The Southern African Migration Project

The Haemorrhage of Health Professionals from South Africa: Medical Opinions

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The Haemorrhage of Health Professionals From South Africa: Medical Opinions

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The Haemorrhage of Health Professionals From South Africa: Medical Opinions

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Dedicated to the memory
of the late Dr Anthony Joffe

Contents

Tables

EXECUTIVE SUMMARY

The health sector has been especially hard hit by the brain drain from South Africa. Unless the push factors are successfully addressed, intense interest in emigration will continue to translate into departure for as long as demand exists abroad (and there is little sign of this letting up.) Health professional decision-making about leaving, staying or returning is poorly-understood and primarily anecdotal. To understand how push and pull factors interact in decision-making (and the mediating role of variables such as profession, race, class, age, gender income and experience), the opinions of health professionals themselves need to be sought.

This paper reports the results of a survey of health professionals in South Africa conducted in 2005-6 by SAMP. Since there is no single reliable database for all practicing health professionals, SAMP used the 29,000 strong database of MEDpages. All those on the list were invited by email to complete an online survey. About 5% of the professionals went to the website and completed the questionnaire; some requested hard copies or electronic copies of the questionnaire which they completed and returned. Although the sample is biased towards professionals who have internet access and those who were willing to complete an online questionnaire, the sample represents a good cross-section (though not necessarily statistically representative sample) of South African health professionals and offers insights into their attitudes and opinions about emigration and other topics. In partnership with the Democratic Nursing Organisation of South Africa (DENOSA), SAMP also distributed the survey manually to a sample of nurses and received an additional 178 responses.

Data on 1,702 health professionals was collected. The largest category of respondents was doctors (44%), followed by nurses (15%), dieticians/therapists (12%), psychologists (10%), pharmacists (7%) and dentists (5%). The sample was almost evenly split between males and females. About 70% of the respondents were white, followed by blacks (10%), Indians (6%) and Coloureds (3%). The pre-dominance of whites is primarily a historical legacy of the apartheid system which was racially-biased in its selection of health trainees. About 57% of the sample came from the private sector, 23% from the public sector and 17% had employment in both sectors. Half the respondents were under 42 years of age. Just over 20% were in their first five years of service while 26% had twenty or more years of service. There was more variation within professions but, in general, the sample provided an extremely good mix of professionals at different stages of their career.

The survey asked questions relating to (a) living in South Africa,

(b) employment conditions and (c) attitudes about moving to another country. Each answer was evaluated against the set of basic demographic characteristics to see if there were important differences in response e.g. did health sector make a difference or did gender make a difference? The seven demographic characteristics analyzed were: sex, race, health sector, health profession, domicile, household income and years of service.

The survey revealed the extreme dissatisfaction of many South African health professionals, a sentiment that cut across profession, race and gender. The profession is characterized not by a groundswell of discontent but a tidal wave of unhappiness and dissatisfaction with both economic and social conditions in the country. For example:

- With regard to general conditions in the country, there were very high levels of dissatisfaction with the HIV/AIDS situation (84% dissatisfied), the upkeep of public amenities (83%), family security (78%), personal safety (74%), prospects for their children's future (73%) and the cost of living (45%). In only three categories were there fewer dissatisfied than satisfied professionals: availability of schooling (29% dissatisfied versus 46% satisfied), housing (30% versus 45%) and (perhaps unsurprisingly) medical facilities (19% versus 57%).
- In terms of working conditions, the most important source of dissatisfaction was taxation levels (58% dissatisfied, 14% satisfied) followed by fringe benefits (56% and 17%), then remuneration (53% and 22%), the availability of medical supplies (50% and 28%), workplace infrastructure (50% and 31%). prospects for professional advancement (41% and 30%) and work load (44% and 31%). Consistent with widespread concerns about safety, as many as a third were dissatisfied with the level of personal security in the workplace. Around a third of the respondents were dissatisfied with the level of risk of contracting a life-threatening disease in their work (35% versus 28% for HIV/AIDS; 32% versus 30% for TB and 37% versus 26% for Hepatitis B), an extraordinarily high percentage which is indicative of the conditions under which many work.
- On only two measures was there general satisfaction among the health professionals: collegial relations (76% satisfied, 5% dissatisfied) and the appropriateness of their training for the job (71% versus 14%).
- Variables with the greatest impact on satisfaction levels included profession and sector (public or private). Other variables (e.g. age, gender, race and years of experience) were not significant. The highest dissatisfaction levels expressed were as follows: for Workload: public sector employees, nurses and pharmacists; for

Workplace Security: public sector, nurses, dentists and pharmacists; for Relationship with Management: public sector and nurses; for Infrastructure: public sector, nurses and black professionals; for Medical Supplies: public sector and public/private employees; for Morale in the Workplace: public and public/private sectors and nurses; for Risk of contracting TB: public sector; for Risk of contracting HIV/AIDS: nurses, doctors and dentists; for Risk of contracting HEP B: nurses and dentists; for Personal Safety: black professionals. Overall, public sector employees and nurses tend to have the highest levels of dissatisfaction.

- Income levels do significantly influence satisfaction levels on some broad issues including schooling for children, finding a house, cost of living and availability of products. In general, the higher the income the greater the percentage that are satisfied. Black professionals are more dissatisfied than others regarding finding a house (61%), schooling for children (52%) and accessing medical services for family/children (39%). Younger professionals are the most dissatisfied when it comes to finding a house (51%) and nurses have the highest percentage dissatisfied with the cost of living (62%).
- Comparing life in South Africa today with the situation before 1994, respondents were divided almost equally with 35% feeling it had improved, 31% that it was the same and 35% that it had deteriorated. Not surprisingly, race had a significant impact with over 50% of black, Coloured and Indian respondents feeling that life was better now than before.

In sum, it is alarming that South Africa's health professionals find satisfaction in little except their interaction with colleagues. While their views of living and working in South Africa are very negative, they hold very positive opinions about other places:

- When asked whether life would be better in a number of potential destination countries overseas, responses were overwhelmingly positive. Topping the list of where life would be better were Australia and New Zealand (77% better, 6% worse), followed by North America (77% better, 7% worse) and Europe (72% better, 10% worse). The Middle East was also rated highly, particularly by dentists and nurses. As many as a half the sample felt that their lives would be better there. There was little evident enthusiasm for the Southern African region with 69% of respondents thinking it would be worse to live there, and only 9% thinking it would be better. However, as many as 30% of black respondents said they would do better in other Southern African countries than in South Africa. Asia was viewed in a more positive light than the rest of Southern Africa.

- When asked where they would likely go if they left South Africa (their personal MLD or Most Likely Destination), most selected developed countries or regions. The most popular choices were Australia/New Zealand (33%), the United Kingdom (25%), Europe (10%), the United States (10%) and Canada (9%). The results were generally consistent across the demographic variables although the UK is a more likely destination for dentists (38%) and Europe a more likely destination for psychologists (17%). Only black health professionals rated a move to a SADC country (14%) about as likely as a move to a developed country such as Canada (12%) or the United States (21%).
- Respondents were asked to compare employment conditions in South Africa with those in their MLD. Five features were identified by over 60% of respondents as better in the MLD: workplace security (69%), remuneration (65%), fringe benefits (63%), infrastructure (63%) and medical supplies (61%). Other issues rated by about half as better in the MLD included workload and career and professional advancement. Only training preparation was rated as better in South Africa. Hence, there is a very general perception that most aspects of the work environment are better in the MLD than in South Africa.
- Many also listed existing push factors that would prompt them to seek employment overseas. Some 72% cited inadequate remuneration as a reason to emigrate. Next came workplace infrastructure (cited by 27%), educational opportunity (25%), professional advancement (23%), job security (22%) and workload (19%).

How serious are South African health professionals about actually leaving the country? Almost half of the respondents have given it a great deal of consideration and only 14% have given it no consideration at all. Male health professionals have given emigration more serious consideration than females (53% v 41%); white professionals have given it marginally more serious consideration than black (45% v 41%), while both groups have given it less consideration than Indians and Coloured professionals. Professionals in the private sector have actually given it more consideration than those in the public sector (48% v 44%). And professionals under 30 have given it more consideration than their older counterparts (indeed, this measure of emigration potential declines with age). Type of profession is a clear differentiating variable: pharmacists (at 68%) have given emigration a great deal of consideration, followed by dentists (58%), physicians (48%) and nurses (46%). Place of residence and level of income make little difference. Indeed it would appear that rampant dissatisfaction is translating directly into a serious consideration of leaving for a large percentage of health professionals.

Around half of the respondents (52%) said there was a high likelihood they would leave South Africa within the next five years. This includes 25% likely to move within two years and 8% within six months. About 14% of the respondents had already applied for work permits in other countries. Six percent had applied for permanent residence, 5% for citizenship and as many as 30% for professional registration overseas.

Recruiters are often identified as the guilty party in the "poaching" of health professionals from developing countries and are clearly very active in South Africa. The survey showed that health professionals get most of their information about foreign job opportunities from recruiter advertisements in professional journals and newsletters. Health professional publications such as the South African Medical Journal and Nursing Update carry copious job advertisements, primarily from the UK, Australia and Canada. Many of these advertisements are placed by both local and international health recruitment agencies. Agencies also make direct contact with health professionals about employment opportunities in other countries. Nearly two in five (38%) had been personally approached, with greater than half of all doctors (53%) having been contacted. However, survey respondents minimized the role of recruitment agencies, saying their influence was marginal. Less than a quarter of respondents had actually attended recruitment meetings. Despite this, the role of such agencies should not be discounted as having an impact on emigration.

The survey also provided insights into the phenomenon of return migration. A third of the sample had already worked in a foreign country and returned to South Africa. Are South African health professionals who have international experience more or less satisfied with their life and job than those who have no overseas experience? This is an important issue given the growing attention being paid internationally to encouraging "return migration." Those who have lived and worked in foreign countries might have found that conditions are not as attractive as once imagined. Certainly, there is anecdotal evidence that some émigrés return to South Africa because their expectations are not met. On the other hand, returnees may be influenced to return by nostalgic images of South Africa that fail to reflect current realities. In such a case, those who return to the country may be even more dissatisfied with conditions and choose to emigrate once again.

