CareFlows Project
– Job Mobility in health & social care

Final Report

The CareFlows partners are

Institute for Work & Technology, Germany
University of Limerick, Ireland
Hoegeschool Zuyd, The Nehterlands
Health Service Executive, Ireland
University of Salford, United Kingdom
European Medical Association, Belgium

1. Introduction and Summary

The purpose of the Care Flows project was to analyse conditions and barriers of mobility of health care professionals within North-Western-Europe and to identify and disseminate measures to increase mobility. The initial intention to address labour market miss matches in the health care sector has been extended to increase the awareness about the advantages of mobility in general and to the exchange of best practice as well in health care education as in health care systems and innovations.

This project aimed at the improvement of knowledge of problems and disparities in the health and social care workforce of the North West Europe Area, on two distinct levels. Firstly, the production of a comprehensive research document detailing the factors currently preventing higher levels of labour mobility in the health and social care sector, has been targeted at national and European policy makers. The research built on Directive 2005/36/EC of the European Parliament and the Council on the recognition of professional qualifications. This research considered factors such as legal, economic, inter-cultural attitudes, and political amongst others. This allows for better development and management in N.W.E and improved co-operation and understanding in decision-making and planning processes, resulting in the development of common principles and concepts for efficient planning systems. Secondly, the knowledge base of workers themselves has been improved, as through dissemination of the project and through the national recruitment fairs and taster sessions, providing improved awareness of the opportunities available in other partner countries.

The research has been organised in seven work packages which have been complementing each other in order to produce recommendations for an increase of mobility and to disseminate results in order to support mobility. The work has been evaluated by the European Medical Association (EMA) during the entire process. This evaluation has produced continuous suggestions for adjustments and orientation of the project. Work packages have been:

Work Package 1: Project Management

This work package has been led by the Institute of Work & Technology, Department of Health Care Economy and Living Conditions (IWT) as the lead partner, and has been sustained throughout the lifetime of the Care Flows project. The project team has ensured that all partners took ownership of their allocated actions and responsibilities.

Work Package 2: Professionals Issues Research

This work package undertook research to understand the issues arising in partner countries that promote or hinder the creation and maintenance of the skilled workforce in the health and social care sector. It took into consideration the push and pull factors which affect skilled health and social care professionals, and the professional boundaries of different practitioners in different countries.

This work package was led by Professor Steven Shardlow, the Research Institute Director within the Faculty of Health and Social Care at the University of Salford, and cooperated with all academic partners in order to contribute by providing data on the issues/factors surrounding labour mobility and national job information in their respective countries. Non-academic partners have also been engaged in this work package in order to provide respective comprehensive analysis.

The main output of this work package is a matrix which clearly identifies which North West European countries (represented in this project) have an over supply and those which have an under supply of skilled health and social care workers, based on agreed criteria, and the recognised ratios of employed: unemployed skilled health and social care workers. The matrix also identifies what complementary education and training workers need to undertake in order for them to be professionally competent to work in another country. Identifying these gaps also allows partner countries to identify ways of developing cohesion and mutual support to tackle the problems of low labour mobility.

Work Package 3: Policy Issues Study

This work package was run in parallel to package 2, and provides a comprehensive study into the current national and European policies and initiatives related to the problem of lack of labour mobility in the health and social care sector. It identifies the

current policies of each country represented in this project. The policy issues study has been build on the work of the European Commission, European Parliament and the Council of the European Community in simplifying rules for professional recognition, in particular Directive 2005/36/EC. At the same time it identified those countries, regions, or communities with an over supply and those with an under supply (parallel with work package 1). In addition this work package identified the main factors preventing skilled workers to work in another country. These factors are not just political, but cultural, social and economic, and legal restrictions.

This work package has been led by the Institute of Work & Technology in Northrhine Westfalia, Germany, and cooperated with all partner countries to undertake this policy-based study. Its results have been integrated with work package 2 and has been published in comprehensive country reports.

Main results of work package 2 and 3 are comprehensive recommendations for policy makers on national and European levels. Increasing the awareness about potential solutions supports the development of strategies by establishing functional interdependencies and emphasising synergies to enable cities and regions to complement each other and co-operate to build on the advantages and overcome the problems of low labour mobility of health and social care workers. (ESDP pg 21).

Work Package 4: Development of Transnational Web-Tool

This work package made use of the research and results of work packages 2 and 3, and provides a significant tangible outputs of the project, by offering information relating to jobs assessed and associated information on education and training. An online web-portal provides a selection of health and social care job descriptions for each country and information about the levels of vocational training and competencies and capabilities required to work in another country, and therefore the continuing professional requirements which would need to be undertaken prior to working in another country. The web-portal is linked with other institutions and is supposed to be integrated into the Portal of European Medical Association.

The online transnational tool is available online and is free to access by health and social care practitioners in all partner countries, as well as training providers and public authorities.

The Web page informs about the major output of the project and provides transnational information which all partners and all countries contributed to. The information can be used by health and social care workers themselves, training institutions, local and national public authorities and job/employment centres in the North West Europe area. This web-tool altogether improves the knowledge base of skilled health and social care workers at all levels as to the opportunities they have as European citizens to work in another country within the North West Europe area.

Work Package 5: Co-ordinated Actions to Promote Labour Mobility

This work package was run in parallel to work package 4, and provided tangible activities to make the mobility of skilled health and social care workers more attractive in the North West Europe area. This work package organised events such as recruitment fairs and taster sessions for skilled health and social care workers interested in working in another country. The "recruitment fairs" took place in association with large scale events like the Hauptstadtkongress in Berlin or a large scale job fair in Dublin as well as a number of events of other networks like the thematic network EUROPET. This way a large number of potentially interested health care professsionals and socal workers have been reached. This work package was be led by the Health Service Executive Ireland, and made use of information of all project partners both academic and non-academic.

For each country involved in the project induction packs for workers interested in working in another N.W.E country have been developed. The packs include information about transnational database, work opportunities, complementary training available, social welfare, accommodation information, language information to name a few examples. Also taster sessions have been organised with a minimum of two partner countries working collaboratively to organise visits for a group of health and social care workers. Examples are an exchange of know how in tele health monitoring between the Netherlands and Germany or o number of events in coopration with the EUROPET network. Induction packs are complemented by the web-based portal of-

fering support information regarding national or regulatory legal and professional requirements for practice. This web-portal is also be available for practitioners who do not receive induction packs.

Work Package 6: Dissemination & Spin-Off Activities

This work package has been run throughout the lifetime of the project, and has been lead by Professor Winrich Breipohl and Prof Andler at Pediatric Clinic of Datteln, Germany. It ensured that all partners, academic and non-academic, will engaged in dissemination and publicity. The benefit of having both academic and non-academic partners allowed for wider dissemination in each country. This was achieved through University academics involved in the project and also those in public authority positions either in health and social care, or employment and labour. Within this work package the involvement of three major European networks has been organised, namely the European Medical Association; European Medical Schools Association; and the European Resources Intercultural Communication. These European networks have agreed to be either formal partners or observer partners of the project, which allowed the work of the project to be disseminated much more widely with a greater impact. These networks have been approached to advertise the project at any appropriate opportunity. In addition, the project partnership also has very strong links with the UNEVOC International Centre for Technical and Vocational Education and Training, which is based in Bonn, Germany. Utilising the UNEVOC to publicise the database and other project outputs allowed practitioners worldwide to access the information and resources generated by the Care Flows project and ensured a global impact.

All project outputs have been disseminated widely so as to develop the knowledge base of the North West Europe area on metropolitan systems allowing transnational working in the health and social care sector.

Work Package 7: Evaluation

The evaluation of the Care Flows project has taken place throughout the lifetime of the project. In order to ensure a credible project the European Medical Association has agreed to monitor and evaluate this project, as it is felt that this will allow the pro-

ject to have a greater impact on policy makers, which is ultimately needed for the project to have a greater impact at the national and European level.

Monitoring and evaluation took place at regular intervals throughout the lifetime of the project, and the external evaluator has been required to attend project meetings and meetings held between project partners. The evaluator ensured that the running of the project was to the work-plan and that the relevant outputs and results have been achieved, and that actual developments have taken place as a result of the Care Flows project.

2. Major Outcome of Care Flows

The Care Flows project has produces outcome as planed in the initial proposal. This includes tangible as well as intangible results:

The country reports provide the results of work package 2 and 3 and are published in the web tool of the project as well as in the annex of this report.
The induction packs are also published in the web tool of the project and included in the annex of this report.
The web tool itself provides comprehensive information about mobility of health care professionals and social workers in North-Western-Europe.
Final recommendations have been produced as a core part of this report.
Awareness about the advantages and opportunities of mobility has been increased by numerous events such as job fairs, conferences and workshops.
Thematic networks have been involved in the project and ensure dissemination and sustainability of results.

The overall outcome of the project extents its focus from North-Western-Europe to a global perspective and increases awareness about the opportunities of mobility in and beyond Europe.

3. Recommendations

Mobility of health care professionals in Europe is often seen as an instrument to deal with over and under supply in the labour market, but even also for the exchange of best practices and intercultural learning. Especially with respect to the latter, mobility has to be considered as an asset by itself. It includes advantages of an enlarged labour market, of better distribution of best practice and of increased learning from diversity at the same time.

Instruments for increasing labour market mobility include better transparency of information about job opportunities, the active organisation of exchange and cooperation programmes for students and health care professionals as well as interventions to reduce mobility barriers. These instruments can be related to the assets of mobility in a matrix showing activities for the enhancement of mobility between the European health care systems.

Instruments Assets	Information	Exchange Programmes	Interventions to reduce barriers
Reduce labour market miss-match			
Learning from diversity			
Exchange of best practice			

Whereas the reduction of labour market miss matches aims at existing disparities between supply and demand in the labour markets, learning from diversity focuses on system convergence and making use of opportunities of European diversity. Exchange of best practice is making use of an innovation benchmarking with the purpose of the diffusion of innovative solutions in health care and social work. Mobility is an important approach in addressing all three dimensions and in turn they can increase competitiveness and employment.

1. Reduce Labour market miss-matches

All countries in North Western Europe are at least to some extent concerned about an undersupply of health care professionals or will be in the near future. This varies within countries and regions and between different professions to a considerable extent. The expected shortages may be a reason for these countries to pursue immigration policy with the aim of promoting migration from other European countries and from origins outside of Europe.

Mobility of health care professionals is often reduced by regulations related to quailty. In addition salary differences of health care professionals between countries in North-Western Europe as an incentive for mobility are not as relevant as between other countries. Therefore, measures to increase mobility of health care professionals within North-Western Europe are needed to support the flexibility of the labour markets.

Information about labour market needs includes push and pull factors. Job opportunities are published by a variety of sources such as labour market agencies, employers, internet portals (EURES) and the like. Usually the information is based on a more or less arbitrary basis. Individual job seekers and enterprises in search of employees may find an exchange platform. This certainly is a powerful platform. It could be complemented by the organisation of talent pools that publish lists of graduates from different health care professions. This could provide even better information about the potential of candidates rather than just about explicit job seekers.

There still is a high interest in making use of job opportunities in foreign countries within (North-Western) Europe, but it also often is hampered by insecurity about the complex situation of regulations, career opportunities, living conditions and the like. The Care Flows project has produced and piloted induction packs in order to improve the complex need for information. In several job fairs, conferences and the projects internet platform the respective information has been distributed and evaluated. The induction packs may improve the need for information. However, the distribution on a project basis is not sufficient and sustainable enough. They have to be integrated into continuous exchange networks that combine transnational networks with the information from the induction packs and the information about supply and demand.

Transnational networks as a measure of information exchange need to address the specific thematic concerns of the participating institutions. Therefore the Care Flows project did establish close contacts to established thematic networks. The case of a paediatric network (EUROPET) included different kinds of social and health care professions. The networking demonstrated a common interest in the development of solutions across Europe and seems to be an appropriate infrastructure to combine the exchange of information about innovative solutions with information about working and living conditions as well as supply and demand for professional staff.

The networking approach shows that information is not sufficiently receipted if it is divided from its direct profit. Therefore a core recommendation is to integrate the information on mobility opportunities into networks with existing thematic orientation or to establish such networks. This kind of integrated networking affords a lot of effort and incentives in order to be sustainable however.

In terms of information three recommendations can be made on the basis of the research and evaluation of CareFlows:

- Complement the labour market information with talent pools of graduated professionals in addition to explicit job seekers;
- Extend the information by integrating them into comprehensive induction packs with information about the complex regulations, career opportunities, living conditions and regulations;
- Integrate the information into thematic networks that combine the diffusion of innovation, education, transfer of best practices and labour mobility.

In addition to increased information **exchange programmes** for students as well as health care professionals may support the creation of a culture of mobility. Many health care professionals do not consider mobility by own initiative but may need an additional impulse. The Lifelong Learning Programme 2007 – 2013 provides incentives for European cooperation in education including schools (Comenius) higher education (Erasmus), vocational training (Leonardo da Vinci) and adult education (Grundvig). An increased European cooperation of schools educating health and so-

cial care professionals and of employer associations could additionally promote the exchange of health and social care professionals and enlarge the scope of mobility.

- Well established school partnerships with an exchange of curricular and a systematic exchange of students and teachers can support international mobility;
- International schools for health care and social work can address an international orientation in the education of professionals.

Mobility is still limited by a number of **barriers** that have to be addressed. Such barriers concern language, accreditation, differences in working and living conditions or the consideration of families and relatives. These barriers can not be overcome completely, but may be reduced by an increased culture of mobility as well as specific interventions. Language courses are common measures that can be fine tuned to specific professional orientation. In addition better prepared language courses and supervision on the job during daily work to bridge both language barriers and cultural differences must be an integral part of any recruitment and human resources policy.

Accreditation barriers still exist due to a high diversity of health and social work professions despite European directive 2005/36/EC for the recognition of professional qualifications of doctors, dentists, pharmacists, nurses and midwifes. Mutual recognition of diplomas or professional qualifications across the EU, in line with the relevant Directive, requires good communication between all member states of the EU and means that member states should have to trust each other's education systems to allow free movement of workers in the European Economic Area. The recognition of specialised geriatric or children nurses, specialisation in oncology or diabetes are not self evident today and need to be dealt with by EU and national regulation.

Social conditions such as job opportunities for family members may also cause barriers to mobility. Family programmes that offer jobs for family members may support mobility. Also child care services, regulations for insurances and social security may additionally reduce such barriers. An integrated approach of measures to reduce barriers could include the following measures:

- Diversity training in combination with language courses and supervision on the job during daily work may help to overcome cultural barriers;
- Specialisations and regulation of division of labour between different professions may ease accreditation problems. This also requires harmonisation of

professions across participating countries and requires better communication between member states;
- Social conditions like partner programmes will make mobility more attractive and reduce barriers.

These measures in favour of more mobility and with the purpose to reduce labour market mismatches will also apply for learning from diversity and the exchange of best practice.

2. Learning from Diversity

As important as matching labour market disparities is the process of mutual learning between the health care and social systems in Europe. The international competitiveness of the sector in Europe is strongly influenced by heterogeneity and diversity. This may be turned into a competitive advantage if diversity is used for learning processes that support the appreciation of cultural diversity in health care and social work. The working conditions for health care professionals differ considerably due to these cultural differences and the heterogeneity of health care systems. Therefore a process of supporting the awareness about cultural diversity within European health care systems and the emerging markets is of high importance. Mobility of health care professionals and social workers will be an appropriate approach or could be used more explicitly to increase this awareness.

Information about differences of division of labour in the different European health care systems therefore can not only provide information about individual career opportunities but as well about professional developments. Professional developments such as the establishment of oncology nurses in the Dutch system need to be spread by personal experience of health care professionals. Therefore an innovation monitoring of innovations in health care education and professions could be accompanied by mobility of health care professionals and social workers as well as by educators in order to facilitate an exchange of curricula. According to the talent pools an innovation pool would increase the knowledge and experience about such developments and provide additional incentives to mobility. Examples for monitoring and exchange of professional developments are:

- Somatic specialisations in some countries such as oncology nurses, diabetes nurses, stroke nurses;
- Cross sectional competences in case management, community nurses etc.;
- Social specialisations like geriatric and paediatric nurses addressing the specific needs of social groups;
- Social work in the context of health care like sibling activities for oncology patients in paediatrics;
- Academic careers of nurses and therapists;
- Diversity management in health care and social work.

Across Europe there is a high diversity of such professional developments that need to be monitored, evaluated and benchmarked in order to be able to learn from European diversity of health care and social systems and professional development.

Exchange programmes addressing the international development and diffusion of professional improvements could support a culture of acceptance of diversity and increased mobility. Programmes to support international teams in innovations of health care education and (division of) labour would be favourable. Exchange programmes could especially focus on:

- Exchange programmes for educating institutions that support the diffusion of knowledge about specialised curricula;
- Hospitation programmes that support the accumulation of experience about opportunities and risks of different organisation in the division of labour;
- Mutual projects to transfer experience especially in education between different countries.

Barriers of mobility in case of diversity are especially due to differences in education, training, accreditation and regulations with respect of division of labour. Mobility will often be restricted to an exchange of information and would have the purpose of adapting the health care and social systems within Europe. The respective learning process will especially be based on the increase of awareness about opportunities and risks of differences between the existing systems. This can be addressed by

- Supporting activities for the exchange of information especially in case of different regulatory frameworks that aim at convergence rather than labour market activities;
- Support mutual learning processes in cases of innovation in the development of different professions (e.g. paedriatric and geriatric nurses, community nurses or oncology nurses).

All together learning from diversity will focus on innovation in the convergence of health care and social systems rather than the labour market. Since it supports an increase of efficiency, quality and competitiveness it will have an impact on employment and the development of new career opportunities and therefore is as important for labour market development as well.

3. Exchange of best practice

An additional asset of mobility will be the diffusion of best practice across Europe. Not every experience and innovation has to be made in each single European country. The competitiveness of the European health care and social sector depends on the diffusion of innovations within Europe. Since best practice is bound to personal and tacit knowledge in service industries to a considerable extent, its distribution relies on mobility of the health care and social professionals to the same extent.

The identification of centres of excellence could be one measure to increase the information about best practice. This would require Member-State official regulations to accept the Status of EU Centre of Excellence, both in terms of patient flows as well as in terms of job (qualification) mobility. Too often, for example Leonardo-students face problems upon return, when their additional qualifications reached abroad will not easily be recognized in the curriculum of their ‘home-education’.

Centres of excellence could become a hub for the international exchange of health care professionals. A procedure of defining and promoting such hubs would provide sound information about where and why to go to. Such centres could be institutions as well as projects. E.g. a high transparency on clinical studies and opportunities to participate in such studies would provide information on innovation activities as a ba-

sis for mobility. Support measures for improved information about centres of excellence in Europe could be:

- Agreement about criteria of centres of excellence;
- Identification of centres of excellence;
- Development of a database of centres of excellence as a source of destinations for mobility.

Programmes like Competence Research Centers (CRC) of the EU would be appropriate approaches for an **exchange of experts** in terms of best practice. They are supposed to bridge the gap between technological and economic innovation by combining academic excellence with industrial and/or public needs. The activities within CRCs can be the pooling of knowledge, concentration of infrastructure, creation of new knowledge training and dissemination of knowledge towards target groups of involved actors in a tailor-made way. The definition of and information about such centres in the health care sector would be an appropriate place for exchange programmes of health care professionals and would increase mobility.

The quality of exchange activities is of crucial importance for the success of distribution and diffusion of innovations. Therefore criteria for have to be developed and monitored which include the target groups (from students, post graduate activities to high potential experts) as well as the purpose of mobility (such as learning from good practice, pooling of excellence). Support measures would include:

- The definition of different purposes of mobility in the case of diffusion of best practice;
- A systematic monitoring of mobility and its impact on diffusion of best practices;
- The evaluation of mobility.

Major mobility **barriers** for the exchange of best practice are seen in transaction costs that may reduce the full exploitation of such initiatives. Incentives for mobility could reduce such transaction costs and increase the exchange of best practice. Incentives can be provided by a variety of instruments:

- Increased integration of mobility into the funding conditions of EU research programmes (ingoing and outgoing);
- Specific schemes for increased mobility between, to and from centres of excellence;
- Increased funding of workshops and conferences between centres of excellence;
- Networking between centres of excellence.

Over all measures to increase mobility in the health care and social sector will not differ considerably from other sectors. But health care and social services are traditionally not organised on an international but rather on a regional scale. Therefore special efforts are needed in order to promote the international mobility across Europe

Institut Arbeit und Technik

CareFlows

- Job Mobility in Health and Social Care -

- Country Study Germany

Elke Dahlbeck

Institute for Work and Technology
Department Of Health Care Industry & Life Quality

1. Introduction

Job mobility within Europe is still less. Only 2% of European population in the age of employability are living and working in another European state than there has been born. This fact applies also to the health and social care sector. Only single professions like physicians are more mobile. Demand and supply in the health and social care market differ in the single countries. The differences depend on the health and social care systems, the working activities and functions of the several profession groups, the vocational trainings and graduations. Besides the demand of employers other push and pull factors are important for mobility: Salaries, working conditions, career chances, speech barriers, cultural aspects, laws and acknowledgement of graduation (Buchan/Perfilieva 2006: 5).

2. CareFlows Project: aim and content of country study

CareFlows project has got two main research themes: One aim of the project is the analysis of demand and supply in the social and health care sector in the four partner countries: Germany, the Netherlands, Ireland and the United Kingdom. The second aim is to formulate recommendations, how barriers for mobility can be disposed and stimulation for mobility can be set. These aspects will be described in the four Country studies and summarized in a final report. The CareFlows project focuses on three professions: Nurses, doctors and social workers. The country studies will give support for the experience part of the project. Job fairs and dissemination events and the website http://www.careflows.info will give information to people who are working in the health and social care sector and who are also interested in job mobility.

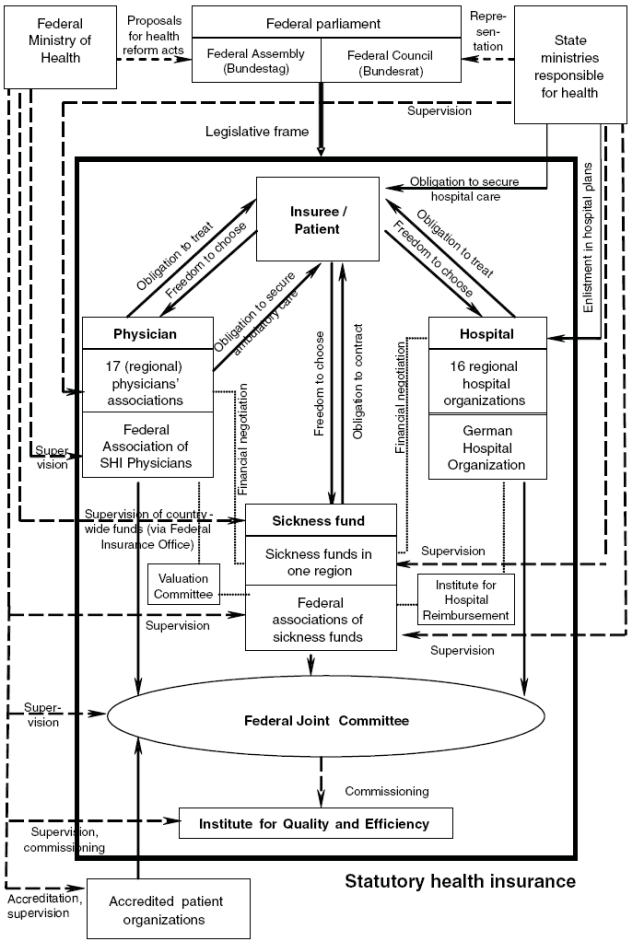
The following German country study gives information about the German national health system. There will be a description of the employment development of physicians, nurses and social workers. Both German and foreign employees in the health and scoial care sector will be described. Because there is no data about the in-or outflow of health and social care workers, job mobility can only be shown by the “Status-Quo”. To find out possible mismatches in the health and social care data of unemployment and vacancies will be analyzed. Main future influences of labour mismatch like the demographic change will be known and discussed. The last chapter shows the main discussion points of the actual debate of health care mobility in Germany.

3. The German National Health Care System

The national health system of Germany belongs to the traditional “Bismarck-Social-Insurance-Type” and is based on a nationwide health insurance, financed by contributions of employees and employers. About 70 mill people (85%) are covered by one of the 280 compulsory health insurances, 10% are full members of one of the 49 private health insurances and 4% received governmental schemes complemented by private health insurance, and approximately 0.2% were not covered by any insurance system (WHO 2005: 5).

The German health care system is based in a decentralized organization, where the main actors - aside from patients - are the Federal Government, the associations of health insurances, physicians´ associations and the associations of hospitals (see figure 1). For large parts, these actors shape a self-governing system.

The organizational relation ship of key actors in the health care system, 2005



Source: Busse, R., Riesberg, A. Health Care Systems in Transition: Germany. Copenhagen, WHO-Regional Office for Europe by order of the European Observatory for Health Care Systems and Health Policy, 2004.

The Federal Ministry of Health proposes the health acts that – once passed by the Federal Parliament – define the legislative framework for the health system.
The main actors are the physicians´ and dentists associations of the providers´ side and the sickness funds and their associations on the purchasers side. Because of the federal system in Germany the actors are organized on federal level as well as state ("Länder") level (Riesberg, A 2005: 21).
The 2,166 hospitals (2004) are also organized on regional and federal level.
The sickness funds collect the contributions to the statutory insurance of health and long-term care and negotiate contracts with the health care providers. The Federal Joint Committee sets up a catalogue and concretises claims for benefit

and the needs for quality of medical care. In 2004 the Institute for Quality and Efficiency was founded as a new controlling instance of the medical care system.

Employees who earn less than 3,525 Euro per month (2005) are compulsorily insured. Since 1996 they have a free choice between the various sickness funds. Children and spouses without an own income are co-insured free of charge. Unemployed people, pensioners, people who recieve welfare benefit like homeless people are also insured. The compulsory health insurance system is based on the principles of solidarity and redistribution and benefit in kind. The average contribution rate amounted to 14.2% of the gross wage in 2004. Up to the last year, the payment of contribution was equally divided by employers and employees (50%), since last year the relation is 46% employers and 54% employees (WHO 2005). Self-employed persons (free-lancers) and people who earn more than 3,525 Euro per months can choose between the voluntary health insurance or a private health insurance. The premium rate of the private insurance depends on personal risks (Potratz, Dahlbeck, Hilbert 2006: 4)..

The German health care delivery system is divided between ambulatory and stationary care. Most of the 134,000 ambulatory physicians are working in their single practice for profit, circa 50% are general practitioners, the other 50% are medical specialists. Patients have free choice of physicians, SHI-insured have free access to 96% of the physicians, because only 4% of the physicians deliver only private patients These 96% physicians are obligatory members of the regional physicians´ associations, which are responsible for the ambulatory care not only during practice-hours, but also at night (WHO 2005:5). The physicians associations have got the monopoly for the ambulatory care in their region and negotiate collective contracts for their members with the various sickness funds. The negotiated budget is divided among the SHI-physicians for their income as measured by the number of patients and admissions and a “complicated pointsystem” for physicians benefits. The rate of outpatient physicians per 1000 inhabitants amounted 1.6 in 2005, the rate of all physicians per 1,000 inhabitants reached 3.4.

Since 2004 patients have to pay 10 Euro per quarter for the first physicians contact. If they want to visit another physician, for example a specialised practitioner, you get a referral from your family doctor. The hope of this new charge is a “gatefunction”, to coordinate and decrease not necessity physicians´ visits (WHO 2005: 5).

A patient's pathway through the health system

Hans Meier has caught a flu. He visits an ambulatory physician of his choice (usually a general practitioner). He receives a treatment and (most probably) a recipe, which he collects in a pharmacy. Mr. Meier's flu is persistent and turns out to be a dangerous pneumonia requiring inpatient treatment. His family doctor will send him to a hospital (of Mr. Meier's choice). Should he be in need of some kind of rehabilitation treatment, he will be sent to a qualified local therapist, a clinic or rehabilitation resort. Treatment, fees and costs on all these stages are covered by his Statutory Health Insurance (SHI), of which he like 90% of his fellow-countrymen is a mandatory member. Following the solidarity principle, he receives these services independently of the level of his contributions. His wage will continue, and in case his stay in hospital should stretch beyond 6 weeks, his insurance would also answer for wage replacement payments.

Quelle: Potratz, Dahlbeck, Hilbert 2006: 5.

Inpatient care is delivered in 2004 by 2,166 acute hospitals, which cared for 17.3 mio. patients and 1,294 clinics for prevention and rehabilitation, where 2 mio. patients were treated. Most of the acute hospitals are public (36%) or non-profit hospitals (38%). In the last years the number of private acute hospitals increased. In 2004 25% of the hospitals were private, but regarding the distribution of beds, only 12% of the 531,000 beds in German hospitals were in private hospitals (Federal Statistical Office). The average length of staying in hospitals (in days) decreased in the last years from 14 in 1991 down to 8.7 in 2004, but the number of admissions increased from 14.6 Mio in 1991 up to 16.8 Mio in 2004. Hospitals are financed by a dual system. The investments in hospitals are planned and financed by the 16 "state" governments, the recurrent costs are financed by the sickness funds, based on a DRG-system since 2004, which put hospitals under economic pressure to become more effecient (Potratz, Dahlbeck, Hilbert 2006: 6).

The traditional strict separation of in- and outpatient care has weakened in the last few years. There is an increasing rate of ambulatory operations in hospitals and trans-sectoral disease-management programmes and trans- sectoral integrated delivery networks (WHO 2005: 7).

Since 1995 long-term care insurance is obligatory for the population. The contribution rate of the long-term care insurance is equally shared by employees and employers (both 1,7% of gross salaries). The claim for long-term care benefit depends on need (WHO 2005: 7). In 2003 2.3% of the population received benefits from long-term care insurance, circa one quarter in old peoples´ home and three quarters at home cared by professional ambulatory care services or by relatives.

In 2004 the health expenditure amounted up to 234 billion Euro or 10.6% of GDP. The expenditures of the compulsory health insurances amounted more than 130 billion Euro, 48% of the benefits paid for acute inpatient care, 22% for pharmaceuticals and 21% for physicians care (Federal Statistical Office).

The health policy of Germany is dominated by cost-containment. Effectiveness, competitiveness and higher quality are the strategies to reach cost reduction. Important regulations are the stepwise introduction of a DRG payment in hospitals, integrated delivery networks or the gate-keeper function of family physicians, the opening of hospitals to the ambulant market and new provisions allowing for dependend employment of doctors and codetermination for patients in the Federal Joint Committee (WHO 2005:10).

4. Description of Research Methods

The research methods of this country study is based on qualitative and quantitative research.
The following interview partners have been interviewed for the qualitative analysis:

- Regional & local Government (Health and socal care department)
- European service of labour administration
- Marburger Bund, (trade-union of stationary physicians)
- Hartmann Bund (trade-union of ambulatory physicians)
- Physicians´ chamber Germany
- International exchange program for nurses (Center of International Health Care,
- Witten)
- Federal Ministry of Health

The sources of the quantitative analysis are from different institutions. This is due to the different professions. The most important source is the labour administration. Others are the physicians chamber or the Federal statistic office.

5. Doctors, nurses and social workers – definiton and development

5.1 Definition

5.1.1 Physicians

Preconditions to study human medicine in Germany are a high school diploma and an accreditation from the national central placing agency for students, because there is a national wide restricted accreditation for students. Basis to get an admission are an excellent high school diploma or practical experience in the health sector. The human medical study is regulated nationally in the Federal Medical Code. The time for this study is 6 years.

The precondition to get a license in order to practise as physician are:

- earn a medical agree from University (6 years, last year practical experience)
- first aid training
- Practical experience in nursing (three months)
- Physicians exam (2)

To become a specialised physician you need professional experience and further post-graduated training. In Germany there are more than 100 possibilities for specialising. Post-graduate training usually stretches over 5 to 6 years.

To care for SHI-Patients physicians need an accreditation of the physicians´ association, because of the monopoly of the physicians association. The association controls the regional outpatient medical delivery system and avoids regional over- or undersupply.

The costs of the medical studies can be estimated by 200,000 Euro (Data for 1997). But these costs will increase in future, because all states decided to establish study fees.

There are big variances in salaries between the several specialisations of physicians. There are differences between inpatient physicians, who are predominantly employees in a hospital and outpatient physicians, who are self-employed. There are also differences in salaries between specialised outpatient physicians or general or family physicians and regional differences because of the rate of private insured patients.
Inpatient physicians are often paid following collective agreements. The net income per month amounts for young physicians (under 35) working (full-time) in public or non-profit hospitals 2,000-2,130 Euro (Data for 2002), the net income per month for all physicians working (full-time) in public or non-profit hospitals 3,140-3,160 Euro (Spengler 2005: 492). But there is a big variance between the income of assistance physicians, which earn 50,000 Euro (gross wage per year) and chief physicians, who earn 250,000 Euro (gross wage per year). The big variance can be accounted by care for many private insured patients in hospitals.

The income of ambulatory doctors differs depending on specialisation and region. Family physicians earn less than their specialised colleagues. There is also a regional factor. Physicians in rural regions for example in eastern Germany do not earn as much as their colleagues in urban regions in West Germany. The rate of private insured patients and hence higher paying patients is much higher in western Germany than in eastern Germany. The (full-time) working-time of physicians is between 46,5-52 hours per week. In comparison to other academic persons working fulltime, incomes of physicians are higher, but the differences decreased in the last years.

The working conditions for assistant physicians in hospitals are not very good. Because of the finance pressure young physicians often get limited labour contracts. Because of the high personal costs, the staff level of hospitals is very low. So physicians often have to step in for sick colleagues or colleagues, who are on holiday. The physical, emotional and personal work load is very heavy. The responsibility is very high, also for young physicians. Because they often have bad working conditions (income), there is an increasing number of young physicians, that do not work in medical care in Germany but in another country or in pharmaceutical research.

5.1.2 Nurses

The occupational image of nurses in Germany differs from other EU-countries. In Germany there are different professions with different protected titles for nursing. There are hospital nurses (only called nurses), child hospital nurses, assistant hospital nurses and nurses for elderly. All of them have different specialized vocational trainings. While hospital nurses belong to the health care sector, geriatric nurses are part of the social care sector.

Hospital Nurses: Precondition to start this training is a secondary school degree. The vocational training for nurses takes three years. The training is divided in a practical part and a theoretical part. The trainees go to a national nursing school for the theoretical part and for the practical part they normally join to hospitals. The trainees have got a labour contract with the hospital. Their income is lower than the income of graduated nurses. The professional title “nurse” is nationally protected, only persons with a successful vocational training are allowed to use this title.

In Germany the working fields of physicians and nurses are separated very strictly. Only physicians are allowed to diagnose a disease, nurses have only got medical assistance functions. They are the gateway between the patient and the physicians.

Typical occupational activities of hospital nurses are:

- Basic nursing (patient washing, meal distribution…)
- Planning and documentation of nursing activities
- Measuring important life parameters (pulse, blood sugar……)
- Physicians assistance
- Distribution of pharmaceuticals

Assistant hospital nurses: The vocational training of assistant nurses takes only one year. Because of this short vocational training period the working field of assistant nurses is much smaller and is focused on assistant activities like beds planning, washing, meal distribution.

The average net income per month amounts for young nurses working (full-time) in public or non-profit hospitals about 1,300 Euro, specialised nurses and elderly nurses earn more money. The working conditions in hospitals are not very well. The psychological / emotional and personal work load is very high. Nurses have to heave patients and have to care often for cureless patient. The cost pressure affects that nurses often do not have enough time to "care" for patients. Another problem is the increasing requirement for documentation so that nurses spend a lot of working time with activities far from the patient. Hospital nurses have little occupational career chances and developing chances. Because of the shift work the working time in hospitals is not family-friendly. The working-time per week is 39-40 hours. So nurses (most of them are female) have got problems to combine childcare and job. These factors affect a high rate of nurses, who leave their profession.

Geriatric nurses: The vocational training period of geriatric nurses is as long as for nurses. It is also a dual vocational training, with a theoretical part in a state school and a practical part in elderly homes or in ambulatory elderly care services. The curriculum of the training is specialised for nursing elderly people. Medical care is not a main part of the education. The working fields for geriatric nurses in elderly homes and also in ambulatory services are:

- Basic nursing (patient washing, meal distribution…)
- Planning and documentation of nursing activities
- Palliative nursing
- Measuring important life parameters (pulse, blood sugar……)
- Distribution of pharmaceuticals
- Consulting of legal rights and supporting in nursing cases

Working conditions of geriatric nurses are often worse than the conditions of hospital nurses.
The income of geriatric nurses is between 1,700-2,000 Euro gross wage per month in the case of fulltime-working. But there are big differences between ambulatory and stationary and between private and public or non-profit institutions. The working-time in non-profit or public elderly homes is about 40 hours.
The work loads in elderly homes are often quite high. The situation in elderly homes is very difficult. Reasons are not only cost pressures. There are new defiances, that are not solved yet: People are older when they go into a elderly home, they live longer and they often are multimorbid or suffer from dementia. Also palliative nursing has getting more important in the last year. These new circumstances were not implemented in the financial basis of the long-term health insurance and in the working process of the single elderly homes. The result is a really high work load for the staff in elderly homes and a high exit rate of geriatric nurses.

Assistant geriatric nurses: This training was constituted in Northrhine-Westfalia in September 2006. The aim of this new training is to avoid shortage of young

employees in this profession. These trainees are only allowed to perform assistant work.

5.1.3 Social Workers and Social Pedagogues

Precondition to start a study “Social Work” or “Social Pedagogy” is an advanced technical college certificate. In Germany you get this certificate after graduating from school successfully after 12 years.
The trainees for Social workers or pedagogues visit a public or a churchly advanced technical college. There is no evident separation between social pedagogic and social work. In general social work is a “react” work while social pedagogic is an “act” work. But the differences are in flow, because the curricula of the study is in the hand of the 16 states, so there are no general curricula in this profession.

Part of the study are for example following themes:

- Theory of Social Work or Pedagogic
- Education
- Social culture work
- Psychology
- Sociology
- Law
- Social management, project management

To get the Bacholor of Arts Certificate the study period is three years, to get the Master of Arts you need two more years. The old certification “diploma” still exists. To get this certificate you have to study 4,5 years.

Typical activities of social workers and pedagogues are:

- Elderly work, child and youth work or family work
- Coaching
- Drugs advice
- Leisure advice or pedagogic
- Education advice
- Social management, case management

The activities of social workers or social pedagogues are advising to prevent or solute social problems of elderly, families, young people or children. Typical employers of social workers are non-profit welfare organizations(often churchly), kindergarten, elderly homes, homes for young people or drugs prevention agencies.

Due to the bad financial situation of locally and churchly authorities there were extensive economies in the social sector. The employment possibilities and situation are strained, so labour contracts of young employees are often limited. The working conditions differ in relation to the activities. Shift work and a high work load due to the emotional and psychological load are marks of this profession. The income of social workers and pedagogues differs in relation to the certificate, the advanced training and the position of the activity. The average gross wage per months amounts between 2,700 – 3,500 Euro.

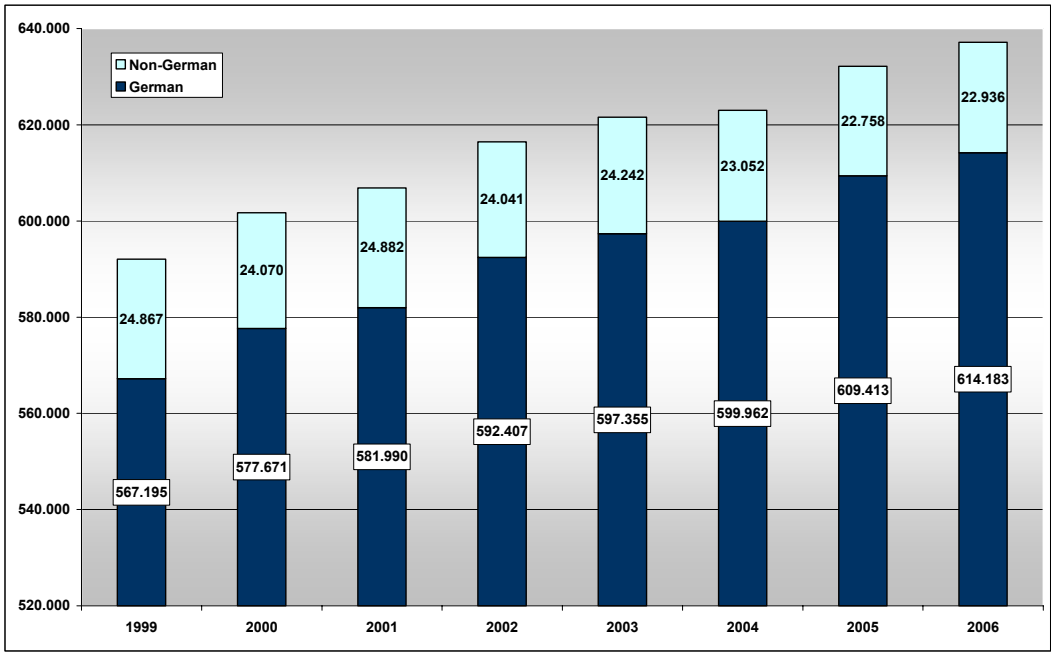
5.2 Employment development

The hospital landscape in Germany is actually in a situation of change. The dual financial system is about to be changed. In addition the introduction of a DRG-system increases the pressure to change the working processes and structures to a more efficient system.
The number of hospitals decreased since beginning of the 90^{ies} by 245 to 2,166. In the same time the number of hospital physicians increased from 110,600 to 131,200, a growth of 19%, the number of hospital nurses went up from 283,000 to 319,000, a plus of 13%. In the same time the number of assistant nurses decreased more than 40% to 19,300 in 2004. The number of child nurses is approximately constant.
This development shows the rising demand for higher qualified staff like physicians and nurses in the hospitals. Reasons are the rising number of falling numbers in hospitals and ambulatory operations (see above) and the decreasing period of staying in hospitals. Because patients are released out of hospitals earlier the demand of simple nursing staff in hospitals decreased.
These are some reasons for the shifting of lower qualified staff from in- to outpatient care. Many nurses and assistant nurses are working in ambulatory elderly care.

5.2.1 Nurses and Assistant Nurses

The number of nurses increased in the last 7 years from 592,100 to 637,100 (7,6%). There is a different development between German and Non-German nurses and assistant nurses. While the amount of German nurses increased between 1999 and 2006 by 8,3% there is a falling number of non-German nurses 7,8%. The reason for this fact can not be clarified within this descriptiv analysis. Maybe formal non-Germans have become Germans. Another reason could be that non-Germans could not participate as good as Germans on the labour market development. Migrants in Germany have got a higher likelihood to get jobless than Germans. Reasons of that fact are: Migrants have got a higher rate of people without school or profeesion graduation, on of the most important factors to get a job.

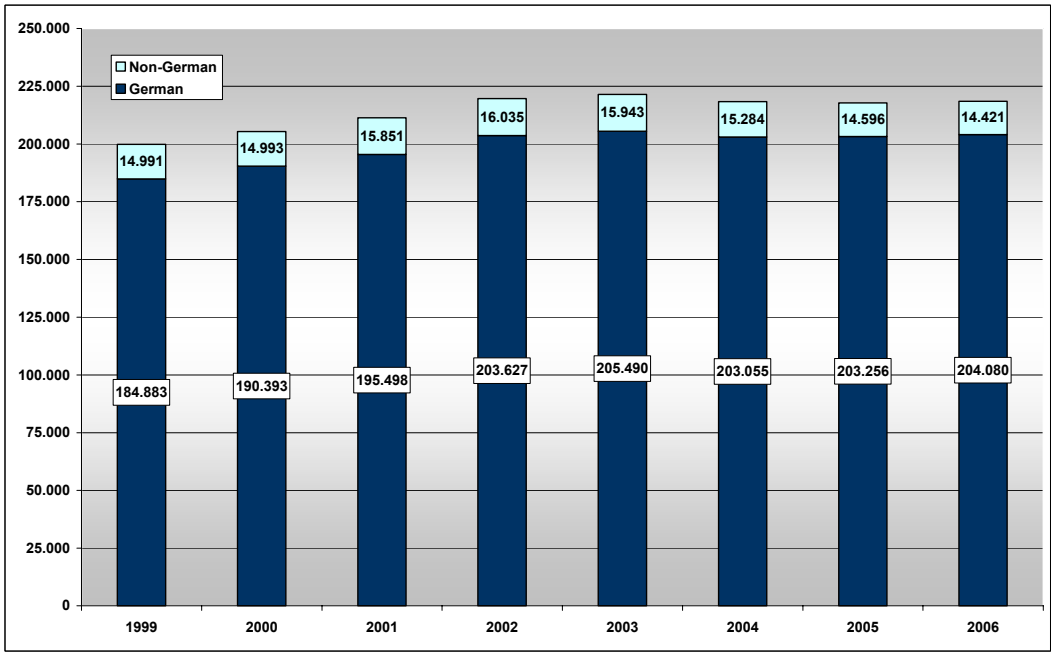
Nurses (without trainees) 1999-2006



Source:IAB, employment statistic of the labour administraion, Illustration: IWT

Because of that fact it does not astonish, that the part of non-German assistant nurses in 2006 (6.6%) is higher than the part of nurses (3.6%). As described above nurses need higher preconditions to work in their profession.

Assistant Nurses (without trainees) 1999-2006



Source:IAB, employment statistic of the labour administraion, Illustration: IWT

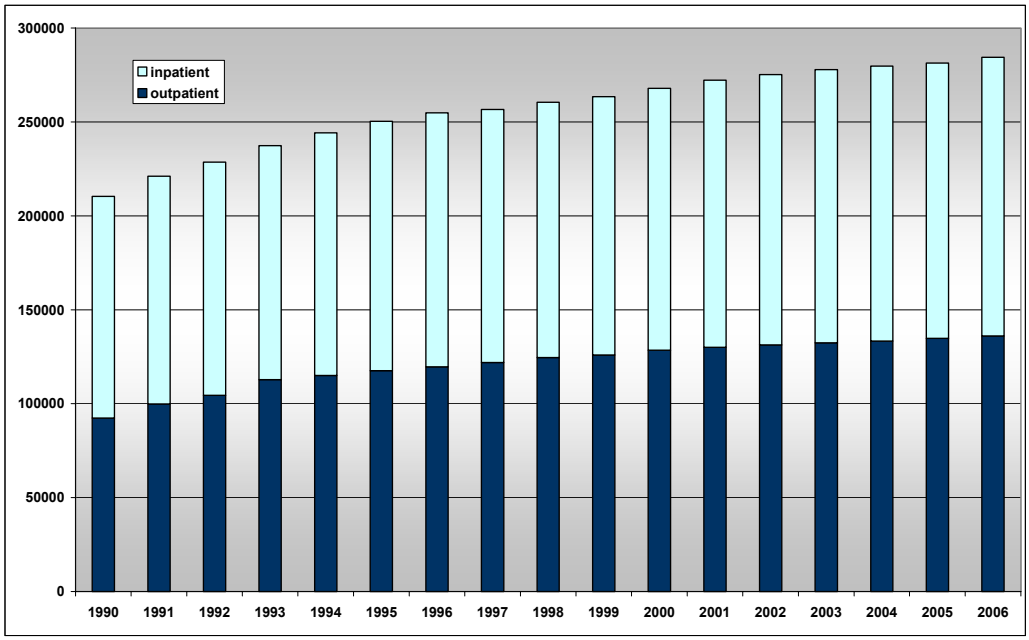
The total development of assistant nurses was positive between 1999 and 2003, between 2003 and 2005 there was a low decrease, but in the last year there wa a plus of 700. Between 1999 and 2006 there is a total growth fraom 199,900 to

218,500 (9,3%). The development between German and non-German assistant nurses is similar to the nurses development. While Germans can profit by the development (10,4%), the development of non-German assistant nurses is negative (-3.8%).

5.2.2 In- and Outpatient physicians

The number of all physicians increased from 210,400 in 1990 to 284,400 (35,2%) in 2006. Nearly 50% of the physicians are family doctors, the others are specialized.

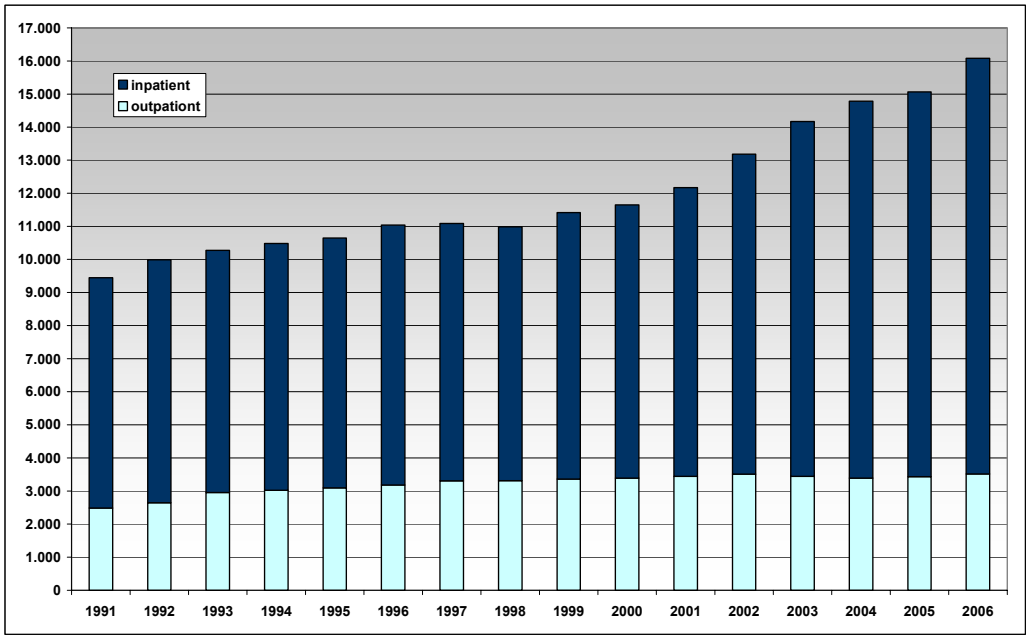
In- and outpatient working physicians, Germany 1990-2006



Source: Federal Physicians` Chamber (BÄK), Illustration: IAT

Since 1990 the number of inpatient doctors has been increasing as well as the number of outpatient physicians increased. The number of outpatient physicians grew up from 92,300 to 136,110 (47.5%), the amount of inpatient physicians from 118,100 to 148,320 (22.3%).
The relation between in- and outpatient doctors amounts 47.85% inpatient to 52.5%.

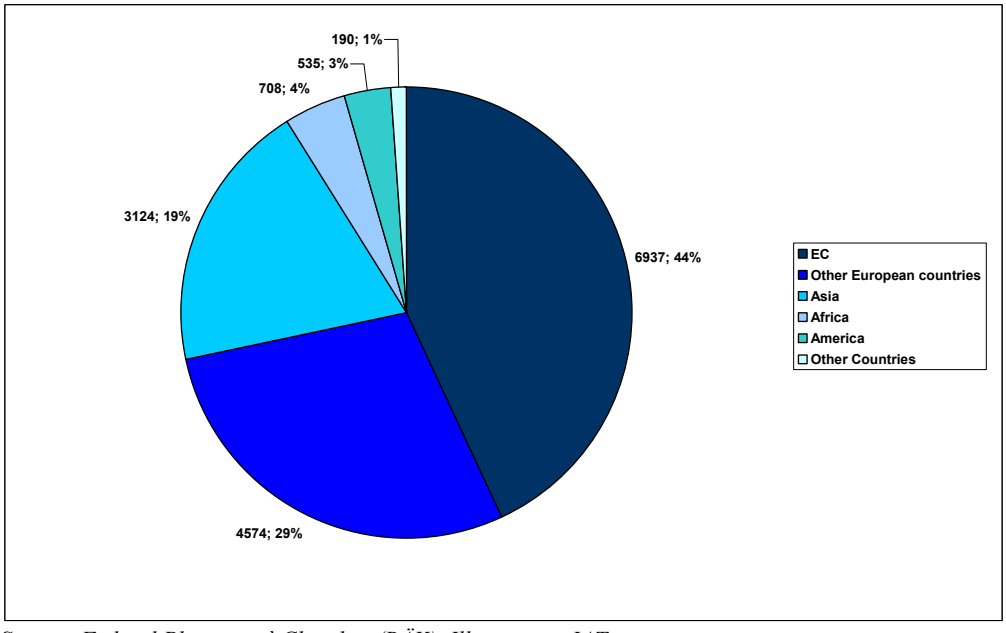
In- and outpatient working physicians, foreigner, Germany 1991-2006



Source: Federal Physicians` Chamber (BÄK), Illustration: IAT

In 2006 nearly 5.7% of all physicians in Germany came from abroad. The number of foreign physicians increased between 1991 and 2006 from 9,450 to 16,080. Since the year 2000 there has been a high rise of foreign doctors. Most of them work in hospitals in 2006, only a few are ambulatory self-employed physicians. The relation between ambulatory and stationary working doctors belongs to 21.9% outpatient and 78.1% inpatient doctors. 8.5% of the inpatient physicians do not have a German passport, 2.6% of all outpatient doctors are not German.

Source continents of foreign doctors in Germany, 2006



Source: Federal Physicians` Chamber (BÄK), Illustration: IAT

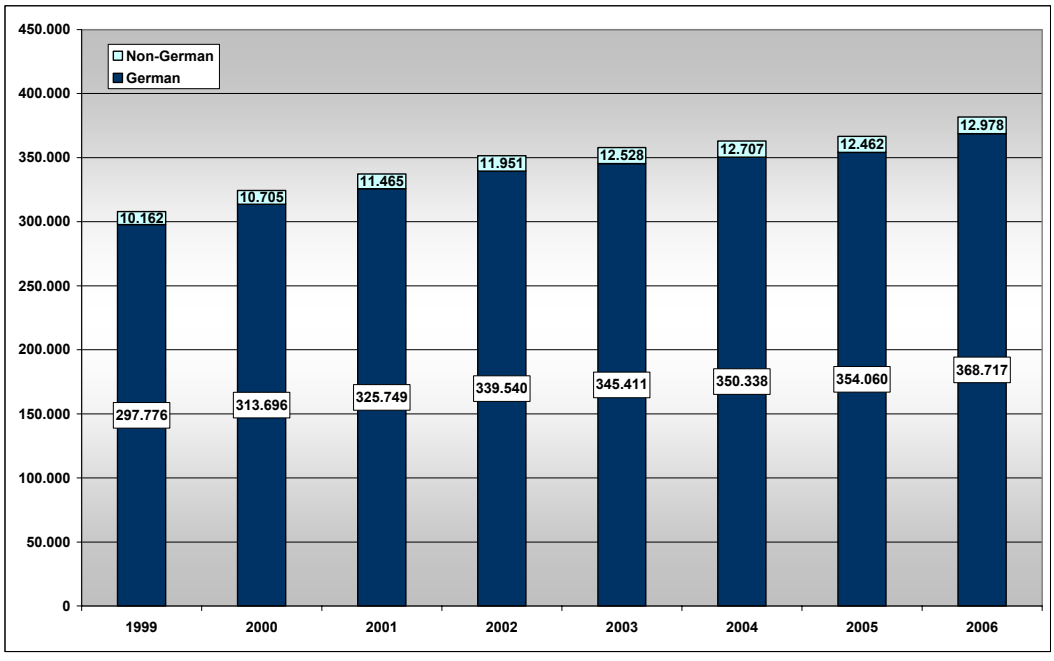
Nearly half of the foreign doctors, who work in Germany are from other EU-Countries, the main source countries are Greece, Austria and Poland. Nearly 30% migrates other European Countries, like Russia and other former Soviet-Union states. Another important source countries are Iran and Syria, the main source countries in Asia.

5.2.3 Geriatric Nurses and Social Workers

Unfortunately in the statistics there is no separation between geriatric nurses and social workers.

The development of geriatric nurses and social workers is just like in the other health profession really positive. In the year 1999 there were nearly 308,000 people working in these professions, in 2006 382,000, a growth of 73,000 (24%). The rate of foreign staff amounts about 3.5% in 2006. Both German and non-German could profit of the positive development. While the numbers of German social workers grew up from 23.8% employees grew up by 23.8%, the number of migrants employees increased by 27.7%.

