Bachelor Thesis

Who Is Responsible?
Fragmented Governance and the Integration of Internationally Trained Healthcare Professionals

The Case of the Mobile Dental Unit in The Hague

Universiteit Leiden

Name: Sjoerd Hofstra
Student number: 4061969
Supervisor: Dr. Christiana Strava
BA: Urban Studies; Faculty of Humanities
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Chapter 1. Introduction

The Dutch healthcare system is increasingly confronted with a dual challenge that is both structural and paradoxical in nature. On the one hand, demand for care continues to rise, particularly in urban areas, while on the other hand the available workforce is insufficient to meet this demand. Simultaneously, healthcare workforce shortages are projected to increase dramatically (FNV 2024), placing additional strain on urban care infrastructures. This pressure is further intensified by demographic developments, including the ageing of both patients and healthcare professionals. Within dentistry specifically, it is projected that approximately 20 per cent of the current workforce will retire before 2030, exacerbating already existing shortages and creating urgent gaps in service provision. At the same time, the Dutch labour market is characterised by a significant underutilisation of international talent. The Dutch Advisory Council on Migration estimates that there are approximately 330,000 migrants who constitute an 'untapped labour potential', particularly concentrated in large urban areas such as The Hague (Adviesraad Migratie 2025, 2). This mismatch between labour shortages and underutilised skills forms a central tension that underpins this thesis.

This paradox is particularly visible in the healthcare sector, where internationally trained professionals often face substantial barriers to entering the labour market. Despite holding relevant qualifications and experience, many internationally trained healthcare professionals remain excluded from practice, especially during the period prior to obtaining registration in the Dutch BIG-register. This exclusion cannot be understood solely in terms of individual deficits, such as language proficiency or unfamiliarity with local systems. Rather, it must also be situated within broader institutional dynamics, including what has been described as processes of 'professional closure'. These processes refer to the ways in which professions regulate access through formal procedures, thereby maintaining standards but also limiting entry for outsiders (Mickleborough and Martimianakis 2021, 33-34). As a result, internationally trained professionals often encounter prolonged and complex pathways towards recognition, which include credential assessments, language requirements, and additional training or examinations.

The consequences of these barriers are not merely procedural but deeply structural. A growing body of literature has described this phenomenon as "brain waste", referring to the systematic underuse of highly skilled migrants whose competencies remain unrecognised or underutilised (Humphries et al. 2013, 3, 7; Alam et al. 2015, 129; Financial Times 2024). In the Dutch context, this manifests in situations where internationally trained healthcare

professionals are employed in low-skilled sectors such as retail, logistics, or agriculture, despite the existence of significant shortages in healthcare. This misalignment between supply and demand is further compounded by institutional barriers. Credential recognition processes are often lengthy and costly, language requirements are stringent, and the pathways towards professional integration are fragmented and unclear (Ham 2020, 462-463; Groothoff et al. 2025,). The beroepsinhoudelijke toets (BI-exam), for example, functions as a formal mechanism to assess equivalence in knowledge and skills, ensuring patient safety and quality of care. However, recent policy developments indicate that the financial burden associated with this BI-exam will increase significantly, potentially creating additional barriers to entry for internationally trained professionals (Ministerie van VWS 2025b, 9).

These structural dynamics are particularly pronounced in urban contexts such as The Hague. Cities concentrate both healthcare demand and diverse migrant populations, making them key sites where labour shortages and underutilisation intersect. Data from Den Haag in Cijfers indicate that several neighbourhoods are characterised by a high proportion of non-working but potentially employable residents(Den haag in Cijfer, 2024), including individuals with healthcare backgrounds who are not currently active in the sector. This includes not only labour migrants but also status holders, whose participation in the labour market remains limited due to language barriers, integration requirements, and institutional obstacles (KIS 2020, 27; Ministerie van Sociale Zaken en Werkgelegenheid 2025, 2, 5-6). The weak labour market position of these groups is not only detrimental to their individual wellbeing but also represents a missed economic opportunity, particularly in light of ongoing labour shortages (Ministerie van Sociale Zaken en Werkgelegenheid 2023, 1-4). At the policy level, there is increasing recognition of this issue. The Social and Economic Council and the 2026–2030 coalition agreement both emphasise the need to better utilise existing labour potential, improve access to the labour market, and facilitate faster professional integration of international workers (Sociaal Economische Raad 2026, 6; Government Coalition Agreement 2026–2030, 39-40). Together, these developments highlight a growing urgency to address the disconnect between available talent and institutional accessibility.

Within this urban context, the Mobile Dental Unit (MDU) emerges as a particularly relevant empirical case. The MDU is a pilot developed in The Hague that seeks to address two interconnected challenges simultaneously. First, it provides accessible dental care to vulnerable populations who may otherwise face barriers to accessing regular dental services. Second, it offers supervised practice opportunities for internationally trained dentists who have not yet obtained full BIG-registration within the Dutch healthcare system. This dual function positions

the MDU at the intersection of care provision and professional integration, making it analytically significant. Rather than functioning as a conventional healthcare facility, the MDU operates as a mobile and flexible infrastructure that adapts to specific urban contexts and needs.

The urban context of the Mobile Dental Unit is important to understanding its significance. The effectiveness of the Leyweg location is likely connected to its position within a wider urban landscape characterised by social and economic vulnerability. The bus is situated near a major commercial area and serves residents from surrounding neighbourhoods such as Moerwijk, Leyenburg, amd Morgenstond. These neighbourhoods contain relatively high concentrations of low-income households, status holders, and residents experiencing broader forms of socio-economic insecurity. Existing research demonstrates that financial barriers remain one of the most significant reasons for avoiding dental care. As Begovic et al. argue, "for those who visit a dentist, money is generally not a problem; for those who do not visit a dentist, lack of money is generally the problem" (Begovic, Van der Heijden, and Listl 2023, 4). Their study further shows that avoidance of oral healthcare is strongly associated with broader patterns of socio-economic disadvantage, including low income, unemployment, chronic illness, debt, and housing insecurity (Begovic, Van der Heijden, and Listl 2023, 9-10). Similarly, CBS data indicate that 37 per cent of adults in the lowest wealth category postpone or avoid dental care because of financial costs, compared with substantially lower percentages among wealthier groups (CBS 2025, 65). People with a migration background also report avoiding dental care due to cost more frequently than those with a Dutch background (CBS 2025, 65). Research conducted in The Hague reaches comparable conclusions, finding that difficulties making ends meet constitute the most frequently reported reason for avoiding dental visits (GGD Haaglanden 2024, 5).

From this perspective, the location of the MDU can be understood as an urban intervention for people who might be disconnected from regular oral care. This is particularly relevant given that vulnerable populations frequently experience limited health literacy and difficulties navigating complex healthcare systems (Heijmans et al. 2024, 1-3; SVG 2024; Begovic, Van der Heijden, and Listl 2023, 11). The municipal initiator similarly emphasises that the bus is deliberately placed "in neighbourhoods where it is needed" and seeks to build trust through practical assistance rather than through information campaigns alone (Municipal initiator, interview with author, 26 March 2026). The MDU therefore represents more than a mobile healthcare facility. In a context where demand for dental care is expected to increase while the amount of practising dentists is projected to decrease (KNMT 2024;

Capaciteitsorgaan 2023), the spatial positioning of such initiatives becomes increasingly relevant for understanding how access to care is organised within the city.

However, it is important not to frame the MDU as a straightforward solution to the challenges outlined before. Instead, it should be understood as an experimental and contested intervention that operates within existing institutional constraints while attempting to navigate and, at times, challenge them. The initiative is shaped by regulatory frameworks, professional standards, and organisational dynamics that both enable and limit its functioning. As such, the MDU provides a unique opportunity to examine how innovative local initiatives attempt to reconcile competing demands, including patient safety and professional integration.

