

Blessing or curse?

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Employing non-German health-care professionals at the Clinic Association Westmünsterland gGmbH

Date: 18/10/2012

Document type: Bachelor thesis

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Acknowledgments

For his useful inputs concerning the English language I would like to thank Josh. Also, I would like to thank Linda and Tobias for the continuous feedback they have been given me while I have been writing this thesis. Last, I would like to thank Anna, Martijn and Frank for being skilful, useful and fun examiners.

Abstract

The migration of health-care professionals is a widely discussed research topic today. Many countries suffer from a lack of health-care professionals, because their demand for health-care is higher than their domestic supply.

This research analyses the reasons for health-care professionals to migrate to Germany and the possible consequences that accompany their employment at the Clinic Association in Germany. This is a holding organisation, located in North Rhine-Westphalia in the county of Borken, comprising three independently operating hospitals. The goal of this research is to give advice to the Clinic Association's HRM department on how to best manage non-German health-care professionals.

A literature review has been made in order to assemble the most common push and pull factors for health-care professionals to migrate away from their country of origin. Also, the most common costs and benefits of this migration stated in the literature have been brought together. Finally, it has been reviewed what is the best possible way, according to the literature, to manage health-care professionals.

In order to enrich the research with empirical data about the push and pull factors of non-German health-care professionals and costs and benefits their employment implies for the Clinic Association, a questionnaire has been administered and an interview has been conducted, respectively.

The results showed that not every push and pull factor that has been mentioned in the literature comes forth in the case of the Clinic Association. In fact, the emphasis on push factors like bad remuneration, poor working conditions, political instability and standard of living is higher in the literature than in this particular research. What concerns the pull factors, political stability does play a minor role in this research compared to the findings in the literature. The costs and benefits were found to be almost equal to the ones presented in the literature, however, the financial benefits of the employment of health-care professionals from abroad proved to be not applicable at the Clinic Association.

In the last part of this thesis is an advice has been given to the Clinic Association's HRM department. The Clinic Association has been advised to implement a commitment-oriented HRM system in order to retain the non-German health-care professionals in the organisation, to cut advertising and training costs and make the organisation less dependent on health-care professionals from abroad.

Abstract (Dutch)

De migratie van artsen is een veel besproken onderzoeksonderwerp in de wetenschappelijke literatuur vandaag de dag. Vele landen kampen met een tekort aan artsen, omdat de vraag naar zorg groter is dan het lokaal beschikbare aanbod. Dit onderzoek analyseert de beweegredenen voor artsen om zich in Duitsland te vestigen en mogelijke consequenties die dit met zich mee brengt voor de Clinic Association in Duitsland. Dit betreft een holding organisatie, welke gevestigd is in Nordrhein-Westfalen in de gemeente Borchen, bestaande uit drie zelfstandig opererende ziekenhuizen. Het doel van dit onderzoek is het adviseren van de HRM afdeling van de Clinic Association in zake het op de beste manier managen van niet-Duitse artsen.

Een literatuuronderzoek is uitgevoerd om de meest relevante push en pull factoren te verzamelen die betrekking hebben op de migratie van niet-Duitse artsen weg van hun thuisland. Daarnaast zijn de meest voor de hand liggende kosten en opbrengsten van deze migratie, zoals in de literatuur beschreven, verzameld. Tenslotte is er een literatuuronderzoek gedaan naar de beste manier van het managen van artsen.

Om empirische data in zake de push en pull factoren met betrekking tot de niet-Duitse artsen en de kosten en opbrengsten die dit oplevert voor de Clinic Association in kaart te brengen, is gebruik gemaakt van een vragenlijst en zijn er interviews afgenomen, respectievelijk.

De resultaten laten zien dat niet elke push en pull factor welke omschreven is in de literatuur betrekking heeft op de situatie in de Clinic Association. Feitelijk is het zo dat de nadruk op push factoren als slechte betaling, slechte werkomstandigheden, politieke instabiliteit en levensstandaard hoger is in de literatuur dan in dit specifieke onderzoek. In zake de pull factoren, politieke stabiliteit speelt een beperkte rol in dit onderzoek in vergelijking met de gegevens zoals deze gevonden zijn in de literatuur. De resultaten met betrekking tot de kosten en opbrengsten laten vergelijkbare uitkomsten zien met die in de literatuur. Echter, de financiële voordelen van de tewerkstelling van artsen uit het buitenland bleek niet te gelden in het geval van de Clinic Association.

In het laatste deel van deze thesis wordt een advies uitgebracht aan de HRM afdeling van de Clinic Association. Het advies behelst het implementeren van een commitment-georiënteerd HRM systeem met als doel om de niet-Duitse artsen voor lange tijd aan zich te binden en hiermee de uitgaven met betrekking tot werving en selectie en trainingen te beperken en minder afhankelijk te worden van een constante toevoer van buitenlandse artsen.

Table of Contents

Abstract	2
Abstract (Dutch)	4
1. Introduction	6
1.1 The migration of health-care professionals	6
1.2 The origin of scientific interest in health-care professional migration	6
1.3 Is the migration of health-care professionals worth researching today?	7
1.4 Research problem	8
1.5 The Clinic Association	8
1.6 Research purpose	10
1.7 Research question	10
1.8 Research approach	10
1.9 Research subquestions	11
1.10 Relevance of the research	12
2.0 Theoretical Framework	12
2.1 Migration: a theory of push and pull factors	15
2.2 Push factors of migration	15
2.2 Pull factors of migration	19
2.3 Benefits and costs of migration for receiving countries of health-care professionals	21
2.4 Managing health-care professionals	23
3.0 Methodology	29
3.1 Data gathering	29
3.1.1 Questionnaire	30
3.1.2 Interview.....	31
3.2 Justification	32
3.2.1 Questionnaire	32
3.2.2 Interview.....	32
3.3 Data processing	32
3.3.1 Questionnaire	33
3.3.2 Interview.....	33
4.0 Results	33
4.1 Results of the questionnaire	33
4.2 Results of the interview	39
4.3 Adapted conceptual model	42
5.0 Discussion	43
5.1 Limitations and further research suggestions	47
5.2 Advice to the Clinic Association	47
Appendix	56

1. Introduction

1.1 The migration of health-care professionals

The migration of health-care personnel is a widely discussed research topic today (Gibson & McKenzie, 2011). Especially the migration of health-care professionals (Smith, 2008; Stewart, Clark, & Clark, 2007) has been given a lot of attention by researchers. The global shortage of health-care personnel (World Health Organization, 2006) ignited a battle for qualified health-care professionals amongst countries that are not able to self sustain their demand. Health-care professionals are no longer being lured to the organisations offering the best possible working conditions *within* their country, but rather to organisations in other countries providing the best possible offer. The labour market for the health-care sector has thus globalised (Stewart, Clark, & Clark, 2006) and accompanying this globalisation is an increasing migration of health-care workers from one country to another. It goes without saying that the migration of professionals does not exclusively happen in the health-care sector. Other sectors are concerned as well (Gibson & McKenzie, 2011) and show similar migration trends of highly skilled and rare personnel.

1.2 The origin of scientific interest in health-care professional migration

The migration of health-care professionals between countries has not always been in the focus of science. In fact, British researchers first began to analyse this phenomenon during the mid-1950s in order to gain insights on the social and professional consequences of the emigration of British medical graduates to North America, Australia and New Zealand (Wright, Flis, & Gupta, 2008). Researchers were concerned about the fact that the knowledge generated in Britain did not find any utilisation in the domestic health-care sector, but in other countries instead.

In the 1960s and 1970s, researchers extended their efforts of analysing these migration patterns to other English-speaking countries like the United States and Canada. These countries generated scientific interest, because of their alarming shortage of physicians and the consequent reliance on foreign-trained health-care professionals in order to fill the gap of missing health-care professionals in their domestic health-care systems (Wright, et al., 2008).

By 1972, researchers were forced to realise that the migration of health-care professionals does not exclusively happen in the Western countries mentioned above, but instead has to be regarded a global phenomenon. According to Wright, et al. (2008), by 1972 about 140.000 of the world's health-care professionals were employed outside of their country of origin.

1.3 Is the migration of health-care professionals worth researching today?

One could argue that the circumstances mentioned above were relevant 40 years ago but do not mirror the status quo. However, one would most certainly be wrong taking this point of view. In fact, the migration of health-care professionals is a topic that enjoys an increasing popularity amongst researchers around the world. Between 2005 and 2009 alone, 247 articles have been written on this matter, which is double the amount of articles written between 1990 and 2004 (Gibson & McKenzie, 2011). The reasons why the migration of health-care professionals is a topic worth researching today are twofold and will be summarised briefly in the following paragraphs.

First of all, the migration of health-care professionals is worth researching today, because many countries' health-care systems worldwide suffer from severe shortages in health-care personnel. Embedded in these health-care systems are organisations that use the migration of health-care professionals as a loophole in order to balance their demand for health-care, which is growing at a faster pace than its domestic supply can compensate for (Stewart, et al., 2007). The migration of health-care professionals can thus be considered a welcomed alternative for organisations in order to staff the positions that would have stayed vacant otherwise. However, this is only one side of the medallion. On the other side, the literature indicates that the migration of health-care professionals on a global scale can also be attended by negative consequences for organisations as well (Hooper, 2008; Stewart, et al., 2007), thus making it an interesting research topic for researchers.

Second, the migration of health-care professionals is not only worth researching due to its possible consequences for countries, companies and organisations, but also from a more broader point of view. As a matter of fact, the migration of health-care professionals has to originate from somewhere. There have to be reasons why health-care professionals choose to migrate to other countries in order to work for organisations in a different health-care system. Authors like Vidyasagar (2006), Serour (2009) and Oberoi and Lin (2006) already indicated that there are various reasons for health-care professionals to migrate, however, these reasons mainly apply to the migration of health-care professionals from developing to developed countries. Consequently, there is a lot of room for researchers to analyse the reasons that motivate health-care professionals to migrate in settings other than from developing to developed countries. The insights gained could not only help researchers to gain a better understanding of the background of migration, but also enable them to find adequate solutions to curtail the consequences originating from migration as discussed above.

1.4 Research problem

The problem that I found during investigating the available literature was, that hardly any data was given concerning the migration of non-German health-care professionals to organisations in Germany. In fact, data given about Germany in connection with the migration of health-care professionals was either outdated (Wright, et al., 2008) or clarifying that Europe is not dependant on health-care professionals from abroad (Stewart, et al., 2007). This leaves two options, namely either that it is true and Germany is not being affected by the migration of health-care professionals like many other countries or there is a huge gap concerning the research density in this area. The point of view taken in this thesis is the latter, because both newspaper articles (Ärzte Zeitung online, 2010) and scientific work (Blum & Löffert, 2010) indicates that health-care professionals in Germany might be scarcer than represented in the literature so far. This lack of German health-care professionals might force German organisations to employ non-German health-care professionals in order to keep their health-care services intact. For this research, I have established contact with the Clinic Association Westmünsterland gGmbH (hereafter: Clinic Association) in Germany, a holding organisation for several hospitals in the Westmünsterland that will be described in the following paragraph. I plan on analysing the reasons for non-German health-care professionals to work for the Clinic Association and the consequences their employment entails for the Clinic Association's HRM. Ultimately, I would like to give the Clinic Association advice on how to make their current HRM strategy more suitable for the employment of non-German health-care professionals regarding possible problems such as language barriers and re-migration.

1.5 The Clinic Association

The Clinic Association is a German holding organisation, located in North Rhine-Westphalia in the county of Borken, comprising three independently operating non-profit organisations, namely

- *St. Marien-Krankenhaus Ahaus-Vreden GmbH*
- *St. Agnes-Hospital Bocholt-Rhede gGmbH*
- *St. Marien-Hospital Borken GmbH.*

The three organisations operate three hospitals at five different locations, namely Ahaus, Vreden, Bocholt, Rhede and Borken. In order to make this structure more clear, a simple diagram has been created below (Figure 1).

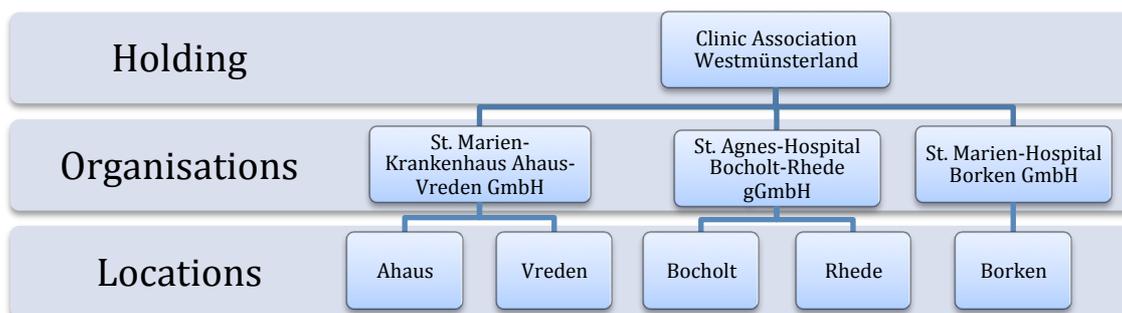


Figure 1. Organisational Structure of the Clinic Association

Apart from the hospitals, the Clinic Association consists of several elderly- and foster centres, day care clinics, housing areas and sanitary centres. However, due to limitations of scope this research will focus solely on the hospitals.

The hospitals of the Clinic Association offer a total of 1332¹ beds, which account for about 69% of the 1931 beds available in the whole county of Borken. The allocation is as follows: The St. Agnes-Hospital Bocholt-Rhede gGmbH accounts for 595 beds, the St. Marien-Krankenhaus Ahaus-Vreden GmbH and the St. Marien-Hospital Borken GmbH account for 400 and 337 beds, respectively (Klinikverbund-Westmünsterland, n.d.-a). During 2010, in all hospitals a total of 47.629 patients has been treated stationary, of which 580 patients have been treated semi-stationary. Additionally, 126.589 patients have been treated ambulant (St. Agnes-Hospital Bocholt, 2010; St. Marien-Hospital Borken, 2010; St. Marien-Krankenhaus Ahaus-Vreden GmbH, 2010; St. Vinzenz-Hospital Rhede, 2010).

Table 1
Patients treated annually at the Clinic Association

Hospital	# Stationary patients	# Ambulant patients
St. Marien-Krankenhaus Ahaus-Vreden GmbH	15.372 (of which 0 semi-stationary)	52.405
St. Agnes-Hospital Bocholt-Rhede gGmbH	20.562 (of which 360 semi-stationary)	51.698
St. Marien-Hospital Borken GmbH	11.475 (of which 220 semi-stationary)	22.486
Total	47.629 (of which 580 semi-stationary)	126.589

¹ This number has been stated on the official homepage of the Clinic Association Westmünsterland gGmbH, however, according to the respective quality records of the hospitals, the total beds offered equal to 1312 beds in total.

The Clinic Association employs around 3800 employees and, thereby, is a major player in the region when it comes to providing employment for healthcare personnel (St. Agnes-Hospital Bocholt, 2010).

In total, the five hospitals employ 276,4 full-time physicians of which 159,7 are medical specialists. The majority of them work for the St. Agnes-Hospital Bocholt-Rhede gmbH, namely 130,6 physicians (of which 72,9 medical specialists). In the St. Marien-Krankenhaus Ahaus-Vreden GmbH 78,6 physicians (of which 47,3 medical specialists) found a place of employment, while the St. Marien-Hospital Borken GmbH only employs 67,2 physicians (of which 39,5 are medical specialists) (St. Agnes-Hospital Bocholt, 2010; St. Marien-Hospital Borken, 2010; St. Marien-Krankenhaus Ahaus-Vreden GmbH, 2010; St. Vinzenz-Hospital Rhede, 2010).

1.6 Research purpose

The purpose of this research is to determine what factors are influencing non-German health-care professionals to work for the Clinic Association and the consequences their employment inherits for the Clinic Association's HRM department. Ultimately, this research aims at giving strategic advice to the HRM department of the Clinic Association on how to best manage non-German health-care professionals in their organisation. The research will be supported by empirical data gathered in form of an interview with the HR manager of the Clinic Association, Frank Vormweg, and questionnaires administered among several non-German health-care professionals at the Clinic Association.

