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Dutch National Contact Point

Small Scale Study II Managed Migration
and the Labour Market –
The Health Sector
The Netherlands

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Immigratie- en Naturalisatiedienst

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List of acronyms and abbreviations

AWBZ	Algemene Wet Bijzondere Ziektekosten	General Law on Special Medical Expenses
BTN	Branchebelang Thuiszorg Nederland	Interest Group for the Dutch Home Care Sector
CAZ	Convenant Arbeidsmarktbeleid Zorgsector	Covenant on the Labour Market Policy for the Care Sector
CBGV	Commissie Buitenslands Gediplomeerden Volksgezondheid	Committee on Holders of Foreign Qualifications in Healthcare
CBS	Centraal Bureau voor de Statistiek	Statistics Netherlands
CIBA	Commissie Instroom Buitenlandse Artsen	Committee for Enrolment of Foreign Medical Doctors
CIBG	Centraal Informatiepunt Beroepen Gezondheidszorg	Central Information Unit on Health Care Professions
CIZ	Centrum Indicatiestelling Zorg	Centre for Healthcare Referrals
CPB	Centraal Planbureau	Netherlands Bureau for Economic Policy Analysis
CWI	Centrum voor Werk en Inkomen	Centre for Work and Income
EBB	Enquête Beroepsbevolking	Labour Force Survey
EER	Europese Economische Ruimte	European Economic Area
EMN	Europees Migratienetwerk	European Migration Network
EU	Europese Unie	European Union
EZ	Economische Zaken	(Ministry of) Economic Affairs
GGD	Gemeentelijke/Gewestelijke Gezondheidsdienst	Community Health Service
IHTP		International Healthcare Training Program
IAO	Internationale Arbeidsorganisatie	International Labour Organisation
IND	Immigratie- en Naturalisatiedienst	Immigration and Naturalisation Service
ISCO-88		International Standard Classification of Occupations-88
NACE		Nomenclature statistique des Activités économiques dans la Communauté Européenne
O,C&W	Onderwijs, Cultuur en Wetenschap	(Ministry of) Education, Culture and Science
PSI		Public Services International
RIAGG	Regionale Instelling voor Ambulante Geestelijke Gezondheidszorg	Regional Institute for Outpatient Mental Healthcare
RIBW	Regionale Instelling voor Beschermd Wonen	Regional Sheltered Housing Institution
RIVM	Rijksinstituut voor Volksgezondheid en Milieu	National Institute of Public Health and the Environment
SBI '93	Standaard Bedrijfsindeling 1993	Standard Industrial Classification 1993
SZW	Sociale Zaken en Werkgelegenheid	(Ministry of) Social Affairs and Employment
Vw 2000	Vreemdelingenwet 2000	Aliens Act 2000
Wet BIG	Wet op de Beroepen in de Individuele Gezondheidszorg	Individual Health Care Professionals Act
WHO		World Health Organisation
V&I	Vreemdelingenzaken en Integratie	(Ministry of) Immigration and Integration
VWS	Volksgezondheid, Welzijn en Sport	(Ministry of) Health, Welfare and Sport
Wav	Wet Arbeid Vreemdelingen	Aliens Employment Act

1 Executive Summary

The study 'Managed Migration and the Labour Market – the Health Sector: the Netherlands' is part of a comparative European study by the European Migration Network (EMN). The ultimate goal of the study is a synthesis report which provides insights into the similarities and differences between member states with regard to managed migration and the health sector. The health sector has been chosen as a case in order to map out the developments in the area of migration management. The study carefully follows the specifications as drawn up by the EMN.

Chapter 2 first deals with the organisation of the health sector in the Netherlands. The national government is ultimately responsible for health care in the Netherlands, through the formulation of legal and financial frameworks and through the strict monitoring of the health sector. Healthcare in the Netherlands is mainly provided by private non-profit organisations and self-employed medical professionals. In the Dutch health sector, the General Practitioner (GP) has an important position, as the gatekeeper for most of the other forms of healthcare. The health sector is financed by both private and public health insurances. Health insurance companies enter into contracts with the various healthcare providers.

Subsequently, chapter 2 maps out the general developments regarding managed migration and the health sector. Labour migration in order to work in the health sector has mainly been an issue in the Netherlands when the economy was booming from the late nineties onwards. Shortages on the labour market led to attempts by health sector employers to recruit foreign personnel as a solution to acute personnel shortages. This caused media attention and political debate, especially in 2001 and 2002. The main conclusion of chapter 2, is that there is an apparent lack of political and social support for the recruitment of foreign personnel, with the debate focussing on the recruitment of nursing auxiliary personnel. Moreover, the experiences of employers were often not positive either and they seem to regard labour migration as the final remedy if all other means have failed. Government has, with a few exceptions, not facilitated recruitment of foreign personnel in health care either, and has fully maintained its restrictive policies in this field.

In chapter 3 the study's methodology is gone into. The study is mainly based on available literature and statistics. One of the main subjects of this chapter is the limited availability of statistical information. The information requested in the specifications has proven not to be available, but there are alternative sources of information available which can provide a picture of the importance of labour migration for the health sector.

Chapter 4 covers the legislation and regulations on labour migration, as well as the organisations and institutions involved. There is a close correlation between aliens legislation on the one hand, regulating the admission to the Netherlands, and the Aliens Employment Act (Wav) (Wet arbeid vreemdelingen) on the other hand, regulating admission to the Dutch labour market. Three forms of admission to the Netherlands are of importance with regards to labour migration to the health sector (incidentally, there is no specific legislation on labour migration to the health sector): admission to work as an employee, admission to work on a self-employed basis and admission as a highly skilled migrant.

Starting point for the legislation and regulations on the first form of admission is, that Dutch and EU/EER labour supply is preferred. Admission to the Dutch the labour market depends on the lack of such priority labour supply. Otherwise, no work permit will be issued, and thus also no residence permit. For admission to work on a self-employed basis, the main condition is the existence of a material Dutch interest, in the case of medical professionals a material Dutch public health interest. From the point of view of managed migration, the highly skilled migrants arrangement is of special interest, as it is explicitly aimed at promoting the Dutch knowledge economy, with the earning of sufficient income as the main condition for admission.

In chapter 5 by means of the available statistical information, first the size and nature of labour migration to the health sector is described. What stands out, is the limited size of this migration, especially compared to the total size of the employed working population in that sector. In 2004 for example, only 206 out of a total of 5,944 new registrations of nurses were with a foreign diploma (4.8%), and 15 out of 1,254 for physiotherapists (1.4%). In contrast, for physicians and especially dentists, labour migration seems to be of relatively greater importance. 445 out of a total of 2,261

new registrations for doctors (22.4%) and 138 out of a total of 373 dentist registrations (43%) concerned persons with a foreign diploma. Even if only medical professionals with a non-EER diploma are taken into account (excluding most Dutch nationals with foreign diplomas) the role of labour migration for these professions turns out to be more than average, especially for dentists.

The chapter also looks at the general labour market situation in the health sector. It turns out there is a clear peak in the number of hard-to-fill vacancies in 2000 en 2001 and the number of vacancies per 1,000 occupied jobs also peaks in 2000-2002. Incidentally, this is even more so the case for the labour market as a whole and for a longer period of time. The statistics also show, that at present there are no great personnel shortages in the health sector. In a number of studies also prognosis of future developments for the health sector have been attempted. Large personnel shortages are not expected in the near future, with the exception of auxiliary personnel in nursing and care homes and in home care. Only a speedy economic revival for the economy as a whole could cause personnel shortages in the near future for more occupations in the health sector. In the long run, there is a chance of personnel shortages, but too many factors play a role for any certain predictions to be made.

In chapter 6, the professional requirements for working in Dutch health care are explained. In order to work in the Dutch health sector, for most medical professions the official recognition of the competence of the foreign medical professional is necessary. This is regulated in the Individual Healthcare Professionals Act (the BIG Act). For a number of medical professions (the so-called article 3 professions), registration in the BIG register is a precondition for being allowed to use their professional title and to perform certain reserved procedures independently. For a number of other medical professions (the so-called article 34 professions) a declaration of competence is needed in order to be allowed to use the protected educational title. If the competence is deemed to be non-equivalent, in order to receive a declaration additional schooling will have to be followed in the Netherlands, paid for by the medical professional or his or her intended employer.

Finally, in chapter 7 some important initiatives towards a policy of managed migration are discussed which are being taken at present in the Netherlands, even though such a policy is not yet fully in place. First of all, the highly skilled migrants arrangement mentioned earlier must be mentioned. Furthermore, there are government proposals for changes in the admission policy for individual entrepreneurs to the Netherlands and for a thorough review of the regular, non-asylum admission policy in the Netherlands, with special attention for labour migration and the influx of highly trained personnel.

The main conclusions of the study are:

- Although only limited information is available, labour migration does not seem to be a major factor in the Dutch health sector, especially regarding the largest professional group, that of nurses and auxiliary personnel. For physicians and especially dentists, the picture is somewhat more nuanced.
- There is little support for labour migration as a solution for personnel shortages in the health sector, especially for nursing and auxiliary personnel. Labour migration of highly skilled medical personnel is less controversial and less debated.
- Forecasts about the future necessity of labour migration for the health sector are difficult to make, as the development of the supply of personnel is uncertain, as is the future support for labour migration as a solution, especially for lower and intermediate personnel.

2 Introduction: The Health Sector in the Netherlands

The objective of this small scale study entitled ‘Managed Migration and the Labour Market – The Health Sector’ is to make a contribution to the current debate on the future of migration and migration management. In this debate the health sector is used as a case to map out the developments, for instance by mapping out changes and trends in the area of labour migration to the health sector.

In this chapter, after taking a look at the structure of the health sector in the Netherlands and at the recent developments in the area of migration management and the health sector, we will describe the legal framework for labour migration for the health sector, dealing with both national and international relevant policy and regulations. By means of quantitative information we will subsequently attempt to provide an insight into the position of migrants in the health sector seen against a background of the general labour market situation in this sector. After this we will look at the training and qualifications required to practice a medical profession. Finally we will look at any other notable aspects with regard to the subject of the study.

Various other member states of the European Union (EU) that participate in the European Migration Network (EMN) will conduct a similar study. The ultimate objective is a comparative report that will provide insight into the similarities and differences between the member states with regard to managed migration and the health sector. The study is intended for policymakers at both national and European level. This study can also be interesting to the relevant administrative authorities, specialists and executives in the health sector.

2.1 The Structure of the Dutch Health Sector

Before we look at the labour migration to the health sector in the Netherlands it is first essential to briefly outline the structure of the Dutch health sector. This structure is extremely complex. On the one hand this is because of the many parties that play a role in the health sector in the Netherlands; on the other hand it has to do with the way the funding for the health sector is organised.

2.1.1 The Parties in the Dutch Health Sector

At a national level the Ministerie van Volksgezondheid, Welzijn en Sport (VWS) (Ministry of Health, Welfare and Sport) has the ultimate responsibility for the promotion of public health and for the quality, accessibility and availability of the different types of healthcare. This responsibility is mainly given shape through the formulation of legal and financial frameworks and through the strict monitoring of the health sector in the Netherlands. For this purpose the Ministry has a broad range of supervisory and regulatory organisations at its disposal.

The health sector in the Netherlands can be classified into the following sectors:

1. Public healthcare
2. Primary healthcare
3. Secondary and tertiary healthcare
4. Mental healthcare
5. Nursing and care

Public healthcare

In the Netherlands, public healthcare is primarily the responsibility of the municipalities. They are legally obliged to promote the realisation, continuity and cohesion of policies for collective preventive healthcare. To this effect they must have a municipal health service in place, among other things. For reasons of efficiency, a number of municipalities will often have a single joint Gemeentelijke/Gewestelijke Gezondheidsdienst (GGD) (Municipal/District Health Service). Municipalities can also instruct other (private) organisations to perform municipal public health tasks.

