Dutch Health and Social Care: international labour mobility

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CESRT Comparative European Social Research and Theory

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This report is part of the Care Flows Project

Country Report: The Netherlands

CONTENTS

1. INTRODUCTION

The main objective of this report is to analyse and inform about international labour mobility, particularly within Europe, from the perspective of the Dutch Health and Social Care Sector.
The report starts by describing the introduction of a new care system in The Netherlands. The government does not participate directly in the actual provision of care. This is a task principally for private care suppliers.
Furthermore, the legal position of the Health and Social Care professions, regulated through the Individual Health Care Professions Act, and questions like the international recognition of degrees and the evaluation of foreign diplomas are discussed.
This is followed by a clarification of the Dutch education system, particularly, relating to the study of medicine, nursing education and social work education.
Subsequently, some core data on the ageing Dutch population are presented. The grey pressure increases and this will have an impact on health spending, health support and the future labour market.
Then what follows is a description of the development of employment in the Dutch Health and Social Care Sector, per branch as well as the professions that are engaged in it. The general picture, at this moment, is that the Health and Social Care labour market is reasonably in balance. This trend will continue in the near future; shortages are expected only in the long term.
All research done on the subject indicates that international mobility of medical and social professionals is still low in the Netherlands. The question remains whether a more active recruitment policy would be a solution for the expected long term shortages.
The report concludes with a look at recruitment policy and some of its developments at the global, national and local level.

Methodology

This country report is produced simultaneously with the reports of the partners participating in the Care Flows project. In order to facilitate comparison between countries, the report's profile is based on a template, which provides common guidelines allowing authors to take account of their national context.
The report was produced through secondary analysis of both statistical and qualitative data. Due to the lack of a uniform data source, the data are obtained from various national and international data sources.
The report also draws upon information gathered from interviews conducted with prominent persons in the field of health and social care which led to relevant information additional to that acquired through secondary analysis.

References to these interviews are made throughout this text and integrated into the report.

Research limitations

The report has some limitations due to the nature and scope of its subject matter.
The first limitation is related to the question of the extent to which national health and social care systems can or should be incorporated into a Europe-wide system. Most European legislation has been implemented on the basis of minimum harmonisation. It allows existing national legislation on social issues to remain in place.
According to Reverda, national social policy, as expressed in education, health care and social security has almost become a symbol of neo-nationalism and new national pride. Social policy, which counts for 44% of the Dutch national budget, is one of the ways the national government can assert itself to its people. Interference from Brussels is not wanted (Reverda, personal interview, May 8, 2007).
Essers suggests that it is not likely to expect a harmonisation of social security systems. In the EU, the subsidiarity principle applies (Essers, personal interview April 3, 2007).
Social security systems tend to move between two models, namely the contributory model and the residual model.
The contributory (or Bismarckian) model is financed basically through the contributions of workers. It is based on employment status. The social benefits are only given to those who were or are on the labour market (and the members of their families).
The residual (also called liberal, Beveridgean or Anglo-Saxon) model, on the other hand, is separated from economic activity and financed through general taxation. It offers social benefits only to those in greatest need.
Germany is closer to the contributory model, whereas the UK and Ireland are closer to the residual model.
The social security system in the Netherlands is a special case. The Netherlands has a system in between the two models. Historically, the system was more contributory, but the new health care system moves in the direction of the residual model.
Reverda refers as an example of this mixed system to the Dutch pension system. It rests on three pillars, namely a state pension that provides an equal income for all residents at a level related to the net minimum wage, occupational pensions supplementary to the state pension and private pension provisions (Reverda, personal interview April 20, 2007).
The second limitation of the report is that it is limited to labour mobility and does not include other relevant factors like patient mobility or service and service provider mobility. Nevertheless, these factors have a substantial impact on

labour mobility or may produce alternative solutions to observed labour mobility problems.

Thus, Baeten indicates that mechanisms of patient mobility are similar to those of labour mobility. Mobile patients are concentrated in border regions and among people with a similar culture. Belgian patients living in the Netherlands choose to be admitted to Belgian hospitals because they are familiar with the culture or are insured in Belgium.

Generally, patients become internationally mobile when they fall seriously ill abroad or in the event of planned care. They are relatively healthy mature people who make a conscious choice and need a one-off intervention (Baeten, personal interview, April 20, 2007).

According to Baeten, contracting with Belgian hospitals can be a strategy for ensuring faster and cheaper care as well as care perceived to be of better quality. Belgian health care is generally perceived by the Dutch as being technologically advanced and of a high quality (Europe for Patients, 2005).

2. THE HEALTH AND SOCIAL INSURANCE SYSTEM FOR CLIENTS

A new Health Care System

A prominent trend over the last decade has been the shift of responsibility for purchasing care from government to insurers.
Since 1 January 2006, the Netherlands has a new insurance system for health care costs (VWS, n.d.). The government does not participate directly in the actual provision of care. This is a task principally for private care suppliers: individual practitioners and care institutions.
The system is of a private character, under public restrictions. The government, for instance, has stipulated that everyone in the Netherlands is obliged to have insurance; anyone who fails to do so, will be fined. Health insurers are obliged to accept everyone, irrespective of age, gender or state of health.
The government no longer arranges everything. Parties in the market have more freedom and responsibility to compete for the business of the insured. On the one hand, citizens have more financial responsibilities, and on the other hand more influence and realistic choices in terms of health care insurance. Care providers will have to pay greater attention to their performance and can supply more tailor-made care for their customers. The government remains responsible for the accessibility, affordability and quality of health care.
Insured parties pay a fixed premium (the nominal premium), in total on average approximately € 1,050 per year (in 2006). The insurer determines the level of the nominal premium, but is obliged to provide the same care to everyone for this premium. The law stipulates the forms of care covered by the health care insurance. Insurers are obliged to accept an insured party for the basic package. This guarantees solidarity within the system. Health care insurers must offer health care insurance to everyone, irrespective of personal characteristics, and subject to the same conditions.
The new system gives the insured greater freedom of choice. In its first year (2006), the Health Insurance Act already witnessed a significant migration of people to different insurers. A large number of government bodies and social organisations also were able to negotiate discounts and other attractive conditions through collective contracts.
Another trend in health care provision is towards more competition among providers of care. Efforts are made to combine market and non-market elements in health care.
Diagnosis and Treatment Combinations (DTCs) are being introduced step-by-step since early 2005 for hospital financing. DTCs are seen as an instrument in the gradual introduction and implementation of regulated competition, as they allow providers and insurers to negotiate on the prices, volume and quality of care contracted for.

Instead of larger budgets, realised production should be central when determining budgets. Although this has led to a general decrease in waiting lists and waiting times, in all medical areas, waiting lists remain an important issue.
With more competition and new instruments at their disposal, insurers can be expected to have stronger incentives and a broader scope to compare what is on offer and look for the best deals, including across the Dutch borders.
The combination of restricted supply (resulting in waiting lists) and insurers' duty to deliver care, means that sickness funds are forced to look abroad for a solution to limited access at home.

The Social Support Act

Part of the health care reform is the introduction of the Social Support Act (WMO), in 2007 (VWS-WMO, n.d.). The Act introduces a new scheme for all Dutch citizens covering care and support in cases of protracted illness, invalidity or geriatric diseases. It puts an end to the various rules and regulations for handicapped people and the elderly. It encompasses the Services for the Disabled Act (WVG), the Social Welfare Act and parts of the Exceptional Medical Expenses Act (AWBZ).
Under the Act, policy responsibility for setting up social support lies with the municipalities, which are accountable to the citizens in the execution of this responsibility. Municipalities now have the opportunity to develop a cohesive policy on social support, living and welfare along with other related matters. The Ministry of Health, Welfare and Sport defines the framework in which each municipality can make its own policy, based on the composition and demands of its inhabitants.
The aim of the Social Support Act is participation of all citizens to all facets of society, whether or not with help from friends, family or acquaintances; the perspective is a coherent policy in the field of social support and related areas.
Critics say that legal equality will be questioned since each municipality is entitled to develop its own rules. This might result in a diversity of services provided by each city. Additionally, budgetary risks will be shifted from the national to local authorities.