1.7 Research question

The research questions that can be formed out of the information provided above are the following:

RQ1: What are the reasons for non-German health-care professionals to work for the Clinic Association?

RQ2: What are the consequences for the Clinic Association's strategic HRM department resulting from the employment of non-German health-care professionals?

1.8 Research approach

In order to be able to give an answer to the research questions stated above I will (1) conduct a literature review and (2) gather empirical data at the Clinic Association.

For the analysis of the reasons for non-German health-care professionals to work for the Clinic Association, the push-pull theory of migration, as e.g. utilised by Meija, Pizurki, and Royston (1979), will be used. The theory states that the migration of health-care personnel is the result of numerous forces (e.g. political, social, economical) working together. These forces have been labelled push and pull factors, because they, on the one hand, push the health-care professionals out of their country of origin, whereas, on the other hand, pull them towards a country of destination. In the case of the Clinic Association, the theory would suggest that the decision of non-German health-care professionals to work for the Clinic Association is being influenced by both factors that push them out of their country of origin and factors that pull them toward the Clinic Association. A review of the common push and pull factors mentioned in the literature will be conducted in chapter three, whereas the empirical data gathered will be presented in chapter four.

The same applies for the consequences of the employment of non-German health-care professionals at the Clinic Association. Chapter three will provide a literature overview of the commonly accepted costs and benefits of employing foreign-born health-care professionals, whereas chapter four will provide empirical data gathered concerning the costs and benefits for the Clinic Association that arise due to the employment of non-German health-care professionals.

Based on the insights gained from analysing the above, the ultimate goal of this research is to give advice to the Clinic Association's HRM department on how to strategically manage the non-German health-care professionals in their organisation taking into account the costs and benefits that result from their employment. Chapter three will provide an overview about how to best manage health-care professionals according to the theory, whereas chapter five will apply this theoretical knowledge to the Clinic Association in the form of an advice given.

1.9 Research subquestions

The subquestions stated in this paragraph will be used as a guideline for the following chapters of this thesis. Answering the subquestions will provide the theoretical basis needed to answer the research questions given above.

Q1: What are the push and pull factors influencing non-German health-care professionals' decision to work for the Clinic Association?

Q2: What are the costs and benefits for the Clinic Association that accompany the employment of non-German health-care professionals?

Q3: How does the employment of non-German health-care professionals affect the Clinic Association's strategic HRM?

1.10 Relevance of the research

The relevance of this research can be summarised under the two fields scientific and organisational relevance.

Scientific relevance

This thesis is of scientific relevance, because it adds valuable insights to the understanding of the reasons for non-German health-care professionals to work in the German health-care sector. Additionally, it contributes to the understanding of the consequences the employment of non-German health-care professionals entails. Due to the fact that there seems to be a lack of research being conducted that focuses on a specific entity operating within the health-care system of a country, the research being presented in this paper helps to understand the extent to which the global phenomenon of the migration of health-care professionals influences the very basis of a health-care system as well.

Organisational relevance

This thesis is of organisational relevance, because its data gathered can help the Clinic Association's HRM department to improve upon their HRM strategy and thereby promote the integration of non-German health-care professionals in their hospitals. This could allow the hospitals to cut costs and increase the level of health-care in in their hospitals and in the Westmünsterland region.

2.0 Theoretical Framework

In the first chapter of this thesis it has been called to attention that the research that goes along with the migration of health-care professionals is other than outright. The research subquestions came up on what the reasons for non-German health-care professionals are to work for the Clinic Association and what consequences their employment inherits for the health-care services at the Clinic Association. Moreover, it has been asked in how far the employment of non-German health-care professionals affects the Clinic Association's strategic HRM. The conceptual model I will design for this research is based on an adapted version of a framework established by Oberoi and Lin (2006) and will provide the theoretical basis for answering the research subquestions of this thesis. The following paragraphs describe the original framework by Oberoi and Lin (2006), explain why I can use this framework in the scope of this thesis and point out its limitations in connection with this research. Finally, an adapted version, which is suitable as a conceptual model for this thesis, will be presented.

The framework by Oberoi and Lin (2006) illustrates both the internal and external migration of health-care professionals. Whereas the internal migration of health-care professionals occurs from rural to urban areas, the external migration of health-care professionals occurs from donor to recipient countries of health-care professionals. It claims that the health-care professionals' choice for external migration is being influenced by pull and push factors from both the recipient and donor country, respectively. The authors distinguish thereby between endogenous and exogenous push and pull factors of migration. The first are factors that are relevant within a certain context (e.g. health-care), whereas the latter are factors beyond the defined context (e.g. quality of life). According to the authors, the external migration of health-care professionals also yields costs and benefits for both the donor and recipient country of the health-care professionals. Donor countries can face e.g. the cost of a brain drain, which is a concept referring to the movement of hundreds of thousands health-care professionals from mainly poor countries (Johnson, 2005) to countries of the developed world, describing migration as a "parasitic relationship" (Hooper, 2008, p. 685). Donor countries can benefit from migration by receiving remittances from abroad. Recipient countries face the cost of an overreliance on foreign health-care professionals to meet domestic shortages, and benefit from e.g. brain gain. The latter is a concept representing the beneficial end of the parasitic relationship described above (e.g. training costs omit due to the employment of already trained health-care professionals from abroad).

The framework built by Oberoi and Lin (2006) is based on the premise that migration is a phenomenon mainly occurring from less developed to developed countries, or, in other words, from poorer to richer economies. That is, because the focus of the authors' research is not migration in general, but the brain drain of migration. However, other than the research done by Oberoi and Lin (2006), this thesis is not concentrating on the parasitic relationships between countries. Rather, it focuses on the effects of migration on a specific entity in a single country and analyses the reasons for individual health-care professionals to work for the Clinic Association in Germany. Nevertheless, the framework of Oberoi and Lin (2006) can be considered useful in the scope of this thesis. This is, because it provides a basic structure for the answering of research subquestions one and two, the push and pull factors influencing health-care professionals' decision to work for the Clinic Association and the resulting costs and benefits their employment implies for the Clinic Association, respectively. The fact, that the original framework is very rich in detail and complicated may seem obstructive at first considering that this thesis will cover only a small and specific part of the migration theory, however, all the parts of the original framework necessary for this thesis can be easily isolated without changing the essence of the framework. The alterations made to the original framework will be described below.

First of all, the framework has to be specifically tailored to the migration of non-German health-care professionals to the Clinic Association. That means that nei-

ther the internal migration of health-care professionals presented in the original model, as well as the migration of health-care professionals between less developed and developed countries are of any relevance for this thesis. Instead, the migration of non-German health-care professionals to the Clinic Association will be in the focus. This alteration can be justified, because it still describes a relationship just like in the original framework, only that the relationship used in this thesis is more specific and between a health-care professional coming from one country, willing to work for the Clinic Association. This is also the reason why push and pull factors from the original framework were kept. It is to be expected that non-German health-care professionals are still being pushed away from their country of origin for numerous reasons, while at the same time being attracted or pulled towards the Clinic Association by several incentives. Due to the fact that this thesis has its ultimate goal to analyse the strategic consequences of the employment of non-German health-care professionals, the costs and benefits for the receiving entity, the Clinic Association, which are part of the original framework will be part of my conceptual model as well, whereas the costs and benefits for the sending entity, the health-care professionals' countries of origin, omit due to limitations of scope. Last, the Clinic Association's strategic HRM has been added to the model, being influenced by both the employment benefits and costs of non-German health-care professionals. That is, because the sum of employment benefits and costs of non-German health-care professionals is assumed to significantly influence the HRM strategy applied at the Clinic Association.

Below, the alterations to the original framework by Oberoi and Lin (2006) are shown schematically (Figure 2). The adapted version of the original framework will serve as a conceptual model for this thesis.

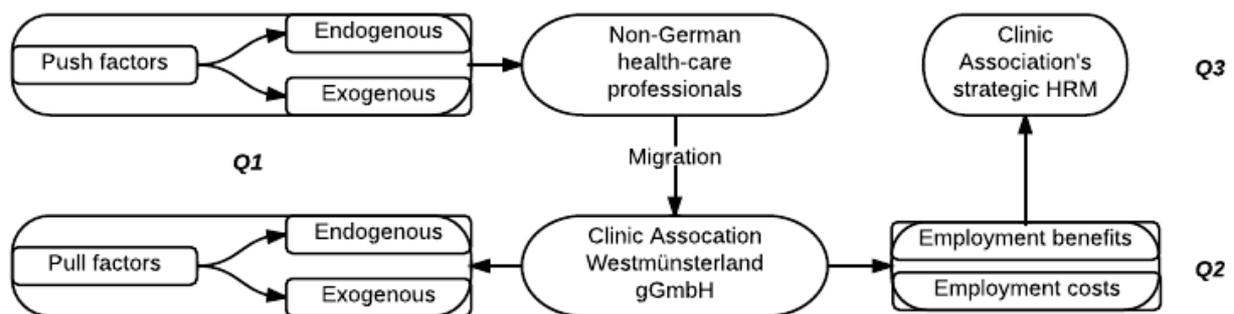


Figure 2. Conceptual model based on the framework for migration by Oberoi and Lin (2006)

The next paragraphs consist of a literature review that will provide the data necessary for the conceptual model. Migration will be defined as well as the push and pull factors and the costs and benefits of migration found in the literature. Moreover, it will be examined what the most suitable HR strategy for non-German health-care professionals is according to the theory.

2.1 Migration: a theory of push and pull factors

According to the theory, migration can be described as a “permanent or semi-permanent change of residence” (Lee, 1966, p. 49). Thereby, it is neither important whether the distance covered is especially long or short, whether the movement occurred by choice or under compulsion, nor whether migration is internal or external (Lee, 1966). Although the theory appears to be very old on first glance, one can say that its underlying premises are still valid in the present day. Authors like Kline (2003) and Stewart, et al. (2007) make use of the definition of migration, as introduced by Lee (1966), in their recent works.

Moreover, migration does not happen arbitrary. In fact, Mejia, et al. (1979) state that “migration [...] is the result of the interplay of various forces [...] at both ends of the migration axis” (p.104). They further explain that these forces can be differentiated into *push* and *pull*. This differentiation does come back in the work of Stewart, et al. (2007) with the difference that they call the push and pull factors *supply-push* and *demand-pull* factors, respectively. For the sake of simplicity, when talking about the forces of migration, I will use only push and pull, not implying that one could not use supply-push and demand-pull as well. Below (Figure 3), the process of migration is shown schematically. One can see that migration comprises a one-directional movement from, in the case of this thesis, the non-German health-care professionals’ country of origin to the Clinic Association. How strong this movement is depends on the presence of both push and pull factors. On the following pages I will provide the most common examples of such factors, relating to the migration of health-care professionals within the literature.

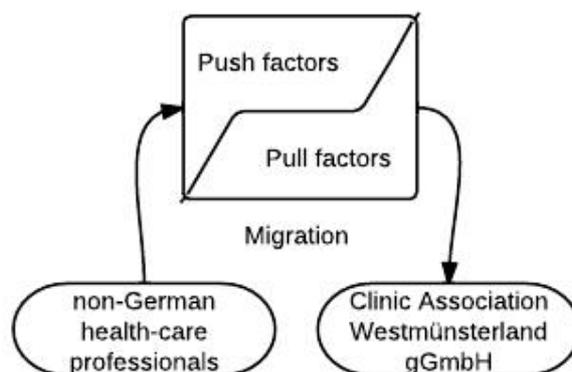


Figure 3. Migration and its push and pull factors

2.2 Push factors of migration

Push factors, can be described as domestic influential factors on health-care professionals’ choice to migrate away from their country of origin. The push factors of migration can be very diverse, but are most commonly related to either work circumstances or personal dissatisfaction (Stewart, et al., 2007). Push factors are predominantly present in low-income countries, because these countries

are facing severe problems with their health-care systems and general living environment. In the following part, I will describe the most common push factors of migration described in the literature. For the sake of simplicity the factors will be grouped according to whether they occur within the health-care environment or outside of it, just like Oberoi and Lin (2006) did in their work. The former will be related to as endogenous push factors of migration, whereas the latter will be termed exogenous push factors of migration, respectively.

Endogenous push factors of migration

The endogenous push factors of migration that have been identified during my literature review are poor remuneration & wages, a lack of education & career opportunities and poor working conditions & low job satisfaction. They will be described briefly in the following paragraphs.

Oberoi and Lin (2006), Stewart, et al. (2007), Chen and Boufford (2005) and Hagopian (2007), to name a few, consider a bad remuneration and low wages paid to health-care professionals to be among the reasons for health-care professionals deciding to migrate away from their country of origin. Thus, although properly trained, the health-care professionals are not able to earn the proper payment for their work. Chanda (2001) e.g. confirms that there is a low payment of medical personnel in Zimbabwe. According to Hooper (2008), it is not unusual for the salary differences of e.g. medical consultants from Sierra Leone and the United Kingdom to be in the hundreds of thousands of dollars. The financial incentives for migration are thus of crucial importance for the health-care sector, especially when one considers the improved standard of living that goes along with a better financial situation.

Another important endogenous push factor is the lack of education and career opportunities health-care professionals face in their country of origin. Mazzarol and Soutar (2002) state that students take the burden to study overseas solely to satisfy their demand for (higher) education. Developing and less developed countries e.g. offer a fairly limited access to quality education. Jenkins et al. (2010) underline the fact that in particular a lack of “continuing professional development” (p. 2) pushes away the highly educated workforce towards countries that offer better training and possibilities to specialize. In addition, Oberoi and Lin (2006) also list a “lack of further education and career development” (p. 27) in their framework of health-care professionals migrating away from less developed countries. One could easily find more examples of authors listing the lack of education and career opportunities amongst their push factors of migration, however, all strings will lead to the fact that many of the providing countries of health-care professionals struggle with severe health-care situations such as diseases like i.a. HIV/AIDS (Kline, 2003) and therefore budgets for health-care are under stress and dependant on donations from developed countries. The tight budgets allow no specialized education and significantly reduce career opportunities. The prob-

lem is, that a basic amount of health-care has not been met yet. A prominent example of how bad the health-care situation is in developing countries is Ghana. According to Johnson (2005), Ghana provides only a mere nine doctors per 100.000 patients. Such circumstances hardly leave any space for a specialized education or career and push health-care professionals, who are eager to learn and improve themselves, away.

Amongst the last endogenous push factors of migration that have been discovered in the literature fairly often are the poor working conditions health-care professionals face in providing countries and the low job satisfaction that is closely related to the working conditions (Kinzl et al., 2005). Jenkins, et al. (2010) e.g. consider poor occupational safety a problem in low-income countries and mentioned HIV as a prime example. It does not come as a surprise that in countries with a high diffusion of diseases the chance of getting contaminated is relatively higher than in countries without these diseases. Additionally, facilities in providing countries of health-care professionals are usually equipped inadequately and lack the constant supply of medicine. According to a study of Hagopian (2007), in some of the East African countries, the situation can get as bad as physicians working in hospitals without electricity, broken x-ray machines and highly limited numbers of oxygen tanks. These kinds of situations are unthinkable in the developed world, however, belong to the daily life in many of the providing countries of health-care professionals. The situation at hand can be described as a vicious circle, because professionals migrate away from these countries being unable to cope with the unprofessional environment any longer, leaving behind a workforce that, consequently, has to fill the gap by working extra hours (Oberoi & Lin, 2006) and thus lowering job satisfaction for the remaining workforce even further (Kinzl, et al., 2005)

Exogenous push factors of migration

The exogenous push factors of migration that have been identified during the literature review are the standard of living & the quality of life, political instability & high levels of crime and the intentions to form a family and a better future for the children. They will be described briefly in the following paragraphs.