Tasks in the area of public healthcare are:

- combating the spread of infectious diseases (among other means, through vaccination)
- youth healthcare
- medical environmentology

- technical hygiene care
- public mental healthcare
- health promotion
- cancer screening

Municipalities and their GGDs are supported in their tasks by the primary healthcare sector and by national institutes and university departments that are involved in different areas of public health. In addition, VWS funds Health Promotion Institutes in an attempt to influence lifestyle factors that put people's health at risk. These institutes often have a combination of tasks, such as providing information, research, consultancy, the promotion of expertise and the implementation of preventative activities. Examples are STIVORO (smoking prevention) and the Voedingscentrum (Nutrition Centre)(nutrition advice). Finally, there are a range of other organisations that advise on prevention or are engaged in prevention development or research. Advisory bodies, research and knowledge institutes (such as the Rijksinstituut voor Volksgezondheid en Milieu (RIVM)(National Institute for Public Health and the Environment)), health funds (such as KWF/Kankerbestrijding (Dutch Cancer Society)) and health insurance companies all play a role (www.brancherapporten.minvws.nl).

Primary healthcare

Primary, or first-line, healthcare in the Netherlands is very comprehensive. A central role is reserved for the General Practitioner (GP), who takes up a special place in the Dutch health sector, since he acts as a kind of gate keeper to other forms of healthcare: a referral from a GP is a precondition for access to other healthcare providers, such as medical specialists, mental healthcare or hospital care. This contributes considerably to the effectiveness and efficiency of the Dutch health sector, because patients are quickly referred to the correct provider. The number of referrals is also relatively low (Exter et al: 2004).

GPs are individual professional practitioners and have their own, often individual, practice, but group practices and health centres (which also provide other forms of primary healthcare) are also on the rise. GPs can only practice if they are registered; this registration is reevaluated every 5 years on the basis of their experience and the retraining they underwent.

Other forms of primary healthcare are:

- pharmacy care, whereby prescriptions are usually filled by pharmacies, GPs with an in-practice pharmacy and hospital pharmacies. They also have a task in medication monitoring and patient care.
- dental healthcare, provided by individual dentists who mostly have their own individual practice. clinical dental technicians and dental hygienists also play a role in the primary dental healthcare.
- midwifery care, which, in the case of normal pregnancies without complications, is provided by first-line midwives or sometimes by GPs. Women usually give birth at home. Maternity care is also available at home, provided by private maternity centres.
- paramedical healthcare provided by physiotherapists, therapeutic radiographer, speech therapists, occupational therapists, dieticians, skin therapists, Mensendieck and Cesar remedial therapists, orthoptists and podiatrists. This care is available both extramurally (individual practices, in health centres, through home care organisations) and intramurally (hospitals, nursing homes, rehabilitation centres).

Secondary and tertiary healthcare

The terms 'secondary healthcare' and 'tertiary healthcare' (also called second-line and third-line healthcare) refer to specialist healthcare, provided by hospitals or other parties. In the case of third-line healthcare, this concerns extremely complex and mostly expensive medical and related services. (WHO: 2006) As mentioned before, access to secondary and tertiary healthcare is only possible after a referral from a provider in the primary healthcare sector. Exceptions to this rule are medical emergencies, whereby patients can get access to specialist facilities via the hospital's accident and emergency room.

In the Netherlands, this healthcare is mostly provided by medical specialists in hospitals. Medical specialists are usually not directly employed by the hospitals but work on a contract basis as self-employed providers for and in the hospital. Treatment can be provided both extramurally and

intramurally. The vast majority of hospitals in the Netherlands (approx. 90%) are private non-profit institutions, whereby we can make a distinction between general hospitals and specialist hospitals. In addition there are also public university hospitals.

Mental healthcare

The term mental healthcare refers to the treatment, care and support of people with mental problems and disorders, as well as to the prevention of mental problems. The institutions in the mental healthcare sector endeavour to promote and restore mental health and/or make chronic mental problems more bearable. (RIVM: 2006) Incidentally, in the Netherlands, addiction care is also classed as part of the mental healthcare sector, but this type of care is not considered in this document.

In the mental healthcare sector we can make a distinction between ambulatory healthcare, extramural healthcare, different forms of semi-mural healthcare, such as assisted living and daytime activity centres, and intramural admission and treatment. The mental healthcare sector is organised on a regional basis. Traditionally we can distinguish between the following players:

- Ambulatory mental healthcare is provided by the Regionale Instellingen voor Ambulante Geestelijke Gezondheidszorg (RIAGGs) (Regional Institutes for Outpatient Mental Healthcare) and individual providers (psychiatrists, psychotherapists and psychologists). For access to ambulatory mental healthcare a referral from a GP is once again needed, except in crisis situations.
- In the area of semi-mural healthcare the Regionale Instellingen voor Beschermd Wonen (RIBWs) (Regional Sheltered Housing Institutions) play an important role, among others, as well as other private non-profit institutions that provide daytime activities for people with mental problems.
- Intramural admission and treatment is mostly provided in general psychiatric hospitals. These are regional facilities for crisis care and for the treatment, nursing and re-socialisation of all categories of psychiatric patients. In most cases general hospitals also have a psychiatric department for the treatment of psychiatric patients. General psychiatric hospitals often also offer forms of ambulatory and semi-mural care.

As a result of mergers, increasingly the aforementioned different forms of care are being provided by single institutions in recent years. We also increasingly see collaborations between the previously separate players in these areas.

Nursing and care

Nursing and care for senior citizens constitute the main bulk of this part of the health sector. In addition, this sector includes the nursing and care for other categories of people in need of help, such as people with physical disabilities and people with chronic illnesses.

When evaluating the need for different forms of formal nursing and care, the option of utilising care provided by close family members and friends is always considered. If such care is not sufficiently available, or if the need for care exceeds what family and friends can be reasonably expected to provide, various forms of formal care (supplementary or otherwise) are available, depending on the situation:

- home care, which includes all forms of nursing and care in the home situation. This comprises the whole of nursing, physical and specialist care, domestic care, treatment and assistance provided in the home of the person requiring care, all with the objective of allowing the person to remain in his/her home environment.
- residential care, which includes all the facilities in which the provision of living accommodation and healthcare are kept separate. The person requiring care is responsible for the accommodation (if necessary in a residential care facility) and any additional necessary ambulatory healthcare is supplied on a custom basis. Living, healthcare and service are kept contractually separate.
- Nursing home and care home facilities, the care provided by and the stay in nursing and care homes. The differences between both types of homes are becoming increasingly vague. One important difference is the fact that in addition to caring for people with serious (chronic) somatic or psycho-geriatric problems, nursing homes also partially focus on the recovery of people after a stay in hospital or for a period of rehabilitation. Care homes specifically offer

accommodation with full or partial care to persons aged 65 and over who require care. We increasingly see mergers between nursing and care homes as well as collaborations.

The main providers of nursing and care are private profit and non-profit home care institutions on the one hand and private profit and non-profit nursing and care homes on the other hand. In addition, in residential care housing associations and municipalities also play an important role.

2.1.2 Healthcare Funding

The greater part of the Dutch health sector is funded by means of a comprehensive structure of public and private health insurance. The Netherlands does not have separate health insurance for employment-related healthcare. On 1 January 2006 a drastic revision of the system took place. (VWS: 2005) It now consists of the following three components, also referred to as compartments:

The first compartment is a compulsory national health insurance for extraordinary medical expenses (the Algemene Wet Bijzondere Ziektekosten (AWBZ) (General Law on Special Medical Expenses)). This is a traditional social insurance policy that is administered by regional care offices that act on behalf of all the health insurance companies. The care office is responsible for achieving an optimal alignment of the supply of and the demand for care in a specific region. Via the AWBZ, every Dutch citizen is insured for care and assistance during long-term illness, disability or old age. To be eligible for facilities provided by the AWBZ a referral decision from the Centrum Indicatiestelling Zorg (CIZ) (Centre for Healthcare Referrals) is needed. People can be referred for domestic care, personal care, nursing, supporting assistance, activating assistance, treatment or stay in a facility. (VWS: 2006)

The second compartment is an insurance for the cost of healthcare aimed at curing medical conditions, the so-called basic health insurance. Every inhabitant of the Netherlands and everyone paying income tax in the Netherlands is obliged by law to have basic health insurance. The coverage is determined by law. In order to safeguard the social character of the basic health insurance there are comprehensive statutory conditions for the 2nd compartment. For instance, health insurance companies have a duty of acceptance and premium differentiation is prohibited. The maximum premium has also been set and an excess-free policy must be made available. The health insurance company is however allowed to decide which healthcare provider will provide the covered healthcare and whether this is done in kind or will be reimbursed retroactively. In the latter case the healthcare insurer must help the insured to find a provider.

The premium for the basic health insurance consists of a direct nominal premium, payable to the insurance company, and an income-based premium (6.5%) that is collected by the Belastingdienst (Tax and Customs Administration). The employer is obliged to fully reimburse this premium to the employee, but the employee does pay tax and social premiums on the reimbursed amount. The government also deposits an amount from the general reserve into the health insurance fund, into which the income-based premiums are also deposited. For the lower incomes there is also a supplementary care benefit that is income-based and is paid by the Belastingdienst (Tax and Customs Administration) as an allowance for the nominal premium. For persons under 18 the insurance is free.

The third compartment consists of voluntary supplementary insurance for those costs that are not covered by the first two compartments. The policies in the 2nd and 3rd compartment are provided by private health insurance companies that are allowed to operate for gain.

Health insurance companies (basic health insurance and supplementary health insurance) and care office (AWBZ) finance the healthcare and enter into contracts with the various healthcare providers. Only part of the available primary healthcare is directly accessible with reimbursement. For access to other forms of healthcare a referral from the GP (paramedical healthcare, secondary and tertiary healthcare) or from the CIZ (nursing and care, mental healthcare) is needed, otherwise the patient will not be reimbursed.

2.2 General Developments in Respect of Migration Management and the Health Sector

As is obvious from the previous paragraph, many different and diverse parties play a role in the health sector in the Netherlands. Also, a broad range of medical personnel works in the sector, employed in different capacities, for instance as individual entrepreneurs and for/in a range of healthcare institutions. The table below also shows that the size of the healthcare labour market is considerable when compared to the total number of employed persons in the same period, between 7.7 -7.9 million. (CBS: 2006).

Table 1: Persons employed in the health sector per professional group

	2000	2001	2002	2003	2004
Medical professions	35,788	36,864	38,064	38,615	38,837
Paramedical professions	36,912	38,128	38,862	39,334	39,746
Nursing and caretaking professions	387,824	399,498	414,179	423,428	426,695 ¹
Assisting professions	41,418	44,315	46,701	48,915	51,662
Total	501,942	518,805	537,806	550,292	556,940

¹ Estimate based on trend.

Source: www.azwinfo.nl

In order to meet the demand for healthcare personnel the healthcare institutions in the Netherlands have a number of options. Recruiting personnel abroad is one of these options. However, labour migration as a solution to personnel shortages in the health sector is currently not really a subject of discussion in the Netherlands. This is in strong contrast to the situation a number of years ago. Since the end of the 1990s acute personnel shortages in the health sector arose, particularly with regard to nursing and caretaking personnel (as we can see in table 1, by far the largest professional group in the health sector). As a result of the flourishing economy toward the end of the 1990s there were major shortages in the labour market which resulted in large numbers of long-term unfillable vacancies in the health sector as well. One of the solutions chosen by employers in the health sector was recruitment abroad. This recruitment took place at the initiative of healthcare institutions and/or private recruitment agencies. The government had little or no involvement in this.

