

Draining the Lifeblood from Nigeria's Healthcare System an Investigation of Critical Drivers of Brain Drain in Lagos' Public and Private Hospitals

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Abstract

High rates of healthcare workforce emigration ("brain drain") pose a critical challenge in Nigeria, depleting the health system of skilled professionals. This study investigates critical workplace factors driving healthcare professionals' intentions to emigrate from Lagos State, Nigeria. A cross-sectional survey of 860 physicians, nurses, and other health workers from public and private hospitals was analysed using structural equation modelling to test the effects of five quality-of-work-life factors: workload, workplace safety, professional autonomy, perceived organisational support, and non-wage benefits on migration intentions. The structural model revealed that workplace safety was the most potent driver of brain-drain intentions, followed by workload and professional autonomy. Unsafe working conditions and excessive workloads significantly heightened intentions to migrate, while limited decision-making autonomy also contributed to higher migration propensity. In contrast, greater perceived organisational support and more robust non-wage benefits were associated with reduced migration intentions, although their mitigating effects were comparatively modest. These findings underscore that beyond low salaries, poor working conditions and lack of support drive healthcare brain drain. Policy interventions focusing on improving workplace safety, balancing workloads, and enhancing professional autonomy, along with strengthening support and non-monetary incentives, are critical to retaining healthcare talent. The study further contributes to the literature by demonstrating the decisive role of quality-of-work-life factors in driving health workers' migration decisions.

Keywords: brain drain; non-wage benefits; perceived organisational support; professional autonomy; workload; workplace safety.

INTRODUCTION

Healthcare workforce migration, often termed "brain drain," poses a persistent and critical challenge to Nigeria's health sector, exacerbated by inadequate infrastructure and limited resources. Despite being home to over 215 million people which is the largest population in Africa despite this Nigeria suffers from a severe shortage of medical professionals, with only 38 doctors per 100,000 people, far below the WHO benchmark of 166 per 100,000 (Ikhide, 2021; World Health Organisation, 2022). This shortage is intensified by the significant

emigration of Nigerian-trained healthcare workers, with nearly half of the country's doctors practicing abroad due to low remuneration, poor working conditions, and inadequate medical facilities (Ikhide, 2021; Premium Times, 2024).

In Lagos State, the country's economic and commercial hub, the outflow of skilled healthcare professionals is particularly acute. Empirical evidence from Akinwale, Kuye, and George (2024) shows that a considerable proportion of doctors, nurses, and allied health workers in Lagos relocate to destinations such as the United Kingdom, Canada, and the United States in search of improved working environments, career advancement opportunities, and enhanced quality of life.

While healthcare worker migration is a global phenomenon, the scale in Lagos is especially concerning given the city's heavy patient burden, overstretched health infrastructure, and chronic underfunding. Public hospitals, which cater to the majority, face acute understaffing, dilapidated facilities, and severe resource constraints that undermine service delivery (Adebogun et al., 2024; Akinwale et al., 2024). Even private hospitals though generally better resourced struggle to retain experienced staff, as many are drawn to foreign healthcare systems offering greater job security, professional satisfaction, and superior working conditions (Esene et al., 2024).

The migration of healthcare workers from Lagos State carries profound and long-term implications, including the depletion of the medical workforce, widening disparities in healthcare access, rising patient morbidity and mortality rates, and heightened performance pressures on those who remain. As the demand for healthcare services rises due to population growth and shifting disease patterns (Asamani et al., 2018; Monsef, Suliman, Ashkar, & Hussain, 2023), the continuous outflow of skilled professionals (Olowolaju, Akpor, & Adeoluwa, 2025) threatens the long-term stability and resilience of Lagos State's healthcare system. Consequently, identifying and addressing the root causes of this migration is essential to developing sustainable retention strategies.

Despite mounting concerns over the depletion of Nigeria's healthcare workforce, government spending on health remains critically low just 3% of GDP which is significantly below the average investment levels of Organisation for Economic Co-operation and Development (OECD) countries (Sasu, 2024). This underinvestment limits the country's capacity to offer competitive salaries, modern medical infrastructure, and professional development opportunities, pushing many healthcare practitioners to pursue better prospects abroad. This trend not only jeopardizes Nigeria's ability to achieve its health related Sustainable Development Goals (SDGs) but also accelerates the erosion of its healthcare workforce, compounding the nation's public health challenges.

Policy responses to healthcare worker migration in Nigeria have largely been reactive, often centering on salary increases or restrictive migration measures, rather than tackling the systemic workplace deficiencies that fuel brain drain. A systematic review by Toyin-Thomas et al. (2023) reveals that macro level issues particularly low remuneration and security challenges are the most influential drivers of migration, cited in 83.2% and 58.9% of studies,

respectively. This underscores the need to address fundamental macroeconomic and working-condition factors as a priority in any effective retention strategy.