3. THE QUALITY ASSURANCE SYSTEM FOR PROFESSIONALS

The Individual Health Care Professions Act

The profession of physicians has been protected in the Netherlands since 1818.
The Medical Practice Act (WUG) of 1865 provided uniform university education and improved legal protection for the profession. The Act recognised only university-educated physicians. This legislation remained unchanged in outline until recently (HiT, 2004).
In recent years, there has been a far-reaching revision of public health care legislation and regulation. The main revision is the Individual Health Care Professions Act (BIG), which regulates medical practice.
Since 1993, the Individual Health Care Professions (BIG) Act regulates the provision of care by professional practitioners, focusing on the quality of professional practice and patient protection (VWS, 2001).
The purpose of the Act is to foster and monitor high standards of professional practice and to protect the patient against professional carelessness and incompetence. The Act focuses on individual health care, i.e. care that is aimed directly at the individual.
As Tjadens states, the Individual Health Care Professions Act is a liberalisation of the previously existing law (Tjadens, personal interview, April 13, 2007). It basically opens up the practice of medicine instead of restricting it, thus giving people more freedom to choose the care provider they want.
However, the act contains provisions relating to the protection of titles, registration, reserved procedures and medical disciplines in order to prevent unacceptable health risks to the patient resulting from a lack of professional competence.
Professions can be regulated in two ways: by Act of Parliament (article 3 of the Individual Health Care Professions Act) or by an Order in Council pursuant to an act (article 34 of the aforementioned legislation). Both regulations enable titles to be legally protected; the most important differences are that the government only maintains a register for the professions covered by section 3.
Article 34-professions do not come under legal registration. Stoop explains this by stating that in the eighties and nineties, privacy protection was more important than legal status, in the Netherlands. However, abroad legal status is very important. Article 3-professions are more appreciated than article 34-professions (Stoop, personal interview, April 23, 2007).
The eight professions covered by article 3 of the BIG Act are: Pharmacist, Physician, Physiotherapist, Health care psychologist, Psychotherapist, Dentist, Midwife and Nurse.
The following professions are covered by article 34 of the BIG Act: Pharmacist's assistant, Dietician, Occupational therapist, Skin therapist, Speech therapist, Dental hygienist, Cesar remedial therapist, Mensendieck remedial therapist,

Orthoptist, Optometrist, Podiatrist, Radiographer (diagnostic), Radiographer (therapeutic), Clinical dental technician and Individual health care assistant.

Legal status of social work

The profession of social worker is not legally recognised. This applies to traditional social workers, social pedagogues and community workers as well. They are not listed in the Individual Health Care Professions Act.
Since the late 80s, attempts have been made to get social work included in the BIG register, but these were not successful. According to Tjadens, one of the problems is the separation between (national-oriented) health care and (municipal-oriented) social care, on-going since the introduction of the Welfare Act in 1994 and reinforced by the Social Support Act, in 2007 (Tjadens, personal interview, April 13, 2007).
Some of the social work professions maintain their own professional register. Being registered is not obligatory. The social pedagogues register with the Professional Register of Agogues (*Beroepsregister van Agogen*), social workers with the Foundation Professional Register of Social Workers (*Stichting Beroepsregister van Maatschappelijk Werkers*).
Registered social workers demonstrate that their competence may be compared with standards applicable in other parts of the world. Their commitment to professionalism is underwritten by the support of the national professional associations: the Professional Organisation of Social Pedagogues (PHORZA) and the Dutch Association of Social Workers (NVMW).

Foreign degrees

A health care professional with a foreign diploma has to satisfy certain quality requirements imposed by the Dutch government if he or she wants to work in Dutch health care. A pharmacist, physician, physiotherapist, health care psychologist, psychotherapist, dentist, midwife or nurse who wishes to use his or her professional title in the Netherlands and to claim the associated authority, must first be included in the BIG-register. A person with a diploma listed in the 'Regulation on the Registration of Foreign Health Care Qualifications' can apply to the BIG-register for registration. Registration is subject to the additional condition that the applicant must be a national of a member state of the European Economic Area (EEA), comprising the European Union member states plus Iceland, Liechtenstein and Norway, or a national of Switzerland.
A health care professional who does not possess a listed diploma, or who does possess such a diploma but is not a national of an EEA state or Switzerland, needs to obtain a Declaration of Professional Competence in order to be included in the BIG-register.

The BIG Register is managed by the Central Information Unit on Health Care Professions (CIBG), an implementing body of the Ministry of Health, Welfare and Sports (VWS/CIBG, n.d). The CIBG also manages an Information and Referral Desk for Foreign Health Care Qualification Holders which helps foreign graduates who wish to practise their profession in the Netherlands by directing them to the appropriate institutions.
The CIBG judges whether people with a foreign diploma may be registered in the BIG register. There are a number of criteria, such as quality requirements and regulations for foreigners, e.g. the obligation of having a residence and work permit or being fluent in Dutch, because, in accordance with Stoop, communicating effectively with patients and colleagues is essential in health care work (Stoop, personal interview, April 23, 2007).

International recognition of degrees

The most important legal instrument for academic recognition is the Lisbon Recognition Convention (Lisbon Convention, 1997).
The European Union has established directives to facilitate international access to these regulated professions.
For some regulated professions - those of doctor, dentist, pharmacist, nurse of general care, midwife, veterinary surgeon, architect and lawyer -recognition of a professional coming from an EU member state in other EU member states is regulated by the EU sectoral directives that are individual for each of the professions. By 20 October 2007, twelve sectoral directives - covering the same professions except for the profession of lawyer - and three directives which have set up a general system for the recognition of professional qualifications and cover most other regulated professions, will be consolidated in one new directive (EU/leg, 2007). The new directive may further improve transparency of qualifications and competences and facilitate mobility between countries throughout Europe.
Stoop suggests, that another labour mobility promoting factor would be to establish a system of international exchange of data. Within the Netherlands, the Information Management Group (IBG), a semi-independent part of the Ministry of Education, Culture and Science, is already setting up a diploma database by digitising millions of diplomas of secondary vocational and higher education (Stoop, April 23, 2007).

Evaluation of foreign diplomas

In the Netherlands, two centres of expertise work together on evaluating foreign diplomas: Nuffic and Colo. They set up an Information Centre for Credential Evaluation.

Colo is the association of national bodies responsible for vocational training for the private sector. Colo represents 21 such bodies, or 'knowledge centres', each of which is organized around one sector of business or industry. Colo also has its own department for international credential evaluation, which is a centre of expertise on the diplomas, certificates and other qualifications awarded in other countries which are comparable to the Dutch qualifications acquired through vocational and adult education. This service has an official character. The education ministry has also appointed Colo to serve as the national information centre regarding the EU Directives for a General System, which regulate access to certain professions within the member states of the EU and the EEA.

