The migration of Flemish doctors to the Netherlands

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Summary: The cross border migration of Flemish general practitioners (GPs) to the Netherlands was examined. In the recent past Belgium experienced a surplus in GPs, while in the Netherlands a shortage was observed. Despite the availability of potential incentives in respect of income and professional practice, surprisingly very few Belgian GPs have moved to practices in the Netherlands. Most probably considerations with regard to social-cultural factors are the most important elements in individual decisions on whether or not to migrate.

Keywords: International Labour Migration, Health Care, General Practitioners, Belgium, Netherlands

In the Netherlands, there was a shortage of general practitioners (GPs) in the recent past.1,2 By contrast, over the same period a surplus was observed in the neighbouring country of Belgium.3 As there are no language barriers between the Netherlands and Flanders (the Dutch speaking part of Belgium) and no formal obstacles with regard to the recognition of the professional qualifications, it would not have been surprising if these conditions had resulted in significant inward migration flows of Flemish doctors to the Netherlands.

From the perspective of potential labour migration within the European Union, it is of interest to explore whether these conditions did indeed lead to significant migration. Therefore, a study was set up to determine migration patterns of GPs working in the Netherlands. Data from Statistics Netherlands on population and the number of contacts with GPs per inhabitant were also used. Similar data on the number of GPs, population and number of GP contacts were also gathered for Belgium as a whole, and Flanders in particular, from the Belgian Federal Organisation of Public Health Insurance, RIZIV (Rijksinstituut voor Ziekte- en Invaliditeits-Verzekering) and Statistics Belgium. Furthermore, an examination was made of relevant literature, while key informants from both the Netherlands and Belgium were interviewed in order to obtain a more qualitative insight into possible explanations for the migration pattern observed.

Push and pull factors: selected drivers and obstacles

Social and psychological conditions, as well as professional opportunities, can influence an individual's decision to migrate. In the scientific literature these conditions are often called push and pull factors.4 Not all commonly presented factors have the same relevance within the context of the Flemish/Dutch situation. Several factors were considered most pertinent and thus studied in more depth: professional opportunities; working conditions; income; educational opportunities and culture.

Professional opportunities

In general, professional opportunities depend on the position within the health care system, the workforce situation and job responsibilities. In this regard, a comparison between the two regions yielded a number of findings. Firstly, the most prominent difference between the two countries is illustrated by the 'gatekeeper' function the Dutch GPs play in the health care system, which is in contrast to the position of their Flemish colleagues. Referral by a GP to a specialist is required for the coverage of specialist treatment in the Netherlands, whereas in Belgium patients are allowed to visit a specialist without such a referral. Moreover, the health insurance system in the Netherlands requires the registration of patients with a specific GP (patient-list), again something that does not apply in Belgium. As a consequence, Dutch GPs have a significantly stronger position as doctors of first contact for patients.

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The Netherlands has 5.4 GPs per 10,000 inhabitants (see Table 1). In Belgium there are 10.0 GPs per 10,000 inhabitants, with a similar supply of 9.4 GPs per 10,000 inhabitants in Flanders. Therefore, there are almost twice as many GPs in both Belgium and Flanders as in the Netherlands. However, for a more appropriate comparison, working time equivalents should be taken into account. Based on a crude comparison, more GPs in Belgium and Flanders seem to work on a part-time basis than is seen in the Netherlands. The average GP in the Netherlands works 0.81 of a Full Time Equivalent (FTE), while the average Belgian GP works only about 0.74 FTE. This leads to an estimated 4.4 FTE GPs and 7.4 FTE GPs per 10,000 inhabitants in the Netherlands and Belgium respectively; which is still a remarkable 1.7 times more in Belgium compared to the Netherlands.

Support from auxiliary health professionals also influences workforce capacity. Working with a practice assistant allows for the delegation of tasks, resulting in a higher number of patients that a doctor can care for. In the Netherlands, each GP has roughly one practice assistant; in Belgium, the use of such professionals is rare. Differences in the number of medical specialists might also shed light on the difference in the number of GPs. The number of medical specialists per 1,000 inhabitants in the Netherlands is low compared with the situation seen in Belgium. As with GPs, Belgium has almost twice as many medical specialists. On the other hand, in the Netherlands about 1,100 specialised ‘nursing home physicians’ provide care for patients in nursing homes and similar institutions. This type of specialist does not exist in Belgium where GPs must also provide care for nursing home residents.