Although the recruitment of medical personnel abroad only took place on a limited scale (more about this in chapter 4), this engendered a lot of political and social discussion, particularly with regard to recruitment outside the European Economic Area (EEA). In 2001 and 2002 the political and social debate on the subject reached its peak. In addition to media attention for the specific recruitment programmes and the subject in general there was also political discussion in Parliament. There were various debates and parliamentary questions on the subject, as well as various letters from the government on the issue (among others Staatssecretaris van Volksgezondheid, Welzijn en Sport: 2000 en 2002; Minister van Volksgezondheid, Welzijn en Sport: 2001a en 2001b; Minister van Volksgezondheid, Welzijn en Sport et al.: 2001). In addition, the issue was also the subject of consultation between the central government and the interest groups representing employers and employees in the health sector.

The discussions were held against a background of the restrictive migration policy of the Dutch government, which also applies to labour migration. The proponents of labour migration (particularly the healthcare institutions involved) considered it, for the most part, the last resort for resolving the acute personnel shortages in the health sector since the end of the 1990s. Sometimes it was also argued that using labour migration as a solution for future personnel shortages in the health sector will prove inevitable in the long term. Because of the 'greying' (ageing) of the population (increase in the percentage of people aged 65 and over in the total population) and the 'de-greening' (dejuvenation) of the population (reduction in the percentage of young people between the ages of 0 and 15) an increase in the demand for healthcare - and therefore for medical personnel - is expected, while the workforce is shrinking. In addition, the health sector is faced with a weak competitive position in the labour market with respect to the nursing and auxiliary professions, with high levels of absenteeism, a large outflow as a result of the physical demands of the job and the high work pressure. The sector has a bad image because the chances for promotion

are negligible and the work pressure is high. Already there are not enough students to fill the demand for personnel. (Roosblad: 2005) However, politically and socially the argument of the unavoidability of labour migration as a solution to these problems does not meet with a lot of response.

Recruitment abroad was mostly viewed critically both by the political arena and by society. Firstly, the critics pointed to the considerable supply of unutilised labour in the Netherlands (the large number of people who are economically inactive). Political parties and social organisations made it clear that they would prefer for this unused labour supply to be deployed. The risk of unfair competition with regard to employment terms was also pointed out, among others by the unions. Furthermore, the initial experiences employers had with foreign medical personnel were not entirely positive. Recruitment did not always run smoothly and the deployment of nurses and caretakers from a different culture and/or with a different mother tongue required a lot of additional effort on the part of the employer. In the political and social debate the presumed disadvantages of cultural and language differences in professions in which communication plays such an important role was also highlighted. Finally, the 'brain drain' discussion also played an important role in the debates surrounding the health sector. The risk of the quality of the healthcare in the countries of origin coming under pressure as a result of potential mass recruitment of personnel by Western countries was pointed out from different sides (for instance by political parties, unions and development organisations).

The attitude with regard to labour migration as a solution for personnel shortages in the health sector is best demonstrated in the agreement on labour migration to the health sector that was entered into between employers, employees and the Ministry of Health, Welfare and Sport in 2000, the *Convenant Arbeidsmarktbeleid Zorgsector (CAZ)* (Covenant on the Labour Market Policy for the Care Sector), effective from 1 July 2000 to 1 July 2004. With the assent of all the parties this Covenant subjected the recruitment of medical personnel abroad to additional restrictions, in addition to the restrictions imposed by the general policy for labour migration. Both the *Ministerie van Sociale Zaken en Werkgelegenheid (SZW)* (Ministry of Social Affairs and Employment) and the unions considered labour migration to be an undesirable solution. It was contrary to policy to recruit more Dutch jobseekers for the sector. Unions want to prevent employers ceasing to invest in measures to make the sector more attractive (for instance improved employment terms and conditions). The employers, finally, in view of the aforementioned political and social debates, wanted to demonstrate their desire to properly regulate labour migration to the health sector. (Roosblad: 2005)

What is clear from the debates of that time is the fact that support for labour migration as a solution to personnel shortages in the health sector is limited. Both from the political and social corner there appears to be a lot of resistance against this solution. Even for employers, recruitment abroad proves to be a last resort measure for filling vacancies. Once the scarcity in the healthcare labour market disappeared after 2002 the subject rapidly disappeared from the agenda. Medical personnel is still recruited abroad, but the practice has not been significant in recent years and is no longer the subject of intense political and social debate. From the academic corner there is not much attention for the role of labour migration in the health sector either. Only a few studies focus on this subject.

As explained before, the aforementioned debate was the result of the recruitment that took place from the end of the 1990s onwards. But even at the time when there were acute personnel shortages in the health sector, recruitment abroad only took place on a limited scale (Roosblad: 2005; Van Wijck: 2002) and was mostly done at the initiative of individual healthcare institutions that were looking for personnel. In most cases the healthcare institution would use a commercial mediation agency that would make a preselection, after which the healthcare institution would make the final selection in the country of origin. It always concerned small groups (5-15 persons). After following a language course in their own country, the recruited candidates would then travel to the Netherlands. There was hardly any collaboration between the different institutions. Countries that are often mentioned in the context of recruiting medical personnel are Suriname, South Africa, the Philippines, Poland and Indonesia. In some cases the recruitment agencies would take the initiative and approach the healthcare institution with the offer of recruiting personnel for them abroad. (Roosblad: 2005)

One private initiative in this period that was undertaken on a larger scale, namely a project toward the end of 2001 at the initiative of, among others, *Branchebelang Thuiszorg Nederland (BTN)* (Interest Group for the Dutch Home Care Sector) aimed at recruiting 10,000 caretaking personnel in

Slovakia to work in the home care sector was received very critically by the parliament and the government, because it did not fit in with the Dutch policy in respect of labour migration (Staatssecretaris van Volksgezondheid, Welzijn en Sport: 2002). Because of the restrictive legislation and regulations at the time, from which the government did not intend to deviate, the project died a quiet death.

In this period also two more official initiatives were started up that could count on support from the central government:

- The International Healthcare Training Program (IHTP), conceived at the initiative of the Dutch and Indonesian Ministries of Health, whereby Indonesian nurses were brought to the Netherlands with the objective of following (continuing) education here and gaining experience in the Dutch health sector, which they could then utilise in their country of origin. (Minister van Buitenlandse Zaken en Minister voor Ontwikkelingssamenwerking: 2000)
- In addition, a pilot project was started up in 2000 by five institutions for intramural care for the elderly in which Polish nurses were recruited, with the objective of achieving large-scale recruitment at a later stage. The then Minister of Health, Welfare and Sport considered this a good temporary solution for the personnel shortages in the health sector. The decision to choose Poland was a result of the surplus of nursing personnel in that country and the future entry of Poland into the EU. As a result, the Polish Minister of Health and the Dutch Minister of Health, Welfare and Sport signed a 'letter of intent' about a framework for bringing Polish nurses to the Netherlands and on their prospects of suitable employment upon their return. In practice, however, this did not result in a relaxation of policy and, in view of the aforementioned resistance and the decreasing scarcity in the labour market, the large-scale recruitment of Polish nurses never got off the ground. (De Lange and Pool: 2004)

Even in these cases the Dutch government focused on pre-conditions only, and was not actively involved in the recruitment of foreign medical personnel. In both cases the starting point was and is a temporary stay in the Netherlands with an aspect of international collaboration. In general the Dutch government, in line with the aforementioned debates on the subject, did not prove itself a proponent of the recruitment of nursing and caretaking personnel abroad. The existing legislation and regulations have not been not relaxed.

Although migration management with regard to the health sector is currently not a subject for discussion, the subject of migration management itself is. This debate specifically focuses on the question whether there is a need to make the Netherlands more attractive for highly qualified migrants. To this effect a highly skilled migrant arrangement was formulated at the end of 2004, for instance, aimed at the fast and flexible admission of highly skilled migrants. The promotion of labour migration as a solution to personnel shortages for less highly qualified personnel (such as nursing and caretaking personnel) is receiving a lot less attention and support for this solution therefore still appears to be minimal.

3 Methodology

For the purpose of this study a number of potential sources of information were identified with the aid of literature research, information gathering on the Internet and by contacting the national network of the Dutch national contactpoint of the European Migration Network and institutions that play a role in migration management in the health sector. The reliability of the information source was the main factor in determining its relevance.

With regard to substantive information, official documents such as legislation and regulations and parliamentary documents, as well as information material published by various government agencies, were studied for the purpose of formulating the study. Research reports and academic studies were also used. In order to obtain an insight into the social debate on migration management and the health sector various media sources were also studied, specifically via the Internet.

As a statistical source the following resources were used:

- the annual Labour Force Survey of the Centraal Bureau voor de Statistiek (CBS) (Statistics Netherlands), a random survey in which the target population consists of all persons aged 15 and over in the Netherlands, with the exception of persons in institutes, institutions and homes (institutional population) and with a survey scope of 131,000 addresses in 2004, of which 81,000 were approximated and 51,000 invalid (untraceable, uninhabited or not contacted);
- the Quarterly Vacancy Survey of the CBS, a random survey in which the target population consists of all companies and institutions in the Netherlands with personnel, with a net survey scope of over 21,000 companies and institutions, with a response of over 85%;
- the yearly CBS Survey on Employment and Wages, a random survey in which the target population consists of all companies and institutions in the Netherlands with personnel, with a net survey scope of about 70,000 companies and institutions, who account for about 74% of the total number of jobs. The response is about 80%, accounting for about 90% of the total number of jobs;
- information from the Centrum voor Werk en Inkomen (CWI) (Centre for Work and Income) on the number of work permits applied for and granted each year;
- information from the Centraal Informatiepunt Beroepen Gezondheidszorg (CIBG) (Central Information Unit on Health Care Professions) on the annual number of applications for and actual registrations of holders of foreign diplomas in the Individual Healthcare Professionals register (BIG-register) and the number of requests from foreign diploma holders for permission to use a protected medical educational title.

For the purpose of this study the government departments responsible for the policy relating to this subject, namely the Ministry of Justice, the Ministry of Health, Welfare and Sport and the Ministry of Social Affairs and Employment were contacted. Information was also requested from the Immigratie- en Naturalisatiedienst (IND) (Immigration and Naturalisation Service), CBS, CWI and CIBG.

During the study it became clear that there were a number of obstacles. For instance, no statistical information is available in line with the requested definitions and at the requested level of detail. Information for the requested years is not always available either. For this reason a lot of attention was paid to localising other statistical information that made it possible to obtain an insight into the importance of labour migration for the healthcare labour market. Furthermore, only limited and often fragmented information proved to be available on the subject of the study. For instance, only one comprehensive recent authoritative academic study on labour migration and the health sector, which focuses exclusively on the recruitment of nursing and caretaking staff, is available: the study entitled 'Vissen in een vreemde vijver: het werven van nurses en verzorgenden in het buitenland. Ervaringen met en toekomstverwachtingen over arbeidsmigratie in de zorgsector' (*Fishing in a foreign pond: recruiting nurses and auxiliaries abroad. Experiences with and future expectations for labour migration in the health sector*) by Judith Roosblad (Roosblad: 2005), part of an international study carried out by Public Services International (PSI), the international Union for the public sector.

The research specifications for this study request that the following statistical information for the years 1997-2004 be supplied, if available:

- The number of indigenous (or autochthonous) and migrant male and female workers employed in a number of clearly defined professions in the health sector, based on the International Standard Classification of Occupations-88 (ISCO-88) occupational classification of the International Labour Organisation (IAO), namely Medical doctors/Physicians, Dentists, Dental assistants, Pharmacists, Pharmaceutical assistants, Nursing and midwifery professionals and associate professionals, Psychologists, Physiotherapists and associated professionals (e.g. Chiropractor, Podiatrist);
- The number of vacancies for these same professions.