Nuffic is the Dutch Organisation for International Cooperation in Higher Education and Research. Its Department for International Credential Evaluation is responsible for comparing education and assessing diplomas. The aim of Nuffic's work involving the evaluation of credentials and competencies is to remove obstacles standing in the way of students and workers who wish to be internationally mobile and either enter or leave the Netherlands (IDW, n.d.). Nuffic also carries out projects in the field of credential evaluation, e.g. the project "Strengthening the Role of the Croatian ENIC NARIC" that examines the Croatian law on professional recognition in higher education (EVD, 2006).

A typical problem in diploma evaluation and how it can be solved is the following, reported by Feiertag:

A Romanian wants to become an English teacher. A rule is that, when he has taken the first three classes in Romania, then in principle this also will hold in the Netherlands, if there are no substantial differences. For example, a substantial difference with the Dutch situation is, if a Romanian graduates in engineering, but spends a lot of time on other subjects besides technology. In such cases, the degree is often valued as a bachelor degree. The diploma is evaluated according to the Dutch law. The Dutch education situation often is used as a standard, whereas the European standard should be used (Feiertag, personal interview, May 3, 2007).

4. THE HEALTH AND SOCIAL CARE EDUCATION SYSTEM

General structure of the educational system

In the Netherlands, in the areas of health and social welfare, secondary vocational education (*middelbaar beroepsonderwijs*) is offered, varying in length from one to four years as well as in level (1 to 4). Higher education is offered at two types of institutions: research universities (*universiteiten*) and universities of applied sciences (*hogescholen*).
Since September 2002, the higher education system has been organised around a three-cycle degree system consisting of bachelor, master and PhD degrees. The higher education system continues to be a binary system, however, with a distinction between research-oriented education and professional higher education.
Graduates obtain the degree of Master of Arts or Master of Science. Graduates of a professional higher education master's programme obtain a degree indicating the field of study (for example, Master of Social Work). The third cycle of higher education, leading to a doctor's degree, will be offered only by research universities (HBO-raad, n.d.).
The educational system applies differently in different professional settings, such as the study of medicine, nursing education and social work education.

Study of medicine

The study of medicine is currently phased: the first phase provides education for a Master's degree, including two stages: the first year and the senior years (from second to fourth year), with exams at the end of each stage. The second phase of the study of medicine takes 2 years (the fifth and sixth) and is concluded with the Doctor of Medicine examination. During the second phase, students are introduced to a clinical setting. The Doctor of Medicine degree qualifies a person to start practising medicine.
Those who pass their Doctor of Medicine examination but have not (yet) taken supplementary courses are fully qualified to practise medicine, all the same. They must, however, stay within the limits of their own knowledge and competence. They may call themselves doctors and are legally qualified to prescribe medicine and provide medical certificates, such as death certificates.
There is a number of supplementary courses available after the Doctor of Medicine examination: specialist training, GP training, research and PhD programmes, and medical officer training.
Depending on the speciality, medical specialist training takes 4–6 years. Currently there are 29 recognised medical specialities. The medical specialist is usually self-employed, with the exception of a number of categories of specialists, who are employed by university hospitals, psychiatric clinics and rehabilitation

centres. Whether self-employed or not, specialists often depend on hospitals and outpatient clinics for their work (HiT, 2004).

Nursing education

Since 1997, there are two educational routes for nursing education, namely secondary professional education and higher professional education. The secondary professional nursing programme can be followed after four years of secondary school; the higher professional nursing programme can be followed after five years of secondary school. Both programmes fulfil the acceptance criteria for the EC sectoral directives.
All registered nurses are entitled to enter specialist training courses (post-basic nurse training). The aim of specialist nurse training is to obtain extra competencies and qualifications on professional skills specific to a category of clients (EC, 2000).
Between 1993 and 1995, the Dutch government issued a policy aimed to reduce the current differences in the qualification and education of nurse practitioners, and to reduce the shortage of nurses, resulting from the absence of career possibilities. The policy intended to lower the work load of medical doctors (Health Policy Monitor, 2003).

Social work education

Until the nineties, a great variety of social professions was set up with little thought given to the overall professional structure. In 1992, the 13 traditional professions were reduced to five: social pedagogy, social work, personnel and labour, creative therapy, cultural and social education. The Dutch system places the five branches within the category of social-agogic work (Haydn Davies Jones, n.d.).
In 2006, the Dutch Institute for Care and Welfare (NIZW), with cooperation of the Dutch Association of Social Workers (NVMW), developed a new professional structure for the Care and Welfare Sector. The field of social-agogic work includes community work (*sociaal-cultureel werk*), traditional social work (*maatschappelijke dienstverlening*), social pedagogy (*pedagogisch werk*) and social care (*maatschappelijke zorg*), a shared field of the social-agogic and nursing/caring professions.
The Dutch Institute for Care and Welfare (NIZW, 2006) states: "The professional structure Care and Welfare is a coherent description of professions in care and welfare. It is a joint product of the employers' organisations and the trade unions in the sector that thus explain to vocational training which professions are needed in care and welfare and which competencies an employee should possess."

While some *hogescholen* offer education programmes of Traditional Social Work, Social Pedagogy and Community Work as a combined programme of Social Work, other ones offer these as separate programmes.
In the present situation, the Netherlands has no master's or doctoral degree in social work.

5. DEMOGRAPHY AND EMPLOYMENT

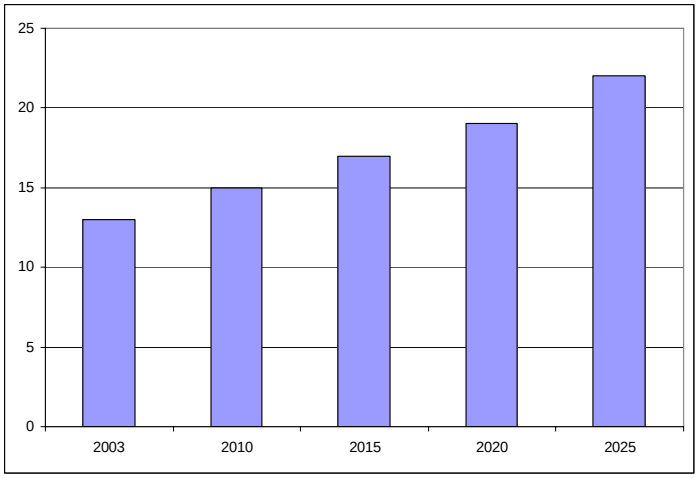
Population ageing

The aging of the population that is anticipated will have a large impact on health spending, health and disability support, and the labour market.
The greying of the population will reach its peak in just over 30 years. In 2038, a quarter of the 17 million Dutch people will be over 65 (Statistics Netherlands, 2006).
Grey pressure, that is the ratio between people over 65 and the potential labour force (people aged between 20 and 65), is increasing faster than the share of people over 65. This is because the number of people over 65 increases, while the potential labour force decreases by 1 million. The grey pressure will rise from the current 23 percent to 47 percent in 2038.
The population is expected to increase modestly until 2034 by tens of thousands a year. After 2034, the growing number of deaths will cause the population numbers to decline slightly.
Life expectancy for men is expected to rise from 77.6 in 2006 to 81.5 in 2050, and life expectancy for women from 81.7 to 84.2. More people are expected to reach retirement age, and retired people are expected to live longer.
The increase in life expectancy in the Netherlands was below average, i.e. 4.5 years, while in Germany and Belgium, our neighbouring countries, the increase was 8.1 and 7.1 years, respectively. On the other hand, in 1960 life expectancy in those countries was lower than in the Netherlands. Dutch life expectancy is dropping towards the European average (RIVM, 2006).
Because of demographic ageing and the shrinking population in Europe as a whole, too few professionals will be available to respond to the increasing demand for care; this will cause a huge need for professionals in care and welfare. According to Reverda, this predicted development might be a reason for the EU to pursue immigration policy. In a way, this is already going on, e.g., in Spain, legalisation of 500.000 illegal workers was only possible because they could be used in the care services. A possible risk would be loss of quality: if you do not swiftly take measures, you may be happy with everyone who is willing to do something.
Today's discussion about the growing 'burden of ageing' must not neglect the substantial
productive potential of the elderly population. The proportion of healthy ageing people within the total population is expected to increase in the future and so is their productive potential (Reverda, personal interview, May 8, 2007).

