European Journal of Mental Health 4 (2009) 2, 195–219
DOI: 10.1556/EJMH.4.2009.2.3

ISTVÁN VINGENDER*, JUDIT MÉSZÁROS & JÚLIA KIS

MIGRATION POTENTIAL OF HUNGARIAN HEALTHCARE PROFESSIONALS – DYNAMICS OF ATTRACTION AND REPULSION

(Received: 18 September 2008; accepted: 25 March 2009)

The reason why the migration of healthcare professionals has not been described and analyzed yet in Hungary can obviously be found in the authenticity and the lack of this of the Hungarian society. There are several theoretical approaches to the migration processes. Each and every one of them analyzes and defines migration from a different point of view. Our goal was to find out the nature of the migration willingness and activity of Hungarian healthcare specialists. We intended to concentrate primarily on the sociological, cultural-anthropological and social-psychological aspects of this complex phenomenon. This sub-cultural phenomenon can be derived form numerous factors: (a) the family background of Hungarian healthcare specialists, (b) their typical, modal system of values when choosing a profession, (c) the fact that they are typically women, (d) the lack of former experience and knowledge of inspirations in mobility. At the Semmelweis University Faculty of Health Sciences we have already carried out several research projects and their synthesis might lead to the description of the migration trends of healthcare specialists. Four years ago, when we did a study about migration to work abroad, the number of those who predicted leaving the country for sure was the same as today. But the number of those who rejected the whole idea was far higher than nowadays. At that time 20% of healthcare specialists considered a career like this impossible, while now their number is less than 5%. When taking into consideration the fact that the recruiting processes are far more intensive and organized than they used to be, we can expect that a larger number of people can be convinced than ever before. However, the migration intentions are not definite, homogenous or final. The interventions, aiming to keep healthcare specialists in Hungary, still have a chance.

Keywords: acculturation problems, healthcare professionals, human resource management, labour market, mental problems, migration, migration of women, motivation, social integration

* Corresponding author: István Vingender, Faculty of Health Sciences, Department of Social Sciences, Semmelweis University, Vas u. 17, H-1088 Budapest, Hungary; vingenderi@se-etk.hu.

1788-4934 / $ 20.00 © 2009 *Akadémiai Kiadó, Budapest*

Das Migrationspotential von ungarischem, medizinischem Fachpersonal – Die Dynamik von Anziehung und Abstoßung: Der Grund dafür, dass es in Ungarn keine adäquate Beschreibung und Analyse der Migration von medizinischem Fachpersonal gibt, ist in der Authentizität der ungarischen Gesellschaft bzw. in deren Fehlen zu suchen. Für die Betrachtung von Migrationsprozessen gibt es verschiedene theoretische Ansätze. Jeder davon analysiert die Migration aus unterschiedlichen Perspektiven und von verschiedenen Seiten. Ziel unserer Forschungsarbeit war es, die Migrationsabsichten und -aktivitäten des ungarischen medizinischen Fachpersonals sowie deren soziale, sozialpsychologische und kulturanthropologische Eigenschaften kennen zu lernen. Wir untersuchen diesen Problemkreis einerseits aus wissenschaftlichem Interesse und als Grundlage für berufspolitische Entscheidungen, andererseits zur Unterstützung unseres eigenen Programms zur Institutionsentwicklung. Bei diesem Thema handelt es sich um ein subkulturelles Phänomen, das sich auf zahlreiche Faktoren zurückführen lässt: auf die Herkunft des medizinischen Fachpersonals, sein spezifisches modales Wertesystem, auf dem die Berufsentscheidung basiert, auf die Frage, ob es sich vorrangig um Frauen handelt, auf das Fehlen von Vorereignissen und Erfahrungen, die eventuell zur Mobilität motivieren könnten, usw. An der Fakultät für Gesundheitswissenschaften der Semmelweis-Universität versuchen wir schon seit einigen Jahren, mit unseren Untersuchungen einen Beitrag zur Erfassung des Migrationspotentials von medizinischem Fachpersonal zu leisten. In einer vor vier Jahren durchgeführten Untersuchung fanden sich genauso viele sichere Indikatoren für Arbeitsmigration wie heute, doch die Zahl derer, die diese Möglichkeit klar ablehnten, war deutlich höher: Damals hielt ein Fünftel des medizinischen Fachpersonals eine solche Karriere für ausgeschlossen, heute sind es nur noch knapp 5%. Wenn man berücksichtigt, dass die Rekrutierung von medizinischem Fachpersonal im Ausland heutzutage wesentlich besser organisiert ist und intensiver erfolgt, ist zu erwarten, dass ein größerer Anteil als früher dazu zu bringen sein wird, eine Stelle in einem anderen Land anzunehmen. Gleichzeitig aber lassen die Migrationsbemühungen bzw. -vorstellungen nicht alles andere irrelevant werden, sie sind nicht homogen und nicht fatalistisch. Für Interventionen, die die Arbeitnehmer in der Heimat zurückhalten wollen, ist es noch nicht zu spät.

Schlüsselbegriffe: Akkulturationsprobleme, medizinisches Fachpersonal, Personalmanagement, mentale Störungen, Migration, Migration von Frauen, Motivation, soziale Integration

As participants in several international research and professional network building projects (CD-Master, Cost, DG Sanco), we, at the Semmelweis University Faculty of Health Sciences, are concentrating on the migration potential of healthcare specialists in our scientific research work.[1] We decided to analyze the participation of Hungarian graduate healthcare workers in international integration processes, the social-psychological and cultural-anthropological characteristics thereof, partly for scientific interests and to assist political decision making, partly for developing our own institutional programs.

[1] VINGENDER, I., E. NAGY, A. DOBOS, M. PÁLVÖLGYI & E. GARAJ (2005) 'Egészségügyi szakdolgozók mobilitása, migrációja és társadalmi-szakmai beilleszkedése az európai integrációs folyamatok tükrében' (manuscript).

1. The main points and theoretical background of migration, relevant to our research

The willingness to emigrate or to find work abroad for healthcare professionals in Hungary is considered to be the current burning issue and possibly that of the up-coming years in social and professional politics of the country. The general and the professional public are alike flooded by the questions caused by the migration of healthcare workers from Hungary and the neighbouring countries, their reasons and motives and of course the resulting social and professional vacuum in their homeland. The present mobility trends are obvious, not only showing the fact that the new wave of migration trends mainly affect the professional employees in the healthcare system, but also the unusually intensive and direct social effects they go along with.

The exodus as the inherent migration trends (FEJÉRDY et al. 2004) of the medical doctors is a more and more widely known fact in Hungary, and an increasing number of reports, based on research, are born about the dark future. Although in Poland and the Baltic States for instance, the joining to the EU and the partial opening of the labour market caused a mass migration towards the so-called Western countries, in Hungary the medical doctors' society seems to have not reacted so actively and in significant numbers to the new challenges.[2] The Hungarian healthcare workers' tendency to migrate is still lower; according to the annual report of the Hungarian Association of Healthcare Professionals 103 people (out of approximately 100,000 members of that professional group) officially went abroad to work in 2007. Of course there are bound to be many more emigrants, but the exact number of them is not known.