Smith (2008) mentions poverty and the search for higher living standards as reasons for “autonomous individual medical practitioners” (p. 2) to migrate away from their country of origin. Likewise, Chanda (2001) states that the migration of health-care professionals is i.a. driven by a search for a better living standard. According to Oberoi and Lin (2006), doctors from southern Africa also migrate because the quality of life is simply not available there. In a nutshell, the literature indicates that both the lack of personal and economic opportunities push health-care professionals away from their countries of origin. The reason for this is that the countries providing health-care professionals are mostly amongst the poorest countries in the world. Notably, the sub-Saharan countries provide more health-

care professionals globally than they can afford (Vidyasagar, 2006). The same is true for India and the Caribbean (Mullan, 2005). Basically everything that influences the standard of living in some way might as well influence the willingness to migrate. Does a country offer limited access to education (Mazzarol & Soutar, 2002)? Are power cuts the order of business? Is it difficult to get specific consumer goods (Hagopian, 2007)? A low standard of living pushes highly skilled people out of their home country, because they possess both the knowledge and resources in order to provide a better living environment for themselves and their family in richer parts of the world. Especially countries which suffer from nationwide diseases (Chen & Boufford, 2005) push away highly skilled people and, thus, show high emigration rates towards countries that do not suffer from deadly diseases.

Oberoi and Lin (2006) state in their work that interviewees found both high levels of crime and political instability to be among the number one exogenous push factors for health-care professionals. Smith (2008, as cited in The World Health Organization, 2006) agrees on that fact and adds that imperfect labour markets, bad public funding and complicated bureaucracy instigated by governments are prime examples for exogenous push factors. He argues that individual nation states' approaches to "policy, regulation, and legislation" (p. 2) can result in legal environments that promote migration. That is probably what Chanda (2001) is referring to when writing about nurses that migrated from Zimbabwe to Australia due to i.a. political instability in their country of origin. Chen and Boufford (2005) represent the same opinion by saying that political insecurity pushes health-care professionals towards more politically stable countries. Summing up, professionals of all kinds, who have the financial means, are not willing to accept either unstable governments or high crime rates. If they have the feeling of being overruled by a broken system and that they do not feel secure any longer, they simply migrate, thereby regaining both political and personal security.

According to Chen and Boufford (2005) family aspirations also push many health-care professionals out of their country of origin. Vidyasagar (2006) augments further by saying that professionals migrate to offer their children a better future. Although not being mentioned that often in the literature, family does influence the decision whether to migrate or not in many individual cases. Actually, both the latter two exogenous push factors of migration are closely related to taking good care of one's family. Parents do not want their children to grow up in areas that are known for high crime rates, nor do they want their children to grow up without a certain standard of living; especially when they have the financial means and qualifications to migrate elsewhere. The low standards in the providing countries thus forces the much needed health-care professionals to migrate, driven by their desire for a better family life and future prospects for their children.

2.2 Pull factors of migration

Pull factors of migration originate in countries receiving health-care professionals from abroad. According to Mazzarol and Soutar (2002), these factors make the host country more attractive to students, but one can safely assume that pull factors exist that attract graduated health-care professionals as well. In general, pull factors can be considered to be opposed to push factors and vice versa, because both factors intensify each other. For instance, if a health-care professional is being influenced by several push factors to leave his country of origin, pull factors might make his decision even easier by making the push factors occur worse. The same is true the other way round. If pull factors do exist, existing push factors can make the decision to migrate easier. As well as for the push factors of migration, the pull factors will be subdivided into exogenous and endogenous pull factors of migration.

Endogenous pull factors of migration

The endogenous pull factors of migration that have been identified during the literature review are high remuneration & wages, excellent education & career opportunities and professional working conditions & high job satisfaction. They will be described briefly in the following paragraphs.

According to a report from Peterson and Burton (2007) the average compensation for health professions is very high in countries like the Netherlands, Australia, the United States and Germany. A high compensation makes a country attractive and most certainly influences the decision of health-care professionals to migrate from countries that provide a lower income. In fact, two of the countries mentioned above employ a huge share of health-care professionals from abroad (Diallo, 2004). Stewart, et al. (2007) calculated that, even when taking into account the costs of living, the salary of a nurse in Australia and Canada is twice as high as the salary of nurses in South Africa. In Ghana and Zambia the difference is more explicit with 14 and 25 times as much income compared to the developed countries, respectively. Other authors like Jenkins, et al. (2010) underline the fact that high income countries are pulling the professionals toward them by, to say it in the words of Shafqat and Zaidi (2005), means of “material lures” (p. 492). All in all, the higher payments in developed countries are a crucial, if not the most important, endogenous pull factor of migration for health-care professionals according to the literature. In particular, the fact that money can buy a whole new standard of living makes this pull factor so important that it must be taken into account when analysing the reasons for health-care professionals being pulled to developed countries.

The excellent education available in countries receiving health-care professionals is also an important endogenous pull factor. Jenkins, et al. (2010) state that access to higher training and the possibility to continue professional development are

pull factors, which receiving countries of health-care professionals use in order to attract foreign professionals. Especially, individuals originating from developing countries are being attracted by means of higher payment (Stewart, et al., 2007) and opportunities to update the economic status (Mazzarol & Soutar, 2002). Vidyasagar (2006) summarises the striving for higher career opportunities as “professional satisfaction” (p. 246), which, as a matter of fact, is given especially in highly developed countries. Among the countries fulfilling the needs for the global health-care workforce are the United Kingdom, the United States, Ireland, Australia, Canada and, interestingly, South Africa (Stewart, et al., 2006). According to a survey analysed by Kingma (2001) one of the major incentives for nurses and highly trained professional personnel to migrate are both payment and learning opportunities. To sum up, the evidence of the importance of education and career opportunities for health-care professionals is given by multiple sources throughout the literature.

Receiving countries of health-care professionals do have a higher expenditure on health compared to countries that are providing health-care professionals. The European region, for instance, has a much higher per capita total expenditure on health at an average exchange rate than the African regions. Whereas Europe invested a total of \$2283 per capita, the African region provided a mere \$83 per capita (World Health Organization, 2011). It does not come as a surprise that countries that invest more into their health-care systems also have the more professional working conditions, which, in turn, can lead to a higher job satisfaction (Kinzl, et al., 2005). Thus, better working conditions as well as state of the art facilities are pulling health-care professionals towards high-income countries (Jenkins, et al., 2010). The respondents of Stilwell et al. (2004)’s survey seem to agree on that matter. Among the reasons for health professionals from five African countries to migrate are working in a better-managed health system, the opportunity to experience a more conducive working environment and the need for continuation of education or training. A recent survey conducted by Brunner et al. (2010) in Austria revealed that 23% and 62% of the respondents are either very satisfied or satisfied, respectively, with their health-care profession. This job satisfaction is, as stated above, hardly given in e.g. developing countries and thus pulls educated workers towards developed countries.

Exogenous pull factors of migration

The exogenous pull factors of migration that have been identified during the literature review are both political stability & low crime rates and standard of living & the higher quality of life. They will be described briefly in the following paragraphs.

The political stability in countries receiving health-care professionals is, in general, higher than in countries providing health-care professionals. The reason for this is that there is i.a. no warfare (Oberoi & Lin, 2006). Whereas in developing or

underdeveloped countries conflicts arise over lack of resources, leadership and country boundaries, developed countries have powerful political mechanisms in order to prevent such conflicts from breaking out. Moreover, the crime rates in countries receiving health-care professionals are relatively low compared to the crime rates of countries providing health-care professionals (Appendix B). That is an important exogenous pull factor, because high levels of crime tend to push people away rather than to attract them. A recent study by the United Nations Office on Drugs and Crime (2011) also showed that North America, Australia and Europe are the continents with the smallest homicide rates in the world. In fact, the countries with the highest numbers of foreign-born health-care professionals can be found on these continents as well (Arah, Ogbu, & Okeke, 2008). The political stability and low crime rates of these countries can be considered a persuasive argument pulling doctors into the developed world according to the literature. According to Oberoi and Lin (2006) countries receiving health-care professionals offer a “better quality of life” (p. 27). That is, because countries like the USA, England, Australia or New Zealand are rich compared to countries like Ghana, Zimbabwe or countries within the Caribbean. Money can buy a lot of luxury, but in this case it is important to note that money can raise the quality of life as well. Rich countries can provide better drinking water, have more money to spend on health-care (Appendix A) and, thus, less infectious diseases (Central Intelligence Agency, 2012). One has to accept the fact that rich and developed countries can offer a better quality of life with a high life expectancy, which cannot be provided by many of the countries providing health-care professionals. Therefore, the standard of living can be considered an exogenous pull factor.

2.3 Benefits and costs of migration for receiving countries of health-care professionals

The costs for countries receiving health-care professionals are, according to the literature, sparse. The foreign health-care personnel could both negatively influence the domestic wages paid and the working conditions. Additionally, developed countries make themselves dependent on the supply of health-care professionals from abroad. Among the benefits are cost savings and the fact that foreign health-care professionals can work in sparsely covered areas. Both the benefits and costs of migration for receiving countries of health-care professionals will be described briefly in the following paragraphs.

Costs

The benefits involved with the medical brain drain for countries receiving health-care professionals outweigh the costs. The fact that a lot of money can be saved due to the missing training costs nullifies both recruitment and resettlement costs that would, otherwise, be counted as costs. However, according to Stewart, et al.

(2007) it is notable that the wages and working conditions can be affected by an increasing stream of health-care workers from abroad. They might be more willing to accept lower payment and more demanding working conditions. Yet, evidence on that matter seems to be scarce among the related literature. The same can be said about the assumption that an increasing amount of foreign health-care workers affects the quality of health-care in general because of e.g. lacking language skills.

Not an imminent cost, but rather a danger, is the growing dependency of developed countries on the output of health-care professionals by other countries around the world. According to Vidyasagar (2006) the USA is the centre of attraction for highly skilled health-care workers and, thus, heavily dependant on the foreign workforce. In fact, the UK employs a great amount of foreign workers as well and in 2003 the number was even “staggering high” (p. 246). Chen and Boufford (2005) acknowledge these facts by stating that 25% of the American physicians are of international origin and that the amount is even higher in the United Kingdom, Canada and Australia. Developed countries cannot meet their demand of health-care domestically and, increasingly, make themselves dependent on external sources of health-care professionals. If the providing countries of health-care professionals would stop the export of their workforce, the health-care systems of the countries mentioned above would collapse instantly.

Benefits

According to the literature, the benefits of the in-migration of health-care professionals are mainly cost related. Due to the fact that training costs are much lower, the countries receiving health-care professionals can cut their costs drastically (Stewart, et al., 2007). A recent report by Curtis (2010) clarifies that the costs of training a physician in the United Kingdom is somewhere around a 6-digit number. If these costs can be spared by just buying the required knowledge from abroad that ends up to be a huge advantage for the health-care systems of the developed world. Even though the foreign health-care professionals have to attend training that enables them to work in their new business environment (e.g. language courses), the benefits outweigh the costs.

Another great advantage is that the foreign-trained health-care professionals are able to cover areas that have either a lack of medical personnel or specialists (Chen & Boufford, 2005). That is important to mention, since even countries like Canada struggle to meet the demand for health-care in specific areas (Gray, 1999). Predictions from the USA are pessimistic as well. In 2020, there will be a shortage of 200.000 physicians and 800.000 nurses (Chen & Boufford, 2005). The same predictions apply to Germany, since Blum and Löffert (2010) speak of a shortage of 108.260 health-care professionals until 2019, not even taking into account the shortage of nurses and other health-care personnel.

2.4 Managing health-care professionals

In the latter two paragraphs, I have shown what the most common push and pull factors for migrating health-care professionals are according to the literature. Also, the costs and benefits have been identified in the literature in conjunction with the employment of health-care professionals from abroad. Thus, so far a theoretical basis for subquestions one and two has been established. However, in order to be able to give advice to the Clinic Association and an answer to subquestion three, a theoretical basis on how to manage non-German health-care professionals in a strategic way is needed. The following paragraph will thus contribute to that matter and explain what type of employees non-German health-care professionals are and how this employee group should best be managed by a HRM department according to the literature.

Characterisation of health-care professionals

In order to characterise health-care professionals, I will make use of the HR architectural perspective (Lepak & Snell, 2002, 2007). Based on this perspective, an organisation should subdivide its employees according to two dimensions, namely *strategic value* and *uniqueness*. Strategic value is being defined as “the skill sets of employees that enable a firm to enact strategies that improve efficiency and effectiveness, exploit market opportunities, and/or neutralize potential threats” (Lepak & Snell, 2007, p. 213). Uniqueness of human capital “refers to the degree to which it is rare, specialized and, in the extreme, firm-specific” (Lepak & Snell, 2002, p. 519). Consequently, the two dimensions form a matrix comprising four employee groups, which are contract workers, job-based employees, alliance partners and knowledge employees (Figure 4).

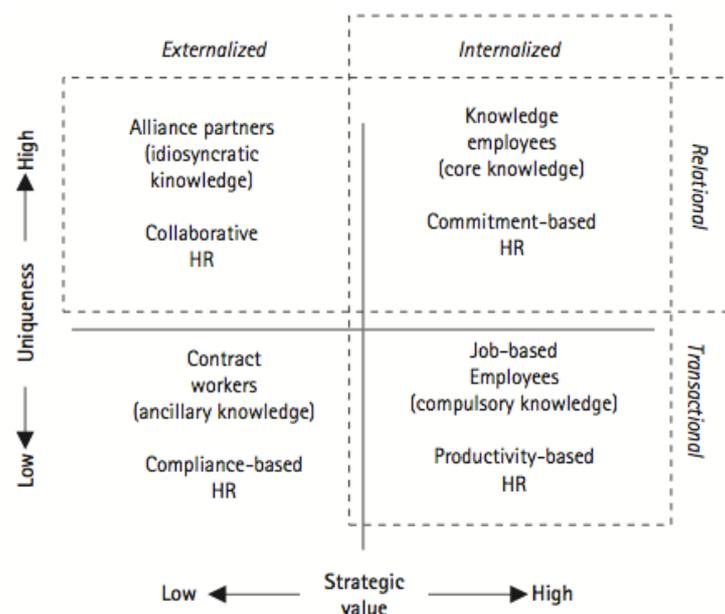


Figure 4. HR architectural perspective (Lepak & Snell, 2007, p. 214)

Lepak and Snell (2007) state, that each employee group shown in the matrix differs “in terms of employment subsystems, employment relationships, and the HR systems used to manage employee groups” (Lepak & Snell, 2007, p. 213). Contract workers are characterised by their low uniqueness and strategic value. They provide ancillary knowledge and should be managed by a compliance-based HR system. Job-based employees are characterised by their low uniqueness but high strategic value. They provide compulsory knowledge and should be managed by a productivity-based HR system. Alliance partners are characterised by their high uniqueness but low strategic value. They provide idiosyncratic knowledge and should be managed by a collaborative HR system. Last, knowledge workers are characterised by their high uniqueness and strategic value. They provide core knowledge and should be managed by a commitment-based HR system.

Having specified the different employee groups an organisation can have, the next step is to identify the group health-care professionals belong to. This will provide the theoretical basis for the strategic advice that will be given to the Clinic Association’s HRM department at the end of this thesis.

The health-care professionals at the Clinic Association can be considered to have a high strategic value. That is, because health-care professionals contribute directly to the Clinic Association’s core competency, which is voiced in the organisation’s ambition to provide care and treatment of a high quality to its patients (Klinikverbund-Westmünsterland, n.d.-e). In fact, without health-care professionals, whether German or non-German, the Clinic Association would not be able to cure its patients and therefor not be able to comply with its ambition. For the Clinic Association, health-care professionals are of strategic importance, because without the accumulated knowledge these employees have to offer, the Clinic Association could not provide the resultant medical practices necessary to attract patients. Health-care professionals at the Clinic Association can also be considered to be of a high uniqueness. The reasons for this are various. First of all, the supply of health-care professionals in Germany is very circumscribed (Blum & Löffert, 2010). Thus, the Clinic Association can only access a limited pool of human resources that have the specialised knowledge necessary to conduct complex medical procedures. Especially the fact that the Clinic Association has over 50 different medical facilities (Klinikverbund-Westmünsterland, n.d.-c) and numerous medical care units (Klinikverbund-Westmünsterland, n.d.-d), of which many have a certification representing a high medical standard, makes it inevitable for the Clinic Association to rely on health-care professionals that are specialised in the offered medical fields. In fact, the certified medical care units can be considered a service that distinguishes the Clinic Association from other hospitals, because it helps the Clinic Association to attract additional patients (KTQ, 2012). Thus, it is of even higher importance to keep these units operating at a high level by staffing them with the necessary specialised health-care professionals.

