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KWAZULU-NATAL

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**Ethical implications of doctor migration on rural healthcare delivery in
South Africa**

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In the

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**School of Religion Philosophy and Classics, College of Humanities,
University of KwaZulu-Natal, Pietermaritzburg, South Africa.**

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Supervised by

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DECLARATION

I, **ZESULIWE MHLONGO**, declare that:

(i) The research reported in this full dissertation, except where otherwise indicated, is my original work.

(ii) This dissertation has not been submitted for any degree or examination at any other university.

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DEDICATION

This dissertation is dedicated to my mother;

Ntombikayise Thobile Manatha,

And

All my Siblings.

ACKNOWLEDGEMENT

For the successful completion of this dissertation, it is a fact that numerous people have contributed, without whose support and guidance, this dissertation would not have been completed. Therefore, in this section, I would like to thank all the following individuals for dedicating their time to supporting and providing guidance throughout the completion of this dissertation.

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ABSTRACT

South Africa's healthcare system is characterized by a complex interplay between the public and private sectors, providing a comprehensive range of services nationwide. This dual approach aims to meet the diverse needs of the population, ensuring accessible healthcare for all while also catering to those who prefer premium services through the private sector. The public healthcare system, funded by the government, serves the majority, especially in rural areas where resources are limited. In contrast, the private healthcare sector, supported by medical aid schemes and out-of-pocket payments, offers a higher standard of care, attracting those who can afford it. Despite significant efforts to expand healthcare access since the end of apartheid, the public health system still suffers from resource shortages and faces numerous challenges, particularly in rural regions. As a result, many medical professionals consider migrating to more developed countries as a viable option. This study leverages secondary data from government reports and academic literature to examine the ethical implications of physician migration through the lens of consequentialism theory. The findings suggest that the migration of doctors exacerbates the shortage of medical professionals in rural areas, negatively impacting patient care and the rural healthcare system. While this migration offers individual benefits for doctors who choose to leave, it raises ethical concerns about the impact on rural communities in their home country. Nonetheless, this study suggests measures to create a more equitable healthcare system by improving rural working conditions and providing incentives to retain medical professionals.

Key terms: Brain drain, doctor migration, South Africa, rural healthcare, rural areas.

ACRONYMS AND ABBREVIATIONS

ART-Antiretroviral Therapy

CCS-Compulsory Community Service

CHWs-Community health workers

CSMOs-Community Service Medical Officers

EMS-Emergency Medical Services

HIV- Human Immunodeficiency Virus

HWs-health workers

ICESCR-International Covenant on Economic, Social, and Cultural Rights

IMGs- International Medical Graduates

IOM-International Organization for Migration

JSTOR-Journal Storage

NCDs-Non-Communicable Diseases

NELM-New Economics of Labor Migration

NGOs-Non- Governmental Organizations

NHI-National Health Insurance

OECD-Organization for Economic Co-operation and Development

OMA-Ontario Medical Association

PHC-Primary Healthcare

PPPs-Public-private partnerships

PPS-Professional Provident Society

RCIC-Regulated Canadian Immigration Consultant

RoS-Return-of-Service

SACMC-South African Cuban Medical Collaboration

SAMA-South African Medical Association

SAO-Surgical, Anesthesia, and Obstetrics

SA-South Africa

SDA-Secondary Data Analysis

UIF-Unemployment Insurance Fund

UK-United Kingdom

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CHAPTER 1

INTRODUCTION TO THE RESEARCH

1.0 Introduction

Doctor migration has become a critical issue in global health ethics, particularly for countries with limited healthcare resources. While migration is often framed as an individual professional choice, its consequences extend beyond personal advancement to affect health systems, population well-being, and the ethical principle of equitable access to healthcare. These consequences are especially severe in rural areas, where healthcare provision is already constrained by shortages of skilled medical personnel. In rural healthcare settings, doctor migration deepens existing structural inequalities by reducing service availability and weakening the capacity of public health systems to meet community needs. Ethical concerns arise regarding distributive justice, the moral obligations of healthcare professionals, and the responsibilities of governments to retain essential human resources for health.

South Africa exemplifies these challenges. Despite significant investment in medical training, the country continues to experience the outmigration of doctors, particularly from the public sector and rural communities. Persistent issues such as inadequate infrastructure, heavy workloads, and limited professional development opportunities have contributed to this trend. Against this backdrop, this chapter introduces the ethical implications of doctor migration on rural healthcare delivery in South Africa. It provides background and motivation of the study, the research questions and objectives, a preview of the methodology, and a preview of the theoretical framework guiding the study. The chapter also presents an outline of the paper's chapters. By examining the complexities of doctor migration, this study aims to highlight its ethical implications and propose viable solutions to address the ethical consequences arising from this migration of doctors.

1.1 Background and Motivation of the Study

Similar to many other African nations, South Africa is reportedly grappling with the significant issue of doctors leaving the country to pursue employment opportunities abroad, particularly those

trained within South Africa who are relocating to wealthier nations. As noted by Bezuidenhout et al. (2009:1), the migration of doctors from their home countries is a persistent trend with substantial implications for South Africa's healthcare system, especially in rural and underserved areas where healthcare facilities and medical professionals are already in short supply.

The movement of health workers (HWs) poses a significant challenge in South Africa, resulting in a skills shortage and diminished capacity within the country's health systems (George et al., 2013). Research on healthcare worker migration patterns, particularly doctors, in South Africa highlights the impact of this movement on the country's health systems. Labonté (2015:6) identifies several factors influencing healthcare workers' decisions to migrate, including the lack of established positions, limited career opportunities, insufficient advanced training, inadequate service benefits, high crime rates, and the need for a secure work environment. Govender (2024:2) notes that South Africa has a long history of migration, especially in the post-apartheid era, when urban centres became more accessible. The migration of doctors began with a trend of rural-to-urban movement, which persists today, with Gauteng, the wealthiest province, experiencing the largest influx of migrants (Govender, 2024:3). However, this shift from rural to urban areas often leads to further migration abroad as physicians seek better opportunities, exacerbating the brain drain and contributing to the existing healthcare workforce shortage in the country. Mthombeni (2022:2) notes that the loss of qualified healthcare workers not only impacts service delivery but also hinders the country's ability to achieve broader health objectives, such as universal health coverage.

Moreover, the emigration of doctors from South Africa to other countries has dire consequences, particularly for underserved communities already facing shortages of medical professionals. In certain rural areas, a single doctor may be responsible for caring for an entire community, leading to long patient wait times and increased stress for the remaining physicians. Schaefer et al. (2021:1) emphasize that due to an insufficient number of physicians and the need for continuous care, full-time physicians are often compelled to work extended hours, frequently resulting in fifty-six-hour workweeks. Consequently, many individuals experience fatigue while struggling to balance their personal lives, family responsibilities, patient empathy, and innovative problem-solving in healthcare. Many doctors' experience burnout and seek sustainable solutions to align their professional duties with their personal and family lives.

The migration of medical professionals significantly contributes to the persistent shortage of doctors and the lack of access to healthcare in rural areas. Rural areas consistently face the challenges of limited healthcare access, particularly those in the rural regions of KwaZulu-Natal. From an early age, I have observed a notable shortage of doctors in these rural communities. These towns face considerable challenges due to long commutes to clinics, extended waiting times, and a general scarcity of medical services in the region. These factors have informed the focus of this study on healthcare, specifically in understanding the primary reasons why rural communities face such challenges.

Many qualified South African doctors find themselves unemployed, raising further ethical questions, particularly concerning the implications of unemployment. What do these unemployed doctors do, and where do they go? Further investigation revealed that many doctors are considering relocating abroad as a solution, prompting a broader examination of the consequences of doctor migration. Thus, the ethical implications of physician migration and its practical effects are worthy of investigation. What exactly can be considered the root cause of this migration of doctors, and when medical doctors move, what impact does this movement have on rural communities? To support a more equitable and balanced healthcare system, these enquiries justify a focus on the ethical implications of physician migration in rural South Africa.

1.2 Problem Statement

Many South African medical doctors are leaving their home country for wealthier nations in search of higher salaries, career advancement, better working conditions, and higher standards of living (Govender, 2024:1). While this move personally benefits the doctors who choose to relocate, it significantly impacts the country's healthcare systems, particularly in rural areas that are already severely underserved. Rural South African populations face ongoing challenges in accessing high-quality healthcare, including inadequate staffing, insufficient infrastructure, and lack of resources (Schaefer et al., 2021:1-2). The migration of medical professionals exacerbates these issues, making it difficult for rural clinics to retain and hire highly qualified staff members. This leads to higher mortality rates, subpar healthcare outcomes, and the spread of deadly diseases, which are among the serious long-term consequences of migration (Labonte et al., 2015:2). This raises significant ethical concerns. An ethical dilemma arises when doctors trained with public funding in South Africa migrate to other countries. While medical doctors have the right to seek better opportunities

elsewhere, they also share the responsibility of supporting underserved regions, especially when they have been supported by public funds (Gardiner, 2023:416). Despite several government initiatives, such as community service requirements and rural placement programs, the long-term viability of rural healthcare remains uncertain. Investigating the ethical implications of physician migration and critically analysing how this global phenomenon affects healthcare equity and access in South Africa's rural areas are key priorities.

1.3 Key research question

What are the ethical effects of physician migration on rural healthcare delivery in South Africa?

1.4 Sub-research questions

- What are the factors contributing to doctors' migration from South Africa?
- What are the outcomes of physician migration on rural healthcare delivery in South Africa?
- How can the ethical theory of consequentialism be applied to understand and address the ethical challenges arising from the migration of doctors?

1.5 Key research objective

The major objective of this research is to explore the ethical implications of doctor migration on healthcare delivery in rural areas of South Africa.

1.6 Sub-research objectives

- To identify the factors contributing to doctor migration from South Africa.
- To understand the consequences of physician migration on rural healthcare delivery in South Africa.
- To apply consequentialism to understand and address the ethical challenges of doctor migration.

1.7 Preview of the Methodology Adopted

This study employs desktop research, also known as secondary research, to collect and analyse information from various sources, including academic journals and books. The Internet was used to provide context and insights, while online databases such as SABC News reports offered

additional context. This study employs an exploratory design to investigate the ethical implications of physician migration on rural healthcare, with a particular focus on underserved communities (Baran, 2022). The study employed the DECA approach, which stands for Describe, Evaluate, Consult, and Act, in analyzing the data. It defines the problem of physician migration and its ethical implications for rural healthcare, identifies key stakeholders, and explores practical solutions. This study employs consequentialist theory to examine the ethical implications of physician migration, including the potential for limited healthcare access in rural communities (Horta et al., 2022). The goal was to present an in-depth investigation of the problem and inform the development of initiatives to address this complex problem (see Chapter 3).

1.8 Preview of a Theoretical Framework

This study was anchored in a consequentialism theoretical framework, which posits that an action is deemed right if it yields the best possible outcome (Hurley, 2020). This theory highlights the moral implications of doctors' migration from South Africa. Consequently, this study examined the ethical implications of this migration, particularly its potential effects on rural communities that are already struggling with access to healthcare. By focusing on the outcomes of specific actions or decisions, consequentialism guided the investigation into the effects of doctor migration and the challenges faced by remaining doctors and rural areas due to this issue. This study addressed this matter with greater nuance by considering the specific contexts and conditions surrounding the medical brain drain in South Africa through the lens of consequentialism. It aimed to inform practice and policy by identifying the most effective strategies to address the challenges associated with doctors' migration. Consequentialism theory is especially apt for addressing the complex issues surrounding this crisis, as it considers both the long-term effects of physician migration on the healthcare system and the ethical concerns regarding its impact on rural communities (Horta et al., 2022). Furthermore, it considers the frustrations and disillusionment of the remaining doctors, who may feel unsupported and under-resourced, which could potentially lead to burnout and diminished healthcare service delivery in rural areas.

1.9 Outline of Chapters

Chapter 1: Introduction to the Research

This chapter outlines the extent of this research project. It includes background information on the research issue, the primary research question, along with its sub-questions, the main research objective and its sub-objectives. Additionally, it provides a preview of the research methodology and theoretical framework.

Chapter 2: Literature Review

This chapter offers a comprehensive review of the literature pertinent to the study's research question. It examines the writings of other authors on the study's research challenge and how their insights contribute to its advancement.

Chapter 3: Method and Methodology

This chapter explores the research methods and methodology, providing an overview of the strategy utilised in this project as well as the data collection techniques.

Chapter 4: Theoretical Framework

This chapter explores the ethical theories employed in this study. The selected theory is relevant to the research issue. This segment also describes how this ethical theory contributes to the advancement of the field.

Chapter 5: Ethical Analysis

This chapter focuses on the ethical examination of the research topic, "Ethical Implications of Doctor Migration on Rural Healthcare Delivery in South Africa." Utilising the ethical framework of consequentialism, this study aims to emphasise the difficulties encountered by rural populations. These communities already face challenges in accessing healthcare due to a shortage of doctors, and the emphasis is on how doctor migration will impact these vulnerable groups in the future.

Chapter 6: Conclusion and Recommendations

This chapter presents the conclusions of the research study, summarizes the study, and offers recommendations for further research on the topic.

1.10 Conclusion

South Africa faces numerous challenges due to the migration of doctors, a situation that this study seeks to address. However, this chapter provides an overview of the study's background and motivation, outlines the research questions and objectives, offers a preview of methodologies and theoretical framework employed, and presents the thesis structure, illustrating how the project was executed. Chapter 2 (Literature Review) examines the existing literature on doctor migration and its impact on rural healthcare delivery in South Africa, highlighting key scholarly findings that shed light on the phenomenon of medical brain drain.

CHAPTER 2

LITERATURE REVIEW

2.0 Introduction

In the previous chapter, the study's topic was introduced and briefly outlined to establish a foundational understanding of the migration of medical professionals. This chapter examines the ethical implications of doctor migration within the context of rural healthcare in South Africa. It draws on the insights of esteemed scholars and medical practitioners who have made significant contributions to the understanding of this complex issue. Recent discussions by key stakeholders, including Dr. Mvuyisi Mzukwa, the chairperson of the South African Medical Association, have highlighted additional factors driving doctor migration (Govender, 2024:1). Reports from eNCA News (2023) and SABC News (2024) further underscore the significance of unemployment as a push factor, while Mthombeni (2023:15) identifies multiple social and political issues contributing to the migration of South African healthcare workers to the United Kingdom. Gumede et al. (2021:2) emphasised the persistent challenge of attracting healthcare professionals to rural areas. Building on these findings, this literature review explores the causes, effects, and challenges of doctor migration in rural South Africa, with a particular focus on the ethical implications for healthcare systems and underserved communities. The review is presented thematically in the following sections: definition of brain drains and doctor migration, primary causes and types, effects, specific challenges faced by rural healthcare systems and underserved communities, and gaps and limitations in current research.

2.1 Understanding the Concept of Brain Drain

Brain drain is a phenomenon that occurs when highly educated individuals leave their home countries for better work and living conditions, often involving individuals who are specialised in science and technology. According to Young (2023:1), there are three types of brain drain: organizational, industrial, and geographic. When highly qualified professionals relocate to a different nation with greater possibilities, this phenomenon is known as the geographic brain drain. Political unpredictability, poor standard of living, restricted access to healthcare, and lack of economic opportunities in the nation of origin are some of the factors that frequently lead to this type of

migration. These motivating aspects encourage talented individuals to seek environments where they can enhance their quality of life and advance their careers. However, Wanniarachchi (2022:1489) defines organizational brain drain as the wholesale exodus of highly qualified workers from a particular organization, usually due to perceived instability, a lack of prospects for advancement, or discontent with the workplace. Workers may believe that other businesses provide greater opportunities for long-term success and professional growth. In contrast, industrial brain drain refers to the mass departure of highly qualified individuals from the entire industry. This often occurs when an industry fails to adapt to shifting societal norms, technological advancements, or economic conditions. Consequently, talented workers depart for industries that are more stable, innovative, and aligned with their career objectives (Young, 2023:4).

Since ancient times, notable population movements have occurred, gaining prominence in the 19th century with the introduction of industrial capitalism in the region. The International Organization for Migration (IOM) defines brain drain as the movement of highly educated and skilled people from their home country to another, which undermines the country's skill resources (Cakir, 2025:1). It is mainly perceived as a movement from less developed to industrialized nations that offer better employment prospects and higher living conditions (Wanniarachchi, 2022:1500). Because of unplanned and inexpensive educational systems, the number of qualified and well-educated people may be high in poor or developing nations. However, restricted employment prospects have created an imbalance between the demand and supply of skilled labour. To address this, developed countries often import talent from less-developed countries, as skilled labour is a crucial element that contributes significantly to their economies. Brain drain is a global phenomenon that also occurs in developed countries, such as the United Kingdom, which attracts skilled workers and loses professionals to countries such as the USA and Canada (Cakir, 2025:2).

Countries such as Zimbabwe, Nigeria, Ghana and South Africa have experienced a persistent emigration of high skilled professionals to more developed countries. However, Mlambo and Adetiba (2019:2) point out that the most significant consequences often experienced by countries that lose their skilled labour force are typically found in developing or underdeveloped regions. These countries face a decline in human capital, which, in turn, weakens their economic, educational, and healthcare systems. According to Mlambo and Adetiba (2019), one of the immediate effects is the loss of tax revenue, as emigrated professionals no longer contribute to the domestic economy. This

deficit may strain the government's already limited funds by compromising infrastructure and public services. There are severe shortages in the medical field due to the departure of physicians, nurses, and specialists, particularly in neglected and rural areas of the country. Due to a shortage of staff, the efficiency of healthcare services is compromised, and the impact of foreign help is lessened. Similarly, beyond the direct loss of doctors, the migration of professionals in other sectors further strains the healthcare system by weakening infrastructure development, medical training, and technological support services. The exodus of innovators and highly qualified experts in industries such as technology exacerbates the technical divide between rich and developing countries, impeding local progress and perpetuating global inequality (Mlambo and Adetiba, 2019:8).

The South African brain drain poses a significant obstacle to succession planning and talent management from a human resources standpoint (Guru, 2025:1). Organizations struggle to fill key roles, which increases the workload of current employees and lowers morale. The loss of skilled professionals also results in the loss of institutional knowledge and mentorship, making it more challenging to develop and train the next generation of leaders in the field. It also creates a cycle of dependency on external talent, which can be both costly and unsustainable. In addition to disrupting the company culture, frequent personnel turnover has a detrimental impact on productivity. Guru (2025:2-6) outlines that the long-lasting growth potential of both public and private sector organisations is compromised by the incapacity to retain and train talented individuals. Emigration from South Africa has equally complicated policy implications. The government faces the challenge of creating an environment that attracts qualified doctors, both those currently employed in the nation and those who may consider returning.

While brain drain has negative effects on developing nations, industrialized ones frequently benefit from it as well, a phenomenon known as “brain gain.” These countries attract highly qualified professionals who make substantial contributions to their technical, scientific, and economic advancement (Batista et al., 2025:1). In important areas such as healthcare, education, and research, this consistent flow of talent improves service delivery and fortifies institutional capacities. Consequently, industrialised nations can sustain and increase their competitiveness in the global market. In contrast, developing nations that already face structural limitations struggle to recover the knowledge and skills they have lost. The ongoing professional exodus exacerbates skill gaps,

impairs the provision of public services, and limits socioeconomic advancement (Batista et al., 2025:4).

2.2 The Nature of Doctors' Migration in South Africa

Doctors' migration refers to the movement of healthcare professionals, specifically physicians, from one country to another in pursuit of better opportunities. This phenomenon is often categorised as "brain drain", wherein skilled professionals relocate from developing nations to wealthier ones seeking higher salaries, improved working conditions, and elevated living standards (Majid, 2024:249). Govender (2024:1) characterizes brain drain as a unidirectional flow of highly skilled workers, primarily benefiting the host nations. This issue presents a significant challenge for many developing countries, with far-reaching consequences. Notably, the loss of qualified medical professionals directly compromises the health of donor nations, leading to inadequate medical care and diminished overall health outcomes in those countries. Govender (2024:2) illustrates this in the South African context, where the country faces a critical shortage of medical professionals, particularly in rural communities, exacerbated by brain drain. This trend extends beyond healthcare, encompassing teachers, academics, and engineers, all of whom are vital to the country's socioeconomic development.

Mlambo and Adetiba (2019:1942) emphasise that in South Africa, the healthcare system is further strained by poor working conditions and subpar salaries, driving skilled doctors to migrate. The public health sector is plagued by numerous vacancies that have remained unfilled for years due to a lack of skilled medical professionals. Even when foreign nationals with the necessary qualifications are available, they may face challenges in securing employment because they are perceived as outsiders. The loss of qualified personnel and brain drain are significant contributors to the South African economy's inconsistent growth. Unfortunately, the government lacks a clear policy to mitigate brain drain, which will likely have further negative impacts on the country's socioeconomic development (Mlambo and Adetiba, 2019).

Furthermore, the Organization for Economic Co-operation and Development (OECD) report (2019:9) posits that the number of physicians and nurses in OECD countries has increased significantly over the last decade, with foreign-born and foreign-trained healthcare professionals contributing substantially to this growth. The report also notes a trend in which native-born citizens

of some Organization for Economic Co-operation and Development (OECD) countries, including Israel, Norway, Sweden, and the United States, are returning to their home countries after completing their primary medical degrees abroad (OECD, 2019:10).

As experienced physicians, including specialists and consultants, leave the public sector or emigrate abroad, academic hospitals and training institutions face severe shortages of qualified mentors and supervisors. This exodus weakens the clinical training environment for medical students, interns, and community service doctors, who rely on senior professionals for hands-on guidance and professional development (Govender, 2024:2). The loss of these mentors reduces the quality of clinical education and undermines the confidence and competence of newly qualified doctors entering the system. According to Mlambo and Adetiba (2019:1950), teaching hospitals struggle to maintain their academic standards without skilled trainers, thereby compromising the sustainability of the healthcare workforce pipeline. Furthermore, students trained in under-resourced environments may become more inclined to emigrate, perpetuating a cycle of skill loss and institutional decline. This erosion of medical education infrastructure represents a long-term threat to the resilience of South Africa's healthcare system, diminishing its ability to replenish its workforce internally.

According to Libera (2025:2–5), a report from the Canadian Bureau of Statistics indicates that between January 2020 and July 2024, Canada issued 7,781 temporary work permits to South Africans. Of these, 600 individuals were employed in the medical field, with approximately 350 being specialists such as cardiologists, neurologists, and emergency physicians. Approximately 200 healthcare workers are expected to relocate to Canada this year, indicating the rapid momentum of this movement. Nicholas Avramis, a regulated Canadian immigration consultant (RCIC) and managing director of Beaver Immigration, a consultancy that helps international professionals, particularly South African doctors and nurses, emphasises that the steady migration of South African doctors to Canada, which started in 2022, is expected to continue growing in 2025 and possibly in 2026 as more professionals explore their options overseas. Several Canadian provinces have specifically targeted South Africa for recruitment, offering attractive incentives such as higher pay and professional recognition.

Canada is a particularly appealing option because the Royal College of Physicians and Surgeons of Canada accepts South African medical credentials, thereby saving physicians from having to

undergo drawn-out recertification procedures. With a shortage of 10,000 family doctors and 60,000 nurses, Canada has emerged as a desirable destination for South African healthcare professionals. In Ontario alone, a critical shortage of family doctors has left 2.5 million residents without one, a figure that is expected to rise to 4.4 million in two years. The Ontario Medical Association, cited by Libera (2024:2-5), notes that high administrative costs and burdensome tasks deter doctors from entering family practice, contributing to healthcare delays that often prompt patients to seek emergency care. The Ontario Medical Association (OMA) urges more robust political action to protect family physicians and enhance patient care, even in the face of government initiatives aimed at increasing the number of physicians and medical education in Ontario. Canada is prepared to pay top dollar to recruit medical specialists to handle this situation. British Columbia and Alberta are also popular options because of their high demand for specialists and general practitioners. According to a regulated Canadian immigration consultant, salaries range from R4 million to R10 million, depending on experience and qualifications (Ontario Medical Association cited by Libera, 2024).

In this context, interest in emigration among South African healthcare professionals has increased markedly. A regulated Canadian immigration consultant of Beaver Immigration reported a 50% rise in enquiries from healthcare workers, with over 17,000 applications submitted by South Africans since January 2023. According to Libera (2024:3), the managing director suggests that as the healthcare crisis in South Africa deepens and Canadian provinces continue to relax licencing requirements for general practitioners and specialists, this number may double or even triple. As reported by Employment and Social Development Canada, occupations such as registered nurses, general practitioners, specialist physicians, and medical technicians are among the most in-demand. The facilitation of entry for foreign-trained professionals in Canada has contributed to the accelerating outflow of South African medical personnel. This trend exacerbates the strain on South Africa's already fragile healthcare system. In contrast, Canada's professional environment, perceived as both open and attractive, continues to draw disillusioned South African healthcare workers, thereby intensifying the ongoing human capital crisis within the country's medical sector (Libera, 2024).

Hadley (2023:2) provides a clear example of how South African-trained doctors are leaving their home country, particularly rural areas, to fill physician shortages in rural communities abroad,

notably in Canada. International medical graduates (IMGs) with a South African education have become a targeted policy option for Canadian health authorities due to the ongoing difficulties in recruiting and retaining medical professionals in these isolated areas. This pattern is indicative of a larger worldwide phenomenon in which high-income countries utilize the professional pools of lower- and middle-income countries to address the shortage of healthcare professionals, often at the expense of previously underserved areas in source countries. The South African government frequently cites health worker migration as the primary cause of the difficulties in the nation's healthcare system (Govender, 2024:1). Thousands of doctors, nurses, and other medical professionals are leaving South Africa to work in countries such as the US, Australia, New Zealand, and the UK. A report by the Organization for Economic Co-operation and Development (OECD) found that more than 23,400 South African health workers are now working in those countries. The South African healthcare system is being significantly impacted by this significant exodus of qualified workers, with many doctors and nurses leaving, resulting in a shortage of experienced medical staff in the country to properly care for patients.

2.3 Types of Doctors' Migration

2.3.1 Internal and International Migration

Tsegay (2023:2) distinguished between internal and international migration patterns among doctors. Internal migration refers to the movement of medical professionals within their home country, typically from rural to urban areas, in pursuit of improved employment opportunities, living conditions, and access to advanced medical resources. This rural-urban migration has long been prevalent in South Africa, with doctors favouring urban centres such as Gauteng due to superior opportunities, infrastructure, and resources. Consequently, rural areas continue to experience a scarcity of healthcare resources and doctors, exacerbating the existing healthcare disparities between urban and rural communities (Tsegay, 2023:3). The concentration of doctors in urban areas compromises the quality of healthcare services in rural regions and perpetuates health inequities, underscoring the need for targeted interventions to address these systemic imbalances.

