UNIVERSITY OF KWAZULU-NATAL

MIGRATION OF MEDICAL DOCTORS FROM THE PUBLIC TO THE PRIVATE SECTOR: A CASE STUDY OF MAHATMA GANDHI MEMORIAL HOSPITAL AND LIFE HEALTHCARE HOSPITAL GROUP, DURBAN

BY

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DECLARATION

I, Joyce Adefunke Ayandokun Ayeni, hereby declare that migration of medical doctors from the public to the private sector is my personal study; that it has not been submitted for the award of a degree or for consideration in any other university, and that all the sources used or cited have been acknowledged through comprehensive referencing.

Signed ..... Date: .....

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I owe a debt of gratitude to my supervisor Prof. Sanjana Brijball Parumasur for your relentless guidance and support. You are a source of inspiration, you are highly appreciated.

My reflective gratitude goes to my Mum, Mrs. Lydia Ojuolape Ayandokun who stood by me and was never tired of praying for me and encouraging me. Mum, you are rare gem and I decree length of days in good health and prosperity into your life In Jesus name.

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ABSTRACT

There is a rising inclination for medical doctors to migrate to the private sector from the public sector, thereby leaving a high percentage of the population without quality care. The influx of medical practitioners into the private sector is of utmost concern to both the government and the general public. The South African public healthcare sector is faced with the challenge of retaining health workers in the appropriate area of need. This study aims to identify the factors that are responsible for the migration of medical doctors from the public to the private sector and make recommendations that can foster retention. A total of 115 medical doctors participated in this study.

The study used both qualitative and quantitative approaches to ensure a detailed analysis and reach an encircling supposition. They were supported by three research tools: semi-structured in-depth interviews, document review, and a survey. Data collected through semi-structured in-depth interviews were analysed using the thematic analysis method while content analysis was used to evaluate data collected through documentary method. Data collected via the use of questionnaires was analysed using both descriptive and inferential statistics.

The findings from this study revealed that employee relations policy is the key reason why medical doctors seek employment in the private sector. The inability of some doctors to gain employment with the public sector due to the moratorium on employment was also identified as a reason they seek solace in the private sector. The study also established a close link between monetary rewards and non-monetary rewards in influencing retention. The study also reflected that the dissatisfaction of doctors in the public health sectors goes beyond the confinement of wages.

In order to foster the retention of doctors in the public sector, various strategies are recommended such as heightened awareness of the significance of effective communication, more employee involvement in decision-making procedures, quick resolution of labour disputes, embracing total reward approach, talent management planning, succession planning, clear alignment of personal values with organisational values and lifting of the moratorium on employment.

Keywords: Department of Health, human resources for health, medical doctors, migration, primary healthcare, retention.

DEDICATION

I dedicate this study to the giver of life, maker of all things, the help of the helpless, the hope of the hopeless and the father to the fatherless who granted me the divine wisdom, strength, knowledge and sustained me when I felt like giving up, to him be all glory, honour and adoration forever and ever. I also dedicate it to the memory of my late father Mr. Edmund Adenrele. Ayandokun, who abandoned his PhD programme in 1983 to take up employment with the Central Bank of Nigeria to give us a better life, you will always be a source of inspiration to me. Love you always daddy, I will always be grateful to God for the gift of a quintessential father like you.

TABLE OF CONTENTS

CHAPTER 5: PRESENTATION OF RESULTS

CHAPTER 6: DISCUSSION OF FINDINGS

LIST OF TABLES

LIST OF FIGURES

LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral therapy
DoH	Department of Health
HIV	Human Immunodeficiency Virus
HPCSA	Health professional Council of South Africa
HRH	Human Resource for Health
MDG	Millennium Development Goals
NGO	Non-government organization
NHLS	National Health Laboratory Service
OECD	Organisation for Economic Co-operation and Development
OSD	Occupation Specific Dispensation
PDU	Pharmacy Dispensing Unit
SADC	Southern African Development Community
SAMRC	South African Medical Research Council
TB	Tuberculosis
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION AND OVERVIEW OF THE STUDY

1.1 INTRODUCTION

The migration of medical doctors or health workers, in general, is not a new phenomenon. However, the migration of health professionals has been on the increase in recent years both nationally and internationally. No level of the health workers is left unaffected; from the experienced practitioners to the newly inducted health workers especially in developing countries. Incidentally, sub-Sahara African countries with insufficient numbers of health professionals happened to have the most alarming rate of healthcare migrants.

The mass exodus of health personnel in developing countries is further fueling the already deteriorated healthcare system. Nonetheless, this phenomenon is an indication of a fundamental health system issue that is worth exploring for the wellbeing of developing countries. The exploration might be a pointer to fresh ideas on employee engagement, motivation, and retention in the health system specifically in the public sector which serves a greater percentage of the citizenry.

South Africa has a comparatively ample supply of health personnel, with over four doctors, nurses, and midwives per 1 000 people, according to the World Health Organization's (WHO) Global Atlas. Nevertheless, South Africa's internal distribution of health personnel is vastly inequitable. Since 1990, there has been a significant paradigm shift in the preferences of the medical scheme population from the utilisation of public hospitals to private hospitals.

The movement of health workers particularly doctors from the public to the private sector in South Africa has been a major source of concern to the health sector. This phenomenon has arguably placed heavy pressure on the already laden public health sector thereby resulting in a shortage of skilled personnel and the inability to deliver quality health care. The shortage of doctors arising from this movement increases the strain on the remaining doctors in the public sector.

Previous studies have recognised several factors as being responsible for the migration, among which are the poor provision of service benefits, high crime rate, lack of career opportunities and lack of secure work environment (Hamilton & Yau, 2004). Nevertheless, the disparity in potential earnings between the public and private sectors are often suggested as the determining factor behind the movement.

Due to the highly inequitable distribution of doctors between the public and private sectors in South Africa, this study seeks to investigate the fundamental elements that stimulate this movement. The purpose of this study is to make a constructive contribution and heighten the understanding of the factors that influence the intra-country movement of doctors from the public to private sector.

1.2 HEALTHCARE IN SOUTH AFRICA

The National Department of Health (DoH) is tasked with the responsibility of managing the healthcare delivery to all the South Africa public through the primary health approach. The healthcare structure in South Africa comprises of a public sector (large), fast growing private sector as well as non-government organisation sector (NGO). The financial support for the Department of Health activities comes directly from the government (McIntyre, 1995). The department actively works to ensure the realisation of the health goals of the government that is focused on a sustainable, healthy life for South African citizens. This ongoing contribution has brought about an improvement in the number of HIV-infected citizens who receive ARVs to more than 3.4 million and a reduction in the HIV-infection rate (Statistics South Africa, 2016). The public hospitals contribute in no small ways to the realisation of the health goals because a vast majority of the citizens use their services. The general household survey (Statistics South Africa, 2016) stated that seven out of ten citizens visit the nearest public healthcare facilities as the first point of call when sick or wounded. There are about 87 medical aid schemes in South Africa as at 2016, with about 8.8 million recipients (Statistics South Africa, 2016).

The high rate of unemployment and poverty in South Africa imply that healthcare funding remains mainly the burden of the government. The Health Professions Council of South Africa (HPCSA) registered 165 371 trained health experts in both the private and public

sector. The 143 hospitals in the urban area and 233 in the rural areas bring the number of public hospitals to 376.

The Department of Health (DoH) is supported by the National Health Laboratory Service (NHLS) which renders health research and affordable diagnostic services to all hospitals and clinics. The national health laboratory has 268 laboratories spread across the country, and it is the largest diagnostic service provider in South Africa. Another important organisation that lends its support to the realisation of the goals of the national department of health is the South African Medical Research Council (SAMRC). This organisation is authorised to foster quality of life and health through technology and growth of medical research. There has been the introduction of various technologies such as the pharmacy dispensing unit (PDU) in 2016 which is a self-service machine that hands out medication to patients thereby eliminating queues in public hospitals. Even though the PDU is a laudable initiative, it is yet to meet the needs of all the provinces sufficiently. Other technologies are momconnect, stock visibility system and medication adherence application.

1.2.1 THE PUBLIC SECTOR

The primary healthcare clinics which are the foundation of the public healthcare sector are usually the first point of call for people. The district hospitals are the next level of healthcare in the public sector. Severe cases are referred from the clinics to the district hospital. The services provided by the clinics are free, but the quality of the service offered by these clinics has nose-dived in many cases. There are also academic hospitals at the highly specialised level which are tasked with the responsibility of providing advanced treatments, diagnostic measures as well as training for healthcare workers. It is important to state that despite the 40% of the total expenditure being contributed to healthcare by the government, quality healthcare is still not accessible to all South Africans to the extent that the government intended. The government owns all the health facilities in the public sector while their health professionals are paid on a fixed salary scale (Schultz, Girard & Scheckler, 1992). The high level of unemployment and poverty necessitated that the government carries the burden of public healthcare funding. The public sector is overstretched and constantly under pressure in many areas because it renders services to 80% of the population on a daily basis. The different levels of healthcare within the public health sector have experienced worsening infrastructures, poor management, and insufficient funding and the dearth of medical

personnel. The Department of Health controls all affairs relating to healthcare provision in South Africa. The Department of Health is divided into nine provinces in South Africa which are referred to as provincial health departments, and they coordinate the healthcare service deliveries through the district based healthcare model. The management of local hospitals is given the authority to aid faster responses to issues and also handle operational matters. The budget allocation of the Department of Health is shared between the nine provinces although the percentages given to provinces differ. Even though public healthcare may be experiencing insufficient funding while the facilities may have deteriorated, it is accessible to more people, and its employees are more community-oriented.

1.2.2 PRIVATE HEALTHCARE

The private health sector comprises of healthcare experts who fund and provide services privately (usually via private health centers) to those who need it. The private healthcare is financed by individual subscriptions to medical aid. The private health sector provides services to middle and high-income earners who have the membership of different medical aid schemes and is mainly managed as a business venture thus giving limited access to those below the middle class. There are about 188 private health centers in the city areas with about 50 in the rural areas. One of the major issues with the private health system is its concentration in the urban areas where the target market is while neglecting a larger percentage of the population. The public health system attracts most of South Africa's health experts and is regarded as one of the priciest in the world according to the World Health Organisation (World Health Organisation, 2011).

The perception many people have about the private health system is that it delivers exceptional quality service, has ultra-modern medical facilities and gives particular attention to the patients. This opinion may seem logical, but it is not entirely accurate; while private healthcare service delivery is persistently costly, it is not always of good quality. It is interesting to note that 73% of general practitioners work in the private sector despite the fact that the public health sector is saddled with the health burden of the majority of the population.

1.2.3 EXEGESIS ON THE DIVISION BETWEEN THE PRIVATE AND PUBLIC HEALTH SECTOR

The disparity in the South Africa healthcare sector had its root in the apartheid era which focused on service delivery to the White minority to the detriment of the Black majority. While more Black women were trained as nurses during the apartheid era, the opportunity for Black people to be trained as doctors was very few. During the apartheid era, consideration was only given to Black people if their health condition was a threat to the White minority. The apartheid era was characterised by disintegration, the disparity in funding of the diverse systems of healthcare that was available at that time that further produced racial discrimination in terms of access to healthcare and the conditions of employment for health workers. Also, the medicine and medical expertise during the apartheid era centered on therapeutic and hospital care to cater for the health needs of the White minority in the cities. It was a herculean task dismantling the old dichotomy under the health system at the inception of a democratically led government in 1994 to give way to a fair and broad national health system, but legal provisions lent support in ensuring that the objectives of the national health system are achieved.

The new health structure is aimed at correcting the ills of the past apartheid regime through the introduction of a new standard for healthcare that delivers quality care to the public, a better condition of employment for health workers, improved community participation as well as minimising the disease burden of the South African public. Due to the disparity between the public and the private health sector, the major burden of disease is addressed by the public sector which has the responsibility of providing health services to a greater percentage of the public. The public health sector also ensures that Sections 27 and 28 of the constitution are adhered strictly to, that give access to healthcare to all citizens. The public sector also renders its services to an increasing number of private medical aid scheme members. It is also the responsibility of the public sector to provide quality healthcare to the general public that is based on shared interest even though there is some inefficiency.

1.3 BUILDING HUMAN RESOURCES FOR HEALTH

South Africa's health sector is experiencing a serious challenge in the area of human resources. The shortage of health personnel is not peculiar to South Africa; it is a phenomenon affecting many Africa countries. The situation affects the rural areas more than

the urban because of doctors' preference for urban areas thus aiding the imbalanced distribution of health personnel. Annually, the medical schools across South Africa produce about 1 200 medical doctors that rendered their services to short-staffed clinics and hospitals through the two years of compulsory community service. Despite this annual production of doctors by educational institutions, there are still a lot of gaps to be filled. As inequalities exist between the public and private sector regarding human resources for health, there is also the existence of inequality among provinces.

The universities are not generating a regular and adequate number of doctors to cater for the human resources needs of the health sector due to years of inadequate investment in educational facilities such as scarce academic staff, weak health infrastructures among others. The issues of the health personnel are multifaceted. Some of these problems are limited career prospects, heavy workloads, inadequate infrastructures that impact on the efficiency of the health workers. One of the key challenges being faced by the health sector is the successful management of the health workforce. Even though there has been some improvement in the health workers development, there is also the issue of inadequate administration of the programmes.

1.4 HUMAN RESOURCE FOR HEALTH CHALLENGES

Human resources for health (HRH) are acknowledged as the pillar and vital assets of the health system. The continent of Africa is combating the harsh scarcity of health personnel that has resulted in a fragile health structure without sufficient capability to realise the health objectives.

The goals of the national Department of Health (DoH) such as the ten-point strategic plan and the health related aims of the national development plan is dependent upon skilled health workers working together to realise the set goals. As it was earlier discussed under building human resources for health, the output generated from the educational institutions is insufficient to meet the needs of the health sector. The World Health Organisation report (World Health Organisation, 2011) also affirms this insufficiency. The student to staff ratios authorised by the HPCSA is getting very hard to achieve. More than 80% of the population are treated by less that 40% of the total number of medical doctors in South Africa (Padarath, Ntuli & Berthiaume, 2004). There is also the issue of insufficient facilities such as skills

laboratory and places for clinical and non-clinical teaching and learning. There is also the scarcity of supervisors for clinical teaching and learning due to heavy workloads in the public sector as well as the migration of experienced health personnel.

The immigration laws as well as the Health Professions Council of South Africa's (HPCSA) regulations has also placed a significant limitation on the employment of foreign doctors through the introduction of a mandatory two years community service among other restrictions thereby reducing the avenue to strengthen the health workforce. It is a major concern to note that the existing health workforce, as well as the future ones, does not have the capacity to meet the needs of the health sector.

Another obvious challenge is the narrow and declining number of healthcare experts seeking postgraduate studies or specialty in a particular area of medicine. This career prospect issue has made it difficult to obtain an adequate skill-mix in the health sector especially in the public sector. While it is very easy to get a substantial number of specialists in the area of family medicine in the public sector, some areas of specialty are not so fortunate.

An inadequate budgetary allocation to the health sector is a major barrier to human resources for health recruitment, training, and retraining strategies. The heavy burden of disease and the inability to engage in effective planning to meet the health needs of the citizens are key challenges facing the public health sector. The increase in HIV cases scourges (6.19 million South Africans living with the disease) and population growth (from 21 million in 1994 to 55.9 in 2016) further enhances the demand for health workers (Statistics South Africa, 2016). Although the government enacted legislation granted South African citizens access to healthcare and also prioritises primary health, this legislation can only be effective with adequate health workers to realise its provisions. Even though the introduction of the occupation specific dispensation (OSD) in 2007 was a good initiative aimed at attracting and retaining doctors and nurses in the deprived areas, it increased the expenditure of the public health sector while retention is still a major issue. It is pertinent to state that a substantial improvement was made in the area of medical technologies, physical infrastructures and information systems by the public health sector but inadequate skilled health personnel has hampered the impact.

1.5 BACKGROUND OF THE STUDY

Mahatma Gandhi Memorial Hospital Mount Edgecombe is the public hospital to be used for this study. The reason for this choice is due firstly to the fact that it is a district/regional hospital dedicated to ensuring a viable, comprehensive and integrated health services to its District/Region with regards to the Patient's Right charters and Batho Pele principles and secondly, because of the large percentage of the population being served by this hospital. It incorporates 350 beds and is presently working towards developing into a fully-fledged regional hospital package. Currently, it renders the several services at the regional level, namely, obstetrics and gynecology, internal medicine, pediatrics, and neonatology while it offers general outpatients, surgery, crisis center and orthopedics in the district.

The Life Healthcare hospital network comprises of 63 hospitals (among which they have the majority ownership in 56 and minority ownership in 7). They provide diverse types of healthcare services in South Africa and Botswana. This hospital group has hospitals in seven of the country's nine provinces, namely, Pretoria, Johannesburg, Durban, Cape Town, East London, Bloemfontein and Port Elizabeth. Life Healthcare facilities are structured to cater for local demand in the various provinces of the country. The life healthcare group has six hospitals in KwaZulu-Natal, but this study will focus on the three which are located in the Durban area, namely, Life Entabeni Hospital, Life Westville Hospital and Life Mount Edgecombe Hospital.

The reason for choosing the Life Healthcare group is based on the quality of service provided and also due to the significant role performed by medical doctors in ensuring the success of the group. The three hospitals were chosen because of their location which is in line with the study site.

1.6 STATEMENT OF THE RESEARCH PROBLEM

The National Health Services Commission in the 1940s cited by SAHR (Pick, 1995, p. 14) affirms that "a national health service cannot be planned, neither can it be carried into effect without taking into account the numbers of medical and other necessary personnel available now and in the near future".

This study is of utmost importance now because of the growing trend of medical doctors migrating to the private sector from the public sector, thereby leaving a high percentage of the population without quality medical attention. Even though the private hospitals perform important roles in the South Africa health system such as bridging the distance people have to travel to access a medical facility, the cost implication of the services provided by the private sector makes it inaccessible to many.

The migration of doctors from the public to the private sector has dire consequences for South Africa. This trend is creating a brain drain in the public sector and may continue to weaken its health system. The migration is stretching the available doctors in the various government hospitals to the limit. How then can we expect the best medical attention from a doctor that is burdened? If this trend is left unchecked, it will get worse and may eventually take away good health care from the general public.

The percentage of the population being reached by the public sector is greater than the private sector. In the event that people do not have access to quality services due to this trend, there is the probability of the mortality rate increasing. Also, if illnesses are not treated promptly due to this trend, it may result in disability thereby enhancing the percentage of the yearly budget that is earmarked for disability grants which would impact significantly on government expenditure.

1.7 RESEARCH QUESTIONS

This study investigates the following research questions:

- What informs (Push) the migration of medical practitioners from the public sector to the private sector and how?
- To what extent does this migration affect the public sector in terms of service delivery and how?
- To what extent do monetary rewards (for example, wages, bonus, performance pay) and non-monetary rewards (for example, letters of commendation, awards, recognition) impact on the retention of medical doctors in the public sector and how?
- To what extent do the medical doctors in the public sectors presently have the intention to leave and why?

- Is there any retention policy in place and to what extent does it fit and support the culture of the public healthcare organisations now or as the need may arise in the future?

1.8 RESEARCH OBJECTIVES

Erasmus (2006) argues that having an insight into the reasons for perceived skills shortages will help to determine the suitable measures required to assuage these shortages. Hence, the objectives of this research are:

- To investigate the reasons behind the migration of medical practitioner to the private sector from the public sector.
- To explore the effect of the migration on the public sector in terms of service delivery.
- To establish a clear link between monetary rewards (for example, wages, bonuses, performance pay) and non-monetary rewards (for example, letters of commendation, awards, recognition) and retention.
- To assess the intention of the remaining doctors in the public sector to migrate.
- To investigate whether there is a retention policy in place with reference to the public health sector.

In an attempt to investigate the rationale behind the migration of medical doctors to the private from the public sector, different theories were scrutinized such as Systems and Network theory, Push-pull theory, and The bandwagon theory.

Four variables were deduced from the systems and networks theory, namely, structure, linkage, process and future projection. The first variable enabled the study to investigate the kind of structures available in the public and private sectors with regards to the case studies. The second variable enabled the study to establish the link between the systems operating in both public and private sectors and migration. The third variable was used to understand the impact of process dynamics on migration. While the fourth variable enabled future projections to be made with regards to the migration of doctors from the public to the private sectors.

The first variable under the push and pull theory which is the economic factor was used to examine the influence of economic factors (such as working condition, remuneration packages and standard of living) on doctors' decision to migrate. The second variable was

used to investigate the significance of social factors (such as better healthcare facilities, educational or career prospect) on migration.

The first variable under the bandwagon theory which is precedence was used to investigate the influence of the success rate of medical doctors in the private practice on migration. The second variable which is the thrill of adventure was used to investigate the extent to which it pushes doctors in the public to migrate to the private sector. The variables of the study are graphically depicted in Figure 1.1.

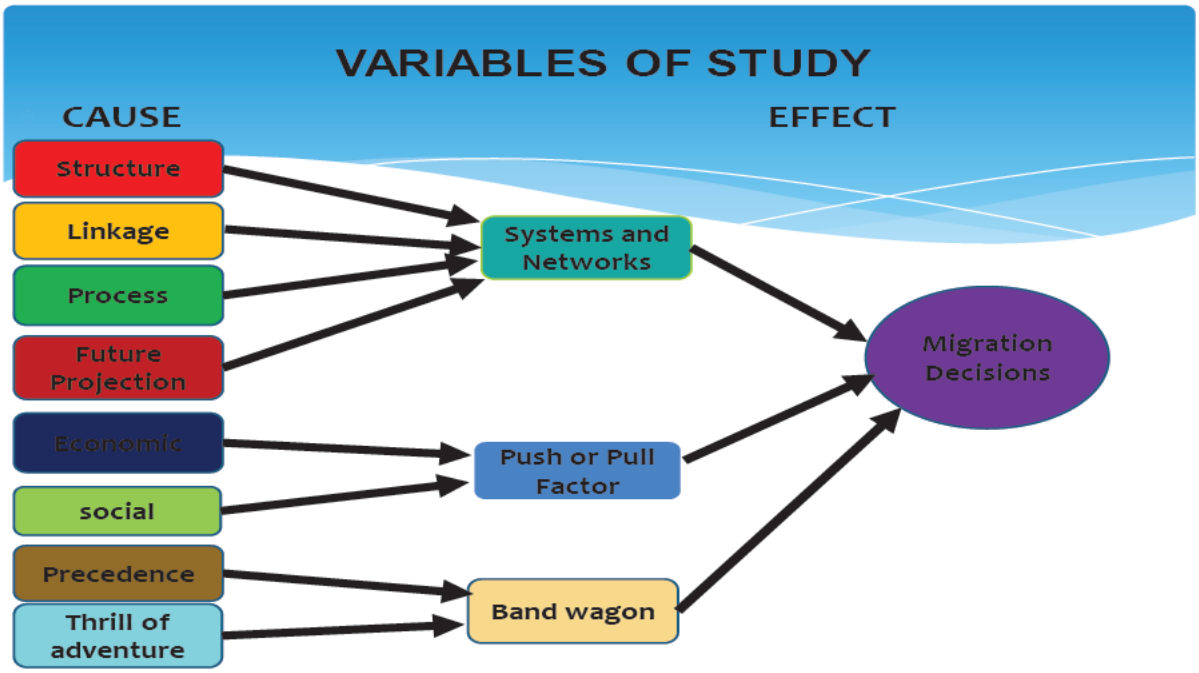


Figure 1.1 Graphical representation of the conceptual framework

1.9 RESEARCH HYPOTHESES

This study strives to ascertain the sources of internal migration of medical doctors from the public sector to the private sector in South Africa by testing several aspects in the following hypotheses:

Hypothesis 1

There is a significant difference in the perceptions of doctors varying in the respective biographical profiles (marital status, race, length of service in profession, length of service in

sector, age, gender, educational qualification and sector) regarding the influence of monetary and non-monetary rewards on migration.

Hypothesis 2

There is a significant difference in the perceptions of doctors varying in biographical and institutional profiles (gender, educational qualifications, sector) regarding the influence of monetary and non-monetary rewards on migration.

Hypothesis 3

There is a significant relationship between the basis for performance (reward, increased efficiency, commitment, punishment, financial security) and attempts to migrate.

Hypothesis 4

There is a significant relationship between recognition of performance and attempts to migrate.

Hypothesis 5

There is a significant relationship between recognition of performance and the main reason for migrating.

Hypothesis 6

There is a significant relationship between recognition of performance and the basis for performance (reward, increased efficiency, commitment, punishment, financial security).

Hypothesis 7

There is a significant relationship between the main reason for leaving despite recognition of performance and the most significant reason for preferring to stay with the public sector.

Hypothesis 8

There is a significant relationship between the main reason for leaving despite recognition of performance and the second most significant reason for preferring to stay with the public sector.

Hypothesis 9

There is a significant relationship between the main reason for leaving despite receiving recognition of performance and the third most significant reason for preferring to stay with the public sector.

Hypothesis 10

There is a significant relationship between the main reason for leaving despite receiving recognition of performance and the most significant reason for seeking employment in the private sector.

Hypothesis 11

There is a significant relationship between the main reason for leaving despite receiving recognition of performance and the second most significant reason for seeking employment in the private sector.

Hypothesis 12

There is a significant relationship between the main reason for leaving despite receiving recognition of performance and the third most significant reason for seeking employment in the private sector.

Hypothesis 13

There is a significant relationship between the biographical profiles of the doctors (marital status, race, education, length of service in practice, length of service in current sector, age, gender) and their main reason for leaving the public sector despite them receiving recognition of performance.

Hypothesis 14

There is a significant relationship between the biographical profiles of doctors (marital status, race, education, length of service in practice, length of service in current sector, age, gender) and their most significant reason for preferring to stay with the public sector.

Hypothesis 15

There is a significant relationship between the biographical profiles of doctors (marital status, race, education, length of service in practice, length of service in current sector, age, gender) and the most significant reason that might inform the decision to seek employment in the private sector.

Hypothesis 16

There is a significant relationship between the most significant reason for preferring to stay with the public sector and the most significant reason that might inform the decision to seek employment in the private sector.

The conclusions and recommendations will enable the public health management and policymakers to effect the necessary adjustments.

1.10 SIGNIFICANCE OF THE STUDY

This study seeks to contribute to a clearer understanding of internal migration of medical doctors in the South African healthcare sector by revealing the main reasons behind the migration, its effect and effective means by which it can be reduced and subsequently come up with a theory that can be applied to public healthcare organisations. This study is undertaken with the aim of providing new evidence on the factors affecting migration of medical doctors and thus aiding further research on this subject in South Africa. The study seeks to support literature on the retention of medical doctors in the appropriate areas of need in South Africa.

This study can also assists in reducing government expenditure on disability grant which may arise out of medical expert shortage to attend to serious medical conditions promptly in the public sector.

1.11 JUSTIFICATION OF THE STUDY

As noted by Simon Caulkin (2001), the management and development of employees has one of the most powerful effects on overall business performance. How far reaching is this statement? The rationale behind this study is to critically examine and establish the impact of

medical practitioner migration from the public to the private sector. The aim is to focus on proposing effective means to curtail this movement to the barest minimum.

1.12 LIMITATIONS OF THE STUDY

The obvious limitation to this study would be the lack of a patient perception. Access to patients' viewpoint would have been of immense advantage to this research's role in determining the effect of the migration more accurately in terms of patient satisfaction. To overcome this limitation to some extent, the researcher collected data from both sides of the delivery system, namely, managers and employees.

Another imitation to this study is the issue of social desirability while gathering quantitative data as respondents might want to project a good image of themselves or the organisation. This limitation was addressed to some extent by ensuring anonymity on questionnaires.

1.13 CONCLUSION

The focal point of this chapter is the persistent exodus of medical doctors from the public health sector to the private sector in South Africa. The human resources for health challenges and its effects on the healthcare sector were also highlighted to stress the need for an urgent solution to the menace. The existence of different types of healthcare standards in South Africa was highlighted as well as the factors responsible for the disparity in the health sector. The two distinct sectors that made up the South Africa health sector, that is, the public and the private health sector were also discussed. The population growth and the rise in HIV cases continued to exert pressure on the health workforce which is affecting service delivery and triggering migration. There is a need for improvement in the production of human resources for health (especially medical doctors) to be on par with the growing population. There are various options available to health workers both within and outside the country; hence, it is the responsibility of the National Department of Health to ensure their recruitment and retention to forestall a collapse of the public health sector.

CHAPTER TWO

MIGRATION: A PROPELLING FORCE TOWARDS PROGRESSION OR RETROGRESSION

2.1 INTRODUCTION

Prior to any meaningful analysis, it is imperative to state that migration flow data is often erratic and incomplete across countries. Usually, migration information is gathered from a disparate range of sources like sample surveys; population censuses; visa, permit and residence applications; occupational and administrative registers and border point statistics. The substantial information gaps and contrasting information often associated with data collection is as a result of the disparity in data collection tools, as well as differences in cross-country data collection policies. The issues mentioned above challenge the validity of data and regularly result in under-representation of the actual migration. Despite the fact that these limitations existed, the degree and range of existing data on migration trends and patterns to and from South Africa still give allowance for reliable studies and evaluations.

The healthcare sector is essentially a client-oriented and labour-intensive service sector that hinges on trained human resources. Skilled personnel are pivotal to the success of healthcare. Based on the fact that health workers are the key element of the healthcare system, the effect of skilled labour loss in the public health sector is abysmal. Confronted with the dearth of health personnel and a high degree of distributional inequality within limited personnel supplies, the shortage of medical personnel at the present rates profoundly increases the already sub-standard service delivery in the public sector. There is an increase in the workload of the already over-burdened remaining health workers, which diminishes the level of regulation and support given by proficient supervisors and colleagues and directly hinders good quality and quantity of healthcare service delivery. Apart from the added pressure on the remaining healthcare personnel and the weakened capacity of the healthcare structure, there is also economic loss on the part of the government, who may have given grants and scholarships to some of the practitioners while studying.

The healthcare scheme in South Africa encounters a human resources disaster, as a result of the huge ‘brain drain’ from the public sector and inadequate funding of the healthcare system.

There are insufficient numbers of healthcare personnel to cater for the needs of the general populace, especially in the rural and underprivileged areas.

2.2 HISTORY OF MIGRATION

Migration has been in existence since forever; no human history is complete without the inclusion of migration studies. In fact, it is a perpetual physiognomy of human antiquity. Human migration is generally believed to be the human movement from one location to another with the aim of either settling permanently or temporarily at the new place of duty. This is not far from the truth even though there is more to migration than that. Migration is usually over lengthy distances or one long distant geographical location to another, although there is the possibility of short distance or internal migrations as well (Luthi, 2010). Migration could be forced, intended, permanent or time-based, it could also occur in phases or at once. In fact, it could involve a whole family unit or just an individual depending on the reason for the migration and the goal of the migrant. People are motivated by various factors at different times to migrate, and as long as human beings remain on earth migration will not cease. The stricter the border control measures, the more determined people get to evade them (Luthi, 2010).

Primeval movement of people originates with the migration of Homo erectus from Africa about 1.75 million years back while the migration to America occurred between 15,000 to 20,000 years ago (Manning, 2005). Other remarkable human migration efforts consist of the First Medieval Great migrations which include Turkic growth, Neolithic Revolt, and Indo-European expansion. The migration of comparatively small elite populations in certain places brought about a significant Cultural Revolution; Azerbaijan and Turkey are typical examples. Roman and Norman's conquests are also viewed in the same light in Britain (Manning, 2005).

Prehistoric humans' migration is largely due to various reasons such as scarce food supply, landscape and fluctuating climate (Manning, 2005). The migration of the Celtic people and the late Migration period from the East and North are the two dominant flows of migrations in the demographic distributions of Europe. The current study on migration proposes that the arrival of Austronesian seafarers from Indonesia led to the inhabitation of Madagascar during the 5th and 6th centuries AD. Consequent movements from both Africa and the Pacific

promoted the consolidation of this unique fusion. Since early modernisation times, accelerated speed was witnessed in migration due to the European imperialism and Age of Exploration. Conceivably, around 240,000 Europeans crossed the threshold of American ports in the 16th century while above 50 million Europeans entered America in the 19th century (Axtell, 1992; Eltis, 1987).

2.2.1 BRIEF HISTORY OF TWENTIETH CENTURY MIGRATION

The diversity and intricacy of the twentieth-century migration flow is revealed in a very selective manner (Harzig, Hoerder & Gabaccia, 2009). Refugee migrations in startling numbers were activated by the First and the Second World Wars as well as the Balkan Wars in the course of the first half of the twentieth century. Even though millions of refugees were generated by the First World War, the program of 'unmixing people' was also introduced by new post-war nations which influenced the number of refugees (Naimark, 2001). Additional industrial workers were no longer in demand by most states in the North Atlantic world by the end of the First World War, which ended the dominance of labour refugees across the world. As nation-state seized the control of the valid means of movement, admittance protocols became more obstructive and the need for soldierly service and allegiance to the nation-state is greater than before with the introduction of citizenship and identity documentation under the sovereign state regimes (Luthi, 2010).

For instance, a forceful incursion was propelled into Korea after 1900 by Japan, after which Manchuria and China were invaded respectively before final onslaught was unleashed on most of the East and Southeast Asia. Lots of Chinese migrants escaped the advancing armies by the late 1930s. At the time of Japan's invasion of Asia, the Nazi ideology has also inundated not only Germany's government policies but also those of their agents all over Europe, leading to the extradition of political opponents, European and German Jews, homosexuals, Gypsies, alien enemies, and many others to the concentration camps (Luthi, 2010). Severe labour oppression cannot be divorced from forced migration as part of the consequences of war after the capture of power by the defunct Soviet Union under the leadership of Stalin, especially in the 1930s. After the forced collectivisation of farming, there was a breakdown in production that gave rise to famine-stimulated mass migrations. (Luthi, 2010)

Apart from the migration of many displaced people and migrants escaping from the new socialist governments in the eastern and central Europe, another hallmark of World War II and the interwar period was colonisation and those territories which provided platforms for the current international migration. Imbalanced global terms of trade enforced on the southern hemisphere by the North and decolonisation swayed labour movements and migrant to the south after the end of World War II. The Western nations, which were in the habit of sending their nationals overseas, suddenly turned into preferred destinations for a lot of greatly deprived immigrants, and to date extremely equipped border measures and controls have generally been unsuccessful. People tend to look for loopholes in the boundary measures and gain access into their destination country. The hunger for independence gave birth to Wars by citizens of the Asia colonies as well as people of the North and sub-Saharan Africa. By the 1960s, decolonisation forced the countries of Britain, France, the Netherlands, Italy and Belgium out of their former colonies (Luthi, 2010).

The topographical concentration of these migrant movements shifted to southeastern and southern Asia in the 1970s, due to the Vietnam War and skirmishes somewhere else in Indochina (Koser, 2007). Decolonisation also resulted into three main categories of migration apart from the migrant movements it stimulated (Harzig et al., 2009). The first category is 'displacement migrations' which is due to the restructuring of the social order within the new autonomous states. The second category is the 'reverse migrations' that took colonial masters and their workforces back to their home countries while the third one is the income generating labour migration overseas. A universal embryonic apartheid established through imbalanced trade terms caused the deprivation of the South and maintained the earlier structure of unswerving abuse and exploitation which triggered persistent migrations. Attempts to gain entrance into the prosperous North increased greatly, by both the authorised and unauthorised persons due to the availability of better job prospects. The demand for Southern labour in the western and northern Europe and subsequently, in the North Africa was first created by economic development and postwar reforms in the 1950s and 1960s (Luthi, 2010). The visible changes in the society shaped by the U.S. capital investments and the North American labour market enticed the Caribbean, Mexican and other Latin American migrants.

Provincial migration structures were also established in the South and Central America and in the Caribbean. Right-wing governments with the support of US government generated large refugee movements in some Latin American nations. Unsettling World Bank-enforced reduction in social services and development barriers caused rural-urban migration as well as international migration to former colonialist countries from countries in the sub-Sahara Africa.

Migrants' freedom of movement was endangered with the emergence of the twenty-first century which brought about issues of race intolerance or xenophobia in several nations, religious fundamentalism and strict homeland security measures. Just as migrants are frantically seeking entrance into societies that guarantees workable lives and good standard of living, the demand for migrant labour is also increasing concurrently (Luthi, 2010).

2.2.2 MIGRATION BEYOND THE WEST PRECINCTS

Over the years, migration research in other parts of the world has been conducted under the shadow of America and Europe migration research. The perspectives from which the researchers were conducted were narrow and seen as an extension of European migration movements. The reason for this might not be unconnected with the fragmented nature of the field of migration history. It is believed that researchers in migration field from Asia and Africa do not position their work clearly within the migration studies pattern. Therefore, their erudition and contribution is repeatedly overlooked by migration historians.

Adam McKeown, an expert on Chinese migration is part of a group of researchers who do not believe in the dominance of the migration field of history by Europe and America and criticised the imbalance in the area of migration studies (McKeown, 2008). He affirmed that decentralisation of America and Europe will permit the inclusion of other regions as well as challenges general suppositions on the effect of race on movement and the issues bordering on the 'West and the Rest'. McKeown wrote an inventive article titled "Global Migration" covering the period between 1846-1940, in which he basically challenged the general notion of the uniqueness and volume of the mass migration in the Atlantic biosphere during these periods (McKeown, 2004).

McKeown (2008) in his article strived to shift the paradigm of his readers through the usage of macro tactics to two other crucial migration structures in the southeast and northern Asia that occurred in the middle of nineteenth century and the eruption of the Second World War. Also, he maintains that the Asian migrants' movement was in response to economic stimuli towards areas that are in high demand for what they have to offer (Lucassen, 2007).

Migration in Africa has been in existence for a long time. Understanding migration is better done from the perspective of the political and historical development of African people. As a matter of fact, periods of both political and historical development are fundamental to the knowledge of migration generally. The visibility of the impact of colonisation and decolonisation on African development and migration is obvious when studied within the context of the three profound pre-colonial, colonial and post-colonial eras (Adepoju, 1998).

During the colonial period, some intimidating procedures as well as motivations were introduced to provide for the increase in labour demands on the mines and plantations. The French colonies in West Africa, such as Mali and Upper Volta were mobilised through various approaches by the French colonial government. The case is different in Southern and Eastern Africa, where people were subjected to tough economic policies to enlist the required number and quality of personnel for the plantations and mines (Adepoju, 1998).

In recent years, the rising inequality in economic growth among nations contributed immensely to the deliberate movement of people internally and internationally (Adepoju, 1998). The significance of such movement is not lost on the demographic, economic, social and political aspects of the nation. According to the World Migration Report (International Organization for Migration, 2008), an estimated 440 000 people migrated from Africa within 2000-2005. Chains of political and economic factors dictate the structure of opportunities in any country and subsequently determine the migration trend, either internally or internationally. An economic boom and employment opportunities are an important source of attraction for emigrants to return to their countries. No matter how comfortable or established an immigrant is, in a foreign land, he/she is still a foreigner. The actual sense of belonging can only be felt in the home country. There are heights that an immigrant cannot attain, no matter how efficient, in most developed countries even though, they proclaim equality for all.

There are many unspoken and undrafted rules that have been limiting immigrants in developed countries for years.

The strategies of multinational corporations in terms of investment to support national growth policies remarkably influence the social, economic and political structures of host countries, particularly with regards to the types of job opportunities, location, earnings and standards of living which have subsequently swayed internal and international movement in Africa (Adepoju, 1998).

2.3 CONTEMPORARY HISTORY OF MIGRATION

Legal and illegal immigrants played very significant roles in the migration study of the twentieth century and have remained important to date. They will continue to be pivotal to future studies on migration due to these key roles played by them even though they have usually been the object of intense debate globally. Migrants are generally regarded as legal or illegal in any society. The legal migrants are those who have been granted the authority to stay in a particular country temporarily, permanently or indefinitely while the illegal migrants are those occupying a country unlawfully. It is important to note that, some illegal migrants might at some point be legal, but might have earned the illegal insignia due to staying beyond the permitted period in the destination country, which is probably the most popular factor that confers the illegal status on migrants.

Forced movement of people from their homelands is also a contributing factor to migration. More and more people are been involuntarily moved from their native lands now and then without choices which invariably means that forced movement of persons is not a new occurrence. Migration history will not be complete if the focus is only on people who migrate on their volition without taking into account those who are made to migrate against their will. The forced migration may occur through kidnapping, invasion, natural disasters and luring with unrealistic opportunities. Nonetheless, its current dominance of academic research and its legal notion is a vital part of modern migration.

Refugee, according to the 1951 United Nations Geneva Convention, was well-defined as an individual's pursuit of protection by crossing the foreign frontier due to well-established dread of persecution on the basis of religion, race, political opinion, nationality or affiliation

to a particular social group (Dirk, 2002). The espousal of the above definition made the spread of refugees reach a universal scope. According to Koser (2007), the issue of refugee which began mainly as a problem of Europe at the end of the World War II has actually developed into a universal phenomenon with enormous complications. As a matter of fact, Europe took the lead in generating refugees in the first half of the 20th century, even though the refugee definition was initially for those who escaped the persecution of Nazi in Germany to Europe. The 1960s upward witnessed fresh refugee populations that emanated out of decolonisation and wars in the developing countries of Africa, Central America and Asia.

Due to the peculiarity of our world today, the current veracities of refugees cannot be precisely addressed by the Geneva Convention of 1951 (Dirk, 2002). There are current heated debates in determining the exact benchmarks to earn the status of a refugee. The provision of the convention for conferring refugee status is not adequate to address the dynamics of the present world that we live in, thereby excluding some people who should automatically qualify for the status. It is a bit restrictive which may be connected to the peculiarity of the situation of things at the time the convention was held.

Some of the constricting issues noted are: The convention criteria do not confer refugee status on economic migrants even though economic variations produce a higher number of refugees than socio-political conflicts. Although the Convention emphasis was on public oppression and persecution, current refugees' movement is not due to definite persecution but more often about the common insecurity or uncertainty of war. Likewise, situations like ecological deterioration and sexuality-based oppression are not clearly approved as flight-stimulating reasons (Dirk, 2002; Manning, 2005). In conclusion, the Convention is centered on the political philosophy of independent federations and, therefore, did not make any provision for internally displaced people, especially in the case of civil wars.