In a nutshell, the health-care professionals working at the Clinic Association can be considered knowledge employees, because both their strategic value and uniqueness are on a high level.

Managing health-care professionals

In the last paragraph I analysed, that health-care professionals should be classified as knowledge employees. According to Lepak and Snell (2007), this would have the implication, that health-care professionals should be managed by a commitment-based HR system. A commitment-based HR system, like any other HR system, consists of three different levels of HR (Lepak, Marrone, & Takeuchi, 2004), namely the HR architecture/philosophy, the HR policies/programs and the HR practices. The three levels of HR get increasingly specific. Since the HR practices form the foundation of HR, representing specific implementations of HR, the following paragraph will summarise the HR practices commonly applied in a commitment-based HR system throughout the literature.

According to Ostroff and Bowen (2000) there are several HR practices that lead to an increasing commitment of employees towards the organisation they are working for. An organisation could base part of the employee's payment on the success the organisation and thereby increase his identification. Moreover, an internal labour market could be established that allows employees to develop inside an organisation and thereby reduce their turnover rate. Another option to increase commitment is the availability of job security. Employees that have been offered a secure employment are more unlikely to search for alternative employers. Last but not least, the promotion of diversity and good relations between unions and the management are likely to increase employee commitment as well. However, according to Lepak and Snell (2007), a commitment-based HR system is not solely based on HR policies increasing the employee's commitment to the organisation through the above-mentioned HR practices. Rather, it also invests in "employee competencies, empowers employees, and encourages participation in decision-making and discretion on the job" (p. 213). The corresponding HR policies should thus be based on HR practices that not only value the employee's set of skills but also gives them a voice inside of the organisation. Moreover, the authors state that a commitment-based HR system should offer sufficient long-term incentives and feedback to its employees in order to retain them together with the strategic advantage accompanying their employment. Consequently, HR policies should also consist of HR practices that enable health-care professionals to receive feedback and give them long-term incentives to work for the organisation. Lepak and Snell (2002) further add, that a commitment-based HR system should be based on practices that grant employees frequent training, career development, skill-based pay, information sharing and performance appraisal.

The following table (Table 2) summarises the HR practices commonly referred to in the literature in connection with a commitment-based HR system.

Table 2
HR practices and its effects (high commitment)

HR Practice	Effect
Organisation-based payment	The payment of an employee is (partly) based on e.g. stocks or organisational profits. Thus, employees are motivated to go the extra mile and increase commitment towards the organisation.
Internal labour market	The establishment of an internal labour can increase commitment by showing employees the possibility to advance and develop internally.
Job security	By offering job security, an organisation can increase the commitment of its employees, because employees get the feeling of being taken care of.
Promotion of diversity	The promotion of positive relationships between diverse sets of employees can increase commitment amongst employees, because it increases the sense of belonging.
Establishing good relations between management and unions	A good relationship between the management and unions can increase the commitment of employees, because the employees sense a lack of conflict in the organisation.
Investment in employee competencies	The (visible) investment into employee competencies through e.g. frequent training helps employees to establish a greater commitment towards an organisation.
Employee empowerment	The empowerment of employees creates a feeling of belonging and, thus, commitment.
Encouragement of participation in decision-making	Just like the employee empowerment, the encouragement of employee participation in decision-making creates a feeling of belonging and, thus, commitment.
Discretion on the job	Discretion on the job helps employees to satisfy their intrinsic needs, which can boost their commitment.
Sufficient long-term incentives	Long-term incentives increase commitment, because they motivate employees to invest their energy into an organisation for a certain (future) outcome.
Providing continued and useful feedback to employees	By providing continued and useful feedback, employees get the possibility to improve upon their knowledge and skills, which can lead to organisational commitment.
Career development	Offering a proper career development to employees can increase their organisational commitment.
Skill-based payment	By basing an employee's payment on his skill, his commitment towards an organisation can increase, because he gets the feeling of being valued.

Information sharing	Sharing information with employees overcomes the feeling of being left out and can increase commitment.
Performance appraisal	By valuing the performance of employees, their commitment towards the organisation can increase.

Apart from the insights gained above, Kinnie, Hutchinson, Purcell, Rayton, and Swart (2005) argue that “the nature of professional work requires autonomy, application of deep technical expertise to ambiguous problems and the generation of intellectual capital from specialised human capital” (p. 13). The authors state that professional employees, or knowledge workers, “value focused and up-to-date skill development that contributes to their employability, demand a performance management that reflects their technical expertise, and prefer to have high degrees of discretion” (p. 13). Since health-care professionals are knowledge employees, the HR practices mentioned above have also been taken into consideration when applying a commitment-based HR architecture. The authors also found that the knowledge employee’s commitment to an organisation is directly linked to a number of factors, namely their satisfaction with performance appraisal, rewards, recognition, involvement, communication, openness and work-life balance (Kinnie, et al., 2005). It shows that knowledge workers especially value HR practices that offer an intrinsic over a monetary motivation. Arthur (1994) shares this point of view by stating that commitment-based HR-systems “shape desired employee behaviours and attitudes by forging psychological links between organisational and employee goals” (p. 672). According to him, the commitment-based HR-system should be based on HR practices that help to deeply integrate workers into the organisation. Consequently, commitment-based HR-systems would also influence the turnover rates of employees positively, because employees seem to have a higher motivation being ruled by a commitment-based HR-system over other systems (e.g control-based). Boselie (2010) underlines the fact that some HR practices affect certain employee attitudes. In his work, he especially focuses on the stimulation of commitment through HR practices, because he considers human assets a “health care organisation’s most important asset” (p. 55). The following table (Table 3) summarises the HR practices commonly referred to in the literature in connection with knowledge workers.

Table 3
HR practices and its effects (knowledge workers)

HR practice	Effect
Autonomous work	Knowledge employees value autonomy in their workplace, because they value exercising their own professional judgements.

Application of deep technical expertise to ambiguous problems	By allowing knowledge employees to apply their expertise to ambiguous problems, the employees stay motivated and challenged, which could increase commitment.
Generation of intellectual capital from specialised human capital	This practice allows knowledge employees to fulfil their intrinsic need of sharing knowledge that is based on their expertise.
Focused and up-to-date skill development	Knowledge employees value focused and up-to-date skill development that is in line with their employment.
Performance management that reflects technical expertise	Knowledge employees require being managed in a way that it reflects the skills they possess (e.g. professional work environment).
Satisfaction with rewards, recognition, involvement, communication, openness and work-life balance	Knowledge employees value a good mixture between work and life. Moreover, they favour a work environment that promotes openness, communication among colleagues, involvement, recognition and rewards.
Psychological links between organisational and employee goals	For knowledge employees to be most effective, there should be a good trade-off between the employees' goals and the organisational goals. Most effectively, the employees' goals are equal to the organisational goals.

Linking business strategies with HR systems

For a business level strategy to be successfully implemented into an organisation, not only the HR philosophy, with its corresponding HR practices, is important, but also the desired employee contributions. Namely, according to Lepak, et al. (2004), the business level strategy directly determines which desired employee contributions are necessary and indirectly influences which HR philosophy should be applied. Both desired employee contributions and the HR philosophy ultimately influence the HR policies implemented in an organisation (Appendix F). Desired employee contributions “encompass a variety of employee attitudes, behaviours, and work-related outcomes that enable employees to contribute toward the implementation of strategic objectives” (Lepak, et al., 2004, p. 647). Ostroff and Bowen (2000) identified numerous desired employee contributions in the scope of their research, namely knowledge & skills, identification/commitment, satisfaction, intrinsic motivation, reward motivation, citizenship collaboration, flexibility and monitoring & control. Each of these desired attributes would then lead to the implementation of different HR practices that, ultimately, influence the employees' actual contributions to the strategy of the organisation. In the case of knowledge workers, or health-care professionals in particular, the desired employee contributions have already been identified. It is expected from this employee group to have a positive attitude towards autonomous work and to value

e.g. recognition, involvement, openness and communication. Consequently, the desired behaviours and work-related outcomes of health-care professionals can be summarised as commitment-based with a strong identification with the organisation. Accordingly, HR practices should be chosen that underline those employee contributions.

In a nutshell, the strategy of an organisation has to be specifically tailored to the way in which employees can add value to the firm's strategy and according to the HR philosophy, which has been chosen.

3.0 Methodology

In the last chapter I established a conceptual model that will be used in order to answer the research question stated in the beginning of this thesis. Together with this conceptual model, evidence from the literature has been provided to generate a general picture of the forces at work that form the migration of health-care professionals; the push and pull factors. Apart from the push and pull factors of migration, it has also been reviewed what the possible costs and benefits are for countries receiving migrating health-care professionals. Last, a theoretical basis on how to best manage health-care professionals has been provided.

However, the literature does only provide general pieces of information on the migration of health-care professionals and cannot contribute directly to the answering of the research subquestions. This is, because the research subquestions are specifically tailored to the Clinic Association. In order to be able to analyse the push and pull factors of the migration of non-German health-care professionals to the Clinic Association and the consequences of their employment for the Clinic Association, direct information has to be collected from the Clinic Association. The methods that have been used within the scope of this research to gather the relevant information will be described together with their justification in the following paragraphs. Moreover, it will be described how the data will be analysed in particular and used to produce results.

3.1 Data gathering

In order to gather empirical data that can help answering the research subquestions, two data gathering methods were used. Namely, a questionnaire was administered and an interview conducted. The following paragraphs will introduce both methods in detail.

3.1.1 Questionnaire

The first method used in order to gather empirical data was a questionnaire. It was designed to provide answers to the first subquestion of this research:

Q1: What are the push and pull factors influencing health-care professionals' decision to work for the Clinic Association?

The questionnaire was administered among a total of seven non-German health-care professionals at the Clinic Association. Since the five hospitals of the Clinic Association employ a total of 276 health-care professionals, of which five per cent are non-German, the seven respondents represent 50 per cent of the Clinic Association's non-German health-care professionals. The questionnaire was developed with the help of Google Docs (docs.google.com), which is a free online tool that allows the creation of questionnaires, and distributed via Frank Vormweg, HRM manager of the Clinic Association. It consists of a mixture of ten closed questions that are accompanied by twelve open questions for further elaboration. Although the questionnaire is aimed at respondents that are non-German, Frank Vormweg advised me to compose it in German, since that would be the language to be best understood. Both the original questionnaire (Appendix C) as well as its results (Appendix D) can be found in the appendix of this thesis.

The questionnaire itself has been divided into the following five topics:

1. Questions on general information
2. Questions about the migration to Germany
3. Questions concerning the Clinic Association Westmünsterland gGmbH
4. Questions about the attractiveness of Germany
5. Questions about homeland patriotism

The first part of the questionnaire consists of questions about the health-care professionals' profession, age and origin. These questions are necessary to verify that the respondents are in fact health-care professionals with an origin outside of Germany.

The second part of the questionnaire contains questions about the factors that pushed the non-German health-care professionals away from their country of origin. At first, the health-care professionals have been asked to mark the endogenous and exogenous push factors, identified in the literature review, which are most applicable to them, which then have been supplemented by open questions for further elaboration. Moreover, it has been asked whether the health-care professionals had to rely on financial aids in order to migrate to Germany, where the aid came from and whether they attended courses that made their emigration easier.

The third part of the questionnaire is characterised by questions about the Clinic

Association. The health-care professionals have been asked to answer why they have chosen to work for the Clinic Association and how the Clinic Association Westmünsterland gGmbH raised their attention. Furthermore, it has been asked for how long the health-care professionals are working for the Clinic Association and for how long they are planning to work there. This part might clarify the Clinic Association's attractiveness towards non-German health-care professionals and determine whether the health-care professional's intentions to work for the Clinic Association can be considered short-term or long-term.

The fourth part of the questionnaire aims at finding out what factors pulled the health-care professionals towards Germany and, consequently, towards the Clinic Association. Similar to the second part of the questionnaire, the health-care professionals have first been asked to mark the endogenous and exogenous pull factors, identified in the literature review, which are most applicable to them, which then have been supplemented by open questions to explore further options.

The last part of the questionnaire analyses the health-care professionals' intentions to return to their country of origin and asks for possible reasons. This part is relevant for determining whether the Clinic Association can actually influence the health-care professionals' decision to return to their country of origin or not.

3.1.2 Interview

The second method used in order to gather empirical data was an interview. Although the interview also provides insights over the interviewee's assessment of the possible incentives for non-German health-care professionals to work for the Clinic Association, it was primarily designed to provide answers to the second sub-question of this research:

Q2: What are the costs and benefits for the Clinic Association that accompany the employment of non-German health-care professionals?

The interview has been conducted with Frank Vormweg, the HRM manager of the Clinic Association. It was held via telephone and took roughly 45 minutes. A transcript of the interview in German can be found in the appendix (Appendix E).

The first questions asked in the interview were aiming at discovering whether the Clinic Association has a shortage of health-care professionals and what the ratio of German to non-German health-care professionals looks like. It has been asked whether this ratio can be considered stable of the past years and what Frank Vormweg's assessment of a future ratio looks like. It has been asked whether there are incentives for non-German health-care professionals to work for the Clinic Association from Frank Vormweg's point of view. The core of the interview, however, were questions on whether there are any costs and benefits related to the employment of non-German health-care professionals for the Clinic Association. Furthermore, it has been asked what the Clinic Association does in order to

reduce the barriers of migration and for what time span health-care professionals stay at the Clinic Association on average. Concluding, it has been asked how the Clinic Association establishes contact with the non-German health-care professionals and how the Clinic Association represents itself abroad.

3.2 Justification

This part serves as the justification of the research methods presented above. It will provide information about why these specific research methods have been chosen over other research methods and what the chosen research methods' limitations are.

3.2.1 Questionnaire

The questionnaire has been chosen to gather data about the push and pull factors influencing non-German health-care professionals, because Frank Vormweg advised me to do so in the first place. The time of health-care professionals is fairly limited and a questionnaire was the only way to oblige the health-care professionals. Most certainly, this does not justify a questionnaire as a suitable research method for answering an explorative type of question, however, it does explain why I chose this method over e.g. in-depth interview. Consequently, the questionnaire has several limitations as a research method for this thesis. First of all, it has a low number of responses and, additionally, these responses are not limited to qualitative data, but quantitative data as well. This would influence the generalizability severely, if the data was not processed in a qualitative manner. How the data gathered from the questionnaire was processed will be described below.

3.2.2 Interview

The interview has been chosen to gather data about the costs and benefits of the employment of non-German health-care professionals at the Clinic Association. This method can be justified, because the HRM manager of all the hospitals belonging to the Clinic Association should be well aware of the costs and benefits that stem from the employment of non-German health-care professionals for his organisation. The interview provides qualitative data in order to answer an explorative type of question. How the data gathered from the interview was processed will be described below.

3.3 Data processing

This part will describe how I analysed the data gathered through the chosen research methods and explain how it will be used in order to produce results.

3.3.1 Questionnaire

Because a total of seven respondents denies me the possibility to analyse the data in a quantitative way, the data will be processed qualitatively. Babbie (2007) suggests a case-oriented analysis across cases in order to look for interesting patterns in a specific research topic when the number of respondents is not especially high. By doing so, I cannot make up for the small number of respondents, however, this method might still be able to produce trend-setting indications for the push and pull factors of non-German health-care professionals. The data gathered from the seven questionnaires will thus be transformed into qualitative cases describing the story of every individual non-German health-care professional. These cases will contain the push and pull factors that led the non-German health-care professionals next to other pieces of information that make the cases more complete. Once the cases have been constructed, they will be processed with a technique called *open coding*. Open coding suggests scanning the cases for its most important statements and labelling them appropriately. The aim is to identify patterns across the cases and to show these patterns in a well-arranged figure as the results of research subquestion one.