Health and Social Care's share of the labour market

The Health and Social Care Sector occupies a big part of the labour market in the Netherlands. In 2004, 15,2% of all workers in the Netherlands were employed in this sector.
Between 2000 and 2005, the number of jobs in the Health and Social Care Sector rose by a yearly average of 3,8%, while the number of jobs in the total labour market rose by only 0,1% per year. Employment opportunities in the Health and Social Care Sector increased due to extra investments in waiting list reduction.
After 2005, a yearly growth of 2,5% and a proportionate growth of personnel is predicted in the Health and Social Care Sector.
Until 2010, the number of employed people in the total labour market will increase by a yearly 0,25% and then decrease, according to predictions from Statistics Netherlands.

Employed persons in Health and Social Care in % of the total Dutch labour market



Source: Prismant, 2004 (adapted by CESRT)

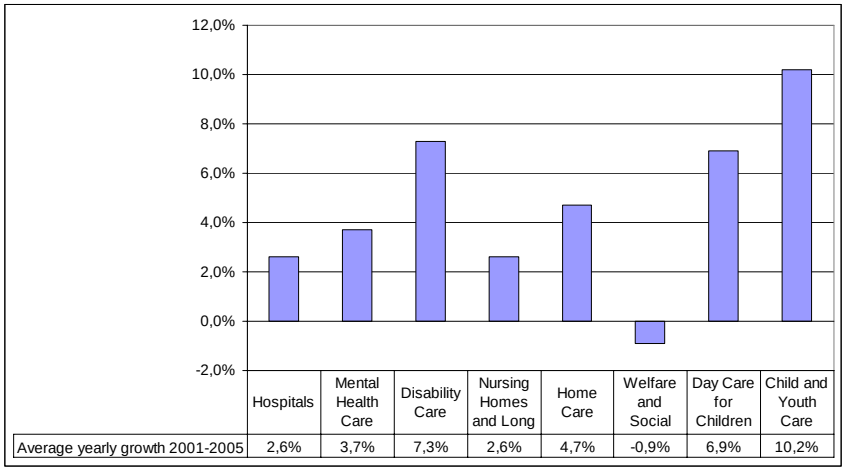
Employment by branch

The hospitals are in a phase of transition from a supply-oriented to a demand-oriented system of budget financing. The introduction of the Diagnostic Treatment Combination (DTC), an output based payment method, is an important part of it. The transition phase leads to reserve in setting up long-term labour market policies. Since 2001, the growth of employment in the hospitals is flattening out. Employment did not grow much (an average yearly growth of only 2,6%).

The last years saw a slight growth of employment in Mental Health Care (3,7% per year). In Disability Care, the growth of employment was considerable (yearly 7,3%).
Between 2001 and 2005, employment in Nursing and Long Term Care Homes increased by an average of 2,6%, while employment in Home Care increased by a yearly average of 4,7%. Home Care is most sensitive to changes caused by the introduction of the Social Support Act, in 2007. As a consequence of this law, Home Care organisations may lose their monopoly in the performance of services.

Employed persons in Health and Social Care by branch 2001-2005

	2001	2002	2003	2004	2005
Hospitals	219.980	233.430	239.400	241.280	244.000
Mental Health Care	59.630	60.180	65.750	67.140	69.000
Disability Care	115.269	129.688	138.873	147.928	152.600
Nursing Homes and Long Term Care Homes	214.588	225.587	226.869	230.102	237.800
Home Care	129.410	143.900	147.100	152.990	155.800
Welfare and Social Service	73.300	73.700	68.382	71.712	70.700
Day Care for Children	39.100	45.700	48.633	49.009	51.100
Child and Youth Care	18.200	22.600	26.227	25.295	26.800
Total	869.477	934.785	971.234	985.456	1.007.800



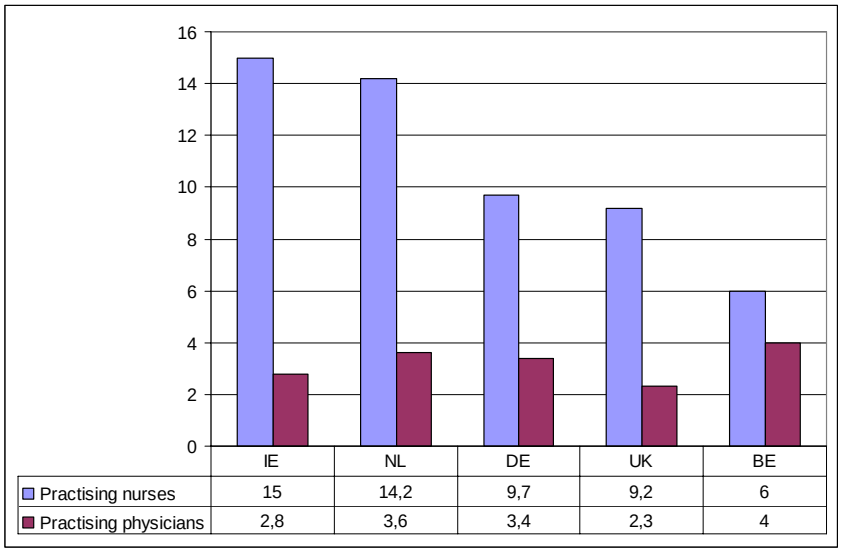
Source: Databank AZWinfo.nl; VWS, 2006 (adapted by CESRT)

Employment in Welfare and Social Service diminished by an average of 0,9%, not in the last place by stopping the most part of subsidised influx and throughflux jobs. This programme for long-term unemployed people was introduced in January 2000.
Since 2002, employment in Day Care for Children and Child and Youth Care is increasing (by an average of, respectively, 6,9% and 10,2%).

Employment by occupational groups

According to an analysis done by Tjadens, in the Netherlands, the proportion of physicians per thousand is normal by international standards, but the proportion of nurses is above normal. It can not sufficiently be explained by the number of part-time workers, because the same proportion, if converted to an FTE based proportion, stays above normal (Tjadens, personal interview, April 13, 2007).