The professional working society of the healthcare system includes more than just medical doctors though, there are also the healthcare specialists. Only a few and rather theoretical statements have been published about their willingness and actual practices in migration up to now. Most of the time these statements carry a message to society, according to which healthcare specialists react to the anomalies between the Hungarian professional situation and the opportunities to work abroad, similarly to the practice of the MDs, by migration as the faraway possibilities look more seducing.

The Western European scientific society has been for several decades dealing with both the theoretical and practical questions of migration (DIALLO 2004; STILWELL et al. 2003; BUCHAN et al. 2003). In the meantime in Hungary this problem could not receive a coherent and synthetic scientific base, despite there being a few isolated endeavours to describe the question on a theoretical and empirical basis. The reason why migration has not been described and analyzed yet can obviously be found in the authenticity and the lack of this in the Hungarian society. The problem of migration is

[2] BALÁZS, P. (2003) 'Migráció a magyar orvostársadalomban, és az 1989-es rendszerváltozás hatása', *Egészségügyi Gazdasági Szemle* 4, 5–12.; BALÁZS, P. (2005) 'Migrációs hatások leképeződése a magyar orvostársadalomban', *Informatika és Menedzsment az Egészségügyben* 2, 5–10.; EKE, E., E. GIRASEK, E. GAAL & M. SZÓCSKA (2007) 'Migrációs potenciál és motivációs erőtér a magyar rezidens orvosok és orvostanhallgatók körében', (Research data 2004–2007, Semmelweis Egyetem Egészségügyi Menedzserképző Központ, Magyar Rezidens Szövetség, manuscript).

a brand new one in scientific thinking and in political decision making alike, since Hungarian society has always been sort of unopened for centuries (not counting foreign occupation, shared thrones and other historical phenomena, which could not be counted as modern types of migration). Accepting all these characteristics, international migration research and the theoretical work based on it can be effectively used in many ways to organize the knowledge related to this specific problem.

There are several theoretical approaches to the migration processes (RAVENSTEIN 1885; PAPASTERGIADIS 2000). Each and every one of them analyzes and defines migration from a different point of view. The various theories are remarkable not only because they allow a multi-faceted analysis of this complex question, but also because they offer diverse causality-based explanations for the migrating ambitions and procedures. For that reason, the analysis of healthcare specialists' migration can only be based on these theoretical systems as interpretation fields. In Massey's opinion, migration may be defined within the confines of the neoclassical and modern economic theories, the concepts of the dual labour market, the workforce supply, the world system, the network and institution theory and the cumulated causalities (MASSEY et al. 1998). Following these concepts the migration processes always derive from the unequal conditions of the labour market, the decrease of risks and the relative surplus of incomes, the labour needs and seducing conditions of the developed countries, the globalization, the network of emigrants and its supportive potential, the institutional objectivation of migration and the social labelling of several social-economic indicators.

So, in the case of healthcare specialists we intend to answer the following questions: what kinds of labour market forces attract them to go and work abroad; how strongly they are influenced by the net profit seeker strategy; how much they are motivated by the subjective deprivation and the ambition to be objectively relatively privileged; how much they are able to integrate into the worldwide globalization processes – the economic, cultural and social dimensions included –; and what kinds of social network and institutional migration organizations support them in fulfilling their ambitions.

To the above theories of migration many other micro-social indicators can be added as they can all affect the 'letting-go' and 'letting-in' potential of a country in question. Portes and Böröcz explain the intensity and strength of 'leaving' a country by the 'keeping forces' of the collectivities and the migration propensity. Under the term 'collectivity' they define companies and societies like the state, the region, the city, the workplace collectivity, even the family. The second term describes mainly those cultural traditions, which do or do not allow the chances of mobility to be formed in a society or in one of its sub-cultures – this includes past migration experience, on which the individual or the group might build the present willingness to migrate. When analyzing these micro-social factors of healthcare specialists, they all seem relevant. Since migration is taking place among countries sharing the same structure of higher education (PORTES & BÖRÖCZ 1989), the question how the introduction of the 'Bologna System' to Hungarian higher education affects the migration ambitions of healthcare specialists seems quite important.

What effect does the implicit, structural and cultural entity of the cognitive factors which appears strongly in the migration processes in the background have on the specific waves in the mobility of healthcare specialists? The globalization of knowledge, way of thinking, beliefs and values are generally important supporters of migration ambitions (COHEN & KENNEDY 2007). The question is how these conditions are present in the life of Hungarian healthcare specialists and how they regulate the steps taken towards migration.

The research into and theoretical framework of migration have for a long time considered women as 'left behind' members of a society. Men used to be mainly the active participants of migration, while women were left in their homeland bound to their social duties. Later, women started to take an active part in migration and their proportion steadily increased in the migrating population, and by the middle of the 90s women outnumbered men in migration (CAMPANI 1995). The migration of women poses several serious social questions from the viewpoint of the country of origin and destination, too: different structures of education, family contexts, children, different content of health-spectrum, health-culture and health-behaviour, keeping contact with 'home', other types of abilities in acculturation, and so on. Among migration theories, the migration of women has become a specific field, an individual field of science. Most Hungarian healthcare specialists are women. Based on this fact the gender-specific migration characteristics may be looked upon as primary questions and should be taken into consideration.

One of the most relevant questions of migration is the problem of identity, even if it leads to social-psychology and cultural-anthropology. On the one hand, identity in the way of conditions and forms exists before the migration process itself, on the other hand, what happens to the identity of the migrated, what metamorphosis he/she survives and which conflicts he/she has to deal with and last but not least, how the identity of the migrated is affected by these changes. Concerning these questions, an important change has happened in the world of paradigms lately. Past theoretical concepts, which used to emphasize the acculturation problems, have been replaced by new concepts, especially the transnational theory, underlining the fact that emigrants are moving in a single, unique social space in the globalized world, between their 'left' and the 'new' country. Telecommunication, transportation, the reality of global societies, the global world narrow in space, and the intensity of cultural relations can significantly reduce the pressure and crisis in identity caused only by migration (BRETTELL 2000).

The analysis of the identity predispositions leading to the migration of healthcare specialists is one of the most important parts of our research. This question is even more important if we consider the fact that the professions in healthcare are generally filled with identities. The fact is that this is connected to the profession, the professional knowledge and experience itself, so maybe the identity is the factor of motivation and generating the mobility.

Last but not least, there are several migration researches which analyze the connection between migration and the mental health of the individual. Referring to Ingleby and Waters, they found that even if the different populations of migration – e.g. refugees

or emigrants – find themselves in a special mental state, having specific mental symptoms, they do not receive appropriate mental care. The maximum is to get help and care from the institution and collectivity's culture born to handle the mental problems of the inhabitant society (INGLEBY & WATERS 2005). In case of healthcare workers, the awaited and expected mental problems might appear in a special context: first, the social and psychological pressures and conflicts behind the migration ambitions; second, the weight of a migration without previous experience; third, the more direct sensitivity towards health-relevant mental problems, even on a prospective manner.

2. The problem – focal points, questions, goals

In this study we intend to highlight those segments of migration problems, which are relevant to answering such questions as:

1. What is the social, cultural, cognitive and mental context of the healthcare specialists' migration like, both of the already active employees and the future ones?
2. What is the migration type of healthcare specialists?
3. What are the paradigms to describe the migration forms motivating healthcare specialists?