3.3.2 Interview

The data gathered during the interview will be processed as follows. First of all, the interview will be transcribed. That means that every question answered by Frank Vormweg during the spoken interview will be written down in text form. Next, the written interview will be processed with open coding. Thus, the written interview will be scanned for its most important statements, which then will be labelled according to their content. To get an overview over the findings, they will be presented in form of a figure as the results of research sub question two.

4.0 Results

Whereas the last chapter described the methods of data gathering for this research, this part will be devoted to the analysis of the actual data obtained.

4.1 Results of the questionnaire

The questionnaire conducted amongst seven respondents provides the data for seven individual cases that should help to clarify why non-German health-care professionals choose to work for the Clinic Association. Below, the cases will be presented individually, followed by a comparison of the push and pull factors mentioned in the literature and found in the cases.

Case 1

The first case represents a health-care professional from Greece within his twenties. He decided to migrate to Germany, because his partner has already been working in Germany and acquired the necessary language skills. The Clinic Association gained his attention through an employment ad, which consequently led to an establishment of contact through a consulting agency. The health-care professional's reasons to react to the ad of the Clinic Association in the first place have been predominantly job-related. He complained about a lack of advanced training and career possibilities together with a bad remuneration and bad working conditions in this country. Also, a low standard of living and political instability were factors influencing his decision to leave Greece. According to him, health organisations in Germany offer a more attractive payment, better working conditions and better training and career possibilities. Apart from that, he is of the opinion that Germany offers a higher standard of living than Greece. Although he attended several language courses in Germany and has been working for the Clinic Association for less than a year, the health-care professional has the intention to return to Greece after three years of working. According to him, he feels that his roots are in Greece and not Germany.

Case 2

The second case represents a health-care professional from Greece within his thirties. A contact from his university and several health-care professionals who already worked in Germany influenced his decision to migrate to Germany. He first established contact with the Clinic Association through recommendations from personal contacts as well as the internet, which then helped him to migrate to Germany by providing financial aids in form of a scholarship. The health-care professionals' decision to migrate was, on the one hand, fuelled by missing training and career possibilities as well as bad working conditions, and, on the other hand, a low standard of living in Greece. It were especially the job-related factors that pushed him away from Greece. According to him, Germany does provide a better payment and various possibilities for advanced training. Moreover, he is of the opinion that the German health-care sector has higher working standards. Apart from that, he considers the standard of living in Germany is higher than in Greece. In order to be able to work for the Clinic Association, the health-care professional had to attend a language course. Today, he is working for the Clinic Association for about one year and plans to work there another two years. He has the intention to return to Greece, because there he already got several career opportunities.

Case 3

The third case represents a health-care professional from Greece within his thirties. The Clinic Association caught his attention coincidentally, because a colleague who already worked there advised him to work there as well. His decision to migrate to Germany has been influenced by the numerous possibilities for health-care professionals that Germany provides. According to him, these possibilities are lacking in Greece. Especially his interests in acupuncture and homeopathy could not be satisfied in Greece. Apart from that, he also finds Greece a politically instable country. The reasons for his migration to Germany were mainly job-related. The health-care professional considers Germany a country with more attractive payments and a broad spectrum of training and career possibilities. That, together with a higher standard of living and political stability were the factors pulling this health-care professional towards Germany and the Clinic Association. Due to the fact that he didn't have the financial means to migrate to Germany, the Clinic Association provided him with the money necessary to do so after all. He is working at the Clinic Association for less than a year, plans on working there for at least four years and has no intentions to return to Greece after this period of time.

Case 4

The fourth case represents a health-care professional from Romania within his twenties. He decided to migrate to Germany and work for the Clinic Association in order to improve his medical knowledge, gain more experience and payment. In fact, he has had some friends in Germany that recommended him to work for the Clinic Association. The health-care professional's decision to migrate has further been influenced by numerous reasons, which were mostly job-related. The health-care professional didn't like the remuneration, the working conditions, the lack of quality educational institutions and the subsequent lack of training and career possibilities in Romania. Moreover, it has been the political instability and the bad environment for both family and children that pushed him out of his country of origin. The health-care professional valued, on the other hand, that Germany does provide an attractive payment, a high working standard and numerous possibilities to develop. He thinks that Germany can offer him a higher living standard, political stability and a good environment for his family. For his migration, the health-care professional got financial aid from Germany and he also attended several language courses in order to master the language. He has been working for the Clinic Association for about one year and intends to stay there as long as possible. He has no intentions to return to Romania.

Case 5

The fifth case represents an assistant health-care professional from Belgium within her twenties. The Clinic Association caught her attention through a job advertisement, which, together with a personal recommendation and the work of a consulting agency, led to her employment. She was motivated to work in Germany, because her German language skills were already good and made the language test omit. Moreover, Belgium did not offer her sufficient training and career opportunities and a bad environment for her family and children. The reasons why she came to Germany were predominantly job-related. According to her, Germany does offer a more attractive payment, a higher working standard and better training and career possibilities than Belgium. Additionally, a higher standard of living and a good environment for her family and children pulled her towards Germany. In particular, she was being attracted by the childcare services the Clinic Association has to offer. The assistant health-care professional is working for the Clinic Association for two years now and is planning to work for them for over five years. She does have intention to go back to Belgium out of personal reasons she didn't specify any further.

Case 6

The sixth case represents an assistant health-care professional from Iran within his forties who worked last in Norway. He established the first contact with the Clinic Association through their internet presence and reacted on one of their job advertisements with the help of a consulting agency. His intentions to work in Germany strengthened, because of his already existing German language skills and his motivation to further qualify in Germany. This assistant health-care professional did not need any financial aid in order to move to Germany, nor did he attend any language courses. The forces pushing him away from Iran were the bad working conditions and the fact that Iran has been a bad environment for his family. Although the working conditions in Norway were better than in Iran, he decided to migrate to Germany, because he needed a change of career and wanted to qualify as internist. Thus, it have been mainly the job-related reasons that made him migrate to Germany and work for the Clinic Association. According to him, the Clinic Association offers precisely that, a high standard of working and various career and training opportunities. Moreover, Germany provides him with a high standard of living, compared to e.g. Iran. At the moment, this assistant health-care professional is working for the Clinic Association for less than a year, but plans on staying there above five years with no intentions to return to his home country.

Case 7

The last case represents an orthopaedic surgeon from Jordan within his twenties. He decided to work for the Clinic Association, because friends recommended the organisation randomly to him. Moreover, he thinks that Germany is a country that has a good reputation in health-care services. For his migration, he needed financial aid from his parents and he also attended courses that made his migration easier. The health-care professional denounced the bad payment and low standard of living in Jordan. Additionally, it was important to him to get to know a new culture. He stated that it were especially the job-related reasons that pushed him to Germany. According to him, Germany offers better educational facilities as well as better training and career possibilities. Apart from that, Germany provides a higher standard of living than Jordan. The health-care professional is working for the Clinic Association for less than one year and is planning to work there for more than five years. He does have intentions to return to Jordan, but does not mention why he wants to go back there.

Summary

Having described the cases, I have been able to make a comparison between the push and pull factors commonly mentioned in the literature and the ones found in my research. Below (Table 4) one can see a clear indication that not all the endogenous and exogenous push and pull factors of migration mentioned in the literature actually apply for the migration of non-German health-care professionals to the Clinic Association. Whereas a good proportion of non-German health-care professionals has been pushed out of their country for endogenous reasons such as a lack of education and career opportunities and poor working conditions, only a minority of the respondents considered the payment in their country of origin a problem, despite of this factor being mentioned in the literature. The exogenous push factors seem to vary between a low standard of living, political instability and family aspirations, without a clear trend towards a certain factor. What concerns the endogenous pull factors, a clear trend became visible. Just like mentioned in the literature, the non-German health-care professionals working at the Clinic Association have been pulled towards the organisation because of a good remuneration and better education and career opportunities. A small amount of health-care professionals, however, seems to have been pulled by the high working standards at the Clinic Association. Last but not least, all of the cases have been pulled towards Germany, because of a higher standard of living. This seems to be the deciding exogenous factor for non-German health-care professionals to migrate to Germany, taken the fact that political stability, although mentioned in the literature, only played a minor role in most of the cases.

Table 4
Comparison of the push and pull factors: theory and results

Push and pull factors as stated in the theory		Case							Total
		1	2	3	4	5	6	7	#
Push factors (endogenous)	Bad remuneration	X	-	-	X	-	-	X	3
	Lack of education and career opportunities	X	X	X	X	X	-	-	5
	Poor working conditions	X	X	-	X	-	X	-	4
Push factors (exogenous)	Low standard of living	X	X	-	-	-	-	X	3
	Political instability	X	-	X	X	-	-	-	3
	Family aspirations	-	-	-	X	X	X	-	3
Pull factors (endogenous)	Good remuneration	X	X	X	X	X	-	-	5
	Education and career opportunities	X	X	X	X	X	X	X	7
	High working standards	X	-	-	X	X	X	-	4
Pull factors (exogenous)	High standard of living	X	X	X	X	X	X	X	7
	Political stability	-	-	X	X	-	-	-	2

Apart from the factors that have already been identified in the literature, the analysis of the cases brought forward five other factors that influenced the non-German health-care professionals to migrate, which have not been mentioned explicitly in the literature (Table 5). Among other things, case six mentioned the desire for a change of career as an endogenous push factor influencing his migration decision. Case seven made it clear that next to the factors mentioned above, he was interested in getting to know a new culture. This would translate to an exogenous push factor. Both case four and five were pulled to Germany, because they felt the need to provide a better environment for their family and children. Although this exogenous pull factor seems to resemble a high standard of living, the two factors cannot be considered equal. Whereas the standard of living is the “level of wealth, comfort, material goods and necessities available to a certain socioeconomic class in a certain geographic area” (Investopedia, 2012), the need to provide a better environment for family and children is more specifically aimed at the provision of a safe and stable environment for a family to live in. Moreover, the health-care professionals described in cases one, five and six have been pulled towards the Clinic Association through active recruitment, thus advertisements and recruitment agencies. This pull factor can be considered endogenous. Last, a majority of the cases described (cases two, three, four and seven) has been pulled towards the Clinic Association through recommendations by their friends, colleagues and family members. This seems to be the most important endogenous pull factor that is apparent in the case of the Clinic Association.

Table 5
Additional push and pull factors: results

Push and pull factors not stated in the theory		Case
Push factor (endogenous)	Desiring a change of career	Case 6
Push factor (exogenous)	Getting to know a new culture	Case 7
Pull factor (exogenous)	Providing a better environment for family and children	Case 4; Case 5
Pull factor (endogenous)	Active recruiting	Case 1; Case 5; Case 6
Pull factor (endogenous)	Recommendations	Case 2; Case 3; Case 4; Case 7

4.2 Results of the interview

The interview with the HRM manager of the Clinic Association, who fulfils an additional function of strategic HR development, serves as a basis for information concerning the costs and benefits for the Clinic Association the employment of non-German health-care professionals inherits. Moreover, it covers information about the Clinic Association, its attractiveness towards foreign health-care professionals and its current employment strategy. The results will be presented below.

Costs

According to Frank Vormweg, the costs that non-German health-care professionals create at the Clinic Association are various. First of all, non-German health-care professionals require extended job training in order to be able to work for the Clinic Association. That includes for example language courses as well as familiarisation strategies. These trainings and courses cost the Clinic Association additional money. Moreover, the employment of non-German health-care professionals increases the Clinic Association's advertising costs. The health-care professionals have to be attracted from abroad through external entities and that costs the Clinic Association additional money. Additionally, the quality of health-care might suffer every now and then due to the lacking German language skills of non-German health-care professionals. This has consequences for the working climate as well as for the communication between patients and health-care professionals. Non-German health-care professionals also work less efficient than German health-care professionals due to the fact that German is not their mother

tongue. It will take them more time to e.g. write medical reports than it would for their German counterparts. Last but not least, the Clinic Association is dependent on the non-German health-care professionals, because the organisation is not able to staff all its positions without the help of migrating health-care professionals.

Benefits

According to Frank Vormweg, the non-German health-care professionals have the advantage that they can be staffed in positions where no German alternative is available. He considers the cultural advantage gained by foreign health-care professionals as rather small, if not irrelevant in the Westmünsterland region. Apart from these advantages, non-German health-care professionals do not add an advantage to the Clinic Association and are considered equal to their German counterparts.

Additional information

According to Frank Vormweg, the demand for non-German health-care professionals in his organisation has most certainly risen over the past years due to factors like demographics and the feminisation of health-care. Frank Vormweg states that the Clinic Association particularly has the problem of staffing assisting health-care professionals from Germany. That is why the present-day ratio of health-care professionals from abroad to health-care professionals from Germany is merely 5%, whereas the ratio of assistant health-care professionals from abroad to assistant health-care professionals from Germany is close to 40%. Frank Vormweg, however, doubts that the ratio will remain static. In fact, he made the experience that the ratio is changing in a cyclical manner. Now there is a lack of German health-care professionals on the market, but this could also change within a few years of time due to increasing training efforts at schools and universities.

At the time of writing, the Clinic Association employs a majority of non-German health-care professionals from Europe. Many of the non-German health-care professionals migrate to Germany from Hungary, Romania, Greece; others come from Syria or Egypt. The non-German health-care professionals are being staffed in nearly any department of the Clinic Association. Internal medicine, urology, gynaecology, radiology are just some examples. The non-German health-care professionals have to pass a language course with at least a B2 diploma in order to be able to work for the Clinic Association. Their professional competence will be evaluated in during a period of probation. The Clinic Association has three ways of getting in contact with the non-German health-care professionals. First, they place job advertisements on networks like Stepstone.de or Kliniken.de. Second, they make use of recruiting agencies. Last, they hire a personnel consultant who

searches explicitly for personnel that is needed on specific positions and cannot be found out of the Clinic Association's own initiative.

Frank Vormweg states that non-German health-care professionals are being attracted by the Clinic Association due to its relatively small size. That gives the health-care professionals the time to acclimatise and enhance their language skills. This is, because the workload at the Clinic Association, compared to bigger hospitals, is relatively lower. Moreover, the Clinic Association employs a particular set of skilled people that new health-care professionals from abroad might find exciting to work with. Once the non-German health-care professionals have been employed, the Clinic Association prepares them for their work by providing job training that especially suits their needs. The non-German health-care professional gets the possibility to take additional language courses and courses explaining the organisation's computing processes.

Last, Frank Vormweg mentioned that the average time non-German health-care professionals stay at the Clinic Association varies. Assistant health-care professionals stay between two to six years and after this period of time the Clinic Association strives for a long-term employment. The same is true for health-care professionals who already took their examinations.

Summary

In summary, the costs and benefits found during the interview do not differ a lot from the ones found during the literature review. The interview brought forward that the Clinic Association faces additional training and recruitment costs as well as quality and efficiency issues accompanying the employment of non-German health-care professionals. Moreover, the interview brought forward that the Clinic Association is dependent on health-care professionals from abroad in order to keep their services running. Apart from the efficiency issues, these costs have also been found in the literature review.

What concerns the benefits, the interview brought forward the advantage of flexible staffing. This benefit has also been found in the theory. What the interview could not confirm, however, are the cost advantages that are involved with the employment of health-care professionals according to the theory.

A comparison of all the costs and benefits found in the literature and the interview can be found below (Table 6).

Table 6
Comparison of the costs and benefits: theory and results

	Theory	Interview
Costs	Additional training costs	Additional training costs
	Additional recruitment costs	Additional recruitment costs
	Quality issues	Quality issues
	Dependency	Dependency
	-	Efficiency issues
Benefits	Flexible staffing	Flexible staffing
	Cost advantages	-

4.3 Adapted conceptual model

Having discussed the results of both the questionnaire and the interview, it is now possible to adapt the conceptual model presented in the theoretical part of this thesis to the extent that it represents the thesis' findings. Below, the adapted model can be found.