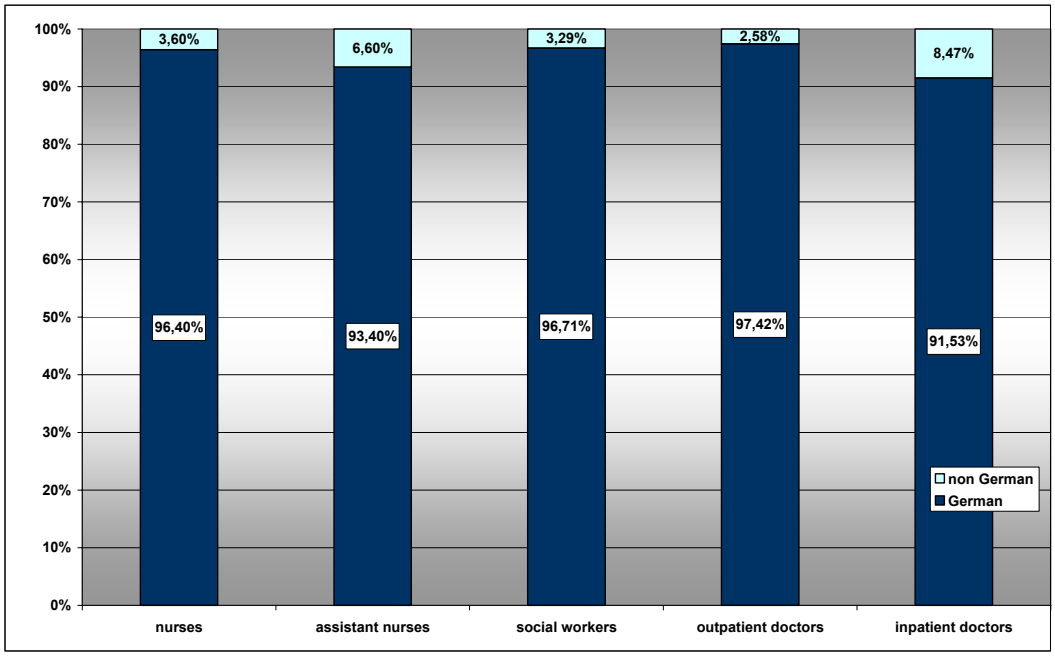
Social workers and geriatric nurses, Germany 1999-2006



Source: Labour administration, Illustration: IWT

The figure below gives an overview of the participation of the Status-Quo of the labour market participation of migrant in the health and social care sector in 2006 in Germany. Two professions have got a higher foreign rate: hospital doctors (8.5%) and assistant nurses (8.8%). Both of these rates are higher than the average rate of foreign employees of 6.9%, but still less than the population rate of foreign people in the age of 15 to 64 years that is about10.4%.

Rate of German and Non-German employees in different health profession, 2006



Source: Labour administration, physicians chamber; Illustration: IWT

6. Data on shortages and surplus of doctors, nurses and social workers

There are many difficulties to get a real picture about the labour market situation in the health and social care sector. On the one hand there is a high growth of employment, on the other hand e.g. the employment growth is partly based on a substitution from full-time work to part-time work or to marginal part-time workers, because the founded budget of hospitals decreased in the last years. Another problem is that employers do not announce the vacancies to the labour administration, but use newspapers of special health or social care magazins or internet for their job advertisement. Because of that fact the official data of the labour administration (e.g. number of unfilled vacancies) does not describe the real picture of the labour market. It can only be regarded as an extract of the labour market situation.

Unemployed persons (average of a year), 2000-2005, Germany[1]

	2000	2001	2002	2003	2004	2005	change 2000 2005	change 2000 2005 (in %)
total	3.890.000	3.853.000	4.061.000	4.377.000	4.381.000	4.860.000	970.000	24,9%
health sector	148.000	139.000	136.000	148.000	165.000	151.151	3.151	2,1%
physicians (inpatient)	8.900	8.100	7.100	6.500	6.400	6.269	-2.631	-29,6%
nurses	17.200	16.100	15.300	16.100	18.800	18.592	1.392	8,1%
nurse`s assistant	21.300	19.100	18.500	19.400	20.600	20.029	-1.271	-6,0%
social workers,geriatric nurse	36.400	37.100	39.000	44.800	51.500	36.735	335	0,9%
..geriatric nurse	20.800	21.700	23.500	27.700	33.300	36.106	15.306	73,6%

Source: Federal Labour Administration

The number of unemployed physicians has been decreasing for the last five years from 8,900 to 6,400. There is also a falling number of unemployed nurses assistants from 21,300 to 20,000. On the other hand there is a growing number of unemployed nurses and geriatric nurses. This development can be explained as follows: There is a rising demand of geriatric nurses and nurses (see above and below). There is a rising employment rate of geriatric nurses, because of the demogaphic change. One reason for the high increase of unemployed geriatric nurses could be that the demand of nurses in elderly homes grew in the last years and that there is a labour displacement from geriatric nurses to nurses in elderly homes (see above).

Unfilled vacancies (average of a year), 200-2005, Germany

	2000	2001	2002	2003	2004	2005	change 2000 2005	change 2000 2005 (in %)
total	519.979	506.507	453.167	373.026	321.026	413.078	-106.901	-20,6%
health sector	32.417	37.922	40.778	27.566	17.819	16.678	-15.739	-48,6%
physicians (inpatient)	2.828	3.436	3.766	3.067	2.132	385	-2.443	-86,4%
nurses	6.013	6.799	7.778	5.113	3.128	3.374	-2.639	-43,9%
nurse`s assistant	1.682	1.623	1.625	1.042	640	1.441	-241	-14,3%
social workers,geriatric nurse	8.502	9.849	10.491	7.508	4.729	5.389	-3.113	-36,6%
.....geriatric nurse	5.242	6.228	7.170	5.056	2.916	5.240	-2	0,0%

Source: Federal Labour Administration

There was a high decrease of vacancies since 2002 in all three professions, but there still are a lot of unfilled vacancies, especially for geriatric nurses (more than 5,000). More than 3,300 vacancies for nurses and 1,400 for nurse assistants were recorded.
A reason concerning the low number for doctors could be that hospitals use other instruments or institutions to recruit their staff. There are many job opportunities for physicians but many of them are in rural regions or the jobs are temporal limited.

7. Factors influencing shortages, surplus, mismatches between supply and demand

[1] The high increase between 2004 and 2005 can be explained by the labour market reform 2004/2005. The aim of the reform was a combination of the social benefit and the unemployment benefit. So most of the persons, who got social benefit until 2005 were not official registered in the unemployment statistic, but from 2005 there are in this official statistics.

The most important factor concerning a further growing of the social and health care sector is and will be the demographic change.
In 2004 82.5 million people lived in Germany, nearly 9% of them were foreigners. Since 1990 there was a growth of foreign residents about 1,700 people that equal 30%.

The age structure in 2004 was as follows:

- the share of people under 20 years is about 20%,
- 55% are in the age of the working age population (20 up to 59 years)
- and more than 25% are older than 60 years. The share of people 80+ is 4,3%.

In the next years the age structure will change because of demographic development. The forecast made by the Federal Statistical Office estimates a reduction of inhabitants while people get older. The population age structure in 2030 will look like this:

- The share of young people under 20 years will decrease to 17,1%,
- There will be also a decrease in the working age population (20 up to 60 years) down to 48,5%,
- Only the amount of older people (60+) will increase up to 34,4%. The share of persons older than 80 years will be more than 7%.
- *(Federal Statistical Office)*

The ageing population will have strong effects on the demand for personnel in the health and social sector. Estimates made by the German Institut for Economic Research (DIW) in 1998 and 1999 predict following development:

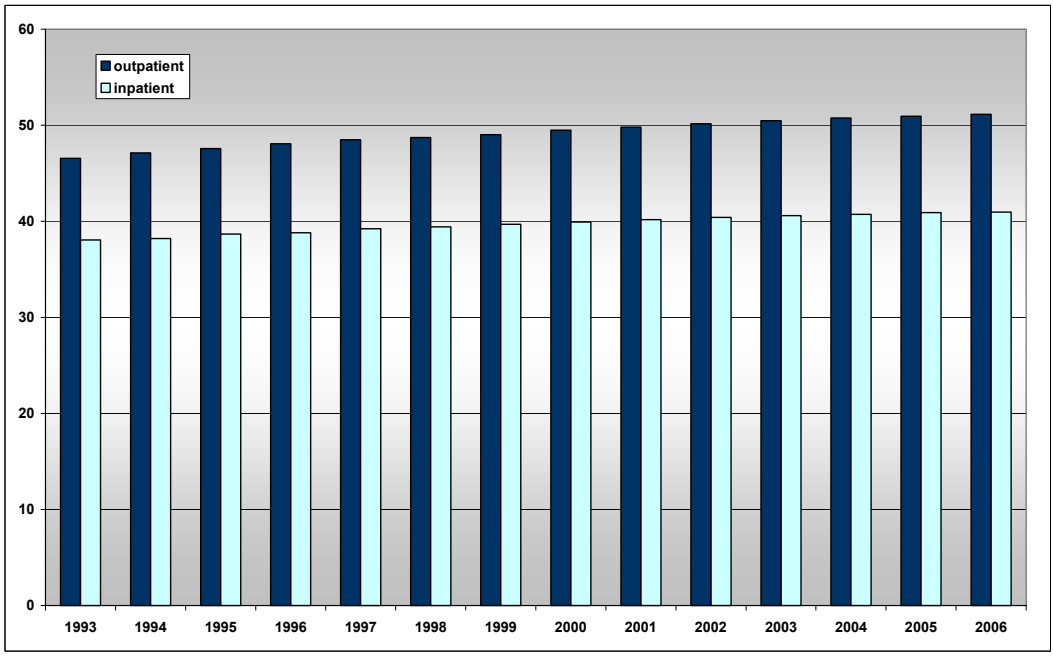
- The amount of hospital falling cases will increase from 15,9 Mio. up to 18,5 Mio. in 2020 (+ 16%) and up to 19,3 Mio. in 2050 (+21%) (Schulz 2000: 22)
- The case numbers for long-term care will grow from 1,9 Mio. in 1999 up to 2,9 Mio. in 2020 (+52%) and up to 4,7 Mio in 2050 (+145%) (Schulz 2001: 20).

This demographic change will effect a rising numbers of inpatient acute and long-term care and this will increase the demand of employment in the health and social care.
A prediction made by the Institute for Work & Technoloy for the health care sector in Nortrhine-Westfalia estimates, that there will be a high demand until 2015. It could be shown that there will be a job demand of 90,000- 200,000 until 2015, most of them in elderly care. For Germany you can estimate, that there will be an increase of 400,000 – 800,000 new jobs in health and social care.

The German health system will get many problems in the near future in order to get high qualified staff. On the one hand there is the ageing staff. On the other hand there are trends, that the amount of medical students and trainees of nurses are decreasing. These trends are not only a fact of the demographic change, but from bad working conditions.

The average age of doctors is shown in the figure below. The average age of outpatient physicians is 51, the average age of inpatient physicians is 41. As mentioned before the reason of the elderly age structure of self-employed outpatient physicians is the post-graduated training. To become a specialised physician you need professional experience and further post-graduated training. In Germany there are more than 100 possibilities for specialising. Post-graduate training usually stretches over 5 to 6 years.

Average age of in- and outpatient doctors, 1993-2006 Germany



Source: Federal Physicians` Chamber (BÄK), Illustration: IWT

The average age of doctors has risen up in the last 13 years. But the problem of this development are not the old doctors, but the missing young physicians. On the one hand there is a decreasing number of medicine study alumni in the last years from 11,555 in 1993 to 8724 in 2006 (-24,5%)(physicians chamber). On the other hand the amount of young doctors, who do not want to work as a physician, but in another profession, rise up. One reason for this development are the bad work conditions especially for young doctors (see chapter definitions).

There is no general demand for doctors in Germany, but there is a regional and functional mismatch. Especially general practitioner in rural areas in eastern Germany are missing. Many house doctors get and will get problems to find a follower of their practice in some rural areas of Germany. The main reason for that

are the lower income in that region because of a lower rate of private insured patients combined with a wider areas and in fact of this a longer drive to their patients. Additional to that the infrastructure in rural areas is less attractive (no cultural offers, no higher school for their children…).

Average age of social employed persons, Germany 2005

	under 25	25-29	30-34	35-39	40-44	45-49	50-54	55+
physicians (inpatient)	0,3%	9,5%	19,6%	20,4%	18,0%	12,2%	8,8%	11,3%
nurses	14,2%	12,0%	12,1%	15,5%	16,7%	13,7%	9,2%	6,6%
nurse`s assistant	11,2%	10,2%	9,8%	12,8%	15,3%	15,4%	13,7%	11,7%
social workers,geriatric nurse	13,4%	9,6%	9,1%	13,1%	16,6%	15,9%	12,5%	9,8%
health sector	**15,0%**	**12,8%**	**12,0%**	**14,1%**	**15,4%**	**13,4%**	**9,6%**	**7,7%**
total	**11,9%**	**10,1%**	**11,4%**	**15,1%**	**15,8%**	**13,5%**	**11,2%**	**11,1%**

Source: Federal Labour Administration

The table above shows the proprational rates of employees by age groups:
There is a high rate of young doctors 19% (30-34) working. These doctors are working in hospital to get specialization.
There is a low proportion of nurses who are older than 55. The exit rate of nurses, who leave their job is much higher in Germany than in other countries. Most of the nurses are women. The work laod of nurses is very high and so many of the nurses leave or think about leaving their job (Simon/Tackenberg/Hasselhorn u.a. .2005: 53)

8. Data on international labour market

8.1 German physicians working abroad

There is no official statistics about Germans working abroad. Because of that fact, data concerning job mobility is not complete and the interpretation of this data has to be done carefully.

German physicians working abroad

	Year	Amount
UK	2007	4.129
USA	2001	2.694
Switzerland	2007	2.565
Austria	2007	1.457
Sweden	2005	1.116
France	2006	975
Norway	2004	650
The Netherlar	2007	584
Italy	2001	538
Belgium	2007	338
Spane	2001	259
Luxenbourg	2001	116
Portugal	2004	106
Ireland	2004	104
Denmark	2004	87
Finland	2006	65
Total		**15.783**

Source: Federal Association of physicians

There are more than 12,000 physicians working abroad. All interview partners confirmed that the interest of physicians to work in another country increased in the last years. Reasons thinking about job mobility are that the working conditions for doctors got worse in the last years. Many physicians are dissatisfied about the increasing administration, lower income or further circumstances. Most of the physicians are interested to wok in Switzerland, Austria or Sweden or Great-Britain.

There are no statistics or examinations about German nurses or social worker working abroad.

8.2 How to be recognised as a physician or a nurse?

As described before, the profession titles of physicians and nurses are – in opposite to social workers – nationally protected. Foreign nurses or physicians need the national accreditation to work as a nurse or a physician. The procedures are similar.
EU-citizens do not have that problems than non-EU-Citizens or people from acceding EU-countries. Because the CareFlows Project focuses in EU-Citizens only this cases are described:
Basis for recognition is the Directive 2005/36/EC on the mutual recognition of qualification the qualification framework. This directive described the minimum standards of the education, that are needed to be recognised in an EU-Country as a nurse or physician.

<u>Nurses</u>
To get the allowance to work in German hospitals or in ambulatory care as a nurse, foreign nurses has to announce themselfes at the local health office. They need

- signed application
- short curriculum vitae
- certificate of the vocational training in the home country
- certificate of the vocational training institution, range and period of the vocational training
- birth certificate, (marriage…)
- certificate of nationality and registration certificate that you live in Germany
- certificate of health
- school leaving certificate of secondary school or lower secondary school in relation with a vocational training as a nurses assistance (2 years)
- certificate of language skills

(source: website of several local and regional governments)

Evidence of formal qualifications of nurses responsible for general care in the partner countries

Country	Evidence of formal qualification	Body awarding the evidnce of qualifications	Prfessional title	Refernce date
Germany	Zeugnis über die staatliche Prüfung in der Krankenpflege	Staatlicher Präfungsausschuss	Gesundheits- und Krankenpfleger (-in)	29 June 1979
The Netherlands	1. Diploma's verpleger A, verpleegster A, verpleegkundige A 2. Diploma verpleegkundige MBOV (Middelbare Beroepsopleiding Verpleegkundige) 3. Diploma verpleegkundige HBOV (Hogere Beroepsopleiding Verpleegkundige) 4. Diploma beroepsonderwijs verpleegkundige — Kwalificatieniveau 4 5. Diploma hogere beroepsopleiding verpleegkundige — Kwalificatieniveau 5	1.Door een van overheidswegebenoemde examencommissie 2. Door een van overheidswegebenoemde examencommissie 3. Door een van overheidswege benoemde examencommissie 4. Door een van overheidswege aangewezen opleidingsinstelling 5. Door een van overheidswege aangewezen opleidingsinstelling	Verpleegkundige	29 June 1979
Ireland	Certificate of Registered General Nurses	An Bord Altranais (The Nursing Board)	Registered General Nurses	29 June 1979
United Kingdom	Statement of Registration as a Registered General Nurse in part 1 or part 12 of the register kept by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting	Various	State Registered Nurse — Registered General Nurse	29 June 1979

Source: Directive 2005/36/EC, Office Journal of the European Union, pp 93-95.

The costs of the acknowledgement process differ, you can estimate the costs on 152 Euro (searching of files, without an individual verbal or practical skill test).

If nurses are not EU-citizens or came from one of the acceding EU-States they have to make an individual equivalent test. The test is divided in a practical (3 hours) and a theoretical part (30 minutes), and are placed in the federal states

nursing schools. The cost for the test are at least 600 Euro, and German language skills are premises for the test. The test can be repeated only once again. Most of the health schools offer preparation courses for that tests.

Another way to get the recognition of the national title is the regular vocational training in nursing. The normally three years period could be reduced, if the existent vocational training of the home country is 2/3 equivalent with the German training.

Physicians

To get a lisence to work as a physicians, you have to go to two offices. The regional health office is the contact point to get a recognition of the basis medical training. Because in Germany the physicians chambers have the responsibility for the medical specialisation, the recognition of the specialisation has to be done by the chamber. The minimum standards of the partner countries are shown on the tables below.

Evidence of formal qualificatons in basis medical training

Country	Evidence of formal qualification	Body awarding the qualifications	Certificate accompanying the qualifications	Refernce date
Germany	- Zeugnis über die Ärztliche Prüfung - Zeugnis über die Ärztliche Staatsprüfung und Zeugnis über die Vorbereitungszeit als Medizinalassistent, soweit diese nach den deutschen Rechtsvorschriften noch für den Abschluss der ärztlichen Ausbildung vorgesehen war	Zuständige Behörden		20 December 1976
The Netherlands	Getuigschrift van met goed gevolg afgelegd artsexamen	Faculteit Geneeskunde		20 December 1976
Ireland	Primary qualification	Competent examining body	Certificate of experience	20 December 1976
United Kingdom	Primary qualification	Competent examining body	body Certificate of experience	20 December 1976

Source: Directive 2005/36/EC, Office Journal of the European Union, pp 58-59.

Evidence of formal qualificatons in medical specialization

Country	Evidence of formal qualification	Body awarding the qualifications	Refernce date
Germany	Fachärztliche Anerkennung	Landesärztekammer	20 December 1976
The Netherlands	Bewijs van inschrijving in een Specialistenregister	— Medisch Specialisten Registratie Commissie (MSRC) van de Koninklijke Nederlandsche Maatschappij tot Bevordering der Geneeskunst — Sociaal-Geneeskundigen Registratie Commissie van de Koninklijke Nederlandsche Maatschappij tot Bevordering der Geneeskunst	20 December 1976
Ireland	Certificate of Specialist doctor	Competent authority	20 December 1976
United Kingdom	Certificate of Completion of specialist training	Competent authority	20 December 1976

Source: Directive 2005/36/EC, Office Journal of the European Union, pp 60-61.

- Following premises are necessary and has to be sent to the regional governmental agency, department public health:
- signed application
- short curriculum vitae
- medical Diploma
- certificate of the home government administration, that the person is allowed to work as a physicians in the home country
- birth certificate
- certificate of nationality
- clearance certificate
- certificate of health
- personal signed determination of exemption from punishment
- in case certificate of German language skills (for example Goethe-Institute, level B2 of the Common European Framework of Reference for Languages)
- in case certificate of promotion

(source: website of several local and regional governments)

In some cases the regional administration will prove the professional language skills in the agency before they will issue the approbation.

The graduation period takes about 2 weeks, the costs for the approbation differ between 130 Euro – 500 Euro.

Physicians who made their medical diploma in acceding countries have some more difficulties to get the approbation.
The governmental administration agency will prove the medical diplomas individually. These physicians need all the certificated above and they need a certificate, that they have worked in their home country in the last years (3 years from the last 5 years).

In most of the cases the physicians have to make an equivalent test, to prove, that their medical skills are on the same level as skills of German physicians.
This test will be made by the examination office of the federal states. The costs are ca. 280 € in North Rhine-Westphalia.

In preparation for the test, the physicians are allowed to work (together with an physicians, who has the approbation) for example in a hospital (maximum 18 months) as in a practical year. In that period they have to learn internal medicine (6 months), general theory (6 months), and a special medicine subject (6 months, free chosen).

The equivalent test is very difficult and you can repeat it only once again. So the practical year can be very helpful for the foreign physicians. In this practical years the physicians are not allowed to earn money. They are only allowed to get benefit from the labour administration. The benefit level is on the level of the living wage and it could be very difficult to pay the costs for the test, learning material and something like that.
In that case there are founding from the physicians trade union “Hartmann-Bund”. They support the foreign physicians and their families.

Once the test is succeeded, the physicians will get their approbation or a work permission. People, who do not have the right to get the approbation, only get a regional and temporal work permission. After working in Germany 5 years (married) or 8 years (not married) you have the chance to get the approbation, if the personal presumptions are convenient.

9. Discussion on main research question

As described there is a growing demand for health and social care profession in Germany. On the other side many employees are dissatisfied about their working conditions like income, working time or espacially in elderly homes a growing work load. As described these could be push-factors for job mobility. So one solution for the unsatisfied working conditions could be working abroad, but this is only one of many other possiblities. Another solution could be a sectoral mobil-

ity and looking for another profession. Reasons for job mobility are often multi-faceted, push and pull-factors have to be contrasted.

The barriers for medical and social care professions are much higher than for other professions because of the high regulated market. The state with the social insurance system take care of the medical quality. As described within the EU there are directives to regulate this acknowledgement, but there are many individual exclusions. These persons have to make an indiviual test (medical skills or language skills). So job mobility often leads to a lower income in the beginning of the new start abroad, because the diploma or vocational training is not accepted and the person has to work to get " more professional experience". Also the language skills must be very good due to this individual-related services in the health and social care sector.

So it becomes obvious that job mobility is an important aspect between developing countries and industrialised countries. Here are big differences between economic status, working conditions, infrastructure, life qualitiy, disease as the most important push- and pull- factors. Job mobility within NW-Europe is not based on these existential questions. The reasons are much more individual and can not be described in general.

To increase job mobility in health and social care sector within Europe the following recommondations may be helpful:

1. *Development of a database of in- and outflow of health and social care workers:*

   Today politician and researcher only have information about the Status-Quo of foreign people working in Germany. There are no reliable data about the in- or outflow of employees.

2. *Further approach process of curricula:* To get the same minimum standards it would be helpful if the curricula process went further on. It would be helpful for students, who want to study abroad but also for employess because the recognition procedure would be easier.

3. *Better Control system of Language skills*: Because health services are a special kind of personal related service language skills are absolutely necessary to get a high standard of medical and social care. In some interviews it became clear, that the language skills of many candidates and employees are inadequate.

4. *Promotion of work experience (practicals) abroad for non academic professions:* While medical students often use exchange programmes like LEONARDO while their study or after their study to get professional experience to get a specialization, non-academic health workers do not use this programmes

often. A better promotion and marketing of existing project for non-academic health and social care professions could be helpful.

5. *Standardization of recognition procedures:* The recognition procedures in the several countries are completely different. There are differences in relation to the necessary documents or the test you have to do. A standardization concerning documents and procedure would be helpful for all parties: employees and the registration offices in the source and destination counties.

10.Literature

Buchan,J. / Perfilieva, G. 2006: Health workers miogration in the European Region: Country Case Studies and Policy Implications.

Busse, R., Riesberg, A. Health Care Systems in Transition: Germany. Copenhagen, WHO-Regional Office for Europe by order of the European Observatory for Health Care Systems and Health Policy, 2004.

European Commission 2007: Directive 2005/36/EC, Office Journal of the European Union.

Riesberg, A. 2005: Germany, in: Grosse-Tebbe, S./ Figueras, J. 2005: Snapshots of health systems. European Observatory on Health Systems and Policies, Copenhagen, pp 21-23.

Potratz, Dahlbeck, Hilbert 2006: Economics of the public health sector in Northrhine-Westphalia: From money pit to profit centre, WHO.

Schulz,E/ König, H./ Leidl R. 2000: Auswirkungen der demographischen Alterung auf den Versorgungsbedarf im Krankenhausbereich - Modellrechnungen bis zum Jahre 2050. Berlin, DIW-Wochenbericht 44/00.

Schulz,E./ Leidl, R./ Koenig, H. 2001: Starker Anstieg der Pflegebedürftigkeit zu erwarten: Vorausschätzungen bis 2020 mit Ausblick auf 2050. Berlin, DIW-Wochenbericht 5/01.

Simon, M./ Tackenberg, P./ Hasselhorn, H./ Kümmerling, A./Büscher, A. & B. 2005: Auswertung der ersten Befragung der NEXT-Studie in Deutschland. Universität Wuppertal. http://www.next.uni-wuppertal.de

Spengler, Hannes 2005: Einkommen und Arbeitszeiten junger Klinkärzte in Deutschland. Berlin, DIW-Wochenbericht 34/05.

WHO 2005: HiT summary Germany. European Observatory on Health Systems and Policies, Copenhagen.

Country Report – Ireland

An Evaluation Of Factors Effecting Labour Mobility Among Health And Social Care Practitioners In Ireland.

Compiled for the Careflows Project in partnership between the University of Limerick and the National Recruitment Projects Office, Health Service Executive.

by

Denis Ryan & Dermot Coughlan, University of Limerick

Introduction

In an effort to understand the factors that impinge on labour mobility in the health and social care sector in Ireland (with particular reference to the North West area of the EU), a study was undertaken involving key organisational stakeholders and drawing on the experiences of individual practitioners in the Irish Health and Social Care environment. A qualitative study was undertaken, involving a series of semi structured interviews were organised with participants. Four interviews were undertaken with representatives from the Irish Nurses' Organisation; the Health Services Executive, the Department of Health and the Association of Social workers. An Interview was also requested with a representative from the Irish Medical Organisation, but this was not confirmed within the time period available for data collection. The HSE representative represented nursing and the Department of Health and Children representative had an advisory role with the Department of Health and Children in relation to a range of Clinical Therapies.

In addition, a series of individual interviews were also undertaken with health care professionals who had relocated to Ireland. Participants for this element of the study were identified initially from the database of employees maintained by the National Shared Projects Office of the HSE. Potential participants were identified by this Office and invited to participate by letter and were selected based on the country of origin identified for them and their occupations. One respondent was a Non Consultant Hospital-based Doctor (NCHD), three were hospital based nurses and one was a speech and language therapist. Two of the respondents were men and three were women. Two respondents had relocated from the UK, two were from Germany and one from the Netherlands, so all had come from the reference area.

The Irish Healthcare System - An Overview

The organisation and delivery of health and social services in Ireland is governed under statute and in particular the Health Acts up to and including the Health Act (2004). In addition, the policy context has been influenced by the two Health Strategies – Shaping a Healthier Future (Department of Health, 1994) and more recently Quality and Fairness: a Health System for You (Department of Health and Children, 2001). The Irish health care system is currently in a period of significant transition and reform. Until recent times, the health services in Ireland were managed by 11 health authorities organized on a regional basis. Eight of these health authorities, referred to as health boards were established under the 1970 Health Act. In the late 1990s the first major reform of health services

meant that the health board responsible for the Eastern region, with the largest population based around Dublin was replaced by three health areas, with an overarching regional authority.

Within the structures that existed from 1970, the Department of Health, and subsequently the Department of Health and Children combined some executive and policy functions, especially in relation to services offered by the voluntary and private sectors. From the mid 1990s, reform of health services was heralded in two national strategies published by the government in 1994 and subsequently in 2001. These reports, as well as a series of other reports highlighted the difficulties and deficiencies in terms of the management and delivery of health and indeed social services in Ireland. The government outlined a program for reform in 2003.

This essentially proposed a separation of executive and non-executive functions. It proposed that the department of health and children would have primary responsibility for strategic and policy issues. It also proposed the development of a unified organization, titled the Health Service Executive, which was entrusted with the remit of delivering services on a national basis, specified by the department within budget. Within that context, the Department of Health and Children retains ultimate responsibility for holding the Health Service Executive accountable for its performance. In terms of health service delivery, the Health Service Executive is organized into three key service units. The national hospitals office holds responsibility for the management of the acute hospital sector across the country.

The second major organizational unit responsible for service delivery within the HSE is the primary, community and continuing care directorate. This directorate has responsibility for the management, organization and delivery of services within both primary and community care as well as continuing care services.

The third key organizational unit is the office for population health. This office is charged with responsibility for the promotion and protection of health.

The following map outlines the geographical regions served by the four Health Service Executive areas nationally. These geographic regions represent the administrative units within a the health service executive for the delivery of services by the directorate of primary, community and continuing care as well as by the national hospitals office.

The Irish population has risen by over 17% since the early 1990's. The age cohorts that show the greatest increases are in the 50 – 59 age group and those over 80. This suggests that the population profile is ageing, though not at the same rate as some other European countries. This profile is likely to have a significant impact on health service delivery and service demands.

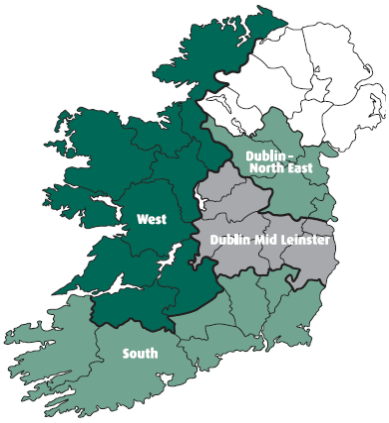


Figure 1: HSE Areas (Source: HSE 2006)

When compared with other OECD countries, some of the key indicators suggest that Ireland has some way to go to achieve the norms of other OECD countries, despite its significant economic growth in recent years. For example, in 2004, the average number of acute inpatient beds in the OECD region is 2.1 beds per 1,000 population. Ireland, at that time had 2.9 acute beds per 1 000 population.

In the same year, Ireland's healthcare, which was (and remains) mainly in the public sector and publicly funded had total expenditure which represented approximately 7% of GDP, which compared with an average of nearly 9% across OECD countries (OECD, 2006). In total, non capital expenditure on health in 2004 was just over €9billion. This represents approximately a 50% increase from expenditure in 1999 (Department of Health and Children, 2006b). When measured in terms of per capita spending, it is estimated that spending per capita increased in Ireland in real terms by just over 9% per year between 1999 and 2004. While this seem a very significant increase, it should be viewed in light of Ireland's strong economy within the same period. Within that context, the proportion of GDP devoted to health has actually only increased only by one percentage point over the period (OECD, 2006).

Employment In The Health Service Executive

The Health Service Executive is a major employer. Nationally, the Public Health Services employed a total of 101,978 whole time equivalents in the public health services in 2005 (Department of Health and Children, 2006). Of those, 35,248 WTE's were allocated to nursing posts and 7,266 were in medical/dental grades, some 13,952 were categorised as Health and Social Care professionals.

Region \Grade Category	Medical / Dental	Nursing	Health and Social Care Professionals	Management /Administrative	General Support Staff	Other Patient and Client	Total
Eastern	3,196	13,119	6,468	6,637	5,273	5,420	40,113
Midland	328	1,949	797	859	314	1,568	5,815
Mid-Western	486	2,838	1,033	1,372	677	1,620	8,026
North-Eastern	514	2,581	841	1,390	765	1,468	7,559
North-Western	420	2,389	685	1,216	1,377	970	7,057
South-Eastern	589	3,480	941	1,390	1,790	766	8,956
Southern	980	5,040	1,908	2,099	1,932	2,061	14,020
Western	753	3,852	1,279	1,737	1,098	1,712	10,431
Total	7,266	35,248	13,952	16,699	13,227	15,586	101,978

Figure 2 - Numbers Employed in the Public Health Service end-December 2005 (All figures expressed as whole-time equivalents) Source: Department of Health & Children Personnel Census -
http://www.dohc.ie/statistics/health_service_employment_statistics/2005Q4_numbers_employed_by_region.pdf?direct=1

Note1: Management/ Administrative includes staff providing a direct service to the public including Consultants Secretaries, Out-Patient Departmental Personnel,
Medical Records Personnel & Telephonists. This category also includes staff providing Payroll, Human Resource Management (including training), Service
Managers, IT Staff, General management, legislative and Information supports.

The actual number of staff employed either directly by the HSE or in agencies funded by the HSE was 101,977. Of those, 35,248 were nurses; with 13,952 employed in Health and Social Care Professions and 7,266 in Medical/Dental positions. Of those, approximately 98, 400 were employed between the two largest organisational units of the HSE (Primary, Community and Continuing Care and the Acute Hospital Sector. There are therefore 3,554 medical/dental, nursing and/or health/social care professionals working outside these two units, representing approximately 3% of the total employees.

Staff Category	December 2006
Nursing	35,248
Management/Administration	16,699
General support Staff	14,945
Health & Social Care Professionals	13,952
Other Patient & Client Care	13,867
Medical/dental	7266
Total	101,977

Figure 3 – Staff employed by the HSE

It is estimated that 49,086 staff work in Primary, Community and Continuing Care and 49,337 are employed in the Acute Hospital sector (Health Service Executive, 2005). In the Primary, Community and Continuing Care sector, there were 15,774 nurses employed, with 8,196 staff employed as health and social care staff and 1,617 in medical/dental posts. This compares with those working in the acute hospital services where there were 19,321 nurses in employment and 7,552 in Health and Social Care posts as well as 5,528 in medical/Dental posts. This means that the combined workforce in these three categories of staff in the Primary, Community and Continuing Care sector is 25,587; this compares with 30,453 in Acute Hospitals. This suggests that despite the refocusing of health services to primary, community and continuing care, the majority of health service caring staff continue to be based in acute hospitals.

Nursing in Ireland

Nursing in Ireland is a regulated profession, with An Bord Altranais, the regulatory authority operates under statutory provisions as set out in the 1985 Nurses Act. The Board maintains a register of nurses and midwives. Despite the fact that Midwives and Nurses are understood to be separate professions, the Register of Nurses includes midwives. In that context, An Bord Altranais (2005) reported that there were a total of 78, 552 nurses in 2005. Of those, 69,639 are on the 'Live Register' which means they are available to work.

The following table presents the areas of qualification. It should be remembered that these registrations do not represent individual nurses/midwives. In total there are 85, 919 active qualifications registered among the 69,639 'active' nurses. This suggests a significant level of multiple registrations.

Entry to the profession has traditionally been mainly by direct entry to particular areas of practice. For example, entry to general, psychiatric and intellectual disability is now

exclusively through undergraduate programmes offered in 13 higher educational institutions. These programmes are required to meet approval requirements set out by An Bord Altranais and successful completion of these programmes leads to registration with An Bord Altranais in the relevant area of practice. Entry to Midwifery and Children's nursing is generally through educational programmes which require registration on another division of the register although midwifery is now also offered by direct entry routes.

Since 2002, entry to the General, Psychiatric and Intellectual Disability registers requires successful completion of an honours primary degree level (level 8). However, the academic level of practitioners who qualified prior to that and are at both diploma and certificate levels are also accepted for registration purposes. Midwifery is now evolving to have the same entry requirements. Recognition of foreign qualifications is also managed by An Bord Altrananis.

Ireland compares very favourably with other countries in relation to the numbers of nurses per 1,000 population. According to OECD statistics, Ireland has 15 nurses per 1,000, which is the highest in the OECD countries (OECD, 2006). Interestingly, all nurses in Ireland are professionally qualified and registered nurses. Direct comparisons with other OECD countries are somewhat difficult insofar as not all nurses are qualified or professionally registered. Ireland has had cycles of both over and under supply of nurses (Ryan et al, 1999), with nurses traditionally finding employment in countries such as the UK, Australia and the US and other English speaking countries in particular. This also means that direct comparisons in terms of shortages or over/under supply of nurses is problematic.

Social Work in Ireland

The international definition of social work adopted July 2000 by the International Federation of Social Workers says that:

> *"The social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilising theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work."*

In an Irish context, social workers work in a range of work settings offered by statutory, voluntary as well as community social service agencies. The principle agencies would include the Health Service Executive, working in hospital and community based services,

ranging from child, adolescent and adult hospitals, mental health and older person services as well as community services. Other significant employers would include the Probation and Welfare Services as well as Local Authorities, housing services and community development work; adoption services; Counselling work; Child protection services as well as Learning Disability Services. In private industry, some social work practitioners would work in employee assistance programmes.

Entry to the profession is now normally through either an undergraduate or postgraduate academic qualification, with recognition and accreditation by a national body. Social work qualifications are accredited by National Social Work Qualifications Board in Ireland since 1993. It is the designated Irish body for the profession of Social Work. It both accredits national qualifications and recognises international qualifications. The mission of the NSWQB is to sustain and develop quality social work education and training, so as to ensure that social workers are equipped to work and contribute effectively to statutory, voluntary and community social services (NSWQB, 2004).

In order to practice as a professional social worker in Ireland, it is necessary to hold one of the following;

- National Qualification in Social Work (NQSW) – now the national professional standard.

The Certificate of Qualification in Social Work – this certification was offered by UK accreditation body up to 1993. The CQSW is recognised by the NQSWB as being equivilant to the NQSW

Recognised qualifications that predate the CQSW are also recognised for professional practice.

Non-national qualifications accredited by the NSWQB.

The NQSW is awarded to students who successfully complete a recognised course in Ireland. There are currently a range of postgraduate and undergraduate courses offered by four universities nationally. The NUI (Cork) offers a Masters of Social Work/Higher Diploma in Social Work Studies (MSW/HDSWS). NUI Galway offers a Masters in Social Work as does the University of Dublin (Trinity College); while NUI Dublin offers a Masters of Social Science Social Work)/Higher Diploma in Applied Social Studies MSocSc(SW)/HDASS). Entry to these programmes requires a professional qualification and relevant work experience.

NUI (Cork) offers an undergraduate programme, combining both an academic qualification and professional training. This programme is the Bachelor of Social Work (with European Pathway) (BSW). A similar programme is also offered by the University of Dublin (Trinity College). This programme is the Bachelor in Social Studies (with Honours) (BSS).

The NSWQB (2004) reported that since 1993 there have been 1178 graduates who have been awarded a NQSWG at both undergraduate and postgraduate level. In addition, it reported that it has accredited over a thousand qualifications from countries drawn from each continent, with the majority coming from Great Britain, Australia, the US and Northern Ireland.

Medicine in Ireland

As with all international countries, medicine is a graduate profession requiring extensive training. Practitioners may operate either privately or within the public sector, with the majority in either the public sector or operating shared services both privately and on a contractual basis to the Health Service Executive. Services are essentially offered at Consultant, Non Consultant or Primary care General Practitioner level. The following tables indicate the numbers of posts and numbers practicing within the former regional health boards as well as by speciality. Health service delivery systems within the public health system have traditionally been Consultant led, with a significant reliance on both non consultant doctors as well as other disciplines. Within team based systems of care, medical consultants held dominant organisational as well as clinical positions within health services. This continues to be the case, with recent recommendations in Mental Health Services that Consultant Psychiatrists continue to hold overall clinical responsibility and leadership in terms of care delivery.

HOSPITAL CONSULTANTS: NUMBER OF POSTS AND NUMBER PRACTISING BY HEALTH BOARD/REGIONAL AUTHORITY - 1 JANUARY 2002, 2003, AND 2004

Health Board / Regional Authority	Number of Posts			Number Practising			Number Practising per 10,000 Population*		
	2002	2003	2004	2002	2003	2004	2002	2003	2004
Eastern	770	812	843	663	708	730	4.7	5.1	5.2
Midland	62	69	79	56	54	59	2.5	2.4	2.6
Mid-Western	105	111	121	96	100	97	2.8	2.9	2.9
North-Eastern	97	105	118	79	80	81	2.3	2.3	2.3
North-Western	91	92	99	80	81	82	3.6	3.7	3.7
South-Eastern	133	138	149	115	118	132	2.7	2.8	3.1
Southern	209	223	226	170	186	199	2.9	3.2	3.4
Western	165	181	189	135	144	151	3.5	3.8	4.0
Total	1,632	1,731	1,824	1,394	1,471	1,531	3.6	3.8	3.9

* *Rates are based on the 2002 Census of Population.*
Source: Comhairle na nOspidéal.

Figure 4 – Hospital Consultant Posts

HOSPITAL CONSULTANTS: NUMBER BY SPECIALITY - 1 JANUARY 2002, 2003 AND 2004

Health Board / Regional Authority	Number of Posts			Number Practising			Number of Vacancies		
	2002	2003	2004	2002	2003	2004	2002	2003	2004
Accident & Emergency	21	265	51	20	236	28	1	29	23
Anaesthetics	257	31	272	219	22	241	38	9	31
Intensive Care	1	1	1	0	0	1	1	1	0
Medicine	296	316	342	254	274	293	42	42	49
Obstetrics/Gynaecology	90	93	98	85	85	83	5	8	15
Paediatrics	88	96	101	78	82	83	10	14	18
Pathology	149	159	165	123	132	138	26	27	27
Psychiatry	261	276	281	203	211	227	58	65	54
Radiology	153	163	169	130	138	142	23	25	27
Surgery	316	331	344	282	291	295	34	40	49
Total	1,632	1,731	1,824	1,394	1,471	1,531	238	260	293

Source: Comhairle na nOspidéal.

Figure 5 – Hospital Consultants by speciality

NON-CONSULTANT HOSPITAL DOCTORS: DISTRIBUTION BY GRADE WITHIN THE PUBLIC HEALTH SERVICE, 31 DECEMBER 2000-2004

Grade	2000	2001	2002	2003	2004
House Officer/House Officer Senior	1,481	1,615	1,727	1,708	1764
Intern	414	440	466	471	485
Registrar	1,167	1,240	1,308	1,241	1,250
Registrar Senior/Specialist	287	431	593	668	699
Total	3,349	3,726	4,093	4,087	4,199

Note: Excludes Specialist Agencies.
Source: Department of Health and Children Personnel Census.

Figure 6 – Non Consultant Hospital Doctors

NUMBER OF DOCTORS PARTICIPATING IN THE CHOICE OF DOCTOR SCHEME, 1994-2004

Health Board/ Regional Authority	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Eastern	528	528	518	513	504	518	573	588	719	740	749
Midland	101	97	99	100	99	98	101	101	115	119	123
Mid-Western	144	144	141	140	140	148	163	173	197	200	204
North-Eastern	126	124	125	130	124	128	145	152	159	163	163
North-Western	110	109	111	111	112	114	120	123	131	129	131
South-Eastern	187	185	189	186	186	189	194	206	207	216	212
Southern	275	271	268	265	267	281	289	299	359	363	372
Western	195	194	196	196	197	203	213	221	247	251	256
Total	1,666	1,652	1,647	1,641	1,629	1,679	1,798	1,863	2,134	2,181	2,210*

* 226 GPs who do not hold GMS agreements and who were registered as providing services uner the Primary Childhood Immunisation Scheme, the Health (Amendment) Act 1996, Heartwatch and the Methadone Treatment Scheme at year end are included above.

Source: General Medical Services (Payments) Board.

Figure 7 – General Practitioners in Choice of Doctor Scheme 1994 – 2004

A major review of medical manpower needs (Government of Ireland, 2003) recommended both a change of both the delivery of services and the education and preparation of medical training. Currently, there are five medical schools that offer medical training and education in Ireland. These medical schools are located in the National University of Ireland, Cork, National University of Ireland Galway, University College Dublin, Trinity College Dublin and the Royal College of Surgeons in Ireland.

Following graduation, graduates complete internship training in approved hospitals. There is a lively debate in Ireland currently in relation to entry requirements, with a proposal to move from a position of undergraduate entry requiring extremely high academic attainment in the terminal examination at second level education to graduate entry. This proposal was strongly resisted by the regulatory body, the Medical Council (Medical Council, 2004)

There is a strong reliance on non national as well as non EU students within the schools of medicine. The Medical Council reported that there were 831 medical students in the 2003 intake, 315 of whom were EU entrants, while the majority - 516 were non-EU students. This level of intake outstrips the recommendations of the Hanly Report (Government of Ireland, 2003), which suggested that an annual intake of 767 undergraduates were needed to meet medical needs in the immediate to medium term, though the reliance on non EU entrants has been the subject of some criticism.

The following graph from the Medical Council report (2004) compares the situation from 2000 to 2003. While the intake of non EU students has remained reasonably consistent in

the RCSI, each of the other colleges has shown a significant increase. The Medical Council (2004) recommended a decrease on the reliance on the higher fees that non EU students contribute.

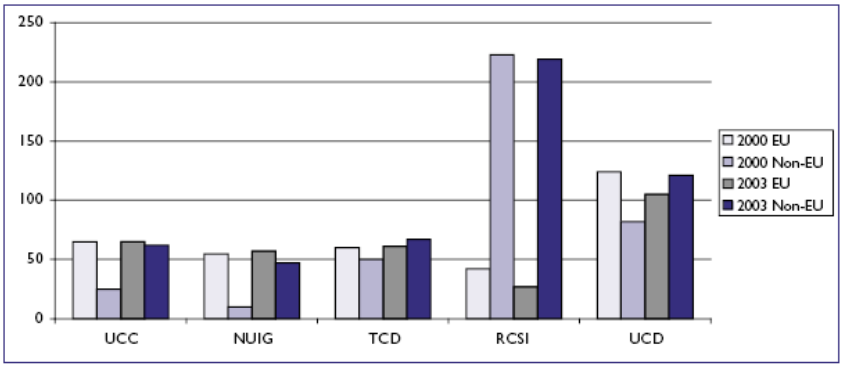


Figure 8 Medical Student intake 2000 – 2003 (Source Medical Council ,2004)

Additional evidence of the ongoing and increasing reliance on Non EU students in Irish Medical Schools is evident in the comparison between the intake of students between 1995, 2000 and 2003 (Medical Council, 2004).

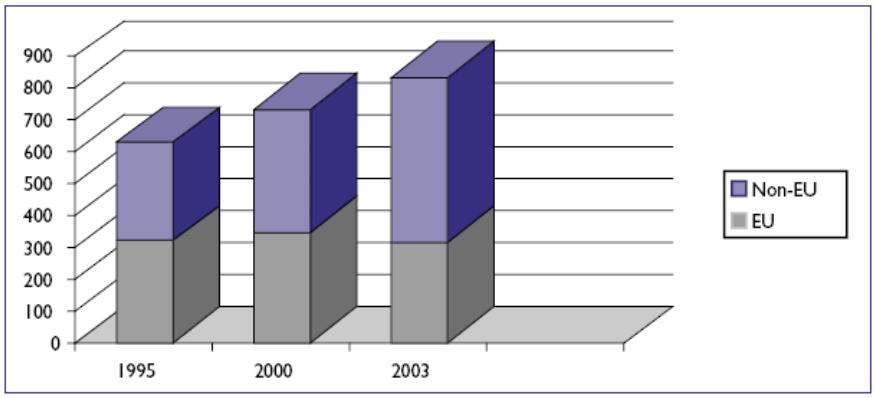


Figure 9 - Medical places 1995, 2000 and 2003 - Source Medical Council (2004)

Methodology

The use of semi-structured interviews was deemed appropriate given the nature of the investigation as the principal aim of the study was to explore the perceptions of the key stakeholders and individuals who had relocated to Ireland in relation to job mobility in the Health and Social Care sector in North West Europe.

As indicated, the participants were purposefully selected. Purposive selection presumes that participants are well informed or knowledgeable on the topic area and willing to share their knowledge. A general interview schedule was developed for use across all

individual interviews and was based on one used in all participating countries in the Careflows project. The schedule of questions and prompts were adhered to and the participants were willing co-participants in the process. The interviews with the key stakeholder groups, which were audio taped, lasted from 20-30 minutes. All ethical considerations were addressed. Participants were guaranteed anonymity and were assured of their rights to either not participate or withdraw from the study at any point and this was respected.

The overall analysis was guided by Burnard's (1991) framework. This framework is deemed appropriate because it is intended for use with all forms of qualitative data. It had been previously used in a study of role evaluation by Torn and McNichol (1998) and role perception in Irish Health Services (Ryan, 2007). Therefore it has an established use in ascertaining perception or understanding of their life situation (e.g. Armstrong, 1999; O'Neill, 2002).

Both face to face as well as telephone interviews were conducted. All of the key stakeholder interviews were audio tape recorded and in the case of the individual practitioners, five people were interviewed in total. In their case two were interviewed by telephone and three, through face to face interviews. Two of the face to face interviews were tape recorded with the consent of the respondents; the third face to face interview was recorded using written notes. Notes were also taken during all the telephone interviews. Participants were sent copies of the transcripts of their interviews so that they could clarify any detail if necessary.

The data were content analysed looking at emerging themes, similarities and differences between the responses of the various participants.

Results

This section presents the main findings from the interview process. The findings are presented in terms of the reasons for work mobility, the factors that support mobility and the factors that inhibit it. Despite efforts to address mobility to and from Ireland, participants in the study focussed their responses on issues relating to immigration rather than emigration. Varying views were expressed in relation to whether or not inward or outward mobility was the greatest challenge.

Reason for Labour Mobility

In the case of the key stakeholder groups, mobility within the North Western region of Europe was not seen as the primary area of labour mobility and discussion around reasons for moving to Ireland tended to be more generalised. The principal areas identified were the US, the UK, Australia, New Zealand other English speaking countries. Ironically, these were referred to as the 'developed world' and were identified mainly as destinations for emigration;

"It tends to be the developed world as such so a therapist leaving here Australia is the big destination, Canada, the States, New Zealand, some to the UK but actually there's employment problems in the UK now as well, so I'd say Australia is the big hitter" [R7].

Outside of the UK in the reference area, immigration or emigration were not seen as major issues of concern. In general terms, it was suggested that within the health sector there has been a traditional reliance on workers from outside the country to meet demand across the sector, except in nursing;
"the immigration has been very important to us in terms of meeting service needs"[R7].

Until recent times, nursing was a net 'exporter' of labour, with evidence that the country is producing sufficient graduates to meet national needs, but in recent years there has also been difficulties retaining nurses. In that regard, there has also been active international recruitment drives identified, but ethical concerns were raised in relation to policy positions and some of these recruitment drives. For example one respondent noted that;

" I think if you make a choice to move for experience, for education, for promotion, for culture, for anything else that's fine. If you move because you have to move that's a whole different thing and the countries that are moving are moving because of economic reasons. They're moving because of unemployment, they're moving because they have to bring back money to their country and they're moving because of actual problems with safety. Like there's abuse, there's rape, there's death there's all sorts of conditions". [R6]

While this is a general concern, this contrasted with the reasons provided by those who had actually moved to Ireland from within the North West region of Europe. The key stakeholders did recognise that there were a range of reasons as to why health and social care practitioners moved to Ireland;

"Well some of them are family reasons, you know that they've married somebody or whatever but some of it is to do with heritage, they want to come back and live in Ireland

because they have relations here or whatever, but largely I'd say it's to do with travel or it could be a year out too whatever". [R9]

However, the consensus seems to be that people moved primarily for either personal or professional reasons. One respondent noted that immigrant workers could be dichotomised into two distinct groups;

"We get one group who are looking for life experience and are travelling etc. and fit in a bit of work and they tend to be Australians, Americans, Canadians, some UK people, some Europeans although not, language can be a bit of an issue a smaller number, we get those. And then we get the other category of people who are the people who come here because they want a job and they need to earn money and they tend to come from more developing countries such as India, some of the African countries, Philippines etc." [R7]

Interestingly, all the respondents in the individual practitioner interviews had moved to Ireland primarily for personal reasons. Three had met partners who were Irish and felt it was easier for them to get a job in Ireland than for their partners to relocate to mainland European countries where English was not the main language.

Respondents in the individual practitioner interviews identified some expectations that they had prior to moving to Ireland. Clearly Ireland had a reputation which many were aware of. That reputation seemed to relate to both the country's economic performance and the state of the health and social care system. One respondent noted that;

"I expected more from the health system because of the Celtic Tiger" [R2].

Another person echoed this by saying:

"I heard Ireland was a good place to live so long as you did not get sick"
[R4].

Another respondent cited a personal challenge associated with mobility:

"[I] wanted to see if I could do it" [R5] (i.e. move to a new country and make a new start).

Economic reasons for moving here were identified by both key stakeholders and individual practitioners. While not explicitly cited as a reason for moving here, individual participants did generally point out that they are earning more here than they would have earned in the country they came from, only one reported that the job being undertaken

was not well paid. However, in addition to the additional remuneration, this was offset by the cost of living, which was seen as higher in Ireland:

"on my salary I can't keep a family" (R1).

Another also reported not having been able to buy a house in Ireland. There were no reports of any problems with regard to transferring bank accounts or issues with regard to pensions. Two respondents raised the issue of the lack of financial help with costs of moving.

The attraction of Ireland as a work location was seen by the organisational stakeholders as being related to both the remuneration and lifestyle, For example one participant, reflecting on the traditional movement of nurses from Ireland to the UK suggested that there had been a reversal of that trend in recent years because of improved economic, lifestyle and career opportunities in Ireland;

"we were seeing a shift that the nurses were coming back in because of the conditions and salaries had slightly increased and there was more job opportunities and better job opportunities over here. So the movement was from England to Ireland". [R6]

Traditionally, the opposite was the situation. Finally, the issue of mobility of the Irish health and social care practitioners was viewed positively, but conditionally so. Respondents from the key stakeholder group indicated that they welcomed opportunities for Irish practitioners to travel, gain experience and encounter other health systems.

"Emigration up until now in most instances were people just wanting travel, wanting life experience etc. and combining it with getting work experience" [R7]

"but I do think probably it might be quality of life or people looking for something different, particularly like Australia and nicer weather or just to be able to experience. And sometimes it's because you are able to do it". [R8]

However, that welcome was conditional on their return, with fears expressed that many either did not return or moved out of the sector;

Factors Facilitating Labour Movement

The second major theme to emerge related to the Facilitative Factors in terms of job mobility. Data from the individual participants clearly indicated that the most important factor for most respondents was having a partner or other family here when they moved. Clearly for four respondents this had been the main reason for moving and so it is not

therefore surprising that this would be a facilitating factor. The quality of the education system in Ireland was cited as a reason which was attractive in terms of making the move to the country, although there were varying experiences of the educational system reported. In one case it was also suggested that children are put under pressure at school while another respondent felt that the school was very helpful in helping children who moved with their families to settle in.

In terms of organisational and social supports, one respondent who relocated without any family support found that the factors that helped in the move were being offered flexibility in the work setting to do tasks related to the relocation, e.g. setting up a bank account. She was able to do this during her first week at work rather than having to try and fit these tasks in at lunchtime. Supports in terms of integration were also identified by the key organisational stakeholders. For example, the potential for social and professional isolation experienced by individual practitioners, such as social workers was referred to by one respondent;

"I think it's probably different to nursing and anything like that in the sense that you know if you pick a hospital there's going to be a number whereas you might be the only social worker, so there was a certain amount of isolation. Some different HSE areas are treated better than others, so some would say 'right we'll look after these people like in terms of accommodation or whatever', others haven't, you're on your own. So I think and some people I think would have felt that they had to hit the ground running and that the induction was lacking" [R9]

Clearly, therefore it is not just the lack of organisational support in terms of integration that is important, but also the inconsistency of approach across the health and social care sector that is potentially problematic.

Challenges related to Labour Mobility

There were a number of difficulties which were identified by individual practitioners in the process of both getting a job and starting work. These included the recruitment process itself, organisational support structures, professional recognition, language and integration challenges.

The recruitment process

Two key elements of the recruitment process were identified as problematic. Firstly the apparent 'rigidity' of the interview process was cited and the lack of support for applicants to come and appraise services. There was reliance on 'face to face' interviews

which were established to suit the employer rather than potential foreign applicants and lacked sensitivity to applicants positions. Likewise some individual practitioners reported difficulties in securing interviews for jobs outside a 'recruitment cycle'. One respondent cited such difficulties, despite the fact that the hospital were in the process of recruiting nurses from the Philippines at the time.

Another respondent also commented that she was asked to come for an interview mid-week which would have involved taking three days off work. This was difficult for her when she had not yet given notice to her previous employer. In this situation she herself suggested that she might have a telephone interview, which was agreed and did happen and she then subsequently travelled to Ireland at a weekend to meet the service manager and look around. While the request was facilitated, the key issue in this regard was that the flexibility had to be prompted by the applicant and it did not seem to be part of the organisational culture. Both of these respondents drew attention to the fact that they were not offered any financial assistance with attending for interview nor with moving when the time came, which would have been the norm in the countries from which they were moving.