The main conclusions are as follows:

- The vast majority of return migrants were doctors (63% of the total and 50% of doctors in the sample). Very few nurses had worked outside the country (only 5% of the total and 11% of nurse respondents).
- While living and working conditions are a major driving force in

emigration; they do not attract people back. People return for a variety of less tangible reasons including family, a desire to return "home", missing the South African lifestyle, patriotism, wanting to make a difference, and the fact that the 'grass is not as green' as anticipated on the other side.

- Returnees are generally more satisfied with living and working conditions than those who have never worked in a foreign country. With regard to employment and working conditions, return migrants are less dissatisfied on virtually every measure. The difference is particularly marked with regard to prospects for professional advancement (35% of return migrants dissatisfied versus 58% of non-migrants), income levels (34% versus 59%) and taxation (32% versus 60%). When it comes to living conditions in South Africa, return migrants are more positive about some issues, especially the cost of living, finding suitable accommodation and schools, and medical services. But they are equally as negative about certain others, especially the HIV/AIDS situation in the country, personal and family safety, public amenities and their children's future prospects. In other words, while experience overseas has softened some attitudes about many determinants of emigration, it has done little to affect opinions related to safety or perceived health risks, especially as it relates to HIV/AIDS.
- Return migrants are primed for re-emigration. Those who have returned to South Africa are just as likely to leave again as those who have never left. For example, 12% of return migrants said they would probably leave within 6 months (compared to 6% of non-migrants). About a quarter of each (27% and 25%) said they would probably leave within two years. And around half (53% and 51%) said they would probably leave within five years.

Finally, the survey provided insights into the attitudes of health professionals towards government policy. The South African government has moved recently towards more proactive retention policies for the health sector. Despite this, there is considerable scepticism among health professionals that conditions will improve. The overwhelming majority (94%) disapproved of the way the government has performed its job in the health sector over the last year. The survey results reported in this paper demonstrate the intense dissatisfaction of health professionals with working and living conditions in the sector and the country. Emigration is set to continue and even accelerate. The possibility that the health professional shortfall will be met by health professionals currently being trained in South Africa is disproved by a recent SAMP survey which showed that the emigration potential of health sector students is greater than students in the non-health sector; 65% indicated they would emigrate within five years.

The level of dissatisfaction in the sector is such that it may seem difficult for government to know where to begin. Certainly it could begin with itself. There can be few professions where practitioners are as unhappy with their government department. The reasons for this need to be addressed and confidence built or restored. The health department, in concert with its provincial counterparts, also needs to address workplace conditions identified by respondents as needing change. When it comes to other factors, family and personal safety and security are rated as reasons to leave. Unless and until the level of personal security improves, health professionals will continue to be attracted by countries that are perceived to be safer.

The other policy option facing South Africa would be for the country to become a recruiter and net importer of health professionals itself. Here there is a very real dilemma. To date, the Department of Health has adopted a policy of not recruiting health professionals from developing, particularly other African, countries. The problem, as some critics have pointed out, is that if South Africa does not recruit them, someone else will. At least this way, it is argued, health professionals are not lost to the region or continent. The only way this would benefit other countries is if they had greater access to South African health care facilities in return.

There are compelling reasons for South Africa to adopt a more open immigration policy towards the immigration of health professionals from parts of the world that are being actively recruited by developed countries. In May 2007, under its new quota system for immigrants, the government announced the availability of 34,825 work permits in 53 occupations experiencing labour shortages. Significantly, not a single health professional category is on the designated list. This is clearly not in the country's best interests. There is a decided and growing shortage of health professionals. Morality may suggest that a no-immigration policy is the best one to pursue but no country uses morality as a basis for making immigration decisions and South Africa certainly is not applying such criteria to other sectors. A twin-pronged strategy is urgently needed: address the conditions at home that are prompting people to leave and adopt a more open immigration policy to those who would like to come.

INTRODUCTION

Over the last decade, South Africa has been forced to contend with an accelerating "brain drain" of skills.[1] Political, economic and social push factors have prompted a major exodus of skilled workers seeking greener pastures. The social and economic impact of the brain drain on South Africa has yet to be fully-documented although government now regularly speaks of a "skills crisis" in both the public and private sectors. The impact of the brain drain will undoubtedly be exacerbated by the HIV/AIDS epidemic which is decimating a whole generation of young, skilled and productive men and women.[2] Government and the private sector have not yet developed particularly successful retention or return policies. Given that measures to actually stop people from leaving would be unconstitutional, various other ameliorative strategies are clearly necessary.

One strategy involves trying to craft bilateral and multilateral agreements to discourage destination countries from "poaching" scare skills. For obvious reasons, advanced industrial countries have not been particularly responsive to these overtures. Their efficacy in a world of hypermobility and instant access to information about global employment opportunities is, in any case, questionable.[3] Immigration and greater investment in skills training is another possible response. South Africa has emerged from a decade of anti-immigrationist policy with a Joint Initiative on Priority Skills Acquisition (JIPSA).[4] JIPSA promotes a twin strategy of local training of scarce skills and attracting migrants from abroad. South Africa also now recognizes that working on the "stick factors" is probably the best way forward in terms of retention strategies. However, it is not always clear exactly what these are or how (where they can be identified) to address them. For example, wage differentials between developed and developing countries are commonly cited as a major cause of skills migration. Yet it is highly unlikely that the country has the wherewithal to close the gap in any meaningful manner.

Most observers predict that the brain drain will continue or even accelerate in the future.[5] The Southern African Migration Project (SAMP) has devoted considerable attention to this issue and has developed rigorous methodologies for assessing the emigration potential of the skills base of the country. Recently, a SAMP survey demonstrated that the emigration potential of students in their final year of training is extraordinarily high.[6] In the six SADC countries studied, about 36 percent of students said it was likely that they would emigrate within 6 months of graduation, and 52 percent within 2 years of graduation. In the case of South Africa, the figures were 37 percent and 48 percent. The survey showed extremely low levels of satisfaction with current and prospective personal and national economic conditions and considerable

pessimism about income, job satisfaction and prospects for professional advancement.

The health sector has undoubtedly been hardest hit by the brain drain from South Africa.[7] Training programmes are not keeping pace with the outflow of professionals and, in any case, newly trained health professionals cannot be expected to replace the years of experience and practical skills of those who are leaving. Health professional decision-making about leaving or staying is poorly-understood. The skilled are generally strongly influenced in their decision-making by the experience and perception of pull and push factors mediated in complex ways by variables such as age, gender, family ties, number of children, property ownership and so on.[8]

Local push factors are both endogenous (internal) and exogenous (external) to a particular profession. Endogenous factors in the health sector include remuneration, working conditions, job satisfaction, medical infrastructure, safety and risk of disease. Exogenous factors include political stability, crime, taxation levels and standards of service delivery. Professionals are also influenced by the pull factors that attract them to a specific country or place. Pull factors include the explosion of job opportunities in developed and wealthier developing countries accompanying globalization; aging populations; social networking with those who have already emigrated; and the comparative advantage of destination countries (in terms of salaries, working conditions, prospects for professional advancement, quality of life, education of children and so on).[9] These factors obviously apply to all skilled workers but work themselves out in ways that are specific to the health sector and in different ways in different countries.

To understand exactly how push and pull factors and the mediating variables interact in decision-making, it is necessary to solicit the opinions of health professionals themselves. SAMP has sought to go beyond the anecdotal and small sample surveys that characterize much research on this topic. For its national surveys of skilled migrants and emigrants, SAMP has developed rigorous, statistically-representative methodologies that provide greater insight into how the members of a profession as a whole are thinking and making decisions about the emigration question. By measuring the emigration potential of skills that remain in a country, SAMP has countered alarmist notions that the entire workforce in sectors such as health can and will shortly emigrate. At the same time, SAMP's findings suggest little room for complacency. Levels of professional dissatisfaction are intense and interest in emigration is extremely high in many professions.[10] Unless the push factors are seriously addressed, intense interest in emigration will continue to translate into departure, for as long as demand exists abroad (and there is little sign of this letting up).

The consequences of the health brain drain are severe. The vicious cycle of health professional emigration has been described as follows:

> Understaffing results in stress and increased workloads. Many of the remaining health professionals are ill-motivated, not only because of their workload, but also because they are poorly paid, poorly equipped and have limited career opportunities. These, in turn, lead to a downward spiral where workers migrate, crippling the system, placing a greater strain on the remaining workers who themselves seek to migrate out of the poor working conditions. The ultimate result is an incontestable crisis in health human resources.[11]

The health brain drain also represents a massive subsidy for developed countries. The costs of training health professionals are borne by their home country; the benefits of that training are transferred to the country of destination. However, it is debatable that the "subsidy" is nearly as high for an individual who goes abroad for training and then does not return. This is a real enough problem for many developing countries, particularly if there is an expectation that the individual will return or it has in any way sponsored that training abroad.

SIZING THE HEALTH DRAIN

The size and permanence of the SADC (and South African) health brain drain are matters of dispute. It is well-established that official South African statistics undercount the emigration of professionals by as much as two-thirds.[12] Destination country census and immigration data provide a more accurate reading of the numbers of SADC health professionals abroad. A recent study by the Centre for Global Development shows that in 2000, nearly 30% (17,000 out of 57,000) of SADC-born physicians were resident outside their country of birth (Table 1).[13] The greatest number of locally-born physicians residing abroad were from South Africa (7,363 or one in five), followed by Angola (2,102), Zimbabwe (1,602), Tanzania (1,356) and Mozambique (1,334). The numbers of Zimbabwean-born physicians outside the country has undoubtedly increased considerably since 2000.

The major destinations for South African-born physicians include the United Kingdom (3,509 or 35% of those abroad), the USA (1,950), Canada (1,545) and Australia (1,111). South Africa is still not as badly off as many other SADC countries, however. In a significant number of cases there are more locally born physicians residing outside their country than in it. They include Mozambique (75%), Angola (70%), Malawi (59%), Zambia (57%), Tanzania (52%) and Zimbabwe (51%). The majority of SADC countries have fewer than 100 doctors per 100,000 people.