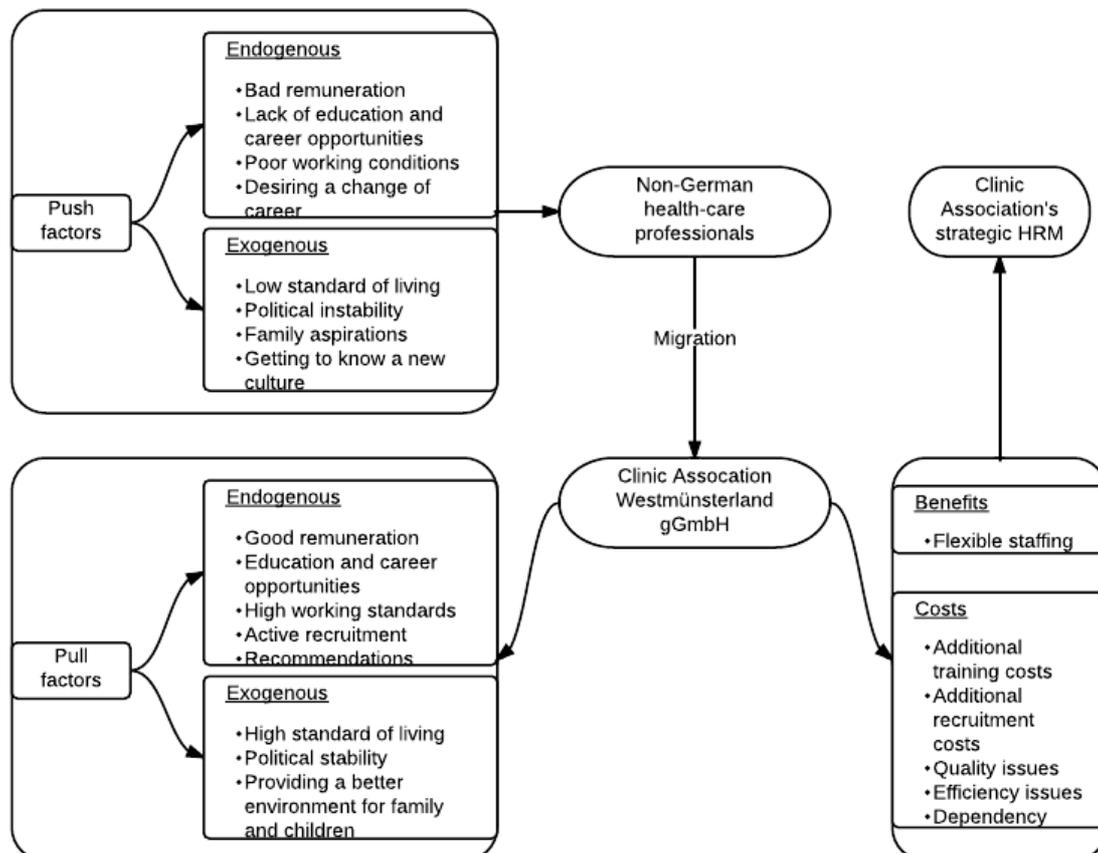


Figure 5. Conceptual model (with results)

It is worth mentioning that the adapted conceptual model remains in the dark concerning the Clinic Association's strategic HRM that results from the costs and benefits the employment of non-German health-care professionals comprises. This part of the conceptual model will be filled in in the form of an advice, which will, ultimately, conclude this thesis. However, first of all the thesis' results will be discussed and limitations that accompany this thesis will be brought forward in the following chapter.

5.0 Discussion

In the beginning of this thesis it has been called to the reader's attention that the migration of health-care professionals is a research topic that has caught the worldwide interest of numerous researchers today. However, despite the great amount of research done today within that area, the implications of the migration of health-care professionals from their country of origin to organisations within another country remained fairly unstudied. To fill this lack of information I have established a conceptual model on the basis of a literature review. It shows that the migration of non-German health-care professionals is being influenced by both push and pull factors and yields possible costs and benefits for the Clinic Association. Based on these consequences, the Clinic Association should adapt its strategic HRM in order to provide the most suitable environment for its non-German health-care professionals.

The most common push and pull factors presented in the literature have been analysed as well as the most commonly found costs and benefits of migration. In order to enrich this research with empirical data, I established contact with the Clinic Association and conducted an interview and a questionnaire with the HR manager of the Clinic Association and its non-German health-care professionals, respectively. The findings of this research will be discussed below.

Push and pull factors

A pattern that became visible during the analysis of the push and pull factors for non-German health-care professionals that migrated to Germany in order to work for the Clinic Association is that all of the respondents made their decision to migrate dependant predominantly on endogenous factors. Especially the numerous possibilities for advanced training and career opportunities seem to pull health-care professionals towards the Clinic Association. Moreover, the non-German health-care professionals polled are attracted by the good remuneration and, to a lesser extent, by the high working standards organisations in Germany have to offer. These findings reflect precisely the endogenous pull factors that have been identified in the literature by authors like Jenkins, et al. (2010) and Stilwell, et al. (2004). It seems almost like the endogenous pull factors that affect health-care

professional's migration patterns are mainly limited to the payment they receive, the development possibilities they are being offered and the quality of work they can expect from the organisation they are migrating to. However, a noteworthy amount of non-German health-care professionals have also been pulled towards the Clinic Association through recommendations by colleagues and friends and through the persistent active recruitment of the Clinic Association. These endogenous pull factors have not been mentioned explicitly in the literature so far.

What concerns the exogenous pull factors, differences have been found. The results of the questionnaires show, that all of the respondents came to work in Germany and for the Clinic Association, because Germany has to offer a higher standard of living than the countries the non-German health-care professionals originate from. Hardly any of the non-German health-care professionals, however, got pulled to Germany by its high political stability. In contrast, the theory presented both factors as equally strong (Oberoi & Lin, 2006). The reason for this could be that the literature predominantly focuses on the migration of health-care professionals from rather poor to rich countries. Between those countries the differences concerning the political stability is greater, because poor countries often have problems retaining their political stability. Next to the findings that were also represented in the literature, although with a different weighting, this research showed that providing a better environment for family and children can be considered an exogenous pull factor as well. It seems as if non-German health-care professionals who have a family appreciate an environment that supports their family and children.

The endogenous push factors that have been identified with the help of the questionnaire are distinct. Whereas a majority of non-German health-care professionals decided to leave their country of origin because of a lack of education and career opportunities, only a few non-German health-care professionals thought of the bad remuneration and poor working conditions as an issue. The literature stated that health-care professionals predominantly migrate to increase the payment they get for the same amount of work, to gain additional education and career opportunities and to escape the poor working conditions (Chen & Boufford, 2005; Hagopian, 2007; Oberoi & Lin, 2006; Stewart, et al., 2007). However, the empirical data gathered clearly does not reflect that. Both the poor working conditions and payment do not seem to be the decisive factor for health-care professional migration. The cases made clear that many health-care professionals working for the Clinic Association were seeking additional opportunities, which would match with the fact that knowledge employees are predominantly motivated by intrinsic factors (Kinnie, et al., 2005). In fact, one of the respondents got pushed out of his country of origin, because he felt the desire to change his career into a different direction.

Finally, the data gathered about the exogenous push factors is rather inconclusive. Some non-German health-care professionals mentioned a low standard of living as the primary push factor that affected their decision to migrate, others the polit-

ical instability or family aspirations. No real pattern emerged concerning the weight of these factors. However, one can say that all the factors that have been found in the literature (Chen & Boufford, 2005; Oberoi & Lin, 2006; Smith, 2008) were in some way applicable for the non-German health-care professionals who work at the Clinic Association as well. Next to the factors mentioned in the literature, one of the respondents found it important to get to know a new culture, which influenced his decision to migrate to Germany. This exogenous factor is interesting, because it can hardly be influenced by anyone, which is probably the reason why it has not mentioned explicitly in the literature.

What has been interesting about the results is that although there are many factors that push non-German health-care professionals towards Germany and pull them away from their country of origin, the majority of the cases made it clear that these people are not per se planning to stay in Germany forever. Although some of the individuals have only been working for the Clinic Association for less than a year, they have already the intention to go back to their country of origin for either personal reasons, career opportunities or a deep bond to their country.

Costs and benefits

Apart from the push and pull factors, the costs and benefits of the employment of non-German health-care professionals has been analysed as well.

The interview brought forward that the Clinic Association has only one benefit from the employment of non-German health-care professionals. In fact, the workforce from abroad allows the Clinic Association to staff positions that, otherwise, would have stayed unstaffed, because of a lack of domestic alternatives. These findings are in conflict with the findings from the literature review. Namely, the literature states that the main benefits of the employment of health-care professionals from abroad are cost-related (Stewart, et al., 2007). The literature stresses the fact that employing foreign health-care professionals enables organisations to cut their costs drastically by not having to invest in the training of health-care professionals and focuses less on the fact that health-care professionals enable an organisation to cover areas that lack domestic personnel. It is interesting that the Clinic Association has no financial incentives to employ non-German health-care professionals and rather pays additional recruitment and familiarisation costs in order to obtain the workforce needed to keep the quality of health-care up.

The costs, on the other hand, are diverse. Non-German health-care professionals need an extra amount of training in order to be able to work at the Clinic Association. They need language courses and courses familiarising them with the work routine. The costs for these courses weigh on the Clinic Association, just like the health-care professional's housing and travelling expenses. Thus, although the non-German health-care professionals are able to fill gaps in the workforce of the Clinic Association, they do have higher costs. Moreover, foreign health-care professionals can lead to inefficiency within the Clinic Association. That is due to the

fact that German is not their mother tongue in most of the cases. Non-German health-care professionals are slower at filling out the relevant paperwork and cannot communicate as good with their colleagues and patients as could e.g. German health-care professionals. The last part is especially important for the Clinic Association, because their clientele does often speak with an accent, which makes it even harder for the foreign health-care professionals to communicate with patients. Moreover, in special cases the employment of non-German health-care professionals can lead to cultural problems as well. If e.g. a health-care professional has a problem with treating female patients, a German health-care professional has to take his job, which might add additional stress to the working atmosphere. Last but not least, the lack of domestic health-care professionals makes the Clinic Association dependent on health-care professionals from abroad. That can be considered a cost, taking into consideration the additional costs these employees create and their tendency to return to their countries of origin. The moment the non-German health-care professionals re-migrate back to their countries of origin, all investments into these employees will be nullified.

The costs mentioned above are not reflected in the literature to the extent as they should be. The literature merely mentions that health-care professionals need additional training, which costs the organisation additional money, and that their employment somehow affects the working conditions of an organisation (Stewart, et al., 2007). The literature largely disregards the cultural problems, the problems concerning the quality of health-care and the efficiency problems that occur due to the employment of foreign health-care professionals.

In a nutshell, the information above identified the relevant information that is necessary to answer the first two research subquestions stated in the beginning of this research:

Q1: What are the push and pull factors influencing health-care professionals' decision to work for the Clinic Association?

Q2: What are the costs and benefits for the Clinic Association that accompany the employment of non-German health-care professionals?

What is missing, are the limitations that come along with this thesis and, taking those limitations into consideration, an advice for the Clinic Association's HRM on how to strategically manage the non-German health-care professionals in their organisation taking into account the insights gathered so far. Thus, the following paragraphs will describe the thesis' limitations followed by an advice, which, in the same vein, will conclude this thesis by answering its research questions.

5.1 Limitations and further research suggestions

The limitations that I encountered are the following. First of all, the empirical data that has been gathered allows no room for generalisation. That is, because the number of respondents is simply too low. Thus, although a debate about the migration of health-care professionals from abroad to the Clinic Association is possible, the gained insights cannot be transferred to other hospitals or organisations without running the risk of the potential conclusions being biased. Moreover, the methods that have been used to obtain the needed data have been restricted by Frank Vormweg, under which the richness in detail of the obtained data suffered a lot. Although a questionnaire has the power to verify theoretical data with empirical data, it is a bad method to explore new possibilities and gain new insights. In-depth interviews e.g. could have allowed me to dig deeper into the non-German health-care professionals' reasons to migrate to Germany based on their individual cases.

For further research, I suggest to conduct this research on a greater scale among numerous hospitals in different regions in Germany. This would allow researchers to generalise their findings to a higher level due to an increased amount of non-German health-care professionals with a greater geographical variety. Furthermore, I would suggest researchers to conduct in-depth interviews in place of questionnaire, because of the questionnaire's obvious limitations as a research method for this particular area of interest.

5.2 Advice to the Clinic Association

In the beginning of this thesis I have asked the following research questions:

RQ1: What are the reasons for non-German health-care professionals to work for the Clinic Association?

RQ2: What are the consequences for the Clinic Association's strategic HRM department resulting from the employment of non-German health-care professionals?

In order to have sufficient data available to answer these research questions, I answered research subquestions one and two first. Answering these question led to the insight that non-German health-care professionals migrate out of numerous endogenous and exogenous reasons and that their employment, other than stated in the theory, is attended by numerous negative consequences. The Clinic Association has additional training and recruitment costs and its quality and efficiency of health-care is at stake due to e.g. language and culture barriers. On top of that, the Clinic Association faces the problem that many of the non-German health-care

professionals that were asked have the intention to return to their country of origin after a short amount of time although the Clinic Association is admittedly dependent on this employee group and invests a lot of money into their employment.

With the information available from answering research subquestions one and two, it is now possible to give an answer to the last research subquestion:

Q3: How does the employment of non-German health-care professionals affect the Clinic Association's strategic HRM?

In fact, the Clinic Association's strategic HRM department is being affected by the employment of the non-German health-care professionals in so far that it has to ask itself the question on how to keep the supply of health-care professionals into their organisation steady and their quality of health care on a high level (Klinikverbund-Westmünsterland, n.d.-e) or, in other words, whether the Clinic Association's future supply of health-care professionals comprises a high number of health-care professionals from abroad, accompanied by the numerous negative consequences, or not. Due to the fact that the Clinic Association is dependent on non-German health-care professionals, the latter question leaves no alternative but to rely on the foreign workforce. The question remaining is, how should the Clinic Association tackle the problem that many of its non-German health-care professionals employed have the intention to return to their country of origin? There are two options: either the Clinic Association closes the gap that re-migrating non-German health-care professionals leave behind by trying to recruit more actively abroad or trying to retain their current workforce with the help of a suitable HRM strategy. Personally, I believe the latter would be the better alternative, because it helps the Clinic Association to keep their investments in the organisation, thus sparing it a lot of costs. Even though it will, most likely, not be possible to retain every single non-German health-care professional, also a small amount of non-German health-care professionals staying at the Clinic Association for the long-term could make up for the costs that rest of this employee group creates. It goes without saying that non-German health-care professionals that will stay at the Clinic Association for a long time span will have an increased efficiency, because they have had more time to learn the German language. This would also help to counter the problem of a reduced quality of health-care, because this problem mainly originates from the fact that German is not the non-German health-care professionals' mother tongue, and, more importantly, it would reduce the dependency on non-German health-care professionals and lower the recruitment costs of the Clinic Association.

In the theoretical part of this thesis I described how to best manage health-care professionals according to the theory. The following paragraph will make use of the insights gained above and explain, in detail, how to build a commitment oriented HRM system at the Clinic Association and, thereby, conclude this thesis.

In order to retain its non-German health-care professionals, the Clinic Association has to build a commitment-oriented HRM system. In order to do so, the theory suggested a number of HR practices that can help the Clinic Association to create a stronger bond between its non-German health-care professionals and the organisation that might convince the non-German health-care professionals not to leave the organisation after a short time period and release their full potential.

