qualifications from Italy. In the period 2014 to 2017, that changed, with nurses becoming the biggest group (39 %). This reflected the trend in decisions on qualifications of nurses, which multiplied by five between 2013 and 2016.
- The emigration of Italian nurses and doctors can be linked to the economic crisis and resulting cuts in public spending in the health sector. Italy has recently invested in education and training in this field, as well as further specialisation opportunities, making Italian healthcare professionals the target of recruitment agencies from other countries.
- No evidence could be found of the potential effect of recognition of qualifications on mobility to or from Italy. However, the lack of recognition of qualifications seems to be an important reason for overqualification among EU movers already working in Italy.
- Italy itself does pursue any strategies to attract workers from abroad.
- In Italy, migrant health workers are concentrated in nursing professions and lower-level health auxiliary occupations, with overqualification common in the private sector, where standards and qualifications are less rigid.

LIST OF STAKEHOLDERS CONSULTED

Table 1: Stakeholders consulted for the case study on Italy

Stakeholder	Category
Direzione generale delle professioni sanitarie e delle risorse umane del Servizio Sanitario Nazionale	Ministry of Health
Direzione generale delle professioni sanitarie e delle risorse umane del Servizio Sanitario Nazionale Ufficio 2 - Riconoscimento titoli delle professionalità sanitarie e delle lauree specialistiche e magistrali	Ministry of Health
Federazione Nazionale delle Professioni Sanitarie e Sociosanitarie (MIGEP)	Professional Organisation (Health and Social Professions)
Federazione Nazionale degli Ordini dei medici	Professional Organisation (Doctors)
Associazione Nazionale Operatori Socio Sanitari (OSS 2.0)	Professional Organisation (Health and Social Professions)
Italian Assistance Centre for professional qualifications of the Department for European Policies	Competent authority (Presidency of the Council of Ministers, Department for European Policies)

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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