Bearing in mind this code of conduct, the influence of official documents to establish social peculiarities and make classifications according to the conventional criteria point to a vital aspect of the contemporary migration strategy. The general asylum processes in Europe have become harder since the 1980s, and the prospects for global refugee welfare from the underdeveloped nations have been extremely challenged due to further constricting laws and classifications premeditated to prohibit applicants. Zetter (1991, 2007) in his broadly quoted

articles on 'Labelling Refugees' reiterated that exploring the process involved in choosing labels and how they are applicable to those migrating can give clarification on the vital influence of certain administrative, political and other procedures and interests in defining labels like refugee (Zetter, 1991, 2007). What determines the labelling process and its eligibility differs from nation to nation, and the way they go about their labelling is a reflection of their policies. This goes to show that label status conferred on a person in one place may be inappropriate in another location depending on their legislation. Zetter (2007) argues that labels are the physical images of policies and programs.

It is of utmost importance that we take into account the occasional premeditated segmentation and fusion of labels in the interest of the nation. For the purpose of the historical study on migration, it is imperative to note that it is the desire of governments all over the world to regulate migration even though some have recorded more failure than others. More and more restrictive measures are being established to discourage people from migrating both in the developed and developing world but it is interesting to know that intending migrants are not relenting in their efforts as well. The fear of failing or being caught at the border is not enough deterrence to stop them from trying to gain access illegally. The stringent measures seem to boost their determination.

2.4 ECONOMIC DEVELOPMENT AND THE UPSURGE OF INDEPENDENCE

The rise of independence in the 19th century greatly increased migration and made a child's play out of the increase witnessed in the 18th century. The relationship already established between the colonial masters, and the colonies gave ample opportunities for many inhabitants of the colonies to migrate mostly for academic and employment reasons. Three main types of migration were proposed by Manning (2005), namely, urbanisation, labor migration and refugee migrations. These three types of migration mentioned by Manning (2005) are relatively long-term while no typology was made for movements that are short-term. The emergence of urbanisation had its root in Britain in the later part of the 18th century and extended to other regions of the world until today.

Migration trends are usually stimulated by the emergence of the different era of Industrialisation. Eras of Industrial development create migration inclinations that are peculiar to it, which could be as a result of new discoveries or inventions. Emerging and

rapidly growing commercial hubs regularly enticed voluntary immigrants who see it as an opportunity to better their lot, improve their conditions and possibly obtain permanent residence from their host community (Manning, 2005). The world is becoming increasingly globalised, and the labour market is not left behind; relatively smooth interconnectivity between countries fostered by upgraded transport systems has contributed in no small measures to migration. For instance, the West African countries agreed on the use of ECOWAS passport for easy passage within them which has not only promoted trade alliance but also provides the citizens of member countries with bigger opportunities for career prospects.

In the 19th century, the illimitable European business empires emerged as well as ethnocentrism and idealistic independence. While some states were more convivial, other states were not so welcoming; they appraised cultures that were different from theirs based on their preconceived notions that originated from their cultural standards. Another notable influence of colonialism is the fact that it steered migration from both ends of the stick. While it directed migration of some citizens of the home states to the captured colonies, it also steered migration of some of the citizens of the captured colonies to the countries of their colonial masters (Cohen, 1997; Friedman & Randeria, 2004).

The significant internal migration that was experienced in the United States from 1910 to 1970 was linked to industrial development. This includes the noteworthy movement of about 7 million African American descents from the southern countryside where there were huge social and political bigotry and unfavorable conditions of living to commercial centres of greater economic opportunities in the West, Northeast and the Midwest (Harzig et al., 2009). This occurrence was actually labeled as the Great Migration in the United States. The significant economic improvement in the south of the United States and the death of legal discrimination against African-Americans saw the return of millions of migrants to the south since the 1980s which brought about the phenomenon referred to as the New Great Migration.

People who migrate from one place to another are called immigrants while they are referred to as emigrants at the point of departing their place of origin. People displaced by immigration regulations are called refugees while a relatively small number of people

migrating to improve a region or place that is regarded as under-developed can be called colonists or colonisers (Fell & Hayes, 2007). Migration has persisted either voluntarily or involuntarily within countries and outside the countries, and there seems to be no end in sight for migration. Situations will continue to arise that will necessitate the migration of people internally within the states and internationally. The involuntary migration can be in the form of human trafficking, slave trades and natural disasters while the voluntary ones are usually motivated by political, economic and social factors.

No matter from what perspective migration is being considered, its account explores the following areas:

- Firstly, the scopes and forms of movement through time and space. This movement could be periodic, globular, definite, war-related, economically or politically motivated.
- Secondly, it explores the rationale and circumstances behind the movement of people from their place of origin and its influence on their societies, immediate families as well as the extended ones.
- Thirdly, it investigates the process through which the migrants are received or rejected by the host communities, together with the impression that the migrants make on the host nations**;** it also examines the linkage between the places of origin and the destination point and the authority that the states exert over migrants and the expertise established to coordinate migrants.

Historians in the field of migration further examined the migrants' agency involved in migration procedures within definite fundamental restrictions, for instance, networks, motivations and effect on family and state structure (Lucassen, 2009).

Understanding the twentieth-century global migration flow is dependent on its connection with the intra and inter-regional movement of labour required in the development and decolonisation processes across borders (Moch, 1992). In order to comprehend global migration, we need to consider the whole range of migration procedures within a definite region with the interfaces among all recognisable forms of migration. It is also important to put the growth of the states and their heightened concern to restrict human movement in and out of their states into consideration. It is necessary to consider the conveyance structure, that

is, the mean through which they were transported from the point of departure to destination and the communication tools as well. Consequently, it is of utmost importance for researchers to make a distinction between the different topographies and methods of movement.

Studies on migration have been buttressed by the various sources that have been providing evaluation on the global migration flows. The International Organization for Migration has been publishing an annual report on World migration since 1999 while the World Bank have also been publishing an annual Migration and Remittances Factbook since 2008 (World Bank, 2011). The statistics division of the United Nations also manages a database on global migration. Even though researchers on global migration is limited in scope and often restrict their scope to international migration, significant numbers of internal movements take place within various countries which also requires considerable attention. The internal migration could either be seasonal in nature, which may be due to tourism to urban centres and agriculture, and it could also be movement of people into urban areas for greener pastures which are called urbanisation.

The differences between voluntary and involuntary migrations are often made just as the differences between labour migrants and refugees. It is difficult to establish this differences which to some extent is biased since several reasons for migration are usually interconnected. The 2011 Migration and Remittances Factbook by the World Bank itemised the following estimates for 2010: Total number of immigrants is 3.2% of global population or 215.8 million (United Nations Fund for Population Activities, 2013). According to The World Bank report estimates of 2010, 7.6% or 16.3 million of migrants can be classified as refugees. The top ten destination nations are the UK, USA, Germany, Russian Federation, Canada, France, Saudi Arabia, Australia, Spain, and India. The top ten states of origin are the UK, Turkey, Pakistan, China, India, the Russian Federation, Bangladesh, Mexico, the Philippines and Ukraine (World Bank, 2011) while the top ten migration passages globally are 1. Philippines-United States; 2. Mexico–United States; 3. China–United States; 4. Bangladesh–India; 5. Turkey–Germany; 6. China–Hong Kong; 7. Russia–Kazakhstan; 8. Kazakhstan–Russia; 9. Ukraine–Russia; 10. Russia–Ukraine.

2.5 GLOBAL TRENDS IN MIGRATION STUDIES

Largely, human migration can be referred to as navigating the borders of a governmental entity for the least possible period (Luthi, 2010). Distinctively, internal migration denotes movement from one political area to another within the same nation; it could be from one district, municipality or province to another. International migration is defined as navigating the boundaries that separate one nation from another. Some researchers claimed that these two main typologies of migration (that is, the internal and international migration) should be jointly evaluated as they are a fragment of the same process. Not all human movement from one location to another can be regarded as migration. For instance, temporary migration of people for the primary purpose of tourism, pilgrimages and vacation, medication attention or sporting events cannot be viewed as migration. So also is a nomadic movement that is usually seasonal and without the intention of settling at the new place.

As the world is evolving, migration is not left behind. There has been a shift in the pattern of migration and remittances globally in recent times. Nearly one in every seven people today is a migrant. More people are been attracted by different reasons to migrate and it is not restricted to a certain tribe or region. According to the International Organization for Migration (2014) Data Report, 740 million people are internal migrants while 232 million people are international migrants. One of the notable recent trends in migration is the increase in the number of women migrants, with women accounting for 48% of the international migrants (United Nations Department of Economic and Social Affairs, 2013). Also, 74% of the global migrants are of working age which lays a solid foundation for the notion that the financial factor might be a cogent reason for migration. Forced migration has also increased, and the certainty about global displacement and relocation is becoming more difficult. Recently, the number of displacements caused by war and violence is the highest experienced since the Second World War.

By the end of 2013, refugees were projected to be 16.7 million people (United Nations High Commissioner for Refugees, 2014) while internally displaced persons due to war and violence were anticipated to be 33.3 million (Internal Displacement Monitoring Centre, 2014). The estimated number of asylum seekers in 2013 was stated to be 1 067 500 people while the developing countries played host to 86% of the World refugees by the end of the same year. The key recipients of fresh applications for asylum by individuals were USA,

France, Germany, Sweden and South Africa. The lnternational Organization for Migration (2014) Data Report from the Displacement Tracking Matrix (DTM) stated that an estimated number of over 1.7 million people were recently displaced due to war-related reasons in Iraq from January-September 2014.

Remittance growth has been exponential even though transfer costs are high. Remittances to the developing countries were estimated to be 404 billion dollars by the World Banks in 2013 (World Bank, 2013). The increase in the flows of remittances to the developing countries is anticipated to grow at 8.4% per annum in the next three years. Nevertheless, the recent research by McKenzie and Clemens (2014) proposes that improved reporting methods and changes in the measurement of remittances might be the reasons behind the noted growing remittances to developing countries. Sub-Sahara Africa has been noted to be the most expensive remittance receiving region due to the high transfer cost. Permanent labour migration is dwindling among the OECD countries, mainly due to recession in Spain and Italy. Even though Intra-EU migration is rising, the migration pattern generally differs across OECD states (Organisation for Economic Cooperation and Development, 2007).

In the last two decades, more countries are embracing consistent migration. Generally, the percentage of states with migration reducing regulations dropped to 16% in 2011 compared to 40% in 1996 while countries seeking to increase migration improved to 11% in 2011 from 4% in 1996 (United Nations Department of Economic and Social Affairs, 2013). It is important to note that integration strategies were more frequent in developed countries than in the developing countries. A disposition toward a greater acceptance of immigrants is mostly evident in developed countries.

McKinsey Global Institute (2012) research affirms that migrants from developing countries constitute roughly 40% of the labour force rise in developed countries in 1980-2010. More personnel have arrived in developed countries with innovative skills, especially in the recent times. For instance, migrants workers in the United States constituted 17% of total employment in engineering, science, technology and math-related jobs in 2008 (International Organization for Migration, 2014).

2.6 HISTORICAL CONFIGURATION OF MIGRATION AND URBANISATION IN SOUTH AFRICA

The development in South African was molded traditionally by procedures to control the migration and establishment of Black populaces. There were obvious restrictions during the apartheid era that limited the mobility of people to the urban areas and some of those that found their ways there had their hopes dashed due to segregation. Various restrictive strategies were put in place to curb access to urban areas that actually restrain people from leaving the rural communities with narrow economic opportunities as well as opportunities to maximise their potentials. Even though some of these restrictive strategies lost their grips from the 1980s, people still found it hard settling into urban life because some of these restrictive strategies still wield much influence. This occurrence has greatly hampered the mobility of people from the rural areas and migration was not as swift as one would have expected. According to Cohen (2003), there has been a noticeable decline in urbanisation and as a matter of fact it is lower than during the apartheid era. This decline is not peculiar to South Africa only as it is the case globally.

Post-apartheid research on migration and sub urbanisation in South Africa has been irregular and hindered by the lack of consistent logical data; this has constituted a clog in the wheel of migration studies. To this end, this study gathered together existing studies to provide a general platform for diverse forms of migration as well as trends with the aim of exposing the simple dynamic forces that are fundamental to migration in South Africa today. Also, 57.5% of the South African population resides in the urban areas according to the 2001 census as against the 55.1% that was recorded during the 1996 census exercise which was the first census done after the abolition of apartheid era.

Even though there was a noticeable increase from the first census that may be due to the removal of some of the restrictions that existed under the apartheid period it still leaves more to be desired. Typically, it was expected that people will move in droves to the urban cities to take advantage of the various opportunities available after the apartheid era but it seemed that the past restrictions created a stereotype that is difficult to erase from the mind of some people and impacted greatly on their decision to migrate. The past restrictive structures gave birth to an inferiority complex and deep-seated fear about moving out and maximising their potential.

Persistent migration of people from the rural areas (locations) to the cities is a major issue for city management council because it stretches the available infrastructural facilities to their limits and impact on the budget. This shows that some government structures in the cities might be benefitting from not having large numbers of migrants from the rural areas. The city is a dream that must be realised to many rural dwellers; they aim at it, plan towards and work to achieve it from childhood. Families in the rural settings see this movement as their ticket to a better standard of living which emphasise the fact that there will always be mobility from the rural to the urban areas.

Defining urban in the context of the peculiar nature of the South African society is very difficult. The South Africa's apartheid history contributed in no small measure to this difficulty. The way the rural areas were structured under the apartheid regime made it awkward to classify them as rural. The large rural settlement populations were actually formed out of the resettlement processes of displaced Black people from White definite occupations on commercial farms, betterment planning, segregation, restrictive laws and African freehold land which have generated some argument on whether they are qualified to be regarded as rural areas. Several pieces of research were carried out in the late 1990s to investigate the aftermath of these dense settlements that emerged out of government resettlement schemes in the countryside (Centre for Development and Enterprise, 1998; Krige, 1996; Meth, 2001). In many of these settlements, employment decline occurred despite the job provision in few of these areas as a result of the industrial decentralisation policy. In spite of anticipations that the end of apartheid will bring about a rapid exit of people from these settlements in large numbers, many of the people refused to leave the settlements although a certain level of out-migration was also witnessed according to the studies. The reasons for these patterns were attributed to reduced service costs, better housing scheme than in the urban areas, social and network links and the existence of transport subsidies.

With regards to the social surveys and the noteworthy study by the Nkuzi Development Association (Wegerif, Russell & Grundling, 2005), the population of those displaced from these commercial farms mostly owned by the Whites within 1994-2004 was 2.4 million, among which 942 303 people were ejected. Those who were not ejected left out of their

volition, mostly due to challenging circumstances on the farms (Atkinson, 2007). This report incidentally was lower during the apartheid era compared with the post-apartheid period. The study showed a population of 1.8 million displaced people within 1984-1993, among which only 737 114 were ejected from farms. Most households in this settlement were reliant upon pensions, settlements or remittances and other sources of income, and they have an inadequate agricultural base. The industrial development that they expected to emerge and create jobs based on the decentralisation policies on industries did not materialise in many of these settlements (Harrison, Todes & Watson, 2008).

The census data showed an increase in the Black population on commercial farms within those periods that Nkuzi eviction survey presented substantial displacement figures (Wegerif *et al*., 2005). However, eviction survey scholars, who conducted an investigation into the incongruity, asserted that an error might have occurred in the taxonomy of enumerator areas by Statistics South Africa which impacted on the total figures. Besides, there is the possibility of Nkuzi's eviction survey figures having been overstated. Therefore, the displacement figures are open for further discussions. According to the survey, 67% of the ejected population settled in the metropolitan areas out of which 38% settled in the deprived parts of the townships or shacks and the remaining 29% settled in informal settlements (Wegerif *et al*., 2005). Despite leaving the rural area with high hopes for greener pastures in the cities, many find it difficult to blend fully, and the lack of basic education and proper qualification makes getting good employment seem far-fetched.

Globally, natural increase is often referred to as the principal cause of growth rates in the urban area (United Nations, 2004). This assertion can also be seen in the growth of the main internal migration destination in South Africa which is Gauteng. According to Cross, Kok, Van Zyl, O'Donovan, Mafukidze, and Wentzel (2005), about 70 percent of its growth between the period of 1996 and 2001 was as a result of natural increase that further buttresses the finding of the United Nations. One of the important trends revealed by the analysis of the census data of 1996 and 2001 is the attraction of people to urban areas that are enjoying economic buoyancy and growth especially Gauteng and other commercially viable cities with fast growth. The aspiration of people tends to push them towards those areas where they feel their dreams can be easily realised. Most migrants leave home with heavy family burdens on their shoulders and cannot afford to fail, which usually sway their decisions in favour of those

areas that are economically booming. It is also an opportunity for some of these people to enjoy those urban privileges and amenities that their fathers were deprived of during the apartheid period. The attraction of the educational structures in the urban areas cannot be over-emphasised which is also a catch for rural dwellers.

Typically, there were obvious movements away from economically weakened Northern and Eastern Cape regions to the north-east region and Western Cape (Tomlinson, Abrahams, & Gildenhuys, 2003) for better prospects. How economically or commercially viable a region is will determine its migration inflow. It is natural for people to stay away or avoid areas that have little or nothing to offer to better their lot. Population and economic growth rates have been faster than the average rate in the eThekwini municipality and also in Cape Town while they have been inconsistent in the other secondary metropolises (Development Bank of Southern Africa, 2005; South African Cities Network, 2004).

Gauteng and KwaZulu-Natal housed the largest population of ejected people from the commercial farms largely due to the allures of these metropolitan centres in terms of employment which migrants found to be irresistible (Wegerif *et al*., 2005). Even though the metropolitan areas are attractive, these poor evictees and displaced farm workers are rather untrained with respect to the available employment; therefore, unemployment rates are high (Atkinson, 2007), which depict a fundamental reason most aspirations and dreams of those migrating from the rural areas to the urban areas do not get fulfilled. Many do not possess qualifications to enable them to secure well-paying jobs so instead of getting the greener pastures that they seek they are still wallowing in poverty and many other challenges and, therefore, cannot fulfill the promises made to their families back home. It is a case of using what an individual has in terms of experience, skills and qualification to get what he or she wants.

However, it is pertinent to state that some studies on displaced farm workforce differ on their destination. Atkinson (2007) and other studies abridged in Todes (1999) affirmed that these displaced people usually move to small townships some of which are experiencing a deteriorating economy. Marais and Krige (2000) also supported this assertion and attributed the decision of displaced people to move to these small towns to the lopsided housing supply in some provinces. A logical point was also made by Cross, Mngadi, Mbhele, Mlambo,

Kleinbooi, and Saayman (1997, 1999) that many of these displaced people do not find it easy to move straight to the big cities; they would rather move to the nearest small towns at first to allow themselves to make concrete arrangements before eventually moving to the cities, although some usually decide to make their stay indefinite. Nevertheless, particular forces in small towns made most of their migration fruitless and the forces are the limited capacity and revenue that makes the absorption of migrants difficult. There is a limit to what the small towns can take, and any additional pressure will not only stretch the capacity but can damage it. In a situation where too many people struggle for a facility that is meant for few, there is bound to be problems and chaos. Many service delivery unrests in small towns have been linked to these forces, and the 2005 service delivery protest was not an exception; even the recent xenophobic attacks have been linked to service delivery issues and unemployment.

The globalisation of the marketplace is increasing at a fast rate and South Africa as a nation operates consistently in it while competing fairly with numerous countries such as the United States and the European Union. However, there has been deregulation of the agricultural sector involving the removal of most tariff protections, subsidies and marketing boards in the past few decades. In order to mitigate against the deregulation burdens, mechanised farming increased, and new technologies were also introduced by commercial farmers. The mitigation also came at a cost; it brought about a widespread partnership among farm owners which resulted in the reduction of farms from 57 980 in 1993 to 45 818 in 2002. The reduction of farms brought about a chain reaction which reduced regular employments to 480 000 in 2002 as against 1 700 000 in 1993 while casual jobs increased from 14 000 to 460 000 also within 1993-2002 (Aliber, 2007).

Wegerif *et al*. (2005) assert that two-thirds of farm expulsions are job-related while periods of famine was also recognised to have a great influence on farm evictions. Another crucial factor for eviction and displacement from farms, as quoted by the Centre for Development and Enterprise (2005), is the fear of crime by White farmers. Even though access to good services, freedom and better facilities are some of the benefits of living in towns, the costs of living are very high with little prospect to supplement one's income through farming or any other means (Atkinson, 2007; Wegerif *et al*., 2005). This demerit notwithstanding, the majority of the ejected farm workers still prefer living in towns compared with the farm and only 27% would like to return to the farm given the opportunity (Wegerif *et al*., 2005). This

is largely because many of the farmworkers believe that they stand a better chance of prospering in the towns than staying on the farm. Also, there are many opportunities and infrastructural facilities that are available in the cities that you do not find on the farm that informed the decision of some to live in the towns.

The emergence of the land reform is expected to offer a substitute to urban migration, but its level is yet to correspond to the magnitude of displacement and farm evictions. About 164 185 families have profited from the land reforms in the form of tenure rights and land as at July 2005 with only 7 543 being farm workers' families which depict that only a handful of farm workers have profited from the scheme (Wegerif *et al*., 2005). Only 4.3% out of the targeted 30% of lands has been redistributed by the end of 2014 (Centre for Development and Enterprise, 2005) which depicts that the delivery rate of land reforms falls below expectations and did not create the expected employment opportunities even though there has been an increase since 2002 (Aliber, 2007). The inadequate benefit derived from the programme has been blamed on the absence of post-settlement support, poor capacity and insufficient land (Hall, 2004).

There was a heavy dependency on remittances and grants that showed a tight connection to the metro areas while agriculture is only used to supplement these remittances and grants. As a matter of fact, the remittances and grants fund the agricultural practices. This heavy dependence on remittances is a major factor that pulls more people to the urban areas to be able to support their families. However, Posel, Fairburn, and Lund (2006) assert that the accessibility of grants does not in any way pose a threat to admission to labour markets but appears to enable patterns of circular migration. Economic reform and its effects on employment which brought about retrenchment in manufacturing industries and mining also had a ripple effect on remittances to rural households in some areas, thereby increasing migration to small towns and cities (Bank & Minkley, 2005). There is significant increase in migration between provinces with the Eastern Cape estimated to have had the highest outflow of migrants in 2013, closely followed by Limpopo while Gauteng is estimated to have paid host to most of the migrants with Western Cape closely on its heels (Statistics South Africa, 2013).

2.7 ESTABLISHED FORM OF MIGRATION IN SOUTH AFRICA

The level of migration in South Africa has been unusually persistent around 12%, given the various factors that could have triggered it according to the studies carried out by Kok and Collinson (2006) which covered 3 periods, namely, during apartheid (1975-1980), political transition era (1992-1996) and the post-apartheid era (1996-2001).

Circular migration is prevalent in South Africa, and it exists on different levels due to the impact of apartheid on population movement (Collinson, Tollman, Kahn, Clark, & Garenne, 2006). It can also be described as repeat migration in which migrant workers temporarily move repeatedly between their homes and destination areas (usually urban) basically for employment (International Organization for Migration, 2008). Circular migration is closely linked to some benefits such as brain gain in terms of human capital, social capital as well as the enhancement of financial capital. Even though there are obvious benefits in circular migration, it usually exists at a cost especially to the home economy or departure point. Some of the costs are brain drain with regards to labour, difficulty in transferring acquired skills back home, and it also has the tendency of promoting forced labour. Although, circular migration is typically connected to internal migration and urbanisation (Newland, 2009), it can also be cross-country.

The mining sector and other Industries in the metropolitan areas draw cheap supply of male labour from the rural areas all over South Africa as well as other Southern African Development Community (SADC) countries while their unemployed families remained in the rural areas due to legal requirements. This form of recruitment actually instituted a form of circular migration that is still in existence to date. The 2001 report stated that there is at least a temporary migrant in 55% of families. The South Africa internal policies in the second half of the 19th century only allowed men to migrate legally to cities; women only got the opportunity to migrate in 1986 after the influx control was lifted. However, the percentage of the females involved in circular migration has greatly increased in recent times. Generally, circular movement in South Africa is high and still rising as people continue to search for better employment opportunities in areas where they can also give the best to their children in terms of education (Collinson *et al*., 2006).

Contemporary Policy on migration primarily focuses on the dichotomous models of temporary (short-term) and permanent (long-term) movements with little recourse to circular migration despite its existence (O'Neil, 2003). There are diverse categories under circular migration such as seasonal migration that is mostly linked to agriculture but applies to other sectors like construction and tourism (Newland, Agunias & Terrazas, 2008). We also have the non-seasonal low wage labour and the migration of professional, entrepreneurs and academics (Newland *et al*., 2008). One obvious benefit of circular migration is the opportunity to concurrently engage with both the host country and the home country, which allows for the preservation of one's tradition, family and nationality which is not obtainable under temporary migration. This concurrent engagement with the two places takes away the pressure of having to make a choice between them (Newland, 2009).

One of the crucial elements in the economic growth of South Africa is the migrant labour system and its relation to regulation that repressed and controlled the development of African people. There were high hopes regarding the exit of circular migration at the end of the apartheid era to allow people to live permanently where they want especially in places closer to their workplaces; nonetheless, there are no indications that it ended or even waned in the 1990s (Posel, 2004). Forms of circular migration are still in existence while fresh ones are also emerging (Davies & Head, 1995). More women are migrating in pursuit of employment even though getting jobs in the small towns and cities for most rural women is difficult, which can encourage many (who do not see going back to the rural areas as an option) to enter into reliant relationships with men primarily for survival (Hunter, 2006), while those who cannot bear the heat give up the struggle and return to the rural area.

Roberts (1989) asserts that the presence of circular migration is regular in environments where an insecure labour market is prevalent. Cox, Hemson and Todes (2004) supported this assertion and also affirm that circular migrants are taking up a range of insecure jobs such as security personnel, domestic work and other informal jobs with poor pay structures, that may be due to the fact that they do not have the training nor the experience that can secure them with good jobs and they engage in any manner of work to earn a living. In some cases, sending remittances home is a herculean task because they hardly have any excess after expending money on bills, transportation, feeding and housing. Despite the provision of

income support and expected remittances by circular migration to most African migrants' families in the rural areas, they are still living in abject poverty (Posel, 2003).

It is, however, necessary to state here that the indigent find it difficult to engage in circular migration due to lack of required financial and social network supports (Collinson *et al*., 2006). Although many, if not all, rural dwellers desire to engage in circular migration not everyone can afford to do so. Some amount of money is needed by migrants for sustenance while still looking for a job as well as social network support to give guidance on what to do, what to avoid, how to go about getting employment and housing. All of these are a luxury that some rural dwellers cannot afford; hence, their inability to engage in circular migration.

2.8 IMPACT OF INTERNATIONAL MIGRATION ON THE SOUTH AFRICA ECONOMY

The emergence of Democracy in the early 1990s conferred a new title of the most preferred African bride upon South Africa and made it attractive to many including citizens of other Africa countries. Several people who would never dream of setting their foot on South Africa soil now perceived it as an ideal place for many reasons. Many reasons gave rise to international migration to South Africa, among which are wars and persecution, educational and career opportunities, political unrest and pressure, high rate of unemployment and poor economic conditions in their homelands. The end of the apartheid era which signified prospective migrants the opening of the country's border has provided the opportunity for prospective migrants from India, Asia, and within Africa to migrate. The paradigm of people all over the world shifted from viewing South Africa as a land of the oppressed to a beautiful land that is appealing to all.

Democracy brought about a significant change in the scope, form, and level of migration in South Africa. The South African economy occupies a central position in the region that also contributed to its attractiveness not only in the region but also in the global economy. It is also necessary to state that the high level of excellent infrastructural facilities, good roads and easy interconnectivity, great technological advancement and good trade exchange relationship projects positive signals about South Africa.

Furthermore, there are increased opportunities for skilled labour due to the economic prosperity and the introduction of the critical skills immigration programmes, that draws skilled persons into areas of critical needs like health, education, science and technology in the South African economy from all over the world. The high rate of HIV/AIDS and tuberculosis in South Africa as a nation created an additional burden on the healthcare of the country, that is difficult for only South African health professionals to handle which also impacted on the international migration of health professionals to South Africa.

Trade alliance and social networking also contributed in no small measure to international migration, like in the case of China and South Africa which saw the inflow of many China businesses into South Africa and subsequently increased Chinese presence a great deal all over South Africa. The existence of a mutual relationship and sisterhood among countries especially in the SADC region as influenced cross-border migration in this regard as well. According to the Statistics South Africa mid-year report of 2013, the influx of migrants increased the population of the country to 53 million and the rapid growth of the country was attributed to this influx. The migrants brought with them a wealth of experiences and abilities that contributed significantly to the sustainability of the economy. There was an increase in population size from 51.8 million people in 2011 to 52.9 million in 2013. About 864 000 migrants of African origin arrived in South Africa between 2001 and 2005, 974 000 arrived between 2006 and 2010. The population of migrants of Asian origin that entered South Africa was estimated to be 23 300 between 2001 and 2005, 34 700 between 2006 and 2010 while the total number of migrants in South Africa was 1 578 541 by 2016.

The 2008 xenophobic and the recent Afrophobic attacks in which a number of Black Africans lost their lives and properties may have dented the shining image of South Africa and makes it less attractive to migrants within the African territories, in particular for those that left their homeland for fear of insecurity, war and persecutions. The number of foreign nationals living in South Africa is one of the most combative post-apartheid issues facing migration studies in South Africa. Quantifying the number of foreign nationals currently residing in the country is a clause in migration studies due to the fact that not all these migrations were properly documented; therefore, there is no record of some of their presence in South Africa. For instance, there have been discrepancies in the number of Zimbabweans living in South Africa illegally (Africa Check, 2013) while their reserve bank peaked the estimate at 1.2 million.

Recent indications have shown that the estimation may be higher. A lot of backdoor movement frequently occurs from the neighboring SADC nations that are not recorded and contribute to the discrepancies. Nonetheless, there has not been a consistent research methodology to actually quantify the total number of both legal and illegal immigrants in South Africa (Reitzes, 1997).

The 2001 Census figure showed the total of foreign nationals to be 1 025 072, among which 687 678 were from SADC, 228 318 from the European Union and 41 817 from the rest of Africa (Crush & William, 2003). This figure cannot be totally relied upon due to several undocumented migrants who did not partake in the Census exercise. A total of 210 000 undocumented migrants were deported in 2005 (Department of Home Affairs, 2006) while a total of 167 000 were deported by the department of home affairs in 2004. The South African government is not relenting in its effort to rid the country of illegal migrants but the more they try, the more the illegal migrants and their agents devise other means of escaping the wrath of the law.

The majority of border crossing movements on a temporary basis are primarily for the purpose of tourism, shopping, sporting events, conferences, medical care, education or visiting relatives which are not work related (Wentzel & Tlabela, 2006). However, border crossing to South Africa in the last decade has increased tremendously from around a million in the 1990s to above 5 million in 2005 especially among SADC nations (Crush & Williams, 2003). The majority of migrants move towards the cities on arrival in South Africa. This trend is due to the diversity of culture in urban centres as against strict cultural practices in the rural areas which makes foreigners feel like an outcast while some of those that have been working here for a while move to the farms or the mines. This situation notwithstanding, some migrants to farms still move back to cities thus buttressing the fact that cross-border migrants are likely the causative factor to urban development in South Africa (Wentzel & Tlabela, 2006). Migrants are generally drawn to the urban areas for economic and survival reasons. They also feel a sense of acceptance in the city that aids their settling in faster. Migration decisions are not usually very easy to make and people do not just leave their homelands without their survival instincts on the alert, although, some tend to get carried away with the thrills of the urban centres and forget where they are coming from or the reasons for leaving. Policy reforms towards constricting standpoint particularly after 1994

brought about a drop in granting permanent residence status to people, for instance, 2 138 permits were granted in 1994 compared to the 14 499 granted in 1990 (Department of Home Affairs, 2006).

The economy of nations thrives on the development of cities. Vast economic activities brought about by the concentration of both local and multinational companies in the city centres makes the economy boom. These corporations through their various corporate social responsibility programs also foster the development of the cities. According to the State of Cities Report (South African Cities Network, 2006, p. 2-7/8), cities are seen as the backbones of the economy; it provides companies with the biggest customer bases and markets due to its large population size which brings high patronage. As the companies thrive, the economy of the nation thrives as well. Concentration of largest number of educational facilities can be found in the cities so also are employment opportunities that are one of the key reasons people prefer to migrate to the cities. Cities provide an enabling environment for all-round growth for the economy and serve as the provider of prime distribution functions in the national, regional and global economy. In economic terms, the Gauteng province had a growth rate of 3.7% per annum in comparison to the national growth rate of 2.5% over the same period (Robbins, Todes, & Velia, 2004).

2.9 CONFORMATION OF INTERNAL MIGRATION IN SOUTH AFRICA

The historical milieu of migration in South Africa is germane to lay a solid background for the study and also buttress our understanding of the migration trend. South Africa came into relevance as part of the world economy in the latter part of the 1800s. During this era most South Africans were involved in subsistence farming thereby, restricting urban settlements to the four quad cities, namely, Durban, Cape Town, East London and Port Elizabeth (Gelderblom & Kok 1994). Nevertheless, as South Africa emerged as a modern capitalist economy, growth in commercial activities attracted people to the cities. A greater number of South African males flooded the urban parts of the country for better employment offers as early as 1840. In other words, movement of South Africans to cities took the form of labour migration. Lobola payment for marriage was part of the motivating factors for young South African men to join labour migration (Turrell, 1987). The eruption of economic activity in the metropolitan hubs at Johannesburg and Kimberley started with the unearthing of the first diamonds in 1867 and the Witwatersrand gold fields in 1886 that presented better

opportunities and higher demand for labour (Burger, 2002). This opportunity drew a lot of male South Africans from the rural areas to search for employment in these places.

It is pertinent to state that past prejudices during the apartheid era, through dogmatic migration laws, cannot be easily forgotten. Even though, the past prejudice has been subdued, its impact scars and, elements are still present to date. The dawning of a profound political era that took place in the early 1990s had an enormous impact on eliminating the origin of this prejudice for most South Africans but may not automatically have enduring effects. There are some stereotypes that people have and some that they inherited which has continued to shape their reaction to things and their behavior. Even though, the apartheid era is over some South Africans still live in its shadow and feel caged to maximise their potentials. Wentzel & Tlabela (2004, p. 1) indicated that "South Africa has a sad past of racially centered government interferences in the migration and settlement patterns of its own citizens and also of those from other Southern African countries with critical effects on the welfare of most of its population". The deprived rural people, who are still mentally enslaved by the legacy of the homeland policy during the apartheid era, will probably have difficulty escaping from their situation. Some of them to date have still not mustered enough courage to leave their areas to try something new elsewhere because they feel restricted. According to Collinson *et al*. (2006), families that can afford to possess livestock assets or send a temporary migrant, are the survival of the former homeland system legacy. Such families have been able to break free from past prejudice entanglement to explore the opportunities presented by the post-apartheid era.

The economic, political and social changes of the post-apartheid era in the 1990s also gave birth to some changes in the internal migration patterns of South Africa. The restrictive structures were broken, and there was freedom of movement for citizens to live anywhere they so desire. While some scope of internal migration continued to maintain their level of importance in spite of the changes that has taken place, the same cannot be said of others who lost the relevance they used to have in the past. Fresh patterns of internal migration have also been noticed. Inquiry into historical context is of utmost importance in understanding these patterns of present and emerging internal migration.

The six urban metropolises in South Africa are Pretoria, Cape Town, Johannesburg, Durban, Port Elizabeth, and East Rand. Other three big metropolises with populations of over 250 000 are Bloemfontain, East London and Pietermaritzburg. Several writers affirm that the enticing factor for most migrants is the blend of the prospect of multiple streams of livelihood and accessibility to good infrastructure amenities in the urban areas. The kind of exposure that migrants receive in the urban areas gives them leverage above those in the rural areas. Based on the study of individual migration from 1992-1996, there has been a significant reduction in rural-urban migration, even though most urban-bound migration has usually originated from the rural areas mainly because of the existence of high-income disparity between the rural and urban areas, and also due to better employment opportunities.

Several policy makers, all over the globe, erroneously continue to oppose migration despite its noticeable benefits to both the migrant and the society as a whole. Most opposition to migration is due to the belief that migrants might overstretch the available facilities, take opportunities meant for their citizens and contravene their laws among other reasons. According to Terminski (2012), poverty reduction is likely in rural areas of societies that permit free movement within its boundaries; in other words, boundless urbanisation foster wealth distribution and also, it is essential for economic growth. This also means that attempts at limiting or controlling migration could have adverse effects on the society (Terminski, 2012). There is bantam proof that rural-urban migration has visibly reduced in the face of the poor conditions in some urban cities and constricting planning regulations.

Sequel to the abolition of the Group Areas Act and influx regulation in the late eighties and the dawn of the nineties, there was an expectation of huge migration flows to urban areas. These huge migration movements were debated to bring the settlement patterns back to status quo and eradicate the superficially created apartheid settlements (Bauder, 2006). Strategic changes in government policy will not instinctively transform into population increases even though the elimination of movement restrictions has improved mobility. Individuals might be unwilling to migrate due to reliance on multiple livelihood strategies where they are located, asset acquisition and family or spiritual commitments. It is apparent that the effect of apartheid rules and policies on settlement patterns will take a while before it is totally eliminated. This elimination task involves everyone and not only the government alone.

2.10 CURRENT TREND IN HEALTH CARE MIGRATION IN SOUTH AFRICA

There is a high level of uncertainty with regards to migration in South Africa. Facts on migrant figures into and within South Africa are poorly gathered, inadequately evaluated, and so often confusing. According to the Forced Migration Studies Programme (2010) migrations within provinces, between them and within municipalities are not consistently captured by the official data (such as the 2001 national census, and the 2007 community survey). Migration is often viewed from a negative angle and linked with problems despite its several advantages. Migration is often perceived as the consequence of economic exploitation, violence, riots, civil, social or political tensions, health issues, environmental disasters and most especially brain drain though occasionally it is also regarded as positive from a wider perception, as in the case of Bangladesh, Jamaica, Turkey, and the Philippines, where the governments directly and indirectly support immigration (De Haan, 2000).

South Africa as a whole has a dearth of over 80 000 healthcare specialists. The dearth is relatively caused by a lack of considerable growth in the number of graduates from the medical schools. On average, 1 300 doctors were produced annually by South Africa's eight medical schools between 2000 and 2008. The vast majority of these graduates will opt for the private sector or seek employment abroad leaving an insufficient number of doctors to work in the public sector (George, Atujuna, & Gow, 2013).

There are significant inequalities in the distribution of healthcare which resulted from public-private healthcare challenges. Only 7.9 million of the South Africa population is covered by medical insurance while those that rely on the public healthcare system exceeds 41 million. The per capita expenditure on healthcare in the private sector was about six times higher than the public sector in 2009; also, in 2010 healthcare expenditure was more than 53% in the private sector. This situation is very clear since a higher percentage of healthcare specialists work in the private sector in comparison with the public sector. As a matter of fact, in 2010, 47% of healthcare personnel in the private sector were employed as specialists compared with 28% in the public sector.

The management of the healthcare system is under immense pressure at virtually all levels. It is generally accepted that care stages, results and administration of the public health system are under pressure relatively because of major staff shortages, scarce skills base and a mal-

distribution of competencies between rural and urban areas. Prevalent incompetence results in services that fall short of health and patient expectations/needs, and a lack of accountability exists on a huge scale (Health and Welfare Sector Education and Training Authority, 2011).

There has been an internal movement of medical practitioners from the public to the private sector. Even though this is not a new phenomenon it is worth investigating. This movement has brought about a high degree of inequality in the distribution of medical practitioners between private and public sectors in South Africa. There is a need to know the factors driving this kind of migration and how to enhance the retention of medical practitioners in the public sector.

The migration of medical doctors in South Africa occurs in three major ways, namely, public to private sectors, rural to urban areas and migration to richer nations such as Australia, the United Kingdom, United States and Canada (Crush, 2002; Naicker, Plange-Rhule, Tutt, & Eastwood, 2009).

The Occupation Specific Dispensation (OSD) policy was executed in 2007 by the South African Department of Health in the public sector which includes job profiles, unique remuneration structures for different medical professions and centrally determined rating and opportunities for career progression (Department of Public Services and Administration, 2007). The Privileges for various medical professions include pension fund, increased basic salary, 13th cheque, scarce skills allowance and rural allowance as the case may demand (Department of Public Services and Administration, 2007). The OSD implementation in 2008/2009 brought about a significant increase in the remuneration packages across the board which was based on years of experience and qualifications (Mahlathi, 2009). Given the information above regarding the OSD policy, how effective has this been in retaining medical doctors in the public sector? This is one of the mysteries that this study seeks to unravel.

The significance of the economic factor on migration cannot be overemphasized. Numerous studies have lent some strength to its impact in swaying the migration decision from one healthcare sector to the other and some asserted that it is the most important factor that determines migration in the health sector. This study is skeptical about this since there are many factors equally as important as the economic factor, and it intends to establish all these

significant factors. George, Gow, and Bachoo (2013) assert that health workers' decisions are influenced by the stress level in the public sector, age factors and working conditions. They also affirmed that public health workers are more prone to migration due to pull and push factors. The push factors includes poor working condition, excessive work burden, poor infrastructural facilities, lack of supervision and management support among others, while the pull factors are conducive working condition, better salary structure, opportunities for professional development among others (Department of Health, 2006). One of the needs that the OSD policy was created to serve is to reduce the disparities in remuneration structure and foster retention of health workers in the public sector but have these needs been met?

The National Health Act (2003) had the aim to provide reasonable healthcare facilities in South Africa through a national health scheme involving both the public and the private sectors. South Africa has a comparatively ample supply of health personnel, with over four doctors, nurses, and midwives per 1 000 people, according to the World Health Organization's (WHO) *Global Atlas*. The definition by the Joint Learning Initiative in 2006 also affirms that South African supply of healthcare personnel is higher than the critical benchmark of 2.5% per 1000 people. Nevertheless, South Africa's internal distribution of health personnel is vastly inequitable. This occurrence threateningly tasks the capability of the South African health system to effectively handle its public health issues, such as HIV and TB epidemics among others.