Regarding these differences, the way in which the workforce is regulated should be considered. In the Netherlands, the number of GPs is regulated in two ways: firstly, through a legally set ‘numerus fixus’ for undergraduate education; secondly, by a limited number of positions for the postgraduate vocational education scheme. In Flanders, by contrast, the only limitation to the intake of undergraduate students is an admission examination, which has only been in existence since 1997. Moreover, it was only in 2004 that any restrictions were introduced on the number of positions available in the postgraduate vocational education scheme.

In general, no substantial differences between the two countries exist regarding job responsibilities of GPs. Consultation, diagnosis, prevention, treatment, referral to a specialist or allied health professional and prescription of medicines are the
common elements of a position which is crucial in the continuity of health care provision.

Working conditions

In Belgium, most GPs work in single-handed practices, without practice auxiliaries. In contrast, many Dutch GPs are members of group-practices consisting not only of several GPs, but also allied health professionals and practice auxiliaries. The benefits for these doctors of working in a structured collaboration like group-practice are less working hours per week and working days per year.

Workloads are dependent on the number of patients per GP and patient appeal to the GP. The difference in the relative number of GPs per 10,000 inhabitants indicates that one GP in the Netherlands has to deliver care to approximately 1,840 inhabitants. In Belgium this population to GP ratio is 1,004:1 and in Flanders 1,061:1. In addition, individuals in the Netherlands on average visit a GP 3.6 times a year per inhabitant. In Belgium and Flanders the number of GP-contacts per inhabitant is 28% higher at 4.6 times a year. On average, each GP has about 6,600 with a patient per year in the Netherlands, compared with about 4,600 in Belgium and 4,900 in Flanders. So, compared to the average Belgian or Flemish GP, Dutch GPs have to deal with 43% or 36% more contacts per year.

Time per contact also varies. In the Netherlands, the average patient contact in a GP practice lasts about ten minutes while in Flanders, this is about 15 minutes. Moreover in Belgium as a whole, 31% of all contacts are house-calls, compared with less than 10% of contacts in the Netherlands. This again will result in differences in workload.

Income

Recent OECD data indicates that the average income of Dutch GPs was twice the average of Belgian GPs in 2002: €100,000 vs. €50,000. A number of caveats must however be applied. First of all, the definition of ‘GP’ is not the same in both countries. In the Netherlands, the title of ‘huisarts’ (Dutch for GP) is legally protected and allowed to be used only by those doctors who have successfully followed the post-graduate vocational training scheme and who have been registered on the formal register for GPs. In Belgium, however, the title of ‘general physician’ can be used by all doctors who have not finished formal specialist training. In this sense, more than 17,000 Belgium doctors are considered to be ‘general physicians’. However, the number of professionally active GPs is less, at about 10,000, or 14,000 if we count those doctors who are accredited GPs and perform at least 1,250 patient contacts according to the RIZIV. As a consequence, when dividing the cost of GP care by 10,000 instead of 17,000, one arrives at a gross average income for Belgian GPs that does not differ much from that of their Dutch counterparts. Secondly, the average income figures for GPs in the OECD data reflect the gross income of doctors. To fully interpret these figures, differences in taxation and post-retirement provisions for doctors have to be taken into account, in order to reach a judgement on actual disposable income.

Continuing professional development

Continuing professional development (CPD) is crucial in terms of quality assurance in health care. Until recently, no formal obligation for CPD existed for Belgian GPs, but CPD contributed to ‘accreditation’ by health insurance companies, including access to higher rates fee-for-service. In 2006 some quality criteria were introduced in order to retain qualifications. In the Netherlands, the system of a legally protected title is tied to a system of periodical re-licensing. Practicing Dutch GPs can be re-licensed if they can prove that they have been involved in CPD activities above a certain minimum level. Recently, the Belgian Minister of Health approved legislation aiming to develop a future system of mandatory CPD activities for Belgian GPs.