A more concerning issue emerged from the data in relation to perceptions of bias. One respondent felt that his nationality would have been an issue in relation to his employment. While the participant secured employment, it was argued that;

"I knew that only if an Irish applicant did not turn up then I would be considered" [R1].

This personal experience was not reported by anyone else and seems at odds with the data collected from the key stakeholder organisations, where strong emphasis was placed on the value of labour mobility, the necessity for inward migration and the supports to achieve this. One respondent noted that;

"*so there's been a fair amount of energy put into that side of things ensuring that there was appropriate visa, permit schemes etc. because we wanted to encourage it"* [R7]

Another aspect of the recruitment process that proved problematic was the belief that there was an inordinate and inexplicable delay between the selection process, being offered a position and commencing work. One participant recounted receiving verbal confirmation of getting the new job in September. She then gave in her notice to her employer and was ready to start work in Ireland. However the HR department seemed to be very slow with the "paperwork" and it was November before she was able to start

work. This had caused her to apply for other jobs and she felt that, in the absence of a written contract:

"this could go really wrong" (R5)

In fact the delay in this case had led to financial problems for her.

Professional recognition

One of the key areas to emerge related to registration of qualifications in Ireland. Among the key organisational cohort, it was argued that the issue of registration was of vital importance from two perspectives; namely protection of the profession and the public and also the maintenance of standards of practice. One noted that ensuring professional competence and standardisation of qualification levels was essential;

"And we are going to have problems with Eastern countries coming to the West and their different systems of training and their different competency levels" [R6].

Registration of all professionals was seen as a means of contributing to this process of standard setting and quality assurance;

"with registration you won't be able to use that title unless you have the qualification" [R9]

While that may well be a laudable aim, some individual practitioner participants had particular problems with the process of *registering their qualifications* in Ireland.

" First of all, it took me a while to get all the papers together…. and then it took about three months or so after I sent it off. I don't know what caused the hold up then because I didn't have anything to do with it but I found that very difficult and very long and you know the way you have to give your employer notice and I didn't know when I was going to go and I found that difficult" (R3).

This respondent also had to gather a lot of information and to have it translated from their own language, which in itself was time-consuming. The personal experience of individual practitioners was a source of irritation among them, but it prompted questions of either lack of awareness of European legislation or compliance with it;

"actually all the official bodies involved in Ireland are not only awkward but are not aware what European law is. I think the difficulty is that it is probably rather new for them to have European Citizens coming into Ireland as opposed to leaving Ireland they are not familiar with the procedures" (R1).

Organisational Support Structures

Four respondents reported that there was a lack of structure about the start to their new job. The process of induction seemed erratic and unstructured. Only two individual practitioners had any structured or formal induction programme. One of these was a one day programme for all new staff which was informal. The other respondent had a two week formal programme which covered mandatory training such as manual handling and client protection. This participant was also offered IT training if needed and given the opportunity to visit other facilities within the broader service where she was working, but otherwise the most frequent system of induction seems to have been "on the job" induction. The experience of integrating into the system was not easy, but there seems to have been understanding among the individual practitioners that this was not any individual's fault, more a systems issue;

"well, it wasn't that easy…but it's nobody's fault really" (R3).

However, another respondent felt that the induction process:

"is one of the things that is extremely poor here. All the people start on the 1st January, you could organise that very well" (R1).

The issue of induction was not the only aspect of support that was mentioned. Ongoing support and an 'appropriate mix' of indigenous and foreign workers was also seen as important to ensure standards, address language or cultural issues and facilitate integration;

"if you're recruiting a lot of overseas nurses then it would be good to have a spread so that you would have a percentage, a small percentage of overseas nurses with a fairly bigger percentage of say 25% overseas nurses and 75% in any one area. But if you have a very large percentage of overseas nurses then it leaves a lot of pressure on the one or two Irish or local nurses that are working because they have the responsibility of ensuring these nurses are trained and ready to take over and that puts huge pressure on our system. And it's not good for anybody, it means that there's no mentoring of the people that are coming in and there's no support" [R6]

Language

Two of the respondents were already English speaking and coming to work here from the UK so language was not an issue, although one did comment about the different use of words for the same thing e.g. press=cupboard. The other three respondents did report language difficulties at first. One respondent discussed this mainly in terms of social integration and communication at first:

"language was an issue to start with like our initial conversations on the telephone was hilarious" (R1).

Another respondent described initial problems with the language as the main difficulty on coming to work here.

"I mean…. the main difficulty for me…. It would have been the language. I remember one thing on the first day and I had English and it wasn't that I didn't understand them but there would have been words that you wouldn't have heard outside the hospital like syringe. It is the easiest thing but I remember one nurse asking me to get her a 10ml syringe and I didn't know what a syringe was. You're not stupid but you still look stupid because you didn't know what a syringe was. It is just a simple thing" (R3).

This respondent felt that it was easier at first to talk to the patients:

*"Sometimes I found it easier to talk to the patients rather than the colleagues because they used all these complicated words and the patients were on my level on medical terms. What I found as well was the different accents if some one came in from the [**named area**] I was completely lost. But it doesn't take that long up to pick it up and people are easy going here. But it was stressful and difficult in the beginning - the first two or three weeks, I'd say after that it was ok"* (R3).

This issue was also raised by another respondent who said that it was difficult to understand certain accents and that this can be a problem with older people, who may have stronger accents. She reported sometimes having to check with colleagues what they have said or indeed the meaning of what was said. This respondent also said that talking in a different language is easier than writing in it and also that it is harder to think in another language. This was reinforced by the key organisational stakeholders. One respondent from this cohort remarked on the distinctions between the use of English in social and professional contexts;

"You can have English language but you mightn't be able to communicate in medical terminology. You mightn't be able to understand the colloquialisms. Or your accent might be so different and the people's accents might be so different that you can't communicate at all. So even if your English is good, it's still an issue" [R6].

Social integration

As already stated three of the individual practitioner participants had moved to Ireland because of a partner and another moved here to be nearer to family. In that regard, no significant difficulties emerged in relation to social integration. In terms of occupational integration, all practitioners found their work setting a sociable place. Integration was helped by inclusion in social occasions, whether they were directly related to work or

otherwise. While participants reported their own integration as having been largely uneventful, some participants were aware of difficulties encountered by others in similar situations;

"they wouldn't have integrated and they thought it was quite difficult meeting Irish people, rather than just having a pint and saying good-bye like" (R1).

References

Central Statistics Office (2006)
http://www.hse.ie/en/Publications/HSEPublications/FiletoUpload,2829,en.pdf, page 13
Accessed November 20th, 2006

Department of Health and Children (2006)
http://www.dohc.ie/statistics/health_service_employment_statistics/2005Q4_numbers_employed_by_region.pdf?direct=1. Accessed November 20th, 2006.

Department of Health and Children, (2006b) Health Statistics 2005. Department of Health and Children. Dublin.

Department of Health and Children (2001) Quality and Fairness: a Health System for You. Department of Health and Children, Dublin.

Department of Health (1994) Shaping a Healthier Future. Department of Health. Dublin.

Health Service Executive (2005) Annual Report. Naas. Health Service Executive.

Medical Council (2004) Review of Medical Schools in Ireland 2003: a report to the public. Medical Council. Dublin.

Ryan, D. (1999). Student Recruitment and psychiatric Nursing. In: Reflection and Rejuvenation; issues for Irish psychiatric nursing into the millennium. D. Ryan, A. Jacob and M. Kirwan. Kilkenny, Association of Psychiatric Nurse Managers.

Dutch Health and Social Care: international labour mobility

By Albert Riga

Zuyd University
CESRT Comparative European Social Research and Theory

This report is part of the Care Flows Project

Country Report: The Netherlands

CONTENTS

1. INTRODUCTION

The main objective of this report is to analyse and inform about international labour mobility, particularly within Europe, from the perspective of the Dutch Health and Social Care Sector.

The report starts by describing the introduction of a new care system in The Netherlands. The government does not participate directly in the actual provision of care. This is a task principally for private care suppliers.

Furthermore, the legal position of the Health and Social Care professions, regulated through the Individual Health Care Professions Act, and questions like the international recognition of degrees and the evaluation of foreign diplomas are discussed.

This is followed by a clarification of the Dutch education system, particularly, relating to the study of medicine, nursing education and social work education.

Subsequently, some core data on the ageing Dutch population are presented. The grey pressure increases and this will have an impact on health spending, health support and the future labour market.

Then what follows is a description of the development of employment in the Dutch Health and Social Care Sector, per branch as well as the professions that are engaged in it. The general picture, at this moment, is that the Health and Social Care labour market is reasonably in balance. This trend will continue in the near future; shortages are expected only in the long term.

All research done on the subject indicates that international mobility of medical and social professionals is still low in the Netherlands. The question remains whether a more active recruitment policy would be a solution for the expected long term shortages.

The report concludes with a look at recruitment policy and some of its developments at the global, national and local level.

Methodology

This country report is produced simultaneously with the reports of the partners participating in the Care Flows project. In order to facilitate comparison between countries, the report's profile is based on a template, which provides common guidelines allowing authors to take account of their national context.

The report was produced through secondary analysis of both statistical and qualitative data. Due to the lack of a uniform data source, the data are obtained from various national and international data sources.

The report also draws upon information gathered from interviews conducted with prominent persons in the field of health and social care which led to relevant information additional to that acquired through secondary analysis. References to these interviews are made throughout this text and integrated into the report.

Research limitations

The report has some limitations due to the nature and scope of its subject matter.

The first limitation is related to the question of the extent to which national health and social care systems can or should be incorporated into a Europe-wide system. Most European legislation has been implemented on the basis of minimum harmonisation. It allows existing national legislation on social issues to remain in place.

According to Reverda, national social policy, as expressed in education, health care and social security has almost become a symbol of neo-nationalism and new national pride. Social policy, which counts for 44% of the Dutch national budget, is one of the ways the national government can assert itself to its people. Interference from Brussels is not wanted (Reverda, personal interview, May 8, 2007).

Essers suggests that it is not likely to expect a harmonisation of social security systems. In the EU, the subsidiarity principle applies (Essers, personal interview April 3, 2007).

Social security systems tend to move between two models, namely the contributory model and the residual model.

The contributory (or Bismarckian) model is financed basically through the contributions of workers. It is based on employment status. The social benefits are only given to those who were or are on the labour market (and the members of their families).

The residual (also called liberal, Beveridgean or Anglo-Saxon) model, on the other hand, is separated from economic activity and financed through general taxation. It offers social benefits only to those in greatest need.

Germany is closer to the contributory model, whereas the UK and Ireland are closer to the residual model.

The social security system in the Netherlands is a special case. The Netherlands has a system in between the two models. Historically, the system was more contributory, but the new health care system moves in the direction of the residual model.

Reverda refers as an example of this mixed system to the Dutch pension system. It rests on three pillars, namely a state pension that provides an equal income for all residents at a level related to the net minimum wage, occupational pensions supplementary to the state pension and private pension provisions (Reverda, personal interview April 20, 2007).

The second limitation of the report is that it is limited to labour mobility and does not include other relevant factors like patient mobility or service and service provider mobility. Nevertheless, these factors have a substantial impact on labour mobility or may produce alternative solutions to observed labour mobility problems.

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

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

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

2. THE HEALTH AND SOCIAL INSURANCE SYSTEM FOR CLIENTS

A new Health Care System

A prominent trend over the last decade has been the shift of responsibility for purchasing care from government to insurers.

Since 1 January 2006, the Netherlands has a new insurance system for health care costs (VWS, n.d.). The government does not participate directly in the actual provision of care. This is a task principally for private care suppliers: individual practitioners and care institutions.

The system is of a private character, under public restrictions. The government, for instance, has stipulated that everyone in the Netherlands is obliged to have insurance; anyone who fails to do so, will be fined. Health insurers are obliged to accept everyone, irrespective of age, gender or state of health.

The government no longer arranges everything. Parties in the market have more freedom and responsibility to compete for the business of the insured. On the one hand, citizens have more financial responsibilities, and on the other hand more influence and realistic choices in terms of health care insurance. Care providers will have to pay greater attention to their performance and can supply more tailor-made care for their customers. The

government remains responsible for the accessibility, affordability and quality of health care.

Insured parties pay a fixed premium (the nominal premium), in total on average approximately € 1,050 per year (in 2006). The insurer determines the level of the nominal premium, but is obliged to provide the same care to everyone for this premium. The law stipulates the forms of care covered by the health care insurance. Insurers are obliged to accept an insured party for the basic package. This guarantees solidarity within the system. Health care insurers must offer health care insurance to everyone, irrespective of personal characteristics, and subject to the same conditions.

The new system gives the insured greater freedom of choice. In its first year (2006), the Health Insurance Act already witnessed a significant migration of people to different insurers. A large number of government bodies and social organisations also were able to negotiate discounts and other attractive conditions through collective contracts.

Another trend in health care provision is towards more competition among providers of care. Efforts are made to combine market and non-market elements in health care.

Diagnosis and Treatment Combinations (DTCs) are being introduced step-by-step since early 2005 for hospital financing. DTCs are seen as an instrument in the gradual introduction and implementation of regulated competition, as they allow providers and insurers to negotiate on the prices, volume and quality of care contracted for.

Instead of larger budgets, realised production should be central when determining budgets. Although this has led to a general decrease in waiting lists and waiting times, in all medical areas, waiting lists remain an important issue.

With more competition and new instruments at their disposal, insurers can be expected to have stronger incentives and a broader scope to compare what is on offer and look for the best deals, including across the Dutch borders.

The combination of restricted supply (resulting in waiting lists) and insurers' duty to deliver care, means that sickness funds are forced to look abroad for a solution to limited access at home.

The Social Support Act

Part of the health care reform is the introduction of the Social Support Act (WMO), in 2007 (VWS-WMO, n.d.). The Act introduces a new scheme for all Dutch citizens covering care and support in cases of protracted illness, invalidity or geriatric diseases. It puts an end to the various rules and regulations for handicapped people and the elderly. It

encompasses the Services for the Disabled Act (WVG), the Social Welfare Act and parts of the Exceptional Medical Expenses Act (AWBZ).

Under the Act, policy responsibility for setting up social support lies with the municipalities, which are accountable to the citizens in the execution of this responsibility. Municipalities now have the opportunity to develop a cohesive policy on social support, living and welfare along with other related matters.

The Ministry of Health, Welfare and Sport defines the framework in which each municipality can make its own policy, based on the composition and demands of its inhabitants.

The aim of the Social Support Act is participation of all citizens to all facets of society, whether or not with help from friends, family or acquaintances; the perspective is a coherent policy in the field of social support and related areas.

Critics say that legal equality will be questioned since each municipality is entitled to develop its own rules. This might result in a diversity of services provided by each city. Additionally, budgetary risks will be shifted from the national to local authorities.

3. THE QUALITY ASSURANCE SYSTEM FOR PROFESSIONALS

The Individual Health Care Professions Act

The profession of physicians has been protected in the Netherlands since 1818.

The Medical Practice Act (WUG) of 1865 provided uniform university education and improved legal protection for the profession. The Act recognised only university-educated physicians. This legislation remained unchanged in outline until recently (HiT, 2004).

In recent years, there has been a far-reaching revision of public health care legislation and regulation. The main revision is the Individual Health Care Professions Act (BIG), which regulates medical practice.

Since 1993, the Individual Health Care Professions (BIG) Act regulates the provision of care by professional practitioners, focusing on the quality of professional practice and patient protection (VWS, 2001).

The purpose of the Act is to foster and monitor high standards of professional practice and to protect the patient against professional carelessness and incompetence. The Act focuses on individual health care, i.e. care that is aimed directly at the individual.

As Tjadens states, the Individual Health Care Professions Act is a liberalisation of the previously existing law (Tjadens, personal interview, April 13, 2007). It basically opens up the practice of medicine instead of restricting it, thus giving people more freedom to choose the care provider they want.

However, the act contains provisions relating to the protection of titles, registration, reserved procedures and medical disciplines in order to prevent unacceptable health risks to the patient resulting from a lack of professional competence.

Professions can be regulated in two ways: by Act of Parliament (article 3 of the Individual Health Care Professions Act) or by an Order in Council pursuant to an act (article 34 of the aforementioned legislation). Both regulations enable titles to be legally protected; the most important differences are that the government only maintains a register for the professions covered by section 3.

Article 34-professions do not come under legal registration. Stoop explains this by stating that in the eighties and nineties, privacy protection was more important than legal status, in the Netherlands. However, abroad legal status is very important. Article 3-professions are more appreciated than article 34- professions (Stoop, personal interview, April 23, 2007).

The eight professions covered by article 3 of the BIG Act are: Pharmacist, Physician, Physiotherapist, Health care psychologist, Psychotherapist, Dentist, Midwife and Nurse.

The following professions are covered by article 34 of the BIG Act: Pharmacist's assistant, Dietician, Occupational therapist, Skin therapist, Speech therapist, Dental hygienist, Cesar remedial therapist, Mensendieck remedial therapist, Orthoptist, Optometrist, Podiatrist, Radiographer (diagnostic), Radiographer (therapeutic), Clinical dental technician and Individual health care assistant.

Legal status of social work

The profession of social worker is not legally recognised. This applies to traditional social workers, social pedagogues and community workers as well. They are not listed in the Individual Health Care Professions Act.

Since the late 80s, attempts have been made to get social work included in the BIG register, but these were not successful. According to Tjadens, one of the problems is the separation between (national-oriented) health care and (municipal-oriented) social care, on-going since the introduction of the Welfare Act in 1994 and reinforced by the Social Support Act, in 2007 (Tjadens, personal interview, April 13, 2007).

Some of the social work professions maintain their own professional register. Being registered is not obligatory. The social pedagogues register with the Professional Register of

Agogues (Beroepsregister van Agogen), social workers with the Foundation Professional Register of Social Workers (Stichting Beroepsregister van Maatschappelijk Werkers).
Registered social workers demonstrate that their competence may be compared with standards applicable in other parts of the world. Their commitment to professionalism is underwritten by the support of the national professional associations: the Professional Organisation of Social Pedagogues (PHORZA) and the Dutch Association of Social Workers (NVMW).

Foreign degrees

A health care professional with a foreign diploma has to satisfy certain quality requirements imposed by the Dutch government if he or she wants to work in Dutch health care. A pharmacist, physician, physiotherapist, health care psychologist, psychotherapist, dentist, midwife or nurse who wishes to use his or her professional title in the Netherlands and to claim the associated authority, must first be included in the BIG-register. A person with a diploma listed in the 'Regulation on the Registration of Foreign Health Care Qualifications' can apply to the BIG-register for registration. Registration is subject to the additional condition that the applicant must be a national of a member state of the European Economic Area (EEA), comprising the European Union member states plus Iceland, Liechtenstein and Norway, or a national of Switzerland.
A health care professional who does not possess a listed diploma, or who does possess such a diploma but is not a national of an EEA state or Switzerland, needs to obtain a Declaration of Professional Competence in order to be included in the BIG-register.
The BIG Register is managed by the Central Information Unit on Health Care Professions (CIBG), an implementing body of the Ministry of Health, Welfare and Sports (VWS/CIBG, n.d). The CIBG also manages an Information and Referral Desk for Foreign Health Care Qualification Holders which helps foreign graduates who wish to practise their profession in the Netherlands by directing them to the appropriate institutions.
The CIBG judges whether people with a foreign diploma may be registered in the BIG register. There are a number of criteria, such as quality requirements and regulations for foreigners, e.g. the obligation of having a residence and work permit or being fluent in Dutch, because, in accordance with Stoop, communicating effectively with patients and colleagues is essential in health care work (Stoop, personal interview, April 23, 2007).

International recognition of degrees

The most important legal instrument for academic recognition is the Lisbon Recognition Convention (Lisbon Convention, 1997).

The European Union has established directives to facilitate international access to these regulated professions.

For some regulated professions - those of doctor, dentist, pharmacist, nurse of general care, midwife, veterinary surgeon, architect and lawyer -recognition of a professional coming from an EU member state in other EU member states is regulated by the EU sectoral directives that are individual for each of the professions. By 20 October 2007, twelve sectoral directives - covering the same professions except for the profession of lawyer - and three directives which have set up a general system for the recognition of professional qualifications and cover most other regulated professions, will be consolidated in one new directive (EU/leg, 2007). The new directive may further improve transparency of qualifications and competences and facilitate mobility between countries throughout Europe.

Stoop suggests, that another labour mobility promoting factor would be to establish a system of international exchange of data. Within the Netherlands, the Information Management Group (IBG), a semi-independent part of the Ministry of Education, Culture and Science, is already setting up a diploma database by digitising millions of diplomas of secondary vocational and higher education (Stoop, April 23, 2007).

Evaluation of foreign diplomas

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

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

Nuffic is the Dutch Organisation for International Cooperation in Higher Education and Research. Its Department for International Credential Evaluation is responsible for

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

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

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

4. THE HEALTH AND SOCIAL CARE EDUCATION SYSTEM

General structure of the educational system

In the Netherlands, in the areas of health and social welfare, secondary vocational education (middelbaar beroepsonderwijs) is offered, varying in length from one to four years as well as in level (1 to 4). Higher education is offered at two types of institutions: research universities (universiteiten) and universities of applied sciences (hogescholen).

Since September 2002, the higher education system has been organised around a three-cycle degree system consisting of bachelor, master and PhD degrees. The higher education system continues to be a binary system, however, with a distinction between research-oriented education and professional higher education.

Graduates obtain the degree of Master of Arts or Master of Science. Graduates of a professional higher education master's programme obtain a degree indicating the field of study (for example, Master of Social Work). The third cycle of higher education, leading to a doctor's degree, will be offered only by research universities (HBO-raad, n.d.).

The educational system applies differently in different professional settings, such as the study of medicine, nursing education and social work education.

Study of medicine

The study of medicine is currently phased: the first phase provides education for a Master's degree, including two stages: the first year and the senior years (from second to fourth year), with exams at the end of each stage. The second phase of the study of medicine takes 2 years (the fifth and sixth) and is concluded with the Doctor of Medicine examination. During the second phase, students are introduced to a clinical setting. The Doctor of Medicine degree qualifies a person to start practising medicine.

Those who pass their Doctor of Medicine examination but have not (yet) taken supplementary courses are fully qualified to practise medicine, all the same. They must, however, stay within the limits of their own knowledge and competence. They may call themselves doctors and are legally qualified to prescribe medicine and provide medical certificates, such as death certificates.

There is a number of supplementary courses available after the Doctor of Medicine examination: specialist training, GP training, research and PhD programmes, and medical officer training.

Depending on the speciality, medical specialist training takes 4–6 years. Currently there are 29 recognised medical specialities. The medical specialist is usually self-employed, with the exception of a number of categories of specialists, who are employed by university hospitals, psychiatric clinics and rehabilitation centres. Whether self-employed or not, specialists often depend on hospitals and outpatient clinics for their work (HiT, 2004).

Nursing education

Since 1997, there are two educational routes for nursing education, namely secondary professional education and higher professional education. The secondary professional nursing programme can be followed after four years of secondary school; the higher professional nursing programme can be followed after five years of secondary school. Both programmes fulfil the acceptance criteria for the EC sectoral directives.

All registered nurses are entitled to enter specialist training courses (post-basic nurse training). The aim of specialist nurse training is to obtain extra competencies and qualifications on professional skills specific to a category of clients (EC, 2000).

Between 1993 and 1995, the Dutch government issued a policy aimed to reduce the current differences in the qualification and education of nurse practitioners, and to reduce the shortage of nurses, resulting from the absence of career possibilities. The policy intended to lower the work load of medical doctors (Health Policy Monitor, 2003).

Social work education

Until the nineties, a great variety of social professions was set up with little thought given to the overall professional structure. In 1992, the 13 traditional professions were reduced to five: social pedagogy, social work, personnel and labour, creative therapy, cultural and social education. The Dutch system places the five branches within the category of social-agogic work (Haydn Davies Jones, n.d.).

In 2006, the Dutch Institute for Care and Welfare (NIZW), with cooperation of the Dutch Association of Social Workers (NVMW), developed a new professional structure for the Care and Welfare Sector. The field of social-agogic work includes community work (sociaal-cultureel werk), traditional social work (maatschappelijke dienstverlening), social pedagogy (pedagogisch werk) and social care (maatschappelijke zorg), a shared field of the social-agogic and nursing/caring professions.

The Dutch Institute for Care and Welfare (NIZW, 2006) states: "The professional structure Care and Welfare is a coherent description of professions in care and welfare. It is a joint product of the employers' organisations and the trade unions in the sector that thus explain to vocational training which professions are needed in care and welfare and which competencies an employee should possess."

While some hogescholen offer education programmes of Traditional Social Work, Social Pedagogy and Community Work as a combined programme of Social Work, other ones offer these as separate programmes.

In the present situation, the Netherlands has no master's or doctoral degree in social work.

5. DEMOGRAPHY AND EMPLOYMENT

Population ageing

The aging of the population that is anticipated will have a large impact on health spending, health and disability support, and the labour market.

The greying of the population will reach its peak in just over 30 years. In 2038, a quarter of the 17 million Dutch people will be over 65 (Statistics Netherlands, 2006).

Grey pressure, that is the ratio between people over 65 and the potential labour force (people aged between 20 and 65), is increasing faster than the share of people over 65. This is because the number of people over 65 increases, while the potential labour force

decreases by 1 million. The grey pressure will rise from the current 23 percent to 47 percent in 2038.

The population is expected to increase modestly until 2034 by tens of thousands a year. After 2034, the growing number of deaths will cause the population numbers to decline slightly.

Life expectancy for men is expected to rise from 77.6 in 2006 to 81.5 in 2050, and life expectancy for women from 81.7 to 84.2. More people are expected to reach retirement age, and retired people are expected to live longer.

The increase in life expectancy in the Netherlands was below average, i.e. 4.5 years, while in Germany and Belgium, our neighbouring countries, the increase was 8.1 and 7.1 years, respectively. On the other hand, in 1960 life expectancy in those countries was lower than in the Netherlands. Dutch life expectancy is dropping towards the European average (RIVM, 2006).

Because of demographic ageing and the shrinking population in Europe as a whole, too few professionals will be available to respond to the increasing demand for care; this will cause a huge need for professionals in care and welfare.

According to Reverda, this predicted development might be a reason for the EU to pursue immigration policy. In a way, this is already going on, e.g., in Spain, legalisation of 500.000 illegal workers was only possible because they could be used in the care services. A possible risk would be loss of quality: if you do not swiftly take measures, you may be happy with everyone who is willing to do something.

Today's discussion about the growing 'burden of ageing' must not neglect the substantial productive potential of the elderly population. The proportion of healthy ageing people within the total population is expected to increase in the future and so is their productive potential (Reverda, personal interview, May 8, 2007).

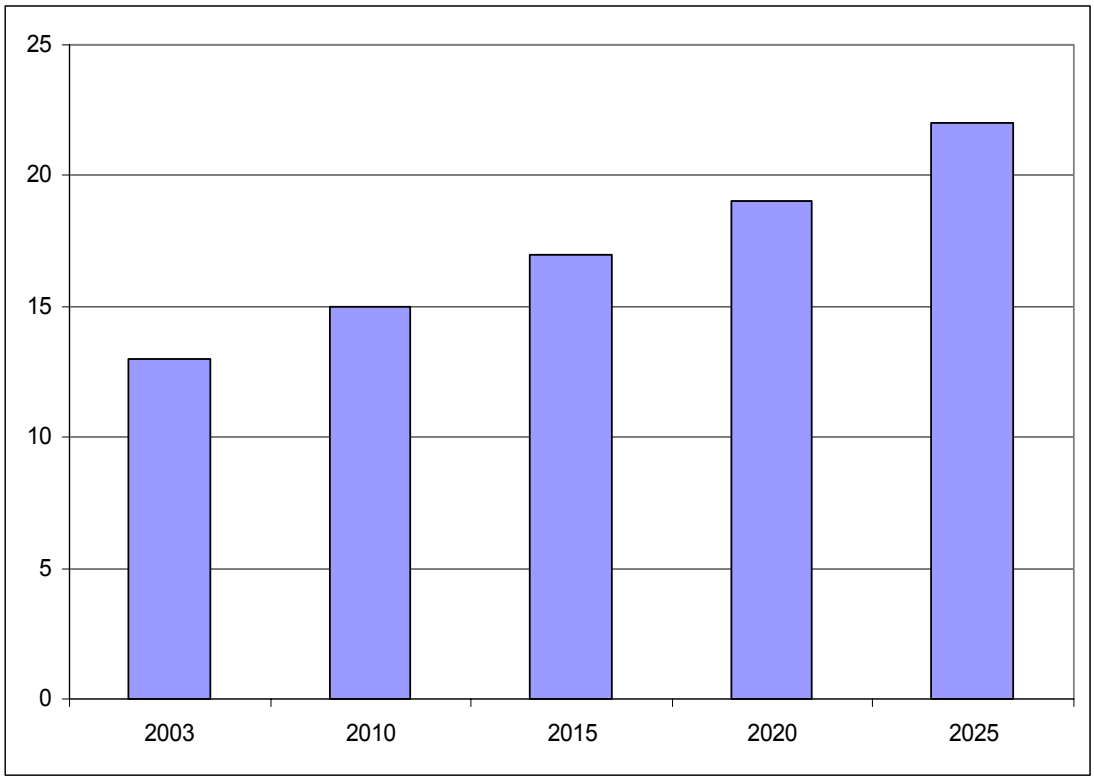
Health and Social Care's share of the labour market

The Health and Social Care Sector occupies a big part of the labour market in the Netherlands. In 2004, 15,2% of all workers in the Netherlands were employed in this sector.

Between 2000 and 2005, the number of jobs in the Health and Social Care Sector rose by a yearly average of 3,8%, while the number of jobs in the total labour market rose by only 0,1% per year. Employment opportunities in the Health and Social Care Sector increased due to extra investments in waiting list reduction.

After 2005, a yearly growth of 2,5% and a proportionate growth of personnel is predicted in the Health and Social Care Sector.
Until 2010, the number of employed people in the total labour market will increase by a yearly 0,25% and then decrease, according to predictions from Statistics Netherlands.

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



Source: Prismant, 2004 (adapted by CESRT)

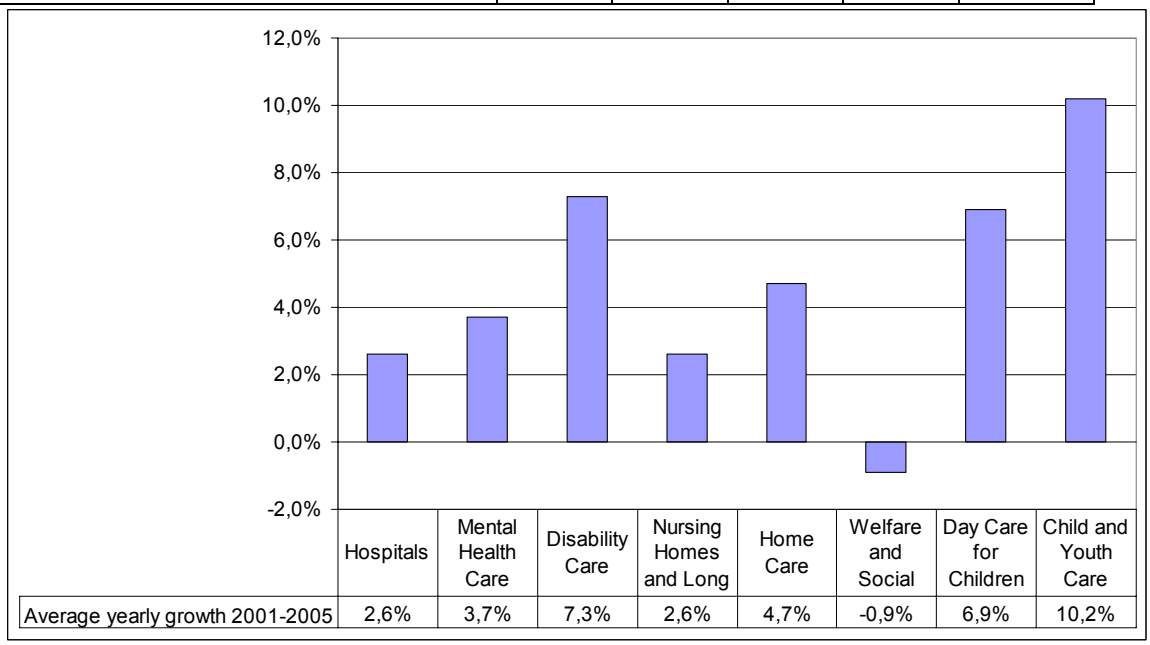
Employment by branch

The hospitals are in a phase of transition from a supply-oriented to a demand-oriented system of budget financing. The introduction of the Diagnostic Treatment Combination (DTC), an output based payment method, is an important part of it. The transition phase leads to reserve in setting up long-term labour market policies. Since 2001, the growth of employment in the hospitals is flattening out. Employment did not grow much (an average yearly growth of only 2,6%).
The last years saw a slight growth of employment in Mental Health Care (3,7% per year). In Disability Care, the growth of employment was considerable (yearly 7,3%).
Between 2001 and 2005, employment in Nursing and Long Term Care Homes increased by an average of 2,6%, while employment in Home Care increased by a yearly average of

4,7%. Home Care is most sensitive to changes caused by the introduction of the Social Support Act, in 2007. As a consequence of this law, Home Care organisations may lose their monopoly in the performance of services.

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

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



	Hospitals	Mental Health Care	Disability Care	Nursing Homes and Long	Home Care	Welfare and Social	Day Care for Children	Child and Youth Care
Average yearly growth 2001-2005	2,6%	3,7%	7,3%	2,6%	4,7%	-0,9%	6,9%	10,2%

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

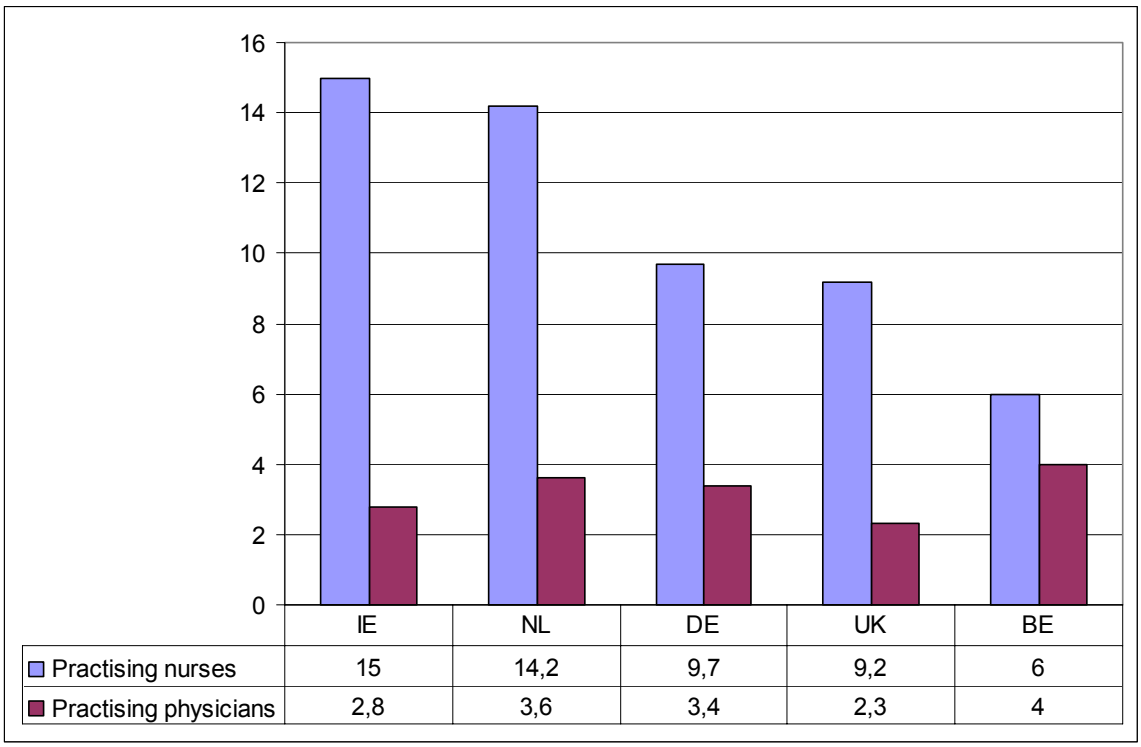
Employment in Welfare and Social Service diminished by an average of 0,9%, not in the last place by stopping the most part of subsidised influx and throughflux jobs. This programme for long-term unemployed people was introduced in January 2000.

Since 2002, employment in Day Care for Children and Child and Youth Care is increasing (by an average of, respectively, 6,9% and 10,2%).

Employment by occupational groups

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

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



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

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

Physicians

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

Nursing and caring professionals

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

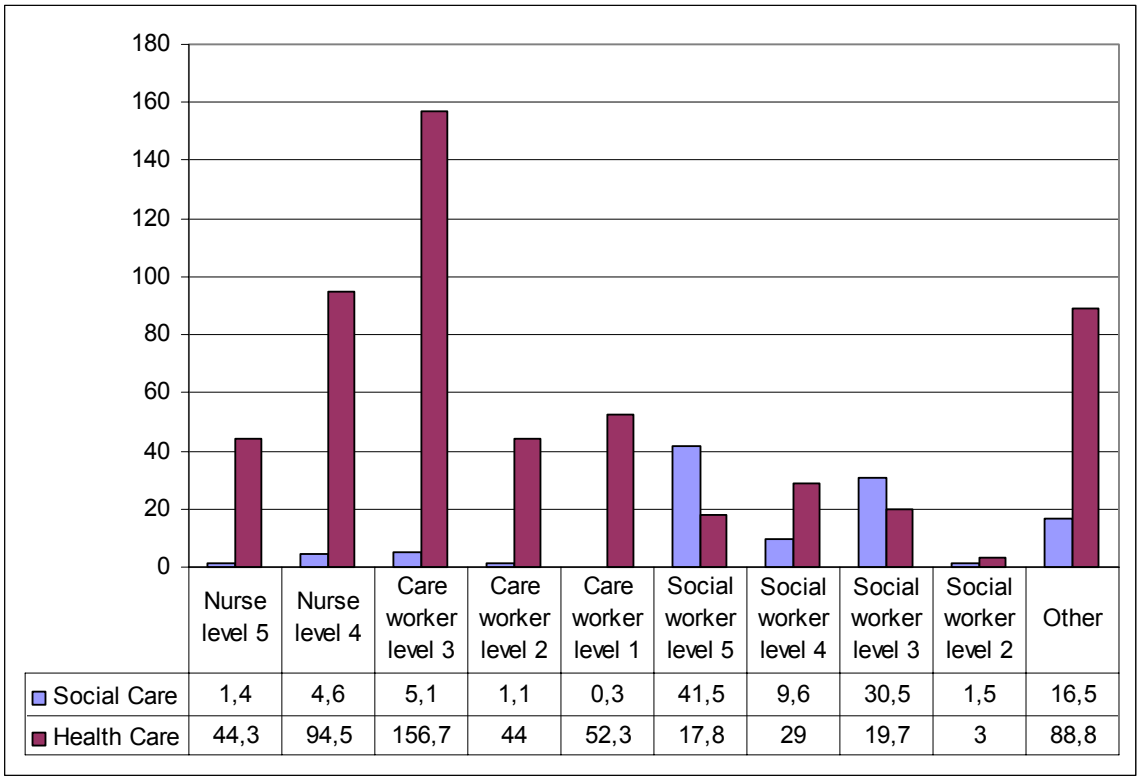
Between 2000 and 2004, the number of nursing and caring professionals grew with a yearly average of 2,3%. In 2004, there were 436.694 nursing and caring professionals (VWS, 2006).

In 2005, nearly all (97%) nursing and caring professionals had positions in Health Care, only 3% of them in Social Care (Regiomarge, 2005). Only 11,3% of the nurses are highly educated (i.e., level 5 and higher).

Shortages of nursing and caring personnel may occur over the next few years, at least from 2008 on (RIVM, 2006). The shortages will vary from 1% in hospitals to 5% in Home Care. The greatest shortages are estimated to occur in jobs requiring the lowest levels of vocational education and training, that is level 1 and to a lesser extent levels 2 and 3.

.

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



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

Source: RegioMarge 2006 (adapted by CESRT)

Social workers

Social workers have positions in a wide range of occupational settings in all branches of the Health and Social Care Sector and even outside of it. They are employed not only in social service provision (welfare, public housing, health care, employment and education), but also in business services (WRR, 2004).

According to the Collective Labour Agreement for Welfare and Social Services (CAO, 2006), in 2006, the gross monthly salaries of social workers (social pedagogues, commu-

nity workers and traditional social workers) were between a minimum of €2089 and a maximum of €2928, depending on periodical salary increases.
In 2005, in the Netherlands, 61% of the social workers were employed in Social Care and 39% in Health Care (Regiomarge, 2005). Of all social workers, 39% are highly educated (i.e., level 5 and higher).
At this moment, the labour market in the social care sector is in a reasonable balance: big shortages are not occurring any more and few social professionals are unemployed. In the near future, the surplus of social professionals is expected to increase until 2006 and decrease, from then on. In the long term, shortages are expected, again, first in Welfare and Social Service (from 2009 on), then in Child and Youth Care (from 2010 on) and, only in the longer term, in Day Care for Children. This scenario is based on an expected yearly growth of employment by 1,2% in Welfare and Social Service and Child and Youth care and by 1,7% in Day Care for Children. This growth is low compared with that of the last years

6. INTERNATIONAL MOBILITY

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

Access to the Labour Market for Third Country Nationals

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

Free movement of labour in the EU-25

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

Cross-border workers

A cross-border worker is an employee who works in one EU Member State (State of employment) and lives in another (State of residence). It is essential that he retains his normal place of residence outside the State of employment. If the cross-border employee moves to the State of employment, he becomes a migrant worker. A resident who moves to a neighbouring State but continues to work in his original State of employment (migrant resident), is also a cross-border or frontier worker (Vanpoucke & Essers, 2004).
According to Essers, half of the cross-border workers are migrant workers, half are migrant residents. The last named, sometimes designated as "Nether-Belgians" (Nederbelgen) or "Nether-Germans" (Nederduitsers), do not want to become naturalised as a Dutch citizen. They are in a peculiar situation, because no specified rules are made for them.
In 1970s, 80s and 90s, there was an eastward flow of migrant workers: many Belgians went to work in the Netherlands, and the Dutch went to Germany. The residential flow pointed in the opposite direction. After 2000, the flow of Dutch workers to fill jobs in Germany diminished.
Currently, the employment agencies try to drag Germans to the Netherlands. Although the share of flexible work in total employment is decreasing, it is still high, in the Netherlands. Flexible contracts cause a problem for the Germans (Essers, personal interview, April 3, 2007).

International mobility in the Health and Social Care Sector

International mobility of medical and social professionals is still low in The Netherlands, as it is in other European countries. According to a report of The Dutch Council for

Health and Care (RVZ, 2006), the proportion of foreign physicians, nurses and caring professionals is limited. Only 1% of all registered physicians and 0,5% of the total nursing and caring personnel are of foreign origin.
Although no data are available about the number of foreign social workers going to work in the Netherlands, their number is presumably very low.

Physicians

At this moment, there is no threat of a shortage of physicians. The demand and supply of physicians are in good balance. For this reason, there is no need to think about an active recruitment policy for foreign physicians, because future shortages are not in sight. The question is whether a more active recruitment policy should be developed to tackle expected future shortages.
It should be taken into consideration, that other countries do have shortages. In many European countries, the shortage of physicians is a cause for concern. Furthermore, The Netherlands has a disadvantaged competitive position in the international market because of language. English speaking countries are more attractive for physicians wanting to work abroad.
Data about foreign physicians are more easily retrievable than, for instance, caring professionals. This is because physicians are obliged to register in the BIG-register. Yearly, between 200 and 300 physicians from non-European countries, wanting to work in the Netherlands, report to the Register. About half of the requests are refused. Many of the applications come from Afghanistan, Iraq, Ukraine, Poland, Russia and South-Africa. After the EU's 2004 enlargement, not as many physicians as expected went from Eastern Europe to the Netherlands.
Per 1 January 2006, the BIG-register recorded on a total of 2181 physicians with a foreign diploma. Of these, 1960 got their diploma in a EU/EEA country, 221 outside this area. An important number of physicians, namely 1255, got their diplomas in Belgium. The Register does not specify, whether they are active as practitioners or available for the labour market.

Nursing and caring professionals

The exact number of foreign nurses and caring professionals in the Dutch Health Care sector is hardly retrievable. The number of delivered work permits can say something about the interest from other countries to work in the Netherlands. The number of delivered work permits decreased from 501 in 2002, to 230 in 2005. From underlying

data, it appears that the largest interest is from people originating from South Africa, Indonesia and the Philippines. Smaller numbers of caring professionals are from the former Eastern Bloc countries.

Per 1 January 2006, 1615 nurses with a foreign diploma are listed in the BIG register. Of those, 791 received their diploma in EU/EEA countries, 562 of which came from the neighbour countries Belgium or Germany. There were 824 non EU/EEA nurses registered, mainly from Surinam, the Philippines and Indonesia. Again, the Register does not specify whether they are active as practitioners or available for the labour market.

The Netherlands has looked to former colonies like Surinam and Dutch speaking countries such as South Africa as a source for health professionals (UNU-WIDER, 2006)).

A publication of OSA, Institute for Labour Studies (ZW, 2002), stated that few nurses in the Netherlands came from the EU. Few nurses working in the Netherlands were educated in another EU country.

Nearly half was from Belgium and another 20 percent from Germany. More than half (58%) of the Belgian nurses were cross-border workers: they worked in the Netherlands, but lived in Belgium. Only 8% of the German nurses were cross-border workers.

A publication on "Experiences of foreign European nurses in the Netherlands" (Health Policy, 2004) reports that approximately 1500 nurses from other EU/candidate states entered the Netherlands. Personal reasons, including marriage, were the most common reasons for coming. Half of the nurses took one or more courses before starting work in nursing in the Netherlands. These were often Dutch language courses. The nurses were obliged to adapt themselves, linked to their unfamiliarity with Dutch laws and the fiscal and social security systems, recognition of their qualifications and application for permits. Even some basic issues, such as how to write a letter of application, caused problems.

7. RECRUITMENT POLICY: SOME DEVELOPMENTS

Global migration of nurses

In an issue paper on international migration of nurses (ICN, 2005) , the authors assert that in the last few years, migration of nurses appears to have grown significantly, with the potential to undermine attempts to achieve health system improvement in some developing countries.

The effects of international migration of health service workers on the nations supplying the workers are cause for concern.

The main gaps and recommendations for policy action concern the overall impact of out-migration of nurses on source countries, the experiences of international nurses now working in destination countries.

Dutch recruitment policy: Polish nurses

The migration of Polish nurses may have been anticipated by an event of September 6, 2001 which has been reported in a document from the Polish Ministry of Foreign Affairs (Republic of Poland, 2001):

'While on a working visit to Holland Prime Minister Jerzy Buzek met with Prime Minister Wim Kok. „After Poland enters the European Union Poles should have access to the Dutch labour market. We are opening our borders" – said the Dutch Prime Minister. Prime Minister Buzek thanked him for that declaration and pointed out that of all the EU countries Holland was the first one to make such a promise. Jerzy Buzek assured his hosts that after opening the border Poles of a certainty „wouldn't inundate the Dutch labour market". The Polish Prime Minister also spoke of employing Polish nurses in Holland. Wim Kok promised that all „technical" problems connected with this matter would be solved soon.'

A few years later, a Polish-Dutch Twinning Project on Mutual Recognition of Qualifications for Medical Professions was started. The project's objective was that the Netherlands, as a Member State of the EU, would help Poland as a State applying for membership to satisfy ballot conditions, i.e. to meet the Copenhagen accession criteria (NIZW, 2004). Mutual recognition of diplomas or professional qualifications across the EU, in line with the relevant Directives, requires good communication between all member states of the EU and means that member states should have to trust each other's education systems to allow free movement of workers in the European Economic Area (Tjadens, personal interview, April 13, 2007).

The issue of how to communicate about mutual recognition of professional qualifications was not as easy to handle as it seemed. The following incident, told by Stoop, may illustrate this. The Foundation KVV (now called Florence) in The Hague started to recruit nurses from Poland. The Honorary Consul in Krakow for the Netherlands had the idea to create additional training in Poland. Response: The minister determined that the level of training is equivalent. Thus, you cannot carry out additional training. In fact, the EU has recognised and explicitly named a very limited number of equivalent trainings. The Polish government has objected against this (Stoop, personal interview, April 23, 2007).

From 2003 until 2005, the Dutch and Polish Ministries of Health Care developed a pilot project "Polish nurses in the Netherlands; development of competencies" (IOM, 2005). Within the framework of this project, Polish nurses got the opportunity to learn and work in nursing homes in the Netherlands for a maximum period of two years. The Dutch government requested the International Organization for Migration (IOM) to monitor the activities of three intermediate organisations that recruited Polish nurses as part of the pilot project. Many of the employers acknowledged that the nurses' level of Dutch language skills was not really sufficient to function in an optimal way.

The nurses confirmed the general opinion of the employers. All nurses had difficulties at work related to the inadequate knowledge of the Dutch language. The low level of language skills was also an obstacle to follow training.

Better prepared language courses and thorough supervision on the job during daily work are crucial to bridge both language barriers and cultural differences.

Another problem that is experienced concerns differences in training. In the Netherlands, the nurses are trained for skills which require functionally independent actions, the Polish nurses are trained for technical skills. In Poland, it is unthinkable to have nurses in an ambulance or in intensive care. In the Dutch context, their technical actions are considered to be extremely out of date.

An approach might be not to allow Polish nurses to work here in the Netherlands as a nurse but to let them work as a care worker. However, calling them care workers, would be experienced as an insult. A more elegant solution was found in the United Kingdom, where a distinction is made between registered nurses and enrolled nurses (in fact, care workers). In United Kingdom they call the Polish nurses enrolled nurses, which is accepted by them (Stoop, personal interview, April 23, 2007).

A local example of best practice: the Academic Hospital Maastricht

According to Dewalque, the Academic Hospital Maastricht (AZM) has a long tradition in recruiting Flemish health workers. For 40 years, the Flemish work in the hospital, particularly in nursing. It concerns Belgian nurses with a Belgian diploma but some of them have a Dutch diploma. Currently, approximately one third of the nurses and more than 40 percent of the specialists are Flemish.

Due to its location in a border region, the AZM has a more favourable position with respect to the foreign country than other institutions. But it is important to make use of it and this is done in Maastricht.

All new Flemish employees are joined with an already employed Flemish colleague. They get, just like all new employees, extra training in the specific working method of the AZM.

People stay, they don't look for a job in their home country. It is not because of the money but the professional development opportunities and less hierarchical cultures that are offered in Maastricht.

Nobody from Wallonia (French Belgium) has a job in the AZM. This is indicative of the language barrier as an important factor in cross-border nursing. Some British and Germans work in the operating room, which is understandable, because the language problem does not occur.

Migrant residents are rare, which opposes the general pattern. The hospital disposes of 800 addresses, of which 600 Belgians and 200 "Nether-Belgians", in all kinds of professions. Of these, 400 are working as nurses, this is one third of all the 1200 nurses working in the hospital.

AZM offers internship positions for the university of professional education in Hasselt.

Recognition (BIG) of a Belgian diploma is easy. Until 10 years ago, the nurses trained in service; these have frequently levels between 4 and 5. Since then, however, the difference between higher education (HBO) and secondary vocational education (MBO) has risen. Currently, 70% of the nurses have level 4 and 30% level 5 education (Dewalque, personal interview, April 16, 2007).

According to Kuijer, the vision of the hospital is that in a proper human resources policy, differentiation of staff should be a leading term. However, the road to function differentiation is still at a beginning stage.

In former days, the hospital world circulated around the doctor; this changes in product-market combinations. It means that health care has to be organised differently, from a Florence Nightingale type of organisation to a much more commercial organisation. More diversity of people, with a great variety of competencies, is needed. The organisation must have a clearer profile of which people are needed and how to use skills in a flexible way in certain activities. For certain tasks you need technical people (e.g. the Vebego cleaning services); for other tasks cultural skills are needed (e.g. Belgian nurses who typically have empathy competencies, but are sensitive to hierarchical relations).

Cultural intelligence will play an ever larger role in the hospital. It enables one to determine what people really can do. The training of doctors and nurses must include cultural skills.

The Netherlands does not produce sufficient employees in the lower part of the care market. It is revealing that the two newest hospitals (Groningen and Maastricht) have the

lowest number of highly educated people. This shows a new trend in the labour market. There will be a large need to attract people from a foreign country (Kuijer, personal interview, April 25, 2007).

8. CONCLUSION

This report has provided background information on the new health care system and public health care legislation and regulation in the Netherlands.

Furthermore, the report has shown, that population ageing, although it is yet to come, will have a large impact on health spending, health and disability support, and the future labour market.

International mobility of medical professionals is still low in the Netherlands, as it is in other European countries. Shortages of nursing and caring personnel may occur over the next few years. The greatest shortages are estimated to occur in jobs requiring the lowest levels of vocational education and training.

The expected shortages may be a reason for the government to pursue immigration policy.

A special case is to be made for the free movement of workers from Central and Eastern Europe on the Dutch labour market. Recruitment projects have already been initiated on the national as well as the local level.

9. SOURCES OF INFORMATION

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

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

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

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

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

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

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

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

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

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

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

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

Health Policy (2004), De Veer A, Ouden D and Francke A . *Experiences of foreign European nurses in the Netherlands.* Health Policy 68, 55-61, Oxford University Press, UK.
URL:
http://www.healthpolicymonitor.org/en/Policy_Survey/Search_for_Policy_Reforms/Survey_Details/
Nurse_Practitioner_Curriculum.html (Accessed, November 2006)

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

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

ICN (2005), International Council of Nurses, James Buchan, Mireille Kingma, F. Marilyn Lorenzo, *International migration of nurses: trends and policy implications,* Geneva.

URL: http://www.icn.ch/global/Issue5migration.pdf (Accessed, November 2006)

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

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

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

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

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

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

NIZW (2004), EU- PHARE Twinning Project, *From mutual recognition to mutual communication?*
URL:
http://www.nizw.nl/internationaal/Docs/TwinningPolen/FINAL%20REPORT%20WARSAW%20SEMINAR%2022-23%20SEPTEMBER%202004.pdf (Accessed, June 2007)

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

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

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

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

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

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

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

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

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

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

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

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

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

VWS (n.d.), *The new care system in the Netherlands,* Ministry of Health Welfare and Sport.
URL: http://www.minvws.nl/images/boekje-zorgstelsel--engels_tcm20-107938.pdf (Accessed, November 2006)

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

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

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

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

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

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

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

WRR (2004), Wetenschappelijke Raad voor het Regeringsbeleid, H. Dijstelbloem, P.L. Meurs en E.K. Schrijvers (red.) , *Maatschappelijke dienstverlening, een onderzoek naar vijf sectoren*, Amsterdam.

URL: http://www.nizw.nl/digitaalmagazijn/MaatschappelijkedienstverleningWrr2004.pdf (Accessed, November 2006)

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

Interviews

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

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

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

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

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

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

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

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

Care Flows

Country Report for UK

Partner Meeting, Gelsenkirchen
26/27 April 2007

Centre for Social Work Research/ Institute for Health and Social Care Research
Allerton Building
Frederick Rd
Greater Manchester
M6 6PU

John Sudbery: (0)161 295 2053 Prof Steven Shardlow: (0) 161 295 245
Mike Murphy, Mike Dean, Dr Eileen Oak

Care Flows - Country Report: United Kingdom

Introduction

This report is divided into three main sections. Section 1 describes the National Health Service in the UK. Section 2 refers to medical and other health professions, and section 3 refers to social work and other social care occupations. In each section, the description and analysis is intended to assist a discussion about workforce issues in relation to European mobility. An additional very brief section provides a summary of demographics in the UK.

Section A: The National Health Service

The principles of the National Health Service (NHS) in the UK are that it provides health care free at the point of delivery “from the cradle to the grave”. Treatment is determined by clinical need.

Social Care has never been provided free as of right, although since the greater part of its users have been in poverty, issues of payment did not figure prominently until the last two decades. Unlike the National Health Service, the organisation of social care has traditionally been located at local government level.

However, the reality of the health and social services is not so simple. They are organisations of extraordinary size and complexity whose current functioning is difficult for anyone to understand or describe. The contradictions hidden in the first paragraph above (the potentially unlimited nature of demand, the expense of new treatments, ethical decisions about life) are increasingly the subject of explicit public policy discussion.

Providing services to 60 million people, the National Health Service employs 1.3 million staff, 1.07 million fulltime equivalents (table 1 below). Since many functions (such as catering, cleaning, building maintenance) are contracted out to private firms, the authors of this report assume that the health service provides UK employment to numbers of citizens significantly in excess of this. Workforce planning in the NHS has been described Prof Niall Dickson, chief executive of the King's Fund as “a bit like landing a jumbo jet on a pin” (BBC, 2007).