Since 1990, there has been a significant paradigm shift in the preferences of the medical scheme population from the utilisation of public hospitals to private hospitals. This phenomenon has resulted in the considerable growth experienced by the private hospitals with the total number of beds in the private hospitals snowballing by 32% since 1998.

The dearth of proficient healthcare personnel remains a key issue in the health sector. This is a challenge that arises from both external migration and internal migration of healthcare personnel within South Africa. Both internal and external migration in South Africa has led to a 'brain drain' of competent workers from deprived rural areas and some urban areas. Public healthcare sector suffers from major staffing shortages. Staffing shortages are mainly influenced by higher demand for healthcare services, retention issues and the migration of health personnel. There were roughly 281 000 employees in the public healthcare sector in

2010 as against the 2008 projected need for 315 087 healthcare personnel to cater for the needs that come with population growth and the growing problems of diseases. The employment of healthcare personnel in the public sector keeps on falling short of the World Health Organisation minimum requirement to attain the Millennium Development Goals (MDGs). With just 209 doctors per 100 000 population, South Africa falls below the WHO standard of 230 doctors needed to meet the millennium development goals.

According to the Development Bank of Southern Africa (2008) and Department of Health (2011a), South Africa lacks an effective human resources policy that will guarantee adequate resourcing of the public sector in order to provide an ample supply of healthcare experts. The government, leading bodies in South Africa and the trade unions, have emphasised inefficiencies in the healthcare system, lack of accountability, inadequate skills training, and organisational development as critical human resource issues in South Africa (Development Bank of Southern Africa, 2008; Health and Welfare Sector Education and Training Authority, 2011).

Given the 2011 release of the Health Department's Human Resources for Health (HRH) Strategy, the migration from the public sector to the private sector in South Africa is affected by the following factors:

- Workload in the public sector
- Working conditions
- HIV/Aids
- Morale in the workplace
- Relationship with management in the public sector

The new policy guidelines that were announced in May 2011 by the Minster of Health include an overhaul of the healthcare scheme, new human resources for health (HRH) priorities and new management structures. This new policy has major resource, staffing and training consequences, which will be tough to achieve given the pervasive shortages of healthcare personnel in the public sector and the weighty problem of disease.

2.11 PERSPECTIVES ON CAUSES OF MIGRATION

The nineteenth-century geographer Ravenstein (1885, 1889) contributed the first academic review on migration in two articles, whereby his 'laws of migration' were formulated. Ravenstein (1885) avowed that the economic factor has a major influence on migration and that migration and developments are intertwined. Other researchers like Skeldon (1997) presumed that distance and population density impact on migration patterns. The dominant viewpoint on migration tends towards a definite expanse of economic symmetry that has endured actively in the work of several economists, demographers, geographers and sociologists to date (Castles & Miller, 2003) and is the fundamental postulation upon which push-pull theories are built.

Economic justifications have ruled prevalent and intellectual philosophy on migration despite the fact that migration as a subject has not received significant attention in conventional economic theory (Bauer & Zimmermann, 1998; Passaris, 1989). Migration was explained through the topographical variances in the demand and supply for labour by the neo-classical theory, at the macro level, and it is asserted that internal migration occurs due to this variance. Also on the macro level, wage differentials influence workers' decisions to move to high-income regions where their expertise will be more rewarded thereby causing labour shortage at the origin and labour surplus at the destination. On the other hand, neo-classical theory on migration at the micro level uses the human capital approach (Sjaastad, 1962). It sees migrants as an individual, rational player whose migration decision is contingent on cost-profit estimation and whose decision to migrate is only taken when the expected return is positive based on their calculations (De Haas, 2010). Armed with unlimited access to information and unrestricted choice, migrants are likely to proceed to the areas where they are most productive and can possibly turn the productivity into maximum wages. Nevertheless, the structure of the labour market and the specific skills possessed by the migrants will go a long way in determining if the capability can in reality produce the desired maximum wage. The human capital approach offers a suitable explanation for migrants' selectivity but is difficult to test empirically.

2.12 IMPACT OF MIGRATION ON HEALTH CARE SECTOR

The effect of migration on the healthcare sector is enormous. The main costs of medical practitioners' migration are borne by the public health sector that lose substantial numbers of

them and any additional loss to the private sector will render the embattled public sector unfit to meet their responsibilities.

The loss of human capital in the sector has dire consequences on the South African healthcare system. The drop or reduction in the capacity of public healthcare human resources can only spell doom for the nation at large. Medicine as a profession requires doctors who are ready to serve in the rural part of the public sector as well as possess skills (such as proactive skills, communication and problem-solving) that will equip them to survive the severities of rural practice (Erasmus, 2006). Several studies have attempted to look into why health workers in the public sector migrate internally within South Africa. Some factors were discovered to be responsible for this migration. George *et al*. (2013) asserts that job satisfaction, stress level and age are the issues influencing health workers in migration decisions.

Whether we want to admit it or not the migration of employees in the public health sector is a major issue that cannot be trivialised. The present strain on the public sector is unimaginable; the public are complaining of service delivery issues in which the healthcare sector is one of the topmost areas being complained about. It has created a ripple effect in which the migration decisions are causing skill shortages, while the skill shortages are increasing the workload, and the heavy workload is impacting on the quality of service being offered to the populace. Very few people thrive under immense pressure; the majority will break down. Getting the best out of medical practitioners that are overburdened is a colossal task. There have been cases of doctors giving a wrong prescription and making life-threatening mistakes under pressure; they are also human, and there is a limit to how much they can take.

The case of the South African healthcare sector is not a peculiar one; as a matter of fact, most nations in sub-Sahara Africa are faced with the same issue basically because of better resources elsewhere (Dovlo, 2007). As Nigeria and Congo are losing their trained medical practitioners to South Africa so is South Africa also losing theirs to Australia and Canada. Previous studies on healthcare migration only focused on its impact in the developing countries (Brush, Sochalski, & Berger, 2004; McCoy, Bennett, Pond, Gow, Chand, Ensor, & McPake, 2008), whereas 25% of the global disease burden is borne by sub-Sahara Africa with only 1.3% trained healthcare human resources (Dovlo, 2007). According to the Econex Report in 2010, the migration of medical doctors has reduced the ratio to 55 physicians per

100 000 patients in South Africa. The percentage of those found in the private sector is higher than the public sector out of the 55 doctors, which uncovers the mounting inequality that gave rise to this study. It is disheartening to note that, the majority of the challenges being faced by the public health sector stemmed out of the shortage of experienced medical practitioners. Without a drastic measure being taken, the migration will continue to increase and might collapse the public healthcare sector.

Another noteworthy impact of the public to the private sector migration of medical practitioners is the inability of the public sector to quickly find a replacement for the exiting ones, which then puts greater burdens on the remaining doctors. This added burden has the potential of influencing migration decisions and pushing more doctors out of the public sector. The number of medical doctors being produced is not at par with the population increase which also questions the ability of the public health sector in mitigating against this skills shortage caused by migration (George, Quinlan, & Reardon, 2009).

There is an undeniable global shortage in the healthcare sector especially for healthcare experts which makes it difficult to meet the health requirements of its citizens. More and more societal and demographic issues are creating longstanding skills shortages in healthcare sectors of developing and developed nations. The periodic shortages of healthcare workers experienced in the developed nations due to demand exceeding supply are taken care of through the introduction of bigger incentives into the employment market to lure healthcare workers. These incentives have assisted developed countries a great deal but have had adverse effects on developing countries that are continuously losing their trained and capable healthcare workers. This continuous brain drain of developing countries is making it increasingly challenging to cater for the health needs of its citizens (Buchan & Dovlo, 2004).

2.13 CONCLUSION

The retention of medical doctors in the appropriate areas of need within South Africa is an important matter, given the government's renewed pledge to deliver HIV treatment to the populace after a period of denial (Nattrass, 2007). The success of the proposed National Health reiterated that employee retention is as vital as customers' retention as customer loyalty is contingent upon employee loyalty. The public healthcare sector was not established just for income generation, even though the government gets some returns from the services

rendered to the public. The objective of the government is to provide affordable, accessible and excellent healthcare services to the people; therefore, the retention issue is essential to achieving their targets.

Several factors have been identified by scholars as influencing the internal migration of doctors. Ashmore (2013), in his study identified job satisfaction as the main determinant of retention. The study presumed that job satisfaction is a result of the satisfaction of individuals' needs, as well as their values and prospects. The goal theory of Locke also refers to job satisfaction as a positive emotional state resulting from job appraisals or experiences. There is no denying the fact that job satisfaction is crucial to retention since it can influence the decision to either leave or stay in an organisation. However, to lay the burden of migration on job satisfaction might not be entirely true.

The previous study conducted by Ashmore (2013) on the inequality in the distribution on medical practitioners in both the public and private sectors focused basically on specialists and came to the conclusion that job satisfaction determines their migration. This phenomenon might be true for specialists but might not be applicable for general practitioners. This has provided the foundation for future research, to further investigate why the burden of specialist migration was placed on job satisfaction and identify the driving force behind the migration of general practitioners.

Although the concept of job satisfaction may seem realistic and an established way to understand retention behavior or turnover, it is not the only key factor that determines migration. According to Morrel and Arnold (2007), two schools of thought dominate the study and practice of turnover. One school of thought focuses on external factors like wage differentials and the availability of alternative jobs locally, nationally or globally, while the other school of thought focuses on job satisfaction and commitment (Taplin, Winterton & Winterton, 2003). Most of the researchers agree that no school of thought is capable on its own to provide a logical explanation for the reason people leave a particular job or predict future turnover.

The Chartered Institute of Personnel and Development (CIPD) survey of 2007 concluded that unless an organisation could find a way to incorporate workers into routines and remunerate

them appropriately they will continue to have retention issues. Is this applicable to medical practitioners too? Do healthcare organisations conduct exit interviews for those leaving? If yes, how effective has this been in reducing migration to the private sector? All these are part of the issues that this study seeks to address.

From the 1990 and 1998 study carried out by Sibbald, Enzer, Cooper, Rout, & Sutherland (2000) doctors have been found to be empirically disappointed, to a large extent, by non-financial factors such as the state of the hospital and demanding patients. In South Africa, much has been said of the deplorable state of public healthcare facilities in the media; nonetheless, no comprehensive research has been undertaken to determine the reason for this internal migration especially for general practitioners. Although there are few case studies on specialist migration to the private sector, it is not exhaustive; hence, this study aims at addressing these gaps.

The need for more research on internal health care migration cannot be over emphasised. There is the need to investigate and understand the degree at which medical practitioners migrate from the public sector and handle the challenges accordingly to forestall an adverse impact on service delivery.

CHAPTER 3

METHODOLOGIES AND PERCEPTIONS TO THEORISING MIGRATION

3.1 INTRODUCTION

It has been widely circulated that migration received minimal exposure from researchers before the 20th century, but a great deal of attention was given to migration thereafter which shed light on several frameworks that exist under it. The end of the 20th century witnessed a shift from the state-centered framework to highlighting the diversity existing in categories under migration, such as race, eras, age-grade, and gender, among others. Fresh models have emerged in migration since the 1990s confronting popular fallacies that have dominated migration studies. It is noteworthy to state that migration has progressively evolved into an interdisciplinary subject; it has attracted contribution from researchers in various fields and is still attracting many (Brettell & Hollifield, 2000).

This varied contribution provides interesting perspectives to migration studies and a clearer understanding of the phenomenon whilst tackling misconceptions and stereotypes. Fresh facts are emerging using previous studies on migration as a foundation for stronger research works. Widespread notions on migration have experienced a paradigm shift due to new and ongoing studies on migration. Migration norms and models of internal and international migration have also been challenged based on evolving facts. The exclusive emphasis on 'the west' or European migration as a model for international migration has shifted to multifaceted global migration patterns and flows.

The significance of the theoretical framework of the study cannot be over-emphasised. It enables the reality about a phenomenon under study to be established while exposing the misconceptions around it. Model building provides the opportunity to make new discoveries, generalise the result of the study to other situations as well as form the basis for future exploration. Adequate understanding of the subject can be gained by examining the cause and effect highlighted in previous models. Model building can also support the researcher in predicting future occurrence with regards to the phenomenon and achieve the purpose of science which is to cultivate descriptive theories. Models and theories depend on the use of research questions and hypotheses which are approached through logical analysis to examine

the connections between different variables. The result of the logical analysis can be used to negate, support or reform the original theories and models.

3.2 NEO-CLASSICAL THEORY

The neo-classical theory on migration views rural-urban migration as an integral element of the entire development process, in which the urban industrialised economy is supplied with excess labour from the rural sector (Lewis, 1954) while the urban economy reciprocates by supplying the rural area with economic boom through the gains from the employments. The theory of neo-classical migration is steadfastly engrained in developmentalism, transformation or modernisation philosophy centered on favorable views inferring development to be a common direct method involving consecutive phases (Rostow, 1960). The rudimentary two-sector model of rural-to-urban migration of labour was popularised by Harris and Todaro (1970).

Incidentally, this great 'Harris-Todaro' model lingered to become the foundation of the neo-classical migration concept to date. The new model was established basically to proffer an explanation for the ostensibly conflicting phenomenon of steady migration from the rural areas to the urban cities in developing nations regardless of a growing redundancy in the metropolises. The emergence of this model was due to the displeasure with nebulous justifications for the migrants' attraction to the city such as the sparkling lights of the city (Harris & Todaro, 1970). Harris and Todaro (1970) reasoned that, understanding this phenomenon of persisting migration requires transformation from merely looking at prevailing income variances to also focusing on the anticipated rural-urban income differential that hinges on the probability of getting a job opportunity in the urban area.

The anticipated earnings in the destination area are also dependent on the prospect of employment and not only on the average remunerations at the destination point. Even though migrants usually leave the departure point with a high expectation of securing a job, this might take a while or might not materialise. The perception of the model is that, as long as there is a high disparity in wages between the rural and urban areas which supersede the fear of temporary or permanent unemployment in the urban areas, a steady flow of rural migrants will exist (Todaro, 1969). The attraction of higher wages is often too strong to be ignored by migrants. The Harris-Todaro model was later polished to give it a more realistic outlook

(Bauer & Zimmermann, 1998). The realistic approach created an avenue for other factors to be considered as having significant influence on the anticipated income gains other than unemployment. For many years, unemployment enjoyed the monopoly of being the key cause that sways migration decision due to projected income gains by migrants but the reform shifted the fixed gaze on unemployment and broadened the scope of migration studies.

The Harris-Todaro model was originally propounded for internal migration but can be applied to global migration if modified. The model can be interpreted within the context of human capital if further expansion occurs. Human capital was and is being progressively recognised as being pivotal to economic growth in the modern world. The human capital concept embraces the fact that physical abilities, skills and qualification/education of an individual enhance economic production. The human capital perception created an opening to view and hypothetically explain migration choices beyond costs. It is important to state that, due to these differences in our skill level, age, education, gender, physical abilities, ambition and preferences, there will also be differences in the anticipated gain per migrants. These differences also impact tremendously on migration decisions. The younger generation might have higher tendencies to migrate while older people might not see the need for it; this creates a theoretical prospect of explaining why the tendency to migrate reduces with age. Also, some certain skills are in higher demands in some destination points than others which can influence migrants in possession of such skills to migrate; this also explains why highly skilled people, especially in the developing countries display a higher inclination towards migration (Forcier, Simoens, & Giuffrida, 2004).

The selectivity of migration was noted in the several later improvements of the neo-classical migration theory. This selectivity is affected by the labour market segmentation and specific structures that impact on migration policies and employment opportunities. Even though wage differential is crucial to the migration decision, the importance of the costs and risks associated with migration cannot be undermined. Logically, it is pertinent to state that migration research with the focus solely on occupation and wage differential cannot do justice to the study. Other variables like the importance of individual socio-economic features, internal structures and labour market segmentation should also be considered (Bauer & Zimmermann, 1998). The integration of all these factors other than wage differentials may broaden our understanding of the compound nature of the perfect migration system.

3.3 PUSH OR PULL THEORY

Neither the historical-structural theory nor the neo-classical theory of migration succeeded in explaining the rationale behind the decision to migrate in a region while others are indifferent (Massey, Arango, Hugo, Kouaouci, Pellegrino, & Taylor, 1993; Reniers, 1999). Ravenstein's 19th century laws on migration were reviewed by Lee (1966) and a new systematic framework was proposed for migration. Lee (1966) asserts that migration decisions are based on the following reasons: issues related to the area of origin, issues related to the area of destination, personal concerns and supposed prevailing problems (for instance distance, physical barriers, immigration laws, and so on). According to Lee (1966), migration is selective with regards to the features of individual migrants since people react differently to positive and negative issues at origins and destinations and handle prevailing problems differently (Reniers, 1999). Hence, migrants can hardly be regarded as representing the area where they originated from. Lee's assertion collaborates with the neo-classical belvedere that clarifies migration selectivity based on personal differences in human capital talents. The push-pull model is essentially similar to neo-classical models.

Even though the term 'Push-Pull' was not ostensibly formulated by Lee, his complete outline is generally called that (Passaris, 1989). The push-pull model has become the central model in understanding migration decisions. While the push factors are those uncomplimentary element that motivates people to migrate from their area of origin, the pull are the attraction inherent in the areas of destination. It is widely proposed that achieving a holistic assessment of labour migration is only possible through the model due to its obvious good capability to incorporate other general perceptions (Bauer & Zimmermann, 1998; Schoorl, 1998).

The model is famous and still gaining more admiration in migration literature; hardly can there be any study on migration without the mention of the push-pull model. The model has brought about the popular supposition that migration decisions can be swayed by economic, environmental and demographic factors which have been supported by several researchers who have applied it.

The push-pull theory of migration involves several elements. However, the push factor has been widely reported to play a far greater role in doctors' decisions to migrate than pull factors. Push factors are those reasons that make you want to leave a place while the pull is

those factors that attract you to a certain location. Some of the push factors that cause doctors to want to go away include displeasure with working conditions and remuneration packages, exposure to HIV/AIDS and other diseases, high rate of violence and crime, political instability, lack of prospects, natural disasters, lack of religious tolerance, terrorism, poor housing, discrimination and war amongst others. The pull factors include better remuneration packages, support from family and friends, better standard of living, religious tolerance and safety.

The main elements of this theory are the economic, social and political factors. The economic factor assumes that issues like working conditions, remuneration packages, shelter, food and standard of living contribute significantly to either pulling or pushing medical doctors away from either the public or the private sector. The economic factor is widely believed to control the migration decision. It is a stereotype held by several people for many decades which has resulted in some attributing the entire burden of the migration decision on the economic factor. Without mincing words, economic factors are very powerful and might wield more influence than other factors in the migration decision. It is one of the factors that motivates people to invest more in themselves and want to achieve as much as possible to guarantee some level of stability; therefore, most people will be ready to cross boundaries, break barriers and climb the highest mountains to ensure that their economic needs are met. The quest to achieve professionalism or career achievements can be directly linked to the desire for a better standard of living and being able to access the necessities like food and shelter. The human need for food and shelter is genetically programmed which clearly shows that we have little or no control over it.

The drive-reduction model by Clark Hull (1943) also supported the assertion that the biological need, such as thirst or hunger is capable of creating an undesirable condition in the body of anyone, and until this requirement is met, an individual will be in a state of tension and will be driven to ease the tension by satisfying the need. This evidently shows that the human being will ensure that there is a continuous supply of food. To ensure this continuous supply, there have to be adequate means of getting the supply in the form of remuneration or wages. The hierarchy of needs by Abraham Maslow (1943) also emphasised the importance of biological needs in achieving self-actualisation. This study will examine the extent to which economic factors influence doctors' decision to migrate. It is also vital to establish if

indeed the push-pull model together with the other supporting models like drive reduction model and hierarchy of need lend credibility to the significance of the economic factors in the migration decision.

The social factor is the second prominent factor under the push-pull model that is widely believed to influence migration. The social factor assumes that family structures and supports, religious tolerance, better healthcare facilities, educational or career prospect can either attract or push a doctor away. An in-depth look at family structure and support shows that there is a link between everyone and the family where they originate from although the link is stronger in some than others. Nonetheless, human desire for affection, love and sense of belonging is capable of exacting some influence on migration but the extent of the influence needs to be established.

People are becoming more aware of how much influence they have in determining their life expectancy. Good and reliable healthcare facilities are issues people are no longer toying with; there is the desire to be in an environment where proper healthcare facilities are easily accessible and curb illnesses before they escalate. Another important factor is career and educational prospect, especially if the migrant resides in an area where there is little or no career and educational prospect. Some academic disciplines are not appreciated or well remunerated in some areas which could trigger migration. The impact of religious stability cannot be undermined; it usually comes with the safety of lives and property. While on the other hand, religious instability or intolerance erodes peace of mind, creates fear and uncertainty thereby influencing some people to migrate to safety. It is therefore, crucial to investigate the significance of the social factor on migration.

The political factors hold that issues like political instability, terrorism, the right to vote and freedom of expression can motivate migration. Freedom of expression and right to vote is critical to civilisation and it is being advocated by various organisations around the globe including human rights organisations. Situations that tamper with the right to vote and freedom of expression are not usually treated mildly all over the world. The political instability that has characterised many developing countries of the world is being cited by many to influence migration. Smooth transition to power is becoming difficult for many nations, resulting in war, bloodshed and mutiny. Some people without the intention to

migrate found themselves fleeing from the aftermath of political instability. Terrorism is a plague that has plunged the world into great disasters; thousands of lives are being lost to terrorism yearly. Terrorism has created an endless battle all over the globe that world powers have been preoccupied with. There is the issue of ISIS militant claiming responsibility for plane hijacks, bombings and killings in different parts of the world; there is Boko Haram in Nigeria that has killed thousands of people and threatening the stability of the country. This study intends to ascertain the influence of political issues on the decisions to migrate.

According to the study carried out by Stewart, Clark and Clark (2007), the dissatisfaction of healthcare workers with their careers and work in the country of origin stemmed from factors, such as career prospect, poor remuneration/compensation, standards of working and living conditions. These factors were referred to as supply-push factors. It is imperative to state that these factors are not peculiar to healthcare workers in the developing nations alone even though the percentage might be higher. These factors have been found to also influence migration from one developed nation to another, which shows that human beings can be influenced by the same conditions irrespective of their origin, race or location.

Some of the push-pull factors revealed through the migration studies conducted on healthcare workers by Eastwood, Conroy, Naicker, West, Tutt, and Plange-Rhule (2005) and Naicker *et al*. (2009) are training unavailability for advanced level health workers, absence of career prospects and established posts, absence of a secure workplace, dismal provision of service entitlements and high crime rate. However, the impact of the disparity in the expected remuneration between the place of origin and destination is being conjectured as crucial to the migration decision (Naicker *et al*., 2009).

The factors raised above is in agreement with the positing of Abraham Maslow and Herzberg that understanding labour migration should be done within the complex processes that outlines aspects that affect each employee such as job satisfaction (Herzberg, 1968). One of such processes identified was the impact of the work environment on achieving workers' contentment while also motivating them satisfactorily. It is unfortunate to note that the healthcare system in developing countries is struggling with numerous difficulties such as poor infrastructural facilities that makes the work environment unsatisfactory, stressful and in most cases unsafe. The inability of the public health sector to meet the demand of the large

percentage of the population that depend on it for quality healthcare delivery is also a common feature of the developing economy and one of the major reasons for this study. Management issues and lack of adequate training opportunities cannot be exempted from the features. All these features can serve as demotivating factors among the health workers and eventually push or pull them away from the place of origin.

However, there are fundamental flaws of the push-pull model. In reality, the model has the tendency of creating an infinite reservoir of migration determinants. The model also has the tendency of ignoring the internal stratification of various cultures; common background factors consistently referred to as either push or pull factors may probably influence people differently, stimulating some to stay while inspiring others to leave. The scientific usefulness of the push-pull model has not been proven. Its limited analytical use can also be seen in its inability to position migration as a vital fragment of wider revolution processes instead of concentrating on external causes of migration.

The push-pull model is relatively descriptive in nature that allows for various factors influencing migration decisions to be itemised in a relatively subjective manner. Another key challenge with the push-pull model is its tendency to muddle various scales of analysis without allowing the allocation of relative weights to the diverse factors inducing migration decisions. The model also disallows experimental tests on the significance and role of factors that have been incorporated or omitted. Another vital flaw is the fact that push and pull factors are usually reflected in each other. The appeal of high-income pull towards big cities is usually directly or indirectly made in connection with low wage push from the place of origin. Establishing the dominance of the push or pull factors becomes open to biased judgement depending on the researcher. Push-pull models find it difficult to clarify return migration and the concurrent incidence of migration from and to the same region. The model is also guilty of not considering the effects of migration and its influence on the central frameworks at the origin as well as the destination (De Haas, 2007).

Zachariah, Mathew and Rajan (2001) and Schwartz and Notini (1994) proposed other factors such as environmental deprivation, demographic pressure or population gravity as being responsible for migration in addition to wage differentials. The limitation of the push-pull model was also revealed in the population gravity factor. People naturally get attracted to

crowded metropolitan cities since these places provide better prospects regarding business, education, medical facilities, employment, recreational amenities and safety. Population gravity attracts people and discourages them from migrating to areas of low population density instead of the notion that it motivates them to migrate. This reveals that population gravity is relative and cannot sufficiently on its own provide a concise explanation for the migration decision (Farrag, 1997). According to Coleman (1999), population growth which is usually proposed as a reason for migration pressure is just an element of a multifaceted chain of processes and is only applicable if the ceteris paribus trick is involved.

Another weakness of the model is to single out environmental factors in collaboration with population gravity as the reasons for migration. While there is no denying the importance of environmental factors, they ought to be seen in alliance with other factors such as economic, political, cultural and social factors that ultimately regulate the living standards. Furthermore, justifications aiming at natural resources have continued to depict subtly the place of origin as a self-sustaining and closed region. However, in reality the closed region picture is far from the truth considering the increasingly globalised world that we live in (Bebbington, 1999).

Finally, the push-pull model in similarity with the neo-classical ideology is also guilty of idealistically portraying migration as a cost-benefit intention of an individual without courtesy being given to major restrictions that indicate the inequality that exist in accessing available resources. It is germane to state that personal aspirations, mission and vision significantly influence the tendency to migrate which is a crucial factor often disregarded by the push-pull model and its contemporaries such as the neoclassical and the structuralist model (Petersen, 1958). There is usually the generalisation of needs and factors influencing migration as being persistent. Individual goals and visions in life are not the same based on the diversity and complexity of human nature; as the world is changing so is the individual's aspirations.

3.4 SYSTEMS AND NETWORKS

The International Organization for Migration that economic factors motivate migration of labour specifically for better standards of living is valid to a large extent but cannot wholly carry the migration burden (Jennissen, 2007). The role of factors such as social networks,

culture, institutions, systems, history and geographical proximity is very vital in establishing a new pattern in migration studies. The pioneer migrants typically set the pace for consequent migrants and the migration pattern. Information from the forerunners usually enlightens the people at the place of origin; all the unforeseen circumstances and unplanned decisions may be communicated which can impact on their decision whether or not to migrate. This assistance commonly obtained through information could make settling down easier for new migrants especially regarding accommodation and employment. Lee (1966) also claimed that successive migration is enabled by the information flow from the destination to the place of origin.

Much of the early theorisation on migrants and migration originating particularly from the international economics literature presented migration as a decision made by individuals to seek a better employment opportunity elsewhere typically in urban areas (Fields, 1975; Harris & Todaro, 1970). The components of this assumption have been challenged by proponents of the systems and networks approach.

The migration system theory was propounded by Mabogunje, a geographer in 1970 and it was well defined as a set of places connected by movements and counter movements of people, information, goods and services, with the tendency of enabling further interchange between those places, as well as fostering migration. Mabogunje (1970) laid emphasis on the significance of feedback modus operandi in communicating the treatment received at the destination and progress made back to the place of origin as well as its resultant effect on the migration system. He also stressed the importance of information in determining the migration decision; while practical information may increase structured migration from a particular place of origin to a designated place of destination, negative information may deter the migration flow.

Portes and Böröcz (1987) and Kritz, Lim and Zlotnik (1992) have extended Mabogunje's study to international migration even though it originally concentrated on rural-urban migration within the African region. According to Stark (1991), there is more to migration than individualistic optimising behavior. Stark's submission on the migration decision is compatible with the systems approach that is generally regarded as a prolific and broad framework for migration studies, due to its multiple systematic focus on process structure and

linkage. The attraction of a system approach is that it enables the perception of migration to move beyond a rectilinear, push-pull movement to an emphasis on migration as multi-causal and inter-reliant, with the impact of a change in a section of the system being linked to the rest of the system (Faist, 1997). Vertovec (1999) affirms that migration systems connect individuals, families, and societies over space that is currently referred to as international communities. He also avows the feedback mechanism of international migration systems that link the passage of individuals between certain areas, towns or countries to the affiliated movements of information, goods, remittances and concepts (Gurak & Caces, 1992).

There is a close connection between migration system theory and network theory. The migration systems and network models center on the dynamics that generate, modify and preserve migration. The network theory essentially assumed that the economic, social, institutional and cultural conditions get modified by migration at the place of origin as well as the destination point. The network theory mostly laid emphasis on the importance of personal relationships between migrants and non-migrants, and how this social capital enables, maintains and alters migration mechanisms. The migration systems model goes deeper to accentuate the impact of migration in the reformation of the whole societal framework of the actual system in which migration occurs, both at the origin and destination points. The migration system model seems primarily appropriate for expounding a theoretical context that positions migration in an extensive development standpoint due to its two-way link of dynamic interaction and reciprocity between development and migration. The migration systems model is essentially different and contradictory to the neo-classical, structural and the push-pull approaches that focused on the flawed inactive concept that migration and development are not complements but rather are alternatives.

According to Joaquín Arango (2004), networks rank among essential clarifying factors for migration. Recent studies depict network migration terminology to be a replacement for a process once defined as chain migration. The relational, social and personal networks constitute the core level between macro and micro designs of migration, helping one to move beyond the remote method of push-pull theories of migration and to connect personal and socio-structural reasons for migrating (Faist, 1997; Goss & Lindquist, 1995). Migration networks add three vital perceptions into postulating the migration process: firstly, understanding the dynamics of different types of migration; secondly, forecasting future

migration; and thirdly, resolving an important hypothetical division between the primary causes of migration and its continuation (Fussell, 2012).

The key elements in migration systems and networks model are structure, linkage, process and future projection. The structure element assumes that the kind of structure in a particular society or organisation can also impact on migration. Once the migration system has been established, it has the inclination of operating rather independently of border controls and government regulations or policies. Its establishment tends to assume a general structure that is embedded in the geographical factor. Lee (1966) reinforces the fact that the flow of migration and the counter-flows of information, goods, ideas and remittances have the tendency to be geologically structured. Factors such as wage, unemployment and other differentials cannot naturally describe this clustered structure of migration flow.

There is the tendency for some particular ethnic groups or regions to be interested in migrating to specific locations nationally or internationally. It is an undefined structure; even though people are not mandated nor forced, there is usually a heavy migration flow of those ethnic groups to some specific locations. For instance in Nigeria, the dominant region that usually migrates to the United Kingdom is the western region or the Yoruba tribe while there are more people from the Eastern part of Nigeria in South Africa. There are no regulations or rules that govern this kind of movement, but there is an existing structure even though undefined that shapes the migration flow. This undefined structure can be directly linked to network connections. According to Massey (1989), migration becomes self-preserving once the figure of the network links stretches to an alarming level due to the social structures it generates to maintain the process (Appleyard, 1992) that explains why there is migration flow from certain places of origin to certain destination points.

The enabling role of network links makes migration infamously challenging to control for most government agencies. It is important to state that network links as a form of social capital is critical in influencing the migration decision in addition to human capital and material resources. Massey, Arango, Hugo, Kouaouci, Pellegrino and Taylor (1993) put forward this claim to also buttress the impact of network links as an avenue for people to have access to international employment due to its role as a form of social asset or capital.

The Linkage factor affirms that effect of change in the system will have a ripple effect on the other aspects; in other words, there is interconnectivity between every part of the system. This interconnectivity shows that the causes of migration must be examined together with the consequences for better understanding. There is a continuous link between the place of origin and destination that alters the initial situations and perceptions on both of them. Migration not only alters the economy through remittances (Van Dalen, Groenewold, & Fokkema, 2005) but concurrently reforms the socio-cultural development, education, politics and other aspects of the community which can probably trigger migration flow or sway consequent migration patterns. The effect of migration flows to and from the origin and destination points while carrying its implications along. The difference between internal and international migration is concealed in the inclination of both the national and international networks to be strictly intertwined (Fawcett, 1989). Accurate knowledge of interconnectivity and the feedback processes between migration and development demands the review of the whole migrant communities, which is inclusive of non-migrants, actual local contexts and multinational spaces where they are situated.

Process element assumes that if the existing process is dissatisfying, it can motivate migration. There is the tendency for the people from the sending areas to become dissatisfied with the existing process based on the flow of information from the pioneer migrants who might open their eyes to the processes and opportunities elsewhere. The flow of information, identities, ideas and behaviours are very significant not only in possibly stimulating family creation, migrant free enterprise and political integration but also in influencing the views and ambitions of people. The flow can impact on the consequent migration pattern especially when it reflects satisfying and rewarding processes outside of the place of origin. Most of the time people find themselves discontented with the processes around them that limit their potentials and do not provide enough opportunities to showcase their human capital; the flow of information and ideas provides some respite to maximise their potential. The importance of social remittances was also emphasised by Levitt (1998) which she construes as a local-level, migration-motivated type of cultural distribution. The inflow of remittances from abroad to immigrant families can aid migration flow by fostering intra-community inequity and the emotional state of deprivation among non-migrants. Massey (1990) asserts that modifications in economic and social structures are encouraged by migration that propels subsequent migration.

The future projection element holds that due to the ability of networks in producing migrants, future prediction with regards to the migration flow can be made with adequate provision for migrants. The establishment of migrant communities or concentration of migrants at a definite destination point will probably intensify migration flow to that definite place (Appleyard, 1992) which provides a platform for future projections to be made. Accessibility of new migrants to information and support from relatives and friends can either make it easy or difficult to get accommodation, employment and documentation for residence permit among other things that can also have a chain reaction on future projections positively or negatively. In a situation whereby accessibility to vital information and support is easy, it will increase migration flow to that particular place and vice versa. Migration systems and network connections go a long way in determining subsequent migration flow from a particular sending area to a particular receiving area.

According to Massey *et al*. (1993), networks can be referred to as sets of social ties that link migrants, non-migrants and former migrants at the sending and receiving areas through friendship, clan membership, shared common origin and kinship ties. The interactive ties foster a sense of belonging and togetherness among migrants and explain the disposition of migrants towards remittances to their places of origin which are a deviation from some models such as neo-classical (Taylor, 1999). These ties mostly do not wane no matter how long the migrant stayed or gets integrated at the destination points; the ties are often preserved and passed from one generation to another. The depth of integration at the destination points does not in any way reduce the inclination to send remittances to the places of origin. The understanding of the shared impact of migration on the whole development process made the inclusion of non-migrants possible in the migration effect study as migration affects not only migrants but also the places of origin.

The popularity of the migration network study has skyrocketed in the past two decades, which might have increased the inclination to consent to the perceptions of network theories. Nonetheless, the model is not without flaws. According to Massey, Arango, Hugo, Kouaouci, Pellegrino and Taylor (1998), the globular logic of these models gave the impression that migration is perpetual which gave the impression that migration system and networks cannot crumble. The migration of labour has the tendency of decreasing or ending in the long run once the major reasons for migration wane. The network model shares a flaw

with the push-pull model, that is, the inclination to prove the dominant enabling role of migrant networks empirically without stipulating their relative weight with other enabling and restricting aspects influencing migration.

Most case studies used under network studies have the tendency of sampling network variables which makes them hypothetically partial towards the situations where the networks perform their attributed migration enabling or restrictive roles. These roles are usually given more elaboration that makes their findings subjective. It is important to state that network variables are not entirely reliable since internal forces at both places of origin and destination can weaken network structures and decrease migration. In as much as first migrants can be 'forerunners' facilitating movement of several people from their place of origin, they can also constitute themselves into obstructive strongholds debarring people from migrating by not providing the needed support or information required by the intending migrant that is against the principles of the network model (De Haas, 2003). Another notable weakness of the model is the fact that it does not provide awareness of the processes that ultimately caused the failure of migration systems and networks. There is no indication of the internal and external processes as well as fundamental issues that thwart the inclinations that promotes migration through systems and networks (Klaver, 1997).

A vital suggestion from the network model was that there is a tendency for migration selectivity to reduce after the lapse of the early phases of pioneer migration that could bring about the circulation of migration experience all over the societies. The migration experience would have dealt with some stereotypes and myths that the people might have held over the years which will subsequently affect migration selectivity positively. Nevertheless, the moral here is that the decline of migrant networks might increase migration selectivity yet again. Besides, even though kinship networks are very vital in migration, it also has the tendency of excluding people outside of the kinship groups especially under the constricting migration policies context (De Haas, 2003).

3.5 THE NEW ECONOMICS OF LABOUR MIGRATION

The new economics of labour model affirms that understanding the various forms of migration and flow only comes from the examination of the broader social units along with individuals and their economic motivations. Migration was identified as a type of ideal

distribution of production factors that is beneficial to all by the supporters of the neo-classic conjectural model. To this end, Todaro (1969) viewed the redistribution of labour from the rural (sending area) to the urban (receiving area) as a vital criterion for economic development. One cannot successfully separate the homes of migrants from migration if the proper understanding of migration study is to be gained; therefore, the household is part of the social entity that is essential for the understanding of migration. The flow of capital from the migrants in the form of remittances to their households generates additional income that boosts economic activities in the sending areas. As migrants move away from the sending area, capital moves back as remittances that serve as a benefit to non-migrants even though their prospect of benefiting from the migration process was not acknowledged by previous neoclassical methodologies (Djajic, 1986).

There are two core constructs of the new economics of labour migration. The first construct is that migration decisions are not individualistic in nature. This invariably means that decisions (when to go, where to go, for what period of time) are taken collectively by members of a particular household. Occasionally the circle of the decision-making unit goes further into the extended families and broader communal groups (Massey *et al*., 1998).

Taylor (1999) supported the fact that the neo-classical model ruled out migrants' remittances to the sending areas due to the view of a migrant as an individual entity without defined responsibility to society. This assertion is in variance with Massey *et al*. (1998), and the fact that no man is an island. Everyone has a biological connection with other people and feel obligated most times to make decisions that are beneficial to the households and contribute their quota. Also, family orientation makes it difficult to operate on a solo level without consideration for the feelings of other members of the family. This model affirmed that even though people may have individual ambitions, making migration decisions does not rest on an individual. The households wield a great influence on the outcome of the migration decision, even though unforeseen circumstances have the tendency to also affect the outcome.

The neo-classical model affirmed that the society only benefit in the form of increase in labour price as a result of scarcity at the sending areas but they are not part of the decision making process. Accurate perception of the actual effects of the migration process on the areas of origin was not provided by the neo-classical model. However, policy makers and

researchers promoting migration as pivotal to economic growth have continued to highlight the vital roles played by remittances in creating opportunities for development at all levels of society. Migrants feel obliged to remit back to the sending area since the migration decision was collectively made. The sense of responsibility is positively linked to the collective nature of the migration decision making under the new economics of labour model. It is popularly assumed that migrants especially the skilled ones, do not only remit income but also information and ideas which are transformational to the place of origin. The return migrants are usually perceived as change agents that enhance development processes due to their exposures to better conditions in terms of technology, infrastructures and education among other things.

The second construct is that logical-choice decision making is not only about boosting income and wage but is also about risk aversion and income diversification. The migration of labour was perceived as a fundamental part of the modernisation process proposed by the developmentalist who presumed that developing countries can attain rapid economic growth and transformation through huge capital transfer (such as remittances and aids). Finance is and has always remained a major challenge in the growth of developing countries. The supporters of the development model sees the historical experience of rural to urban migration that occurred in Europe and United States in the nineteenth century as well as the early twentieth century on migration and development as a valid example for developing countries to follow to achieve rapid growth and modernisation.

Labour migration on a huge scale started to increase from the developing countries to the developed ones in the post-war era. According to Adler (1981), migration was seen as a vital instrument to stimulate growth and therefore was supported by the government of developing countries. Some governments have policies in place to encourage their citizens in diaspora to contribute towards the development of the sending areas. Developing countries engage in constant interaction with their citizens in diaspora through the high commissioner representing their country to ascertain what they can contribute to enhance development. Keely and Tran (1989) enunciated that remittances from labour migrant would offer better quality of life and increase income distribution more than other methods of development. This assertion showed that even non-migrants at the sending location can partake in the income distribution through remittances. Expectations are usually high for labour migrants

both personally and from the social groups. There is an expectation on the part of the society that migrants will return with enough capital for industrial growth in their areas of origin (Beijer, 1970). Migration is perceived to promote economic growth, financial freedom and liberation from indigenous socio-economic restrictions and difficulties.

Ghosh (1992) stated that several countries of origin have established specific strategies to exhaust the possibilities presented by remittances and to encourage investments by migrants. The new economics of labour model could be useful in the formulation of development policy for developing countries due to the fact that it does not concentrate on the migrants alone but involving non-migrants and other entities that are connected one way or the other to the migration process.

While the destination point can benefit immensely from huge flow of migrants in the form of surplus labour, the place of origin can also benefit greatly through large volumes of remittance which can trigger rapid development on both ends.

Some countries continuously view migration as a core instrument of domestic economic growth (Bertram, 1999) regardless of various measures being put in place by policy makers to curtail movements around the world. The recent rise in terriorism has tampered greatly with positivism of the development model. More border control measures are being developed to minimise migration streams and safeguard lives and properties.

3.6 THE BAND WAGON THEORY

This theory took its root from the imitation theory of social psychology. People naturally lean towards a trend not necessarily because they know the rationale behind it or have properly thought it through; since others have done it or are doing it makes the action attractive. The theory of imitation is the most famous among several efforts at relating psychology to the understanding of social phenomena. The theory was first proposed by Gabriel Tarde (1890) and then autonomously by Prof Baldwin. Professor Baldwin (1895) concluded from his study on child mental development that the primary method of a child's learning is by imitative immersion of the expressions, actions and thoughts of others; hence, imitation is the technique for personal growth. An individual develops rationally and ethically by imitating the mental attitudes and actions of those around him or her. People

want to do things the way others are doing it and most times will not do things outside of the societal norms and be seen as a misfit. The desire to have a sense of belonging is closely tied to the imitation theory.