Practising nurses and physicians 2004 (within NWE) density per 1000 population



	IE	NL	DE	UK	BE
Practising nurses	15	14,2	9,7	9,2	6
Practising physicians	2,8	3,6	3,4	2,3	4

Source: OECD Health Data, 2006 (adapted by CESRT)

Physicians

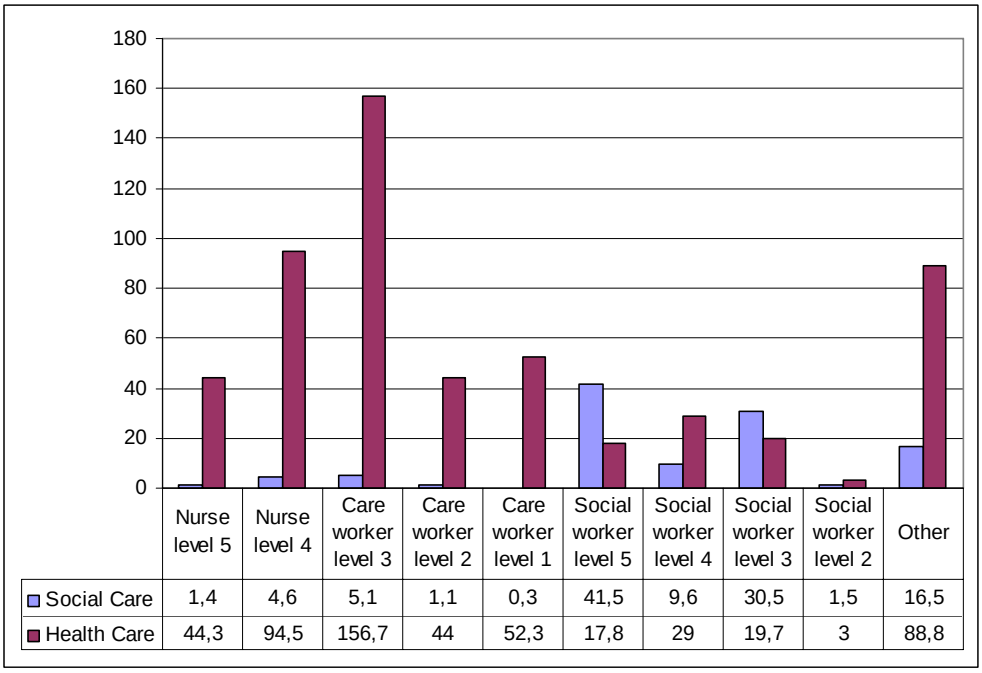
The gross starting salary of a medical graduate varies from €2400 to €2750 per month.
Someone in training to be a specialist starts earning approximately € 2750 gross per month (Medisch Contact, 2005).
Between 2000 and 2004, the number of physicians grew with a yearly average of 1,9%. In 2004, there were 38.738 physicians (VWS, 2006).
For physicians, no great shortages are being expected in the short term with the current influx. The greatest shortages are expected for GPs: from 1.5% to 9% in 2020 on the assumption of an unchanged policy (NIVEL/RIVM, 2005).

Nursing and caring professionals

A starting nurse at level 5 can count on a gross monthly salary of € 1.680,-. This can rise up to approximately € 2.565,- (Gobnet 2007).
Student nurses (alternately learning and working) get benefits (compensation in pocket money) or the minimum wage, increasing with age.

Between 2000 and 2004, the number of nursing and caring professionals grew with a yearly average of 2,3%. In 2004, there were 436.694 nursing and caring professionals (VWS, 2006).
In 2005, nearly all (97%) nursing and caring professionals had positions in Health Care, only 3% of them in Social Care (Regiomarge, 2005). Only 11,3% of the nurses are highly educated (i.e., level 5 and higher).
Shortages of nursing and caring personnel may occur over the next few years, at least from 2008 on (RIVM, 2006). The shortages will vary from 1% in hospitals to 5% in Home Care. The greatest shortages are estimated to occur in jobs requiring the lowest levels of vocational education and training, that is level 1 and to a lesser extent levels 2 and 3.

Number of nurses, care workers and social workers by level and sector, in 2005 (x 1000)



	Nurse level 5	Nurse level 4	Care worker level 3	Care worker level 2	Care worker level 1	Social worker level 5	Social worker level 4	Social worker level 3	Social worker level 2	Other
Social Care	1,4	4,6	5,1	1,1	0,3	41,5	9,6	30,5	1,5	16,5
Health Care	44,3	94,5	156,7	44	52,3	17,8	29	19,7	3	88,8

Source: RegioMarge 2006 (adapted by CESRT)

Social workers

Social workers have positions in a wide range of occupational settings in all branches of the Health and Social Care Sector and even outside of it. They are employed not only in social service provision (welfare, public housing, health care, employment and education), but also in business services (WRR, 2004).
According to the Collective Labour Agreement for Welfare and Social Services (CAO, 2006), in 2006, the gross monthly salaries of social workers (social pedagogues, community workers and traditional social workers) were between a minimum of €2089 and a maximum of €2928, depending on periodical salary increases.

In 2005, in the Netherlands, 61% of the social workers were employed in Social Care and 39% in Health Care (Regiomarge, 2005). Of all social workers, 39% are highly educated (i.e., level 5 and higher).

At this moment, the labour market in the social care sector is in a reasonable balance: big shortages are not occurring any more and few social professionals are unemployed. In the near future, the surplus of social professionals is expected to increase until 2006 and decrease, from then on. In the long term, shortages are expected, again, first in Welfare and Social Service (from 2009 on), then in Child and Youth Care (from 2010 on) and, only in the longer term, in Day Care for Children. This scenario is based on an expected yearly growth of employment by 1,2% in Welfare and Social Service and Child and Youth care and by 1,7% in Day Care for Children. This growth is low compared with that of the last years

6. INTERNATIONAL MOBILITY

International mobility is an issue that becomes increasingly relevant to questions about the future Health and Social Care labour market.

Access to the Labour Market for Third Country Nationals

Working in the Netherlands is permitted to persons of Dutch nationality or the nationality of one of the countries within the European Economic Area.
The Foreigners Employment Act (WAV) is aimed at regulating the internal Dutch labour market by giving preferential treatment to potential workers who originate from one of the countries in the European Economic Area. The Act specifies that employers who want to hire third country nationals, must first apply for approval (work permits) from the Centre for Work and Income (CWI).
The CWI has identified the sectors that are eligible for these specific regulations: International transport, domestic shipping and the health sector. For the health sector, this concerns the following professions: operating room assistants, radiotherapy laboratory assistants and radio-diagnostic laboratory assistants (SZW, n.d.).

Free movement of labour in the EU-25

In an attempt to address the complex implications of the EU's 2004 enlargement, several member states from the EU-15 introduced transitional restrictions on the movement of the labour force from the new member states.
As a first step to slowly phase out restrictions, the Dutch government opened, on 17 September 2006, 16 sectors of its labour market to workers from the EU-8 states.
With respect to the 1 January 2007 enlargement, which has brought Romania and Bulgaria into the EU, many EU-15 and even EU-8 member states are more reluctant to open their labour markets (Euractiv, n.d.).

Cross-border workers

A cross-border worker is an employee who works in one EU Member State (State of employment) and lives in another (State of residence). It is essential that he retains his normal place of residence outside the State of employment. If the cross-border employee moves to the State of employment, he becomes a migrant worker. A resident who moves to a neighbouring State but continues to work in his original State of employment (migrant resident), is also a cross-border or frontier worker (Vanpoucke & Essers, 2004).
According to Essers, half of the cross-border workers are migrant workers, half are migrant residents. The last named, sometimes designated as “Nether-

Belgians" (*Nederbelgen*) or "Nether-Germans" (*Nederduitsers*), do not want to become naturalised as a Dutch citizen. They are in a peculiar situation, because no specified rules are made for them.
In 1970s, 80s and 90s, there was an eastward flow of migrant workers: many Belgians went to work in the Netherlands, and the Dutch went to Germany. The residential flow pointed in the opposite direction. After 2000, the flow of Dutch workers to fill jobs in Germany diminished.
Currently, the employment agencies try to drag Germans to the Netherlands. Although the share of flexible work in total employment is decreasing, it is still high, in the Netherlands. Flexible contracts cause a problem for the Germans (Essers, personal interview, April 3, 2007).

International mobility in the Health and Social Care Sector

International mobility of medical and social professionals is still low in The Netherlands, as it is in other European countries. According to a report of The Dutch Council for Health and Care (RVZ, 2006), the proportion of foreign physicians, nurses and caring professionals is limited. Only 1% of all registered physicians and 0,5% of the total nursing and caring personnel are of foreign origin.
Although no data are available about the number of foreign social workers going to work in the Netherlands, their number is presumably very low.