Table 1: Number of Southern African Physicians Residing Abroad

Sending country	Home	Abroad	UK	USA	France	Canada	Australia	Portugal	Spain	Belgium	South Africa	% abroad
Angola	881	2,102	16	0	5	25	0	2,006	14	5	31	70
Botswana	530	68	28	10	0	0	3	0	0	1	26	11
DRC	5,647	552	37	90	139	35	0	42	4	107	98	9
Lesotho	114	57	8	0	0	0	0	0	0	0	49	33
Malawi	200	293	191	40	0	0	10	2	1	1	48	59
Mauritius	960	822	294	35	307	110	36	1	0	20	19	46
Mozambique	435	1,334	16	20	0	10	3	1,218	4	2	61	75
Namibia	466	382	37	15	0	30	9	0	0	0	291	45
Seychelles	120	50	29	0	4	10	3	0	0	0	4	29
South Africa	27,551	7,363	3,509	1,950	16	1,545	1,111	61	5	0	0	21
Swaziland	133	53	4	4	0	0	0	1	0	0	44	28
Tanzania	1,264	1,356	743	270	4	240	54	1	1	3	40	52
Zambia	670	883	465	130	0	40	39	3	0	3	203	57
Zimbabwe	1,530	1,602	553	235	0	55	97	12	1	6	643	51
To tal	40,501	16,917	5,930	2,799	475	2,100	1,365	3,347	30	148	1,557	29

Source: see Note 14

Only the two island states of Mauritius and Seychelles have more. These figures compare with 2,560 in the USA, 2,300 in the United Kingdom and 2,140 in Canada, all of which are major destinations for emigrating SADC physicians.

With regard to the nursing profession, approximately 10% of SADC-born nurses were outside their country of birth in 2000 (5% in the case of South Africa) (Table 2). The greatest absolute number of nurses abroad are from South Africa (4,844), followed by Mauritius (4,531), Zimbabwe (3,723), the DRC (2,288) and Angola (1,841).[14] However, on a proportional basis, the countries most affected are Mauritius (63% of nurses abroad), the Seychelles (29%), Zimbabwe (24%), Mozambique (19%) and Malawi (17%). These are the countries most likely to be impacted by nurse emigration, a movement which has accelerated since 2000. In Zimbabwe, for example, Chikanda recently concluded that "most of the country's public health systems are grossly understaffed and the skeletal staff remaining is reeling under heavy workloads."[15]

South Africa is clearly the best-resourced SADC country in terms of health-related human resources but is also experiencing the biggest absolute drain of health professionals. Within the SADC, all countries have under-resourced and under-staffed health sectors. However, the distribution of professionals (intra and inter-country) is extremely uneven. Hence, some countries inevitably feel the impact of the loss of skills more acutely, even though the actual numbers of emigrants may not be as high. South Africa is also, of course, a potential beneficiary of the brain drain and stands to benefit greatly from the exodus of health professionals from other African countries. In terms of impact, it presumably

Table 2: Number of Southern African Nurses Residing Abroad

Sending country	Home	Abroad	UK	USA	France	Canada	Australia	Portugal	Spain	Belgium	South Africa	% abroad
Angola	13,135	1,841	22	135	12	10	4	1,639	8	11	0	12%
Botswana	3,556	80	47	28	0	0	0	0	0	0	5	2%
DRC	16,969	2,288	44	207	206	50	0	9	4	1,761	7	12%
Lesotho	1,266	36	5	6	0	0	0	0	0	0	25	3%
Malawi	1,871	377	171	171	0	10	14	0	0	0	11	17%
Mauritius	2,629	4,531	4,042	107	86	75	195	1	0	22	3	63%
Mozambique	3,664	853	12	64	0	10	0	748	2	6	11	19%
Namibia	2,654	152	18	6	0	0	4	1	0	6	118	5%
Seychelles	422	175	80	28	8	30	29	0	0	0	0	29%
South Africa	90,986	4,844	2,884	877	20	275	955	58	3	33	0	5%
Swaziland	3,345	96	21	36	0	10	4	0	0	0	25	3%
Tanzania	26,023	953	446	228	0	240	32	2	1	0	4	4%
Zambia	10,987	1,110	664	299	0	25	68	2	0	0	52	9%
Zimbabwe	11,640	3,723	2,834	440	0	35	219	14	3	0	178	24%
Total	189,147	21,059	11,290	2,632	332	770	1,524	2,474	21	1,839	439	10%

Source: See Note 14

matters little to a Zimbabwean rural hospital if its only doctor moves to England or South Africa.

To date, however, the African brain drain to South Africa has been slowed by South Africa's post-1994 immigration policy which, until recently, has not favoured the importation of skills in any sector.[16] Although that has now changed, the South African government is adamant that it will not do what it criticizes developed countries for doing i.e. poaching health professionals from other African countries. Notwithstanding, the data does show that some African health professionals are being admitted to South Africa. In 2001, for example, there were 1,557 physicians and 439 nurses in South Africa who had been born in other SADC countries.

The migration of health professionals from South Africa takes a permanent (emigration) and temporary (migrant) form. The temporary loss of skills involves movement to another country outside the region, often on a contract basis. Skills shortages are the inevitable consequence of both forms of movement. While health migrants, in particular, retain strong backward linkages, including remittance flows, their physical absence for periods of time directly depletes the public and private health care sector.

STUDY METHODOLOGY

In order to derive a sample population for this study of health professional attitudes to emigration, the Department of Health and the Professional

Associations were approached for details and contact addresses of all practicing professionals. None were able to provide reliable and up-to-date data. SAMP therefore adopted a different method of determining a population from which to draw a study sample. The 29,000 strong database of South African health professionals maintained by MEDpages was made available to SAMP. All of those in the database were contacted by email and asked to complete an online questionnaire. This was SAMP's first use of a web-based interviewing format, an experiment that proved relatively successful. Email announcements about the project went out on 30 November 2005 and again on 6 February 2006 to all MEDpages subscribers. The data collection phase ended on 28 February 2006. The questionnaire used for the project was developed from previous SAMP skills-based surveys and revised by SAMP's Health Professionals Project (HPP) working group.

About 5% of the professionals contacted went to the website and completed the questionnaire; some people requested hard copies or electronic copies of the questionnaire which they completed and returned. Although the sample is biased towards professionals who have internet access and those who were willing to complete an on-line questionnaire, the sample represents a good cross-section (though not necessarily statistically representative sample) of South African health professionals and offers insights into their attitudes and opinions about emigration and other topics.

DENOSA, a partner in the HPP, advised that many nurses would not have access to the internet. DENOSA informed nurses of the survey and undertook the task of distributing and returning questionnaires for data entry. The nurse total of 261 includes 178 nurse questionnaires submitted by mail or email that were entered into the database manually.

The survey sample is generally representative of the MEDpages database in terms of health professional categories. Comparing the percentages for MEDpages with the HPP survey data shows very similar proportions of doctors (44.2% v 43.8%), dentists (6.4% v 5.4%) and psychologists (10.6% v 10.1%). Dieticians/therapists were under-sampled, and pharmacists and nurses were over-sampled.

HEALTH PROFILE

Data on 1,702 health professionals was collected (Table 3). The largest category of respondents was doctors (44%), followed by nurses (15%), dieticians/therapists (12%), psychologists (10%), pharmacists (7%) and dentists (5%). The sample was almost evenly split between males and females. About 70% of the respondents were white followed by blacks (10%), Indians (6%) and Coloureds (3%). The pre-dominance of whites

Table 3: Profile of Survey Respondents			
		N	%
Health Professional Category	Nurse	261	15.3
	Doctor	745	43.8
	Dentist	92	5.4
	Psychologist	172	10.1
	Pharmacist	110	6.5
	Dietician/Therapist	203	11.9
	Other	119	7.0
	Total	1702	100.0
Sex	Male	868	51.4
	Female	822	48.6
	Total	1690	100.0
Race	Black	175	10.4
	Coloured	43	2.5
	White	1214	71.9
	Indian	108	6.4
	Other	34	2.0
	Not disclosed	114	6.8
	Total	1688	100.0
Health Sector	Public	391	23.0
	Private	974	57.2
	Private/Public	298	17.5
	Other	39	2.3
	Total	1702	100.0
Age	22-34	380	22.7
	35-42	457	27.3
	43-50	424	25.3
	50+	416	24.8
	Total	1677	100.0
Domicile	Large City	1137	67.4
	Large Town	283	16.8
	Small Town	199	11.8
	Rural Area	69	4.1
	Total	1688	100.0
Monthly Household Income (R)	<20,000	578	37.5
	20,000-35,000	392	25.4
	35,000-50,000	274	17.8
	>50,000	297	19.3
	Total	1541	100.0

is primarily a historical legacy of the apartheid system which was racially-biased in its selection of health trainees. About 57% of the sample came from the private sector, 23% from the public sector and 17% had employment in both sectors. Half the respondents were under 42 years of age. Most respondents came from cities or large towns. This is an important weakness of the sampling method. Conditions in rural areas for professionals are generally thought to be worse than in many urban centres. In other words this survey presents the views primarily of urban health professionals. The sample is relatively well paid with over 60% earning more than R240,000 per annum. Most of those earning less were nurses.

The experience level of the sample was not dominated by any one group (Table 4). Around 22% were in their first five years of service while 26% had twenty or more years of service. There was more variation within professions but, in general, the sample provided an extremely good mix of professionals at different stages of their career.