So, our goal was to find out the nature of the migration willingness and activity of Hungarian healthcare specialists within the frame defined below and by the help of our own focal points. We intended to concentrate primarily on the sociological, cultural-anthropological and social-psychological aspects of this complex phenomenon. In our opinion, based on this knowledge not only the Hungarian healthcare system's HRM (Human Resource Management) can be calculated more precisely, but by intervening in the fields of special politics or of training, the probable undesired effects of migration processes could also be minimalized.

When one is willing to know more about the migration potential of Hungarian healthcare specialists, the following specific questions appear:

1. Can any trend-like change be described and/or foreseen between the present migration activity and that of the following few years?
2. How long do healthcare specialists plan to stay abroad, what for, under what kinds of conditions? What is its mythology and social-environmental background like?
3. What are the factors which can differentiate the strength of migration willingness: age, marital status, attachment to a group of the same specialization in work, or speaking foreign languages, or something else?
4. How strongly do the intercultural and multicultural competencies and sensibility needed for active migration support the exodus of healthcare specialists?

These problematic questions, or focal points might only allow for a simple description of the basic situation. Nonetheless, we expect that this would also point into a professional direction based on which further research work might be done in the future.

3. Hypothesis

Being part of healthcare higher education and having an insight into the socio-cultural activity of the students, the specialists working on the field, and even that of those who already left the profession, we are quite confident to declare that the migration potential of Hungarian healthcare specialists is unique in society as a whole and also in the medical field.

This sub-cultural phenomenon can be derived from numerous factors:

- the family background of Hungarian healthcare specialists;
- their typical, modal system of values when choosing a profession;
- the fact that they are typically women;
- the lack of former experience and knowledge of inspirations in mobility.

Not only the strength of the intentions and willingness for migration, but also the characteristics of these define an authentic model of their mobility. As expected, these will orientate towards the second extremity of the following coordinates:

- permanent – temporary,
- moving abroad – working abroad,
- changing lifestyle – saving money.

This implies another question: If this is the case how can we speak about migration at all? Is it not an already known but still new phenomenon, which is also full of social integration problems, but is certainly different from the one defined among those who leave the country for good?

The practically strong socio-cultural and socio-demographic homogeneity of this professional group will probably not lead to significant differences in the migration willingness. Only the age groups or generation differences may possibly specify this potential, which factor is obviously not a healthcare-specific one.

The migration activity would certainly be broken by the lack or weakness of former experience of basic changes, of own experiences of the same kind and of the network background already existing. On the other hand, the already existing pieces of experience and knowledge influence the migration willingness negatively. Another blocking factor can be the fact that this professional group is very poorly or not at all involved in globalization.

4. Tools, directions, methods, and model of this research

For the present study the results of several researches were used, which can together answer the questions above or prove or reject our hypothesis in a synthetic way. At the Semmelweis University Faculty of Health Sciences we have already lead several researches, of which four might lead to the description of the migration trends of healthcare specialists:

1. Mobility and migration of healthcare specialists and their social-professional integration, compared to the European integration processes.

2. Marketing analysis of the target group of professional training at the Semmelweis University Faculty of Health Sciences.
3. Migration potential of healthcare specialists.
4. The follow-up analysis of healthcare specialists who graduated at the Semmelweis University Faculty of Health Sciences.

Each and every research was carried out during the last three years; the first one was performed in 2006, and the last two were done in 2007. The first one was a rather qualitative kind of research, which observed and analyzed the integration problems of primarily Hungarian speaking healthcare specialists from other countries of origin, moving to Hungary. The method was conducting interviews and analysis (N = 41). Although that research seems to be orientated towards another topic, the immigration of foreign people into Hungary, without doubt many typical problems and questions could be highlighted at the theoretical and mainly at the methodological level. Therefore, we deal with that step of the research process as a methodological preparation for other statistics based researches. Nonetheless, its results can also be used as background to the main questions. The method followed for the last three quantitative researches was filling in questionnaires through in-person interviews or via mail (N = 654, N = 307, N = 241). The first research concentrated only on employees, the other three included students and employees, too.

In the first research we could not set the goal of reaching a representative sample as the basic population had not been known at all. We could randomly choose a sample from different regions of Hungary, from different kinds of institutions. The last three researches were selected to have a precise representation of healthcare specialists' normal population in age, gender, geographic place of the work and professional group.

5. Results

5.1. Plans and background factors in migration

The majority of Hungarian healthcare specialists are planning to work abroad with more or less certainty. It is also true that their decision regarding the question is not at all final: 'Migration potential of healthcare specialists' – (N = 307)

– 12.7% of those asked are certain about going to work abroad,
– 42.8% consider this possible,
– 30.4% think it is not probable.

Only 4.7% of those asked refuse the idea of working outside the borders of Hungary. The rest (9.4%) have not thought about this question yet.

Analyzing the plans to work abroad allows reaching two strong statements. On the one hand, healthcare specialists rather tend to this kind of future. On the other hand, the number of those who foresee the building of a professional career in another country is approximately three times that of those who definitely reject the whole idea. To sum up, based on the concepts about the future we might say that half of the

healthcare specialists are going to find a job outside of Hungary, although these kinds of prognoses might not be equal to necessary realization.

Working abroad does not definitely mean having any sort of intention to move abroad forever. More than a quarter of the healthcare specialists asked (28.4%) have not even had such kinds of thoughts in mind, the rest could only imagine final emigration under the following conditions and circumstances (see *Figure 1* below):

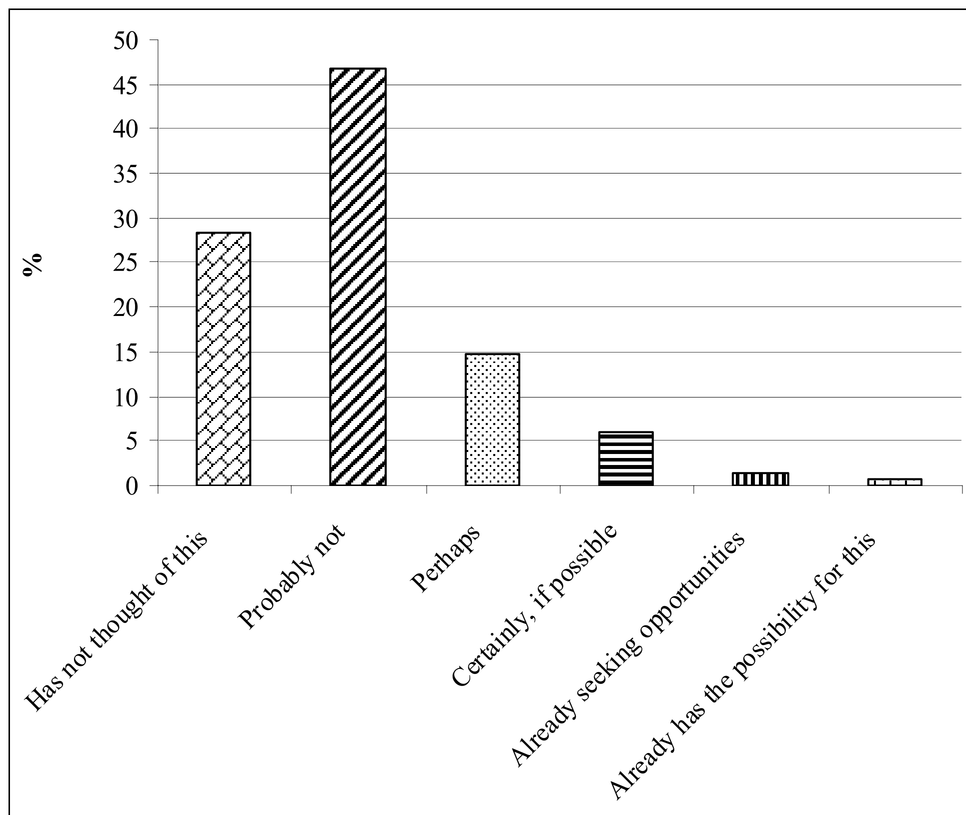

Figure 1
Are you planning to move abroad/to leave Hungary? (%) (N = 307)