Tarde (1890) approached the subject of imitation from the sociological angle; he affirmed that the fundamental element in the process of imitation could be generalised. Through the study on social phenomena such as crime, crowds, fashion and trends, Tarde (1890) asserts that imitation can be used as a source of a structure of social philosophy.

There are two key elements of this theory; the first one is precedence while the second is thrill of adventure. Precedence assumes that due to the fact that others have successfully done it before then it is possible regardless of the risks involved. Precedence presents an example to follow, what to do and what to avoid, how to go about it, and also learning from the mistakes of predecessors. Tarde (1890) claimed that society in itself is imitation; he further assumed that the 'key to the social enigma' is the replication of an action that has been previously done by someone else due to the effect of a suggestion received (Tarde, 1890). The suggestion-imitation process clarified the effect of one person's mind upon others which subsequently explained all migrations and changes in the community (Tarde, 1890). He also attributed the structural and functional harmony within the society to imitation. These assertions by Tarde (1890) depict that, as people engage in actions that others have done before, it encourages unity and brotherhood. Steadily with the position adopted above, Tarde (1890) affirms that all the actions of human beings from the discoveries of art and science to satisfying biological needs are as a result of the imitation process.

The imitation theory formulated by Professor Baldwin is more systematic. The development of individual lives gives meaning to the development of social life which revealed that the imitation theory can also be applied to social progression. Baldwin (1899) affirmed that imitation is the process of a social group or association and that every growth within the society occurs through the generalisation of the invention of individuals by imitation (Baldwin, 1899). This kind of circular method ensures that people progress ethically and mentally through the imitation of the actions and intellectual outlooks of people around them while the modification of society also occurs through sustained imitation practices.

It is important to state that a reliable theory of social process was developed by Professor Baldwin which Tarde (1890) could not achieve. Baldwin's (1899) theory hinges on practical facts and is often regarded as being more rational; he believed that the suitability of our choice for imitative replication and application is the origin of our choice. According to Baldwin (1899), people imitate purely what they have become habituated to imitate and that one's personality becomes structured through this habituated imitation. This theory is at par with some current psychological philosophies on the learning process. Another major criticism of the imitation theory is that it is preposterous to conclude that a single nature or instinct (imitation) determines the whole process of all individual and societal development (Baldwin, 1894).

The imitation theory of Tarde (1890) and Baldwin (1899) was criticised on the premise that people consciously choose who to imitate and do not just imitate everyone around them. People generally tend to imitate those who have been successful in their area of interest without considering the personal sacrifices, risks and other factors that was involved. This assertion shows that there is selectivity in imitation; even if the person is perceived to be a subordinate or an enemy, so far as the imitator is able to establish the success factor, imitation can occur.

Thrill of Adventure, which is the second element under the bandwagon theory, holds that the excitement to try something new can sometimes lead people to join the bandwagon. The quest for adventure can push people into action without weighing the pros and cons properly.

Migration has emerged as one of the solutions to assuaging tangible or alleged psychological and environmental threats that societies have been defending themselves against throughout history. Paradoxically, the number of adventure seekers is on the increase even as societies sought to defend themselves against threat of any form. The thrill to try something new or engage in something daring is not peculiar to the madcaps; more ordinary people are getting involved in adventure due to inquisitiveness.

Most adventure seekers are tired of hearsays and reading other people's experiences; they want to have a firsthand experience of things and bear the brunt of their actions or inactions. Even when some have the opportunity of being warned or exposed to information like in the

case of network theory that could dissuade them from proceeding on migration, they will still be adamant due to the thrill they derive from trying something new. The thrill of adventure gives a sense of purpose that supplies the much needed boost and determination.

Duffy (1957) in his optimal arousal model on adventure affirmed that people will pursue stages of arousal that are consistent with their expertise, circumstances and past experience. The levels of arousal differ from one person to another. In order to ensure optimal arousal, according to Berlyne (1960), the location or circumstance must consist of a proper blend of 3 factors: firstly, new task/quest or an old task done differently; secondly, there must be some degree of insecurity with regards to the result and thirdly, some level of self-confidence to succeed in the task. Berlyne (1960) summarised this unique blend into novelty, dissonance and complexity.

Optimal arousal shows circumstances surrounding an individual can impact on the migration decision; circumstances like an unfavorable environment, poor working condition, war, gender inequality, among other things which create a feeling of uncertainty about the present as well as the future and can arouse the interest of an individual to move to another location - this is the dissonance factor under Berlyne's blend. Naturally, people experience a feeling of insecurity when their survival is threatened or when exposed to something new. This feeling of insecurity usually compels a modification in the behavioural pattern which provides information about the success of the modified behavior. Every situation comes with its own demands and in order to be efficacious in meeting these requirements, learning of new things and behavior is necessary. Through the learning of new things and behaviours new inventions are developed as well as precedence for future growth.

On the other hand, the environment might be favourable but the expertise of an individual and the self confidence that he/she possesses the ability to succeed in any location might be the arousing factor to migrate which is the complexity factor. The increase in proficiency tends to impact on one's exposure and interest to explore more, thereby fostering adventure. The effect of past experiences on arousing the thrill of adventure cannot be undermined. In some cases, past failures has given people renewed zeal and interest to do things differently to achieve a better result which is the novelty factor under Berlyne's unique blend.

Information contents and power of motivation, with growth in dissonance and uncertainty have been identified as the secrets to effective arousal.

White (1959) affirmed through his competence-effectance model that people engage in adventure to establish their capability to affect the environment. This assertion was also supported by Deci (1975) that there is a human requirement for feeling proficient. From the competence-effectance viewpoint, the migration of medical doctors from the public sector to the private may be due to fact that they feel they are capable enough to provide quality medical services on their own without government affiliations. These feelings of proficiency can optimally arouse an individual to delve into alternative course of action or new terrain and effectively deal with the demands that might arise. Compatibility in proficiency and the demands of the new situation will create a feeling of satisfaction which can boost the interest of an individual to seek greater quest as his/her competence increases.

The concept of specialisation promoted by Bryan (1979) with regards to adventure can also be an important pointer to why doctors migrate from the public sector to the private sector. It is common knowledge that a medical specialist gets more financial reward in the private sector depending on the level of demand for his/her services. Could the exodus of doctors from the public sector as soon as they get qualified as a specialist be linked to this? According to the concept of specialisation, as people increase in specialty, the desire to try out their dexterity increases; there is an arousal to venture into something new no matter how risky it might seem.

Self-efficacy propounded by Bandura (1977) is a key component of the competence effectance model and it refers to self-perception of one's ability to handle tasks or situations, especially the challenging ones. It is perhaps one of the most used models of human personality in adventure. Self-efficacy accounts can be established or improved through individual achievements, verbal encouragement, stimulation levels and meditated experience. Personal perceived level of ability determines the involvement of an individual in adventure, but rational appraisal of one's level of capability in handling expected demands goes a long way in determining this self-perception. Is this theory of self-efficacy relevant to the study on the migration of doctors?

According to Bandura (1977), self-efficacy entails a personal evaluation of the following aspects:

- Self-perception of one's ability
- Extent of effort needed
- Expected task challenges
- Level of anticipated support expected
- Type of environmental conditions
- Prior forms of success or failure

All the aforementioned factors might be examined to ascertain the success rate of the adventure before venturing into it. Self-efficacy expectations differ depending on the size of the task at hand, the extent to which the perceived ability can be extended to other tasks and perseverance when faced with an unsuccessful venture. The effectiveness of performance accomplishment in influencing self-efficacy was emphasised by Harmon and Templin (1980) due to the fact that they are based on individual proficiency. It is natural for a feeling of proficiency to develop after achieving a remarkable feat personally. This feeling of proficiency is capable of propelling an individual to embark on more challenging tasks.

Nonetheless, self-efficacy does not entirely clarify participation of people in adventure or the desire to venture into a new terrain. With regards to the migration of doctors, there are many doctors both specialist and otherwise who have the capability to establish a private practice but decided to continue working with the government. The overwhelming assumption of self-efficacy is that success in one area of endeavor is an indication of success in other areas which is a fallacy. There are many factors involved in migration decisions that transcend the concept of self-efficacy.

People venture into adventure with various expectations. While some expectations are sociological in nature others are either somatic or psychosomatic. Challenge and interest were identified by Progen (1979) to be the major expectations of adventure. The sociological expectation may involve conviction, concern and socialising, the somatic expectation may involve well-being and freedom while the psychosomatic may involve self-reliance and self-concept enrichment. Self-efficacy contributes in no small measure to our expectations. Self-perception makes people have either realistic or unrealistic expectations. Doctors like every other individual have expectations that drive their decisions. These individual expectations

can be affected firstly by a personal belief with regards to the capability to effectively perform specific exercises, secondly, the degree to which actualising the goal is difficult and thirdly, the level of perceived control that an individual has over his/her accomplishment. Expected benefits are also a major influence on thrill of adventure and some of the benefits may include pleasure, realisation of goal, personal experiment and socialising.

Imitation, without a doubt is a process of personal and societal growth. Even though it is a perpetual feature of individual lives and the society, other phases of growth should not be ignored in order to ensure a thorough study. A proper process of development can be achieved through the collaboration of imitation with other factors. The controlled and restrictive nature of imitation particularly by inherent urges makes it incapable of sufficiently handling the process of both personal and societal growth.

Adventure has played a significant role in various fields of endeavor bringing about inventions that has made the world a better place to live in. The thrill of adventure in swaying the migration decision might give a fresh clue on migration studies. Thrill of adventure is a complete deviation from the various models that have lent their view on the migration decision and is definitely a foundation for a fresh conceptual framework on migration. People have different reasons for behaving in a certain ways; therefore, it is time to look beyond the tradition models on migration and explore other factors that might provide us with the necessary solutions.

3.7 RETENTION

The retention of medical doctors in the appropriate areas of need within South Africa is an important matter, given the government's renewed pledge to deliver HIV treatment to the populace after a period of denial (Nattrass, 2007). The retention rate can be used to deduce information on who leaves, why they leave, the costs of their leaving to the organisation and the next course of action (Waldman & Arora, 2004).

The Chartered Institute of Personnel and Development (2004) affirms that the retention rate could help an organisation to improve its policies if need be, particularly in the case of the high frequency of such departure and the need for replacement of high performers. Productivity and continuity and the entire workforce of an organisation may be hampered

where the turnover is high. Peak (1996) reiterated that employee retention is as vital as customers' retention as customer loyalty is contingent upon employee loyalty. The success of the proposed National Health Insurance (NHI) depends largely on the adequacy of medical practitioners.

According to the study conducted by Ashmore (2013), job satisfaction was identified as the main determinant of retention. The study presumed that job satisfaction is a result of the satisfaction of individuals' needs, as well as their values and prospects. The goal theory of Locke also refers to job satisfaction as a positive emotional state resulting from job appraisals or experiences. There is no denying the fact that job satisfaction is crucial to retention since it can influence the decision to either leave or stay in an organisation. However, to lay the burden of migration on job satisfaction might not be entirely true.

The previous study on the inequality in the distribution on medical practitioners in both the public and private focused basically on specialists and came to the conclusion that job satisfaction determines their migration. This might be true for specialists but might not be applicable for general practitioners. Even though this has provided the foundation for future research works, there is need to investigate the driving force behind the migration of general practitioners as well.

Although the concept of job satisfaction may seem realistic and an established way to understand retention behavior or turnover, it is not the only key factor that determines migration. According to Morrel and Arnold (2007), two schools of thought dominate the study and practice on turnover. While one school of thought focuses on external factors like wage differentials and the availability of alternative jobs locally, nationally or globally, the other school of thought focuses on job satisfaction and commitment (Taplin *et al*., 2003). Most of the researchers agree that no school of thought is capable on its own to provide a logical explanation for the reason people leave a particular job or predict future turnover.

The CIPD survey of 2007 concluded that unless an organisation could find a way to incorporate workers into routines and remunerate them appropriately they will continue to have retention issues. Is this applicable to medical practitioners too? Do healthcare

organisations conduct exit interviews for those leaving? If yes, how effective has this been in reducing migration to the private sector?

Sibbald *et al*. (2000) also stated that doctors have been found disappointed empirically, to a large extent, by non-financial factors such as the state of the hospital and demanding patients. In South Africa, much has been said on the deplorable state of public healthcare facilities in the media; nonetheless, no comprehensive research has been carried out to determine the reason for this internal migration especially for general practitioners. Although there are few case studies on specialist migration to the private sector, it is not exhaustive; hence, this study aims at addressing these gaps.

The need for more research on internal healthcare migration cannot be over-emphasised. There is a need to investigate and understand the degree at which medical practitioners migrate from the public sector and handle the challenges accordingly in order to forestall a negative impact on service delivery.

3.8 CONCLUSION

In spite of public opinions, laying the burden of migration on an individual factor such as wages will not do justice to migration studies. A proper blend of both established and fresh models might just be a pointer to the missing clue on the migration of medical doctors. As needs constantly change so too do expectations, which make an individual factor incapable of discovering the main reason behind migration. People get motivated differently and in order to ensure a study that can be generalised, there is a need to take cognisance of a combination of factors that will make the realisation of the study goal possible. For an effective study that is devoid of bias, other elements within the wider health context in which the migration occurred will be examined apart from the migrants.

CHAPTER 4

RESEARCH METHODOLOGY

4.1 INTRODUCTION

The research methodology is known to be the framework that shapes the research route and the outcome of a study. It entails the methods that a study intends to explore to objectify its goals. The importance of the research methodology in achieving a proper research study is enormous. It gives direction to the research and enables the efforts to be structured into one cohesive and conceptual unit. A sound research methodology will not only ensure that the research objective is realised but will also generate fresh ideas about a future study.

This chapter focused on the research methods and the instruments used in studying the migration of medical doctors from the public sector to the private sector, and the research questions were addressed accordingly.

4.2 RESEARCH PHILOSOPHY

The accomplishment of a research study based on definite techniques can validate it as a good study (Salmon, 2003). The direction of research methodologies is determined by the methods employed and the procedures it entails (Silverman, 2000). Therefore, taking cognisance of the research philosophy is valuable to a researcher in facilitating the assessment of diverse research techniques that will expose the challenges of each technique early enough thereby reducing the time wasted on irrelevant work. The interpretivism and the positivism models are the two fundamental models that management studies are inclined to focus on (Saunders, Lewis & Thornhill, 2003).

Waugh and Waugh (2004) referred to positivism as the collation and analysis of data through a systematic approach. Simpson, Dickinson & Greenblatt (2005) see interpretivism as a technique by which the researcher observes, writes, transcribes and creates text for data analysis from interviews. The nature of the study together with the means of data collection and analysis appear to suggest that the combination of positivist and interpretivist will add more value to the study. The diverse methods employed by this study are the documentary data, structured interview, semi-structured interview and questionnaire. The data gathered

from the documentary sources, the structured interview and the questionnaire were evaluated using quantitative analysis while the qualitative measures were used to collect and assess semi-structured interview data.

4.3 RESEARCH DESIGN

This study employed the use of the case study research design. The reason for the choice of the case study design is because it is an ideal methodology when detailed and rounded investigation is required on a subject (Feagin, Orum & Sjoberg, 1991). According to Scotter and Culligan (2003), a case study clarifies why something functions the way it does, how it functions, what may cause it to malfunction and what are the prerequisites required to make it function. Villardi (2003) asserts that a case study could be either descriptive or explanatory and is often used as a research method to heighten an in-depth knowledge of the complexity of a phenomenon as well as to assist in decision making.

The case study approach has a unique way of drawing the researcher closer to the truth and accentuates thorough background inquiry into events and their association. It also provides the prospect of gaining a profound comprehension of the phenomenon of the research and the procedures employed in accomplishing it. Researchers such as Yin (1993), Stake (1995) and Creswell (2009) have made extensive use of the case study design for the examination of current real-life situations to provide the foundation for the application of ideas and extension of methods. Yin (1993) asserts that the case study technique is an experiential enquiry into existing phenomena within its real framework; when the borders between context and phenomenon are not visibly distinct, and multiple sources of data are used.

The case study approach is specifically useful in drawing the researcher to the knowledge of a complex research issue and can also stimulate the consciousness of current information about an occurrence through the previous study. Data collection and analysis approaches in experimental and quasi-experimental study are known for hiding some facts (Stake, 1995) but case studies are aimed at exposing every fact from the perspective of the participants using multiple sources of data. The application of a case study can be single-case or multiple-case applications contingent upon the phenomenon under study.

This researcher chose to use the case study design because it is directed towards exploring a detailed contextual enquiry into the motives and impacts of medical practitioners migrating to the private sector from the public sector using different qualitative and quantitative approaches. Preliminary inquiries revealed that very few studies have been conducted to investigate this phenomenon in KwaZulu-Natal.

Even though the case study approach appeared to have numerous benefits, it is not without limitation. One profound limitation of the case study approach is that its results are typically narrow and limited in scope which may create generalisability issues, especially with regards to the usage of one case study. This limitation will not pose any threat to this study because of the use of more than one case study as well as triangulation.

4.4 RESEARCH APPROACHES/PARADIGMS

Research methodology is divided into two main categories, namely, quantitative and qualitative research. According to Aliaga and Gunderson (2000), quantitative research is concerned with explaining phenomena through the collection of numerical data that are examined using statistically based methods while the qualitative research is a form of research methodology that allows the researcher to collect data that is rich in documentary description of how a target population is experiencing a phenomenon (Creswell, 2009, 2012).

In this study, qualitative and quantitative methodologies were used to ensure a detailed analysis and to reach an encircling conclusion on the motive behind the migration of medical practitioners to the private sector and its effect on the healthcare system. The qualitative approach maintained a deeper focus on the research questions with the aim of finding the purpose while the quantitative approach focused on accurate description of the common features in different cases. Qualitative research is typically much less arduous to structure than quantitative research and, thus, there is the likelihood of obtaining unanticipated information by the researcher and also missing some information at the same time (Blumberg, Cooper & Schindler, 2005).

Qualitative research methodology will enable researchers to collect data on the human perspective of the research problem (Creswell 2012; Glesne 1999). Nonetheless, quantitative research is far more effective to analyse than qualitative research although the researcher may

miss some details. Quantitative and qualitative research methods can be used to complement each other; although there are obvious dissimilarities between them, they do not exist in isolation (Saunders *et al*., 2003).

4.5 STUDY SITE

Creswell (2009) described the study site as the physical place where a study is to be conducted and the required data collected. In this study, the study site is Mahatma Gandhi memorial hospital and Life Healthcare private hospital group, Durban, which forms part of the eThekwini municipality. The hospitals are located in Durban, which is the largest city in the KwaZulu-Natal province of South Africa with a population of 3.468 million. Durban also stands second to Johannesburg as the most important manufacturing hub in South Africa. Its area is 2,292 km² (Statistics South Africa, 2011). Durban is one of the key tourism centres in South Africa.

4.5.1 HISTORY OF MAHATMA GHANDI MEMORIAL HOSPITAL

Mahatma Gandhi Memorial Hospital is the public hospital to be used for this study. The reason for this choice is firstly because it is a district/regional hospital dedicated to ensuring viable, comprehensive and integrated health services to its District/Region with regards to the Patient's Right Charters and Batho Pele principles and secondly, because of the large percentage of the population being served by this hospital. It incorporates 350 beds and is presently working towards developing into a full-fledged regional hospital package. Currently, it renders several services at the regional level, namely, obstetrics and gynecology, internal medicine, paediatrics and neonatology while it renders general outpatients, surgery, crisis centre and orthopedics at the district level with receiver of referral patients from clinics.

4.5.2 LIFE HEALTHCARE HOSPITAL GROUP

The Life Healthcare hospital network comprises of 63 hospitals (among which they have the majority ownership in 56 and minority ownership in 7 hospitals). They provide diverse types of health services in South Africa and Botswana. This hospital group has hospitals in seven of the country's nine provinces, namely, Pretoria, Johannesburg, Durban, Cape Town, East London, Bloemfontein and Port Elizabeth. Life Healthcare facilities are structured to cater for local demand in the various provinces of the country. The Life Healthcare group has six hospitals in KwaZulu-Natal, but this study focused on the three which are located in the

Durban area, namely, Life Entabeni Hospital, Life Westville Hospital and Life Mount Edgecombe Hospital.

The reason for choosing Life Healthcare group is based on the quality of service provided and also due to the significant role performed by medical doctors in ensuring the success of the group. The three hospitals were chosen because of their location which is in line with the study site.

4.6 TARGET POPULATION

The target population is the aggregation or collection of units or people with specific characteristics the researcher is interested in (Trochim, 2006). Usually, members of the population are known to have shared or binding features. The target population of this study was the entire medical Practitioners at both Mahatma Gandhi Memorial hospital and Life Healthcare private hospital group.

4.7 SAMPLING METHOD

Tabachnick and Fidell (2007) refer to a sample as a subset of the entire population from which data is to be collected by the researcher. The sample of this study was selected from all the departments at the hospitals.

This study used both qualitative and quantitative research methodologies, and probability sampling was used to select participants for inclusion. Probability sampling is a technique where the samples are assembled in the process that ensures that all the individuals in the population get an equal likelihood of being selected (Babbie, 2001).

Simple random type of probability sampling was utilised to select both the specialist and the general practitioners. Simple random is the method in which every member of the population has an equal probability of being chosen. It will also give the opportunity to generalise the results from the sample back to the entire population (Trochim, 2006). The population-to-sample size table by Sekaran and Bougie (2010) was used to determine the sample size.

Stake (1995) defined sampling as a method involved in the selection of a small portion or part of the population to represent the target population while a sample size is the total number of

units or people selected to participate in the study. Mahatma Gandhi hospital like the Life Healthcare hospital group, has different departments which handle diverse health conditions. There are 70 medical practitioners presently at Mahatma Gandhi Hospital; hence, according to the Sekaran and Bougie's (2010) sample table, the corresponding proportionate minimum sample size should be 59 doctors.

There are 77 medical doctors in Life Entabeni Hospital, 52 medical doctors in Life Mount Edgecombe Hospital and 63 medical doctors in Life Westville Hospital bringing the total of medical doctors from Life Healthcare group to 192 and the corresponding sample size to 128 medical doctors using Sekaran and Bougie's (2010) sample table. The total number of participants for this study was 187. The reason for the larger sample from the private hospital as compared to the provincial hospital is because the sample is proportionately determined and the sample size also depicts exactly the magnitude of the problem on the ground.
The sample size is depicted in Table 4.1

Table 4.1

Proposed sample for given population size per hospital

Name of hospital	**Population (N)**	**Sample size (S)**
Life Healthcare group	192	128
Mahatma Gandhi	70	59

Even though a total of 187 respondents received the questionnaires only 115 respondents completed and returned it within the specified timeframe which brought about the reduction in the intended sample size for the study. However, the actual sample size allowed the study to establish the estimate of effect, the correct confidence interval as well as the p value. The actual number received from the respondents provided the study with adequate number of participants to effectively address the research questions.

Table 4.2

Actual composition of sample

Biographical Variables	Percentages
Gender	
Male	73.9
Female	26.1
Marital Status	
Single	24.3
Married	73.9
Divorced	1.7
Race	
Black	7.8
White	17.4
Indian	67.8
Others	7
Qualification	
First Degree	27.4
Specialist	72.6
Types of Sector	
Public	31
Private	69
Length of service	
0 - 1	11.6
1 - 5	11.6
5 - 10	18.8
11 - 15	12.5
16 - 20	8.9
21 and above	36.6
Current Sector	
0 - 1	19.1
1 - 5	24.3
5 - 10	12.2
11 - 15	8.7
16 - 20	14.8
21 and above	20.9
Age	
26 - 35	33
36 - 45	29.6
46 - 55	5.2
56 – 65	32.2
Total	**100**

4.7.1 Gender

The data obtained in the gender category shows that 73.9% of the respondents were male while 26.1% were female. There was significant difference between the number of male respondents and their female counterpart. This was not predetermined as all the doctors at the study sites were given the questionnaire which provided an equal opportunity for both gender to partake in the study. This clearly shows that there are more male than female doctors in the hospitals used for this study and not because there is any gender prejudice in the selection technique. This may be a pointer to gender suitability issues in the medical profession.

The data is representation in Table 4.3 and Figure 4.1

Table 4.3

Gender distribution of respondents

Gender	Percentage (%)
Male	73.9
Female	26.1

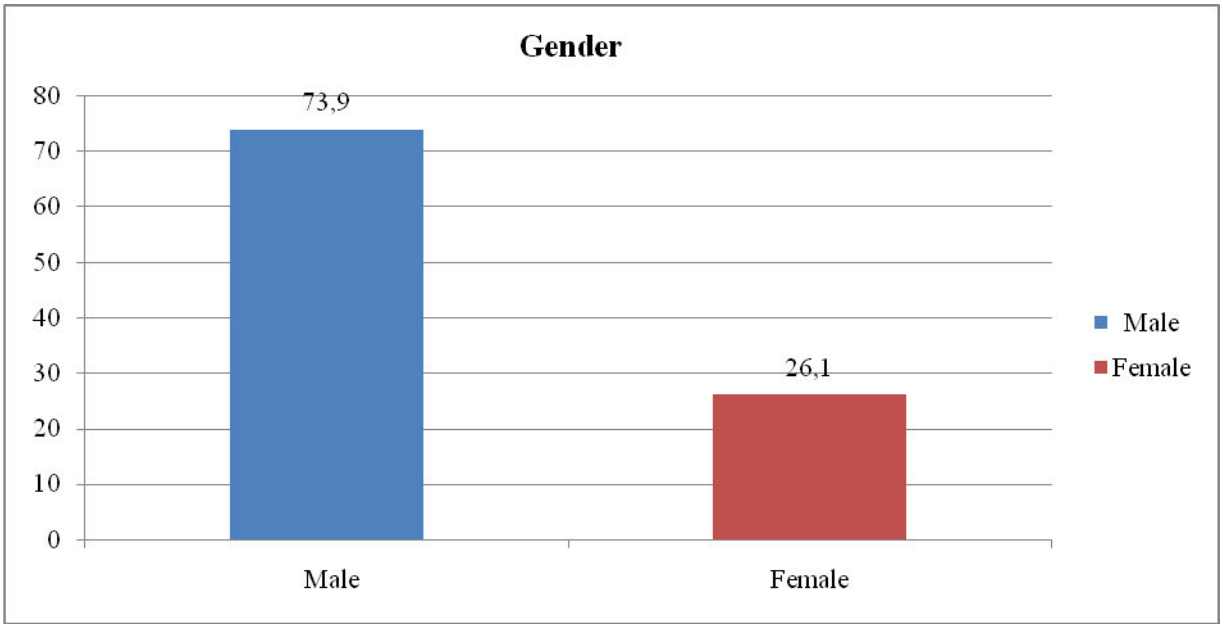


Figure 4.1 Graphical representation of respondents' gender

4.7.2 Marital Status

Data obtained under this category portrays that 24.3% were single, 73.9% of the respondents were married while 1.7% were divorced. The outcome in this category indicates that the

majority of the respondents are married. It was not established if there was any correlation between the work ethics and the marital status of medical doctors. A healthy debate and further research could arise from the quest to establish if the work ethics or working conditions have any influence on the marital status of doctors. The data is representation in Table 4.4 and Figure 4.2.

Table 4.4

Marital Status distribution of respondents

Marital Status	**Percentage (%)**
Single	24.3
Married	73.9
Divorced	1.7

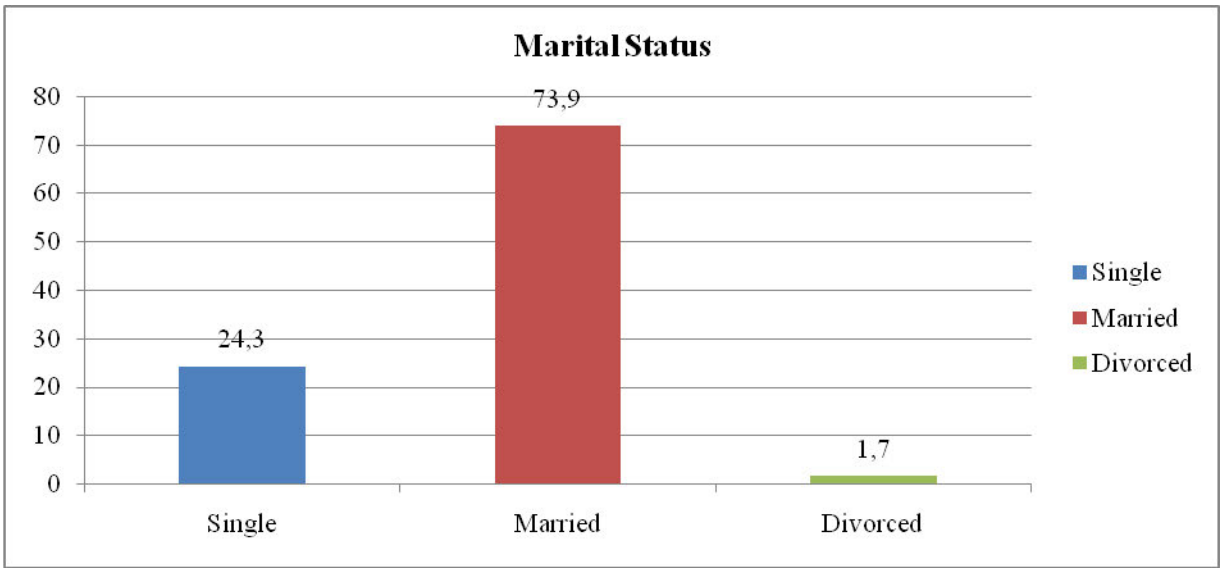


Figure 4.2 Graphical representation of respondents' marital status

4.7.3 Race

Data obtained under the race category showed that 7.8% of the respondents were Blacks, 17.4% were White, 67.8% were Indians while 7% were others. Preference was not given to a particular race as all doctors irrespective of their race were given equal opportunities to participate. The findings are presented in Table 4.5 and Figure 4.3.

Table 4.5

Race distribution of respondents

Race	Percentage (%)
Black	7.8
White	17.4
Indian	67.8
Others	7.0

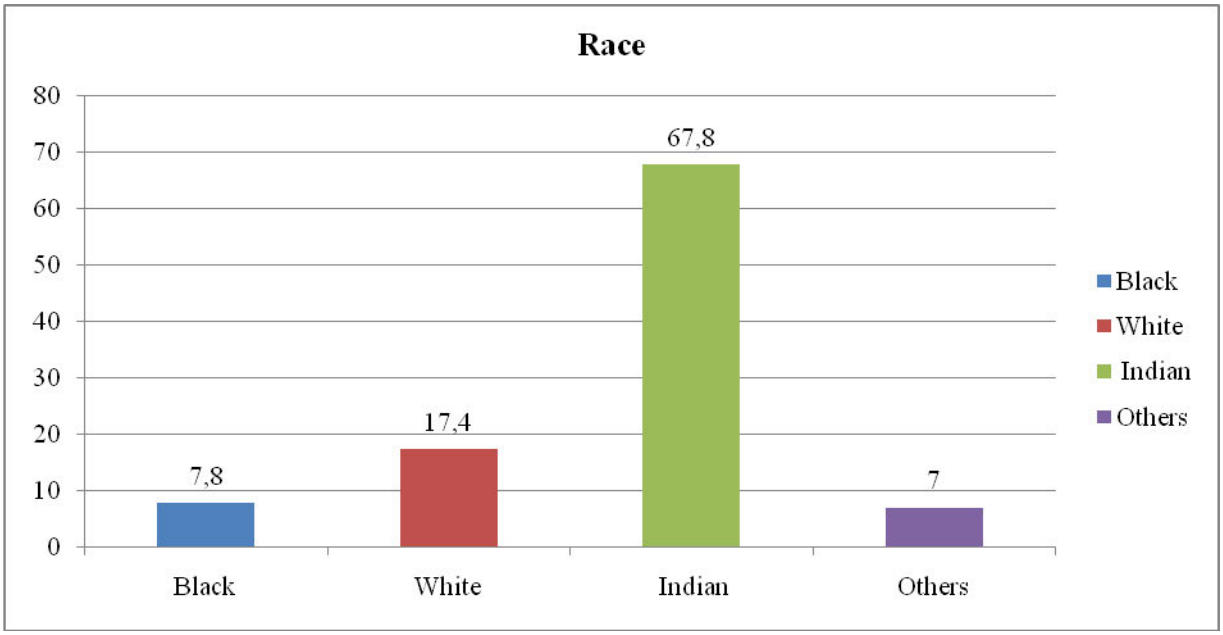


Figure 4.3 Graphical representation of respondents' race

4.7.4 Educational Qualification

The data showed that 72.6% of the respondents are specialists in various medical fields while 27.4% of the respondents are general practitioners. This study focused on both the general practitioners and the specialists. The previous studies on doctors' migration focused on specialists; the inclusion of the general practitioners is germane in realising a robust view on the subject and obtain a rounded representation of medical doctors' perception on internal migration. The respondents' educational profiles are reflected in Table 4.6 and Figure 4.4.

Table 4.6

Educational qualification distribution of respondents

Educational qualification	Percentage (%)
First Degree	27.4
Specialist	72.6

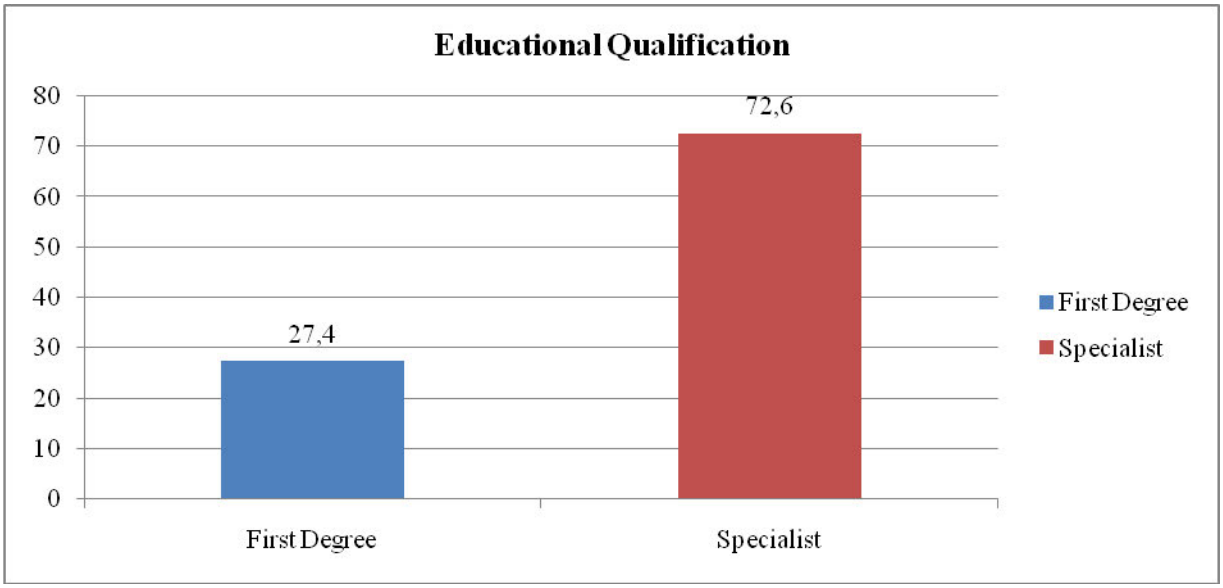


Figure 4.4 Graphical representation of respondents' educational qualification

4.7.5 Type of sector

The obtained data revealed that 31% of the respondents practice in the public sector while 69% are in the private sector. The perception of doctors in both the public and the private sector were sought for this study. Having a higher percentage from the private sector may be due to the fact that three private hospitals under the Life healthcare hospital group were included in the study with only one public hospital. The profile based on sector is presented in Table 4.7 and Figure 4.5.

Table 4.7

Sector distribution of respondents

Sector	Percentage (%)
Public	31
Private	69

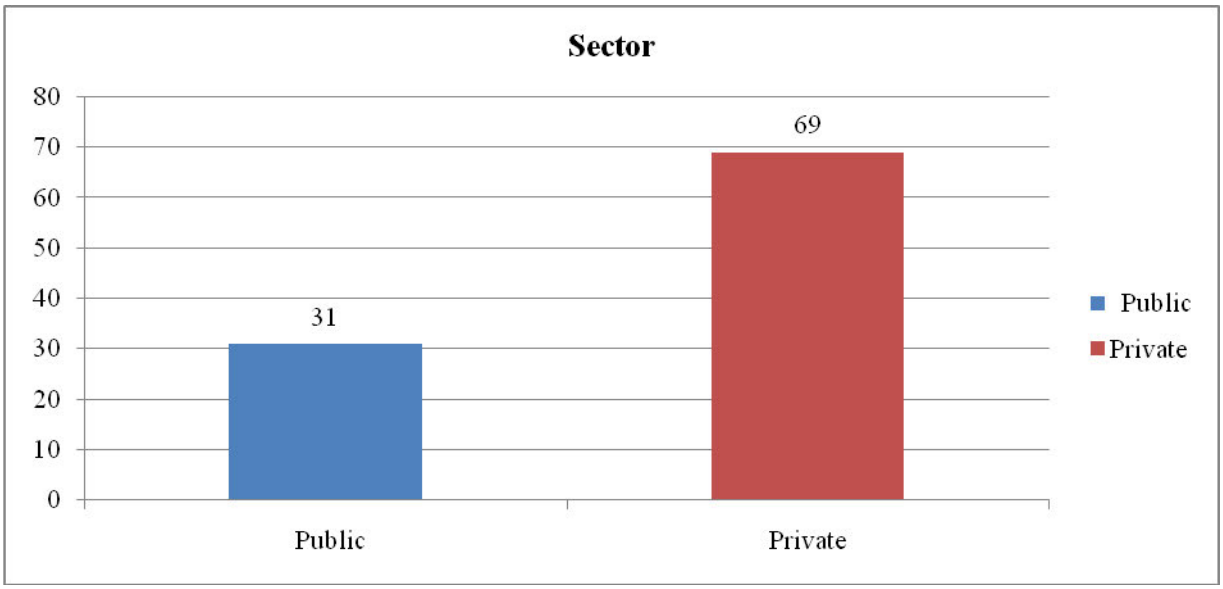


Figure 4.5 Graphical representation of respondents' sector

4.7.6 Length of service as a medical doctor

The obtained data here showed that 11.6% of the respondents have been practicing as a medical doctor for less than a year while 11.6% have spent between 1-5 years. Furthermore, 18.8% have been a medical doctor for between 5-10 years, 12.5% between 11-15 years, 8.9% between 16-20 years and 36.6% respondents have been in medical practice for 21 years and above. The data revealed that a higher percentage of the respondents have been practicing as doctors for between 21years and above. A greater percentage of those that have spent 21years and above is in the private sector while there are younger doctors in the public sector. This further fuels the concerns on the retention issue constantly facing the public sector and the need to revisit the established structure in the public sector. The profile based on tenure in practice is presented in Table 4.8 and Figure 4.6.

Table 4.8

Distribution of respondents by length of service

Length of service	Percentage
0 – 1 Year	11.6
1 – 5 Years	11.6
5 – 10 Years	18.8
11 - 15 Years	12.5
16 – 20 Years	8.9
21 and above	36.6

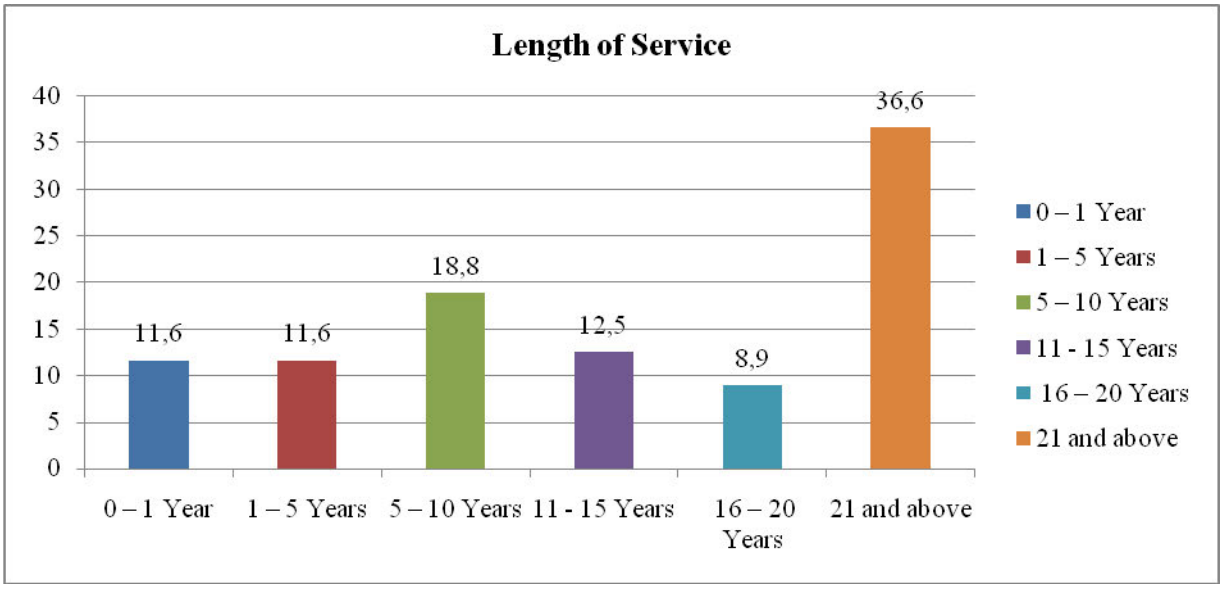


Figure 4.6 Graphical representation of respondents' length of service

4.7.7 Length of service in the current sector

The data obtained showed that 19.1% of the respondents have spent less than a year in their current sector while 24.3% have spent 1-5years. Furthermore, 12.2% have spent 5-10 years in their current sector, 8.7% spent between 11-15 years, 14.8% have spent 16-20 and 20.9% have been in their current sector for 21 years and above. The data revealed that respondents who have stayed longer in their current sector are more than those that have been moving from one sector to the other. Further investigation revealed that out of those within 21years and above length of service, there are more respondents in the private sector than the public sector. This reveals an attraction in the private sector that keeps pulling doctors. The

information here is relevant when taking into account the broad findings of this research on retention of doctors in the public sector. The data is presented in Table 4.9 and Figure 4.7.