Table 4: Experience of Survey Respondents

	Years in health sector								Total	
Health Professional Category	0-4		5-10		11-19		20+		N	%
	N	%	N	%	N	%	N	%		
Nurse	36	14.0	79	30.8	71	27.6	71	27.6	257	100.0
Doctor	147	19.7	212	28.5	195	26.2	191	25.6	745	100.0
Dentist	13	14.1	21	22.8	20	21.7	38	41.4	92	100.0
Psychologist	65	37.7	50	29.1	34	19.8	23	13.4	172	100.0
Pharmacist	12	10.9	23	20.9	23	20.9	52	47.3	110	100.0
Dietician/ Therapist	65	32.0	68	33.6	34	16.7	36	17.7	203	100.0
Other	30	25.2	42	35.3	21	17.6	26	21.8	119	100.0
Total	368	21.7	495	29.2	398	23.4	437	25.7	1698	100.0

The survey asked respondents to answer questions relating to (a) living in South Africa, (b) employment conditions and (c) attitudes about moving to another country. As part of the analysis each question was evaluated against the set of basic demographic characteristics to see if there were important differences in response. The seven variables analysed were: sex, race, health sector, health profession, domicile, household income and years of service. Where the demographic characteristics made a statistically significant difference (a valid chi square test and a contingency coefficient of 0.200 or greater) in answers to questions, they are commented upon in the analysis. When no mention is made of demographic characteristics it means the answers were consistent across the various demographic variables.

During the course of the survey, it emerged that a third of the professionals had prior experience working overseas. This raises interesting questions about why they had returned. It also raises the issue of whether actual (as opposed to imaginary and often idealized) exposure to working and living in other countries makes a difference to attitudes and opinions. In other words are those who have worked outside South Africa more or less likely than those who have not to have negative attitudes and higher (re)emigration potential?

DISSATISFACTION WITH LIFE AND WORK IN SOUTH AFRICA

Satisfaction and dissatisfaction with living conditions and quality of life have a major impact on a person or family's decision to migrate, so it is important to assess how contented health professionals are with life and work in South Africa. The survey therefore posed a series of questions to gather information on health professionals' perceptions of work and life in South Africa.

As regards working conditions, health professionals were most dissatisfied with taxation levels (58% dissatisfied, 14% satisfied), fringe benefits (56% and 17%), remuneration (53% and 22%), the availability of medical supplies (50% and 28%), infrastructure (50% and 31%), prospects for professional advancement (41% and 30%) and workload (44% and 31%). As many as 41% were dissatisfied with their level of personal safety in the workplace.[17] Around a third of the respondents were dissatisfied with the level of risk of contracting a life-threatening disease in their work (35% versus 28% for HIV/AIDS; 32% versus 30% for TB and 37% versus 26% for Hepatitis B), an extraordinarily high percentage indicative of the conditions under which many work. On only two measures was there general satisfaction: collegial relations (76% satisfied, 5% dissatisfied) and the appropriateness of their training for the job (71% and 14%).

Very negative sentiments were expressed about more general conditions in the country including the HIV/AIDS situation (84% dissatisfied), the upkeep of public amenities (83%), family security (78%), personal safety (74%), their children's future (73%) and the cost of living (45%) (Table 5). In only three categories, was there more satisfaction than dissatisfaction: the availability of schooling (46% satisfied versus 29% dissatisfied), housing (45% versus 30%) and medical facilities for themselves (57% versus 19%). These results indicate more than a groundswell of discontent; indeed, they suggest a tidal wave of unhappiness and dissatisfaction with both economic and social conditions in the country.

Significantly, income levels influence satisfaction on some issues including schooling for children, finding a house, cost of living and availability of products. The survey found that the higher the income the greater the percentage that are satisfied. Black professionals are more

dissatisfied than others regarding finding a house (61%), schooling for children (52%) and access to medical services for family/children (39%). Younger professionals are the most dissatisfied group in regards to finding a house (51%) and nurses have the highest percentage dissatisfied with the cost of living (62%).

The respondents were also asked to compare life in South Africa today with the situation before 1994. Answers were divided almost equally between the three categories with 35% feeling it had improved, 31% that it was the same and 35% that it had deteriorated. Not surprisingly, race had a significant impact with over 50% of Black, Coloured and Indian respondents feeling that life was better now than before.

Table 5: Levels of Satisfaction with Working Conditions

	Satisfied		Neutral		Dissatisfied	
	N	%	N	%	N	%
Remuneration	378	22.4	408	24.2	898	53.3
Fringe benefits	260	17.3	396	26.3	850	56.4
Workload	515	30.8	428	25.6	727	43.5
Relationship with management	544	39.8	427	31.2	397	29.0
Relationship with colleagues	1233	75.8	307	18.9	87	5.3
Infrastructure	826	50.1	305	18.5	518	31.4
Ability to find job	500	30.5	492	30.0	650	39.6
Job security	525	31.6	528	31.8	607	36.6
Taxation	235	13.9	473	28.0	981	58.1
Medical supplies	762	50.1	336	22.1	422	27.8
Workplace morale	641	39.3	427	26.2	561	34.4
Risk contracting HIV/AIDS	530	35.0	559	36.9	424	28.0
Risk contracting MDR TB	488	32.3	572	37.8	453	29.9
Risk contracting Hep B	562	37.0	568	37.4	389	25.6
Personal security	687	41.3	414	24.9	564	33.9
Education/career opportunities	637	38.6	430	26.1	582	35.3
Training	1201	71.1	253	15.0	234	13.9
Professional advancement	479	30.1	463	29.1	651	40.9
Workplace security	670	41.0	482	29.5	484	29.6

Table 6: Levels of Satisfaction with Living Conditions						
	Satisfied		Neutral		Dissatisfied	
	N	%	N	%	N	%
Cost of living	418	24.5	525	30.8	760	44.6
HIV/AIDS	39	2.3	238	14.1	1413	83.6
Find house	742	44.5	419	25.2	505	30.3
School for children	650	46.3	346	24.6	408	29.1
Medical services for family	911	56.8	383	23.9	311	19.4
Personal safety	120	7.1	315	18.6	1263	74.4
Family's safety	109	6.6	255	15.3	1298	78.1
Children's future	136	8.7	280	18.0	1139	73.2
Upkeep public amenities	68	4.0	217	12.8	1411	83.2
Availability of products	548	32.2	569	33.4	585	34.4
Customer service	117	6.9	460	27.1	1121	66.0

Are health professionals more dissatisfied with life in South Africa than other professionals? Unfortunately, there is no directly comparable data for other professions as SAMP has not conducted a recent general survey. However, there is a useful point of comparison with the data from an earlier SAMP survey of South African professionals published in 2002.[18] The number of health professionals in that particular survey was insufficient for us to make comparisons within that survey. What is abundantly clear, though, is that health professionals in 2006 were considerably more negative and pessimistic than the professional population as a whole 5 years earlier (Table 6). In virtually every category (with the exception of cost of living and taxation levels), the levels of dissatisfaction of health professionals with economic and social conditions are considerably higher. In only one category (medical services) are health professionals more satisfied today than professionals as a whole five years earlier.

Variables with greatest impact on satisfaction levels included profession and sector (public or private). Other variables (e.g. age, sex, race and years of experience) were not significant. The highest dissatisfaction levels were as follows: for Workload: public sector employees, nurses and pharmacists; for Workplace Security: public sector, nurses, dentists and pharmacists; for Relationship with Management: public sector and nurses; for Infrastructure: public sector, nurses and black professionals; for Medical Supplies: public sector and public/private employees; for Morale in the Workplace: public and public/private sectors and nurses; for Risk of contracting TB: public sector; for Risk of contracting HIV/AIDS: nurses, doctors and dentists; for Risk of contracting HEP B: nurses and dentists; for Personal Safety: black professionals. Overall, however, public sector employees and nurses tend to have the highest levels of dissatisfaction.

Table 7: Comparative Measure of Dissatisfaction		
Lifestyle measure	Professionals (2002) % Dissatisfied	Health Prof. (2006) % Dissatisfied
Working conditions		
Cost of living	71	45
Income level	37	53
Taxation level	59	58
Job availability	40	40
Security	26	29
Job advancement	30	41
Living conditions		
Personal safety	66	74
Family's safety	68	78
Children's future	55	73
Quality of schools	27	29
Upkeep of amenities	70	83
Housing availability	21	30
Medical services	21	19
Product availability	28	34
Customer service	56	66

In sum, with the exception of two "soft" measures, a significant proportion of the respondents were dissatisfied with their current employment conditions and prospects. Highest levels of dissatisfaction attached to the economics of their profession (remuneration, fringe benefits and workload). While collegial relations are excellent, workplace morale is not. Only 40% were satisfied with morale (with 34% dissatisfied). Added to their more general dissatisfaction with life in South Africa, it is not surprising that many professionals are restless.

Dissatisfaction with one's job generally prompts consideration of alternatives, including emigration. Health professionals are generally thought to be particularly sensitive to levels of remuneration and working conditions, probably because there is such variability within the profession and staff shortages have an immediate and negative impact on those who remain. Respondents were first asked how easy they thought it would be to find another job in their profession within South Africa. Despite the fact that 40% were dissatisfied with the availability of jobs, over half the sample thought it would be easy to find another job. Doctors (at 65%) felt it would be easiest, followed by pharmacists (63%), dieticians/therapists (59%) and nurses (56%). The majority of respondents also thought their employers would have a difficult time replacing them (71%). Those who thought it would be the most difficult were pharmacists (84%), doctors (79%) and nurses (73%). Nearly all respondents thought it would

be difficult to find someone who was more qualified for their job (91%). In other words, most health professionals see themselves as both potentially mobile and indispensable to their employers. In such circumstances, "loyalty" to the employer is likely to have little effect. If this perception is correct, employers will have to work that much harder to keep their disgruntled employees.

PREDICTING THE OUTFLOW

The extreme dissatisfaction of so many South African health professionals cuts across profession, race and gender, and therefore represents a very serious problem. It is extraordinary that these health professionals find satisfaction in little except collegial interaction. Without doubt, one bonding mechanism is sharing complaints about the health system and the possibility of leaving. These professionals are certainly not chronic pessimists as they have very positive opinions about other places, particularly when asked to compare them with South Africa. Topping the list of destinations about where life would be better for them were Australia and New Zealand (77% better, 6% worse), North America (77% better, 7% worse) and Europe (72% better, 10% worse). The emerging destination of the Middle East was also rated highly, particularly by dentists and nurses. As many as a half the sample felt that their lives would be better there. There was little evident enthusiasm for the Southern African region with 69% of respondents thinking it would be worse to live there, and only 9% thinking it would be better. However, as many as 30% of black respondents said they would do better in other Southern African countries than in South Africa. Asia was viewed in a more positive light than the rest of Southern Africa.