To ensure the best possible comparability, the definition of ‘migrant’ as it is worded in Article 2 of the proposed Directive¹ relating to Community statistics on migration and international protection should ideally be used: “a natural person who establishes his or her usual residence in the territory of a Member State for a period that is, or is expected to be, of at least twelve months, having previously been usually resident in another Member state or a third country” (European Commission: 2005).

However, this data has proven to be unavailable for the Netherlands. First of all, no reliable information is available at the requested level of the ISCO-88 occupational classification. There are two reasons for this:

1. In the Netherlands a different occupational classification is normally used, namely the 1992 Standard Occupations Classification of the CBS. Although this classification is based on the ISCO-88 classification, the conversion is not accurate enough at the level of the requested professions.
2. The available information comes from random surveys, such as the Enquete Beroepsbevolking (EBB) (Labour Force Survey) and the Quarterly vacancy surveys. To the extent that they are available, the numbers for the level of the requested professions are too low in relation to the scope of the random survey to be sufficiently reliable. The margin of error is too high.

Secondly, there is currently not yet any information available in the Netherlands on the position of migrants in the health sector according to the definition in the proposed Directive. In the Netherlands, only information based on the nationality or based on the distinction persons of foreign heritage/persons of native Dutch heritage is currently available, in any case with regard to the subject matter. A person of foreign heritage person is classed as a person of whom at least one of the parents was born in another country.

The healthcare labour market also had to be defined in a different way, as the requested information at an occupational level was not available. Based on data availability, it was decided to collect the information as much as possible on the basis of the industry sector. For this reason the Standard Industrial Classification '93 (SBI '93) was used, a systematic and hierarchical system in which industry units are classed by their main activity. This classification largely corresponds with the NACE Rev. 1 (Nomenclature statistique des activités économiques dans la Communauté Européenne) classification adopted by Eurostat. In the SBI '93 and NACE classifications the health sector has code 851. It also became clear that sometimes information was only available for the health and welfare sectors combined (SBI and NACE code N).

The information about the number of persons of foreign heritage in the health sector does not give a complete image of labour migration to the health sector, as the group of persons of foreign heritage is larger than the group of migrants (in 2005, 49% of the total number of persons of foreign heritage was born in the Netherlands (source: www.cbs.nl)). A large proportion of the persons of foreign heritage who work in the health sector were probably either born and raised in the Netherlands or migrated to the Netherlands for reasons other than employment in the health sector. This is why more specific information was sought to demonstrate the importance of labour migration for the health sector. On the one hand the number of granted work permits by nationality is an indication of labour migration to the health sector. On the other hand there are also figures on the Netherlands' acknowledgement of diplomas and professional skills obtained in other countries. This acknowledgement is necessary to work in the Dutch health sector. These figures also constitute an indication of the nature and scope of labour migration to medical professions, with a breakdown of the countries where the diplomas were obtained.

¹ COM (2005) 375 final

4 Migration Policy and the Health Sector in the Netherlands

This chapter describes the legal framework of migration policy in respect of labour migration to the health sector as it currently applies. It will also focus on the influence of EU regulations and of bilateral and multilateral treaties. In addition to the relevant legislation and regulations, this chapter will also briefly look at the experiences with the recruitment of foreign personnel for the health sector.

4.1 Legislation and regulations in respect of labour migration

The starting point for the admission of migrants to the Dutch labour market is, that the need for labour has to be met, as much as possible, by utilising the labour supply that is available or can reasonably be expected to become available in the Netherlands, or the labour supply from the EU member states or states that are a party to the EEA Treaty, insofar as the free movement of employees applies to these states. This is the so-called priority labour supply, as defined in Article 1, under g, of the Aliens Employment Act (Wav) (Wet arbeid vreemdelingen). This starting point also applies to labour migration for the health sector. The legal framework for labour migration to the health sector does not differ from the legal framework for labour migration in general. In the Netherlands, labour migration is a matter for the central government, in which regional and local authorities do not play a role.

The rules for admission into the Netherlands are documented in the Aliens Act 2000 (Vw 2000) (Vreemdelingenwet 2000) and the resulting legislation and regulations. The Wav regulates the admission of foreign nationals to the Dutch labour market. Admission to the Netherlands with the objective of working is not possible if the foreign national does not have access to the labour market and vice versa. The decisions relating to the application for a residence permit and the application for a work permit therefore affect each other, which Wav Employment Act are closely interlinked.

Article 8, first paragraph, under c, of the Wav stipulates that a foreign national who wants to access the Dutch labour market must have a residence permit that allows him to do so. Article 13, opening sentences and under b, of the Vw 2000 stipulates that an application for a residence permit can only be granted if the presence of the foreign national serves a material Dutch interest. For foreign employees the determination whether the foreign national's presence serves a material Dutch interest is made by the Centrum voor Werk en Inkomen (CWI) (Centre for Work and Income) on behalf of the Minister of Social Affairs and Employment (SZW) (Sociale Zaken en Werkgelegenheid). The CWI, using the Wav, decides whether the intended employer will be granted a work permit. If the applicant wants to work in the Netherlands independently, the advice of the Minister of Economic Affairs (EZ) (Economische Zaken) is generally sought in order to determine the material Dutch interest. In the case of medical professions, however, the advice of the Minister of Health, Welfare and Sport (VWS) (Volksgezondheid, Welzijn en Sport) will mostly be sought.

4.1.1 Aliens legislation and regulations

The decision whether or not to grant a residence permit is made on the basis of the Vw 2000 and the ensuing legislation and regulations. Pursuant to Article 14 of the Vw 2000, a residence permit is granted subject to certain restrictions associated with the objective for which the residence is allowed. These residence objectives are listed in the Vw 2000. The main employment-related residence objectives are:

Working on a self-employed basis

Migrants who want to settle in the Netherlands as self-employed entrepreneurs can apply to the IND for a residence permit with the restriction 'working on a self-employed basis'. This method of gaining admission to the Dutch labour market must certainly be mentioned here, because, as explained in chapter 2, many medical professional practitioners in the Netherlands are self-employed. No work permit is required in order to work on a self-employed basis, as Article 3 of the Wav also shows.

In addition to a number of general conditions a foreign national must comply with, such as being in possession of a valid border crossing document and having adequate financial resources, foreign

nationals wishing to settle in the Netherlands in order to work on a self-employed basis must meet the following conditions:

1. The migrant must meet the requirements for practising the profession in question. If there are special competency requirements for the profession the foreign national wants to practice on a self-employed basis, the foreign national must demonstrate that he meets these requirements. When it comes to medical and paramedical professions the IND can seek the assistance of the Ministerie van Volksgezondheid, Welzijn en Sport (VWS) (Ministry of Health, Welfare and Sport) to determine if the foreign national does in fact meet these requirements, according to the Aliens Act Implementation Guidelines 2000 (VC 2000) Vreemdelingen-circulaire 2000).
2. The business activity must serve a material Dutch interest. In order to determine whether the business activity serves a material Dutch interest, advice from the Ministry of Economic Affairs is generally sought. General conditions that must be met are:
 - the business activity must have clear innovative value, in other words, it must make a positive contribution to the Dutch economy;
 - the business activity does not upset the competitive balance in the sense that healthy market competition is negatively affected.

In the case of admission of (para)medics it is also relevant whether the business activity serves a material Dutch public health interest. To determine this the advice of the ministry of VWS is sought (Paragraph B5/8.1 VC 2000). Incidentally, this is only the case for legally regulated (para)medical profession (see chapter 6). At the moment there is no clarity on the competence to advise on professions which are not legally regulated (such as the profession of chiropractor).

Working as an employee

Migrants who come to the Netherlands with the objective of working for an employer can apply for a residence permit with the restriction 'working as an employee'. To be granted a residence permit with this restriction, the foreign national must have access to the labour market in accordance with the stipulations of the Wav, either because the employer has been granted a work permit, or because he/she is exempt from the requirement of having a work permit. In addition, the applicant must also meet a number of general conditions, such as being in possession of a valid border crossing document and having adequate financial resources. A residence permit with the restriction 'working as an employee' is granted for a maximum period of 3 years, after which it can be extended yearly.

The highly skilled migrants arrangement

Subject to certain conditions, migrants who come to the Netherlands to work for an employer can also apply for a residence permit with the objective 'residence as a highly skilled migrant'. As a result of the resolutions made during the Barcelona and Lisbon European Councils to make the European Union the most dynamic knowledge economy in the world by 2010 (the Lisbon agenda), the highly skilled migrants arrangement came into effect on 1 October 2004. The objective of this arrangement is to simplify the admission of highly skilled migrants from outside the EU/EEA (Minister voor Vreemdelingenzaken en Integratie: 2004), thus reinforcing the position of the Netherlands as a knowledge economy.

The Aliens Employment Act Implementation Decree (Besluit uitvoering Wet arbeid vreemdelingen) stipulates that highly skilled migrants do not need a work permit. The Decree also defines when a migrant is considered a highly skilled migrant. A highly skilled migrant is a foreign national who will earn a gross annual income of at least € 45,495 – or € 33,363 if he is under 30 - on the basis of an employment contract or a public service appointment (these amounts are adjusted yearly). If the employee will be employed by an educational or research institution as a doctoral candidate, and for postgraduates and university lecturers under the age of 30, the gross income must at least be equal to the welfare norm.

In addition to this condition, which will be assessed during the processing of the residence permit application, the foreign national must also meet a number of general admission conditions, such as being in possession of a valid border crossing document. In addition, the intended employer must have signed a statement containing a number of guarantees in respect of the highly skilled migrant's stay. If it appears unlikely that the employer can comply with these guarantees, the applicant will be refused stay as a highly skilled migrant working for the employer in question.

An important element of the highly skilled migrants arrangement, apart from the simplified admission criteria, is the fact that the procedure must be accelerated. The IND endeavours to make

a decision regarding a residence permit within two weeks of receiving a request for advice or an application (Paragraph B15/4 of the VC 2000).

Other categories

In addition to migrants who come to the Netherlands for the purpose of employment, there are also migrants who are admitted to the Netherlands on other grounds, for instance as refugees or in the context of family reunification. The Wav stipulates in what cases they are given free access to the labour market.

4.1.2 Aliens Employment Act (Wav)

As mentioned earlier, the regulations relating to the admission of foreign employees to the Dutch labour market are documented in the Wav. The further implementation rules are documented in the Aliens Employment Act Delegation and Implementation Decree (Delegatie- en uitvoeringsbesluit Wet arbeid vreemdelingen). The starting point of the Wav is, on the one hand, the protection of the Dutch and European labour market through the restricted admission of labour migrants. On the other hand, the Wav is also intended to combat illegal labour and the associated unfair competition. (SZW: 2006)

This is why the law decrees that an employer is, in principle, prohibited from employing a foreign national in the Netherlands without a work permit. Such a permit is only granted if a number of strict conditions have been met and does, in principle, have a maximum validity of three years. This is because the starting point of the labour migration policy is the premise that admission to the Netherlands with the objective of paid employment is, in principle, temporary in nature. This three-year maximum term is intended to prevent a permanent residence entitlement with free access to the labour market being created. For this reason it is, in principle, not possible to extend a work permit, if with this the maximum term would be exceeded.

As explained in the previous paragraph, a work permit is not necessary for foreign nationals with highly skilled migrant status, or if the foreign national is admitted with the residence objective of working on a self-employed basis. Neither does the obligation to hold a work permit apply if the applicant is exempt pursuant to international obligations. This applies specifically to subjects of the EU, the EEA and Switzerland, with the exception of the new member states from Middle and Eastern Europe. Family members of American and Canadian diplomats are for example also exempt pursuant to international obligations (Delegatie- en uitvoeringsbesluit Wet arbeid vreemdelingen) (Aliens Employment Act Delegation and Implementation Decree).

