Austria

Population
8,901,000

Area
83,882 km^2

Capital
Vienna

3 largest cities
Vienna (1,897,000)
Graz (289,000)
Linz (206,000)

Neighboring countries
The Czech Republic, Germany, Hungary, Italy, Liechtenstein, Slovakia, Slovenia, Switzerland

1. Migration history
2. Estimated number of people with a migration background with dementia
3. National dementia plan
4. National dementia care and treatment guidelines
5. Services and information for people with a migration background with dementia
6. Professional qualification and people with a migration background in healthcare
7. Support for family caregivers
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1. Migration history

Austria has a long history of migration, characterised by waves of emigration of smaller population groups, but mainly by immigration and transit migration [1]. For example, more than half of the increase in Vienna's population between the end of the 18th century and 1916 (from 235,000 to 2,239,000) was due to international migration [2]. From 1919 to 1937, more than 80,000 people from Austria emigrated overseas and many more to Palestine, Germany, and the Soviet Union. As a result of Nazi annexation, 128,000 Jews had to leave Austria between 1938 and 1941, and 64,500 Jews had been murdered by 1945 [1]. During the Second World War, about one million slave labourers (1944) worked on Austrian territory [3]. Immediately after the war, about 1.4 million foreigners were living in Austria. These included more than half a million so-called 'displaced persons' (war refugees, former concentration camp prisoners, forced labourers, prisoners of war) and more than 300,000 German-speaking expellees, so-called "Volksdeutsche" (ethnic Germans) from Central and Eastern Europe. Most of them left the country in the following years [2]. After the Second World War, Austria became one of the most important transit countries for refugees from Eastern Europe. Between 1945 and 1990 about 650,000 people (mainly from Hungary, Czechoslovakia, and Poland) migrated to the West via Austria [2, 3]. At the same time, about 20,000 people from Hungary (1956/1957), 12,000 from the Czech Republic and Slovakia (1968), and a few thousand from Poland (1981/1982) settled permanently in Austria. As a result of bilateral labour recruitment agreements, about 265,000 guest workers immigrated to Austria between 1961 and 1974, most of them from Yugoslavia and Turkey (in 1973, 78.5% of guest workers were from Yugoslavia and 11.8% were from Turkey). In 1974, the Austrian government decided to stop the recruitment of guest workers and to adopt a restrictive policy. This led to a 40% decline in the number of foreign workers between 1974 and 1984. At the same time, many guest workers extended their stay and family reunification compensated the decline in labour migration. The coup d'état in Romania at the turn of the year 1989/1990 and the armed conflicts in Croatia, Bosnia-Herzegovina, and Kosovo between 1991 and 1999 resulted in larger flows of refugees to Austria. After the accession of Bulgaria and Romania to the EU in 2007, the number of immigrants from these countries increased [2]. Immigration to Austria reached its peak with approximately 110,000 people during the wave of large-scale migration of refugees in 2015 [3]. The biggest migrant groups in Austria according to the country of birth are people from Germany (232,200), Bosnia and Herzegovina (168,500), Turkey (159,700), Serbia (143,200), and Romania (121,100) (as of 01.01.2019) [4]. The migrant population (born abroad, 793,200 to 1.8 million) and its proportion in the total population (10.3 to 19.9%) roughly doubled between 1990 and 2019 [5]. Austria has also had a positive net migration rate (the difference between the number of persons immigrating and emigrating per year, per 1,000 persons) for decades and an increasing annual rate for some years (2020: 7.4) [6]

2. Estimated number of people with a migration background with dementia

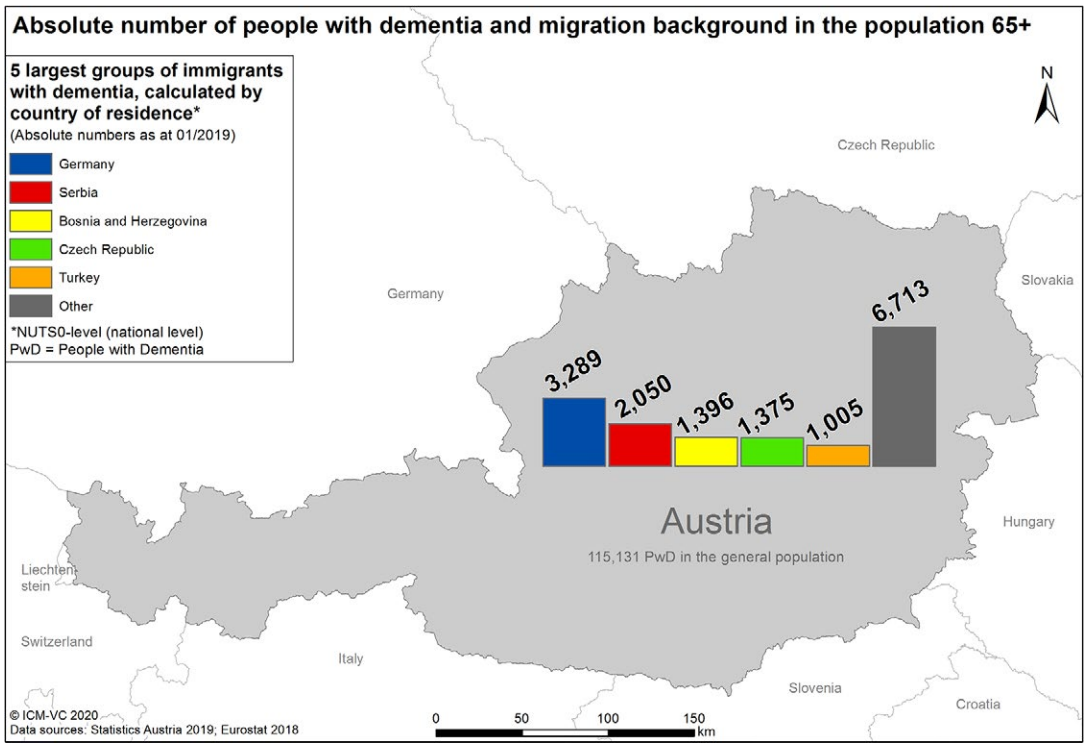

Fig. 3.7.1.1: Absolute number of PwM with dementia aged 65+ (Austria – Nation)