Table 4.9

Distribution of respondents by length of service in the current sector

Length of service in current sector	Percentage
0 – 1 Year	19.1
1 – 5 Years	24.3
5 – 10 Years	12.2
11 - 15 Years	8.7
16 – 20 Years	14.8
21 and above	20.9

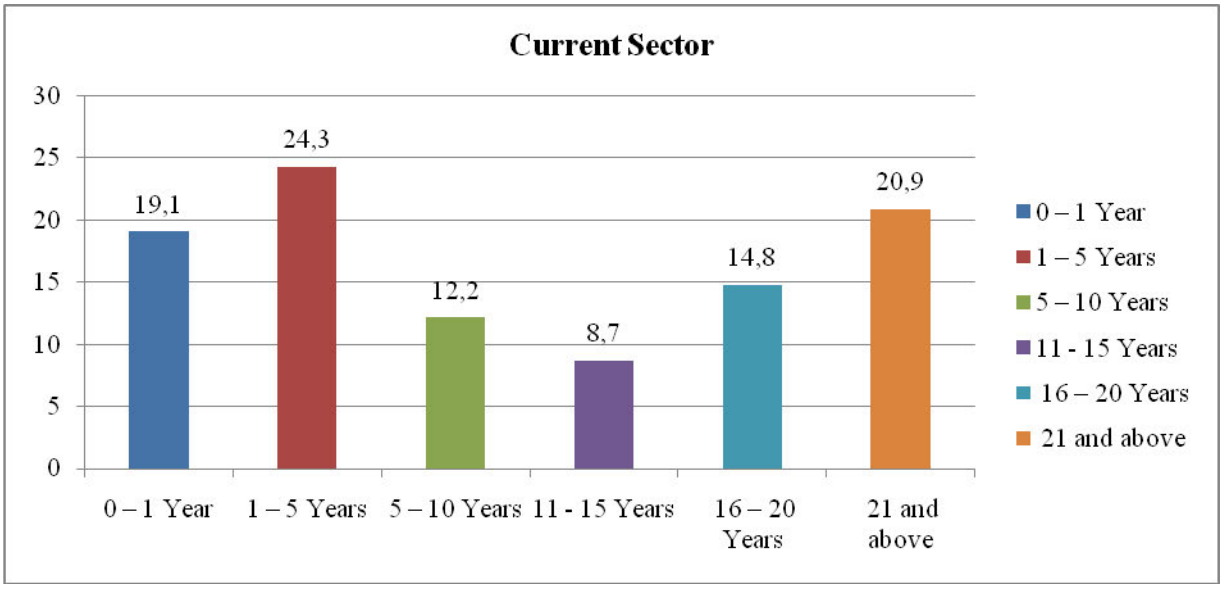


Figure 4.7 Graphical representation of respondents' current sector

4.7.8 Age

The data showed that 33% of the respondents fall within 26-35 years, 29.6% between 36-45 years, 5.2% fall within the age range of 46-55 years while 32.2% between 56-65 years. The data properly depict a good representation of age groups in the medical profession. There is no stipulated minimum age for recruitment into the medical field. The employment equity act does not state specifically the retirement age in South Africa but the data collected by

ieconomics from 2011-2015 showed that the retirement age between men and women is 60 years. The age profile is presented in Table 4.10 and Figure 4.8.

Table 4.10

Distribution of respondents by age

Age	Percentage
26 – 35	33
36 – 45	29.6
46 – 55	5.2
56 – 65	32.2

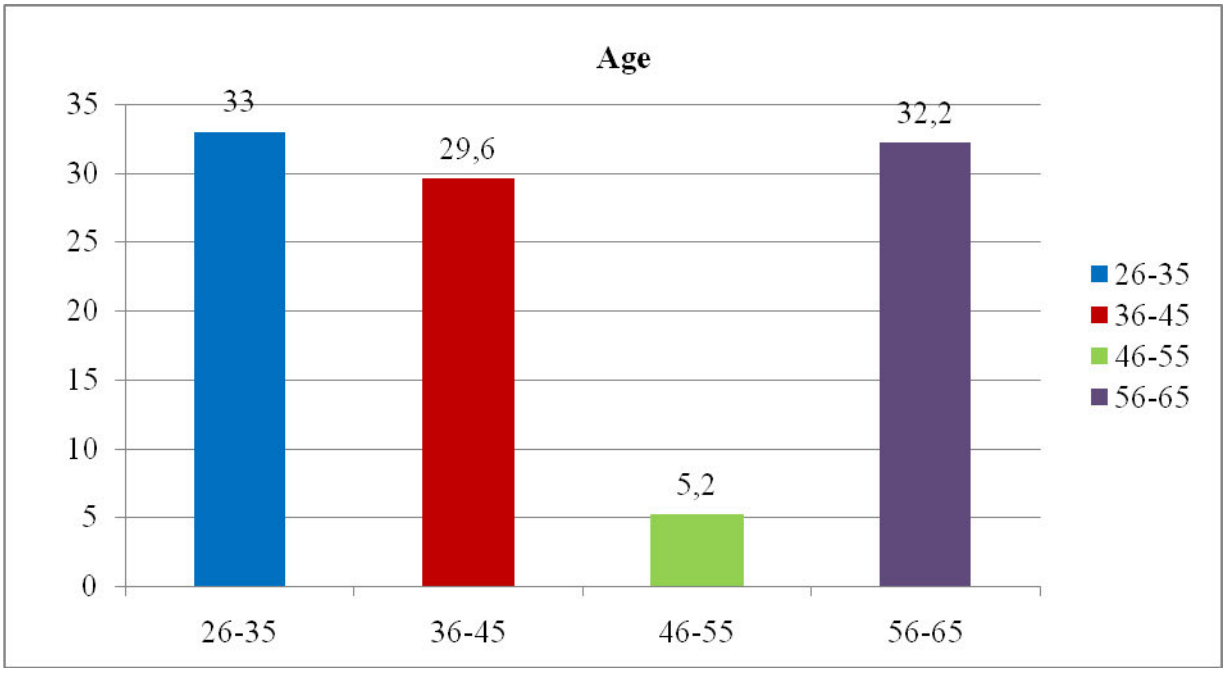


Figure 4.8 Graphical representation of respondents' age

4.8 DATA COLLECTION INSTRUMENTS

Data is defined as information collected in the process of research while data collection instruments refer to devices used to collect data (Strauss & Corbin, 1998; Rubin, 2008). The research used three different techniques of data collection to enable the accomplishment of the research objectives: semi-structured interviews, survey (through questionnaires and structured interviews), and document review from journals, health reports, archives, hospital websites, and magazines. These methods of data collection are strategically chosen in order to ensure a high degree of reliability and validity.

4.8.1 SURVEY

Two main types of survey techniques were employed which are the questionnaire and structured interviews. The questionnaire approach is usually used because it saves time, it is cost effective in research and facilitates data collection and analysis quantitatively. However, to lend more credibility to the quantitative data collection, structured interviews were conducted with some of the respondents, but no respondent was under any pressure to participate. The aim was to establish a good rapport between the researcher and the respondents and consequently gain participants' cooperation.

4.8.1.1 QUESTIONNAIRES

The questionnaire is one of the survey techniques used in this study (Appendix ii). A questionnaire enables data collection and analysis quantitatively which made it an appropriate technique in this study. It is clearly stated on the questionnaire that the identity of the respondent is not required which guarantees their confidentiality and privacy. The questionnaires were circulated among the 164 respondents from Mahatma Gandhi Hospital and Life Healthcare hospital group which includes both the specialists and general practitioners. This is because this study is inclusive of all medical practitioners.

The questionnaire was divided into three sections. The first section consists of eight questions that relate to personal information such as gender, marital status, race, academic qualification, sector, the length of service, age, marital status and years spent in the current sector. The first section was to establish the relationship between the personal information and the first research question on what informs (push) the migration of medical practitioners from the public sector to the private sector. This data collected from this section shed light on the influence of gender, age, marital status, length of service, race and academic qualification on the migration of doctors. This data led to unraveling deeper factors that trigger this type of migration.

The comparison of the response of each respondent on the length of service with their current sector provided clarification to the four elements in the networks and systems theory.

- The structure element that affirmed that the kind of structure in a particular organisation can influence migration enables the investigation of the kind of structures available in the public and private sectors with regards to the case study.

- Linkage element enabled the study to establish the link between the systems operational in public sector and other factors that influence the migration of doctors.
- The Process construct was used to understand the impact of process dynamics on migration.
- The future projection element enabled future projections to be made with regards to the migration of doctors from the public to the private sectors.

The second section consists of seven questions that relate to the reward structure, performance management, management style/structure, basis for performance, job design and job satisfaction. This section provided insight into the extent to which monetary rewards (for example, wages, bonus, performance pay) and non-monetary rewards (for example, letters of commendation, awards, recognition) impact on the retention of medical doctors in the public sector. The economic element of the push-pull theory reinforced the data collection from this section which was used to examine the influence of economic factors like working conditions, remuneration packages, shelter, food and standard of living on doctors' decision to migrate. The social element such as better healthcare facilities, educational or career prospect strengthened the investigation into the significance of the social factor on migration.

There are five questions in the third section. They are dedicated to obtain information on migration reasons, reward structure, performance management, management structure, job design, job satisfaction, retention, employee relations and productivity. The questionnaire was designed with the objective of gaining insight into the diverse perceptions on the migration of medical doctors from the public to the private with emphasis on rewards, relations, and retention and also to answer the research questions on the extent to which the medical doctors in the public sectors presently have the intention to leave and to know if there is a retention policy in place and to what extent it fits and supports the culture of the public healthcare organisations now or as the need may arise in the future. The questions in the third section also enabled the study to obtain answers that will underpin the second element in the new economics of labour migration theory which affirms that migration is a logical-choice decision making; it is not only about boosting income and wage but is also about risk aversion and income diversification.

To enable the quantitative analysis of data, the questions were closed-ended. The questionnaire options have the tendency to be limited in scope, that is, it might not cover all the responses that respondents will want to indicate which explains the reason for the use of the structured interview to lend credibility as well as buttress the answers provided in the questionnaire. The structured interview adequately caters for this vital disadvantage of the questionnaire approach. The items were structured using the Likert scale ranging from strongly disagree (1) to strongly agree (5).

4.8.1.2 STRUCTURED INTERVIEWS

Interviews can be referred to as a dialogue between two or more people. It involves social interaction, unlike the questionnaire approach which does not necessarily require a personal contact or social interaction with respondents. The interview approach gives the researcher the opportunity to generate more data through the structured questions. Hidden facts that the researcher does not have knowledge of can be exposed, simply by allowing the respondents to express themselves beyond the confinements of options.

The structured interview is the type of research approach that involves a set of structured questions designed to be asked precisely as phrased. The structured interview approach uses a consistent format for all respondents which depicts that the same set of question is asked without modification. This consistent format is referred to as interview schedule. Usually, the interview process is recorded in order not to leave out any detail from the responses and enables the data received to be transcribed for later analysis. However, permission was obtained from the respondents for recording the interviews. Under the interview process, it is important for a researcher to use the terminology that is suitable or peculiar to the group being studied to foster smooth interaction and realise the objectives of the survey.

The structured interview is directed at establishing the role of precedence and thrill of adventure on migration, which are the main elements of the band wagon theory. The precedence element enabled the study to know if the success rate of doctors in the private sector can influence migration flow while the thrill of adventure will establish if the excitement to explore a new terrain can influence doctors to migrate. The structured interview established the link between the migration of doctors and the first element of the new economics of labour migration theory which affirm that migration decisions are not

individualistic in nature. This emphasised the importance of family structure on migration decision of doctors.

One strong point of the structured interview approach is that it can be easily tested for reliability because of its replication ability that involves a fixed set of closed-ended questions being asked. Another merit of the structured interview approach is that it saves time which allows for many interviews to be done within the shortest possible time. This merit also translates into an opportunity to obtain a large sample of a population and also have the ability to be generalised. One major demerit of the structured interviews approach is the fact that they are not flexible. The interview schedule must be followed at all times which might not allow the researcher to gather as much data as the semi-structured approach. Spontaneous questions that can shed more light on the phenomenon under study cannot be asked as it will interfere with the interview schedule.

Generally, interview processes are expensive and not cost effective especially in the case of a limited budget for the study. It is vital to note that interviews might not be applicable in all situations especially in delicate cases; it is advisable to firstly conduct a pilot study to know the suitability of the interview approach to such a study. The pilot study was conducted. The structured interviews were recorded to ensure that all the responses are well captured and also to avoid the distortion of information provided by respondents.

4.8.2 SEMI-STRUCTURED IN-DEPTH INTERVIEWS

The semi-structured interview is perceived as the most reliable method. It affords the researcher an opportunity to have direct access to respondents to collect information while observing them at the same time which makes it the least susceptible technique (Lahikainen, Hyvärinen & Palander, 1991). The opinions of the disadvantaged groups in the organisation or society can be revealed under the semi-structured interview thus empowering them (Banister, Burman, Parker, Taylor & Tindall, 2002).

It is important to state that the semi-structured interview approach requires a high level of mental preparedness and proficiency which is being demonstrated all through the cause of this study, focusing only on the relevant points. Inquiry into complex issues through

qualitative approach is possible with the use of semi-structured interview which also offers the opportunity of gathering realistic information.

A semi-structured in-depth interview was employed to collect data on the fundamental issues responsible for this migration from the hospital managers and medical managers. Because the HR managers in the private hospitals do not interfere with doctor's appointment, only the hospital managers in each of the private hospitals and the CEO of the public hospital under study were interviewed for the research, the total respondent for the semi-structured interview was three hospital managers and one CEO.

The semi-structured interview was directed at stimulating responses to the research question on the extent to which migration affects the public sector in terms of service delivery and how. The six questions were also proposed to obtain views on migration and the impact of employee relations on the retention of medical doctors in the public sector. The semi-structured interview provided the opportunity to know the impact of political factors on the internal migration of medical doctors from the public sector to the private sector which is the third element under the push-pull theory. It established the influence of the size of the hospitals on migration of medical doctors, the benefits or drawbacks of this migration on both the private sector and the public sector and the motivations that drive this migration. The reactions of each respondent to the questions were noted.

The resolution to use the semi-structured was because it is a more open research collection method that allows the researcher to document perspectives outside the formulated questions. To ensure in-depth data collection, the interviewees were briefed on the interview questions and given time to prepare for the answers.

It is pertinent to state that interviewer's bias has been viewed as a major limitation of semi-structured interview approach (Banister *et al*., 2002). The nature of an interview has a way of testing the personal objectivity of the researcher. In order to ensure a high level of objectivity, the responses were recorded in the purest of forms without any manipulation which allows for accurate interpretation.

4.8.3 DOCUMENT REVIEW

Document review or collection is the gathering of documents that contain information on the phenomenon under study (Bailey, 1994; Payne & Payne 2004). Documentary data clearly provides the foundation for new research to commence; therefore, it laid a sound basis for the phenomenon under study. The amount of time, energy, as well as the cost, expended in data collection can be saved using the documentary data. Besides, it is evidently cost-effective to make use of current documentary data than having to collect new ones. Therefore, a precise and reliable documentary data will offer an opportunity for replication which will aid the validity obtained from the findings of the other research approaches used in the study.

Purposive sampling was used to collect specific background information which was helpful in proffering answers to some of the research questions in this study. Diverse documentary evidence was reviewed for different stages of the study. Documents on the two hospitals were reviewed via the internet from their respective websites. Among documents considered are health journals, district health reports, hospital websites and newsletters. The focus that gave direction to document review include: (a) Hospital reports on medical practitioner turnover, its effect and how the situation is being managed; and (b) Documents on reward policy, code of conduct and method of operation.

Nonetheless, it is germane to state that the documentary data might not meet the definite need of a particular study (Sekaran, 2000). Another key limitation of the documentary data is restrictive access to information that might be valuable to a particular study. Fortunately, the documentary data has been particularly useful and relevant to the objectives of this study, and its limitation was compensated for by the use of other approaches.

4.9 PILOT STUDY

A pilot or practicality study was conducted. This served as a preliminary analysis to gather information and exam logistics before the main study and, to enhance the quality of the main study. The pilot study revealed any hidden inadequacies of the design of the proposed study. The pilot study sample included three respondents from Mahatma Gandhi and two from the Life Healthcare hospitals

4.10 TRIANGULATION

Triangulation is simply the use of more than two methods in a study with the intention of substantiating the outcomes. Triangulation, according to Voss, Tsikriktsis and Frohlich (2002), is the coming together of diverse research methods in investigating the same phenomenon, to increase the precision of the outcome thereby enhancing validity. Triangulation can likewise be described as cross-examination. The central idea of triangulation is that the achievement of a similar result by different techniques will boost the strength of the outcome. The fundamental principle of triangulation is that the inherent limitations usually associated with a single approach can be overcome through the combination of the strength of diverse approaches. The correct application of the research approach has a strong tendency to heighten the dependability and validity of research outcomes.

Three research methods were employed in this study by the researcher. The restrictions of the questionnaires were catered for by the application of the structured interview, documentary data, and semi-structured interviews. The structured and semi-structured interview provided an opportunity for the elucidation of any ambiguity perceived in the questionnaire especially for situations whereby none of the answers provided appropriately represented the respondent's opinion or reactions.

4.11 RELIABILITY AND VALIDITY

Reliability is the degree of consistency of a measuring device while validity examines if the research techniques measures what it set out to measure. Validity is the extent to which a scale programmed into questions correctly assesses the variable it is designed to appraise (Gill & Johnson, 1997). The prerequisite for determining validity is determining reliability (Gay, 1987). The validity of a measurement method can be evaluated through the benchmarking of its result with situations where the validity has previously been proven. The respondents were allowed to exercise their free will to participate in the study and they were not pressurised into participating.

The three research methods employed by this study were the survey, semi-structured interview and the documentary data. The utilisation of the semi-structured interview and the secondary data makes up for the limitations of the survey method. The content validity of the questionnaire was assured by only including items that repeatedly surfaced as potential factors that influence the migration decisions of doctors when conducting the literature

review, when reviewing archival data and when conceptualising the topic in the contexts (public and private hospitals). The reliability of the questionnaire was assessed using Cronbach's Coefficient Alpha which generated a good level of overall internal consistency ($\alpha = 0.742$). The qualitative data will be assessed for its trustworthiness through cross-questioning and follow up questions.

4.12 DATA ANALYSIS

The positivist method was used to analyse scientifically the data generated from the questionnaires, structured interviews, and the document reviews. Specific statistical tools of the Microsoft Excel were used while the outcomes were presented statistically.

The questionnaire was fragmented into three main sections: Section A focused on information such as gender, marital status, race, academic qualification, sector, the length of service, age, marital status and years spent in the current sector. Segment 2 and 3 focused on obtaining responses on migration reasons, reward/pay structure, performance management, management structure, job design, job satisfaction, retention, employee relations and productivity. The theoretical context formed the basis for the evaluation of the questionnaire.

The semi-structured interview makes use of the interpretivist approach to analyse its data because it can only be explained through the qualitative method. The semi-structured interview was designed to seek out the view of the three hospital managers and one CEO on the reasons behind the migration of medical doctors from the public sector to the private sector and its resultant effect on the public health system. The structured and semi-structured interview aided the data from the questionnaire thereby validating its outcomes.

4.13 DATA QUALITY CONTROL

Data quality control means ensuring that the data-collection tools used measure what they are expected to measure and measure in a dependable way (Rubin, 2008). Data quality refers to the extent to which a set of data features satisfies requirements. Some of the features include validity, consistency, availability, accuracy, timeliness, and completeness. The control over the data quality to realise the objective of the study includes:

- The mark of quality demonstrated by the data in connection with the representation of the real situation.

- The form of consistency, validity, accuracy, completeness and timeliness that ensures that the data is suitable for a precise use.
- The whole characteristics of data that influence its capability to fulfil a specific purpose.
- The methods and the expertise involved in safeguarding the adaptation of data ethics to acceptance standards and business requirements.

4.14 RESEARCH GOVERNANCE

The research governance is a structure by which an institution certifies that the conducted study complies with appropriate jurisdictional, national and established criteria and regulations. Research governance deals with the safety of research participants, the quality of research, confidentiality, encourages good research practice and philosophy, supervisory and legal matters, risk management, and financial morality.

Essentially, the research governance sets criteria for the research work, outlines contrivances to deliver the criteria and describes the evaluation and monitoring schedules. The research governance is significant for the following reasons:

- Promoting scientific excellence and ethical awareness.
- Avoiding misdemeanours and poor performance.
- Upholding good practice.
- Making sure lessons are learnt while decreasing adverse occurrences.

Ensuring highest degrees of excellence in research is of utmost importance in research governance. The two components of research governance are ethical consideration or approval and institutional authorisation.

4.14.1 ETHICAL CONSIDERATIONS

The necessary ethical consent was obtained from the University of KwaZulu-Natal Ethics Committee. This research work did not pose any harm to the participants as all involvement was voluntary without penalty for non-participation. Informed consent of the participants was obtained. Informed consent is a process in which a participant is informed about the facts about the study for him/her to decide whether or not to participate. High level of confidentiality was maintained by educating the participants of their right to limit access to

private information. No respondents were under duress to provide information and confidentiality was maintained at all times.

4.14.2 INSTITUTIONAL AUTHORISATION

Typically, a prior arrangement with regards to data access has to be concluded and approved by the study sites to ensure a smooth progress for the study. This study, therefore, ensured that all relevant approvals and authorisation were obtained from KwaZulu-Natal Department of Health, Mahatma Gandhi hospital management and Life Healthcare hospital group ethics committee to gain access to documentary data such as records, journals, and the websites as well as allowed their staff to be involved in the completing of the questionnaires, responding to the semi-structured and structured interviews.

4.15 LIMITATIONS OF THE STUDY

The obvious limitation of this study would be the lack of a patient perception. Access to patients' viewpoint would have been of immense advantage to this study in determining the effect of the migration more accurately on their satisfaction with healthcare. However, the researcher collected data from both sides of the delivery system, namely, managers and employees. Another limitation to this study is the issue of social desirability while gathering quantitative data as respondents might want to project a good image of themselves or the organisation. This limitation was addressed by offering anonymity on questionnaires.

4.16 CONCLUSION

The research methodology is vital in every study to ensure a reliable outcome. The use of an unreliable method in research methodology will yield inaccurate outcomes that will weaken the value of data analysis, and the entire study. The aforementioned research methodology has evidently articulated the motives behind the choice of all the techniques used.

The research methodology also shows that the data generating methods were in accordance with the acceptable practice in the field of social science. Not only were the methods consistent with the acceptable practice but they were also suitable to fulfill the general objectives of the study. The various anticipated challenges were discussed, and solutions were also proffered to prevent them from negatively affecting the study.

CHAPTER 5

PRESENTATION OF RESULTS

5.1 INTRODUCTION

The data obtained from the distributed questionnaires, structured interviews, semi-structured interviews and documents are evaluated in this chapter. This study was conducted with the aim of establishing the rationale behind medical doctors' migration from the public sector to the private sector in South Africa. In order to achieve this, semi-structured interviews were conducted with the hospital managers of the private hospitals and the chief executive officer of the public hospital while questionnaires were distributed among 187 medical doctors from both the public and the private sector. Finally, 115 responses were received out of the 187 targeted responses, thereby confirming a 68% response rate. The questionnaires were administered to medical doctors from the Life healthcare hospital group and Mahatma Gandhi hospital. The results are presented using tabular and graphical representations.

5.2 DESCRIPTIVE AND INFERENTIAL STATISTICS

Descriptive statistics are used to assess the key dimensions of the study relating to the migration of doctors from the public sector to the private sector, that is, people management practices, performance, attempt to migrate, retention and reasons for staying (Table 5.1). Respondents were required to respond to eleven items using a 5 point Likert scale.

Table 5.1

Descriptive Statistics: Key dimensions of the study relating to the migration of doctors from the public sector to the private sector

Dimension	Mean	95% Confidence Interval		Std. Dev.	Min.	Max.
		Lower Bound	Upper Bound			
People management practices	2.96	2.820	3.10	0.772	1	6
Performance						
Basis for Performance	3.27	3.08	3.47	1.063	1	5
Recognition of Performance	1.81	1.74	1.89	0.391	1	2
Attempt to migrate	2.47	2.33	2.61	0.768	1	3
Retention						
Reason for leaving	2.67	1.09	4.25	1.506	1	4
Reasons for staying						
Career Prospect	2.17	1.13	3.20	0.983	1	4
Employee relations policies	3.17	1.02	5.31	2.041	1	5
Job satisfaction	3.00	1.24	4.76	1.673	1	5
Wage differentials and benefits	3.00	2.34	3.66	0.632	2	4
Values	3.67	2.09	5.25	1.506	1	5
Factors that might influence migration	2.83	2.04	3.62	0.753	2	4
Career prospect	3.50	2.93	4.07	0.548	3	4
Employee relations policies	3.33	1.38	5.29	1.862	1	5
Job satisfaction	3.00	1.37	4.63	1.549	2	5
Wage differentials and benefits	2.33	0.17	4.50	2.066	1	5
Values						

Table 5.1 depicts that medical doctors differ in their perceptions of the above listed dimensions which in descending order based on the mean ranking are:

- Basis for performance (reward, increased efficiency, commitment, punishment, financial security) (Mean = 3.27)
- Monetary and non-monetary rewards (Mean = 2.96)
- Reasons for leaving (Mean = 2.67)
- Attempt to migrate (Mean = 2.47)
- Recognition of performance (Mean = 1.81)

The basis for performance, that is, what drives doctors to perform, had a mean score of 3.27. This is directed at knowing the motivation behind the performance of job roles and responsibilities given to medical doctors. Under the basis for performance, there were five listed variables which the respondents were asked to respond to, such as reward, increase efficiency, commitment, punishment and financial security. In order to accurately evaluate all the variables under the basis for performance, frequency analyses were employed and it was found that 38.3% of the respondents agreed that commitment is the basis for performance which shows that medical doctors perform their duties basically due to their commitment to the profession. Furthermore, 27% of the respondents indicated punishment as the basis for performance which shows that the fear of losing their jobs or having their license withdrawn by the Health Professions Council of South Africa (HPCSA) is a major motivation for performance. It is however surprising to note that, reward had the lowest percentage of 6.1 which depicts that there are other variables more important than reward that drive doctors to perform.

The people management practices had a mean score of 2.96, thereby indicating that the people management practices have some degree of influence on the migration decision. In order to accurately evaluate the people management practices dimension, frequency analyses were conducted and it was found that 59.1% of the respondents believed that the benefit/reward structure in relations to the information received when joining the sector is satisfactory while 16.5% indicated that the information was good. The analysis of the relationship between management and medical doctors showed that 43.5% of the respondents think the relationship is satisfactory while 32.2% feel that the relationship is poor. Furthermore, 43.5% of the respondents rated the performance management structure as being satisfactory while 31.3% rated it as being poor. In addition, 50.4% of the respondents were not convinced that role/jobs were designed to facilitate job satisfaction and increase productivity and a further 32.2% disagreed. Employee involvement is essential in fostering employee engagement and retention yet 46.1% of the respondents disagreed that there is employee involvement in reward management decisions and a further 45.2% of the respondents were not convinced. This shows a major challenge in employee involvement.

Reasons for leaving under the retention dimension had a mean score of 2.67, thereby signifying that despite receiving recognition for their performance some doctors still decided to migrate to the private sector. The factors responsible for the migration were poor career prospect, poor employee relations policies, poor pay and benefit structure and lack of job satisfaction. In order to accurately evaluate reasons for leaving, frequency analyses were conducted and it was found that 72.2% of the respondents indicated that the question is not applicable to them while 11.3% cited the lack of job satisfaction closely followed by poor career prospects (10.4%) as potential factors for migration.

Attempt to migrate had a mean score of 2.47, thereby indicating that since joining the public sector some doctors have attempted going into the private sector. In order to correctly evaluate attempt to migrate, frequency analyses were conducted and it was found that 63% of the respondents indicated that the item was not applicable. Furthermore, 20% of the participants indicated that they have never attempted going into the private sector while 16.5% indicated that they have attempted going into the private sector.

Recognition of performance had the lowest mean of all the items with a mean score of 1.81, thereby depicting that only a small percentage of doctors have had their performance recognised or awarded since joining the sector. In order to correctly evaluate recognition of performance, frequency analyses were done and it was found that 81% of the respondents have never had their performance recognised nor received an award while only 18.3% reflected that they have received recognition for their performance.

Medical doctors also differ in their reasons behind preferring to stay with the public sector. This is arranged in descending order based on the mean ranking as:

- Values (Mean = 3.67)
- Employee relations policies (Mean = 3.17)
- Job satisfaction (Mean = 3.00)
- Wage differentials and benefits (Mean = 3.00)
- Career prospect (Mean = 2.17)

With regards to reasons behind preferring to stay with the public sector, values have the highest mean value of 3.67, thereby indicating that personal values have a significant impact on the decision to continue working in the public sector where other factors might have

failed. Employee relations policies had the next highest mean score of 3.17, thereby displaying the importance of formulating good policies on people management. Job satisfaction and wage differentials and benefits had the same mean score of 3.00. Job satisfaction is quite significant for doctors who decided to stay in their sector which is an indication that it is a key retention factor. Wage differentials and benefits influence the decision of doctors to stay with the public sector which shows the strong influence of remuneration on retention. Career prospect had the lowest mean score of 2.17, thereby indicating that some doctors decided to continue working in the public sector due to the career opportunities that are available to them. This shows that career prospect is the least significant reason keeping some doctors in the public sector.

Medical doctors hold divergent views on why they may seek employment in the private sector. This is also arranged in descending order based on the mean ranking as:

- Employee relations policies (Mean = 3.50)
- Job satisfaction (Mean = 3.33)
- Wage differentials and benefits (Mean = 3.00)
- Career prospect (Mean = 2.83)
- Values (Mean = 2.33)

Medical doctors believe most strongly that they will seek employment in the private sector because of employee relations policies (Mean = 3.50). In other words, the kind of policies enacted with regards to employee relations in the healthcare sector, has a significant bearing on the decision of doctors to migrate. Furthermore, medical doctors may seek employment in the private sector for the purpose of job satisfaction (Mean = 3.33). This shows that when doctors are dissatisfied with their jobs in the public sector, it can influence them to migrate. Wage differentials and benefits under factors that might influence migration had a mean score of 3.00. Wage differentials and benefits were indicated to influence the reason to migrate from the public to the private sector which indicates that the influence of remuneration on migration cannot be undermined. Wage differentials and benefits were indicated to influence the reason for staying and the reason to migrate which shows that the influence of remuneration on migration and retention cannot be overemphasised. Some doctors do believe that career prospect can influence their decision to migrate (Mean = 2.83). Furthermore, values (Mean = 2.33) can also be a motivating factor for the migration of

doctors from the public to the private sector. This is a reflection of the fact that some doctors perceive values to be the most important element that can influence their migration decision. Figure 5.1 indicates the association between the reasons behind preferring to stay with the public sector and why doctors might migrate to the private sector.

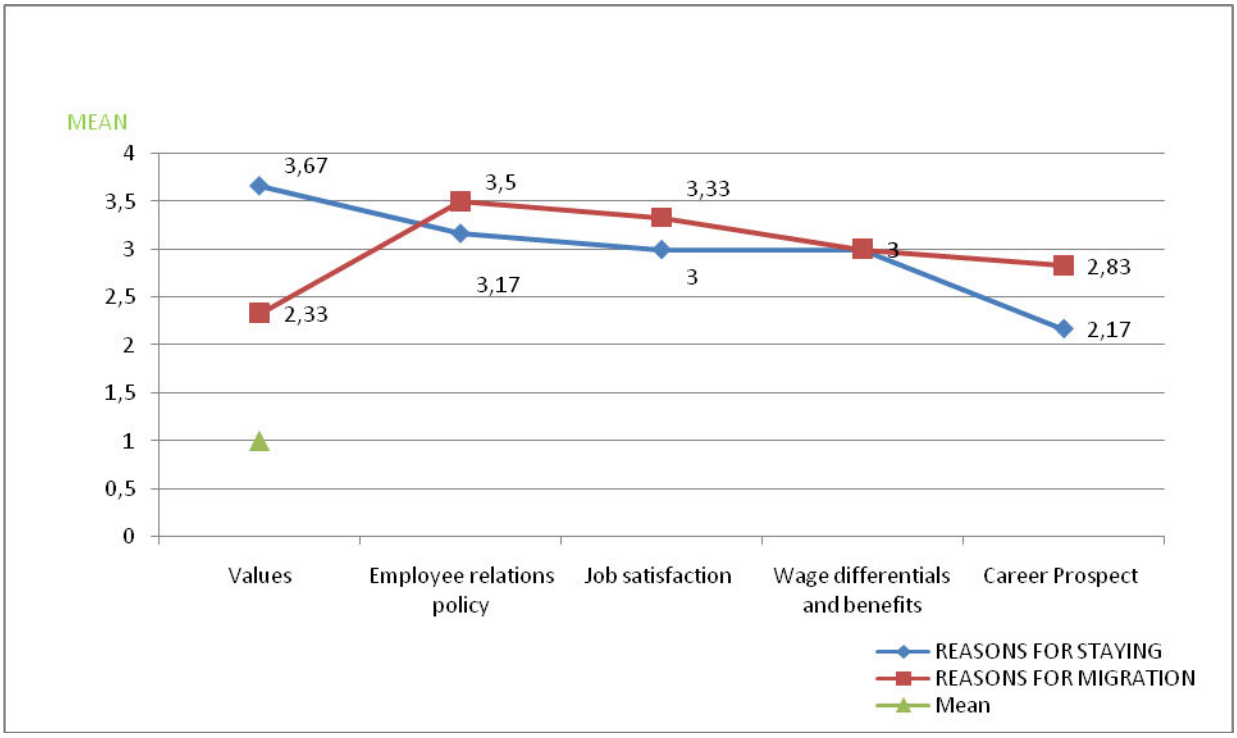


Figure 5.1 Line graph for the means of reasons for staying and reasons for migration

It is evident from Figure 5.1 that personal values was a major factor that influences the retention of medical doctors in the public sector, but the influence of values on why doctors might migrate to the private sector is not as profound. Personal values are ideas, beliefs, and principles that shape the perception of an individual to life. They are things that one stands for or believes in that affects one's decision-making process. Evidently, medical doctors' values bind them into providing their service in the public sector to a greater extent than causing them to migrate.

Employee relations policy and job satisfaction reflect a significant impact on why doctors might migrate to the private sector than remaining in the public sector. This is an indication that there is dissatisfaction with the employee relations policy which can affect the satisfaction that doctors derive from their job. It also shows that employee relations policy

and job satisfaction are potential push factors that encourage the migration of doctors from the public sector to the private sector.

The influence of wage differentials and benefits on retention and migration is the same. This shows that the impact it will have on doctors' decision to migrate to practicing in the private sector will depend on how significant the wage differentials and benefit is to an individual.

Figure 5.1 also reflects that career prospect has a significant influence on why doctors might migrate to the private sector than its ability to retain them in the public sector which is evidently a push factor into the private sector. A greater percentage of the respondents believe that there is a better prospect for their career in the private sector than in the public sector.

When the employee relations policies, job satisfaction, and career prospects are not realised, medical doctors are more likely to migrate while on the other hand, the only significant factor influencing retention in the public sector is personal values.

Hypothesis 1

There is a significant difference in the perceptions of doctors varying in the respective biographical profiles (marital status, race, length of service in profession, length of service in sector, age, gender, educational qualification and sector) regarding the influence of the people management practices on migration (Table 5.2).

Table 5.2

Kruskal-Wallis ANOVA: Influence of people management practices on migration and Biographical Data

Biographical Profile	Chi-square	Df	P

Marital status	8.030	2	0.018**
Race	5.106	3	0.164
Length of service in practice	6.182	5	0.298
Length of service in current sector	11.488	5	0.043**
Age	6.746	3	0.080

**** p < 0.05**

Table 5.2 indicates that there is a significant difference in the perceptions of doctors varying in marital status and length of service in current sector regarding the influence of people management practices on migration respectively at the 5% level of significance. No other significant differences were noted. Hence, Hypothesis 1 may only be accepted in terms of marital status and length of service in current sector.

In order to assess exactly where the significant differences lie, mean ranks are compared (Table 5.3).

Table 5.3

Comparison of Mean Ranks: Influence of people management practices on migration

Dimension	**Category**	**N**	**Mean Rank**
Marital status	Single	28	49.25
	Married	85	59.55
	Divorced	2	114.50
Length of service in current sector	Less than 1 year	22	56.84
	1-5 years	28	60.09
	6-10 years	14	31.29
	11-15 years	10	64.75
	16-20 years	17	66.24
	21 years and above	24	63.56

Table 5.3 indicates that married doctors' decisions to migrate are more likely to be influenced by the people management practices than single doctors' decisions. It is important to state that there are only 2 divorced doctors and this has the potential to distort the rank. Furthermore, doctors with 16-20 years of service in the current sector, followed by those between 11-15 years and then 21 years and above, believe that people management practices

influence their decisions to migrate. Evidently, doctors with >10 years of service in the current sector are more likely to migrate due to people management practices.

Hypothesis 2

There is a significant difference in the perceptions of doctors varying in biographical and institutional profiles (gender, educational qualifications, sector) regarding the influence of people management practices (Table 5.4).

Table 5.4

Mann-Whitney Test: Influence of people management practices on migration and Biographical Profiles

Dimension	**Mann-Whitney U (Private)**	**Wilcoxon W (Public)**	**Z**	**P**
Gender	1144.000	1609.000	-0.844	0.399
Educational qualification	1259.500	1755.500	-0.075	0.940
Sector	827.000	1457.000	-3.376	0.001*

*** p < 0.01**

Table 5.4 indicates that there is a significant difference in the perceptions of doctors from the private and public sectors regarding the influence of people management practices on migration at the 1% level of significance. The influence of people management practices on migration is higher in the public sector than in the private sector which signifies that its impact on the migration decision is more significant in the public sector according to the information received from the respondents. Some of the factors examined under people management practices dimension are benefit/reward structures, relationship with management, employee involvement, performance management and job/role designs. This result portrays people management practices to be a major factor that pushes doctors to the private sector. No significant differences were noted in terms of gender and educational qualification. Hence, Hypothesis 2 may only be accepted in terms of sector.

Hypothesis 3

There is a significant relationship between the basis for performance (reward, increased efficiency, commitment, punishment, financial security) and attempts to migrate (Table 5.5).

Table 5.5

Chi-square Test: Basis for performance and Attempts to migrate

Statistic	Value	Df	P
Pearson Chi-square	27.670	8	0.001*

*** p < 0.01**

Table 5.5 indicates that there is a significant relationship in the perceptions of doctors from both the private and public sectors regarding the association between the basis for performance (reward, increased efficiency, commitment, punishment, financial security) and attempts to migrate at the 1% level of significance. Hence, hypothesis 3 may be accepted.

In order to engage in deeper analysis of the relationship between basis for performance and attempts to migrate, a cross-tabulation is assessed (Table 5.6).

Table 5.6

Comparison in percentages between Basis for Performance and attempt to migrate

What is the basis for performance?	Have you ever tried to go into private practice after joining the public sector?			Total
	Yes	No	Not applicable	
Reward	0.9	2.7	2.7	**6.2**
Increased efficiency	5.3	7.1	1.8	**14.2**
Commitment	5.3	5.3	28.3	**38.9**
Punishment	2.7	4.4	20.4	**27.4**
Financial security	2.7	0	10.6	**13.3**
Total	**16.8**	**19.5**	**63.7**	**100**

The results in Table 5.6 reflected that a certain percentage of the respondents (16.8%) believe that rewards, increased efficiency, commitment, punishment and financial security are the bases for performance and have a significant combined influence on attempt to migrate. However, commitment had the highest impact (38.9%) of all the variables hence, hypothesis 3 may be accepted in terms of commitment. This shows that commitment to the profession impact greatly on the migration decisions of some doctors thereby fostering retention. Even

when they are dissatisfied with others things they will still not attempt to migrate because of their commitment to serve the populace who need their services and might not be able to pay for it in the private sector.

Despite having a diverse perspective on the basis for performance 16.8% of the doctors have attempted migrating to the private sector while 19.5% of the respondents indicated that they have not attempted going into private practice. Out of the 16.8% that indicated that they have attempted going to the private sector, equal number of respondents (5.3%) believed commitment and increased efficiency are the bases for performance while 2.7% indicated punishment and financial security, only 0.9% indicated reward. Furthermore, 7.1% of those that indicated not to have attempted going into private practice believe that increase efficiency is the basis for performance, 5.3% indicated commitment, 4.4% believe that punishment is the basis for performance while 2.7% indicated reward. It is however interesting to note that none of the doctors that indicated not to have attempted going into private practice believed financial security to be a basis of performance.

Hypothesis 4

There is a significant relationship between recognition of performance and attempts to migrate (Table 5.7).

Table 5.7

Chi-square Test: Recognition of performance and attempts to migrate

Statistic	**Value**	**Df**	**P**
Pearson Chi-square	5.282	2	0.071

Table 5.7 indicates that there is no significant relationship between recognition of performance and attempts to migrate. Hence, Hypothesis 4 may not be accepted. In order to engage in deeper analysis of the responses between recognition of performance and attempts to migrate, a cross-tabulation is assessed (Table 5.8).

Table 5.8

Comparison in percentages between recognition of performance and attempt to migrate

Recognition of your	**Have you ever tried to go into private practice**	**Total**

performance since joining the sector	after joining the public sector?			
	Yes	**No**	**Not applicable**	
Yes	5.2	0.9	12.2	**18.3**
No	11.3	19.1	51.3	**81.7**
Total	**16.5**	**20.0**	**63.5**	**100**

The majority of those who tried to migrate (11.3% of 16.5%) indicated that they did not receive recognition of their performance since joining the sector while nearly 20% indicated that despite the fact that their performances has not been recognised since joining the sector they have not attempted migrating to the private sector. Even though recognition of performance is good for employees' morale the result shows that a relationship cannot be established between it and attempts to migrate.

Hypothesis 5

There is a significant relationship between recognition of performance and the main reason for migrating (Table 5.9).

