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SECOND SMALL SCALE STUDY II

MANAGED MIGRATION AND THE LABOUR MARKET – THE HEALTH SECTOR

AUSTRIAN REPORT

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EXECUTIVE SUMMARY

The main purpose of this study is to examine approaches towards migration management in the health sector. In many European countries, the health sector has a high demand for migrant workers. As European societies will be confronted with increasing demographic ageing in the future, the demand for persons working in the health care and nursing sector will continue to rise. In a culturally diverse society, which Austria is already today, there is also a strong need for fostering intercultural competence in health care services, which includes the employment of immigrants or persons with a migration background. Even though this study mainly focuses on the health sector, it will partly also include an examination of long-term care and nursing needs, especially for the elderly, which falls partly under the responsibility of the Federal Ministry of Social Security, Generations and Consumer Protection (BMSGK).

The first chapter provides an overview of the Austrian health care sector and the main health care services provided. It elaborates the competences in this sector, the institutions that provide services as well as the system of health insurance in Austria.

The core part of this study deals with migration policy and the health care sector. The authors of this chapter, Helga Amesberger, Brigitte Halbmayr and Barbara Liegl, point out that although a demand in additional labour has been articulated by different players, a comprehensive policy approach to deal with this problem has not yet been developed. Especially the area of long-term care and care for the elderly has been described as a “state of emergency” with regards to available qualified personnel. Although single initiatives were launched to at least facilitate the access for EU-10 nationals to the health care sector, these measures were rather short-term reactions to acute problems, but not part of a larger migration policy. Due to the lack in organisations offering home health care services that people can afford, particularly the increasing need in nursing personnel in the field of home health care resulted in a “grey market” for care personnel. Looking at recruitment of health care personnel abroad, special measures have been undertaken between the early 1970s and 1990s (differing from region to region). However, this was not based on bilateral treaties but rather carried out by individual actors.

Concerning the status quo of the employment of migrants in health care professions, the analysed data is fragmentary due to the lack of a detailed central database. In general, a total number of about 15,000 foreign nationals working in the health, social and veterinary sectors were recorded in 2005, which is a percentage of about 9% of the total number of employees in this sector. In the same year, a total of about 4,500 workers with foreign

nationality, who were subject to the Aliens' Employment Act (Ausländerbeschäftigungsgesetz, AuslBG) and thus required a work permit, were registered. Regarding employees in Austrian hospitals (excluding medical doctors), the percentage of foreign nationals is respectively high in a number of professions, e.g. qualified health carers and nurses, midwives and physiotherapists. Of the total number of foreign nationals working in Austrian hospitals, around 83% work in the nursing and care professions. It is interesting to see that the majority among these employees are EU- nationals. Certainly, citizenship is not a reliable criterion when it comes to immigration. As separate data provided on midwives shows, a large number of persons with a migration background might already be naturalised and "disappear" in these statistics.

Education and training for health care professions is regulated by separate laws for most of the professions. These also contain provisions on the recognition of qualifications and training completed in another foreign country. In general, different procedures are foreseen for third country nationals and EEA (including Swiss) nationals. For the latter, recognition is regulated by Community legislation, which intends to simplify the procedure. Third country nationals have to go through the procedure of validation. In the framework of this procedure, the responsible authority will examine whether the foreign diploma corresponds to Austrian standards. Typically, the applicant will be obliged to take additional courses and pass exams in order to be admitted to the profession.

The last chapter of this study intends to give a short overview of research on migration and health in general, which has particularly been focusing on issues such as the health conditions of migrants and their access to health care services. In addition, it deals with initiatives and studies that focus on enhancing the cultural competence of health care and nursing services. Examples for interesting projects are the "Equal" project "Diversity@care - Immigrants in mobile care and nursing" and the project "Migrant-Friendly Hospitals in an Ethno-culturally Diverse Europe".

1. INTRODUCTION: THE HEALTH SECTOR IN AUSTRIA

Aims of the Study

This small-scale study aims at contributing to an area of increasing importance in the discourse on future migration and migration management by gaining knowledge on existing changes and trends in immigration with respect to the health sector in the EU Member States.

It is the second small-scale study of the European Migration Network (EMN); based on the country studies, which are written by the National Contact Points, a synthesis report summarising the main findings will be compiled. This synthesis report will focus on identifying the similarities and differences in the approaches of the EU Member States towards migration management and the health sector. Moreover, this small-scale study shall help to further assess both the action-oriented research capacity of the network and the extent to which working structures should be modified. The target audience of this study shall mainly be policy makers as well as relevant administrative bodies, specialists and management personnel in the health sector.

The health sector is seen as an area where there is a high demand for labour migration. This demand will be increasing rather than declining in the future. In addition, it needs to be understood that culturally diverse societies (which are a result of immigration in past decades) have an increasing demand in health care services, which reflect this diversity. The purpose of this study is to examine the legal framework for migration policy in the health sector (including recruiting policies), education and training for health professions and the state of migrant employment in health care professions by making use of quantitative data.

General Structure of the Austrian Health Care System

Austria is a federal state consisting of nine provinces. Public health services are a federal matter in terms of legislation and execution. However, the competence for health issues does not lie exclusively with the Federal Ministry of Health and Women (Bundesministerium für Gesundheit und Frauen, BMGF). Responsibilities are also assumed by other federal ministries, provinces and municipalities and the social security institutions as self-administrated public corporations (BMGF 2005a, 15). To give an example, the authority in charge of university education for medical doctors is the Federal Ministry of Education, Science and Culture (Bundesministerium für Bildung, Wissenschaft und Kultur, BMBWK).

Concerning the hospital system, for example, the basic principles are determined at the federal level, while the provinces are responsible for the adoption of implementation laws and their execution. Despite the distribution of competencies among several entities, the financing of the Austrian health system is rather complex as well: besides a variety of funding sources, the Austrian health system is financed by health insurance contributions, patient co-payment and federal, provincial and municipal subsidies.

It is important to mention that the BMGF has no federal sub-authorities in the public health sector, so the health administration is executed by provincial and municipal administrations. As a consequence, each provincial government has its own health department responsible for health administration. Moreover, each district administrative authority (Bezirksverwaltungsbehörde) has a health department (ibid.).

The main organisation in the area of research matters and planning in the health sector is the Austrian Health Institute (Österreichisches Bundesinstitut für Gesundheitswesen, ÖBIG), which is a fund with its own legal entity, but under the aegis of BMGF. Furthermore, the Ministry has an advisory body – the National Health Council (Oberster Sanitätsrat).

Social and Health Insurance

The main element of the Austrian social security system is the model of compulsory insurance, both for employed and self-employed people. For employees, it is not possible to choose an insurance institution as it depends on the place of employment and the employer respectively.

In Austria, approximately 98% of the population is covered by social health insurance (BMGF 2003). The majority of medical doctors in private practice have a contract with one or more social insurance institutions. These are based on agreements between the Association of Austrian Social Security Institutions (Hauptverband der österreichischen Sozialversicherungsträger, SV) and the Medical Chambers[1] (Ärztekammern) on the provincial level.

Health Care Services

Outpatient medical care

In the following, general facts on the organisation of main health care services in Austria will be summarised. Generally, one can distinguish between inpatient and outpatient health care services.

[1] The Medical Chamber is the professional representation of medical doctors. It is subdivided into nine provincial chambers. It is established by law and membership is compulsory for medical doctors.

In case of illness, usually the general practitioner, who provides outpatient medical care in private practice, is contacted. The general practitioner will refer the patient to a specialist or an outpatient clinic if necessary. In case of emergency, medical service is provided by outpatient clinics of specialist departments in nearly all public and non-profit hospitals. As of 2003, there are approx. 900 outpatient clinics and a number of outpatient hospital departments throughout Austria. These are mainly run by private organisations, of which a number has contracts with social insurance institutions (BMGF 2005a, 53).

Hospitals

As for the inpatient sector, Austria disposes of 275 hospitals (data of 2003; only 272 hospitals provided statistical data for this year), of which 159 (133 public hospitals and 26 private hospitals) operate on a non-profit basis. In general, there is a large number of relatively small hospitals in Austria[2] (BMGF 2005b, 13). With regards to ownership, approximately one third of the hospitals are run by the provinces or provincial associations (which corresponds to 52% of the beds provided in Austrian hospitals). Other institutions that run hospitals are municipalities, religious associations, health insurance institutions, insurance companies and private persons. Of 272 hospitals, 51% are provincially funded hospitals, and are funded by public resources via nine provincial funds; these correspond to 73% of the bed capacity provided in Austria (ibid.).

Psycho-social and psychiatric care

In the field of psycho-social and psychiatric care, services are provided by a varied system of different providers both in the health and social fields. The provided services range from psychotherapeutic counselling to inpatient and outpatient care for psychiatric patients. Attention has to be drawn to the fact, that no general contract has been concluded between psychotherapists and health insurance institutions. However, psychotherapist treatment is under certain circumstances to some extent refunded.

Rehabilitation

Concerning rehabilitation, treatment is provided by the 29 specialized hospitals run by social insurance providers as well as private facilities, of which many have a contract with a social insurance institution (BMGF 2005a, 76).

Services for disabled people

Among the services for disabled people, day care is distinguished from assisted living models. Concerning day care, there were 384 institutions and 13,550 places (excluding

[2] To give an example, there are nine hospitals with 1,000 and more beds, which dispose of 19% of all beds provided (BMGF 2005, 54).

Carinthia) for people with mental or multiple disabilities in 2002. In addition, approx. 447 institutions offered 8,400 places in the framework of models for assisted living (full, partial or case-by-case assistance) (Carrington et al. 2005, 23).

Care for the elderly

Medical, nursing and social care for the elderly lies, depending on the kind of service, under the responsibilities of two ministries: the BMGF and the Federal Ministry of Social Security, Generations and Consumer Protection (Bundesministerium für soziale Sicherheit, Generationen und Konsumentenschutz, BMSGK). While the BMGF is responsible for health care services, the BMSGK is in general responsible for social and nursing care, which is regulated individually for each province. Municipalities assume responsibilities as well. The following services for elderly people are provided: home care services/outpatient care, day-patient care, outpatient care, inpatient care, residence places, nursing homes, assisted living and short term care (Carrington et al. 2005, 20-22).

The BMGF estimates that the number of elderly people in need of care amounts to around 560,000 persons, expecting that this number will exceed 800,000 within a period of 20 years. According to the BMGF, in 2005 there were 750 senior and nursing homes in Austria with a total of 68,461 places. It is important to mention that about 80% of those persons who require nursing care are treated at home. In this regard, mobile care services play an important role, for which provinces and municipalities are in charge of setting up the required infrastructure. According to the BMGF, the divided responsibilities are one reason why there is no nationwide reporting facility, which would document the number of persons involved (7,810 full-time nursing and care personnel according to the latest survey and certainly many part-time workers) (BMGF 2005a, 77-79).