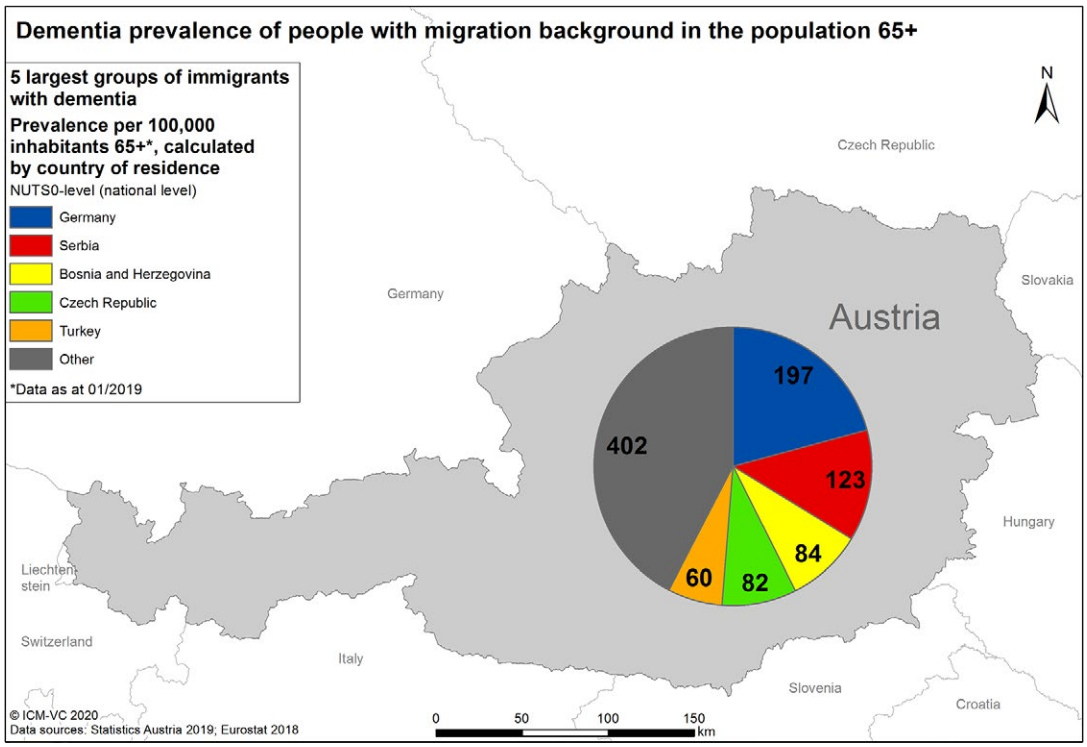

Fig. 3.7.1.2: Prevalence of PwM with dementia among the population aged 65+ (Austria – Nation)

Tab. 5: PwM with dementia: Absolute numbers, prevalence among PwM aged 65+, and prevalence among overall population aged 65+ (Austria – Nation)

NUTS	Total	AT	1. largest group	2. largest group	3. largest group	4. largest group	5. largest group	Other
Absolute Numbers								
Austria	115,131	99,302	DE 3,288	XS 2,050	BA 1,396	CZ 1,374	TR 1,005	6,713
Prevalence/10,000 inhabitants with migration background 65+								
Austria	5,019	-	DE 143	XS 89	BA 61	CZ 60	TR 44	293
Prevalence/100,000 inhabitants 65+								
Austria	6,900	5,951	DE 197	XS 123	BA 84	CZ 82	TR 60	402

Data source: Statistics Austria (2019)

There are 229,400 PwM aged 65 or older. Of those, approx. 15,800 are estimated to exhibit some form of dementia. Figure 3.7.1.1 shows the most affected migrant groups presumably originate from Germany (approx. 3,300), Serbia (approx. 2,100), Bosnia and Herzegovina (approx. 1,400), the Czech Republic (approx. 1,400) and Turkey (approx. 1,000). The second graph highlights the number of PwM with dementia in Austria per 100,000 inhabitants aged 65 or older (figure 3.7.1.2). Table 5 displays the values depicted in the maps on the national level. The following maps show the distribution of non-migrants with dementia and PwM with dementia from Germany, Serbia, Bosnia and Herzegovina, the Czech Republic, and Turkey throughout the country in the NUTS2 regions (figures 3.7.1.3 – 3.7.1.7.8).