The survey asked respondents to translate these comparisons into potential emigration behaviours. Each was asked where they would be most likely go to if they left South Africa (their personal Most Likely Destination or MLD). Most cited developed countries or regions as their MLD: Australia/New Zealand (33%), United Kingdom (25%), Europe (10%), United States (10%) and Canada (9%) (Table 7). The results were generally consistent across the demographic variables although UK is a more likely destination for dentists (38%) and Europe a more likely destination for psychologists (17%). Only black health professionals rated a move to a SADC country (14%) about as likely as a move to a developed country such as Australia/New Zealand or Canada (Table 8).

Table 8: Most Likely Destination of Emigration		
	No	%
Australia/New Zealand	555	33.2
United Kingdom	414	24.8
United States	161	9.6
Europe	168	8.6
Canada	143	6.8
SADC	94	5.6
Asia/China	21	1.3
Africa	6	0.4
Other	109	6.5
Total	1671	100

Table 9: Most Likely Destination by Race								
		Black	Coloured	White	Indian	Other	Not disclosed	Total
Australia/ New Zealand	N	22	12	446	29	12	34	555
	%	14.2	28.6	36.8	26.9	36.4	29.8	33.4
United Kingdom	N	48	13	275	41	6	26	409
	%	31.0	31.0	22.7	38.0	18.2	22.8	24.6
United States	N	26	4	104	7	6	11	158
	%	16.8	9.5	8.6	6.5	18.2	9.6	9.5
Europe	N	6	4	137	7	2	12	168
	%	3.9	9.5	11.3	6.5	6.1	10.5	10.1
Canada	N	18	3	97	8	4	13	143
	%	11.6	7.1	8.0	7.4	12.1	11.4	8.6
SADC	N	21	1	66	2		5	94
	%	13.5	2.4	5.4	1.9	4.4	5.7	
Asia/China	N	2		12	5	1	1	21
	%	1.3		1.0	4.6	3.0	0.9	1.3
Africa	N	1		5				6
	%	0.6		0.4				0.4
Other	N	11	5	70	9	2	12	109
	%	7.1	11.9	5.8	8.3	6.1	10.5	6.6
Total	N	155	42	1211	108	33	114	1663
	%	100	100	100	100	100	100	100

How serious are South African health professionals about actually leaving? Given the high levels of dissatisfaction in the health professions, it is not surprising that many are extremely serious. Almost half of the respondents have given moving to another country a great deal of consideration (47%) and only 14% have given it no consideration at all. The

earlier SAMP survey of skilled South Africans found that, by comparison, only 31% had given emigration a great deal of consideration, while another 31% had given it no consideration.

Male health professionals have given emigration more serious consideration than females (53% v 41%); whites have given it marginally more serious consideration than blacks (45% v 41%), although both have given it less consideration than Indian or Coloured professionals. Professionals in the private sector have actually given it marginally more consideration than those in the public sector (48% v 44%) and professionals under 30 have given it more consideration than their older counterparts (indeed, this measure of emigration potential declines with age) (Table 10). Type of profession is a clear differentiating variable: pharmacists (at 68%) have given emigration most consideration, followed by dentists (58%), physicians (48%) and nurses (46%). Place of residence and level of income make little difference. In sum, while there is some in-sample variation, at least 40% of virtually all sub-groups have given emigration a great deal of consideration. Less than 25% of all sub-groups have given it no thought at all. Rampant dissatisfaction is translating directly into a serious consideration of leaving for a very high percentage of health professionals.

Seriously considering emigration is not the same thing as actually leaving. Around half of the respondents (52%) said it was likely they would leave within the next five years, 25% within two years and 8% in the next six months. In other words, government and employers have a very brief "grace period" in which to act to improve the situation and address the factors that make health professionals so disgruntled. Of course, even an expression of likelihood does not automatically translate into departure. However, about 14% of the respondents had already applied for work permits in other countries. Six percent had applied for permanent residence, 5% for citizenship and as many as 30% for professional registration overseas (Table 11). These figures tend to suggest that likelihood is a very serious measure of intent.

DIAGNOSING THE PROBLEM

To counter this intention to emigrate it is necessary to address the push factors present in South Africa. However, given the all-pervasive dissatisfaction with so many elements of living and working in South Africa amongst health professionals, it is difficult to identity which push factors have the greatest influence. For example, while a reduction in the crime rate and an increase in family and personal security would make health professionals much happier, the most intense push factors (measured by levels of dissatisfaction) are clearly work-related.

Table 10: Consideration Given To Leaving South Africa					
	Considered moving to another country to live/work				N
		A great deal (%)	Some (%)	None at all (%)	
Sex	Male	52.7	37.1	10.3	847
	Female	40.5	42.0	17.5	788
	Total	46.8	39.4	13.8	1635
Race	Black	40.8	34.3	24.9	169
	Coloured	58.5	19.5	22.0	41
	White	45.2	42.3	12.5	1177
	Indian	60.4	28.3	11.3	106
	Other	48.4	41.9	9.7	31
	Not disclosed	56.0	33.9	10.1	109
	Total	46.8	39.4	13.7	1633
Health sector	Public	44.3	37.7	17.9	379
	Private	48.4	38.8	12.8	946
	Private/Public	46.5	42.6	10.9	284
	Other	29.7	48.6	21.6	37
	Total	46.7	39.4	13.9	1646
Age	22-34	51.9	38.2	9.9	372
	35-42	49.0	38.3	12.8	439
	43-50	49.6	39.2	11.1	413
	50+	36.7	43.0	20.4	398
	Total	46.8	39.6	13.6	1622
Health professional category	Nurse	46.2	30.0	23.7	253
	Doctor	45.4	42.7	11.9	729
	Dentist	58.4	31.5	10.1	89
	Psychologist	34.1	50.6	15.2	164
	Pharmacist	68.0	23.3	8.7	103
	Dietician/Therapist	46.6	41.5	11.9	193
	Other	45.7	39.7	14.7	116
	Total	46.7	39.3	14.0	1647
Domicile	Large city	46.4	39.9	13.7	1106
	Large town	48.9	40.6	10.5	276
	Small town	46.5	36.9	16.6	187
	Rural area	45.3	34.4	20.3	64
	Total	46.8	39.4	13.8	1633
Monthly household income	2-20,000	45.9	37.2	16.9	1633
	20,000-35,000	47.9	39.5	12.6	549
	35,001-50,000	42.0	46.1	11.9	269
	+50,000	44.4	42.3	13.3	293
	Total	45.4	40.4	14.2	1491

Table 11: Applications for Foreign Permits			
		N	%
Work permit	Yes	233	13.9
	No	1350	80.6
	In process	92	5.5
Permanent residence	Yes	104	6.2
	No	1513	90.8
	In process	49	2.9
Citizenship	Yes	88	5.3
	No	1538	92.4
	In process	38	2.3
Professional registration	Yes	505	30.2
	No	1058	63.2
	In process	110	6.6

Respondents were first asked to compare employment conditions in South Africa with those in their Most Likely Destination (MLD) (Table 12). Five features were identified by over 60% of respondents as better in the MLD: workplace security (69%), remuneration (65%), fringe benefits (63%), infrastructure (63%) and medical supplies (61%). Other issues rated by about half as better in the MLD included workload and career and professional advancement. Only training preparation (35% versus 22%, with 45% feeling it is about the same) and collegial relations were considered better in South Africa. Hence, there is a very general perception that most aspects of the work environment are better in the MLD than in South Africa.

A follow up question asked respondents to list the employment issues most likely to make them leave (Table 13).The issue of remuneration came to the fore, with 72% citing it as a reason to emigrate. Next came infrastructure (27%), followed by educational opportunity (25%), professional advancement (23%), job security (22%) and workload (19%). In other words, while there is no "quick fix", improved remuneration for all professionals would have a marked impact on propensity to emigrate.

Another research project by DENOSA found the major reasons for nurses considering emigration included lack of competitive incentives in the public service, work pressure, lack of professional growth opportunities, desire for a better resourced working environment, escalating crime and the rise of HIV/AIDS.[19] A more recent study of nurse emigration noted that improving salaries "is essential to address South African nurses' emigration potential."[20] To get nurses back from overseas would require considerably more than a pay raise, however.

Table 12: Comparing South Africa and the Most Likely Destination			
		No.	%
Remuneration	Better in South Africa	328	20.6
	About the same	233	14.7
	Better in MLD	1029	64.7
	Total	1590	100.0
Fringe benefits	Better in South Africa	298	19.4
	About the same	271	17.7
	Better in MLD	966	62.9
	Total	1535	100.0
Workload	Better in South Africa	244	15.6
	About the same	484	31.0
	Better in MLD	834	53.4
	Total	1562	100.0
Relationship with management	Better in South Africa	206	15.9
	About the same	682	52.6
	Better in MLD	408	31.5
	Total	1296	100.0
Relationship with colleagues	Better in South Africa	273	19.5
	About the same	900	64.1
	Better in MLD	230	16.4
	Total	1403	100.0
Infrastructure	Better in South Africa	320	20.3
	About the same	271	17.2
	Better in MLD	989	62.6
	Total	1580	100.0
Medical supplies	Better in South Africa	293	19.7
	About the same	293	19.7
	Better in MLD	904	60.7
	Total	1490	100.0
Workplace morale	Better in South Africa	247	17.3
	About the same	517	36.3
	Better in MLD	662	46.4
	Total	1426	100.0
Workplace security	Better in South Africa	296	19.1
	About the same	190	12.3
	Better in MLD	1064	68.6
	Total	1550	100.0
Career advancement	Better in South Africa	320	20.8
	About the same	353	23.0
	Better in MLD	865	56.2
	Total	1538	100.0