Total numbers of NHS staff, 2006	
Headcount	1,333,100
Full-time equivalents	1,071,200
Qualified doctors	122,000
Qualified nurses	404,000
Professions allied to medicine and other qualified therapists (at 2004)	129,000
Source: NHS Staff 1995-2005. See NHS (2007)	

table 1: National Health Service Workforce

Family doctors are self-employed professionals who contract with the NHS (but may not take private patients). Hospital Consultants (senior medical specialists) are employees of the health service (but are allowed by contract to take private patients).

The budget for the health service this year will be over £100,000,000,000 (approx 150.000 million euros - a report by a private banker concluded that it was underfunded by £200, 000,000,000 over the last 30 years – Wanless, 2002).

The NHS is the largest organisation of any kind in Europe, and the third or fourth largest employer in the world (after the Chinese army and the Indian railways). With such size and complexity, it is not surprizing that any attempt to describe it, analyze its functioning, or evaluate its performance is contested. Much publicity, for example, was given earlier this year to a statement by the responsible politician that “the NHS has had its best year ever” at the same time as others were describing the organization as in the grip of a crisis.

In Scotland and Wales, the NHS is the responsibility of the devolved administrations. Developments which have focussed attention on the different directions being taken in the countries include: in Scotland, social care (for example residential or domiciliary care) is free of charge and in Wales there is no charge for medications (in England, this is one area in which the citizen pays a standard fee towards - but not covering – the cost).

As will be set out later, about 922,000 people are employed in the social care sector, and a further (estimated) 650,000 NHS staff are employed in "social care" responsibilities.

Structure

The Department of Health has political responsibility for the Health Service. At the moment, there are 152 Primary Care Organisations ("Trusts") responsible for overseeing family community services and for obtaining (commissioning) services in their areas from 290 provider units ("Trusts"). These include hospital trusts (operating through hospitals, treatment centres and specialist care in about 1,600 hospitals), NHS Ambulance Services Trusts, NHS Care Trusts and NHS Mental Health Services Trusts.

The NHS provides a simplified picture of its current structure, with clickable links, at http://www.nhs.uk/England/AboutTheNhs/Default.cmsx. (fig 2). This is a cross-section snapshot of a longitudinal picture of constant organisational change. Another good and accurate introduction can be found on Wikipedia (2007)

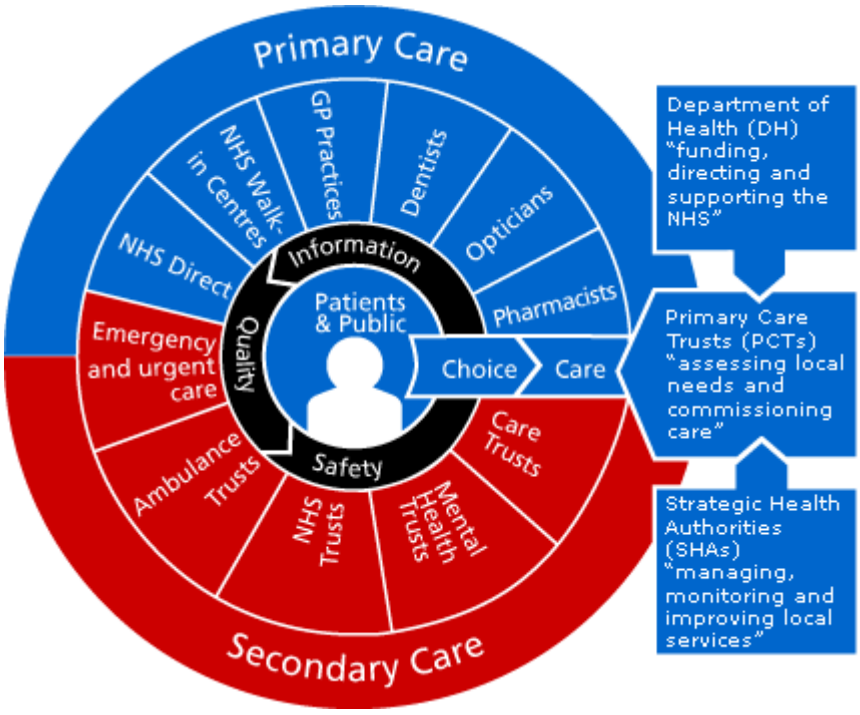


Fig 2 Government diagram of the structure of the NHS

Fig 3 below indicates some aspects of its constant and continuing evolution. It has always been recognized that health care cannot be organized as a centrally planned bureaucracy, and the NHS has never operated as a vertically integrated business (witness the employment status of family doctors as independent contractors). Fear of the inefficiencies involved and political ideology has led to fitful and erratic introduction of competition and internal market mechanisms.

Currently, some competitive and quasi-market features involving financial independence are combined, not always consistently, with centrally set targets and performance management. In many areas this results in a climate of constant and unstable change. Of the government and quasi-government bodies referred to in this document, most were not in existence in 1999 (although the functions, for different geographical arrangements, or for different groups, or with different remits, or by different organisations, were carried out before that date).

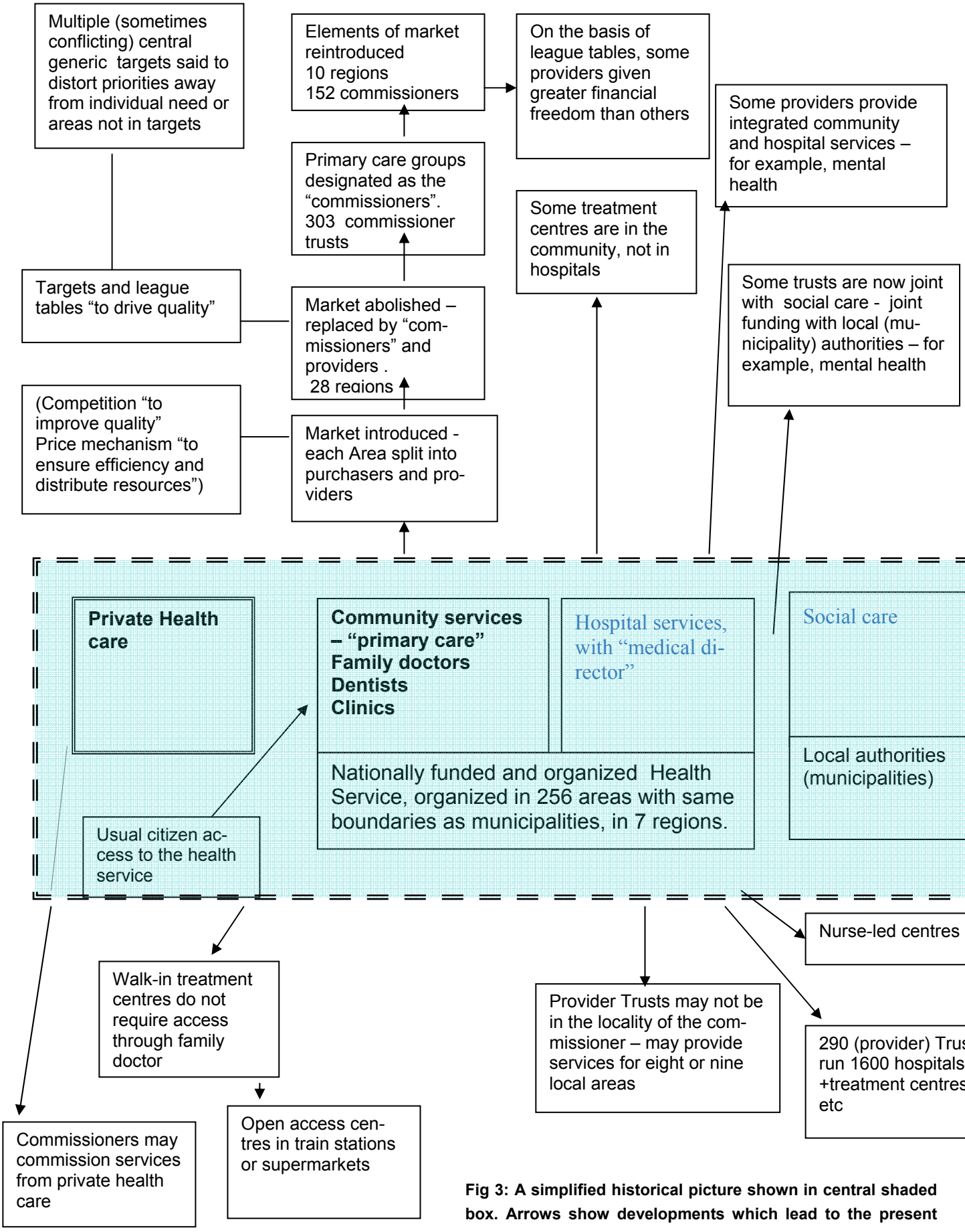


Fig 3: A simplified historical picture shown in central shaded box. Arrows show developments which lead to the present mixed arrangements

Education, Training, Research and Workforce

Education, training, research and workforce issues are all linked with the "quasi market" arrangements, so when NHS economic cycle is in "boom" phase, staff need to be recruited from abroad and numbers in training are high; when the internal market is "cold", prices paid to train staff are low and graduating students cannot get jobs. At the moment, it is claimed that 34,000 medical students will graduate this year but despite an analysed workforce shortfall, only 18,000 jobs are available.

The BBC reported a leaked NHS pay and workforce strategy for 2008 to 2011 in England as follows: "It predicted there will be volatility in the immediate future with as much as a reduction of 2.7% - nearly 37,000 jobs - in the workforce this year alone. But it said by 2011 the health service will experience a shortage of 1,200 GPs, 14,000 nurses and 1,100 junior and staff-grade doctors by 2011" (BBC, 2007)

Section 2: Medical and other Health Professions in England and Wales

Overall workforce statistics are given above, figure 1.

Doctors

England 2004 – 2006. Recruitment figures are available for various periods 2004-5 as follows. There has been an increase of 529 GPs between March and July, 2004, an increase of 959 consultants from March to September, and a shortfall of 166 consultants identified at that point. In general, there has been a major increase in the numbers of doctors since the year 2000. (DOH, 2005)

Wales 2005 – 2006. 144 new consultants were recruited between July 2004 – July 2005. Welsh Assembly argues that it is on course to achieve it target of 700 more doctors by 2010.

Recruitment and Retention Strategies. Recent initiatives include a new pay structure for junior doctors and Senior Registrars, new training schemes at post graduate level for doctors, and a new scheme to attract doctors from deprived backgrounds. There are also new Immigration Rules for Oversees doctors

Family doctors. Shortage rates are evaluated by calculating the number of vacancies in a practice which have been vacant for three months or more

Location of Family doctors (GPs)	**Vacancies which are unfilled for 3-month or more**
England	2.4%
Wales	2.1%
rural	1.1%
urban	4.2%
Practices with heaviest workload	3.6
Practices with least heavy workload	1.2

Fig 4: Family doctor (GP) vacancies

The proportion of unfilled vacancies which had been outstanding for more than six months at the end of 2004, was 67% The percentage of unfilled vacancies outstanding over 12 months was 40%

Nursing, Professions allied to Medicine and Qualified therapists

Numbers have increased by 42% since 2000, but the type of employment created by this increase is unclear. Market pressures in other areas of operation have meant that at March 07, there has been loss of jobs and a sudden surplus of supply (including graduating students) over demand, even though on “target” measures there is are shortages of staff.

In physiotherapy, for example, the Chief Executive of the UK Chartered Society of Physiotherapists gave evidence to a Parliamentary commission on workforce planning and stated afterwards (Gray, 2007): 'There is a growing demand from patients for physiotherapy services, yet the current workforce planning arrangement are failing patients and professionals - particularly new physiotherapy graduates - alike. It is deeply worrying that so many highly trained physiotherapy graduates are out of work when patients are waiting longer for

essential physio treatment" This has also meant that the attractiveness of the profession has suddenly changed. From being a training which because of competition attracts the very top academic students, the courses are now recruiting lower (though in absolute terms, still high) academic entry levels. In tandem with this, the market in training has meant that health employers negotiate less per student place to higher education institutes.

Entry to the nursing and other professions is through a three year degree (BA) programme, with standards of proficiency specified by the Nursing and midwifery Council (created 2002) or the Health Professions Council (created 2001).

Migration and the nursing workforce

Figure 3 sets out the registrations for UK and non-UK admissions to the UK nursing register.

Non-UK and UK initial admissions to the United Kingdom Central Council (UKCC) Register, and non-UK as a percentage of all initial admissions

Year	*Non-UK admissions*	*UK admissions*	*Non-UK admissions as percentage of all initial admissions*
1993/1994	2121	17 948	11
1994/1995	2452	17 411	12
1995/1996	2762	16 870	14
1996/1997	3774	14 210	21
1997/1998	4300	12 082	26
1998/1999	4891	12 974	28
1999/2000	7383	14 035	35
2000/2001	9709	15 433	39
2001/2002	16 155	14 538	53
2002/2003	13 629	18 048	43

Source: UKCC/Nurses and Midwives Council (NMC).

Figure 5: UK and non-UK admissions to the nursing register (Buchan, 2004)

In 2001, foreign-trained nurse recruits exceeded the number of new British-trained recruits on the UK nurse register for the first time. Over the next years, health care service providers relied increasingly on overseas nurses. The distribution was heavily skewed towards London and the Southeast. "Areas with

the highest vacancy rates also have the highest representation of foreign recruits, with 24% of foreign-trained nurses in the UK residing in the London area and another 16% in the SouthEast (comparable numbers for British-trained nurses are 11% and 13%, respectively)" (Batata 2005).

	Total registrants	Training source			
		UK	Int'l	%UK	%int'l
England TOTAL	503522	476044	27478	94.5	5.5
Wales	33281	32022	1259	96.2	3.8
Scotland	66817	65935	882	98.7	1.3
Northern Ireland	21645	20591	1054	95.1	4.9

Fig 6. nursing registrants in UK by place of training

Batata provides the above analysis from published sources and then uses a different methodology to calculate the vacancy rate for current nursing posts if no internationally-trained nurses were employed. This figure is much higher - 8.3% overall for England, 3.7% in Wales and 2.5% in Scotland. It is as high as 20% in some areas.

Section 3: Social Work and other Social Care

Social work

The relevant government department describes social work:

> *Social workers form relationships with people. As adviser, advocate, counsellor or listener, a social worker helps people to live more successfully within their local communities by helping them find solutions to their problems. Social work also involves engaging not only with clients themselves but their families and friends as well as working closely with other organisations including the police, NHS, schools and probation service.*
>
> *There is a specific status associated with the job title "social worker". Social workers are professionally qualified staff who assess the needs of service users and plan the individual packages of care and support that best help them. Becoming a social worker involves taking an honours degree in social work and registering with the General Social Care Council. Almost all social workers start their careers with experience in social care.*
>
> *Department of Health,(2006)*

In relation to adults, roles include working with people with mental health problems or learning difficulties in residential care; working with offenders, by supervising them in the community and supporting them to find work; assisting people with HIV/AIDs and working with older people at home helping to sort out problems with their health, housing or benefits. With children and their families, roles include providing assistance and advice to keep families together; working in children's homes; managing adoption and foster care processes; providing support to younger people leaving care or who are at risk or in trouble with the law; or helping children who have problems at school or are facing difficulties brought on by illness in the family.

In the UK, “Social worker” is a protected title which may only be used by those registered with the General Social Care Council. There is a separate register of social workers for each country (England, Ireland Scotland and Wales). The register of is currently open to UK-qualified and international social workers, and student social workers. One priority of the Regulatory Council is to introduce registration arrangements for other social care workers.

There are about 110,000 registered social workers in the UK. In England 78% were employed by local authorities (including agency staff), eight percent in independent sector care homes and domiciliary care, 13% by other public and voluntary sector employers and, apparently, less than one percent in the NHS. There is reason to believe that not all social care staff employed in the NHS are being recorded as such.

Pay

Social workers’ pay levels are among the lowest of the professional occupations. At April 2004 the median gross weekly pay of male social workers in the UK was £475.30, which is below the corresponding rates for probation officers and nurses and well below that of teachers of all types. (Office of National Statistics Annual Survey of Hours and Earnings)

Median gross weekly pay for full-time female social workers was £448.30, above that for probation officers and nurses though again well below all types of teacher.

Pay levels for social workers in London are substantially higher than in other regions.

Overseas social workers

In England (we do not have figures for internationally qualified social workers in Scotland, Wales or Ireland), there are now more than 70,000 registered and qualified social workers:

Social workers	Number
UK qualified registrants	67,000
Internationally qualified registrants	5,000
SW students registrants	10,500

Fig 7: Registrations with the General Social Care Council in England

Country of Qualification	Number
Australia	864
Canada	327
Germany	186
India	439
NZ	230
Philippines	132
Romania	163
South Africa	937
USA	574
Zimbabwe	249

Fig 8: non-UK countries providing the largest number of qualified GSCC registrants

It can be seen that some of these countries have particular links with the UK either through language, former colonial ties (Commonwealth) and current political ties (EU/EU application in process).

Registrations from the European Union were as follows:

Country	Number
Germany	186
Romania	163
Netherlands	56
Spain	58
Poland	48
Sweden	37
Ireland	24
Denmark	18
Hungary	18
Greece	17
Bulgaria	14
Czech R	13
Finland	12
Austria	11
Belgium	11
Italy	10
Norway	10
Portugal	10
Others (inc France)	36
Total	752

Fig 9 EU registrations (social work)

It is possible that ties of language may account for the number of social workers present from English speaking countries. This language 'pull' may also involve ease of migration, ease of attraction (advertising etc), international recognition of qualification, social (family) factors; the desire to do social work in English

However the explanation of language does not explain the high number of staff registered from Germany, Romania or the Philippines. Also the explanation of language does not help to explain the very low migration of social workers who qualified in Ireland.

Former colonial (or current commonwealth) ties may account for significant social work migration. These ties have significantly affected general trends of migration in the last hundred years. This would account for the relatively large numbers of social workers who qualified in South Africa, Canada, India, Australia and New Zealand. But there are still significant anomalies in this hypothesis. How do we account for the relatively high number of migrants from India, but very low numbers from Pakistan and Bangle Desh? This hypothesis also fails to explain the low migration of social workers from Ireland.

Similar although not entirely comparable data was collated for Wales and Northern Ireland and Scotland (which does not record details of a registrant's country of origin or country of qualification).

Staffing levels/vacancies- Scotland

The Scottish Executive (2006) provide the following information

35% of all vacant social worker posts have been vacant for over six months. This ranges from 19 per cent in the generic provision (decrease of 21 percentage points since October 2005) to 39 per cent in services for children Nearly half of all senior social worker vacancies have been vacant for over 6 months.

The number of filled social worker posts has increased by 16 Whole Time Equivalent (WTE) between October 2005 (4,916) and January 2006 (4,931).

The number of social worker vacancies has decreased by 38 WTE vacancies from October 2005 (536) to January 2006 (498).

The proportion of all vacant social worker posts has fallen slightly between October 2005 and January 2006, from 9.8 per cent to 9.2 per cent.

The number of filled adult services posts have decreased slightly from 1585 WTE in October 2005 to 1575 WTE in January 2006, but vacancies have also decreased from 170 to 130 over the same time period.

In children's services, the number of filled posts has increased slightly by 4 WTE from 2247 WTE in October 2005 to 2251 WTE in January 2006, but vacancies have also risen slightly from 272 WTE to 274 WTE over the same time period.

All Social Care (social work and non-social work):

Social Care Employers

There are an estimated 31,000 social care providing organisations in England This estimate includes local authorities, various parts of the NHS, and independent, i.e. private + voluntary, sector organisations. Adding childcare brings this total to 55,000, and to 127,000 if childminders are included too. In addition, there were 13,000 people individually buying social care via direct payments.

The majority of social care providers are in the private sector.

There were about 21,000 registered care homes for adults. Of which 1,400 were adult placement homes. Of the remaining 19,500, the majority (71%) are privately owned and 17% owned by voluntary sector organisations, taking the independent

sector's share of adult care homes excluding adult placement to 88%. Nearly four-fifths (79%) of the 19,500 adult care homes are registered to provide care only, the rest to provide care with nursing. The latter are even more dominated by the private sector (89% privately owned) and the great majority of these are operated by small independent businesses.

There are about 3,700 branches of registered agencies providing domiciliary care staff and nearly 1,000 providing nursing staff. An estimated 700 provide both types of staff. Of total registrations, 77% were private sector, five percent voluntary/not for profit and the rest local authority and others. The provision of around 35,000 supported housing/assisted living units is not included.

The number of providers of day care for adults is largely unknown.

The 13,000 individuals in receipt of direct payments at end September 2003. Most were for adult care.

Just over 2,000 children's homes were registered with the CSCI, of which 59% were privately and 34% local authority owned. A total of 232 independent and 143 local authority fostering agencies, 62 voluntary and 148 local authority adoption agencies, and 35 residential family centres were also registered.

Around 34,900 childcare-providing organisations – day nurseries, playgroups, out-of-school & holiday clubs and crèches – were registered with Ofsted at September 2004, along with 71,900 individual childminders, providing a total of 1,470,000 childcare places. Around 85% of the organisations are in the independent sector. Since registration began in March 2003, the total number of providers (including childminders) has increased by seven percent and places by 12%.

Staff

In 2003-4, an estimated 922,000 people were employed in 'core' social care as traditionally defined, i.e. including local authority social services staff, residential, day and domiciliary care staff, agency staff and a limited number of NHS staff. Of these, an estimated 61% were working in services for older people, 19% in disabled adults services, 13% in children's services and seven percent in mental health services.

If a wider range of NHS staff who do some care work, and if childcare, foster carers and early years and school teaching assistants and other support staff are included, the estimated number of people working in social care increases to 1.6 million.

Using the very limited data available, it is estimated that a total of 390,000 staff, of whom 288,000 are care workers, are employed in independent sector adult care and with-nursing homes. The independent sector domiciliary care workforce is estimated at 106,500, of whom 97,500 are care workers.

The learning and Skills Council for the Sector (Skills for Care, 2005 – formed 2005) estimates that 305,000 staff were being employed in early years childcare, including 72,000 in childminding, and a further 45,000 in early years (nursery school/nursery class) settings. Depending on the definitions used, there could perhaps be 100,000 staff working in care-type roles in post-early years state sector education.

Workforce numbers and non-UK staff

The Learning and Skills Council for the social care sector commissioned an investigation into the numbers of overseas workers working with children, their qualifications and training and the experiences that employers have had of them. They present numbers as follows (table 5):

Code	Name	UK Born		Non-UK		Total
		Numbers	%	Numbers	%	Numbers
2442	Social workers	90,000	*81%*	22,000	*19%*	111,677
3222	Occupational therapists	28,000	*91%*	3,000	*9%*	30,563
3231	Youth and community workers	89,000	*95%*	5,000	*5%*	93,865
3232	Housing and welfare officers	158,000	*89%*	19,000	*11%*	177,666
6111	Nursing auxiliaries and assistants	197,000	*90%*	23,000	*10%*	219,796
6114	House-parents and residential wardens	35,000	*95%*	2,000	*5%*	37,398
6115	Care assistants and home carers	535,000	*84%*	105,000	*16%*	640,686
6121	Nursery nurses	151,000	*95%*	7,000	*5%*	157,949
6122	Childminders and related occupations	99,000	*81%*	23,000	*19%*	122,197
6123	Playgroup leaders & assistants	51,000	*98%*	1,000	*2%*	52,040
6124	Educational assistants	353,000	*92%*	29,000	*8%*	382389
Total		**1,787,000**	*88%*	**240,000**	*12%*	**2,026,226**

Table 5: Employment in the Social Care Sector (main job) April-June 2006

Source: Experian/ Skills for Care (2007) Overseas Workers in the UK social care

The Department of Health has now set up Care Group Workforce Teams for Mental Health, Children, Older People and Long Term Conditions. We have not at the moment been able to include data from these teams.

Workforce demographics and employment patterns

The social care workforce is predominantly female: 80%+, increasing to 95%+ in sectors such as residential and domiciliary care and some early years childcare. Mainly as a consequence of this, part-time working is common — around 50% of the total workforce work part-time.

The workforce includes people of all ages, but especially 35–49 year olds who account for 40% of the total, compared with 35% under 35s and 25% 50+s. However, settings for older people tend to employ older workers, while childcare workers tend to be younger. Occupational therapists and qualified nursery nurses are among the youngest in the workforce.

Workforce vacancy and turnover rates

Vacancy rates in social care are about twice as high as those for the average of all employment in England.

Little is known about current vacancy and turnover rates in the independent sector. The average vacancy rate for all directly-employed staff in local authority social services departments in England at September 2003 was 11.0% (one in nine posts vacant); the average turnover rate for 2003-4 was 12.7% (one in every 7–8 staff leaving).

However, there is wide variation, both geographically and between individual authorities. Regional vacancy rates continued to be highest in London (17.2%)

Vacancy and turnover rates were particularly high for local authority occupational therapists (vacancy 19%, turnover 17%), children's social workers (vacancy 12%, turnover 12%), care workers in children's homes (vacancy 13%, turnover 14%) and domiciliary care workers (vacancy 11%, turnover 15% including retirement, 13% excluding retirement).

Recruiting occupational therapists is as difficult in the NHS. Three-month vacancy rates for occupational therapists in 2004 reached five percent, higher than the average for all allied health professionals (4.3%). Over half these vacancies were in London and the South East.

In the childcare sector, estimated 2003 staff turnover rates were 18% in day nurseries, 14% in playgroups and 20%+ in after-school and holiday clubs. In early years settings they were lower (11% or less). Around 20% of childcare and 10% of early years staff leave the sector each year.

At April 2004 the median gross pay of female care workers was £6.40 per hour. This ranged from £4.80 per hour or less in the bottom 10% of workers, to over £8.30 for the top 10%. Care workers in the public and voluntary sector earn on average 22% more than those in the private sector, and pay is highest in London. Lowest-paid care workers earn similar amounts to retail sector cashiers and check-out operators. However, the pay range is much wider, reflecting the diversity of seniority, experience, qualifications, settings and employer types among care workers. Nationally, 50% of care workers earn more than the highest paid check-out operators. There is a little evidence to suggest that NVQ-qualified care workers are paid more than unqualified ones.

In the childcare and early years sectors, staff qualified to supervisory level, including nursery nurses, are paid at least 10%-15% more than unqualified childcare and support staff.

Social work training and qualifications

UK social work training is by BA honours degree (at 78 Universities or affiliated Colleges) or Masters Degree (at 41 Universities). The professional competency requirements are the same for both and are set out by the General Social Care Council – (GSCC). The academic benchmarks are laid out by the Higher Education Council (HEFCE) and differ between the two levels. In addition, courses have to meet two other sets of regulatory requirements – the National Occupational Standards for Social Workers (set by Skills for Care) and the Government's Department of Health prescribed curriculum and the admission requirements for the degree in Social Work. These various requirements do not always combine easily into a single programme of study and training.

Table 2 above indicated there were 10,500 social work students in training. The number of entrants each year is increasing, the GSCC (2007) quoting an enrolment of 5567 students in 2005. Recruitment to courses has never been problematic, but a government recruitment campaign from 2001 has undoubtedly been helpful. About 1000 of these entrants are employment-based, pursuing their qualification as part of their employment.

There is a (changing) system of post qualification training in the UK, and specialist training of this sort is an advantage or a prerequisite for some social work responsibilities.

Social care training and qualifications – excluding "social work"

At the time of writing, up-to-date analyses of numbers of staff in agencies providing social who hold NVQs and other qualifications specified in the National Minimum Standards were not available.

At September 2003 an estimated 10% of registered managers in local authority care homes (including children's) held manager's award at NVQ level 4 (approx ISCD level 4, I think – see Hogeschool Zuyd, 2006). 26% were studying for it. A third held other management qualifications and 37% a professional social work qualification (ISCD level 5). The proportion of qualified managers appears to be steadily increasing. No information about managers in independent sector care homes was available at the time of writing.

Information about the proportion of care workers in care homes who are qualified to the appropriate NVQ level is incomplete, but generally points to non-achievement of the 2005 targets at a national level (though many individual homes have achieved them).

Missing information about the social care workforce

There is a great deal that is not known about the social care workforce in the UK. The key areas where information is lacking are: the independent sector workforce, levels of training and qualification in the workforce as a whole, day care, employees of partnership bodies, social care staff in the NHS, information about new types of care providers.

Section 4: A note on demographics

The population of the UK is 59 million. The most numerous age group is the cohort born 1946-51 It grew by 375,100 people in the year to mid-2005. (1 July 2005 population estimates by UK National Statistics). The age distribution differs considerably in different parts of the country. The 1946-51 group reaches retirement age from 2006 onwards (women from 2006 and men from 2011), and the sudden increase in the number has led politicians and political commentators to fear a "pensions or care crisis".

The United Kingdom has been a significant destination of immigration (and emigration) for the last two hundred years. One question relevant to this study is

whether the 'pathways' of general migration are reflected in the pathways of employment migration, and to what extent the migratory patterns for the various occupational groups in health and social care differ.

Appendix 1
Definitions/limitations to social work role

Social work

A profession which promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well being. Utilising theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work

BASW code of ethics 2002

The International Association of Schools of Social Work and the International Federation of Social Work agreed the following definition:

The social work profession promotes social change, problem-solving in human relationships, and the empowerment and liberation of people to enhance well-being. Utilising theories of human behaviour and social systems, social work intervenes at points where people interact with their environments. Principles of human rights and social justice are fundamental to social work (July 2001)

References

Batata, A S (2005) International nurse recruitment and NHS vacancies: a cross-sectional analysis Globalization and Health 2005, 1:7

BBC (2007) Shortage of NHS staff predicted. BBC news 04 January 2007 online at http://news.bbc.co.uk/1/hi/health/6228659.stm

Buchan, J (2004) Commentary. Nurse workforce planning in the UK: policies and Impact Journal of Nursing Management, 12, 388–392

Department of Health (2006) What is Social Work. online at http://www.socialworkandcare.co.uk/socialwork/what/index.asp Also Booklet "social work" .

Department of Health (2005) *Staff in the NHS 2004.* London: Department of Health

Experian/ Skills for Care (2007) Overseas Workers in the UK social care, children and young people sector: A report for Skills for Care and Development

General Social Care Council (2007) *Annual Report.* London: General Social Care Council

Health Professions Council (2005) *Standards of Proficiency:Physiotherapists* . London: Health Professions Council. Available online at the Council's website

Hellowell, M (2005) Briefing note for the House of Commons Health Committee on proposed changes to the functions of NHS Primary Care Trusts. The Centre for International Public Health Policy, School of Health in Social Science, University of Edinburgh 10th November 2005

Hogeschool Zuyd, 2006) Care Flows document for 4th Care flows meeting Limerick, 7-8 December 2006)

Nursing and Midwifery Council (03-04) Standards of Proficiency for Pre-registration midwifery education. London: Nursing and Midwifery Council

Nursing and Midwifery Council (2004) The NMC code of professional conduct: standards for conduct, performance and ethics. London: Nursing and Midwifery Council

NHS England (2007) http://www.ic.nhs.uk/statistics-and-data-collections/workforce

NHS England (2007) *About the NHS* http://www.nhs.uk/England/AboutTheNhs/Default.cmsx Accessed 20.04.2007

NHS Scotland (2007) S*cotland's Health on theWeb* http://www.show.scot.nhs.uk/

NHS Wales (2007) *Health of Wales Information Service* http://www.wales.nhs.uk/

Scottish Executive (2006) Staff Of Scottish Local Authority Social Work Services, 2005. Scottish Executive: A National Statistics Publication

Skills for Care (2005) Skills Research and Intelligence 2nd Annual Report: The State of the Social Care Workforce, 2004*:*

Wanless, D (2004) Securing Good Health for the Whole Population an independent evidence-based assessment of the long-term resource requirements for the NHS . Available on http://www.hm-treasury.gov.uk/consultations_and_legislation/wanless/consult_wanless_index.cfm accessed 24 april 2007.

Wikipedia (2007) *National Health Service* http://en.wikipedia.org/wiki/National_Health_Service#Structure

Institut Arbeit und Technik

CareFlows Project – Job mobility in health & social care
- Induction Pack Germany -

Elke Dahlbeck
Institute for Work & Technology
January 2008

Introduction

CareFlows – Job mobility in Health and Social Care in North West Europe - has got two main research themes: One aim of the project is the analysis of demand and supply in the social and health care sector in the four partner countries: Germany, the Netherlands, Ireland and the United Kingdom. The second aim is to formulate recommendations, how barriers for mobility can be disposed and stimulation for mobility can be set. These aspects are described in the four Country studies, that you can find on the CareFlows webpage: http://www.careflows.info. The CareFlows project focuses on three professions: Nurses, doctors and social workers.

The other aims of the project is more practical: To increase job mobility CareFlows organized Job fairs and dissemination events and induction packs for specially for health & social care staff who are interested to work abroad. The webpage http://www.careflows.info gives an overview of publications, news and interesting links for people who like to move to one of the partner countries.

The aim of the following information pack is to give a short overview of main contact persons/institutions for people who like to move to Germany and are working as a doctor / or nurse or social worker and want to get more information about possibilities to work in Germany. Because there are many general country packs existing (e.g. by the European Commission or the German labour administration) the focus of the pack is health & social care. The induction pack is a result of the interviews and desk-tops research for the Country German Germany, which was made for CareFlows in 2007. Important parts concerning working conditions or recognition process has bee taken completely for this information pack. You can download the Country Report Germany on the CareFlows webpage.

General Country Information

Germany is a democratic-parliamentary federal state in central Europe. Berlin is the capital of Germany. 82 million people are living in Germany, on an area of 357,092km². There is a population density of 231 inhabitants per km². Almost 20 % of the inhabitants have their roots abroad, but most of them posses German passports, 7 million have got foreign passports. The largest immigration groups are Turks, Greeks, Italians, Poles, Russians Serbs and Croats.

The head of the state is President Prof. Dr. Horst Köhler, the head of the government is chancellor Dr. Angela Merkel.

The gross national income 2006 was EUR 2.318,83 billion the gross domestic product was EUR 2.307,20 billion, the GDP per inhabitant was EUR 28,012. The shares of the GDP were 69.2% by services, 29.9% by industries and construction and 1.0% by agriculture (data 2006). Germany does not have many raw materials, so it becomes obvious, that knowledge, research & development and so the human capital are very important and for the economic growths.

The structural change in the last decades showed that there is high decreasing demand of lower qualified people and a high demand of high skilled persons. Certainly the demand depends on the branches and sectors, but many predictions explained that there will be a rising lack of skilled personnel in the coming years. There will be a lack of IT-Workers, Engineers, teachers, but there will be also a growing demand of people working in elderly care, doctors, especially doctors who will be working in rural areas. In Germany, there are 4.5 million people working in the health care industries. The demand of personnel working in the health industries will be grow up from 2001 until 2015 up to 800,000.

To get a very good overview of the German labour market and German labour conditions please see the webpage of the labour administration (www.arbeitsagentur.de) or the European Portal for Job Mobility Eures (http://europa.eu.int). The labour administration published helpful documents about working in Germany. You will find it here: (free of charge)

Mobility cross Europe: Your job in Germany: http://www.ba-auslandsvermittlung.de/lang_de/nn_7688/SharedDocs/Publikationen/Mobil-in-Europa/Themenhefte/GGTSPU-iat-gate.iatge.de-11787-446594-DAT/Your-Job-in-Germany-MIE-Themenheft,templateId=raw,property=publicationFile.pdf

Further links about living & working in Germany:
www.deutschland.de
www.bundesregierung.de
www.ec.europa.eu
www.hdg.de/lemo/
http://www.tatsachen-ueber-deutschland.de/index.php?L=1

The federal countries of Germany and their regional capitals are:

- Baden-Württemberg – Stuttgart www.baden-württemberg.de
- Bavaria – Munich www.bayern.de
- Berlin www.berlin.de

- Brandenburg - Potsdam www.brandenburg.de
- Bremen www.bremen.de
- Hamburg www.hamburg.de
- Hesse – Wiesbaden www.hessen.de
- Mecklenburg-Western Pomerania – Rostock www.mecklenburg-vorpommern.de
- Lower Saxony – Hannover www.sachsen.de
- North Rhine-Westphalia – Düsseldorf www.nordrhein-westfalen.de
- Rhineland-Palatinate – Mainz www.rheinland-pfalz.de
- Saarland – Saarbrücken www.saarland.de
- Saxony – Dresden www.sachsen.de
- Saxony-Anhalt – Magdeburg www.sachsen-anhalt.de
- Schleswig-Holstein – Kiel www.schleswig-holstein.de
- Thuringia – Erfurt www.thüringen.de
-

Job seeking in Germany - General aspects -

There are many possibilities to find a job in Germany in health & social care sector. You can find General and special facilities to get a job e.g. the labour administration, newspaper, (internet)job exchanges, special profession organizations or trade unions.

In Germany the consulting by the labour administration is for free for employees. Every town or region has got a local or regional labour administration office. (www.arbeitsagentur.de). The labour administration offers also a special service for people who like to work abroad http://www.ba-auslandsvermittlung.de/.

There is also a special Europe Internet job exchange, where you can get information about job possibilities and country information http://ec.europa.eu/eures.

Newspapers are also important to find a job in Germany. If you are interested in finding a job in one special region, there are a lot of regional newspapers. While the regional ones has got more job advertises for lower qualified people, most of the national wide newspapers only contains higher qualified jobs. Here are three examples of important newspapers:
www.zeit.de
www.fazjob.net
www.suedeutsche.de

Further links about working in Germany:
http://www.germanmedicine.net/en/index.html
http://www.howtogermany.com
http://www.arbeitsagentur.de/zentraler-Content/Veroeffentlichungen/Merkblatt-Sammlung/GGTSPU-iat-gate.iatge.de-11787-836447-DAT/MB7-Beschaeftigung-ausl-AN.pdf

Health & social Care system

The national health system of Germany belongs to the traditional "Bismarck-Social-Insurance-Type" and is based on a nationwide health insurance, financed by contributions of employees and employers. About 70 mill people (85%) are covered by one of the 280 compulsory health insurances, 10% are full members of one of the 49 private health insurances and 4% received governmental schemes complemented by private health insurance, and approximately 0.2% were not covered by any insurance system (WHO 2005: 5).
The German health care system is based in a decentralized organization, where the main actors - aside from patients - are the Federal Government, the associations of health insurances, physicians´ associations and the associations of hospitals. For large parts, these actors shape a self-governing system.

The Federal Ministry of Health proposes the health acts that – once passed by the Federal Parliament – define the legislative framework for the health system.

The main actors are the physicians´ and dentists associations of the providers´ side and the sickness funds and their associations on the purchasers side. Because of the federal system in Germany the actors are organized on federal level as well as state ("Länder") level (Riesberg, A 2005: 21).

The 2,166 hospitals (2004) are also organized on regional and federal level.

The sickness funds collect the contributions to the statutory insurance of health and long-term care and negotiate contracts with the health care providers. The Federal Joint Committee sets up a catalogue and concretises claims for benefit and the needs for quality of medical care. In 2004 the Institute for Quality and Efficiency was founded as a new controlling instance of the medical care system.

Employees who earn less than 3,525 Euro per month (2005) are compulsorily insured. Since 1996 they have a free choice between the various sickness funds. Children and spouses

without an own income are co-insured free of charge. Unemployed people, pensioners, people who receive welfare benefit like homeless people are also insured. The compulsory health insurance system is based on the principles of solidarity and redistribution and benefit in kind. The average contribution rate amounted to 14.2% of the gross wage in 2004. Up to the last year, the payment of contribution was equally divided by employers and employees (50%), since last year the relation is 46% employers and 54% employees (WHO 2005). Self-employed persons (free-lancers) and people who earn more than 3,525 Euro per month can choose between the voluntary health insurance or a private health insurance. The premium rate of the private insurance depends on personal risks (Potratz, Dahlbeck, Hilbert 2006: 4).

The German health care delivery system is divided between ambulatory and stationary care. Most of the 134,000 ambulatory physicians are working in their single practice for profit, circa 50% are general practitioners, the other 50% are medical specialists. Patients have free choice of physicians, SHI-insured have free access to 96% of the physicians, because only 4% of the physicians deliver only private patients. These 96% physicians are obligatory members of the regional physicians´ associations, which are responsible for the ambulatory care not only during practice-hours, but also at night (WHO 2005:5). The physicians associations have got the monopoly for the ambulatory care in their region and negotiate collective contracts for their members with the various sickness funds. The negotiated budget is divided among the SHI-physicians for their income as measured by the number of patients and admissions and a “complicated pointsystem” for physicians benefits. The rate of outpatient physicians per 1000 inhabitants amounted 1.6 in 2005, the rate of all physicians per 1,000 inhabitants reached 3.4.

Inpatient care is delivered in 2004 by 2,166 acute hospitals, which cared for 17.3 m. patients and 1,294 clinics for prevention and rehabilitation, where 2 m. patients were treated. Most of the acute hospitals are public (36%) or non-profit hospitals (38%). In the last years the number of private acute hospitals increased. In 2004 25% of the hospitals were private, but regarding the distribution of beds, only 12% of the 531,000 beds in German hospitals were in private hospitals (Federal Statistical Office). The average length of staying in hospitals (in days) decreased in the last years from 14 in 1991 down to 8.7 in 2004, but the number of admissions increased from 14.6 Mio in 1991 up to 16.8 Mio in 2004. Hospitals are financed by a dual system. The investments in hospitals are planned and financed by the 16 “state” governments, the recurrent costs are financed by the sickness funds, based on a DRG-system since 2004, which put hospitals under economic pressure to become more efficient (Potratz, Dahlbeck, Hilbert 2006: 6).

The traditional strict separation of in- and outpatient care has weakened in the last few years. There is an increasing rate of ambulatory operations in hospitals and trans-sectoral disease-management programmes and trans- sectoral integrated delivery networks (WHO 2005: 7).
Since 1995 long-term care insurance is obligatory for the population. The contribution rate of the long-term care insurance is equally shared by employees and employers (both 1,7% of gross salaries). The claim for long-term care benefit depends on need (WHO 2005: 7). In 2003 2.3% of the population received benefits from long-term care insurance, circa one quarter in old peoples´ home and three quarters at home cared by professional ambulatory care services or by relatives.

In 2004 the health expenditure amounted up to 234 billion Euro or 10.6% of GDP. The expenditures of the compulsory health insurances amounted more than 130 billion Euro, 48% of the benefits paid for acute inpatient care, 22% for pharmaceuticals and 21% for physicians care (Federal Statistical Office).

The health policy of Germany is dominated by cost-containment. Effectiveness, competitiveness and higher quality are the strategies to reach cost reduction. Important regulations are the stepwise introduction of a DRG payment in hospitals, integrated delivery networks or the gate-keeper function of family physicians, the opening of hospitals to the ambulant market and new provisions allowing for dependend employment of doctors and codetermination for patients in the Federal Joint Committee (WHO 2005:10).

The Federal Ministry of Health and the Federal Ministry of Work and Social Affairs:
http://www.bmg-bund.de
http://www.bmas.de

To get the links of all federal states ministries please see the table below (doctors).
Further links:
http://www.die-gesundheitsreform.de/index.html
http://www.euro.who.int/observatory/Hits/TopPage

Doctors

The most important employers for doctors are hospitals. As described above there is a strict separation between ambulatory and stationary care. If doctors work in a hospital they work as employees generally, physicians in ambulatory care have got their own practice and are employers theirselves.

Because Germany does not have a central national health system like Great Britain or Ireland, and because of the federal structure of Germany there is no big institution as an employer in the health care. There are 2,104 hospitals in Germany, 38% non-profit, 34 public and28% private hospitals in the single 16 federal state as possible employers. The number of private hospitals increased in the last years, while public hospitals decreased (Federal Statistic Office 2006). Other important working places are the 1,255 rehabilitation hospitals, 18% are public, 25% non-profit and 56% private ones.

There is a rising demand of doctors in the eastern part of Germany. In General there is a higher demand in rural than in urban areas.

Medical Study

Preconditions to study human medicine in Germany are a high school diploma and an accreditation from the national central placing agency for students, because there is a national wide restricted accreditation for students. Basis to get an admission are an excellent high school diploma or practical experience in the health sector. The human medical study is regulated nationally in the Federal Medical Code. The time for this study is 6 years.
The preconditions to get a license in order to practise as physician are:

- earn a medical agree from University (6 years, last year practical experience)
- first aid training
- Practical experience in nursing (three months)
- Physicians exam (2)

There are a lot of Universities in Germany to study medicine.
Some links for further information of medical study:
http://www.medizinstudent.de/
http://www.thieme.de/viamedici/schueler/medizinstudium/uebersicht.html
http://www.hrk.de

To become a specialised physician you need professional experience and further post-graduated training. In Germany there are more than 100 possibilities for specialising. Post-graduate training usually stretches over 5 to 6 years.
To care for SHI-Patients physicians need an accreditation of the physicians´ association, because of the monopoly of the physicians association. The association controls the regional outpatient medical delivery system and avoids regional over- or undersupply.

The costs of the medical studies can be estimated by 200,000 Euro (Data for 1997). But these costs will increase in future, because all states decided to establish study fees.

Working conditions

There are big variances in salaries between the several specialisations of physicians. There are differences between inpatient physicians, who are predominantly employees in a hospital and outpatient physicians, who are self-employed. There are also differences in salaries between specialised outpatient physicians or general or family physicians and regional differences because of the rate of private insured patients.

Inpatient physicians are often paid following collective agreements. The net income per month amounts for young physicians (under 35) working (full-time) in public or non-profit hospitals 2,000-2,130 Euro (Data for 2002), the net income per month for all physicians working (full-time) in public or non-profit hospitals 3,140-3,160 Euro (Spengler 2005: 492). But there is a big variance between the income of assistance physicians, which earn 50,000 Euro (gross wage per year) and chief physicians, who earn 250,000 Euro (gross wage per year). The big variance can be accounted by care for many private insured patients in hospitals.

The income of ambulatory doctors differs depending on specialisation and region. Family physicians earn less than their specialised colleagues. There is also a regional factor. Physicians in rural regions for example in eastern Germany do not earn as much as their colleagues in urban regions in West Germany. The rate of private insured patients and hence higher paying patients is much higher in western Germany than in eastern Germany. The (full-time) working-time of physicians is between 46,5-52 hours per week. In comparison to other academic persons working fulltime, incomes of physicians are higher, but the differences decreased in the last years.

The working conditions for assistant physicians in hospitals are not very good. Because of the finance pressure young physicians often get limited labour contracts. Because of the high personal costs, the staff level of hospitals is very low. So physicians often have to step in for sick colleagues or colleagues, who are on holiday. The physical, emotional and personal work load is very heavy. The responsibility is very high, also for young physicians. Because they often have bad working conditions (income), there is an increasing number of young physicians, that do not want to work in medical care in Germany but in another country or in pharmaceutical research.

www.wikipedia.de

Recognition

Doctors as other health professions have got a special kind of national protection. To get an accreditation to work as a doctor in Germany, you have to go to two offices. The regional health office is the contact point to get an accreditation of the basis medical training. Because in Germany the physicians´ chambers have the responsibility for the medical specialisation, the recognition of the specialisation has to be done by the physicians´ chamber. The mutual recognition of the diplomas and specialisations in the EC are regulated in the Directive 2005/36/EC.

Following premises are necessary and have to be sent to the regional governmental agency, department public health:

- signed application
- short curriculum vitae
- medical Diploma
- certificate of the home government administration, that the person is allowed to work as a physicians in the home country
- birth certificate
- certificate of nationality
- clearance certificate
- certificate of health
- personal signed determination of exemption from punishment
- in case certificate of German language skills (for example Goethe-Institute, level B2 of the Common European Framework of Reference for Languages)
- in case certificate of promotion

(source: website of several local and regional governments)

In some cases the regional administration will prove the professional language skills in the agency before they will issue the approbation.

The graduation period takes about 2 weeks, the costs for the approbation differ between 130 Euro – 500 Euro.

Physicians who made their medical diploma in former non-EC countries like Poland have some more difficulties to get the approbation.

The governmental administration agency will prove the medical diplomas individually. These physicians need all the certificated above and they need a certificate, that they have worked in their home country in the last years (3 years from the last 5 years).

In most of the cases the physicians have to make an equivalent test, to prove, that their medical skills are on the same level as skills of German physicians.

This test will be made by the examination office of the federal states. The costs are ca. 280 € in North Rhine-Westphalia.

In preparation for the test, the physicians are allowed to work (together with an physician, who has the approbation) for example in a hospital (maximum 18 months) as in a practical year. In that period they have to learn internal medicine (6 months), general theory (6 months), and a special medicine subject (6 months, free chosen).

The equivalent test is very difficult and you can repeat it only once again. So the practical year can be very helpful for the foreign physicians. In this practical years the physicians are not allowed to earn money. They are only allowed to get benefit from the labour administration. The benefit level is on the level of the living wage and it could be very difficult to pay the costs for the test, learning material.

There are especial founding programmes made by the physicians trade union “Hartmann-Bund” to support the foreign physicians and their families.

Once the test is succeeded, the physicians will get their approbation or a work permission. People, who do not have the right to get the approbation, only get a regional and temporal work permission. After working in Germany 5 years (married) or 8 years (not married) you have the chance to get the approbation, if the personal presumptions are convenient.

http://www.medknowledge.de/germany/study/physicians_germany.htm
http://jobcenter-medizin.de

An interesting publication of the labour administration about doctors labour market situation: http://www.arbeitsagentur.de/zentraler-Content/Veroeffentlichungen/AM-Kompakt-Info/GGTSPU-iat-gate.iatge.de-11787-873366-DAT/AM-Info-Facharztmangel

Important journal:

http://www.aerzteblatt.de

Table 1: Overview of links of important institutions for doctors in Germany

Federal states	Ministry of Health/Social Affairs	Physicians´ Chamber	Association of SHI patients	Marburger Union of Employed (Hospital) Physicians	Hartmann Union of ambulatory physicians	German Hospital Association	Therapeutic bath association
National	http://www.bmg.bund.de/ http://www.bmas.bund.de	http://www.bundesaerztekammer.de	http://www.kbv.de	http://www.marburger-bund.de	http://www.hartmannbund.de	http://www.dkgev.de	http://www.deutscher-heilbaederverband.de/
Baden-Württemberg	http://www.sozialministerium-bw.de	http://www.aerztekammer-bw.de	http://www.kvbawue.de	http://www.marburger-bund-bw.de	http://www.hartmannbund.de/06_landesverband/lv_baw.php?lv=baw	http://www.bwkg.de/	http://www.heilbaeder-bw.de/
Bavaria	http://www.stmugv.bayern.de http://www.stmas.bayern.de	http://www.blaek.de	http://www.kvb.de	http://www.marburger-bund.de/marburgerbund/landesverbaende/lv_bayern/index.php	http://www.hartmannbund.de/06_landesverband/lv_bay.php?lv=bay	http://www.bkg-online.de/	http://www.bay-heilbaeder.de/
Berlin	http://www.berlin.de/sengsv/index.html http://www.berlin.de/sen/ias/index.html	http://www.aerztekammer-berlin.de	http://www.kvberlin.de	http://www.marburger-bund.de/marburgerbund/landesverbaende/lv_berlin-brandenburg/index.php	http://www.hartmannbund.de/06_landesverband/lv_ber.php?lv=ber	http://www.bkgev.de/	
Brandenburg	http://www.masgf.brandenburg.de	http://www.laekb.de	http://www.kvbb.de	http://www.marburger-bund.de/marburgerbund/landesverbaende/lv_berlin-brandenburg/index.php	http://www.hartmannbund.de/06_landesverband/lv_bra.php?lv=bra	http://www.lkb-online.de/	http://www.kurorte-land-brandenburg.de/
Bremen	http://www.soziales.bremen.de	http://www.aekhb.de	http://www.kvhb.de	http://www.marburger-bund.de/marburgerbund/landesverbaende/lv_bremen/index.php	http://www.hartmannbund.de/06_landesverband/lv_bre.php?lv=bre	http://www.hbkg.de/	

Hamburg	http://www.bsg.hamburg.de	http://www.aerztekammer-hamburg.de	http://www.kvhh.net	http://www.marburger-bund.de/marburgerbund/landesverbaende/lv_hamburg/index.php	http://www.hartmannbund.de/06_landesverband/lv_ham.php?lv=ham	http://www.hkgev.de/	
Hessen	http://www.hsm.hessen.de	http://www.laekh.de	http://www.kvhessen.de	http://www.mbhessen.de/	http://www.hartmannbund.de/06_landesverband/lv_hes.php?lv=hes	http://www.hkg-online.de/	http://www.hessischer-heilbaederverband.de/
Mecklenburg-Western Pomerania	http://www.sozial-mv.de	http://www.aek-mv.de	http://www.kvmv.info	http://www.marburger-bund.de/marburgerbund/landesverbaende/lv_mecklenburg-vp/index.php	http://www.hartmannbund.de/06_landesverband/lv_mec.php?lv=mec	http://www.kgmv.de/	http://www.baederverband.m-vp.de/
Lower Saxony	http://www.mfas.niedersachsen.de	http://www.aekn.de	http://www.kvn.de	http://www.marburger-bund.de/marburgerbund/landesverbaende/lv_niedersachsen/index.php	http://www.hartmannbund.de/06_landesverband/lv_nie.php?lv=nie	http://www.nkgev.de/html/nkg.html	http://www.baederland-niedersachsen.de/
North Rhine-Westphalia	http://www.mags.nrw.de	http://www.aekno.de	http://www.kvno.de http://www.kvwl.de	http://www.marburger-bund.de/marburgerbund/landesverbaende/lv_nrw-rlp/index.php	http://www.hartmannbund.de/06_landesverband/lv_nor.php?lv=nor http://www.hartmannbund.de/06_landesverband/lv_wes.php?lv=wes	http://www.kgnw.de/	http://www.nrw-heilbaeder.de/
Saarland	http://www.justiz-soziales.saarland.de	http://www.aerztekammer-saarland.de	http://www.kvsaarland.de	http://www.marburger-bund.de/marburgerbund/landesverbaende/lv_saarland/index.php	http://www.hartmannbund.de/06_landesverband/lv_saa.php?lv=saa	http://www.skgev.de/	http://www.rlp-info.de/
Rhineland-Palatinate	http://www.masfg.rlp.de	http://www.laek-rlp.de	http://www.kv-rlp.de	http://www.marburger-bund.de/marburgerbund/landesverbaende/lv_rheinland-pfalz/index.php	http://www.hartmannbund.de/06_landesverband/lv_rhe.php?lv=rhe	http://www.kgrp.de/	http://www.rlp-info.de/
Saxony	http://www.ms.sachsen.de	http://www.laek.de	http://www.kvs-sachsen.de/	http://www.marburger-bund.de/marburgerbund/landesverbaende/lv_sachsen/index.php	http://www.hartmannbund.de/06_landesverband/lv_sac.php?lv=sac	http://www.kgs-online.de/	http://www.sachsenkur.de/
Saxony-	http://www.ms.sachsen-	http://www.aeksa.d	http://www.kvsa.de	http://www.lvsa-	http://www.hartmannbund.	http://www.kgsan.de/	http://www.kuren-

Anhalt	anhalt.de	e		marburgerbund.de	de/06_landesverband/lv_sat.php?lv=sat		sachsen-anhalt.de/
Schleswig-Holstein	http://www.schleswig-holstein.de/Portal/DE/LandesregierungMinisterien/MSGF/MSGF__node.html__nnn=true	http://www.aeksh.de	http://www.kvsh.de	http://www.marburger-bund.de/marburgerbund/landesverbaende/lv_schleswig-holstein/index.php	http://www.hartmannbund.de/06_landesverband/lv_sch.php?lv=sch	http://www.kgsh.de/	http://www.heilbaederverband-sh.de/
Thuringia	http://www.thueringen.de/de/tmsfg	http://www.laek-thueringen.de	http://www.kv-thueringen.de	http://www.marburger-bund.de/marburgerbund/landesverbaende/lv_thueringen/index.php	http://www.hartmannbund.de/06_landesverband/lv_thn.php?lv=thn	http://www.kgsh.de/	http://www.thbv.de/

Nurses

The most important employers for nurses are hospitals and childrens´ hospitals, geriatric homes and ambulatory care services. As described above many of the hospitals and elderly homes and ambulatory care services are carried by non-profit organizations, for example the Caritas hold by the catholic church.

Vocational training:

The occupational image of nurses in Germany differs from other EU-countries. In Germany there are different professions with different protected titles for nursing. There are hospital nurses (only called nurses), child hospital nurses, assistant hospital nurses and nurses for elderly. All of them have different specialized vocational trainings. While hospital nurses belong to the health care sector, geriatric nurses are part of the social care sector.

Hospital Nurses: Precondition to start this training is a secondary school degree. The vocational training for nurses takes three years. The training is divided in a practical part and a theoretical part. The trainees go to a national nursing school for the theoretical part and for the practical part they normally join to hospitals. The trainees have got a labour contract with the hospital. Their income is lower than the income of graduated nurses. The professional title “nurse” is nationally protected, only persons with a successful vocational training are allowed to use this title.