Also, the Royal Decree of 23 August 1995 for the implementation of the Aliens Employment Act designates categories of foreign nationals and employment for which these obligations do not apply. However, for labour migrants who want to perform work related to the health sector under the restriction 'working as an employee', the exceptions listed in this Decree are not relevant.

The employer is responsible for applying for a work permit for the foreign national he wishes to employ. In the following cases the application will always be rejected:

- If the CWI determines that priority labour is available in the labour market for the vacancy in question.
- If the employer did not report the vacancy to the CWI at least five weeks prior to submitting the application for a work permit (in the Netherlands the CWI is also responsible for, among other things, bringing employers and jobseekers together, and provides jobseekers with means to find a job).
- If the foreign national will not be earning the statutory minimum monthly wage.
- If the foreign national does not have a residence permit that allows him to work, or has not applied for such a residence permit.

The application may also be rejected if:

- the employer is unable to demonstrate that he has made sufficient efforts to fill the vacancy with priority labour available in the labour market or if he obstructed the fulfilment of the vacancy with priority labour;
- it may be anticipated that such priority labour will become available in the near future;
- the current employment terms and/or the employment terms that are common to the sector are not complied with;

- the foreign national does not have suitable accommodation;
- the foreign national is under 18 or over 45 years of age²;
- the foreign national did not comply with restrictions of a previous permit;
- the foreign national was previously admitted to the Netherlands and was granted a non-renewable temporary work permit and did not move his principal residence outside the Netherlands for a period of at least one year after expiry of this permit; and
- the recruitment did not take place in a manner that was prescribed by an covenant for the sector in question.

The determination of the availability of priority labour within the Netherlands and other EU countries (insofar as the free movement of persons applies to these countries) is made by the CWI on the one hand; on the other hand the employer also has an individual recruitment obligation. If the CWI concludes that priority labour is available, the permit will not be issued. The employer must also have tried to recruit permit-exempt labour from within the EU using the Eures system or a comparable method. If he has not done so, he will be deemed to have made insufficient efforts to mobilise priority labour.

This condition in particular creates a serious barrier for obtaining a work permit. Incidentally, this has proven to generate fewer complications for highly educated personnel than for less educated personnel, as the supply of highly educated personnel in the labour market is also lower. For trainees and academic personnel the availability of priority labour is not taken into account at all. (Klaver and Odé: 2002)

Moreover, for the health sector between 1 July 2000 and 1 July 2004, the Covenant on the Labour market Policy for the Healthcare Sector referred to in chapter 2, between the ministry of VWS, the social partners in the health sector and Arbeidsvoorziening Nederland (the Dutch Employment Services Agency) (now the CWI), which contains additional restricting conditions for labour migration of nurses in hospitals and caretaking personnel in nursing and care homes applied. However, this Agreement, a Covenant within the meaning of Article 9, first paragraph, under i, of the Wav, was not renewed and therefore no longer applies. (Roosblad: 2005)

Based on Article 19a of the Implementation rules of the Wav the CWI can designate sectors and/or professional groups for which a more relaxed assessment of the priority labour requirement will apply for a period of three months. In the health sector, such an exception applied between 1 May 2004 and 30 April 2004 in respect of foreign nationals from the new EU member states for the professions of operating theatre assistant, therapeutic radiographer and diagnostic radiographer, as a result of a shortage of these professional groups in the labour market (CWI: 2005a). However, according to information supplied by the CWI, no employers availed themselves of this exception during this period. It is not known why this was the case.

4.2 Influence of international law

Labour migration within the EU is, of course, primarily regulated by European legislation. This is no different for labour migration in the health sector. Community citizens (subjects of member states of the EU, the EEA and the Swiss Federation) have free and full access to the labour market. They are also permitted to start their own company in the Netherlands. In that case the same conditions apply as for Dutch subjects. Subjects of Estonia, Hungary, Latvia, Lithuania, Poland, Slovenia, Slovakia and the Czech Republic, and their family members, do not have free access to the labour market. In the first instance this is the case until 1 May 2006. An extension of this period is currently a subject of political discussion and it looks like free access to the labour market for subjects of these Member States will be granted no earlier than 1 January 2007. However, many professions in the health sector are practiced on a self-employed basis (GP, dentist, medical specialist, etc.). This means that for these professions free access to the labour market now exists, provided the practitioners establish themselves in the Netherlands as self-employed entrepreneurs.

Because diploma recognition is also very important for employment in the health sector, the EU Directives that regulate this are therefore also important. These are the first, second and third Directives on a general system for the recognition of professional education and training (89/48/EEG, 92/51/EEG and 99/42/EG) and the sector Directives for physicians, dentists,

² This condition applies only to foreign nationals who have not previously been admitted to the Netherlands.

pharmacists, nurses and obstetricians. The diplomas that qualify a person for these professions are automatically recognised.

4.3 Recruitment of Labour Migrants for the Health Sector: Institutions and Procedures

As explained in chapter 2, the government does not play an active role in the recruitment of medical personnel abroad. Recruitment normally takes place at the initiative of a healthcare institution, which will usually deploy a commercial recruitment agency. The decision which country to recruit in appears to depend on:

- the supply available from mediation agencies and personal connections of the healthcare institution,
- the labour market situation in the source country,
- whether the recognition of diplomas from the source country is a problem or not;
- the existence of historical colonial ties (Surinam, Indonesia); and
- cultural similarities with the Netherlands and/or knowledge of the Dutch language.

The responsibility for granting a residence permit pursuant to the stipulations of the Aliens Act lies with the Minister of Alien Affairs and Integration (Vreemdelingenzaken en Integratie). The responsibility for granting the foreign national access to the labour market pursuant to the Aliens Employment Act lies with the Minister of Social Affairs and Employment.

A large number of institutions play a role in the recruitment of medical personnel abroad. In addition to the private recruitment agencies and the healthcare institutions, the following organisations are involved in the admission of personnel to the Netherlands and to the labour market:

- The Immigratie- en Naturalisatiedienst (IND) (Immigration and Naturalisation Service), an agency of the Ministry of Justice, is the organisation that decides on the granting of a residence permit.
- The CWI, an individual administrative body working on behalf of the Ministry of Social Affairs and Employment. The CWI decides on admission to the labour market by means of a work permit (unless the applicant is exempt or will be working as an individual).
- The Ministry of Health, Welfare and Sport is involved in issuing advice as to whether there is a material Dutch public health interest, which is a condition for granting a residence permit to persons who want to work in the Dutch health sector on a self-employed basis.
- In some cases the Ministry of Economic Affairs is involved in advising on the existence of a material Dutch interest in respect of a residence permit for employment on a self-employed basis in the Dutch health sector, rather than the Ministry of Health, Welfare and Sport.

The aforementioned institutions are involved in the application of the rules and regulations on admission to the Netherlands and to the labour market discussed at length in this chapter. In addition however, for a person to work in the Dutch health sector recognition of the person's medical qualifications is also of great importance. In chapter 6, the rules and regulations covering this subject will be dealt with extensively. For now, the most important institutions and organisations will be mentioned that foreign medical professionals have to deal with when trying to obtain recognition of their medical qualifications:

- The BIG-register, part of the Centraal Informatiepunt Beroepen Gezondheidszorg (CIBG) (Central Information Unit on Health Care Professions), an agency of the Ministry of Health, Welfare and Sport. This is a frequently updated register that lists pharmacists, physicians, physiotherapists, healthcare psychologists, psychotherapists, dentists, midwives and nurses and makes a note of any limitations to their qualifications.
- The CIBG subunit Vakbekwaamheidsverklaringen Buitenslands Gediplomeerden Volksgezondheid (Declarations of Competence for Foreign Health Care Professionals) will evaluate, on behalf of the Minister, whether the foreign diploma - possibly in combination with the relevant professional experience - and a possible specialisation or additional training is equal to the Dutch equivalent. A request for a declaration of professional competence can be submitted for that purpose. For the aforementioned professions this is a condition for registration and for a number of other professions this is a condition for practising the profession in question while using the educational title in question.

- The Minister of Health, Welfare and Sport can ask the (advisory) Commissie Buitenslands Gediplomeerden Volksgezondheid (CBGV) (Committee on Holders of Foreign Qualifications in Healthcare) for advice about an application for a declaration of professional competence.
- The Nuffic, the Dutch organisation for international collaboration in higher education, can be asked to evaluate a diploma in the context of determining professional competence. The Nuffic, a non-profit service organisation, has been designated by the Minister of Education, Culture and Science (O, C&W) as the centre of expertise for the evaluation of diplomas from foreign higher education.
- The Colo, Vereniging Kenniscentra Beroepsonderwijs Bedrijfsleven (Colo, Association of Centres of Expertise on Vocational Education, Training and the Labour Market), may also be asked to evaluate diplomas. This Association has been designated by the Minister of Education, Culture and Science as the centre of expertise for the evaluation of diplomas from other forms of education, such as intermediate vocational education.

5 The Employment of Immigrants in the Health Sector

In this chapter we will try to map out the position of migrants in the working population in the health sector. In addition, with the aid of figures on the development of the number of vacancies in the health sector, we will provide an outline of the labour market situation.

5.1 The Role of Migrants in the Labour Market for the Health Sector

In chapter 3, we already indicated that the numerical information, as requested in the research specifications for this study, is not available. This does not alter the fact that other information is available that can provide an insight into the scope of labour migration with the objective of working in the health sector, the proportion of migrants in the health sector and the number of vacancies in the sector.

Labour migration to the health sector

As mentioned before, no figures are available on the number and proportion of migrants employed in the requested medical professions in line with the requested definitions. There is however information available about the proportion of persons of foreign heritage in the health sector (SBI'93, code 851, see also chapter 3), derived from the aforementioned EBB survey.

Table 2a: Employed working population by origin and industry classification

	1997			1998			1999			2000		
	Healthcare sector	Other	Total NL	Healthcare sector	Other	Total NL	Healthcare sector	Other	Total NL	Healthcare sector	Other	Total NL
Origin	x1000											
Persons of native Dutch heritage	317	5162	5479	329	5288	5617	342	5399	5741	342	5501	5843
EU/EEA	18	265	283	19	269	288	15	284	299	16	276	293
New EU member states	.	.	.	.	.	.	.	.	.	.	.	.
Other persons of Western foreign heritage ³	19	262	281	20	278	299	20	289	309	20	313	332
Turks	1	65	66	1	71	72	1	79	80	1	89	90
Moroccans	3	49	52	1	58	60	2	61	63	1	56	57
Surinamese	7	97	104	6	113	119	6	117	123	7	127	134
Antilleans / Arubans	2	25	27	3	28	31	2	35	37	2	38	40
Other non-western countries	7	83	89	3	98	101	4	110	114	5	123	128
Total	375	6009	6384	383	6204	6587	393	6375	6768	394	6523	6917
In terms of percentage	5.9%		100%	5.8%		100%	5.8%		100%	5.7%		100%

Source: Centraal Bureau voor de Statistiek (CBS) (Statistics Netherlands), Enquête Beroepsbevolking (EBB) (Labour Force Survey)

³ Person of Western foreign heritage: person of foreign heritage with, as the origin grouping, one of the countries in the continents Europe (excluding Turkey), North America and Oceania or Indonesia or Japan.

Based on their socio-economic and socio-cultural position, persons of foreign heritage originating from Indonesia and Japan are classed as persons from Western ethnic groups. These are mainly people who were born in the former Dutch East Indies and employees of Japanese companies with their families.