Training preparation	Better in South Africa	523	34.6
	About the same	649	43.0
	Better in MLD	338	22.4
	Total	1510	100.0
Professional advancement	Better in South Africa	318	20.9
	About the same	428	28.1
	Better in MLD	775	51.0
	Total	1521	100.0
Job security	Better in South Africa	334	22.7
	About the same	489	33.2
	Better in MLD	651	44.2
	Total	1474	100.0

Table 13: Employment-Related Reasons to Leave

	N	% of respondents mentioning issue
Remuneration	1217	71.5
Infrastructure	456	26.8
Educational/career opportunities	425	25.0
Professional advancement opportunities	396	23.3
Workplace security	371	21.8
Job security	335	19.7
Workload	316	18.6
Fringe benefits	269	15.8
Medical supplies	140	8.2
Workplace morale	135	7.9
Relationship with management	116	6.8
Risk of HIV/AIDS	107	6.3
Training	50	2.9
Relationship with colleagues	34	2.0
Other	392	23.0
Total	4778	
N = 1702. Note: multiple responses allowed		

Box 1: Why Nurses Leave

Nurses constitute the largest professional group in South Africa's health care services. Factors contributing to South African nurses' emigration were studied qualitatively by analysing expatriate nurses' responses to open-ended questions, and quantitatively by analysing newly registered nurses' responses to structured questionnaires. These results reveal that nurses' inability to meet their physiological needs, due to inadequate remuneration, was

the major factor contributing to nurses' emigration potential. While improved salaries might enable more nurses to remain in South Africa, expatriate nurses would not return to South Africa unless certain esteem and self-actualisation needs could also be satisfied. Improving nurses' salaries is essential to address South African nurses' emigration potential. However, improved working conditions, enhanced workplace security, improved levels of job satisfaction and the appointment of nurses into currently frozen posts are also necessary, as is governmental and public recognition of the value of the profession. The South African nursing profession, health care services, Government and society should urgently address factors contributing to South African nurses' emigration potential; otherwise a serious shortage of nurses could cause the collapse of this country's health care services.

Source: Oosthuizen, "Emigration of South African Nurses".

Remuneration is not simply an issue of salary levels, as one physician noted, pointing to how professionals in the private sector were being squeezed by the medical aid industry.

Box 2: Emigration and Medical Aid

I am in the private sector practicing optometry in a low income area. My main reasons for finding emigration so tempting are:

- It has been the trend over the past 5-6 years that medical aid schemes generally decrease their payments to us annually, i.e. every year members benefits decrease, remain the same, or the medical aid schemes stop paying for certain extras that patients are accustomed to. Our expenses naturally increase by inflation diligently, hence our profits decrease.
- Members' premiums also religiously increase every year. Since the medical aid schemes are decreasing payments to all health professionals, they are the ones that are benefiting.
- As a result of the medical aid schemes paying us less we have no choice but to increase our fees to our cash patients in order to survive. I personally used to charge very low rates to my cash patients but this is no longer possible. So the man on the street is penalised and the medical aid industry is scoring. Healthcare hence becomes unaffordable to the poor people.
- Pharmacists have also taken a huge knock in their payments from medical aid.
- Most specialists no longer accept medical aid and patients have to submit their claims and pay cash. What then is the use of having medical aid? I pay R3600 per month for medical aid for my husband, daughter and I, and still have significant excesses to pay.
- There are many countries, like Australia for example, that sub-

sidise medical expenses to their citizens. You don't even need medical aid.

- The health professionals in this country have studied very hard to obtain their degrees. They are generally also the people that obtained the best matric symbols in their respective years. Did we do all of this to be struggling in our professions?
  It's my theory that this is the primary reason for the emigration of health professionals along with the prospects of less violence, safer neighbourhoods for our children and a less corrupt industry.

THE IMPACT OF RECRUITMENT

One of the major concerns of developing countries is what they label the "poaching" of health professionals by developed countries. One of the major mechanisms is proactive recruiting by international and local recruitment firms. A recent SAMP study of health professional recruitment noted that much of the international policy debate up to now has been on how to regulate and mitigate the impact of recruiters in developing countries through Codes of Conduct.[21] The activities and impact of the global recruiting industry is an issue of growing concern.[22]

What kinds of interaction have these respondents had with recruiters? More broadly, where do they get information about job opportunities in other countries? The survey showed that respondents often get information from professional journals and newsletters (67%), professional associations (46%), newspapers (37%), friends (33%) and family (21%) (Table 14). Health professional publications such as the *South African Medical Journal* and *Nursing Update* carry copious job advertisements primarily from the UK, Australia and Canada. Many of these advertisements are placed by local and international health recruitment agencies.[23] Agencies also make direct contact with health professionals about employment opportunities in other countries (Table 15). Nearly two in five (38%) had been personally approached, with doctors (53%) contacted more often than other health professionals. The survey respondents minimized the role of recruitment agencies, and less than a quarter of respondents had actually attended recruitment meetings. However, the role of such agencies should not be discounted as having an impact on emigration as they certainly help to create a climate that is receptive to the idea of emigration.

Table 14: Sources of Information About Overseas Job Opportunities			
		N	%
Professional journals/ newsletters	Often	1128	66.8
	Once in a while	347	20.5
	Seldom	131	7.8
	Never	83	4.9
Newspapers	Often	618	37.2
	Once in a while	530	31.9
	Seldom	349	21.0
	Never	166	10.0
Friends	Often	660	39.2
	Once in a while	557	33.1
	Seldom	289	17.2
	Never	176	10.5
Family	Often	345	20.8
	Once in a while	410	24.7
	Seldom	458	27.6
	Never	447	26.9
Professional associations	Often	769	45.7
	Once in a while	466	27.7
	Seldom	257	15.3
	Never	190	11.3

Table 15: Interactions with Health Recruiters			
		N	%
Contacted by recruitment agency	Often	643	37.9
	Once in a while	497	29.3
	Seldom	167	9.8
	Never	391	23.0
Personally approached about work abroad	Often	417	24.6
	Once in a while	553	32.6
	Seldom	305	18.0
	Never	422	24.9
Attended recruitment meetings	Often	105	6.2
	Once in a while	255	15.0
	Seldom	256	15.1
	Never	1081	63.7
Influence of recruitment agencies	Important role	189	11.6
	Some role	311	19.1
	Minor role	409	25.2
	No role at all	717	44.1

Emigration: Temporary or Permanent?

Do South African health professionals view emigration as a temporary or permanent move? Certainly the global opportunities for temporary employment overseas are on the increase. On the other hand, many of the major destination countries have immigration systems that encourage permanent settlement. While 56% of the respondents said they would stay away for more than five years, only 11% said they would leave for less than a year. In other words, the majority are thinking of long-term or permanent emigration (Table 16).

Table 16: Duration of Emigration and Frequency of Return

		N	%
Length of stay in most likely destination	Less than 6 months	86	6.1
	6 months to 1 year	75	5.3
	1-2 years	159	11.3
	2-5 years	302	21.4
	More than 5 years	789	55.9
Return to South Africa	Weekly	21	1.4
	Monthly	39	2.5
	Once every few months	307	20.1
	Yearly	767	50.1
	Once every few years	331	21.6
	Never	65	4.2

About three quarters of respondents (76%) expressed a preference for permanent residence in their MLD. Some 72% said they would want to become citizens and 60% would want to retire in their MLD (Table 17). All of this indicates that the majority of health professional emigrants are interested more in permanent departure. This is broadly confirmed by the fact that as part of a move to the MLD, about half of the respondents are willing to sell their house, and take their savings and investments. However, only 4% said they would never return to South Africa (Table 16). As many as 75% said they would make visits to South Africa at least once a year. In other words, departing health professionals intend to maintain strong links with their country of origin, an important finding in the light of the growing international interest in diasporas as agents of development.[24]

Table 17: Permanence of Emigration			
Desired outcome	Extent of desire	N	%
Become permanent resident	Large extent	768	49.3
	Some extent	410	26.3
	Hardly at all	161	10.3
	Not at all	219	14.1
Become citizen	Large extent	677	43.6
	Some extent	433	27.9
	Hardly at all	177	11.4
	Not at all	265	17.1
Retire in most likely destination	Large extent	566	37.6
	Some extent	332	22.0
	Hardly at all	248	16.5
	Not at all	360	23.9

RETURN MIGRATION

While the focus of this study is on the reasons why health professionals leave South Africa, it emerged that a considerable number of respondents had already worked outside South Africa and then returned home. Fully a third of the sample had worked in a foreign country, the vast majority being doctors (63% of the total and 50% of doctors in the sample) (Table 18). Very few nurses had worked outside the country (only 5% of the total and 11% of nurse respondents). Those who had worked in a foreign country and returned to South Africa were primarily white (79%) and male (63%) with about equal representation from all age and income groups.

Table 18: Health Professionals with Foreign Work Experience			
		N	%
Sex	Male	369	63.1
	Female	216	36.9
Race	Black	23	3.9
	Coloured	9	1.5
	White	459	78.5
	Indian	34	5.8
	Other	12	2.1
	Not disclosed	48	8.2
Health sector	Public	142	24.3
	Private	304	52.0
	Private/public	129	22.1
	Other	10	1.7

Age	22-34	135	23.1
	35-42	160	27.4
	43-50	135	23.1
	+50	155	26.5
Health professional category	Nurse	29	5.0
	Doctor	371	63.4
	Dentist	33	5.6
	Psychologist	40	6.8
	Pharmacist	16	2.7
	Dietician/therapist	63	10.8
	Other	33	5.6
Domicile	Large city	429	73.3
	Large town	87	14.9
	Small town	55	9.4
	Rural area	14	2.4
Monthly household income	Less than R2000	3	0.5
	R2000-5000	8	1.4
	R5001-10,000	33	5.6
	R10,001-15,000	44	7.5
	R15,001-20,000	51	8.7
	R20,001-25,000	66	11.3
	R25,001-35,000	68	11.6
	R35,001-40,000	46	7.9
	R40,001-50,000	69	11.8
	R+50,000	139	23.8
	Not disclosed	58	9.9

A series of questions were asked to find out what had influenced their decision to return to South Africa. Employment issues identified by a significant minority included remuneration (mentioned by 39%), a job (33%), career opportunities (26%) and professional advancement (23%) (Table 19). In other words, working conditions are not particular drawcards except for those who obviously had well-paying jobs or jobs to return to. The only factor relating to more general living conditions mentioned by a significant proportion of the returnees (42%) was the cost of living. Anecdotally, South Africans who go abroad (especially to Europe) are taken aback by the high cost of living there. By comparison, South Africa may seem like a cheap place to live (Table 20).