In Germany the working fields of physicians and nurses are separated very strictly. Only physicians are allowed to diagnose a disease, nurses have only got medical assistance functions. They are the gateway between the patient and the physicians.

Typical occupational activities of hospital nurses are:

- Basic nursing (patient washing, meal distribution…)
- Planning and documentation of nursing activities
- Measuring important life parameters (pulse, blood sugar……)
- Physicians assistance
- Distribution of pharmaceuticals

Assistant hospital nurses: The vocational training of assistant nurses takes only one year. Because of this short vocational training period the working field of assistant nurses is much smaller and is focused on assistant activities like beds planning, washing, meal distribution.

Working conditions:

The average net income per month amounts for young nurses working (full-time) in public or non-profit hospitals about 1,300 Euro, specialised nurses and elderly nurses earn more money. The working conditions in hospitals are not very good. The psychological / emotional and personal work load is very high. Nurses have to heave patients and have to care often for cureless patient. The cost pressure affects that nurses often do not have enough time to "care" for patients. Another problem is the increasing requirement for documentation so that nurses spend a lot of working time with activities far from the patient. Hospital nurses have little occupational career chances and developing chances. Because of the shift work the working time in hospitals is not family-friendly. The working-time per week is 39-40 hours. So nurses (most of them are female) have got problems to combine childcare and job. These factors affect a high rate of nurses, who leave their profession.

Geriatric nurses: The vocational training period of geriatric nurses is as long as for nurses. It is also a dual vocational training, with a theoretical part in a state school and a practical part in elderly homes or in ambulatory elderly care services. The curriculum of the training is specialised for nursing elderly people. Medical care is not a main part of the education. The working fields for geriatric nurses in elderly homes and also in ambulatory services are:

- Basic nursing (patient washing, meal distribution…)
- Planning and documentation of nursing activities
- Palliative nursing
- Measuring important life parameters (pulse, blood sugar……)
- Distribution of pharmaceuticals
- Consulting of legal rights and supporting in nursing cases

The working conditions of geriatric nurses are often worse than the conditions of hospital nurses.

The income of geriatric nurses is between 1,700-2,000 Euro gross wage per month in the case of fulltime-working. But there are big differences between ambulatory and stationary and between private and public or non-profit institutions. The working-time in non-profit or public elderly homes is about 40 hours.

The work loads in elderly homes are often quite high. The situation in elderly homes is very difficult. Reasons are not only cost pressures. There are new defiances, that are not solved yet: People are older when they go into a elderly home, they live longer and they often are

multimorbid or suffer from dementia. Also palliative nursing has gotten more important in the last years. These new circumstances were not implemented in the financial basis of the long-term health insurance and in the working process of the single elderly homes. The result is a really high work load for the staff in elderly homes and a high exit rate of geriatric nurses.

Assistant geriatric nurses: This training was constituted in North Rhine-Westphalia in September 2006. The aim of this new training is to avoid shortage of young employees in this profession. These trainees are only allowed to perform assistant work.

To get more information about nursing in Germany:

http://de.wikipedia.org/wiki/Pflege

http://www.pflegewiki.de

http://www.dbfk.de/

http://www.dbfk.de/english.html

http://www.wernerschell.de/

http://www.vincentz.net/

http://www.pflege-deutschland.de

Some journals about nursing in Germany:

http://www.dicvmainz.caritas.de/aspe_shared/form/download.asp?form_typ=115&nr=88652&ag_id=784

http://ec.europa.eu/internal_market/qualifications/docs/nurses/2000-study/GGTSPU-iat-gate.iatge.de-11787-743186-DAT/nurses_germany_en.pdf

Recognition

To get the allowance to work in German hospitals or in ambulatory care as a nurse, foreign nurses have to announce themselves at the local health office. They need

- signed application
- short curriculum vitae
- certificate of the vocational training in the home country
- certificate of the vocational training institution, range and period of the vocational training
- birth certificate, (marriage…)
- certificate of nationality and registration certificate that you live in Germany
- certificate of health
- school leaving certificate of secondary school or lower secondary school in relation with a vocational training as a nurses assistance (2 years)

- certificate of language skills

(source: website of several local and regional governments)

The mutual recognition of the diplomas in the EC are regulated in the Directive 2005/36/EC. The costs of the acknowledgement process differ, you can estimate the costs on 152 Euro (searching of files, without an individual verbal or practical skill test).

If nurses are not EU-citizens or came from one of the acceding EU-States they have to make an individual equivalent test. The test is divided in a practical (3 hours) and a theoretical part (30 minutes), and are placed in the federal states nursing schools. The cost for the test are at least 600 Euro, and German language skills are premises for the test. The test can be repeated only once again. Most of the health schools offer preparation courses for that tests.
Another way to get the recognition of the national title is the regular vocational training in nursing. The normally three years period could be reduced, if the existent vocational training of the home country is 2/3 equivalent with the German training.

Social Workers

Precondition to start a study “Social Work” or “Social Pedagogy” is an advanced technical college certificate. In Germany you get this certificate after graduating from school successfully after 12 years.
The trainees for Social workers or pedagogues visit a public or a churchly advanced technical college. There is no evident separation between social pedagogic and social work. In general social work is a “react” work while social pedagogic is an “act” work. But the differences are in flow, because the curricula of the study is in the hand of the 16 states, so there are no general curricula in this profession.

Part of the study are for example following themes:

- Theory of Social Work or Pedagogic
- Education
- Social culture work
- Psychology
- Sociology
- Law
- Social management, project management

To get the Bachelor of Arts Certificate the study period is three years, to get the Master of Arts you need two more years. The old certification “diploma” still exists. To get this certificate you have to study 4,5 years.

Typical activities of social workers and pedagogues are:

- Elderly work, child and youth work or family work
- Coaching
- Drugs advice
- Leisure advice or pedagogic
- Education advice
- Social management, case management

The activities of social workers or social pedagogues are advising to prevent or solute social problems of elderly, families, young people or children. Typical employers of social workers are non-profit welfare organizations (often churchly), kindergarten, elderly homes, homes for young people or drugs prevention agencies.

Due to the bad financial situation of locally and churchly authorities there were extensive economies in the social sector. The employment possibilities and situation are strained, so labour contracts of young employees are often limited. The working conditions differ in relation to the activities. Shift work and a high work load due to the emotional and psychological load are marks of this profession.

The income of social workers and pedagogues differs in relation to the certificate, the advanced training and the position of the activity. The average gross wage per months amounts between 2,700 – 3,500 Euro.

http://www.dbsh.de
http://de.wikipedia.org/wiki/Sozialp%C3%A4dagogik
http://socialwork.de/
http://www.info-sozial.de
http://sozialarbeitsnetz.de
http://www.ifsw.org/home
http://www.sozialarbeit.de/
http://www.deutsche-gesellschaft-fuer-sozialarbeit.de
http://www.bildungsserver.de/zeigen_e.html?seite=1515
There is also a paper about the qualifications of social workers in Germany:

http://www.ku-eichstaett.de/Fakultaeten/SWF/downloads/HF_sections/content/GGTSPU-iat-gate.iatge.de-11787-746221-DAT/Qualifikationsrahmen%20Soziale%20Arbeit%20englisch.pdf

Recognition

Because nurses and physicians are national protected professions, every nurse or doctors needs a national recognition. Social workers are not protected by the state. In fact of this foreign social workers do not need a special permission as nurses or doctors, when they start to work in Germany.
Nevertheless to get the same recognition of the diploma and the same working conditions by employers, social workers can get information about the accreditation of their diploma by the association of universities and other higher education institutions in Germany.

http://www.hrk.de

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

WORKING AND LIVING IN IRELAND GUIDE

For further information please check out www.healthcaresolutions.ie

N.B. please note that all of the information provided here is strictly for use as a guide only and should not be taken as an endorsement by the Health Service Executive of Ireland of any of the services or products listed.

FINDING ACCOMODATION

The main options are to either buy a property, lease privately (i.e. directly from the owner of a house / apartment) or, lease via a property management centre.

The Health Service Executive will fund accommodation for your first six weeks in Ireland.

Rental Accommodation

In general, private rented accommodation is obtained through:

- Local newspapers
- Public notice boards (e.g. in the hospital)
- Friends / work colleagues
- Property management centers / local auctioneers

Rent is normally payable monthly in advance and an initial deposit of 1 months rent is usually also required. The weekly local newspapers will have many adverts for shared accommodation.

The owner or property rental agent may look for:

- A signed lease agreement
- Bank references
- Letter confirming your employment
- Refundable deposit held as security for the duration of the lease

A further point worth noting is that, by law, all tenants are entitled to a rent book or a written tenancy agreement.

How do I find private rental accommodation in Ireland?

You can look for private rental accommodation through local newspapers, real

estate agencies or websites. www.daft.ie is a useful website for searching for rental accommodation. www.let.ie is a similar website which also has lists of various letting agents for different regions of Ireland. The quality of rental accommodation can vary so you should view the property before making any agreement.

How do I pay for rental accommodation?

You usually pay rent monthly, in advance and an initial deposit of one or two months is also required.

What is a rent book?

A rent book is a document that records details about the tenancy and notes all payments of rent that you have made to the landlord. By law you are entitled to a rent book. Usually it is in booklet form but it can be in another form provided it contains all the necessary details.

Your rent book should contain the following information:

- The address of your accommodation
- Your landlord's name and address or the landlord's agent (if any)
- Your name
- The date the tenancy started
- The length of the tenancy
- The amount of deposit paid
- The amount of rent and how it is to be paid
- Details of any other payments for services, e.g., for heating or cable elevision
- A statement on the basic rights and duties of landlords and tenants
- A list of furnishings and appliances supplied by the landlord.

What can I do if I have a problem with my accommodation or I have a dispute with my landlord?

If you cannot resolve the problem directly with your landlord you can contact Threshold.

Threshold offer advice, information and advocacy to tenants.
Threshold Head Office, 21 Stoneybatter, Dublin 7. Telephone + 353 1 678 6096
Web: www.threshold.ie

How can I check if my landlord is legitimate?

You can contact the Private Residential Tenancies Board (PRTB). All landlords are required to register with the Board and they also offer a dispute resolution service for landlords and tenants. If you call the Board and give them the address of the property they will confirm if it is registered or not.

Private Residential Tenancies Board, Canal House, Canal Road,
Dublin 6. Tel: + 353 1 888 2960 Fax: + 353 1 888 2819 Web:
www.prtb.ie

Where can I find out more information on buying a house in Ireland?

The price of houses in Ireland has increased dramatically since the mid 1990's. Prices vary a lot depending on where the house is. Houses tend to be significantly less expensive in the West of Ireland. The sales section of www.daft.ie is a useful gauge of the prices of specific houses all over Ireland. Other useful websites include www.propertyireland.ie www.propertyladder.ie and www.myhome.ie you can also contact Real Estate Agents for house prices.

How do I get a mortgage (house loan) in Ireland?

You can get a mortgage from banks, building societies or mortgage brokers. Interest rates vary and may be at a fixed or variable rate. You will need to so some research to find the best deal.

What other costs are involved in buying a house?

You will also face many other additional costs when buying a house. Depending on the cost and size of the house you may have to pay tax to the government called Stamp Duty. In general you will also have to pay a solicitor about 1% of the purchase price. If you require further information on the costs of buying a house in Ireland, you should contact:

I.A.V.I. (Institute of Auctioneers and Valuers in Ireland), 38 Merrion Square,
Dublin 2. Tel: + 353 1661 1794 Web: www.iavi.ie

BANKING

The range of services provided by retail banks in Ireland has expanded over the past number of years. This of course is mainly due to technological developments. In general any transactions will be reflected in your account on the day which they occur.

24-hour telephone banking is becoming standard and all of the larger banks now also have internet banking facilities.

Most banks will have the standard 'current' account and 'deposit' (savings) accounts on offer. They will also have variations such as current accounts that are accessible with an ATM card, or savings accounts that can earn interest.

Depending on your requirements it is worth shopping around to see what services the different banks offer and more importantly how much they charge for their services.

As your salary will probably be paid directly into a bank account for you, it would be wise to set up an account as soon as you can. You will be assisted in doing this on arrival in Ireland.

By law in Ireland you must supply two official forms of identification for example a passport or driver's license, and also a proof of residence, such as a rental contract or a household bill with your name on it.

Which bank you choose will obviously depend on the type of account and services you require. It may however be worthwhile to ask your employer which bank they use. If your account is with a different bank your salary may take slightly longer to be transferred to your account.

Below is a list of the main retail banks in Ireland:

National Irish Bank - http://www.nationalirishbank.ie/
Ulster Bank - http://www.ulsterbank.ie/
AIB - Allied Irish Bank - http://www.aib.ie/
Bank of Ireland - http://www.bankofireland.ie/
Permanent TSB - http://www.permanenttsb.ie/
Bank of Scotland (Ireland) - http://www.bankofscotland.ie/
EBS Building Society - www.ebs.ie
First Active www.firstactive.com

HSE have a working agreement with the National Irish Bank to help you set up a bank account as soon as possible. Post interview our Irish based recruitment team will talk you through the process

CHILDCARE

The provision of childcare in Ireland broadly falls into the following categories:

- Community pre-school playgroups

- HSE funded nurseries
- Home based playgroups
- Home based child minders
- Private Nurseries
- Early Start programmes

The following is a list of places to obtain information on childcare in Ireland:

Internet site: www.childcare.ie which is Ireland National Childcare Directory
Internet site: www.babysitters.ie
The Golden Pages publication or online at www.goldenpages.ie under Crèches, Playgroups, Montessori Schools.

The Health Service Executive will also provide list of registered childcare facilities. These can be obtained from the Child and Family Resource centers or the Pre-School Services Officer in your area

So what are your choices for child care?

As in every other modern society they boil down to private arrangements or contacting a professional organisation.

COST OF LIVING

The cost of living in Ireland can vary from region to region. Dublin, being the capital and quite densely populated, is the most expensive region, comparatively speaking.

Ireland is one of the most expensive countries in Europe and the cost of living can be high depending on your own individual needs. Ireland is currently at the grip of high inflation and this is most noticeable in the cost of buying property. Ireland, in particular Dublin, is also expensive for groceries, alcohol, eating out in restaurants, petrol, etc. To help prepare yourself, consult the list below which lists the approximate cost for basic necessities in Dublin.

Shopping Basket	
Litre of Milk	€ 1.15
Loaf of bread	€ 1.25
Litre of water	€ 1.35
Half Pound of butter	€ 1.69
Bag of sugar (1kg)	€ 1.05
Jar of coffee (200g)	€ 7.89
Lion Bar	€ 0.63
Tin of Baked beans	€ 0.69
12 pack sausages	€ 2.79
Cornflakes (500g)	€2.02
Cheese (200g)	€1.99
Chicken Breasts x 5	€7.35
Litre coca cola	€ 1.20
Bag of potatoes (5kg)	€ 6.99
Eggs (6 pack)	€ 1.40
Cooked ham (120g)	€ 2.95
Apple	€ 0.37
Timotei Shampoo	€ 3.25
Razors (Disposable 5 pk)	€ 2.65
McDonalds Big Mac Meal	€5.20
6 bottles of Heineken	€9.79
Pint of Guinness (in pub)	€4.50
Pack of 20 cigarettes	€6.50
Glass of house wine	€5.00
Daily Newspaper	€1.45

Dublin Rental Market Snapshot average

Area	Studio	1 Bed	2 Bed	3 Bed	4 Bed
Dublin 1	€581	€898	€1,247	€1,740	
Dublin 2	€657	€961	€1,368	€1,922	
Dublin 3	€605	€817	€1,123	€1,369	€1,788
Dublin 4	€704	€1,014	€1,483	€2,072	€3,040
Dublin 5	€800	€1,146	€1,316	€1,492	
Dublin 6	€572	€831	€1,192	€1,694	€2,564
Dublin 6w	€848	€1,158	€1,397	€1,830	
Dublin 7	€529	€840	€1,166	€1,384	€1,657
Dublin 8	€551	€855	€1,147	€1,383	€1,684
Dublin 9	€540	€801	€1,091	€1,341	€1,576
Dublin 11	€830	€1,065	€1,222	€1,450	
Dublin 12	€846	€1,088	€1,270	€1,470	
Dublin 13	€910	€1,329	€1,278	€1,842	
Dublin 14	€883	€1,219	€1,491	€1,761	
Dublin 15	€854	€1,040	€1,193	€1,385	
Dublin 16	€873	€1,201	€1,267	€1,503	
Dublin 18	€1,025	€1,182	€1,365	€1,545	
Dublin 20	€868	€1,069	€1,211		
Dublin 22	€834	€1,038	€1,156		
Dublin 24	€890	€1,075	€1,198	€1,321	
South Co.	€608	€952	€1,295	€1,636	€2,447
North Co.	€850	€1,036	€1,204	€1,534	
West Co.	€6.50	€803	€1,001	€1,146	€1,466
Commuter	€814	€1,032	€1,154	€1,351	
Dublin Avg.	**€588**	**€878**	**€1,191**	**€1,362**	**€1,791**

Cork Rental Market Snapshot

Area	1 Bed	2 Bed	3 Bed	4 Bed
Suburbs	€706	€875	€920	€1,170
City Centre	€699	€866	€968	€1,325
Commuter	-	-	€942	€1,175
Cork Avg.	**€701**	**€872**	**€935**	**€1,207**

Galway Rental Market Snapshot

Area	1 Bed	2 Bed	3 Bed	4 Bed
Suburbs	€697	€849	€936	€1,017
City Centre	€703	€922	€1,225	€1,216
Galway Avg.	**€700**	**€879**	**€979**	**€1,054**

Limerick Rental Market Snapshot

Area	1 Bed	2 Bed	3 Bed	4 Bed
Limerick Avg.	**€653**	**€906**	**€898**	**-**

Source: http://www.daft.ie

Further Information

www.daft.ie
www.myhome.ie
www.irishpropertynews.com
www.hostels-ireland.com

Utilities

Separate accounts will need to be set up with the electricity http://www.esb.ie/main/home/index.jsp , telephone http://www.eircom.ie/ , gas http://www.bordgais.ie/corporate/index.jsp where applicable and cable TV companies. All of these will usually require standing orders on your bank account.

A TV Licence

To have a TV in Ireland you must pay for a TV licence. Currently a TV licence costs €158 per year.

CULTURE ADJUSTING TO LIFE IN A NEW COUNTRY

The influx of new people to Ireland has been very welcome and evidence that Ireland has at last started the transition to a multicultural society is increasingly evident.

Culture Change: "Culture Shock" refers to the changes that most people experience when relocating to a new country. There are different stages of "Culture Shock" from the initial excitement of moving to a new country to the difficulties you may encounter for example language difficulties etc. Young children seem to settle fairly quickly, particularly if they soon meet new friends. Re-locations can be tough for adolescents. Apart from leaving behind friends at an age where they are all-important, they may be entering a school system that is radically different from what they are used to.

Here are few points to minimise Culture Shock:

- Discuss how you feel with someone
- Create a support network to help you feel less isolated
- Fine somewhere quiet to relax and unwind
- Try thinking of how things were prior to the transition. This includes the good things you want to remember.
- Take exercise and keep fit
- Concentrate on positive aspects of your current situation
- Try to accept the reality of your situation
- Try to avoid comparing the old and the new
- Treat yourself and your family
- Think about the reasons why you made the move and what you want for your family and yourself
- Don't feel compelled to deal with everything at once; take one decision at a time

CURRENCY

The currency in Ireland, since January 1st, 2002 is the Euro.

Approximate Euro conversions are:

1 EUR = 1.31 USD

1 EUR = 1.66 AUD

1 EUR = 1.86 NZD

1 EUR = 0.67 GBP

Further information on the Euro can be found at

http://www.gov.ie/ecbi-euro/

The euro is also the currency for twelve other countries within the European Union (EU). The symbol for the euro is €.

Coins & Notes

The bank notes increase in size as the denomination rises. Euro notes are issued in seven denominations, 5, 10, 20, 50, 100, 200 and 500 as illustrated below. Pictures are in actual dimensions.


500
500 EURO
Specimen


500
S00630387745
Specimen
S00630387745
500 EURO
500


200
200 EURO
Specimen


200
P00641307178
Specimen
P00641307178
200 EURO
200


100
100 EURO
Specimen


100
L00105481787
Specimen
L00105481787
100 EURO
100


50
50 EURO
Specimen


50
V02387040034
Specimen
V02387040034
50 EURO
50


20
20 EURO
Specimen


20
Y00309901015
Specimen
Y00309901015
20 EURO
20

DRIVING IN IRELAND

In Ireland we drive on the left side of the road and also operate under a penalty points system. It is an offence to drive without having your driver's license with you. To learn more about this and all other offences log on to www.penaltypoints.ie .

Drivers are required to pass a driving test in order to qualify for a driving license. Certain EU and Australian licenses can be exchanged for an Irish license within one year of arrival. Holders of all other licenses must take a practical and oral test. An International Driving License obtained in your current country may be used for a limited period of time; it is important to check with your insurer as this may have premium implications. Driver's licenses are issued in each county by the local Motor Taxation Office. These offices are under the direction of the Department of the Environment which can be reached by telephone within the country on 1890 20 20 21 or from outside the country on +353 962 42 00. Their website is www.environ.ie it would be advisable to purchase a copy of the 'Rules of the Road' from any Post Office or good bookshop.

Driver's Licence

Can I use my driver's licence if I am returning from a country covered by EC Regulations?

Yes. If you have a driver's licence from a country covered by EC regulations, you are entitled to use your country's driver's licence in Ireland. If your driver's licence is about to expire, you should apply to the Irish authorities to renew your driver's licence. You will not have to resit the driving test.

What countries are covered by EC regulations?

Austria, Belgium, Czech Republic, Cyprus, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Norway, Malta, Poland, Portugal, Slovakia, Slovenia, Spain, Sweden, The Netherlands, The UK

Can I use my driver's licence if I am returning from a country with which Ireland has an Exchange Agreement?

Yes. You can use your driver's licence up to 12 months after which time you must apply for an Irish driver's licence. Remember your driver's licence must be valid (it cannot be out of date) when you apply for an equivalent Irish licence. If your driver's licence has expired, you will have to re-sit the test.

What countries does Ireland have an Exchange Agreement with?

Australia, Gibraltar, Isle of Man, Japan, Jersey, South Africa, South Korea, Switzerland.

Can I use my driver's licence if I am returning from a country not covered by Exchange Agreements?

Yes. If you are not from any of the above countries, (for example, if you are from Canada, the United States or New Zealand) and you hold a national driving licence or an international driving permit from your own country, you may use this driver's licence to drive in Ireland for a maximum of 12 months. If you intend to remain in Ireland for longer than 12 months you must apply immediately for an Irish driver's licence.

How do I apply for a driver's licence?

To apply for a driver's licence, you must:

- Complete a driver theory test
- Apply for a provisional driving licence
- Complete your driving test in Ireland.

How do I exchange my driver's licence for an Irish driver's licence?

You must complete an "Exchange of Driving Licence" Form **(Form D900)**. These forms are available from your local Motor Taxation Office. Completed Forms should be sent to your local Motor Taxation Office.

What documents do I need to provide?

- 2 identical passport photographs (you must sign the back of both photos)
- Your current driving licence (it must be valid)
- The appropriate fee (contact your local Motor Tax Office for more details)
- A medical report (if applicable).

Do I need to get a medical report?

You must get your doctor to complete a medical report form **(Form D 501)** if you are applying for a driving licence for categories C, C1, D1, D, EC1, EC, ED1, or ED. You do not need this if you have previously provided a medical report that is still valid.

A medical report is compulsory for any driving category if you:

are aged 70 or more or
you suffer from any disabilities, epilepsy or alcoholism or if you regularly take drugs **or**

medication that is likely to impair your ability to drive safely. A registered practitioner should carry out your medical examination and then complete **Form D401**. This form is available from the Motor Tax Office or your local Garda station. You must sign the Declaration on the medical report form in the presence of the registered medical practitioner.

Where can I get more information?

You can more information by ringing 1890 40 60 40 (from within Ireland) or by contacting the Driver Testing Section, Department of Transport. Government Buildings, Ballina, Co. Mayo. Tel: + 353 96 24200 Web: www.transport.ie dcmj. ***You must carry you Drivers License at all times when driving***.

Motor Insurance

Do I need Motor Insurance to drive a vehicle in Ireland?

Yes. It is a legal requirement in Ireland to have motor insurance if you want to drive your car in a public place.

Should I bring details of my motor insurance abroad when I return to Ireland?

Yes. Some insurance companies will give a bonus to people who have a no-claims bonus from an EU country or another country with similar insurance laws, e.g. Australia, United States and Canada. However each case is as-

sessed individually. You should bring details of your motor insurance record when you are returning to Ireland.

Where can I find out more information about motor insurance in Ireland?

Individual insurance companies have customer service departments that will give you
information on their policy options. A useful service is the Insurance Information Service (IIS). This is an information and complaints telephone service operated by the Irish Insurance Federation (IIF) to which many insurance companies in Ireland belong. Its purpose is to answer policyholders' questions and help resolve problems. For further information you should contact: Insurance Information Service, 39 Molesworth Street, Dublin 2. Tel: +353 1 676 1914 Web: www.iif.ie

Tax on your vehicle

If I am importing my vehicle from another country into Ireland will I have to pay tax on it?

Yes. Vehicle Registration Tax (VRT), a percentage of the expected retail price of the imported vehicle, is chargeable on registration of the vehicle in Ireland. All motor vehicles in the state other than those bought in temporarily by visitors must be registered.

How do I pay Vehicle Registration Tax?

You can register the car and pay the Vehicle Registration Tax at a Vehicle Registration Office. Further information about Vehicle Registration Tax and locations of Vehicle Registration Offices around Ireland can be got from the central Vehicle Registration Office at: St John's House, Tallaght, Dublin 24. Tel: +353-1- 414 9777 Fax: +353-1- 414 9720 Web: www.revenue.ie

Motor Tax

What is Motor Tax?

Motor Tax is a separate charge from Vehicle Registration Tax. It is a legal requirement in Ireland to have motor tax if you want to drive your vehicle in a public place. The more powerful your vehicle, the higher the cost of your motor tax. Not only are you obliged by law to pay motor tax to drive your vehicle, you are also required to display evidence that you have paid on the windscreen of your vehicle. This is done by displaying your tax disc on the windscreen. Failure to display the disc is considered a motoring offence and will result in an on-the-spot fine issued by a traffic warden or a Garda.

Where can I find more information?

For more information or to apply for Motor Tax contact the Local Authority in your area. Details

of Local Authorities can be got from:
The Department of Environment, Heritage and Local Government, Custom House, Dublin 1.
Telephone: + 353 1 888 2000 Web: www.environ.ie

Vehicle Testing

What is an NCT and do I need one?

An NCT is a National Car Test. Since 2002 all cars four years old or more must be tested. Vehicles that pass the test will have to undergo repeat tests every 2 years. The test is aimed at improving road safety and enhancing environmental protection by ensuring the car meets minimum standards.

Where can I book a National Car Test and find out more information about it?

There are National Car Test centres all over the country. For information on your nearest NCT centre contact: Citywest Business Campus, Lakedrive 3026, Naas Road, Dublin 24. Tel: 1890 200 670 (from Ireland only) Fax: + 353 1 413 5996 Web: www.ncts.ie

Speed Limits

Are speed limits in Ireland still signposted in miles?

No. Since the 20th of January 2005 all speed limits are signposted in kilometeres per hour (kph).

What are the speed limits in Ireland?

Speed limits also changed on the 20th of January 2005.
There are a total of five different types of speed limits throughout Ireland:

1. Town and city speed limits (50 km/h)

A speed limit of 50 kilometres per hour is in place in built-up areas (other than motorways or special speed limit zones).

2. National road speed limits (100 km/h)

A speed limit of 100 kilometres per hour is in place on all national roads (including dual carriageways) throughout Ireland.

3. Regional and local speed limits (80 km/h)

A speed limit of 80 kilometres per hour is in place on all regional and local roads (sometimes referred to as non-national roads).

4. Motorway speed limits (120 km/h)

A speed limit of 120 kilometres per hour is in place for all mechanical vehicles on all motorways. You should note that learner drivers, vehicles under 50 cc, bicycles, pedestrians, animals and invalid carriages are not allowed on motorways in Ireland.

5. Special speed limits (30 km/h or 60 km/h)

Special speed limits are sometimes applied to designated roads and zones (mainly, for example, on roads on the outside of built-up areas, around schools, etc.). Special speed limits are generally 30 km/h or 60 km/h.

Penalty Points

Ireland operates a penalty point system for driving offences to learn more about how there operate please log on to http://www.penaltypoints.ie

EDUCATION

Participation rates in Irish Education are very high. Ninety percent of all Irish children take part in secondary education and 50% go on to third-level education. Many changes and improvements have been made to the Irish educational system over recent years, creating greater access and flexibility in the delivery of education at all levels. Whether you are interested in primary, secondary, further or third-level education in Ireland, the range of choices available to you is constantly increasing. At primary and secondary level, there are more multi-denominational and co-educational schools than in the past. You can also choose from schools that teach the curriculum through Irish (Gaelscoileanna) or from those that teach modern European languages to children from a very young age. State-funded education is available at all levels, so you will not have to pay fees unless you choose to send your child to a private school or college. Third-level options have also improved and there are a number of alternative practical routes that lead to advanced qualifications if the traditional academic path is not appropriate. Opportunities have also improved for adults who wish to return to education on a full-time or part-time basis. Whatever area of education you wish to pursue for yourself or for your

child, it is important to find out as much as possible about the options that are open to you.

Moving your Child to an Irish Primary School/Secondary School

If you are moving to Ireland and you have a child of school-going age, you will require information regarding the educational choices available to you and the procedures involved in getting your child enrolled. Irish (Gaelic) is normally compulsory in primary and second level schools. However, if your child has been educated outside of Ireland up to the age of 11, your child is exempt from studying Irish.

The Irish school year for primary school children stretches from 1 September to 30 June approximately. Children attend school from around the age of 4 or 5 years until they are 12 or 13 years of age. The primary school cycle is 8 years long. Schools generally have 2 years of infant classes, followed by class 1 to class 6.

The school-going age in Ireland

Your child will not be *obliged* to attend school before the age of 6. However, it is common for Irish children to attend school at 4 or 5. As a result, the youngest classes in the primary school system incorporate much of what would be considered "pre-schooling" in other countries.

You also have a constitutional right to educate your child at home , however, this is not common practice.

The types of schools available

The Irish primary education sector consists of state-funded primary schools, special schools and private primary schools. State-funded primary schools used to be known as national schools and you may still hear this term being used. State-funded schools include religious schools, non-denominational schools, multi-denominational schools and Gaelscoileanna, which are schools that teach the curriculum through the Irish language.

Religion in Irish schools

Most Irish primary schools are under the management of one denomination or another and the majority of these are Roman Catholic. There is, however, a growing choice of schools of other denominations and of multi-denominational schools.

Schools that cater for a single religion may give priority to children of that religion but they will also admit children with other religious beliefs, or none. Children do not have to attend religion classes and you may choose to withdraw your child from such classes if you wish.

Regardless of religion, all primary schools operate under similar rules. The main differences relate to the appointment of the principal of the school and the choice of teacher representatives on the Board of Management.

The primary school curriculum

The Irish primary school curriculum is child-centred. It emphasises: The "full and harmonious" development of the child, with allowances made for individual difference. The central importance of activity and guided-discovery learning and teaching methods. Teaching and learning through an integrated curriculum and through activities related to the child's environment. In recent years, a pilot project has introduced the teaching of modern European languages to 5th and 6th class students, in a number of schools around the country.

Primary School

You should, in theory, be able to send your child to the school of your choice. However, when it comes to enrolling your child, you may find that there is little or no choice in the area in which you live.

Each school operates an admissions policy, which they must make available on request. It is important to ask for the admissions policy of any school in which you are interested. State-funded primary schools tend to give priority to children living in the immediate area, but problems can arise if their classes are already full and they have a waiting list. Multi-denominational schools, non-denominational schools and Gaelscoileanna each decide their own admissions policy. Some secondary schools give priority to the students from certain primary schools so it may be useful to plan ahead when choosing a primary school for your child.

Secondary School

The Irish secondary school cycle is generally 5 or 6 years long. Children begin their secondary school studies around the age of 12 and leave around the age of 17 or 18, having taken two state exams in that period. Whether you are coming to Ireland for the first time or whether you are returning after an absence, you may find the Irish educational system very exam-focused. However, a lot of changes and improvements have been made to the educational system over recent years and a far greater range of options is now open to students than in the past.

Most schools offer students the option of a Transition Year after they have completed the first 3 years of secondary education. This allows students to explore other non-academic interests, whether they are social, creative or linked to the world of business. It gives them a chance to look around and to mature before moving into the Senior Cycle, which will lead them to the final Leaving Certificate exam. The exam system itself has also been altered. The Intermediate Certificate examination has been replaced by the more flexible Junior Certificate and final year students may now choose from 3 different Leaving Certificate programmes. They can take the traditional Leaving Certifi-

cate or they can choose from the Leaving Certificate Vocational Programme or the Leaving Certificate Applied Programme, both of which focus on a student's more practical and technical abilities.

The school year

The Irish secondary school year stretches from the first week in September to the first week in June. If your child is going in to a Junior Certificate Class or a Leaving Certificate class, however, they will not finish until the end of June, as they will be taking their exams at that time.

The types of schools available

The secondary school system includes secondary schools, vocational schools, community or comprehensive schools and private secondary schools. The majority of Irish children go to secondary schools, which are privately owned and managed and often run by religious orders, although the teachers in these schools are generally lay staff. The majority of secondary schools are free, but there are fee-paying schools also.

Vocational schools and community or comprehensive schools are all free. These schools tend to provide both academic and technical education and they often provide additional further education opportunities for school-leavers and adults in the local community.

There are a small number of private international schools in Ireland including a French school, a Japanese school and a German school.

The points system

If your child wishes to go to university or another third-level institution, they will need to score sufficient points in their Leaving Certificate exams. They will receive points for the 6 best grades they receive with the highest points going to an A1 in a paper at Honours level. Most students take 7 subjects in the Leaving Cert. The points they need for third-level courses will depend on the subject they wish to study. If they are interested in one of the very competitive courses such as Veterinary Medicine, Dentistry or Law, they will need to score in excess of 500 points in their exams. The highest possible number of points is 600. For more information on going to third level education, see Application procedures and entry requirements

FEES - Primary School

The majority of primary schools are state-funded. This means that you will not have to pay annual fees for your child's education. In practice, however, schools often need to raise extra funds for additional resources such as computers, sports equipment or improved facilities. You may be asked to make a contribution or to take part in fund-raising for the school, but your participation in these activities must always be voluntary. State-funded schools cannot require you to make contributions. If you choose to send your child to a private school, you will have to pay annual fees. These can vary considerably from

school to school. Contact the school of your choice to ask for details of fees and other expenses.

Secondary School

Education in state-funded second-level schools is free. Fees charged by private secondary schools can vary considerably. You will need to check with each individual school. Whatever school you choose, you will need to pay for school books and, where appropriate, school uniforms. Usually, you will also have to pay for extra-curricular activities.

HOW TO APPLY? - Primary Schools

Contact the school to which you want to send your child. Ask for their admissions policy and check whether you need to register your child's name on a waiting list. Apply directly to the school of your choice. You can find contact information for primary schools throughout Ireland here.

Secondary Schools

Apply directly to the school in which you are interested, well before the start of the school year. Ask about their admissions policy. Some will have waiting lists and, if they have developed links with a particular primary school, they may favour children coming from that school. Some schools may ask your child to sit an entrance exam, for which they will charge a fee. There are some organisations that will arrange to place a child in an Irish secondary school for a fee.

EMPLOYMENT FOR OTHER FAMILY MEMBERS

Your nearest Irish embassy or Consulate will be able to advise on whether a travel visa and a work visa or work authorisation is needed before coming to Ireland. If you have a professional qualification, you should check with the Irish branch of your professional body as to whether your qualifications are acceptable for use in Ireland.

Non-EU/EEA nationals

Owing to shortages of certain skills in the Irish economy, the Irish Government has introduced certain rules that make it possible for prospective employees from non-EU/EEA countries who have job offers from employers in Ireland to obtain immigration and employment clearance in advance of travel to Ireland. This immigration and employment clearance (called the Working Visa and Work Authorisation Scheme) is provided by the Irish embassy or consulate with responsibility for the country in which you live.

Casual work

Given the growth rates in the Irish economy, it is relatively easy to obtain casual employment in Ireland. There is a wealth of available jobs in a wide range of areas, many of which do not require any professional qualifications. These jobs are often advertised in shop windows, in shopping centres,

through daily Irish newspapers and through employment agencies. While many of these jobs do not require any specific professional qualifications, it is advisable to bring evidence of any educational standards (i.e., secondary school certificates, diplomas, degrees, etc.) you have attained with you to Ireland. It is also useful to bring an up-to-date resume/CV in the English language with you as you may be requested to supply information on any experience or expertise you may have. If you are planning to come to Ireland and are seeking casual employment, you could register with a recruitment agency in advance of your journey. You should also keep an eye on advertisements for casual workers in shops/stores.

Professions and Careers

Finding a career job in Ireland will involve a little more planning than looking for casual work. While a career job may take a little longer to secure, you are advised get organised and start applying for jobs before you travel. It is also useful to bear in mind that these jobs are generally paid at a higher level than other jobs that do not require any qualifications. Almost all professions in Ireland have associations or societies in Ireland that represent and often regulate their members. These associations will provide information on recognition of professional qualifications, employment opportunities and careers. Almost all of these organisations have their own websites, which you can search for online using any good search engine.

Depending on the profession, you may find contact information for this association on the OASIS – Information on Public Service Website http://www.citizensinformation.ie . Some information on these professional bodies is supplied at the end of this document.

Rules

All employees in Ireland, irrespective of their nationality, experience, expertise or profession, are protected by the law in Ireland. These laws set down specific rules about minimum rates of pay, working hours, holidays and leave, health and safety, changing jobs and employment rights.

If you are applying for a job in Ireland through a recruitment agency, it's worth bearing in mind that it is very unusual that you are charged for these services.

How to apply

If you are a non-EEA national, you should contact your nearest Irish embassy or Consulate to enquire whether you need a work authorisation or working visa for Ireland. Your Irish embassy will also be able to advise on whether you will require a travel visa for Ireland also. There is a wide range of recruitment agencies in Ireland that offer a wide range of employment opportunities -

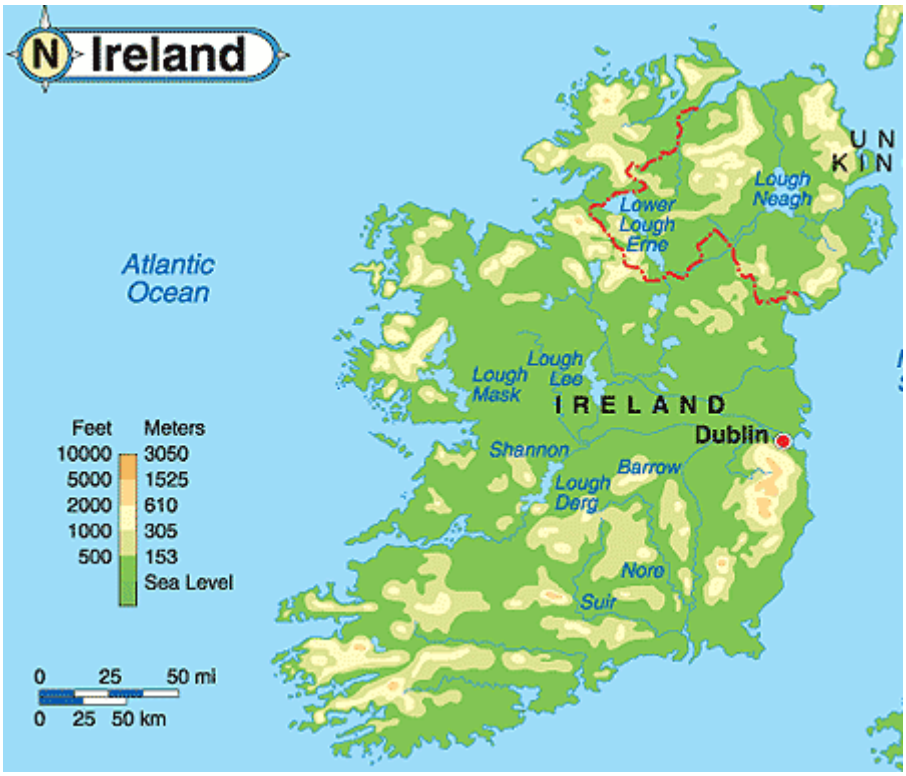
ranging from casual employment to specialised skills. Contact information for recruitment agencies in Ireland is available in the Golden Pages or through an online search. If you are seeking employment in Ireland, the job advertisement or recruitment agency will inform you how to apply for the job.

Where to apply

Apply for the job directly to the employer or recruitment agency. You will find a list of professional bodies in Ireland on the following website http://www.citizensinformation.ie – Information on Public Service Website.

FACTS ABOUT IRELAND

GEOGRAPHY
MAP OF RIVERS & MOUNTAINS IN IRELAND



The most north-westerly country in the European Union, the island of Ireland is 480 kilometres long and 305 kilometres wide. It is battered from the west by the Atlantic Ocean and lapped from the east by the choppy Irish Sea.

Ireland is divided into 32 counties, including the six British-controlled counties in Northern Ireland, and four provinces - Ulster, Leinster, Connacht, and Munster.
The centre of the country, or midland area, is dominated by limestone lowland, while the coasts are generally more mountainous. Glaciation has

shaped the landscape, with a resultant smoothing of the coastal mountains and the deposit of large volumes of clay and sand in the central plain.

Flowing from north to south is the Shannon, the longest river in Ireland and Britain. Nearly half of the Shannon above the estuary comprises three lakes; Lough Allen, Lough Ree and Lough Derg. All Ireland's principal rivers flow from the plain and an interior canal system facilitates transportation.

The highest mountain in Ireland, Carrantuohill in the MacGillicuddy's Reeks range, stands at 1,041 metres (3,419 ft) and is located in the south-western county of Kerry. Other prominent mountain ranges are the Nephin Beg range in the west with Mount Nephin at 719m (2,359 ft); the Caha Mountains in the south-west with Mount Knockboy, 707m (2,321 ft); the Boggaragh Mountains in the south; rising to 640m (2,100 ft) and the Wicklow Mountains in the east, reaching more than 915m (more than 3,000 ft).

Among the many wonders of the Irish landscape is the Burren, Co Clare, in the mid-west of the country. The Burren, meaning 'great rock', is described by geologists as 'Karst', after a similar Slovenian formation. It is a strange lunar-like region of bare carboniferous limestone, occupying 250 square kilometres north-west of Lisdoonvarna. The Burren is known for its rare alpine flowers and spectacular caves, streams, potholes and 'turloughs' (seasonal lakes).

Dublin city is located midway between north and south on the east coast of Ireland, in Leinster. As the Dublin metropolitan area increases in density on the approach to the coast, it is split by the River Liffey, which creates a natural north/south division; the subject of much Dublin snobbery from those who perceive the southside to be more affluent. The city centre's perimeter is traced by the Royal Canal to the north and the Grand Canal to the south, while the Liffey, Dodder and Tolka are the rivers of note.

CLIMATE / WEATHER

When it comes to Irish weather anything can happen!

Usually though we have a mild, temperate climate. However showers can occur at any time, but they shouldn’t last long. During summer, temperatures fluctuate from around 16-20°C/ 60-67°F and during winter, from 4-7°C/ 39-44°F. Our weather is unpredictable so even during summer months it is advisable to always carry an umbrella.

Ireland's climate is influenced by the warm waters of the Gulf Stream, and is in the path of the prevailing southwesterly winds coming from the Atlantic Ocean. This makes for equitable conditions over the whole country and means Ireland is never exposed to extremes of weather.

POPULATION

The Republic of Ireland, with an area of 70,282 sq km, according to the 2006 census findings indicate that the population of the Republic of Ireland is 4,234,925 million, an increase of 8.6% since 2002 and at its highest since the 1861 census. The total population for the island now stands at just under 6 million (estimates).

Approximately two-thirds of Irish people live in cities or large towns with the largest population concentration living in the wider Dublin area.
Unemployment is currently at around 4.3 per cent. Overall, the population is quite young and below lists the breakdown from the most recent census:

0-*14 years:* 20.6% (male 438,100; female 415,200)
15-64 years: 68.14% (male 1,418,600; female 1,398,300)
65 years and over: 11.15% (male 202,300; female 258,300) (2005 est.)

ECONOMY

Ireland is currently in a state of boom, boasting the fastest-growing economy in the European Union, which is one of the best-performing in the industrialised world. This can partially to attributed to the injection of billions of pounds worth of European structural funds and the efficient management of the National Debt.
Between 1993 and 1997, the economy grew by an unprecedented 40 per cent, and the trend has continued, albeit it at a slower rate. Growth in 2004 was a healthy 4.9 per cent in real GDP and a record 5.5 per cent in real GNP. This has led to a buoyant labour market and higher standards of living, in addition to spiralling house prices.

The ESRI (Economic and Social Research Institute) has warned that the boom years of the Celtic Tiger have passed the outlook remains good. Ireland's unemployment rate stood at around 4.4 per cent in 2004. However, Ireland still had the second lowest unemployment rate in the EU in 2004 at less than half of the EU 25 average.

While inflation has steadied, Ireland remains an expensive place to live and rising house prices remain a significant concern.
As one of the first to satisfy the criteria for the introduction of the euro, the country joined the new European single currency on January 1, 1999 and the euro went into use for electronic transfers and for accounting purposes. Euro coins and bills were issued in 2002, at which time the punt or the Irish pound ceased to be legal tender.

Also on January 1, 1999, control over Irish monetary policy, including setting interest rates and regulating the money supply, was transferred from the Central Bank of Ireland to the European Central Bank (ECB) which is responsible for all monetary policies of the European Union.

While the term 'Celtic Tiger' is used to define the strong booming economy, not all are basking in the affluence. Many suburban areas of the major cities are dogged by cycles of long-term unemployment, where whole generations of families have been without work. Drug addiction, crime and violence blight Dublin life, just as elsewhere in Europe. In addition, it is not uncommon to see homeless young adults and children begging on the streets of the city. Meanwhile, previously run-down areas have been transformed into popular residential areas, and in rural areas, EU structural funds have vastly improved the infrastructure. Construction is at an all-time high with the most intensive building works taking place in the Dublin area.

RELIGION

Some 88 per cent of Irish people described themselves as Roman Catholic in the census of 2002, the most recent figures available. However, Anglican, Methodist, Presbyterian, Jewish and Quaker communities have existed in Ireland for many years, and other religions such as Buddhism, Islam, and Christian Science have developed followings in recent times.
Although the number of Roman Catholics in the country remains high, the Roman Catholic Church can no longer claim to be the force it once was. In fact 3.5 per cent of the population said they had no religion in the last census. Anglican, Methodist, Presbyterian churches can be found in most towns however other religions tend to to have services in the large cities only. A useful source is the Irish Times Newspaper especially on a Saturday as it lists various services taking place.

Traditionally high attendance at Sunday mass and confession have fallen in recent years and there has been a marked downturn in the numbers of those joining the clergy. In addition, anecdotal evidence suggests that the conviction of a number of individual clergymen for the sexual abuse of children and revelations that two of the most prominent church figures in the country had fathered children in the 1970s (but continued to preach as celibates) have dramatically undermined confidence in the Church.

This comes at a time when sexual morality is increasingly seen as a private matter in which Church dogma should have little or no say. Meanwhile, the Church's preoccupation with the subject in former times has become for many Irish people the subject of ridicule and caricature, although periodic statements from members of the hierarchy seek to reaffirm its "moral authority" on sexual matters.

It would, however, overstate the case to say that the power of the Church has diminished altogether. A clause in the 1937 Constitution guaranteeing an ill-defined "special position" for the Church was rescinded after a referendum in 1970, but divisive referendum campaigns on abortion and divorce in the 1980s and '90s showed the Church's continuing determination to influence legislation.

This is also the case with organisations such as the Conference of Religious in Ireland, which has made strident critiques of various governments' economic and social policies, and several Church-backed charities.

Furthermore, the Church has often played a crucial and at times very subtle role in Northern Ireland politics, where inter-religious tension is a complex issue.

In education the Church co-operates with the State in running schools at both primary and secondary level and clergy often take part in the management of lay schools. Even in healthcare, Church orders have played a very active, though diminishing, role in the running of hospitals and hospices.

For all that, many young people now regard regular church-going as the preserve, or obligation, of their elders. Described as "lapsed" Catholics, they may go to Church for occasional weddings, funerals and baptisms, or maybe Mass on Christmas day, but notions of sin per se, fears of eternal damnation and aspirations to piety are rare.

The stereotypical notion of a priest-ridden society of god-fearing religiosity is no longer valid. The modern Irish do as they please. Bans on contraception, divorce, homosexuality and "evil" literature have gradually been removed from the statute books. The expectations of Irish women are no longer confined to motherhood and housewifery, while the stigma attaching to unmarried motherhood, which led in the past to thousands of babies being given up for adoption, is slowly evaporating.
The Church has in many instances opposed the so-called "liberal agenda", or movement towards a more open society.

Bank Holidays

There are 9 Bank / Public holidays in Ireland:

* A Bank holiday means that if you are rostered for duty on this day, you may receive additional pay for working.

- January (New Year)
- March (St Patrick's Day)
- April (Good Friday - bank holiday only)
- April (Easter Monday)
- May
- June (Spring Holiday)
- August (Summer Holiday)
- October (Halloween)
- December 25 (Christmas)
- December 26 (St Stephens)

HEALTHCARE

Anyone who is ordinarily resident in Ireland, or who moves to and is accepted as being ordinarily resident in the State, is eligible for public health services. Visit www.hse.ie for further information.

Public Healthcare

There are two main categories of entitlement to public health care in Ireland. Persons with Category One eligibility are issued with a Medical Card and are entitled to a full range of medical services free of charge. This category is subject to strict income guidelines and generally applies to lower income families and students. Category Two are those who do not qualify for a Medical Card. This means that you have to pay for routine visits to your GP (currently approximately €45 per visit) and for prescriptions and medicines.

You also have to pay for any routine dental, optical or aural services. Persons in this category are entitled to public hospital and medical services in public wards, subject to a payment of a daily hospital services charge of €33 up to a maximum of €330 in any 12 month period. Most outpatient public hospital services are also covered. A maternity and infant service covers the services of a General Practitioner during pregnancy and for up to 6 weeks after the birth. Under the Drugs Payment Scheme an individual or family only has to pay the first €85 per calendar month of the cost of prescribed medicines. Also persons on certain long-term medication may obtain their relevant drugs and medicines free of charge.

GP and Pharmacy Services

General Practitioner (GP) is the official term for the doctor in Ireland who provides services to people in his/her surgery or in the patient's home. Most people simply refer to GPs as their doctor or family doctor. GPs provide services to medical card holders free of charge. Certain GPs provide maternity and infant welfare services and services to people with Hepatitis C who contracted the disease through the use of Human Immunoglobulin-Anti-D or from the receipt within Ireland of any blood product or a blood transfusion and who have a Health Amendment Act Card, free of charge. Other patients must pay for GP service, typically €45 per visit.

A list of General Practitioner in your local area will be given to you on arrival in Ireland

A qualified doctor may set up in General Practice provided he/she meets all the requirements of the Medical Council, which is the regulatory body for doctors. Some doctors then enter into contracts with Health Service Executive Areas (formerly known as 'health boards') to provide GP services to medical card holders. These doctors are sometimes referred to as doctors who are in

the Primary Care Re-imbursement Service (PCRS). (The PCRS Scheme was formerly known as the GMS Scheme). In order to be in the PCRS scheme, doctors must have a number of years' experience and meet other requirements. Medical card holders choose or are allocated to an individual doctor for services.

On **1 January 2005**, all **health boards** in Ireland were **abolished and replaced by Health Service Executive (HSE) Areas**. HSE Areas have now **assumed responsibility** for all former **health board services**.

Some doctors only cater for private patients. However, these doctors may enter into contracts with the Health Service Executive (HSE) Areas to provide services to people who become entitled to medical cards once they reach the age of 70 or people with Hepatitis C who have Health Amendment Act Cards and who express a wish to remain as patients of the doctor who has been treating them. Most doctors who cater only for private patients provide services to them on behalf of the HSE Area such as maternity and infant welfare services and vaccinations.

Approved prescribed drugs and medicines are free of charge for medical card holders and people with Hepatitis C who have Health Amendment Act Cards. (Certain low cost items which you are expected to buy over the counter are not approved). People with certain long-term illnesses may get the approved prescribed drugs and medicines for those illnesses free of charge. Under the Drugs Payment Scheme, no person or family unit should ever have to pay more than 85 euro per calendar month for approved prescribed drugs and medicines.

In general, prescribed drugs and medicines can be obtained from your local pharmacy. Virtually all pharmacies have contracts with the Health Service Executive (HSE) Areas to provide approved prescribed drugs and medicines to medical card holders, people with Hepatitis C who have Health Amendment Cards and long-term illness card holders and to implement the Drugs Payment Scheme. Such pharmacists are also described as being in the Primary Care Re-imbursement Service scheme. In certain circumstances, drugs and medicines may be provided directly by doctors or by hospitals and other specialist institutions. There are strict government rules about the setting up and staffing of community pharmacies. These rules deal with the qualifications of staff and the general control of the sale of drugs. If you are a medical card holder, a person with Hepatitis C with a Health Amendment Act Card or a long-term illness card holder, you can go to any community pharmacist to have your prescription filled - you do not become a patient of a particular pharmacist as you do with a particular doctor. In order to avail of the Drugs Payment Scheme, you must use the services of one community pharmacist in a particular month.

Though Ireland provides health care for all those living and working within the country, a large % of the populations still hold private health insurance. It is not a necessity but popular none the less.

It is relatively inexpensive and there are a number of providers.

There are 3 private health insurance companies in Ireland: VHI, Vivas & Quinn-Healthcare

1. **VHI**

http://www.vhi.ie/
http://www.vhihealthcare.com/members/welcome.html

The VHI is a statutory non-profit mutual organisation, which was established in 1957 to provide independent healthcare. Members are insured against the financial costs of Hospitalisation, Professional Care, and certain Primary/Out-Patient Treatments.

Plans differ only in the nature of hospitals and accommodation included in each - for example, Plan A includes only semi-private rooms in Public Hospitals, while Plan E covers private rooms in public and private hospitals including The Mater and Blackrock Clinic (Dublin based)

Annual rate for an Individual varies from 255.08 Euro for Plan A to 1030.16 Euro

Contact Information
The Voluntary Health Insurance Board.

- Dublin: +353-1-8724499,
- Cork: +353-21-277188,
- Galway: +353-91-563715,
- Limerick: +353-61-316122,
- Dun Laoghaire: +353-1-2800306

2. **QUINN – Healthcare (Formerly BUPA)**

http://www.bupaireland.ie/

QUINN-Healthcare officially started trading in April 2007 when the Quinn Group purchased BUPA Ireland.

QUINN-Healthcare offers 4 different health schemes: HealthManager, Essential, Essential Plus and Gold with monthly premiums ranging from €27.61 to €150.40 for a single person

Full details on these plans is available at
http://www.bupaireland.ie/ourproducts/index.htm

If you have any queries on their service please call the QUINN-healthcare helpline on 1890 700 890, email info@quinn-healthcare.com or contact:

The Customer Service Manager,
QUINN-healthcare,
Mill Island,
Fermoy,
Co. Cork.

3. Vivas Health

http://www.vivashealth.ie/

VIVAS Health, markets itself on customised plans rather than the 'one size fits all'. Their plans offer a choice of hospital cover, day-to-day cover, (which is for everyday health expenses such as visits to a G.P. or Physiotherapist), or both of these together.

They are the most recent entrant into the Irish market with annual quotes for a single person ranging from €306 to €650

For a hardcopy of any of their brochures, or for more advice on plans, you can contact them on: **1850 717 717**

PPS NUMBER

Allocation of PPS Number
A PPS number is what is used to identify you within the Irish taxation system. In Ireland tax is deducted at source by your employer and paid to the Revenue Commissioners (Irish Tax Authority). Healthcare Solutions will help you to obtain this on your arrival to Ireland.

Where a PPS Number cannot be traced, the customer should complete a PPS Number Application Form (REG 1) available from the Healthcare Solutions team. The information required on Page 1 of the form - "Public Service identity Data" - is prescribed by law (Social Welfare (Miscellaneous Provisions) Act 2002, section 12). Proof of identity is a vitally important aspect of the PPS Number allocation procedure and must be established before a PPS Number is allocated. Presented Documents may be held for checking and the applicants signature on the form must be witnessed by the officer receiving the application form.