International migration involves doctors relocating to another country for a period of at least one year. This form of migration often involves crossing national borders to pursue enhanced economic prospects, educational opportunities, or safety, with profound implications for migrants and their

countries of origin (Bertoli, 2024:1). International migration can lead to brain drain in the country, depriving it of skilled healthcare professionals and undermining its capacity to deliver quality healthcare services. In contrast, South Africa loses valuable expertise and experience as skilled medical professionals emigrate to other countries in pursuit of better opportunities abroad. This brain drain can compromise the country's healthcare system, underscoring the need for policies that mitigate the loss of skilled healthcare professionals and encourage their return or retention in South Africa (Bertoli, 2024:2).

Building on the distinctions between internal and international migration, the South African migration profile report (Statistics South Africa, 2023:75) elaborates on internal migration, particularly for healthcare professionals. This emphasises that internal migration in South Africa is driven by various factors, such as lifestyle choices, education, family reunion, and financial prospects (Ginsburg et al., 2021; Alam & Mamun, 2022). According to South African report statistics, internal migration can be categorised into lifetime migration, which contrasts doctors' place of birth with their usual place of residence, and period migration, which measures movement within a specified period, such as the past decade.

2.3.2 Circular Migration

Circular migration is an important migration pattern to consider. The term "circular migration" refers to the frequent and temporary relocation of healthcare workers between their countries of origin and destination, often driven by personal, professional, or job-related factors. While maintaining ties to their home country, this type of migration enables doctors to obtain better working conditions and gain invaluable foreign experience (Ansary, 2025:103). Circular migration, as opposed to permanent international migration, involves a periodic return to the country of origin, facilitating the ongoing exchange of resources, expertise, and skills. According to Weber and Saarela (2019:1), circular migration, however, comes with drawbacks, such as the potential for sporadic shortages of medical personnel in countries of origin and the unpredictability of the long-term effects on the health system's capacity.

2.3.3 Temporary Migration

Temporary migration is increasingly recognised as a distinct and significant type of doctor migration, characterised by mobility that is limited in duration and purpose. The complex realities of

migrants who relocate for set periods, such as for training, short-term contracts, or specific healthcare projects, without intending to settle down permanently, are reflected in Triandafyllidou's (2022:3850) argument that temporary migration should be viewed as both a category of analysis and a lived category of practice. Medical professionals can enhance their skills, gain international experience, and adapt to the workforce's needs in their new country through such migration. However, the temporality of this migration often blurs with longer-term mobility, as some doctors extend their stay or transition into permanent roles, which can contribute to the brain drain experienced by countries like South Africa. The dynamic character of temporary migration highlights how economic demands and policy frameworks shape global health labour markets, promoting flexible, short-term mobility while also posing challenges to workforce stability and retention in source countries. A critical insight into the movement patterns of healthcare professionals in today's globalized world can be gained by viewing temporary migration as both a strategic decision and a policy tool (Triandafyllidou, 2022: 3851-3854).

2.3.4 Labour Migration

Oso et al. (2022:117) identify labour migration as another significant category of doctors' migration, primarily motivated by the search for better employment opportunities and income. The desire for compensated jobs, career promotion, or entrepreneurial endeavours is the driving force behind this type of migration, which involves people moving within the framework of global workforce dynamics. Deeply rooted in economic motivations, this type of migration has been thoroughly examined through various disciplinary lenses, including geography, economics, and sociology. Consequently, a variety of theoretical approaches have been developed, including neoclassical economic theory, dual labour market theory, the New Economics of Labor Migration (NELM), and transnational migration frameworks. According to Oso et al. (2022:124), findings in the healthcare industry indicate that labour migration is particularly noticeable among highly qualified professionals, such as doctors, whose migration is often influenced by differences in pay, working conditions, and opportunities for professional growth between nations and regions. Although occasionally unclear, the distinction between high- and low-skilled labour provides a helpful framework for understanding the unique difficulties migrant physicians face. South African doctors are in high demand due to the global need for qualified healthcare professionals, which has led to increased outbound labour migration and contributed to the ongoing "brain drain." As

such, labour migration intersects with both internal and international migration patterns, revealing how structural and systemic issues within the healthcare system drive doctors' professional mobility in search of better employment conditions and career advancement (Oso et al., 2022).

2.3.5 Family Migration

Furthermore, family migration has been recognised as a unique and increasingly significant type of migration, especially in relation to the mobility of highly qualified professionals, such as physicians. Kofman et al. (2022:137) define family migration as the worldwide movement of people based on pre-existing or newly developed family ties, such as marriage, spousal reunification, or the relocation of dependents. Although it may not be the primary cause of medical migration, it often intersects with labor migration, as some physicians choose to relocate to be closer to their families or to improve their living conditions, access to education, and home safety. The job possibilities of both partners often impact relocation decisions in dual-career families. According to Kofman et al. (2022:138), changing social norms, gender roles, and caregiving obligations are additional factors that influence family mobility and have a significant impact on how migrant doctors integrate into their new communities. These insights build on those previously discussed by Kofman and Kraler (2006), who noted that migration law often fails to adapt to changing societal definitions of family. Family-related considerations constitute a critical, though sometimes overlooked, component of doctors' international migration, revealing the deep interconnection between professional aspirations and personal life circumstances.

2.3.6 Lifestyle Migration

McGarrigle (2022:169) and Hayes (2021) emphasise that lifestyle migration is another significant and increasingly relevant category of doctors' migration, particularly among South African health professionals with the resources and qualifications to relocate abroad. The focus on personal welfare, quality of life, and overall life satisfaction rather than just economic advancement sets lifestyle migration apart, even if it frequently overlaps with labour migration. In addition to better pay and working conditions, many South African doctors want to leave because they seek safer surroundings, more reliable healthcare systems, better educational opportunities for their children, and access to improved infrastructure. These elements reflect lifestyle aspects that significantly influence migration decisions. According to Hayes (2021:170), lifestyle migration is facilitated by

global inequalities in citizenship and mobility rights, allowing those with professional and financial capital, such as doctors, to navigate international borders more easily and affordably. In this context, South African doctors often choose destinations such as the United Kingdom, Australia, Canada, or New Zealand, where they can combine professional advancement with a higher standard of living. This type of migration illustrates how the distinction between lifestyle and economic variables is becoming increasingly blurred, and how aspirational objectives and structural push factors influence migrants' decisions. Therefore, lifestyle migration offers a useful framework for understanding the broader range of societal, familial, and personal factors that influence the global mobility of South African doctors (Hayes, 2021; McGarrigle, 2022).

2.3.7 Student Migration

According to Alves and King (2022: 180), student mobility, or student migration, is a unique and crucial pathway within international migration systems. Student migration is crucial in determining the global mobility of physicians, although it is often overlooked in assessments of skilled professional migration. Many medical professionals begin their migration paths by studying medicine overseas for their undergraduate or graduate degrees. The perceived prestige of international credentials, the limited availability of domestic training options, and the potential for long-term employment in the host nation are often the driving forces behind this choice (Alves & King, 2021). These trends are especially prevalent among students from the Global South, such as those from South Africa, Nigeria, and Zimbabwe, who enrol in medical schools in countries like China, Russia, Cuba, and the United Kingdom to practice medicine either domestically or overseas. According to Alves and King (2021; 2022), this type of student mobility frequently leads to "status switching", in which post-graduate student migrants convert short-term student visas to permanent employment or residency permits. This allows individuals to enter the skilled labour market and support the global healthcare industry. Therefore, student migration is a deliberate path to long-term professional migration and an educational experience. This blurring of educational and labour migration reflects the increasingly complex and layered mobility patterns among doctors in a globalised healthcare labour market, where factors such as licencing regimes, credential recognition, and language proficiency significantly shape migration trajectories (Alves, 2022).

2.4 Causes of Doctors' Migration

2.4.1 Desire for Professional Growth

Hadley (2023:33) identifies a key driver of physician migration from South Africa: the pursuit of better professional opportunities in countries like Canada. South African-trained doctors are motivated by the desire for “prestige”, encompassing professional recognition, status, and opportunities perceived as limited within South Africa. However, they often encounter a discrepancy between their expectations and the reality of working in rural generalist roles in developing countries, which are perceived as having lower prestige than locally trained doctors' positions.

Furthermore, Hadley (2023:40) mentioned the pervasive sense of professional isolation experienced in rural settings as another significant factor contributing to the emigration of South African doctors. Many recently graduated physicians are assigned to isolated or underserved locations as part of the nation's required community service program, where they frequently operate alone without adequate peer collaboration, professional support, or expert counsel. Opportunities for clinical mentoring, ongoing professional growth, and intellectual engagement are all essential for career advancement, and job satisfaction is restricted by isolation. Rural South African doctors often work in divisions, are under-resourced, and are cut off from larger professional networks, in contrast to high-income nations such as Canada, the United Kingdom, and Australia, where they are frequently incorporated into structured support systems that encourage collaboration, continuing education, and remote specialist access (Hadley, 2023:44). Consequently, many doctors are drawn to foreign health systems that offer stronger institutional support, structured career paths, and greater opportunities for interdisciplinary collaboration. The inability of the South African healthcare system to provide adequate professional reinforcement and sustainable working conditions in rural settings thus functions as a strong push factor, particularly for early career professionals seeking growth and recognition within their field.

2.4.2 Poor Working Conditions and National Health Insurance System Concerns

The South African Medical Association's chairperson, Dr. Mvuyisi Mzukwa, highlighted additional factors. According to eNCA News (2024), hundreds of South African doctors and nurses are leaving the country due to poor working conditions, irregular payments, and concerns regarding the National Health Insurance (NHI) system. A 2022 survey revealed that approximately 36% of

healthcare workers, primarily younger doctors under 45 years of age, were considering emigration to nations like Canada, Australia, and the United Kingdom. Dr. Mvuyisi Mzukwa criticised the NHI structure for prioritising financial aspects over ethical leadership and government management. Furthermore, he acknowledges the challenges South Africa faces in retaining domestically trained doctors due to unsafe working conditions, burnout, and mental health issues, reinforcing the findings of Hadley and Tankwanchi et al. (2020) regarding the role of poor working conditions and inadequate pay.

South African healthcare professionals are highly valued globally, and many are leaving the country due to a lack of trust in the government's rollout of the NHI and other issues (Khan and Olla, 2024:1). Statistics indicate that while the emigration of professionals decreased in 2020, the situation remains concerning for the healthcare sector. The South African Medical Association (SAMA), which represents approximately 17,000 doctors in South Africa, conducted a survey that revealed that as many as 38% of its members intended to leave the country in response to the anticipated implementation of the NHI scheme (SAMA, as cited in Khan and Olla, 2024:3). SAMA chairperson Dr. Mvuyisi Mzukwa pointed out that trust between the government and the medical profession has decreased due to current events. According to a survey conducted by the Professional Provident Society (PPS), a mutual financial services giant, out of the 2,905 medical professionals who participated (including doctors, dentists, attorneys, and medical engineers), 58% of respondents expressed pessimism about the NHI, citing concerns about capacity and infrastructure limitations, the potential financial burden on taxpayers, and the government's ability to effectively roll out the NHI (PPS cited by Khan and Olla, 2024).

The Professional Provident Society highlights that the NHI would be hindered by the departure of these highly qualified individuals, who would undoubtedly have a significant impact on healthcare service delivery. The implementation of the NHI has sparked concerns about the future of healthcare in South Africa, as noted by South African statistics from 2024. Perceptions have been mixed; some view it as an opportunity to provide quality healthcare for all South Africans, which motivates some professionals to stay because they are inspired by the ability to make a difference in the country. Other professionals have expressed concerns about the uncertainty and changes in remuneration, job security, and the current state of the medical profession in South Africa, which

they believe encourages emigration to other countries. For the NHI to succeed, it requires core competencies in resource allocation, funding, and human resources (Khan and Olla, 2024:5).

Significant imbalances are reflected in the deeply ingrained two-tiered structure of South Africa's healthcare system. Most people are served by the government-funded public sector, while only around 16% of the population who can afford private insurance or out-of-pocket medical costs are served by the private sector (Khan and Olla, 2024:6-7). There have been numerous requests for a more integrated healthcare paradigm to ensure fair resource allocation and improved service delivery, as this current split has perpetuated unequal access to healthcare services. The implementation of NHI was considered a possible way to close this gap. However, healthcare experts, especially those in the private sector, are somewhat unsure about its proposed implementation. According to Dr. Mzukisi Grootboom, chairperson of the South African Medical Association (SAMA), many South African doctors and nurses are emigrating to countries such as Canada and the United Kingdom, both of which have their own models of universal health coverage (Libera, 2025:7). This implies that professionals' objections are more likely to be related to the structure, governance, and viability of South Africa's particular NHI model than to the idea of universal healthcare. These issues are at the heart of persistent professional discontent and are likely a factor in the growing trend of qualified healthcare personnel leaving the country.

2.4.3 Social and Political Factors

In addition to the previously described structural, professional, and economic problems, Mthombeni (2023:15) identified multiple important social and political issues that contribute to the migration of South African healthcare workers, including doctors. One of the most significant inspiring factors is the country's high rate of violent crime, which has produced a widespread sense of fear and insecurity among healthcare professionals. Mthombeni (2023:16) found that approximately 76% of healthcare professionals cited personal safety and the risk of violence as key reasons for choosing to leave. High income tax and mandatory deductions from South African salaries also contributed to doctors' decisions to seek employment beyond South Africa's borders. According to the SA labour law, South African citizens earning an income are obligated to pay tax to the South African government. Mthombeni's (2023) study reported that the majority of participants felt that they were not in control of their hard-earned money, as the government was taking a portion of it. Deductions from salaries included taxes, Unemployment Insurance Fund (UIF),

retirement pension, and sometimes medical insurance. Furthermore, ongoing political instability and racial tensions exacerbate uncertainty and discontent regarding South Africa's working and living conditions.

Phase one of Mthombeni's study found that low salaries (87%), desire to gain international experience (56%), poor working conditions and environment (46%), and poor management at the workplace (40%) were other crucial factors that contributed to respondents' decision to seek employment outside of South Africa. However, Mthombeni and Vincent-Lambert (2025:3) reported that the factors that attract doctors to work abroad are the primary reasons for their departure from South Africa. These pull factors include increased job opportunities in high-income countries, particularly in the Middle East and Europe, where healthcare professionals can expect competitive salaries, safer and more supportive working environments, and additional benefits, such as housing allowances and educational support for their families. The stability and predictability of governance and health policy in high-income countries serve as strong pull factors for South African doctors. In contrast to the uncertainty surrounding South Africa's NHI and broader political instability, countries such as Canada, the United Kingdom, and Australia offer clear and consistent healthcare frameworks and reliable administrative systems (Mthombeni and Vincent-Lambert, 2025:4).

2.4.4 Corruption and Lack of Infrastructure

Among the various push factors driving the emigration of South African doctors, corruption has emerged as a critical and often overlooked factor. Although inadequate compensation, poor working conditions, and few prospects for professional advancement are commonly mentioned, these problems are exacerbated by deeper structural issues associated with corrupt governance. High profile cases such as the Thembisa hospital corruption saga, which exposed extensive mismanagement and the collapse of infrastructure, illustrate how public healthcare resources are diverted away from patient care (Bhana, 2025). Similarly, corruption linked to the Covid 19 personal protective equipment (PPE) procurement process, which ultimately led to the resignation of the former minister of health, Dr Zweli Mkhize, further eroded trust in health system governance (Rose-Ackerman, 2021:16). As noted by Chivandire et al. (2024:426), the lack of infrastructure and service delivery has resulted from the improper handling of healthcare finances, including the misallocation or stealing of resources designated for public hospitals and clinics. Doctors are often

forced to work in under-resourced environments without access to the most basic medical supplies, thereby compromising professional standards and patient care.

2.4.5 Violence and Lack of Institutional Support

Furthermore, workplace violence in South African emergency departments has become a significant and often overlooked factor contributing to the emigration of medical professionals from South Africa. High levels of physical and verbal violence are routinely experienced by doctors, particularly in emergency care settings, where tensions run high and staffing is limited. A study in Gauteng revealed that 73.8% of healthcare workers, including doctors, had encountered some form of workplace violence, with verbal abuse being the most common (Nkadimeng et al., 2024:252). Furthermore, approximately 82% of these incidents were never formally reported due to fears of reprisal, cumbersome reporting systems, and perceptions that complaints would not be adequately addressed (Nkadimeng et al., 2024:254). This underreporting reflects not only a failure of institutional support structures but also the systemic normalisation of abuse. Similarly, a national survey by the Medical Protection Society (2024) found that over half of the doctors in South Africa reported being abused by patients or their families, with 80% of those considering emigration citing abuse as a key contributing factor. Chronic exposure to violence, without adequate protective policies or support systems, deteriorates the mental health, morale, and job satisfaction of healthcare professionals, often making emigration a necessary choice rather than a preference.

The lack of transparency in policy execution, especially regarding significant reforms such as the NHI, has worsened circumstances by fostering an environment of mistrust and uncertainty. Many medical professionals see the NHI as a politically motivated program that is susceptible to corruption and inefficiency rather than a step toward egalitarian care (Whyle and Olivier, 2023:247). According to SABC News (2024), surveys conducted between 2023 and 2024 indicate that a significant number of doctors are either preparing to leave or have already begun the process, citing concerns that corruption and poor management will plague the NHI system. These concerns are acknowledged by Dr. Mvuyisi Mzukwa, chairperson of the South African Medical Association, whose commentary reinforces the growing disillusionment within the medical community regarding the current health policy direction in South Africa.

2.4.6 Political Interference and the Erosion of Professional Ethics

Another critical cause of doctors' migration from South Africa, particularly from the public and rural health sectors, is the decline in professional ethics and political interference. Mantzaris and Pillay (2021:2) argue that when promotions, appointments, and institutional decisions are driven more by political connections or favouritism than by merit, the integrity of the medical profession is severely compromised. This practice undermines fair career progression and demoralises highly skilled and ethical healthcare professionals committed to service delivery. Over time, the erosion of trust in public health institutions fostered a sense of exclusion and injustice among dedicated doctors, many of whom began to feel unsupported and undervalued. However, they are more likely to seek employment in countries or institutions where professionalism, transparency, and merit-based advancement are upheld. This trend exacerbates the ongoing brain drain and further weakens the already fragile healthcare system in rural and underserved communities (Mantzaris and Pillay, 2021:3-4).

2.4.7 High Rates of Unemployment

Furthermore, it is crucial to consider the effect of unemployment on medical professional migration. Medical doctors in South Africa are facing unemployment after investing years of study, including hard work, to save lives. However, the government is complaining about budget constraints and posits that the financial crisis is the key problem preventing young doctors from being employed in South Africa (SABC NEWS, 2024). They cannot place the doctors they have, who are ready to serve the country, because of a lack of demand for these positions within the government's budget. One example is Sunhera Sukdeo, who graduated cum laude from the University of KwaZulu-Natal in 2023 (Kunene et al., 2024:2). In early January, she wrote in the Daily Maverick: *"It is currently January 2024. I am a highly qualified medical doctor. I am sitting at home, unemployed. But I am not alone. The majority of my peers are in the same boat."* Consequently, this unemployment crisis forces doctors to seek work abroad (SABC NEWS, 2024).

Emerging data also show that many unemployed doctors actively interact with government institutions to address the crisis before leaving the country, despite the fact that systemic and economic issues are widely acknowledged (SABC News, 2025). In January 2025, Mpumalanga medical graduates staged a public protest at provincial government offices, calling for immediate

placement and highlighting the ongoing lack of open positions in the public health field (SABC News, 2025). These demonstrations are part of a larger trend in which doctors have petitioned and approached provincial health authorities directly to obtain job opportunities. Despite these initiatives, the responses of governmental institutions have been insufficient, which has made doctors feel even more excluded and neglected in their careers. Therefore, many view emigration not as a first choice but as a last resort in response to ongoing inaction and limited career prospects within the domestic healthcare system (SABC News, 2025).

2.4.8 Influence of Social Media

Adetiba (2025:59) acknowledges the influence of social media as an increasingly significant yet nuanced driver of doctor migration from South Africa, serving as both a communication channel and a migration-enabling infrastructure. Modern doctors use social media sites like Facebook, WhatsApp, TikTok, and YouTube to gain real-time insights from colleagues already employed overseas, whereas traditional emigration routes often relied on formal placement agencies and word-of-mouth recommendations. These platforms offer peer-generated, uncensored content on quality of living, employment availability, licensing processes, and working conditions in host nations. According to Adetiba (2025:64), social media does more than just connect individuals; it also influences decision-making by reducing uncertainty and enabling prospective migrants to obtain affordable, accurate, and context-specific information.

However, early career physicians and those disillusioned with the public healthcare system in South Africa due to structural problems, such as inadequate infrastructure, safety concerns, and career stagnation, would find this especially interesting. Social media narratives that emphasise the advantages of better pay, work-life balance, and professional recognition overseas are often curated by South African physicians currently working in the United Kingdom (UK), Canada, or Australia and frame migration as both possible and desirable (Adetiba, 2025:66). These dynamics are similar to Lee's (1966) theory of migration, which holds that personal traits, push and pull forces, and intervening barriers all affect migration decisions. By establishing virtual support networks that direct and promote emigration, social media successfully lessens these intervening barriers in today's digital environment, including knowledge gaps, emotional ambiguity, and logistical complexity. Furthermore, psychological change is facilitated by continuous exposure to the success stories of former coworkers, wherein local professional discontent is exacerbated by the belief

that greater opportunities are easily accessible elsewhere. In this way, social media acts as a subtle but powerful accelerant of medical brain drain, enabling doctors to become active agents in planning their departure while rendering domestic retention strategies increasingly ineffective.

2.5 Healthcare in Rural Areas of South Africa: An Overview

Rural and underserved communities worldwide, particularly in South Africa, face numerous structural and systemic barriers that severely limit access to quality healthcare services. According to Chikafu and Chimbari (2021:3), one of the most urgent issues is inadequate infrastructure. Healthcare facilities such as clinics, hospitals, and diagnostic laboratories are either non-existent or inadequately furnished in many rural areas. For basic and emergency medical care, communities must either travel great distances or rely on overburdened local clinics to receive medical attention. The second obstacle caused by these long travel distances is that access becomes particularly challenging for patients with chronic illnesses, pregnant women, and the elderly. Due to inadequate road infrastructure and a lack of dependable public transportation, people in rural areas, such as Ingwavuma in northern KwaZulu-Natal, frequently walk for hours to reach the closest clinic. Delays in receiving care led to worsening health issues and lost chances for an early diagnosis (Chikafu and Chimbari 2021:4-5).

The third obstacle is the lack of qualified healthcare workers. Rural regions often have significantly fewer doctors, nurses, and specialists per capita than urban areas. In South Africa, despite approximately half of the population residing in rural areas, only about 12% of doctors practice there (Singh, 2025:1). Notably, KwaZulu-Natal was particularly affected. In January 2025, a group of unemployed doctors protested outside the KwaZulu-Natal Department of Health, demanding jobs after completing their community service requirement. Their demonstration emphasised the irony: despite the province's chronic scarcity of medical experts, budget constraints and administrative delays prohibited their deployment to underprivileged communities (Singh, 2025:2). This situation results in high workloads for existing rural healthcare staff, long waiting times for patients, and little to no access to specialised care, such as mental health support, maternal care, or chronic disease management.

In South Africa, rural healthcare facilities usually face serious supply chain issues that impair service delivery, in addition to a lack of medical experts. Zuma (2022:578) posits that a lot of clinics

and hospitals frequently run out of necessary medications, vaccines, and medical supplies, which makes it challenging for medical staff to deliver reliable and efficient service. These challenges are often attributed to ineffective inventory management, insufficient procurement planning, and logistical limitations related to the transportation of goods to remote areas with restricted infrastructure. Consequently, patients are frequently denied access to essential medications or are compelled to travel great distances to receive care elsewhere. In addition to interfering with continuity of care, this erodes public trust in the healthcare system and exacerbates health outcomes in rural areas (Zuma, 2022:579). Thus, persistent drug shortages serve as critical indicators of deeper systemic issues in rural healthcare, intensifying existing structural challenges and amplifying health disparities.

According to Mindu et al. (2023:2), the application of contemporary health solutions, such as telemedicine, is restricted by rural areas' restricted access to digital technology and the Internet. Many residences in the rural areas of KwaZulu-Natal, including the uMkhanyakude District, lack smartphones or reliable Internet access, rendering it impossible for them to utilize online health consultations or receive health warnings. Rural areas often lack access to services that could mitigate the consequences of physical remoteness from healthcare facilities due to the digital divide (Mindu et al., 2023). Collectively, these obstacles -poor infrastructure, long travel times to care, a lack of staff, and digital exclusion -raise death rates, uncontrolled chronic illnesses, and avoidable disease rates. For instance, a 2023 study by the Africa Health Research Institute found that in uMkhanyakude, 93% of people with diabetes and over half with hypertension had unmet health needs, often because they lived too far from clinics or could not access consistent treatment (Wong and Singh, 2023:2).

SANews (2022) highlights the substantial health issues faced by South African rural communities, especially considering the combined burden of HIV and non-communicable diseases (NCDs). Research has continuously demonstrated that HIV is still very common in rural regions. For instance, KwaZulu-Natal has the second-highest HIV prevalence in the country, at over 16% (SANews, 2022). The countrywide rollout of antiretroviral therapy (ART) has advanced, but access to ART in rural areas is still insufficient and unequal. Many studies have identified structural obstacles that contribute to unsatisfactory adherence and retention in care, including stigma, long commutes to medical facilities, inadequate transportation infrastructure, and ongoing pharmaceutical shortages

(Ramalivhana et al., 2024:4). These difficulties make many patients more vulnerable to opportunistic infections and the advancement of their diseases, resulting in variable treatment outcomes. Furthermore, research shows that rural healthcare practitioners frequently work in extremely underfunded settings, which makes it challenging to provide the continuous monitoring and assistance needed for HIV care to be effective.

Simultaneously, there is mounting evidence that the prevalence of non-communicable diseases (NCDs) has sharply increased in rural regions. Conditions such as hypertension, diabetes, and cardiovascular disease, once thought of as urban health issues, are now prevalent in South African rural communities. When comparing health outcomes in low-resource urban and rural settings, Ramalivhana et al. (2024:7-9) found that people living in rural areas had a higher burden of non-communicable disease (NCD) risk factors, including poor dietary habits, functional impairments, and physical inactivity. According to their findings, shifting lifestyle patterns and limited access to early diagnosis and chronic illness treatment services may make rural populations more susceptible to NCDs than urban populations. The inadequacy of rural healthcare infrastructure, including the absence of diagnostic tools, chronic medication shortages, and a shortage of trained professionals, has been widely noted as a barrier to effective NCD care (Ramalivhana et al., 2024). This aligns with broader findings in the literature that underscore the chronic underfunding and neglect of rural health systems in sub-Saharan Africa.