Physicians

At this moment, there is no threat of a shortage of physicians. The demand and supply of physicians are in good balance. For this reason, there is no need to think about an active recruitment policy for foreign physicians, because future shortages are not in sight. The question is whether a more active recruitment policy should be developed to tackle expected future shortages.
It should be taken into consideration, that other countries do have shortages. In many European countries, the shortage of physicians is a cause for concern. Furthermore, The Netherlands has a disadvantaged competitive position in the international market because of language. English speaking countries are more attractive for physicians wanting to work abroad.
Data about foreign physicians are more easily retrievable than, for instance, caring professionals. This is because physicians are obliged to register in the BIG-register. Yearly, between 200 and 300 physicians from non-European countries, wanting to work in the Netherlands, report to the Register. About half of the requests are refused. Many of the applications come from Afghanistan, Iraq, Ukraine, Poland, Russia and South-Africa. After the EU's 2004 enlargement, not as many physicians as expected went from Eastern Europe to the Netherlands.

Per 1 January 2006, the BIG-register recorded on a total of 2181 physicians with a foreign diploma. Of these, 1960 got their diploma in a EU/EEA country, 221 outside this area. An important number of physicians, namely 1255, got their diplomas in Belgium. The Register does not specify, whether they are active as practitioners or available for the labour market.

Nursing and caring professionals

The exact number of foreign nurses and caring professionals in the Dutch Health Care sector is hardly retrievable. The number of delivered work permits can say something about the interest from other countries to work in the Netherlands. The number of delivered work permits decreased from 501 in 2002, to 230 in 2005. From underlying data, it appears that the largest interest is from people originating from South Africa, Indonesia and the Philippines. Smaller numbers of caring professionals are from the former Eastern Bloc countries.
Per 1 January 2006, 1615 nurses with a foreign diploma are listed in the BIG register. Of those, 791 received their diploma in EU/EEA countries, 562 of which came from the neighbour countries Belgium or Germany. There were 824 non EU/EEA nurses registered, mainly from Surinam, the Philippines and Indonesia. Again, the Register does not specify whether they are active as practitioners or available for the labour market.
The Netherlands has looked to former colonies like Surinam and Dutch speaking countries such as South Africa as a source for health professionals (UNU-WIDER, 2006)).
A publication of OSA, Institute for Labour Studies (ZW, 2002), stated that few nurses in the Netherlands came from the EU. Few nurses working in the Netherlands were educated in another EU country.
Nearly half was from Belgium and another 20 percent from Germany. More than half (58%) of the Belgian nurses were cross-border workers: they worked in the Netherlands, but lived in Belgium. Only 8% of the German nurses were cross-border workers.
A publication on "Experiences of foreign European nurses in the Netherlands" (Health Policy, 2004) reports that approximately 1500 nurses from other EU/candidate states entered the Netherlands. Personal reasons, including marriage, were the most common reasons for coming. Half of the nurses took one or more courses before starting work in nursing in the Netherlands. These were often Dutch language courses. The nurses were obliged to adapt themselves, linked to their unfamiliarity with Dutch laws and the fiscal and social security systems, recognition of their qualifications and application for permits. Even some basic issues, such as how to write a letter of application, caused problems.

7. RECRUITMENT POLICY: SOME DEVELOPMENTS

Global migration of nurses

In an issue paper on international migration of nurses (ICN, 2005) , the authors assert that in the last few years, migration of nurses appears to have grown significantly, with the potential to undermine attempts to achieve health system improvement in some developing countries.
The effects of international migration of health service workers on the nations supplying the workers are cause for concern.
The main gaps and recommendations for policy action concern the overall impact of out-migration of nurses on source countries, the experiences of international nurses now working in destination countries.

Dutch recruitment policy: Polish nurses

The migration of Polish nurses may have been anticipated by an event of September 6, 2001 which has been reported in a document from the Polish Ministry of Foreign Affairs (Republic of Poland, 2001):
'While on a working visit to Holland Prime Minister Jerzy Buzek met with Prime Minister Wim Kok. „After Poland enters the European Union Poles should have access to the Dutch labour market. We are opening our borders" – said the Dutch Prime Minister. Prime Minister Buzek thanked him for that declaration and pointed out that of all the EU countries Holland was the first one to make such a promise. Jerzy Buzek assured his hosts that after opening the border Poles of a certainty „wouldn't inundate the Dutch labour market". The Polish Prime Minister also spoke of employing Polish nurses in Holland. Wim Kok promised that all „technical" problems connected with this matter would be solved soon.'
A few years later, a Polish-Dutch Twinning Project on Mutual Recognition of Qualifications for Medical Professions was started. The project's objective was that the Netherlands, as a Member State of the EU, would help Poland as a State applying for membership to satisfy ballot conditions, i.e. to meet the Copenhagen accession criteria (NIZW, 2004). Mutual recognition of diplomas or professional qualifications across the EU, in line with the relevant Directives, requires good communication between all member states of the EU and means that member states should have to trust each other's education systems to allow free movement of workers in the European Economic Area (Tjadens, personal interview, April 13, 2007).
The issue of how to communicate about mutual recognition of professional qualifications was not as easy to handle as it seemed. The following incident, told by Stoop, may illustrate this. The Foundation KVV (now called Florence) in The Hague started to recruit nurses from Poland. The Honorary Consul in Krakow for the Netherlands had the idea to create additional training in Poland.

Response: The minister determined that the level of training is equivalent. Thus, you cannot carry out additional training. In fact, the EU has recognised and explicitly named a very limited number of equivalent trainings. The Polish government has objected against this (Stoop, personal interview, April 23, 2007).
From 2003 until 2005, the Dutch and Polish Ministries of Health Care developed a pilot project "Polish nurses in the Netherlands; development of competencies" (IOM, 2005). Within the framework of this project, Polish nurses got the opportunity to learn and work in nursing homes in the Netherlands for a maximum period of two years. The Dutch government requested the International Organization for Migration (IOM) to monitor the activities of three intermediate organisations that recruited Polish nurses as part of the pilot project. Many of the employers acknowledged that the nurses' level of Dutch language skills was not really sufficient to function in an optimal way.
The nurses confirmed the general opinion of the employers. All nurses had difficulties at work related to the inadequate knowledge of the Dutch language. The low level of language skills was also an obstacle to follow training.
Better prepared language courses and thorough supervision on the job during daily work are crucial to bridge both language barriers and cultural differences.
Another problem that is experienced concerns differences in training. In the Netherlands, the nurses are trained for skills which require functionally independent actions, the Polish nurses are trained for technical skills. In Poland, it is unthinkable to have nurses in an ambulance or in intensive care. In the Dutch context, their technical actions are considered to be extremely out of date.
An approach might be not to allow Polish nurses to work here in the Netherlands as a nurse but to let them work as a care worker. However, calling them care workers, would be experienced as an insult. A more elegant solution was found in the United Kingdom, where a distinction is made between registered nurses and enrolled nurses (in fact, care workers). In United Kingdom they call the Polish nurses enrolled nurses, which is accepted by them (Stoop, personal interview, April 23, 2007).

A local example of best practice: the Academic Hospital Maastricht

According to Dewalque, the Academic Hospital Maastricht (AZM) has a long tradition in recruiting Flemish health workers. For 40 years, the Flemish work in the hospital, particularly in nursing. It concerns Belgian nurses with a Belgian diploma but some of them have a Dutch diploma. Currently, approximately one third of the nurses and more than 40 percent of the specialists are Flemish.
Due to its location in a border region, the AZM has a more favourable position with respect to the foreign country than other institutions. But it is important to make use of it and this is done in Maastricht.