The following are the prescribed documents to accompany a PPS Number application:

PROOF OF ID - IRISH NATIONALS
• Birth Certificate
and
• Valid photographic ID e.g. Current Valid Passport or Full driving license,

Employment ID Card etc.
and
• Evidence of address

PROOF OF ID - UK NATIONALS (may include residents of Northern Ireland)
• Current Valid Passport
or
• Birth Certificate (long form preferred) **and** valid photographic ID e.g. Full Driving
Licence, Employment ID (with photo)
and
• Evidence of **either** work/claim/residency/Tax liability/education history in the UK
or Northern Ireland
and
• Evidence of address

PROOF OF ID - EEA citizens (EU NATIONALS - (other than UK) and citizens of Iceland, Norway and Liechtenstein) plus Switzerland
• Current Valid Passport or National Identity Card
and
• Evidence of either birth /work /unemployment /residency /tax liability /education
in an EU/EEA country or Switzerland
and

· Ireland – lo-call: 1890 350 250
• Evidence of address in Ireland

PROOF OF ID - NON EEA NATIONALS
• Current Valid Passport or Certificate of Registration with the Department of Justice, Equality and Law Reform (**Green Book or** Plastic Card)
and
• Evidence of either birth /work* /unemployment /residency /tax liability /education
in the relevant country. (* includes Work Permit or letter from the Dept. of Justice, Equality and Law Reform giving permission to work)
and
• Evidence of address in Ireland

The following must not be accepted as Proof of ID

- Short version of a Republic of Ireland Birth Certificate
- Provisional Driving Licence
- Baptismal Certificate
- Personal letters

- Photo-copies of certificates
- Savings accounts recently opened

The following are acceptable documents showing address:

Household Bill, Official letter/document, financial statement, property lease or tenancy agreement, verified employers letter. All documents **must** show the applicants name and address.

Notification of PPS Number

In cases where a new PPS Number is allocated, the customer will be advised of his/her new number through the issue of a letter of notification sent automatically to the address given on the application form within 3 to 5 working days. This letter is acceptable as proof of one's number for transactions with specified bodies for public services e.g. health, education, Revenue, employment, drivers licence.

PROFESSIONAL ASSOCIATIONS

AOTI

The Association of Occupational Therapists of Ireland (AOTI) is an organisation that promotes the profession on behalf of all therapists here in Ireland.
It is reliant entirely on the voluntary efforts of its members.

AOTI, 29 Gardiner Place, Dublin 1, Ireland. Tel/Fax**:** 353 1 8780247 email: aoti@eircom.net. http://www.aoti.ie/

IASLT

The I.A.S.L.T. is the recognised professional association of Speech Language Therapists in Ireland.

Irish Association of Speech and Language Therapists, PO Box 541, Ballinlough, Cork. Tel: 0857068707 http://www.iaslt.com/

RECREATION & LEISURE

Ireland has one of the most unspoilt landscapes in Europe, with spectacular scenery of mountains, rivers, lakes and coastline. There are many varied leisure and sporting facilities available throughout the region for the whole family to enjoy.

Golf

The country is a paradise for keen golfers.

Theatre & Cinema

There are many excellent theatres throughout the country and modern cinema complexes.

Pubs

Pubs are an integral part of Irish culture. Pubs throughout the country are offering cosy fire-sides, Irish music sessions, plenty of conversation and lots of good old Irish “craic”.

Eating Out

As well as many of the pubs offering good quality and reasonably priced food, there are a wide variety of restaurants and hotels that will suit all palates and pockets.

Beaches

There are a number of beaches which have been awarded the coveted European Blue Flag Award.

Surfing

Surfing of an international standard may be enjoyed throughout the country.

Hiking & Biking

There are great walking and hiking routes to be explored and many organised groups for the enthusiast to join.

Public & Private Leisure Centres

There is a wide choice of good quality centres for all the family to enjoy. Even the most exclusive private leisure centres are within the reach of most pockets with annual subscriptions only a fraction of the cost of similar facilities in Ireland’s major cities.

Rugby,Tennis, Squash, Badminton, Basketball & Soccer

There are many clubs offering these sports throughout the region.

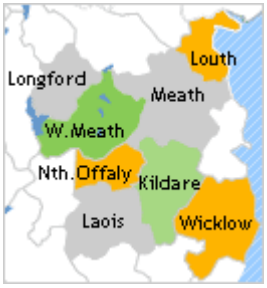
Angling

There is a great variety of fishing available in many regions of

Ireland.

REGIONAL INFORMATION

East Coast & Midlands



Kildare - Laois - Longford - Louth - Meath - North Offaly - Westmeath - Wicklow

East Coast & Midlands stretches from the magnificent golden beaches of the East Coast to the majestic Shannon in the Midlands. This area offers visitors a wide range of unrivalled facilities and amenities to suit the young and old. Some of Irelands finest heritage attractions are sited on the region. The East Coast & Midlands Region of Ireland has a huge amount to offer visitors in terms of places to go and things to see.You will be spoilt for choice when you visit the majestic East Coast & Midlands of Ireland.

Containing some of the most beautiful landscapes in Ireland with magical mountains, forests, valleys, rivers & glens, including some breathtaking blue flag beaches & lakes.

Something new & wonderful is to be discovered in each county including archaeological gems along the way. With so much to participate in & enjoy, everyone is catered for.

West Of Ireland

Galway, Mayo and Roscommon make up the region of Ireland West

Galway

Galway is just one of those places, those special, magical places that everyone wants to visit if they've never been there; that every visitor wants to return to; and that anyone lucky enough to live in, never, ever wants to leave.

Mayo

Jutting proudly into the Atlantic Ocean, the county of Mayo boasts a stunningly beautiful unspoilt environment and a magical attraction for visitors. Cosmopolitan towns positively burst with charm and personality, as welcoming as the Mayo people themselves.

Roscommon

Roscommon is often described as ‘the heart of undiscovered Ireland’. We invite you to unlock the treasures of this land of castles and ancient kings, of stately homes and wonderful landscapes, where shimmering rivers, lakes and forest parks abound.

North West & Lakelands

Donegal, Sligo, Leitrim, Cavan and Monaghan are the counties of the North West and Lakelands area.

The beauty of the North West is not just what the eye can behold, but what the heart can perceive. The stunning scenery is matched by the genuine warmth and friendiness of the people. One truly can forget the cares of modern life by escaping to one or all of the five counties that comprise the North West Region.

The spectacular scenery and rich heritage of culture provide every variety of recreational activity from the arduous to the languorous - watercolour painting to mountaineering, golfing on pefect fairways to surfing the Atlantic rollers; horse riding in bracing winds to lazing in seaweed baths.

South East

The South East consists of the five counties of Carlow, Kilkenny, Tipperary, Waterford and Wexford. Fondly referred to by the 'Irish' as the 'Sunny South East', the region is famous for its vibrant towns, rural getaways and coastal villages and resorts.

The landscape of the South East comprises a mix of rolling hills, woodlands and farmlands, picturesque river valleys of the Blackwater, Barrow, Nore, Suir and Slaney, and a craggy coastline adorned by a necklace of quaint fishing villages and coastal resorts.

Early visitors, invaders, and raiders, merchants and traders helped create many structures, distinguishing marks and locations. Visitors from overseas are attracted by the richness and variety of heritage sites in the South East. Kilkenny Castle and the Rock of Cashel are among's most visited sites. Likewise the Irish National Heritage Park and the Dunbrody Heritage Ship

in Co Wexford draw a huge number of visitors.
Craft and culture enthusiasts flock to the Waterford Crystal Visitor Centre to marvel as they view master cutters create the world famous glassware, and those with more time on their hands based themselves in the region while enjoying all the region has to offer.

South

The Cork Kerry region of South-West Ireland is one of the most attractive areas in Ireland. This area has a spectacular coastline of over 1,000 km and has Ireland's highest mountain Carrauntoohil at 1,039 m. This Region also has Ireland's most southerly point and the most westerly point. The Cork Kerry Region is a region of scenic contrasts. The long indented coastline blends with spectacular mountains, and the many rivers and lakes combine with these mountains to give a landscape that has much to offer.

County Cork has hosted the Irish Open Golf Championships on a number of occasions in recent years. Long distance walking is very popular in the region, as are the many cycle routes. In all about 1,000 kms of developed walking routes are available and about the same distance of developed or planned cycling routes await the visitor.

With such a long coastline sea and shore fishing is widely available as is excellent game angling. Good coarse angling facilities are available in County Cork.

Visitors have been enjoying this Region for about 250 years and many of these early travellers visited Killarney in County Kerry and Blarney in County Cork. The Cork Kerry region is also a special part of Ireland that has hosted many international festivals and events.

Irish Newspapers On-line

- Andersonstown News. Weekly news from West Belfast.
- Athlone Observer. Athlone.
- Belfast Telegraph. Belfast.
- The Clare Champion. Serves the mid-west of Ireland.
- Clogheen News. Up-to-date news and sport.
- The Connaught Telegraph. Weekly newspaper from Castlebar.
- Derry People and Donegal News. News in the north-west of Ireland.

- Dojo News Todays News in depth
- The Echo. Tallaght.
- The Examiner.
- Foinse. Nuachtán náisiúnta foilsithe sa Spidéal.
- The Galway Advertiser. Weekly newspaper from Galway.
- The Galway E-dependent. Irish community at home and abroad, published in Galway.
- The Galway Independent.
- GCN: Gay Community News. Gay and lesbian news in Ireland, published in Dublin.
- Gerard's Southside.
- Irish Emigrant. Galway.
- Evening Echo. Cork.
- The Irish Herald. California's Irish newspaper.
- The Irish Independent. Daily Irish news and analysis, published in Dublin.
- The Irish News.
- Irish Post.
- The Irish Times. The leading national newspaper, published in Dublin.
- Irish Voice Online.
- Irish X-Press. Daily and evening paper.
- The Kerryman. Co. Kerry.
- Kerry's Eye. Regional paper for Kerry.
- The Kingdom Online. Kerry regional newspaper.
- Lá. Nuachtán náisiúnta foilsithe i mBéal Feirste.
- Leinster Leader. Archive newspaper.
- Leinster Times and The Nationalist.
- The Limerick Leader.
- The Limerick Post.
- The Liberty. South Inner City Dublin local newspaper produced by DIT journalism students.
- The Mayo News.
- The Munster Express.
- The Nationalist. For the Leinster area
- Newshound Links to Northern Ireland newspapers
- An Phoblacht / Republican News.
- Saoirse. Monthly newspaper of Republican Sinn Féin.
- Skerries News. North Dublin issues.
- Sligo Weekender.
- Southside Northside News. News from Co. Cork.
- Sunday Business Post. Ireland's financial, political, and economic news online.
- The Sunday Tribune.
- Sunny Daze.
- Waterford Today.
- Western People.
- Westmeath Examiner.

SHIPPING YOUR BELONGINGS

What to Bring and What Not to Bring?

While it probably does not make sense to take all your belongings with you, you should investigate the cost of shipping, as it may make financial sense to ship many of your high quality items. You need to bear in mind that house sizes are probably different to where you currently live and that not all electrical goods can be used here. Mains electricity is supplied at 220 Volts (50 cycles per second). Plugs are flat with three pins. You need an adapter to convert to the correct plug size. Certain appliances, such as electrical clocks, will not work even with a transformer. Cordless telephones may not work, video formats may be different, and televisions that do work will still be of limited use, because broadcasting standards differ from country to country.

When choosing a shipping company, make sure it is one with a good reputation. You should go through their written conditions in detail, including their loss and damage cover. Shop around for the best value in insurance. Obviously you need to take into account how long the shipment will take, what you need straight away and what you can discard before you leave. If you are travelling with children, it is a good idea to bring some of their favourite toys with you, rather than leaving everything to a surface shipment.

To determine what clothes to take with you remember the coldest months are January and February, with mean daily air temperatures of four to seven degree Celsius. The warmest months are July and August with mean temperatures of 14 to 16 degrees Celsius; the sunniest are May and June, averaging five to seven hours of sunshine per day.

Removal Companies

There are many removal companies in operation in Ireland. As well as transporting your goods to Ireland, many of these companies also offer a storage service. When contacting these, and in fact, any organisations or services from abroad, it is useful to note the time differences

between your home country and Ireland. From late March to October, Ireland is on GMT, i.e. 5 hours ahead of US Eastern Time and 1 hour behind standard European Time. From late October to March, Ireland is on GMT plus 1 hour, i.e. 6 hours ahead of US Eastern Time.
The following are details of some removal firms:

Nat Ross Tel: +353 (0) 1 457 1011 www.natross.com
Allen Removals Tel: +353 (0) 1 451 3585 www.allenremovals.com
Crown Worldwide Movers Tel: +353 (0) 1 839 1261 www.crownworldwide.com
Oman Moving & Storage Tel: +353 (0) 1 605 7845 www.oman.ie
A & A Cronin Tel: +353 (0) 1 839 1261 www.cronin-movers.ie
Careline International Tel: 1800 511 212 www.careline.ie

Shopping

Shopping facilities in Ireland are excellent with a wide range of stores and boutiques in the main towns and villages, as well as a choice of supermarket chains. From clothing to craftwork and from food to furniture, there are many stores selling uniquely Irish products, but as more and more people come to live here from abroad, shop shelves are changing to include products from overseas to meet the growing demand.

Opening hours for most shops are from 9am to 6pm. In the larger towns the major supermarkets remain open until 9pm many evenings. Also many smaller grocery stores and local shops have very long opening hours. Most petrol stations have convenience shops, many of which remain open 24 hours. Ireland changed to the metric system some years ago and meat and vegetables are usually measured in kilos, though old habits die hard and most fresh food is quoted in both pounds and kilos. Clothing sizes are similar to British sizing and imported clothing and footwear usually has a list of major European sizes on the label.

SOCIAL WELFARE

As the Social Welfare system caters for such a wide range of people in many different circumstances, the amount of information available is vast. The Department of Family, Social and Community Affairs bears responsibility for developing and implementing policies and for administering payments through a network of Social Welfare Offices. In 1993, the Social Welfare (Consolidation) Act was passed, bringing together more that 80 years of social welfare law. The Department of Family, Community and Social Affairs have become very customer-focused over the years and produces a range of literature explaining how the system works at different levels of detail, from leaflets to 200 page book. All of the informational literature is free, available in English and Irish and in some case Braille. Each publication is accorded its own identification code, starting with the letters “SW”.

When you get to Ireland, your local Social Welfare office can provide all relevant information to you. If you are not yet in Ireland and want to receive any of the details mentioned, contact: Information Service, Department of Family, Community and Social Affairs, Aras Mchi Dhiarmada, Store Street, Dublin 1. Tel: (01) 874 8444, Website: www.dscfa.ie.

TAXATION

PRSI

In addition to income tax, PRSI (Pay Related Social Insurance) will also be deducted through the tax system by employers.

VAT

Value Added Tax is a general sales tax charged on goods and services supplied within Ireland. Prices of goods and services have VAT already included in them so there are no shocks at the store checkouts. Further information may be accessed at www.revenue.ie

Application for Certificate of Tax Credits

You will need to complete Form 12A to apply for your Certificate of Tax Credits if any of the following applies:
• you are starting your ***first*** employment in the State
• you are a national of another country living in Ireland and are starting your ***first*** employment in the State
• you are recommencing employment following a period of unemployment.

The form 12 A is available from http://www.revenue.ie/forms/form12a.pdf

Note 1: How do I apply for my Certificate of Tax Credits?

Complete the appropriate sections on Form 12A. Your claim will be processed promptly if you quote your **Personal Public Service Number (PPS No.)**, your **Employer's PAYE Registration Number**, and you complete all relevant sections of the form. Send the completed form to your local Revenue Office or call in person with the completed form. Both you and your employer will be notified of your tax credits and Standard Rate Cut-Off Point.

Your employer will then make the necessary tax deductions from your salary.

Note 2: How do I obtain my Personal Public Service Number (PPS No.)?

In general, Irish nationals born before 1971 who are not already registered for tax in the State and nationals from other countries coming to work here, will not have a PPS Number.

If you do not have a PPS Number, you must register with a Social Welfare Local Office of the Department of Social and Family Affairs. This must be done **before** you apply for your Certificate of Tax Credits.
LeafletSW100 'Personal Public Service Number' issued by the Department of Social and Family Affairs gives further information on how to register for your PPS Number. The leaflet is available from your Social Welfare Local Office and on the Department's website at **www.welfare.ie**

Note 3: General Information for individuals coming to live in Ireland.

Residence Status and Domicile influence the extent to which an individual is liable to tax in Ireland and their entitlement to tax credits. It is important to tell your local Revenue Office what your intentions are with regard to residing in Ireland. Irish nationals returning to work in Ireland and nationals from other countries coming to work in Ireland, must answer the residence questions at **Section B on Form 12A**. In this section, state if you have moved / returned to live here on a permanent or temporary basis. If you are living here for a temporary period or for temporary holiday work, state the expected duration of

your stay. This information will assist your local Revenue Office in determining your tax credit entitlements.

Revenue's publication **'RES 2 Coming to live in Ireland'** gives general information on the revenues Residence rules.

Note 4: What is Emergency Tax?

If your employer does not hold a Certificate of Tax Credits for you, tax will be deducted at Emergency Rates. However, there are different rules that apply depending on whether or not you provide your employer with your PPS Number.

If you give your PPS Number to your employer, it will mean that for the first four weeks of employment, tax will be calculated at the standard rate of tax and reduced by 1/52nd (if weekly paid) or 1/12th (if monthly paid), of the personal tax credit. For the next four weeks, tax will be calculated at the standard rate of tax without any tax credit. From week nine, tax will be calculated at the higher rate and no tax credit will be given. If you do not give your PPS Number to your employer, tax will be calculated at the higher rate and no tax credit will be applied. This will continue until either you provide your PPS Number to your employer or a Certificate of Tax Credits is received.

It is very important that you obtain your Certificate as quickly as possible to avoid Emergency Tax deductions.

Further Information

For further information, including the address of your local Revenue office, please visit our

website **www.revenue.ie** or alternatively you can contact your Regional PAYE LoCall Service whose number is listed below
Our tax operations are now primarily built around clearly defined regions, each comprising of a county or counties. Each region in turn is made up of a number of districts. PAYE customers are dealt with in the district where they reside.

Border Midlands West Region 1890 777 425
Cavan, Monaghan, Donegal, Mayo,
Galway, Leitrim, Louth, Offaly, Longford,
Roscommon, Sligo, Westmeath

Dublin Region 1890 333 425
Dublin (City and County)

East & South East Region 1890 444 425
Carlow, Kildare, Kilkenny, Laois,
Meath, Tipperary, Waterford,
Wexford, Wicklow

South West Region 1890 222 425

Clare, Cork, Kerry, Limerick

If you are calling from outside the Republic of Ireland, please phone 00 353 (1) 647 4444.

www.reachservices.ie provides a single point of access to government and public services in Ireland.

Transport

By Air

Ireland is well linked internationally by both air and ferry networks. Most European and World cities have regular direct flights inland out of at least one of the following airports: Dublin, Cork, Shannon and Belfast.

By Sea

Ireland is linked to Britain and Europe by regular ferry services on a number of routes. All have drive-on/drive-off facilities. There are between one and six sailings in each direction per day, depending on the route and time of the year. Services operate between Scotland and Northern Ireland and between Wales and the Republic of Ireland. High-speed "super-ferries" make the crossing between Holyhead and Dublin or Dun Laoghaire in about an hour-and-a-half. Services from Fishguard and Pembroke operate to Rosslare and there is a service between Swansea and Cork. Ferries also operate from France to Rosslare and Cork, and because Ireland is a member of the Eurail network, your fare on these services is included in the price of a Eurail pass. Full details on any of these services can be obtained from travel agents or by visiting Bord Failte's website at www.ireland.ie

Bringing a Car to Ireland

If you are bringing your car to Ireland you must be able to show that you have owned and used it for at least 6 months before relocating. If this is the case you will be exempt from VRT and VAT (Vehicle Registration Tax & Value Added Tax). Declaration form VRT4 will need to be completed. It will be necessary to be able to show that VAT and duties have been paid in your home country and in this regard it is advisable to be well prepared with supporting documentation.

Further information may be obtained by contacting The Vehicle Registration Office, General Enquiries, St. John's House, Tallaght, Dublin 24. Tel: +353 (0) 1 414 9777 or the Office of the Revenue Commissioners, Dublin Castle, Dublin 2. Tel: +353 (0) 1 647 5000 or visit www.revenue.ie

Value Added Tax (VAT) is currently payable on new vehicles at 21 per cent and is assessed on the value of the vehicle for Customs purposes, as increased by the amount of customs and excise duties payable. Further information can be obtained from the Office of the Revenue Commissioners, Dublin Castle, or from your local Vehicle Registration Office.

Procedure

You need to declare the importation of your vehicle at the time of importation and pay the appropriate charges. You will also need to complete a customs entry from if the vehicle is coming from outside the EU. More information about the actual import charges can be obtained from the Office of the Revenue Commissioners, Dublin Castle, www.revenue.ie, telephone 00353 1 6474444 or from your local Vehicle Registration Office.

Internal Transport & Travel Systems

Bus Eireann (Irish Bus) http://www.buseireann.ie/site/home/ has a nationwide network of buses servicing all cities and most towns and villages. There are also many private tour operators running luxury coach services to many parts of Ireland and the UK.

Iarnrod Eireann (Irish Rail) http://www.irishrail.ie/home/ operates a mainline train service from Dublin throughout Ireland. The service is limited and does not service all parts of the country.

For a comprehensive list of travel operators, please consult your local Irish telephone directory online at www.goldenpages.ie or www.eircom.ie

Car rental companies are in operation at all of our airports and their services are widely available in all Irish cities and towns.

Useful contacts:

Avis Rent a Car, Dublin +353 (0) 1 605 7563
Hertz Car Rental, Arrivals Hall,
Dublin Airport +353 (0) 1 844 4371

USEFUL DOCUMENTS

- Passports
- Birth Certificates for each member of the family
- Marriage Certificate for legal matters
- Social insurance records
- Medical and dental records
- Medical, motor and all other insurance records
- Educational certificates
- Bank account details and a reference from your home country's bank
- A reference from a previous landlord where applicable
- Evidence of your new position and salary
- Proof of address
- Drivers License / International Driving License
- Examples of children's current schoolwork to assist in placement where applicable

Emergency Numbers

Irish emergency number is 999. Calls to these services are free of charge. You ask the operator for the emergency service you require: Fire, Gardai (police), Ambulance, Boat and Coastal Rescue, Mountain and Cave rescue. When the emergency service answers, state the address or location at which help is needed.

APPENDIX

Emergency Services: 999 from either a landline or a mobile.
Operator Assistance: 114 (International) or 10 (Ireland, Northern Ireland, Great Britain)
Directory Enquiries: 11811 or 11850 (both of which can be expensive, particularly from mobile telephones)

(For you to write in and display in a prominent place)

Important Telephone Numbers	**Name**

Government Information:

Department	**Phone number**	**Lo-Call Number**
Agriculture & Food	01-6072802	1890-20-05-10
Arts Sport & Tourism	01-6313800	1890-38-30-00
Communications, Marine & Natural Resources	01-6785444	1890-44-99-00
Community, Rural and Gaeltacht Affairs	01-6473130	1890-47-48-47
Defence	01-8042108	Not Applicable (N/A)
Education & Science	01-8734700	Not Applicable (N/A)
Enterprise, Trade & Employment	01-6312119	1890-22-02-22
Environment, Heritage & Local Government	01-8882000	1890-20-20-21
Finance	01-6767571	1890-66-10-10
Foreign Affairs	01-4780822	1890-42-67-00
Health & Children	01-6354000	1890-20-03-11
Justice, Equality & Law Reform	01-6028202	1890-22-12-27
Social & Family Affairs	01-8748444	Not Applicable (N/A)
Taoiseach (Prime Minister)	01-6194000	1890-22-72-27
Transport	01-6707444	1890-44-33-11

Speech & Language Therapist Staff (Basic) Grade
Job Profile

About the Irish Health Service

The health service reform programme is the biggest change process ever undertaken in the Irish State and the key elements of the programme include a major rationalisation of health service agencies to reduce fragmentation. This includes the abolition of health boards into a single unitary system managed by the Health Services Executive with three health service delivery units:

- **National Hospitals Office (NHO)**

The National Hospitals Office is responsible for managing and co-ordinating the delivery of acute hospital services in 53 publicly funded hospitals and Ambulance Pre-hospital Emergency Care services throughout the country.

- **Primary Community and Continuing Care (PCCC)**

Primary, Community and Continuing Care is responsible for a range of non-hospital services. This includes general practice, community based health and personal social services, services for older people and children, disability services, mental health services and social inclusion. Further details on the Primary Care Strategy is available from http://www.primarycare.ie/primary_care_strategy/

- **Population Health**

The purpose of Population Health is to promote and protect the health of the whole population with a particular emphasis on reducing health inequalities. It achieves this by positively influencing health service delivery and outcomes through strategy and policy recommendations. Population Health is responsible for immunisations, infection control and the environmental health office and at local level its functions are organised through PCCC and the Acute Hospitals Service

Further information on the HSE is available on the website www.hse.ie .

National Recruitment Campaign 2007
Occupational Therapist Basic (Staff) Grade Job Specification

Job Title, Grade & Commencement Date	Occupational Therapist Basic (Staff) Grade
Competition Reference	
Closing Date	
Location of Post	*HSE National*
Organisational Area	
Details of Service	***About the Irish Health Service*** The health service reform programme is the biggest change process ever undertaken in the Irish State and the key elements of the programme include a major rationalisation of health service agencies to reduce fragmentation. This includes the abolition of health boards into a single unitary system managed by the Health Services Executive with three health service delivery units: • **National Hospitals Office (NHO)** The National Hospitals Office is responsible for managing and co-ordinating the delivery of acute hospital services in 53 publicly funded hospitals and Ambulance Pre-hospital Emergency Care services throughout the country. • **Primary Community and Continuing Care (PCCC)** Primary, Community and Continuing Care is responsible for a range of non-hospital services. This includes general practice, community based health and personal social services, services for older people and children, disability services, mental health services and social inclusion. These services will be delivered through multi disciplinary primary care teams and networks. Further details on the Primary Care Strategy is available from http://www.primarycare.ie/primary_care_strategy/ • **Population Health** The purpose of Population Health is to promote and protect the health of the whole population with a particular emphasis on reducing health inequalities. It achieves this by positively influencing health service delivery and outcomes through strategy and policy recommendations. Population Health is responsible for immunisations, infection control and the environmental health office and at local level its functions are organised through PCCC and the Acute Hospitals Service Further information on the HSE is available on the website www.hse.ie .
Reporting Relationship	Is responsible to Occupational Therapist Manager.
Purpose of the Post	The Occupational Therapist will be responsible for the provision of a high quality person-centred Occupational Therapy service to a designated clinical area(s) and will carry out clinical and educational duties as assigned by the Senior Occupational Therapist / Occupational Therapist Manager.
Principal Duties and Responsibilities	**Professional / Clinical** The Occupational Therapist will: • Be responsible for assessment, planning, implementation and review of treatment / intervention programmes for service users according to service standards • Manage own caseload in accordance with the needs of the post • Collaborate with service users, family, carers and other staff in treatment / intervention planning and in the provision of support and advice • Plan discharge or transition of the service user between services as appropriate • Document all assessments, treatment plans, progress notes, reports and discharge summaries in accordance with local service and professional standards

	• Communicate verbally and / or in writing results of assessments, treatment / intervention programmes and recommendations to the team and relevant others in accordance with service policy • Participate in teams as appropriate, communicating and working in co-operation with other team members • Attend clinics, review meetings, team meetings, case conferences, ward rounds etc. as designated by Senior Occupational Therapist / Occupational Therapist Manager • Arrange and carry out duties in a timely manner within settings appropriate to service users needs and in line with local policy / guidelines • Maintain quality standards of practice and participate in quality assurance and clinical audit as appropriate • Seek advice and assistance from his / her supervisor / manager with any assigned cases or issues that prove to be beyond the scope of his / her professional competence in line with principles of best practice and clinical governance • Maintain professional standards in relation to confidentiality, ethics and legislation • Operate within the scope of Irish Occupational Therapy practice and in accordance with local guidelines **Education and Training** The Occupational Therapist will: • Participate in mandatory training programmes • Participate in continuing professional development including in-service training, attending and presenting at conferences / courses relevant to practice, promoting and contributing to research etc. as agreed with the Occupational Therapist Manager • Engage in support / supervision with Senior Occupational Therapist / Occupational Therapist Manager and participate in performance review • Participate in the practice education of student therapists. Actively participate in teaching / training / supervision of other Occupational Therapy and non-Occupational Therapy staff / students and attend practice educator courses as appropriate **Health & Safety** The Occupational Therapist will: • Work in a safe manner with due care and attention to the safety of self and others • Implement agreed policies, procedures and safe professional practice by adhering to relevant legislation, regulations and standards • Be aware of risk management issues, identify risks and take appropriate action • Document appropriately and report any near misses, hazards and accidents and bring them to the attention of the relevant person(s) **Administrative** The Occupational Therapist will: • Comply with department procedures with regard to assessment, recommendation and provision of all assistive equipment / custom made devices • Keep up-to-date statistics and other administrative records as required within the Occupational Therapy department • Participate in the establishment and maintenance of standards for quality improvement and adhere to existing standards and policies • Assist in the organisation, maintenance and / or ordering of equipment and materials used in assessment and treatment • Contribute to the planning and development of the Occupational Therapy Service

	and participate in service improvements • Participate in audits / outcome measurement of intervention as directed by the Senior Occupational Therapist / Occupational Therapist Manager • Represent the department at meetings and conferences as required by the Senior Occupational Therapist / Occupational Therapist Manager • Engage in IT developments as they apply to service user and service administration • Keep up to date with developments within the organisation and the Irish Health Service • Carry out other duties as assigned by the Senior Occupational Therapist / Occupational Therapist Manager
Eligibility Criteria **Qualifications and/ or experience**	Candidates must on the latest date for receipt of application forms: (a) Possess the B.Sc (Hons) Degree in Occupational Therapy from the University of Dublin **or** (b)Possess the Diploma of Occupational Therapy **or** (c)Possess the M.Sc (Hons) Masters in Occupational Therapy from the University of Limerick **or** (d) Possess a recognised qualification at least equivalent to (a) (b) or (c) Under EU Regulations, qualifications obtained outside the Republic of Ireland must be validated by Department of Health & Children
Skills, competencies and/or knowledge	• Demonstrate proficiency in the English language so as to effectively carry out the duties and responsibilities of the role • Demonstrate sufficient clinical knowledge, clinical reasoning skills and evidence based practice to carry out the duties and responsibilities of the role • Demonstrate the ability to plan and deliver care in an effective and resourceful manner and the ability to manage self in a busy working environment • Demonstrate a commitment to the delivery of a high quality, person centred service • Demonstrate ability to take initiative and to be appropriately self-directed • Demonstrate the ability to evaluate information and make effective decisions in relation to service user care • Display effective communication and interpersonal skills including the ability to collaborate and work in partnership with colleagues, service users, families, carers, schools etc. • Demonstrate effective team skills • Demonstrate flexibility and openness to change • Demonstrate the ability to follow line management directions appropriately and to utilise supervision effectively • Demonstrate commitment to continuing professional development • Demonstrate a willingness to develop IT skills relevant to the role
Other requirements specific to the post	The postholder may require access to transport as the post may involve frequent travel throughout the HSE area(s). This is dependent on the location of individual posts.
Competition Specific Selection process	Short listing may be carried out on the basis of information supplied in your application form. The criteria for short listing are based on the requirements of the post as outlined in the eligibility criteria and skills, competencies and/or knowledge section of this job specification. Therefore it is very important that you think about your experience in light of those requirements. Failure to include information regarding these requirements may result in you not being

	called forward to the next stage of the selection process.
The reform programme outlined for the Health Services may impact on this role and as structures change the job description may be reviewed. This job description is a guide to the general range of duties assigned to the post holder. It is intended to be neither definitive nor restrictive and is subject to periodic review with the employee concerned.	

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Speech & Language Therapist Staff (Basic) Grade
Job Profile

About the Irish Health Service

The health service reform programme is the biggest change process ever undertaken in the Irish State and the key elements of the programme include a major rationalisation of health service agencies to reduce fragmentation. This includes the abolition of health boards into a single unitary system managed by the Health Services Executive with three health service delivery units:

- **National Hospitals Office (NHO)**

The National Hospitals Office is responsible for managing and co-ordinating the delivery of acute hospital services in 53 publicly funded hospitals and Ambulance Pre-hospital Emergency Care services throughout the country.

- **Primary Community and Continuing Care (PCCC)**

Primary, Community and Continuing Care is responsible for a range of non-hospital services. This includes general practice, community based health and personal social services, services for older people and children, disability services, mental health services and social inclusion. Further details on the Primary Care Strategy is available from http://www.primarycare.ie/primary_care_strategy/

- **Population Health**

The purpose of Population Health is to promote and protect the health of the whole population with a particular emphasis on reducing health inequalities. It achieves this by positively influencing health service delivery and outcomes through strategy and policy recommendations. Population Health is responsible for immunisations, infection control and the environmental health office and at local level its functions are organised through PCCC and the Acute Hospitals Service

Further information on the HSE is available on the website www.hse.ie .

Job Title, Grade & Commencement Date	Speech & Language Therapist Staff (Basic) Grade
Competition Reference	
Closing Date	
Location of Post	*HSE National*
Organisational Area	
Details of Service	*This section will be completed locally and is post specific. It will provide candidates with an overview of the hospital / service / unit. It should provide the following information:* • *What service does the unit provide?* • *What client group is served by the unit?* • *What are the possible future developments for the service?* • *What is the team structure?* • *What area is covered by this service?* • *Size of hospital / number of beds (if applicable)*
Reporting Relationship	Reports and is accountable to the Speech & Language Therapist Manager.
Purpose of the Post	To provide a high quality speech and language therapy service to the designated client group(s)
Principal Duties and Responsibilities	**Professional/ Clinical** The Speech & Language Therapist will: • Be responsible for assessment, diagnosis, planning, implementation and evaluation of treatment / intervention programmes for service users according to professional standards • Arrange and carry out assessment and treatment / intervention programmes in appropriate settings in line with local policy / guidelines and professional standards • Communicate results of assessments and recommendations to the service user and relevant others as appropriate • Document all assessment, diagnosis, treatment / intervention plans, clinical notes, relevant contacts and summaries in accordance with department and professional standards • Collaborate with service user, family, carers and other staff in goal setting and treatment / intervention planning • Foster close working relationships with colleagues and other relevant professionals in maximising the service users' potential • Provide support and information in relation to communication and / or feeding, eating, drinking and swallowing disorders etc. to service users and relevant others • Attend clinics and participate in meetings, case conferences, ward rounds etc. as agreed with the Speech and Language Therapist Manager • Participate in teams as appropriate, communicating and working in collaboration with the service user and relevant others as part of an integrated package of care • Maintain professional standards of practice • Represent the department / profession / team at meetings and conferences as designated • In conjunction with the Speech and Language Therapist Manager, contribute to the development and implementation of procedures, policies and guidelines while adhering to existing standards and protocols • Actively engage in team based performance management, where appropriate • Maintain professional standards in relation to confidentiality, ethics and legislation • Seek advice and assistance from Speech and Language Therapist Manager with any assigned cases or issues that prove to be beyond the scope of his / her professional

	competence in line with principles of best practice and clinical governance • Operate within the scope of Speech & Language Therapy practice as set out by the Irish Association of Speech & Language Therapists • Participate in and develop activities which support Health Promotion • Carry out other duties as assigned by the Speech & Language Therapist Manager **<u>Education & Training</u>** The Speech and Language Therapist will: • Participate in mandatory and recommended training programmes in accordance with departmental / organisational guidelines • Maintain continuing professional development e.g. by attending in-service events, training courses, conferences and involvement in research • Engage in reflective practice, support / supervision with designated supervisor(s) / manager • Participate in the practice education of student therapists and provide teaching / training / supervision to others (e.g. to staff, service users, carers) as appropriate • Attend practice educator courses as required • Engage in planning and performance reviews as required with the Speech and Language Therapist Manager **<u>Health & Safety</u>** The Speech and Language Therapist will: • Comply with the policies, procedures and safe professional practice of the Irish Healthcare System by adhering to relevant legislation, regulations and standards • Assist in the development, implementation and review of the department's Health and Safety statement, as appropriate • Document appropriately and report any near misses, hazards and accidents and bring them to the attention of the relevant person(s) • Work in a safe manner with due care and attention to the safety of self and others • Be aware of risk management issues, identify risks and take appropriate action • Comply with department procedures with regard to assessment, recommendation and / or manufacturing of all assistive devices • Support a culture that values diversity and respect <u>Administrative</u> The Speech and Language Therapist will, in consultation with the Speech & Language Therapist Manager: • Keep up-to-date administrative records, reports and statistics as required by the Speech & Language Therapist Manager • Be responsible for organisation and maintenance of own clinical equipment and identification of equipment needs as appropriate • Participate in the planning and development of the Speech & Language Therapy Service • Represent the department at meetings and conferences as designated • Participate in the review, evaluation and audit of Speech and Language Therapy services, identifying changing needs and opportunities to improve services • Assist in ensuring that the Speech & Language Therapy Service makes the most efficient and effective use of developments in Information Technology • Keep up to date with organisational developments within the Irish Health Service
Eligibility Criteria **Qualifications and/**	• Graduate of a School of Speech and Language Therapy recognised by the IASLT • Qualifications from outside the Republic of Ireland require Department of Health and Children (DoHC) validation

or experience	• Applicants whose first language is not English and /or who have not undergone their Speech & Language Therapy training through English must have achieved the following: ➢ A minimum score of 8.0 in the International English Language Testing System (IELTS) ➢ A pass in the Clinical English Language Competence Exam (CECE)
Skills, competencies and/or knowledge	• Demonstrate sufficient command of the English language to effectively carry out the duties and responsibilities of the role • Demonstrate sufficient clinical knowledge and knowledge of evidence based practice to carry out duties and responsibilities of the role • Demonstrate an ability to apply knowledge to evidence based practice • Demonstrate a commitment to assuring high standards and strive for a user centred service • Demonstrate the ability to plan and deliver care in an effective and resourceful manner and the ability to manage self in a busy working environment • Display the ability to evaluate information and make effective decisions especially with regard to service user care • Display effective communication and interpersonal skills including the ability to collaborate with families, carers, schools etc. • Display awareness and appreciation of the service user and the ability to empathise with and treat service users / others with dignity and respect • Demonstrate effective team skills • Demonstrate flexibility and openness to change • Demonstrate ability to utilise supervision effectively • Demonstrate a willingness to develop IT skills relevant to the role
Other requirements specific to the post	*Outline of criteria that are specific to the post e.g.* • Participate in rotation as required • To attend and work the days and hours at the centres to which s/he is assigned, and other such centres as the Speech and Language Therapist Manager may direct
Competition Specific Selection Process	Short listing may be carried out on the basis of information supplied in your application form. The criteria for short listing are based on the requirements of the post as outlined in the eligibility criteria and skills, competencies and/or knowledge section of this job specification. Therefore it is very important that you think about your experience in light of those requirements. Failure to include information regarding these requirements may result in you not being called forward to the next stage of the selection process.

The reform programme outlined for the Health Services may impact on this role and as structures change the job description may be reviewed.

This job description is a guide to the general range of duties assigned to the post holder. It is intended to be neither definitive nor restrictive and is subject to periodic review with the employee concerned.

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

OCCUPAT

IONAL

[redacted]

OCCUPATIONAL HEALTH QUESTIONNAIRE

[redacted]

Occupational Health Questionnaire

All information provided in this questionnaire will be kept in strict confidence. This document and its contents will remain in the Occupational Health Department of the hospital in which you will be employed and will not be disclosed to another party without your consent. The purpose of this questionnaire is to assess whether you are fit for the post for which you have applied for in order to protect your health and the health and safety of others.

If you respond YES to any particular section you will be required to provide details regarding the condition. Details which may be useful include:

- The onset and duration of the problem.
- What types of treatment, if any did you receive?
- Were you admitted to hospital, unable to work or prevented from carrying out your normal activities because of this problem?
- Does the condition continue to affect you in any way?

You are requested to complete each section of the questionnaire to the best of your knowledge. Any relevant information known to you, which is not disclosed may result in your employment contract being terminated.

THE CONTENTS OF THIS FORM ARE HELD IN STRICT CONFIDENCE BY THE OCCUPATIONAL HEALTH DEPARTMENT

PERSONAL DETAILS

First names ……

Last name ……

DD / MM / YY

Sex: Male ☐ Female ☐ Date of Birth __ __/__ __/ 19__ __

Address ……..

……..

……..

……..

……..

Email address ……...

Telephone …… Mobile ……

General practitioner ……

Address ……

……..

……..

……..

Telephone No. of general practitioner
(Including country and area code) ……

Position Applied For: ……

EMPLOYMENT HISTORY

Please provide dates of *all* previous posts held since qualifying.

Job title	Employers name and address	Dates from DD/MM/YY:	Dates to: DD/MM/YY:

How do you consider your state of health at present?

Please **circle** the word that most represents your response:				
POOR	FAIR	GOOD	VERY GOOD	EXCELLENT

Please answer all of the following questions. If you answer **YES** please give full details in the space provided.

Do you suffer from or have you ever had	YES	NO	DESCRIBE
1. Heart problems or circulatory disorders? e.g. high blood pressure, heart murmur, heart attack, anaemia, circulatory problems, e.g. varicose veins			
2. Asthma, bronchitis, chest problems or any other lung or respiratory problems?			
3. Exposure to and/or treatment for tuberculosis?			
4. Any of the following symptoms; persistent cough, sputum, coughing up blood, fever, tiredness, weight loss, breathlessness, night sweats?			
5. Eczema, dermatitis, psoriasis or any other rashes or skin disease?			
6. Any allergies? e.g. drugs, latex, food or chemical allergies.			
7. Problems with your eyes, ears, nose or throat?			
8. Problems with your glands e.g. diabetes or thyroid problems or any other gland problems?			

Please answer all of the following questions. If you answer YES please give full details in the space provided.

Do you suffer from or have you ever had	YES	NO	DESCRIBE
9. Any prostate or kidney problems? e.g. kidney failure, kidney stones or infections.			
10. Stomach, bowel, jaundice, hepatitis, or any other liver disease, gallbladder or pancreatic problems?			
11. Any gynaecological problems?			
12. Any problems with your back, neck or your joints including pain, swelling or stiffness? e.g. arthritis, gout, repetitive strain injuries etc.			
13. Any difficulty in standing, bending, lifting or other movements?			
14. Fits, blackouts, epilepsy, recurring migraines or any other neurological disorders?			
15. Any mental illness or psychological problems? e.g. anxiety, depression, eating disorders, work stress etc.			
16. A tumour - benign or malignant?			
17. Any operation or been hospitalised for any other reason?			

Please answer all of the following questions. If you answer **YES** please give full details in the space provided

	YES	NO	DESCRIBE
18. Are you attending or have you attended a doctor or hospital for medical care or treatment in the last five years? inc chest x-ray.			
19. How many times in the last 12 months and for what reasons did you visit a health practitioner?			
20. Are you currently taking any medications? If so please give the name of the medication and indicate the nature of the problem.			
21. Have you ever used drugs for recreational purposes or have you ever been treated or had counselling for a drug or alcohol problem?			
22. How many units of alcohol do you consume per week? _____Units **1 pint of beer = 2 units** **Spirit = 1 ½ units** **Glass wine = 1 unit** Has your intake changed in last five years?			
23. Do you smoke? If so, how many per day?_____			

Please answer all of the following questions. If you answer **YES** please give full details in the space provided

	YES	NO	DESCRIBE
24. Have you tested positive for hepatitis B, hepatitis C or HIV?			
25. Have you ever applied for or received compensation for a disease, accident or injury?			
26. Have you ever had an illness that may have been caused or made worse by your occupation?			
27. Have you had any illness/injury, which has caused you to be absent from work for a continuous period in excess of two weeks?			
28. Do you have any impairment, which we ought to be aware of that may affect your ability to work safely?			
29. Do you have any other medical conditions or complaints that have not been included in this questionnaire?			

We may need to contact your general practitioner or any other health professional regarding the information on your health questionnaire. All information requested will be held in the strictest confidence within the occupational health dept.

I give my consent for the Occupational Health Dept to obtain a medical report from my general practitioner or any other doctor, hospital, clinic or medical facility who I have any time attended, if this is deemed necessary.

APPLICANTS SIGNATURE…… DATE ……

Declaration

I declare that the information given on this form is true to the best of my knowledge. I understand that a failure to provide information and/or a submission of inaccurate information relating to my health may result in a breach of contract and could lead to dismissal.
I am willing to undergo a medical examination if necessary.

APPLICANTS SIGNATURE…… DATE ……

IMMUNE STATUS ASSESSMENT

Have you ever had any of the following vaccinations or tests, please indicate YES or NO. Please give dates and test results where known.

Immunisation	Vaccination received			**Immune status**
	Yes	**No**	**Date**	**Test Result/titre**
BCG (TB vaccination)				
TB test (Heaf, Tine, Mantoux)				
Rubella (German Measles)				
Varicella (Chickenpox)				
Measles				
Mumps				
Hepatitis B Injection No. 1				
Injection No. 2				
Injection No. 3				
What was the Hepatitis B antibody level post vaccination?				
Known non-responder to Hepatitis B vaccination				
Was further vaccination required?				

Please note that formal documentation of these results are required by the Occupational Health Department in the Hospital in which you will be employed.

HEALTH SERVICES EXECUTIVE

Terms and Conditions of Employment
Title of Post Occupational Therapist Senior Grade

Tenure	The appointment is whole-time, permanent and pensionable. Appointment as an employee of the Health Service Executive is governed by the Health Act 2004 and the Public Service Management (Recruitment and Appointment) Act 2004.
Remuneration	The Salary scale for the post at 1.6.07: Euro 38,066 – 39,341 – 40,420 – 41,538 – 42,643 – 43,777 – 44,904 – 46,031 – 47,218 – 48,466 – 49,713 – **50,712 LSI**
Working Week	The standard working week applying to the post is: 35 Hours per week
Annual Leave	The annual leave associated with the post is: To be confirmed by Line Manager
Superannuation	All pensionable staff become members of the pension scheme.
Probation	Every permanent appointment of a person who is not already a permanent officer of the Health Service Executive or of a Local Authority shall be subject to a probationary period of 12 months as stipulated in the Department of Health Circular No.10/71.
Age	Age restrictions shall only apply to a candidate where he/she is not classified as a new entrant (within the meaning of the Public Service Superannuation Act, 2004). A candidate who is not classified as a new entrant must be under 65 years of age.
Health	A candidate for and any person holding the office must be fully competent and capable of undertaking the duties attached to the office and be in a state of health such as would indicate a reasonable prospect of ability to render regular and efficient service.
Character	Each candidate for and any person holding the office must be of good character.

Speech & Language Therapist Staff (Basic) Grade
Job Profile

About the Irish Health Service

The health service reform programme is the biggest change process ever undertaken in the Irish State and the key elements of the programme include a major rationalisation of health service agencies to reduce fragmentation. This includes the abolition of health boards into a single unitary system managed by the Health Services Executive with three health service delivery units:

- **National Hospitals Office (NHO)**

The National Hospitals Office is responsible for managing and co-ordinating the delivery of acute hospital services in 53 publicly funded hospitals and Ambulance Pre-hospital Emergency Care services throughout the country.

- **Primary Community and Continuing Care (PCCC)**

Primary, Community and Continuing Care is responsible for a range of non-hospital services. This includes general practice, community based health and personal social services, services for older people and children, disability services, mental health services and social inclusion. Further details on the Primary Care Strategy is available from http://www.primarycare.ie/primary_care_strategy/

- **Population Health**

The purpose of Population Health is to promote and protect the health of the whole population with a particular emphasis on reducing health inequalities. It achieves this by positively influencing health service delivery and outcomes through strategy and policy recommendations. Population Health is responsible for immunisations, infection control and the environmental health office and at local level its functions are organised through PCCC and the Acute Hospitals Service

Further information on the HSE is available on the website www.hse.ie .

Physiotherapist Staff Grade Job Profile

Job Title and Grade	Physiotherapist
Competition Reference	
Closing Date	
Location of Post	*HSE National*
Organisational Area	
Details of Service	***About the Irish Health Service*** The health service reform programme is the biggest change process ever undertaken in the Irish State and the key elements of the programme include a major rationalisation of health service agencies to reduce fragmentation. This includes the abolition of health boards into a single unitary system managed by the Health Services Executive with three health service delivery units: • **National Hospitals Office (NHO)** The National Hospitals Office is responsible for managing and co-ordinating the delivery of acute hospital services in 53 publicly funded hospitals and Ambulance Pre-hospital Emergency Care services throughout the country. • **Primary Community and Continuing Care (PCCC)** Primary, Community and Continuing Care is responsible for a range of non-hospital services. This includes general practice, community based health and personal social services, services for older people and children, disability services, mental health services and social inclusion. Further details on the Primary Care Strategy is available from http://www.primarycare.ie/primary_care_strategy/ • **Population Health** The purpose of Population Health is to promote and protect the health of the whole population with a particular emphasis on reducing health inequalities. It achieves this by positively influencing health service delivery and outcomes through strategy and policy recommendations. Population Health is responsible for immunisations, infection control and the environmental health office and at local level its functions are organised through PCCC and the Acute Hospitals Service Further information on the HSE is available on the website www.hse.ie .
Reporting Relationship	Reports to Physiotherapy Manager and / or his / her designated person as appropriate.
Purpose of the Post / Role Summary	The provision of a quality Physiotherapy service in line with standards of Physiotherapy practice. To provide quality, client centred Physiotherapy assessment and treatment to identified client groups at designated centres as directed by the Physiotherapy Manager.
Principal Duties and Responsibilities	**Professional / Clinical** The Physiotherapist will: • Carry a clinical caseload appropriate to the post • Be responsible for client assessment, development and implementation of individualised treatment plans that are client centred and in line with best practice • Be responsible for goal setting in partnership with the client, family and other team members as appropriate • Communicate and work in co-operation with other team members • Develop effective communication with and provide instruction, guidance and support to service users, family, carers etc.

	• Document client records in accordance with professional standards and departmental policies • Provide a service in varied locations in line with local policy / guidelines and within appropriate time allocation (e.g. clinic, home visits) • Participate in review meetings, case conferences, ward rounds etc. as appropriate • Maintain professional standards of practice • Maintain quality standards of work and co-operate with quality assurance programmes • Work within own scope of professional competence in line with principles of best practice, professional conduct and clinical governance • Seek the advice of relevant personnel when appropriate / as required • Operate within the scope of practice of the Irish Society of Chartered Physiotherapists **Education & Training** The Physiotherapist will: • Participate in mandatory training programmes • Take responsibility for, and keep up to date with Physiotherapy practice by participating in continuing professional development such as reflective practice, in service, self directed learning, research, clinical audit etc. • Engage in performance review processes including personal development planning • Participate in the practice education of student therapists. Take part in teaching / training / supervision of staff / others as appropriate (once sufficient clinical experience has been attained) and attend practice educator courses as relevant to role and needs **Health & Safety** The Physiotherapist will: • Implement agreed policies, procedures and safe professional practice and adhere to relevant legislation, regulations and standards • Work in a safe manner with due care and attention to the safety of self and others • Be aware of risk management issues, identify risks and take appropriate action • Report any adverse incidents or near misses • Adhere to department policies in relation to the care and safety of any equipment supplied for the fulfilment of duty • Report any malfunctions or defects in equipment or any such suspicions immediately to the Senior Physiotherapist / Physiotherapy Manager **Administrative** The Physiotherapist will: • Actively participate in the improvement and development of Physiotherapy services by liaising with the Senior Physiotherapist / Physiotherapy Manager • Gather and analyse statistics and participate in audits as directed by the Senior Physiotherapist / Physiotherapy Manager • Represent the department at meetings and conferences as designated • Assist in ensuring that the Physiotherapy service makes the most efficient and effective use of developments in IT • Promote a culture that values diversity and respect in the workplace • Keep up to date with organisational developments within the Irish Health Service • Carry out other duties appropriate to the post as required from time to time by the Physiotherapy Manager •

Eligibility Criteria **Qualifications and/ or experience**	Candidates must on the latest date for receipt of application forms: (a) Be a member of, or be eligible for membership of the Irish Society of Chartered Physiotherapists **or** (b) Possess a B.SC (Hons) degree in Physiotherapy from the University of Dublin **or** (c) Possess the Bachelor in Physiotherapy (Hons) Degree from the National University of Ireland **or** (d) Possess the Diploma in Physiotherapy of the University of Dublin or the National University of Dublin **or** (e)Possess the BSc (Hons) Degree in Physiotherapy from the University of Limerick **or** (f) Possess a qualification in Physiotherapy at least equivalent to (b), (c), (d) or (e) Under EU Regulations, qualifications obtained outside the Republic of Ireland must be validated by the Irish Society of Chartered Physiotherapists
Skills, competencies and/or knowledge	• Demonstrate sufficient communication skills to effectively carry out the duties and responsibilities of the role • Demonstrate experience of applying evidence based practice • Demonstrate sufficient clinical knowledge to carry out the duties and responsibilities of the role • Demonstrate an ability to apply knowledge to best practice • Demonstrate the ability to plan and deliver care in an effective and resourceful manner within a model of person-centred care • Demonstrate the ability to manage self in a busy working environment • Demonstrate the ability to evaluate information and make effective decisions especially with regard to service user care • Display effective communication and interpersonal skills including the ability to collaborate with colleagues, families, schools etc. • Display awareness and appreciation of the service user and the ability to empathise with and treat others with dignity and respect • Demonstrate effective team skills • Demonstrate flexibility and openness to change • Demonstrate ability to utilise supervision effectively • Demonstrate a willingness to develop IT skills relevant to the role • Demonstrate commitment to continuing professional development
Other requirements specific to the post	*Outline of criteria that are specific to the post e.g.* • To participate in emergency / evening / weekend / bank holiday / on call / rotation schemes / services as required
Competition Specific - Selection Process	Applications must be made on the official application form. All sections must be completed. Short listing may be carried out on the basis of information supplied in your application form. The criteria for short listing are based on the requirements of the post as outlined in the eligibility criteria and skills, competencies and/or knowledge section of this job specification. Therefore it is very important that you think about your experience in light of those requirements. Failure to include information regarding these requirements may result in you not being called forward to the next stage of the selection process. Candidates should ensure that you meet the eligibility requirements for the competition

	before attending for interview. If you do not meet these essential entry requirements but nevertheless attend for interview you will be putting yourself to unnecessary expense as the HSE will not be responsible for refunding any expenses incurred. In the absence of shortlisting, candidates meeting the eligibility criteria will be called to interview. Candidates will be further advised as to the structure and content of the interview. The HSE will run this campaign in compliance with the codes of practice prepared by the **Commissioners for Public Service Appointments (CPSA)** and will consider requests for review in accordance with the provisions of the codes of practice published by the CPSA. Codes of practice are published by the CPSA and are available on www.cpsa-online.ie
The reform programme outlined for the Health Services may impact on this role and as structures change the job description may be reviewed. This job description is a guide to the general range of duties assigned to the post holder. It is intended to be neither definitive nor restrictive and is subject to periodic review with the employee concerned.	

HEALTH SERVICES EXECUTIVE

Terms and Conditions of Employment
Title of Post Physiotherapist Staff Grade

Tenure	The appointment is whole-time, permanent and pensionable. Appointment as an employee of the Health Service Executive is governed by the Health Act 2004 and the Public Service Management (Recruitment and Appointment) Act 2004.
Remuneration	The Salary scale for the post at 1.6.07: Euro 38,066 – 39,341 – 40,420 – 41,538 – 42,643 – 43,777 – 44,904 – 46,031 – 47,218 – 48,466 – 49,713 – **50,712 LSI**
Working Week	The standard working week applying to the post is: 35 Hours per week
Annual Leave	The annual leave associated with the post is: To be confirmed by Line Manager
Superannuation	All pensionable staff become members of the pension scheme.
Probation	Every permanent appointment of a person who is not already a permanent officer of the Health Service Executive or of a Local Authority shall be subject to a probationary period of 12 months as stipulated in the Department of Health Circular No.10/71.
Age	Age restrictions shall only apply to a candidate where he/she is not classified as a new entrant (within the meaning of the Public Service Superannuation Act, 2004). A candidate who is not classified as a new entrant must be under 65 years of age.
Health	A candidate for and any person holding the office must be fully competent and capable of undertaking the duties attached to the office and be in a state of health such as would indicate a reasonable prospect of ability to render regular and efficient service.
Character	Each candidate for and any person holding the office must be of good character.