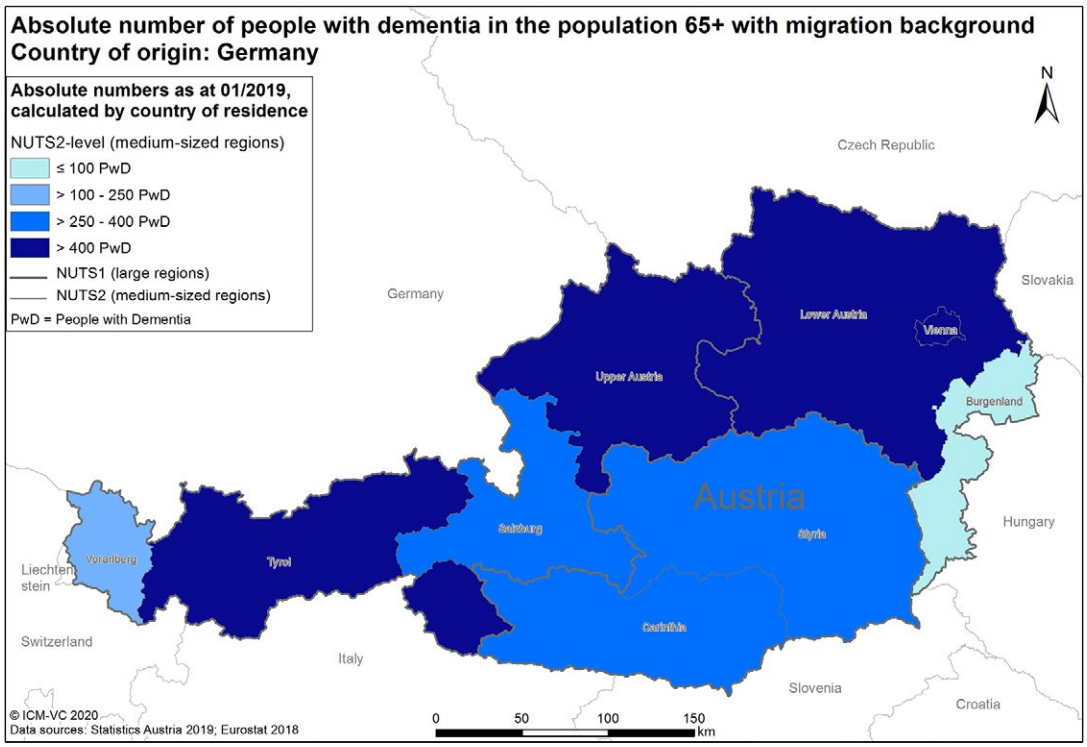

Fig. 3.7.1.3: Absolute number of PwM with dementia aged 65+.
Country of origin: Germany (Austria – NUTS2)

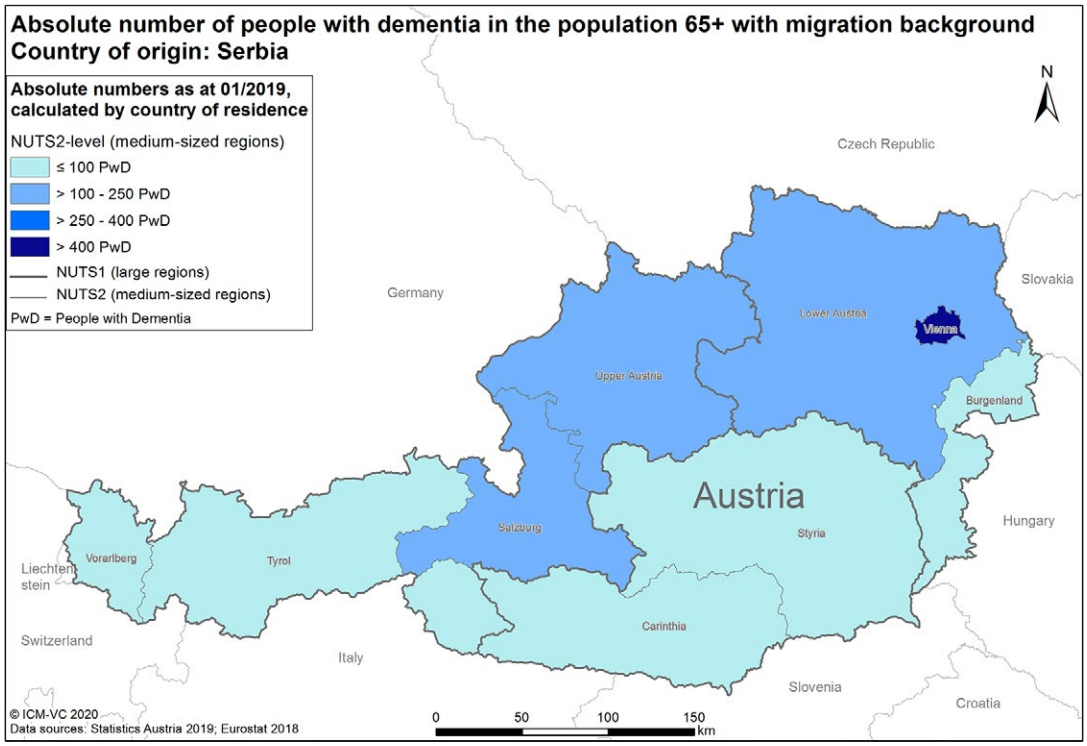

Fig. 3.7.1.4: Absolute number of PwM with dementia aged 65+.
Country of origin: Serbia (Austria – NUTS2)