Overview of national developments in the field of managed migration and the health sector

As the analysis in chapter four will show, a migration policy focusing exclusively on the health sector has not yet been set on the political agenda. However, at least single initiatives have been implemented to facilitate the employment of nationals of the new EU member states in health care services.

In reality, Austria is facing an increasing demand for personnel working in the health and care sector. Particularly the lack of qualified personnel in the care for the elderly was a topic in Austrian newspapers. Articles reported that in the coming decade, there will be a lack of about 30,000 health care professionals (Kurier, 4.7.2005). The lack of workforce is especially

significant in the field of mobile care services. It is assumed that also irregular migrants fill this gap to a certain extent (see e.g. Wiener Zeitung, Die Presse, Der Standard 21.4.2005). This view is criticized in a study carried out by the Ludwig Boltzmann Institute for the Sociology of Health and Medicine (LBISHM), which states that the number of these illegally working migrants is highly overestimated (LBISHM 2005).

One strategy to cope with the increasing demand in care personnel, is to encourage young people to work in care professions. Consequently, an image campaign was launched in 2004 by the government together with aid organisations (such as Caritas and Volkshilfe).[3] In addition, the Public Employment Service (Arbeitsmarktservice, AMS) provides financial assistance for training in health care professions. It particularly focuses on unemployed persons or persons who want to change jobs.

[3] Besides advertisements on TV, a special webpage was created promoting the campaign: http://www.jobdeslebens.at.

2. METHODOLOGY

Concerning the topic migration and health, research mainly focuses on aspects such as health conditions of migrants, the access of migrants to the health system and fostering intercultural competence and diversity in the health care sector. The desk analysis of available research work on migration policy and the health sector as foreseen by this study's specifications was difficult, as the material available is limited.

Among the materials were reports on the Austrian health system compiled by the Federal Ministry of Health and Women (BMGF). A main source of information about the health care professions were certainly the various laws stipulating provisions for these professions (e.g. Medical Doctors' Act), such as scope and responsibilities, rights and obligations, criteria for admission, qualification and training, etc. Another basis of information was brochures, information leaflets and websites of different institutions and associations. Statistical data was provided by BMGF on personnel working in Austrian hospitals and by the Association of Midwives. A very interesting source we want to draw intention to was a seminar organised by the Counselling Centre for Migrants (Beratungszentrum für Migranten und Migrantinnen)[4] held in Vienna on the recognition and validation of diplomas for health care professionals, where officials of the BMGF and the provincial government of Vienna reported on procedures, practices and problems. We further included studies and projects dealing with other interesting aspects, such as intercultural competence in care services.

Although articles about the need for immigration of health care professionals have appeared in Austrian media from time to time, a concrete policy in this field has not been followed nor have bilateral agreements promoting immigration of persons for work in health professions yet been concluded. As Austria is a federal state, many authorities on different levels (federal state, provincial, district, etc.) assume responsibilities and deal with health issues. Unfortunately, the research design of the study ("Small-scale Study") at hand did not allow for more in-depth research like for example interviews with different actors (provincial governments, administration of largest hospitals, Public Employment Services, NGOs, etc.). We assume that more information on migration policy and the health sector is available, but difficult to find as it is widely spread. Certainly, practices may differ between provinces and other actors respectively. To give an example, the responsibility for validation of diplomas acquired by third country nationals abroad, lies with the nine provincial government departments; in this regard it would have been interesting to integrate experiences and

[4] The seminar, held in Vienna on 29 March 2006, was part of a series of workshops about possibilities of recognition of qualifications acquired in a foreign country named "AMPEL – Bildung anerkennen". For more information about the Counselling Centre see: http://www.migrant.at and on the project: http://www.interculturexpress.at/.

(possibly varying) practices in our study, which was not possible due to constraints in time, length and scope. While the majority of the study was written in-house, we decided to outsource chapter four on “Migration policy and the health sector in Austria”, which required a large amount of investigation, as there is not much material to revert to.

3. MIGRATION POLICY AND THE HEALTH SECTOR (Barbara Liegl, Helga Amesberger, Brigitte Halbmayr)

The national level has not developed an explicit and coherent labour migration policy for the health sector yet. Migrants seeking employment in the health sector have by and large been subject to the same regulations as all other labour migrants. However, since 2004 a few exceptions for migrants from the EU-10 (the new member states), who do not have free access to the labour market[5] at least up to 2009 and would like to work in the health sector, have been introduced. This was in reaction to the pressure exerted by the provincial governments, who run most hospitals and have the political responsibility for care-taking institutions (König et al. 2005, 5) and have to cope with the so-called "state of emergency" with regard to the already existing and even increasing shortage in qualified health care personnel.

The Austrian health sector covers resident doctors, inpatient acute care (in hospitals) and long-term care (including nursing homes, semi-stationary care and home health care). Statements on the number of people employed in these sectors are difficult to make, as some organisations count the number of employees and others calculate the equivalent number of full-time employees. In 2002, 107,077[6] full-time employees were registered for inpatient acute care[7], and 30,130 for long term care (Bundesministerium für Soziale Sicherheit, Generationen und Konsumentenschutz s.a., II-IV). According to the Austrian Labour Market Service, 4,635 third country nationals subject to the Aliens' Employment Act (Ausländerbeschäftigungsgesetz, AuslBG) worked in the health sector in 2002, 82% (3,797) of whom were women[8].

Different professional groups working in the health sector fall within the competences of different ministries. The Federal Ministry for Health and Women is responsible for regulations regarding (resident) medical doctors, professional health care and nursing personnel as well as assistant nurses. The Medical Doctors' Act[9] specifies that persons, who have acquired their doctoral degree abroad and are not immediately admitted to practicing their profession in Austria, can only be authorized as doctors when they fulfil several qualification requirements. These include an adequate knowledge of German and a situation where the

[5] EU Expansion Adjustment Law (EU-Erweiterungs-Anpassungsgesetz 2004, BGBl 28/2004).

[6] This number includes all hospitals that are publicly financed and covers about 52% of the hospitals, the remaining hospitals employed 20,164 people both fulltime and part-time. See Federal Ministry for Health and Women (Bundesministerium für Gesundheit und Frauen, BMGF), Krankenanstalten in Zahlen, http://www.kaz.bmgf.gv.at, accessed in April 2006.

[7] BMGF, Krankenanstalten in Zahlen, http://www.kaz.bmgf.gv.at, accessed in April 2006.

[8] Public Employment Service (Arbeitsmarktservice, AMS), http://iambweb.ams.or.at/, accessed in April 2006 and own calculations.

[9] § 33 Medical Doctors' Act (Ärztegesetz 1998, BGBl. I 169/1998).

prospective location of employment is in an area in need of a doctor and no already authorised doctor can be found to practice there. The authorisation is limited to a period of three years and is renewable on a three-year basis. The Health and Nursing Professions Act [10] regulates professional health care and nursing as well as assistant nursing. Austrian citizenship was a prerequisite for access to vocational training until 1997. Several institutions, however, did not comply with this regulation due to manpower needs (Carrington et al. 2005, 37). Professions working with those in need of (long-term) care fall within the competence of the Federal Ministry of Social Security, Generations and Consumer Protection and are regulated by the federal provinces; only five out of nine provinces have passed legislation regarding vocational training in this area (Carrington et al. 2005, 34).

Especially the area of long term care has been described as being in a "state of emergency", which is not only used by interest organisations as a political battle cry but is also how the sector describes itself (Krajic et al. 2003, Krajic et al. 2005). This is evidenced by the difficulties in filling vacancies with adequate personnel[11], which is partly a result of the massive increase in human resources initiated in the inpatient acute care over the past 15 years. This development lead to allowing the employment of personnel from temporary work agencies in the health sector[12] and resulted in minor changes making access to the labour market a little easier for qualified personnel from the EU-10 than for third country nationals.

Since 2003, labour immigration has been restricted to qualified personnel. In 2005, only 1,600 residence permits out of 7,500 were earmarked for qualified personnel and their family members (König et al. 2005, 5), for 2006 the quota was lowered to 1,025 out of 7,000[13]. The concept of qualified personnel is defined by income. Key professionals have to earn at least 60% of the income marking the threshold for social security contributions. In 2005, this meant € 2,178 14 times a year and in 2006 € 2,250 – an income well above the median income in Austria (König et al. 2005, 5). In 2004, this threshold was lowered for health and caretaking professions from the EU-10 to 40 per cent of the threshold[14] – in 2005 the income amounted to € 1,452 and in 2006 to € 1,500. Furthermore, this group was exempted from the federal quota (*Bundeshöchstzahl*), which determines the maximum share in third country national employees and unemployed persons of the total labour supply[15].

[10] The Health Care and Nursing Act (Gesundheits- und Krankenpflegegesetz, GuKG), BGBl I 108/1997 regulates the tasks, obligations, qualifications and vocational training of this professional group.

[11] Informed guesses talk about a shortage of 1,400 to 6,500 full time employees (Krajic et al. 2003, 6).

[12] § 35 Abs. 2, GuKG-Novelle 2005, BGBl I 69/2005.

[13] Settlement Decree 2006 (Niederlassungsverordnung 2006, BGBl. II 426/2005).

[14] Änderung der Bundeshöchstzahlüberziehungsverordnung, BGBl II 352/2004.

[15] Änderung der Bundeshöchstzahlüberziehungsverordnung, BGBl II 352/2004.

The increased need in nursing personnel in the area of home health care due to a lack of organisations offering affordable round-the-clock service (Hartmann et al. s.a., 11) has led to the externalisation of the sector's problems (Krajic et al. 2005, 9) by way of a "grey market". Organisations recruit voluntary and charitable members who, like au pairs, live in the household with the person in need of care and work on the basis of a daily allowance (Hartmann et al. s.a., 13-18). They receive € 40 to € 60 a day, whereas a regular hour of home health care costs between € 25 and € 36 per working hour (Museum Arbeitswelt Steyr et al. 2004, 6). It is suggested that about 400 to 2,400 migrants work as home health care personnel (Krajic et al. 2005, 37) under such precarious conditions, and who are not subject to the Office of Labour Inspection (*Arbeitsinspektorat*) responsible for monitoring working conditions, since private households do not fall under its field of competence. According to the Aliens' Employment Act the employer would have to be penalised, which is seen as rather difficult when he/she is mortally ill and in desperate need of care[16]. There are voices demanding the legalisation of these services, which would however put enormous pressure on the wages paid in this sector and undermine legally regulated working conditions.