The central problem addressed in this thesis therefore lies in the tension between these different domains, each of which imposes its own requirements and constraints. The key issue is not whether the initiative is effective in a narrow outcome-oriented sense, but rather how it is organised, governed, and experienced in practice. By focusing on these dimensions, the thesis aims to uncover the underlying barriers and opportunities that shape the functioning of the MDU and to explore what this reveals about the broader possibilities and limitations within the current professional integration of internationally trained dentists.
Against this background, the central research question of this thesis is formulated as follows:

How does the Mobile Dental Unit navigate and reveal the fragmented institutional responsibilities within Dutch healthcare governance regarding the professional integration of internationally trained dentists?

Sub-questions may address how the initiative is organised and implemented, how different actors perceive and engage with it, and what factors enable or constrain its viability. The aim of this research is to provide an in-depth, qualitative analysis of the MDU as a local governance experiment. The study is based on a limited number of semi-structured interviews with key stakeholders, including policymakers, institutional actors, and professionals involved in the initiative. As such, it does not seek to produce generalisable conclusions about healthcare governance or migrant integration at the national level. Instead, it offers a contextualised understanding of how one specific initiative operates within a particular urban and institutional setting. By situating the MDU in the context of intensified healthcare shortages and ongoing migration debates within the urban environment of The Hague, this thesis explores how cities experiment with innovative forms of care provision to address complex social challenges.

The remainder of this thesis is structured as follows. The next chapter presents a review of the relevant literature and introduces the theoretical framework that underpins the analysis, focusing on governance, Bourdieu's forms of capital, and responsible rebellion. Chapter three outlines the methodological approach, including research design, data collection, and analytical strategy. Chapter four presents the empirical analysis and findings, examining how the MDU functions in practice, how it produces cultural and social capital, where tensions emerge, and why opportunities emerge through "responsible rebellion". Chapter five discusses these findings in relation to the theoretical framework, and the final chapter concludes by summarising the main insights, reflecting on the limitations of the study, and suggesting directions for future research.

Chapter 2. Theoretical Framework and Literature Review

The integration of internationally trained healthcare professionals into national labour markets has been widely studied across different contexts, yet a persistent pattern emerges: despite possessing relevant qualifications and professional experience, internationally trained healthcare workers often remain excluded from practising in their field. This exclusion is particularly pronounced during the pre-registration phase, in which migrants must navigate complex and often lengthy procedures before obtaining formal recognition. Existing scholarship demonstrates that these barriers are not incidental but systemic in nature. Ham (2020, 462-463) shows that first-generation internationally trained healthcare professionals in the Netherlands face multiple institutional obstacles that extend beyond individual competencies, including limited access to professional networks and unfamiliarity with organisational cultures. Similarly, Kehoe et al. (2016, 1018-1020) emphasise that the transition into host-country healthcare systems is shaped by structural conditions rather than solely by individual preparedness. Nwankwo et al. (2025, 4-5, 20) further argue that support interventions often remain fragmented, focusing on isolated aspects such as language training without addressing broader institutional barriers.

A central mechanism through which this exclusion operates is the process of credential recognition. In the Dutch context, the BIG-register functions as the primary gatekeeping institution, determining whether internationally trained professionals can legally practise. The beroepsinhoudelijke toets (BI-toets) serves as an assessment tool to evaluate whether the knowledge and skills of foreign-trained professionals are equivalent to Dutch standards. While this system is justified in terms of safeguarding patient safety and ensuring quality of care, it simultaneously introduces significant delays and uncertainties into the integration process (Ministerie van Volksgezondheid, Welzijn en Sport 2025a). As Groothoff et al. (2025) note, even when such assessments are improved or streamlined, they continue to function as institutional bottlenecks that shape access to the profession.

The consequences of these processes extend beyond procedural delay. They contribute to what has been described as “brain waste”, a phenomenon in which highly skilled migrants are unable to utilise their qualifications and are instead employed in low-skilled or unrelated sectors. Humphries et al. (2013, 3-4) describe this as a cyclical process of “brain gain, waste and drain”, in which host countries attract skilled migrants but fail to effectively integrate them into the workforce. Alam et al. (2015, 128-129) characterise this situation as a form of “double jeopardy”, where migrants face both structural barriers and personal disadvantages. Hajian and

Randall (2025, 6-8) further show that prolonged periods of inactivity can lead to loss of confidence, erosion of professional identity, and diminished motivation to pursue re-entry into the profession. These findings are reinforced by critical analyses of professional closure, which highlight how institutional and cultural norms reproduce exclusion by privileging locally trained professionals and marginalising those trained elsewhere (Mickleborough and Martimianakis 2021, 33-34).

Importantly, these barriers are not solely external constraints but are embedded within broader institutional logics. The emphasis on standardisation, quality assurance, and risk management, while essential for patient safety, also creates rigid pathways that are difficult to navigate for those unfamiliar with the system. As a result, professional integration often fails, not because of a lack of individual capability, but because of a mismatch between institutional structures and the needs of internationally trained professionals. This literature therefore establishes a clear empirical problem: access to professional practice is unequal, and existing integration mechanisms are insufficient to bridge this gap.

To understand why these inequalities persist, it is necessary to move beyond descriptive accounts of barriers and examine the underlying social mechanisms that produce them. The work of Pierre Bourdieu (1986) provides a particularly useful framework in this regard. Bourdieu conceptualises social life in terms of five different forms of capital; cultural, social, economic, and symbolic, which shape individuals' positions and opportunities within a given field (Bourdieu 1986, 243-248). Within the context of internationally trained healthcare professionals, these forms of capital offer a way to analyse how seemingly neutral institutional processes reproduce inequality.

Cultural capital, in this context, extends beyond formal qualifications to include tacit knowledge of professional norms, language use, and workplace practices. As Erel (2010, 645-647) argues, internationally trained professionals often possess significant cultural capital acquired in their country of origin, yet this capital is not always recognised or valued in the host context. She emphasises that "migrants' cultural capital is not simply lost but is reconfigured and revalued in the migration process" (Erel 2010, 647). This revaluation often results in a devaluation of existing skills, requiring migrants to acquire new forms of context-specific knowledge before they can re-enter their profession.

Similarly, social capital plays a crucial role in shaping access to opportunities. Nowicka (2013, 13-15) demonstrates that professional success is often dependent on networks and connections that facilitate entry into labour markets. Internationally trained professionals, however, frequently lack such networks, limiting their ability to access internships, mentorship,

or informal opportunities for skill development. This absence of social capital reinforces their marginal position, even when they possess the necessary qualifications.

Economic capital further compounds these challenges. The process of credential recognition often involves significant financial costs, including BI-examination fees, language courses, and periods of unpaid training. As Bourdieu (1986, 247) notes, economic capital underpins the ability to acquire other forms of capital, meaning that financial constraints can have cascading effects on professional integration. In the Dutch context, the increasing costs, from 1500 euro in 2026 to 7900 euro in 2028, associated with the BI-toets, risk further excluding those who lack the financial resources to complete the required procedures (Ministerie van VWS 2025b, 9; CIBG, 2026 (see appendix A)).

Taken together, these forms of capital illustrate that the exclusion of internationally trained healthcare professionals is not merely a matter of bureaucratic procedure but reflects deeper structural inequalities. The Mobile Dental Unit can be understood, in this light, as an intervention that attempts to address these inequalities by facilitating access to cultural and social capital through supervised practice and professional interaction. By providing a space in which internationally trained dentists can observe, learn, and participate, the initiative contributes to the accumulation of context-specific knowledge and the formation of professional networks. At the same time, by offering a voluntary and flexible pathway, it partially mitigates the economic barriers associated with formal training trajectories. Bourdieu's framework therefore provides a robust explanatory mechanism for understanding both the persistence of the problem and the potential of such interventions.