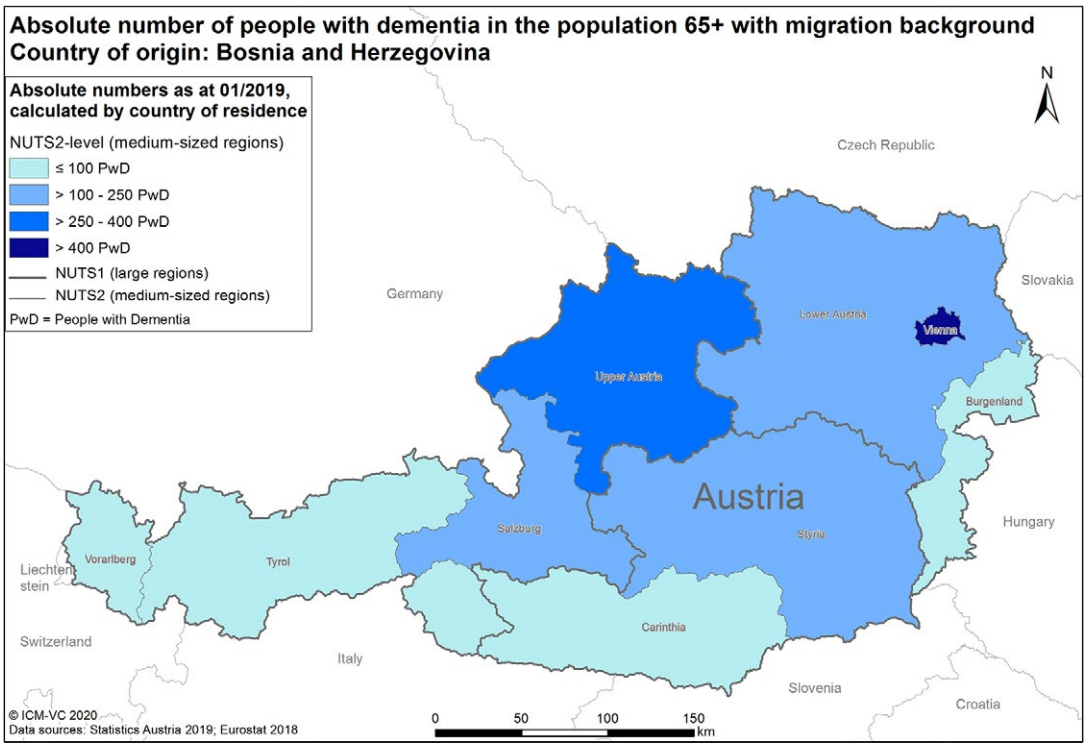

Fig. 3.7.1.5: Absolute number of PwM with dementia aged 65+.
Country of origin: Bosnia and Herzegovina (Austria – NUTS2)

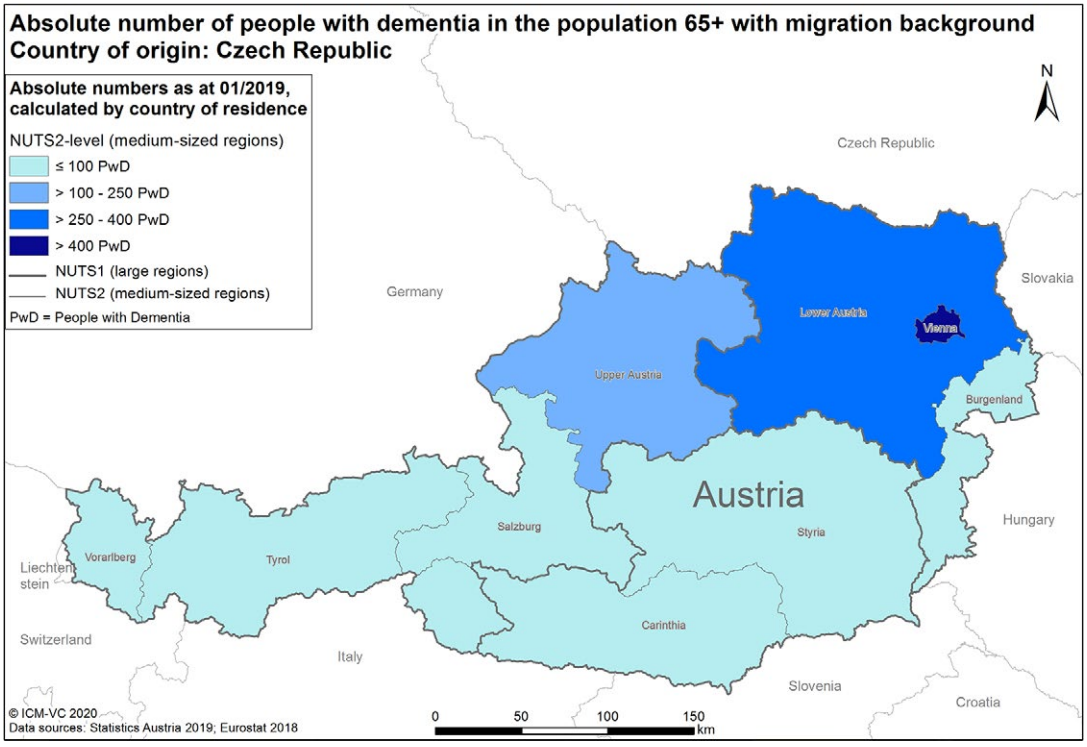

Fig. 3.7.1.6: Absolute number of PwM with dementia aged 65+.
Country of origin: The Czech Republic (Austria – NUTS2)