The measures taken since 2004 are not part of a larger immigration policy but are rather short-term reactions to current and acute problems of the health sector. Issues like the improvement of recognition procedures regarding the qualifications of third country nationals and the promotion of anti-discriminatory policies are not elements of public debate. Only two[17] of the nine hospital associations of the federal provinces responsible for the financing of the hospitals have a guideline or code of conduct stating that all patients are treated equally independent of their ethnic belonging. Three associations[18] publicly display their equal treatment commissioners who can be contacted when the employees are discriminated.

Individual actors like the nine hospital associations or single hospitals no longer have the freedom of recruiting personnel abroad, as was done between the early 1970s and 1990s. Recruitment by these players was driven by the shortage in qualified health care personnel and differed from region to region. The City of Vienna started recruiting graduated, unmarried Philippine women in 1973, whose employment contracts were limited to at least three years and whose qualifications were legally recognised after they had attended a German course. Between 1973 and 1982 about 560 Philippine nurses were recruited, but the actual number

[16] Information by the Federal Ministry for Economics and Labour (Bundesministerium für Wirtschaft und Arbeit, BMWA), 12 April 2006.

[17] These are the „Wiener Krankenanstaltenverbund" and the „Krankenanstalten-Betriebsgesellschaft des Landes Kärnten".

[18] Tiroler Landeskrankenanstalten Ges.m.b.H., http://www.tirol.gv.at/themen/gesellschaftundsoziales/frauen/gb_zustaendig.shtml; Steiermärkische Krankenanstaltengesellschaft m.b.H., http://www.verwaltung.steiermark.at/cms/beitrag/10167270/8535; Landeskliniken Holding http://www.noe.gv.at/SERVICE/LAD/LAD1/Gleichbehandlung/GBKLandesdienst.pdf, accessed in April 2006.

was much higher as many relatives came as tourists by way of chain migration and took up work (Waldrauch et al. 2004, 409). In the 1980s and 1990s, the City of Vienna continued its recruitment through exchange programs with countries like the former Czechoslovakia, the former Yugoslavia and the Philippines; it also sent off delegates to Indonesia[19], China and Belarus, who recruited people on the spot after they had taken a German test[20]. Another institution involved in recruitment was the "Queen of the Apostles" sisters' order, which recruited Indian sisters, who worked in Catholic hospitals in Austria in the 1970s. Migration from India was also initiated by students of Catholic Theology who realised the shortage in nursing personnel and prompted relatives and friends in their hometowns to come to Austria (Hintermann 2001, 71).

Similar to the recruitment procedures of labour migrants in general, which began in the 1960s, no formal bilateral treaties were concluded for the health sector. Such agreements facilitated administrative procedures of recruitment and did not set decision mechanisms for admittance to the labour market. This gate keeping was done by the Social Partners who determined the number of migrant workers. In 1993, quotas for immigration and family reunification were introduced (König et al. 2003, 229) and immigration slowed down, especially for those who had relied on chain migration like health care personnel from the Philippines and India. As the relaxing of requirements for accessing the labour market during the last two years have been limited to citizens of the EU-10, migrants from the traditional countries of origin for the health care sector have been further cut off.

[19] The first nurses from Indonesia arrived in Vienna in November 1965 (Wien im Rückblick, http://www.wien.gv.at/ma53/45jahre/1965/1165.htm, accessed in April 2006).

[20] Information provided by Krankenanstaltenverbund, Geschäftsbereich Personal on 13 April 2006.

4. THE EMPLOYMENT OF MIGRANTS IN THE HEALTH SECTOR

In the following part we will elaborate an overview on employment of immigrants in Austria by presenting statistical data. A problem we want to point out in this regard is that there is no central data source covering detailed data on all persons working in the health care sector (employed and self-employed). We assume that in general more data is available, but this would require special analyses.

The data collected do not allow for a distinction into "autochthonous" and "migrant" as foreseen by the study specifications. Mostly, statistics are only broken down by citizenship as no information on country of birth is available. This is certainly not sufficient when it comes to determining the extent migrants or people with migration background are employed in health care services. Austria has been facing a rising number of naturalisations in the last decade; consequently, naturalised persons who immigrated to Austria are recorded as Austrians in the databases and therefore "disappear" in the statistics. On the other hand, many members of the second generation, who were born in Austria, still hold a foreign citizenship.

Although the overall responsibility for the health care sector lies with the Federal Ministry of Health and Women (BMGF), it only collects data on personnel employed in hospitals[21] (excluding medical doctors). There is no central data source on persons working in health professions elsewhere (e.g. in outpatient clinics etc.). In order to cover the remaining areas and in particular to gather information on medical doctors, we contacted professional representations of some of the medical professions in order to collect their data. The professional representations are established by law and membership is based on the practice of a certain profession. As a consequence, they include all the members of a certain profession and dispose of their data.

The Medical Chamber, which we contacted to collect data on medical doctors, did not provide us with statistics for various reasons. We were told that they already provide data on migrating medical doctors (with EU citizenship) to Eurostat on a regular basis. However, due to restrictive definitions, these statistics do not properly reflect the phenomenon of intra-EU migration of medical doctors. To give an example, EU nationals (e.g. usually German citizens), who studied abroad and come to Austria to complete their practical training after graduation, are not counted in these statistics (even though the person would stay and work

[21] Hospitals can be distinguished into hospitals financed by provincial funds (public hospitals including private non-profit hospitals, which are funded by public means) and hospitals not funded by provincial funds. Both provincially funded hospital as well as non-funded hospitals are obliged by law to submit statistical data to the BMGF. The database on hospitals covers all hospitals approved by law: general hospitals, specialised hospitals, rehabilitation centres, recovery centres, long-term care hospitals and sanatoriums. Outpatient clinics not connected to an inpatient hospital are not included (see BMGF, Krankenanstalten in Zahlen, http://kaz.bmgf.gv.at).

as a medical doctor afterwards). In addition, statistics on medical doctors disaggregated by citizenship are not published (although possible to produce) as they lack expressiveness. Citizenship is not an appropriate indicator for measuring migration, as the profession of a medical doctor is in principal restricted to Austrian and EEA nationals. In the case of EEA nationals, the question remains when (or whether) the person migrated to Austria (he/she might even have been born here).

As the Ministry's hospital statistics only cover midwives employed in Austrian hospitals, the Midwives' Association was contacted to provide additional data (presented below), as they dispose of a registry of working midwives.[22] The Chamber of Dentists was not able to provide data[23], nor was the Chamber of Pharmacists[24].

For other health professions, such as medical-technical services (comprising the higher medical-technical service[25] and the medical technical services) and auxiliary health professions[26] (with the exception of the cardiotechnical service, for which a central register exists) there are no central registries on the number of employees in these professions. Apart from hospitals, they may also be employed in private practices, outpatient clinics, private laboratories, etc. As stated above, the personnel of such institutions are not covered by any central database.

Moreover, no useful data was available about psychologists. The Professional Association of Psychologists (Berufsverband der Psychologen) does not dispose of migration related data of its members (such as country of birth and/or citizenship)[27]. The same goes for psychotherapists. Psychiatrists are medical doctors and therefore registered by the Medical Chamber.

General data on employment in the health sector

Statistics provided by the Central Association of Social Security Institutions (Hauptverband der Österreichischen Sozialversicherungsträger, HV) and the Public Employment Service

[22] Both employed and self-employed midwives are obliged by law to register at the Midwives' Association, which maintains the Midwives' register (see Midwives' Act (Hebammengesetz 2002)).

[23] In this regard, it must be mentioned that the Chamber of Dentists was only established on 1 January 2006; previously, the professional representation of dentists was the Medical Chamber and data on dentists subsumed under data on special practitioners.

[24] Theoretically, a break-down by citizenship would be possible, but these statistics are not processed. However, it is assumed that the employment of migrants as pharmacists is not too numerous.

[25] The higher medical-technical service includes the following professions: physiotherapists, biomedical scientists, radiology technologists, dieticians, occupational therapists, logopedics and orthoptists.

[26] These are surgery assistant, laboratory assistant, mortuary assistant, doctor's assistant, occupational therapy assistant, disinfection assistant, cardiotechnical service, medical masseurs and therapeutic masseurs and emergency medical service.

[27] In addition, not all psychologists are registered members of this association. In July 2005, the association recorded 3,155 members. For more information see: http://www.boep.or.at.

(Arbeitsmarktservice, AMS) give an overview of the numbers of employees in the health and social services. Nevertheless, these institutions only provide general data (not broken down into detailed health professions) and do not cover self-employed persons. In 2005 (annual average), a total number of 171,232 persons worked in the field of health, veterinary and social services, of whom 77% were women. Of the total number, 14,928 held a foreign nationality, of whom 80% were women (data provided by HV).

The AMS provides data on foreign nationals who are subject to the Aliens' Employment Act (Ausländerbeschäftigungsgesetz, AuslBG). Nationals of the old EU member states, Swiss nationals and core family dependants of Austrian and EEA nationals are exempted from this law. In 2005, a total of 4,397 non-nationals holding such a work permit were employed in the health sector, 83% of whom were female. According to AMS, 1,092 job vacancies[28] in the health sector were recorded by the end of April 2006. The number of employees working in the health, veterinary and social sector has been significantly increasing in recent years. HV and AMS assume that this growth will continue in the future due to demographic changes and the decline in care provided by family members. Most of the job vacancies are in the field of health care and nursing. In 2004, the total (cumulated) number of vacancies in this profession, which were reported to AMS, was 3,215 (data source: AMS and HV). [29]

General Data on Medical Doctors

In the following we want to present general figures on the total numbers of medical doctors working in Austria. But as already mentioned, we cannot present data broken down by citizenship or country of birth. In 2004, there were 38,422 medical doctors in Austria (2.9 doctors per 1000 inhabitants), thereof 11,716 general practitioners, 16,426 specialist practitioners, 4,106 dentists and 6,174 doctors in postgraduate hospital residencies (BMGF 2005a, 89-90). Among these, 6,221 general practitioners and 11,804 specialist practitioners (including dentists) provide outpatient medical care in private practice.

Data on personnel in Austrian hospitals

Looking at the data of employed hospital staff (excluding medical doctors) provided by BMGF for the years 1997-2004 (see Annex for detailed table)[30], statistics are broken down into the

[28] These are only the job vacancies that are reported to AMS.