When having a close look at what drove the non-German health-care professionals to migrate to Germany and work for the Clinic Association in the first place, it is noticeable that especially the education & career opportunities and a good remuneration pulled the non-German health-care professionals towards the Clinic Association. Therefore, the Clinic Association should implement HR practices that support those needs. The Clinic Association could i.a. offer its health-care professionals numerous possibilities to advance professionally through creating an internal labour market, providing a proper career development and investing into the employees' competencies. By doing so, the non-German health-care professionals could satisfy their intrinsic desire to develop their skills and gain competencies they need to execute their profession the best way possible. In fact, the Clinic Association partly complies with those HR practices by offering in-house training (Klinikverbund-Westmünsterland, n.d.-b), continuous language training and computing courses. Moreover, in the course of this thesis it has become apparent that health-care professionals from abroad value the good working conditions that prevail in Germany and at the Clinic Association. The Clinic Association should make this knowledge to their advantage by keeping the level of their working conditions high by implementing HR practices that are valued by knowledge workers. Good working conditions for health-care professionals can be created by offering i.a. a high discretion on the job and an creating an environment that allows health-care professionals to execute autonomous work, be recognised and involved. Moreover, there should be an atmosphere that promotes communication and openness. During the interview with Frank Vormweg it has not become clear in how far the Clinic Association can satisfy these needs of health-care professionals. The Clinic Association is a relatively small organisation, which increases the odds that a good communication between the organisation's management is given and that it has on open culture. However, it cannot be verified whether the Clinic Association actively promotes these HR practices or whether they are simply available due to the organisation's nature. Last but not least, the findings of this thesis crystallised that some of the non-German health-care professionals were pulled towards Germany, because it provides a better environment for the non-German health-care professionals' family and children. The Clinic Association should pick up on this desire and promote a work environment that actively supports a proper work-life balance. According to my knowledge, the Clinic Association provides e.g. day-care at its hospitals, which allows health-care professionals with children to work and have their children being taken care of, and a high job security. This is a good start in promoting a good work environment, however, not

enough. The Clinic Association should also make sure of giving the health-care professionals a payment, which resembles their level of skill, in order to create organisational commitment and give them the feeling of being valued for their performance.

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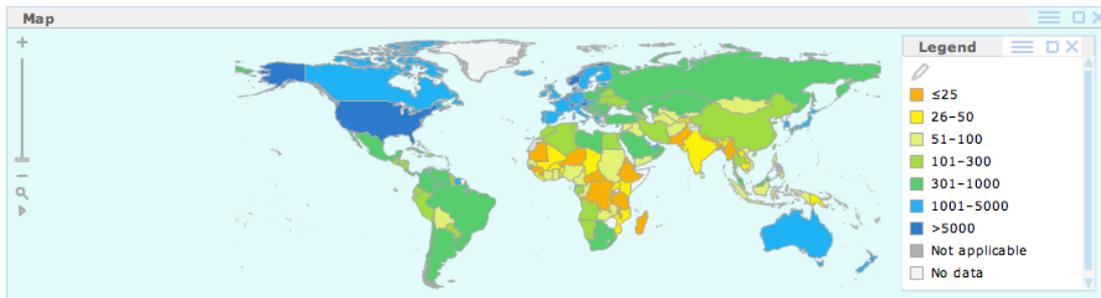
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Appendix

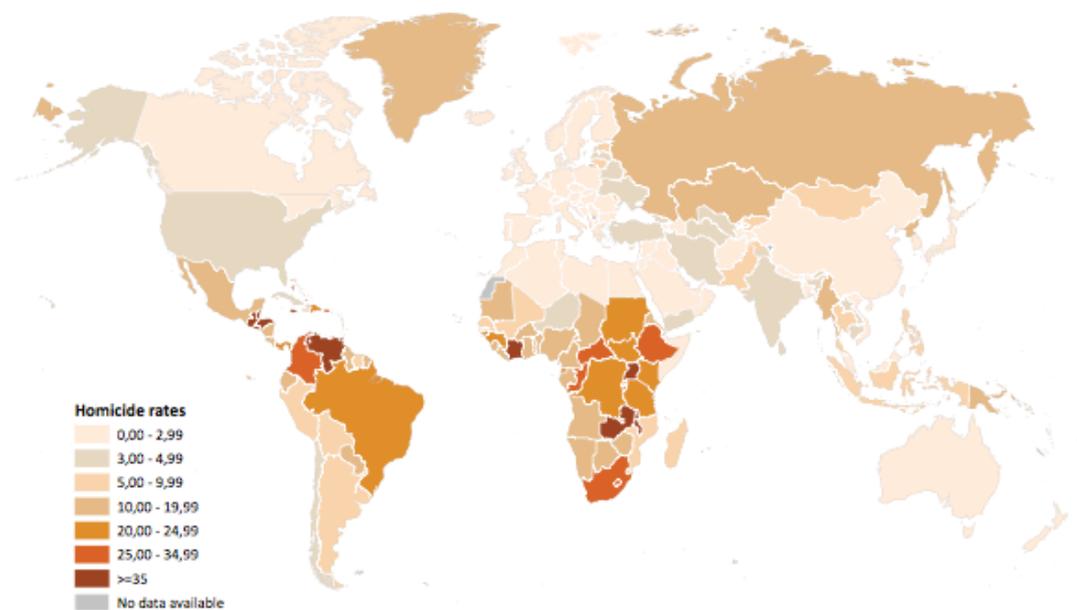
A: Health Financing - Per capita total expenditure on health at average exchange rate (US\$), 2009



(Retrieved from http://gamapserver.who.int/gho/interactive_charts/health_financing/atlas.html?indicator=i3&date=2009)

B: Homicide rates - By country, 2010 or latest available year

Map 1.1: Homicide rates by country (2010 or latest available year)



Note: The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations.

(Retrieved from http://www.unodc.org/documents/data-and-analysis/statistics/Homicide/Globa_study_on_homicide_2011_web.pdf)

C: Questionnaire

Brain Drain: Ausländische Ärzte in Deutschland (Ein Fragebogen von Dustin Schilling)

Dieser Fragebogen dient der Evaluierung der Beweggründe ausländischer Ärzte in Deutschland beruflich tätig zu sein. Der Kern des Fragebogens ist sowohl die Analyse der Beweggründe von ausländischen Ärzten ihr Heimatland zu verlassen um in Deutschland zu arbeiten, als auch der Anreize Deutschlands die letztlich dazu führen, dass Fachkräfte aus dem Ausland nach Deutschland emigrieren wollen.

Alle Daten in diesem Fragebogen werden vertraulich behandelt und nicht veröffentlicht. Die Ergebnisse dienen einzig und allein der Fertigstellung meiner Bachelorarbeit an der Universität Twente in den Niederlanden.

* Erforderlich

Allgemeine Fragen zur Person

Was ist Ihr Beruf? *

Wie alt sind Sie? *

- 20-30
 31-40
 41-50
 51+

Welcher Herkunft sind Sie? *

Fragen zur Migration nach Deutschland

Welche der folgenden beruflichen Gründe haben Sie dazu animiert Ihr Herkunftsland zu verlassen und nach Deutschland zu emigrieren? *

- Schlechte Lohnverhältnisse
 Mangelnde Qualität der Bildungseinrichtungen
 Fehlende Weiterbildungs- und Karriereöglichkeiten
 Schlechte Arbeitsbedingungen



Gab es neben den oben genannten Gründen noch weitere berufliche Gründe nach Deutschland zu emigrieren?

(optional)

Welche der folgenden persönlichen Gründe haben Sie dazu animiert Ihr Herkunftsland zu verlassen und nach Deutschland zu emigrieren? *

- Niedriger Lebensstandard
- Politische Instabilität
- Hohe Kriminalitätsrate
- Schlechtes Umfeld für Familie und/oder Kinder

Gab es neben den oben genannten Gründen noch weitere persönliche Gründe nach Deutschland zu emigrieren?

(optional)

Waren es vor allem die beruflichen oder persönlichen Gründe die die Entscheidung nach Deutschland zu emigrieren beeinflusst haben? *

- Vor allem berufliche Gründe
- Vor allem persönliche Gründe

Warum haben Sie sich dazu entschlossen speziell nach Deutschland zu emigrieren? *

Hatten Sie finanzielle Unterstützung nötig um nach Deutschland zu emigrieren? *

- Ja
- Nein



Falls ja, woher haben Sie finanzielle Unterstützung bekommen?

Haben Sie Kurse besucht um die Migration nach Deutschland zu vereinfachen? *
(z.B. Sprachkurse)

Fragen zum Klinikverbund Westmünsterland

Warum haben Sie sich für den Klinikverbund Westmünsterland als Arbeitgeber entschieden? *

Wie hat der Klinikverbund Westmünsterland Ihre Aufmerksamkeit geweckt? *
(z.B. durch aktives Anwerben oder passiv durch Zufall)



Wie lange arbeiten Sie schon für den Klinikverbund Westmünsterland? *

- < 1 Jahr
- 1 Jahr
- 2 Jahre
- 3 Jahre
- 4 Jahre
- > 5 Jahre

Wie lange haben Sie geplant für den Klinikverbund Westmünsterland zu arbeiten? *

- < 1 Jahr
- 1 Jahr
- 2 Jahre
- 3 Jahre
- 4 Jahre
- > 5 Jahre

Fragen zur Attraktivität Deutschlands

Welche der folgenden beruflichen Gründe haben Sie nach Deutschland gezogen? *

- Attraktive Lohnverhältnisse
- Angesehene Bildungseinrichtungen
- Zahlreiche Weiterbildungs- und Karrieremöglichkeiten
- Hoher Arbeitsstandard

Gab es neben den oben genannten Gründen noch weitere berufliche Gründe die Sie nach Deutschland gezogen haben?

(optional)

Welche der folgenden persönlichen Gründe haben Sie nach Deutschland gezogen? *

- Hoher Lebensstandard
- Politische Stabilität
- Niedrige Kriminalitätsrate
- Gutes Umfeld für Familie und/oder Kinder



Gab es neben den oben genannten Gründen noch weitere persönliche Gründe die Sie nach Deutschland gezogen haben?

(optional)

Fragen zur Heimatverbundenheit

Besitzen Sie Intentionen z.B. nach vollendeter Ausbildung zurück in Ihr Heimatland zu kehren? *

- Ja
 Nein

Falls ja, welche Gründe wären am wahrscheinlichsten für eine Rückkehr?

(nennen Sie z.B. eine Auswahl von beruflichen oder persönlichen Gründen)

Vielen Dank für Ihre Teilnahme!

Bei Fragen können Sie mich gerne kontaktieren unter folgender Email-Adresse:

d.schilling@student.utwente.nl

E: Questionnaire (results)

Frage 1: Was ist Ihr Beruf?

Antworten: Arzt (4)
Assistenzarzt (2)

Frage 2: Wie alt sind Sie?

Antworten: 20-30 (3)
31-40 (2)
41-50 (1)
51+ (0)

Frage 3: Welcher Herkunft sind Sie?

Antworten: Griechenland (3)
Rumänien (1)
Belgien (1)
Iran (1)

Frage 4: Welche der folgenden beruflichen Gründe haben Sie dazu animiert Ihr Herkunftsland zu verlassen und nach Deutschland zu emigrieren?

Antworten: Fehlende Weiterbildungs- und Karrieremöglichkeiten (83%)
Schlechte Arbeitsbedingungen (67%)
Schlechte Lohnverhältnisse (33%)
Mangelnde Qualität der Bildungseinrichtungen (17%)

Frage 5: Gab es neben den oben genannten Gründen noch weitere berufliche Gründe nach Deutschland zu emigrieren?

Antworten: Ein breites Spektrum an Fortbildungsmöglichkeiten
Berufliche Veränderung
Weiterbildung als Innerer Mediziner

Frage 6: Welche der folgenden persönlichen Gründe haben Sie dazu animiert Ihr Herkunftsland zu verlassen und nach Deutschland zu emigrieren?

Antworten: Politische Instabilität (50%)
Schlechtes Umfeld für Familie und/oder Kinder (50%)
Niedriger Lebensstandard (33%)
Hohe Kriminalitätsrate (0%)

Frage 7: Gab es neben den oben genannten Gründen noch weitere persönliche Gründe nach Deutschland zu emigrieren?

Antworten: Interesse an Akkupunktur und Homöopathie

Frage 8: Waren es vor allem die beruflichen oder persönlichen Gründe die die Entscheidung nach Deutschland zu emigrieren beeinflusst haben?

Antworten: Vor allem berufliche Gründe (100%)
Vor allem persönliche Gründe (0%)

Frage 9: Warum haben Sie sich dazu entschlossen speziell nach Deutschland zu emigrieren?

Antworten: Bereits vorhandene Sprachkenntnisse (3)
Weiterbildungsmöglichkeiten für Ärzte (2)
Kontakte über die Universität
Bekanntschaften zu Ärzten die bereits in Deutschland arbeiten
Verbesserung der medizinischen Kenntnisse
Finanzielle Gründe

Frage 10: Hatten Sie finanzielle Unterstützung nötig um nach Deutschland zu emigrieren?

Antworten: Ja (50%)
Nein (50%)

Frage 11: Woher haben Sie finanzielle Unterstützung bekommen?

Antworten: Klinikverbund Westmünsterland (66%)
Deutschland (33%)

Frage 12: Haben Sie Kurse besucht um die Migration nach Deutschland zu vereinfachen?

Antworten: Sprachkurs (50%)
Nein (50%)

Frage 13: Warum haben Sie sich für den Klinikverbund Westmünsterland als arbeitgeber entschieden?

Antworten: Durch Empfehlung (50%)
Vermittlung durch Dritte (50%)

Frage 14: Wie hat der Klinikverbund Westmünsterland Ihre Aufmerksamkeit geweckt?

Antworten: Empfehlung durch persönliche Bekanntschaft (3)
Stellenanzeige (2)
Empfehlung über das Internet
Internetauftritt
Zufällig

Frage 15: Wie lange arbeiten Sie schon für den Klinikverbund Westmünsterland?

Antworten: < 1 Jahr	(50%)
1 Jahr	(33%)
2 Jahre	(17%)
3 Jahre	(0%)
4 Jahre	(0%)
> 5 Jahre	(0%)

Frage 16: Wie lange haben Sie geplant für den Klinikverbund Westmünsterland zu arbeiten?

Antworten: < 1 Jahr	(0%)
1 Jahr	(0%)
2 Jahre	(0%)
3 Jahre	(33%)
4 Jahre	(17%)
> 5 Jahre	(50%)

Frage 17: Welche der folgenden beruflichen Gründe haben Sie nach Deutschland gezogen?

Antworten: Weiterbildungs- und Karrieremöglichkeiten	(100%)
Attraktive Lohnverhältnisse	(83%)
Hoher Arbeitsstandard	(83%)
Angesehene Bildungseinrichtungen	(33%)

Frage 18: Gab es neben den oben genannten Gründen noch weitere berufliche Gründe die Sie nach Deutschland gezogen haben?

Antworten: /

Frage 19: Welche der folgenden persönlichen Gründe haben Sie nach Deutschland gezogen?

Antworten: Hoher Lebensstandard	(100%)
Politische Stabilität	(33%)
Gutes Umfeld für Familie und/oder Kinder	(33%)
Niedrige Kriminalitätsrate	(0%)

Frage 20: Gab es neben den oben genannten Gründen noch weitere persönliche Gründe die Sie nach Deutschland gezogen haben?

Antworten: Kinderbetreuung am Krankenhaus

Frage 21: Besitzen Sie Intentionen z.B. nach vollendeter Ausbildung zurück in Ihr Heimatland zu kehren?

Antworten: Ja (50%)
 Nein (50%)

Frage 22: Falls ja, welche Gründe wären am wahrscheinlichsten für eine Rückkehr?

Antworten: Berufliche Perspektiven im Heimatland
 Verbundenheit zum Heimatland
 Persönliche Gründe
 Ich weiss noch nicht

E: Interview (Transcript, German)

Frage 1: Wer sind Sie und was ist Ihre Aufgabe im Klinikverbund Westmünsterland?