Most of the healthcare specialists asked do not think about entirely moving abroad or definitely reject this idea. Hardly 20% of the employees in healthcare consider the possibility of moving to and living in another country to be real, and only a very tiny minority of them has moved towards realization so far. Among students of general medicine, 77.7% plan to move abroad. Regarding the strength of plans, the situation is quite similar to the vision of the healthcare professionals (SZÓCSKA et al. 2007). As for the willingness and tentative of migration, the sample of the healthcare specialists asked shows an ambivalent picture: They share a strong willingness to work, but reject

the idea of living abroad (emigration): 2.2% (among students of general medicine 5%) (SZÓCSKA et al. 2007). So, it can be stated that the probable migration tendencies in a standardized environment are going to be limited in time and mainly employment-related.

Considering the fact that the healthcare specialists asked were not all employed – some of them still held a student status, so were at the moment involved in study or training processes – we might ask whether they had plans of training or studying abroad behind their migration actions.

More than one-third of the healthcare specialists asked (35.4%) are willing to study in foreign countries; while most of them (31.4%) would leave Hungary only for a few months, 4% of them would like to graduate from some foreign institution. But two-thirds of the sample do not even consider the possibility of studying abroad or are not thinking about this question ($N = 654$). It seems that academic migration fits the working abroad type of migration better than the emigration type. The three analyzed migration processes and the interconnection analysis of the tentative shows another result. Namely that the migrations with different purposes finally have a strong correlation: employment is in a significant relation with emigration (Pearson's Correlation = 0.284, sig.level = 0.000) but has no connection with the study-abroad sort of migration. At the same time this last one correlates to the final move (exodus) (Pearson's Correlation = 0.198, sig.level = 0.001) but does not correlate to employment. We can see from all the above that regardless of what the reason for leaving the country is, working or studying abroad, it is firmly tied to the willingness of emigration, while the mobilities with employment or study purposes happen in the same dimension both strategically and in action taking.

The migration tentative with the purpose of having an employment, studying and emigration is not entirely segregated, but there are common points in it. Yet it is still a relevant question whether these have a model drawn or it can be found among the healthcare specialists asked or there are any well-defined clusters among them. So, the question is which groups tend to realize and follow one or the other mobility model. To find out which kinds of socio-demographic and other types of cognitive background factors that we already considered may have an impact on the initiatives of migration, we used the method of stepwise regression. We found all types of migration tentatives with different aims strongly diverge, except for one factor (foreign language knowledge). Planned migration with the purpose of working abroad (employment) finally depends definitively on having a language exam of the appropriate level and on the job opportunities.

Table 1 shows the fact that the willingness of working abroad appears in a quite homogenous form among healthcare specialists. Among the analyzed indexes only the existence of a language exam and the satisfaction level with the job opportunities in Hungary have proven significant.

Study abroad motivated mobility is specified in *Table 2*.

Table 1
Regression model of migration with the purpose of working abroad (*N* = 307)

Model	*R*	R^2	*Adjusted* R^2	*Std. error of the estimate*	*Sig.*
Language exam	0.224	0.050	0.047	0.978	0.000
Satisfaction with job opportunities	0.255	0.065	0.059	0.972	0.000

Excluded Variables – Specialty, Sex, Date of birth, Education level, Living place, Part of the country, Existential status, What language, Life of the parents, Material opportunities, Profession, Professional language, Educational level of the father, Educational level of the mother.

Table 2
Regression model of academic mobility (*N* = 307)

Model	*R*	R^2	*Adjusted* R^2	*Std. error of the estimate*	*Sig.*
Specification	0.274	0.075	0.072	1.270	0.000
Level of studies	0.314	0.099	0.093	1.256	0.000
Language exam	0.337	0.113	0.104	1.248	0.000
Date of birth	0.354	0.126	0.114	1.241	0.000

Excluded Variables – Sex, Living place, Part of the country, What language, Satisfaction with job opportunities, Life of the parents, Material opportunities, Professional knowledge, Educational level of the father, Educational level of the mother.

Twice as many factors (4) influence these types of ambition and possible actions to be taken as in the previous group. The specification, the level of studies, the language exam again and the age. So, these basically ‘learnt’ cultural conditions and age have an influence on how strong the study abroad motivated migration is in the ideas of the healthcare specialists asked.

Finally, the case is different when speaking about leaving the country and moving abroad (emigration).

The final emigration to a foreign country definitely depends on how satisfied the healthcare specialists asked were with the lives of their own parents in Hungary, on their language exams and on their gender. This type of migration is preferably a phenomenon depending on the way of life in general, and on the individual position in life. The gender in this question is certainly not explained as a biological fact, but as a role framed by social norms, mobility chances and social controls.

Table3
Regression model of emigration (N = 307)

Model	*R*	*R^2*	*Adjusted R^2*	*Std. error of the estimate*	*Sig.*
Satisfaction with the life of the parents	0.149	0.022	0.019	1.016	0.001
Language exam	0.205	0.042	0.035	1.008	0.002
Sex	0.234	0.055	0.045	1.003	0.001

Excluded Variables – Date of birth, Living place, Part of the country, What language, Satisfaction with job opportunities, Life of the parents, Material opportunities, Specification, Professional knowledge, Educational level of the father, Educational level of the mother.

If examining the relationship between the different migration ambitions and their explanatory factors closely, it can be found that in all cases the language exam linearly defines the strength of the mobility tentative. The higher the level of the language exam, the more definite the mobility willingness is (in all 3 cases: Pearson's Chi-Square = 41.428, sig.level = 0.000). Those healthcare specialists who are satisfied with the job opportunities think less, although not significantly, of the idea of working abroad. Contrary to this, those who have to face difficulties in this field seek opportunities in foreign countries in higher numbers (Pearson's Chi-Square = 29.704, sig.level = 0.075, Pearson's R = –0.098, sig.level = 0.09).

The study abroad possibility is mainly chosen by those working/studying specially in nursing (Pearson's Chi-Square = 53.825, sig.level = 0.001, Pearson's R = 0.274, sig.level = 0.000), those who are younger (Pearson's Chi-Square = 173.865, sig.level = 0.027, Pearson's R = 0.021, sig.level = 0.721), and those having a higher education level (Pearson's Chi-Square = 39.911, sig.level = 0.005, Pearson's R = 0.235, sig.level = 0.000).

The possibility of finally moving abroad (emigration) is a preferred choice of men (Pearson's Chi-Square = 19.050, sig.level = 0.582, Pearson's R = 0.117, sig.level = 0.044), and those who are satisfied with the way of life of their parents (Pearson's Chi-Square = 60.114, sig.level = 0.000, Pearson's R = –0.149, sig.level = 0.010).