While Bourdieu helps to explain why inequalities exist, it does not fully account for how institutional systems are organised and how interventions such as the Mobile Dental Unit are implemented within these systems. To address this, it is necessary to introduce governance as a structural lens. Governance refers to the processes through which multiple actors coordinate, regulate, and implement policies within complex institutional environments. Rather than being directed by a single authority, governance increasingly occurs through collaborative arrangements involving public agencies, professional organisations, educational institutions, and civil society actors (Ansell and Gash 2008, 544-547). Such arrangements depend on trust, shared objectives, and institutional mechanisms that enable coordination across organisational boundaries (Ansell and Gash 2008, 550-554). In the context of healthcare and professional integration, governance is inherently multi-layered, involving national regulations, local initiatives, and organisational practices.

Ham et al. (2025, 22-24) highlight that integration initiatives in the Dutch healthcare sector are often characterised by fragmented responsibilities, with different organisations overseeing separate aspects of the process. This fragmentation creates challenges in coordination, as actors operate within distinct institutional logics and regulatory frameworks. Bauer (2010, 5-7) similarly emphasises that successful integration requires alignment between organisational processes, support mechanisms, and individual needs. Without such alignment, interventions risk remaining isolated and ineffective.

The governance of credential recognition further illustrates these complexities. The BIG-register, regulatory bodies, municipalities, and labour institutions such as the UWV all play distinct roles in shaping access to the profession. However, the lack of clear coordination between these actors can result in gaps and overlaps that hinder effective integration. Governance, in this sense, determines not only how policies are implemented but also how access to different forms of capital is structured and mediated.

Within this framework, the MDU can be understood as a local governance experiment operating in an institutional space where responsibilities are distributed across multiple organisations and policy domains. The initiative brings together actors from healthcare, labour market policy, education, and municipal government in an attempt to address a problem that none of these actors can solve independently. Governance scholars argue that such arrangements depend on collaboration, trust-building, and the creation of shared capacities across organisational boundaries (Ansell and Gash 2008, 55862; Emerson, Nabatchi, and Balogh 2012, 15-18). At the same time, these collaborative efforts remain constrained by existing regulatory frameworks, professional standards, and institutional divisions of responsibility. Governance therefore provides the structural context within which the inequalities described by Bourdieu are reproduced, negotiated, or potentially transformed

However, governance alone cannot fully capture the dynamics of innovation and adaptation that characterise initiatives such as the MDU. To understand how actors navigate and, at times, reshape institutional constraints, it is necessary to introduce the concept of responsible rebellion. Drawing on literature on positive deviance and tempered radicalism, responsible rebellion refers to actions that deviate from established norms in order to achieve improved outcomes, while remaining committed to the underlying goals of the organisation (Spreitzer and Sonenshein 2004, 829-832; Meyerson and Scully 1995, 587; Meyerson 2008, 22). Rusinovic et al. (2020, 3-5) define rebellion as the capacity of actors to “act otherwise” within institutional contexts, using reflexivity and innovation to identify alternative solutions. Crucially, this form of rebellion is not oppositional but constructive. As Wallenburg et al. (2019,

871) argue, “positive deviants tend to shake up the organisation but do not intend to harm or leave the organisation, rather seeking to care for the organisation and its purposes”. This distinction is essential, as it frames rebellion not as resistance but as a form of institutional work aimed at improving existing systems.

Van Bochove et al. (2021, 174-175) further emphasise that responsible rebellion is oriented towards a higher societal goal, such as improving access to care or better utilising available resources. In this sense, rebellion becomes a means rather than an end: it involves the willingness to explore solutions that do not fit neatly within existing frameworks, while remaining accountable to broader societal objectives. This aligns closely with the challenges faced by initiatives such as the MDU, which must navigate regulatory constraints while attempting to address urgent labour shortages and integration gaps.

The literature also highlights that rebellion is rarely an individual endeavour. Rather, it emerges within networks of actors who collectively negotiate which rules can be adapted and which must be maintained. Felder et al. (2022, 22-24) show that such collective action is essential for sustaining innovative practices within highly regulated environments. These networks often include both “deviants” who challenge existing norms and “guardians” who ensure continuity and mitigate risks, creating a balance between innovation and stability. In this light, responsible rebellion provides a valuable lens for analysing how actors within the MDU create space for alternative forms of practice. It allows for an examination of how rules are interpreted, adapted, or circumvented in order to facilitate learning and integration, and how these practices are embedded within broader institutional contexts. By focusing on the interaction between actors and structures, this concept captures the dynamic and negotiated nature of innovation within constrained environments.

Taken together, this chapter has developed a cumulative argument that moves from empirical context to theoretical explanation and analytical framing. The literature on professional integration of migrants establishes the problem of unequal access and systemic exclusion. Bourdieu’s theory of capital provides a framework for understanding the underlying mechanisms that produce these inequalities. Governance literature situates these processes within complex institutional arrangements, highlighting issues of coordination and responsibility. Finally, the concept of responsible rebellion offers a way to analyse how actors navigate and reshape these structures in practice. This integrated framework forms the foundation for the empirical analysis that follows, enabling a nuanced examination of the MDU as a site where structural constraints, social inequalities, and innovative practices intersect.

Chapter 3. Methodology

This study was designed as a qualitative single-case study focusing on the Mobile Dental Unit in The Hague as a local governance experiment situated at the intersection of healthcare provision and professional integration. The choice for a qualitative approach followed directly from the research aim, which was not to measure outcomes or test causal relationships, but to understand how the initiative functioned in practice, how it was organised, and how different actors interpreted and navigated its constraints. A qualitative design allowed for an in-depth exploration of meanings, practices, and institutional dynamics that could not be captured through quantitative methods. As Yin (2009, 15, 52-53) argues, case study research is particularly suitable for investigating contemporary phenomena within their real-world contexts, particularly when the boundaries between the phenomenon and its surrounding context are difficult to distinguish. This was the case here, as the MDU was embedded within broader regulatory, organisational, and social systems that could not be separated from the initiative itself. The study therefore prioritised depth over breadth, with the explicit intention of producing a contextualised and analytically rich account rather than generalisable findings.

The unit of analysis was defined as the MDU as a local governance experiment. This framing was chosen deliberately to align the empirical material with the theoretical framework developed in the previous chapter. Rather than treating the MDU solely as a healthcare intervention or a labour market initiative, it was conceptualised as a site where governance arrangements, institutional constraints, and forms of capital intersected. This approach allowed the research to focus on how responsibilities were distributed, how decisions were made, and how actors navigated existing systems. Importantly, the study did not aim to produce a general model of governance or professional integration in the Netherlands. Instead, it sought to provide an in-depth understanding of one specific case, acknowledging that its findings are context-dependent and exploratory in nature.

Participant selection followed a purposive sampling strategy, aimed at identifying actors who were directly involved in or relevant to the functioning of the MDU. Initially, the intention was to include a broad range of participants, including international dentists, supervising dentists, and institutional stakeholders. However, following feedback during the research process, the focus was refined towards institutional and governance actors, as these were most directly relevant to the research question. This shift strengthened the coherence of the study, ensuring alignment between the empirical material and the analytical lens of governance. Participants were contacted through an existing professional network or via referrals from the

municipal initiator or other interviewees, a strategy often described as snowball sampling. This approach proved effective in accessing relevant stakeholders within a relatively short timeframe, particularly given the limited duration of the research.