However, numerous studies have shown that the comorbidity of Human Immunodeficiency Virus (HIV) with non-communicable diseases (NCD) places a significant burden on rural health systems, making the confluence of these two illnesses a challenging task. Coordinated multidisciplinary care is necessary for patients with HIV and chronic illnesses, such as diabetes or hypertension; however, this degree of integration is frequently absent from rural clinics. According to the literature examined by Ramalivhana et al. (2024:10-12), health services in these regions are usually dispersed, resulting in care inefficiencies and lost opportunities for comprehensive treatment. Furthermore, it is commonly stated that social determinants of health, such as poverty, food insecurity, and low health literacy, hinder the capacity of rural populations to successfully manage chronic illnesses. These factors reduce treatment adherence and contribute to poor outcomes, even when basic services are available.

Furthermore, although home births are not necessarily a choice, they are still common in many South African rural areas due to structural obstacles such as poor transportation and the great distance to medical facilities. In remote areas, clinics and hospitals are often located several kilometers away from communities, with limited or no access to public transportation. According to Johnson et al. (2023:6), long travel times and a lack of reliable transportation are key predictors of home deliveries, particularly in provinces such as Limpopo, the Eastern Cape, and KwaZulu-Natal. Ambulance services, when available, are often delayed due to poor road conditions or resource shortages, sometimes taking hours to arrive, if at all (Marabele et al., 2020: 691). Consequently, many women are forced to give birth at home, often without the assistance of trained medical professionals. The risk of complications for both the mother and newborn, including bleeding, infections, and birth asphyxia, is greatly increased by these unattended deliveries. Maternal and infant mortality rates in these places are consistently high due to a combination of large distances, poor emergency transport infrastructure, and underfunded rural health institutions (Marabele et al., 2020:694).

Recent research by Willie and Maqbool (2023:35) indicates that South Africa's rural healthcare systems lack essential infrastructure, particularly in terms of the unequal distribution of hospital beds across districts. According to Willie and Maqbool (2023:35), although the Eastern Cape Province is estimated to have between 1.7 and 2.3 hospital beds per 1,000 people, exceeding the international benchmark of 1.5 beds per 1,000, this aggregate figure conceals substantial inequities. With less than one bed per 1,000 residents, their data show that rural and underdeveloped districts such as OR Tambo and Alfred Nzo fall well short of this criterion. In contrast, better-resourced districts, such as Amathole and Joe Gqabi, meet or exceed the recommended ratio.

Districts with the greatest need often have the least capacity, highlighting larger systemic problems in healthcare planning and funding. As people in under-resourced locations face delayed admissions, fewer emergency services, and greater travel difficulties when seeking hospital-based care, the literature highlights how this inequality directly correlates with poor health outcomes (Willie and Maqbool, 2023:40). Furthermore, these disorders are especially harmful to vulnerable groups that require urgent or frequent medical care, such as the elderly, people with chronic illnesses, and pregnant women. Willie and Maqbool (2023:50) argue that although national statistics may suggest that infrastructure targets are being met, these averages fail to reflect the lived experiences of rural

populations that remain systematically underserved. This misalignment between data and reality underscores a critical gap in equitable health service provision and reinforces the need for spatially sensitive policy approaches that prioritise access to and distribution of healthcare services. The findings position bed shortages and their uneven geographic allocation as core indicators of the persistent underdevelopment of rural healthcare systems in South Africa.

In addition to the lack of access and infrastructure, traditional healing techniques are very prevalent in rural South Africa and have a significant impact on patient behaviour and the operation of medical facilities. Traditional healers are seen as reliable and approachable individuals who offer diagnoses and treatments that are culturally appropriate in many rural communities. Consequently, patients frequently seek biomedical therapy after consulting traditional healers, or they employ both systems at the same time, combining prescribed medication with herbal cures or even combining traditional treatments with injections given in a hospital (Sangana et al., 2024: 2708-2715). This practice led to delayed presentation at clinics or hospitals, misinterpretation of symptoms, drug interactions, and reduced treatment efficacy. From a clinical perspective, such blending complicates diagnosis and undermines continuity of care. Healthcare workers in rural areas frequently report frustration when patients return after initially consulting traditional practitioners, often in a worse condition. Marabele et al. (2020:169) note that this dynamic not only places pressure on rural clinics but also weakens trust in formal medical interventions when patients experience poor outcomes after combining treatments.

The successful provision of psychological care in rural South Africa is severely restricted by the lack of mental health experts, particularly psychiatrists. According to Janse van Rensburg et al. (2022:492), rural populations in South Africa are severely neglected because of the country's highly lopsided psychiatric allocation toward urban areas. A shortage of specialist mental health providers, such as psychologists and psychiatric nurses, in many rural clinics, which frequently lack even the most basic counselling services, exacerbates this shortfall (De Kock and Pillay, 2017). Consequently, many rural patients rely heavily on traditional healers for the diagnosis and treatment of mental illness. Ngobe et al. (2021: 884) note that traditional healers in rural provinces like Mpumalanga provide culturally grounded mental health care, often attributing psychological ailments to supernatural causes and employing traditional treatment protocols. The reliance on traditional healing practitioners underscores the gaps in formal mental health service provision and

highlights the necessity of integrating these systems to improve access and outcomes for rural populations in South Africa.

2.6 Effects of Doctors' Migration on Rural Healthcare and Underserved Communities

The migration of doctors significantly impacts rural healthcare systems and underserved communities in South Africa, exacerbating the existing shortage of healthcare professionals and compromising the quality of care. Gumede et al. (2021:2) emphasise the persistent challenge of attracting healthcare professionals to rural areas. As previously mentioned, these communities face numerous barriers to accessing healthcare, including financial constraints, inadequate transportation, and long distances to healthcare facilities (Gaede & Versteeg, 2011:1). The shortage of doctors and 24-hour services forces existing doctors to work excessive hours without being paid bonuses, leading to burnout and a diminished capacity to provide empathetic and innovative care (Schaefer et al., 2021:1). This relentless workload and lack of support can push the remaining doctors to seek opportunities elsewhere, either in more urban settings or abroad, where the work environment and personal well-being may be more sustainable. Such a movement not only exacerbates current healthcare problems but also sets off an endless cycle in which those left behind become even more overburdened, increasing the likelihood of further doctors leaving. Consequently, the rural healthcare system becomes more vulnerable, with fewer physicians available to meet the increasing patient demand.

Patients often experience prolonged waiting times, which can be detrimental to their health and wellness, and are frequently referred to distant hospitals, with many unable to access transportation, resulting in adverse health outcomes or fatalities. Gumede et al. (2021:2) highlighted the disparity in doctor-to-population ratios, with South Africa having only 60 doctors per 100,000 people compared to the global average of 152. Rural living conditions pose significant challenges, with a substantial proportion of households located more than an hour away from clinics and hospitals. Tankwanchi et al. (2020:1) underscore the ethical implications of this migration, arguing that while doctors have a right to migrate, their movement exacerbates the challenges faced by their home country, particularly in rural areas. According to Mthombeni (2023:20), doctor migration starts from rural to urban areas, where it worsens urban overcrowding and service strain on

the remaining doctors. In contrast, rural areas face severe staff shortages, delayed care, and an increase in preventable deaths.

According to Willie and Maqbool (2023:36), in addition to staff shortages and delayed care, this doctor exodus places a heavy financial burden on rural patients, worsening their pre-existing problems. Many people are forced to seek medical attention at distant hospitals because they have limited access to healthcare providers in their area. When public services are overburdened or unavailable, out-of-pocket costs for transportation, lodging, and occasional private consultation fees are incurred. Willie and Maqbool (2023:38) state that these expenses are unaffordable for low-income households and often lead to care being postponed or skipped, especially for maternal health needs and chronic illnesses. Beyond direct expenses, there are hidden economic losses, such as lost income due to time away from work or caregiving duties, which disproportionately affect women and elderly caregivers. A case in Centane, Eastern Cape, for instance, showed that a 60-year-old woman required R1,500 for private transportation to receive care at a hospital 60 kilometres away, necessitating her family to postpone food purchases to pay for the journey (Health-e News, 2025). In the absence of local healthcare resources, many rural families are compelled to make difficult trade-offs, as illustrated in this instance. The inability to pay for these expenses perpetuates health disparities, resulting in a vicious cycle of poverty and disease in rural areas, as Willie and Maqbool (2023) pointed out. This absence of accessible and affordable healthcare forces patients to ration care, rely on home remedies, or delay seeking treatment until conditions become emergencies, further increasing the likelihood of negative health outcomes.

An illustrative example of the consequences of doctor shortages, especially in times of crisis, is provided by Benson et al. (2022:1), who examined the psychological toll and professional challenges faced by physicians during the COVID-19 pandemic. Due to their lack of resources and medical staff, rural and underdeveloped areas were disproportionately affected by the pandemic, worsening the already existing vulnerabilities in healthcare systems worldwide. According to Benson et al. (2022:3-4), physicians were frequently left to handle excessive workloads in settings characterised by a lack of personal protective equipment, significant patient distress, false information, and an uncertain future. These factors further weakened healthcare workers' capacity to provide high-quality care by raising their rates of burnout, emotional tiredness, and mental health issues. In rural areas, where even a small number of doctors leaving due to migration or burnout

can have a pyramid effect, leaving the remaining medical staff overworked and more likely to leave themselves, these pressures are especially severe. The COVID-19 pandemic serves as a stark example of how doctor shortages intensified by migration critically weaken healthcare delivery.

However, Benson et al. 's (2022) findings align with Hain et al. 's (2021:1) work and also provide an example of the issues experienced by doctors in rural areas by investigating the mental health status of medical professionals working in 15 rural district hospitals in northern KwaZulu-Natal. Hain et al. (2021:3) research found disturbingly high rates of burnout (68.5%), depression (35.6%), and anxiety (23.3%) among these doctors. These mental health issues were especially prominent among female doctors and community service medical officers (CSMOs), two groups that frequently form the backbone of rural healthcare. Importantly, this study discovered a strong connection between these psychological pressures and doctors' plans to leave the public health profession within two years. These findings highlight the compounding effect of physician migration; as more doctors move abroad, those who stay are left with increasingly untenable workloads under tough conditions, further jeopardising the sustainability of healthcare services in rural areas.

The migration of doctors from South Africa to international locations has had profound and severe consequences for rural healthcare systems, where shortages of qualified healthcare professionals are critical. Disadvantaged rural populations are particularly affected by this emigration, as the lack of medical professionals causes many people to rely on traditional healers and informal healthcare providers as their main sources of care. According to Sangana (2024:2709), while traditional medicine has its roots in cultural customs and provides easily accessible care, excessive dependence on unauthorised or informal practitioners raises questions about the effectiveness, safety, and quality of healthcare delivery. In many cases, patients frequently suffer from incorrect diagnoses or poor therapies, especially for major illnesses that require biomedical interventions, such as HIV/AIDS, TB, and chronic disorders. The lack of trained medical professionals in rural areas thus not only compromises the standard of care and perpetuates the spread of harmful myths and misinformation, which can worsen health outcomes and delay access to appropriate treatment. This circumstance reveals a severe healthcare shortage aggravated by the movement of doctors (Sangana, 2024:2712).

Rural healthcare institutions suffer from a lack of manpower and a decline in infrastructure investment, as many doctors depart South Africa to work overseas. If rural clinics and hospitals are

unable to retain qualified physicians, policymakers and government planners frequently consider them less sustainable or feasible (Cowley, 2025:1). As a result, money for essential improvements, such as medical equipment, building maintenance, and crucial utilities, such as water and electricity, is sometimes reduced for these facilities. This underfunding leads to a vicious cycle: rural health facilities cannot provide high-quality care without adequate infrastructure, which deters physicians from practising in these areas. The state of the facilities serves as a powerful barrier, hindering attempts to hire new medical professionals. Furthermore, programs in rural areas without steady medical personnel may be difficult for Non-Governmental Organisations (NGOs) and international funders. Inequalities in underprivileged communities are exacerbated, and access to care is worsened by the exodus of doctors from South Africa, which also adds to the underdevelopment and neglect of rural health infrastructure. Cowley (2025) uses the Eastern Cape as a pertinent example of this situation, as numerous clinics and hospitals struggle with a significant lack of staff and decaying facilities. Due to a shortage of medical staff, Livingstone Hospital's outpatient clinics have been forced to close, leaving only enough employees to perform emergency procedures. The findings emphasise that this situation is compounded by the provincial government's refusal to fill vacant doctor posts and provide adequate resources to frontline facilities, leading to a collapse in healthcare services.

2.7 The government's response to doctors' migration

In response to the persistent migration of healthcare professionals, specifically doctors, the South African government has implemented several strategic policies; however, their effectiveness is limited. The Return-of-Service (RoS) bursary is a major intervention that offers financial assistance for medical training conditioned on future work in the public sector or rural areas. Although RoS schemes initially enhance staffing, Mabunda et al. (2023:2) found that the mechanisms for monitoring and enforcement are insufficient, and that less than 25% of South African grantees remained after their service commitments. Policymakers who participated in qualitative interviews reached similar results, pointing out that implementations frequently lack interdepartmental coordination and post-service placement planning, and contract defaults can range from 1 to 30 percent (Mabunda et al., 2022).

In addition to the RoS bursary, South Africa mandates a one-year Compulsory Community Service (CCS) for all newly qualified doctors. Reid et al. (2018:651) emphasise that although this policy

temporarily places doctors in underserved regions, it fails to anchor them; their long-term retention in underserved areas is weak, as many treat the placement as a contractual obligation rather than a career opportunity, departing immediately after completing the service. Insufficient supervision, poor infrastructure, and the absence of structured career development during CCS deterred extended rural engagement. Flexible work arrangements have been implemented at the facility level as part of efforts to alleviate burnout, a major factor in the migration of healthcare workers. Schaefer et al. (2021:3) assessed a pilot program that implemented job sharing and part-time contracts in a rural training hospital in George. Staff retention increased, burnout decreased, and morale increased because of the project. These projects are still localised and have not yet been expanded nationally, despite their success.

The government also supports pipeline reforms, such as focusing medical training on students from rural areas to create a more sustainable rural workforce. MacGregor and Ross (2024:6) found that graduates of the Umthombo Youth Development Foundation from rural backgrounds were significantly more likely to return to and remain in rural practice. Long-term participation is fostered by this alignment of cultural heritage and community allegiance. Nevertheless, these programs continue to lack national institutional integration and are insufficiently funded. Most recently, by centralising funding and reorganising service delivery through strategic purchasing, the NHI program, which was enacted into law in 2024, aimed to increase fair access to healthcare. Despite its stated goals of bolstering the public health system and enhancing conditions for physicians, the NHI has raised concerns among medical experts. The South African Medical Association claims that many physicians are afraid of over-centralisation, uncertain reimbursement procedures, and diminished autonomy (Fraser, 2024:1). Due to these worries, a sizable percentage of physicians are thinking about leaving the country before the policy is fully implemented, which might worsen the current labour crisis.

Despite the suite of policies, Return of Service (RoS) bursaries, Compulsory Community Service (CCS), flexible contracts, rural-origin recruitment, and now NHI, the situation has not improved. The migration of physicians remains a major issue. These initiatives frequently do not address underlying structural problems, including inadequate working conditions, limited career trajectories, and poor infrastructure. They also frequently function in isolation and lack robust implementation frameworks. According to Reid et al. (2018), Schaefer et al. (2021), and Mabunda et al.

(2023), in addition to contractual and monetary incentives, systemic changes that foster long-term rural service are also necessary for sustainable doctor retention. Considering its potential, the NHI's effectiveness depends on professional support, a clear strategy, and large reinvestment in rural healthcare systems.

2.8 Gaps in Literature

Current research predominantly focuses on the economic, professional, and social factors driving doctors' migration and its impact on the healthcare system. However, a significant gap exists in exploring the consequences of this migration from a consequentialist perspective in the literature. While the benefits of migration for doctors, such as improved income, working conditions, and career development, are acknowledged, less attention is given to the negative outcomes for rural communities, which are already underserved. To contribute to this under-researched area, this study aims to investigate the impact of doctor migration on health outcomes in underserved rural populations.

2.9 Conclusion

This literature review has examined the various studies conducted by different scholars on the migration of doctors and its ethical implications for rural healthcare in South Africa, starting with an overview of the nature of doctor migration and its different forms. Doctors moving from rural to urban areas is known as internal migration, whereas healthcare workers moving abroad in pursuit of better working circumstances, higher wages, and increased personal safety is known as international migration. In rural areas, where healthcare systems are extremely understaffed and underfunded, all types of migration, including circular, temporary, labour, family, lifestyle, and student migration, contribute to the ongoing health crisis. The causes of doctors' migration were also examined; these included low pay, unsafe working conditions, inadequate infrastructure, mental health burnout, and terrible working conditions. Many skilled doctors find themselves compelled to seek better opportunities abroad due to the severe problem of unemployment, particularly among recent graduates. Pull factors, such as safer environments, career development opportunities, and better compensation in other countries, have also played a significant role. The continuous loss of medical professionals has also been exacerbated by criminality, political unpredictability, and uncertainty surrounding the NHI system in South Africa.

The difficulties facing South African rural healthcare have been thoroughly described, including a lack of medical infrastructure, a shortage of medications, the need for specialists and mental health workers, and long distances to hospitals and clinics. These factors directly affect the management of chronic illnesses, maternal health, and the growing prevalence of both infectious and non-communicable diseases in the country. Due to the inaccessibility of contemporary medical care, many patients are either left untreated or compelled to turn to traditional healers. The unequal distribution of hospital beds and digital exclusion serve as additional examples of systemic disparities between rural and urban health systems. The effects of doctor migration were also explored, demonstrating how the exodus of medical professionals leads to overworked rural staff, longer wait times for patients, and poor health outcomes. Burnout, depression, and anxiety are among the mental health issues that rural doctors face as a direct result of this movement, and they raise the possibility of additional turnover. Ethical concerns have been raised about the needs of vulnerable rural populations that experience unequal access to treatment compared to the right of doctors to relocate.

Various initiatives by the South African government were evaluated, including recruiting students from rural areas, implementing flexible work schedules, mandatory community service, and RoS bursaries. While these programs aim to retain doctors in their positions, research suggests that they are often poorly implemented, lack follow-up support, and fail to address the fundamental reasons for doctors' migration. Despite being intended to increase healthcare equity, the NHI has caused professionals to express concerns and may have inadvertently forced more physicians out of the system. Finally, it should be noted that the opinions and research findings in this literature evaluation were gathered from academics in a variety of fields, including public health, policy studies, sociology, and ethics. The next chapter, chapter three, presents the research methodology adopted for the study.

CHAPTER 3

RESEARCH METHODS AND METHODOLOGY

3.0 Introduction

Chapter two covered research literature review. This chapter focuses on research methods and methodology. According to McMillan and Schumacher (2010), research is the systematic process of gathering and rationally analysing evidence to achieve a specific goal. However, this definition is somewhat generalized because numerous approaches are taken to investigate a specific subject or question. The procedures used to gather and analyse data are known as research methods (forming a research methodology). These techniques were developed to acquire knowledge in a valid and reliable manner. According to McMillan and Schumacher (2010), a research methodology is deliberate and methodical, designed to generate information for a particular study subject.

Gounder (2012:13) conceptualises research methodology as a systematic framework to address research problems, encompassing the procedures through which researchers perform tasks related to describing, explaining, and predicting phenomena. It is also defined as the study of methods for acquiring knowledge and serves as a work plan for research. Research methods, which consist of various procedures such as algorithms, experimental studies, and statistical approaches, are the techniques employed by researchers during their studies. These methods are characterized by their planned, scientific, and value-neutral nature and are essential for data collection and problem-solving (Sileyew, 2019:3). In scientific research, methodologies emphasize explanations founded on empirical evidence rather than mere reasoning, permitting only those that can be verified through experimentation. Therefore, research methods are concerned with finding solutions to specific research questions, while research methodology focuses on the appropriate implementation of procedures necessary for effective research, illustrating that methodology precedes the application of research methods in both scientific and non-scientific contexts.

This section outlines the research design, methodology, and procedures employed in this study to explore doctor migration and rural healthcare in South Africa. The primary goal is to provide a brief and comprehensive overview of the sampling plan, data collection techniques and research methodology being used to collect and analyse the information.

3.1 Different Types of Research Approaches

Research approaches offer methodical frameworks that direct the procedures used in a study, including data collection and analysis techniques. Pawar (2020:47-50) asserts that selecting the most suitable technique that aligns with the study's aim and objectives requires an understanding of the various research approaches. These are the primary categories of research methodologies commonly used in both academic and practical settings.

3.1.1 Applied Research

According to Pawar (2020:47), applied research focuses on the development and implementation of research-based knowledge concerning a field of common practice. Applied fields include social work, education, engineering, and medicine. Compared to other types of research approaches, applied research generates information that can be used to solve broad issues. In simple terms, applied research prioritizes the issues that are representative of a given field. In education, this type of research approach typically focuses on issues that need to be addressed to improve practice. When broad theories are tested, the findings can be applied in a wide range of educational contexts (McMillan and Schumacher, 2010:21). For instance, a new curriculum may evaluate fundamental theories of human memory, which have been developed through basic research, to enhance science concept recall. Studies that evaluate various teaching philosophies, pinpoint the traits of successful institutions, and look at how extending the school day affects student performance are other examples of applied research in education (McMillan and Schumacher, 2010:21-22). Therefore, rather than focusing on universal knowledge, the focus of educational research is on understanding theories and methods in education. According to Pawar (2020), Applied research plays a significant role in decision-making by addressing critical issues that have immediate relevance. It can have both direct and indirect effects; for example, as the results are shared over time, it might change practitioners' perspectives on common problems. Pawar (2020:47-48) further explains that this form of research has become increasingly dominant in the field of educational studies, largely because of the federal government's focus on implementing and evaluating field research intended to identify effective strategies to enhance student achievement.

3.1.2 Qualitative Research

Qualitative research is a methodology for scientific inquiry that emphasizes the depth and richness of context and voice in understanding social phenomena. This approach is interpretive or constructive, and rather than merely quantifying occurrences, it aims to disclose the "what," "why," "when," "where," "who," and "how" underlying social behaviours and interactions (Lim, 2025:200). A comprehensive investigation of subjective experiences is the goal of qualitative research, which embraces openness and uses a variety of methods. Participant observation, qualitative interviews, focus groups, and open-ended inquiries are some of these methods. Researchers can gain a deeper understanding of people's perspectives and interpretations of their social settings by employing this method (Lim, 2025:201). Pawar (2020:47) emphasises that qualitative research is highly regarded for its adaptability and flexibility, as well as its commitment to recording a wide variety of human experiences and viewpoints. Qualitative methods focus on constructing understanding through the experiences of researchers and participants, aiming to provide context-rich insights deeply rooted in real-life experiences while adhering to rigorous academic integrity and methodology.

3.1.3 Quantitative Research

Quantitative research is defined as the systematic study of phenomena using statistical, mathematical, or computational methods, along with the collection of numerical data. According to Adedoyin (2020:1), the positivist paradigm, which underpins quantitative research, supports statistical breakdown-based methods and integrates additional methods, such as randomization, blinding, hypothesis testing, inferential statistics, mathematical explanations, systematic protocols, and surveys, with a restricted set of prearranged solutions. Adedoyin (2020:2) emphasizes that the objectives of quantitative research are quantitative and closely related to variables and theories. Variables are ideas that have multiple possible values, and theories are unproven presumptions or assertions about the relationship between variables. In quantitative research, ex post facto designs, case studies, surveys, and experiments are the most commonly used research techniques.

It is essential to describe the distinguishing characteristics of quantitative research to gain a comprehensive understanding of it. The scope of quantitative research is to employ measurable elements and statistical information to describe social phenomena. According to Lim (2024:326), this type of study assumes that complex issues may be divided into smaller, measurable elements for

objective analysis. On the one hand, quantitative research emphasizes numerical data, structured methodologies, and objective analysis to minimize bias and produce results that can be generalized across contexts. On the other hand, in non-quantitative research, qualitative traits, including human perceptions, reactions, and experiences, are more significant. Such research seeks to comprehend circumstances in their native setting rather than restricting them to numerical quantities. The core of objectivity in quantitative research is its dedication to impartiality and disengagement from the subject. This type of research aims to minimize biases and produce results that could be used in different situations (Lim, 2024:327). On the other hand, the use of non-quantitative research acknowledges the importance of contextual relevance and subjectivity as crucial elements for a deeper comprehension of the study issue.

The purpose of quantitative research is to test hypotheses, develop predictive models, or draw conclusions about causality. Such studies aim to demonstrate cause-and-effect correlations between variables, provide empirically proven predictions, or confirm or refute preexisting ideas (Borgstede and Scholz, 2021:2). In contrast, non-quantitative research may serve more exploratory goals by concentrating on developing hypotheses, creating descriptive narratives, or conducting thematic investigations. Numerical data is used in quantitative research and is collected using consistent, organized methods, such as interviews and experiments. Such information is appropriate for statistical analysis, which supports the objective validation of hypotheses. Conversely, non-quantitative research relies on non-numerical data that may not be suitable for statistical analysis and is typically obtained through qualitative methods, such as observations or interviews (Borgstede and Scholz, 2021:2). In terms of approach, computing methods, mathematical models, and statistical software are commonly employed in quantitative research to analyze data. These technologies enable researchers to effectively evaluate large datasets, allowing them to identify quantitative trends and separate variables. Conversely, non-quantitative research employs interpretive methods, such as thematic and content analysis, to identify ideas or themes and tell stories without the need for numerical analysis.

3.1.4 Descriptive Research

Shinija (2024:1-15) defines descriptive research as a method that outlines current situations without the researcher exerting control over variables. It aims to determine, describe, or identify phenomena, compared to analytical research, which seeks to understand the reasons behind those

phenomena. Descriptive studies have three main goals: to describe, explain, and validate research findings, making them particularly suitable for topics that resist quantification. This research method illuminates current issues through data collection, enabling researchers to depict situations more thoroughly than they could without it. Descriptive research answers “What?” but does not address “Why?”

Key characteristics of descriptive studies include:

- The necessity of at least one variable, despite the potential for multiple variables.
- A strong association with observational studies, while also utilizing case studies and surveys as data collection methods.
- The facilitation of further research, leading from “What?” to “Why?” considerations.