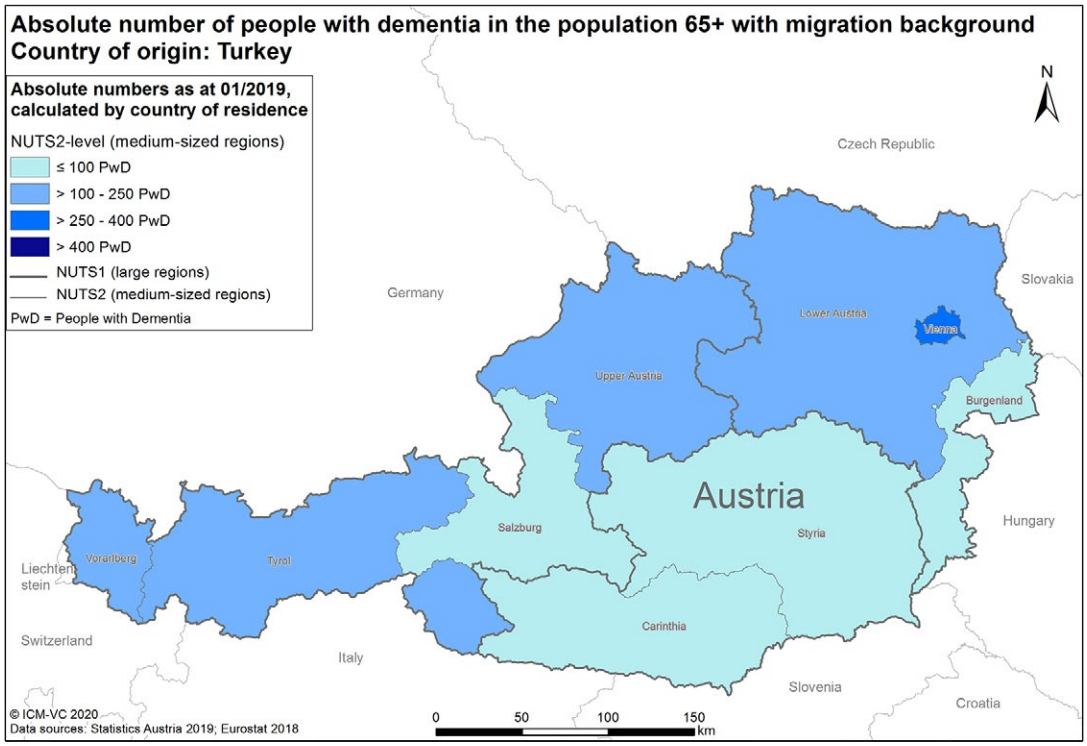

Fig. 3.7.1.7: Absolute number of PwM with dementia aged 65+.
Country of origin: Turkey (Austria – NUTS2)

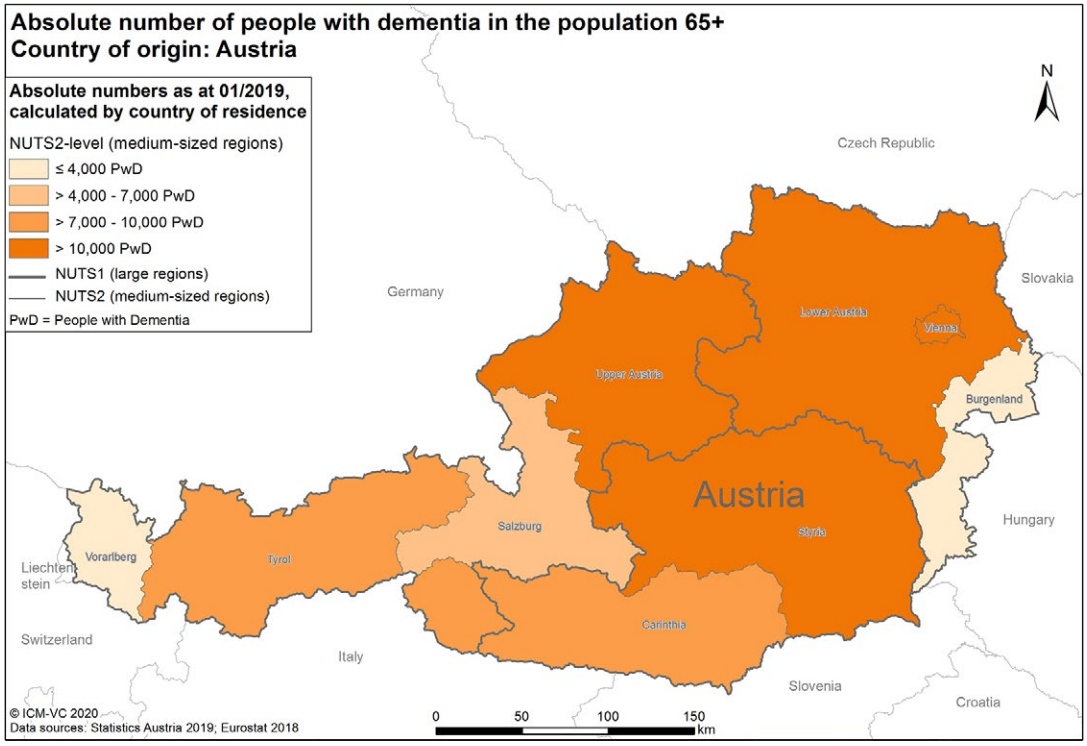

Fig. 3.7.1.8: Absolute number of people with dementia aged 65+.
Country of origin: Austria (Austria – NUTS2)

The graphics below highlight which immigrant groups are estimated to be the most affected at the NUTS2 level. The first map illustrates the absolute numbers of PwM with dementia in the NUTS2 regions (figure 3.7.1.9). The second graph shows the number of PwM with dementia per 100,000 inhabitants aged 65 or older in the NUTS2 regions. (figure 3.7.1.10). The values from the NUTS2 level can be found in table 6 [7, 8].