[29] Data accessible at the Webpage of the Public Employment Service (AMS): http://iambweb.ams.or.at, accessed in April 2006.

[30] The statistics comprise the following professions: midwives, general qualified health carers and nurses, qualified paediatric nurses/child carers, qualified psychiatric health carers and nurses, cardiotechnical service, physiotherapeutical service, medical-technical laboratory service, radiological-technical services, dieticians, occupational therapy services, logopedic therapy services, orthoptists, medical-technical service, medical masseurs and therapeutic masseurs, emergency medical service,

general categories “nationals” and “non-nationals”. For non-nationals, a distinction into “EU citizens” and “third country nationals” is possible as of 2004. In general, in the year 2004 a total of 76,131 employees were working in Austrian hospitals in the covered professions, of whom 4,410 were foreign nationals (6%). Among these foreign nationals, 2,916 (66%) are EU citizens and another 1,494 employees (34%) are third country nationals. Definitely, more detailed information on countries of origin would be interesting in this regard, which is unfortunately not available.

Between 1997 and 2004, the number of employees in these health professions increased by about 7%. The number of employed foreign nationals does not show the same trend: their number declined by 22% from 1997 until 2002. Between 2002 and 2004, the number increased again by about 38%, the absolute number in 2004 being higher than in 1997 (the largest amount of this increase was recorded between 2003 and 2004 at 31%). The data for the group of qualified health carers and nurses shows a similar trend; but this is not astonishing insofar as the majority of non-nationals work in this profession, which comprises in general the largest number of employees of all health professions. The reasons for this increase as well as the decline during the years before, would require a more detailed analysis and particularly more information on countries of origin. In addition, data about the admission of non-nationals to health care professions (recognition of qualifications) would be very useful.

In comparing all of these professions, most of the employees work as general qualified health carers and nurses (2004: 41,523 persons; 55% of the total number of employees). This is followed by the assistant nursing service (9,868 persons) and qualified paediatric nurses/child carers (3,850). Summing up the nursing and care professions[31], a total of 58,083 persons (76% of the total employees) work in these professions. Looking at the total number of non-nationals, around 83% work in the nursing and care professions.

Considering the percentage of non-nationals in each of the professions, migrant employment seems to play a rather significant role in the following areas: midwives (7%), general qualified health carers and nurses (7%), qualified paediatric nurses/child carers (8%), physiotherapists (9%), occupational therapists (8%) and the assistant nursing service (5%). In all these professions, except for the assistant nursing service, the majority of non-nationals are EU

assistant nursing service, surgery assistant, laboratory assistant, mortuary assistant, balneotherapist assistant, doctor’s assistant, occupational therapy assistant and disinfection assistant.

[31] These are general qualified health carers and nurses, qualified paediatric nurses/child carers, qualified psychiatric health carers and nurses and the assistant nursing service.

citizens.[32] As for the assistant nursing service, 71% of the non-nationals are third country nationals. Unfortunately, no data is available on the countries of citizenship.[33]

Data on Midwives

Concerning midwives employed in Austrian hospitals, a total number of 1,139 persons was recorded in the year 2004. Thereof, 77 midwives were foreign nationals (7 %). The vast majority (74%) of these non-nationals were EU citizens (data source: BMGF).

Based on the data provided by the Association of Midwives (Hebammengremium), which maintains a register of midwives (recording all employed and self-employed midwives), of a total of 1,661 midwives 258 were born abroad (16%)[34]. Of these 258 midwives, 48% hold the Austrian citizenship. The percentage of non-nationals of the total number of midwives is around 8%. According to the Association of Midwives, statistics also show waves in the inflows of midwives, for example due to simplified admission procedures for EU nationals. This resulted in a rising number of midwives coming from Germany and – after the EU enlargement – from the new EU member states, particularly from the Republic of Slovakia and Poland (information provided by the Association of Midwives).

[32] Percentages of EU nationals among the non-nationals in the professions that are most relevant here: midwives (74%), general qualified health carers and nurses (69%), qualified paediatric nurses/child carers (92%), physiotherapeuts (88%), occupational therapists (97%) and logopedics (75%).

[33] Based on information about recognition of diplomas provided in a seminar on recognitions of qualifications organised by the Counselling Centre for Migrants and additional information provided by the Association of Midwives (Hebammengremium), the main countries of origin in the EU are Germany, the Slovak Republic (especially for nurses) and Poland. Among the third countries, states such as India, the Philippines as well as the successor states of the Former Yugoslavia were mentioned.

[34] In total, 1,715 are in the register, but for 53 persons data on the place of birth is missing. Certainly, place of birth abroad does not mean in every case that immigration has taken place, but this criterion is more useful than the variable citizenship.

5. EDUCATION AND TRAINING

This chapter will deal with education and training for the existing health professions. In principal, preconditions and criteria for admission to health professions is regulated by a number of specific laws[35]. Before focusing on the health professions considered to be the most important for migrant employment, we will outline general information on the admission to health professions as well as provisions for the recognition of qualifications acquired in a foreign country. According to the qualification required, the following types of professions can be distinguished:

- Professions for which university studies are a prerequisite: medical doctors, dentists and pharmacists.
- Professions which require trainings at academies or colleges (pre-condition to be admitted to these trainings is the school-leaving certificate "Matura", which entitles to study at an Austrian university): higher medical-technical services[36], midwives and psychotherapists.
- Qualified health carers and nurses
- Professions with apprenticeship training or other training after compulsory school: medical-technical services[37], auxiliary health professions[38], dental assistants, pharmaceutical assistants[39] and assistant nursing service.

Despite the respective qualifications, persons working in health care professions have to fulfil other criteria as stated by the respective professional laws: medical fitness, mental ability, confidentiality (to be proved by a statement of criminal records) and knowledge of German[40]. As the admission to a health profession is connected to a specific qualification, university degrees and diplomas awarded in a foreign country need to be validated. Validation (Nostrifizierung) means the conversion of a foreign university degree or any other professional diploma into a corresponding Austrian degree by the organ in charge. Certainly, validation is only possible, if it is a prerequisite for admission to a certain profession, which is

[35] These are the Medical Doctors' Act (Ärztegesetz), Health Care and Nursing Act (Gesundheits- und Krankenpflegegesetz), Midwives' Act (Hebammengesetz), Pharmacies Act (Apothekengesetz), Dentists' Act (Zahnärztegesetz) and Higher Medical-Technical Services Act (Medizinisch-Technischer Dienst Gesetz) as well as a number of orders based on these laws.

[36] The higher medical-technical services comprise the physiotherapist service, medical-technical laboratory service, radiological-technical service, logopedical therapy service, orthoptists, occupational therapy service and dieticians.

[37] To be distinguished from the higher medical-technical services.

[38] These are surgery assistant, laboratory assistant, mortuary assistant, doctor's assistant, occupational therapy assistant, disinfection assistant, cardiotechnical service, medical masseurs and therapeutic masseurs and emergency medical service.

[39] Dental and pharmaceutical assistants are not health professions in a strict sense.

[40] The obligation to test the language abilities lies with the employer.

the case for most of the health professions. In all other cases the acceptance of degrees and diplomas lies with the employer.

The administrative fees for validation amount to at least € 150, excluding additional costs (e.g. for translations and notarisations of diplomas, language courses, study fees for additional training)[41]. Generally, the applicant has to bear all the costs.

After completion of the validation procedure, the foreign diploma is validated (by an official notification) and the person is granted the same rights that an Austrian degree entitles to. During the validation procedure, content and scope of the lectures completed are evaluated: these have to be equivalent to the respective Austrian degree or diploma. In order to fulfil these criteria, the person may (and effectively will) be obliged to attend additional courses and pass exams.[42] No general statement can be made on how long the procedure will take for the different health professions, as it mainly depends on how long it will take the applicant to pass the courses (besides waiting time for the admission to courses, administrative procedures, etc.).

As there are special directives regulating the access to academic and other professions and the recognition of diplomas[43] within the EU and the EEA (including Switzerland), validation is no longer necessary or possible. However, it goes far beyond the range and scope of this study to deal with the different provisions in all details. In general, the recognition of diplomas acquired by EEA nationals in EEA countries (Swiss nationals and Swiss diplomas included) follows a shortened recognition procedure, which is simplified compared to the general procedure of validation. The responsible authority for the admission of EEA nationals is the Federal Ministry of Health and Women. A problem in this regard is the recognition of the diplomas of citizens of the new EU member states, as the Directives only apply for diplomas that were issued after accession to the EU. In addition, not all Directives are yet transposed into national law, which makes it difficult for Austrian authorities to examine whether diplomas correspond to the minimum EU standards.

Besides these special provisions for EEA nationals, exceptional procedures exist for certain university study degrees obtained in certain countries[44] according to bilateral and multilateral

[41] For the application for validation, applicants have to submit a variety of documents such as personal documents (passport, registration certificate, etc.), diplomas certifying the professional education and a detailed curriculum of the professional education (content and length of courses, etc.). Eventually other documents such as a proof of professional experience or a proof that the education is officially recognised in the country of origin might be required. All documents need to be translated into German and notarised.

[42] In case the validation is not approved, the applicant has the possibility to study in Austria and apply for the recognition of single courses completed abroad.

[43] For Community legislation on health care professions see: http://europa.eu.int/comm/internal_market/qualifications/specific-sectors_en.htm#nurses-legislation; accessed in April 2006.

[44] A detailed list containing the countries concerned is available at: http://www.bmbwk.gv.at/medienpool/5946/14015_tafelaner.pdf; accessed in April 2006.

agreements, such as Bosnia and Herzegovina, Croatia, Italy, Liechtenstein, Macedonia, Serbia and Montenegro, Slovenia and Pontifical universities, which simplify the validation process[45].

Concerning both the recognition and validation of diplomas, the responsible authority varies with the type of profession (university, BMGF or the administration of the provincial government). There are no official Austrian-wide statistics on how many applicants successfully accomplish the validation or the recognition procedure. To give examples on main countries of origin of applicants for validation in Vienna, the Former Yugoslavia, India and the Philippines can be mentioned.[46] In 2005, the BMGF completed about 2,300 procedures for the professional admission of EEA nationals in the health care sector. Of the persons admitted, more than 60% originated from Germany, about 15% from Slovakia and 6% from Poland. The percentage of women is about 80%.[47]

Foreign nationals are also subject to more general laws, which regulate immigration, residence and the access to the labour market. In addition to the validation of their degrees and diplomas, third country nationals require a work permit according to the Aliens' Employment Act (Ausländerbeschäftigungsgesetz, AuslBG). Citizens of the new EU member states (with the exception of Malta and Cyprus) are also subject to the provisions of this law.[48] Third country nationals with beneficiary treatment (core family of Austrians, EEA and Swiss citizens) have free access to the labour market. Of course, recognised refugees are exempted from the scope of the AuslBG.