According to Singh (2023:5), some of the examples of descriptive research are in the social sciences, this might be demonstrated by looking at a community's demographics to identify its socio-economic characteristics. In the business world, a descriptive study would be a market research survey that aims to characterize consumer preferences, and a researcher studying ecology might survey all the different kinds of monocots that are found in a certain area and categorize them down to the species level. Singh (2023) further emphasise that descriptive research offers several advantages, such as its efficacy in analysing non-quantified issues, the ability to observe phenomena in natural settings, incorporating quantitative and qualitative data collection methods for a comprehensive outcome, reduced time requirements compared to quantitative experiments, and practical implications for decision-making. However, Singh (2023) posits that descriptive research has several disadvantages, including the inability to statistically test or verify research problems, potential biases resulting from a lack of statistical testing, challenges in repeatability due to observational reliance, and limitations in identifying the causal relationships behind observed phenomena.

3.1.5 Analytical and Fundamental Research

Analytical research involves analysing phenomena using existing facts and information, typically employing analytical tools for critical evaluation. It encompasses several types:

Reviews include a meta-analysis of quantitative methods and formal assessments of various studies to derive useful conclusions. Historical research is a systematic approach on collecting and

evaluating data for understanding past events and actions, using sources such as documents and oral statements. The primary goal is to uncover truths and contextualize histories, though there is no universally accepted definition of what constitutes a temporary history (Pawar, 2020:48). Furthermore, philosophical research focuses on the theoretical bases of experience and knowledge, tackling fundamental aspects of reality, knowledge, and existence. Research synthesis, which involves summarizing findings from multiple studies addressing a specific question, and grounded theory, which is developed through comparative analysis, are methodologies that emphasise the systematic discovery of theories from qualitative data, including interviews and observational studies (Pawar, 2020:49). In all these types, the research methodology prioritizes the phenomenon under study rather than the methods employed, highlighting the researcher's role in data interpretation and category creation. On the other hand, Pawar (2020) further explains fundamental research as a research approach that aims to acquire new knowledge through experimentation and theoretical work. Its benefits include economic gains, societal advantages, and the establishment of new knowledge, although it is not usually designed for immediate practical applications.

3.1.6 Conceptual Research

The primary goal of conceptual research, also known as theoretical research, is to study theories, concepts, and ideas. Its main focus is on hypothetical and abstract concepts, with the goal of improving comprehension and producing fresh ideas. To propose new frameworks or models, conceptual research often involves a comprehensive assessment of the current literature, as well as the analysis and synthesis of various theories and concepts (Salawu, 2023:2105). The use of deductive reasoning is one of the main characteristics of conceptual inquiry. To generate new hypotheses or frameworks, researchers begin with a collection of pre-existing theories or concepts and apply logical reasoning. Salawu (2023) emphasise that researchers can contribute new ideas and expand on existing information by using this deductive approach. Exploratory in nature, conceptual research aims to broaden our understanding and lay the groundwork for additional empirical studies.

Conceptual research is especially useful in areas where it may be hard or impossible to find actual data. It enables researchers to investigate complex phenomena, create theoretical models, and formulate hypotheses that can subsequently be empirically tested. Conceptual research guides researchers in their pursuit of empirical data by concentrating on abstract concepts and theories, which serve as a theoretical basis for empirical investigations (Dreher, 2018:1). Furthermore, the

creation of new disciplines or interdisciplinary domains depends heavily on conceptual research. It facilitates the creation of a shared theoretical framework and vocabulary, making it easier for academics from diverse backgrounds to collaborate and communicate effectively. According to Dreher (2018), the foundation for empirical research is laid by conceptual research, which advances knowledge by synthesizing current information and putting forth new ideas.

3.1.7 Empirical Research

Observable data collection and analysis are the focus of empirical research as opposed to conceptual research. It seeks to verify theories, test hypotheses, and draw conclusions supported by data. The methodical gathering of data using a variety of techniques, including surveys, experiments, observations, and interviews, is the foundation of empirical research (Hürlimann, 2019:1). To arrive at significant findings, the collected data is subsequently examined using statistical or qualitative methods. The use of inductive reasoning is a primary characteristic of empirical research. To create broad hypotheses or conclusions, researchers begin with data or observations. Researchers can draw broader conclusions from particular cases using this inductive method, which serves as a foundation for generalization. Frequently hypothesis-driven, empirical research uses data collection and analysis to test and validate ideas or hypotheses.

The potential of empirical research to provide verifiable evidence and validate or refute existing beliefs makes it extremely valuable. It enables researchers to use empirical data to make well-informed decisions, comprehend cause-and-effect relationships, and examine real-world phenomena (Bouchrika, 2021:1). Empirical research contributes to the accumulation of knowledge in a field by using observable data to support its findings, which enhances its credibility and reliability. Furthermore, applied fields that rely on real-world applications and practical implications benefit greatly from empirical study. According to Bouchrika (2021), empirical research enables researchers to measure the results of certain actions, analyse the impact of policies, and appraise the efficacy of initiatives. Evidence-based practices, policy creation, and decision-making processes can all benefit from the insightful information that empirical research offers.

After outlining the different kinds of research approaches, this study proceeds on to the specific method used:

3.2 Desktop/Secondary Research Approach

Desktop research approach is a method of using information previously collected by other researchers for a variety of purposes to address new research questions. In the social and behavioural sciences, where primary data collection may be hampered by logistical or ethical issues, this method is very helpful. Secondary data may be qualitative or quantitative, and it may be re-analysed independently or in integration with other datasets.

In a secondary data analysis (SDA), investigators start with a hypothesis or research question, then identify a dataset or datasets that are pertinent to address it; alternatively, they are already familiar with a dataset and search it for other questions that the data may address (Wickham, 2019:396). In practice, researchers conducting secondary data analysis (SDA) most likely alternate between these methods. Wickham (2019:397) illustrates a common scenario faced by investigators in the research process. When starting with a predetermined research question, the investigator may need to modify this question based on the accessibility and quality of the available data. This adaptation is particularly necessary when the initial dataset lacks certain essential variables needed to comprehensively address the research inquiry. As such the ability to adjust research questions in light of data limitations is an important skill in the field of research. Analysis of secondary data researchers can access primary data from both official sources, such as publicly available research datasets or those institutionally archived, and informal sources that aggregate data independently collected by multiple researchers. Secondary data analysis can involve various data sets that researchers may find in numerous locations, such as academic institutions or government websites. For instance, a graduate student may utilize the datasets from an advisor's previous research. Notable online resources for secondary data include the National Cancer Institute, which offers several dataset categories, and the NYU Libraries Data Sources (Wickham, 2019). Furthermore, researchers can harness the power of the Google search engine by searching for specific phrases like "archive sources of datasets," complemented by relevant oncology keywords, to locate additional datasets.

3.2.1 Arguments for Desktop/Secondary Data

The benefits of secondary research that are most frequently mentioned are labour, time, and financial savings as well as the convenience of using pre-existing data instead of gathering primary

data, which is often the most costly and time-consuming stage in the research process (Rew et al., 2000; Johnston, 2014; Tripathy, 2013 cited by Wickham, 2019:397). According to Cheng and Phillips (2014), the cost of acquiring datasets is usually quite low when compared to collecting data independently. Comprehensive details regarding data collecting and statistical assistance may also be accessible. In addition to avoiding data collection obstacles (such as obtaining study participants, getting a large enough sample size to yield convincing results, avoiding study dropout, and finalizing data collecting in an acceptable amount of time), desktop research approach can help an inexperienced investigator advance their clinical research expertise. Additionally, Rew et al. (2000), cited by Wickham (2019:398), posit that secondary data analysis may allow the evaluation of more factors than would be feasible in smaller research, including surveys of more diverse groups, the chance to re-evaluate data, and the application of more advanced statistical techniques in analysis.

3.2.2 Arguments Against Desktop/Secondary Data

However, there are also some possible drawbacks to secondary data analysis. It is nearly impossible to be totally certain of the data's quality unless you have personally gathered it. Despite the availability of survey instruments linked to datasets, it is not always possible to determine the interviewer reliability of surveys that are beyond one's control or whether the information has been affected by interviewer bias or other interviewer impacts (Wickham, 2019:399). Moreover, it is not always feasible to locate required information for analysis. Concerns about the selection process for the subjects present another drawback when using secondary data. To extrapolate findings to the broader community, participants in the majority of research studies are typically selected from a representative sample (Wickham, 2019:399). In many instances, it is impossible to determine whether a case chosen by another scholar is genuinely random or biased, similar to how it's not easy to determine whether interrogator influences were deliberately included in data collection process. When research analysis and primary data are utilized, one can be certain of the methods employed to gather data, select samples, and determine whether research questions and other metrics are relevant to the study's theoretical framework (Wickham, 2019). However, this may not constantly be the case, when it comes to secondary data analyses. Any inferences made from data in samples with bias or sampling error cannot be applied to the entire population.

3.2.3 Implementation of the Desktop Approach in this Study

This research was conducted as desktop research approach, which is frequently referred to as secondary research or literature study, that entails consulting and analysing already existing information from various sources such as academic journals, books, etc. (Goundar, 2012: 38). Specifically, secondary data was utilized to build upon prior knowledge and expertise to gain insights and conclusions without the need to gather new information, which eventually save time, since the available data is compiled and summarized to improve the overall efficacy of the study. The internet, which has access to academic journals, articles, government reports, and books, was used explicitly in this study. Furthermore, since doctor migration from South Africa is a current issue, online databases like SABC News reports was used to provide meaningful context and insights.

Before gathering any data, I verified that available sources, including books, academic articles, PDFs, and news reports, can be utilized to substantiate the arguments made. After that, I reviewed each source's pertinent material and summarize it, ensuring that it aligns with the research question. The main research engines utilized in this study included Google Scholar, ResearchGate, PubMed, Academia.edu, Journal Storage (JSTOR), and Sage Journals which were employed to locate relevant books, articles, and abstracts, and Google to access PDFs materials. After gathering the information, I thoroughly examine, comprehend, and confirm it. Following a careful review, I organized the information into separate sections. Then I categorized the information according to themes by highlighting any subthemes in each section. With this methodical approach, I present a thorough and organized analysis of the data.

3.3 Research Design

Research design serves as a foundation for the entire study, lowers expenses, and exerts considerable control over the consistency of the data obtained. Planning ahead can help one to receive the greatest information while minimizing expenses and effort. Research design is employed to gather pertinent data and methods that help various research operations scale smoothly, allowing for the production of the most information.

3.3.1 Different Types of Research Design

A study's research design acts as a guide that describes the steps and techniques for gathering and evaluating data. According to Pawar (2020:52-57), selecting the right research design is crucial for

ensuring the reliability and validity of study findings. The primary categories of research designs commonly employed in various fields are outlined in the following section.

Descriptive and Exploratory Design

A descriptive research design does not require internal validity to handle observable phenomena and population features. It offers frequency counts, averages, and statistical data. Benefits include overviews for identifying study variables and comprehensive data gathering for future use. However, it is mostly dependent on measurement equipment and is unable to refute theories (Pawar, 2020:52). According to Zukauskas et al. (2018:11), exploratory research design facilitates the formulation of questions and hypotheses while collecting background data, which is helpful in situations where prior research is inadequate. It makes topics more understandable, but it lacks a systematic approach and may lead to generalized findings.

Experimental and Longitudinal Design

This approach to experimental design emphasizes causal linkages and requires careful control of experimental variables. Even if it produces elevated levels of evidence, some techniques may be limited by ethical and technical constraints, which could make it expensive (Garton et al., 2020:3). According to Caruana et al. (2015:1-4), longitudinal research design tracks behavioural changes and establishes causal linkages by repeatedly observing a certain group over time. Detailed data collection is one of its benefits, but the presumption that patterns will persist may be a disadvantage.

Cross-Sectional and Action Research Design

In a cross-sectional research design, data are gathered from a sample population at a single point in time. Large topic groups can be included; however, they struggle to prove causality and historical correlations (Capili, 2021:59). According to Cohen et al. (2017:1), this cyclical approach of action research design supports educational and community-focused initiatives by emphasizing problem-solving and experiential learning. Potential researcher bias and the intricacy of record-keeping are obstacles.

Cohort Research Design and Casual Design

A Cohort research design involves studying a short population over time, reflecting statistical rates in open- and closed-cohort studies. It emphasizes ethical considerations and provides insights into effects over time, but lacks randomization and requires extended periods for credible results (Pawar, 2020:5). A causal research design explores cause-and-effect relationships, framed as "If A, then B." It includes principles like non-superiorness and appropriate time order, but faces challenges in establishing definitive causality (Pawar, 2020:56). However, the exploratory research design was deemed as the most suitable approach based on the goals and aspects of this investigation.

3.3.2 An Understanding of an Exploratory Research Design

According to Churchill and Iacobucci (2005) and Aaker et al. (2007), as cited by Swaraj (2019:666), Exploratory research, sometimes referred to as qualitative research, is used to generate initial ideas and insights and to provide direction for any further research that may be necessary. An exploratory research study is important when a researcher wants to identify issues, provide a more explicit definition of the issue, and identify any objectives or information requirements that need to be addressed through further research (Kinneer and Taylor, 1996 cited by Swaraj, 2019). According to Aaker et al. (2007), as cited by Swaraj (2019), exploratory research is characterized as qualitative, highly adaptable, and unstructured. When a study is conducted with the goal of either examining the viability of completing a particular research study or analysing an area where little is known, it is referred to as exploratory research.

One of the characteristics of exploratory research is its adaptability. Exploratory research is the first phase used by researchers when a problem is wide and not precisely defined. Exploratory research is an effective method for comprehending current circumstances, looking for new viewpoints, asking questions, and evaluating phenomena from an alternative perspective (Swaraj, 2019:667-668). The purpose of exploratory research is to formulate problems, elucidate concepts, collect explanations, acquire insight, and conduct a study more accurately. Exploratory research may produce hypotheses, but its goal is not to test them. Removing notions that aren't feasible and developing theories. Exploratory studies are typically conducted using surveys, focus groups, literature reviews, and case studies.

According to Daniel Katz (1953), as cited by Swaraj (2019), exploratory research can be divided into two main stages: the first involves identifying important factors in a particular scenario, and the second involves determining how these variables relate to one another. Katz (1953) emphasises the importance of precisely defining the field of study and cautions against assuming that a single study can account for all variations in complex social phenomena. Instead of aiming to cover the entire topic in a single study endeavour, he supports a focused examination of a core group of variables. Theodor, (1973) noted that exploratory research is necessary because it may provide deeper insights than confirmatory research, especially when dialectical thinking is employed. According to Adorno (1973), cited by Swaraj (2019), dialectics enables constructive progress through negation. Exploratory research becomes crucial for gaining initial insight into issues, thereby facilitating the formation of more precise investigative frameworks. This is because the social sciences are relatively new, and existing theories often lack adequate guidance for empirical research, being either too broad or too narrow. Formative research is another name for this kind of study.

Additionally, Selltiz and Associates (1959), cited by Swaraj (2019), describe a three-step procedure for carrying out exploratory research, which consists of:

- A literature review, which comprises reading pertinent books, papers, and reports to find hints and leads that might help develop research, create viable hypotheses, and discover key factors.
- An experience survey that includes casual interviews with people who are familiar with the subject of the study. These interview subjects must be chosen to reflect a range of experience levels. For example, it would be helpful to consult with rural studies specialists, development administrators, social workers, financial institutions, and community leaders when examining rural development.
- An examination of “insight-stimulating” cases, which enables deeper comprehension by looking at certain instances that spark fresh concepts and study-related thoughts.

Together, these stages contribute to constructing a well-rounded exploratory framework, laying the groundwork for more detailed empirical investigation.

According to Singh (2021:1), exploratory research is a useful strategy for researchers with little background or comprehension of a specific area of study. Instead of starting these studies from a

place of insufficient knowledge, this kind of research acts as a prelude that establishes the groundwork for more thorough and definitive investigations. Its main goal is to improve the researcher's understanding by defining and clarifying the essence of an issue or idea. Exploratory research might take the form of a single study or a collection of unofficial investigations intended to give context. It requires ingenuity and adaptability in selecting information sources, enabling researchers to explore a range of low-cost options to obtain pertinent knowledge on the issue at hand. When constructing exploratory investigations, methodological rigor must be maintained despite the necessary flexibility (Singh, 2021:2). Exploratory research has many applications, determining the nature of an issue and analysing circumstances are two of its main uses. Žukauskas et al. (2018:11) emphasize that exploratory research helps make sure that future research efforts are targeted and successful by clarifying the aspects of a problem. Furthermore, it aids in establishing research goals and can offer guidance on lesser-known subjects, enabling a more knowledgeable diagnosis. Additionally, when several opportunities arise but thorough investigations are not possible due to financial limitations, exploratory research can be crucial in evaluating potential options. By examining market data and opportunities, researchers can identify the most promising solutions and efficiently direct decision-making processes (Zukauskas, 2018:120). Exploratory research provides evaluative information that can inform whether concepts or products are viable for further examination, but it does not replace conclusive research. According to Singh (2021), the necessity for exploratory research is often driven primarily by concept testing, which encompasses a range of research techniques used to refine the definitions and connotations of the issues under investigation.

3.3.3 Implementation of an Exploratory Research Design in this Study

This study employs an exploratory research design to investigate the ethical implications of doctor migration on rural healthcare in South Africa, with a particular focus on underserved communities. The flexible and adaptive nature of this design allows for an evolving approach, enabling the research to refine itself as new insights emerge throughout the process (Swedberg, 2020: 2). The primary goal is to contribute to the broader understanding of the impact of doctor migration on rural healthcare, specifically within the context of South African healthcare and its ethical dimensions. The primary objective of this exploratory research approach is to gain an in-depth understanding of the experiences, perceptions, and ethical concerns of underserved communities

affected by doctor migration, while identifying substantial relationships, themes, and patterns that contribute to this complex issue. Some of the guiding exploratory questions for this research include: What are the ethical consequences of doctor migration for rural healthcare in South Africa? How do underserved communities perceive the impact of doctor migration on their healthcare access and outcomes? These questions serve as a foundation for data collection and analysis, assisting in the discovery of insightful information that could guide the development of solutions to the ethical challenges and healthcare disparities caused by doctor migration in rural South Africa.

3.4 An Understanding of the DECA Approach

The DECA approach is a variation of the See-Judge-Act method for moral decision-making (Ally et al. 2011:272), which encourages students to reflect on past choices and actions, as well as apply ethical theories to real-world business problems (Kretzschmar, Bentley & Van Niekerk 2009:83–96). The DECA steps are outlined below.

Describe

Describing the ethical dilemma or problem is the first stage. (The distinctions between a specific moral difficulty and a general moral problem, as well as the nuanced connotations of the terms "morality" and "ethics," are not covered in detail.) It is advised that the students approach the issue as impartially as possible. According to Kretzschmar and Bentley (2013:5), the first steps in determining the nature of the dilemma are taken by the student by standing back, outlining the situation, and listing the various possibilities. As a result, they may have started to formulate an understanding of the most suitable course of action.

Evaluate

The student's second phase is to evaluate the moral dilemma and the potential solutions that were discussed in the previous stage. A student achieves this by applying the three distinct ethical standards: deontology, teleology, and virtue ethics to the selected moral problem. According to Kretzschmar and Bentley (2013:5), the purpose of all three conventional methods for making ethical decisions is to expose students to significant insights and promote critical thinking about a purely consequentialist and pragmatic "win-win" strategy. When applying the deontological method, the primary concern is whether the proposed solution is correct in light of legislation, rules, ethical standards, and principles. For instance, a student would be guided by corporate codes

of conduct, ethical tendering procedures, and civil laws pertaining to favouritism if a relative submits an offer for a particular project to be carried out by an organisation where the student works. The significance of ethical standards and values is emphasized on a deeper level.

Using teleological criteria, the student further assesses the issue. How can I benefit is not the only important question here, but rather: Are the proposed solution, its objectives, and its implications ethically acceptable? based on the aforementioned example, the student can conclude that while a relative may profit financially in the short term from abusing tenders, breaking the rules governing tenders, as outlined in company and civil legislations, exposes the relatives to disciplinary action, which may include being fired and/or facing fraud charges. This is predicated on the existence and application of appropriate accountability protocols. Therefore, the result of this course of action will not be beneficial in a moral way. Additionally, tender fraud has very detrimental long-term implications on the communities and societies in which it occurs, both ethically and practically. In summary, unethical behaviour does not advance a stable society or the common good.

Kretzschmar and Bentley (2013) further posit that students evaluate moral dilemmas and suggest fixes using virtue ethics. The essential question is: would a decent person take this action? Given that our perception of personal virtue is often arbitrary, this is arguably the most challenging step in the evaluation process. Additional factors are influenced by culture, religious affiliation, upbringing, and the individual adoption of norms and principles. Among the essential qualities that must be ingrained in one's personality for this third type of ethical standards to be used in practice are integrity, justice, and responsibility. Since virtue ethics can help learners make moral decisions, it would be wise for them to be aware of its significance. If moral capacity (personal behaviour and ethical leadership) is to be created, then character development and the application of moral bravery are crucial.

Consult

The third stage of the decision-making process is consultation. "No one person has all the answers, so this step is crucial" (Ally et al. 2010:272). It is always preferable to get an alternative viewpoint, even if a student believes they can make a moral choice regarding the situation they are in. This could be in the form of guidance from a suitable friend, colleague, or supervisor. Meditation, prayer, and seeking advice from spiritual authorities are pertinent if the individual holds certain religious beliefs. Speaking with another individual about the possibilities available can help a

student ensure that they have not overlooked anything in the process of making moral decisions and that their conclusions are not unduly influenced by self-interest or personal prejudices. Through the consultation process, students will ensure that they have considered the issue and are prepared to have people with different viewpoints confirm their choice. Therefore, the crucial component of collective wisdom is included in this stage (Kretzschmar and Bentley, 2013:6).

Act

Following the consultation process, the student is advised to implement their decision. This constitutes the final step, which is referred to as the act. The student is now prepared to approach the matter confidently if they wish to behave in a morally justifiable manner.

3.5 Implementation of the DECA Method in this Study

Another research method used in this study is DECA, which, according to Kretzschmar and Bentley (2013:2), stands for Describe, Evaluate, Consult, and Act. Under ‘Describe,’ I define the problem of doctor migration and its ethical implications for rural healthcare in South Africa, identifying the interests at stake, including migrating doctors, underserved rural communities, healthcare organizations, patients, and the government. I also explored practical solutions to the problem. Furthermore, when evaluating, I judge whether the ethical implications of doctors’ migration, such as limited healthcare access for rural communities, are right or wrong using consequentialism ethical theory. Then I consult and gather my findings from other sources to justify sources already written about. Then, at last, I act by deciding what needs to be done and give recommendations.

3.6 Conclusion

This research involved the use of pre-existing literature, reports, and data sources to obtain information on the ethical dilemma of doctor migration in South Africa. Instead of collecting primary data through surveys, interviews, or experiments, this study relied on previously available resources to address the research questions. Drawing on existing knowledge and data, this study aims to provide a comprehensive overview of the issue of doctor migration in South Africa and to inform the development of initiatives to address this complex problem. The next chapter present the ethical theory that guides this project and explain how and why it advances the field of study.

CHAPTER 4

THEORETICAL FRAMEWORK

4.1 Introduction

The method and methodology were discussed in previous chapters. This chapter examines consequentialism, the ethical theory applied in this investigation, and its relevance to the subject of study. This approach evaluates actions based on their outcomes, providing a useful perspective on the complex issue of doctor migration from South Africa. Consequentialism presents the opportunity to examine in detail how the migration of doctors affects the delivery of healthcare in rural South Africa by focusing on what arises as a result of actions rather than just following rules or having particular features. This chapter will cover the main ideas of consequentialism, including its strengths and weaknesses, as well as modern techniques for addressing its critics. It will also explore how this ethical theory has been used to guide investigations into real-world issues, such as doctors' migration, and how it has contributed to the formulation of conclusions.

4.2 The Ethical Theory of Consequentialism

A theoretical framework known as consequentialism holds that one's actions' results define their morality (Elliott and June, 2018: 159). Philosophers Jeremy Bentham and John Stuart Mill first proposed the idea, arguing that actions should be judged based on the utility or pleasure they bring (Elliott and June, 2018). Consequentialism is a component of teleological ethics, which maintains that an action's moral value is determined by its tendency to produce intrinsic value (Portmore, 2020: 25). According to this theory, an action is justified if it produces a more equitable distribution of good and evil than any practical alternative. Consequentialism is distinct from virtue ethics, which prioritizes the agent's character, and deontological ethics, which emphasizes laws and moral obligation (Elliott and June 2018:159). While some contend that human rights can only be justified by their outcomes, others contend that consequentialist and deontological views are not mutually exclusive. In actuality, the same behaviour is contractually required by Kantian deontology and rule consequentialism (Elliott and June 2018: 162).

According to Roby (2018: 24), consequentialism focuses on the moral value of the action itself, rather than the moral value of the agent (the person performing the action), and the behavior is categorized as either right or wrong. The two main types of consequentialism are hedonistic and pluralistic. Hedonistic consequentialism, which is simpler, stresses both pleasure and pain and only values pleasure. This stance has been contested by some, who contend that human life is no more valuable than animal life. Some are against it, arguing that it minimizes the significance of solid interpersonal bonds, achievement, and superficial forms of freedom. Pluralistic consequentialism, on the other hand, is more nuanced and takes a more superficial view of the importance of freedom, achievement, and friendship. Roby (2018:24) provides an example of an “experience machine,” a completely fictional device that gives users the impression of being with friends, earning prizes, or experiencing more pleasure than suffering. Nevertheless, this illustration demonstrates that hedonism is limited because there are other important aspects of life besides pleasure and suffering (Roby, 2018: 25).

Savulescu and Wilkinson (2019:2) define consequentialism as a theory of proper behaviour that encourages actors to count every action—including doing nothing at all—and assign a value to the possible outcomes of each action. By aggregating the value of each action's outcomes and multiplying it by the probability of occurrence, the expected value of each action is determined. The action with the highest predicted value should be chosen by the agent. The two main pillars of consequentialism are the probability of circumstances, which ought to be determined by the best available data, and the value of the results, which is an ethical evaluation of the good. There are other forms of consequentialism, such as welfare consequentialism, which maintains that welfare or well-being is the only thing that matters or is desirable (Savulescu and Wilkinson, 2019: 3). A kind of welfare consequentialism known as utility consequentialism instructs the agent to act in a way that maximizes utility, which is defined as happiness or preference satisfaction. Hedonistic utilitarianism and preference utilitarianism are examples of consequentialist perspectives (Savulescu and Wilkinson, 2019). The traditional objective of medicine has been to advance health, but it has evolved to include well-being to advance the best interests of the patient. Welfare consequentialism and the "best interests" concept of medicine are closely related. In terms of public health or resource allocation, medicine is openly welfare consequentialist, aiming to maximize community well-being.