Table 5.9

Chi-square Test: Recognition of performance and the main reason for migrating

Statistic	Value	Df	p
Pearson Chi-square	7.385	3	0.061

Table 5.9 indicates that there is no significant relationship between recognition of performance and the main reason for migrating, that is, poor career prospect, poor employee relations policies, poor pay and benefit structure or lack of job satisfaction. Hence, Hypothesis 5 may not be accepted. In order to engage in deeper analysis of the responses to recognition of performance and main reason for migrating, a cross-tabulation is assessed (Table 5.10).

Table 5.10

Comparison in percentages between recognition of performance and the main reason for migrating

Recognition of your performance since joining the sector	If your response to recognition of performance is yes, what is your main reason for leaving?				Total
	Poor career prospect	Poor employee relations policies	Poor pay and benefit structure	Lack of job satisfaction	
Yes	9.4	0.0	9.4	0.0	**18.8**
No	28.1	3.1	9.4	40.6	**81.3**
Total	**37.5**	**3.1**	**18.8**	**40.6**	**100**

In Table 5.10, an equal segment of doctors (9.4%) migrated due to poor career prospects and poor pay and benefits structure in the public sector despite the recognition of their performance. Of those whose performance was not recognised, the majority (40.6%) migrated due to poor job satisfaction followed by poor career prospect (28.1%). Poor job satisfaction is significant among those doctors who have not experienced recognition of performance which might be a pointer to their displeasure at not being appreciated for their efforts.

Hypothesis 6

There is a significant relationship between recognition of performance and the basis for performance (reward, increased efficiency, commitment, punishment, financial security) respectively (Table 5.11).

Table 5.11

Chi-square Test: Recognition of performance and the basis for performance

Statistic	Value	Df	p
Pearson Chi-square	18.269	4	0.001*

*** p < 0.01**

Table 5.11 indicates that there is a significant relationship between recognition of performance and the basis for performance (reward, increased efficiency, commitment, punishment, financial security) respectively at the 1% level of significance. Hence, Hypothesis 6 may be accepted.

In order to engage in deeper analysis of the relationship between recognition of performance and the basis for performance, a cross-tabulation is assessed (Table 5.12).

Table 5.12

Comparison in percentages between Recognition of performance and basis for performance

Recognition of your performance since joining the sector	**What do you think is the basis for performance?**					**Total**
	Reward	**Increase efficiency**	**Commitment**	**Punishment**	**Financial security**	
Yes	0.0	0.0	3.5	9.7	5.3	18.6
No	6.2	14.2	35.4	17.7	8.0	81.4
Total	**6.2**	**14.2**	**38.9**	**27.4**	**13.3**	**100**

The percentage of doctors that indicated commitment (38.9%) reinforced its influence on retention; hence, hypothesis 6 may be accepted in terms of commitment. Medical profession can be likened to a humanitarian service due to the commitment of the practitioners in the face of unfavorable and threatening situations.

Of those doctors that believed that their performance was recognised (18.6%), the majority (9.7%) felt that their performance was due to fear of punishment such as losing their license to practice as a medical doctor. The majority of the respondents did not believe that their performance was recognised (81.4%) and felt that their performance was mainly due to commitment (35.4%) followed by fear of punishment (17.7%), then increased efficiency (14.2%), financial security (8%) and reward (6.2%).

Hypothesis 7

There is a significant relationship between the main reason for leaving despite recognition of performance and the most significant reason for preferring to stay with the public sector (Table 5.13).

Table 5.13

Chi-square Test: Main reason for leaving despite recognition of performance and the most significant reason for preferring to stay with the public sector

Statistic	Value	Df	P
Pearson Chi-square	12.800	12	0.384

Table 5.13 indicates that there is no significant relationship between main reason for leaving despite having recognition of performance and the most significant reason for preferring to stay with the public sector. Hence, hypothesis 7 may not be accepted. In order to engage in deeper analysis of the responses to recognition of performance and the most significant reason for retention in the public sector, a cross-tabulation is assessed (Table 5.14).

Table 5.14

Comparison in percentages between main reason for leaving despite receiving recognition of performance and the most significant reason for preferring to stay with the public sector

If your response to recognition	First most significant reason for preferring to stay with the public sector	Total

of performance is yes, what is your main reason for leaving?	Career prospect	Employee relations policies	Job satisfaction	Wage differentials and benefits	Values	
Poor career prospect	16.7	8.3	8.3	8.3	0.0	**41.7**
Poor employee relations policies	0.0	8.3	0.0	0.0	0.0	**8.3**
Poor pay and benefit structure	8.3	0.0	0.0	0.0	16.7	**25.0**
Lack of job satisfaction	8.3	16.7	0.0	0.0	0.0	**25.0**
Total	**33.3**	**33.3**	**8.3**	**8.3**	**16.7**	**100**

An equal segment of 33.3% was indicated as the most significant reasons that can influence doctors to stay in the public sector, namely, career prospects and employee relations policies. The influence of employee relations policies and career prospect on retention is further highlighted in this table even though a relationship cannot be established between the two dimensions. Of the doctors that indicated that their performance was recognised but still migrated due to poor career prospect (41.7%), 16.7% believed that career prospect has a strong influence on retention in the public sector. Of those that indicated poor pay and benefits structure as the reason for migrating (25%), 16.7% believed that value is the most significant reason for retention while of those that indicated poor job satisfaction as the factor behind their migration (25%), 16.7% felt employee relations policies is the most significant factor behind doctors' retention in the public section.

Hypothesis 8

There is a significant relationship between the main reason for leaving despite recognition of performance and the second most significant reason for preferring to stay with the public sector (Table 5.15).

Table 5.15

Chi-square Test: Main reason for leaving despite receiving recognition of performance and the second most significant reason for preferring to stay with the public sector

Statistic	Value	Df	P
Pearson Chi-square	15.200	9	0.086

*** p < 0.01**

Table 5.15 indicates that there is no significant relationship between the main reason or leaving despite receiving recognition of performance and the second most significant reason for preferring to stay with the public sector. Hence, hypothesis 8 may not be accepted. In order to engage in deeper analysis of the responses to main reason for leaving and second most significant reason for preferring to stay with the public sector, a cross-tabulation is assessed (Table 5.16).

Table 5.16

Comparison in percentages between main reason for leaving despite receiving recognition of performance and the second most significant reason for preferring to stay with the public sector

If your response to recognition of performance is	Second most significant reason for preferring to stay with the public sector	Total

yes, what is your main reason for leaving?	Career prospect	Employee relations policies	Wage differentials and benefits	Values	
Poor career prospect	0.0	8.3	8.3	25.0	**41.7**
Poor employee relations policies	8.3	0.0	0.0	0.0	**8.3**
Poor pay and benefit structure	0.0	0.0	25.0	0.0	**25.0**
Lack of job satisfaction	8.3	8.3	0.0	8.3	**25.0**
Total	**16.7**	**16.7**	**33.3**	**33.3**	**100**

Wage differentials and benefits and values have the highest percentage of 33.3% each thus identifying them as second most significant reason influencing the decision to stay in the public sector. Of those that migrated due to poor career prospects, 25% felt values are the second most significant reason behind retention in the public sector. Of those that indicated poor pay and benefit structure as the reason for migrating, 25% believe wage and differentials and benefits are the second most substantial factor for retention in the public sector. The importance of personal values and wage differential and benefit on retention was emphasised in Table 5.16.

Hypothesis 9

There is a significant relationship between the main reason for leaving despite receiving recognition of performance and the third most significant reason for preferring to stay with the public sector (Table 5.17).

Table 5.17

Chi-square Test: Main reason for leaving despite receiving recognition of performance and third most significant reason for preferring to stay with the public sector

Statistic	Value	Df	P

Pearson Chi-square	12.833	9	0.170

Table 5.17 indicates that there is no significant relationship between the main reason for leaving despite receiving recognition of performance and the third most significant reason for preferring to stay with the public sector. Hence, hypothesis 9 may not be accepted. In order to engage in deeper analysis of the responses to the main reason for leaving and the third most significant reason for preferring to stay with the public sector, a cross-tabulation is assessed (Table 5.18).

Table 5.18

Comparison in percentages between main reason or leaving despite recognition of performance and the third most significant reason for preferring to stay with the public sector

If your response to recognition of performance is yes, what is your main reason for leaving?	**Third most significant reason for preferring to stay with the public sector**				**Total**
	Career prospect	**Job satisfaction**	**Wage differentials and benefits**	**Values**	
Poor career prospect	9.1	27.3	0.0	0.0	**36.4**
Poor employee relations policies	0.0	0.0	9.1	0.0	**9.1**
Poor pay and benefit structure	0.0	27.3	25.0	0.0	**27.3**
Lack of job satisfaction	9.1	0.0	9.1	9.1	**27.3**
Total	**18.2**	**54.5**	**18.2**	**9.1**	**100**

Job satisfaction (54.5%) was indicated as the third most significant reason for retention in the public sector. Of those that migrated due to poor career prospect despite receiving performance recognition, 27.3% felt job satisfaction is the third most significant retention factor in the public sector. Of those that migrated due to poor pay and benefit structure, 27.3% also believe that job satisfaction is the third most important retention factor in the public sector. Job satisfaction has the potential to bring about personal fulfillment in employees and thus influence the doctors' decision to stay with the public sector.

Hypothesis 10

There is a significant relationship between the main reason for leaving despite receiving recognition of performance and the most significant reason for seeking employment in the private sector (Table 5.19).

Table 5.19

Chi-square Test: Main reason for leaving despite receiving recognition of performance and the first most significant reason for seeking employment in the private sector

Statistic	Value	Df	P
Pearson Chi-square	7.389	6	0.286

Table 5.19 indicates that there is no significant relationship between the main reason for leaving despite receiving recognition of performance and the most significant for seeking employment in the private sector. Hence, hypothesis 10 may not be accepted. In order to engage in deeper analysis of the responses, a cross-tabulation is assessed (Table 5.20).

Table 5.20

Comparison in percentages between main reason for leaving despite receiving recognition of performance and the most significant reason for seeking employment in the private sector

If your response to recognition of performance is yes, what is your main reason for leaving?	The first most significant reason why you may seek employment in the private sector			Total
	Employee relations policies	Job satisfaction	Wage differentials and benefits	
Poor career prospect	5.3	21.1	15.8	**42.1**
Poor employee relations policies	5.3	0.0	0.0	**5.3**
Poor pay and benefit structure	0.0	5.3	15.8	**21.1**
Lack of job satisfaction	5.3	10.5	15.8	**31.6**
Total	**15.8**	**36.8**	**47.4**	**100**

The majority of the respondents felt that wage differentials and benefits (47.4%) is the most significant reason that might influence a doctor in seeking employment in the private sector. In addition, 15.8% of the doctors that migrated because of poor career prospect, poor pay and benefit structure and lack of job satisfaction despite having their performance being recognised indicated wage differential and benefit as the factor responsible for migration to the private sector. Table 5.20 also indicates that the search for job satisfaction is the second most important reason for seeking employment in the private sector.

Hypothesis 11

There is a significant relationship between the main reason for leaving despite receiving recognition of performance and the second most significant reason for seeking employment in the private sector (Table 5.21).

Table 5.21

Chi-square Test: Main reason for leaving despite receiving recognition of performance and the second most significant reason for seeking employment in the private sector

Statistic	Value	Df	P
Pearson Chi-square	9.529	9	0.390

Table 5.21 indicates that there is no significant relationship between the main reason for leaving despite receiving recognition of performance and the second most significant reason for seeking employment in the private sector. Hence, hypothesis 11 may not be accepted. In order to engage in deeper analysis of the responses, a cross-tabulation is assessed (Table 5.22).

Table 5.22

Comparison in percentages between main reason for leaving despite receiving recognition of performance and the second most significant reason for seeking employment in the private sector

If your response to recognition of performance is yes, what is your main reason for leaving?	The second most significant reason why you make seek employment in the private sector				Total
	Career prospect	Employee relations policies	Job satisfaction	Wage differentials and benefits	
Poor career prospect	0.0	5.9	17.6	17.6	**41.2**
Poor employee relations policies	0.0	0.0	5.9	0.0	**5.9**
Poor pay and benefit structure	11.8	0.0	5.9	5.9	**23.5**
Lack of job satisfaction	0.0	5.9	17.6	5.9	**29.4**
Total	**11.8**	**11.8**	**47.1**	**29.4**	**100**

Job satisfaction (47.1%) was indicated as the second most significant reason for migration to the private sector followed by wage differentials and benefits (29.4%). Of those that migrated due to poor career prospect, an equal percentage of 17.6% felt job satisfaction and wage differentials and benefits are the second most important reasons for migration to the private sector. Of those that migrated due to lack of job satisfaction 17.6% believe job satisfaction is very significant in swaying migration decision towards the private sector.

Hypothesis 12

There is a significant relationship between the main reason for leaving despite receiving recognition of performance and the third most significant reason for seeking employment in the private sector (Table 5.23).

Table 5.23

Chi-square Test: Main reason for leaving despite receiving recognition of performance and the third most significant reason for seeking employment in the private sector

Statistic	Value	Df	P
Pearson Chi-square	13.062	9	0.160

Table 5.23 indicates that there is no significant relationship between the main reason for leaving despite receiving recognition of performance and the most significant reason for seeking employment in the private sector. Hence, hypothesis 12 may not be accepted. In order to engage in deeper analysis of the responses, a cross-tabulation is assessed (Table 5.24).

Table 5.24

Comparison in percentages between the main reason for leaving despite receiving recognition of performance and the third most significant reason for seeking employment in the private sector

If your response to recognition of performance is yes, what is your main reason for leaving?	The third most significant reason why you make seek employment in the private sector				Total
	Career prospect	Employee relations policies	Wage differentials and benefits	Values	
Poor career prospect	30.8	7.7	0.0	7.7	**46.2**
Poor employee relations policies	0.0	0.0	7.7	0.0	**7.7**
Poor pay and benefit structure	0.0	7.7	0.0	0.0	**7.7**
Lack of job satisfaction	23.1	0.0	7.7	7.7	**38.5**
Total	**53.8**	**15.4**	**15.4**	**15.4**	**100**

Table 5.24 reflects that the doctors believed that career prospect (53.8%) is the third most significant factor that influences migration to the private sector. It was reliably gathered from the doctors that there are more opportunities for career prospect in the private sector than in the public sector. Of those that migrated due to poor career prospect, 30.8% felt career prospect is the third most important factor driving migration to the private sector while 23.1% of those that migrated due to poor job satisfaction also believe that career prospect is an important element in migration.

Hypothesis 13

There is a significant relationship between the biographical profiles of the doctors (marital status, race, education, length of service in practice, length of service in current sector, age, gender) and their main reason for leaving the public sector despite them receiving recognition of performance (Table 5.25).

Table 5.25

Spearman rho correlation between Biographical variables and main reason for leaving despite receiving performance recognition

Dimension	rho/p	Main reason for leaving
Marital status	rho	0.373
	p	**0.036****
Race	rho	-0.251
	p	**0.166**
Educational qualification	rho	0.263
	p	**0.153**
Length of service in practice	rho	0.385
	p	**0.030****
Length of service in current sector	rho	0.461
	p	**0.008***
Age	rho	0.345
	p	**0.053**
Gender	rho	-0.014
	p	**0.940**

*** p < 0.01**

**** p < 0.05**

Table 5.25 indicates that there is a significant relationship between some biographical profiles of the doctors (marital status, length of service in profession, length of service in current sector) and their main reason for leaving the public sector despite receiving recognition of performance at the 1% (length of service in current sector) and 5% (marital status, length of service in profession) levels of significance. No other significant relationships were noted. Hence, hypothesis 13 may only be accepted in terms of marital status, length of service in profession and length of service in sector. A detailed analysis of each of these significant biographical impacts is represented.

Table 5.25 shows a significant relationship (p = 0.036) between the single, married and divorced doctors on recognition of performance and the decision to migrate. The frequency analyses of the biographical data in Chapter four showed that the majority of the respondents are married which means that the significance of the association between marital status and the decision to migrate will be stronger among the married doctors. This could be an

indication that the private sector offers more job satisfaction to married doctors thus influencing migration from the public sector.

Table 5.25 indicates a significant relationship (p = 0.030) between the number of years a doctor had been in the profession and the recognition of performance and the decision to migrate. The frequency analyses of length of service in the profession in Chapter four reflect that medical doctors who had between 21 years and above working experience have the highest percentage among the respondents which could be an indication that experienced doctors are more prone to migration. This is perhaps an indication of their displeasure with the public sector.

Table 5.25 displays a significant relationship (p = 0.008) in the correlation between length of service in the current sector and the recognition of performance and the decision to migrate. Frequency analyses in Chapter four reflect that doctors with 1-5 years of service in the current sector have the highest percentage thereby showing how deeply migration has eaten into the healthcare system. Despite the fact that we had more respondents in the 21 years and above category under length of service in the profession, migration affected the finding received for length of service in current sector.

Hypothesis 14

There is a significant relationship between the biographical profiles of doctors (marital status, race, education, length of service in practice, length of service in current sector, age, gender) and their most significant reason for preferring to stay with the public sector (Table 5.26).

Table 5.26

Spearman rho correlation between biographical profiles of doctors and their most significant reason for preferring to stay with the public sector

Dimension	rho/ p	Significance of reason for preferring to stay with the public sector				
		1st Career Prospect	2nd Employee relations policies	3rd Job satisfaction	4th Wage Differentials & benefits	5th Values
Gender	rho	0.080	0.176	0.099	0.092	-0.140
	p	**0.588**	**0.230**	**0.566**	**0.629**	**0.459**
Marital status	rho	0.163	0.027	-0.397	-0.312	-0.042
	p	**0.269**	**0.857**	**0.017****	**0.094**	**0.827**
Race	rho	0.118	0.208	-0.052	-0.091	0.108
	p	**0.424**	**0.156**	**0.765**	**0.633**	**0.571**
Educational qualification	rho	0.187	-0.115	-0.329	-0.229	0.051
	p	**0.209**	**0.441**	**0.053**	**0.232**	**0.792**
Current sector	rho	0.152	-0.126	-0.329	-0.229	0.256
	p	**0.308**	**0.400**	**0.053**	**0.232**	**0.180**
Length of service in practice	rho	0.117	-0.040	-0.224	-0.311	0.097
	p	**0.430**	**0.787**	**0.188**	**0.094**	**0.612**
Length of service in current sector	rho	0.055	-0.004	-0.160	-0.223	-0.046
	p	**0.708**	**0.979**	**0.350**	0.**235**	**0.808**
Age	rho	0.065	-0.075	-0.113	-0.122	0.090
	p	**0.660**	**0.611**	**0.512**	**0.520**	**0.636**

**** p < 0.05**

Table 5.26 shows a significant relationship between marital status and the third most significant reason for preferring to stay with the public sector (p = 0.017), which is job satisfaction. No other significant relationships were noted. Therefore, hypothesis 14 may only be accepted in terms of marital status and job satisfaction as a reason for preferring for staying with the public sector. It was reliably gathered from the finding stated in chapter four that 73.9% of the doctors are married while 24.3% are single and 1.7% are divorced. This depicts the importance of marriage on the decision of migration or retention reflecting that

married doctors are more inclined to find job satisfaction in the public sector. This association between the married doctors and job satisfaction could be linked to factors such as job security and litigation. In the private sector, the doctor single handedly carries the entire litigation burden which can impact on job satisfaction. Also, a little issue can send a doctor in the private sector out of job while there are structures within the public sector that fosters job security; this can impact positively on retention in the public sector. Married doctors have responsibilities and cannot afford to be out of job; hence, the decision to stay where they can have some measure of stability.

Hypothesis 15

There is a significant relationship between the biographical profiles of doctors (marital status, race, education, length of service in practice, length of service in current sector, age, gender) and the most significant reason that might inform the decision to seek employment in the private sector (Table 5.27).

Table 5.27

Spearman rho correlation between biographical profiles of doctors and the most significant reason that might inform the decision to seek employment in the private sector

Dimension	rho/ p	Significance of reason that might inform the decision to seek employment in the private sector				
		1st Career prospect	2nd Employee relations policies	3rd Job satisfaction	4th Wage differentials & benefits	5th Values
Gender	rho	0.010	-0.070	0.157	-0.089	-0.232
	p	**0.932**	**0.590**	**0.262**	**0.528**	**0.167**
Marital status	rho	-0.014	0.212	0.236	-0.276	-0.150
	p	**0.903**	**0.098**	**0.089**	**0.046****	**0.377**
Race	rho	-0.043	-0.077	0.060	-0.127	0.003
	p	**0.718**	**0.554**	**0.671**	**0.365**	**0.985**
Educational qualification	rho	-0.041	0.207	0.011	-0.067	-0.102
	p	**0.730**	**0.110**	**0.939**	**0.635**	**0.555**
Current sector	rho	-0.076	0.173	-0.063	-0.141	0.085
	p	**0.521**	**0.183**	**0.658**	**0.319**	**0.621**
Length of service in practice	rho	0.044	0.199	0.006	-0.077	-0.186
	p	**0.715**	**0.125**	**0.968**	**0.587**	**0.278**
Length of service in current sector	rho	0.077	0.135	0.110	-0.038	-0.209
	p	**0.517**	**0.294**	**0.431**	**0.788**	**0.214**
Age	rho	0.032	0.219	0.001	-0.194	0.012
	p	**0.787**	**0.088**	**0.997**	**0.165**	**0.942**

**** p < 0.05**

Table 5.27 indicates a significant relationship between marital status and the fourth most significant reason that might inform the decision to seek employment in the private sector which is wage differentials and benefits. No other significant relationships were noted. Therefore, hypothesis 15 may only be accepted in terms of marital status and wage differentials and benefits as a reason for seeking employment in the private sector. The percentage of the married doctors (73.9%) that participate in this study is more than the single

(24.3%) or divorced (1.7%) doctors as indicated in Chapter 4, which have a significant bearing on the finding. This finding reflects that married doctors are more inclined to go to the private sector in search of a better wage and benefit. It is generally believed that responsibilities come with marriage. This additional responsibility such as, caring for two sets of parents, biological children, extended family members on both sides could impact on the earnings of a married doctor thereby influencing his/her decision to seek for higher pay in the private sector. Even though it is not the most significant reason for seeking employment in the private sector it also exerts some influence on the migration decision. It is also evident that whilst married doctors will be motivated to remain in the public sector in search of job satisfaction as their third reason for remaining (see Table 5.26), they are also likely to be attracted to the private sector in search of wage differentials and benefits (see Table 5.27). It will certainly depend on which pull is stronger at the time of decision making because job satisfaction is the third reason for remaining in the public sector and the search for wage differentials and benefits is the fourth reason for leaving the public sector.

Hypothesis 16

There is a significant relationship between the most significant reason for preferring to stay with the public sector and the most significant reason that might inform the decision to seek employment in the private sector (Table 5.28).

Table 5.28

Spearman rho correlation between the most significant reason for preferring to stay with the public sector and the most significant reason that might inform the decision to seek employment in the private sector

The most significant reason for preferring to stay with the public sector	The most significant reason that might inform the decision to seek employment in the private sector					
	rho/ p	1st Career prospect	2nd Employee relations policies	3rd Job satisfaction	4th Wage differentials & benefits	5th Values
1st Career prospect	rho	0.066	0.059	0.184	-0.128	-0.552
	p	**0.658**	**0.705**	**0.275**	**0.451**	**0.003***
2nd Employee relations policies	rho	0.083	0.123	0.246	-0.455	-0.077
	p	**0.574**	**0.433**	**0.142**	**0.005***	**0.702**
3rd Job satisfaction	rho	0.064	-0.010	-0.332	0.463	0.302
	p	**0.709**	**0.954**	**0.073**	**0.010***	**0.152**
4th Wage differentials & benefits	rho	-0.214	-0.474	-0.333	0.575	0.450
	p	**0.255**	**0.008***	**0.072**	**0.001***	**0.027****
5th Values	rho	0.400	-0.019	-0.551	-0.176	0.423
	p	**0.028***	**0.922**	**0.002***	**0.351**	**0.040****

*** p < 0.01**

**** p < 0.05**

Table 5.28 show a significant relationship between the reasons for preferring to stay with the public sector and the reasons that might inform the decision to seek employment in the private sector. Hence, hypothesis 16 may be accepted. A detailed analysis of the significant relationships is discussed below.

Table 5.28 indicates a significant association (p = 0.003) between the first most significant reason for preferring to stay with the public sector (career prospect) and the fifth most significant reason that might inform the decision to seek employment in the private sector (values) at the 1% level of significance.

Table 5.28 also indicates a significant relationship (p = 0.005) between the second most significant reason for preferring to stay with the public sector (employee relations policy) and the fourth most significant reason that might inform the decision to seek employment in the private sector (wage differentials and benefits) at the 1% level of significance.

Table 5.28 shows a significant association (p = 0.010) between the third most significant reason for preferring to stay with the public sector (job satisfaction) and the fourth most significant reason that might inform the decision to seek employment in the private sector (wage differentials and benefits) at the 1% level of significance.

Table 5.28 indicates a significant relationship between the fourth most significant reason for preferring to stay with the public sector (wage differentials and benefits) and the second (employee relations policies), third (job satisfaction) and fourth most significant reasons for preferring to stay with the public sector (wage differentials and benefits) respectively at the 1% level of significance.

Table 5.28 depicts a significant relationship between the fifth most significant reason for preferring to stay with the public sector (values) and the first most significant reason that might inform the decision to seek employment in the private sector (career prospects) at the 1% level of significance. Furthermore, a significant relationship was indicated between the the fifth most significant reason that might inform the decision to seek employment in the private sector (values) and the fifth most significant reason for preferring to stay with the public sector (values) respectively at the 5% level of significance.

5.3 FINDINGS FROM SEMI-STRUCTURED INTERVIEWS

A semi-structured interview was conducted with the hospital manager of Life Entabeni, the hospital manager of Life Mount Edgecombe and the CEO of Mahatma Gandhi hospital by the researcher. Below are the focus areas and findings:

5.3.1 Impact of Political Regime change and economic decisions on internal migration

While some respondents stated that the failing of the public sector in terms of its facilities and bureaucratic structure is more to blame for the migration than the political or economic factors, others held a varied opinion that the political regime affects the management of the healthcare sector. The influence of political regime change on the health sector especially with regards to internal migration was examined from the angle of policies and management. Usually, every political party candidate comes into power with his/her agenda, party manifesto, policies, interests and political associates who he/she can trust to oversee things in various departments. The knowledge of each leader coupled with what they think is more important will affect how things are being administered in a particular regime. A recurrent law which is brought about by changes in political office holders was also identified as a potential cause. It is interesting to gather that some doctors currently in the private sector would have preferred to stay in the public sector but for the inefficiency caused by high politicking.

5.3.2 Influence of the size of the hospitals on the migration of medical doctors

The respondents stated that size has a significant impact on the movement, that is, how a hospital is staffed will be dependent on how big it is. The workload in a clinic will be different from the workload in a district hospital. It was also gathered that for some specialists the size of the hospital could influence the impact of their expertise on healthcare. Other respondents stated that the migration of doctors cannot be blamed on the size of a hospital directly; they hold the view that the department an individual works in within the hospital has more influence on migration. While some departments see few patients daily, others have to constantly work under pressure which can push them to seek employment in another sector.

5.3.3 Benefits or drawbacks of the migration of doctors on both the private sector and the public sector

The respondents stated that the real benefit for some doctors that migrated from the public to the private sector is financial and the fact that they are no longer working for anyone. One of the advantages stated about the private sector is that when you work hard, you reap the reward of the hard work financially. Another benefit is that they can choose how much time they spend at work which gives ample opportunity for doctors in the private sector to embark on more research work while their public sector counterparts might not have enough time for

research due to work pressures. The private sector also affords doctors the opportunity to manage their own business and control things from the beginning until the end which gives them an opportunity for personal development.

While one of the drawbacks is medico-legal, the public is litigating more because there are more attorneys interested and advertising for medical litigation. A doctor that is involved in litigation for negligence even when it is not his/her fault will experience significant strain. All the drawbacks of the private sector automatically serve as a benefit to the public sector. For instance, those doctors who do not like the pressure of business, those who are afraid of medico-legal and insurance cost will enjoy working in the public sector. The researcher learnt that the cost of medical insurance is on the increase especially in neurosurgery and obstetrics; the specialists pay around R65 000 per month on insurance so if there are opportunities/incentives in the public sector the specialists will be willing to go back.

One of the drawbacks of the public sector gathered from the respondents is that they cannot determine or restrict the number of patients to see per day neither do they have absolute control over their working hours. Another drawback gathered is doctors' frustration with the bureaucracy in the public sector. Most physicians in the public sector are not there as a bureaucrat or to get involved in management politics; they are simply there to save lives so when politics interfere with their works it makes life tough for them. The respondents affirmed based on their conversation with some doctors that migrated from the public sector that they left due to the lack of a position for them after completion of their specialist programmes, so the only option left for them is to move to the private sector.

One significant benefit of the public sector gathered from the respondents is that, there is an opportunity to learn a lot and gain more experience because decision taking does not rest on an individual. A wide range of cases, both familiar and unfamiliar ones are encountered daily because the population being served by the public sector is larger and the more cases the doctors deal with, the more experience they gain. There is also an opportunity to get different views from different departments and consultants over a particular case which will ensure that an informed decision is made and enhances the opportunity for learning and development.

5.3.4 Motivation that drives this migration to the private sector

The respondents held that limited career opportunities in the public sector are a key factor driving migration. The frustration and annoyance of being in an environment where they cannot practice medicine in a right way due to lack of equipment, excessive workload and long working hours were also noted as driving forces. Although one of the respondents mentioned that the remuneration structure of the public health sector is commendable and that doctors in the private sector work very hard to make money, physicians in the public sector do not entirely share this opinion. Some of the migrated doctors are neither businessmen nor business oriented and would have preferred to work for someone but only left due to unfavorable conditions in the public sector.

5.3.5 Type of migration that is prevalent in South Africa and the effects of this kind of migration

All the respondents agreed that internal migration is prevalent compared to international migration among doctors in South Africa. The respondents noted that in their years of experience as managers it is a rare occurrence to see doctors leaving for overseas, but it is common to see doctors moving between sectors in the country. The effect of the internal migration especially on the public sector is skill drainage. Not only do patients suffer but other doctors who could have benefitted from the wealth of experience of those migrating are not able to do so. This migration plunges the public sector into a deeper service delivery chaos. Internal migration causes the public sector to lose expertise and affects the overall efficiency of service delivery.

5.4 DOCUMENTARY SECONDARY DATA

The researcher gained access to the KZN Department of Health documented annual reports where retention strategies were recorded. The past and present policies of the department regarding recruitment, human resources supply, redeployment and retention have pursued the following objectives through variable success and sustainability:

- To expand students' intake at tertiary institutions to grow the numbers of mid-level health staff and professionals;
- To start affirmative recruitment of students (on gender and race basis) into tertiary training and the partisan recruitment of applicants from rural areas with the aim of deploying them to work in these areas on completion of their training;

- To train mid-level medical category officers to serve as replacements for doctors in understaffed areas and facilities;
- To train groups of South African students to become doctors in Cuba and be employed in the public health sector on completion of their training;
- To recruit foreign health professionals to serve in designated facilities in the public sector and also in the rural areas;
- To introduce an OSD (occupation-specific dispensation), a motivation driven strategy to improve compensation for health professionals and service conditions to attract and retain them in the public sector;
- To introduce different financial incentive structures enclosed in scarce skills and rural allowances to address the rural-urban and private-public and rural-urban disparity in the supply of health professionals;
- To deploy private general practitioners into the public sector to work in understaffed public facilities and improve public healthcare services through contractual agreements;
- To boost partnerships between the public-private sectors to increase the financial sustainability, the managerial productivity and the value of public healthcare delivery,
- To introduce mandatory community service (CS) for all health experts on completion of their training programme;
- To allow health professionals to go into dual practices and to moonlight into private sector services.

Public health practitioners have been allowed to work on a part-time basis in the private sector since the 1990s, through the Limited Private Practice policy and the Remunerated Work Outside the Public service (RWOPS) since 2001. The stability index aided the researcher in calculating the retention rate for the period of five years starting from 2011 to 2016:

$$\frac{\text{Number of staff with one or more years service}}{\text{Number employed a year ago}} \times 100$$

The retention rate from 2011-2016 is depicted in Table 5.29.

Table 5.29

Retention rate from 2011-2016

Year	Medical Officer	Medical Specialist	Total No of Staff	No a year ago	New staff	Retention Rate
2011/12	2781	600	3381	3100	281	11%
2012/13	3429	696	4125	3381	744	4.5%
2013/2014	3459	786	4245	4125	120	34%
2014/15	3577	804	4381	4245	136	31%
2015/16	3479	737	4216	4381	165	27%

The report plainly depicts a substantial decline in the retention rate from 2013-2016. It was revealed that in 2013/14 one of the strategic goals of the Department of Health (DoH) was to expand the training of registrars in the province to enhance the percentage of specialists employed in the public sector and retain 75% of qualified specialists by 2014/15, but budget constraints forced the review of intakes.

The department has had challenges in filling the vacant specialist positions at facility levels due to the limited budget. It was gathered that a percentage of qualified specialists decided not to remain in the public sector after the completion of their programme or to move to outside facilities where posts are available due to limited placement opportunities.

The turnover rate retrieved from the KZN Department Annual Health Report from 2011-2016 is reflected in Table 5.30.

Table 5.30

Turnover rate from 2011/2016

Year	2011/12	2012/13	2013/14	2014/15	2015/16
Medical Officers - Permanent	16.4%	15.5%	15.1%	17.2%	18.1%
Medical Officers - Temporary	19.5%	19.9%	31.7%	33.5%	
Medical Specialist - Permanent	6.7%	9.5%	6.1%	9.6%	9.9%
Medical Specialist - Temporary	17.6%	16.3%	21.9%	22.7%	

Turnover rates can be interpreted to be the ratio of employees replaced within a defined period to the average number of staff. Table 5.30 reflects that there has been a significant increase in the turnover rate of medical practitioners (GP) and Medical specialists particularly from 2013-2016. It was discovered from the documentary data that medical specialists had displayed a steady decline in turnover more than the general practitioners. Furthermore, the researcher learnt that no performance bonuses were paid from 2013-2016 due to cost constraints.

It was also interesting to note that despite the implementation of the occupational specific dispensation (OSD) in 2008/09, the turnover rate for medical officers revealed an alarming increase. The total turnover rate in 2014 increased from 4.6% to 7.4% in 2015/16; while the highest rate of turnover was documented for Allied Health Staff, the medical practitioners were next on the chart table. The maximum vacancy rate of 27.7% was recorded for Medical Specialists.

The high vacancy rates continue to be a source of primary concern to the department, and the majority of available key positions during 2015/16 were not filled because of over-spending of R167 216 million on the compensation of employees. In the study conducted by the department in 2014-2015 on the effect of skills shortages on service delivery, the outcome shows that the inability of the department to deliver on its promises was due to a dearth of suitable human resources (DOH 2015/16).

Some of the difficulties experienced in 2013/14 comprise of the following:

There has been a level of resistance from some medical managers to undertake the role of both CEO and medical manager that was brought about by the reclassification of hospitals. This issue is being dealt with in agreement with the principles governing the department.

The execution of the Human Resources for Health (HRH) Plan, in agreement with the HRH Strategy for the healthcare sector from 2012/13 –2016/17, is still to be meaningfully realised. The human resources demand of the public health sector and the percentage of the resources being supplied have continued to be a major challenge while the retention policies need to be re-evaluated.

There is still the existence of certain internal structures that create bottlenecks in the public health sector that are yet to be addressed such as the complicated and lengthy procedures involved in unfreezing posts, and the appointment into positions and overtime payment approvals, requires urgent action and amendment of methods.

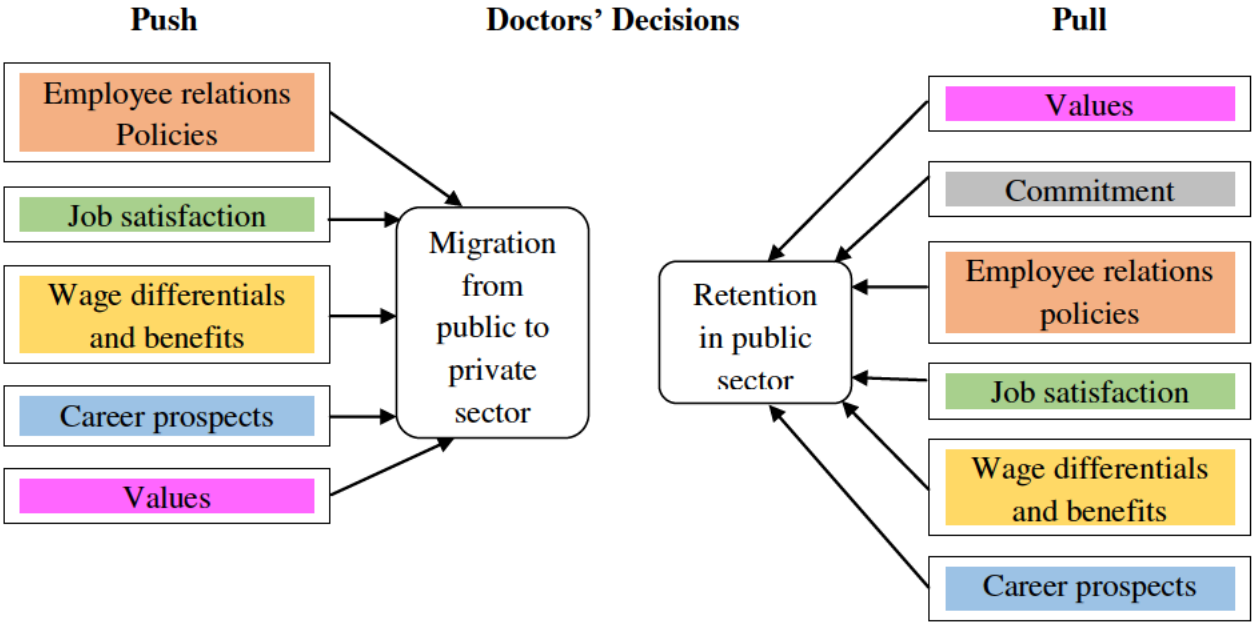
The KZN Department of Health as at 2015/16 has 28.5 medical officers per 100 000 people. The turnover rate for medical officers stood at 18.1% based on the latest annual report, and it is still a herculean task to attract and retain doctors particularly in the rural areas. The projection of the department is that the appointment of bursary holders and medical officers that partook of the Cuba training will reduce the pressure of turnover and shortage of staff.

5.5 FACTORS AFFECTING THE MIGRATION DECISION

From the quantitative and qualitative results of the study, it is evident that numerous push and pull factors exist that impact on doctors' decisions to migrate from the public to the private sector or to remain in the public sector as illustrated in Figure 5.2.

Figure 5.2

Factors affecting doctors' migration decisions: Empirical results



From Figure 5.2 it is evident that doctors' decisions to migrate from the public to the private sector are mainly influenced by employee relations policies and least by personal values. However, their decision to remain in the employ of the public sector is mainly influenced by personal values and least by career prospects.

5.6 CONCLUSION

Under this chapter, various dimensions such as monetary and non-monetary reward, basis for performance (reward, increased efficiency, commitment, punishment, financial security), recognition of performance, attempts to migrate, reasons for leaving, the reasons for staying and factors that might influence migration were examined respectively.

The impact of biographical profiles of medical doctors on aspects of retention and migration were assessed. Comparisons was also drawn between the biographical variables (gender, marital status, race, educational qualification, sector, length of year in practice, length of year in current sector, age) and the main reason for leaving despite recognition of performance, reasons for preferring to stay in the public sector and reasons why a doctor may seek employment in the private sector. The results were then grouped in to push and pull factors that respectively cause doctors to migrate from the public sector to the private sector

CHAPTER SIX

DISCUSSION OF FINDINGS

6.1 INTRODUCTION

The data obtained from various research instruments will not be of any advantage without adequate discussion of the outcomes. The results emanating from the distributed questionnaires, structured interviews, semi-structured interviews and the documentary data were evaluated in this chapter. This study was conducted with the aim of establishing the rationale behind medical doctors' migration from the public sector to the private sector in South Africa.

6.2 DISCUSSION OF RESULTS

The results of the study will be discussed by comparing and contrasting the findings of the study with that of other researchers in the field in terms of the key areas that were assessed that either enhance or inhibit the migration of doctors.

6.2.1 People management practices within the public and the private sector

The moderate percentage of the respondents that indicated that the information received with regards to monetary and non-monetary rewards is satisfactory reflects the need for improvement in the area of communication within the healthcare sector.

The importance of effective communication to the health sector cannot be undermined. Diverse formal and informal communication channels were employed by the health sector to circulate information about the reward structure and other matters. The line managers, supervisors, and departmental heads are charged with the responsibility to disseminate the information. The distribution of information on the reward and benefit structure is initiated from the selection stage where the organisational policies and expectations, and individual job designs, are communicated to prospective employees. Obtained information from the documentary secondary data confirmed the existence of consultation between the management and employee unions, especially in the public healthcare sector but the moderate result received from the data analysis leaves little to be desired. There is no significant improvement in the shortage of medical doctors in the appropriate area of need despite the

past and constant efforts by the government in handling this issue such as increasing salaries, upgrading hospitals and clinics and the introduction of foreign doctors (Kotzee & Couper, 2006) while possibly not addressing the relationship between the management and doctors which could affect migration decisions ominously. Kotzee and Couper (2006) in their study on the retention of rural doctors in the Limpopo province also established that appropriate communication channels between the hospital/clinic management and rural doctors are essential. These communication channels could assist in locating the difficult areas and make resolutions possible.