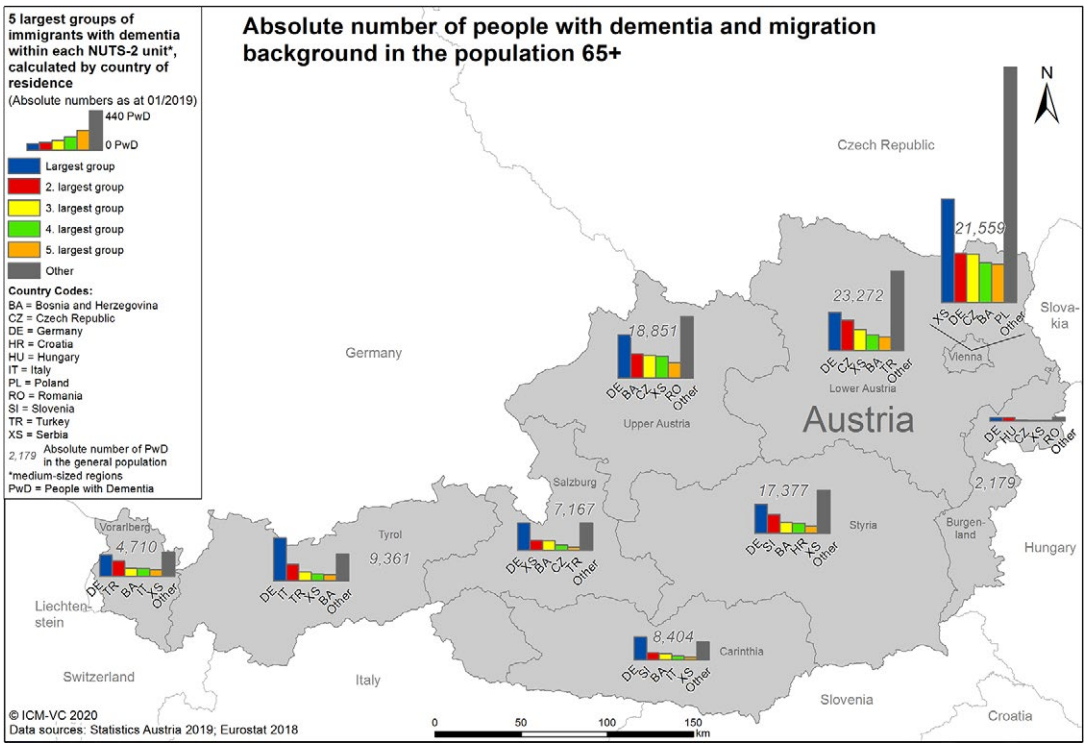

Fig. 3.7.1.9: Absolute number of PwM with dementia aged 65+ (Austria – NUTS2)

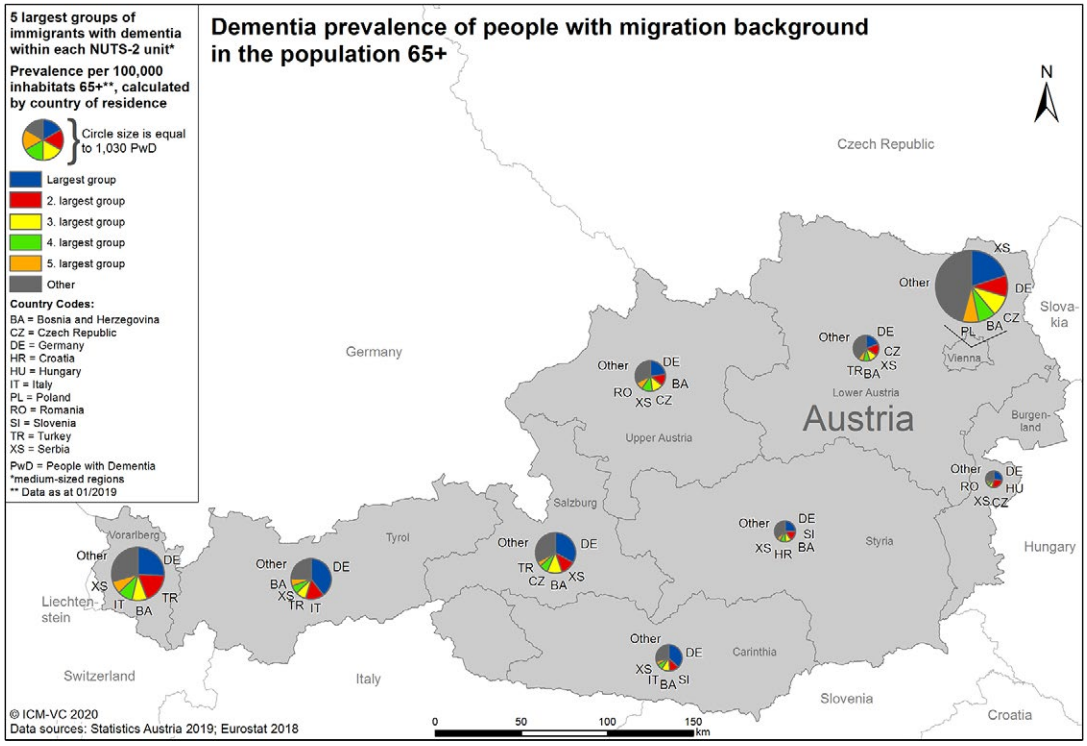

Fig. 3.7.1.10: Prevalence of PwM with dementia among the population aged 65+ (Austria – NUTS2)

Tab. 6: PwM with dementia: Absolute numbers, prevalence among PwM aged 65+, and prevalence among overall population aged 65+ (Austria – NUTS 2)

NUTS	Total	AT	1. largest group	2. largest group	3. largest group	4. largest group	5. largest group	Other
Absolute Numbers								
Burgenland	2,179	2,042	DE 38	HU 35	CZ 10	XS 8	RO 7	39
Lower Austria	23,272	21,085	DE 420	CZ 334	XS 233	BA 172	TR 151	877
Vienna	21,559	15,832	XS 1,150	DE 547	CZ 538	BA 443	PL 426	2,623
Carinthia	8,404	7,593	DE 302	SI 96	BA 84	IT 54	XS 38	237
Styria	17,377	16,040	DE 329	SI 210	BA 121	HR 115	XS 78	484
Upper Austria	18,851	16,771	DE 477	BA 268	CZ 249	XS 242	RO 169	675
Salzburg	7,167	6,101	DE 351	XS 127	BA 126	CZ 71	TR 42	349
Tyrol	9,361	7,964	DE 551	IT 212	TR 117	XS 92	BA 81	344