5.2. The attributes of time and place in migration

The migration processes do not only mean leaving a country but also getting somewhere. So, we can say healthcare specialists finally decide to leave Hungary based on and mainly because of difficulties in employment, individual lives, and typical attitudes of different lifecycles. Another important question is what attracts, motivates them in migration, what can be behind their mobility.

Table 4
Which are the preferred points of working abroad (N = 307)

	%
Work must be legal	59.9
Position equal to level of studies	58.5
High salary	56.2
Useful experience	50.8
Information on the job before getting there	47.8
Good career opportunity	25.4
Depending on the opinion of the family or partner	21.1
Can study while working	14.4
Other	3.7
'I do not know'	2.3
'Position does not matter, I would do anything'	0.7

The preferred points of view in working abroad reflect a special professional culture. Healthcare specialists do not fit into the nowadays so fashionable employment strategies. First, the stability of the employment means the most for them. The legality of the job taken is the strongest, and the 'does not matter what' opportunity is the weakest preferred value for healthcare specialists. At the same time the professional motivation and relation is also very strong, while the high salary can be a motivating aspect. But it seems the career, the social, environmental and study factors do not play any special role in their willingness to migrate. Of course these viewpoints of choice describe different trends in the sample.

The final result of factors (4 factors) can explain over 50% of the original information (Explained % of Variance for the first four factors: 16.826, 12.205, 11.205, 9.837%), so they can be accepted as ways of reducing items.

We can observe the following in the foreign employment (working abroad) strategies of healthcare specialists:

– There is a conscious, well-defined strategy seeking legal and social stability.
– There is an individual, independent, professionally well-founded selection mechanism working in the background.
– There is a career and salary centred decision making model.
– There is a free choice making model motivated by the possibility of studying, and gaining experience.

These trends are rather independent and basically describe all migration tendencies among healthcare specialists. Based on the examined factors it can be said that it is not a homogenous decision and choice making culture but it is the influence of

Table 5
The rotated factor matrix of the social background indexes of working abroad
(N = 307)

	Component				*Initial Eigenvalues*		
	1. Legal and social stability	*2. Professionality*	*3. Career and salary*	*4. Studies and gaining experiences*	*Total*	*% of variance*	*Cumulative %*
Level of studies	0.159	0.749	–0.009	–0.049	1.851	16.926	16.926
Salary	0.195	–0.130	0.710	–0.075	1.343	13.475	30.301
Experience	0.072	0.529	0.152	0.441	1.233	12.205	41.236
Better career	–0.087	0.082	0.780	0.100	1.082	10.837	51.073
Studying	0.130	–0.088	–0.163	0.733	0.965	9.775	59.848
Legal	0.681	0.281	0.109	0.058	0.939	9.536	68.384
Information	0.788	–0.045	–0.144	0.118	0.886	9.358	76.743
Whatever	0.026	–0.071	0.127	0.643	0.818	8.432	83.868
Family	0.411	–0.431	0.136	0.002	0.710	7.455	100.00

rather strongly differentiated motivation factors that lead our colleagues abroad. The correlations of the individual factors (decision and choice making viewpoints) were examined by several socio-demographic and professional groups, with correlation calculations. But no significant correlation could be found between them and the factors mentioned. This fact means that the strategy of foreign employment is not organized based on well-defined professional-social groups of certain life situations, but it is rather formed based on individual value preferences. We can only report the relatively strong trends of these latter ones.

5.3. Time, place and goal aspects of migration tentative

The aspect of time in case of the study-abroad type of migration has already been analyzed and shown. In general, it could be said that healthcare specialists can only imagine a few months spent abroad studying, but to think of staying for a longer term in a foreign country is not yet typical among them. The dimensions of time when speaking about moving abroad forever (emigration) are quite self-explanatory. Thus, the only real question is related to the idea and length of working abroad. The actual dilemmas in professional and training policies also appear in this dimension of migration.

More than one-third of healthcare specialists (38.1%) tend to stay and work abroad for several years. Less than 20% of the healthcare specialists asked plan to work in a foreign country for a much shorter period of time and 10% of them would

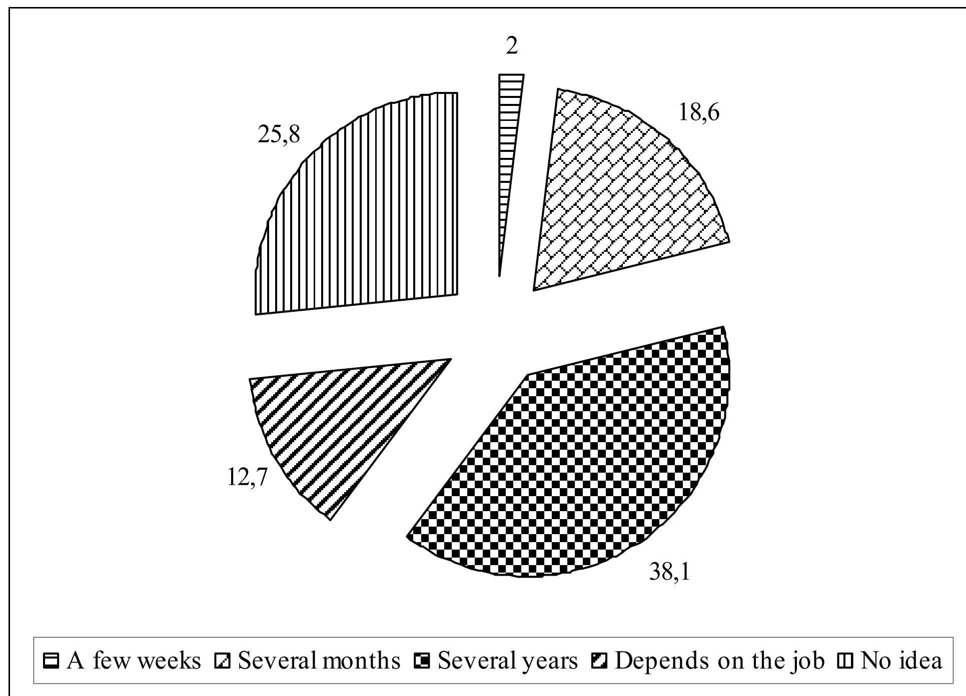

Figure 2
How long do you intend to work abroad? (%) ($N = 307$)

stay abroad depending only on the job opportunities. 25% do not have any exact idea concerning the length of their stay abroad. All this demonstrates the fact that those who are planning to leave Hungary to work in a foreign country do not share common views on the length of time to be spent abroad either. This trend also suggests that there is no standard, homogenous vision in case of migration in the minds of the healthcare specialists asked.

The most important motivating factors in migration tentative are the financial ones and the possibility to learn the language. The opportunities in gaining experience do have an important role in the formation of the willingness in migration. However, self-realization, network building and job opportunities in themselves do not constitute any relevant attractive factor. So, it is the cultural and capital gathering strategies that primarily motivate the tentative to work abroad.