The unions (such as National Education Health and Allied Workers' Union, Nehawu) played a significant role in the implementation of the occupation-specific dispensation (OSD) in 2009 even though the deal was struck in 2007 after a long strike by skilled public servants to bring pay in line with the private sector. It was a major problem at the time because experienced people were leaving the public sector, but if after 7 years of OSD implementation there is still significant movement of doctors from the public to the private sector then there is an urgent need to go back to the drawing board. It is important that the channel used in information dissemination is active in nurturing good communication and resolving grievances within the organisation. Even though the unions are effective in mediating between workers and management, the significance of face to face communication cannot be overemphasised because it gives the utmost opportunities for feedback to management on issues affecting employees. Wrench, Punyanunt-Carter, and Ward (2015) affirm that the human relations approach to management is vital because it encourages two-way communication between employees and their managers as opposed to the one-way communication. Also, the human relations angle perceives communication as a management tool that can be used to secure the cooperation of workers. Atambo and Momanyi (2016) assert that ineffective communication is destructive not only to the organisation but also to managers and the employees; it has the potential of leading to poor service delivery and discontented customers, poor performance and tense interpersonal relationships in the organisation. It is necessary for managers at all levels within an organisation to be a good communicator to ensure organisational effectiveness and also to achieve a competitive edge (Jones & George, 2011). Atambo and Momanyi (2016) attribute most organisational problems to inadequate communication; hence, the importance of communication as a management feature cannot be overstressed. Organisational communication is seen as a method in which the participation of everyone

generates a resourceful culture in the organisation. This results in idea generation, knowledge sharing, operational decision making and also enhances organisational efficiency. The public healthcare might have to look into improving communication to foster the retention of medical doctors in the appropriate areas of need.

Kupperschmidt (2000) and Bodjrenou, Ming, Bomboma (2016) assert that employee retention should commence from the initial recruitment stage. Communicating core and ample information to new hires are vital to retention. Rewards do not only aid the retention of high performers but also enables the realisation of the organisation's goals (Menefee & Murphy, 2004). Bratton and Gold (2012) affirmed that the attraction and retention of employees in the appropriate area is one of the many objectives of a reward system.

The analysis of the relationship between management and medical doctors showed that less than half of the total respondents were satisfactory while the next favorable response was poor. The CIPD Black Box study, headed by Purcell in 2003 stressed the role of line managers/supervisors in people management in any organisation and the relationship between the employees and management was acknowledged as the most significant influence on employee's willingness to perform (Chartered Institute of Personnel and Development, 2004). Even though the data showed that the relationship between the management and doctors is satisfactory, there is still room for improvement. Some respondents identified employee relations as the primary factor responsible for their migration to the private sector which shows that management must persistently work at sustaining a decent relationship with medical doctors through which the public health sector can identify the various issues facing them. It is also suggested that there has to be a regular review of the working conditions, the performance management system and other factors that can impact on job satisfaction for the public health sector in order to meet the diverse health demands in South Africa. With particular emphasis on literature, the Chartered Institute of Personnel and Development (2007) report stated that employee relations can be hampered and often results in labour turnover if a negative relationship develops between the supervisor/line manager and the employee. Beardwell, Holden, and Claydon (2004) also assert that managers/supervisors must have required supervision skills in order to function effectively.

The thirst for a performance management system that attaches importance to honest communication between the management and employees and the setting up of trust-centered relationships that are crucial for effective employee involvement was given a boost by the rise in the reputation of human resources management (Sparrow, 2008). According to Chartered Institute of Personnel and Development (2009b), employee voice that is essential in employee involvement are those initiatives from management that are aimed at involving employees and proactively strive to encourage better output through two-way communication.

The importance of performance measurement was proven through the data collection. It was established that a successful reward structure is a prerequisite for an effective performance management structure. Armstrong (2009) asserts that managing the performance of the employees is an effective method for developing employees and fostering organisational growth. Briscoe and Claus (2008) perceives performance management as a way through which management outlines work target, institutes performance criteria, allocates and evaluates work performance, provides feedback on the performance of an individual employee, ascertains training and development needs/options and apportions rewards.

The results propose that the performance management system of the healthcare system is to some extent useful in outlining work target, assigning work responsibilities accordingly, establishing performance criteria, evaluating job performance, offering practical feedback on the performance of an individual employee, ascertaining training needs/options and apportioning rewards. In fact, 42.5% of the respondents rated the performance management structure as being satisfactory while 21.2% believe it is good and 20.4% rated it as being poor. Even though work responsibilities are assigned, it was discovered that many public hospitals defy the Health Professions Council of South Africa's (HPCSA) guidelines for good practice in the healthcare professions that allowed doctors to attend to a maximum of 20 patients daily. Junior doctors are constantly overworked and have to see 30-40 patients daily at a stretch. Although the performance management system will attest to the fact that they have performed their job function satisfactorily the reward structure does not consider the extra workload nor adjust to accommodate it which can influence migration. Appelbaum, Roy and Gilliland (2011) and Datta (2012) argue that employees' morale are also driven by extrinsic rewards, and the sharing of these external rewards usually have a significant impact

on the organisation, particularly in agreement with performance appraisals in the modern eras. Chartered Institute of Personnel and Development (2009a) found it to be rational when employees are remunerated in line with their actual performance, proficiency or contribution. Chartered Institute of Personnel and Development (2009a) views performance management as a complete procedure that consists of activities that mutually contribute to effective people management with the aim of realising improved organisational performance. Ajila (1997) asserts that the performance of employees, as well as the outputs of the organisation, can be improved through the organisational policy on reward. Rounok and Parvin (2011) also emphasised the importance of reward. Oshagbemi (1996) argues further that younger employees are more content with external (extrinsic) rewards than internal (intrinsic) rewards in most developed countries. Even though extrinsic rewards might wield a strong influence on employees, Deci (1971) argue that extrinsic rewards adversely impact on intrinsic drive. Balkin and Dolan (1997) also supported this perspective that the intrinsic attraction of a job can be destroyed due to the application of extrinsic rewards which are closely linked to a team's performance and can increase the craving of employees for money. Largely, the highly involved employees that are focused on their occupation rely more on intrinsic incentive than extrinsic ones (Wood, 1974).

The analysis of whether the role/jobs were designed to facilitate job satisfaction and increase productivity showed that 50.4% of the respondents were neutral, while 32.2% disagreed and only 17.4% agreed with the statement. The percentage of those that refused to take any side on this important question and those that disagreed depicts the need to reevaluate role and job designs in the healthcare industry particularly in the public sector. Kupperschmidt (2000) recommends that management should offer employees substantial independence and control over their job roles, how they perform it as well as their work environment. According to the Chartered Institute of Personnel and Development (2007), employees will logically seek for alternative employments when they are subjected to inappropriate working conditions or hours. Curtis and Wright (2001) suggested that job/roles should be designed to completely exploit task importance, skill diversity, autonomy, and feedback, and also provide an opportunity for development. These outcomes seem to indicate a lack of doctors' satisfaction with the job/role design structures of the healthcare sector.

Employee involvement is essential in fostering employee engagement and retention. Only 8.7% of the respondents stated that there is employee participation in the reward management decision and 45.2% of the respondents were neutral while 46.1% disagreed. This depicts that the majority of the total respondents did not agree with the assertion that there is employee involvement in reward management decision which depicts clearly that there is a challenge with regards to employee participation in the reward structure. The comments made regarding employee involvement by the majority of the respondents who are presently in the public sector and those who have passed through the public sector showed that they were involved in reward management decisions through the chief executive officer (CEO) of their various hospitals who attend management meetings. This indicates that there is no proper forum or opportunity for doctors to be involved in reward structure decisions individually and directly. Routing their suggestions through their CEO may distort the original meaning and the significance of the message. Gennard and Judge (2005) avow that the fundamental guiding principle in employee relations mission is to institute the strategies that will give direction to employment relationships in the organisation. The employment relationship strategies are usually in agreement format and are implemented through a range of employee relations techniques such as employee involvement.

Although the responses relating to the relationship with management and, performance management rating were more positive than other variables, there is still ample room for improvement. It indicates that it is necessary for the management of the healthcare sector to improve their working relationship with the doctors and also improve their performance rating to include any additional job roles that an employee might take on and should be rewarded accordingly. The result obtained from job design and employee involvement also indicates the need for significant improvement when compared with the findings from other questions above.

6.3 FACTORS THAT DRIVE DOCTORS TO PERFORM

The data obtained on the basis for performance show that 38.3% of the employees agree that the basis for performance is commitment, 27% agreed that the basis for performance is punishment while 13.9% of the respondents feel that the basis of performance is increased efficiency and 13% indicated financial security. The lowest score of 6.1% was recorded under reward as very few respondents viewed it as a basis for performance in their sector.

This finding is very impressive; it shows that the basis for the performance of doctors is their commitment to their profession and their inner need to use their proficiency to facilitate the well-being of the people. This finding is a paradigm shift from the perception that doctors are influenced solely by reward in their migration decisions. Three forms of organisational commitment were suggested by Meyer and Allen (1991) which are the normative commitment that exerts influence on a worker to stay in an organisation as a consequence of responsibilities to the organisation, affective commitment that evaluates the emotional connection and involvement of the employee in the organisation and continuation commitment which denotes the commitment linked to the costs an individual perceives as the related benefits of the unceasing involvement in the organisation and the related costs of leaving. Camilleri's (2002) examination on employees' commitment identified personality, the level of qualification and position as vital in determining the employee's level of commitment to the organisation. Further findings by Camilleri (2002) revealed that personality is considerably stronger for the affective and continuance forms of commitment while position and level of qualification are considerably stronger for the normative and continuance forms of commitment.

6.4 RECOGNITION OF PERFORMANCE

The analysis of the responses on recognition of performance shows that the majority of the respondents (81.7%) indicated that they have neither been recognised nor honored for their performance since joining their sector while only a small segment (16.5%) believe that they have been recognised based on their performance. The significant percentage of those that have never experienced recognition in the healthcare sector despite their contributions might also be a pointer to a factor influencing the migration of doctors. Although the management holds the view that the basis for appraising performance is to measure productivity and appreciate good performance via rewards, the total reward should be emphasised and not only the financial rewards. Mathauer and Imhoff (2006) mentioned that the most significant motivational factor for healthcare workers is the recognition by the organisation and the community. The finding on recognition shows that most contributions and commitments of doctors are left unrecognised.

Regular employee recognition was acknowledged as a strategic retention technique for top performers by Nelson (1997). Menefee and Murphy (2004) also supported the assertion that

reward structures may be the most effective method of influencing performance in an organisation. Performance review is the vital pillar of performance management and also a viable technique in employee management (Chartered Institute of Personnel and Development, 2009a).

It was noted that little emphasis was placed on non-financial rewards knowing fully well that the thought of reward encourages employees to want to meet their performance target and surpass it. People get motivated differently, even though the impact of financial reward is high, non-financial rewards also have tremendous potential to motivate employees so it should, therefore, be encouraged in the healthcare sector especially in the public sector. Based on the widely held view of the respondents, the inference made from the outcome showed that there is the existence of a negative psychological contract between the doctors and management on performance management and review. Armstrong and Murlis (2007) stated that an effective performance management is and should form the basis for the growth of a positive psychological contract. The clarification of the mutual expectations of doctors and management is essential for a healthy relationship as well as efficient performance management.

6.5 REASON FOR LEAVING THE PUBLIC SECTOR DESPITE RECOGNITION OF PERFORMANCE

Of the 16.5% of the respondents that indicated yes for having been given recognition or award for their performance, 11.3% of them still left the public sector due to the lack of job satisfaction, 10.4% left because of poor career prospect, 5.2% left because of poor pay and benefits structure while 0.9% indicated poor employee relations policy. The succeeding question (if your response to recognition of performance is yes what was your main reason for leaving) made it possible to infer that the respondents that indicated yes are all presently in the private sector as other respondents indicated no or not applicable.

Evidently, job satisfaction was gathered to have more influence on their migration decision compared to other factors. Some of the factors identified to impact on job satisfaction by Grobler, Warnich, Carrell, Elbert and Hatfield (2011) are the type of job, good supervision, opportunity to grow and co-worker relations while the type of job an individual performs

(whether stimulating or stressful) was identified as probably the most significant factor in job satisfaction.

In line with the data collected on the basis for performance, it is glaring that doctors are motivated to perform based on their commitment and desire to achieve job satisfaction for their dedication more than reward or benefit. Personal factors (which is closely related to personal values) and professional support were specified as the main factors that influence job satisfaction by Kotzee and Couper (2006). Tagliaferri's (1988) assertion was in agreement with Grobler *et al*. (2011) on the impact of supervision and interpersonal relationship on job satisfaction and he also added poor work environment and poor pay as causative factors to job dissatisfaction.

6.6 ATTEMPTS TO MIGRATE FROM THE PUBLIC TO THE PRIVATE SECTOR

The analysis of the responses on whether the respondents have ever made any move to going into private practice since joining the public sector reflect that the majority of the doctors (63.5%) indicated not applicable, 20% indicated 'no' while 16.5% responded in the affirmative.

6.7 REASONS FOR PREFERRING TO STAY IN THE PUBLIC SECTOR

Values was the leading and dominant reason (highest Mean of 3.67) for the retention of doctors in the public sector which signifies a strong influence of personal values on the migration decision in favour of remaining in the public sector. Values were defined as rational depictions of anticipated, intellectual, trans-situational goals that function as guiding ethics in people's lives (Schwartz, 1992). Schwartz (1992) purported that personality traits might be responsible for shaping values. McCrae and Costa (1990) assert that traits are persistent dispositions to act in typical behaviours connected to a steady pattern of thoughts which could be responsible for the reason doctors stay long in the public sector even if they will eventually migrate and this is consistent with the finding that doctors who have spent 16-20 years in the public sector are more prone to migration. The prospect of young doctors staying longer in the public sector is due to the introduction of the compulsory community service for newly graduated doctors as well as the opportunities and desire to gather more experience.

Gonzalez (1992) and Wilke (1991) assert that newly graduated doctors have a higher probability of being an employee than the experienced doctors which was attributed to a dominant pattern of career cycle among doctors after acquiring substantial resources to stand on their own or go into partnership with others. According to this assertion, it is possible to infer that the retention of doctors in the public sector is due to personality traits that structured their values. Feldman (2003) argues that values organise our knowledge and offer restriction across issues which could be the reason it exerts such a strong influence on the retention of doctors in the public sector and acts as a check on migration. The capability of doctors to articulate their values aid them in making clear, reliable and rational decisions. Values have a significant impact on the decision to continue working in the public sector where other factors might have failed.

The findings reflected employee relations policies as having the 2nd highest mean (Mean = 3.17) in terms of factors influencing one's decision to remain in the public sector. This result depicts the significance of formulating sound policies on employee relations. With regards to employee relations issues in 2011/12, only 6 cases were finalised out of the 139 cases received while 169 previous cases were not finalised.

Some of the challenges discovered in the public sector include imbalances in human resource distribution, discrepancies in clinical workload distribution, unfairness in the placement of staff, demand overriding supply of medical personnel, insufficient competencies and the dearth of critical skills such as ophthalmologists. A study by Schaay, Sanders and Kruger (2011) also revealed the existence of major human resource problems, particularly at primary and community levels in the public health sector, characterised with the dearth of skilled health staff in deprived areas, despite the formulation of a national Human Resource Policy in 1999/2000 as well as the framework of a human resource blueprint in 2006. Bateman (2009) also lends his voice to the significant skills shortage facing the healthcare sector and added that fundamental aspects of primary healthcare are not available. Guy, Williams, Aldridge and Roggenkamp (2007) assert that the climate in which the public and private healthcare organisations function grows more dynamic and multifaceted, offering new prospects and also presenting new challenges that necessitate continuous evaluation of the human resource plan.

Job satisfaction and wage differentials and benefits were rated the same in terms of reasons for remaining in the public sector (Mean = 3.00). Job satisfaction is vital for doctors who stay in their sector which depict that it is a crucial retention factor. Job satisfaction is a gratifying feeling as a result of the view that one's job realises or is in tandem with the realisation of one's vital job values (Locke, 1976). According to Noe, Hollenbeck, Gerhart and Wright (2010), the definition of Locke (1976) reveals three key facets of job satisfaction. The first key is that job satisfaction is determined by values, which is referred as what a person willfully or unintentionally wishes to achieve. Secondly, the depiction stresses the differences in the opinion of employees on which values are significant, which is crucial in defining the degree and form of their job satisfaction. One person may value staying within a particular geographic region, another may value the opportunity to get the opinion of other medical experts that is readily available, and another may appreciate the peace of mind of working for the government and not running a business. The third key feature of job satisfaction is perception (Noe *et al*., 2010). Different people may have varied opinions of the same situation; hence, an individual's perception may not be an entirely accurate reflection of realism which may be responsible for the reason some doctors perceive job satisfaction as a retention tool in the public sector and others viewed it as a migration factor that can push them out of the public sector.

The influence of wage differentials and benefits on retention was also highlighted. To a large extent, a doctor in the public sector can accurately determine his paycheck monthly which has nothing to do with the number of patients seen because it has been indicated in the contract of employment while those in the private sector will depend on the number of patients that they attend to monthly. The researcher was also informed of the benefit of leave allowances and the fact that one's salary does not stop when one is on leave which is not the same for someone in the private sector. The certainty in remuneration and benefits is a major factor that might make a doctor stay in the public sector.

Career prospects had the lowest mean score which depicts that it is the least important reason that might influence the retention of doctors in the public sector. This finding buttress the fact that career prospect is presently limited in the public sector due to the budget reduction that is affecting the accommodation of research funding and further studies. The implication

of this is that if it is the least important factor in the retention of doctors in the public sector it is probably a cogent reason for migration to the private sector.

6.8 REASONS FOR DOCTORS SEEKING EMPLOYMENT IN THE PRIVATE SECTOR

Employee relations policies (Mean = 3.50) was specified as the primary factor that can sway the migration of doctors toward the private sector. According to Edwards (2005), the focus of employee relations is the connection between staff and employers, with its mutual and contrary interests. Budd (2004) contends that the aim of the employment relationship is to reach a balance between equity, productivity, and voice and that extreme situation are both unwanted and unmanageable. He suggests that there has to be a balance between economic performance, fair employment standards, and treatment which is equity and valuable contribution to decision making which is the voice. In other words, employee relations policies must consist of well-defined employment ethics that aid considerable employee involvement and excellent management of the employee. When employees are well treated and considerably involved in an organisation in line with the policies governing the organisation, there is bound to be employee engagement which often results in retention.

Moreover, job satisfaction (Mean = 3.33) was also specified as a factor that might influence the migration of doctors to the private sector. Diverse factors can add to job dissatisfaction. In the study on employee motivation, a number of prominent models, such as those by Herzberg (1966) and Maslow (1943), point to intrinsic factors such as stimulating and wide-ranging work, the personal and career development opportunity, performance recognition, as crucial factors in the employment relationship, the absence of which could result in job dissatisfaction. Any issue with employees' treatment, involvement or the employment standards might result in job dissatisfaction. Dovlo and Martineau (2004) associated migration decisions and exhaustions of medical doctors with increased workload which impact significantly on job dissatisfaction.

The employee relations objectives and policies must be in agreement with the corporate strategy. It is not enough to draft a good policy, but there must be a commitment on the part of management to adhere strictly to it. Awases, Gbary, Nyoni and Chatora (2004) ranked migration reasons from improved remuneration system, individual training, and enhanced

management participation to improved working environment. All the reasons mentioned by Awases *et al*. (2004) are influenced by the policies governing the employee relations one way or the other in an organisation. Grobler *et al*. (2011) assert that any organisation that will proceed unrestricted with the implementation of its goals, objectives and strategies must maintain a stable workforce which implies that if the public health sector will be able to deliver on its promises they also need stable doctors. A good employee relations policy will influence the retention of doctors and ensure a stable workforce in the public health sector.

Wage differentials and benefits surfaced as the 3rd factor that might influence migration (Mean = 3.00). It is interesting to note that the findings showed the same level of importance for wage differentials and benefits on the reason for migration and the reason for staying which demonstrates the equitable and balanced impact of remuneration on retention and migration. Organisational policies that utilise the reward systems to increase performance level hinges on the human motivation assumption proposed by Vroom (1964) in his expectancy-valence-instrumentality theory. The theory suggests that rational decisions are made by people when deciding on which course of action to take and that their choice is swayed mainly by their opinion of which option will supply the highest reward. This showed that while wages and benefit are perceived to provide the highest reward to some doctors and influenced them to stay in the public sector, it also had the same effect on the views of those that decided to migrate from the public to the private sector.

Some doctors indicated that career prospect could influence their decision to migrate (Mean = 2.83). The ability of an organisation to offer development opportunities to workers will enhance their ability to retain their employees and also attract employees easily. Proffering ample career opportunities for doctors in the public sector can impact significantly on retention.

6.9 REASONS FOR LEAVING THE PUBLIC SECTOR DESPITE THE RECOGNITION OF PERFORMANCE AND BIOGRAPHICAL DATA

The findings showed a significant relationship between marital status, the length of service in current sector, the length of service in the profession and the core reason for leaving the public sector despite the recognition of performance.

A significant relationship (p = 0.036) was noted between marital status (the single, married and divorced doctors) and the decision to migrate despite the recognition of performance. It was deduced from the frequency analyses that married doctors received the highest level of recognition of performance but still migrated to the private sector, thus showing marital status as a key factor influencing migration to the private health sector as compared to those who are single or divorced. This might be a pointer to the discovery that marital responsibilities such as family time could influence doctors to migrate. It was gathered that most doctors in the private sector do not do 24 hours call, like their counterparts in the public sector, which gives ample opportunity for family time. The private sector doctors also have the authority to determine the number of patients to treat. Hence, the doctors are not subjected to excessive workload which could also impact on their family life. The research conducted by the Cornell University Institute of Workplace Studies (1999) indicates that roughly 10% of workers who spent 50 to 60 hours working on a weekly basis recount serious work-family struggles. There is an increase in the percentage (30%) of those that reported work-family issues as the working hours increases (more than 60 hours). The above study further highlighted how the working condition could hurt the doctor's family life.

A significant relationship (p = 0.030) was noticed between the number of years a doctor had been in the profession and the decision to migrate despite receiving recognition of performance. The frequency analyses revealed that medical doctors who had between 16-20 years of working experience exhibited the highest disposition towards migration despite the recognition of their performance. This is an indication that even though recognition of performance is good, it cannot prevent doctors from migrating in the long run. It also showed that they had ample time to think and examine the scheme of things in their sector before deciding to migrate. The commitment of doctors to the medical profession is commendable, and from the findings, it is evident that the doctors do not rush in taking the migration decision even in the face of challenges. The service of doctors to humanity and their allegiance to the oath taken at the start of their careers motivates them to persist in the face of difficulty before deciding to migrate from the public to the private sector.

Job commitment is viewed as the employee's level of participation in his/her job, how important the job is to him/her and his/her readiness to devote the required time and vigor necessary for the success of the job (Roodt, 1997). The above perception by Roodt (1997)

encapsulates the commitment of doctors to their profession. Tladinyane (2012) asserts that high levels of job commitment are linked to the scope of job tasks as well as the optimistic outlook about one's job.

A significant relationship (p = 0.008) was also noticed between the length of service in the current sector and the decision to migrate. The frequency analyses depict that doctors with 16-20 years of service in the current sector showed a higher preference towards migration despite the recognition of their performance in the public sector. The implication of this finding is that the public sector is losing experienced doctors to the private sector which has been affecting service delivery. Experience is vital in the medical field. The finding reveals that there are more experienced doctors in the private sector than in the public sector yet the latter caters for the health needs of a higher percentage of the population Rispel and Moorman (2010) contend that persistent exposure of public health personnel to hostile working environments that are demanding might make them demotivated and incapable of satisfying their clients.

Investigating the pull factors in the private sector and replicating them in the public sector could impact on retaining experienced doctors. The push factors should be decisively dealt with to prevent the migration of doctors from the public to the private sector.

6.10 RELATIONSHIPS BETWEEN FACTORS INFLUENCING RETENTION AND MIGRATION DECISION

A significant association (p = 0.003) was noticed between career prospect (first main reason for preferring to stay with the public sector and values (the fifth most significant reason that might inform the decision to seek employment in the private sector). Another significant association (p = 0.028) was noticed between values (fifth main reason for preferring to stay with the public sector) and career prospect (the first most significant reason that might inform the decision to seek employment in the private sector). The association between values and career prospect is because career prospect is one of the intentional or unintentional things that doctors desire to achieve according to the definition of values which had the greatest influence in keeping doctors in the public sector. Suar and Khuntia (2010) stated that values are the primary forces behind personal, professional and social choices which buttress the fact that values sway how people live personally and professionally. Employees carry their goals,

personal beliefs, perceptions, choices, and actions with them into an organisation. According to Rohan (2000), individuals depend on their personal values to assess people and circumstances around them, and eventually to make choices. Connor and Becker (1979) also proposed that values underpin individual thoughts that result in the growth of decision-making actions thus stressing the significance of values in determining migration decisions. Values when fully intellectualised become benchmarks for decisions, preferences, and selections (Williams (1979). Ferrell and Gresham (1985) and Fritzsche (2007) held the notion that values are the fundamental building blocks of the decisions made by individuals. Posner and Schmidt (1993) suggest that understanding values are vital because they influence how employees feel about themselves, their job, and their organisations.

A significant relationship ($p = 0.005$) was discovered between employee relations policy (the second most significant reason for preferring to stay with the public sector) and wage differentials and benefit (the fourth most significant reason that might inform the decision to seek employment in the private sector). Another significant relationship ($p = 0.008$) was evident between wage differentials and benefit (the fourth most significant reason for preferring to stay with the public sector) and employee relations policy (the second most significant reason that might inform the decision to seek employment in the private sector). This relationship showed the importance of having a clearly defined competitive remuneration as well as benefits packages in the employee relations policies of the public sector in order not to push doctors away to the private sector. Nacinovic, Lovorka and Nevenka (2009) establishes that reward system must fulfill an open and complete transparency on the subject of implementation, the announcement of reward availability, the conditions to be fulfilled, and the recognition of the award beneficiaries. Porter, Lawler and Hackman (1975) confirm that the clarity of the connection between the extra effort and the reward being awarded validates the reward method as being transparent which is a pointer to the fact that doctors deserve incentives for the extra effort resulting from excessive workloads.

A significant association ($p = 0.010$) was seen between job satisfaction (the third most significant reason for preferring to stay with the public sector) and wage differentials and benefit (the fourth most significant reason that might inform the decision to seek employment in the private sector). Although there are several contributory factors to job satisfaction, the

importance of wage differentials and benefits in fostering job satisfaction cannot be undermined. Pay is perceived to be a pointer to the status of an individual within the organisation or society. Therefore, for some individuals, their self-worth is revealed through pay, so pay satisfaction takes on a critical role with regards to retention (Currall, Towler, Judge & Kohn, 2005) which also shows the impact of wages in fostering the level of job satisfaction of doctors.

A significant relationship ($p = 0.001$) was also observed between wage differentials and benefits (the fourth most significant reason for preferring to stay with the public sector) and wage differentials (the fourth most significant reason that might inform the decision to seek employment in the private sector). This association strengthens the importance of wages and benefit in migration decisions. Rose (2003) proposes that extrinsic factors such as job security, wage, and career prospects are more significant in clarifying job satisfaction and forces that push the employee to seek employment elsewhere. Even though the significance attached to wages and benefits differs from one person to another, it is a vital secondary reinforcement that can impact on whether doctors stay or migrate from a particular sector.

A significant relationship ($p = 0.027$) was apparent between wage differentials and benefits (the fourth most significant reason for preferring to stay with the public sector) and values (the fifth most significant reason that might inform the decision to seek employment in the private sectors). While some doctors attached more importance to wages and benefits, others found other factors to be more gratifying. The values of individual doctors significantly affect the impact that wages will have on their migration decision which reflects the relationship between the two.

A significant association ($p = 0.002$) was also evident between values (the fifth most significant reason for preferring to stay with the public sector) and job satisfaction (the third most significant reason that might inform the decision to seek employment in the private sector). This was also evident among the doctors with regards to migration decisions. The influence of values on the migration decision cannot be over-emphasised as Locke (1976) identified values as the first key that determines job satisfaction (Noe *et al*., 2010). Differences in our values are the reason why a factor that brings about job satisfaction in one individual might be an object of dissatisfaction in another.

A significant relationship (p = 0.040) was visible between values (the fifth most significant reason for preferring to stay with the public sector) and values (the first most significant reason that might inform the decision to seek employment in the private sector). Even though values were significant in the retention of doctors in the public sector more than it is in pushing them to the private sector, values are still relevant in taking migration decisions. Differences in our values are responsible for the reason why some doctors decided to continue working in the public sector, and others preferred to migrate to the private sector.

6.11 SIGNIFICANT RETENTION FACTORS AND BIOGRAPHICAL DATA

A significant relationship was noticed between marital status and the third most significant reason for preferring to stay with the public sector which is job satisfaction (p = 0.017). Job satisfaction has been defined as self-appraisal about the degree to which an individual likes or dislikes his/her occupation (Spector, 1997). The finding revealed that married people are more prone to stay in the public sector due to job satisfaction. Bultendach and De Witte (2005) proposed that there is a relationship between job satisfaction, values, needs, and expectations. According to Weaver (1978), single workers are less satisfied than their married colleagues. The finding from the current study also showed higher levels of job satisfaction among married doctors in the public sector thereby impacting on their decision to stay. Job security and the assurance of a specific pay at the end of the month could affect the job satisfaction of married doctors. Married doctors have responsibilities that cannot wait at the end of the month. Not all doctors are risk takers and will be willing to leave certainty (of specific monthly pay) for uncertainty (where you are not certain of the number of patients that will show up regularly). The stress of litigation is also a burden that doctors do not want to carry; hence, staying in the public sector will mitigate against this. Structures in the public sector provide the necessary support for doctors in the public sector thereby removing the burden of having to handle issues on their own which can impact significantly on retention.

6.12 SIGNIFICANT MIGRATION FACTORS AND BIOGRAPHICAL DATA

A significant relationship was apparent between marital status and wage differentials and benefits (p = 0.046) which is the fourth most important reason that might inform the decision to seek employment in the private sector. Doctors like other professionals have

responsibilities which get enlarged through marital commitment which could push them towards a sector that offers a higher pay.

This finding showed that married doctors are more prone to seek for employment in the private sector due to wages and benefits than their single counterparts. Although wage differentials and benefits are not the most significant reason for seeking jobs in the private sector, it is attractive enough to lure doctors away to the private sector which is in agreement with the assertion of Peak (1996) that pay is significant in the retention of the employee. Even though the pay in the public sector is acceptable, there is a need to bridge any remaining gap to make the private sector less attractive to doctors. Curtis and Wright (2001) identified remuneration as the most cost-effective way of meeting employees' needs.

6.13 STANCE OF THE RESPONDENTS

With regards to the data obtained from the respondents on the questionnaires, more than half of the respondents (52.2%) were not sure if their colleagues have a similar stance as them about their responses to migration/retention issues while 39.8% were certain about their colleagues' views and 8% believed that their opinion is different from others. Given the high percentage of those that were certain that their colleagues hold a similar view, the findings of this study are reliable and can be generalised albeit with caution as in any study.

6.14 FINDINGS FROM SEMI-STRUCTURED INTERVIEWS

The regulations imposed by a country's legal system can strongly affect the management of its human resources. The political-legal structure often guides the conditions for critical employment practices such as remuneration, training, employee relations, recruitment and retrenchment (Noe *et al*., 2010). The opinions received from the respondents showed that the political regime could affect healthcare management as well as the presence of a bureaucratic system in an organisation. The policies enacted by each political regime impacts significantly on healthcare management. The values, as well as the knowledge of a leader, will determine the type of policies that will be implemented.

It is interesting to gather that some doctors currently in the private sector would have preferred to remain in the public sector but chose to migrate as a result of the inefficiency in the public sector. Some of the migrated doctors are neither businessmen nor business

oriented; they would have preferred to work for someone but only left due to unfavorable conditions in the public sector.

The way a hospital is staffed is dependent on the level of the hospital, that is, a community health center will be staffed differently from a district hospital due to their size. The number of patients being attended to by the various levels of healthcare center differs and impacts on their staffing requirement. It was gathered that if a hospital is understaffed, it will impact on the workload which could trigger migration. According to Cullinan (2006), 26 babies lost their lives at Mahatma Gandhi Hospital as a result of Klebsiella in 2005 which was caused by the unhygienic environment. Even though no staff was held liable for the incidence, the hospital reported that the neonatal intensive care unit was short-staffed and overcrowded.

Some respondents held contrary views on the impact of size on migration, and they assert that varying workloads in departments within a healthcare can influence the migration decisions of doctors. This finding means that some units carry heavier workloads than others. One of the key issues encountered by the public hospitals in South Africa according to Day and Gray (2008) is the fast growth in the number of people who depend on the services rendered by the public healthcare sector thereby emphasising an increase in the workload of doctors to meet this challenge. This challenge is making it difficult for the public health sector in South Africa to provide quality care to those that require it.

The finding also showed that the expertise of some specialists in healthcare could be affected by the size of the hospital such as the super-specialist. The super-specialists are doctors who have undergone very specialised training in a narrow field such as the kidney transplant specialist after the completion of a specific residency programme and fellowship; if they feel that their expertise is not well utilised or the environment is not challenging enough, they may be motivated to migrate. George, Quinlan, Reardon and Aguilera (2012) also emphasised the importance of the responsibilities undertaken by public healthcare professionals in South Africa.

There are obvious benefits to working with either the private or the public sector. One of the advantages of working in the private sector is the opportunity to be in control, that is, doctors can take decisions without waiting for approvals from anyone which is an avenue to improve

business and management skills as well as foster personal development. The findings identified financial gain as one of the benefits of working in the private sector and that doctors' reap a financial reward that is commensurate to their efforts. Receiving the dividend of hard work without delays is enough motivation for doctors and is capable of attracting others to the private sector. Rust and De Jager (2010) also affirm that several healthcare personnel have a preference for the private sector which provides an environment that exceeds the public sector on employment conditions and remuneration.

Furthermore, doctors in the private sector have the opportunity of determining and controlling their working hours which is a major drawback for the public sector. Being able to control working hours affords doctors the opportunity to engage in more research work which is beneficial to the general public. Overworked doctors in the public sector cannot give off their best on the job let alone having time for research whilst doctors in the private sector can explore as many opportunities as possible to improve themselves and stay relevant. A study conducted by Coomber and Barriball (2006) also supported this assertion by proposing that work overload among medical personnel has been revealed to cause job dissatisfaction.

The private sector is not without its demerits. The upsurge in medico-legal is a major snag on the private sector which could serve as a tool to draw migrated doctors back to the public sector. Involvement in litigation places strains on doctors and their abilities to perform their job functions. Another drawback of the private sector is the issue of combining seeing patients with the pressure of managing a business which is something some of the doctors are not comfortable with. It was noted that some of the doctors would have appreciated focusing only the treating patients without being bothered with business management as opposed to be given an enabling environment which is one of the merits of working in the public sector. Insurance cost in the private sector is also a major issue threatening the existence of some private practices.

It was gathered from the findings that doctors have the opportunity of getting more opinions on medical issues before taking a decision. The public sector provides an opportunity to gain more skills as well by listening to the advice of others on various cases because hospitals in the public sector have different departments that work towards the same goal and not

personal gains. This kind of exposure to diverse perceptions and inputs aids learning and personal developments as well as ensuring that informed decisions are made regarding cases.

Another benefit of working in the public sector is the structures that guarantee that doctors do not have to bear litigation issues alone nor carry the insurance burden for treating patients. The structures provide checks and balances that minimise errors and negligence which in turn reduces litigation cases as against the private sector where only one person makes all the decisions. Another advantage of the public sector is that doctors who do not want the pressure of managing a business can focus on the job roles entirely without distractions. Managing a business requires a lot of concentration and planning which could have an adverse effect on the efficiency of a doctor in the long run if he or she does not have business acumen.

One major drawback of the public sector obtained from the finding is the failure to restrict the number of patients to attend to daily and neither do doctors have total control over their working hours which is one of the strengths of the private sector. Doctors are human and having to engage in long hours of work or seeing an unregulated number of patients in a day could be exasperating. Hospitals in the public sector rotate doctors on 24 hour call, even though they get paid for these calls it is not about money for some of them as values differ from one person to another.

The bureaucratic structures of the public sector are also a push factor for some doctors. It was gathered that these structures have the ability to delay decisions being made as one has to wait for one approval or the other, which is often influenced by alliances and networks, which is frustrating. The findings indicated that most doctors are interested in saving lives and not office politics and the interference of politics in their daily duties have the potential of leading to job dissatisfaction.

The inability of some doctors to secure employment with the public sector after their graduation as a general practitioner or as a specialist in various fields of medicine is a major challenge. Limited employment opportunities in the public sector caused by the Moratorium on Employment (MoE) is a major factor that the central government of South Africa will need to address if the dearth of medical doctors in the public healthcare sector will be reduced

to the barest minimum. The moratorium on employment was triggered by the drop in the budget allocation due to the reduction in the population of a province such as KwaZulu-Natal. The last census exercise conducted in 2011 showed a significant decrease in the population of KZN from 21.1% in 1996 to 19.8%. This budget allocation reduction impacted on the compensation of employee salary (COE) and made it difficult to employ as many specialists as possible to meet the need of the general public. This reduction has also affected the residency program as fewer opportunities are available for general practitioners (GPs) who are interested in becoming specialist thereby migrating to another province where their needs can be met. There is the need for the Moratorium on Employment (MoE) to be lifted especially in provinces where there are significant shortages of medical doctors. Excessive workload, long working hours and the lack of equipment were also noted as motivating factors for migration as all these factors make it difficult for doctors to carry out their duties efficiently.

The findings also revealed that the internal migration of medical doctors from the public to the private sector is prevalent in South Africa and it has been a primary cause of skills shortages in the public sector. The brunt of the internal migration is not borne by the patients alone as junior doctors are also deprived of benefitting from the experiences of the older doctors knowing fully well that experience is crucial in medicine. Having the opportunity of handling several cases gives better exposure and equips doctors adequately for their duties which the medical school cannot achieve alone. The experienced doctors can share their knowledge with the younger doctors as well as give direction and assistance as the case may demand, but in a situation whereby the skilled hands are limited, they will find it difficult to perform all their obligations correctly. The ongoing internal migration significantly affects service delivery in the public sector as overall efficiency is negatively impacted. The finding also showed that given an enabling environment (absence of politics and inefficiency), some doctors in the private sector are willing to return to the public sector.

The researcher gathered from the management's view that the public sector has initiated strategies to effectively deal with this type migration but is still much to be desired. The public health management is committed to ensuring the retention of doctors not only in the urban areas but also in the rural areas where they are mostly needed. Some policies were established to aid these goals.

6.15 FINDINGS FROM DOCUMENTARY DATA

The researcher secured access to the South Africa healthcare documented strategies on retention record for the period of five years. The general policy on employee relations deals with the relationship between employees and management both on an individual and collective basis, delineating daily communication practices between management and employees as well as guidelines on grievance and disciplinary procedures.

The KZN Department of Health evaluates the retention rates of doctors annually and can determine the actual vacancy figure across the province which is supposed to aid human resources planning, but the primary challenge remains insufficient funding to fill the vacant positions.

The perusal of the documentary data showed a considerable drop in the retention rate of doctors from 2013-2016. High labour turnover rate can be an indication of complications with human resources policy or practice such as ineffective grievance and disciplinary techniques, poorly planned or uncompetitive compensation systems as well as failed recruitment and selection processes (Marchington & Wilkinson, 2008). Budget restrictions were fingered as one of the main culprits affecting the filling of positions in the public health sector, especially for the specialist. KwaZulu-Natal has only 16% of the total number of doctors in South Africa as at 2004 despite being the most populated province (Cross *et al*., 2005). One of the 2013/14 planned goals of the KwaZulu-Natal Department of Health is to increase the number of specialists through the expansion of Registrar training and retain 75% of them by 2014/15 in the province. The budget restriction factor has resulted in limited placement prospects for qualified specialists within the public sector leaving them with no other option but to seek employment elsewhere. This finding showed that it is not an intentional decision for some doctors to migrate to the private sector but they took the decision to have an opportunity to put their expertise to use. The payment of performance bonuses from 2013-2016 was also affected by budget constraints which could have served as a motivating factor for the migration for doctors in the public sector. This constraint has placed severe burdens on service delivery within the public sector at all levels of care.

The findings also revealed a major increase in the turnover rate of specialists and general practitioners mainly from 2013-2016. The rate of turnover increased from 4.6% in 2014 to

7.4% in 2015/16 which is quite high for a sensitive sector such as healthcare. Currently, the rate of turnover of medical officers is 18.1% according to the 2015/16 Annual Report. The percentage of resources being supplied is not meeting the human resources needs of the public sector which have remained a critical challenge despite it being part of the Human Resources for Health plan from 2012/13-2016/17.