Medical doctors

The Medical Doctors' Act[49] (Ärztegesetz, ÄrzteG) stipulates the criteria for admission and requirements for exercising the occupation. A prerequisite to working as medical doctor in Austria is a doctoral degree in general medicine awarded at an Austrian university or an equivalent degree obtained in a foreign country, which needs to be validated. In addition to the university degree, a diploma of the Austrian Medical Chamber (Österreichische Ärztekammer, ÖAK) on practical training according to the requirements for general practitioners or specialist practitioners is necessary.

[45] Information on recognition of university degrees is also provided by the National Academic Recognition Information Centre (NARIC) within the Federal Ministry for Education, Science and Culture (Bundesministerium für Bildung, Wissenschaft und Kultur, BMBWK): http://www.bmbwk.gv.at/naric; accessed in April 2006.

[46] According to a presentation by the an official of the Viennese municipal department MA 15 (which is responsible for validations) during a seminar held in Vienna on 29 March 2006 on the recognition and validation of diplomas for health care professionals, organised by the Counselling Centre for Migrants (Beratungszentrum für Migranten und Migrantinnen).

[47] These figures were presented by officials of the BMGF during the above mentioned seminar.

[48] For more information on general immigration legislation, see the Policy Reports of the Austrian NCP to the EMN (NCP 2004 and 2005, available for download at http://www.emn.at).

[49] Medical Doctors' Act (Ärztegesetz, ÄrzteG) 1998, BGBl I 169/1998, amended version BGBl I 156/2005.

In general, the admission to the profession is restricted to Austrian, EEA and Swiss citizenship. Exempted from this condition are recognised refugees according to the Asylum Law (Asylgesetz, AsylG). Exemptions also apply to third country nationals, who are dependants of Austrian and EEA nationals (core family), and to citizens of a contracting state to a convention with the European Communities and their member states, which obliges the member states to treat these citizens as equal to their own citizens according to settlement law and trade in services. Third country nationals who do not fall under these mentioned exemptions, can – under certain circumstances – be admitted to work as medical doctor by the Medical Chamber, but with a limited duration of three years at most (§ 32 ÄrzteG). Certainly this is only possible if there is no other medical doctor available to fill the job, who already fulfils the criteria for admission.

The recognition of qualifications of EEA and Swiss nationals is regulated according to the provisions of Directive 93/16 EEC[50]. Concerning third country nationals, the responsible authorities for validation of a university degree in medicine are the medical universities in Vienna, Graz and Innsbruck. According to the Medical Chamber, language ability is proved to be sufficient if the person has five years of professional experience as medical doctor in the German-speaking region, has studied in German or acquired the Matura (school-leaving exam in Austria) in German.[51] If the applicant does not fulfil any of these requirements, he is obliged to pass a language exam.

Dentists

In 2005, a new Dentists' Act[52] (Zahnärztegesetz, ZÄG) was adopted, which stipulates the criteria of admission for exercising the professions. Before, dentists fell under the legal provisions for medical doctors. In terms of qualification prerequisites, the medical doctor in dentistry[53] must acquire his/her credentials in Austria or have completed an equivalent diploma in a foreign country. Contrary to medical doctors, citizenship is not a precondition for exercising the occupation.

The recognition of diplomas acquired by other EEA (including Swiss) nationals in the EEA (including Switzerland) is based on the Council Directives 78/686/EEC[54] and 81/1057/EEC[55].

[50] Council Directive 93/16/EEC of 5 April 1993 to facilitate the free movement of doctors and the mutual recognition of their diplomas, certificates and other evidence of formal qualifications.

[51] See information of the Austrian Medical Chamber: http://www.aerztekammer.at/pdf/homepage32_Jan2006.pdf accessed in March 2006.

[52] Dentists' Act (Zahnärztegesetz, ZÄG) 2005, BGBl I 126/2005, amended version BGBl I 39/2006

[53] University studies in dentistry were only established as from 2003. Before, persons had to acquire a degree in general medicine, which was followed by a three-year training.

[54] Directive 78/686/EEC concerning the mutual recognition of diplomas, certificates and other evidence of the formal qualifications of practitioners of dentistry, including measures to facilitate the effective exercise of the right of establishment and freedom to provide services.

Diplomas acquired by EEA (and Swiss) citizens in third countries are recognised, if they are accepted in another EEA state and after the examination by the Chamber of Dentists, whether these diplomas correspond to the requirements applied in the EEA (and Switzerland). Diplomas of third country nationals have to be validated by an Austrian university offering dentistry studies.

Pharmacists

In order to work as a pharmacist, after completing university studies in pharmacy (minimal duration five years), a year of professional training (aspirant's year) must be completed, which terminates with an additional exam. To run a pharmacy as a self-employed pharmacist[56], five years of professional experience as employed pharmacist are obligatory.

According to the Pharmacies' Act[57] (Apothekengesetz), only Austrian, EEA and Swiss nationals are entitled to run a pharmacy as self-employed pharmacists. Yet, EEA and Swiss nationals are only allowed to take over an already existing pharmacy and not to open up a new one (this is only allowed for Austrians).

If third country nationals desire to work as employed pharmacists in Austria, their university degree acquired abroad needs to be validated by a responsible university. The recognition of the professional education of citizens of other EEA states (including Switzerland) is based on Council Directive 85/433/EEC[58] and its amending directives, which list the types of diplomas to be recognised.

Health care and nursing professions

In Austria, health care and nursing professions are distinguished into the professional health care and nursing service on the one hand and the assistant nursing service on the other hand. The professional health care and nursing service is divided into three types of professions: qualified health carers and nurses, qualified paediatric nurses/child carers and qualified psychiatric health carers and nurses. Training in general health care and nursing is provided at nursing schools with a duration of three years and is completed with a diploma examination. Besides the general preconditions of reliability, physical fitness and mental

[55] Directive 81/1057/EEC supplementing Directives 75/362/EEC, 77/452/EEC, 78/686/EEC and 78/1026/EEC concerning the mutual recognition of diplomas, certificates and other evidence of the formal qualifications of doctors, nurses responsible for general care, dental practitioners and veterinary surgeons respectively, with regard to acquired rights.

[56] The representation of interest of self-employed pharmacists is the Pharmacists' Association (Apotherkverband) (see http://www.apoverband.at). The membership is not compulsory.

[57] Pharmacies' Act (Apothekengesetz) 1907, RGBl 5/1907, amended version BGBl I 41/2006.

[58] Council Directive 85/433/EEC concerning the mutual recognition of diplomas, certificates and other evidence of formal qualifications in pharmacy, including measures to facilitate the effective exercise of the right of establishment relating to certain activities in the field of pharmacy.

ability as stipulated in the Health Care and Nursing Act[59] (Gesundheits- und Krankenpflegegesetz, GuKG), applicants with a minimum age of 17 years must have completed the tenth grade and pass an acceptance test.[60]

The professional training for the assistant nursing service takes one year and is completed with an examination, for which a certificate is awarded. It is organised as a nursing course at a hospital or a facility run by a district authority that provides home nursing services (the trainee might be employed). Precondition is the successful completion of compulsory school (nine years of school attendance) and the age of 17 years.

As a consequence of Community legislation, the recognition of diplomas acquired by EEA nationals in the EEA (including Switzerland) follows special provisions, which are specified in detail in the Health Care and Nursing Act. Diplomas for the general health care and nursing service[61] acquired by EEA nationals in an EEA country as from 1 January 1994 are accepted as proof of qualification, if they are listed in the Annex of Directive 77/452/EEC[62]. If the diploma was awarded before 1 January 1994, it has to comply with the minimum standards set out in the Directive 77/453/EEC[63]. The applicant might have to prove with a certificate issued by the country of origin that the diploma is in line with Directive 77/453/EEC. If the diploma does not meet these minimum criteria, but has been issued before the Directive was applied, the applicant has to prove at least three years of professional experience within the last five years.

EEA nationals have to file their application at the Federal Ministry of Health and Women (BMGF). Applicants from EEA countries, who fulfil the mentioned criteria, will be admitted to the professional health care and nursing service by the minister of health within a period of three months after submitting the required documents. Since February 2006, the BMGF has introduced a one-stop procedure for health care professionals who have obtained their diplomas in certain countries, which allows admission even within one day (if the applicant

[59] Health Care and Nursing Act (Gesundheits- und Krankenpflegegesetz, GuKG) 1997, BGBl. I 108/1997, amended version BGBl I 69/2005

[60] For persons, who have completed the training for assistant professions such as the assistant nursing services, the duration of training for the professional health care and nursing services is shorter. Vice versa, for persons, who broke off the training for the professional health care and nursing services, completed courses and practical training will be counted towards the assistant nursing service training. For more information see http://www.oegkv.at.

[61] Diploma for qualified paediatric care and qualified psychiatric health care do not fall under the provisions of the Directives 77/452/EEC and 77/453/EEC, which only apply to the general health care and nursing service. For these professions, the more general Directives 89/48/EEC and 92/51/EEC are applied, which will not be elaborated here in detail.

[62] Council Directive 77/452/EEC of 27 June 1977 concerning the mutual recognition of diplomas, certificates and other evidence of the formal qualifications of nurses responsible for general care, including measures to facilitate the effective exercise of this right of establishment and freedom to provide services.

[63] Council Directive 77/453/EEC of 27 June 1977 concerning the coordination of provisions laid down by Law, Regulation or Administrative Action in respect of the activities of nurses responsible for general care.

fulfils the requirements).[64] As the EU-10 countries only acceded to the EU in 2004, the recognition procedure is more complicated as the Directives 77/452/EEC and 77/453/EEC only apply to diplomas awarded from 2004 onwards. Consequently, in most cases applicants have to provide proof issued by the country of origin stating that the diploma is in line with the mentioned Directives. In addition, they have to prove length and content of professional experience in the country of origin.

In general, third country nationals have to go through the procedure of validation, even if they acquired a diploma in an EEA country.[65] The same applies to EEA nationals who completed their education in a third country. The authority responsible for applications for validation is the provincial government department of the applicant's residence and/or desired workplace. The main requirement for validation is the equivalence of content and scope of lectures; professional experience can be accredited. If content and scope are not considered equivalent (which usually is the case), additional board exams and/or practical training are required. To pass these exams, nursing schools offer special validation courses, but applicants might face waiting periods before they can start with a course. The duration of a validation course including practical training is about nine months. For admission to nursing school, knowledge of the German language is a prerequisite. The costs for these courses vary depending on the nursing school and the number of exams and courses the applicant has to complete. To give an example, the total costs for the complete validation course at the "Pflegeakademie Barmherzige Brüder"[66] in Vienna amount to € 1,600, which the applicants must pay themselves.