Mein Name ist Frank Vormweg. Ich bin Leiter des Personalwesens im Klinikverbund Westmünsterland und habe die Zusatzaufgabe „Strategische Personalentwicklung“.

Frage 2: Denken Sie, dass Deutschland seinen Teil zum Braindrain beisteuert indem es Fachkräfte aus dem Ausland anwirbt oder, dass der Braindrain gar nicht erst ermöglicht wird durch eine restriktive Gesetzgebung Deutschlands im Gegensatz zu anderen Ländern?

Deutschland wirbt Ärzte aus anderen Ländern ab. Sie sollten aber differenzieren zwischen Fachärzten und Ärzten in Weiterbildung, denn Fachärzte sind Ärzte die bereits eine Weiterbildung abgeschlossen haben. Wenn z.B. ein georgischer Facharzt nach Deutschland kommt, dann wird seine Facharztqualifikation in Deutschland nicht anerkannt. Georgien ein Entwicklungsland in Bereich der Medizin und das Curriculum ist unterschiedlich und darum müssen georgische Ärzte in Deutschland eine erneute Facharztausbildung machen. Das ist eine wichtige Differenzierung, weil Fachärzte explizit aus dem Ausland haben wir ganz wenige. Deutschland wirbt Ärzte aus dem Ausland an, weil der Bedarf sicherlich gestiegen ist aufgrund verschiedener Faktoren wie z.B. Demographie und die Feminisierung der Medizin. Dadurch werden die Stellen nicht mehr alle besetzt und das veranlasst den Klinikverbund Westmünsterland auch ins Ausland zu gehen um dort Absolventen der Universitäten anzusprechen.

Frage 3: Würden Sie sagen, dass der Klinikverbund Westmünsterland einen Mangel an Fachärzten hat und aus eigener Kraft nicht genügend Ärzte aufbringen kann um die Versorgung auf gleichbleibend hohem Niveau zu halten?

Facharztmangel haben wir nicht. Wir können fachärztliche Stellen besetzen, also mit Ärzten die eine abgeschlossene Weiterbildung haben. Die Besetzung von Stellen für Assistenzärzte, also Ärzte in Weiterbildung, ist allerdings schwieriger.

Frage 4: Wie ist das Verhältnis von deutschen und ausländischen Fachärzten bzw. Assistenzärzten?

Das Verhältnis von Fachärzten aus Deutschland und dem Ausland liegt bei 95% zu 5%. Bei den Assistenzärzten liegt das Verhältnis bei 60% zu 30-40%. Die Ärzte die derzeit anfangen sind in der Regel ausländische Ärzte.

Frage 5: Hat sich das Verhältnis von deutschen und ausländischen Fachärzten und Assistenzärzten mit der Zeit verändert oder ist es unverändert geblieben?

Es ist zyklisch. Am besten lässt es sich mit dem sogenannten „Schweinezyklus“ erklären. Es gibt einen Mangel an Ärzten, woraufhin die Arbeitgeber sich viel Mühe geben Ärzte zu gewinnen und neue ausländische Ärzte in dieser Zeit gewonnen werden. Dieser Mangel kommt dann bei den Schulen und Schülern an und wieder mehr Leute wollen Ärzte werden wodurch wieder ein Überangebot entsteht. Es ist also immer ein Wechsel zwischen Mangel und Überangebot. Derzeit ist es aus verschiedensten Gründen dahin gekommen, dass es einen Mangel an Ärzten gibt.

Frage 6: Denken Sie, dass sich das Verhältnis demnach in der Zukunft wieder anpasst und mehr Deutsche Ärzte für den Klinikverbund Westmünsterland arbeiten werden?

Ob das für Regionen die nicht so stark sind weiß ich nicht. Man muss sehr stark differenzieren zwischen Köln und Westmünsterland oder Münster und Westmünsterland, das ist multifaktoriell. Es wird sich wieder verändern. Es gibt bereits jetzt bestimmte „Konsolidierungen“, dass sich Situationen wieder verändert haben die dazu führen, dass wir nicht mehr jeden Arzt annehmen müssen. Das ist auch sehr stark anhängig von der Lage. Für uns im Klinikverbund ist es notwendig auch zukünftig ausländische Ärzte sehr schnell in unsere Teams zu integrieren und davon gehen wir aus.

Frage 7: Diese „Konsolidierung“ von der Sie sprachen, stammt diese eher von der Krankenhausleitung oder von einer höheren Ebene wie z.B. die Politik auf der Sie keinen Einfluss haben.

Die Menge an Ärzten die nach Deutschland und Österreich kommen möchte scheint schon gestiegen zu sein. Es hat inzwischen dann auch den Letzten erreicht, dass es hier sehr gute Bedingungen gibt. Dadurch sind vielleicht auch mehr

Leute auf dem Markt. Andererseits arbeiten wir auch durch verschiedene strategische Instrumente daran Leute für den Medizinberuf zu begeistern. Es ist natürlich auch ein Faktor, dass 40% der Medizinstudenten ihr Studium abbrechen. Daran wird auch gearbeitet, das sind alles Faktoren die eine Rolle spielen.

Frage 8: In welchen Bereichen sind die ausländischen Fachkräfte und Assistenzärzte tätig?

Das ist ähnlich wie bei den deutschen Ärzten. Sehr gefragt ist die Chirurgie, die innere Medizin, Urologie, Gynäkologie und die Radiologie. Außerdem ist der gesamte assistenzärztliche Bereich betroffen.

Frage 9: Woher kommt ihr ausländischen Personal?

Hierbei verweise ich Sie auf die Liste die ich Ihnen bereits habe zukommen lassen. Generell kommen viele Ärzte aus Ungarn, Rumänien und Griechenland. Außerdem kommen viele Ärzte aus Syrien und Ägypten. Der Klinikverbund hat einen Inder angestellt, der aber über Rumänien nach Deutschland gekommen ist. Das Personal kommt weitestgehend aus Europa.

Frage 10: Können Sie sich erklären warum das meiste Personal aus Europa kommt?

Die Einwanderungspolitik in Deutschland, wahrscheinlich dann auch in Europa, scheint sehr restriktiv zu sein. Das wurde vor allem deutlich durch die Stellungnahmen der Parteien zum Ausländergesetz und der Blue Card in letzter Zeit. Außerdem werden Fachkräften durch die Green Card Einkommensgrenzen gesetzt. Das ist nicht interessant für Inder oder Informatiker. Wir haben manchmal Anfragen von Ärzten aus Südamerika, aber da gibt es wahrscheinlich auch auf verbandsrechtlicher Ebene keine Verbindung. Indische Ärzte gehen lieber in die USA und pakistanische Ärzte nach Indien. Wahrscheinlich haben sie dann den stärksten Braindrain in Pakistan. Es gibt auch bei uns das Phänomen, dass Ärzte aus Rumänien weggehen obwohl die Situation in Rumänien vom Gesundheitswegen her prekär und schwierig ist.

Frage 11: Haben Sie besondere Auswahlkriterien für ausländische Ärzte?

Ja klar. Wir beurteilen die Sprachqualität. Bedingung ist ein B2 Diplom obwohl dieses eigentlich nicht reicht. Erstkriterium ist die Sprache, denn die medizinische Qualität kann man im Erstgespräch nicht rausbekommen. Um die medizinische Qualität zu evaluieren wird die Probezeit von einem halben Jahr genutzt.

Frage 12: Was sind die speziellen Anreize für Ärzte aus dem Ausland im Klinikverbund Westmünsterland zu arbeiten?

In unserer Klinik arbeiten Menschen die besonders sind. Wir haben sicherlich teilweise besondere Konstellationen. Die Größe des Hauses ist für manchen Arzt attraktiv. Wenn es ein kleines Krankenhaus ist mit einer überschaubaren Patientenzahl, dann heißt das umgekehrt auch, dass ein neuer Arzt aus dem Ausland

Zeit hat sich zu akklimatisieren und die Sprache zu lernen. Wenn es eine große akutmedizinische Abteilung ist, ist auch der Druck entsprechend grösser und es muss das Vorwissen des Arztes grösser sein. Darüber hinaus entstehen Kontakte. Ärzten ist es egal wo sie arbeiten und die Region ist Ihnen oft nur sekundär. Die Ärzte sind für 3-4 Jahre hier und wollen lernen. Nur ganz wenige kommen explizit in die Region weil ihnen diese am Herzen liegt. Das Münsterland und das Ruhrgebiet werden aber immerhin noch wahrgenommen als Einheit auf Europäischer Ebene.

Frage 13: Was bringen ausländische Fachkräfte für Vorteile?

Der Vorteil ist, dass diese Ärzte eine unbesetzte Arztstelle besetzen. Das ist der einzige Vorteil. Die ausländischen Ärzte sind tariflich bezahlt wie alle anderen Ärzte auch. Sie bringen zwar mitunter Erfahrungen mit, aber das eine spezifische Expertise aus Georgien oder aus der Türkei kommt mag ein Kulturvorteil sein, aber der ist bei uns in der Region auch eher gering.

Frage 14: Was bringen ausländische Fachkräfte für Nachteile?

Wir handeln die Ärzte nicht im Preis runter und geben eher mehr Geld aus für Einarbeitung und Stellenbesetzung. Es ist nicht so, dass wir dadurch Gewinn haben, finanziell zumindest. Die Anstellung von Kräften aus dem Ausland birgt auch nicht unbedingt Risiken eines Qualitätsverlusts. Ein Assistenzarzt z.B. ist per Definition ein Arzt der nicht selbstständig arbeitet. Es gibt immer einen Facharzt der ihm über die Schulter schaut. Die Kommunikation, allerdings, kann natürlich schon schwieriger werden durch den Einsatz von ausländischen Kräften. Wenn Gespräche zwischen Fachärzten und Assistenzärzten auf Englisch geführt werden hat das Auswirkungen auf das Betriebsklima. Es ist aber auch immer eine Frage der Offenheit des Arztes der kommt. Wenn es jemand ist der aufgrund seiner Kultur Probleme hat mit Frauen, dann sind das Belastungen die auch Risiken mit sich bringen. Des Weiteren hat es eine Auswirkung auf die Patientenkommunikation. Patienten im Münsterland sprechen oftmals Plattdeutsch und können sich schwieriger mit ausländischem Personal unterhalten. Ein weiterer Nachteil ist der Effizienzverlust. Die Arbeit wird langsamer, denn ein Arztbrief auf Deutsch schreibt sich langsamer als in der Heimatsprache. Eine Abhängigkeit besteht außerdem. Der Klinikverbund hätte Probleme alle Stellen zu besetzen gäbe es die ausländischen Kräfte nicht.

Frage 15: Was machen Sie um den Ärzten den Einstieg in Deutschland zu erleichtern um u.a. auch die oben genannten Risiken zu verringern?

Wir haben Einarbeitungskonzepte. Wir diskutieren darüber welche besonderen Anforderungen die Einarbeitung von ausländischen Ärzten braucht. Wir haben ein Projekt wodurch die bestehenden Strukturen nochmals erweitert werden. Im Wesentlichen wird es darum gehen, dass es fokussiert auf einzelne Thematiken nochmals Zusatzschulungen für ausländische Ärzte geben wird. Die Schulungen sind vor allem im Bereich der Sprache oder EDV. Ausländischen Ärzten wird z.B. das Krankenhaus Informationssystem näher gebracht.

Frage 16: Wie könnte man Ihrer Meinung nach dem Braindrain entgegenwirken?

Der eigene Arbeitsmarkt müsste besser unterstützt werden. Wir machen deswegen strategisches Personalmanagement. Ich spreche Schüler an und versuche Wege aufzuzeigen zum Medizinstudium oder zum dualen Studium in der Pflege das wir Stellen im Gesundheitswesen zukünftig besetzen können. Wir arbeiten aber auch auf Prozessebene daran. Das wir schauen welche Tätigkeiten muss ein Arzt übernehmen und was kann ein Assistent übernehmen. Es gibt verschiedenste Bewegungen. Im OP gibt es z.B. chirurgische Assistenten die bestimmte Operationen übernehmen dürfen. Das ist aber gesetzlich alles noch sehr stark reguliert.

Frage 17: Für welchen Zeitraum bleiben die ausländischen Ärzte? Strebt der Klinikverbund eine dauerhafte Anstellung an?

Die Mehrzahl der Arbeitsverträge bezieht sich auf die Ärzte in Weiterbildung und ist daher befristet entsprechend der Weiterbildungsbefugnis der Einrichtung. Das können minimal 2-3 Jahre sein oder ein Maximum von 6 Jahren. Danach macht der Arzt die Facharztprüfung und es wird geschaut, dass man diesem Arzt eine Perspektive im eigenen Haus bildet. Facharztverträge sind in der Regel nicht mehr befristet. Das hängt aber auch immer von der persönlichen Lebensplanung der Menschen ab, wie viel Heimweh sie haben, ob sie vor Ort heiraten und sich niederlassen. Das ist sehr individuell.

Frage 18: Wie werben Sie Ärzte aus dem Ausland an?

Es gibt drei Wege. Eine Möglichkeit ist eine Anzeige ins Internet unter Kliniken.de, Stepstone.de oder auf unserer Homepage zu schalten und daraufhin melden sich dann Ärzte bei uns, Ärzte die tatsächlich z.B. in Kairo Kliniken.de anschauen. Der zweite Weg ist ein Markt von Personalvermittlern die Kontakte herstellen und verkaufen. Wir haben Rahmenverträge mit Unternehmen wie z.B. Jobscout24 die uns mit Ärzten versorgen. Die letzte Möglichkeit wäre das direkte Beauftragen von Personalberatern auf Basis von Provision. Letzteres wird gebraucht um spezielle und schwierige Bereiche zu besetzen.

Frage 19: Wie repräsentieren Sie sich im Ausland?

Wir repräsentieren uns im Ausland mit den oben genannten speziellen Anreizen für ausländische Ärzte.

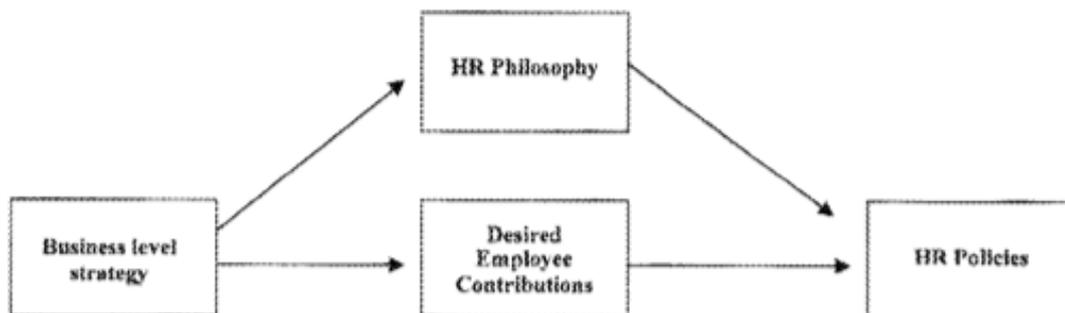
Frage 20: Bekommt der Klinikverbund Subventionen oder Gelder für das Anstellen von ausländischen Ärzten?

Leider nicht. Es gibt keine Subventionen. Es wäre auch moralisch schwierig, denn das Phänomen „Braindrain“ sollte nicht noch durch den Staat unterstützt werden.

Frage 21: Welche Kosten trägt der Klinikverbund für die Migration von ausländischen Ärzten?

Wir übernehmen Bewerbungskosten bis zu einer bestimmten Höhe. Wir übernehmen zum Teil die Kosten für das Wohnen sowie alle Kosten für Weiterbildungen und Pflichtschulungen; auch Sprachkurse. Weiterhin übernehmen wir die Reisekosten nach Deutschland. Die Kostenerstattung an sich wird eher persönlich als pauschal geregelt. Falls Ärzte Hilfe nötig haben können sie persönlich mit uns in Kontakt treten um gemeinsam mit uns nach einer Lösung für das Problem zu suchen.

F: Relationship – Business strategy, HR Philosophy, Desired employee contributions, HR policies



(Lepak, et al., 2004, p. 647)