Table 2b: Employed working population by origin and industry classification

	2001			2002			2003			2004		
	Healthcare sector	Other	Total NL	Healthcare sector	Other	Total NL	Healthcare sector	Other	Total NL	Healthcare sector	Other	Total NL
Origin	x1000											
Persons of native Dutch heritage	356	5536	5892	357	5531	5888	363	5479	5842	383	5386	5769
EU/EEA	20	298	318	16	284	300	18	295	313	18	284	302
New EU member states	.	.	.	.	.	.	.	.	.	2	31	33
Other persons of Western foreign heritage	20	297	317	23	308	332	23	302	325	18	270	288
Turks	2	98	100	2	97	99	2	100	102	2	105	106
Moroccans	2	71	73	3	79	82	3	73	76	2	69	71
Surinamese	7	128	135	6	130	136	8	131	139	9	135	144
Antilleans / Arubans	2	41	43	2	46	48	1	46	47	3	42	46
Other non-western countries	5	138	143	4	146	150	8	148	156	7	152	159
Total	413	6608	7021	414	6621	7035	427	6575	7001	445	6473	6919
In terms of percentage	5.9%		100%	5.9%		100%	6.1%		100%	6.4%		100%

Source: CBS, Enquête Beroepsbevolking (EBB) (Labour Force Survey)

These figures do not provide a complete picture of the proportion of migrants in the health sector. On the one hand, not all persons of foreign heritage are also migrants, because children of migrants also form part of this group. On the other hand, the above figures also include persons of foreign heritage who migrated to the Netherlands primarily for reasons other than employment, for instance in the context of family reunification or as refugees. The above figures show that the proportion of persons of foreign heritage in the health sector in the working population in the health sector hovers around 14%, while their proportion in the total labour force between 1997 and 2004 grew from around 14% to almost 17%.

In addition, we looked for more specific information that would demonstrate the proportion of labour migrants in the health sector. As described in chapter 4, in most cases a work permit is required for labour migrants to gain access to the Dutch labour market. Information from the CWI about the number of granted and refused work permits for the health sector in the period 2001-2004 provides an initial indication of the importance of labour migration for the health sector. Information about the nationality of the applicants is also available. This gives an initial indication of countries of origin that are important to labour migration for the health sector. Incidentally, the CWI registers these permits by the main activity of the function. The healthcare-related activities are shown.

Table 3: Granted and refused work permits by activity (absolute numbers)

Activity	2004		2003		2002		2001		total	total		total	gr.	ref.
	gr.	ref.	gr.	ref.	gr.	ref.	gr.	ref.		gr.	ref.			
AGOGIC / SOCIAL WORK	121	38	150	27	130	34	131	8	639	532	83%	107	17%	
CARING / ASSISTING - PEOPLE	152	71	145	33	90	23	48	12	574	435	76%	139	24%	
NURSING A- GENERAL	44	3	93	52	119	8	154	19	492	410	83%	82	17%	
CARING / ASSISTING - PEOPLE NURSING	43	7	120	6	99	13	113	2	403	375	93%	28	7%	
CARING / ASSISTING - PEOPLE THE ELDERLY	51	6	131	6	79	2	32		307	293	95%	14	5%	
HEALING: PEOPLE SPECIALIST	57	4	58	3	41	4	33		200	189	95%	11	6%	
HEALING: PEOPLE: DENTIST	68	8	58	8	18	2	6		168	150	89%	18	11%	
NURSING	7	17	16	8	55	12	3	2	120	81	68%	39	33%	
MEDICAL ASSISTING	18	8	29	12	16	12	21	3	119	84	71%	35	29%	
HEALING: PEOPLE	23	13	12	16	20	4	18	4	110	73	66%	37	34%	
MEDICAL ASSISTING: SPECIALIST	10	2	30	5	33	3	14	1	98	87	89%	11	11%	
MEDICAL ASSISTING: DENTIST	5	3	25	6	17	2	3	2	63	50	79%	13	21%	
THERAPEUTIC SUPPORT (PHYSICAL) CHIROPRACTOR	11	1	14	2	17		15		60	57	95%	3	5%	
CARING / ASSISTING: PEOPLE HOUSEHOLD	15	5	13	4	13	4	3		57	44	77%	13	23%	
CARING / ASSISTING: PEOPLE HOME NURSING CARE	5	2	9	5	10	3	6	1	41	30	73%	11	27%	
TOTAL	653	194	998	208	796	135	658	60	3,7	3,11	84%	597	16%	

CWI: 2006

Table 4: Granted and refused work permits in the health sector by nationality (absolute numbers)

Nationality	2004		2003		2002		2001		total	total		total	gr.	ref.
	gr.	ref.	gr.	ref.	gr.	ref.	gr.	ref.		gr.	ref.			
Indonesian	76	26	203	37	191	25	175	6	739	645	87%	94	13%	
South African	90	5	137	12	64	12	65	5	390	356	91%	34	9%	
Polish	43	19	127	9	97	5	24		324	291	90%	33	10%	
Turkish	65	28	90	7	59	5	33	3	290	247	85%	43	15%	
Philippino	36	6	52	29	62	3	72	1	261	222	85%	39	15%	
Surinamese	23	13	39	10	44	12	67	15	223	173	78%	50	22%	
American	24	3	39	5	40	6	43	1	161	146	91%	15	9%	
Moroccan	16	9	24	16	14	13	23		115	77	67%	38	33%	
Chinese	18	7	7	6	12	3	13	2	68	50	74%	18	26%	
Romanian	23	2	9	5	6	5	15	1	66	53	80%	13	20%	
Iranian	13	6	17	2	16	5	2	2	63	48	76%	15	24%	
Croatian	13	1	15	4	17		12		62	57	92%	5	8%	
Lithuanian	22	1	25		9	1		1	59	56	95%	3	5%	
Sierra Leonan	12	2	16	2	6		2		40	36	90%	4	10%	
Angolan	14	1	12		5		6		38	37	97%	1	3%	
Total	653	194	998	208	796	135	658	60	3.702	3.105	84%	597	16%	

CWI: 2006

In any case, the above information makes it clear that the number of requests for work permits is very low in relation to the number of persons working in the health sector. This gives a clear indication of the small numbers involved in labour migration with the objective of working in the

health sector. However, the number of work permits granted does not give us an insight into the numbers of migrants who have settled in the Netherlands to work in the health sector on a self-employed basis (and thus do not need a work permit), nor does it show the numbers of migrants who work in the health sector as labour migrants and are exempt from needing a work permit (in particular, highly skilled migrants and migrants from the EU, with the exception of the new Middle and Eastern European member states, the EEA and Switzerland).

In order to get an idea of the number of migrants in the health sector that does include the aforementioned groups, the figures that are available in the context of the Individual Healthcare Professionals Act (the BIG Act) can be used. Pursuant to this Act there is a register for a number of medical professions (the so-called article 3 professions), the BIG register. For the article 3 professions, being listed in this register is a condition for using the title and practising reserved procedures (chapter 6 looks at this in more detail).

Table 5: Number of professional practitioners by basic profession (Article 3 professions), Reference date 01/01/2004

Basic profession	Number of persons
Pharmacists	4,960
Physicians	56,541
Physiotherapists	33,880
Healthcare psychologists	9,673
Psychotherapists	6,012
Dentists	9,836
Midwives	2,835
Nurses	226,200
Total	349,937

Source: CIBG and CBGV: 2005

If a person with a foreign diploma wants to register in the BIG register with an article 3 profession, this person will normally have to request a declaration of professional competence. The number of requests with a foreign diploma is registered and, compared against the total number of registered professional practitioners, gives a fair picture of the nature and scope of the labour migration to the health sector. What is missing, however, are those persons who registered with a diploma listed in the Regulation on the Registration of Foreign Health Care Qualifications (Regeling aanwijzing buitenlandse diploma's gezondheidszorg), a so-called 'listed' diploma (see chapter 6). For the article 3 professions these are all diplomas from member states of the EU, the EEA and Switzerland.

Table 6: 2004 Processed requests within the EEA and Switzerland; article 3 professions

Professions	Equivalent	Virtually equivalent/Material differences	Rejection
Pharmacist	1	1	3
Physician	37	35	14
Physiotherapist	11	10	10
Healthcare psychologist	4	1	8
Psychotherapist	1	4	6
Dentist	8	7	9
Midwife	2	0	8
Nurse	21	8	38
Total	85	66	96

Source: CIBG and CBGV: 2005

Table 7: 2004 Processed requests outside the EEA and Switzerland; article 3 professions

Professions	Equivalent	Virtually equivalent	Rejection*
Pharmacist	0	0	28
Physician	37	71	187
Physiotherapist	1	4	23
Healthcare psychologist	1	1	6
Psychotherapist	0	1	4
Dentist	35	96	66
Midwife	1	1	28
Nurse	15	20	137
Total	90	194	479

Source: CIBG and CBGV: 2005

* In the case of article 3 professions the application is halted in approximately one quarter of all requests. Often these are professional practitioners who do not have a residence permit or who are trying to get their diploma recognised in other European countries as well.

For 2003 and 2004, figures are also available about the number of registrations in the BIG register with a Dutch and a foreign diploma, broken down by type of foreign diploma (EEA/Switzerland or Non-EEA/Switzerland). The listed diplomas are included in these figures. It must be noted, however, that quite a few Dutch citizens obtain a medical qualification in another EEA country (specifically Belgium and Germany), because in the Netherlands admission to a number of medical courses (specifically medicine, dentistry and physiotherapy) is restricted. For this reason the BIG registrations with an EEA diploma for these professions will often also relate to Dutch citizens, and will therefore not be relevant to labour migration.

Table 8: Number of professional practitioners registered in a specific year

Professional group	Type of diploma	2003	2004	Total	
		(Reference date 8-1-2004)	(Reference date 11-1-2005)		
<i>Pharmacists</i>	Non-EEA	0	0	0	0.0%
	EEA	25	12	37	7.4%
	Dutch	246	215	461	92.6%
	Total	271	227	498	100.0%
<i>Physicians</i>	Non-EEA	151	40	191	4.2%
	EEA	422	405	827	18.2%
	Dutch	1699	1816	3515	77.5%
	Total	2272	2261	4533	100.0%
<i>Physiotherapists</i>	Non-EEA	5	0	5	0.2%
	EEA	19	15	34	1.4%
	Dutch	1227	1239	2466	98.4%
	Total	1251	1254	2505	100.0%
<i>Healthcare psychologists</i>	Non-EEA	4	0	4	0.3%
	EEA	1	3	4	0.3%
	Dutch	627	653	1280	99.4%
	Total	632	656	1288	100.0%
<i>Psychotherapists</i>	Non-EEA	0	1	1	0.3%
	EEA	1	2	3	0.9%
	Dutch	209	117	326	98.8%
	Total	210	120	330	100.0%
<i>Dentists</i>	Non-EEA	80	23	103	12.9%
	EEA	125	115	240	30.1%
	Dutch	220	235	455	57.0%
	Total	425	373	798	100.0%
<i>Midwives</i>	Non-EEA	0	0	0	0.0%
	EEA	62	60	122	35.7%
	Dutch	102	118	220	64.3%
	Total	164	178	342	100.0%
<i>Nurses</i>	Non-EEA	178	70	248	2.0%
	EEA	216	136	352	2.8%
	Dutch	6331	5738	12069	95.3%
	Total	6725	5944	12669	100.0%

(Source: Verwijspunt Buitenslands Gediplomeerden Volksgezondheid et al.: 2004; CIBG and CBGV 2005)

*In the registrations with a foreign diploma the conversions from a registration with special stipulations to a registration without special stipulations have not been included, as they are not new registrations.