Saaida and Debo (2024:2) specify that consequentialism is characterized by several fundamental ideas that influence its ethical approach. As a teleological theory, it places more emphasis on the results or objectives of activities than on their motivations or strategies. An action's moral value is established by its outcomes rather than by the actor's intentions. Maximizing goodness, or fostering as much positive value as possible, such as happiness, joy, or general well-being, is one of consequentialism's main goals. Another crucial characteristic is impartiality, which means that the interests and welfare of every person impacted by a decision are considered equally and without bias. Consequentialism frequently employs a moral calculus to determine the best course of action by assessing the possible outcomes of various options (Saaida and Debo, 2024:3). This involves aggregating consequences, where the sum of an action's good and bad outcomes is used to calculate its overall ethical value. Consequentialism provides a systematic framework for evaluating activities based on their effects through these principles.

Hurley (2020: 423) makes an argument between two important strands of consequentialist theory: local consequentialism and global consequentialism. The main area of difference between the two systems is the extent to which moral judgment is applied. According to global consequentialism, the only way to judge the morality of any given action, purpose, law, institution, or personal quality is to look at its effects. According to Hurley (2020: 440), this type of consequentialism aims to establish a unified ethical framework in which each morally significant item is evaluated based on its contribution to the greater good or harm. Proponents argue that such a comprehensive system of evaluation enhances moral impartiality and consistency, enabling ethics to transcend individual acts to encompass broader moral patterns. For example, assessing a rule of conduct, a policy, or a virtue like honesty would all entail determining if these have better overall effects than the alternatives that are accessible. By doing this, global consequentialism upholds the fundamental notion that morality is outcome-dependent rather than limited to immediate or discrete choices.

Local consequentialism, on the other hand, emphasizes what an agent should do in a particular situation based on anticipated outcomes and concentrates exclusively on the moral assessment of individual actions. Local consequentialism allows for the inclusion of agent-relative elements, including societal roles, personal responsibilities, and context-specific norms that may affect moral reasoning, as opposed to applying the consequentialist standard uniformly (Hurley, 2020: 450). This paradigm is more in line with pragmatic moral intuitions, such as the legitimacy of prioritizing

family members or honouring commitments even when doing so may have negative effects on wider outcomes. Proponents contend that by eschewing the excessively strict and occasionally contradictory judgments seen in global versions, local consequentialism provides a more flexible and realistic ethical framework. Critics counter that local techniques weaken the consequentialist commitment to maximizing the common good by running the risk of being inconsistent and veering toward deontological reasoning. The main difference between the two types is the extent that they adhere to the fundamental consequentialist tenet that results are what really count (Hurley, 2020: 451).

Examining how results are compared to the agent's knowledge and intent at the time of the action is another crucial aspect of consequentialist theory. Regardless of the agent's intentions, traditional versions of consequentialism evaluate the morality of actions solely in light of the outcomes they cause. However, when unforeseen repercussions arise, this can result in conclusions that are paradoxical. Classical consequentialism would still consider it ethically wrong, for instance, if someone contributes to a charity in the belief that it will help the underprivileged, but the organization instead finances illegal operations like arms trafficking. Mohn (2022:1) claims that versions like reasonable consequentialism and expectable consequentialism have developed to solve these ethical issues. Contrary to expected consequentialism, a course of action is ethically correct if it is anticipated to result in favourable results given the information at the moment. Given their reasonable expectation of assisting others, the donor would have done decently in this instance. The proper course of action is the one with the best reasonably predicted outcomes, according to reasonable consequentialism, which also emphasizes making a well-informed and logical decision before acting. These sophisticated methods demonstrate how consequentialist reasoning has evolved to take moral risk and information gaps into consideration (Mohn, 2022:2).

A normative ethical paradigm known as consequentialism theory judges the morality of actions by their results rather than their motivations. It holds that an action's ethical worth is determined by its effects, whether positive or negative. According to Nwadiugwu (2015:2), behaviour is deemed ethically correct if it results in a favourable outcome. Conversely, this consequence-focused approach, deontological ethics, evaluates activities based on their compliance with moral obligations or standards, independent of the results. The fundamental tenet of consequentialism is that when an action has negative consequences, good intentions alone cannot be used to defend it.

Nwadiugwu (2015:3) emphasizes that utilitarianism, ethical egoism, and ethical altruism are the three primary schools of consequentialist thought. Ethical egoism places self-interest at the centre of moral evaluation, arguing that behaviour is ethically justified if it benefits the person performing it. Ethical altruism, on the other hand, maintains that a deed is only ethically justified if it helps others, not the actor. The most popular kind of consequentialism, utilitarianism, holds that a course of action is ethically correct if it results in the greatest good for the greatest number of people, including the one performing the action. All these subtypes believe that consequences are the best indicator of moral worth, even though their priorities vary (Nwadiugwu, 2015:5).

According to Horta et al. (2022:368), the principle of outcome-dependence, which maintains that the morality of deeds, laws, or personal qualities is completely reliant on the results they produce, is the most basic definition of consequentialism; any theory is considered necessary to meet this requirement to be categorized as consequentialist. The scholars emphasize that there is a great deal of disagreement on consequentialism, particularly among scholars who focus on moral theory. Value-dependence, maximization, and agent-neutrality are three further criteria that are frequently linked to consequentialist theories in addition to outcome-dependence. According to value-dependence, an action's morality is determined by how good or bad its results are. The concept of maximization holds that actions are only ethically justified if they maximize particular values, like happiness or welfare. Under the principle of agent-neutrality, moral judgments are supposed to be objective and apply uniformly to every agent, regardless of individual perspectives. Horta et al. (2022:369) contend that different assumptions about which of these criteria are necessary often lead to disputes over whether a specific viewpoint counts as consequentialist. For example, a minimum definition that simply requires outcome-dependence might still classify a theory that prioritizes equality over overall welfare as consequentialist, while definitions that additionally require value-dependence or maximization would not. Their findings reveal that many philosophical disagreements surrounding consequentialism are not about substantive ethical positions but about different understandings of the term itself.

4.3 Arguments for the Ethical Theory of Consequentialism

4.3.1 Consequentialism Encourages Practical and Flexible Ethical Decision Making

Cummiskey (2020) contends that consequentialism is a beneficial ethical theory since it stresses improving society well-being by judging an action's morality based on its effects. He emphasizes how this approach promotes reasoning and adaptability in decision-making, enabling decision-makers to consider a wider range of factors and possible outcomes. This flexibility may be useful in situations that are unclear or complicated, where strict regulations might not offer clear guidance. According to Portmore (2020), consequentialism encourages a broader moral perspective by considering the well-being of everyone affected by a decision. Contrary to other ethical theories that focus more emphasis on intentions or character attributes, consequentialism emphasizes the actual effects of our actions as the fundamental measure of good behaviour. This practical and intentional approach to morality is more appealing than theories that focus on personal motivations or abstract principles (Cummiskey, 2020:1). Other scholars like Roby (2018: 26) emphasize that consequentialism is a theory that emphasizes optimizing overall pleasure or well-being by defining specific and impartial standards for assessing activities. It provides useful direction for making realistic judgments by assessing possible outcomes and focusing on those with the biggest beneficial impact. Consequentialism encourages impartiality and results in justice by considering everyone's happiness or suffering equally. It allows for adaptable ethical decision-making in a variety of circumstances since it is outcome oriented. It is a helpful guidance that enables individuals and decision-makers to focus on the outcomes of their decisions to maximize their beneficial effects.

4.3.2 Morally Impartial and Philosophically Superior Ethical Theory

Another scholar like, Bergström (1971:3), emphasizes that consequentialism is a powerful moral philosophy that emphasizes the importance of treating others how one would like to be treated. It condemns all forms of racism, ethnocentrism, and egoism and is unbiased and temporally impartial. Consequentialism resolves moral disputes because it provides a general solution that, although it might be challenging to apply in practical situations, still exists. Consequentialism is a bold theory that both contradicts and explains the relative success of other theories due to its simplicity and broad applicability. Despite their incompatibility with consequentialism, moral standards can be motivated by consequentialism if they are viewed as useful approximations for practical

application. Furthermore, compared to many other perspectives, such as existentialist, Christian ethics, Kantianism, natural right theories, and so on, consequentialism is more comprehensive. Theoretically, consequentialism has contributed to the development of moral philosophy since Sidgwick's time by motivating philosophers to clarify details and respond to difficult criticisms. John Rawls's theory has had a major influence on the numerous thought-provoking issues and professional debate that have resulted from it. As a result, consequentialism is the best theory developed to date and appears to be superior to the other theories of rightness that are currently in use. Despite its flaws, it is justifiable to maintain a theory if it is the best available explanation and effectively addresses significant issues, applicable in both science and ethics (Bergström, 1971: 4).

4.3.3 Logical Consistency and Moral Clarity

Building on Bergström's approval of consequentialism as a solid and comprehensive ethical theory, current scholars such as Sinnott-Armstrong (2023:2) provide additional justifications for its philosophical viability. The universal moral sense that we should make the world a better place when we can, is one of the main arguments in favour of consequentialism. The central tenet of consequentialism, that morality is determined completely by results, becomes credible if no strong arguments show why, it is necessary to include restraints other than consequences (Sinnott-Armstrong, 2023:4). Rebutting objections does not constitute a good defence, according to critics, but consequentialists also provide several valuable points. For example, they use an elimination technique in which they critically assess other theories like contractualism, virtue ethics, or Kantianism and stick to consequentialism when none of them provide adequate answers. Furthermore, compared to its competitors, consequentialism provides a superior logical account for a large number of moral intuitions. Without using arbitrary cutoffs, deontologists frequently find it difficult to defend where to draw moral lines in difficult situations like killing one to rescue five versus, one to save a million. Nonetheless, consequentialists can consistently refer to the balance of advantages and disadvantages. This explanatory benefit also applies to obligations where consequentialist reasoning about projected harm offers clarity, such as when choosing between competing commitments (Sinnott-Armstrong, 2023:5). The ability of consequentialism to explain a wider range of moral judgments with internal coherence shows a theoretical strength that other moral frameworks lack, even if it occasionally produces paradoxical results.

Consequentialism has been defended by logical arguments based on abstract moral intuitions in addition to its capacity for explanation. According to Sidgwick's famous argument (1907), cited by Sinnott-Armstrong (2023), the principle of utility can be derived from self-evident principles like universalizability (if an act ought to be done, then every other act that resembles it in all relevant respects also ought to be done), rationality (one ought to aim at the good generally rather than at any particular part of the good), and equality (that the good of each individual holds the same moral weight). If these fundamental ideas are recognized, a utilitarian framework follows naturally. On the other hand, some consequentialists express doubt regarding moral intuitions and instead look for explanations that go beyond conventional moral reasoning. Mill (1861), cited by Sinnott-Armstrong (2023) makes an effort to build the utility principle on factual observations of human preferences. Gewirth (1978) relies on metaphysical assertions regarding agency, while Hare (1963&1981) bases his utilitarianism on the logic of moral language and rationality (Sinnott-Armstrong, 2023). Another strong argument originates from contractarian philosophy. Harsanyi (1977, 1978), cited by Sinnott-Armstrong (2023) posits that unbiased, reasonable people who are not aware of their particular social status would support a kind of consequentialism. Broome (1991), cited by Sinnott-Armstrong (2023) continues this line of reasoning. All these arguments support consequentialism's intellectual legitimacy, despite the fact that they are still up for debate, and no one provides definitive evidence. Consequentialism remains a prominent and valid moral paradigm in modern ethics, even in the absence of clear justification and compelling evidence to the contrary.

4.3.5 Public Policy and Collective Moral Reasoning

According to Schmidt (2024:430), another defence of consequentialism is that it applies to public policy and collective moral reasoning, where conflicting interests need to be balanced. Consequentialism provides a framework that allows civilizations to think collectively about fairness, resource distribution, and institutional goals, in contrast to moral theories that place an emphasis on individual virtue or obligation in isolation. It is especially well-suited to pluralistic, democratic environments where choices frequently affect sizable and diverse populations because of its capacity to consider the interests of all parties involved. In this way, consequentialism is inherently consistent with the principles of openness, equity, and rationality in public discourse. For example, consequentialist ideas assist policymakers in focusing on positive outcomes and damage reduction

in fields such as criminal justice reform, pandemic response, and climate ethics, providing morally sound explanations for contentious trade-offs (Schmidt, 2024). Moreover, consequentialism promotes long-term ethical planning over strict commitment to precedent or sentiment by requiring individuals to consider the predictable effects of laws, regulations, and systemic structures. This strengthens its standing as a strong framework for public moral debate as well as a personal ethical theory, particularly in a time when juggling local and global problems is necessary (Schmidt, 2024:432).

4.3.6 Love

According to Maguire (2017:693), the profound connection of consequentialism with the moral ideal of love, which is acknowledged in many cultural and religious traditions, is another strong argument in favour of the theory. The well-known moral precept to “love others as we love ourselves” is sometimes interpreted as articulating a universal moral concern that goes beyond simple spiritual sentiment or emotional attachment to include proactive caring by advancing the welfare of others. Therefore, consequentialism provides a logical explanation of what it means to love effectively and impartially: to do good to others, to limit damage, and, where feasible, to maximize overall benefit. This view of love as outcome-driven and action-oriented is consistent with consequentialism's dedication to improving well-being for everyone, not just those we know directly (Maguire, 2017:694). If morality entails both sound judgment and a sincere concern for others, then consequentialism's tenet that each person's enjoyment or suffering should be given equal weight demonstrates a strong ethical commitment to caring for everyone. Proponents of consequentialism contend that true moral love is rooted in the pursuit of the greatest good rather than in partiality, confirming consequentialism as a potent expression of what it means to love humanity in moral practice, despite critics' concerns that such impartiality could jeopardize the value of intimate personal relationships.

4.4 Arguments Against the Ethical Theory of Consequentialism

4.4.1 Limitations of Outcome-Based Ethics

The ethical theoretical framework known as consequentialism which bases all decisions on the results of an action, is criticized by several arguments. One major concern is the difficulty of predicting long-term consequences, which complicates the moral choice. According to this idea,

immoral actions may be justified if they produce the intended effect since, they violate moral norms and standards (Mukerji, 2013: 655). Moral relativism, which bases morality on circumstances rather than universal principles, is encouraged by this contempt for moral absolutes. It prioritizes satisfaction and pleasure over other significant aspects of the human experience, such as autonomy, justice, and dignity (Mukerji, 2013: 656). Abuse and exploitation are more likely when people's rights and dignity are violated (Grisez, 1978: 24). Consequentialism discourages moral intuition, empathy, and compassion in favour of a utilitarian, heartless understanding of morality (Grisez, 1978: 22). It simply focuses on results, neglecting the moral value of intent and motivation. A lack of accountability and personal responsibility might result from neglecting agent morality (Grisez, 1978: 23). Furthermore, the theory excludes moral restrictions like the prohibition on harming innocent people, which has unanticipated consequences that are against morality and common sense (Mukerji, 2013: 656). Additionally, consequentialism theory emphasizes the usefulness of actions, which usually results in ethical issues. It is criticized for being unfeasible since it necessitates assessing and contrasting the potential results of each action. Utilizing the moral dilemma of sacrificing one individual to save five others, the argument presents a significant critique of consequentialist ethical theories. These theories are often criticized for potentially undermining justice and disregarding individual rights in their pursuit of maximizing overall good. The example underscores the tensions between utilitarian principles and the moral imperative to respect individual dignity and justice (Mukerji, 2013). Additionally, the theory lacks intuition since it frequently disregards the actor's moral character or the reasons behind their actions, which can lead to a lack of focus on virtue growth. Furthermore, compared to methods like virtue ethics that emphasize the worth of becoming a specific kind of person, it may place more emphasis on isolated acts than the development of consistent moral character (Roby, 2018: 27).

4.4.2 Demanding

Act-consequentialism, a moral theory, is frequently rejected as a moral theory because it is thought to be excessively demanding. The two premises of the demanding objection are that consequentialism is extremely demanding and that proper morality should not be too demanding. According to Miklós and Tanyi (2024: 2), consequentialism forces agents to advance the good to the extent that doing so burdens them as much as it helps others. However, the world's current situation is far from ideal, with high rates of poverty that cannot be eliminated by the existing levels of charity

giving. Act-consequentialism demands agents to commit most of their resources to humanitarian projects, which are more likely to have positive outcomes than pursuing individual objectives and projects. Most would agree that this is not acceptable since people should not be forced to make such sacrifices to meet moral expectations. This is the objection's second pillar, which places a restriction on acceptable moral theories by mandating that they refrain from making unreasonable demands. If they do not, we can conclude that these ideas cannot serve as our moral compass (Miklós and Tanyi, 2024: 4).

4.4.3 Modern Responses and Persistent Challenges

However, Saaida and Debo (2024: 8) contend that modern consequentialist approaches provide new perspectives and understandings into ethical theory, resolving some of the issues and constraints that have been raised. Rule consequentialism, two-level consequentialism, and pluralism consequentialism are three contemporary perspectives on consequentialism. Rule consequentialism establishes a balance between the benefits of act consequentialism and deontological ethics by highlighting the effects of following particular rules rather than the results of individual actions. It emphasizes that some policies that try to improve general happiness or well-being and are based on the utility principle typically provide better outcomes than others. One advantage of rule consequentialism is that it provides a more rational and manageable framework for decision-making. People can rely on pre-established rules that are intended to maximize overall well-being instead of having to calculate the repercussions of each individual action. This approach also addresses some of the criticisms of act consequentialism, such as the problem of demandingness and the lack of direction in ethical decision-making. However, some moral principles or rights may be violated for the sake of the greater good (Saaida and Debo, 2024:8).

Two-level consequentialism is another modern method of consequentialism. There are two levels of moral reasoning in this one: critical and intuitive. People make fast judgments about what is right and evil at the intuitive level based on their moral intuitions and emotions. In contrast, these intuitions are vulnerable to biases and heuristics and are not always correct. When an individual reaches the critical level, they evaluate and improve their moral intuitions through critical thinking (Saaida and Debo, 2024). Actions and their guiding concepts need to be taken into consideration at this level. By integrating both levels of moral thought, two-level consequentialism seeks to strike a balance between the logic of critical review and the practicality of intuitive judgments. It

acknowledges that our instincts can occasionally deceive us, but it also recognizes the value of quick decisions and moral judgments in day-to-day circumstances (Saaïda and Debo 2024: 9). Pluralistic consequentialism is another contemporary approach that seeks to overcome some of the shortcomings of traditional consequentialism. It emphasizes that rather than focusing exclusively on enhancing happiness or overall well-being, various intrinsic goods or values should be considered when making ethical decisions. Consequentialism is more suited to a variety of circumstances and ethical dilemmas when viewed from a pluralistic standpoint.

4.4.4 Challenge in Measuring and Aggregating Consequences

Card and Smith (2020:4) state that establishing a precise and widely accepted method for assessing results is one of consequentialism's most basic challenges. How to decide which consequences are superior to others is still a very difficult subject, even if one knows exactly how various choices will affect the future. The most popular framework in consequentialist theory, classical utilitarianism, holds that the optimal course of action is the one that maximizes the sum of all well-being. This strategy, however, has a number of significant obstacles. First, assessing personal well-being is subjective by nature and does not have a valid way to compare people fairly (Binmore, 2009 as cited by Card and Smith, 2020). Second, it is computationally intensive to determine the expected value of hypothetical events, frequently necessitating fine-grained data that may not be practically available. Third, interpreting widely disparate distributions of well-being as morally similar ignores problems like inequality when welfare is combined into a single overall value. Apart from that, the impartiality principle, which is frequently at the heart of consequentialist thought, has come under criticism for being implicitly paternalistic and neglecting historical and social power disparities (Smart and Williams, 1973; Kittay, 2009). Card and Smith (2020: 34) contend that the idea that consequentialist frameworks provide an objective foundation for moral decision-making is undermined by the fact that value judgments within these frameworks are intrinsically political and contentious.

4.4.5 The Issue on Temporal Discounting and Future Generations

Furthermore, another major obstacle to consequentialism is the question of temporal discounting, or how much moral weight should be given to the welfare of future generations in comparison to those who are living today. Although discounting future outcomes because of uncertainty and time preferences is typical in economics, there is no obvious ethical basis for doing so when it comes

to moral value (Cowen, 2006; Parfit, 1992 cited by Card and Smith, 2020: 4). According to philosophers like Singer (2013), denying future welfare unfairly diminishes the significance of existing lives and suggests that future lives should be treated with the same moral weight as present lives, and avoiding temporal discounting is challenging in practice. However, the longer the temporal horizon, the less accurate it is to forecast the long-term effects of decisions. Even with full causal knowledge, the accuracy of any projections is severely limited by the chaotic and complex character of the universe and the exponential development in the number of potential future scenarios (Cowen, 2006 cited by Card and Smith, 2020). This leads to a contradiction in consequentialism: while the theory calls for an objective evaluation of results over time, real-world limitations constrain decision-makers to neglect future consequences, which may result in a disregard of future interests. This moral conflict also emphasizes a crucial ethical obligation to consider the well-being of future generations in spite of epistemic constraints, since they are unable to speak for themselves. Therefore, temporal discounting reveals a basic flaw in consequentialist ethics, diminishing its capacity to provide precise instructions on how to strike a balance between short-term and long-term moral considerations.

4.4.6 Conflict with Moral Intuition and Common Sense

According to Foot and Greene (1967; 2013), cited by Card and Smith (2020:5), the fact that consequentialism might produce moral conclusions that conflict with commonly accepted intuitions of commonsense morality is another important argument against it. The “trolley problem” and its several variations are a well-known illustration of how consequentialist thinking seems to support giving up one life to save multiple others. Such thinking frequently conflicts with moral intuitions regarding fairness, individual rights, and the acceptability of purposeful harm, even though it might be in line with maximizing well-being in the short term. Furthermore, as previously mentioned, consequentialism may seem overly demanding. The theory seems to suggest that morally motivated people are required to sacrifice the great majority of their personal resources in order to alleviate suffering elsewhere, given the magnitude of suffering that occurs around the world and the principle of declining marginal value (Smart and Williams, 1973; Driver, 2012 cited by Card and Smith, 2020:6). The reality is that consequentialism frequently calls for actions that go against our deeply held moral convictions about justice, rights, and reasonable moral expectations, even though some of these worries can be resolved by taking long-term effects into account or by

embracing more expansive conceptions of value that take personal sustainability into account (Kagan, 1991). This conflict sheds doubt on consequentialist theories' ability to provide a psychologically sound and useful basis for moral guidance in day-to-day interactions.

4.4.7 The Limits of Human Moral Thinking

A major critique of consequentialism is that it promotes a potentially cruel and immoral way of thinking (Walschots, 2021:13). According to this argument, a life that is dictated by constant consequence calculation, in which one must consider possible outcomes before acting, is incompatible with the kind of moral existence that embodies integrity, honesty, love, and personal dedication. For example, we naturally anticipate an honest response to a question posed by someone who is sincere and not motivated by a cold, utilitarian calculation about the wider ramifications of revealing the truth. Similar to this, a morally upright person keeps their word when they make commitments or take on personal projects not because doing so consistently enhances utility, but rather because integrity and commitment demand consistency (Sinnott-Armstrong, 2023:6). A lack of integrity is suggested by a persistent re-evaluation of results prior to fulfilling obligations. Furthermore, when a person chooses to spend time with a loved one based more on abstract calculations about global utility than on emotional connection or personal devotion, true attachment and relationships are compromised. According to Walschots (2021:13), such a consequentialist perspective deprives moral existence of its humane aspects and substitutes impersonal impartiality for moral identification and empathy.

Furthermore, this objection directly challenges forms of consequentialism such as reasonable and dual consequentialism, which require agents to act only based on reasonably expected consequences. However, it does not undermine all forms of consequentialism, as plain consequentialism and rule consequentialism can reject this inhuman deliberation style by demonstrating that it frequently results in worse outcomes (Budolfson, 2019:1713). Supporters of these viewpoints may contend that arriving at a “reasonable estimate” does not require conscious thought but rather may reflect deeply held moral convictions or behaviours. Some have responded by proposing double consequentialism, which makes a distinction between moral and objective rightness. The former is based on actual consequences, while the latter is based on what one reasonably believes to be right, perhaps by deferring to morally reliable sources such as religious teachings, cultural norms, or personal commitments. For instance, a person may still be morally correct if they refuse to steal

from a loved one, even if they believe that doing so will benefit others more. This is not because they assess the costs and benefits of their actions, but rather because they respect established moral standards (Budolfson, 2019:1714). Critics contend that if consequences are the true determinant of objective rightness, then appeals to moral authority are at best epistemological shortcuts and are unable to redefine what is ultimately right. This perspective aims to reconcile consequentialist theory with human moral experience.

4.5 How the Ethical Theory of Consequentialism Guides the Study

The most appropriate theory that guide this research is consequentialism, which highlights the moral significance of the repercussions of doctor migration on rural healthcare delivery in South Africa. This theory analyses the moral consequences of doctor migration, considering potential effects on patients, the rural healthcare system, and the remaining doctors. By emphasizing the outcome of doctor migration, consequentialism guides the study into its effects on healthcare access, quality of care, and health outcomes. Consequentialism allows for a more nuanced approach to this problem since it considers the particular conditions and context of doctor migration in rural South Africa. This theoretical framework is especially appropriate for tackling the intricate problems related to physician migration because it considers both the long-term effects on the rural healthcare system and ethical concerns about the impact on patients and healthcare delivery. In accordance with the study goal of influencing practice and policy, consequentialism aims to determine efficient methods to mitigate the negative consequences of doctor migration and improve rural healthcare delivery. By using consequentialism, the research can carefully assess the issues arising from doctor migration and inform strategies to address them.

4.6 Conclusion

In this chapter, the theoretical framework that underpins the study, namely consequentialism, was presented. In the discussion, the definition and principles of consequentialism were explored, emphasizing its focus on the outcomes of actions and their impact on overall well-being. Different forms and applications of consequentialism were also examined, arguments for and against consequentialism were presented, showcasing its strengths and limitations as a theoretical framework. The concept of consequentialism was applied to the context of physician migration and its implications for rural healthcare delivery in South Africa. The theoretical relevance of consequentialism

in understanding the ethical implications of physician migration was highlighted, emphasising its potential to inform strategies that mitigate the negative consequences of physician migration. The next chapter presents the analysis, where consequentialism is used as the lens for the ethical examination of doctor migration and its implications for rural healthcare delivery in South Africa. In this study, consequentialism guides the investigation of the consequences of doctor migration and potential strategies to address its impact on rural healthcare, ultimately contributing to a more effective and ethical healthcare system. The following chapter outlines and analyse some of the ethical issues that arise as a result of doctors' migration through the lens of consequentialism, an ethical theory discussed in Chapter 4.