Austria

NUTS	Total	AT	1. largest group	2. largest group	3. largest group	4. largest group	5. largest group	Other
Vorarlberg	4,710	3,807	DE 233	TR 166	BA 85	IT 82	XS 70	267
Prevalence/10,000 inhabitants with migration background 65+								
Burgenland	10,903	-	DE 189	HU 175	CZ 52	XS 41	RO 33	200
Lower Austria	7,342	-	DE 133	CZ 105	XS 74	BA 54	TR 48	276
Vienna	2,597	-	XS 138	DE 66	CZ 65	BA 53	PL 51	317
Carinthia	7,155	-	DE 257	SI 82	BA 71	IT 46	XS 32	202
Styria	8,968	-	DE 170	SI 108	BA 62	HR 59	XS 40	251
Upper Austria	6,253	-	DE 158	BA 89	CZ 83	XS 80	RO 56	224
Salzburg	4,639	-	DE 272	XS 82	BA 81	CZ 46	TR 27	182
Tyrol	4,622	-	DE 272	IT 105	TR 58	XS 46	BA 40	169
Vorarlberg	3,600	-	DE 178	TR 127	BA 65	IT 63	XS 54	203
Prevalence/100,000 inhabitants 65+								
Burgenland	6,900	6,463	DE 120	HU 111	CZ 33	XS 26	RO 21	126
Lower Austria	6,900	6,252	DE 125	CZ 99	XS 69	BA 51	TR 45	259
Vienna	6,900	5,067	XS 368	DE 175	CZ 172	BA 142	PL 136	840
Carinthia	6,900	6,235	DE 248	SI 79	BA 69	IT 44	XS 31	194
Styria	6,900	6,369	DE 131	SI 83	BA 48	HR 46	XS 31	192
Upper Austria	6,900	6,139	DE 174	BA 98	CZ 91	XS 88	RO 62	248
Salzburg	6,900	5,874	DE 338	XS 122	BA 121	CZ 69	TR 40	336
Tyrol	6,900	5,870	DE 406	IT 156	TR 86	XS 68	BA 60	254
Vorarlberg	6,900	5,577	DE 341	TR 244	BA 124	IT 121	XS 103	390

Data source: Statistics Austria (2019)

3. National dementia plan

For Austria, two national documents that support care planners and care providers in developing strategies and action plans to improve the living and care situation of people with dementia and their relatives were found. The first document of this type, the 'Austrian Dementia Report 2014', was published in January 2015. This document has a separate chapter on migrants with dementia. It comprises four pages and points to the problems of late diagnosis and the lower utilisation of care services, especially by migrants from Turkey. In this chapter, reference is made to various international studies on the situation of dementia patients with a migration background and, in a separate section, to a national study on the care of migrants with dementia from Turkey (Barkhordarian 2013). The report points to major gaps in information on dementia and migration. For example, it says that no definitive statements can be made about the number of PwM with dementia and on their care situation in Austria. Moreover, it also discusses the evident lack of migrant-specific healthcare services, especially with regard to dementia prevention. In general, there seem to be both qualified dementia experts and qualified migration experts, but there is a lack of cooperation, exchange, and networking between these two groups. Dementia experts seem to know little about the needs of migrants suffering from dementia and their family carers, and conversely, migration experts and family carers seem to lack information on suitable prevention or healthcare services. The gaps in information and knowledge and the lack of migrant-specific prevention services, together with the use of dementia diagnostic tools that are not suitable for migrants, and language barriers are cited as reasons why migrants with dementia are often diagnosed later than non-migrants. Results of the national study on the care of migrants from Turkey with dementia mentioned above indicate that PwM with dementia from Turkey rarely make use of formal care services and that their family caregivers hardly use any support services. Cultural and religious factors are mentioned as central causes for this tendency. Healthcare providers are encouraged in this report to pay special attention to the needs of PwM with dementia. Specific needs may arise inter alia from taboo and fear of stigmatisation within the community, as well as previous traumatic experiences associated with migration history, which can again become a problem in the case of dementia. To better address the needs of migrants, native speakers with intercultural experience should be employed, caregivers trained, and staff in migrant counselling centres made aware of available services. For the families of PwM with dementia, information and support structures tailored to their needs must be created. In the context of the problem of standardised dementia diagnostic procedures that are inappropriate for migrants, the 'Austrian Dementia Report 2014' also refers to the screening instrument Transkulturelles Assessment mentaler Leistungen (=Transcultural Assessment of Mental Performance) (TRAKULA) developed at the University of Cologne for the detection of cognitive disorders in PwM, which has been in the testing process since 2008 (status: 2015) [9].

The second document was also published in 2015 and is entitled 'Dementia Strategy – Living Well With Dementia'. This Austrian dementia strategy contains seven impact goals and 21 recommendations for action. However, none of these goals and recommendations directly relate to migration. The document only refers to migration in two passages using different terms. First, in the section on the 'Principles for the development of impact goals and recommendations for action' at the beginning of the dementia strategy, it is stated

that in the context of identifying the needs of people with dementia and their relatives, the inequalities regarding the access of minorities and PwM to support services must be taken into account. Second, an indirect reference to migration is made within the framework of the recommendation for action for low-threshold information services, that suggests conducting multilingual information dissemination events. Overall, migration is treated as a very minor topic 'Dementia Strategy – Living Well With dementia', in contrast to the 'Austrian Dementia Report 2014'. The two recommended actions that may be relevant for PwM are set in brackets and therefore appear optional [10].