Table 8 shows that the proportion of foreign diploma holders in the annual registrations is generally low. Only for physicians and dentists is this different, both with regard to the proportion of EEA and non-EEA diplomas. In addition, a relatively high number of midwives have an EEA diploma. For 2003-2005, figures in respect of the annual registrations are also available per country. Table 9 reflects the number of diplomas from non-EEA countries. These figures indicate that a relatively high number of South African physicians and dentists and Surinamese physicians practice in the Netherlands. The figures also clearly show that the numbers of nurses with a foreign diploma working in the Netherlands are relatively minor, whereby Indonesia, Surinam, the Philippines and the Dutch Antilles are the main countries of origin.

Table 9: Foreign diplomas outside the EEA, registered by country and type of diploma

Professional group	Country	2003 (Reference date 8-1-2004)	2004 (Reference date 11-1-2005)	2005 (Reference date 3-1-2006)	Total	In terms of percentage
<i>physicians</i>	South Africa	62	18	24	104	45%
	Surinam	12	6	4	22	9%
	Croatia	7	6	3	16	7%
	Poland*	12	0	0	12	5%
	Romania	6	1	1	8	3%
	India	6	0	0	6	3%
	Turkey	3	2	1	6	3%
	Egypt	3	1	1	5	2%
	Indonesia	2	2	1	5	2%
	United States of America	4	1	0	5	2%
	Other	34	3	6	43	19%
Total		151	40	13	232	100%
<i>physiotherapists</i>	Hungary*	2	0	0	2	29%
	United States of America	1	0	1	2	29%
	Australia	1	0	0	1	14%
	Canada	1	0	0	1	14%
	South Africa	0	0	1	1	14%
	Total	5	0	2	7	100%
<i>healthcare psychologists</i>	Yugoslavia	2	0	0	2	40%
	Australia	1	0	0	1	20%
	Argentina	1	0	0	1	20%
	Brazil	0	0	1	1	20%
	Total	4	0	1	5	100%
<i>psychotherapists</i>	Brazil	0	1	0	1	
<i>dentists</i>	South Africa	60	15	13	88	67%
	Israel	7	1	10	18	14%
	Romania	8	2	2	12	9%
	Hungary*	4	0	0	4	3%
	United States of America	0	2	1	3	2%
	China	0	1	0	1	1%
	Iran	0	0	1	1	1%
	Japan	1	0	0	1	1%
	Nigeria	0	0	1	1	1%
	Tanzania	0	1	0	1	1%
	Turkey	0	1	0	1	1%
Total	80	23	28	131	100%	
<i>nurses</i>	Indonesia	23	20	11	54	17%
	Surinam	28	11	8	47	15%
	The Philippines	27	7	6	40	13%
	Dutch Antilles	16	10	9	35	11%
	Aruba	15	6	8	29	9%
	Australia	12	3	3	18	6%
	South Africa	8	5	4	17	5%
	United States of America	4	1	4	9	3%
	Iran	6	1	1	8	3%
	Israel	1	3	3	7	2%
	Other	38	3	9	50	16%
	Total	178	70	66	314	100%
All registrations		418	134	110	662	

(Source: BIG register)

*Hungary and Poland joined the EU in 2004, which is why only figures for 2003 are listed

In addition to the registration of article 3 professions, the BIG Act also regulates the protection of the educational title of other medical professions (the so-called article 34 professions). For these professions, holders of a foreign diploma must apply for a declaration of professional competence to be allowed to use the educational title. Figures are also available for these numbers.

Table 10: 2004 Processed requests within the EEA and Switzerland; article 34 professions

<i>Professions</i>	<i>Equivalent</i>		<i>Material differences</i>		<i>Rejection</i>		<i>Total</i>	
	<i>2003</i>	<i>2004</i>	<i>2003</i>	<i>2004</i>	<i>2003</i>	<i>2004</i>	<i>2003</i>	<i>2004</i>
Pharmacist's assistant	1	4	3	4	2	2	6	10
Dietician	8	1	0	0	0	1	8	2
Occupational therapist	11	3	3	0	0	3	14	6
Speech therapist	9	2	0	4	0	1	9	7
Dental hygienist	0	1	0	0	0	3	0	4
Mensendieck remedial therapist	1	1	0	0	0	0	1	1
Optometrist	0	0	0	0	0	1	0	1
Orthoptist	0	0	0	1	0	0	0	1
Podiatrist	3	1	0	0	0	0	3	1
Radiodiagnostic technician	7	3	2	1	0	1	9	5
Radiotherapeutic technician	1	0	0	0	0	0	1	0
Clinical dental technician	0	0	2	2	0	1	2	3
Auxiliary in the private health sector	0	0	1	5	6	10	7	15
Total	41	16	11	17	8	23	60	56

(Source: Verwijspunt Buitenslands Gediplomeerden Volksgezondheid et al.: 2004; CIBG and CBGV 2005)

Table 11: Processed requests outside the EEA and Switzerland; article 34 professions

<i>Professions</i>	<i>Equivalent</i>		<i>Virtually equivalent</i>		<i>Rejection</i>		<i>Total</i>	
	<i>2003</i>	<i>2004</i>	<i>2003</i>	<i>2004</i>	<i>2003</i>	<i>2004</i>	<i>2003</i>	<i>2004</i>
Pharmacy assistant	3	1	0	1	14	16	17	18
Dietician	2	2	0	0	1	2	3	4
Occupational therapist	5	0	0	1	0	0	5	1
Speech therapist	0	1	0	0	3	0	3	1
Dental hygienist	1	0	0	0	6	5	7	5
Mensendieck Remedial therapist	0	0	0	0	0	0	0	0
Optometrist	1	0	0	0	2	1	3	1
Orthoptist	0	0	0	0	0	0	0	0
Podiatrist	0	1	1	0	0	0	1	1
Radiodiagnostic technician	6	2	1	0	9	5	16	7
Radiotherapeutic technician	1	0	0	1	1	0	2	1
Clinical dental technician	0	0	0	0	1	1	1	1
Auxiliary in the individual health sector	0	6	0	4	27	41	27	51
Total	19	13	2	7	64	71	85	91

(Source: Verwijspunt Buitenslands Gediplomeerden Volksgezondheid et al.: 2004; CIBG and CBGV 2005)

The above figures in tables 5 to 11 give a clear indication of the relatively minor importance of labour migration on the healthcare labour market, certainly when it comes to labour migration from outside the EEA and Switzerland. Especially in the largest professional group in the health sector, the group of nursing and auxiliary personnel, labour migration does not appear to play a significant role based on the above data. For instance, the total number of requests for registration as a nurse processed in 2004 was only 239 and of this total, nearly three quarters were rejected, while the total number of nurses with a BIG registration at that time was 226,200. Only 206 nurses with a foreign diploma were newly registered in the BIG register in that year, compared to 5,738 with a Dutch diploma.

Both on the basis of the number of work permits issued for medical professions and on the basis of the number of requests for registration or applications for a declaration of professional competence in relation to the total working population in the health sector, the conclusion that labour migration to the health sector in the Netherlands is negligible in size, with the exception of the influx of physicians and especially dentists with a foreign diploma, is justified. Although part of this influx will consist of Dutch citizens studying abroad, it still appears that migration on the labour market for these professions plays a more important role.

5.2 Vacancies in the Health Sector

The above information throws some light on the role of migrants in the health sector. In addition, it is also important to gain an insight into the labour market in the sector. This is done by looking at the development of the number of vacancies. The CBS has figures available on the numbers of vacancies, the vacancy rate and the number of vacancies that are difficult to fill. These figures are derived from the CBS Quarterly Vacancy Survey and the CBS Survey on Employment and Wages. Here, too, we are talking about random surveys and once again no reliable information at the professional level requested in the specifications is available. But here, too, figures *are* available based on the industry sector. Unfortunately no figures are available on the health sector as a whole separately, only on the combined healthcare and welfare sectors (SBI '93 and NACE code N). This means that institutions for social socio-cultural work and boarding schools are also included in these figures.

Table 12: Number of outstanding vacancies by industry classification (SBI '93)
Annual figures
x 1000

	1998	1999	2000	2001	2002	2003	2004	2005
Total	134.9	171.5	202.8	197.1	149.3	109.4	118.3	149.8
Healthcare and welfare sectors	12.9	15.9	19.1	22.4	21.2	16.3	14.5	15.8

Centraal Bureau voor de Statistiek (CBS) (Statistics Netherlands), Voorburg/Heerlen 2006-04-28

Table 13: Hard-to-fill vacancies by business sector, SBI code N:
Healthcare and welfare sectors (reference date 30 September)
x1000

	2000	2001	2002	2003	2004
Hard-to-fill vacancies	8.4	11.8	5.7	3.4	1.9

Centraal Bureau voor de Statistiek (CBS) (Statistics Netherlands), Voorburg/Heerlen 2006-04-03

The available information shows that the number of vacancies in the healthcare and welfare sectors experienced a peak in the period 2000-2002. As we can see from the development of the number of hard-to-fill vacancies as reflected in table 12, the scarcity in the healthcare labour market, which showed a clear peak in 2001, has now been completely resolved.

Table 14: Vacancy rate by industry classification (SBI '93)
1st quarter

	1997	1998	1999	2000	2001	2002	2003	2004	2005
Total	15	21	24	32	31	25	18	18	23
Healthcare and welfare sectors	12	16	17	22	25	25	17	13	15

Centraal Bureau voor de Statistiek (CBS) (Statistics Netherlands), Voorburg/Heerlen 2006-04-03

The vacancy rate (table 12) also shows a similar picture of the developments in the labour market in the healthcare and welfare sectors. The vacancy rate is the number of outstanding vacancies per 1,000 occupied jobs. It is a measure of the scarcity in the labour market: the higher the vacancy rate, the greater the scarcity in the labour market. This indicator also shows a clear peak for the health sector in the period 2000-2002. This is contrary to the peak in the labour market as a whole, which was already past its maximum height by 2002. It is also clear that, based on the vacancy rate, it appears that the scarcity in the labour market as a whole between 1997 and 2005 was, in most cases, greater than that in the healthcare and welfare sectors, with the exception of the years 2002 and 2003.

How the labour market in the health sector will develop in the future is of course uncertain. In the context of the research programme entitled 'The Labour market in the Healthcare and Welfare Sectors', which was financed by the government and social partners in the health sector, a report on the current situation and expected developments in the labour market in the healthcare and welfare sectors was published in 2005 (Ott a.o.: 2005). With the exception of auxiliary personnel in nursing and care homes and home care, no personnel shortages are expected in the health sector in this period. Only in the case of a rapid economic upswing are shortages of nursing personnel expected in the period up to and including 2010. For the other professional groups there is, for the moment, a sufficient supply of personnel. This is also supported by other reports (ROA: 2005 and CWI: 2005).

The long-term study of the Centraal Planbureau (CPB) (Netherlands Bureau for Economic Policy Analysis) into four future scenarios for the government and healthcare up to and including 2040 (Bos a.o.: 2004) does not give an unambiguous answer to the question whether there will be personnel shortages that may make labour migration unavoidable. In all scenarios the proportion of the health sector in the labour market increases as a result of the ageing of the population. Depending on the development of such things as the economy as a whole, the productivity in the health sector and the labour market situation as a whole, personnel shortages in the health sector may or may not occur.

6 Education and Training

In addition to the legislation and regulations in respect of admission to the Netherlands and to the labour market it is also important for migrants wanting to work in the health sector what requirements apply in respect of the necessary qualifications to practice medical professions. Particularly relevant in this respect is the BIG Act, which came into effect in 1997. The BIG Act introduced a single uniform structure of authorisations for applicable professions in the area of individual healthcare. On the one hand the objective of the Act is to promote and monitor the quality of the professional practice and to protect the patient against inexperienced and careless actions in the area of individual healthcare. On the other hand the patient must have the freedom - where possible - to choose his/her own provider, authorised or otherwise.