The data collection process took place between the end of March and late April, with one additional interview conducted in mid-May. Interviews were conducted with representatives from key institutions involved in the governance and implementation of the MDU, including regulatory bodies (CIBG/CBGV), credential recognition organisations (Nuffic), labour market institutions (UWV), and municipal actors responsible for the initiative. In addition, interviews were conducted with two supervising dentists and four international dentists. While these latter interviews provided valuable insights into practical experiences and day-to-day functioning, they were not treated as the primary analytical focus. Instead, they served as supporting perspectives that enriched the understanding of how the initiative operated in practice. All intended institutional participants were successfully interviewed, with the exception of the KNMT (Royal Dutch Dental Association). Although the KNMT declined to participate in an interview, stating that they believed they could not add significant value, they did provide an extensive written response outlining their views on the organisational structure, responsibilities, and perceived risks of the MDU. However, as no explicit consent was obtained to use this material in the research, the decision was made to exclude its contents from the analysis, in line with ethical considerations.

Data collection was conducted through semi-structured interviews, allowing for both consistency across interviews and flexibility to explore participant-specific insights. Each participant received a tailored topic list in advance, designed to reflect their institutional role while maintaining a shared set of core themes. These themes included governance structures, implementation processes, perceived constraints, opportunities, and responsibilities. The use of semi-structured interviews enabled the researcher to guide the conversation while allowing participants to elaborate on issues they considered important. In practice, many interviews developed into open and in-depth conversations, typically lasting between 45 minutes and one and a half hours. This format proved particularly effective in eliciting detailed accounts of institutional practices and perspectives.

All interviews were conducted in Dutch, which was both the researcher’s native language and that of most participants. This facilitated a natural and nuanced exchange, reducing the risk of misinterpretation and allowing participants to express themselves freely. In the case of international dentists, a combination of Dutch and English was used where necessary, depending on the participant’s level of comfort. Interviews were conducted either in

person or via Microsoft Teams, depending on logistical considerations. The use of online interviews did not appear to limit the depth or quality of the data; in most cases, interactions were comparable to those conducted face-to-face, supporting findings from previous research that suggest minimal differences between in-person and online qualitative interviews (Anthony et al., 2025, 8; Shapka et al., 2016, 364; Woodyatt, et al., 2016, 747).

Following data collection, all interviews were transcribed using AmberScript, after which a manual process of thematic analysis was conducted. Thematic analysis was chosen as it provides a flexible yet systematic approach to identifying patterns and themes within qualitative data (Clarke and Braun, 2006). The coding process focused on key themes derived from both the research question and the theoretical framework, including governance arrangements, implementation practices, institutional constraints, opportunities for innovation, and forms of capital. Codes were developed iteratively, allowing for both deductive and inductive insights. This approach ensured that the analysis remained grounded in the data while also being informed by the conceptual framework.

Ethical considerations played an important role throughout the research process. Particular attention was paid to the position of the international dentists, who could be considered a vulnerable group due to their uncertain professional status and dependence on institutional processes. It was therefore essential to ensure that participation in the study would not affect their future opportunities or how they were perceived by institutions. Participants were all given an informed consent document which informed that their responses would be anonymised and used solely for research purposes. Care was taken to create a safe environment in which they could speak openly, including the option to switch between languages if needed.

To further protect participant anonymity, the interviews conducted with internationally trained dentists were analysed and referenced collectively rather than individually. Although the dentists differed in background, migration trajectory, and stage of professional integration, distinguishing between individual respondents could have increased the risk of identification due to the small number of participants involved in the pilot. Aggregating these interviews into a single respondent category allowed common themes, experiences, and perspectives to be analysed while ensuring confidentiality. This approach was considered particularly important given the relatively vulnerable position of the participants, many of whom were still navigating BIG-procedures, employment opportunities, and long-term settlement in the Netherlands.

Ethical considerations for institutional stakeholders were less pronounced but nonetheless significant. In several interviews, respondents explicitly indicated that certain statements were

off the record. These boundaries were respected, and data was handled with care to avoid potential harm to individuals or their respective organisations.

Despite its strengths, the study also had several limitations that must be acknowledged. First, the sample size was relatively small, reflecting both the scope of the research and the limited timeframe. While the selected participants provided valuable insights, the findings cannot be generalised beyond the specific context of the MDU. Even for the MDU there were a lot more people involved in the startup and even more behind the scenes within for example the municipality. Second, the focus on a single case limits the ability to compare different initiatives or draw broader conclusions about national systems. Third, the exploratory nature of the study means that it primarily identifies patterns and themes rather than testing hypotheses or establishing causal relationships. These limitations were not considered weaknesses but rather inherent characteristics of qualitative case study research, which prioritises depth and contextual understanding over generalisability.

The underlying assumption guiding this research was that the challenges faced by internationally trained dentists are not solely the result of individual deficits but are shaped by structural and institutional factors. More specifically, it was hypothesised that the MDU functions as a space in which these structural constraints are both reproduced and negotiated, allowing for alternative pathways of professional integration to emerge. The chosen methodology was therefore appropriate, as it enabled a detailed examination of how these processes unfolded in practice, capturing both the formal structures of governance and the informal dynamics through which they are navigated.

Chapter 4. Analysis

4.1
The MDU as an Intermediary Space Between Exclusion and Professional Recognition

The Mobile Dental Unit, functions in practice as an initiative that combines two objectives that are rarely brought together. On the one hand, the initiative seeks to improve access to oral healthcare for individuals who might be unable to get regular dental care due to financial struggles, undocumented status, or broader social vulnerabilities. On the other hand, the MDU provides internationally trained dentists with an opportunity to gain supervised practical experience during the lengthy period preceding full BIG-recognition in the Netherlands.

The daily operation of the initiative rely upon a relatively straightforward organisational structure. Patients are reached through existing municipal networks and visit the bus for low-complexity dental treatments. Procedures are carried out by internationally trained dentists under the supervision of Dutch BIG-registered dentists. The legal basis for this arrangement is the so-called ‘verlengde-arm’ construction, under which specific dental procedures can be delegated while end responsibility remains with the supervising dentist. According to the municipal initiator, this arrangement enabled internationally trained dentists to practise procedures such as fillings, extractions, dental cleaning and preventive advice under direct supervision while remaining within the boundaries of existing legislation (Municipal initiator, interview with author, 26 March 2026).

Although the legal arrangement appears straightforward, the interviews demonstrate that the success of the initiative depends heavily on trust. Supervision involves considerably more than ensuring technical quality and patient safety. Supervising dentists describe their role as helping internationally trained dentists become familiar with Dutch professional routines, workplace expectations, and patient interaction. One supervising dentist highlights that “for them, it is kind of an eye-opener, to come in contact with the way things work in the Netherlands” . The MDU exposes participants to materials, techniques and methods that they would otherwise rarely encounter during their preparation for the BI-exam (Supervising dentists, interviews with author, April 2026). They also highlighted the importance of learning professional terminology, noting that many participants completed their entire education in another language and therefore need opportunities to learn Dutch clinical vocabulary through practical experience rather than classroom instruction alone.

This workplace dimension emerges as one of the most significant aspects of the initiative. The internationally trained dentists participating in the MDU are not students but

qualified professionals who often possess years of clinical experience in their countries of origin (International dentists, interviews with author, April 2026). Nevertheless, respondents repeatedly emphasise that professional competence alone is insufficient for successful integration into Dutch healthcare. The programme manager argues that participants learn how Dutch healthcare functions through daily interactions with patients and colleagues (Programme manager, interview with author, 30 March 2026). Supervising dentists similarly observe that patient-professional relationships in the Netherlands differ substantially from those in many countries of origin, where healthcare professionals often occupy a more authoritative position "in Suriname a doctor is in such a position that he is almost a deity" (Supervising dentists, interviews with author, April 2026).