Culture

Flanders and the Netherlands are neighbouring geographical areas where the same language is spoken. In this respect, from a distance it may look as if both societies are very similar. However, this is not really the case. The general feeling in both countries is that there are significant cultural differences which are reflected also in the overall attitudes of doctors. The prevailing attitude of Dutch physicians is aimed at transparency in medical practice and professional accountability: the science of medicine, or in Dutch ‘geneeskunde’. This is illustrated in the development of various professional guidelines that are ‘evidence based’. These guidelines play not only an important role in everyday practice, but they are also commonly used as a benchmark for ‘professional standards’. Belgian doctors, on the other hand, while naturally taking into account available scientific evidence, tend to include more ‘soft’ considerations. In Belgium, medicine is still considered more of an art, in French expressed as ‘l’art de guérir’, or in Dutch as ‘geneeskunst’. Potentially, this difference in attitude could be a driver for migration of doctors who feel more attracted to the other approach.

In addition to these professional factors, social differences can also play a very important role. These can include educational opportunities for children, including the quality of secondary education, labour opportunities for partners and, last but not least, family and friends.

Facts on cross border migration of GPs between the two regions

Before 1999, about two Belgian born (and probably Flemish) GPs entered the Dutch GP workforce each year. Compared to the total inflow of GPs with foreign GP training, these Belgian/Flemish GPs only accounted for 7% of the total during this period. Furthermore, compared to the total inflow of some 250 GPs per year with Dutch GP training, the Belgian/Flemish inflow was almost negligible.

From 1999 until 2003, the inflow of Flemish GPs was eleven per year, about one quarter of all foreign trained GPs who entered the Dutch workforce. Compared to the total number of Dutch trained GPs in this period (300 per year), the inflow from Belgium remained marginal.

In 2004, only seven Flemish GPs entered the Dutch GP workforce and in 2005 only five. So, while the inflow was relatively high in 2000, it has been declining in recent years.

Interestingly, most GPs with foreign GP training who entered the Dutch GP workforce are in fact Dutch born GPs who went abroad for their vocational education. This was due to the restrictions on the number of vocational education positions in the Netherlands. Most went to Belgium and returned after a few years to the Netherlands. A few went to England, others to Germany.

The number of Dutch GPs who settle in Belgium, is less than one per year. The total number of GPs who are going to work outside the Netherlands is about 5 per year. They move worldwide, to work in any country. From these data it can be
concluded that very few GPs migrated between Flanders and the Netherlands during the last decade. In general, Belgian GPs do not tend to settle in practice abroad frequently. Over the last decade on average 15 GPs per year migrated to France. The estimated numbers of migrant GPs to Germany or the United Kingdom were even smaller.

**Shortage or surplus?**

Based on the facts presented on the available workforce and workload in Belgium and the Netherlands, it is very difficult to state objectively that in one situation a shortage existed and in the other a surplus. Waiting lists are often mentioned as a yardstick for a shortage in provision; unemployment for a surplus. It should however be noted, that shortfalls based on need can co-exist with the employment of health workers, due to local market conditions.

In this survey, no structural problems with regard to the accessibility of GP care in the Netherlands, nor to the unemployment of Belgian GPs, were observed. Therefore, the question remains unanswered as to whether the workforce mismatch in both countries, as experienced by many individuals, reflected a real imbalance between demand and supply for care. Moreover, it can be stated that, methodologically, there are no gold standards for assessing sufficiency of the workforce in health care.

**Discussion and conclusions**

The facts in respect of cross-border migration of GPs between Flanders and the Netherlands show that, despite potentially stimulating factors with regard to income and professional practice, surprisingly very few Belgian GPs have settled in the Netherlands. The small number of migrants and the fact that no sound scientific explanatory model for migration flows is available, do not allow for any general conclusions on the reasons for international migration between two neighbouring countries.

Considering the potential drivers and obstacles described in the literature, it can be concluded that significant differences between professional opportunities, working conditions, income, educational opportunities and cultural values, have not stimulated many of the Flemish to go abroad; even though ‘abroad’ is nearby and no general obstacles, like foreign language or the recognition of professional qualifications played a role. It can also be concluded that individual considerations with regard to social-cultural conditions are the most prominent in the process of deciding whether or not to emigrate in these two western European countries. Consequently, the development of any scientific model that might help to explain objectively the reasons for individual migration does not seem to be realistic; the multitude of potential influences can have quite different values for different individuals (See Box).