CHAPTER 5

ETHICAL ANALYSIS

5.1 Introduction

In Chapter 4, which addresses the theoretical framework, the theory of consequentialism was elucidated and examined to evaluate its pertinence to this study. The complex ethical implications of physicians migrating from South Africa are analysed through the lens of consequentialism, which assesses the morality of actions based on their outcomes. Building on this theoretical foundation, this chapter provides a comprehensive ethical analysis of the effects of physician migration, with particular emphasis on its impact on healthcare provision in rural areas. This study aimed to critically evaluate the advantages and disadvantages of physician migration and assess their moral significance using consequentialist ethics as a framework. While this chapter acknowledges certain benefits of physician migration, such as improved financial security, remittances, and opportunities for specialisation, it primarily focuses on the adverse effects of such migration on rural communities with limited resources. These adverse effects include an increase in strikes, burnout, misinformation, deteriorating healthcare facilities, and a growing shortage of healthcare workers in the country.

5.2 Positive Outcomes of Doctor Migration

As discussed in Chapter 2:23, one of the significant drivers of this migration in South Africa is the government's limited capacity to absorb newly qualified doctors into the public health system. This structural constraint has left many trained professionals with limited employment options within the country, particularly in rural areas of the country. Consequently, a significant number of South African-trained doctors sought employment outside South Africa (abroad). After critically analysing the phenomenon from a consequentialist perspective, the decision to migrate produced some positive outcomes. These outcomes relate not only to their professional advancement but also to improvements in their personal well-being, as discussed in the following subsections.

5.2.1 Better Prospects for Earnings and Financial Stability

The desire for better financial prospects is a primary driver of medical migration. Many recently graduated medical professionals in South Africa experience underemployment, delayed placements, or low pay. Chapter 2 emphasises how budgetary restrictions and a shortage of financed positions in the public healthcare sector exacerbate this issue. These financial strains operate as motivators, leading many physicians to look for work elsewhere, where salaries are substantially greater. However, when this doctor movement produces results that improve the welfare of both individuals and society at large, it becomes morally justifiable to the public. In this instance, doctors who opt to work overseas might make significantly more money, which frequently enables them to pay off their medical school debt, invest in their families' houses, healthcare, and education, and attain long-term financial security (Toyin-Thomas, 2023:4).

Skilled workers, such as physicians, who relocate overseas have a major positive economic influence on both the nations in which they settle and the migrants themselves, claims Maskus (2023:35). Increased income, which improves their quality of life and financial security, is one of the main benefits. Filling important skill gaps in industries such as healthcare also benefits destination countries by increasing economic efficiency and production. According to Maskus (2023:316), benefit-cost ratios could range from 3.7 to 6.9 for every 10% increase in skilled migration within Africa. Therefore, migration may result in up to seven times more positive economic effects than negative ones, including increased earnings, remittances and knowledge transfer. When considering worldwide migration trends, the advantages are considerably greater than the disadvantages. These results support the consequentialist view that the choice to migrate benefits both individual physicians and larger economic systems, especially when the extra funding is used to fund household well-being, entrepreneurship, and education in their native countries.

Furthermore, as mentioned in Chapter 2, countries such as Canada, the United Kingdom, Australia, the United States, and Portugal have emerged as major draws for medical professionals with training from South Africa because they provide better pay, better working conditions, and organised career progression routes (Libera, 2024:1). These nations offer more secure work settings, which starkly contrast the limitations of South Africa's public health system. The financial appeal of these opportunities is demonstrated by the average yearly salary of R891,000 to R1.91 million for South African doctors working abroad (Libera, 2024:1-2). As financial independence and stability

are crucial for both personal and professional well-being, such significant financial benefits ensure ethically significant results for doctors.

5.2.2 Remittances as a Primary Benefit for Families and the South African Economy

Remittances sent home by South African doctors employed overseas are another benefit of health worker migration, including the migration of doctors. South Africa is the second-largest recipient of remittance inflows in Eastern and Southern Africa, with an estimated \$1 billion in inflows each year (Libonte, 2015:8). These programs assist individual families and households in maintaining their standard of living and improving their overall financial security and well-being by covering essentials such as housing, healthcare, and education.

Several systemic issues affect South Africa's rural healthcare systems and prevent patients from receiving timely medical care, including remote locations, inadequate infrastructure, and a lack of transportation (see Chapter 2:25). By allowing families to pay for transportation to distant medical facilities or seek private treatment when state options are inadequate, remittances can be an essential support system in these situations and help close the accessibility gap in rural areas. Their broader impact on systemic healthcare issues is limited, especially in rural regions, because remittances typically do not lead to direct investments in public health or education (Libonte et al., 2015:8). Remittances offer significant financial assistance that may alleviate some of the financial and social strains on immigrant families and communities. Subsequently, remittances greatly enhance household well-being in South Africa, notwithstanding their inability to completely offset the loss of qualified healthcare professionals or the expenses related to training. These remittances also contribute positively to the economy.

5.2.3 Opportunities for Specialization and Professional Development to Benefit the Country

Circular migration is a type of professional migration that is widely mentioned in the literature. It is defined as professionals who temporarily migrate abroad for jobs or training with the intention of coming home occasionally during their careers (Ansary, 2025:103; Weber and Saarela, 2019:1). This idea is especially relevant because it encourages fair sharing of medical expertise, creativity, and professional growth.

One of the main causes of doctor migration and a major benefit is the desire for professional growth, as discussed in Chapter 2:18, which includes access to further training and specialisation.

Similar to many low- and middle-income nations, South Africa has few positions in the public sector, inadequate funding, and sluggish career advancement paths, which limit training options, especially for specialists (Sikwela and Diedericks, 2024:199). As a result of the significant challenges faced by the South African healthcare system, many physicians consider migrating to rich countries as a solution to access better postgraduate training programs and career growth opportunities. This pattern is supported by recent research, which identifies South Africa as a major centre within the broader "surgical diaspora" (Rudolfson et al., 2023:1685). To obtain additional training, many South African medical professionals, especially those working in the surgical, anaesthesia, and obstetrics (SAO) fields, temporarily migrate to high-income nations. This type of movement makes it possible to acquire global competencies and state-of-the-art therapeutic abilities, rather than signifying a permanent loss of ability or a straightforward example of brain drain. These medical professionals return to the South African healthcare system with enhanced skills, which will eventually benefit the country's healthcare system. Therefore, rather than being perceived as attrition, this pattern of temporary movement should be seen as a mechanism for systemic strengthening and skills replenishment (Rudolfson et al., 2023: 1686-1688).

This pattern has significant ethical consequences, as medical professionals pursuing specialisation in another country gain essential skills, professional networks, and access to advanced technologies, enhancing their ability to provide high-quality treatment in their home healthcare system. These highly qualified professionals also bring important clinical expertise, patient care best practices, and the possibility of mentoring when they return to South Africa (Rudolfson et al., 2023:1688). These reinvestments in the local health system, particularly in underprivileged rural areas, constitute ethically significant results because they improve the health of the entire population.

"Return migrants" refers to South African physicians who temporarily relocate overseas for employment or study with the goal of returning and reintegrating into the healthcare system (see Chapter 2:13). Bilecen (2022) outlines several important aspects that drive return migration to South Africa. These include the attractiveness of the nation's lifestyle, culture, and social environment; the pull of the physical surroundings; and close family ties. Conversely, the high cost of living and unfavourable weather in destination countries often motivate migrants to return to their homes. This notion of return migration is supported by significant field data. For example, many

South African doctors do not intend to migrate permanently to the UK. As noted by a head of medicine interviewed by Labonté et al. (2015:6), these doctors view international migration as a strategic move. They plan to spend a few years abroad to gain professional expertise and financial stability, with the ultimate goal of returning to South Africa to establish a local practice in their hometown.

5.2.4 The Contribution of Returning Medical Doctors in Improving South African Healthcare

As previously stated, one of the benefits of medical migration is that returning physicians may significantly contribute to improving and transforming healthcare services in rural South Africa. The South African Cuban Medical Collaboration (SACMC) initiative, which provides South African students from rural areas with the opportunity to study medicine in Cuba, is a significant example of this dynamic phenomenon. After graduation, these students return to work in South Africa's public healthcare system, particularly in underprivileged areas (Motala and van Wyk, 2019:1). The SACMC program was created to increase the number of physicians who have received training to work in rural areas and foster a strong interest in primary health care (PHC), which is the foundation of Cuba's internationally recognised health care system.

Motala and van Wyk (2019:6) discovered that 11 of the 20 doctors who took part in the SACMC program were still actively practicing in rural areas at the time of the study, and 19 of them had completed their service requirement in underserved or rural areas. Most of these physicians were employed as general practitioners in primary healthcare settings, either in private rural clinics or public hospitals in the region. Their medical education in Cuba, which places a strong focus on community involvement, public health, and preventive treatment, was thought to be extremely applicable to rural South Africa. These returning physicians have been able to significantly impacted PHC re-engineering and health equity in South Africa by matching their training with community needs.

This study emphasises the value of social background and individual motivation in addition to improving rural service delivery. Most SACMC graduates came from low-income families and had little access to postsecondary education options in their communities. The Cuban scholarship was a life-changing opportunity for these people to study medicine and support their communities (Motala and van Wyk, 2019:6-7). Their rural upbringing frequently translates into a strong

dedication to providing healthcare where it is most needed, making them perfect facilitators of better healthcare delivery and access in underserved areas. Furthermore, a crucial element is the long-term retention of doctors in South Africa. Nineteen out of the 20 participants in this study planned to stay in South Africa for the long run, indicating that return migration can help build the country's health system sustainably (Motala and van Wyk, 2019:7). According to Rudolfson et al. (2023), this indicates a type of “brain circulation” in which foreign training is reinvested in the local system, defying the popular narrative of brain drain.

Finally, the SACMC initiative supports larger national health policy goals, such as the re-engineering of PHC and NHI (Motala and van Wyk, 2019:7). The program offers a useful approach to resolving historical disparities in the delivery of health services by generating physicians dedicated to helping rural communities and knowledgeable about community-based healthcare approaches. The findings indicate that SACMC graduates are flexible, productive, and dedicated members of the community healthcare system, despite some complaints about the disparities between the clinical training settings in South Africa and Cuba (Motala and van Wyk, 2019). However, the ethical claim that, in the correct circumstances, migration can be a tool for equity and development, improving not only the general health of marginalised communities but also people's professional lives, is backed by the benefits that returning migrant doctors bring to the delivery of healthcare in rural areas.

5.3 Negative Outcomes of Doctor Migration

Although there have been significant economic and personal benefits to the migration of South African-trained doctors, including higher incomes, professional growth, remittances, and eventually returning with more expertise, these benefits must be balanced against a number of major and frequently neglected negative consequences of this migration. From an ethical and holistic perspective, the viability and justice of South Africa's healthcare system are further jeopardised by the migration of medical professionals, especially in underserved and rural areas.

As discussed in chapter two, shortages of medical staff, poor infrastructure, and restricted access to specialised care are just a few of the structural constraints that rural areas currently face. These inequities are exacerbated by the ongoing emigration of medical professionals, which further destroys healthcare services when they are most needed. The loss of skilled healthcare professionals

frequently exacerbates systemic imbalances, leaving a weak system that is unable to adequately train, retain, or replace doctors (Michaeli et al., 2024:217). Furthermore, despite the potential for development, remittances and circular migration cannot completely compensate for the short- and long-term human resource shortages caused by this migration. The “brain drain” issue jeopardises national attempts to establish a strong ethical and equitable public health system and runs the risk of solidifying healthcare access inequalities, particularly if it is not accompanied by guaranteed return or reinvestment (Toyin-Thomas, 2023:9). This section critically analyses the negative consequences of doctor migration, paying special attention to how these patterns affect South Africa's rural healthcare delivery.

5.3.1 Increasing Rural Doctor Shortages and Burnout

As stated in Chapter 2, the severe physician shortage is the most pressing issue affecting South Africa's rural healthcare system. Both patient treatment and the well-being of the few remaining practitioners are negatively impacted by this shortage. In addition to structural constraints, such as insufficient infrastructure and resource distribution, this problem is exacerbated by the continuous migration of medical doctors. Funding new public health roles, especially in rural areas, has become more difficult due to government funding constraints, as discussed in Chapter 2. Consequently, even as more physicians become eligible each year, the state lacks the financial means to properly incorporate them into the public workforce. Both domestic underemployment and international migration are influenced by the disconnect between training output and employment absorption. Consequently, the few healthcare professionals who choose to remain in rural areas face disproportionately high patient loads, shortages of support workers, and insufficient medical supplies.

This was outlined by Schaefer (2021:1), who stated the following:

“Due to this scarcity and the requirement to provide 24-hour services, full-time physicians are required to work overtime, which equates to a 56-hour workweek. This essentially means working eight hours a day, seven days a week. Consequently, many doctors are emotionally and physically exhausted. Self-care, family life, patient empathy, and creative problem-solving regarding complicated medical matters have all become distant realities, separated from day-to-day clinical work. Consequently, many doctors’ experience burnout and wish to quit practising full-time medicine to find long-term answers to their problems. They want to be good doctors while also having a healthy

personal and family life. Having a healthy work-life balance was found to be a significant theme in the reasons why doctors choose to remain in rural parts of South Africa.”

This explanation paints a picture of a system whose design, although possibly intended to maintain services, eventually results in negative and unsustainable effects on the environment. Physical and emotional exhaustion results from long workdays, constant availability, and inadequate support. Consequently, professional motivation declines, care quality decreases, and rural health services are at risk of failure due to staff turnover. Under such circumstances, the cost of providing healthcare is not only quantified in terms of resources but also in terms of the toll it takes on the providers' personal and professional lives. The strategy itself needs to be questioned when the results of a policy or practice are consistently accompanied by burnout, diminished empathy, and departure from the profession. For healthcare systems to be effective, their design must assist service providers and recipients rather than causing harm. Policies that drive physicians into unsustainable work schedules are not only unethical in this context, but also ineffective over the long run (Ebrahimi et al., 2025:107).

Schaefer (2021:1) emphasises a crucial insight, especially regarding the significance of work-life balance. Physicians who choose to continue practising in rural areas frequently do so when the environment permits stability, well-being and balance. These issues are crucial for retaining qualified staff and guaranteeing high-quality care. Systems are more likely to be ethically and practically sound when they are designed to achieve results that promote patient trust, professional satisfaction, and community health.

5.3.2 Mental Health Issues Among Rural Doctors

The declining mental health of South African doctors working in rural areas is a sign of larger systemic problems in the healthcare system, rather than just a personal issue. While the physical effects of long hours and inadequate staff have been demonstrated in previous sections, it is also important to consider the psychological effects as systemic implications of the same. Working conditions create societies where mental strain is the norm rather than the exception, as evidenced by the notable rates of depression, anxiety, and burnout reported by Obeng Nkrumah et al. (2025:1). In rural locations, where professional isolation and emotional demands are more common, the impact of these pressures is more pronounced.

These mental health conditions could be the outcome of system design decisions that do not prioritise the well-being of healthcare personnel, rather than being seen as isolated cases of personal collapse. In remote locations, doctors usually have to handle chronic illnesses, treat patients in emergencies, and handle administrative duties with little support or financing. These stresses erode resilience over time, increasing the likelihood that healthcare workers will experience mental exhaustion and lose interest in their work roles. The quality of treatment given to already underprivileged communities is impacted when doctors begin to feel psychological distress, which impairs their capacity to interact with patients in a meaningful way and make wise clinical judgments (Obeng Nkrumah et al., 2025:02-03). Through the lens of consequentialism, it is clear that systems and activities must be assessed based on their results. As the mental health burden faced by rural doctors directly jeopardises the fundamental objectives of the healthcare system in delivering safe, efficient, and long-lasting care, it has become an ethically complex issue. When poor working conditions lead to clinical errors, emotional fatigue, or detachment, the general health of patients and providers is affected. Because these results are foreseeable and recurrent, they cannot be morally justified within a framework that prioritises the greatest good for the greatest number of people.

One striking illustration of how these vulnerabilities intensify under stress is the COVID-19 pandemic, which is covered in Chapter 2:31-32. A lack of staff capacity, protective gear, and support networks exacerbated the psychological and professional challenges that rural doctors reported during the pandemic (Benson et al., 2022: 3-4). Their research revealed that rural doctors were not only overworked but also forced to work in unethical settings that jeopardised their safety and ability to deliver high-quality care. The loss or departure of even a small number of physicians triggered a vicious cycle that increased the workloads of the remaining staff and worsened systemic instability. Similarly, Hain et al. (2021:1-3) empirically showed a substantial correlation between plans to leave the public sector and high rates of burnout (68.5%), depression (35.6%), and anxiety (23.3%) among doctors in rural hospitals in KwaZulu-Natal. These findings suggest that mental health problems are a direct cause of the reduction in rural healthcare services, rather than being isolated or coincidental. The harm that results for both the professionals and the rural populations they serve renders the existing scenario morally dubious if doctors quit due to poor working circumstances and untreated mental health disorders. Khan et al. (2024:7-8) showed that

structural problems in South Africa's healthcare system continued after the initial COVID-19 pandemic phase, impacting both general well-being and physician retention.

Furthermore, the most vulnerable populations are disproportionately impacted by this migration and burnout trend, which results in systemic injustice (Ngene et al., 2023:88-89). The lack of qualified healthcare professionals most affects patients in underserved and rural areas, who require trustworthy, high-quality care. Chitha et al. (2024:3) demonstrate this by highlighting that patients are regularly referred to distant hospitals, where many are unable to obtain transportation, causing service delays, and that they commonly endure lengthy waiting hours, which can be harmful to their health and wellness. Consequently, the healthcare system has an ethical imbalance and often disregards rural people. Any healthcare system that sustains these unequal results through preventable structural failures cannot be considered morally legitimate from a consequentialist perspective. However, rural physicians face extra psychological strain due to the systemic breakdown in rural service delivery, which is characterized by fragmented care, inadequate infrastructure, hazardous working conditions, and fragmented emergency response procedures. According to Malakoane et al. (2020:2), the absence of institutional support and governance exacerbates emotional distress by turning what is supposed to be clinical care into crisis management. Minor instances of theft or clinic vandalism are more than just a loss of resources for a physician who is already dealing with staffing shortages, unstable infrastructure, and compromised patient safety; they constitute an emotional breach of both professional and personal dignity. A persistent sensation of vulnerability and moral tiredness is brought on by daily exposure to such instability, which eventually undermines clinical confidence.

The oppressive stress of playing several roles as a clinician, administrator, emergency responder, and bureaucrat, often all at once and without sufficient support, exacerbates depression. In rural clinics that are severely understaffed, physicians navigate outmoded infrastructure, uneven medical supplies, and unreliable emergency medical services (EMS) while making critical judgments under extreme stress (Magaisa, 2025:127). In combination with stretching clinical capacity, this convergence of responsibilities pushes healthcare workers beyond the boundaries of professional sustainability when there is no significant institutional support for them. Many physicians eventually suffer from moral harm, which is the psychological distress that results from systemic limitations that prevent them from providing the standard of care they know is required (Mosca and

Kruger, 2023:1). This harm is more than just burnout or exhaustion; it is a profound sense of moral failure, shame, and helplessness that undermines one's personal and professional identities (Magaisa, 2025).

In settings where the healthcare system appears unconcerned about the needs of both patients and providers, this sense of futility is particularly strong. According to Malakoane et al. (2020:6), issues including theft, inadequate security, unclear institutional procedures, and inadequate inter-facility cooperation are commonplace in many rural health facilities. Physicians are frequently left to work in hazardous or chaotic environments, impairing their capacity to carry out even simple duties efficiently. Professional detachment, cynicism, and ultimately withdrawal result from the frustration of knowing that their efforts are compromised by larger administrative problems, combined with a feeling of desertion by the upper levels of the health system. Consequently, it is impossible to consider the mental health crisis among rural physicians in an empty space, separated from the institutional and material neglect that surrounds them. Migration is accelerated, the resilience of the health system is weakened, and the disparity in healthcare delivery throughout South Africa is widened by everyday exposure to avoidable failure and structural injustice (Malakoane et al., 2020:7).

One potential effect of this mental health issue is its impact on the mindsets and decisions of doctors who continue to serve in rural areas. Those who remain are left with larger responsibilities and an increasing sense of hopelessness and frustration as colleagues quit, move, or leave to avoid terrible circumstances (Purbrick et al., 2024:5). As a result of continuous staff shortages, mental strain, and a lack of institutional support, many rural doctors eventually start to see migration as a reasonable and occasionally the only way to protect their professional integrity and personal well-being. This is a predictable reaction to a failing environment that has been formed by systemic neglect and not just an individual choice. Even the most dedicated healthcare workers may feel that it is morally acceptable to leave a system that continuously undervalues their contributions when fatigue becomes accepted and institutional assistance is inadequate (Purbrick et al., 2024:6). The outcome is a morally disturbing feedback cycle, that viewed from a consequentialist lens, makes the healthcare system in rural places more vulnerable and less able to properly serve its populations because the exact circumstances that drive doctors to leave get worse with each departure.

5.3.3 Reputational Damage as a Consequence of Doctor Migration

The damage to reputation caused by the spread of negative word-of-mouth is one of the more widespread and long-lasting effects of South Africa's ongoing doctor migration problem. A significant portion of South African doctors who move to other nations in search of better working circumstances with more stable healthcare systems and institutional backing often explain their reasons for leaving on their social and professional networks. These informal narratives spread through professional associations, scholarly publications, social media platforms, and expatriate networks. They typically highlight issues such as poor management, mental fatigue, political apathy, ongoing understaffing, and a lack of basic resources. In the international medical community, these personal stories based on individual experiences and shared among peers are important. They create a significant counter-narrative that negatively impacts South Africa's reputation as a place for medical professionals (Purbrick et al., 2024:1; Mere et al., 2023:3). In the highly competitive and perception-driven global health labour market, where trust in a system's effectiveness and integrity is crucial for retaining and attracting skilled professionals, damage to reputation becomes especially important to consider.

Reputation affects more than just the South African diaspora. Instead, it has a direct impact on the country's capacity to hire medical professionals with foreign training, especially those who may have otherwise considered working in South Africa through exchange programs, humanitarian missions, or global health alliances. South Africa has traditionally depended on international collaboration to sustain its overburdened public healthcare system, especially in rural and impoverished areas (Ebrahimi et al., 2025:110). However, because of the negative experiences that South African doctors who have left the nation have shared, informal obstacles serve as a warning to foreign-trained medical professionals about the difficult realities of practising medicine in South Africa. A lack of job advancement, poor pay, professional isolation, and moral suffering due to system failure are common themes in these narratives. This eventually creates the impression that South Africa is a dangerous place for medical professionals to work, where the potential advantages are overwhelmed by the personal and professional costs (Ebrahimi et al., 2025:111). Consequently, foreign physicians, especially those from other low- and middle-income nations, may shift their focus to countries that are believed to provide greater institutional support, stability,

and recognition. Therefore, as South Africa's public health sector declines globally, it becomes increasingly difficult to maintain its dependence on attracting professionals from abroad.

This dynamic creates an endless cycle of professional breakdowns. The number of interested foreign-trained medical professionals eager to work in South Africa is declining as more South African physicians depart and share their experiences abroad. This increases the workload for the remaining employees, increasing their risk of burnout, low morale, and disappointment, as mentioned above (Toyin-Thomas et al., 2023:7). Those who remain start to think about emigrating, not just as a job opportunity, but also as a necessary step to maintain their ethics, health, and life in the workforce as working circumstances improve. These physicians often perpetuate the same damage to their careers when they relocate, sharing similar accounts of systematic neglect and frustration. The harm caused by doctors moving abroad extends beyond staffing shortages. It weakens trust in the country's healthcare system, undermines South Africa's reputation among doctors worldwide, and limits the nation's ability to interact with global healthcare networks. Because it threatens the exact processes intended to replace and restore such losses, this reputational crisis can be just as damaging as a real departure of healthcare professionals (Toyin-Thomas et al., 2023:7-8). In this approach, the movement of South African physicians not only exposes the nation's healthcare shortcomings domestically but also multiplies them internationally, preventing new recruits and returnees from joining a system that seems to be in chronic decline.

5.3.4 Disruption of Care and the Rise of Misinformation in Rural Areas

The migration of South African medical professionals further impacts healthcare provision in rural areas, where a shortage of trained doctors has gone well beyond clinical capacity. The spread of false information about medicine, especially myths that could endanger the lives of vulnerable groups, is one of the most morally concerning outcomes of misinformation in medicine. Many rural populations rely on traditional beliefs or informal healthcare professionals to fill the space created by professional emigration, some of whom continue harmful and scientifically unjustified practices.

A notable illustration of the detrimental effects of medical disinformation is the enduring “virgin cleansing myth”, which holds that having sex with a virgin, usually a child, cures HIV/AIDS. This myth has persisted in some rural and underdeveloped communities, where access to health education is restricted and the authority of biomedicine is undermined by the lack of qualified doctors,

even though it has been completely disproved by scientific data. Owusu (2024:634) claims that the false hope of healing has led to sexual abuse against children and people with disabilities because of belief in this myth. A particularly unsettling instance occurred in the Eastern Cape in 2002 when a man sexually assaulted his niece in the hope that it would help him get over his HIV infection (The Lancet, 2002 cited by Owusu, 2024). Even though this case is over a decade old, it serves as a clear warning: there is a greater chance that similarly damaging myths could resurface or spread more widely when rural communities are left without trustworthy medical information and healthcare providers because of the continuous movement of doctors, which is becoming increasingly problematic.

Sangana (2024:2709) mentioned in Chapter 2:32 that a lack of access to qualified professionals is the main reason many South Africans living in rural areas increasingly depend on unauthorised healers. Although many cultures value traditional medicine, excessive dependence on informal care, often without supervision or biological integration, becomes morally and clinically problematic when it results in detrimental interventions or postpones obtaining appropriate therapy. Such delays are harmful, especially in the case of HIV/AIDS, because early biomedical intervention is more important in treating the virus. Doctor migration has produced a systemic space that is the foundation of this issue. When qualified medical professionals depart from their home country, they bring with them not only their medical knowledge but also the safeguarding role, health education, and community trust that help eliminate harmful stereotypes. In the absence of professionals who can correct misinformation and offer accurate diagnoses, communities rely on easily accessible but frequently unreliable information sources. The result is a fragmented health system, where dangerous views become more prevalent and biomedical knowledge is no longer the standard operating procedure (Sangana, 2024:2711). Consequentialism holds that choices regarding policies and actions must be based on the outcomes of those choices. Such effects are ethically unacceptable if the migration of doctors predictably results in an increase in harmful practices, false information, and avoidable harm to vulnerable members of society. In this regard, it is morally unacceptable to allow ongoing healthcare professional outflows in the absence of adequate knowledge infrastructure, rural incentives, or retention strategies. The cost of ignoring the welfare of children subjected to maltreatment based on medical misinformation is too high.