All new Flemish employees are joined with an already employed Flemish colleague. They get, just like all new employees, extra training in the specific working method of the AZM.
People stay, they don't look for a job in their home country. It is not because of the money but the professional development opportunities and less hierarchical cultures that are offered in Maastricht.
Nobody from Wallonia (French Belgium) has a job in the AZM. This is indicative of the language barrier as an important factor in cross-border nursing. Some British and Germans work in the operating room, which is understandable, because the language problem does not occur.
Migrant residents are rare, which opposes the general pattern. The hospital disposes of 800 addresses, of which 600 Belgians and 200 "Nether-Belgians", in all kinds of professions. Of these, 400 are working as nurses, this is one third of all the 1200 nurses working in the hospital.
AZM offers internship positions for the university of professional education in Hasselt.
Recognition (BIG) of a Belgian diploma is easy. Until 10 years ago, the nurses trained in service; these have frequently levels between 4 and 5. Since then, however, the difference between higher education (HBO) and secondary vocational education (MBO) has risen. Currently, 70% of the nurses have level 4 and 30% level 5 education (Dewalque, personal interview, April 16, 2007).
According to Kuijer, the vision of the hospital is that in a proper human resources policy, differentiation of staff should be a leading term. However, the road to function differentiation is still at a beginning stage.
In former days, the hospital world circulated around the doctor; this changes in product-market combinations. It means that health care has to be organised differently, from a Florence Nightingale type of organisation to a much more commercial organisation. More diversity of people, with a great variety of competencies, is needed. The organisation must have a clearer profile of which people are needed and how to use skills in a flexible way in certain activities. For certain tasks you need technical people (e.g. the Vebego cleaning services); for other tasks cultural skills are needed (e.g. Belgian nurses who typically have empathy competencies, but are sensitive to hierarchical relations).
Cultural intelligence will play an ever larger role in the hospital. It enables one to determine what people really can do. The training of doctors and nurses must include cultural skills.
The Netherlands does not produce sufficient employees in the lower part of the care market. It is revealing that the two newest hospitals (Groningen and Maastricht) have the lowest number of highly educated people. This shows a new trend in the labour market. There will be a large need to attract people from a foreign country (Kuijer, personal interview, April 25, 2007).

8. CONCLUSION

This report has provided background information on the new health care system and public health care legislation and regulation in the Netherlands.
Furthermore, the report has shown, that population ageing, although it is yet to come, will have a large impact on health spending, health and disability support, and the future labour market.
International mobility of medical professionals is still low in the Netherlands, as it is in other European countries. Shortages of nursing and caring personnel may occur over the next few years. The greatest shortages are estimated to occur in jobs requiring the lowest levels of vocational education and training.
The expected shortages may be a reason for the government to pursue immigration policy.
A special case is to be made for the free movement of workers from Central and Eastern Europe on the Dutch labour market. Recruitment projects have already been initiated on the national as well as the local level.

9. SOURCES OF INFORMATION

AZWinfo.nl, Labour Market Information Health Care and Welfare
URL: http://www.azwinfo.nl (Accessed, November 2006)

CAO (2006), *CAO Welzijn & Maatschappelijke Dienstverlening 2006-2007,* Utrecht.
URL: http://www.abvakabofnv.nl/docs/cao/cao_57_23_20060101-20070501_t.pdf (Accessed, November 2006)

EC (n.d.), European Commission, *Vocational education and training.*
URL: http://ec.europa.eu/education/policies/2010/vocational_en.html (Accessed, November 2006)

EC (2000), European Commission, *Nursing in the Netherlands.*
URL: http://ec.europa.eu/internal_market/qualifications/docs/nurses/2000-study/nurses_nederland_en.pdf (Accessed, January 2007)

Erasmus – Statistics (2004-2005), *Erasmus student and teacher mobility 2004-2005*
URL: http://ec.europa.eu/education/programmes/socrates/erasmus/stat_en.html (Accessed, June 2007)

(EU/leg (2007). EUROPA, Summaries of legislation, *Reform of the system for the recognition of professional qualifications*
URL: http://europa.eu/scadplus/leg/en/cha/c11065.htm (Accessed, June 2007)

Euractiv (n.d.), *Free movement of labour in the EU-25*.
URL: http://www.euractiv.com/en/enlargement/free-movement-labour-eu-25/article-129648 (Accessed, November 2006)

Europe for Patients (2005), Irene A. Glinos, Nicole Boffin, Rita Baeten August, *Contracting Cross-border Care in Belgian Hospitals: An Analysis of Belgian, Dutch and English Stakeholder Perspectives*.
URL: http://www.ose.be/files/health/BelgianCaseStudy_ForPrint.pdf (Accessed, January 2007)

EVD (2006), Agency for International Business and Co-operation Unit for International Public Co-operation, *Strengthening the Role of Croatian ENIC/NARIC Office,* September 2006
URL: http://www.azvo.hr/lgs.axd?t=16&id=459 (Accessed, June 2007)

Gobnet (2007), Gobnet, *Beroepen*.
URL: http://www.gobnet.nl/beroepenAtotZ.php (Accessed, January 2007)

Haydn Davies Jones (n.d.*), The Social Pedagogues in Western Europe - some implications for European interprofessional care.*
URL: http://www.childrenuk.co.uk/chaug/aug2000/social_pedagogues.htm (Accessed, November 2006)

HBO-raad (n.d.), *The education system in the Netherlands.*
URL: http://www.hbo-raad.nl/upload/bestand/beschrijving_Nederlands_onderwijs.pdf (Accessed, November 2006)

Health Policy (2004), De Veer A, Ouden D and Francke A . *Experiences of foreign European nurses in the Netherlands.* Health Policy 68, 55-61, Oxford University Press, UK.

URL:
http://www.healthpolicymonitor.org/en/Policy_Survey/Search_for_Policy_Reforms/Survey_Details/
Nurse_Practitioner_Curriculum.html (Accessed, November 2006)

Health Police Monitor (2003), *Nurse Practitioner Curriculum,* Reported by (Han van Dijk): Institute of Health Policy & Management, Erasmus University Rotterdam.
URL:
http://www.healthpolicymonitor.org/en/Policy_Survey/Search_for_Policy_Reforms/Survey_Details/
Nurse_Practitioner_Curriculum.html (Accessed, November 2006)

HiT (2004), Exter A, Hermans H, Dosljak M, Busse R. *Health care systems in transition: Netherlands.* Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.
URL: http://www.euro.who.int/Document/E84949.pdf (Accessed, November 2006)

ICN (2005), International Council of Nurses, James Buchan, Mireille Kingma, F. Marilyn Lorenzo, *International migration of nurses: trends and policy implications,* Geneva.
URL: http://www.icn.ch/global/Issue5migration.pdf (Accessed, November 2006)

IDW (n.d.), Information Centre for Credential Evaluation, *Evaluation of foreign diplomas*
URL: http://www.idw.nl/pdf/IDW_Engels.pdf (Accessed, November 2006)

ILO (2005.), International Labour Organization, *Action programme on the international migration of health service workers: The supply side,* Geneva.
URL: http://www.ilo.org/public/english/dialogue/sector/sectors/health/migration.htm
(Accessed, November 2006)

IOM (2005), Internationale Organisatie voor Migratie, *Final Report To the Ministry of Health Care of the Netherlands "Monitoring of the pilot project 'Polish nurses in the Netherlands'; development of competencies",* The Hague
URL: http://www.unitarny.org/mm/File/vdHeuvel_finalreport_polishnursesproject.pdf
(Accessed, November 2006)