4. National dementia care and treatment guidelines

The 'Medical Guidelines for the Integrated Care of Dementia Patients' from 2011 only refers in two sentences within one chapter to a subject area that is relevant for migration. The topic of migration is briefly touched upon without explicitly addressing it. It is pointed out that neuropsychological tests for the differential diagnostic clarification of questionable or mild dementia must consider the socio-cultural background and language skills of a person. In addition, reference is made to the Mini-Cog screening test as a simple test procedure for the early detection of dementia, whose validity is not affected by linguistic and cultural differences. However, it is not pointed out that a migration background or another cultural or linguistic background can be a factor for an uncertain diagnosis and that standardised screening tests or common neuropsychological test procedures may not be suitable for these groups. Screening tests such as the MMSE or clock test are listed, without referring to problems of use with cultural or linguistic minorities. In subsequent chapters, no reference is made to problems related to dementia diagnosis or care for migrants/ethnic minorities [11]. On behalf of the Federal Ministry of Health, the scientific report 'Non-Drug Prevention and Therapy for Mild and Moderate Alzheimer's Dementia and Mixed Dementia' was published in 2015. However, this 241-page report does not refer to the topic of migration at any point [12].

The following parts on services and information for PwM with dementia, professional care, and support for family caregivers are based on an interview with an expert and reflect the experience and opinion of the expert. A selection bias in information and a discrepancy with results from the previous sections might ensue.

5. Services and information for people with a migration background with dementia

Although the topic of dementia and migration is considered very important by healthcare professionals and health experts, there currently seems to be no significant care structure. However, sufficient multilingual information material on dementia (for example in inpatient facilities) is available. In addition, there are institutions such as the Vienna-based joint venture Terra, which provides multilingual counselling, support, and mediation services for migrants in areas such as health and social welfare [13]. According to the expert, there are only a few specialised services for PwM with dementia in Austria. With regard to both inpatient and out-

patient care, models of good practice seem to exist only in individual regions, such as the transcultural outpatient clinic at the AKH (General Hospital) in Vienna. Concerning specialised services for PwM with dementia, the expert could not name such models of good practice. Since the demand is higher than the supply, the expert mentioned insufficient provision as a problem. Moreover, according to the expert, Austria has nationwide standards for inpatient care regarding the consideration of religion-based food needs (e.g. preparing dishes without pork), culture-specific needs during family visits (e.g. setting up visitor rooms for extended families), and language needs (e.g. initiating a video interpreting service at the federal level and incorporating language-support provisions such as professional interpreters and multi-lingual brochures into inpatient facilities). In terms of care for PwM with dementia, there is apparently no uniform strategy at the political or national level. How a person from this population is cared for depends on the individual care provider in the respective region. These care providers probably have different care models. One approach that is widely used and that is also part of the education of healthcare professionals is the model of validation. This means that people with dementia are being heard, accepted, and respected. In doing that healthcare professionals then might try to accommodate the persons and their needs. In the opinion of the expert, PwM with dementia are not receiving adequate care not only due to a lack of services, but also because they rarely (or never) proactively utilise the existing services. In Styria, for example, there is a gerontological psychiatric service that offers state-sponsored home visits, but is not used by PwM.

6. Professional qualification and people with a migration background in healthcare

Although there are dedicated courses on culturally sensitive care for doctors and nursing staff, culturally sensitive care does not exist as a compulsory module within a traditional medical study or nursing education according to the expert. At the level of medical and nursing academies, there are professional training and further education opportunities in intercultural care, but these are also optional courses that are offered mostly in urban areas. In rural areas, there are only a few such training courses.
An interesting characteristic of the Austrian healthcare system is the relatively high proportion of PwM among the labour force in this sector. According to the expert, the proportion of migrants (in both inpatient and outpatient care) among caregivers is at least 14 to 15%. The expert pointed out that in the sector of 24-hour care, only PwM are employed. On the basis of a change in the law introduced in the years 2006 to 2008, PwM can come to Austria as so-called free self-employed persons for a 4-week period and care for a patient at home in 24-hour care. These people are mainly women from Romania, Bulgaria, and Croatia. In general, many caregivers with a migration background originate from former Yugoslavia (for example Croatia) and border regions such as Hungary and Slovakia. The healthcare system and care providers try to use this diversity potential to meet the needs resulting from the diversity of patients and to overcome the existing language barriers between people from certain migrant groups and healthcare providers. There are currently no nationwide interpreting services in Austria, but most hospitals have language lists in which professional caregivers with different mother tongues are listed.

They are contacted and hired as needed, but there are currently no set rules or training requirements imposed on these interpreting services, which leads to various problems. Overall, the expert states that the need for culturally sensitive care is not met by sufficiently qualified professionals and cites the lack of a systematic approach and the absence of a nationwide emphasis on diversity management education as the central cause.

7. Support for family caregivers

According to the expert, family caregivers of PwM with dementia receive the same information material (in the respective mother tongue) as non-migrant family caregivers without a migration background. There is also no significant difference in the provision of other support services. However, a huge difference can be identified in the utilisation of these services as PwM tend to use the services scarcely. For instance, structurally it is possible to be insured as a caring relative in Austria. This provides the legal opportunity to be a professional family caregiver. Recognised family caregivers receive a salary and are entitled to vacation and paid rehabilitation. In principle, this structure is available to regular migrants who are part of the welfare state. Multilingual information material about it is also available. However, this opportunity is also much less used by PwM. A central and huge barrier is the bureaucratic apparatus. To receive such support services, various forms must be filled out. PwM are very often afraid of the bureaucracy and such forms. They are afraid that they will not receive assistance or will receive it very late if they fill in a form incorrectly. As a result, a large part of the services provided by organisations such as Terra to support migrants consists of filling in forms to help them apply for care allowance or support.

While the utilisation of support services by family caregivers of PwM with dementia is very low, partly due to bureaucratic and language barriers, the expert estimated the need for specialised services and information for this population as very high and very diverse. Apart from having to cope with the responsibility of being a family caregiver, which is extremely demanding even for a person without a migration background, there are specific problems, burdens, and care barriers that family caregivers of PwM with dementia are exposed to.

8. References

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