After the application for validation has been filed, the applicant is allowed to work in the assistant nursing service (limited to a duration of two years on the basis of a validation notice, which is issued six to eight weeks after the application was filed). Instead of the validation for the general health care and nursing services, the validation procedure for the assistant nursing service, which may be easier to complete, can be opted for.[67]

[64] See information leaflet published by BMGF, accessible at: http://www.oegkv.at/uploads/media/Information__ber_verk_rzte_Berufszulassungsverfahren__one-stop_.pdf; accessed in April 2006.

[65] Certainly, the procedure of validation is easier in practice, if a third country national has acquired a diploma, which is recognised according to Community law.

[66] See http://www.barmherzige-brueder.at.

[67] According to informal information provided by the Department for Health issues of the province of Vienna (MA 15), a large number of applicants do not successfully accomplish the procedure. Before validating the education for general health care, some persons first run through the procedure for the assistant health care service.

Midwives

In Austria, midwives work either on a self-employed basis or are employed by a hospital or a doctor. Training is provided at midwifery academies with a duration of three years or as a college baccalaureate degree. Prerequisite for attending the midwifery academy is the "Matura" (the school-leaving exam which is a prerequisite for studies at an Austrian university) or an equivalent foreign education.

Basis for the acknowledgement of diplomas for midwifery acquired in EEA countries (including Switzerland) are the Directives 80/154/EEC[68] and 80/155/EEC[69]. The annex of an order of the year 2002 transposing these directives into Austria law, lists all diplomas of EEA countries and Switzerland which correspond to Austrian standards.[70]

The Midwives' Act (Hebammengesetz) stipulates the validation of diplomas for midwives who acquired their education outside the EEA. The competent authority for validation is the Federal Ministry for Health and Women.

Higher medical-technical services

The higher medical-technical services[71] comprise the following professions (which cannot be elaborated on in detail here): physiotherapist, biomedical scientists, radiology technologists, dieticians, occupational therapists, logopedics and orthoptists. Conditions for the admission to these professions, training and qualification, etc. is regulated by the Higher Medical-Technical Services' Act[72] (Bundesgesetz über die Regelung der gehobenen medizinisch-technischen Dienste, MTD-Gesetz). Requirement for the admission to the training for higher medical-technical professions is the "Matura" (school leaving examination, which entitles to university studies). The training takes place at medical-technical academies, or as part of medical-technical college baccalaureate courses with a duration of three years. The training is completed with a board examination and awarded with a diploma. Physiotherapists, logopedics, dieticians and occupational therapists may also work self-employed.

The competence for recognition of qualifications in the higher medical-technical professions lies (both for EEA and for third country nationals) with the Ministry of Health and Women

[68] Directive 80/154/EEC of 21 January 1980 concerning the mutual recognition of diplomas, certificates and other evidence of formal qualifications in midwifery and including measures to facilitate the effective exercise of the right of establishment and freedom to provide services.

[69] Directive 80/155/EEC of 21 January 1980 concerning the coordination of provisions laid down by Law, Regulation or Administrative Action relating to the taking up and pursuit of the activities of midwives.

[70] See Midwives-EEA-Order (Hebammen-EWR-Verordnung) 2002 (BGBl. II Nr. 382/2002).

[71] For more information see the webpage of the Umbrella Association of the Higher Medical-Technical Services (MTD-Dachverband): http://www.mtd-dachverband.at/

[72] Higher Medical-Technical Services' Act (Bundesgesetz über die Regelung der gehobenen medizinisch-technischen Dienste, MTD-Gesetz) 1992, BGBl 460/1992, amended version BGBl 327/1996.

(BMGF). The recognition of diplomas of EEA citizens obtained in EEA countries is based on the Directives 89/48/EEC[73] and 92/51/EEC[74].

Psychologists, psychotherapists and psychiatrists

Looking at the psychological and psycho-social care, three types of professions have to be distinguished: psychologists, psychotherapists and psychiatrists. Despite occasional overlapping in their work, significant differences exist between the professions regarding their educational background in particular. Psychiatrists are medical doctors qualified in psychiatry, and therefore fall under the legal provisions stipulated for medical doctors.

The Psychologists' Act[75] (Psychologengesetz) establishes the state certified professions of "clinical psychologist" and "health psychologist". Since it came into effect, psychologists in clinical practice or the health service must have successfully completed a course of postgraduate training after their university studies of psychology. Concerning the validation of the university studies, the responsibility lies with a university offering studies of psychology. The recognition of degrees acquired in EEA countries is based on Community law and follows a simplified procedure. Concerning the recognition of postgraduate training, the Psychologists' Act contains no special provisions: it only generally states that the qualification required abroad might be accepted in case of equivalence to the Austrian training.

The profession of psychotherapist[76] is regulated by the Psychotherapy Act[77] (Psychotherapiegesetz). Access to training[78] as psychotherapists is open to individually qualified persons, who have either completed the final secondary school-leaving certificate "Matura" or its equivalent. Access is also open to qualified members of certain professions such as health care workers, teachers, social workers, psychologists, members of the medical profession, etc. Many psychologists are also psychotherapists, meaning that they have completed both training courses. There are no special provisions for the recognition of diplomas acquired for psychotherapeutic training in a foreign country. However, it is in

[73] Council Directive 89/48/EEC of 21 December 1988 on a general system for the recognition of higher-education diplomas awarded on completion of professional education and training of at least three years' duration.

[74] Council Directive 92/51/EEC of 18 June 1992 on a second general system for the recognition of professional education and training to supplement Directive 89/48/EEC.

[75] Psychologists' Act (Psychologengesetz) 1990, BGBl 360/1990, amended version BGBl I 98/2001.

[76] Psychotherapists assist individuals in finding solutions to their problems or help solve mental conflicts. They either provide individual counselling or try to elaborate conflict solutions within groups, support organisational development or provide social counselling.

[77] Psychotherapy Act (Psychotherapiegesetz) 1990, BGBl. 361/1990, amended version BGBl I 98/2001.

[78] The fees for psychotherapist training are high: the theoretical part amounts to € 4,000-€ 8,000 (excluding additional costs for supervision), the specific parts amount to € 25,000- € 50,000 (http://www.psychotherapie.at/oebvp/ausbildung/).

general possible that other courses and trainings (e.g. practical training) acquired in Austria or abroad are acknowledged within the framework of the psychotherapeutic training.

Other assistant professions

Further health professions are the medical-technical service (to be distinguished from the "higher medical technical service") and auxiliary health professions[79]. The latter professions include cardiotechnical service, medical masseurs and therapeutic masseurs, and emergency medical service. Provisions for validation and recognition of diplomas are stipulated in the respective laws. The responsible authority for the validation of diplomas of third country nationals is the respective provincial government department. The BMGF is responsible for recognition of diplomas held by EEA nationals.

Dental and pharmaceutical assistants are not considered to be health professions in a strict sense. The training is organised as or similar to an apprenticeship training (completed with a final exam), for which the precondition is nine years of compulsory school. In general, the responsible authority for recognition of apprenticeship and related professional trainings is the Federal Ministry of Economy and Labour (Bundesministerium für Wirtschaft und Arbeit, BMWA), which examines whether the apprenticeship training completed in a foreign country is equaivalent to an Austrian diploma. If the training is not considered to be equivalent, but at least similar to the Austrian training, the person is admitted to the final examination (Ecoplus 2004, 216-221). The recognition of trainings completed by EEA nationals in an EEA country is based on certain directives, which simplify the procedure of recognition.

[79] Both are regulated by the Medical-technical Services and Auxiliary Health Professions Act (Bundesgesetz über die Regelung des medizinisch-technischen Fachdienstes und der Sanitätshilfsdienste, MTF-SHD Gesetz).

6. OTHER RELEVANT ASPECTS

In this last chapter, we will provide a general overview of the aspects research on migration and health has been focusing on in recent years. In addition, we will elaborate on a number of projects, studies and initiatives regarding cultural diversity and intercultural competence in the health and care sector. The employment of migrants in the health care sector is not only important in view of labour shortages, but also in view of increasing the cultural competence of the health system, which becomes more and more necessary in a culturally diverse society.

As already stated, migration policy focusing on the health sector has not yet been a central topic on the political agenda. Looking at the research conducted, migration and health was mainly examined with regards to aspects such as the health situation of migrants and the access to and usage of health care services.

Concerning the research on the health condition of migrants, researchers especially criticised the lack of data and its quality in regard to the group of migrants (see Amesberger/Halbmayr/Liegl 2003). Others point out that apart from information deficits about the Austrian health system (e.g. on the services offered), immigrants also tend to have less information on certain diseases and health prevention in general (see Wimmer-Puchinger/Baldaszti 2001). Concerning the access to health care services, a study conducted by the Ministry of Health and Women in 2003 about persons who have no health insurance, shows that non–nationals and persons with a lower educational level in general may be affected to a higher extent (BMGF 2003). When it concerns the access to health care services, medical treatment as well as information through campaigns, language barriers may constitute a severe problem.

A research project initiated by the NGO Asylkoordination Österreich focused on the intercultural care of the elderly (Kremla 2004). Impetus behind this research is the fact that elderly migrants are not aware or only barely informed about care services for the elderly provided in Austria, as former studies have shown. The study tried to assess on the one hand the demands of elderly migrants vis-à-vis the care system, and on the other hand what kinds of changes of the already existing services the relevant organisations would be ready to implement. One of the results was that care organisations are not confronted with a high demand by migrants (as it is still a small group, but one which will be continuously growing in the future) and do not yet see a need to adapt their services to this group. On the contrary, migrants experience barriers which inhibit the access to these services. Consequently, care organisations do not notice that this group has specific demands.

The “Equal” project “Diversity@care - Immigrants in mobile care and nursing”[80], which is a joint project of the organisations Volkshilfe Österreich and Volkshilfe Wien, Caritas, Vienna Red Cross and Wiener Hilfswerk, deals with cultural diversity in the care and nursing sector. The main objective is the designing of intercultural care and nursing services. The idea behind is that there will not only be a general increase in demand for care services in the future, but also the first generation of immigrants is reaching an age, which makes care facilities and services more and more essential for this particular group. In addition, the project aims at enhancing equal opportunities in the care professions by reducing discrimination and improving the working and training conditions of immigrants who wish to work in the field of mobile care and nursing (especially promoting the engagement of second and third generation migrants to work in the care sector).