The importance of this practical experience becomes particularly visible in the accounts of the internationally trained dentists. One participant describes having completed multiple Dutch language courses through different institutions and having invested substantial personal resources in language acquisition (International dentists, interviews with author, April 2026). Yet practical work stays crucial because the gained language proficiency alone does not prepare them for real clinical interactions. Another participant explains that they initially believed they were not allowed to work before completing their language trajectory and therefore spent a considerable amount of time waiting unnecessarily (International dentists, interviews with author, April 2026). These statements reveal that barriers to professional integration are not only regulatory but also informational. Access to accurate guidance and opportunities to participate in professional environments appears equally important. The latter is also highlighted by several respondents explaining that participation helps them maintain confidence in their professional abilities during lengthy registration procedures. One internationally trained dentist notes that working in the MDU provides reassurance that professional skills have not been lost despite years away from clinical practice. Another describes the initiative as an opportunity to gain practical experience and strengthen self-confidence (International dentists, interviews with author, April 2026).

At the same time, respondents emphasise that the initiative fulfils an equally important role for the patient population it serves. The interviews consistently describe patients as individuals who experience structural barriers to accessing regular dental care. These include homeless individuals, undocumented migrants, people living in temporary accommodation and individuals who cannot afford treatment (Municipal initiator, interview with author, 26 March 2026; Programme manager, interview with author, 30 March 2026; Supervising dentists, interviews with author, April 2026). Supervising dentists also mentioned that many patients

have not visited a dentist for several years and often present with extensive untreated dental problems. Financial barriers emerge as a recurring explanation, as one of the supervising dentists notes, referring patients to conventional practices “is of no use, because they simply don’t have the money’’(Supervising dentists, interviews with author, April 2026).

The social significance of this patient group extends beyond oral healthcare alone. The municipal initiator argues that dental problems are often connected to broader issues such as poverty, mental health challenges, housing insecurity and social exclusion (Municipal initiator, interview with author, 26 March 2026). From this perspective, the MDU functions not only as a healthcare facility but also as a point of contact through which vulnerable individuals become visible to broader support structures. The programme manager similarly describes the initiative as a potential “communal place” for people who are largely disconnected from existing systems of care and support (Programme manager, interview with author, 30 March 2026).

The on-site respondents repeatedly stress that the initiative produces value because it simultaneously addresses two unmet needs. One supervising dentist describes the project as beneficial from every possible perspective because internationally trained dentists remain professionally active while vulnerable patients receive necessary care. Another argues that similar initiatives should be expanded to other cities because they address both professional integration and healthcare accessibility (Supervising dentists, interviews with author, April 2026). Significantly, respondents do not view these objectives as competing priorities. Instead, the educational function of the MDU depends upon the patient population it serves, while the provision of care depends upon the availability and commitment of internationally trained dentists.

Viewed through a Humanities perspective, the MDU challenges dominant assumptions embedded within existing recognition procedures. Professional integration is often treated as a linear process in which internationally trained professionals remain largely excluded from practice until they have completed all formal requirements. The MDU presents an alternative model in which participation precedes recognition. Rather than approaching internationally trained dentists primarily those who lack Dutch qualifications, the initiative recognises and utilises the expertise they already possess. At the same time, it acknowledges that integration involves learning forms of language, culture and professional interaction that can only be acquired through practice.

The findings from the on-site actors suggest that the significance of the MDU lies less in the specific dental treatments provided than in its function as a mid-way between exclusion and professional recognition. Internationally trained dentists are neither fully excluded from the

profession nor fully recognised within it. Instead, they occupy an uncertain position in which qualifications have already been obtained, while access to independent practice remains restricted. The MDU temporarily bridges this gap by allowing participants to remain professionally active while progressing through formal recognition procedures. In doing so, the initiative challenges the assumption that professional integration can only begin after formal recognition has been completed. Rather than treating registration as the starting point of integration, the MDU demonstrates that integration can occur alongside recognition through supervised participation in professional practice. The initiative therefore reveals that the period preceding BIG-registration is not simply an administrative phase but a socially and professionally significant stage in which skills, confidence, and professional identities can either be maintained or gradually lost. The MDU functions as an institutional space that attempts to prevent this process of exclusion while remaining within existing regulatory boundaries.

These findings therefore suggest that the MDU functions as more than a mobile dental practice. It operates as a workplace, a learning environment and a community service simultaneously. By bringing together vulnerable patients, supervising professionals and internationally trained dentists, the initiative creates a practical space in which healthcare provision and professional integration become mutually dependent processes.

4.2

Integration Without Coordination: Dispersed Responsibility across Institutions

For all actors involved, the Mobile Dental Unit is understood as an intervention that simultaneously addresses healthcare access, labour market participation, professional recognition, and social inclusion. What emerges from their interviews is not a shared understanding of what the initiative is, but rather a collection of overlapping interpretations shaped by institutional responsibilities, organisational mandates, and professional interests. As a result, the initiative becomes a revealing case through which broader assumptions about internationally trained professionals, healthcare governance, and institutional responsibility can be examined.

The findings suggest that the MDU emerges in response to governance gaps that existing institutions were unable or unwilling to address independently. The municipal initiator explicitly characterises the project as a form of social innovation, arguing that the MDU emerged from asking how things could be organised differently when existing approaches were

not producing desired outcomes (Municipal initiator, interview with author, 26 March 2026). Rather than beginning with policy and subsequently implementing solutions, she described a flipped approach in which practical experimentation should inform future policy development.

The municipal initiator also positions the MDU as a response to perceived institutional inertia, emphasising that the project did not emerge from an existing policy mandate but from her individual initiative and experimentation. She frames the pilot as evidence that innovative solutions can emerge when actors are willing to move beyond established procedures. Which became particularly visible in the statement: “the politicians were enthusiastic. There was also quick publicity; things got going, but... But the civil servants still had to get used to the idea that we were really doing this” (Municipal initiator, interview with author, 26 March 2026 15).

The interviews reveal that credential recognition remains organised according to fragmented institutional responsibilities, creating uncertainty regarding who is responsible for facilitating professional integration. Nuffic understands its role as making competencies visible. They describe how their standard diploma evaluations were designed for educational progression rather than professional integration, and how the pilot therefore became an opportunity to develop a new form of credential evaluation that provides the municipality and possible future employers with a more comprehensive understanding of candidates’ capabilities (Nuffic representative, interview with author, 17 April 2026).

According to Nuffic, the central challenge lies not in determining whether internationally trained healthcare professionals possess skills but in communicating these skills in ways that are understandable and credible within the Dutch labour market. The revised evaluation method seeks to document not only formal educational achievements but also competencies acquired through work experience and informal learning. As Nuffic explains, the aim is to make the entire spectrum of a candidate's skills visible rather than limiting assessment to formal qualifications. The purpose is to create transparency so that employers can better understand what applicants bring with them (Nuffic representative, interview with author, 17 April 2026).

At the same time, Nuffic emphasises institutional boundaries. While they express interest in exploring these new approaches and adapting their products to labour market needs (Nuffic representative, interview with author, 17 April 2026), they repeatedly stress that decisions concerning professional recognition remain the responsibility of the Ministry of Health, Welfare, and Sport and the CIBG (Nuffic representative, interview with author, 17 April 2026). This reveals an important tension within the governance landscape. Although multiple organisations recognise gaps in existing pathways, institutional responsibilities remain

fragmented. Consequently, municipal actors and Nuffic identify opportunities for change while simultaneously emphasising that implementation lies elsewhere.