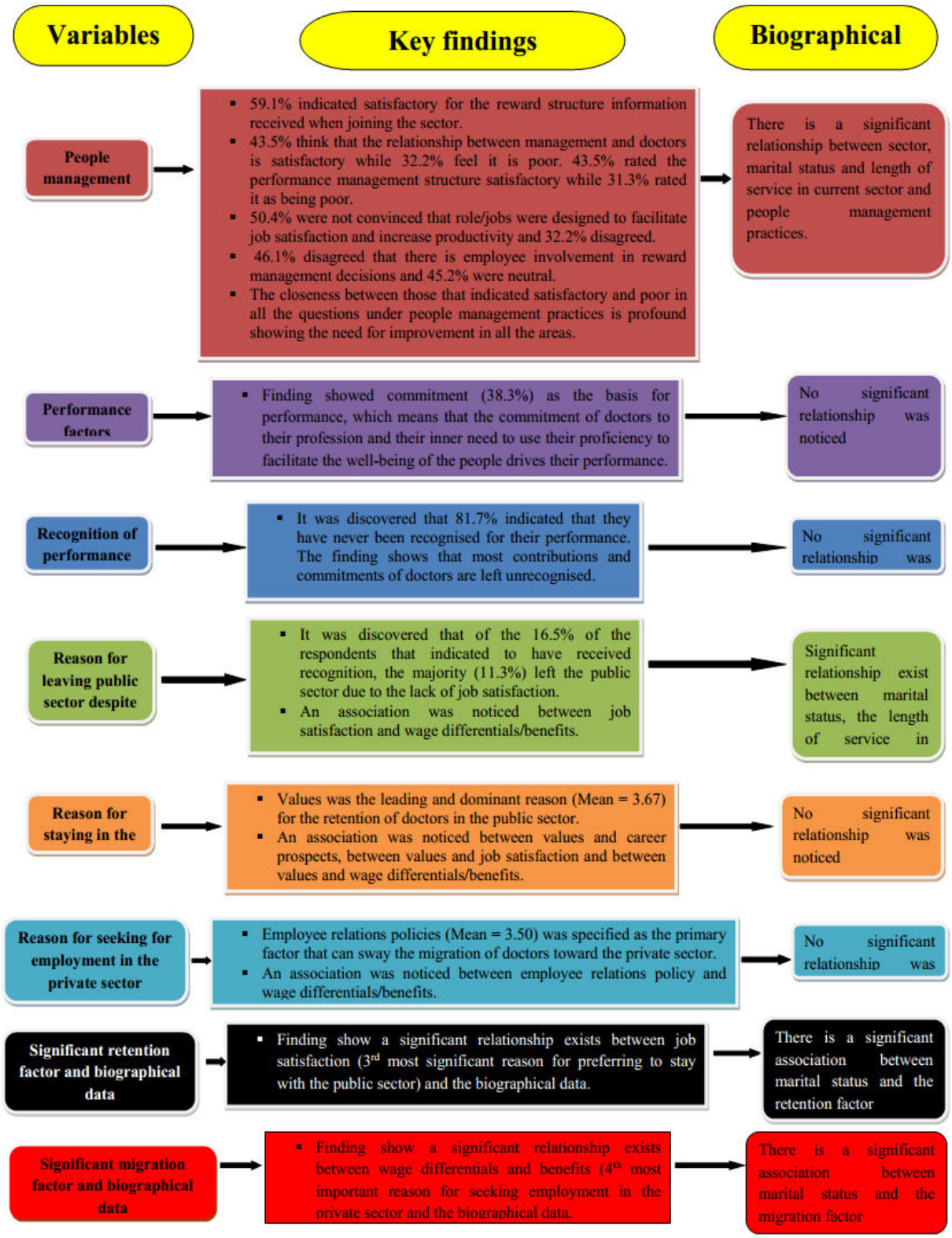
The findings also revealed the presence of some internal structures within the public sector that delays the execution of programmes such as the convoluted and drawn-out procedures attached to the approval of overtime payment as well as the unfreezing and the appointment of human resources into positions. This discovery is part of the factors mentioned by respondents in the semi-structured interviews which they believe is capable of frustrating doctors from getting things done quickly and efficiently. This internal structure also affects the approval of equipment repairs and procurements.

The dearth of qualified human resources was identified as the factor behind the inability of the public sector to deliver on its service promises in the study conducted by the department on the influence of skills shortages on service delivery in 2014-2015 (Department of Health, Province of KwaZulu-Natal, 2016). The finding also revealed the inadequate staffing of the Resuscitation and Casualty centres due to few trained emergency medicine doctors which impacts on supervision, clinical governance and service quality in the public sector. This finding reflected that many lives that could be saved would be lost due to the limited number of doctors to attend to emergency cases. Some of the challenges revealed by the Annual Report are clinical governance, insufficient supportive supervision and mentoring programmes which could have been hampered by the dearth of sufficient experienced doctors to undertake this role.

The aforementioned results of the study and key findings are depicted in Figure 6.1.

FIGURE 6.1

FLOWCHART ON THE DISCUSSION OF FINDINGS



6.16 CONCLUSION

The retention of skilled medical personnel remains a challenge that impacts on the ability of the public healthcare sector to deliver on its obligation. There is a significant relationship between the length of service and migration and the results reflected that the longer employees stay with the public sector, the higher their preference for the private sector which is a matter of concern because experience is vital in the healthcare sector. The findings have sufficiently revealed factors that can influence retention and the ones that can trigger migration which will inform the recommendations to move the public sector forward.

CHAPTER SEVEN

CONCLUSIONS AND RECOMMENDATIONS

7.1 INTRODUCTION

This study set out to broaden the body of knowledge on the migration of doctors from the public sector to the private sector. Every organisation requires skilled, loyal and fully involved workers in order to function adequately as the business environment presents new challenges; the healthcare sector is not an exception. The general efficiency and the survival of the organisational values hinge on these workers, thereby making employee retention a pivotal focus. The attraction, positioning, development, and the retention of these workers whether in the private or public sector is usually a daunting task. Hence, the effort put in by this study to explore the migration of medical doctors from the public sector to the private sector and make recommendations, based on the results of the study, to reduce migration and enhance retention.

7.2 CONCLUSIONS RELATING TO THE OBJECTIVES OF THE STUDY

The first objective of the study to investigate the reasons behind the migration of medical practitioners to the private sector from the public sector was realised in the findings recorded which established employee relations policies as the key reason why doctors seek employment in the private sector. This finding showed that government representatives, doctors' representatives and management of various hospitals and clinics are the parties given the opportunity to make input during policy formulation. The significance of an employee relations policy that benefits not only the management or the government but also the employees cannot be over emphasised. The drafting and implementation of the policies should involve all the doctors in the public sector and not only their representatives. Equal opportunity should be given to everyone to make input during the process of policy formulation without excluding any employee from the process.

Another discovery made by this study regarding factors that influence the migration of doctors from the public to the private sector is the inability of some medical doctors to secure employment with the public sector after their graduation as a general practitioner or as a specialist in various fields of medicine. Limited job opportunities in the public sector caused

by the moratorium on employment is a major factor that the central government of South Africa will need to address in order to reduce the dearth of medical doctors in the public healthcare sector to the barest minimum. The moratorium on employment was triggered by the drop in the budget allocation due to the reduction in the population of a province such as KwaZulu-Natal. The last census exercise conducted in 2011 showed a significant decrease in the population of KZN from 21.1% in 1996 to 19.8%. This budget allocation reduction impacted on the compensation of employee (COE) salary and made it difficult to employ as many specialists as possible to meet the needs of the general public. The moratorium on employment (MOE) has also affected the residency programme as fewer opportunities are available for general practitioners (GPs) who are interested in becoming specialists thereby causing them to migrate to another province where their needs can be met. Budget constraints also affected workshops which could have been a good enlightening and training platform for doctors in the public sector. MOE made doctors apply for the few available positions not necessarily in the department that they are best suited. The moratorium on employment (MOE) also made it difficult to fight effectively against skills shortages and replace the doctors that left the public sector. It is, however, pertinent to note that the number of patients is not reducing, but human resources are diminishing thereby putting pressure on the hospital management.

Another migration induced issue identified by the semi-structured interview is the variation in workload from one department to another which implies that some departments carry heavier workloads than others thereby putting additional pressure on the doctors working in such departments and influencing their migration decisions. Having as many competent staff as possible in those departments with intense workloads will ensure that doctors are not overstrained.

The second objective which is to explore the effect of the migration on the public sector regarding service delivery showed that the migration of medical doctors from the public sector affects service delivery negatively. The lack of adequate staffing unduly increases the workload of the doctors in the public sector and results in poor morale for the remaining doctors. Experienced general practitioners and specialist have been lost from the sector, which has impacted on the quality of care being given to the public at large. However, the inadequate staffing issue is more profound in the rural areas because of the preference of

doctors for the urban areas. One of the factors that emerged in the course of this study is the fact that the majority of the doctors prefer to work in the urban setting due to the attractiveness of city life and the availability of facilities that makes their life and work easy, leaving few GPs and specialists in the rural areas.

The private healthcare system in urban areas provides the public with alternative medical care though at a higher price which is scarce in the rural area. Apart from the provision of quality healthcare service, the private sector also offers an escape route to the dissatisfied public health sector medical doctors which has continued to impede service delivery in the public sector. The inadequate staffing also necessitates that patients will have to wait longer to be attended to at healthcare facilities. The fact that some doctors remained in the public sector while others are leaving for the private sector does not mean that all is well. It was also gathered from the findings that when there is the need for operating on a patient in the private sector, the expertise needed are readily available while in the public sector you might have to call up two or more hospitals to get the expertise necessary for a successful operation which could result into loss of lives. There is also the issue of specialists being overworked and not motivated which could affect the quality of the treatment given to the patients.

The third objective which is to establish a clear link between monetary rewards and non-monetary rewards and the results reflect that there is a strong link between them. The introduction of the occupation specific dispensation (OSD) was to deal with the monetary rewards challenges in the public sector without consideration being given to non-monetary rewards such as recognition. Despite the introduction of the occupation specific dispensation (OSD), doctors were still migrating in large numbers to the private sector. The finding showed that the majority of the doctors have never received recognition for their performance, which could be a pointer as to why doctors are still migrating despite the implementation of occupation specific dispensation (OSD). This showed that the non-monetary reward is equally as important as the monetary rewards. A greater emphasis has been placed on the monetary rewards to the disregard of the non-monetary rewards such as recognition which could serve as a possible retention tool by the public health sector.

It was also noted that doctors in the public sector do not get recognised for remarkable individual performance which may have added to the excellent performance of their clinics or

hospitals. The finding depicts that the public health sector is bigoted in reward management. A shift in paradigm is of utmost necessity for the public health sector in this regard. Even though wages and benefits are important, they cannot satisfactorily ensure higher employee engagement that will guarantee sustainable organisational growth. Evidently, there is the need for change in the reward strategy in provincial medical healthcare.

The fourth objective which is to assess the intention of the remaining doctors in the public sector with regards to this type of migration showed that job satisfaction is the most significant factor driving migration. Even though doctors are committed to their profession and derive fulfillment in helping the public, it gets to a point where their level of satisfaction impacts on their decision whether to stay in the public sector or move to the private sector to continue rendering their services.

The findings in this study indicated dissatisfaction among doctors in the public sector which goes beyond wages and benefits as previously established by the implementation of occupation specific dispensation (OSD). The interviews conducted with the doctors and the hospital managers in the course of this study pointed at unattractive working conditions within the public sector as a major contributor to staff shortage. Although, the occupation specific dispensation (OSD) was introduced in 2007 to significantly increase the remuneration of practitioners within the public health sector in order to address the issue of working condition, taking a cue from the Britain National Health System (NHS) indicates that merely increasing the remuneration of doctors is not likely to have a significant improvement on the state of affairs within the public health sector. The dissatisfaction of doctors in the public health sector outweighs those in the private sector as established by the various interviews conducted.

The fifth objective of this study which is to investigate whether there is a retention policy in place concerning the public health sector shows that there is no formalised retention policy in place. While so much has gone into the re-engineering of the health workers to meet service needs much cannot be said about the policy to retain them. The findings also exposed the existence of some internal structures in the public sector that causes the deferments of programme execution such as protracted processes attached to the authorisation of overtime

payment, unfreezing of posts, the employment of qualified individuals into positions and the amendment of methods.

7.3 RECOMMENDATIONS BASED ON THE RESULTS OF THE STUDY

For the purpose of retaining medical doctors in the appropriate area of need in the South African public sector solid tactical measures must be implemented to uphold the recommendations. The factors that are pushing doctors away from the public sector are entrenched in the public healthcare system, and the first step towards effective retention strategy is the identification of these factors.

With regards to people management practices, the moderate outcome received from the information on reward/benefit structure, performance management system and the relationship between management and medical doctors stressed the need for improvement. The findings received on whether the role/jobs were designed to facilitate job satisfaction and increase efficiency shows the necessity to reassess role/job designs in the public healthcare sector. Furthermore, a significant challenge was also noticed in the area of employee involvement due to the outcome of the study.

It is recommended that there should be a heightened awareness on the importance of effective communication with the doctor which should influence the formulation of the practical guidelines involving both formal and informal communication channels to plainly communicate management plans and decision. Regular consultation should be allowed to serve as a supplement to the face to face communication. The finding further revealed that the various communication channels were directed towards improving employee involvement in decision making. Chartered Institute of Personnel and Development (2009b) factsheet on employee engagement buttresses employee involvement as a major component of employee engagement.

The adoption of a joint consultative forum system, an aspect of employee involvement, can assist the public healthcare sector in knowing the causes of job dissatisfaction that can lead to the migration of the doctors directly. It can be structured on a clinic-by-clinic basis where doctors, the hospital management with government health officials come to together and deliberate on issues affecting them. The regular consultation with the doctors is effective in

offering an excellent prospect for feedback and can assist in tackling issues quickly before they influence doctors to leave the sector.

Effective communication and consultation are vital to organisational success because it boosts fairness, productivity, and rational conflict resolutions and complaints that stemmed from the employment relationship. Employee involvement opportunity should be given to the medical doctors either through the online/intranet facility or open communication forum to personally express their views on various subjects and make propositions extensively without fear or favour. In order to reinforce the relationship between the doctors and hospital management it is also recommended there should be an improvement in doctors' responsibility by initiating an alliance between the public and the private sector which will provide ample support from the experienced practitioners (especially in the private sector) to the junior doctors and also enhance healthcare environments of the public sector.

Role and job design should always be done in collaboration with doctors even though variations may occur due to the peculiarity of each hospital or healthcare environment but doctors should still be adequately informed to ensure the smooth running of operations. A good job design should measure up with the organisational requirements for high efficiency, must be fully integrated with employees' needs and abilities, offer constructive works, challenging goals, job satisfaction and must also offer prospects for career progression. It is recommended that substantial independence and control over the job roles and, how they perform it should be given to doctors by the management which is good for intellectual flexibility and development. Goals and interdependence of roles should be examined to ensure successful job design.

Although the performance management structure of the public healthcare system is practical to some extent, adequate monitoring is recommended in ensuring that all aspects of performance, contributions and job responsibilities are covered at all times, guidelines are strictly adhered to, and the appropriate rewards are given.

The research finding stresses the need for more employee involvement in decision-making procedures of the public health sector. The importance of employee involvement as a participative management practice was also emphasised by Macleod and Clarke (2009),

which also views it as a series of activities deliberately organised to heighten the organisational awareness of the employees, develop their potentials, offer decision-making opportunities to them and support their loyalty to the organisation.

The empirical findings showed that despite having the performance of some doctors recognised they still left the public sector due to the lack of job satisfaction. The result of the study also identified job satisfaction as the second most significant factor that influences the migration of medical doctor from the public sector. The migration of doctors continued in large numbers despite the introduction of the occupation specific dispensation (OSD) in 2007 showing that even though wage differential and benefit is a factor that can foster job satisfaction, it obviously outspreads beyond wage for medical doctors. The performance of an employee is determined by the workplace environment. The research findings has further highlighted the need for heightened awareness by both the management of the public health sector and the government about the concept of job satisfaction and the impact of basic variables such as healthcare infrastructures and quality of life on the performance of doctors and enhancing the working conditions, providing crucial medical devices and medication to be administered by the doctors. It is highly recommended that the management of the public health sector will devote considerable attention to future research to discover other variables that could have significant impacts on job satisfaction in order to preserve the service of experienced medical doctors in the public sector, which is on par with the human resource strategy of the department of health. It is recommended that there should be an upgrading of the hospital infrastructures and hospital environment while also ensuring that hospitals are adequately equipped to make the jobs of the doctors easier and the working environment conducive. Another vital means of improving working condition is to improve communication, allow for more flexibility and reduce bureaucracy to the barest minimum. Doctors must be well motivated, encouraged, appropriately rewarded and their continuous self development must be ensured which will significantly impact on the working condition.

The quick resolution of labour disputes will ensure that informed decisions are made when drafting employee relations policies and this will also impact positively on job satisfaction. The quick resolution of a dispute will not only boost the relationship between the management and the employees, but it will also boost employees' morale.

The findings identified employee relations as the reason doctors might seek employment in the private sector. With regards to employee relations, it is recommended that the notion of total reward that gives consideration to other factors aside from monetary rewards should be considered. The total reward will tackle the flaws that are related to the migration of doctors and also deal with other factors such as recognition, quality of life, flexible working hours and work-life balance that are fundamental needs of employees. Bratton and Gold (2012) affirm that reward shapes work performance and attitude. The idea of total reward will ensure a better integration of the business objectives/policies with employees' needs and boost employee's fulfillment. Recognition should form part of the reward management system of the healthcare sector. Not only should it be done departmentally, but it should also be done individually. Doctors can also be acknowledged through awards, commendation letters and other methods of recognition. The valuable contribution of doctors to the delivery of quality healthcare service to the public must not be disregarded. The findings revealed that the basis for performance is commitment; rewards for the commitment of doctors to service is a brilliant exemplar of offering them the much-desired recognition which will significantly boost their self-confidence and propel them towards greater achievements. The factsheet on total reward by Chartered Institute of Personnel and Development (2009b) stressed that there are other means of reward apart from monetary rewards; total reward emphasises the importance of both monetary and non-monetary rewards within the broad structure of work practice.

The total reward has the potential of being influential in aiding the alignment of human capital and business plans with employees' needs to improve performance. Total reward comprises of the work environment, benefit schemes, flexible pay, the career as well as personal development. Additionally, it may include challenging work functions, flexible working hours, recognition of each employee's contribution, substantial independence on the job and participation in the decision on work procedures. The public healthcare sector according to Thompson (2002) can gain some vital benefits from the practice of total reward such as enhanced organisational efficiency, easy recruitment of experienced staff, improved retentive capability and recognition of the public health sector as an employer of choice.

It is recommended that more prominence should be granted to total reward practices in the public sector, which has the opportunity to become a change instrument and a useful

management tool. A complete integrated total reward practice will guarantee the development of all the aspects of employees' functions into a single flexible package that will boost organisational efficiency. It is also recommended that doctors should receive rewards not only for meeting the set targets but also for any remarkable improvements that they make on the job to uphold the logical structure linking equality, performance records, and rewards to a heightened employee motivation to stay with a particular organisation. This theoretical structure will impact significantly on retention if it is integrated with good employee relations practices such as employee involvement.

The presence of improved talent management within the public healthcare sector is an example of appropriate solutions available to the public sector on employee relations. Organisations are experiencing challenges on how to deal with talent management and reinvent policies particularly in the present business environment where managers must persistently invest in human capital to mitigate against the dearth of talent (Temkin, 2008). Talent management can be defined as the application of integrated approaches intended to improve workplace efficiency by building improved procedures for recruiting, developing, retaining and using individuals with necessary skills to meet existing and potential organisational needs (Oladapo, 2014). Talent management can also be seen as a practice used to manage some events that every employee encounters in the work environment (Perrine, 2005). To sustain exceptional organisational success in the global market, there is the need for organisations to reorganise and reformulate their talent management techniques (Ashton & Morton, 2005). According to De Long and Davenport (2003), successful talent management requires active management involvement, employee commitment, organisational buy-in, and workplace records as well as talent management metrics. Messmer (2006) asserts that retention is enhanced when employees are provided with a stimulating work culture, rewards, opportunity for development and work-life balance.

Lockwood (2006) also recognised the importance of talent management in the competitive business environment as a major force behind organisational success. Retaining experienced doctors in the public sector must be the main objective of public healthcare management which incidentally is one of the prime reasons behind the implementation of the talent management practice.

Another significant element of talent management planning which can aid the public sector in coping with migration is succession planning. Every organisation will experience loss of employees at some point due to factors such as migration, retirement, sickness among others. Irrespective of the cause for losing the employee, organisations are expected to continue the smooth running of operation which will only be possible if there is a succession plan in place. The succession plan will enable the public sector to cope with unanticipated gaps (particularly the loss of experienced doctors) and also reduce the effect of the gaps on service delivery. Even though succession planning is usually done for senior positions in the organisation, it would be more beneficial if it is done at all levels within the organisation which will bring about the development of junior doctors in handling responsibilities. The succession planning will keep the public health sector well equipped for any possibility of migration. Not only will succession planning give the doctors a clear-cut progression with regards to their careers, it will also serve as a motivating factor to improve their performances. Largely, the implementation of the succession planning will give the doctors a sense of belonging which will generate a positive atmosphere in the hospitals, enhance job satisfaction and foster retention. Through the succession planning a definite link will be established between the objectives of the public health sector and the human resources (HR) strategic planning.

Values was recognised as the factor responsible for the retention of doctors in the public sector while some are migrating to the private sector. The personal values of doctors were identified as a strong influence on their retentive abilities, but personal values do not exist in isolation. Organisational values delineate the acceptable code of conduct for all employees in the organisation. It is recommended that organisations should engage in exercises and efforts that will lead to the establishment of organisational values which will project what the organisation represents. Organisational values are usually entrenched in the corporate culture to ensure that employees do not act in ways that are consistent with their personal values to the detriment of the organisational values. A clearly expressed value statement has the tendency of drawing an organisation together, thus building better focus and momentum towards realising the organisational goals. Clear alignment of the personal values of doctors with that of the organisation's will significantly improve their engagement and retention.

The findings revealed a significant association between marital status and job satisfaction while further analysis showed that the 73.9% of the respondents were married. Flexibility with regard to the working hours should be encouraged in the public sector. The changing dynamics in society has made it impossible to have a clear demarcation of roles between men and women which has made flexible working condition more appealing and a vital factor in enhancing job satisfaction for married people.

The findings also established a significant relationship between wage differentials and benefits and marital status. Due to additional responsibilities being shouldered by married doctors there is the need for their wages and benefits to remain competitive at all times. Every extra contribution should not be overlooked but should be rewarded appropriately. The introduction of incentives for spectacular performances will enhance the commitment of doctors and impact on their migration decisions.

With regard to the moratorium on employment (MOE), it should be lifted especially in provinces where there are significant shortages to allow for the employment of general practitioners as well as specialists. Meyer, Mabaso and Lancaster. (2002) uphold the importance of preserving the availability of scarce skills to meet the needs of the public. It is also recommended that the moratorium on employment (MOE) be lifted to provide opportunity for career progression and further studies in medicine for those that are interested in the residency programme. This initiative will show the readiness of public health management to improve service delivery and restore the confidence of the doctors in the system. The availability of career opportunities and training provides doctors with current medical information and knowledge to advance their skills which are good for their morale and improved organisational efficiency. Employment for the specialist for various areas of the public healthcare will reduce the burden being carried by few specialists and might also deal with de-motivation caused by the heavy work burden.

Another factor that emerged in the course of this study is the issue of doctors' preference for the urban setting. This issue can be addressed by making the working environment conducive, developing the rural areas with infrastructural facilities such as accessible roads and also increasing the incentives such as rural allowances to attract more doctors to the rural areas.

It is of particular interest to discover that some doctors in the private sector are ready to work in the public sector given that right opportunities are available. The cost of medical insurance is making it increasing difficult for doctors in the private sector to practice especially in fields such as obstetrics. The public health sector can cash on the issue of medico-legal that has to do with an increase in litigation cases against doctors even when they are not negligent in the private sector. The issue of supervision should also be reviewed while more discretion is given to doctors. The bureaucracy in the public health sector is also a major concern to some doctors. It is therefore recommended that a tight alliance should be supported and nurtured between the public and private health sectors.

In response to the skills shortage, clinical health associates and mid-level healthcare providers were introduced by the Department of Health to handle mild health issues in the rural areas. The South African Department of Health is dedicated to achieving an improved healthcare structure, which focuses on the improvement of the management and functionality of its system. The aim of this improved health system is to foster efficiency and parity within South Africa while ensuring that it is affordable and accessible to all. But while the plan for improved healthcare is still in the pipeline there is an urgent need to address the issue of doctors' migration to prevent a massive healthcare disaster in the country. Even though the Cuban training programme is ongoing to train more individuals into becoming doctors, there is a need to put adequate measures in place to retain those that are presently in the public health sector in order to prevent the disruption of service delivery to the general public knowing fully well that a bird at hand is better than ten in the forest.

The forward-thinking organisations tackle employee retention as a strategic issue by institutionalising distinctive policies that give preference to skills that they intend to retain and the employment proposals appropriate for this purpose (Farley, 2005). Drainage of skills caused by the migration of doctors does not only affect patients but other doctors who will not have access to that knowledge which could have been gained through direct supervision and training. Staffing with the required skills is of utmost importance in the public sector.

It was gathered that the private sector working conditions provide the drive and the time to study which is a challenge for doctors working in the public sector. The introduction of flexi-hours and adequate human resources in each department will provide doctors with the

opportunity for further studies. It was also noted that some doctors migrate to the private sector to experience personal development through managing things on their own without having to take orders from anyone.

The need for more research on internal healthcare migration cannot be over-emphasised. There is the need to investigate and understand the degree at which medical practitioners migrate from the public sector and handle the challenges accordingly to forestall an adverse impact on healthcare service delivery. From the perspective of the medical doctors leaving the public sector for the private sector, migration could be seen as a force towards progression. On the other hand, the government, the management of public health sector and the general public could view the migration of the doctors as a force towards retrogression due to the brain drain that is impacting negatively on healthcare service delivery.

The aforementioned recommendations, based on the results of the study aim at reducing the migration of doctors from the public to the private sector. These recommendations are also graphically depicted in Figure 7.1.

FIGURE 7.1

RECOMMENDATIONS AIMED AT REDUCING THE MIGRATION OF DOCTORS FROM THE PUBLIC TO THE PRIVATE SECTOR

7.4 LIMITATIONS AND FUTURE DIRECTIONS

In the face of the conceivable contributions of this research to the growing literature on the migration of doctors, it is not without some limitations, which may lay the foundation for future studies. Firstly, this research was conducted in the KwaZulu-Natal province of South Africa which might limit the generalisation of its finding to other provinces of immense wealth and opportunities such as Gauteng. Also, there are more rural areas in KZN without proper medical facilities and favourable working conditions for doctors as compared to Gauteng and Western Cape. The conjectural framework may not be the same in the case of other provinces. Future studies on the migration of doctors might attempt to study doctors in different provinces from both the private and the public sectors to arrive at a more robust conclusion and recommendation.

Secondly, another limitation of the study is the semi-structured interview conducted on three hospital managers from the private healthcare sector and one CEO from the public healthcare sector. There is the possibility that these senior management staff interviewed have similar viewpoints regarding some of the factors influencing the migration of doctors which senior management staff in other hospitals may not share. However, given their broad insight, the researcher is certain that they provide a more cogent judgement on the influence of hospital size on migration, motivation that drives migration, benefits, and drawbacks of migration on the private and public sector, the type of migration that is prevalent in South Africa and its effect on the general public. Also, by protecting the identity of the respondents, the researcher was able to aid sincere and useful responses regarding the research questions.

Opportunities for more academic research into different aspects of human resources management is being presented by the healthcare sector. Notwithstanding the above-mentioned restrictions, this research made substantial contributions that will offer an incentive for future research incorporating more variables and prototypes.

Even though several recommendations have been made, the public sector is not expected to implement them at once; the responsibility lies with the management to initiate the best strategic means through which all the recommended retentive initiatives can be executed to ensure sustainable growth as well as uninterrupted quality service delivery.

7.5 CONCLUSION

There is the need for the management of public healthcare at all levels to be resourceful in ensuring the delivery of quality service always despite the current insufficient budget allocation to meet the rising healthcare demands. Even though it is not possible to achieve a 100% success rate at all times, inferior services or errors should be reduced to the barest minimum.

Although some factors were identified by this study to be responsible for migration, there are usually multiple factors responsible for the migration decision of people as a few factors are insufficient to carry the migration burden. For the impact of the improved healthcare system to be felt, there is the need for an honest evaluation of the environment in which the public health sector operates by the South African Department of Health. Adjustments and improvements must be made as the case may demand to dissuade medical practitioners from leaving and gradually attract those that have left back to the public sector. The development of the public sector environment will not only retain doctors but will also correct the impression that superior services can only be obtained from the private sector. It is anticipated that the recommendations vividly depicted in Figure 7.1 has the potential to reduce the migration of doctors from the public to the private sector and hence, enhance public sector retention of doctors.

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Appendix i - POPULATION-TO-SAMPLE SIZE TABLE

N	S
10	10
15	14
20	19
25	24
30	28
35	32
40	36
45	40
50	44
55	48
60	52
65	56
70	59
75	63
80	66
85	70
90	73
95	76
100	80
110	86
120	92
130	97
140	103
150	108
160	113
170	118
180	123
190	127
200	132
210	136

N is population size

S is sample size

Sekaran, U., & Bougie, R. (2010). ***Research methods for business: A skill building approach*** (5th ed.). United States of America: John Wiley & Sons, inc. 295.

Appendix ii - Questionnaire

Migration of Medical Doctors from the public to the private sector: A case study of Mahatma Gandhi memorial hospital and Life healthcare Hospital group, Durban.

This is to solicit for your support and cooperation in the accomplishment of the afore-mentioned study. The purpose is to identify the reasons for the migration of medical practitioners from the public sector, its effect on the public sector and how it can be curtailed.

I am undertaking this research as part of the requirement for the award of PhD in Human Resources Management at the University of Kwazulu Natal, Westville campus and I hope that the findings from this study will be of immense value to the public health sector in South Africa and other developing countries.

Your kind support is essential in completing the attached questionnaire and returning same within a week of receipt.

The questionnaire is anonymous and the confidentiality of all information supplied is guaranteed.

Thanks in anticipation of your co-operation.

Yours faithfully,

Joyce Ayeni

SECTION 1 ***(Kindly tick (√) the appropriate box.)***

Q1. Gender

□1. □ Male 2. □ Female

Q2. Marital Status

1. □ Single 2. □ Married 3. □ Divorced

Q3. Race

1. □ Black 2. □ White 3. □ Indian 4. □Others

Q4. What is your highest educational qualification?

1. □ First degree (MBBS) 2. □ Specialist

Q5. Which sector are you currently?

1. □ Public 2. □ Private

Q6. How long have you been practicing as a medical practitioner?

1. □ Less than 1 year
2. □ 1 – 5 years□
3. □ 5 – 10 years
4. □ 11- 15 years
5. □ 16- 20 years
6. □ 21 and above

Q7. How long have you been in your current sector?

1. □ Less than 1 year
2. □ 1 – 5 years□
3. □ 5 – 10 years
4. □ 11- 15 years
5. □ 16- 20 years
6. □ 21 and above

Q8 What is your age group?

1. □ 26-35
2. □ 36-45
3. □ 46-55
4. □ 56-65

<u>SECTION 2</u> Kindly indicate your views by drawing a circle around the suitable number.

Where 1 – Very poor
2 – Poor
3 – Satisfactory
4 – Good
5 – Very good

Q9. How would you score the benefit /reward structure in relations to the information received when joining the sector?

1 2 3 4 5

Q10. What is your perception of the relationship between the management and medical practitioners in your sector?

1 2 3 4 5

Q11. How would you rate the performance management system of your sector?

1 2 3 4 5

Kindly tick (√) the most appropriate box

Q12. What do you think is the basis for performance?

1. □ Reward 2. □ increase efficiency
3. □ Commitment 4. □ Punishment 5. □Financial security

Q13. Indicate the extent to which you agree or disagree with the statement below:

Role and jobs were designed to facilitate job satisfaction and increase productivity.

1. □ Strongly disagree 2. □ Disagree 3. □ Neutral
4. □ Agree 5. □ Strongly agree

Q14. Indicate the extent to which you agree or disagree with the statement below:

In my sector, there are employee involvements in reward management decisions.

1. □ Strongly disagree 2. □ Disagree 3. □ Neutral
5. □ Agree 5. □ Strongly agree

Q15. Has there been an instance for award/recognition of your performance since joining the sector?

□ Yes 2. □ No

SECTION 3 Kindly tick (√) the most appropriate box

Q16. If your response to question 15 is yes, what is your main reason for leaving?

- □ Poor Career Prospect
- □ Poor employee relations policies
- □ Poor pay and benefit structure
- □ Lack of job satisfaction
- □ Other, please specify

……..……...

Q17. Have you ever tried going into private practice since joining the public sector?

1. □ Yes 2. □ No 3. □ Not Applicable

Q18. Kindly specify in order of importance, your reasons for preferring to stay with the public sector. (Illustrate the ***most significant*** reason by writing figure 1 in the appropriate box; the ***second most significant*** by writing 2 and so on.)

- ☐ Career prospects
- ☐ Employee relations policies
- ☐ Job satisfaction
- ☐ Wage differentials and benefits
- ☐ Values

Kindly indicate others if not listed above ----------

Q19. Kindly specify in order of importance, why you may seek employment in the private sector. (Illustrate the ***most significant*** reason by writing figure 1 in the appropriate box; the ***second most significant*** by writing 2 and so on).

- ☐ Career prospects
- ☐ Employee relations policies
- ☐ Job satisfaction
- ☐ Wage differentials and benefit
- ☐ Values

Kindly indicate others if not listed above ----------

Q20. Do you suppose that your responses express the view of other medical practitioners in the public sector?

1. ☐ Yes 2. ☐ No 3. ☐ Not Sure

Appendix iii - Semi structured In-Depth Interviews

Semi structured In-depth Interview Figure			
Participant's Demographic Data	1	Age	
	2	Gender	
	3	Marital Status	
	4	Race	
	5	Length of service	
Date of In-depth Interview			
Time Allocation			

INTRODUCTIONS

Moderator

Introduction by the moderator and appreciating the participant for assenting to take part.

I appreciate your readiness to spare your time and undertake this interview. My name is Joyce Adefunke Ayandokun Ayeni; a Doctorate Degree Student at the School of Information Technology, Governance and Management, and Discipline of Human Resources Management - University of KwaZulu-Natal (UKZN).

In partial fulfilment of my programme, I am obligated to conduct interviews for my thesis. My research topic is: ***Migration of medical doctors from the public to the private sector: A Case Study of Mahatma Ghandi hospital and Life Healthcare hospital group, Durban.*** *I will moderate our discussion today.*

I will clarify the semi structured in-depth interview guidelines and the duration.

We have the discussion scheduled for between 20-30mins per participant. This is basically to get your perception on the ***Migration of medical doctors from the public to the private sector****.*

I am here to moderate the session today. You will not upset or make me happy with whatever opinions you might offer. I am concerned with hearing your viewpoint.

- *I will try as much as possible to keep the interview focused and within our time frame. If too much time is being spent on one question, I may move the discussion along in order to cover all subjects.*

Addressing the issue of confidentiality

- *I will ensure the voice recording of the discussion in order not to miss out on any comment. Even though, first name will be used today, the final report will be devoid of any names. You are assured of thorough confidentiality.*

Laying the ground rules

To facilitate the process I will lay down a few semi structured in-depth interviews rules:

- *It is just the two of us, so only one person is to speak at a time.*
- *Feel free to express your views. I want to learn from you air your opinions, views, feelings, perceptions are important to me. Don't always just say "I agree"! There is no right or wrong answer and I encourage you to talk to me.*
- *You are responsible for the interview that is to take place during this session.*
- *My role is as to be a moderator not really interviewer so I facilitate the interview not to create it. I urge you to ask each me questions to clarify issues.*
- *You have signed the initial form confirming your participation in this session as well as your agreement to ensure that everything that is discussed in this venue remains confidential and private. Can I confirm that you are satisfied with this arrangement?*
- *I will take notes.*

Participant introduction

Please introduce yourselves- first name is okay. Please tell me which office you work in.

Discussion starter question

As mentioned earlier, the main topic of my theme is your 'personal opinion' on the Migration of medical doctors from the public to the private sector, focusing on Mahatma Ghandi hospital and Life healthcare hospital group in Durban. In order to reach an agreement before proceeding with this exercise, it is pertinent that I spend few minutes to explain the term 'personal opinion'".

THEMES ON MIGRATION OF MEDICAL DOCTORS

To start with, the facilitator will explain to the participants on what is meant by 'Migration of medical doctors' using practical Models.

1. Impact of Political Regime change and economic decisions on internal migration

I would like to get your opinions on the influence of change in government on Migration of medical doctors from the public to the private sector. ***A clear definition on what is meant by 'regime change and economic decisions' will be provided using practical Models.***

- ***Probe:*** *participants' views on the impact of regime change and economic decisions on migration of medical doctors and on the future of the healthcare sector will be sought.*

2. Influence of the size of the hospitals on migration of medical doctors.

I will like to have your view on the correlation between the size of a hospital and Migration of doctors from the public to the private section if there is any. ***A brief clarification on the meaning of 'size' will be provided using practical models.***

- ***Probe:*** *Views on whether the size of a hospital has any link with the Migration of medical doctors from the public to the private.*

3. Benefits or Drawbacks of this migration on both the private sector and the public sector

I would like to get your views on the benefits and drawbacks of medical doctors' migration with regards to the public and private sectors. ***The moderator will explain what is meant by 'benefits and drawbacks' using practical models.***

- ***Probe:*** *On how perceived benefits or drawbacks influence others to either migration or not and the effects of this migration on managers who are either losing or gaining doctors.*

4. Motivations that drives this migration

I would like to get your opinions on the reasons that influence Migration decisions of medical doctors. ***Clarification will be given on the meaning of motivation for migration using practical models.***

- ***Probe:*** *Opinions on the fundamental causes of this type of Migration.*

5. Types of Migration

I would like to get your view on the benefits and value of medical doctors in the private sector. The moderator will clarify what is meant by 'types of Migration' using practical models.

- ***Probe:*** *The dominant type of Migration that medical doctors engage in.*

6. The effects of this type of migration

I would like to get your opinions on the effects of the migration of medical doctors from the public to the private sector. Clarification will be given on what is meant by 'effects of Migration of medical doctors' using practical models.

- ***Probe:*** *the effects of migration of medical doctors from the public to the private sector.*

CLOSING REMARKS

I will give room for any short closing remarks that the participants might be interested in giving.

I am really grateful for your vital contribution today. Is there any final remark that you would like to make? The information given will enable me make some valuable submission in my thesis and heighten the understanding of the government on the migration of medical doctors from the public to the private sector.

Appendix iv - Structured Interview Questions Guide

1. **Regime change and economic decisions**
   - How does government regime change influence migration of medical doctors?
   - Does regime change and economic decisions have any bearing on future migration of medical doctors?
   - What is the effect of regime change on the perceived value of public hospitals?

2. **The influence of the size of a hospital on migration of medical doctors**
   - What makes the size of a hospital a vital basis for Migration of medical doctors?
   - Is there a correlation between the size of a hospital and level of migration of medical doctors?

3. **Benefits and Drawbacks of this migration on both the public and the private sector.**
   - To what extent does position or level influence migration of medical doctors?
   - How does perceived benefits or drawbacks influence other medical doctors to either migration or not?
   - What are the effects of this migration on managers who are either gaining or losing doctors?

4. **Motivations for the migration of medical doctors**
   - What are the fundamental issues that drive Migration of medical doctors from the public to the private sector?

5. **Types of Migration**
   - What are the types of migration that medical doctors engage in?

6. **The impacts of Migration of medical doctors**
   - What are the impacts of the migration of medical doctors from the public to the private sector?

End

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

31 August 2015

Mrs JAA Ayeni 213571075
School of Management, IT and Governance
Westville Campus

Dear Mrs Ayeni

Protocol reference number: HSS/1437/014D
Project title: Migration of Medical Doctors from the public to the private sector: A case study of Mahatma Gandhi Memorial Hospital and Life Healthcare Hospital Group, Durban

Full Approval – Expedited Application

In response to your application received on 24 October 2014, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol have been granted **FULL APPROVAL.**

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Y[redacted]

.....
D[redacted]hair)

/pm

Cc Supervisor: Professor Sanjana Nrijball Parumasur
Cc Academic Leader Research: Prof Brain McArthur
Cc School Administrator: Ms Angela Pearce

Humanities & Social Sciences Research Ethics Committee
Dr Shenuka Singh (Chair)
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www.kznhealth.gov.za

Reference : HRKM287/14
Enquiries : Mrs G Khumalo
Telephone : 033 – 395 3189

Dear Ms JAA Ayeni

Subject: Approval of a Research Proposal

1. The research proposal titled **'Migration of medical doctors from the public to the private sector: A case study for MGMH & Life Healthcare Hospital Group'** was reviewed by the KwaZulu-Natal Department of Health (KZN-DoH).

The proposal is hereby **approved** for research to be undertaken at Mahatma Gandhi Memorial Hospital.

2. You are requested to take note of the following:
   a. Make the necessary arrangement with the identified facility before commencing with your research project.
   b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.

3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Mrs G Khumalo on 033-395 3189.

Yours Sincerely

[redacted]

Dr. E Lutge
Chairperson, KwaZulu-Natal Health Research Committee
Date: 11/11/14

Life Healthcare Head Office
Oxford Manor, 21 Chaplin Road, Illovo 2196
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Telephone: +27 11 219 9000
Telefax: +27 11 219 9001
www.lifehealthcare.co.za

13 March 2015

ATTENTION: A. Ayeni

APPROVAL FOR RESEARCH STUDY

TITLE: Migration of Medical Doctors from the public to private sector: a case study of Mahatma Gandhi Memorial Hospital and Life Healthcare Group, Durban.

The Research & Scientific Committee of Life Healthcare Group hereby grant permission for your study to be conducted within company facilities. Present this letter to the Hospital or Nurse Manager of the facilities you will be using in your studies, when seeking permission at the specific facility.

The approval is conditional to your agreement on the following:

1. An electronic copy of your study is submitted to the committee prior to publication,
2. No direct reference is made to Life Healthcare or its various facilities in your study report or any publications thereafter,
3. The company and its facilities are not in any way identifiable in the study.

We wish you the best in your studies and look forward to the results.

Yours sincerely,

Peggy Naicker
On behalf of the research & scientific committee

Please sign as below and return this letter to the sender:

I, JOYCE AYENI, hereby agree to the conditions (points 1-3) as listed above.

Signature: [redacted]

Date: 18 MARCH 2015

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

MAHATMA GANDHI MEMORIAL HOSPITAL
Postal Address: Private Bag X 13, Mount Edgecombe, 4300
Physical Address: 100 Phoenix Highway, Phoenix 4068
Tel. 031 502 1719 Fax. 031 502 1869
Email: nancy.bridgemohun@kznhealth.gov.za
www.kznhealth.gov.za

Enquiries: Dr.Ndimande
Telephone: 031 502 1719 Ext 2012

3 November 2014

MRS. JAA AYENI
SCHOOL OF MANAGEMENT
WESTVILLE CAMPUS

RE: PERMISSION TO CONDUCT RESEARCH: MIGRATION OF MEDICAL DOCTORS FROM THE PUBLIC TO THE PRIVATE SECTOR: A CASE STUDY OF MAHATMA GANDHI MEMORIAL HOSPITAL AND LIFE HEALTHCARE HOSPITAL GROUP, DURBAN

I wish to inform you that permission is hereby granted for you to conduct the above mentioned research at Mahatma Gandhi Memorial Hospital provided:

1. Authority is obtained from the Department of Health: Kwazulu-Natal

Kindly forward the above documents to my office. You may not commence your study until these documents have been forwarded.

[redacted]

ACTING MEDICAL MANAGER
MAHATMA GANDHI MEMORIAL HOSPITAL