In addition to the push and pull factors described above, it might be the case that for disciplines like ‘family medicine’ with a high contextual ‘load’, migration is not as easy as that observed for more ‘technical’ disciplines such as anaesthesiology or surgery.

**Box: Case study interviews**

Two Flemish general practitioners shared their experiences to illustrate the individual dimensions of international labour migration. One doctor had migrated, the other had not, despite previously planning to do so.

**Belgian GP practising in the Netherlands; Dr A**

At the end of the 1990s, Dr A was not happy in his GP practice in Flanders. Too little income, too heavy a workload and the humble position of Flemish GPs within the health care system, made him think of moving to the Netherlands. After a period of exploration of the opportunities and disadvantages, including serious deliberations within his family, he became a GP in a deprived area in one of the big cities in the Netherlands in 1999. After the decision to migrate, he and his family had to go through a mountain of administrative procedures, not only with regard to the recognition of his professional qualifications, but also with regard to practical aspects of cross-border migration, like residence permits and insurance. Despite these obstacles, the positive expectations for the future remained unbroken. Positive expectations of a more challenging and more rewarding professional life overrode the insecurities of a professional and family life in an unfamiliar environment.

After seven years practicing in a non-native country, Dr A is able to state that his expectations have been met. He feels really at home in the Dutch health care system, considering the position of the GP and the organisation of GP care. In addition, he is very active in professional debates on the changing scene of health care provision in the Netherlands.

**Belgian GP not practising in the Netherlands; Dr B**

In 1999 Dr B considered migrating to the Netherlands due to low income resulting from insufficient patient visits to his general practice in Flanders. At that time, meetings were organised in Antwerp, the main city of Flanders, in order to recruit Flemish GPs to work in the Netherlands. Dr B attended one meeting. This was followed by visits to two locations in the Netherlands, where more GPs were needed and which were potentially interesting work environments. One of these places was in the deprived area of a large city, the other in a small town close to the Belgian border. Dr B was very much interested in this nearby town, but, so were some twenty Dutch GPs. He considered his chances and the needs and desires of his family (a son with severe disabilities, social environment, and housebound wife), and he decided to stay in Belgium.

Dr B made the following general remark. The income differential between Belgian and Dutch GPs, found in almost all international comparative studies, does not reflect the real difference in disposable income. In his view disposable income during working life is about the same in both countries due to differences in taxation. However, pension provisions in Belgium are very poor and require additional payments during working life in order to achieve a reasonable income post retirement.

**References**


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In elections held in Italy in June 2006, the centre-left coalition headed by Romano Prodi was victorious over Silvio Berlusconi’s centre-right formation which had governed Italy since 2001. The transfer of power has been marked by some changes in health care policy, but on the whole there has been continuity. This may come as a surprise given the gulf which separates the two political groupings in most policy areas. Continuity in health policy, however, may be due to the persistence of certain structural problems in the Italian health care system.

Bipolarism in health policymaking

Italy has a constitutionally based system of regionalism. There are twenty regions with elected governors and legislative assemblies. Regional autonomy is most advanced and visible in the health care sector where responsibility is shared between central government and the regions. The State is responsible for setting health policy in broad terms and for promoting and protecting the national interest in health care. This national interest takes concrete form in the tax-financed National Health Service (Servizio Sanitario Nazionale – SSN) and in the national health care entitlement (Livelli Essenziali di Assistenza – LEA), that is services which are guaranteed to all citizens regardless of place of residence. As a result of an amendment to the Constitution in 2001, the State was required to make sure that the LEA is guaranteed to all citizens and to ensure, via equalisation grants, that all regions have the financial means to do this.

The constitutional jurisprudence has for long held that the regions have virtually complete autonomy in the organisation and administration of the regional health services. Until the early 1990s the regions were mainly concerned with the detailed design and implementation of centrally set policies such as market oriented reforms, public management, Diagnosis Related

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