The large number of "other reasons" indicates a multiplicity of complex and overlapping motivations. In other words, while living and working conditions are a major driving force in emigration; they do not attract people back. Pull factors mentioned included more intangible feelings of loyalty, patriotism and wanting to make a difference (see Box 3). These factors are also important to discouraging emigration in the first place,

although this is only true to a certain extent (see Box 4). While they increase the tolerance levels of health professionals, there may come a time when living and working conditions become so overwhelming that departure is the only option. Perhaps what it demonstrates is that if certain key issues changed, e.g. remuneration, infrastructure and security in the work place, the decision to leave would be less easily made.

Table 19: Employment-Related Reasons for Return

Employment Issue	N	% of Responses
Remuneration	226	11.8
Find job	195	10.2
Education/career opportunities	154	8.0
Professional advancement	134	7.0
Training	109	4.8
Workload	86	4.5
Infrastructure	75	3.9
Relationship with colleagues	74	3.9
Fringe benefits	64	3.3
Job security	49	2.5
Workplace morale	44	2.3
Relationship with management	33	1.7
Security workplace	29	1.5
Medical supplies	14	0.7
Other reasons	634	33.9
Total	1920	
Note:N = 585. Multiple response question.		

Table 20: Living Conditions Reasons for Return

Living Condition Issue	N	% of Respondents
Cost of living	245	17.6
Find housing	117	8.4
School for children	63	4.5
Children's future	62	4.5
Family safety	50	3.6
Personal safety	36	2.6
Quality products available	19	1.4
Medical care	15	1.1
Fair taxation	14	1.0
Customer service	7	0.5
Quality amenities	6	0.5
Other	758	44.3
Total	1392	
Note: N = 585, Multiple response question		

Box 3: Existing in a Jail

I think it would be good to add if this is going to government level that instead of making the professionals feel that they must exist in a "jail" that perhaps it be part of one's career, not just training to do one year government work and one year somewhere overseas as part of a 'rotary club' so that they can make up their minds if it really is worth actually immigrating. I'm glad I went for 4 months to the UK but we have so much more scope to work with here in SA and that's why I came back, besides the fact (that) my fiancee at the time and I had wanted to make a life in SA. Today I have been in the Occupational Health field for 7 yrs, have two small children and am quite happy with the home we have made for ourselves.

Box 4: Our Home

South Africa is our home and we owe our services to our lovely country regardless of this honeymoon of democracy amongst the ANC officials. I'm patriotic and believe that even if your neighbour has all the gadgets you should not leave your house to board your neighbour's house, but always strive towards improvement of your own house. As much as our public health situation is in a terrible state in places like the Eastern Cape due to the honeymoon highlighted above, I still owe my worth to South Africa. I will continue working in this country regardless of the agencies hunting us down for greener pastures in England and other first world countries. Let's just continue working towards a better SA and removing unnecessary political allegiances within health and other important service areas within the government sphere.

Are those who have returned to South Africa more or less satisfied with life and jobs than those who have no overseas experience? This is an important issue given the growing attention being paid internationally to encouraging "return migration."[25] Those who have lived and worked in foreign countries might have found that the pastures are not as green as imagined by those who have never left. Certainly, there is anecdotal evidence that some émigrés return to South Africa because their expectations are not met. On the other hand, a positive experience overseas may make returnees even more critical of conditions in South Africa and discourage their returning to the country to stay.

The evidence from this survey suggests that the first of the two scenarios is the more accurate. In other words, returnees are generally less dissatisfied with conditions in South Africa than those who have never worked in a foreign country. With regard to employment and working conditions, for example, return migrants are more satisfied and less dis-

satisfied on every measure. The difference is particularly marked with regard to prospects for professional advancement (35% of return migrants dissatisfied versus 58% of non-migrants), income levels (34% versus 59%) and taxation (32% versus 60%) (Table 21). When it comes to living conditions in South Africa, return migrants are more positive about the cost of living, finding suitable accommodation and schools, and medical services among others. However, they are equally as negative about certain others, especially the HIV/AIDS situation in the country, personal and family safety, public amenities and their children's future prospects (Table 22). In other words, experience overseas has done nothing to change people's attitudes about certain key drivers of emigration.

Does this mean that return migrants are primed for re-emigration? The most striking feature of responses to this question (as measured by the likelihood of emigration within a certain time frame) is that there is very little difference between those who have worked in a foreign country and those who have not. In other words, those who have returned to South Africa are as likely to leave again as those who have never left (Table 23). For example, 12% of return migrants said they would probably leave within 6 months (compared to 6% of non-migrants). About a quarter of each (27% and 25%) said they would probably leave within two years. Around half (53% and 51%) said they would probably leave within five years.

The obvious conclusion is that return migrants are prey to the same push factors as those who have not yet worked overseas.

Table 21: Comparative Attitudes of Non-Migrants and Return Migrants on Employment Conditions

		Worked in a foreign country			
		Yes		No	
		N	%	N	%
Find job	Satisfied	180	36.3	316	29.8
	Neutral	184	37.7	304	28.6
	Dissatisfied	201	31.3	442	41.6
Professional advancement	Satisfied	125	33.5	248	23.2
	Neutral	157	34.2	302	28.3
	Dissatisfied	284	35.4	518	58.5
Job security	Satisfied	188	36.2	332	30.9
	Neutral	195	37.2	329	30.6
	Dissatisfied	186	30.9	415	38.5
Income level	Satisfied	121	40.3	179	16.3
	Neutral	136	33.5	270	24.7
	Dissatisfied	326	33.5	646	59.0
Fair taxation	Satisfied	92	39.1	143	13.1
	Neutral	176	37.8	290	26.6
	Dissatisfied	315	32.4	656	60.3

Table 22: Comparative Attitudes of Non-Migrants and Return Migrants on Living Conditions					
		Worked in a foreign country			
		Yes		No	
		N	%	N	%
Cost of living	Satisfied	165	28.0	251	22.8
	Neutral	185	32.0	335	22.8
	Dissatisfied	236	40.0	513	46.7
HIV/AIDS	Satisfied	11	1.2	28	2.6
	Neutral	79	13.6	157	14.4
	Dissatisfied	490	85.2	909	83.1
Find house	Satisfied	281	49.2	458	42.4
	Neutral	144	25.2	269	24.9
	Dissatisfied	146	25.6	352	32.6
School for children	Satisfied	228	48.1	419	45.8
	Neutral	126	26.6	214	23.4
	Dissatisfied	120	25.3	281	30.7
Medical services for family	Satisfied	322	59.1	583	55.8
	Neutral	135	24.8	243	23.3
	Dissatisfied	88	26.1	219	21.0
Personal safety	Satisfied	39	6.7	79	7.2
	Neutral	117	20.0	195	17.8
	Dissatisfied	428	73.3	823	75.0
Family's safety	Satisfied	35	6.1	72	6.7
	Neutral	86	15.1	167	15.5
	Dissatisfied	450	77.8	836	77.8
Children's future	Satisfied	43	8.1	91	9.0
	Neutral	93	17.6	183	18.1
	Dissatisfied	392	74.3	735	72.8
Upkeep public amenities	Satisfied	26	4.5	42	3.8
	Neutral	82	5.5	131	12.0
	Dissatisfied	475	90.0	922	84.2
Availability of products	Satisfied	217	37.1	327	29.8
	Neutral	199	34.0	364	33.1
	Dissatisfied	169	28.9	408	37.1
Customer service	Satisfied	49	8.4	66	6.0
	Neutral	157	26.9	297	27.1
	Dissatisfied	379	64.7	732	66.8

Table 23: Likelihood of Emigration of Return Migrants and Non-Migrants							
Likelihood of moving		Worked in a foreign country				Total	
		Yes		No		N	%
		N	%	N	%		
Within six months	Likely	68	12.0	60	6.0	128	8.2
	Unlikely	499	88.0	943	94.0	1442	91.8
	Total	567	100.0	1003	100.0	1570	100.0
Within two years	Likely	136	26.7	230	25.3	366	25.8
	Unlikely	374	73.3	679	74.7	1053	74.2
	Total	510	100.0	909	100.0	1419	100.0
Within five years	Likely	227	53.4	380	51.2	607	52.0
	Unlikely	198	46.6	362	48.8	560	48.0
	Total	425	100.0	742	100.0	1167	100.0

ATTITUDES TO GOVERNMENT POLICY

The South African government has moved recently from hand-wringing and moralizing towards more proactive retention policies for the health sector. These are laid out in detail in the Department of Health's 2006 National Human Resources Plan for Health. Given the timing, this survey did not ask health professionals to respond to this plan specifically in detail but did ask for comment and opinion on certain key strategies, some of which have already been implemented.[26]

Respondents were certainly not at all enamoured with general government health policies. Asked about the way the government has performed its job in the health sector over the last year, 94% expressed disapproval. Black professionals gave the highest approval rating at 26%. The four questions related specifically to emigration included (a) should government make it more difficult to emigrate? (b) should all professional school graduates do one year of national service? (c) should citizens be permitted to hold more than one passport? and (d) should government increase emigration fees?

With regard to the first question, only 4% thought that making it more difficult to emigrate would have an impact on emigration rates (Table 24). As many as 44% said that it would have the opposite effect and actually increase emigration. Only 6% felt that requiring all health professionals to do a year of national service would make them less likely to emigrate. The vast majority (71%) said it would make absolutely no difference while nearly a quarter thought it would increase emigration.[27] Forcing people to hold only a South African passport was similarly seen

as a measure with no impact other than (in the eyes of 36%) to make emigration more likely. Increasing emigration fees would also not deter emigration in any significant manner.