In December 2004, the Ministry of Health and Women (BMGF) launched a project group on intercultural competence in the health system. The project group was subdivided into three working groups consisting of external experts analysing deficits migrants are confronted with in the fields of outpatient care, inpatient care and psycho-social care. In addition to the analyses of the status quo, the working groups came up with concrete solutions to be implemented. The project report (BMGF 2005c) summarises the main findings and suggestions of the working groups. To increase cultural competence in the health system, experts recommend that the topic of intercultural competence should be emphasized more in education and training (including advanced professional training) for health care professions. In addition, it would be useful to recruit persons with migration backgrounds for health care professions (particularly immigrant youth, who are long-term residents or were born in Austria). A higher number of interpreters and intercultural mediators as well as the production of information material in multiple languages could help prevent language barriers and as a consequence wrong medical treatment. Another important recommendation is to explicitly inform migrants about health prevention measures and health care services. In case of illness, migrants mostly turn to hospitals and their outpatient clinics instead of medical doctors and specialists in private practice (which turns out to be more costly for the system in general).

Regarding the promotion of cultural diversity in the health sector, the “Migrant-Friendly Hospitals in an Ethno-culturally Diverse Europe”, financed by the European Commission and managed by the Ludwig Boltzmann Institute for the Sociology of Health and Medicine (LBISHM), is of interest.[81] The underlying principle behind the project is that increasing diversity in European societies is an important issue for health systems and health care

[80] For more information see http://www.diversitycare.at.

[81] See the project webpage: http://www.mfh-eu.net.

services. In total, 12 pilot hospitals participated in the project and implemented solutions in the areas of improving interpreting services, migrant-friendly information and training for mother and child care as well as staff training towards cultural competence (LBISHM 2005).

To provide counselling and first information on health care services to migrants, the NGO ZEBRA (Zentrum zur sozialmedizinischen, rechtlichen und kulturellen Betreuung von Ausländern und Ausländerinnen in Österreich) launched a project in 1997 to train migrants as “health mediators”, who work on a voluntary basis, aiming at securing the access of migrants to health care services (ZEBRA, o.J.). The principal task is to mediate between migrants and the health care system. The organisation assumes that the inhibitions to contact these “peers” are lower than to turn to a medical doctor. The mediators serve as first contact persons if a problem arises and will be able to provide advice on who to consult. These health mediators can be further trained as “health consultants” who work for associations and organisations that provide counselling.

CONCLUSIONS

In general, Austria is confronted with an increasing demand for health care personnel. To-date, an approach to migration management that focuses on the health sector has not been put on the political agenda yet. There is no legal framework regulating or promoting the immigration of persons wanting to work in health professions in Austria, nor have recruiting mechanisms been developed or bilateral treaties been concluded. Concerning the recruitment of health care professionals abroad, single measures have been undertaken by individual actors in the past, but not within a broader policy framework. The same is to state when it comes to attempts facilitating the access of migrants to health care professions, which was limited to EU nationals.

Looking at the status quo, the health sector is certainly characterised by immigration that has taken place in the past. Although the quality of the data at hand has its weaknesses, it shows evidence of labour migration in the health care and nursing sector. Interestingly, a large number of persons working in health care professions originate from EU countries.

Concerning the recognition of qualifications, EU nationals definitely have advantages over third country nationals. The latter group is also confronted with administrative barriers as well as waiting periods for admission to validation courses. Due to the lack of a central data source, it is difficult to assess how many applicants completed the validation procedure successfully. There are also cases of nurses trained in a foreign country then working in Austria in the assistant nursing service instead of the qualified nursing service.

Apart from implementing recruitment procedures and facilitating the immigration of health care professionals to meet the increasing demand for health care personnel, it is necessary to promote the access of already resident migrants (especially youth with migration background) to health care professions. As it has been stressed by NGOs and scientists, this is a central issue when it comes to fostering intercultural competence of health care services.

BIBLIOGRAPHY

Amesberger, Helga; Halbmayr, Brigitte; Liegl, Barbara: Gesundheit und medizinische Versorgung von ImmigrantInnen, in: Fassmann, Heinz; Stacher, Irene (eds.): Österreichischer Migrations- und Integrationsbericht. Demographische Entwicklungen – Sozioökonomische Strukturen – Rechtliche Rahmenbedingungen, Vienna 2003, 171-194.

Bundesministerium für Gesundheit und Frauen (BMGF) (2003): Quantiative und qualitative Erfassung und Analyse der nicht-krankenversicherten Personen in Österreich. Vienna.

Bundesministerium für Gesundheit und Frauen (BMGF) (2005a): Public Health in Austria. Vienna, http://www.bmgf.gv.at/cms/site/attachments/8/6/6/CH0083/CMS1051011595227/public_health_in_austria_2005_internet.pdf, accessed in April 2006.

Bundesministerium für Gesundheit und Frauen (BMGF) (2005b): Krankenanstalten in Österreich/Hospitals in Austria, Vienna, http://www.bmgf.gv.at/cms/site/attachments/6/9/9/CH0034/CMS1039007503101/ka-in-oesterreich-2004-2005-internet.pdf, accessed in April 2006.

Bundesministerium für Gesundheit und Frauen (BMGF) (2005c): Interkulturelle Kompetenz im Gesundheitswesen. Project Report, Vienna, http://www.bmgf.gv.at/cms/site/attachments/6/5/0/CH0083/CMS1126253889077/migratinnenplan.pdf, accessed in April 2006.

Bundesministerium für Soziale Sicherheit, Generationen und Konsumentenschutz (BMSG) (s.a.): Ausbau der Dienste und Einrichtungen für pflegebedürftige Menschen in Österreich: Zwischenbilanz, Vienna , https://broschuerenservice.bmsg.gv.at/PubAttachments/Ausbau%20der%20Dienste.pdf, accessed in April 2006.

Carrington, Kimberley; Cepek-Neuhauser, Elisabeth; Küng, Gabriela (2005): Möglichkeiten der Ausbildung und Berufstätigkeit für Migrantinnen im Gesundheits- und Pflegebereich Österreichs: Herausforderungen und Empfehlungen, Linz, http://www.maiz.at/cms/upload/equal/leonardo/VorqualifizierungfurMigrantinnenKopie.pdf, accessed in April 2006.

Ecoplus (eds.) (2004): Arbeitsmarktanalyse. Grenzgebiet Tschechien – Slowakei – Österreich. Krems, http://www.noe.co.at/magazin/00/artikel/20710/doc/d/Arbeitsmarktanalyse_de.pdf, accessed in April 2006.

Hartmann, Robert; Belkameh, Marzena; Linninger, Irene (s.a.):, Modul 5: Erweiterungsprozess der EU und die Arbeitsmarktpolitischen Konsequenzen für den Gesundheits- und Sozialbereich, EQUAL Entwicklungspartnerschaft „Berufsbilder und Ausbildung in den Gesundheits- und Sozialen Diensten“, http://www.berufsbilder.org/content/pdf/modul5neu.pdf, accessed in April 2006.

Hintermann, Christiane (2001): Die Diversifizierung der Zuwanderung nach Österreich – Entwicklung seit Mitte der 80er Jahre, in: GW-Unterricht 82/2002, 68-75, http://www.lehrerweb.at/ms/praxis/gw_unterricht/diversifizierung.pdf, accessed in April 2006.

Kremla, Marion (2004): Interkulturelle Altenpflege in Wien: Angebot und Veränderungsbedarf aus der Sicht von ZuwanderInnen und Trägereinrichtungen, Vienna, http://www.asyl.at/projekte/endbericht_interkulturelle_oeffnung.pdf, accessed in April 2006.

König, Karin; Stadler, Bettina (2003): Entwicklungstendenzen im öffentlich-rechtlichen und demokratiepolitischen Bereich, in: Fassmann, Heinz; Stacher, Irene (eds.), Österreichischer Migrations- und Integrationsbericht. Demographische Entwicklungen – Sozioökonomische Strukturen – Rechtliche Rahmenbedingungen, Klagenfurt/Celovec, 226-260.

Ludwig Boltzmann Institute for the Sociology of Health and Medicine (LBISHM) (2005): Migrant-Friendly Hospitals in an ethno-culturally diverse Europe. Experiences from a European Pilot Hospital Project. Final report, Vienna.

ZEBRA - Zentrum zur sozialmedizinischen, rechtlichen und kulturellen Betreuung von Ausländern und Ausländerinnen in Österreich (eds.) (2003): Ein Praxishandbuch zur Interkulturellen Öffnung im Gesundheitswesen für MultiplikatorInnen und GesundheitsberaterInnen. Graz, http://www.zebra.or.at/projekte/hb_gesundheit/Start.htm, accessed in April 2006.

König, Karin; Perchinig, Bernhard (2005): Austria, in: Niessen, Jan; Schibel, Yongmi; Thompson, Cressida (eds.), Current Immigration Debates in Europe: A Publication of the European Migration Dialogue, http://homepage.univie.ac.at/dilek.cinar/Perchinig_K%F6nig_Austria_2005.pdf, accessed in April 2006.

Krajic, Karl; Vyslouzil, Monika; Nowak, Peter (2003): Pflegenotstand in Österreich? Diagnosen und Lösungsmöglichkeiten mit einem Schwerpunkt auf Entwicklung der Arbeitsbedingungen des diplomierten Pflegepersonals, http://www.univie.ac.at/lbimgs/berichte/pnoe_gutachten.pdf, accessed in April 2006.

Krajic, Karl; Nowak, Peter; Rappold, Elisabeth (2005): Pflegenotstand in der mobilen Pflege? Diagnosen und Lösungsmöglichkeiten, Vienna, http://www.univie.ac.at/lbimgs/berichte/pflegenotstand_eb05.pdf, accessed in April 2006.

Museum Arbeitswelt Steyr; Volkshilfe (2004): Grenzenlose Pflege, Dokumentation der Fachtagung, 2. Dezember 2004.

Waldrauch, Harald; Sohler, Karin (2004): Migrantenorganisationen in der Großstadt. Vienna.

Wimmer-Puchinger, Beate, Baldaszti, Erika (2001): Migrantinnen im Gesundheitssystem: Inanspruchnahme, Zugangsbarrieren und Strategien zur Gesundheitsförderung, in: Wiener Klinische Wochenschrift, 113/13-14, 2001, pp. 516-526.