The motivating values can be placed in three well-defined categories of factors. In the first factor a definitively self-realizing, auto-expressive, identity seeking model can be expressed. In the second one the existence-building, material capital gathering model, while in the third one the work and position oriented thinking can be recognized. Though there might be a connection between the migration strategies and certain socio-demographic or employment market indicators, altogether it can only be said

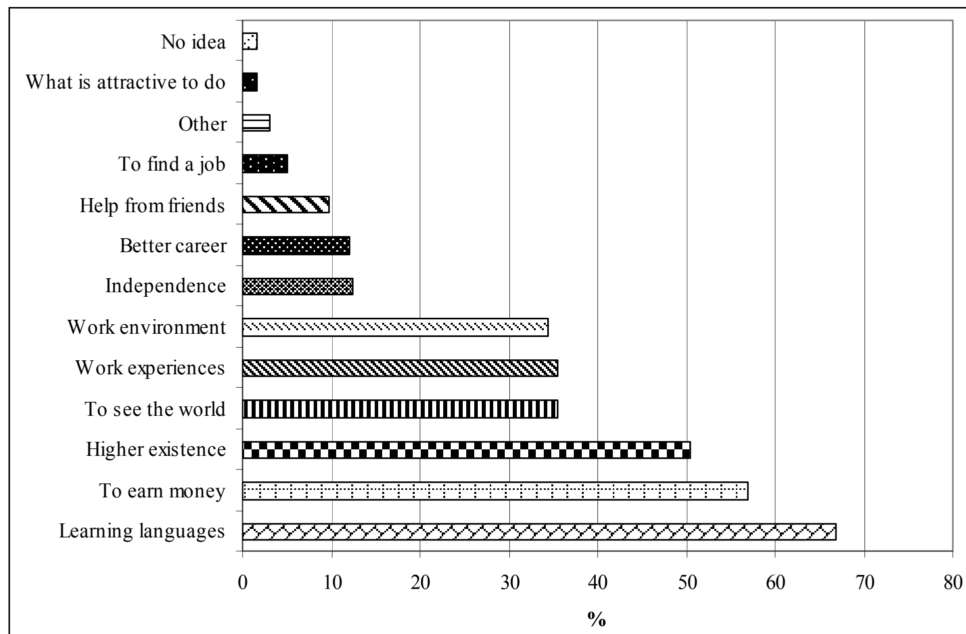

Figure 3
Why would you go and work abroad? (%) (N = 307)

that regarding the motivation system of working abroad no similarly exact model can be seen. As a result, the healthcare specialists interviewed do not form any cluster that could be well-segregated based on the reasons why they would like to work in a foreign country. It is probable that the individual lives, unique cognitive structures, individual life philosophies organize them in one or another model.

5.4. The power lines of the migration potential

As it was already mentioned above, migration intentions and steps always derive from factors leading and attracting towards that same purpose. The migration action is always a result of the motivating potential of two environments: the one which 'lets go' and the other, which 'welcomes'. The main question though is to identify the dominant one. Based on linear regression analysis we can say that in case of all three migration types the welcoming environment has a substantially stronger influence than the other one. The final moving decision is determined by the factors summarised in *Table 7*.

The job opportunities in other countries, the better career possibilities and the dissatisfaction with the lives of the parents are the explanatory reasons of this migration model. To sum up, attractively better conditions and the individual lives' repulsion effect can end up in this form of mobility.

Table 6
The factor matrix of motivations in working abroad ($N = 307$)

	Component			*Initial Eigenvalues*		
	1. Self-realization	*2. Building existence*	*3. Work and position orientation*	*Total*	*% of variance*	*Cumulative %*
To see the world	0.632	0.021	0.154	1.874	14.417	14.417
Learning languages	0.598	0.266	–0.126	1.488	12.449	26.865
Independence	0.667	–0.076	0.024	1.202	10.249	36.114
Work experience	0.332	0.071	–0.422	1.062	9.171	44.285
To earn money	0.058	0.368	–0.107	0.989	8.607	51.892
To find a job	0.095	0.090	0.595	0.964	8.416	59.307
Better career	–0.123	0.477	0.250	0.922	8.092	66.399
Higher existence	–0.163	0.571	0.241	0.855	7.580	72.980
Work environment	0.049	0.334	0.496	0.835	7.421	79.401
Help from friends	0.121	–0.030	0.536	0.793	7.100	91.063
What is attractive to do	0.500	–0.138	0.140	0.723	6.499	100.00

Table 7
The regression model of moving abroad (emigration) ($N = 307$)

Model	*R*	R^2	*Adjusted* R^2	*Std. error of the estimate*	*Sig.*
Work environment	0.224	0.050	0.047	1.002	0.000
Better career	0.267	0.071	0.065	0.992	0.000
Life of the parents	0.300	0.090	0.080	0.984	0.000

Excluded Variables – To see the world, Learning languages, Independence, Save money, Finding job, Higher existence, The help of a friend, What is attractive to do, Concrete language, Specification, Living place, Professional knowledge, Educational level of the father, Educational level of the mother.

Mobility with the purpose of work is mainly motivated by adventure seeking, a better expected work environment and conditions in the welcoming country and also by an unsafe and unformed attitude. It can be seen that the migration process, preferably as a value in itself, motivates this strategy, and the positive image of the work environment attracts the most those who were asked.

Table 8
The regression model of working abroad (N = 307)

Model	*R*	R^2	*Adjusted* R^2	*Std. error of the estimate*
To see the world	0.214	0.046	0.043	0.980
Work environment	0.254	0.064	0.058	0.972
No idea	0.282	0.079	0.070	0.966

Excluded Variables – Learning languages, Autonomy, Work experiences, Save money, Finding job, Better career, Higher existence, Help of other people, Willingness, Concrete language, Life of the parents, Specialty, Living place, Professional knowledge, Educational level of the father, Educational level of the mother.

Table 9
The regression model of the study abroad mobility (N = 307)

Model	*R*	R^2	*Adjusted* R^2	*Std. error of the estimate*
To see the world	0.185	0.034	0.031	1.298
Work experience	0.237	0.056	0.050	1.285

Excluded Variables – To see the world, Learning languages, Independence, To earn money, Finding a job, Better career, Higher existence, Work environment, Help from friends, What is attractive to do, Concrete language, The life of the parents, Higher existence, Living place, Professional knowledge, Educational level of the father, Educational level of the mother.

Those who are motivated by the idea of seeing the world and becoming more experienced at work are the ones who would mainly like to go abroad to study. Finally we can see that all migration intentions, tentative are highly influenced by the attraction potential and certain conditions of the welcoming environment. The process of migration, maybe as this is a ‘new’ possibility, appears as a value, though at the same time the repulsive aspects do not gain a dominant role. Even if the life and working conditions of healthcare specialists do have problematic points, it seems these are not included in the relevance field of the migration potential.

5.5. Socio-demographic indicators of the migration intentions

The differences in migration intentions, tentative primarily appear when considering professional specializations, age, studies and language knowledge. Fewer differences can be recognized among healthcare specialists with different backgrounds, experiences or studies. It is a very interesting fact that neither the place of residence, social status, nor the subjective attitude to that could make any significant difference in

migration intentions. This can be explained by two factors: on the one hand, the migration potential possibly acts as the pre-disposition of the globalization process, and its sub-cultural aspects are hardly definitive. On the other hand, the social status of healthcare specialists, as we have already seen from the previous researches, is very homogenous.