The CIBG and the Ministry of Health, Welfare, and Sport position the MDU through the lens of patient safety and regulatory responsibility. Throughout the interview, they consistently emphasise their statutory obligation to ensure quality of care and protect patients (CIBG representative, interview with author, 16 April 2026). The organisation therefore understands itself primarily as an implementing body responsible for applying legislation objectively and independently. From this perspective, BIG-registration procedures, assessments, and waiting periods are presented not as barriers but as necessary mechanisms for safeguarding professional standards.

However, in the interview a more nuanced position came to light as well. Contrary to the beliefs among other actors, CIBG express their considerable support for initiatives that allow healthcare professionals to gain experience before registration. They explicitly describes the MDU as an initiative worthy of promotion during information sessions and also argue that practical experience prior to registration is highly beneficial because it facilitates language familiarisation, cultural adaptation, professional networking, and preparation for BI-assessments (CIBG representative, interview with author, 16 April 2026). The organisation therefore does not oppose the principle of the MDU. Instead, it views such initiatives as complementary to formal recognition procedures.

At the same time, the CIBG challenges narratives portraying the organisation as an obstacle to professional integration, explicitly rejecting the notion that the organisation is concerned only with procedures and bureaucracy, stressing the importance of recognising the human dimension behind BIG applications. The organisation acknowledges shortcomings, such as indefinitely long waiting lists and capacity constraints, but simultaneously frames these problems as consequences of broader political and financial decisions by the current cabinet (CIBG representative, interview with author, 16 April 2026).

A different perspective emerges from an interview with another BIG- registered dutch dentist, N. He was originally contacted to join the initiative, but decided to withdraw from the project before it actually started. His withdrawal from the initiative gives insight into concerns present within parts of the dental profession. Although his views cannot be considered representative of all dentists collectively, they show how questions of liability and professional responsibility shape participation. He repeatedly emphasises support for improving access to dental care and reducing suffering. Nevertheless, concerns regarding insurance, liability, and

legal responsibility ultimately lead him to withdraw from active involvement (N, interview with author, 28 April 2026).

Importantly, N does not reject the underlying goals of the initiative. Instead, he frames his concerns in terms of risk management within a highly regulated professional environment. His position therefore shows a recurring tension visible throughout the interviews: support for integration and innovation exists alongside concerns regarding accountability and professional responsibility. While discussing the arrangements of supervision, delegation, and patient safety, similar concerns were mentioned, suggesting that resistance often emerges not from opposition to internationally trained dentists themselves but from uncertainty regarding said arrangements.

Taken together, these findings demonstrate that support for the broad objective of professional integration does not automatically translate into clear responsibility for achieving it. Nearly all actors express positive views regarding the integration of internationally trained healthcare professionals, yet each organisation primarily interprets the issue through the boundaries of its own mandate. Nuffic focuses on making competencies visible, CIBG focuses on patient safety and legal recognition, while municipal actors focus on participation and local problem-solving. As a result, responsibility becomes dispersed across institutions rather than concentrated within a single coordinating actor. The MDU emerges precisely within this gap. Rather than being the product of a coherent national strategy, it functions as a local response to the absence of institutional coordination. The initiative therefore reveals an important characteristic of Dutch healthcare governance: broad agreement on goals can coexist with uncertainty regarding who should take responsibility for achieving them.

4.3

Capital Accumulation and Responsible Rebellion Within Fragmented Governance

The interview data reveal that the Mobile Dental Unit functions not only as a practical intervention addressing shortages in dental care access, but also as a site where broader tensions concerning responsibility, professional recognition, professional integration, and institutional innovation become visible. While stakeholders generally agree on the social value of the initiative, they differ substantially in their interpretation of who is responsible for facilitating the integration of internationally trained dentists and how existing barriers should be addressed. These differing interpretations create a pattern of friction that can best be understood through Bourdieu’s concepts of social, cultural, and economic capital, alongside the notion of responsible rebellion.

The most immediate obstacle identified throughout the interviews concerns access to cultural capital. Although internationally trained dentists possess recognised qualifications and often extensive professional experience, multiple respondents emphasise that success within the Dutch system requires much more than technical competence. Supervising dentists explain that working in the Netherlands requires familiarity with Dutch professional culture, communication styles, patient expectations, and clinical routines. Dutch patients are described as considerably more assertive than patients in many countries of origin, requiring practitioners to adapt to a more horizontal practitioner-patient relationship (Supervising dentists, interviews with author, April 2026). Similarly, the programme manager argues that the MDU exposes participants to specifically Dutch workplace expectations, such as openly discussing mistakes and learning from them rather than concealing them (Programme manager, interview with author, 30 March 2026). The MDU therefore serves as a space where cultural capital can be accumulated through practical experience rather than formal education alone.

The importance of this practical exposure is repeatedly emphasised by both supervising dentists and the Ministry representative. The CIBG representative argues that workplace experience before BIG-registration contributes not only to language acquisition but also to understanding Dutch healthcare culture and building confidence (CIBG representative, interview with author, 16 April 2026). Supervising dentists similarly note that participants gain familiarity with Dutch materials, instruments, terminology, and treatment approaches that cannot easily be acquired through language courses alone (Supervising dentists, interviews with author, April 2026). From a Bourdieusian perspective, the MDU therefore functions as a mechanism for converting previously acquired professional qualifications into forms of cultural capital that are recognised within the Dutch healthcare field.

Closely connected to cultural capital is the question of social capital. Several internationally trained dentists describe arriving in the Netherlands with few professional contacts and limited knowledge of available pathways into employment. One participant explicitly states that meeting people and finding work opportunities was more important than the educational component itself. Another explains that she initially believed she was not allowed to work before completing her language training and therefore lost valuable time waiting unnecessarily (International dentists, interviews with author, April 2026). These accounts suggest that information itself functions as a form of social capital. Access to networks, mentors, and knowledgeable intermediaries determines whether opportunities become visible.

The municipality attempts to address this deficit through network-building activities that extend beyond the MDU itself. The programme initiator organises language cafés where participants can discuss workplace issues, cultural differences, and practical challenges while simultaneously expanding their social networks. More importantly, the MDU is explicitly designed as a collective endeavour rather than an individual support programme. As the municipal initiator explains, participants, organisations, and volunteers are all regarded as part of the same movement, creating mutual support structures in which people increasingly help one another (Municipal initiator, interview with author, 26 March 2026). This reflects Bourdieu's understanding of social capital as resources embedded within networks and social relationships rather than within individuals themselves.

The interviews simultaneously reveal substantial deficits in economic capital. internationally trained dentists frequently spend years navigating BIG-procedures while paying for language courses, exams, and daily living expenses. One participant describes completing multiple language courses at different institutions, all of which required personal financial investment. Others continue to work night shifts or even take positions far below their qualifications while preparing for BIG registration examinations (International dentists, interviews with author, April 2026). These circumstances illustrate what the literature describes as brain waste: highly trained professionals becoming trapped in prolonged periods of underemployment despite labour shortages elsewhere in the system.

The forthcoming increase in BI-exam costs further highlights the role of economic capital. The CIBG representative defends the increase by arguing that most applicants are highly educated knowledge migrants for whom the costs represent an investment rather than an insurmountable barrier. They also expresses confidence that grants, loans, or support funds will eventually emerge for refugee applicants (CIBG representative, interview with author, 16 April 2026). However, this perspective contrasts sharply with the experiences described elsewhere in the interviews. The municipality repeatedly emphasises the financial vulnerability of many participants and actively explores ways to provide compensation without jeopardising existing benefits or support arrangements (Municipal initiator, interview with author, 26 March 2026). From the perspective of Bourdieu's theory, economic capital is not merely an individual resource but also a mechanism through which access to professional fields becomes structured and regulated.