Legislation:

EU Expansion Adjustment Law (EU-Erweiterungs-Anpassungsgesetz) 2004, BGBl 28/2004

Aliens' Employment Act (Ausländerbeschäftigungsgesetz, AuslBG) 1975, BGBl 218/1975, amended version BGBl I 157/2005

Medical Doctors' Act (Ärztegesetz, ÄrzteG) 1998, BGBl I 169/1998, amended version BGBl I 156/2005

Health Care and Nursing Act (Gesundheits- und Krankenpflegegesetz, GuKG) 1997, BGBl. I 108/1997, amended version BGBl I 69/2005

Dentists' Act (Zahnärztegesetz, ZÄG) 2005, BGBl I 126/2005, amended version BGBl I 39/2006

Pharmacies' Act (Apothekengesetz) 1907, RGBl 5/1907, amended version BGBl I 41/2006

Midwives' Act (Hebammengesetz, HebG) 1994, BGBl 310/1994, amended version BGBl I 116/1999

Higher Medical-Technical Services' Act (Bundesgesetz über die Regelung der gehobenen medizinisch-technischen Dienste, MTD-Gesetz) 1992, BGBl 460/1992, amended version BGBl 327/1996

Psychologists' Act (Psychologengesetz) 1990, BGBl 360/1990, amended version BGBl I 98/2001

Psychotherapy Act (Psychotherapiegesetz) 1990, BGBl. 361/1990, amended version BGBl I 98/2001

Articles in Newspapers:

Kurier: Lehrlinge sollen Pflegenotstand lindern, 4 July 2005

Wiener Zeitung: Krankenpflege: „Illegale" halten System aufrecht, 22 April 2005

Die Presse: Illegal Beschäftigte verhindern den Pflegenotstand, 21 April 2005

Der Standard: Illegal Beschäftigte verhindern den Pflegenotstand, 21 April 2005

Press review with a focus on the health care and nursing sector: http://www.kongressinfo.oegkv.at/index.php?id=524&L=0, accessed in April 2006

ANNEX

Employees in Austrian hospitals
Health professions excluding medical doctors

	Year	Total	Non nationals	EU nationals	Third country nationals
Total number of employees	**1997**	**70.957**	**4.104**	**-**	**-**
	1998	**71.851**	**3.730**	**-**	**-**
	1999	**73.079**	**3.655**	**-**	**-**
	2000	**74.734**	**3.529**	**-**	**-**
	2001	**74.951**	**3.340**	**-**	**-**
	2002	**75.590**	**3.186**	**-**	**-**
	2003	**76.161**	**3.362**	**-**	**-**
	2004	**76.131**	**4.410**	**2.916**	**1.494**
Midwifes	1997	1.059	62	-	-
	1998	1.083	48	-	-
	1999	1.093	56	-	-
	2000	1.079	56	-	-
	2001	1.101	48	-	-
	2002	1.132	52	-	-
	2003	1.134	60	-	-
	2004	1.139	77	57	20
General qualified health carers and nurses	1997	36.222	2.614	-	-
	1998	37.007	2.389	-	-
	1999	38.275	2.319	-	-
	2000	39.442	2.245	-	-
	2001	39.999	2.089	-	-
	2002	40.616	2.007	-	-
	2003	40.950	2.057	-	-
	2004	41.523	2.861	1.970	891

	Year	Total	Non nationals	EU nationals	Third country nationals
Qualified paediatric nurses/child carers	1997	3.596	147	-	-
	1998	3.620	142	-	-
	1999	3.678	152	-	-
	2000	3.713	164	-	-
	2001	3.633	164	-	-
	2002	3.624	185	-	-
	2003	3.627	216	-	-
	2004	3.850	291	267	24
Qualified psychiatric health carers and nurses	1997	3.151	16	-	-
	1998	3.139	16	-	-
	1999	3.118	20	-	-
	2000	3.175	15	-	-
	2001	3.037	18	-	-
	2002	3.148	19	-	-
	2003	3.110	23	-	-
	2004	2.842	31	26	5
Cardiotechnical service	1997	-	-	-	-
	1998	-	-	-	-
	1999	-	-	-	-
	2000	-	-	-	-
	2001	-	-	-	-
	2002	-	-	-	-
	2003	-	-	-	-
	2004	220	4	4	0
Physiotherapeutical service	1997	1.991	123	-	-
	1998	2.057	110	-	-
	1999	2.147	113	-	-
	2000	2.229	126	-	-
	2001	2.269	124	-	-
	2002	2.281	139	-	-
	2003	2.414	151	-	-
	2004	2.522	234	206	28
Medical-technical Laboratory Service	1997	2.838	74	-	-
	1998	2.927	64	-	-
	1999	2.884	68	-	-
	2000	2.934	64	-	-
	2001	2.959	57	-	-
	2002	3.038	55	-	-
	2003	3.055	56	-	-
	2004	3.132	101	67	34

	Year	Total	Non nationals	EU nationals	Third country nationals
Radiological-technical services	1997	2.141	70	-	-
	1998	2.205	60	-	-
	1999	2.268	66	-	-
	2000	2.384	65	-	-
	2001	2.416	60	-	-
	2002	2.458	59	-	-
	2003	2.490	54	-	-
	2004	2.602	72	45	27
Dieticians	1997	400	3	-	-
	1998	403	2	-	-
	1999	419	4	-	-
	2000	425	7	-	-
	2001	439	5	-	-
	2002	444	6	-	-
	2003	465	6	-	-
	2004	487	11	6	5
Occupational therapy services	1997	435	11	-	-
	1998	474	10	-	-
	1999	521	11	-	-
	2000	548	8	-	-
	2001	600	16	-	-
	2002	660	27	-	-
	2003	685	37	-	-
	2004	743	58	56	2
Logopedic therapy services	1997	252	11	-	-
	1998	252	11	-	-
	1999	282	9	-	-
	2000	279	11	-	-
	2001	297	11	-	-
	2002	318	14	-	-
	2003	315	15	-	-
	2004	335	28	21	7
Orthoptists	1997	104	1	-	-
	1998	97	1	-	-
	1999	115	0	-	-
	2000	112	0	-	-
	2001	104	3	-	-
	2002	108	1	-	-
	2003	110	1	-	-
	2004	96	10	1	9

	Year	Total	Non nationals	EU nationals	Third country nationals
Medical-technical service	1997	1.820	31	-	-
	1998	1.818	36	-	-
	1999	1.896	28	-	-
	2000	1.920	22	-	-
	2001	1.952	25	-	-
	2002	1.897	8	-	-
	2003	1.839	11	-	-
	2004	2.037	20	8	12
Medical masseurs and therapeutic masseurs	1997	-	-	-	-
	1998	-	-	-	-
	1999	-	-	-	-
	2000	-	-	-	-
	2001	-	-	-	-
	2002	-	-	-	-
	2003	-	-	-	-
	2004	544	13	7	6
Emergency medical service	1997	1.104	98	-	-
	1998	1.075	76	-	-
	1999	1.331	130	-	-
	2000	1.450	107	-	-
	2001	977	66	-	-
	2002	1.071	37	-	-
	2003	1.135	51	-	-
	2004	797	22	7	15
Assistant nursing service	1997	11.795	768	-	-
	1998	11.760	703	-	-
	1999	11.140	613	-	-
	2000	11.132	571	-	-
	2001	11.281	570	-	-
	2002	10.798	482	-	-
	2003	10.824	533	-	-
	2004	9.868	456	134	322
Surgery assistant	1997	2.335	36	-	-
	1998	2.360	33	-	-
	1999	2.315	27	-	-
	2000	2.355	32	-	-
	2001	2.359	49	-	-
	2002	2.403	47	-	-
	2003	2.379	49	-	-
	2004	2.442	79	15	64

	Year	Total	Non nationals	EU nationals	Third country nationals
Laboratory assistant	1997	428	9	-	-
	1998	324	6	-	-
	1999	315	7	-	-
	2000	296	7	-	-
	2001	318	7	-	-
	2002	288	4	-	-
	2003	292	4	-	-
	2004	282	9	3	6
Mortuary assistant	1997	142	1	-	-
	1998	138	0	-	-
	1999	132	1	-	-
	2000	129	1	-	-
	2001	133	1	-	-
	2002	128	1	-	-
	2003	124	1	-	-
	2004	124	2	1	1
Balneotherapist assistant	1997	51	1	-	-
	1998	49	0	-	-
	1999	36	0	-	-
	2000	82	0	-	-
	2001	43	0	-	-
	2002	40	0	-	-
	2003	46	0	-	-
	2004	109	6	5	1
Doctor's assistant	1997	247	4	-	-
	1998	231	5	-	-
	1999	237	5	-	-
	2000	253	5	-	-
	2001	251	7	-	-
	2002	273	9	-	-
	2003	284	8	-	-
	2004	268	11	5	6
Occupational therapy assistant	1997	55	7	-	-
	1998	54	6	-	-
	1999	47	5	-	-
	2000	55	6	-	-
	2001	52	1	-	-
	2002	49	4	-	-
	2003	48	5	-	-
	2004	57	1	0	1

	Year	Total	Non nationals	EU nationals	Third country nationals
Disinfection assistant	1997	99	6	-	-
	1998	93	2	-	-
	1999	106	10	-	-
	2000	93	7	-	-
	2001	90	5	-	-
	2002	105	8	-	-
	2003	105	10	-	-
	2004	112	13	5	8
Balneotherapist and therapeutic masseurs (data collected until 2003)	1997	692	11	-	-
	1998	685	10	-	-
	1999	724	11	-	-
	2000	649	10	-	-
	2001	641	14	-	-
	2002	711	22	-	-
	2003	730	14	-	-
	2004	-	-	-	-

Source: Federal Ministry of Health and Women

Notes:
Tables contain data for the years 1997-2004 as of 31 December. Note that the group of non nationals is broken down into "EU nationals" and "Third country nationals" only as of 2004.
The figures are based on data of Austrian inpatient hospitals officially recognised by law (Austrian Federal Hospitals Act (Krankenanstalten- und Kuranstaltengesetz des Bundes, KAKuG)): general hospitals, specialized hospitals, rehabilitation centers, recovery centers, long term care hospitals and sanatoriums. Out-patient clinics which are not connected to an in-patient hospital unit are not included. Hospitals can be distinguished into hospitals financed by provincial funds (public hospitals including private non-profit hospitals, which are funded by public means) and hospitals not funded by provincial funds. In 2004, a total of 137 hospitals were financed by provincial funds (in total, a number of 263 hospitals reported to the BMGF in this year). According to the BMGF, these more or less represent the in-patient acute care sector in Austria (but excluding accident hospitals and sanatoriums).