Table 10
Plans to work or study abroad (in different specializations and in different age groups) (%) ($N = 654$)

	Mean of age	*Certainly not*	*Not possible*	*Probably*	*Surely*	*No idea*	*No answer*	*Total*
Students from the faculty of Nursing and Patient Care (full time)	19.6	3.5	16.5	48.7	21.7	8.7	0.9	100.0
Students from the faculty of Healthcare and Prevention (full-time)	20.2	5.4	25.0	50.0	12.5	7.1	0.0	100.0
Students from the faculty of Public Health Officer	29.2	5.6	33.3	27.8	0.0	33.3	0.0	100.0
Nurses	28.7	5.9	51.0	35.3	3.9	3.9	0.0	100.0
Ambulance officers	31.3	3.1	34.4	40.6	9.4	12.5	0.0	100.0
Optometrists	33.4	0.0	55.6	29.6	3.7	3.7	7.4	100.0

Pearson Chi-Square 57.422, $R = 0.000$

The differences are most visible among those who predict the migration walk of life to be chosen with certainty. Although most of the young, still studying future healthcare specialists (25% of the students from the faculty of nursing and patient care), who are still doing their studies in healthcare higher education programs are certain about working abroad, those healthcare specialists who are actively working in healthcare, generally belonging to an older generation, predict such a lifestyle for themselves in a significantly lower prevalence. Among them the prognosis is quite homogenous, except maybe in case of the ambulance officers, who can see more chances in working abroad.

We can find the same types of distributions when considering the study abroad plans, mainly in case of the short term ones (Pearson Chi-Square: 53.825, $R = 0.001$). Among the above groups no clear differences can be seen in case of the long term

mobility with the purpose of studying, similarly to the question of moving abroad (emigration).

The opportunities of mobility with the purpose of working abroad are measured in an ambivalent way by the healthcare specialists with different backgrounds and levels of studies. While those having higher levels of education, mainly those who already have a degree, are more open towards these solutions, their migration intentions are mostly in the 'possibly' category.

Those who certainly want to work abroad are mostly found in the group of healthcare specialists having only a high-school graduation. While a degree in healthcare represents an obvious value on the market and improves the chances of working abroad, people holding qualifications from higher education can fulfil their own ambitions at home, so they are not so motivated in going abroad (Pearson Chi-Square: 35.134, R = 0.019). In the meantime, the most attractive alternative for them is the short term study abroad (Pearson Chi-Square: 39.911, R = 0.059).

Table 11

Working abroad plans based on the number of language exams (%) (N = 654)

	Certainly not	*Not probable*	*Possibly*	*Surely*	*No idea*
No language exams	5.2	42.9	35.1	7.8	9.1
1 language exam	5.5	19.1	53.6	12.7	8.2
2 language exams	0.0	11.4	42.9	34.3	11.4

Pearson Chi-Square 41.428, R = 0.000

The possibilities and chances of migration for working abroad are obviously and linearly increased by having a language exam/speaking a foreign language. The same goes for migration with academic purposes: those speaking a foreign language are more open to such a career (Pearson Chi-Square: 27.233, R = 0.002). But speaking a foreign language does not afford enough background for moving abroad forever (emigration). Even if this step is also mainly taken by those who are better prepared in a foreign language, the difference, compared to those who have less competencies in foreign languages, is not significant (Pearson Chi-Square: 20.652, R = 0.111).

5.6. Characteristics of international and multinational sensitivity and competencies required for the migration activity

The analysis of the language exams highlighted the question of those cultural conditions, which allow or increase the possibility of migration for healthcare specialists. In the present study we can only examine a few elements of this cultural integrity. It is very important to show these, because one's own migration potential depends on per-

sonal attitudes and values concerning multicultural society, communities and everyday life in culturally strange circumstances.

Apart from speaking a language, that is the knowledge-cognitive type of abilities, we must mention the system of values and attitudes. These basically contain an open attitude, tolerance, communication and moderation skills towards persons and colleagues representing other cultures.

Table 12
How would you react if one of the colleagues below arrived from abroad, from an EU member country? (%) ($N = 654$)

	I would accept him/her and would be happy	*I would accept him/her but with reservation*	*I would not care about this*	*I would not be happy*	*I would be against it*	*No answer*	*Total*
Colleague of the same level	70.0	12.0	15.0	2.0	0.0	1.0	100.0
Lower level colleague	66.5	12.5	18.5	1.0	0.0	1.5	100.0
MD	60.0	22.0	14.5	2.5	0.0	1.0	100.0
Head of division MD	52.5	24.0	17.5	4.5	0.5	1.0	100.0
Professional manager	51.0	26.5	15.5	5.0	0.5	1.5	100.0
Member of maintenance	51.5	10.0	34.5	2.0	0.5	1.5	100.0
Patient	61.0	6.5	30.0	1.0	0.0	1.5	100.0
Representative of a (human) rights group	42.5	20.5	20.5	11.0	2.5	3.0	100.0
MD in private	48.5	24.5	17.5	5.5	1.0	3.0	100.0
Healthcare specialist in private	48.5	24.0	21.5	2.0	1.5	2.5	100.0
Politician in healthcare	41.0	15.0	30.5	9.0	2.0	2.5	100.0
Teacher	58.5	13.0	20.0	4.0	3.0	1.5	100.0

The general attitude tends to reflect tolerance and acceptance. This is even spiced with happy acceptance rather than acceptance with reservation. In general, it can be stated that 60–80% of the healthcare specialists asked would accept to work in the same environment with people arriving from the countries mentioned above, and two-thirds of them would be happy to do so. 15–20% of the students are neutral to the country of origin of the others, and do not care about differences of that kind or the problems that may occur based on these cultural differences. Only a very small per-

centage refused the idea of such a situation, and only 1–2 persons asked were definitely against it. This refusal appeared in higher numbers only concerning 2 positions: the representative of a (human) rights group and the healthcare politician. Every tenth student would have problems in accepting foreign people working in these positions.

Table 13
How would you react if one of the colleagues below arrived from abroad, from a so-called 'developing country'? (%) ($N = 654$)

	I would accept him/her and would be happy	*I would accept him/her but with reservation*	*I would not care about this*	*I would not be happy*	*I would be against it*	*No answer*	*Total*
Colleague of the same level	57.0	21.0	17.5	3.0	0.5	1.0	100.0
Lower level colleague	52.0	23.0	21.0	2.5	0.5	1.0	100.0
MD	48.5	28.0	16.5	4.0	1.5	1.5	100.0
Head of division MD	43.5	28.5	18.5	6.0	2.0	1.5	100.0
Professional manager	43.0	26.0	21.5	4.5	3.0	2.0	100.0
Member of maintenance	45.0	13.0	37.0	2.5	1.0	1.5	100.0
Patient	50.0	13.5	31.5	2.5	0.5	2.0	100.0
Representative of a (human) rights group	38.5	22.5	19.5	14.0	3.5	2.0	100.0
MD in private	45.5	23.5	18.0	8.5	3.0	1.5	100.0
Healthcare specialist in private	44.0	26.0	18.0	7.5	2.5	2.0	100.0
Politician in healthcare	36.5	20.0	24.5	12.5	4.5	2.0	100.0
Teacher	52.0	17.5	18.5	6.5	4.0	1.5	100.0

An interesting aspect of the acceptance attitude of the students is that while 2.5% would not accept an MD from abroad as a colleague, in private more than twice this figure would refuse to use the services of a foreign MD from another EU member country. The general acceptance attitude appears in a differentiated way when considering other specializations or professions too. It is mainly visible when speaking about working in the direct environment at the future workplace of the students asked, so MDs, same or lower level healthcare specialists. Concerning the specialists and patients appearing in any other fields, the tolerance level is lower and the accepting attitude is a little bit weaker. In the case of patients this is understandable as here the

number of 'neutrals' increases, so do those who do not care about the country of origin of the patients in question. It is possible that in this case the 'theory of functional specificity' of Pearsons works in the thinking of the students.