The way in which the lack of competent physicians impacts the legitimacy of biological health narratives and encourages alternative, misinformation-based health-seeking behaviours is a significant factor that furthers the ethical and structural ramifications of physician migration. Recent qualitative research conducted in Soweto by Laher et al. (2025:4) found that even among generally well-informed populations, there is still a lot of misinformation regarding the differences between HIV "cure" and "remission", and people continue to rely on culturally promoted treatments, such as herbal tonics. Despite being conducted in an urban environment, the study presents significant analytical questions for rural communities, where the loss of medical professionals hinders clinical services and jeopardises reliable medical communication channels, facilitating the spread of false information, especially in relation to diseases such as HIV/AIDS, which are already associated with stigma and cultural misconceptions. Consequently, the departure of healthcare workers has more effects than just the loss of medical personnel; it also causes a systematic collapse in the framework of health literacy, leaving regular people to manage complex biomedical issues without adequate support from healthcare professionals. The epistemic legitimacy of evidence-based medicine is therefore further undermined by the migration of physicians, raising the possibility of harmful practices and exacerbating systemic health disparities (Laher et al., 2025:5).

5.3.5 The Violation of Healthcare Rights in Rural Communities

International labour and human rights frameworks recognise that medical workers, including physicians, have the right to seek enhanced possibilities abroad. Personal, professional, and financial factors, from the desire for better working conditions and competitive wages to career progression and international exposure, are frequently the driving forces behind medical migration (Constantin and Sternstein, 2023:4). Similar to other competent professionals, South African physicians have the right to make choices that improve their personal and professional lives. The collective rights of rural communities to obtain the necessary healthcare services are combined with the legitimate and constitutionally protected individual right to move (Constantin and Sternstein, 2023:5). Therefore, the difficulty is not in restricting the freedom of physicians but rather in ensuring that their ability to move does not affect the healthcare rights of marginalised communities. The ethical and legal responsibility for the failure of state institutions to reconcile these conflicting rights through workforce planning, retention strategies, and rural health investment lies with the institutions designed to protect public health, not the migrant physicians.

The persistent migration of South African physicians to wealthy countries has exacerbated long-standing disparities in healthcare access, particularly in rural regions. Although Section 27 of the Republic of South Africa's 1996 Constitution guarantees the right to healthcare, millions of people in rural areas are literally unable to access this right due to the widespread migration of qualified professionals (Mahomed et al., 2022:92). As previously indicated, excellent medical treatment is more of a theoretical promise than a reality in rural clinics, which frequently lack doctors, leaving nurses to handle heavy workloads. The resulting scarcity of access to efficient, reliable, and skilled medical care is illegal and violates the moral precepts of equality and fairness, which are essential components of any moral healthcare system. When governmental capacity fails to compensate for this loss, whether through retention policies, training programs, or reinvestment in rural infrastructure, rural communities that already face structural impediments to healthcare become even more marginalised (Mahommed et al., 2022:93).

The combined effects of rising patient mortality, disinformation, stress on the remaining medical staff, and a decline in faith in biomedical care point to a structural breakdown in fulfilling the most fundamental duties in rural communities. As mentioned in previous sections, these effects are reflected in unnecessary deaths, untreated illnesses, and the normalisation of risky actions; they are not hypothetical. Healthcare rights violations are not passive in this setting. They are maintained by unfair resource distribution and delays in policy implementation. A health system that is ethically acceptable must be judged on how well it protects the most vulnerable, not on how well it cares for those who can afford private treatment or move abroad (Yuliati, 2025:36). If rural populations regularly lack the resources and professionals needed to fulfil their right to health, the ethics of the entire healthcare system come into doubt. Furthermore, this continuous exodus of South African doctors to more affluent countries is indicative of a more profound institutional breakdown in respecting social justice and human rights principles (Yuliati, 2025:37). The inability of national and provincial health administrations to stop migration indicates a breakdown in governance that disproportionately affects rural populations. Over time, these issues have worsened due to the absence of trustworthy medical services, deterring young people in disadvantaged communities from pursuing careers in healthcare and losing faith in state-run facilities.

The persistent infringement of healthcare rights in rural areas raises serious issues regarding systemic inequality and the inability of international ethics and national policy to safeguard

disadvantaged groups. Despite being a fundamental right, access to healthcare is mostly symbolic for those living in rural districts because of the lack of strong legal mechanisms to implement Section 27 of the Constitution. States are required by international human rights law, such as the International Covenant on Economic, Social, and Cultural Rights, to proactively work toward the full implementation of the right to health (Mahommed et al., 2022:93). However, the outflow of medical professionals from South Africa without equivalent domestic protections raises major questions about the political will and ability of the state to fulfil these responsibilities. Furthermore, the tendency of migration solidifies socioeconomic and spatial inequality: rural residents face a growing disparity that is structurally reinforced rather than coincidental, while metropolitan private sectors may continue to have access to high-quality medical care (Mahommed et al., 2022:94). Policy failure becomes a persistent violation of human rights when immediate corrective actions are not taken, such as decentralised health professional training, fair budget distribution, and moral international hiring practices. Without adequate mitigating techniques, the ongoing exodus of South African doctors essentially results in a two-tiered health system: one that silently ignores the poor in rural areas while protecting the rights of wealthy countries and migrating doctors.

5.3.6 Loss of Institutional Capacity and Economic Investment

The development and sustainability of rural healthcare systems are seriously threatened by the migration of medical professionals with South African training. As mentioned in Chapter 2, there is a significant shortage of skilled medical staff in rural areas, such as KwaZulu-Natal and uMkhanyakude, with only a small percentage of doctors available to serve over half of the population (Singh, 2025; Chikafu and Chimbari, 2021). When physicians depart from these already underprivileged areas, they leave behind profound contextual knowledge, mentorship skills, and priceless clinical experience that are essential for addressing complex local health issues. This loss weakens institutional capacity by undermining the transfer of expertise required to train junior workers. Rural healthcare services become more fragmented without formal mentorship and assistance, making it impossible to develop or adapt to the challenges these communities face (Hadley, 2024:2). As a result, health facilities become less resilient, leading to lower service quality and deterring medical professionals from working in rural areas. This creates a vicious cycle of poor performance.

From an economic standpoint, the issue is exacerbated by doctor migration, which wastes the significant public funds allocated to medical education and training. To develop qualified doctors who can serve its population, South Africa invests a lot of money, frequently more than a million rand for each graduate (Hadley, 2024:3). The financial gains of this investment are essentially transferred elsewhere when these doctors leave for wealthy countries, with no benefit to their home healthcare systems. The availability of competent workers is diminished by this human capital drain, which also damages the financial foundations needed to strengthen the health system in the home country. As noted in Chapter 2, the infrastructure for rural healthcare is already inadequately supported and ill-equipped, and clinics are experiencing shortages of critical supplies, medications, and diagnostic equipment (Chatterjee et al., 2012; Ewing et al., 2020:2). These problems are exacerbated by the departure of qualified medical personnel, leaving the remaining staff to deal with excessive workloads and inadequate resources, leading to worse health outcomes.

Furthermore, the effects of reduced institutional capacity due to physician migration extend beyond the delivery of direct healthcare. Community health workers (CHWs) play a crucial role in rural areas by providing home visits to newborns and their mothers. However, due to their limited responsibilities, community health workers cannot assume the role of doctors in providing specialized treatment and clinical monitoring (Stansert Katzen et al., 2020). These health programs remain limited and less effective without sufficient investment in professional staff and infrastructure, further disadvantaging vulnerable groups such as pregnant women, the elderly, and patients with chronic illnesses, groups that Chapter 2 identified as being particularly impacted by poor health services and access barriers (Chikafu and Chimbari, 2021:11).

This dynamic significantly restricts the health system's ability to respond to the various health issues that rural communities face, such as the burden of HIV, non-communicable diseases, and maternal health risks, as discussed in Chapter 2. The combined effects of physician migration and underinvestment create a cycle of loss and decline in rural healthcare capacity and economic sustainability. The failure to retain medical professionals erodes local knowledge and leadership, increases service fragmentation, and wastes valuable resources.

5.3.7 Infrastructure Decline and the Erosion of Health System Credibility

As stated above, the ongoing exodus of medical professionals with South African training to affluent nations has exacerbated staffing shortages and the deterioration of rural healthcare

infrastructure. Rural clinics and hospitals frequently struggle to operate efficiently when physicians leave their posts. Vital services are diminished or stopped entirely in the absence of medical personnel. As noted in the literature review chapter, Cowley (2025) provided another instructive example: Eastern Cape's Livingstone Hospital was compelled to close its outpatient clinics due to a shortage of doctors. These interruptions in service discourage investment in essential infrastructure, such as utilities, building maintenance, and equipment, because they convey the idea that rural healthcare facilities are no longer sustainable or important.

As more physicians leave, provincial health administrations are less inclined to fund hospitals that they believe are understaffed or unsustainable. A vicious cycle is created when staffing shortages lead to disinvestment, which in turn affects the hiring and retention of doctors. Medical services cannot be provided safely and effectively in clinics with antiquated equipment, damaged infrastructure, or unstable energy and water supply. Patients begin to lose faith in the healthcare system when they encounter facilities that are in poor condition, have long lines, or offer limited services (Malakoane et al., 2020:6). This undermines the public health system's trust, particularly in rural areas, where systematic neglect is already a significant issue. Furthermore, recruiting doctors in remote areas is more difficult owing to declining infrastructure. Many skilled employees refuse to work in settings without the necessary equipment, support staff, or hygienic and secure environment. Consequently, the problem is exacerbated over time by physician migration, which not only leaves facilities empty but also deters prospective applicants (Malakoane et al., 2020:7).

Infrastructure deterioration also affects patient outcomes. Clinics with poor infrastructure face challenges in managing emergencies, diagnosing patients quickly and accurately, and treating chronic illnesses. This puts additional strain on nurses, community health workers, and support staff to treat patients without the resources or supervision required. This undermines the structural and institutional foundations of the rural health system. It causes service interruptions, lowers infrastructure spending, depresses employee morale, and erodes public confidence (Malakoane et al., 2020:8). The public health system's reputation will continue to deteriorate, and the disparity in access to healthcare between rural and urban areas will widen if specific measures are not taken to retain physicians and reinvest in rural health facilities.

As previously mentioned, in South Africa's rural areas, the chronic lack of qualified doctors not only undermines clinical systems but also slowly erodes health knowledge, trust, and aspirations

over time. Young people in communities that frequently suffer from understaffed clinics, treatment delays, or total service failures have little understanding of what flexible and effective healthcare looks like. Over time, this results in a decrease in youth health-seeking behaviour and a lower expectation of high-quality care, which is embedded in community norms. As discussed in Chapter 2, the social role of doctors as mentors, educators, and role models is further disrupted by the lack of trustworthy medical professionals in the field. This is especially detrimental in places where young people may be at risk for substance abuse, early pregnancy, or avoidable diseases but do not have access to reliable, consistent sources of health advice. The lack of reliable medical specialists who could otherwise reinforce or fill that educational gap makes it even harder for caregivers in rural South Africa to convey important health knowledge to younger generations, as Nilsson et al. (2020:5-6) demonstrated.

Furthermore, when doctor migration restricts the economic and professional opportunities accessible to young people in rural areas, it contributes to structural inequalities. Young people in the area are given the impression that careers in medicine or healthcare are not respectable or feasible when rural clinics are understaffed or in decline. Academic aspirations are discouraged, intergenerational mobility can be weakened, and community involvement in the future of healthcare is compromised. In this way, the influence is both aspirational and health related. Socioeconomically poor households, many of which are concentrated in rural areas, exhibit more pronounced intergenerational patterns of health hazards, including obesity and metabolic diseases, as reported by Nglazi and Ataguba (2022:1-2). These loops can be avoided or broken through early intervention, targeted education, and consistent follow-up care. However, these essential long-term support systems are eliminated when doctors migrate. Consequently, the loss of healthcare workers drives ingrained and genetic health disadvantages across generations, making it more than just a clinical problem.

5.3.8 Delays in Rural Area's Emergency Medical Care

One of the most morally concerning consequences of South African doctors leaving the country is the increasing incapacity of rural healthcare systems to handle medical crises, a failure that directly leads to unnecessary suffering and death. As previously mentioned in the literature review chapter, rural health institutions in places like northern KwaZulu-Natal usually only have one or two doctors covering wide geographic areas, and some do not have any full-time medical staff. Clinics and

hospitals that are ill-equipped to handle emergencies, such as infections, severe injuries from traffic accidents, or difficulties during childbirth, are left behind when these few medical experts relocate overseas. Despite the fact that severe medical illnesses frequently require immediate attention, patients may encounter care delays and be required to be moved to distant facilities, which may have unanticipated consequences.

Data show that, particularly when it comes to emergency obstetric treatment, maternal mortality rates remain startlingly high in rural clinics with a lack of trained medical personnel (Olseén et al., 2020:2-4). Thwala et al. (2019:5) point out that even in urban areas, health districts' capacity to provide emergency services is significantly hampered by ongoing staffing shortages and brittle support networks. The effects are more severe and pervasive in rural communities, where resources are limited. According to Ngwenya et al. (2025:1), the issue is not just a medical one; due to inadequate infrastructure, referral mechanisms, and resources, midwives also face major difficulties in triaging expectant mothers. The widespread and well-known suffering caused by the lack of medical professionals, such as avoidable deaths, deteriorating health outcomes, and the expansion of health inequities, cannot be justified when the drawbacks clearly outweigh the benefits. Policy choices that fail to prevent these losses or implement strategies for rural retention, such as targeted encouragement, binding training, or international collaboration on ethical hiring, permit largely unnecessary damage to continue. For already underprivileged rural communities, who suffer the most from delayed care and reduced services, this is particularly unfair.

A major effect of South Africa's doctor migration is the lack of qualified workers who can perform important emergency procedures, such as Caesarean sections (C-sections), especially in rural clinics. The majority of rural clinics are forced to refer high-risk maternity patients to isolated district hospitals because they lack the staff and equipment necessary to perform surgical deliveries compared to larger urban hospitals. However, this referral system depends on timely coordination and ambulance transport availability, both of which are often affected by resource constraints (Alabi et al., 2015:3). In the rural healthcare system, a shortage of doctors with emergency maternal training creates a barrier, leading to common and often dangerous treatment delays. Sociocultural obstacles that prevent timely access to healthcare facilities further exacerbate this problem (Sumankuuro et al., 2018:79-81). As previously mentioned in the literature review, South Africa has a significantly elevated doctor-to-population ratio, and the workload is exacerbated in rural areas

due to poor infrastructure and geographical distance. Pregnant women and their unborn children are at a higher risk of dying from potentially avoidable complications due to these structural flaws, which are exacerbated by the medical brain drain.

Another woman in obstructed labour died in the Eastern Cape in 2019 after waiting for an ambulance for several hours without it arriving in time, providing a horrifying example of institutional failure (The Citizen, 2019). Due to a lack of qualified medical personnel, the local clinic was unable to conduct a C-section, underscoring the grave and dangerous consequences of the shortage of specialists in rural areas. This example supports the claim that physician migration causes more than a decrease in staffing; it also limits access to life-saving interventions, delays referrals, and eventually results in death. Therefore, the effects of migration are not limited to statistics; they are fundamentally moral in character, posing issues of justice, equity, and the responsibility of the government to protect disadvantaged groups. Skilled professionals who quit the public system, particularly in rural regions, unintentionally contribute to the cycle of emergency care infrastructure breakdowns.

5.3.9 Decrease Political Participation and Voting in Rural Communities

As previously mentioned in Section 5.3.5, basic healthcare rights are being violated by the ongoing degradation of South Africa's rural healthcare system, especially due to physician migration. Rural residents may start to believe that the state does not care about their welfare if they are consistently refused access to basic services such as emergency treatment or safe maternity health. Their broader role in governance is impacted by this perceived neglect, which extends beyond the hospital system. These communities gradually come to distrust the governmental institutions that are supposed to support them, as well as public health systems. The state's failure to enforce constitutional rights, such as access to healthcare (Section 27 of the Constitution), contributes to a broader narrative of abandonment, which has been linked to decreased civic engagement and political disengagement (Mahlangu and Schulz-Herzenberg, 2022:159).

Section 5.3.8 demonstrates how unnecessary deaths and delayed emergency responses caused by a lack of qualified medical workers are not only governance failures but also health disasters. The consequences are felt collectively and serve to foster feelings of exclusion from national development plans; they are not merely personal losses. Rural residents may be less motivated to participate in political processes, such as voting, when they frequently encounter government

incompetence or neglect. This disengagement arises from actual experiences of institutional neglect, rather than ignorance. Mamokhere and Kgobe (2025:79) argue that voter turnout is significantly influenced by the perceived responsiveness of the state, particularly among communities that have historically been excluded from service delivery. Therefore, rather than being a simple lack of interest in politics, political disengagement in these areas is a logical response to a long-standing pattern of unfulfilled governmental commitments.

This tendency supports a risky cycle in which the interests of rural communities are more likely to be overlooked in the formulation of public policy as they distance themselves from official political channels. A recent investigation by News24 (2024) found that repeated service delivery failures and inattentive administration had severely reduced voter turnout in some areas of the nation, particularly in underprivileged communities. Under such circumstances, the breakdown of healthcare becomes a catalyst for the worsening state of democracy, rather than only a sign of political failure. Therefore, among those most impacted, the migration of physicians leads to clinical shortages and a decline in political agency. It becomes even more challenging to push for the systemic changes required to restore their right to health and more social justice when rural residents stop voting because they lack one of the few remaining weapons of accountability at their service.

5.3.10 Strikes During the Breakdown of Rural Healthcare

Strikes are becoming more likely due to the extreme strain that the remaining healthcare workers in rural South Africa face, primarily caused by the continuous migration of doctors. Healthcare workers are pushed to their limits by increasing workloads, burnout, challenging work circumstances, and a lack of support (discussed in Sections 5.3.1 and 5.3.2). These issues not only compromise their well-being but also reduce their job satisfaction and confidence. Healthcare workers are more likely to go on strike or take other types of industrial action to seek improved working conditions and acknowledge their challenges as their frustrations grow. However, the effects of such strikes can be severe, including increased unnecessary deaths, suspension of important services, and delays in essential care in remote areas that are already under-resourced (Section 5.3.8). Strikes are a natural reaction to unsustainable circumstances, but they risk exacerbating the healthcare crisis and sending patients and providers into a vicious cycle where service delivery worsens.

The use of strikes and protests to voice discontent and call for immediate government action may also be increasing in rural communities affected by the persistent abuse of healthcare rights (Sections 5.3.5 and 5.3.9). Communities may resort to coordinated activities to recover their rights and pressure authorities to act when they are consistently denied access to quality medical treatment, which is exacerbated by poor infrastructure and political disregard. Although these collective activities have their origins in legitimate issues, they risk worsening access to healthcare by blocking facilities or reducing cooperation with medical facilities. This expected outcome may increase treatment barriers, erode public health efforts, and deepen distrust between rural communities and health care professionals. Consequently, community-led strikes may exacerbate existing problems rather than solve them, making efforts to improve healthcare in rural regions more challenging.

Due to the combined strains on rural communities and healthcare workers, as well as the unresolved institutional problems discussed in the previous sections (5.3.6, 5.3.7), strikes are not only feasible but also possible. Regardless of whether these strikes are the consequence of overworked doctors or marginalised communities, they are likely to exacerbate an already precarious rural healthcare system. Disruptive strikes are likely to make it more difficult to recruit and retain doctors in remote areas, as they raise political disengagement, cause burnout, and erode the legitimacy of public healthcare. If the underlying reasons for subpar working conditions, resource imbalances, and governance problems are not adequately addressed, these patterns of industrial action could worsen health outcomes and foster instability. This would ultimately worsen the negative effects of doctors' migration.

The 2022 Emergency Medical Services (EMS) worker strike in the Eastern Cape, which nearly brought down emergency transport services in multiple rural areas, is a prime example of these systemic risks. Unsafe working conditions, heavy workloads, and ongoing staff shortages were the main causes of the week-long protest, which reflected the difficulties rural doctors are currently facing. While critically ill patients, such as expectant mothers and children in need of oxygen, were either transported in private vehicles and police vans or left waiting for hours, the Eastern Cape Department of Health was forced to spend more than R1.2 million outsourcing private ambulance services (News24, 2022). Unfortunately, several people did not survive these delays. Even though EMS workers participated in this strike, the institutional neglect and lack of resources that led to it are remarkably similar to those affecting the remaining physicians in rural areas as medical

migration picks up speed. Similar or even more widespread strikes among rural healthcare workers are likely to occur if the migration of qualified physicians persists without significant intervention. As a result, the EMS (Emergency Medical Services) crisis of 2022 should serve as a warning: Industrial action is unavoidable when overworked and unsupported healthcare professionals are pushed to their limits. Without immediate measures to retain physicians, improve working conditions, and rebuild confidence in the rural healthcare system, South Africa faces the risk of falling into a vicious cycle in which overworked professionals' resort to strikes as their only option, putting vulnerable rural populations at even greater risk and accelerating the breakdown of care.

5.4 Conclusion

In conclusion, this chapter has demonstrated, through the ethical lens of consequentialism, that the migration of South African-trained physicians abroad has both positive and negative effects, with the negative consequences being especially severe for healthcare delivery in rural areas. On the one hand, migration can benefit individuals by providing opportunities for specialisation, access to advanced training, and higher incomes that may not be easily found in the South African healthcare system. Remittances and return migration can occasionally provide significant assistance to the nation of origin, acting as channels for long-term growth and career reinvestment.

To balance these individual gains, it is necessary to consider the broader structural repercussions that disproportionately affect vulnerable rural groups. This study asserts that the ongoing exodus of highly skilled workers has led to a severe shortage of medical professionals, resulting in increased workloads and a decline in the stress and mental health of those who remain. Moreover, physician losses exacerbate fragmented treatment, erode institutional expertise, and compromise the stability of emergency response and health infrastructure in the country. The cycle of breakdown within these already unstable systems is exacerbated by the erosion of healthcare rights, the dissemination of misinformation, and increasing disengagement among rural residents. Migration's reputational effects have often impacted the credibility of public institutions, fuelling political disengagement and instability. These results present serious ethical issues from a consequence-based approach. Such patterns lose their moral legitimacy when the most vulnerable suffer systemic harm due to the predictable and avoidable consequences of doctor migration. Decisions that prioritise individual opportunity over community health equity impact the health of entire rural populations. Therefore, it is crucial to closely evaluate the management of doctor migration and

ensure that any potential advantages are not exceeded by extensive and ongoing harm to those who are most in need.

The next chapter provides a comprehensive overview of this dissertation, synthesizing the main conclusions from each section and laying the groundwork for addressing the issues raised by this analysis.

CHAPTER 6

SUMMARY, CONCLUSION, AND RECOMMENDATIONS

6.0 Introduction

In the previous chapter, the ethical implications of doctor migration from South Africa to other countries were analysed and critically examined, focusing on the positive and negative outcomes of this migration through the lens of consequentialism. The analysis chapter highlights the severe challenges faced by rural communities in accessing sufficient healthcare services as a result of losing medical doctors. This chapter provides a summary of this study, along with conclusion and recommendations for mitigating the issues that arise from doctor migration and improving healthcare delivery in rural South Africa.

6.1 Summary of the Study

The primary aim of this dissertation was to explore the ethical implications of physician migration for rural healthcare delivery in South Africa. Chapter one, the introduction, presented the topic of this dissertation along with background and motivation of the study, a description of the objectives and research questions, a preview of the techniques and theoretical framework employed, and the structure of the subsequent chapters. This chapter effectively laid the groundwork for the dissertation by outlining the project's structure and the topic area it covers.

Chapter two offered a literature review on doctor migration, aiming to understand the nature of this phenomenon. This chapter underscored that numerous scholars have explored the migration of healthcare professionals. To gain a comprehensive understanding of this medical brain drain in South Africa, researchers such as Young (2023), Majid (2024), Govender (2024), Libera (2025), and Hadley (2023) have made significant contributions to understanding doctor migration. Additionally, I draw on the work of Adetiba (2025), Nkadimeng et al. (2024), Khan & Olla (2024), Mthombeni (2023), and Mthombeni and Vincent-Lambert (2025), who informed this literature review. These scholars were instrumental in identifying the main push and pull factors that drive doctors' migration abroad. This chapter also effectively summarised the state of South African

rural healthcare, highlighting how migration has worsened conditions in rural areas and the measures taken by the South African government to address the doctor migration issue.

Chapter three consisted of the research methodology adopted. Aspects covered were the research approach, research design and data analysis methods. This chapter began with an in-depth overview of various research approaches, specifically justifying the choice of a desktop approach for this study. Following this, the chapter elaborated on different types of research design and provides a thorough analysis of the exploratory research design implemented. Furthermore, it also introduced the DECA approach and its implementation, ensuring the study was conducted systematically and rigorously.

In chapter four, the ethical theory of consequentialism was thoroughly examined as the theoretical framework for determining its applicability to the moral assessment of medical migration in South Africa. This chapter examined consequentialism, a normative ethical theory that judges the morality of actions based on the consequences they produce. The contributions of prominent proponents of this theory, such as John Stuart Mill and Jeremy Bentham, to the development of utilitarian thought were highlighted. Act consequentialism and rule consequentialism, the two major types of consequentialism, were distinguished and recognised. While act consequentialism assessed the morality of specific actions based on their immediate effects, rule consequentialism assessed the morality of actions based on whether consistently adhering to a set of rules would ultimately benefit everyone. These theoretical perspectives were applied to the issue of doctor migration, helping to assess whether the decisions of healthcare professionals to move from South Africa produced more harm or benefit to the broader population in the long run. The chapter concludes by arguing that consequentialism provided a useful ethical framework for assessing the moral trade-offs between the well-being of marginalized communities as a whole and individual liberty.

In chapter five, the ethical considerations raised by doctors' migration were analysed from a consequentialist perspective. This enabled me to draw attention to these problems by focusing on their effects on rural populations, which already struggled to obtain healthcare due to a lack of doctors. This chapter explored both the advantages and disadvantages of consequentialism. While there are some benefits to this doctor migration, such as improved earnings and financial stability prospects, remittances as a primary benefit, opportunities for specialisation and professional development, and the contribution of returning medical professionals to improving South African rural

healthcare, the chapter makes clear that there are also serious drawbacks that impact rural communities. These drawbacks included an increase in burnout and shortages of rural doctors, mental health issues among rural doctors, disruption of care and the spread of misinformation in rural areas, violations of healthcare rights in rural communities, loss of institutional capacity and economic investment, infrastructure deterioration and erosion of health system credibility, and delays in emergency medical care. The theoretical framework of consequentialism was crucial in critically analysing the serious long-term effects of doctors' migration and in providing a satisfactory response to the main enquiry of this thesis, which was: What are the ethical effects of doctors' migration on rural healthcare delivery in South Africa?