The starting point of the Act is the fact that everyone is, in principle, free to perform procedures in the area of individual healthcare, with the exception of certain medical procedures that are reserved for registered medical professionals. These reserved procedures can only be performed at their own initiative by registered physicians, dentists and midwives. The BIG Act also includes a system for the protection of professional titles. The unauthorised use of a professional title protected by law is an offence.

Although non-authorised persons are allowed to perform medical procedures (with the exception of the reserved procedures), it will be harder for them to practise their profession than for authorised persons. For instance, it is likely to be more difficult to get a job in the Dutch health sector and the employment terms will often be less favourable than those of authorised medical personnel. Independent medical practitioners will, as a rule, notice that existing remuneration systems were designed for actions performed by authorised persons. Health insurance companies will often refuse to pay for treatment by a non-authorised person. This also applies to non-authorised persons working in an institution. (Unit Vakbekwaamheidsverklaringen Buitenslands Gediplomeerden Volksgezondheid: 2006a)

There are two levels of protection for professional titles: constitutional registration with title protection (art. 3 professions) and educational title protection (art. 34 professions). Physicians, pharmacists, physiotherapists, healthcare psychologists, psychotherapists, dentists, midwives and nurses must be registered in the so-called BIG register in order to be allowed to use their professional title. They are entitled to do so if they comply with the competence and educational requirements stipulated in the legislation and regulations. For physicians, dentists and obstetricians registration is also a condition to be allowed to perform certain reserved procedures.

For the art. 34 professions the BIG Act regulates the right to use the protected educational title. A condition for the use of the title is the possession of a diploma that complies with the competence and educational requirements stipulated in the legislation and regulations. There is no legal register for these professions. These professions are:

- pharmacy assistant
- dietician
- occupational therapist
- dermatologist
- speech therapist
- dental hygienist
- Cesar remedial therapist
- Mensendieck remedial therapist
- orthoptist
- optometrist
- podiatrist
- radiotherapeutic technician
- radiodiagnostic technician
- clinical dental technician
- auxiliary in the private health sector

Foreign professional practitioners

Professional practitioners with a foreign diploma may also be eligible for registration and/or recognition. To this effect they must comply with the quality requirements set by the Dutch government.

For a number of foreign diplomas the equivalency with the Dutch diploma is determined in the Regulation on the Registration of Foreign Health Care Qualifications (Regeling aanwijzing buitenlandse diploma's gezondheidszorg). If it concerns a diploma that was obtained in one of the member states of the EEA, the professional practitioner must also have the nationality of one of these member states. In all other cases a declaration of professional competence is needed to be

able to register or to be allowed to use the protected educational title (VWS: 1999). A declaration of professional competence can be requested from the Centraal Informatiepunt Beroepen Gezondheidszorg (CIBG) (Central Information Unit on Health Care Professions).

In the current situation, which still applies to all professions except that of physician, the Ministry assesses the professional competence on the basis of the submitted documents. If the CIBG feels there is reason to do so, the advice of the Commissie Buitenslands Gediplomeerden Volksgezondheid (CBGV) (Committee on Holders of Foreign Qualifications in Healthcare) may be sought. Depending on the kind of education, the Commission will request a diploma valuation from the NUFFIC (the Dutch organisation for international co-operation in higher education) or the Colo, Vereniging Kenniscentra Beroepsopleiding Bedrijfsleven (Colo, Association of Centres of Expertise on Vocational Education, Training and the Labour Market). If necessary, the commission checks references or invites the applicant for a meeting to obtain further information. If the commission still has doubts, it can ask the applicant to take a knowledge and skills test. (VWS: 1999)

A new procedure for determining the professional competence of the applicant is currently being introduced in a phased manner. Since 1 December 2005, a new procedure has applied to physicians. At some point in the future this procedure will also be introduced for other professional groups. Once the submitted documents have been assessed by the CIBG and once the NUFFIC has verified and if necessary evaluated the diploma, the applicant will take a knowledge and skills test in the form of an assessment. This assessment consists of a general part, which tests, among other things, language skills and knowledge of the Dutch health sector, and a medical part. The applicant can further substantiate his application by means of a portfolio listing his previous experience. Next, a consultancy meeting with members of the CBGV is held. During this meeting, using the test results, the portfolio if there is one and the responses to the questions, it will be assessed if, and if yes for what aspects, the participant needs additional training to be able to meet the Dutch requirements for professional practitioners in the health sector. Based on the assessment results and the meeting, the CBGV issues the Minister of Health, Welfare and Sport with its advice. (CIBG: 2006)

Possible results

As a result of the application for a declaration of professional competence for art. 3 professions the following types of advice are possible, both in the current and the new procedure:

1. Equivalent: in the event of equivalency the declaration of professional competence gives the applicant, in principle, the right to be registered in the BIG register without special stipulations, and to be allowed to use the educational title. If the applicant has not yet gained any professional experience in the Netherlands, he must work under supervision for six months (registration with special stipulations). Once the period of supervision has been successfully concluded, the special stipulation is revoked.
2. Virtually equivalent: in the event of virtual equivalency the declaration of professional competence gives the applicant the right to be registered in the BIG register subject to special stipulations. The stipulations will relate to the restrictions the Minister imposes on the professional practitioner. Once the shortcomings in professional competence have been eliminated to the satisfaction of the Minister, for which a maximum period of two years applies, the registration will no longer be subject to special stipulations.
3. Non-equivalent: in the event of non-equivalency, no declaration of professional competence will be issued. The applicant can register with an educational institution for enrolment advice for additional training, unless the level of the previous education is so low that it first needs to be brought up to standard before the applicant can enrol for regular professional training. For physicians who must follow part of the study of medicine in the Netherlands to supplement their previous education, the Commissie Instroom Buitenlandse Artsen (CIBA) (Committee for Enrolment of Foreign Medical Doctors) acts as a national reporting and distribution point

In respect of art. 34 professions, the following types of advice are possible:

1. Equivalent: if the educational level is considered equivalent to the Dutch educational level, the Minister will issue a declaration of professional competence on the basis of which the applicant has the right to use the legally protected educational titles. For some of the professions there is also the option to be registered in the Paramedics Quality Register (a register that was not established by the government, but by the professional associations of a number of paramedical professions).
2. Not equivalent: if the Minister observes important differences, the educational level is not considered equivalent to the Dutch educational level. In this case the application is rejected and

the applicant is advised to qualify by obtaining the relevant Dutch diploma. It is entirely up to the educational institution to determine in what year the applicant can join the training and what else the applicant needs to do to be able to obtain the Dutch diploma for the profession in question.

In the old procedure, knowledge of the Dutch language does not form part of the assessment of professional competence, but in the new procedure it does. However, even for the professions that are not yet subject to the new procedure, knowledge of the Dutch language is essential. The future employer, supervisor and health insurance company are certain to impose requirements in this area.

Additional education

If, in line with the advice, (part of) an education must be followed, mastery of the Dutch language is also a condition. A level that is at least equal to the state examination for Dutch as a Second Language, programme II, is required. Certain training courses will have more stringent Dutch language requirements (Unit Vakbekwaamheidsverklaringen Buitenslands Gediplomeerden Volksgezondheid: 2006b). In most cases the applicant and/or the healthcare institution for which the applicant will be working will be responsible for financing the (additional) training.

For migrants with a foreign diploma who came to the Netherlands for reasons other than employment (for instance refugees) the government may, in some cases, contribute to the additional training.

7 Other Relevant Aspects

In the Netherlands there is currently no fully defined policy of managed migration in place yet - not for the health sector, but not for other sectors either. However, the aforementioned highly skilled migrants arrangement is a step in that direction. Presently, some important developments are also being planned in the Netherlands with regard to migration management. The Minister of Economic Affairs recently notified the government in a letter that he intends to change the admission policy for migrants who want to work in the Netherlands on a self-employed basis. As previously described in chapter 4, the Ministry of Economic Affairs must advise the Minister of Alien Affairs and Integration as to whether the admission of a foreign individual entrepreneur serves a material Dutch interest. The revision of the regulations must result in clear and transparent criteria, whereby the starting point is that these migrants, as individual entrepreneurs, are a source of economic dynamics. (Minister van Economische Zaken: 2006)

The government is presently also working on modernising the entire regular policy (non-asylum related) migration, and the outlines of this policy are expected to become clear in the near future. As is shown by a number of parliamentary documents on this subject, the issue of labour migration plays an important role. This especially concerns the influx of highly skilled personnel. The modernised migration policy must be regarded in the light of “the anticipated shortage of excellent employees in the Dutch labour market and the fact that the US is more successful than the EU in the «battle for brains»” (Minister van Vreemdelingenzaken en Integratie et al.: 2006). The faster admission of migrants who, for instance, contribute to innovation and to the competitive strength of Dutch business, or to academic research in Dutch universities, is one of the starting points in this modernisation. (Minister van Vreemdelingenzaken en Integratie: 2005) The question whether this labour migration must be temporary in nature, also in view of the undesirability of brain drain, continues to play a role in the debate.

8 Conclusions

The objective of this study was to make a contribution to the debate on managed migration in the area of labour migration, whereby the health sector is used as a case to map out the developments in this area. A number of conclusions can be drawn:

Firstly, because of the available information, it is not possible to make firm pronouncements about the proportion of labour migrants in the healthcare labour market. Although the proportion of persons of foreign heritage in the working population in the health sector is considerable, it is not clear how many of them are labour migrants. However, different sources show that it appears that the number of labour migrants is small. With regard to higher educated medical personnel, the picture is slightly different. Labour migration of physicians and dentists to the Netherlands seems to be somewhat more extensive - incidentally, this is not the result of a concrete government policy.

Secondly, we can conclude that the support for labour migration as a solution for personnel shortages in the health sector is limited. It must be noted that this concerns mainly the deployment of foreign employees in the largest professional group in the health sector, namely that of nurses and auxiliaries. There appears to be little doubt about the political and social standpoints on this issue: the unused supply of labour in the Netherlands must be used for this purpose. The deployment of highly educated foreign medical personnel is not or hardly the subject of debate. There is no policy to stimulate this deployment, but the available figures show that it is relatively more extensive than the much-discussed deployment of nurses and auxiliaries. The developments of a more migration management-oriented labour migration policy appear to correspond with a migration flow of highly educated personnel that, at least in the health sector, already exists, although limited in size.

Thirdly, it has proven to be difficult to say whether the role of labour migrants in the health sector will increase in the next 20 years. Whether labour migration will be needed and will be playing a role depends on two factors. On the one hand, this solution will only come into view if there is a scarcity of medical personnel that is difficult to correct, as the experiences toward the end of the 1990s also demonstrated (see chapter 2). The population of the Netherlands is ageing. The demand for healthcare will certainly increase in the next 20 years, but the development of the supply of personnel for the health sector is uncertain, which makes it difficult to make predictions. The available studies (see paragraph 5.2) do show, however, that shortages are likely, especially in the area of nursing an auxiliary personnel, and certain in the case of a flourishing economy.

However, in addition to the existence of personnel shortages, political and public support is also needed for the active recruitment abroad of medical personnel at all levels, from nurses to physicians. For the moment, this support appears to be missing, certainly in the case of lower and intermediate personnel levels. In view of the developments with regard to the highly skilled migration and the modernisation of the migration policy, it is not unthinkable that the government may facilitate the recruitment of highly educated medical personnel in future. However, future active recruitment too, will have to be done by companies and institutions themselves. The same factors then play a role: do large personnel shortages exist, is government facilitating the employment of foreign employees or hindering this and is there public resistance of unions e.g.? Depending on the future developments in these fields, companies and institutions will decide on whether or not to recruit abroad.

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