But it is not so easy to find the answers to the lower level of acceptance of those who are situated further away in the professional field. We receive the following results when the acceptance forms in different professional and activity fields are used as attitude scales (only conditionally).

Whilst the acceptance level of the specialists and experts arriving from developing countries in different positions has a basically similar structure to those arriving from the EU member countries, there are many differences as well. Firstly, it is definitely true that the tolerance level towards the workers arriving from developing countries is much lower than in case of the EU members. This appears in a strange relevance even in the most tolerant field, too (same or lower level colleague, MD). In these positions this is not the refusal but the number of 'acceptance with reservation' that increased compared to the number of tolerance. The students asked prefer to have patients from 'our' cultural world, rather than from further away, or from a cultural environment so different from ours.

Concerning all this it must be mentioned that based on the basic conditions in the Western European healthcare employment market, those who tend to migrate and to work abroad will have to cooperate with colleagues and specialists arriving from developing areas of the world, rather than local professionals. Not to mention the clients, who also represent a different culture.

6. Summary

To sum up, we can say that the dark vision in the public thinking about the migration of healthcare specialists in the near future has some real basis. The prognosis is definitely true inasmuch as the migration processes have certainly increased in potential during the last few years, compared to the past.

Four years ago, when we did a study about migration to work abroad, the number of those who predicted leaving the country for certain was the same as today. But the number of those who rejected the whole idea was far higher than nowadays. At that time 20% of healthcare specialists considered a career like this impossible[3], while now their number is less than 5%. When taking into consideration the fact that the recruiting processes are far more intensive and organized than they used to be, we can expect that a larger number of people can be convinced than ever before. However, the migration intentions are not definite, homogenous or final. They are linked to certain conditions, well-defined background factors. They are unsafe from many view-

[3] VINGENDER, I., E. NAGY, A. DOBOS, M. PÁLVÖLGYI & E. GARAJ (2005) 'Egészségügyi szakdolgozók mobilitása, migrációja és társadalmi-szakmai beilleszkedése az európai integrációs folyamatok tükrében' (Manuscript).

points and do not affect the whole professional group. The interventions, aiming to keep healthcare specialists in Hungary, still have a chance.

Concerning migration types, study (academic) and work (career) purposes dominate. But among healthcare specialists emigration (moving abroad) is not a preferred model. The first two models are very strongly linked. Partly because they have common parts, and partly as one guarantees the other. Yet, the third model is segregated, even on the level of its appearance, and in addition this is not linked to the other two. All this means that the temporary migration and the temporary 'profit increasing' aspect of mobility dominates, but the idea of moving abroad, to leave the country (emigration) do not play any important role in the thinking of healthcare specialists and in their walks of life.

In the background of the above mentioned forms of migration, the following factors have a differentiating role: specialization and education, a job opportunity adding up to these, language skills, gender and age. At the same time, other more specific socio-demographic factors like origin, level of education or place of residency, do not make a difference in the migration potential. This shows the fact, which was reinforced by other markers, that the individual life situations and indicators of walks of life do have a very strong impact on the tentative and willingness of migration. The group of healthcare specialists in Hungary – we speak about 100,000 people – is quite homogenous in the field of determined migration intentions.

The system of values and targets behind the working abroad mobility, which is the most important form of migration, explains quite a lot: priority in motivation is given to the safety values and career opportunities and secondly to the expansion of individual autonomy and studying. As a specific goal the financial (existence building) and language skill improvement appears.

Whilst the migration intentions have a quite homogenous background, the mobility tentative seems to be very divergent. There is no specific migration model in the thinking and life strategy of healthcare specialists. On the contrary, the general situation is composed of many smaller sub-cultures, and of individual forms, therefore we cannot speak about one single social model of migration for healthcare specialists.

Finally, the strength of migration is expected to grow modestly but continuously, as the moving and heterogenous characteristics, the unique constellations of individual factors are most probably in harmony with the fact that the professional group in question shares cultural and globalization predispositions which do not fully support the migration intentions and tentative.

References

BRETTELL, C.B. (2000) 'Theorizing Migration in Anthropology' in C.B. BRETTELL & J.F. HOLLIFIELD, eds., *Migration Theory: Talking across Disciplines* (New York & London: Routledge) 97–136.

BUCHAN, J., T. PARKIN & J. SOCHALSKI (2003) *International Nurse Mobility: Trend and Mobility Implications* (Geneva: World Health Organization).

CAMPANI, G. (1995) 'Women Migrants: From Marginal Subjects to Social Actors' in R. COHEN, ed., *The Cambridge Survey of World Migration* (Cambridge: Cambridge UP) 546–50.

COHEN, R. & P. KENNEDY (2007) *Global Sociology* (New York: Palgrave McMillan).

DIALLO, K. (2004) 'Data on the Migration of Health Care Workers: Sources, Uses and Challenges', *Bulletin of the World Health Organization* 82:8 (Aug) 601–7.

FEJÉRDY, P., J. GERLE & A. KÓBOR (2004) 'A hazai fogorvosi migráció és a decentralizált fogorvosképzés', *Informatika és Menedzsment az Egészségügyben* 8, 24–7.

INGLEBY, D. & CH. WATERS (2005) 'Mental Health and Social Care for Asylum Seekers and Refugees' in D. INGLEBY, ed., *Forced Migration and Mental Health: Rethinking the Care of Refugees and Displaced Persons* (New York: Springer) 193–211.

MASSEY, D.S., J. ARANGO, G. HUGO, A. KOUAOUCI, A. PELLEGRINO & J.E. TAYLOR (1998) *Worlds in Motion: Understanding International Migration at the End of the Millennium* (New York: Oxford UP).

PAPASTERGIADIS, N. (2000) *The Turbulence of Migration: Globalization, Deterritorialization and Hybridity* (Cambridge: Polity).

PORTES, A. & J. BÖRÖCZ (1989) 'Contemporary Immigration: Theoretical Perspectives on its Determinants and Models of Incorporation', *International Migration Review* 23, 606–30.

RAVENSTEIN, E.G. (1885) 'The Laws of Migration', *Journal of the Royal Statistical Society* 48, 167–235.

STILWELL, B., K. DIALLO, P. ZURN, M.R. DAL POZ, O. ADAMS & J. BUCHAN (2003) 'Developing Evidence-Based Ethical Policies on the Migration of Health Workers: Conceptual and Practical Challenges', *Human Resources of Health*, 1:8, (28 Oct) 1478–91.

SZÓCSKA, M., E. EKE, E. GIRASE & E.I. GAÁL (2007) 'Az egészségügy emberi erőforrásai' (Budapest: Egészségügyi Menedzserképző Központ, Semmelweis Egyetem, Magyar Rezidens Szövetség) retrieved 21 May 2008 from http://rezidens.hu/index.php?c = search&action = viewres&id = 574.