6.2 Research Conclusion to Key Study Questions

This study undertook a thorough ethical analysis of the impact of physician migration on South Africa's rural healthcare system, employing consequentialism as its theoretical framework. By systematically examining the intricate factors that drive doctor migration and assessing its profound and extensive effects on rural health systems, this study offers crucial insights into a pressing healthcare crisis affecting vulnerable populations. It applies consequentialist ethical principles to understand and address these challenges. The findings reveal that a complex interplay of push and pull factors influence the migration of doctors. South Africa's healthcare sector faces numerous challenges, including limited career advancement opportunities, insufficient professional recognition, and a lack of support networks. The country also grapples with unfavourable working conditions, shortages of essential medical supplies, and budgetary constraints. Economic challenges include high income taxes, low salaries, and the government's inability to provide jobs for unemployed medical graduates. Concerns about the NHI program, distrust in government implementation, and fears of financial mismanagement exemplify health systems and policy issues. Safety and security concerns include high rates of violent crime and hazardous working conditions in the country. Political instability, corruption, and lack of transparency are examples of political and governance challenges. Social and psychological factors encompass a desire for a safer life and disillusionment with their host country. Destination countries present opportunities for professional recognition, access to global networks and continuous education, secure environments, stable healthcare systems, improved work-life balance and increased compensation. An examination

of these factors effectively addresses the first sub-question: What are the factors contributing to the migration of doctors from South Africa?

This trend exacerbates the already severe shortages in rural areas, where healthcare facilities and resources are limited, by contributing to the ongoing migration of qualified medical professionals from these areas. This migration has significantly and variably impacted healthcare provision in rural areas. The acute shortage of trained medical professionals in these areas directly affects access to prompt and high-quality healthcare. The viability of healthcare provision is further threatened by high levels of burnout and mental health issues among the remaining healthcare workers, resulting from the increasing burden placed on them. This disruption in the continuity of care leads to delays in emergency responses, a reduction in preventive treatment, and a general decline in health outcomes. Furthermore, when rural health institutions fail and economic investment declines, a cycle of inadequate service delivery and health disparities is perpetuated, hindering infrastructure development and resource availability in rural areas.

This study extends its focus beyond immediate symptoms to examine the long-term and broader societal implications of physician migration using a consequentialist ethical framework. Consequentialism advocates policies and interventions aimed at minimising harm and maximising positive outcomes, emphasising that ethical evaluations of actions should be outcome centred. From this perspective, physician migration undermines the right to health and well-being, particularly for rural and underserved populations, rendering it an ethical issue in addition to a healthcare concern. The consequentialist framework ensures that future healthcare policies are informed by ethical commitments to equity and justice, reinforcing the necessity of comprehensive systemic solutions that consider the welfare of patients, healthcare professionals, and communities. This ethical viewpoint guides the urgency and direction of potential interventions, underscoring that addressing physician migration requires a holistic approach that considers broader social, economic, and political factors while improving working conditions, professional support, and healthcare infrastructure. This highlights the importance of collaboration among society, healthcare organisations, and policymakers to develop long-term strategies that mitigate the drivers of migration and enhance the capacity of rural health systems to retain qualified personnel.

The study addresses the second sub-question, which asks about the outcomes of physician migration on rural healthcare delivery in South Africa, by examining its impact on access, continuity of

care, and overall health outcomes in rural areas. Furthermore, the third sub-question, "How can the ethical theory of consequentialism be applied to understand and address the ethical challenges arising from physician migration?" is addressed through the application of consequentialist ethical theories. Based on this, several specific evidence-based recommendations are presented. These recommendations aim to mitigate the adverse ethical and practical effects of physician migration while promoting retention and enhancing healthcare delivery in rural areas. The recommendations include measures such as enhancing non-monetary incentives to boost healthcare workers' morale, implementing RoS agreements to stabilise workforce distribution, developing training programs tailored to rural healthcare needs, increasing the availability of mobile clinic services to alleviate physician burnout, promoting public-private partnerships to improve infrastructure and resource allocation, and fostering cooperation between traditional healers and formal healthcare providers to enhance cultural competence and community engagement. By implementing these multifaceted initiatives, stakeholders can strive to build a more resilient, equitable, and supportive rural healthcare system in South Africa. These initiatives are crucial for ensuring that every citizen, regardless of geographical location, has access to high-quality healthcare. These findings underscore the importance of approaching physician migration from a consequentialist ethical perspective to promote long-term health equity and improve the quality of life in rural South African communities.

6.3 Policy Recommendations of the Study

This dissertation demonstrates that the emigration of South African doctors to practice in other countries, either temporarily or permanently, poses moral dilemmas with practical and ethical ramifications for healthcare delivery, particularly in rural areas. Although migration offers physicians opportunities to work in countries with more favourable conditions, higher remuneration, and enhanced career prospects, it simultaneously leads to significant shortages of trained healthcare personnel in rural regions of their home country. Consequently, policy interventions should aim to address the underlying causes of physician migration, enhance the sustainability and appeal of rural healthcare positions, and mitigate the adverse effects of physician migration on South Africa's healthcare system. The strategies below aim to enhance rural healthcare delivery and advance the career development and well-being of healthcare professionals.

6.3.1 Non-Monetary Incentives for a Healthy Work Environment

The retention of medical professionals poses a significant challenge to South Africa's public health system, particularly in rural areas. Owing to persistent budgetary constraints and economic difficulties, the government is unable to offer competitive salaries to healthcare workers. Consequently, enhancing the non-financial aspects of rural healthcare delivery is crucial and achievable. Improving rural hospitals and clinics, ensuring a reliable supply of electricity and water, and providing adequate medical supplies and prescription medications are essential for enhancing the working conditions (Mburu and George, 2017:6). Physicians encounter difficulties in performing their duties effectively in under-resourced or poorly maintained facilities, which diminishes morale, leads to professional dissatisfaction, and increases the likelihood of their departure from the public sector or country.

A primary underlying cause of this issue is corruption and misallocation of public health funds. Healthcare professionals often work in substandard environments because funds intended for essential services, staffing, and infrastructure in rural clinics are frequently misappropriated or misused by the government. This exacerbates the push factors driving doctors away and directly contributes to the deterioration of the rural health service. Addressing corruption is imperative through the implementation of stricter financial controls, transparent procurement procedures, and regular assessments of the public sector. The adoption of e-procurement platforms is an effective strategy for enhancing transparency and accountability in public healthcare procurement. By transitioning from traditional paper-based procurement to digital methods, corruption, fraud, and poor management can be significantly reduced in public organisations (Molepo and Jahed, 2022:233). E-procurement establishes a standardised, accountable, and transparent system that deters unethical activities by digitally documenting and tracking all procurement operations. Fair competition is promoted by ensuring accessibility for all eligible suppliers, particularly for small and historically underrepresented businesses. Consequently, favouritism and contract monopolisation by politically connected individuals or businesses are diminished. E-procurement facilitates the efficient and equitable delivery of critical resources, especially in underserved and rural areas. By eliminating intermediaries, administrative costs, and inflated pricing, which are often associated with unethical practices, it also enhances cost-effectiveness (Molepo and Jahed, 2022:235). Modern e-procurement platforms with real-time monitoring and data analytics capabilities enable the early

detection of anomalies or suspicious spending patterns, allowing oversight organisations and health officials to investigate and hold individuals accountable for their actions. If corruption is not addressed, even well-designed retention plans will ultimately fail to achieve their full potential (Jarbandhan et al., 2023:85).

To enhance rural physician retention, it is imperative to further develop support groups, improve infrastructure, and eliminate corruption. Recruiting adequate numbers of nurses, community health workers, and administrative staff can significantly alleviate physicians' workloads. Additionally, the quality of life of these professionals is crucial. Many physicians are reluctant to remain in rural areas because of poor living conditions, inadequate housing, limited transportation, and insufficient educational opportunities for their children (Baytopp et al., 2025:3). The provision of essential services and acceptable living conditions can facilitate a more sustainable lifestyle for healthcare workers and their families in rural areas. Addressing this issue necessitates effective collaboration between the Department of Health and the Department of Human Settlement. The field of rural medical work is of significant interest, requiring collaboration among these departments to ensure improved living and working conditions for clinical service providers in the future.

The limited availability of specialisation programs, career advancement opportunities, and further training prompts many healthcare professionals to leave South Africa to seek these opportunities abroad. The absence of promotion prospects may lead to a sense of stagnation among doctors, ultimately diminishing their motivation and commitment to practising medicine in the country. To address this challenge, it is essential to establish publicly accessible, locally based training programs that enable medical professionals to advance their careers without having to relocate to another country. This initiative can be supported by legislation that provides financial assistance and study leave for individuals pursuing additional training or specialization (Thusi and Nkgapele, 2024:1758). The utilisation of technology to deliver online learning modules can also help overcome geographical barriers and offer continuous professional development to individuals, regardless of location. Establishing a supportive work environment is crucial for achieving this. Through formal mentorship programs, doctors can be paired with experienced individuals who provide clinical support, career guidance, and leadership development. According to Burgess et al. (2018), the formation of peer support groups facilitates communication and emotional support, while also reducing professional isolation. Furthermore, expressing gratitude and formally recognizing the

contributions of medical staff in underserved communities can enhance morale, instill pride, and underscore the importance of their work (Willis-Shattuck et al., 2008, p. 5).

The integration of these strategies will facilitate the creation of a more attractive and sustainable work environment, encouraging physicians to remain in South Africa's rural areas. This, in turn, will strengthen the country's healthcare system and mitigate the factors driving doctors to migrate to other countries.

6.3.2 Implement Return-of-Service Agreements

Enhancing and broadening the implementation of RoS agreements is a practical approach to mitigating the adverse effects of doctor migration on South Africa's rural healthcare delivery system. These contracts involve legally binding commitments from government-funded medical students to serve in designated public or rural health facilities for a specified duration after graduation (Mabunda et al., 2022:1). By ensuring that newly qualified healthcare professionals contribute significantly to the public health system rather than seeking opportunities abroad, this policy mechanism directly addresses physician shortages in underserved areas. The effectiveness of RoS agreements depends on robust legal and administrative frameworks that clearly outline graduates' obligations and the consequences of non-compliance. This includes timely monitoring of service placements and enforcing penalties for noncompliance, such as financial penalties or restrictions on professional licences. Effective enforcement ensures a steady influx of physicians into rural healthcare institutions, where they are most needed, and safeguards the government's investment in healthcare professional training (Mabunda et al., 2022:5).

For doctors in rural areas, fostering completion and creating a positive experience during the service term requires more than just enforcement. As Mabunda et al. (2023:6) note, many new medical graduates encounter limited opportunities for skill development, inadequate mentorship, and a sense of professional isolation during their services. These challenges can be alleviated by implementing mentorship programs and ongoing professional development activities, making distant assignments more appealing and sustainable. Such support enhances job satisfaction and increases the likelihood that physicians will choose to remain in rural areas after fulfilling their service obligations. Return-of-Service initiatives must be integrated with broader efforts to improve working conditions and healthcare infrastructure in rural areas (Mabunda et al., 2023:7). Doctors are more likely to remain in rural hospitals if they have access to adequate medical supplies, functional

equipment, and safe living conditions. Even the strictest RoS agreements may ultimately fail to retain healthcare personnel in underserved areas if systemic issues are not addressed. Return-of-service requirements can be paired with incentives that promote further professional development (Mabunda et al., 2023:6). Making rural services more attractive can be achieved by offering preferential access to specialised training and other educational opportunities for physicians who complete their rural service.

Finally, open communication and early engagement of medical students are crucial for the success of RoS agreements. By fostering an early sense of professional and ethical responsibility towards rural communities, the government and educational institutions can build commitment and reduce criticism of mandatory service. Educating students about the importance of healthcare in rural areas and the impact of physician migration may help promote RoS as a vital component of creating a more equitable healthcare system (Mabunda et al., 2023:6-7).

6.3.3 Strengthen Workforce Planning and Training

Improving personnel planning and training is a vital long-term solution to the persistent shortage of doctors in South Africa's rural healthcare system. One of the most effective strategies for ensuring a stable rural health workforce is to prioritise the recruitment and training of students from underserved and rural areas (Mkhize et al., 2025:14). Research conducted in South Africa and globally indicates that medical students from rural backgrounds are significantly more likely to return to and practice in these areas after graduation. Factors such as social familiarity, a sense of belonging, and a strong desire to contribute to their hometowns play a role in this trend (George, 2019:100). To implement this strategy, government agencies and medical schools must revise their admission processes to increase the proportion of students from rural regions. This could be achieved by offering specific quotas or bursary programmes aimed at students from underprivileged families and remote schools (MacGregor and Ross, 2024:46). Despite their potential and willingness to succeed in medical school, rural students often face inadequate academic support systems necessary for university enrolment. However, this challenge can be addressed through targeted recruitment, academic bridging programs, and financial assistance, such as scholarships, bursaries, or other forms of financial support, which can significantly increase the number of students from remote areas entering the health professions pipeline.

Furthermore, providing students with more opportunities to study and practice in rural areas is essential for enhancing the quality of medical education. Currently, most South African medical students are trained in large urban institutions, which differ significantly from rural clinics. Students will be able to observe and comprehend the difficulties, diseases, and scarce resources that healthcare professionals encounter in rural areas if they are required to work at these facilities for a portion of their training (MacGregor and Ross, 2024:47). Students gain increased competence and self-assurance in handling rural healthcare demands as a result of practical experience. More doctors may choose to practice in rural areas in the future, as it helps students view it as a legitimate and fulfilling career choice. Rural training facilities foster interprofessional collaboration and community engagement. Medical students who practice in rural areas frequently gain in-depth knowledge of public health strategies and collaborative care through direct engagement with nurses, community health workers, and other primary care providers (MacGregor and Ross, 2025:2). These experiences hold particular significance in South Africa, where the burden of disease in rural areas is worsened by poor infrastructure, limited access to medical services, and poverty. However, most students who receive education in these environments are better equipped to practice medicine in a clinically and socially responsible manner.

Effective workforce planning is required to ensure that the number of healthcare professionals being trained corresponds with national health priorities. This involves precisely forecasting future requirements, especially in regions such as the Eastern Cape, Limpopo, and KwaZulu-Natal, which persistently face a shortage of medical doctors (Barnacle et al., 2020:2). Lastly, legislators must realise that merely hiring more doctors will not address the healthcare situation in rural areas. Basic healthcare should be the focus of competency-based, context-specific training (Barnacle et al., 2020:2-3). The prevalence of illnesses in rural regions, including infectious diseases, issues with mothers and children, and trauma-related injuries, must be represented in teaching materials. The creation of a curriculum suitable for rural practice and social sensitivity raises the possibility that graduates will feel prepared and motivated to work in these challenging yet fulfilling environments (Barnacle et al., 2020).

6.3.4 Deploy Mobile Clinics to Reduce Burnout Among Rural Doctors

Given the severe staffing shortage and high rates of burnout among rural doctors, mobile clinics can successfully solve the problem of healthcare delivery in rural areas of South Africa (Nkosi,

2024:1). Doctors in South Africa's rural health profession are becoming increasingly concerned about burnout, which is typified by depersonalisation, fatigue, and a diminished sense of personal accomplishment. This is due to the fact that they frequently deal with isolation, heavy patient loads, and little medical assistance. The Department of Health may reduce the pressure on rural healthcare providers by expanding service delivery throughout a wider network of care points using mobile health units (Nkosi, 2024:3). These mobile clinics can provide basic primary healthcare services directly to those who live far away, including immunisation, chronic disease management, health screenings, and prenatal and paediatric examinations. They are usually staffed by nurses, clinical associates, and community health professionals (Nkosi, 2024:4). Doctors may concentrate on more complex situations and better manage their workloads because fewer individuals visit crowded fixed clinics or far-off hospitals.

In remote areas with limited resources, mobile clinics are essential for facilitating collaborative treatment and job moves. Healthcare delivery is shared among suitably qualified support workers rather than relying solely on the small number of doctors available (Callaghan et al., 2025:1). This approach reduces the mental and emotional burden on doctors while trying to meet the unique needs of every patient. This collaborative strategy enhances service effectiveness and reduces professional isolation, which is commonly recognised as a primary contributor to burnout (Akkus et al., 2021:125). Additionally, mobile clinics help clinicians avoid being overloaded with patients in numerous rural areas by facilitating coordinated rotating outreach operations. Most importantly, the use of mobile clinics may increase physicians' confidence by supporting the idea that the healthcare system is accommodating and responsive (Akkuş et al., 2021:127). Incorporating mobile clinics into a coordinated district health system conveys the idea that rural physicians are part of a larger network of healthcare providers rather than operating independently. For retention and mental health, this sense of institutional support is crucial (Akkuş et al., 2021:130). Furthermore, mobile clinics can serve as training grounds for medical students, community service officers, and interns during rural rotations. Additionally, it can facilitate service expansion, offering rural physicians' temporary relief and mentorship opportunities, enabling them to take leave or pursue professional development. Mobile clinics foster a more compassionate workplace while alleviating the mental and physical burdens on rural doctors.

6.3.5 Promote Public-Private Partnerships (PPPs)

Public-private partnerships (PPPs) could help South Africa's rural healthcare system overcome several challenges, including the need to improve service quality and retain medical personnel. In South Africa, where public health services are frequently understaffed, underfunded, or poorly maintained, public-private partnerships involving companies, NGOs, donor agencies, and academic institutions can address serious service-delivery issues. It has been demonstrated that PPPs enhance infrastructure, access to care, and system efficiency in sub-Saharan African healthcare systems, especially when the roles and responsibilities of all parties involved are well defined (Bockmann, 2020:196). Such collaborations are not only beneficial but also necessary in South Africa, particularly given the ongoing challenges in improving healthcare in rural areas, including a lack of public funding, inadequate infrastructure, and high levels of corruption. The capacity of public-private partnerships to support the development and ongoing operation of healthcare facilities in rural areas is one of their most obvious advantages.

One of the most apparent advantages of public-private partnerships is their ability to support the building and maintenance of healthcare facilities in rural areas. For decades, public clinics and hospitals in remote locations have been underfunded, resulting in outdated buildings, frequent power outages, and shortages of essential medical supplies. For healthcare workers, these are extremely disheartening circumstances, and they significantly contribute to high turnover rates. However, public-private partnerships can play a significant role in the construction of new clinics, the renovation of existing ones, and the establishment of quality infrastructure, such as sanitation services, clean water supplies, and solar energy systems, through cooperative investment and long-term service contracts (Bockman, 2020:202-203). This enhances patient care and attracts more medical professionals to rural areas. For instance, one of the most urgent issues affecting the standard of living for rural medical doctors can be resolved by collaborating with public organisations and private engineering and construction companies to build or modify homes for staff close to clinics. The operations of healthcare institutions could be significantly improved through infrastructure-focused collaborations, which would ultimately enhance patient outcomes and employee satisfaction (Bockmann, 2020).

In addition to infrastructure construction, the development of public-private partnerships is important for improving access to technological innovation and digital health. The reduction of

corruption and promotion of transparency can be achieved through digitalization, as stated in Section 6.3.1. Digital health platforms, including supply chain management systems and telemedicine portals, are highly secure and can be designed or operated by private technology companies for their own use. These systems expedite administrative processes and enhance clinical decision-making by connecting rural healthcare providers with specialists in remote areas. Technology can also improve the quality and accessibility of healthcare delivery, especially when practices are transparent and performance evaluations are conducted, as demonstrated by an analysis of the effects of public-private partnerships in medical rehabilitation services (Mazibuko et al., 2023:30). Telemedicine, for instance, improves the quality of care by enabling distant doctors to consult with senior specialists in real time, eliminating the need for patient transfers or long-distance travel.

Through focused education, training, and retention initiatives, public-private partnerships can also significantly contribute to the development of the health workforce. It takes more than just financial incentives to keep doctors in rural areas; they also need career advancement possibilities and professional development opportunities, as previously pointed out (Poulter et al., 2023:6). By collaborating with private medical institutions, hospitals, and funding bodies, government entities can broaden opportunities for learning, guidance, and ongoing skill enhancement for physicians serving under-resourced communities (Gumede et al., 2021:3-4). These alliances can also feature shared learning schemes, work placements, and financial aid packages. This prepares future healthcare workers to practice in remote regions by allowing them to gain experience in both government-run and private medical centres. These efforts provide rural doctors with opportunities for further education, awareness of advanced medical techniques, and connections with other professionals in the field. This can improve their likelihood of staying in their positions and their overall contentment in their job satisfaction. According to Mazibuko et al. (2023:3-4), public-private partnerships can be established to provide comprehensive capacity-building interventions, which are crucial for maintaining knowledgeable and motivated rural health staff.

Public-private partnerships can raise much-needed funds from international donors and development finance organisations. Many donor agencies prefer to channel aid through partnership structures that promote accountability, cost-sharing, and sustainability, as explained by Vincent et al. (2024:2191) in their investigation of Official Development Assistance (ODA) funding for PPPs. This offers South Africa a significant opportunity to employ PPPs as a means of financing chronic

illness management services, maternity and child health programs, preventive care initiatives, and mobile health clinics in remote areas. Companies in rural regions, especially those in the mining, energy, and agricultural industries, can also get involved as community health partners by logistically or financially supporting outreach initiatives that benefit the workforce and local population (Panteleeva et al., 2021:1). These mobile clinics, which I first mentioned in Section 6.3.4 are essential for relieving the strain on stationary rural facilities and helping overburdened medical personnel. Mobile clinics can be deployed more regularly, better equipped, and run sustainably over time with the help of the business sector.

Public-private partnerships can implement more adaptable and effective staffing models that alleviate workloads and protect rural physicians from burnout. During times of high demand or staff shortages, private sector partners may use shared human resource agreements to supply temporary physicians or visiting specialists to rural public clinics (Joudyian et al., 2021:11). These partnerships may also include scholarships, internships, and cooperative training programs that provide prospective medical professionals with the opportunity to gain experience in both public and private healthcare facilities, thereby preparing them for practice in rural areas. These initiatives provide rural physicians with access to continuing education, exposure to cutting-edge medical procedures, and opportunities to network with other experts, all of which enhance retention and job satisfaction.

Partnership contracts can support and strengthen the governance, accountability, and transparency of public healthcare provision, thereby contributing to the development of a robust healthcare system. Private-public partnerships are important for creating a responsive culture that guarantees the efficient application of public funds and effective services to target beneficiaries when they are regulated through open contracts, performance indices, and regular audits (Adu, 2023:23). This is especially critical in the countryside, where abuse and mismanagement have long stood in the way of success. Objective assessments, collaborative oversight bodies, and open collaborations between the government and private entities can help prevent unethical behaviour and promote ethical leadership in healthcare. Beyond improving results, Bockmann (2020:196–200) highlights that these public-private collaborations, when backed by strong organizational structures, also boost the trust and drive of healthcare professionals who directly serve patients, many of whom have lost faith due to problems within the existing system.

6.3.6 Collaboration with Traditional Healers

The lack of doctors and restricted access to physical health services are two major issues facing South Africa's rural healthcare sector. Collaborating with traditional healers is an important strategy that can improve healthcare delivery in underprivileged areas. Deeply ingrained in indigenous societies, traditional medicine is formed by customs, knowledge, and abilities that have been passed down through centuries (Gizaw et al., 2022:1). In terms of physical health, it also covers emotional, social, and spiritual well-being, all of which are highly valued in many rural areas of South Africa. The official healthcare system should include traditional healers to enhance rural healthcare outcomes and alleviate physician shortages in these areas. Traditional healers are the first choice for medical care in rural South Africa because people seek their help for mental health problems, chronic diseases, and culturally specific medical needs (Gizaw et al., 2022:7). The community views traditional healers as trustworthy healthcare providers because they offer accessible and affordable services that align with local cultural practices and beliefs. Traditional healers receive more patient visits than biomedical practitioners because patients feel more comfortable discussing their spiritually based illnesses with them. The healthcare system faces a major coverage gap because traditional medicine practitioners remain essential to their communities, despite the unavailability of formal medical services in rural areas (Gizaw et al., 2022).

The partnership between traditional healers and biomedical healthcare providers leads to better patient treatment adherence and improved health education and referral systems (Mendu and Ross, 2019:104). Traditional healers who learn to recognise serious health conditions, such as mental health problems, TB, and HIV/AIDS, can send patients directly to biomedical clinics for proper treatment. The combination of early disease detection and treatment yields better health outcomes owing to this collaborative approach. The integration of traditional healers into public health programs enables them to support community-based initiatives for immunisation and maternal healthcare services (Mendu and Ross, 2019:109). Including traditional healers in the medical system offers an opportunity to standardise procedures and ensure the safety of patients. National laws and regulations can assist in standardising traditional healing methods, offering certification and training, and shielding patients from dangerous medical procedures. This oversight can strengthen public trust in the harmonious operation of biomedical and traditional healthcare systems.

In the crucial field of mental health, working with traditional healers is extremely beneficial. People may be reluctant to seek help from biomedical services because mental health problems are stigmatised (Green and Colucci, 2022:94). Traditional healers are often the first individuals approached by those with mental health difficulties and are highly regarded in their communities, making them essential for providing culturally appropriate care. By teaching traditional healers about mental health awareness and equipping them with basic counselling skills, health systems can offer mental health support that goes beyond the limited number of psychiatric specialists available (Green and Colucci, 2020:100). Access to basic healthcare services can be greatly enhanced by integrating traditional medicine into national health systems, especially for people living in underserved and remote areas. The World Health Organization recommends incorporating traditional healers to help achieve widespread access to healthcare, especially in areas with limited or inadequate conventional medical services. Studies in South Africa suggest that integrating standard medical care with traditional healing methods may benefit patients (Green and Colucci, 2020:104). This inclusive strategy, which respects cultural customs and values, expands and improves healthcare options, potentially leading to better health outcomes in rural areas.

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To Whom It May Concern

This letter serves to confirm that I, Dr. Olaoluwa O. Olarewaju, completed the language editing of the Master of Arts (MA) dissertation submitted by Ms. Zesuliwe Mhlongo (Student Number: 221061794), titled: "Ethical implications of doctor migration on rural healthcare delivery in South Africa"

The dissertation was edited for grammar, punctuation, clarity, academic tone, logical flow, and overall coherence. As part of the editing process, the use of first-person expressions ("I," "me," "my") was removed to maintain the objectivity and formal tone expected in academic writing.

In addition, the abstract was refined as a complimentary service to ensure alignment with the main text, while the reference list was checked for formatting consistency. I have included comments within the document highlighting areas where reference details may require further verification by the student.

All editing was performed using Microsoft Word's Track Changes feature to allow the student to review and approve all suggested edits.

A final copy of the edited document is kept on record by Emma Vision Consulting.

Sincerely,
Dr. Olaoluwa O. Olarewaju
Lead Consultant | Emma Vision Consulting