Lisbon Convention (1997), European Centre for Higher Education, Convention on the Recognition of Qualifications Concerning Higher Education in the European Region, Lisbon, 11.IV.1997.
URL: http://www.cepes.ro/hed/recogn/lisbon/conveng.htm (Accessed, November 2006)

Medisch Contact (2005), *Wie verdient wat?,* Arts in Spe Nr. 2 - 20 mei 2005.
URL:
http://medischcontact.artsennet.nl/uri/?uri=AMGATE_6059_138_TICH_R152593558439352
(Accessed, January 2007)

NIVEL/RIVM (2005), *Op één lijn. Toekomstverkenning Eerstelijnszorg 2020.* NIVEL/RIVM, 2005.
URL: http://www.nivel.nl/pdf/toekomst-eerstelijnszorg-2020.pdf (Accessed, January 2007)

NIZW (2004), EU- PHARE Twinning Project, *From mutual recognition to mutual communication?*
URL:
http://www.nizw.nl/internationaal/Docs/TwinningPolen/FINAL%20REPORT%20WARSAW

%20
SEMINAR%2022-23%20SEPTEMBER%202004.pdf (Accessed, June 2007)

NIZW (2006), *Klaar voor de toekomst*, Utrecht.
URL:
http://www.nizw.nl/Beroepenstructuur/Docs/KLAAR%20VOOR%20DE%20TOEKOMST.pdf
(Accessed, November 2006)

Nuffic (2005), *International Mobility in Education in the Netherlands 2005*
URL: http://www.nuffic.nl/pdf/information/monitor2005-EN.pdf (Accessed, June 2007)

OECD Health Data (2006), Frequently Requested Data
URL: http://www.oecd.org/document/16/0,2340,en_2649_37407_2085200_1_1_1_37407,00.html
(Accessed, June 2007)

OSA, Institute for Labour Studies
URL: http://www.tilburguniversity.nl/osa (Accessed, November 2006)

Prismant (2004), *Personeel en arbeid*, Prismant magazine, nummer 16, april 2004, Utrecht.
URL: http://www.prismant.nl/prismant/download/publicatie.php?publicatie_id=111
(Accessed, January 2007)

Regiomarge 2006 (2006), Willem van der Windt, Henriëtte Talma, *Regiomarge 2006*, *De arbeidsmarkt van verpleegkundigen, verzorgenden en sociaalagogen,* Prismant Utrecht 2006.
URL: http://www.azwinfo.nl/downloads/RegioMarge2006.pdf (Accessed, January 2007)

Republic of Poland (2001), Ministry of Foreign Affairs of the Republic of Poland, *Materials and documents No. 8-9/2001*
URL: http://www.msz.gov.pl/files/file_library/31/010809_332.doc (Accessed, June 2007)

RIVM (2006), Westert G.P.,Verkleij H. (Editors), *Dutch Health Care Performance Report*
URL: http://www.rivm.nl/bibliotheek/rapporten/260602002.pdf (Accessed, January 2007)

RVZ (2006), *Arbeidsmarkt en zorgvraag,* Den Haag, 2006
URL: http://www.rvz.net/data/download/publ06-08.pdf (Accessed, January 2007)

Statistics Netherlands (2006), *Population ageing. In 30 years a quarter of the population will be over 65,*
URL: http://www.cbs.nl/en-GB/default.htm (Accessed, January 2007)

SZW (n.d.), *Labour Migration,* Ministry of Social Affairs and Employment.
URL: http://internationalezaken.szw.nl/index.cfm (Accessed, January 2007)

UNU-WIDER (2006), Research Paper No. 2006/82, *International Mobility of Health Professionals Brain Drain or Brain Exchange?,* Stephen Bach, August 2006.
URL: http://www.wider.unu.edu/publications/rps/rps2006/rp2006-82.pdf (Accessed, January 2007)

Vanpoucke &Essers (2004), Bart Vanpoucke ABVV & Ger Essers FNV, *Guide for Mobile European Workers*, European Trade Union Confederation 2004.
URL: http://www.etuc.org/IMG/pdf/Mobility_Guide_EN.pdf (Accessed, June 2007)

VWS (n.d.), *The new care system in the Netherlands,* Ministry of Health Welfare and Sport.

URL: http://www.minvws.nl/images/boekje-zorgstelsel--engels_tcm20-107938.pdf (Accessed, November 2006)

VWS-BIG (n.d.), *BIG-register,* Ministry of Health Welfare and Sport
URL: http://www.bigregister.nl/eng/index.html (Accessed, November 2006)

VWS (2001), *The Individual Health Care Professions Act,* Ministry of Health Welfare and Sport
URL: http://www.minvws.nl/images/big-eng_tcm20-107817.pdf (Accessed, November 2006)

VWS (2005), *Arbeid in Zorg en Welzijn 2005*.
URL: http://www.minvws.nl/images/ra-zorg-welzijn_tcm19-105781.pdf (Accessed, November 2006)

VWS (2006), *Arbeid in Zorg en Welzijn 2006*.
URL: http://www.minvws.nl/images/meva-2738702b.doc_tcm19-142253.pdf (Accessed, January 2007)

VWS/CIBG (n.d), Ministry of Health, Welfare and Sport, *Central Information Unit on Health Care Professions (CIBG)*
URL:
http://www.minvws.nl/en/organization/chart/diensten_en_instellingen/CIBG/default.asp
(Accessed, June 2007)

VWS-WMO (n.d.), *Social Support Act,* Ministry of Health, Welfare and Sport.
URL: http://www.minvws.nl/en/themes/social-support-act/default.asp (Accessed, November 2006)

World Health Organization (WHO), *World Health Report 2006.*
URL: http://www.who.int/whr/en (Accessed, November 2006)

WRR (2004), Wetenschappelijke Raad voor het Regeringsbeleid, H. Dijstelbloem, P.L. Meurs en E.K. Schrijvers (red.) , *Maatschappelijke dienstverlening, een onderzoek naar vijf sectoren*, Amsterdam.
URL: http://www.nizw.nl/digitaalmagazijn/MaatschappelijkedienstverleningWrr2004.pdf
(Accessed, November 2006)

ZW (2002), *Grenzen geslecht? Ervaringen van en met zorgpersoneel uit EU-(kandidaat) lidstaten,* A.J.E. de Veer, D.J. den Ouden en A.L. Francke (Nivel), Verschenen: ZW 32, augustus 2002.
URL: http://www.uvt.nl/osa/nieuws/berichtenzw/zw32.html (Accessed, January 2007)

Interviews

Baeten R., Antwerp, April 20, 2007
Policy analyst of the Observatoire Social Européen (OSE)

Dewalque H., Maastricht, 16 April 2007
Project Manager Nurse Education Academic Hospital Maastricht (AZM)

Essers G., Maastricht, April 3, 2007
Adviser on cross-border working for the Federation Dutch Labour Movement (FNV)

Feiertag S., The Hague, May 3, 2007
Account manager of the Netherlands Organization for International Cooperation in Higher Education (Nuffic)

Kuijer S., Maastricht, April 25, 2007
Member of the Governing Board of the Academic Hospital Maastricht (AZM)

Reverda A., Maastricht, May 8, 2007
Director of the MA Comparative European Social Studies (MA CESS)

Stoop H., The Hague, April 23, 2007
Unit Manager of the Central Information Unit on Health Care Professions (CIBG) of the Ministry of Health, Welfare and Sports (VWS)

Tjadens F., Utrecht, April 13, 2007
Researcher of the Netherlands Institute for Long Term Care (Vilans)