These forms of capital intersect with broader questions of professional closure. Several respondents suggest that formal regulations alone cannot explain the difficulties faced by internationally trained dentists. The municipality argues that professional organisations such as

the KNMT demonstrate reluctance to engage with the initiative despite having helped shape the legal framework that makes supervised practice possible (Municipal initiator, interview with author, 26 March 2026). Similarly, the CIBG representative repeatedly emphasises that employers and professional organisations possess greater room for manoeuvre than they often acknowledge (CIBG representative, interview with author, 16 April 2026). The interviews therefore suggest that barriers emerge not only from regulation itself but also from professional cultures that remain hesitant to trust foreign qualifications and experiences.

This tension becomes particularly visible in discussions surrounding responsibility. A triangular pattern emerges throughout the interviews. The municipal respondent frequently directed criticism towards national institutions, arguing that procedures remain too slow, funding insufficient, and support limited (Municipal initiator, interview with author, 26 March 2026). Nuffic similarly acknowledges that municipalities regularly seek more active intervention than the organisation is formally authorised to provide (Nuffic representative, interview with author, 17 April 2026). Meanwhile, CIBG and therefore the Ministry position themselves as constrained by existing legislation, political decisions, and patient safety requirements (CIBG representative, interview with author, 16 April 2026). Rather than accepting responsibility for the broader integration problem, CIBG repeatedly points towards employers and professional organisations as the parties most capable of creating practical opportunities (CIBG representative, interview with author, 16 April 2026).

It is precisely within these institutional gaps that responsible rebellion becomes visible. The MDU emerges because actors refuse to accept the apparent incompatibility between protecting patients, integrating internationally trained professionals, and providing care to vulnerable populations. The municipal initiator explicitly describes the project as a form of social and task innovation developed outside existing policy frameworks. Rather than waiting for formal mandates, new solutions are created through experimentation, risk assessment, and coalition-building (Municipal initiator, interview with author, 26 March 2026).

This closely reflects Wallenburg et al.'s concept of responsible rebellion, in which actors seek to improve systems from within rather than reject them entirely. Importantly, rebellion in this case is collective rather than individual. The initiative depends upon supervising dentists willing to assume responsibility, municipal actors willing to mobilise resources, and institutions such as Nuffic that experiment with alternative forms of credential recognition. Several respondents explicitly describe the need for ambassadors, pioneers, and early adopters who can demonstrate that alternative approaches are possible (CIBG representative, interview with author, 16 April 2026; Nuffic representative, interview with author, 17 April 2026). The MDU

therefore represents a network of responsible rebellious actors attempting to create space within existing structures rather than outside them.

Viewed through Bourdieu's framework, the MDU can be understood as an intervention that compensates for deficiencies in the distribution of capital within existing integration pathways. Formal recognition procedures primarily assess qualifications but provide only limited opportunities to acquire the cultural and social capital required for successful participation in Dutch healthcare. The initiative therefore fills a gap that is left largely unaddressed by existing institutions. At the same time, the findings demonstrate that this gap is not bridged through structural reform but through what can be understood as responsible rebellion. Municipal actors, supervising dentists, and supporting organisations do not reject the existing system. Instead, they create practical solutions within it, using the limited room available to address shortcomings that they perceive in current arrangements. The MDU therefore illustrates how innovation emerges not through the replacement of existing institutions, but through actors who are willing to experiment within institutional constraints. This simultaneously highlights both the potential and the limitations of local initiatives: they can create valuable opportunities for integration, but they cannot fully resolve the structural fragmentation that made their existence necessary in the first place.

The findings ultimately suggest that the MDU functions as a response to institutional fragmentation. It creates cultural capital through practical workplace experience, social capital through networks and mentorship, and limited forms of economic capital through opportunities for professional development. At the same time, the initiative exposes the absence of a coherent system for supporting internationally trained healthcare dentists. Responsibility remains contested, with different actors attributing barriers to different parts of the institutional landscape. The significance of the MDU therefore lies not only in the care it provides or the training opportunities it creates, but also in the way it reveals how access to professional practice is shaped by competing interpretations of responsibility, value, risk, and inclusion within Dutch healthcare governance.

Chapter 5. Discussion

The findings of this study demonstrate that the Mobile Dental Unit (MDU) functions not merely as a local healthcare initiative but as a governance experiment situated within a fragmented institutional landscape. Examined through the theoretical lenses of governance, Bourdieu's forms of capital, and responsible rebellion, the case provides important insights into how professional integration is organised and negotiated in practice. Rather than revealing a coherent integration pathway, the findings point towards a system in which responsibilities are dispersed across multiple actors, requiring local initiatives to bridge institutional gaps.

From a governance perspective, the findings support the argument that contemporary public governance increasingly operates through networks rather than hierarchical structures (Ansell and Gash 2008, 544-547). While responsibilities regarding internationally trained healthcare professional integration are distributed across organisations such as the Ministry of Health, Welfare and Sport, CIBG, municipalities, educational institutions, employers, and labour market actors, no single institution appears responsible for coordinating the integration trajectory as a whole. The MDU reveals how these fragmented arrangements create uncertainty regarding accountability and responsibility. Although all actors support the broader objective of reducing healthcare shortages and improving internationally trained professional integration, they often approach these goals from different institutional perspectives and priorities. Consequently, the governance system appears less as a coordinated pathway and more as a collection of interconnected yet mostly autonomous organisations.

This fragmentation becomes particularly visible when viewed through Bourdieu's theory of capital. The findings demonstrate that successful integration depends not solely on formal recognition of qualifications but also on access to cultural, social, and economic capital (Bourdieu 1986, 243-248). Cultural capital encompasses knowledge of Dutch workplace norms, professional communication, institutional expectations, and patient interactions. Social capital consists of access to networks, mentors, and professional contacts that facilitate entry into employment opportunities. Economic capital refers to the financial resources required to navigate lengthy BIG-registration procedures, language training, and periods of limited professional income.

The findings suggest that existing institutional arrangements focus primarily on formal credential recognition while providing considerably less support in developing the additional forms of capital necessary for successful integration. This observation aligns with Erel's argument that migrant knowledge and skills do not disappear through migration but frequently

require translation and revaluation before they become recognised within a new context (Erel, 2010, 647). Similarly, Nowicka (2013, 13-15) demonstrates that labour market participation is often dependent on access to networks and social connections rather than qualifications alone. The MDU addresses these deficiencies partially by creating opportunities for workplace experience, professional interaction, and network formation. In doing so, it provides access to forms of capital that formal recognition procedures alone cannot generate.

The findings also contribute to the literature on responsible rebellion. Existing scholarship describes responsible rebels as actors who remain committed to institutional goals while seeking alternative ways of achieving them when existing arrangements prove insufficient (Wallenburg, Weggelaar, and Bal 2019, 873; Rusinovic et al. 2020, 5). The MDU reflects this dynamic. Rather than rejecting existing regulations or professional standards, the actors involved attempt to work within institutional boundaries while simultaneously creating space for alternative approaches to integration and care provision. Their actions are motivated not by opposition to regulation itself but by the idea that existing arrangements leave valuable opportunities underused.

Importantly, the findings demonstrate that responsible rebellion is not an individual characteristic but a collective process. The initiative depends upon cooperation between municipal actors, supervising dentists, educational organisations, and internationally trained professionals. This reflects the argument that successful institutional innovation requires networks capable of balancing experimentation with legitimacy (Felder et al. 2022, 24-27). The MDU therefore illustrates how innovation emerges through collaboration between actors who recognise shortcomings in existing systems but remain committed to broader institutional objectives.