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

On completion of this form please return to:

LOCAL OFFICE

PROCEDURE FOR THE COMPLETION OF GARDA CLEARANCE FORMS

Please Read This Leaflet Carefully Before Completing Your Garda Clearance Form

Garda Clearance form must be printed / copied as a DOUBLE SIDED DOCUMENT (ONE PAGE ONLY)

It is imperative that you complete the attached Garda Clearance Form fully and correctly. Failure to do so will result in a delay of your appointment. N.B. Forms stamped by your Local Garda Station or forms forwarded by candidates personally to Garda Headquarters WILL NOT BE ACCEPTED.

Please complete this form using BLOCK CAPITALS & BE LEGIBLE **on completion.**
If a section is not applicable please write "not applicable" (N/A) in the relevant section,
do not leave blank or insert strokes/dashes.

1. **Surname**: Insert your current surname
2. **Previous name**: Insert your previous name here (i.e. maiden name (if applicable)
3. **Forename**: Insert your forename / Christian name
4. **Alias:** If you are known by any name other than that / those on your birth certificate please insert here.
5. **P.P.S. No.** ***(formerly R.S.I Number) :*** Please enter your P.P.S No. here (if you do not have a P.P.S. No, please contact the office of your local Revenue Commissioners to obtain same)
6. **Date of birth**: Insert your date of birth (dd/mm/yy)

7. **Place of birth**: Insert the name of the city or town that you were born in (e.g. Cork City)

8. **Have you ever changed your name?** If yes, tick '**yes**' box, if no tick '**no**' box.
   If yes please state former name: Insert any previous surnames if applicable (e.g. in the event that you were married on more than one occasion or that you have changed your name by deed poll etc.)

9. **Please state all addresses from year of birth to present date**: it is very important that your current address and **all** previous addresses, **including all addresses abroad**, are provided. You must also insert the years that you resided at these addresses year from and year to. These will be checked and if there is any time unaccounted for, the form will be returned to you.

10. **Please note that this clearance will only cover Irish and Northern Ireland addresses. If you have resided in any other countries, for a period of 6 months or more, it will be mandatory for you to furnish this department and Line Manager with a Police Clearance Cert from those countries stating that you have no convictions recorded against you while residing at the overseas addresses.**

11. **Have you ever been convicted of an offence in the Republic of Ireland or elsewhere?** If no, tick 'no' box. If yes, tick 'yes' box and then please provide details of conviction(s), i.e. Date, Court, Offence, Court Outcome.

12. **Declaration**: Please make certain you fill in the position you are applying for in the section marked: **"I, the undersigned have applied to work as a……."**
    You must read this declaration carefully, sign and date it, and also print your name in block capitals underneath the signature. (BLOCK CAPITALS)

Please be aware that any information returned by the Garda Central Vetting Unit to the HSE West area as a result of this request for Garda Clearance may be shared with other HSE areas in the event that you apply for employment in another HSE area.

The section below the line will be completed by the Health Service Executive. **This will be countersigned by an authorised signatory in the Health Service Executive where it will be forwarded to Garda Headquarters. The form will be then be returned to Recruitment following verification.**

If the form is not completed correctly, it may be returned to you for further completion / verification. Please note this could significantly slow your appointment / garda clearance process.

About the Irish Health Service

The health service reform programme is the biggest change process ever undertaken in the Irish State and the key elements of the programme include a major rationalisation of health service agencies to reduce fragmentation. This includes the abolition of health boards into a single unitary system managed by the Health Services Executive with three health service delivery units:

- **Primary Community and Continuing Care (PCCC)**

Primary, Community, and Continuing Care (PCCC) is the central focus for the delivery of health and social services in Ireland. The HSE/PCCC reform implementation promotes a team-based approach to service provision in order to provide a fully integrated primary care service. PCCC is responsible for a range of non-hospital services. This includes general practice, community based health and personal social services, services for older people and children, disability services, mental health services and social inclusion.

Primary Care Teams (PCT's) will operate as part of PCCC and will provide a multidisciplinary, team-based approach to primary care, servicing the majority of people's health needs, at or close to home. The PCT will serve a client population of approximately 8,000 – 12,000 within its catchment area and will be responsible for case management, devising and delivering care plans and facilitating access within the entire health system for people in their defined local population.

Members of the Primary Care Team will carry out their clinical work as part of the multi-disciplinary care delivered by the team. They will continue to have professional responsibility for their contribution to the care of patients and clients of the team. In complex cases, they will contribute to assessment, care planning, treatment, review and after care in line with current professional standards. Responsibility for the delivery and management of care lies with the Primary Care Team, and the team will appoint a key worker for particular cases as required.

A wider Network of additional primary care professionals will support several PCT's, covering a total population of approx 30,000 – 50,000 people.

Improved integration between primary care teams, networks, other specialist services and acute hospital services will be developed. Referral protocols, direct access to diagnostics, individual care plans, discharge planning, integrated care pathways and shared care arrangements will allow for a more fully integrated primary care service.

- **National Hospitals Office (NHO)**

The National Hospitals Office is responsible for managing and co-ordinating the delivery of acute hospital services in 53 publicly funded hospitals and Ambulance Pre-hospital Emergency Care services throughout the country.

- **Population Health**

The purpose of Population Health is to promote and protect the health of the whole population with a particular emphasis on reducing health inequalities. It achieves this by positively influencing health service delivery and outcomes through strategy and policy recommendations. Population Health is responsible for immunisations, infection control and the environmental health office and at local level its functions are organised through PCCC and the Acute Hospitals Service.

Further information on the HSE is available on the website www.hse.ie .

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Job Specification & Terms and Conditions

Note: Sections in blue / italics are prompts for and will be completed by HR personnel

Job Title and Grade	Professionally Qualified Social Worker
Competition Reference	*Completed by HR*
Closing Date	*Completed by HR*
Taking up Appointment	❑ *The successful candidate will be required to take up duty no later than……..*
Location of Post	*This section will be completed locally and is post specific. It will provide candidates with an overview of the service. It should provide the following types of information:* ❑ *Where is the job located?* ❑ *Which geographical area?* ❑ *What service does the unit provide?* ❑ *What client group is served by the unit?* ❑ *What are the possible future developments for the service?* ❑ *What is the team structure?*
Organisational Area	*Completed by HR*
Details of Service	The staff appointed to these posts will be required to participate as a member of a Primary Care Team and wider Primary, Community and Continuing Care (PCCC); working as part of multi-disciplinary teams delivering a coordinated approach to client care. S/he may be required to work as a key worker for particular cases as required.
Reporting Relationship	Professional reporting relationships for the purpose of clinical supervision and professional development will continue to the relevant senior practitioner or Head of Discipline. Responsibility for the delivery and management of care lies with the Primary Care Team / wider PCCC, working closely with local Heads of Discipline and local management in ensuring that a cohesive structure and process for effective clinical governance and service delivery is in place.
Purpose of the Post	The purpose of the post is to provide a social work service that seeks to improve the health and social wellbeing of the service users within the context of the local communities. S/he will achieve this thorough the implementation of an accessible, equitable, person-centred service.
Principal Duties and Responsibilities	**Professional / Clinical** The Professionally Qualified Social Worker will: 1. Provide a direct point of access for the local community in the designated service area and offer initial and holistic social assessment and intervention to individuals, families and groups. 2. Provide an initial assessment service to all care groups and to de-

	velop referral procedures with other social work networked services. 3. Identify service users' individual and collective needs in partnership with them and co-create early interventions and/or social action strategies to meet those needs. 4. Manage and prioritise a caseload appropriate to the post. 5. Provide supportive counselling, emotional and practical support, and information to service users and their families. 6. Adopt a holistic approach aimed at enhancing the quality of life, health and social well-being of all persons within the designated service area. 7. Promote independence, self-reliance, self-determination and empowerment with persons in their environment, with families and local groups. 8. Make it possible for service users to advocate for their own needs, or where appropriate advocate on behalf of service users. 9. Plan, deliver and engage in systemic interventions as appropriate with individuals, families, groups, organisations and communities. 10. Participate and take leadership in community needs assessment and ongoing community involvement including initiating and participating in prevention and health promotion activities. 11. Deliver social work service in collaboration with other disciplines / agencies as required, in appropriate settings reflecting the needs of the service user. 12. Assess where social conditions are a major factor in health and social wellbeing, consult and plan with the service user/ relevant team/ service and arrange appropriate social services for those who need them. 13. Monitor and evaluate outcomes of person centred care plans for individual service users. 14. Actively participate as a member of the relevant team/ service in team building and change management initiatives. 15. Attend case conferences, meetings and other relevant fora as required. 16. Attend court, tribunals etc as required. 17. Work within current legislation, relevant policies and procedures, guidelines and protocols within the HSE. 18. Incorporate Social Work values and ethical principles in planning, developing, implementing and reviewing interventions. 19. Implement models of best practice / evidence based practice. 20. Work within a key worker / case worker system, providing a co-ordinating role for case management where appropriate. 21. Take direction from his / her line manager. 22. Take an active role in an appropriate level of planned professional supervision, in accordance with the local/ national Supervision Policy. 23. Engage in reflective practice. 24. Deputise for the Social Work Team Leader as agreed / appropriate. 25. Promote a culture that values diversity and respect in the workplace. 26. Keep the Team Leader fully informed and up-to-date on all significant matters.

Education & Training

The Professionally Qualified Social Worker will:

1. **Maintain standards of practice and levels of professional knowledge by participating in continuous professional development initiatives and attendance at courses as appropriate.**
2. Engage in career and professional development planning in collaboration with the Social Work Team Leader / Principal Social Worker.
3. Keep up to date with advances in Social Work research, and ongoing review and evaluation of literature relevant to the assigned area.
4. Keep abreast of developments in national policies and strategies and international best practice.
5. Keep up to date with organisational developments within the Irish Health Service.
6. **Act as a resource by participating in the induction, education and training of Social Work colleagues, other health professionals and service user groups as required.**
7. **Participate in the practice education of student Social Workers.**
8. **Support and train other staff in accordance with professional standards as appropriate.**
9. Foster an understanding of the role and contribution of social work by providing professional consultation and education to other members of the service.

Health & Safety

The Professionally Qualified Social Worker will:

- **Comply with and contribute to the development of policies, procedures, guidelines and safe professional practice and adhere to relevant legislation, regulations and standards.**

Administrative

The Professionally Qualified Social Worker will:

1. Maintain a high standard of documentation, including service user files in accordance with local guidelines and the Freedom of Information (FOI) Act.
2. Maintain accurate up to date records and files, and submit activity data as required.
3. Write accurate, clear, concise and purposeful reports.
4. Ensure the maintenance of service user and data confidentiality.
5. Contribute to the development and implementation of information sharing protocols and audit systems.
6. Contribute to policy development, performance monitoring and

	budgetary control of service in conjunction with the Social Work Team Leader/ Principal Social Worker. 7. Collaborate with the Social Work Team Leader / Principal Social Worker or designate in developing the role of the Social Worker and the service e.g. through planning, audit, production of standards, continuing education, quality improvement initiatives and research. 8. Assist in ensuring that the social work service makes the most efficient and effective use of developments in IT. **The above Job Description is not intended to be a comprehensive list of all duties involved and consequently, the post holder may be required to perform other duties as appropriate to the post which may be assigned to him/her from time to time and to contribute to the development of the post while in office.**
Eligibility Criteria Qualifications and/ or experience	Candidates must have obtained a National Qualification in Social Work, (N.Q.S.W.) or a professional qualification in social work which is recognised as equivalent by the Irish National Social Work Qualifications Board.
Post Specific Requirements	*This section may be used to include educational or experience requirements that are deemed necessary for a specific post in a specific location.*
Other requirements specific to the post	*Please outline the specific criteria that are specific to the post, e.g. access to transport as post will involve frequent travel, e.g. fluency in Irish*
Skills, competencies and/or knowledge	• Demonstrate sufficient professional knowledge to carry out the duties and responsibilities of the role. • Demonstrate experience of applying evidence based practice. • Demonstrate an ability to apply knowledge to best practice. • Demonstrate the capacity to plan and deliver care in an effective and resourceful manner within a model of person-centred care. • Demonstrate the ability to manage self in a busy working environment including the ability to prioritise caseloads. • Demonstrate a commitment to assuring high standards and strive for a user centred service. • Demonstrate initiative and innovation in identifying areas for service improvement. • Display awareness and appreciation of the service user as expert through experience including promoting the involvement of the service user in care planning, decision-making and service development. • Demonstrate the ability to empathise with and treat others with dignity and respect. • Demonstrate the ability to evaluate information and make effective decisions especially with regard to service user care. • Display effective interpersonal and communication (verbal and written) skills.

	• Demonstrate effective team skills. • Demonstrate flexibility and openness to change. • Demonstrate ability to utilise supervision effectively. • Demonstrate a willingness to develop IT skills relevant to the role. • Demonstrate commitment to continuing professional development.
Competition Specific Selection process **Shortlisting / Interview**	Short listing may be carried out on the basis of information supplied in your application form. The criteria for short listing are based on the requirements of the post as outlined in the eligibility criteria and skills, competencies and/or knowledge section of this job specification. Therefore it is very important that you think about your experience in light of those requirements. Failure to include information regarding these requirements may result in you not being called forward to the next stage of the selection process. Those successful at the shortlisting stage of this process (where applied) will be called forward to interview.
Code of Practice	The Health Service Executive will run this campaign in compliance with the Code of Practice prepared by the new Commissioners for Public Service Appointments (CPSA). Codes of practice are published by the CPSA and are available on www.careersinhealthcare.ie in the document posted with each vacancy entitled "Code of Practice, Information for Candidates'.

The reform programme outlined for the Health Services may impact on this role and as structures change the job description may be reviewed.

This job description is a guide to the general range of duties assigned to the post holder. It is intended to be neither definitive nor restrictive and is subject to periodic review with the employee concerned.

HEALTH SERVICES EXECUTIVE

Terms and Conditions of Employment
Professionally Qualified Social Worker

Tenure	The appointment is whole-time and pensionable. Appointment as an employee of the Health Service Executive is governed by the Health Act 2004 and the Public Service Management (Recruitment and Appointment) Act 2004. *Amend locally as appropriate.*
Remuneration	The Salary scale for the post is: EURO €42,756 – 44,884 – 47,012 – 49,141 – 51,268 – 53,394 – 55,524 – 56,634
Working Week	The standard working week applying to the post is: *to be filled in locally*
Annual Leave	The annual leave associated with the post is: *to be filled in locally*
Superannuation	All pensionable staff become members of the pension scheme.
Probation	Every appointment of a person who is not already an officer of the Health Service Executive or of a Local Authority shall be subject to a probationary period of 12 months as stipulated in the Department of Health Circular No.10/71.
Age	Age restrictions shall only apply to a candidate where he/she is not classified as a new entrant (within the meaning of the Public Service Superannuation Act, 2004). A candidate who is not classified as a new entrant must be under 65 years of age.
Health	A candidate for and any person holding the office must be fully competent and capable of undertaking the duties attached to the office and be in a state of health such as would indicate a reasonable prospect of ability to render regular and efficient service.
Character	Each candidate for and any person holding the office must be of good character.

HEALTH SERVICES EXECUTIVE

Terms and Conditions of Employment
Title of Post Speech & Language Therapist Staff Grade

Tenure	The appointment is whole-time, permanent and pensionable. Appointment as an employee of the Health Service Executive is governed by the Health Act 2004 and the Public Service Management (Recruitment and Appointment) Act 2004.
Remuneration	The Salary scale for the post at 1.6.07: Euro 38,066 – 39,341 – 40,420 – 41,538 – 42,643 – 43,777 – 44,904 – 46,031 – 47,218 – 48,466 – 49,713 – **50,712 LSI**
Working Week	The standard working week applying to the post is: 35 Hours per week
Annual Leave	The annual leave associated with the post is: To be confirmed by Line Manager
Superannuation	All pensionable staff become members of the pension scheme.
Probation	Every permanent appointment of a person who is not already a permanent officer of the Health Service Executive or of a Local Authority shall be subject to a probationary period of 12 months as stipulated in the Department of Health Circular No.10/71.
Age	Age restrictions shall only apply to a candidate where he/she is not classified as a new entrant (within the meaning of the Public Service Superannuation Act, 2004). A candidate who is not classified as a new entrant must be under 65 years of age.
Health	A candidate for and any person holding the office must be fully competent and capable of undertaking the duties attached to the office and be in a state of health such as would indicate a reasonable prospect of ability to render regular and efficient service.
Character	Each candidate for and any person holding the office must be of good character.

Validation of Qualifications

Certain grades of staff holding a qualification obtained outside the Republic of Ireland may not be employed in the Irish Health Services unless the qualifications obtained have been validated / registered by the designated authority or appropriate professional body.
A list of grades requiring validation / registration together with the names and addresses of the relevant body is set out below.

Medical
Medical Council
Lynn House
Portobello Court
Lower Rathmines Road
Dublin 6
Tel: +353 (0) 1 496 5588
Email: medicalcouncil@mcirl.ie

Physiotherapist
Irish Society of Chartered Physiotherapists
Royal College of Surgeons in Ireland
123 St. Stephen's Green
Dublin 2
Tel: +353 (0) 1 402 2148
Fax: +353 (0) 1 402 2160
Email: info@iscp.ie
www.iscp.ie

Social Worker
National Social Work Qualifications Board
8-11 Lower Baggot Street
Dublin 2
Tel: +353 (0) 1 676 6281
Fax: +353 (0) 1 676 6289
Email: nswqb@nswqb.ie
www.nswqb.ie

Occupational Therapist
Speech & Language Therapist
Occupational Therapist
Speech & Language Therapist
Professional Education
Health and Social Care Professionals
Health Service Executive
HR Directorate,
Merlin Park,
Galway.
Eileen Walsh - eileen.walsh@mailn.hse.ie
Phone no 091 775317
Annette Lyons - annette.lyons@mailn.hse.ie
Phone no 091 775094
Fax no 091 775863

Nursing
An Bord Altranais
18-20 Carysfort Avenue
Blackrock
Co Dublin
Tel: +353 (0) 1 639 8500
Fax: +353 (0) 1 639 8515
Email: admin@nursingboard.ie
www.nursingboard.ie

Care Flows

Induction Pack – welcome to the UK

February 2008

Centre for Social Work Research/ Institute for Health and Social Care Research
Allerton Building
Frederick Rd
Greater Manchester
M6 6PU

John Sudbery: (0)161 295 2053 Prof Steven Shardlow: (0) 161 295 245

The Care Flows project

In four western European countries (UK, Ireland, Netherlands and Germany) The Care Flows project analyses workforce demand and supply in health and Social Care. Its purpose is also to lessen the barriers to workforce mobility.

This is an information pack for people who are thinking of working or studying in the health and social care sector in Great Britain. It contains

- an outline of the organisation of health and social care in Great Britain
- information about careers and jobs in medicine, nursing, health care professions and social work
- some practical information about living and working in the UK
- information and contact points about registration for people wishing to work or study these professions in the UK

The Health and Social Care systems in the UK

The principles of the *National Health Service* (NHS) in the UK are that it provides health care free at the point of delivery "from the cradle to the grave". Treatment is determined by clinical need. Practical advice about obtaining health advice and treatment is given in section 5 below.

Social Care has never been provided free as of right, although since the greater part of its users have been in poverty, issues of payment did not figure prominently until the last two decades. Unlike the National Health Service, the organisation of social care has traditionally been located at local government level.

The UK population is nearly 60 million, and to provide for them, the National Health Service employs 1.3 million staff, 1.07 million fulltime equivalents. Since many functions (such as catering, cleaning, building maintenance) are contracted out to private firms, the health service provides employment to numbers of citizens

significantly in excess of this. The NHS is the largest organisation of any kind in Europe, and the third or fourth largest employer in the world. Private healthcare providers also operate in the UK, sometimes providing services to the NHS under contract. The budget for the health service this year will be over one hundred thousand million pounds (approx 150.000 million euros)

Family doctors, like dentists, are self-employed professionals who contract with the NHS. Hospital Consultants (senior medical specialists) are employees of the health service (but are allowed by contract to take private patients).

Scotland and Wales have devolved administrations – the Scottish Parliament and the welsh Assembly. In these countries, the NHS is the responsibility of the devolved administration. Developments which have focussed attention on the different directions being taken in the countries include: in Scotland, social care (for example residential or domiciliary care) is free of charge and in Wales there is no charge for medications (in England, this is one area in which the citizen pays a standard fee towards the cost).

About 922,000 people are employed in the social care sector, and a further (estimated) 650,000 NHS staff are employed in "social care" responsibilities. There are central Inspection and standards bodies in each country in the UK, but the delivery of social care is the responsibility of Local Government in conjunction with numerous private providers.

Structure. The Department of Health has political responsibility for the Health Service. Citizens normally gain initial health care and advice through "primary care". There are 152 Primary Care Organisations ("Trusts") responsible for overseeing family community services. They obtain further treatments and services from 290 provider units ("Trusts"). These include hospital trusts (operating through hospitals, treatment centres and specialist care in about 1,600 hospitals), NHS Ambulance Services Trusts, NHS Care Trusts and NHS Mental Health Services Trusts.

The NHS provides a simplified picture of its current structure, with clickable links, at http://www.nhs.uk/England/AboutTheNhs/Default.cmsx. (Fig 1).

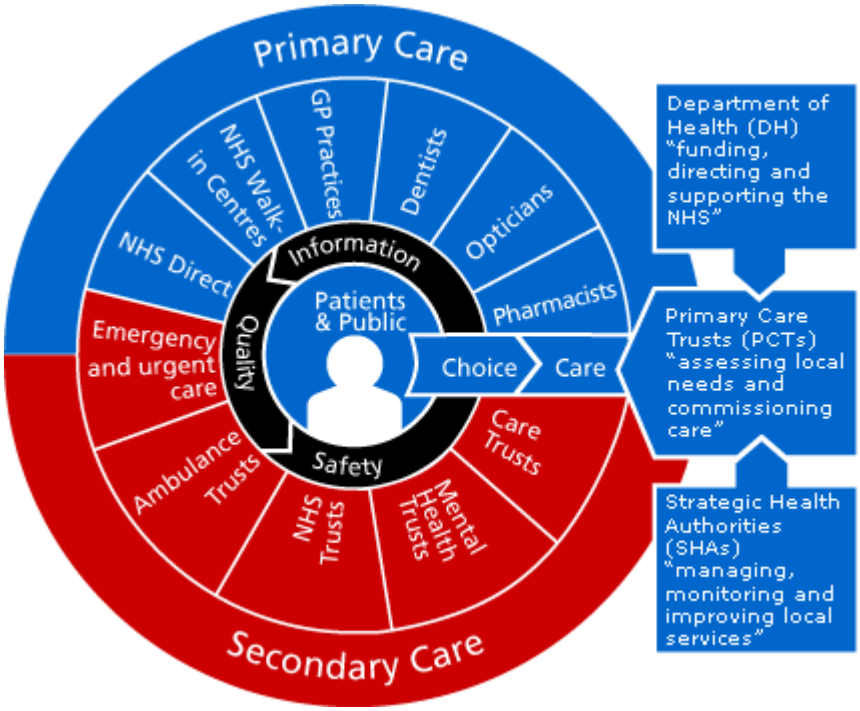


Fig 1 Government diagram of the structure of the NHS

In the National Health Service, some competitive and quasi-market features are combined with centrally set targets and performance management.

Social care. The duties of local authorities include:

- a duty to assess the needs of adults in need of social care,
- responsibilities for the care and protection of children,
- duties to provide services for children in need, and
- roles in relation to people who are a danger to themselves or others – through the mental health system, for example, or youth offending services.

For adults, many services are provided by independent providers (private, voluntary and not-for-profit). For children and families, there is a significant presence of the voluntary sector alongside the local state services, but the use of private providers is not as widespread as in adult services. There is an increasing move to "direct payments" – in which the *employer o*f care staff is the individual service user, although the finance will come through local Government.

Sources of Further information

Further information about the health service in the UK is available from:

NHS England (2007) *About the NHS*

http://www.nhs.uk/England/AboutTheNhs/Default.cmsx

NHS Wales (2007) *Health of Wales Information Service* http://www.wales.nhs.uk/

NHS Scotland (2007) S*cotland's Health on theWeb* http://www.show.scot.nhs.uk/

Further information about social care in the UK is available from:

- General Social Care Council
- The Care Council for Wales
- The General Social Care Council
- The Northern Ireland Social Care Council
- The Scottish Social Services Council

http://www.gscc.org.uk/Home/

Relevant information about the social care workforce in the UK:

GSCC (2007) *Annual Report.* London: General Social Care Council

Scottish Executive (2006) *Staff Of Scottish Local Authority Social Work Services, 2005.* Scottish Executive: A National Statistics Publication

Skills for Care (2005) *Skills Research and Intelligence 2nd Annual Report*: *The State of the Social Care Workforce, 2004*

Experian/Skills for care (2007) *Overseas workers in UK social care*

National Government, Local Government and third sector organisations

National government	**Local government**	**Third sector: private and not-for-profit, voluntary organisations**
Each area elects one person to represent its interests in Parliament. The London Parliament is the parliament for the whole United Kingdom (England, Wales, Scotland and Northern Ireland), and also for all English matters. Some powers, including health and social care, are devolved to the national administrations of Scotland (the Scottish Parliament), Wales (the Welsh Assembly) or Northern Ireland. Matters such as	Local government is elected by local people only. Local Government is responsible for a number of services, often organized through "Council Departments". These services are heavily inspected and controlled by central government. They include housing, education and social services. Local authorities should offer advice and information free of charge.	1 Private enterprises, for example, private schools and hospitals, many nursing homes for older people 2 Voluntary agencies are independent of national or local government. They do not work to make profit. 3 There are other not-for-profit organisations, which are neither charities nor state agencies

defence, immigration, health, are administered through Departments of national Government. Offices of these Departments may be in any location in the United Kingdom.

Jobs in UK Health and Social Care

(a) Careers in the health service

Information about careers in the National Health Service (including, but not only, work as a doctor, nurse, midwife, radiographer or therapist): http://www.nhscareers.nhs.uk/

Out of hospital As more and more healthcare is being delivered in patients' own homes, jobs that had previously been done in a hospital setting are now being done in the community. A community-based career attracts all the same benefits as a hospital-based one.

Pay and benefits. For all staff except doctors and dentists, the standard working week is 37.5 hours; holiday entitlement is 27 days a year, plus eight general and public holidays, rising to 33 days after 10 years of service. Every new employee automatically becomes a member of the NHS Pension Scheme, one of the most generous and comprehensive in the UK. Further details from www.nhscareers.nhs.uk/list/payandbenefits
you can order a copy of this year's pay leaflet by calling helpline on 0845 60 60 655, or emailingadvice@nhscareers.nhs.uk

Doctors. Information about careers is also available from *http://careers.bmj.com/careers/advice/advice-overview.html*
The British Medical Journal (BMJ) sponsors careers fairs for doctors of all specialities: http://careersfair.bmj.com/en/1/national.html

*(b) Job vacancies in the health service***.** Each Trust (the operational units of the NHS) is responsible for employing its own staff. The following website is used for job

advertisements by almost all the Trusts in the NHS. You can search by job type, location or salary. On any day there are over 5,000 jobs listed on the site. As an applicant, you can search and apply on-line for vacancies, and you can also register with the site and be notified by email when matching vacancies arise.
http://www.jobs.nhs.uk/

Flexible contracts Getting a permanent job is not the only way to work in the NHS. A temporary/flexible contract will allow you to gain valuable experience, perhaps with a number of different trusts. Talk to your local trust to see if in-house bank work is available in your area.

Independent sector. Healthcare professionals can work for independent providers, with or without NHS experience.

(c) Careers in social work
Information about careers in social work and social care:
http://www.socialworkandcare.co.uk/

http://www.prospects.ac.uk/cms/ShowPage/Home_page/Explore_types_of_jobs/Types_of_Job/p!eipaL?state=showocc&pageno=1&idno=88

(d) Job vacancies in the social work and social care
General advice and information about finding jobs in social work and social care:
http://www.socialworkandcare.co.uk/socialcare/jobs/index.asp

All social care vacancies currently listed on the official Local Government job site, LGjobs.com, as well as Social Care vacancies with other Public Sector and Not-for-Profit organisations can be found on the following website:
http://www.jobsgopublic.com/socialcarecareers

As the "socialworkandcare" website advises you, however, there are many other jobs in projects and organisations which are not listed on this site. The "socialworkandcare" site has a useful set of links to online resources, and advises you where else to look, particularly in the local press and *Community Care* magazine.

This is the major magazine of the social care sector. Its website contains a wide range of information about current issues in social care, as well as jobs pages.
www.community-care.co.uk

Compass www.compassjobsfair.com is the careers guide distributed to individuals who work, and want to work in social care. It is a careers companion that assists with job hunting, training and professional development. It is for anyone who wants to do part-time voluntary work to those looking to move into senior management positions.

Joint health and social care jobs: Children's services, learning disabilities and social care, amongst other services, are often delivered through partnerships between the NHS and a local authority. Although you may be employed by local government you would still be using your skills and delivering healthcare to patients.

4. Coming to the UK to work

EU citizens have the right to work and live in the UK. The following government website sets out the rights and responsibilities of citizens of the European economic Area when they are in Britain. This webpage also explains how to obtain a registration certificate or residence card to confirm your rights under European law.
http://www.bia.homeoffice.gov.uk/eucitizens/

Healthcare. EU citizens can be treated on the NHS, provided that they have an E111 form. This must be signed and stamped *before* they leave their home country. Private treatment can also be purchased from organizations such as BUPA.

Immigration advice can be obtained from the Immigration Advisory Service, helpline (0)207 378 9191***Housing for NHS staff:***
www.housing.nhs.uk The NHS is made up over 450 different organisations, all with differing needs from their workforce. Some of these offer financial help to make buying or renting a home more affordable. Schemes vary from assistance with rental costs to offering interest-free loans for home purchase

Currency . Currency in the UK is pounds sterling (£) and pennies (pence or p). £1 = 100p. Some major stores also accept euros.

Banking. There are numerous retail banks in the UK. Some of the best known, which have branches in most towns, offer accounts suitable for most family and personal purposes, offer telephone and internet banking, and allow cash to be withdrawn through cashpoints readily available throughout the country, are: *HSBC,* Barclays Bank, Cooperative Bank, Natwest, Lloyds TSB, HBOS (Halifax/Bank of Scotland).

"Building Societies" are a further group of banks which were originally set up as cooperative (not-for-profit, mutually owned) societies to enable citizens to save money and buy their own homes. These are regarded as very safe institutions in which to keep savings. They are the most widely used institutions for obtaining loans to buy a house. The largest of these "mutual" banks is the Nationwide Building Society, but there are many others, often with place names indicating their origins: Norwich and Peterborough Building Society, Cheshire Building Society, Yorkshire Building Society and many more.

A number of "Building Societies" converted to become private commercial banks, including: Alliance and Leicester, Halifax (part of HBOS), Abbey, and Bradford and Bingley.

In general, cash machines with the name of a bank are usually free for cashcards (not credit cards); but increasingly there are cash machines owned by independent providers which charge a fee for withdrawal. If there is a fee, this will always be announced on the screen.

There is a wide choice of credit card accounts and savings accounts outside these "high street banks". Guides to best buys are available on websites such as http://www.moneysupermarket.com/ or http://www.fool.co.uk/

Driving . In the UK, vehicles drive on the left of the road. If you are used to driving on the right, be expecially careful when turning right. Advice about driving, speed limits, laws, etc in English and the major European languages:

http://www.thinkroadsafety.gov.uk/advice/keepleft.htm

Before driving any vehicle (car, motorbike, van etc) in the United Kingdom you should check that you meet all of the legal requirements which apply (a) to the driver and (b) to the vehicle; and that you are aware of the correct procedures, which may be very different from your home country. Detailed information about all aspects of driving in England, Scotland and Wales (Great Britain) can be found on the website of the Driver and Vehicle Licensing Authority (DVLA) at www.dvla.gov.uk . For Northern Ireland: www.dvlni.gov.uk .

If you hold a valid driving licence from an EU country, you can drive for as long as your licence remains valid. Alternatively, you can apply at any time to exchange your licence for a British one. If you wish to continue driving in the UK after your licence expires, a British driving licence must be obtained. The information leaflet INF38 'Driving in Great Britain (GB) as a visitor or a new resident' explains the current rules and is available from the DVLA website at <www.dvla.gov.uk/forms/onlineleaflets. htm>. For driving in Northern Ireland, see the website of Driver and Vehicle Licensing Northern Ireland at

Taxation. For information about the taxation of people coming to live or work in the UK, see *http://www.hmrc.gov.uk/pdfs/ir20.htm* The general introduction to this document begins as follows: "Broadly, the United Kingdom (UK) charges tax on income arising in the UK, whether or not the person to whom it belongs is resident in the UK; on income arising outside the UK which belongs to people resident in the UK; and gains accruing on the disposal of assets anywhere in the world which belong to people resident or ordinarily resident in the UK.

For most health or social care staff, tax is deducted by their employer and sent to the tax authority. The tax year runs from 1 April to 31 March.

Tax becomes payable after earnings of £100.00 weekly or £435.00 monthly . The current rates of tax are: 10% on earnings up to £2,230 (starting rate) 22% from £2,231 to £34,600 (Basic rate) and 40% over £34,600 (higher rate)

There is a second charge, described as ”National Insurance Contributions”, related to the state health and employment benefits. These begin at the same level of earnings as the tax system.

5. Medical and other Health Professions in England and Wales.

Total numbers of NHS staff, 2006	
Headcount	1,333,100
Full-time equivalents	1,071,200
Qualified doctors	122,000
Qualified nurses	404,000
Professions allied to medicine/other qualified therapists (at 2004)	129,000

Figure 2: National Health Service Workforce Source: NHS Staff 1995-2005.

5.1 Doctors

Doctors must be registered with the General Medical Council (GMC) to practise medicine in the UK. Application form for Doctors trained in the EU who wish to register with the General Medical Council (GMC): http://www.gmc-uk.org/doctors/registration_applications/join_the_register/s3_p1.asp (or follow the links from http://www.gmc-uk.org/register/index.asp)

5.2 Nurses and allied health professions

Entry to the nursing and other professions in the UK is through a 3 year degree (BA) programme, with standards specified by the Nursing and Midwifery Council or the Health Professions Council.

Compulsory registration. Nursing is a protected title and registration is compulsory. The health professions with protected titles are listed in the table below.

PROFESSION	PROTECTED TITLE
Arts therapist	Art psychotherapist
	Art therapist
	Dramatherapist
	Music therapist
Biomedical scientist	Biomedical scientist
Chiropodist / podiatrist	Chiropodist
	Podiatrist
Clinical scientist	Clinical scientist
Dietitian	Dietitian
	Dietician
Occupational therapist	Occupational therapist
Operating department practitioner	Operating department practitioner
Orthoptist	Orthoptist
Prosthetist / orthotist	Prosthetist
	Orthotist
Paramedic	Paramedic
Physiotherapist	Physiotherapist
	Physical therapist
Radiographer	Radiographer
	Diagnostic radiographer
	Therapeutic radiographer
Speech and language therapist	Speech and language therapist
	Speech therapist

Source: http://www.hpc-uk.org/aboutregistration/protectedtitles/

It is a criminal offence to use a protected title without registration. Information and application forms for registration from the Councils' websites:
Nursing: http://www.nmc-uk.org/aSection.aspx?SectionID=6
Health care professions: http://www.hpc-uk.org/

A period of rapid expansion in the NHS nursing workforce led to extensive recruitment from overseas (by 2008, this situation has changed, and internal training and workforce supply is more in balance). The place of training of initial registrations on the nursing register is shown in figure 3.

	Total registrants	Training source			
		UK	Int'l	%UK	%int'l
England TOTAL	503522	476044	27478	94.5	5.5
Wales	33281	32022	1259	96.2	3.8
Scotland	66817	65935	882	98.7	1.3
Northern Ireland	21645	20591	1054	95.1	4.9

Fig 3. nursing registrants in UK by place of training

6. Social Work and other Social Care

Compulsory Registration of social workers. In the UK, "Social worker" is a protected title which may only be used by those registered with the General Social Care Council. There is a separate register of social workers for each country (England, Ireland Scotland and Wales). The Council is in the process of introducing registration for other social care workers. Information and application forms for registration: *http://www.gscc.org.uk/Home/*

In relation to adults, roles include working with people with mental health problems or learning difficulties in residential care; working with offenders, by supervising them in the community and supporting them to find work; assisting people with HIV/AIDs and working with older people at home helping to sort out problems with their health, housing or benefits.

With children and their families, roles include providing assistance and advice to keep families together; working in children's homes; managing adoption and foster care processes; providing support to younger people leaving care or who are at risk or in trouble with the law; or helping children who have problems at school or are facing difficulties brought on by illness in the family.

The relevant government Department describes social work as follows:

> *Social workers form relationships with people. As adviser, advocate, counsellor or listener, a social worker helps people to live more successfully within their local communities by helping them find solutions to their problems. Social work also involves engaging not only with clients themselves but*

their families and friends as well as working closely with other organisations including the police, NHS, schools and probation service.

There is a specific status associated with the job title "social worker". Social workers are professionally qualified staff who assess the needs of service users and plan the individual packages of care and support that best help them. Becoming a social worker involves taking an honours degree in social work and registering with the General Social Care Council. Almost all social workers start their careers with experience in social care.

(source: Department of Health (2006) What is Social Work. online at http://www.socialworkandcare.co.uk/socialwork/what/index.asp Also Booklet "social work")

There are about 110,000 registered social workers in the UK. In England. 78% were employed by local authorities (including agency staff), eight percent in independent sector care homes and domiciliary care, 13% by other public and voluntary sector employers

Social work training and qualifications. UK social work training is by BA honours degree (at 78 Universities or affiliated Colleges) or Masters Degree (at 41 Universities). The professional competency requirements are the same for both and are set out by the General Social Care Council. The academic benchmarks differ between the two levels.

UK social work training includes a requirement of 200 days of supervised and assessed practice. It may be this requirement that a person who qualified elsewhere in the EU does not yet meet. They will have to complete them before they become eligible for registration. Details about these procedures, and advice for workers coming from the EU are given on this page of the Council's website:
http://www.gscc.org.uk/The+Social+Care+Register/How+to+register/Workers+from+abroad/I+am+a+national+of+an+EU-EEA+country+or+Switzerland/
(or follow the links from the GSCC homepage)

Overseas social workers. In England (we do not have figures for internationally qualified social workers in Scotland, Wales or Ireland), there are now more than 70,000 registered and qualified social workers. Figure 4 shows the number of home-trained and internationally qualified workers

Social workers in England	**Number**
UK qualified registrants	67,000
Internationally qualified registrants	5,000
SW students registrants	10,500

Fig 4: Registrations with the General Social Care Council in England

The data shows the country of qualification (not country of citizenship, since students come from abroad to study social work in the UK). Figure 5 below shows the countries which provided the largest number of non-UK registrants, and also the number of registrants who qualified in EU countries.

Country of Qualification	Number	Country	Number
Most international registrations:		EU registrations:	
Australia	864	Germany	186
Canada	327	Romania	163
India	439	Netherlands	56
NZ	230	Spain	58
South Africa	937	Poland	48
USA	574	Sweden	37
Zimbabwe	249	Ireland	24
		Denmark & Hungary	18 each
		Greece	17
		Bulgaria	14
		Czech R	13
		Finland	12
		Austria & Belgium	11 each
		Italy, Norway, Portugal	10 each
		Others (inc France)	36

There is a (changing) system of post qualification training in the UK, and specialist training of this sort is an advantage or a prerequisite for some social work responsibilities.

All Social Care (social work and non-social work):

Social Care Employers. There are an estimated 31,000 social care providing organisations in England. This includes local authorities, various parts of the NHS, and independent (private + voluntary) sector organisations. Adding childcare brings this total to 55,000. There were 13,000 people individually buying social care via direct payments. The majority of social care providers are in the private sector.

There were about 21,000 registered care homes for adults. The majority (71%) are privately owned and 17% owned by voluntary sector organisations, Nearly four-fifths (79%) of the 19,500 adult care homes are registered to provide care only, the rest to provide care with nursing.

Just over 2,000 children's homes were registered with the CSCI, of which 59% were privately and 34% local authority owned. A total of 232 independent and 143 local authority fostering agencies, 62 voluntary and 148 local authority adoption agencies, and 35 residential family centres were also registered. Around 34,900 childcare-providing organisations – day nurseries, playgroups, out-of-school & holiday clubs and crèches – were registered with at September 2004,

Guidance about careers and jobs in social care is included in section 2(d) above

Living, working or studying in the Netherlands?

Zuyd University
CESRT Comparative European Social Research and Theory
This report is part of the Care Flows Project

Living, working or studying in the Netherlands?

I Just Landed Guide

Getting used to living in a new country is always a challenge. The Just Landed Guide is designed to help you deal with the day-to-day challenges of living, working or studying in the Netherlands. It is full of useful information and step-by-step guides on how things work and how to survive in Holland.

Just Landed Guide: Health

One of the most important things when going abroad is to make sure that you are covered in case of accidents or illness. Our health guide provides information on health insurance, hospitals, doctors and pharmacies.

Healthcare The medical system

Back to Contents Page

In the Netherlands, the government is not in charge of the day-to-day management of the healthcare system. Private health suppliers are responsible for the provision of services in this area. The government is responsible for the accessibility and quality of the healthcare.

Since January 1st 2006 there is a new healthcare insurance system in the Netherlands and you should be aware of the requirements before you leave for the Netherlands.

If you are living in the Netherlands or you are paying income-tax in the Netherlands you are required to purchase a health insurance at a Dutch insurance company. In the past there was a difference between public and private healthcare in the Netherlands. This however has been changed and everybody is now required to purchase basic health insurance.

The basic package

The government has put together a basic package that covers about the same as the previous system. Health insurance companies are legally obliged to offer at least this basic package and can not reject anybody who is applying for it. With the basic package you are covered for the following:

- Medical care, including services by GP's, hospitals, medical specialists and obstetricians
- Hospital stay
- Dental care (up until the age of 18 years, when 18 years or older you are only covered for specialist dental care and false teeth)
- Various medical appliances
- Various medicines
- Prenatal care
- Patient transport (e.g. ambulance)
- Paramedical care

You can decide to purchase additional insurance for circumstances not included in the basic package. However, in this case insurance companies can reject your application and they have the right to determine the price.

If you are working for a company in the Netherlands, consider purchasing a collective health insurance policy, this can be a good option as it is often cheaper. However,

you are not obliged to buy such a policy when it is offered to you and your employer is not obliged to make you an offer. Ask your employer about the possibilities.

Fees of the basic package

The fees for the basic health insurance package are annually determined by the health insurance companies and are normally approximately €95 per month. Although the Ministry of Health (*Ministerie van Volksgezondheid, Welzijn en Sport)* determines a standard premium, the insurance companies determine the additions fee you will have to pay in the end by charging a certain rate and a no-claim charge. It is with these additional fees that the insurance companies compete with each other. There are various health insurance companies and a new law will make it easier to change between health insurance companies.

If you are required to purchase health insurance and are earning a salary, you will also pay a supplementary contribution from your income (rated 6.5% up to the first €30,000 of earnings; 4.4% for self-employed individuals).

The fees of health insurance companies can differ so it is advisable to compare the various prices. To help you with this choice, you can go to: www.kiesbeter.nl.

For some, healthcare in the Netherlands has become more expensive as a result of the changes. The Dutch government compensates these cases by offering a care grant (*zorgtoeslag*). The Tax Administration (*belastingdienst*) determines if you are eligible by examining your income. Foreigners are also entitled to this grant if they qualify.

Children under the age of 18 years do not have to pay any health insurance and are insured for free for the basic package of health care.

Basic health insurance for foreigners

The length of your stay is important in determining whether or not you are required to purchase health insurance in the Netherlands. People staying temporarily in the Netherlands are not required to purchase health insurance.

If you use Dutch medical services during your stay, make sure that you always keep all the bills, prescriptions and receipts. This can save a lot of trouble on your return to your home country. If you are an EU citizen, you should apply for a European Health Insurance Card (EHIC) through your home national health insurance agency or company. This card makes it easier to access health care in European countries and means you either do not have to pay for emergency treatment or you get healthcare charges refunding more quickly.

Foreigners becoming long-term residents in the Netherlands and/ those earning a salary in the Netherlands are required to purchase a basic insurance from a Dutch health care insurance company. Keep in mind that if you do not purchase a health insurance you may be fined.

Foreigners who settle in the Netherlands and remain receiving an income abroad are not always required to purchase a Dutch health insurance. This is determined by the length of your stay. When your stay is temporary you are not required to purchase a health insurance.

When you stay in the Netherlands is not temporary, you are required to purchase a health insurance. However, rules and regulations about the durability of your stay remain unclear. Generally you can use the following rule of thumb:

- A person who stays in the Netherlands for a period of less than one year is assumed to be on a temporary stay;
- A person who stays in the Netherlands for a period between one and three years is assumed to be on a long-term stay, but this will be accepted as temporary when the person can prove otherwise;
- A person who stays in the Netherlands for a period for more than three years is assumed to be on a long-term stay.

In all cases it will be examined whether the center of your civil and social life is in the Netherlands. This depends on your legal (e.g. residency permit), financial (income, tax duty, etc.) and social (membership of a club, family, etc.) situation.

If it is still unclear whether or not you are required to purchase basic health insurance you should contact the following institutions:

De Belastingdienst (Tax Authorities): www.belastingdienst.nl
Ministerie van Volksgezondheid, Welzijn en Sport (Ministry of Health): www.minvws.nl
Sociale Verzekeringsbank (Social Insurance Bank): www.svb.nl
For more information about the health care system, go to: www.denieuwezorgverzekering.nl.

How to access healthcare

Back to Contents Page

Foreigners are able to use the Dutch healthcare system without many problems. Almost all doctors (Arts or Huisarts) will speak at least English and probably 1 or 2 other foreign languages. Before traveling to the Netherlands you should be well aware whether you are required to have a basic health insurance covering health costs in the Netherlands.

Emergencies

You are lawfully required to have a health insurance covering any health expenses that you make in the Netherlands. However, in the event of an emergency, do not worry about insurance issues and just head directly to the nearest emergency room (*eerste hulp*). Under Dutch law, any health organization - public or private - is required to treat patients in an emergency situation regardless of their insurance status.

Use the general emergency number 112 if you need an ambulance.

Since January 1st 2006 you are lawfully required to identify yourself with official identification before you are treated. Everybody who is older than 14 years (if you are younger than 14 years of age a mention in your parent's passport is sufficient) will need to provide this identification to use the services of the medical staff. If you are rushed to the hospital in an emergency, and you can't identify yourself, you will have to do so within two weeks of your hospital visit.

Pharmacies and drugstores

In the Netherlands there are 2 types of pharmacies; the apotheek (chemist) and the drogist (drugstore).

Prescriptions should be taken to the apotheek. You can get the cost of prescribed medicines prescribed by the doctor refunded by your insurance company. Some medicines will not be refunded by your insurance company. We advise you to ask your doctor, pharmacy, or insurance company beforehand if the medicine will be refunded. You can go to the drugstore for products that do not need a prescription.

Source: Justlanded Netherlands http://www.justlanded.com/english/netherlands

II Information on Health Care Professions

The NVZ Dutch Hospitals Association

Back to Contents Page

About the NVZ

The NVZ Dutch Hospitals Association (Nederlandse Vereniging van Ziekenhuizen) is the organisation of the Dutch hospital sector. This sector comprises a number of organisations offering a coherent package of specialist medical care.

Objectives, duties and members

NVZ primarily focuses on the collective representation of its members' care-related, social and economic needs. These members include all general hospitals, as well as non-affiliated institutions in the Netherlands, such as asthma centres, audiological centres, cancer centres, radio-therapeutic institutes, convalescence centres and dialysis centres. In addition, NVZ has various associate members, including a number of hospitals in Surinam, the Netherlands Antilles and Aruba. They number around 170 in all.

It is NVZ's objective to create frameworks for its members that allow hospitals to respond flexibly to changes in the demand for care. A considerable part of the association's activities therefore focuses on helping create conditions that are compatible with the sector. NVZ achieves this objective by means of policy development, and by lobbying and consulting with relevant parties in the field. The association also supports individual members by providing information regarding general and specific topics concerning the hospital sector. Members also have the opportunity to individually submit issues to NVZ for advice, and a General Meeting of Members is held at least twice a year. NVZ also organises discussion meetings for its members.

Management structure and administrative structure

The association has a management structure and administrative structure that is in line with NVZ's duties. The management is supported in its activities by a number of advisory committees, including two permanent committees dedicated, respectively, to employment terms and to management and funding. The administrative bureau is headed by a director, who also serves as chair of the management team. NVZ administrative bureau comprises two policy departments: Healthcare and Social Affairs. The bureau also includes the service units Administrative and Management Affairs, Communications, Human Resources, Finance, and General Services. NVZ employs a staff of roughly 55 people.

NVZ membership

NVZ invites membership from organisations offering a coherent package of specialist medical care. Such care is defined as curative treatment and other types of specialist medical care for the chronically and terminally ill. By a coherent package we mean

that, within an organisational context, the member is able to offer the full range of diagnostics, treatment, nursing and care.

Representation

NVZ is represented by a number of consultative and advisory bodies. NVZ managers and employees sit on the Board for Healthcare Rates (College Tarieven Gezondheidszorg/Zorgautoriteit i.o., or CTG/ZAio), and the Board for the Development of Healthcare Services (College Bouw Ziekenhuisvoorzieningen, or Bouwcollege), and the Board for Health Insurance (College voor Zorgverzekeringen, or CvZ.) These are decision-making bodies with respect to regulations regarding the hospital sector. The NVZ representatives try to ensure that these laws and regulations remain manageable for the hospitals.

Source: http://www.nvz-ziekenhuizen.nl/content.jsp?objectid=12860

IDW- Evaluation of Foreign Credentials

Back to Contents Page

What is credential or diploma evaluation?

You earned your diploma in another country and want to work or continue your studies in the Netherlands. Or you work for an organization that is regularly confronted with foreign diplomas. In any case, you need to know what a particular credential is worth in terms of the Dutch system.
In the Netherlands, two centres of expertise work together on evaluating foreign diplomas (IDW): Nuffic and Colo. They set up an Information Centre for Credential Evaluation (IcDW). This site is the virtual window for IDW.

How can we help you?

You have a foreign diploma and you want to study in the Netherlands

Who should you contact?
You should first contact the institute at which you are going to study. They will arrange for your diploma to be evaluated.

Costs: Ask the institute if there are any costs related to the evaluation. Mostly, if diplomas are evaluated at the request of one of the regularly subsidized educational institutions, there is no charge. But if the request comes from a private organization or individual, a fee is charged.

You have a foreign diploma and you want to work in the Netherlands
You are not employed and are looking for a job in the Netherlands
If you are unemployed and are looking for a job in the Netherlands, you should go to the nearest Centre for Work and Income (*CWI = Centrum voor Werk en Inkomen*).

The CWI will request a diploma evaluation on your behalf and tell you which documents you will need to supply. Click here for more information about CWI.
Costs: the CWI will pay the fees for the evaluation.

You are already employed but want to find a job in the Netherlands
If you already have a job in a non-regulated profession and are looking for another, you can apply to the IcDW for a diploma evaluation. You can order an application form here.
Costs: € 115. You have to pay this fee yourself.

You are looking for a job in a regulated profession
If you wish to practise a regulated profession in the Netherlands, you will have to get in touch with the official body that grants admission to the profession in question. You can contact the Dutch Information Centre for the Recognition of professional Qualifications (IRAS) to inform whether your profession is regulated in the Netherlands and, if so, which organization you need to contact. Or you can visit the following website if you need more information about practising a regulated professsion in the Netherlands: www.beroepserkenning.nl.
If you want to become a teacher in the Netherlands, please check the following website: www.leraarin.nl
Costs: you have to pay any fees relating to the evaluation yourself.

You have a foreign diploma and you are interested in what it is worth in the Netherlands. You don't know yet if you want to work or study in the Netherlands.
Who should you contact?
You can request a diploma evaluation at a Centre for Work and Income (CWI). See the CWI site for more information.
Costs: If your diploma is evaluated through a CWI, there is no charge.

Source: http://www.idw.nl/index2.html

Colo, Association of Centres of Expertise on Vocational Education, Training and the Labour Market

Back to Contents Page

Since 1954, Colo has been the umbrella organisation of and for the centres of expertise. In this capacity, Colo monitors socially relevant developments and educational and labour market policy at regional, national and international level. The governing body of Colo consists of representatives from the centres of expertise, as well as individuals from employers' and employees' organisations.

Colo initiates and formulates a shared vision and issues recommendations and comments on behalf of the centres of expertise. The centres of expertise are repre-

sented by Colo in respect of national government and other relevant parties. In addition to promoting interests, a further task for Colo is the provision of services in respect of its statutory tasks, both national and international, to its members. Colo also functions as the employers' organisation for the centres of expertise. The mission of the association is to continuously improve vocational education from the perspective of business and industry, nationally and internationally, for example through participation in European networks such as EVTA and ETF.

Source: http://www.colo.nl/?304

Diploma Recognition

Back to Contents Page

Nuffic is one of the largest and prominent knowledge centres in Europe in the field of international recognition of diplomas. We make this knowledge available to Dutch organizations and international organizations through our credential evaluation services.

Nuffic has been designated by the Netherlands Ministry of Education, Culture and Science as the Dutch recognition information centre for two European networks: NARIC and ENIC. We have many years of experience in the field and we work for all organizations that encounter foreign diplomas in the course of their business, such as universities, other higher education institutions, companies and ministries. Nuffic offers the following services and products in the field of credential evaluation:

Evaluation of foreign diplomas (incoming mobility)

Nuffic issues recommendations on the value of higher or secondary education diplomas obtained outside the Netherlands. Where possible, the foreign diploma is compared to a Dutch diploma. As well as evaluating the diploma, we are also able to determine whether a programme or an educational institution is officially recognized. Read more.

Evaluation of Dutch diplomas (outgoing mobility)

Nuffic prepares 'diploma descriptions' for individuals who have been awarded a higher education diploma in the Netherlands, and who wish to work or study abroad. These descriptions provide information about academic qualifications obtained in the Netherlands, and also offer a suggestion on how the qualification should be evaluated in the country in which it is presented. Read more.

Credential evaluation courses

Nuffic is glad to share its expertise with others, and therefore offers two types of courses. These courses are given to clients in the Netherlands and in other countries. The more advanced credential evaluation courses are intended for staff members of educational institutions and companies. The courses can be organized in-

house or at Nuffic's offices in The Hague. An e-learning course in credential evaluation is also available. Read more.

Consultancy and projects

Nuffic's consultancy services focus primarily on credential evaluation for work and further study, i.e. professional and academic recognition. The increased demand for Nuffic's consultancy services is the result of the growing importance of the mutual recognition of qualifications in Europe. Nuffic also conducts projects for businesses and government departments, both in the Netherlands and in other countries. Read more.

Information services

We offer a number of products that provide clients with information about credential evaluation and related subjects. Most of our information is provided electronically so that news and information on the latest developments are always available immediately. The most important sources of our information are our extranet, including a news section and descriptions of foreign systems of education, and a number of dedicated websites such as: www.idw.nl and www.professionalrecognition.nl.

More information

If you need more detailed information on our services and products, please contact Nuffic.

Source: http://www.nuffic.nl/

Central Information Unit on Health Care Professions (CIBG)

Back to Contents Page

The CIBG consists of seven subunits, each of which records information on people who work in health care. The CIBG provides information to the Government and third parties.

Its seven subunits are:

- Health Care Professionals (BIG) Register
- Information and Referral Desk for Foreign Health Care Qualifications
- Declarations of Competence for Foreign Health Care Professionals
- Donor Register
- Pharmacy and Medical Technology Register (FARMATEC)
- Youth Care Registration (central information unit on youth care and sectoral registration unit for youth care)
- Facilities Registers

http://www.minvws.nl/en/organization/chart/diensten_en_instellingen/CIBG/default.asp

What is RIBIZ?

Anyone wishing to work in the healthcare sector in the Netherlands will have to deal with RIBIZ. RIBIZ maintains the BIG register and processes requests for the recognition of foreign qualifications. Anyone, from employer to consumer, can consult the BIG register at RIBIZ. Healthcare providers can register via the site and, once they have been included in the register, they can review their details and generate a confirmation of their registration.

About RIBIZ

RIBIZ stands for Registratie en Informatie Beroepsbeoefenaren in de Zorg (Healthcare Providers Registration and Information). It is a division of the CIBG, an agency of the Ministry of Health, Welfare and Sport which is concerned with all aspects of accreditation and registration of healthcare professionals who are active (or wish to become active) in the Dutch healthcare system.

What do we do?

We administer the registration of healthcare professionals in the BIG-register, doing so on behalf of the Ministry of Health, Welfare and Sport. We also issue a Declaration of Professional Competence to care providers wishing to practise on the Netherlands on the basis of a diploma awarded in another country.