Table 24: Perceived Impacts of Policy Options on Emigration

	More likely		No difference		Less likely	
	N	%	N	%	N	%
Emigrate more difficult	701	43.8	831	51.9	70	4.4
Require all one year	369	23.3	1116	70.5	98	6.2
Only one passport	563	35.6	932	59.0	86	5.4
Increase emigration fees	386	24.1	1135	70.8	81	5.1

Although the vast majority felt that national service was unrelated to emigration potential, over half the respondents did think it was justifiable for the government to require all South African-trained professionals to do one year of community service after completion of their education and for those who received government bursaries to complete some form of national service. Around a third (35%) thought it was justifiable to require all professionals to work in a rural or underdeveloped area for one year after graduation. This is despite the fact that the working conditions of junior health professionals (and professionals more generally) in the rural public sector were criticized by many.

Box 5: Sleepless Nights

My daughter is doing Com Service and we are in favour of this service. However the lack of supervision and ethical guidelines for the young doctors is really bothering me and others. The failure to feel valued is what I believe is driving many away. Now there is anti-retroviral therapy for patients but tomorrow there may be no stock! Poor management – but how does the young doctor tell the patient? The security risk for a young girl driving at night causes parents many sleepless nights. What of those in very rural areas. Exposure to HIV and the need to take anti-retrovirals at odd times without proper support and counselling is alarming. I have heard this from several young doctors. An alarming incidence of needle stick injuries. Why is this – long hours, stress, poor technique!

Box 6: Rural Medicine

Why rural areas are not popular with doctors is a complex issue that is not simply addressed by compulsory rural service. I feel qualified to comment, as I studied medicine specifically to work in rural medicine, and left rural South African medicine after

18 months. Working conditions in South African rural hospitals are often appalling, including poor hospital management, inexperienced doctors with inadequate supervision, poor laboratory quality control, heavy workload, poor equipment, limited drugs, tatty conditions, poor pay, very little support from academia, etc. From rural South African public medicine to remote rural Canadian public medicine is an incredible change. Excellent hospitals, good staff, academic support via telemedicine / phone / referral etc, modern drugs and equipment, a lower workload, good pay, back-up from consultants, etc. And excellent personal and family safety in general.

Box 7: The Burden of Disease

Missing clinical medicine, and feeling public spirited, I recently visited a district hospital with a view to doing part-time session work. I found out that the hourly pay is so low, it would almost be like doing voluntary work. The hospital had such a budgetary problem, that the superintendent was advising the doctors at a meeting I attended, that no patient could be given more than 10 Panado on discharge; if they needed more they'd have to buy it themselves from a pharmacy; a heavy casualty load of trauma victims, rape cases – with all the forensic responsibilities to attend to in very little time, aggressive tik addicts, inadequate drugs for HIV+ patients with secondary complications etc. I noted that the hospital, which was short-staffed, was only staffed by very junior and very old doctors. Indeed the general working conditions at a District hospital in a city appeared worse than at the rural hospital I had left 20 years earlier.

Box 8: Leaving the Public Sector

I was forced out of my profession due to affirmative action and am no longer able to practice, and feel no longer welcome, in the SA public sector. I was replaced by an unqualified, African female by a Manager who thought any person could do any job and I am now working in a completely non-health field. I have seen no point in applying for a position which utilizes my professional qualifications – Public Health and Medical Management – as clearly political and AA considerations will make it unlikely that I could obtain such a position – I think there is a feeling that anyone can do Public Health and it is no longer recognized as a medical specialty. Generally we are replaced by health inspectors and nurses, but in my case it was with a BA.

Obviously after 17 years of dedicated – and in fact highly

> acclaimed – service to the public health sector this is disappointing and many people tell me I would be better to return to the UK – but my original motivations to come here remain the same – a deep commitment to the upliftment and service of the South African people. I have had to call this "other" as your answers do not allow for any kind of vocational calling! – is it absent in SA? – I don't think so. All your answers imply pure self-interest, and I do not believe this is so amongst health professionals, but sometimes the situation defeats us.
> I know of several other highly committed doctors – public health professionals and others with decades of selfless, committed service – who were forced out of the public sector for similar reasons. Your questions and answers do not accommodate them, but it is a major factor causing doctors to give up and emigrate.

Conclusions and Recommendations

According to the South African Health Review, "by 2009 South Africa will need approximately 3,200 doctors, 2,400 nurses, 765 social workers, 765 dieticians (and) 112 pharmacists."[28] This shortfall is primarily a result of the exodus of established and newly-qualified health professionals from the country. Emigration can be expected to grow still further. The survey results reported in this paper demonstrate the intense dissatisfaction of health professionals with working and living conditions in the sector and the country. The survey showed that the only element of their work that health professionals find at all satisfying is their collegial relations. Dissatisfaction is high with virtually every other aspect including remuneration, taxation workload, infrastructure, medical supplies, morale in the workplace, risk of contracting disease and personal safety. Nearly all are dissatisfied with the job government is doing in the health sector. Those working in the public sector and nurses have the greatest number of workplace issues with which they are strongly dissatisfied. In addition to dissatisfaction regarding work related issues, survey participants also had many concerns about living conditions in South Africa. Dissatisfaction is most intense with the lack of family and personal safety and security.

There is always the possibility that the health professional shortfall will be met by health professionals currently being trained in South Africa. However, a recent SAMP survey casts doubt on this taking place.. As part of a study of almost 10,000 final year SADC students, a subsample of Health Sector students was analysed to see how their emigration potential compared with Non-Health Sector students.[29] The

emigration potential of health sector students is greater than students in the non-health Sector; 65% indicated they would emigrate within five years. Health sector students have given more thought to moving to another country and they say they will stay longer. Together with students from other sectors, they also say they think life would be better in developed countries like North America and Europe. They are optimistic about getting a job in their field of study, and they consistently rated almost all the conditions in their most likely destination higher than did non-health sector students. Health sector students gave many of same major reasons for migration identified in this study: professional advancement, level of income, ability to find a job and cost of living.

Against the background of these issues, the survey showed that many health professionals are seriously considering leaving the country. Many think conditions in developed countries will be better for them than in South Africa. Some have already taken active steps regarding emigration such as applying for work permits and professional registration. The most popular destinations are Australia/New Zealand, the United Kingdom, Europe, the United States and Canada. New emigrants would already find many South Africans in these places. The level of dissatisfaction in the sector is such that it may seem difficult for government to know where to begin. Certainly it could begin with itself. There can be few professions where practitioners are as unhappy with their government department. The reasons for this need to be addressed and confidence built or restored. The health department, in concert with its provincial counterparts, also needs to address those workplace conditions that it has power over. When it comes to other "external" factors, family and personal safety and security are prime reasons to leave. This is not confined to the health sector but it is also clear that the jobs (and the locations of those jobs) of many health professionals make them more vulnerable than other professionals. Until and unless the level of personal security improves, health professionals will continue to be attracted by countries with lower rates of personal, violent crime.

The interesting feature of this sample is the large number of "return migrants" amongst health professionals. This allows some analysis of the causes of return migration and the impact of the "overseas experience." Three major conclusions emerge. First, the majority of returnees had left with the intention of returning and some came back to better jobs and remuneration. Second, the reasons for returning for the rest were extremely varied and in many cases had to do with more intangible factors such as patriotism, love of the South African "lifestyle" and wanting to "make a difference." Third, returning to South Africa after a stint abroad does not make these health professionals any more likely to stay in the future. Indeed, returnee health professionals expressed only slightly

lowers levels of dissatisfaction with living and working conditions in South Africa than those who had never been overseas. They are also just as likely to leave again.

Of course, not all health professionals are contemplating leaving. Indeed, some made a point of emphasizing the importance of their attachment to South Africa and the importance of family and kinship ties in keeping them at home. Others mentioned their commitment to providing health care in their home country. In spite of the public sector coming under serious criticism, a not insignificant percentage of health professionals said they would consider doing volunteer or part-time work in the public sector. If the critical areas of dissatisfaction (remuneration, infrastructure and workload) could be addressed, the percentage might even increase. This would seem to be an under-utilized resource that under the right circumstances might help to fill the gap in the public health sector.

The other policy option facing South Africa would be for the country to become a recruiter and net importer of health professionals itself. Here there is a very real dilemma. To date, the Department of Health has adopted a policy of not recruiting health professionals from developing, particularly other African, countries. The problem, as some critics have pointed out, is that if South Africa does not recruit them, someone else will. At least this way, it is argued, health professionals are not lost to the region or continent. However, this can afford little comfort to the patients of a doctor in Malawi or Zambia who may feel that there is little difference if the doctor emigrates to the UK or to South Africa. If he or she has to go, it might even be argued that it would be better that they go to a higher paying job in the UK. That way, at least, the remittance flow is likely to be higher.

There is no easy solution to this predicament and South Africa has largely avoided action to date by refusing entry to the many African health professionals who would gladly come and work in the country. The alternative strategy has been to conclude government-to-government agreements, for example with Cuba and Iran, to provide doctors for the severely under-serviced rural public sector. The jury is still out on the success of this policy. Regardless of whether this policy continues into the future, there are compelling reasons for South Africa to adopt a more open policy towards the immigration of health professionals from parts of the world that are either actively exporting professionals as a matter of policy or from developed countries where there are many professionals who still subscribe to the notion that medicine is not about personal enrichment and would be willing, indeed eager, to spend periods of time in South Africa working in the health sector.

In May 2007, under its new quota system for immigrants, the govern-

ment announced the availability of 34,825 work permits in 53 occupations experiencing labour shortages. Significantly, not a single health professional category is on the designated list. This is clearly not in the country's best interests at all. There is a decided and growing shortage of health professionals. The exodus is alarming and seems set to continue or even accelerate with steady or increased demand in destination countries. Morality may suggest that a no-immigration policy is the best one to pursue but no country uses morality as a basis for making immigration decisions and South Africa is certainly not applying such criteria to other sectors. A twin-pronged strategy is urgently needed: address the conditions at home that are prompting people to attract and accommodate those who would like to come, particularly from developed countries or countries where there is a surplus of health professionals.

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