Taken together, these findings indicate that the MDU serves as both a practical intervention and an analytical lens. It reveals how fragmented governance structures shape professional integration, demonstrates the importance of access to different forms of capital, illustrates the role of responsible rebellion in creating institutional innovation, and highlights the challenges associated with achieving viable forms of organisational embedding. The initiative therefore provides important insights into the broader governance challenges surrounding professional integration of internationally trained dentists within the Dutch context.

Chapter 6. Conclusion

This thesis set out to answer the following research question: How does the Mobile Dental Unit navigate and reveal the fragmented institutional responsibilities within Dutch healthcare governance regarding the integration of internationally trained professionals?

The findings show that the Mobile Dental Unit navigates fragmented institutional responsibilities by creating a local platform where actors from different sectors collaborate around a shared objective. Through cooperation between municipal actors, healthcare professionals, educational organisations, and regulatory institutions, the initiative provides opportunities for internationally trained dentists to gain workplace experience, grow professional networks, and remain connected to their profession while progressing through formal registration procedures. In this way, the MDU functions as a practical response to barriers that existing institutional arrangements do not fully address.

At the same time, the initiative reveals the fragmented nature of Dutch healthcare governance. Responsibilities for professional integration of internationally trained dentists are distributed across multiple organisations, each responsible for specific elements of the process. Credential recognition, labour market participation, financial support, workplace experience, and professional supervision are organised separately rather than through a coordinated pathway. The study demonstrates that while individual actors generally support the integration of internationally trained professionals, no organisation assumes responsibility for the process as a whole. Consequently, gaps emerge between policy objectives and practical implementation.

The main contribution of this thesis lies in demonstrating that professional integration of internationally trained dentists cannot be understood solely through formal recognition procedures. Using Bourdieu's theory of capital, the study shows that successful integration not only depends on recognised academic qualifications but also on access to cultural, social, and economic resources. The MDU contributes to these forms of capital by providing workplace exposure, professional contacts, and opportunities to maintain and develop professional skills. Furthermore, by applying the concept of responsible rebellion, the study illustrates how local actors create innovative solutions within existing institutional constraints rather than waiting for formal policy reform.

Several limitations should be acknowledged. First, the study focuses on a single local initiative in The Hague and therefore does not claim statistical or national representativeness. Second, the research relies primarily on qualitative interview data, meaning that the findings reflect stakeholder perspectives and interpretations rather than measurable outcomes. Third, the

pilot nature of the MDU means that its long-term effects and viability remain uncertain. Despite these limitations, the study highlights several implications for policy and practice. The findings suggest that greater coordination between institutions could reduce fragmentation and improve integration pathways for internationally trained healthcare professionals. The study also indicates the importance of creating opportunities for workplace experience before formal BIG-registration is completed, particularly in sectors facing significant labour shortages. Finally, the findings demonstrate the value of local experimentation as a means of identifying barriers and testing alternative approaches to professional integration.

The Mobile Dental Unit therefore represents more than a local healthcare project. It serves as a window into broader challenges surrounding healthcare governance, professional recognition, and professional integration in the Netherlands. By exposing institutional fragmentation while simultaneously demonstrating possibilities for collaboration and innovation, the initiative offers valuable lessons for future efforts to better utilise the skills and expertise of internationally trained healthcare professionals.

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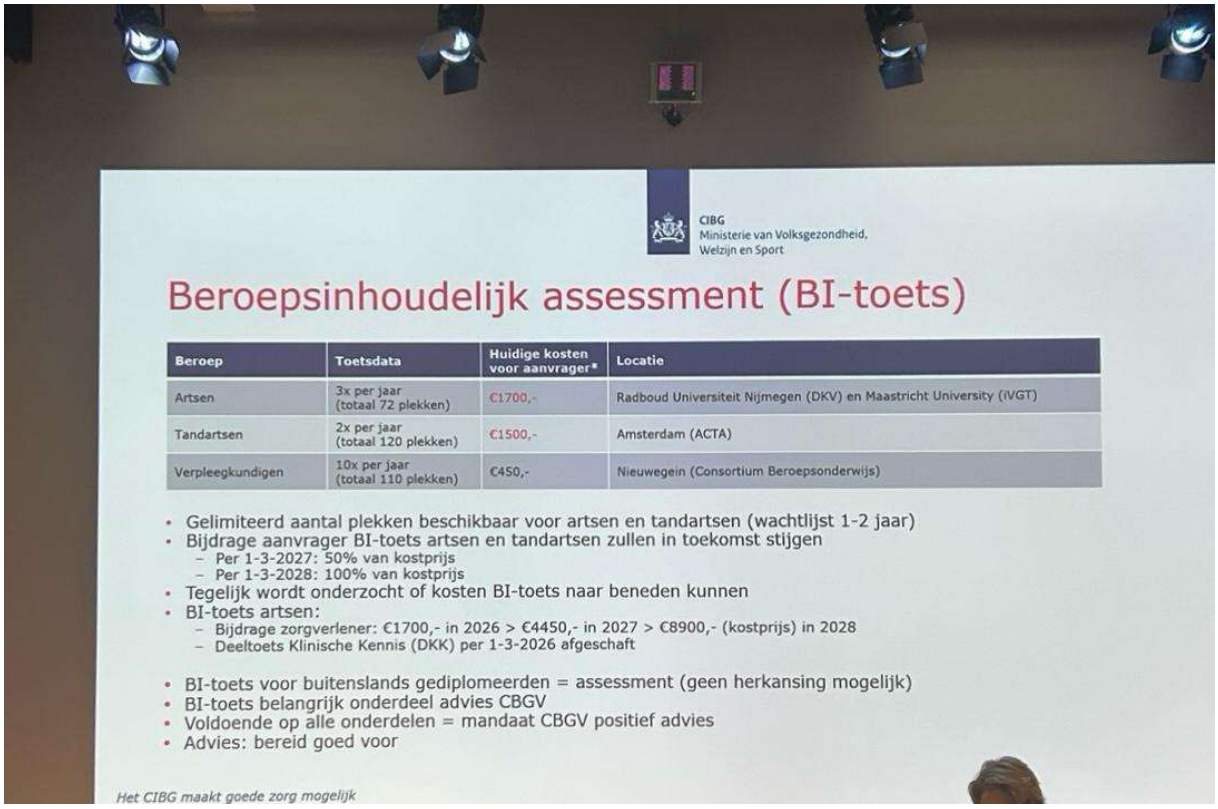
Appendices

Appendix A



Appendix A. Presentation slide on the Beroepsinhoudelijk assessment (BI-toets) presented by the CIBG during the symposium Op naar de Triple Win, , held at Radboud University, 2 April 2026. Photograph by author

Appendix B. Overview of Interviews

Interview Category	Role in Relation to the MDU	Date	Format	Duration (min)
International dentists (n = 4)	Internationally trained dentists participating in the MDU pilot	April 2026	2 via Microsoft Teams, 2 in person	45, 45, 55, 80
Supervising dentists (n = 2)	Dutch BIG-registered dentists responsible for supervision and patient safety within the MDU	April 2026	In person	35, 35
Supervising dentist who withdrew (N.)	Former intended supervising dentist; interviewed as an independent representative of views present within parts of the Dutch dental profession	28 April 2026	In person	60
Municipal initiator	Initiator and coordinator of the MDU pilot on behalf of the municipality	26 March 2026	In person	80
Programme manager	Programme manager involved in the implementation and operation of the MDU	30 March 2026	In person	50
CIBG	Recognition consultant responsible for foreign healthcare qualification recognition procedures	16 April 2026	Microsoft Teams	80
Nuffic	Specialist in diploma evaluation and international credential recognition	17 April 2026	In person	70