The BIG-register

Further to the requirements of the BIG Act, we maintain a register of over 350,000 healthcare professionals, such as doctors, physiotherapists and nurses. This register provides clarity and certainty regarding the care provider's qualifications and entitlement to practise. Is a certain person registered? Does a doctor specialize in a certain area of medicine? Have any restrictions been imposed upon them? Anyone can consult the register, either online or by telephone.

Declaration of Professional Competence

Care providers holding a foreign diploma must meet a number of quality requirements. For example, their training and any subsequent professional experience must enable them to practise at the same level as a care provider who holds a diploma awarded in the Netherlands. We assess whether a care provider with a foreign diploma is able to meet all quality requirements, and make the relevant official decision on behalf of the minister. If a care provider meets all requirements, he will be issued with a 'Declaration of Professional Competence' which entitles him to apply for full registration.

On this website

RIBIZ.nl presents news and background information about the registration of healthcare professionals in the Netherlands. Care providers can apply for registration using the site, or can view the details of their current registration.

RIBIZ also collects and publishes statistical information about registration, and we provide the opportunity for the public to consult the BIG-register online.

Source: http://www.ribiz.nl/en/

III Useful information for international students

Preparing your stay

We have arranged a checklist so you know what to prepare and when. Be sure to allow plenty of time for preparations. You will need to start planning your stay a year in advance.

Visa and permits

Back to Contents Page

To enter Holland for study purposes, nationals of most countries need a visa. Once in the Netherlands, sometimes a residence permit or a work permit is required. Find out which requirement apply to you and how you go about arranging things.

To enter Holland for study purposes, inhabitants from most countries need a visa. Once in the Netherlands, a residence permit or a work permit is often required. Here you can find out which requirements apply to you and how you go about arranging things.

An entry visa is a sticker placed in your passport at the Dutch embassy or consulate in your own country, but it must be applied for well in advance.

For a stay of up to three months, you might need a ‘short stay visa’ (*Visum Kort Verblijf*), depending on your nationality. If you will be staying for longer than three months, you need a ‘provisional residence permit’ (*Machtiging tot Voorlopig Verblijf*, or *MVV*). This requirement does not apply to citizens of the EU/EEA and Switzerland, the USA, Australia, New Zealand, Canada, Japan, Vatican City, Monaco or South Korea.

Short or long stay

There are three elements which are important to find out which procedures apply to you:

- your nationality,
- the length of your stay and
- your purpose of stay.

The starting point your nationality. The second step is the length of your stay. If are staying for three months or less different rules apply than when you will be in Holland for longer than three months.

We advise you to fill in the Student Visa Wizard first before you read more. This way you can find out which procedures apply to you on account of your nationality and the duration of your stay.

Insurance

Dutch law requires everyone living in Holland to be covered by health insurance. Students must make sure that they have adequate cover.

When you are coming to the Netherlands make sure you are properly insured. There are certain rules concerning your healthcare insurance which you have to comply with. Also it is highly advisable to take out a liability insurance.

Health insurance

Back to Contents Page

Before you come to the Netherlands, make sure that you have made arrangements to be properly insured against the costs of medical treatment. Here you can read which insurance applies to your situation.

There are three healthcare insurance possibilities:

1. You have to take out a Dutch public healthcare insurance.
2. Your insurance policy in your home country covers your stay in the Netherlands.
3. You take out a new or special insurance policy for your stay in the Netherlands.

1. You have to take out a Dutch public healthcare insurance

In certain circumstances, for example when you take on a part-time job or when you do a paid internship, you have to take out a Dutch public healthcare insurance. If this obligation applies to you, you can take out such an insurance with every Dutch public healthcare insurance company. Most schools and employers have a contract with an insurance company which offers a discount. It is worth it to find out if you can join these schemes. The Dutch public healthcare insurance can be rather expensive, but people below a certain income level can receive a financial contribution towards their costs through the Healthcare Allowance (zorgtoeslag). Soon more information will be published here about how to apply for this healthcare allowance.

To find out if the Dutch public healthcare insurance applies to you, read the following factsheet:

Download "Healthcare insurance for international students in Holland" (91 kB).

If you are still unsure whether you are obliged to take out a Dutch public healthcare insurance, you can fill in the form "Do I need statutory basic healthcare insurance?"* and send it to the Social Insurance Bank (SVB), who can clear things up for you.

* please note that the SVB can only tell you whether or not you are taking part in the Dutch social security system (volksverzekeringen). When you do take part in the Dutch social security system, you also have the right and the obligation to take out a Dutch public healthcare insurance.

Download the form "Do I need statutory basic healthcare insurance?" (59 kB)

2. Your insurance policy in your home country covers your stay in the Netherlands

The Netherlands has treaties regarding health insurance with a number of countries, including most European ones. If you are insured under the national health insurance scheme of one of these countries, your insurance company can provide you with either an international declaration form or with a European Health Insurance Card. Make sure to bring this with you to the Netherlands. You will need it when you go to see a doctor in the Netherlands. If your insurance does not cover your stay in the Netherlands, and if you cannot make use of the international treaty described above, then you will have to take out a private insurance policy.

3. You take out a new or special insurance policy for your stay in the Netherlands

If you are not covered under the public healthcare insurance of the Netherlands or of your homecountry, than you will have to take out another healthcare insurance. There are special policies available for international students in the Netherlands.

Nuffic has checked the policies and conditions of the following two recommended companies.

- Lippmann: www.ace-ips-nl.com
- AON: https://www.students-insurance.eu

Insurance documents in common European language

Whichever type of insurance you have, make sure that the insurance documents are written in one of the more common European languages.

Healthcare allowance

Back to Contents Page

When you are obliged to take out a Dutch public healthcare insurance (zorgverzekering) you can apply for a financial contribution for the cost of this insurance.

As the costs of a Dutch public healthcare insurance can weigh heavily on a small budget, the Dutch government provides a healthcare allowance to people with a low income. If you have a Dutch public healthcare insurance you can apply for this healthcare allowance.

Health allowance and residence permits

Applying for a health allowance has no effect on your right of residence.

Applying for the health allowance

You can apply for the health allowance through internet or by ordering and filling in the application form. As you need an electronic signature in order to apply online and the application procedure is only available in Dutch, it might be easiest to order the form.

1. Application forms can be acquired at your local Tax Office or through dialing 0800 – 0543 (in the menu first choose 1 and than choose 3). The phone line is open from Monday to Thursday from 8.00 until 20.00 hours and Friday from 8.00 until 17.00 hours.
2. Online applications can be done at www.toeslagen.nl.

Application form translated

The application form of the healthcare allowance is only available in Dutch. In order to apply for this allowance you will need to hand in this Dutch form. To help you fill in this form here you can find a translated version. Please note that you are **not** to fill in this English application form, you can only use it as a tool to help you fill in the original Dutch form. Soon here you will also find a translation of the guidance notes.

Download the English translation of the application of the healthcare allowance (44 kB).

When to apply

You can apply for the healthcare allowance for 2007 until April 2008.

Immigration rules concerning health insurance

Back to Contents Page

Experience has shown that it is not always easy to judge whether a foreign visitor to the Netherlands needs to have healthcare insurance in order to qualify for a visa or residence permit. The situation is explained below.

Short-stay visa, or 'Schengen visa' (*visum kort verblijf*)

If a foreign national intends to apply for a short-stay visa (visa sticker C), they must have travel insurance that covers medical costs for the entire duration of their stay in the Schengen area. This requirement has been in force since 1 June 2004. The insurance policy must provide cover for repatriation on medical grounds, urgent medical care and emergency hospital treatment. Cover must be provided up to at least EUR 30,000.

D+C visa

No healthcare insurance is required when applying for a 'provisional residence permit' (*MVV*, visa sticker D). However, healthcare insurance is required when applying for a D+C visa (i.e. a 'provisional residence permit' that also allows travel under the same terms as a short stay visa). The C portion of the sticker is subject to the same conditions as applicable to a short stay visa, including the medical insurance cover.

First application for a residence permit

When making their first application for a residence permit, foreign nationals must take out healthcare insurance. It is not necessary to take out the healthcare insurance in advance of the application. The insurance may be taken out afterwards. In other words, an application for a residence permit can be granted even if the applicant does not yet have the necessary healthcare cover. However, after obtaining a residence permit, the holder will be under an obligation to arrange healthcare insurance as soon as possible.
Because insurance companies only provide healthcare cover to foreign nationals on presentation of a valid residence permit, this approach means that applicants will never end up in the Catch 22 situation that could otherwise occur.

Renewing the residence permit

When renewing a residence permit, foreign nationals must show that they have suitable healthcare insurance. The cover provided must be at least equivalent to the cover provided under the public healthcare provision in the Netherlands (*zorgverzekering*). The cover must be current at the time the foreign national submits the re-

newal application. There is, however, no requirement for the insurance cover to run until the expiry date of the residence permit being applied for.

Housing

Before you leave your own country, ask your host institution whether or not housing will be arranged for you in advance.

Finding a place to live in a country as crowded as Holland is not easy. It is even difficult for Dutch students to find their own rented rooms on the private market. If you are taking part in an exchange programme or are enrolled on an international course, it is quite possible that a room will be arranged for you. Accept it immediately, or you will regret it later!

Finding good, affordable accommodation can be a problem in the Netherlands. Almost all university towns suffer from shortages. Many Dutch students live with their parent because they're unable to find suitable accommodation near their university.

In many cases, the receiving university will help international students by finding accommodation for them. But don't take this for granted! You should check in advance what the situation is at the university you will be attending.

What to expect

In the Netherlands, students usually have their own bedroom. Depending on the house where you are staying, the shower, lavatory, kitchen and living room may be shared with other students. It is common for men and women students to live together in the same student house. If this would be a problem for you, you should make this known as soon as possible.

Given the shortage of good accommodation, you may find the room you get is rather small and not of the standard you had expected. Usually, there is little that can be done about that, because most universities are glad if they can find accommodation at all for all their students. Accommodation is also expensive, especially in the bigger cities. Find out in advance what a room is going to cost, and don't forget to include additional expenses such as the deposit and the bills for gas, water and electricity. The utilities are not always included in the rent. Thinking about these things in advance could help avoid unpleasant surprises later.

You should also find out whether the room is furnished or not. The quality can vary greatly, and furnishings may range from just a bed and a chair to a fully equipped room with an internet connection. If you rent an unfurnished room, you can find inexpensive furniture at many second-hand shops in every large town.

Diploma evaluation

Back to Contents Page

In the Netherlands is Nuffic the central point of contact for the evaluation of foreign diplomas in higher and general secondary level education. Because of globalization, the number of people coming to the Netherlands with foreign diplomas continues to increase. Nuffic currently evaluates around 9,000 diplomas a year.

Incoming mobility

Where possible, a foreign diploma is compared to a Dutch diploma. If the study programme followed by the diploma holder is unique, a comparable level is indicated. Individual courses or modules that were taken, the study load and the academic level of the programme are taken into account.

Nuffic has a number of in-house experts specialized in the education systems of specific countries. Credentials are evaluated and telephone advice is given on request. Nuffic is a member of a number of national and international networks and has an extensive archive of diplomas and documents, meaning that its staff are well-placed to evaluate foreign diplomas in terms of the Dutch system.

As well as evaluating the diploma, Nuffic is also able to determine whether a programme or an educational institution is officially recognized and tests the authenticity of diplomas.

Outgoing mobility

Nuffic also has a role to play in outgoing mobility. When a person goes to another country to work or study, they assist them by providing advice or written statements. This includes the Diploma Description, for example. A Diploma Description describes a Dutch diploma and compares it to a diploma in the country where it is used. Diploma Descriptions are issued to the person named on the diploma.

If the holder of a Dutch diploma wishes to practice a regulated profession in another EU country, Nuffic can provide him with a declaration that might be of help in the process of registering for the profession in question in that country. This declaration is issued in Nuffic's capacity as National Contact Point for Directive 2005/36/EC on the recognition of professional qualifications.

Both products are recommendations, and as such they do not give the holder any rights in the host country.

Support in your home country

Back to Contents Page

Contacts in your neighbourhood.

Addresses of Netherlands embassies and consulates

Specific information on application forms and scholarships can be obtained from a Netherlands embassy or consulate in your own country. On www.mfa.nl/en/ (website of the Dutch Ministry of Foreign Affairs) you can find out if there is a Netherlands embassy or consulate in your country.

Netherlands Alumni Associations

People who studied or attented courses in the Netherlands founded Netherlands Alumni Associations (NAAs) in several countries. These independent associations organize various activities. For anyone considering a period of study in the Netherlands, alumni are always a good source of first-hand information. They can tell candidates about their own experiences and provide them with practical advice that will help them to prepare for their own stay. For more information, visit the page of the HollandAlumni Network.

If your country is not included in this list, check with the Netherlands Embassy whether an informal NAA exists in your country. The Embassy may provide you with names and addresses.

Netherlands Education Support Offices

Netherlands Education Support Offices (Neso) serve as a channel for information and provide support and liaison for the academic communities of the Netherlands and of the country they are situated in. They also provide information and guidance regarding the choice of an international course or programme of education or training. See for more information www.nuffic.nl/neso

Netherlands Education Information Offices

The following institutes serve as contact points for students and scholars of the host countries who are seeking contact with Dutch universities. Most institutes give courses, conduct research and publish academic literature in fields relevant to their background and location. With growing frequency they organize cultural events, including lectures, exhibitions, excursions and Dutch language lessons.

Staying in Holland

In daily life, you may suddenly find yourself thinking about the things that you take for granted at home, such as finding a place to live, taking out insurance, finding out whether you're allowed to work, and getting used to a different currency. And you're bound to have some practical questions too.

Formalities on arrival

Back to Contents Page

Read about which immigration procedures you need to comply with in the first few days upon your arrival in the Netherlands.

For a stay of up to three months

Unless you are an EU/EEA or Swiss citizen you are required to report to the local immigration authorities (Aliens Police) within three days of your arrival. Read here how to report to the Aliens Police.

For a stay of more than three months

- Unless you are an EU/EEA or Swiss citizen you need to apply for a residence permit. In most cases the host institution where you are going to study will apply for a residence permit on your behalf. In case you do it yourself, you will need to fill in an application form and send it to the Dutch Immigration and Naturalization Service (IND). If you arrived without an provisional residence permit (MVV), because you don't need it, you have to fill in the form 'Application for a regular residence permit without an MVV'. If you arrived with an MVV you have to fill in the form 'Application for a regular residence permit with an MVV'.
- Furthermore, you will need to have yourself registered at the municipality (*Gemeentelijke Basisadministratie*, GBA) as new inhabitant of the town where you are living.

Residence permit

Back to Contents Page

A residence permit is a pass which proves that you are residing legally in the Netherlands. You are obliged to obtain a residence permit if you are a citizen of a

non-EU/EEA country and you would like to stay in the Netherlands for a period of more than three months. If you are staying here for a longer period, you have to extend your residence permit before the expiring date. Furthermore, a change of purpose of stay in Holland also means your residence permit has to be changed.

On arrival – first application

Within five days of your arrival in the Netherlands you must apply for your residence card. Your host institution (university or *hogeschool*) can apply for it on your behalf but until 1 August 2008 you can do it yourself too. The application form has to be send to the IND, Office for Student residence permits applications, Postbus 1078, 2280 CB Rijswijk.

If you come to Holland to do a traineeship (you are studying abroad) or if you come to Holland for the purpose of a work experience (you already have a job abroad), you have to go to the local town hall to apply for a residence permit. In the period between 24 September 2007 until 1 January 2008, the Immigration and Naturalization Service (IND) will open new front office desks which will take over the task of the local town halls.

Arrive with the correct visa! Remember: if you are in the Netherlands on a short-stay visa, you can never be issued a residence permit! It is therefore crucial that you depart from your home country with the correct document in your possession: a short-stay visa if you are staying for three months or less, or an MVV if you are staying for more than three months and if your nationality requires it (see Student Visa Wizard).

Validity of the residence permit

If you are

- *a student preparing for enrolment:* Your residence permit will be valid for a maximum of 12 months. It is not possible to extend it!
- *a student*: Your residence permit will be valid until the end of the academic year (until September 1st), but may be extended.
- *a student doing a traineeship:* Your residence permit will be valid for a maximum of 12 months. It is not possible to extend it!
- *a migrant coming for work experience:* Your residence permit will be valid for a maximum of 6 months. It is not possible to extend it!

Extension of the residence permit

When you are in the Netherlands to study and your stay will be longer than your residence card lasts, you can extend your residence card.

Change in the purpose of your stay

It is possible that you will want to change the purpose of stay while residing in the Netherlands temporarily. You will have to change your residence card accordingly.

Housing

Finding good, affordable accommodation can be a problem in the Netherlands. Almost all university towns suffer from shortages.

Many Dutch students are unable to find suitable accommodation near their university. In many cases, the receiving university will help international students by finding accommodation for them. But don't take this for granted! You should check in advance what the situation is at the university you will be attending.

What to expect

28 Aug 2007

In the Netherlands, students usually have their own bedroom. Depending on the house where you are staying, the shower, lavatory, kitchen and living room may be shared with other students.

It is common for men and women students to live together in the same student house. If this would be a problem for you, you should make this known as soon as possible.

Given the shortage of good accommodation, you may find the room you get is rather small and not of the standard you had expected. Usually, there is little that can be done about that, because most universities are glad if they can find accommodation at all for all their students. Accommodation is also expensive, especially in the bigger cities. Find out in advance what a room is going to cost, and don't forget to include additional expenses such as the deposit and the bills for gas, water and electricity. The utilities are not always included in the rent. Thinking about these things in advance could help avoid unpleasant surprises later.

You should also find out whether the room is furnished or not. The quality can vary greatly, and furnishings may range from just a bed and a chair to a fully equipped room with an internet connection. If you rent an unfurnished room, you can find inexpensive furniture at many second-hand shops in every large town.

Working while studying

Back to Contents Page

Most students will need a work permit if they want to take paid work alongside their studies. There are two options if you want to work while you study: either less than ten hours a week year-round, or full-time during the months of June, July and August only. If you have successfully completed your programme of higher education, you may apply for a residence permit to work. To do this, you must have a contract of employment.

Work Permit (tewerkstellingsvergunning, TWV)

Most foreigners will need a work permit if they want to do a traineeship or work in the Netherlands. Only residents with an EU or EEA or Swiss nationality, except for Bulgary and Romania, won't need a work permit

Do you need a work permit when you are a student and do a traineeship?

If you're a foreign student, you can do a traineeship in the Netherlands. If you already have a job abroad, there is a possibility for you to gain some practical work experience in the Netherlands; this is called a work experience.

Download factsheet 'Immigration procedures for foreign students doing an traineeship'.

Work alongside your studies

If you're a foreign student and you have a valid residence permit with the aim to study, you can work alongside your studies (either full-time seasonal work in June, July and August, or part-time work of no more than ten hours a week. Please note that your Dutch employer does need a work permit for you.
Your employer must apply for the work permit at the Centre for Work and Income (CWI) in Zoetermeer.

Download the CWI application form.

Download factsheet 'International students and part-time jobs'

Links

- www.labourmobility.com, knowledge provider on international work issues
- werk.nl, website on working in the Netherlands
- www.undutchables.nl, website of recruitment agency for internationals

Source: http://www.nuffic.nl/international-students

Dutch universities

Back to Contents Page

When students in Holland finish secondary school they can continue their education at a higher education institution. Holland has two main types of regular higher education and eleven institutes that offer English-taught courses.

- Universities (universiteiten)
- Universities of professional education (hogescholen)
- Institutes for international education

The universities focus on the independent practice of research-oriented work in an academic or professional setting. The universities of professional education are more practically-oriented, preparing students directly for specific careers. A smaller branch of education is provided by Institutes for international education, which offer programmes designed especially for foreign students.

Recognition of universities

Not all of Holland's educational institutions are entitled to award officially recognized degrees and legally protected titles. To do so, an institute must be registered in CROHO (Central Register of Higher Education Programmes). Read more about recognition of universities.

More information

This website helps you to find universities and institutions for higher education which subscribe to this code of conduct and can therefore make your stay and study in Holland more easy: www.internationalstudy.nl.

Degrees

Back to Contents Page

Through our database, higher education institutes offer 1,300 English-taught programmes, of which there are 940 degree programmes and 360 specialised courses.

Students who enroll on higher education programmes will obtain a bachelor's degree upon completion of the undergraduate phase, and a master's degree upon completion of the graduate phase. Universities and universities of professional education

award both types of degrees, IE institutes offer master's programmes, but no bachelor's programmes.

Bachelor

A bachelor's programme at a university requires three years of full-time study (180 credits) to complete while a bachelor's programme offered by a university of professional education requires four years of full-time study (240 credits).

Master

Depending on the discipline, master's programmes at universities, universities of professional education and Institutes for International Education will last one to two years (60 – 120 credits).

PhD

The doctorate (PhD) is offered at universities and takes four years. A master's degree is compulsory for admission. One of the IE institutes (ISS) has the right to confer the doctorate, the other institutes may prepare students for admission to the doctorate at universities.

http://www.nuffic.nl/international-organizations/dutch-higher-education/degrees

IV Working in the Netherlands

Any citizen of an EEA member country can work and live in the Netherlands, though certain conditions must be met and exceptions might apply. Though there are numerous ways to find jobs, the Internet is becoming the dominant medium. 'Short and businesslike' are the keywords for your CV and application letter. In addition, the candidate's motivation is one of the basic selection criteria for Dutch recruiters. Last but not least: make sure to check if your educational diploma's and degree's are valid in the Netherlands.

Who can apply for jobs in the Netherlands?

Back to Contents Page

EEA nationals

In principle, the EU & European Economic Area (EEA) allow for the free movement of money, goods, services and persons. This means that its inhabitants are allowed to live and work in any other member state. This free movement of persons already exists between most of the member states of the EU/EEA. These are currently: Austria, Belgium, Cyprus, Denmark, Germany, Finland, France, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxemburg, Malta, the Netherlands, Norway, Portugal, Spain, Sweden, United Kingdom, Poland, Estonia, Hungary, Latvia, Lithuania, Slovenia, Slovakia and the Czech Republic.

Citizen Service Number (formerly Sofinumber)

In order to work in the Netherlands you need a Citizen Service Number (Burger Servicenummer or, in short, BSN) after January 1st, 2007. This number means you are registered in the tax and social security system. You can apply for a Citizen Service Number at the local office of the Tax and Customs Administration.

If you work in paid employment, your employer will deduct social security contributions and tax from your wage and pay these amounts to the concerned authorities. This payment occurs in advance of the income tax return, which you have to complete once a year. For more information and the addresses of tax offices visit www.belastingdienst.nl or phone 0800 0543 (from the Netherlands) or +31 555 38 53 85 (from abroad).

Residence Permit and Identification

Citizens from EU/EEA member states, do not need a residence permit in order to be allowed to work in the Netherlands. Once you have been in the Netherlands for more than 3 months, you should register with the IND. For more information consult the IND website www.ind.nl. On this website you will find a "residence wizard" through

which you can find out about the rules for residency in the Netherlands for yourself and any family members.

Even if not directly needed, a residence permit can come in handy: sometimes employers ask for it before they enter into a contract with you, banks also ask for it when you open a bank account and other official institutions ask for this document as well. You can apply for a residence permit at the IND office nearest to where you are residing. As of 1 January 2005 everyone aged 14 or older must be able to submit valid identification documents to prove his or her identity. If you are a national of one of the EU member states or of the European Economic Area, you can identify yourself with a passport or an EU/EEA aliens document.

If you are a national of Bulgaria or Romania you are required to apply for a residence permit (proof of lawfull residence).

Finding a job in the Netherlands

Back to Contents Page

Personal contacts

Finding a job through personal contacts is quite common. Making contacts can be done in an informal way. It is not considered correct to ask people directly for a job. Instead, just ask them for information and job opportunities. Do not hesitate to inquire or present yourself by phone.

Public Employment Service

The public employment service, CWI-Centre for Work and Income, plays an important role on the Dutch labour market. They assist people with finding a job, give advice and information and other help. Through an extensive network of partner sites and (temporary) employment agencies, most vacancies registered with these partners are also registered in CWI's online job database.

Temporary employment agencies

Private sector temporary employment agencies (uitzendbureaus) are widespread. Almost all occupations are represented by temporary employment agencies in the Netherlands. Please see the Yellow Pages and links below for addresses.

Media advertisements

Jobseekers should primarily consult Dutch newspapers for vacancies. NRC Handelsblad, de Volkskrant, de Telegraaf and Algemeen Dagblad all carry job offers in their Saturday editions as well as the Internet editions. Regional papers also publish vacancies, mainly on Saturday's and you can find vacancies in the Metro and Spits newspapers, which are free of charge and can be found in public transport facilities on a daily basis.

Internet

Internet is a common and an excellent tool for job hunting. There are many interesting Dutch sites on the Internet. On several sites you can register your CV in a job database. Employers often check them in search of new recruits.

The EURES website specializes in pan-European job vacancies and is available in all major European languages. Please see the list of links below.

Important links

Employment Services
www.werk.nl: CWI / Centre Work & Income
eures.europa.eu: EURES website
workinholland.ikwilhet.nu: Portal Work in Holland

Recruitment agencies
www.detachering.pagina.nl
www.werving-selectie.pagina.nl
www.mercuri-urval.com
www.birdengineering.nl: biotechnology
www.fashionsolution.nl: ready-made clothing and fashion
www.ranger.nl: high educational professionals
www.elanit.nl: IT&T
www.yachtgroup.com: interim management

Recruitment agencies for Non-Dutch speakers
www.undutchables.nl
www.career-abroad.com
www.kellyservices.com
www.manpower.com
www.uniquemls.com
www.bluelynx.nl
www.expatica.nl
www.englishlanguagejobs.com

Newspapers & magazines
www.telegraaf.nl
www.nrc.nl
www.volkskrant.nl
www.intermediair.nl
www.nationalemediasite.nl

Job databases
www.monsterboard.nl
www.jobbingmall.nl
www.jobnews.nl
www.vacaturebank.nl
www.medweb.nl

Job agencies
www.agrojobs.nl: academic jobs (in Dutch and English)
www.academictransfer.nl: graphic work
www.cadjobs.nl: architectural jobs (in Dutch with tips in English)
www.archined.nl: working in Export, partly in English
www.export.nl: transport and offshore
www.medweb.nl: medical jobs

Applying for a job

Back to Contents Page

Letter of application

Although the Dutch are generally good at languages, your application should be written in Dutch. Only in some cases are English applications required. Application letters should be typed. The application letter is preferably a one-page letter in A4 format. The style is short, direct and professional.

In general, a letter starts with the reason for applying. The middle part explains why you are the right candidate for the job. At the end of the letter, it is common to say that you would like to be invited for an interview to elaborate on your application. Remember that research from the Dutch Ministry of Social Affairs has shown that a candidate's motivation is one of the main criteria for selection.

Dutch companies often respond quickly, usually straight away by sending you written confirmation when they receive your application. After the closing date for the application, candidates will be informed by letter if they have been selected for an interview. Contact the employer to make sure your letter has not been misplaced if you do not receive a confirmation of your application within 21 days.

CV and/or resumé

Curriculum Vitae
A Dutch Curriculum Vitae is written in a direct factual style. The order is chronological. Use one or two pages (A4 format). Remember that a Dutch CV only states facts and figures. Save your motivation for the job as well as your personal qualities (like being thorough and precise) for your application letter. In your CV, you should mention the following points, and in this order:

1. Personal details (names, date of birth, address, e-mail, driver's license)
2. Education (including courses, no results are given)
3. Work experience (including dates)
4. Leisure activities

The details about your education and work experience are often given in chronological order, starting with your first working experience and ending with your last job. With regards to the details of your work experience, please mention the employer and the tasks performed. Dutch recruitment officers value leisure activities and civic responsibilities very much. These should therefore be mentioned in your CV. Make them look as relevant as possible for the job (e.g. team sports indicates team spirit). It is advisable to adapt your CV accordingly when applying for different jobs.

It is not necessary to include copies of diplomas, references or other official documents. They will be required and verified at a later stage of the application process. It is not necessary to include copies of diplomas, employer testimonials or other official documents. They will be required and verified at a later stage of the application process.

Resumé

Instead of a CV, writing a resumé is becoming increasingly popular in The Netherlands. Commonly used by people with substantial working experience and in case of speculative applications with recruitment agencies. It is less structured and briefer than a CV. It is also more subjective. The presentation of your achievements, goals in life and career plans are optional. You can choose a historical, analytical, chronological, practical or creative form.

A typical resumé starts off with explaining the type of job desired, followed by a chronological resumé in which you describe your most recent job activities first. Dates are only mentioned if appropriate and emphasis is put particularly on qualities and experience.

It is not necessary to include copies of diplomas, references from previous employers or other official documents. However, they will be required and verified at a later stage of the application process.

Job interview

After successfully applying for a job through an application letter, a job interview is the next step. Small firms are likely to have preliminary talks with candidates by phone, before inviting them for an interview.

During the interview you can expect questions about education and training, work experience, hobbies and personal interest. In addition, questions about your personality, your strengths and weaknesses, extracurricular activities, as well as membership of societies and organisations may be asked. Dutch recruiting officers view leisure activities and civic responsibilities as important factors.

More unstructured questions will be asked about your motivation for the job, your specific interest in the field and the company. Informing yourself about the company through the Chambers of Commerce, annual reports and the Internet can help you with preparing for such questions.

Some helpful tips for the interview:

Research from the Dutch Ministry of Social Affairs showed that a candidate's motivation is one of the main selection criteria during these interviews.

At the end of the interview it is normal to ask some questions yourself. Give some thought to this in advance.

It is very important to distinguish yourself from the other candidates. Make sure to show your enthusiasm and self-confidence.
Bring copies of your curriculum vitae, diplomas, references and any other documents you consider useful.

Contracts

Back to Contents Page

Because the legal rights and obligations differ per type of contract, you have to consider what option suites you most. To help you make this decision, the basic principles of the different contract options are explained below. For more information go to the section about types of agreements.

There are four rather common labour contract options. These are:

1. Temporary labour contract
2. Permanent labour contract
3. Contract with an employment agency
4. Street performers (self employed)

1. Temporary labour contract

A temporary contract has a starting date and an ending date. The contract will end on the agreed date without a dismissal procedure. We strongly advise you to make sure that you get a contract in writing, although a verbal agreement is also valid. The employer has the obligation to inform you about the main issues covered in the labour contract in writing within one month after the commencement of the contract. Within the legal limits, employers and employees are free to decide what will be covered in the labour contract.

Trial period
The trial period is a very common part of a (temporary) contract with the employer. A trial period will apply for both parties and needs to be agreed in writing. If the duration of the temporary contract is less than two years, the maximum trial period is one month. Exceptions can only be made when a Collective Labour Agreement agrees to this. The legal maximum trial period is never any longer than two months. An extension of this period is not possible.

Term of notice
A temporary labour contract will end automatically and legally on the date agreed. This means that there is no dismissal procedure involved. A different situation occurs if both parties or one of them want to end the contract before the agreed date. In this case, the option for termination of the contract before the final date has to be part of the contract. If the employer wants to end the contract before the date agreed, he or she needs to follow a legal dismissal procedure. In this case, it is advisable to contact the local Employment Office to get further information.

Repeated contracts with the same employer
If four temporary contracts with the same employer have been agreed within less than a three-month break between each contract, the rules for a permanent contract will start to apply. If this is the case, please contact the CWI/Employment Office for more information.

2. Permanent labour contract

The most important difference between a temporary labour contract and a permanent labour contract is the fact that a permanent labour contract has no ending date. This means there is no indication of any intention to limit the duration of the contract - such as 'for the duration of the project'. Hence, and unlike temporary labour contracts, there is no mention of an ending date of the contract in a permanent contract. Also the 'term of notice' will be different for a permanent contract, since your legal position is different. The differences concerning termination of a permanent labour contract are explained below:

A permanent labour contract can be ended by one of the parties. The legal terms of notice need to be respected.

The rules are different for employers and employees. The employee has the legal right to end the contract without a procedure, but he or she has to respect the legal and agreed period, which usually is a one-month notice minimum.

The employer needs to apply for a dismissal permit. The term of notice depends on the duration of the contract on the day the employer applies for the dismissal permit. We advise you to contact the local Employment Office for more information if you are confronted with this situation. Or read more in the section about the termination of contracts (available in Dutch).

3. Contract with an employment agency

The contract with an employment agency (uitzendbureau) differs fundamentally from a contract with an employer as described above. In the temp construction the employment agency is your legal employer while you work in a company that hires you from the employment agency. In particular, your protection against dismissal during a certain temp period is not regulated. This on the other hand means that you and the company you are working for can terminate the employment at any given time during the agreed employment period. Employment agencies have their own Collective Labour Agreement. There is an "Allocation of Workers by Intermediaries Act" that regulates issues related to employment agencies e.g.:

Employment agency employers are prohibited from charging temporary workers money (or any other consideration) for being given temporary work.
Employment agencies must inform temps in writing about the working conditions at the place of work in advance.

4. Street performers

EU/EEA citizens have the same rights as Dutch citizens when working in the Netherlands as a street performer as a musician, in theatre or pantomime, as a circus artist, cartoonist or portrait-painter. As this is self-employed work, a work permit is not required for EU/EEA citizens. You may require a residence permit. For more information see above or the 'residence wizard' at www.ind.nl
When is it worthwhile to come to the Netherlands as a street performer?
It is not easy to earn a living in the Netherlands as a street performer. People do not give money easily and the costs of living in the Netherlands are quite high. Your act must be interesting enough for the audience to want to give you money. If your act is seen as causing a nuisance, not only do you not earn much but the police may oblige you to end your performance as well.

What do you need to bring?

Besides identification papers you will need enough money to take care of your daily living costs. You will also need health and accident insurance.

Performers license
In most cities and municipalities you need a license to perform which has to be obtained in person. In order to register for a license you must have a residential address in the Netherlands. Municipalities try to regulate the number of street performers by limiting the duration of performances and allocation of specific areas where street performing is permitted. You will have to pay a fee for your license.

Rules and regulations
Municipalities may differ greatly in their regulations. You are entitled to be informed about local regulations.

Most municipalities give information via Internet. These are mainly in Dutch. Useful websites are:
www.ind.nl: information about residence regulations
www.belastingdienst.nl: information about taxes
www.straattheater.info: information for street performers in Amsterdam
www.goudengids.nl: addresses of municipalities (gemeenten) amongst others

Qualifications and diploma validation

Back to Contents Page

If you have obtained your diploma in another country and want to work in the Netherlands, you probably need to know what a particular credential is worth in terms of the Dutch system. The Netherlands has two centers of expertise in the evaluation of international credentials: Nuffic (for higher education) in The Hague and Colo (for vocational education) in Zoetermeer.

Depending on your plans on how to make use of your qualifications in the Netherlands, you can use either of these centers. It is therefore highly recommended that you first call the Information Center for Credential Evaluation (IcDW) for general advice. The centers of expertise have set up this Information Center.

When you are entitled to live and work in The Netherlands and you are officially registered as a jobseeker at a local CWI-office, CWI can support you in getting the necessary answers regarding your qualifications and diploma validation.

Europass CV

Back to Contents Page

Use of the Europass CV makes applying for a job in Europe, and in Holland in general, a lot easier. The Europass CV is a European standard model Curriculum Vitae with which you can present yourself when you are looking for a job or an internship within the EU.

In the Europass CV you can add information on the following subjects:

- Your identity
- Your work experience
- Training you have participated in and/or have completed
- The level of your language skills
- Personal skills and competencies
- Additional information such as hobbies and extra-curricular activities

Europass is used throughout Europe. And is therefore available in all European languages. That is what makes the Europass CV so cut out for job applications on an international level. In other words: You can use Europass CV when you intend to apply for jobs in a different European country than your own. The special thing about Europass CV is that you can list and present your skills and competencies in a structured way. Employers too, are likely to ask for the Europass CV in the future, when placing a vacancy. Europass is a significant aid in the process of comparing and assessment of qualifications and competencies of candidates.

The CV has an easy-to-use online template format, but you can also download an empty format. You can fill in your CV as well as update your current CV (XML format) by following the link listed below, which will guide you to a European website.

The sections you do not wish to use, can be left empty. These sections do not appear on your CV. Should you wish to add extra information, for instance on your language skills, foreign internships or previously obtained foreign certificates, you can use the other Europass documents in addition to the Europass CV.

Visit http://europass.cedefop.europa.eu/ for more information.

Source: Working in the Netherlands
https://www.werk.nl/portal/page/portal/werk_nl/cwiencijfers/working_in_the_netherlands_cc/inenglish

V Social Security in the Netherlands

Source: AngloINFO The Netherlands - EU Factsheets
http://holland.angloinfo.com/countries/holland/living.asp

The European Union provides a vast amount of valuable information for EU citizens living in (or planning to live in) other Member States.

Here, AngloINFO has collected together all the English-language factsheets that relate to life in the Netherlands and EU member states in general.

Social Security

http://holland.angloinfo.com/countries/holland/socsec.asp

Coordinating arrangements: Maintenance and transfer of rights

Back to Contents Page

The Netherlands has concluded social security treaties with a large number of countries. The aim of these treaties is to promote the equal treatment of one another's nationals.

One of the main sources of treaty law in this field is the European regulations applicable to nationals of the Member States of the European Union (EU) and the countries of the European Economic Area (EEA). The European regulations govern social security by arranging for the preservation and transfer of rights between the Member States of the European Union.

Useful references

The Community Provisions on **Social Security**
The Ministry of Justice **Immigration & Naturalisation** Service

For further information on the issuing of documents to aliens, contact the Immigration and Naturalisation Service (IND) of the Ministry of Justice,

- **Immigration and Naturalisation Service (IND)**
  At: P.O. Box 30125, 2500 GC The Hague
  Tel: (070) 370 31 24
  Website

For further information, you can also contact the international help desk of the body implementing employee insurance schemes, the UWV, on (020) 687 15 06.

E forms: General Overview

Back to Contents Page

As a general rule, people working abroad are no longer insured in their own country for general social security purposes. This may, however, be regulated by a number of E forms. The purpose of E forms is to facilitate cross-border contact with and between social security bodies of the EEA Member States. From your point of view, this means these forms enable you to transfer your existing entitlements to another EEA country.

There are several types of E form:

- the E-100 series is for benefits in the event of sickness, pregnancy and secondment
- the E-200 series is for the calculation and payment of pensions, survivors' benefits and disability pensions
- the E-300 series is used for anything involving unemployment benefit
- the E-400 series is for children's allowance entitlements

These forms can be obtained from various authorities in your own country.

Below is a list of the most commonly used forms:

E101 secondment declaration - issued if you are posted by your employer to a different country for not longer than 12 months; used in conjunction with form E111

- Obtainable from: Social Insurance Bank, International Secondment Department. For Belgium: Belgian Affairs Office. For Germany: German Affairs Office.

E102 renewal of secondment

- Obtainable from: relevant institution in the country of work

E104 proof of insurance with health insurance fund in your own country in order to prevent waiting time in the case of a long stay in another Member State

- Obtainable from: social insurance administration body (UWV) or Social Insurance Bank (SVB); medical insurer

E111 proof of medical insurance for short-term stay in another Member State, also necessary for secondment

- Obtainable from: medical insurer

E119 proof of entitlement to sickness and maternity benefits in another Member State; used in conjunction with form E303

- Obtainable from: medical insurer

E301 insured periods of employment history in a Member State

- Obtainable from: social insurance administration body (UWV)

E303 export of unemployment benefit for not more than three months; used in conjunction with form E119

Obtainable from: social insurance administration body (UWV)

General Organisation

Back to Contents Page

As soon as you start work in the Netherlands, you will automatically begin making payments into the Dutch social security system. The Dutch social security system is one of the most comprehensive in the EU. Anyone legally resident in the Netherlands who lacks the means to support himself or herself owing to long-term disability or unemployment can claim benefit from the Dutch state.

The Ministry of Social Affairs and Employment is responsible for the relevant legislation. Most social security contributions are deducted automatically from your salary. In the case of so-called employee insurance, both you and your employer pay contributions. Below are the contribution percentages valid as at 1 January 2005:

Type of insurance employer employee total max. contrib. income

- **Old-age pension**: 17.90 17.90 30 357 per annum
- **Survivors' benefit**: 1.25 1.25 Idem
- **Exceptional medical expenses**: 13.45 13.45 Idem
- **Invalidity benefit**: 5.60 -- 5.60 167 per day
- **Invalidity benefit computation contribution**: 1.67 -- 1.67 Idem
- **Redundancy pay insurance**: 1.75 -- 1.75 167 per day
- **Unemployment insurance**: 2.45 5.85 8.30 Idem
- **Compulsory health insurance**: 6.75 1.45 8.20 114 per day

1. Average for businesses; for claimants 1.89 percent.
2. Marginal contribution percentage for general unemployment fund from contribution-exempt amount of €58 per day.

The pay limit is €33,000 for people under the age of 65 and €21,000 for people aged 65 and over. A nominal contribution is also payable under the compulsory health insurance scheme. The amount of this contribution is determined independently by the health insurance funds. The average nominal compulsory health insurance computation contribution is €71.84 per adult per annum. No contribution is payable for children who are also insured. The compulsory health insurance contribution on old-age pension is 8.20 percent, and 6.20 percent on supplementary pension.

Sickness Insurance: Beneficiaries and Conditions for Entitlement

Back to Contents Page

Illness

From 1 January 2004, your employer is in principle obliged, when you are ill for a long period, to pay you wages for a maximum of two years. However, you and your employer must do your utmost to get you back to work as soon as possible. Otherwise, sanctions will follow.

An application for invalidity benefit should be filed at the end of the second year, rather than the first year, of illness. The government thinks this is crucial to encourage your return to work. In certain cases, an evaluation test can take place before the end of the two-year period of illness. This only concerns people who are no longer capable of working and where it is entirely clear that there is no likelihood of recovery.

Or you can contact the Public Information Department of the Ministry of Social Affairs and Employment, Tel: 0800-9051.

Invalidity Insurance: Beneficiaries and Conditions for Entitlement

Back to Contents Page

The Invalidity Insurance Act (WAO)

The WAO will be replaced as at 1 January 2006 by the Work and Income According to Working Capacity Act. It consists of a regulation for completely and permanently incapacitated persons (IVA) and a regulation for partially incapacitated persons (WGA).

Employees who are entirely incapacitated and have no chance of recovery will be eligible for benefit of 70 percent of their last wages. Employees who are entirely incapacitated and have a small chance of recovery will also receive benefit of 70 percent of their last wages. They will be re-evaluated every year for the first five years to determine whether they are recovering.

Partially incapacitated persons have the right to assistance in finding work again plus an addition to their wages, whereby their income rises the more they work. Employers and employees are given a greater responsibility to remain in work. The new law contains financial incentives and instruments to promote the resumption of work. From 1 October 2004, incapacitated persons younger than 50 years of age will be evaluated according to new, stricter evaluation requirements. For persons over 50 years of age, the old regulations will continue to apply.

As an incapacitated person you can be re-evaluated according to stricter employment criteria. The social insurance administration body (UWV) will focus more on what you are still capable of, despite your handicap. The employment analyst will still have to indicate three tasks you can fulfil. For each position, there will have to be at least three vacancies in the computer system of the job analyst, instead of the current ten. If you were working part time, you will now also be evaluated for full-time jobs. When indicating tasks you can still fulfil, the lack of a generally common ability cannot constitute an obstacle, as long as this ability can be learned within a reasonable period (six months). In concrete terms, this refers to spoken knowledge of a language and basic use of a computer.

If you are re-evaluated according to the stricter criteria, this can have consequences for your benefits. If you are declared partially fit to work, your benefits will be reduced. If you are declared completely fit to work but cannot find any work, you can apply for unemployment benefit and, if necessary, IOAW (a minimum benefit). Under the IOAW (Law on income for older and partially incapacitated unemployed persons), the income of your partner is taken into account but any capital is not.

Are you not eligible for unemployment benefit or is your unemployment benefit nearing the end? Then you will receive an allowance for a maximum of six months after the incapacity benefit has been reduced or stopped, provided you make an effort to find work. Instead of unemployment benefit, you will receive a similar benefit with a maximum duration of six months. This transitional regulation will be implemented by the UWV and will run until 1 January 2009.

Old-Age Insurance: Beneficiaries and Conditions for Entitlement

Back to Contents Page

The Netherlands has a high-quality, sound and widely accessible pension system which is viewed as a model by many other European countries. The retirement age in the Netherlands is 65 years. The income of people aged 65 years and over consists mainly of state old-age pension and a supplementary pension from a previous job or jobs.

The Dutch pension system is based on three pillars:

- the state old-age pension scheme
- the supplementary pension scheme operated by the employer
- any amounts set aside by employees for their old age

From 2010, hundreds of thousands of Dutch people will claim the state old-age pension and any accumulated supplementary pension. In 2030, there will be four million people aged 65 and over in the country. How can we keep the provision of old age pensions affordable in the future? It is an issue that is preoccupying the nation. If more elderly people remain in work for a longer period, the pressure on the working population to pay for welfare benefits will be more evenly distributed, according to the government. Taking early retirement will therefore no longer be a fiscal advantage.

On 22 February 2005, the early retirement bill was passed by the government. These regulations will take effect on 1 January 2006.
With all these changes, it would be wise to make sure you are sufficiently aware of the (reformed) pension scheme.

State old-age pension amounts as at 1 January 2005:

- State old-age pension Gross per month Gross holiday allowance per month
  Married people €631.81 €30.53
- Married people with a maximum allowance
  (partner under the age of 65) €1,263.62 €61.06
  Maximum allowance €631.81

Single people €924.86 €42.74
Single people with a child under the age of 18 €1,143.92 €54.95

Unemployment Benefits

Back to Contents Page

Unemployment Benefits: Beneficiaries and Conditions for Entitlement: If you lose your job, you can claim unemployment benefit. However, certain conditions are attached to this. For example, you must have worked for at least half a year in the Netherlands. The amount and duration of your benefit depend on your employment history. After you lose your job, you must register as quickly as possible with the **Centre for Work and Income** (CWI).

If you lose your job as an employee, in theory you are entitled to claim unemployment benefit. However, you must be younger than 65 and the loss of your job must not be imputable to your conduct.

The **Unemployment Benefits Act** (WW) applies to all employees who are insured in the Netherlands. In theory, employees in sheltered employment are also insured. The same applies, under certain conditions, to sales representatives, outworkers, musicians and performing artists.

Self-employed persons and personnel who work for less than three days a week in the same private household are not insured. The same applies to trainees who do not receive a full salary.

Unemployment benefit totals 70 percent of your last-earned salary (N.B. There is, however, a maximum daily pay). The length of your entitlement to this benefit depends on your employment history. You calculate this by means of an addition. You take the number of years within the above-mentioned period of five years in which you received your salary. You then calculate how many years have elapsed since the year you reached 18 years of age (including that year) until the start of the five-year period. By adding this up, you obtain your employment history.
Using the following table, you can calculate the length of your salary-related benefit.

Employment history of at least: Duration of salary-related benefit

- 4 years 6 months
- 5-9 years 9 months
- 10-14 years 1 year
- 15-19 years 1.5 years
- 20-24 years 2 years
- 25-29 years 2.5 years
- 30-34 years 3 years
- 35-39 years 4 years

40 years or over 5 years

Minimum Income Guarantee

Back to Contents Page

Minimum Income Guarantee - Beneficiaries and Conditions for Entitlement:

The basic principle of the National Assistance Act (ABW) is that you should support yourself as far as possible. If you cannot do so and cannot claim under any other social provisions, you are entitled to claim national assistance. You are only entitled to assistance if you are legally resident in the Netherlands.

Entitlement to assistance carries with it a number of obligations. You and your partner must do your utmost to start supporting yourself again. This is why you have a duty to apply for work. If you make such a request, you must supply the necessary information to the body administering the system. You are also required to report any changes in your personal circumstances. Similarly, you are required to take part in activities that may help you return to the labour market. Examples are courses in applying for jobs, gaining job experience and participating in an integration course for foreign nationals. If you do not comply with these obligations, the Social Services will impose sanctions on you. Your benefits will be either reduced or suspended entirely until further notice.

On 1 April 2005, the 2005 Income Support Act came into effect. As a result of this law, the amounts of the benefits deducted from the gross minimum wage have changed, and an adjustment has been made to the calculation of the holiday allowance.

Social Assistance Benefit

Standard amounts for social assistance benefit as at 1 April 2005:

- **Married persons or unmarried cohabiting persons, aged 21 - 65**
  per month €1,099.24
  holiday allowance €50.59
  Total €1,149.83
- **Lone parents**
  per month €769.47
  holiday allowance €35.41
  Total €804.88
- **Single persons**
  per month €549.62
  holiday allowance €25.30
  Total €574.92

Persons aged 21 to 65

Maximum allowance for persons aged 21 to 65

- **Lone parents and Single persons**
  per month €219.85
  holiday allowance €10.12
  Total €229.97
- **Married persons or unmarried cohabiting persons, both partners aged 65 or over**
  per month €1,162.55
  holiday allowance €53.51
  Total €1 216.06
- **One partner under 65 years of age**
  per month €1,162.55
  holiday allowance €53.51
  Total €1,216.06
- **Single persons**
  per month €828.50
  holiday allowance €38.13
  Total €866.63
- **Lone parents**
  per month €1,043.48
  holiday allowance €48.03
  Total €1,091.51
- **Married persons or unmarried cohabiting persons, both partners under 21 years of age**
  per month €379.86
  holiday allowance €17.48
  Total €397.34
- **One partner under 21 years of age**
  per month €739.55
  holiday allowance €34.04
  Total €773.59
- **Single persons**
  per month €189.93
  holiday allowance €8.74
  Total €198.67

Persons under 21

For persons under 21 years of age with one or more children in their care, higher amounts are applicable

- **Married persons or unmarried cohabiting persons, both partners under 21 years of age**
  per month €599.71
  holiday allowance €27.60
  Total €627.31
- **One partner under 21 years of age**
  per month €959.40
  holiday allowance €44.16
  Total €1 003.56
- **Lone parents**
  per month €409.78
  holiday allowance €18.86
  Total €428.64

- **Married persons**
  per month €380.73
  holiday allowance €17.52
  Total €398.25

Evaluation of CareFlows

European Medical Association

Evaluation of CareFlows

The CareFlows project developed a matrix on assets and instruments of mobility in of health care professionals and social workers in North-Western Europe. This matrix can be used to evaluate the existing situation of mobility and the recommendations developed by the project (Fig. 1).

Fig. 1: Matrix of objectives and Instruments for mobility

Instruments Assets	Information	Exchange Programmes	Interventions to reduce barriers
Reduce labour market miss-match			
Learning from diversity			
Exchange of best practice			

For evaluation purposes a SWOT analysis can be used in order to identify the objectives of mobility and the recommendations of instruments provided by Careflows. This way as well the empirical analysis as well as its outcome of the project can be evaluated.

The objective to reduce labour-market miss-match by increased mobility clearly shows strength and weaknesses as well as opportunities and threads. The major strength of addressing labour market miss-matches by mobility would be its high efficiency. However a severe weakness within North-Western Europe is a labour market shortage in health care in all countries. Therefore increased efforts for mobility would rather threat additional efforts in qualification that are needed to comply with growing demand. Improved mobility is not expected to address miss-matches within North Western Europe substantially.

Nevertheless Care Flows proposes instruments to improve mobility in terms of labour market miss match. The idea of increased information such as talent pools, induction packs and the use of thematic networks could indeed provide much more transparency. Improved transparency will be a strength in case it matches information about job opportunities as well as information about available staff. This also includes the induction packs providing information about working conditions. It will not be able to overcome undersupply (weakness) as long as there are miss-matches in all regions in the same direction. But it can provide information about the existing opportunities and therefore provide a more realistic description of opportunities of mobility. At the same time it is also a precondition for other objectives of mobility. Especially the induction packs seem to be a good basis for increased mobility. The rapid change of health care systems and labour market conditions are a thread however, since the production of induction packs cause a lot of ongoing effort and it has to be ensured that information will always be up to date.

Making use of existing networks of health care professionals seems to be a precondition for such up to date information. Including the process of information into the every day activities of such networks could achieve as well an improved data basis as providing instruments to deal with the information. Therefore EMA will support the instruments by linking them to EMA networks supporting dissemination and sustainability of the information basis.

Transferring this situation into a SWOT table figure 2 gives an overview on the evaluation of mobility with reference to labour-market miss match:

Figure 2: SWOT Analysis of mobility instruments for labour market miss-match

• Increasing transparency • Increasing awareness • Knowledge about working conditions	• Labour shortage in all countries within NW Europe • Little mobility • barriers concerning language, accreditation, differences in

	working and living conditions or the consideration of families and relatives
• Diversity training in combination with language courses and supervision on the job during daily work may help to overcome cultural barriers; • Specialisations and regulation of division of labour between different professions may ease accreditation problems. This also requires harmonisation of professions across participating countries and requires better communication between member states; • Social conditions like partner programmes will make mobility more attractive and reduce barriers. • Usage by existing network of health care professionals • Good dissemination by networks	• Persistence of barriers • Lack of education and training • Persistent labour market shortage • High effort in keeping up to date

The strength, weaknesses, opportunities and threads have been discussed systematically in a number of partner meetings and have resulted in the involvement of EUROPET and EMA as dissemination partners. EMA is linking the induction packs on its website. In addition the focus was widened to include the involvement of other countries as well as other objectives.

Whereas the integration of other countries has been beyond the focus of the project the additional objectives have become a central aspect of the work of Careflows. However there are some recommendations about the widening of the focus as well. Especially due to wage drift there is a strong pull factor for employees from Eastern and Southern countries. This kind of mobility causes considerable ethical problems because of the brain drain in the respective countries. WHO has already complained about this problem and measures will have to be taken especially to educate more health care professionals in Countries with even higher shortage of qualified labour. This seems to be a good opportunity for additional turnover in education and training on a European level and beyond.

The objective of learning from diversity addresses mutual learning between the health care and social systems in Europe. The concept has been discussed in the context of CareFlows in order to turn a weakness into a strength. Although the diversity has to be considered as a barrier to mobility it can be an objective of mobility as well providing opportunities to learn from different solutions. Therefore CareFlows recommends exchange programmes, hospitation schemes and mutual projects in education. These activities promote mobility. They are limited to learning activities but are not intended to help solving labour market mismatches. In this respect there are strength weaknesses, opportunities and treads incorporated in these suggestions as figure 3 demonstrates.

Figure 3: SWOT Analysis of mobility instruments for mutual learning

• Diversity is used for extending experiences; • Mobility is increased by exchange programmes, hospitation schemes and mutual projects; • Support of life long learning;	• Little relevance for labour market miss-match; • Too little utilisation in practise due to systematic differences (transferability); • Additional learning effort

• Joint solutions can be developed in a cross border context.	
• Convergence of social and health care systems and solutions; • Increase of competitiveness; • Improved diversity management; • Improved career opportunities	• Lack of acceptance of different solutions; • No appreciation for career development; • Loss of specific profiles and specialisations.

These strength, weaknesses, opportunities and threads have been discussed systematically in a number of partner meetings as well. The life long learning opportunities seem to outbalance the weaknesses and risks and turn into an asset of European diversity. Therefore learning from diversity may be of higher importance than addressing labour market miss-matches.

A specific case is the organisation of the exchange of best practice. Due to the high diversity in the European social and health care systems there is a wide variety of solutions and excellences. This may be used to increase speed of innovation by identifying and transferring best practice between member states. Especially within the service sector this requires a high degree of mobility in order to identify, agree upon and transfer best practice. Due to the increased speed of innovation the transfer of best practice will have considerable impact on employment as well.

One of the major tasks of transferring best practice is the identification of appropriate solutions. The CareFlows project could only describe the task as such, but did not try to identify best practice itself. A second difficult task is the adaptation of best practice to its specific environment in a flexible way. Also the acceptation of identified solutions often is questioned (not invented by myself phenomena). This difficulties may be overcome by personal engagement and site visits as suggested by CareFlows.

Addressing strength and weaknesses as well as opportunities and threads in a SWOT analysis shows that CareFlows suggestions show the right way although there will be a lot of difficulties in the implementation process (Fig. 4).

Figure 4: SWOT Analysis of the transfer of best practice

• Support of life long learning • Increased speed of dissemination • High efficiency • Increase of mobility	• Problems of transferability • Deficits in own innovation effort • High effort identifying best practice
• European initiative to identify best practice • Programmes to support mobility with best practice site visits • Flexible adaptation of best practice throughout Europe • Utilisation of size and variety of European market	• Disagreement in identification of best practice • Agreement to share best practice • Lack of flexibility in transferring best practice (one size fits all) • High effort of adaptability in service sector

As SWOT analysis shows, there are advantages and disadvantages of all strategies to improve mobility in the social and health care sector. The CareFlows project reflected these different strategies, provided empirical evidence and increased awareness for these strategies. By reflecting and discussing the strategies with stakeholders in the social and health care sector and the cooperation with thematic networks in Europe the awareness about opportunities and threads of different strategies could be increased.