Policy interventions in Nigeria have largely overlooked factors those related to organizational and job-specific conditions such as limited career advancement opportunities, poor work life balance, and unsafe working environments. The African Union (2023) reports that, when addressing health worker migration, Nigeria and many other African countries tend to rely on restrictive measures, such as curbing outward migration, rather than tackling the underlying drivers, including workplace dissatisfaction and poor working conditions. Moreover, much of the current research on healthcare migration remains focused on macroeconomic determinants, often neglecting these critical organizational and job related influences that shape individual migration decisions (Adebayo & Akinyemi, 2022; Nwafor & Clement, 2024; Poku et al., 2023).

However, recent findings by Okoroafor et al (2023) reveal that primary healthcare workers' workplace preferences are shaped by a combination of working conditions, living environment, and human resources for health (HRH) management practices. Within working conditions, key considerations include facility quality, workload, scope of practice, and community support. The living environment is influenced by housing quality, transport access, and the availability of quality education for children. HRH management practices such as supportive leadership, fair remuneration, opportunities for career progression, and continued professional education also strongly affect workplace choices.

In Lagos State, where healthcare facilities face persistent workforce shortages, deteriorating working conditions, and governance inefficiencies (Adebogun et al., 2024), understanding the influence of Quality of Work Life (QWL) factors is critical in shaping strategies to mitigate brain drain. Without empirical insights into how workload, organizational support, workplace safety, professional autonomy, and non-wage benefits affect migration intentions, retention policies risk being poorly targeted and ineffective (Samuel et al 2025; Ulupinar et al., 2024). This study aims to bridge that gap by providing an evidence based analysis of the workplace realities that drive healthcare professionals in Nigeria's public and private sectors to seek employment opportunities abroad.

Centering on Lagos State which hosts one of the largest concentrations of healthcare professionals in Nigeria (Ibrahim et al., 2024) thereby prompting this study to examine how Quality of Work Life (QWL) practices influence the migration intentions of healthcare workers. Specifically, it seeks to analyze the relationship between workload and brain drain tendencies and evaluate the impact of organizational support, also to investigate concerns around workplace safety, assess the influence of professional autonomy, and determine the extent to which non-wage benefits shape decisions to migrate.

The study is significant in both theoretical and practical terms. From a theoretical perspective, it advances the body of knowledge on healthcare workforce migration by adopting a QWL focused lens to interpret brain drain dynamics. By integrating workplace factors and professional autonomy into existing models, it offers a more nuanced understanding of the

determinants of migration and enriches the wider discourse on labor mobility in developing economies.

From a practical standpoint, this study provides evidence-based insights for policymakers, hospital administrators, and healthcare regulatory authorities aiming to strengthen workforce retention. By pinpointing the QWL factors that shape migration decisions, it delivers targeted policy recommendations that go beyond salary increases to encompass structural reforms designed to boost job satisfaction and professional fulfilment. Such insights are vital for ensuring the long-term sustainability of Nigeria's healthcare workforce.

Furthermore, the findings will inform human resource management and employment relations in both public and private hospitals, shedding light on necessary improvements in working conditions, organizational support, and non-monetary incentives. In the face of Nigeria's ongoing healthcare workforce crisis, these recommendations can guide retention strategies that limit dependency on expatriate workers and curb the long-term impact of brain drain on the health system.

By addressing existing empirical gaps and broadening the policy dialogue to include workplace quality and professional fulfilment, this study presents a holistic understanding of healthcare brain drain and proposes actionable measures to enhance workforce sustainability in Lagos State.

LITERATURE REVIEW

The literature review is structured into three main sections: conceptual, theoretical, and empirical. The conceptual review examines the core elements of Quality of Work-Life (QWL) such as workload, organizational support, workplace safety, non-wage benefits, and professional autonomy alongside an exploration of brain drain intentions. The theoretical review analyses frameworks that link QWL to migration intentions, offering deeper insight into the migration patterns of healthcare professionals. The empirical review consolidates and evaluates prior research, critically analyzing the factors that drive brain drain within Nigeria's healthcare sector. Together, these sections provide a comprehensive foundation for the study, introduce fresh perspectives, contribute to existing scholarship, and address critical gaps in understanding the workplace dynamics influencing healthcare professionals' decisions to seek opportunities abroad.

Concept of Quality of Work Life (QWL)

Quality of Work Life (QWL) refers to the extent to which employees are able to fulfil their personal and professional needs through their workplace experiences (Akinwale et al., 2025). It encompasses multiple dimensions, including fair and adequate compensation, safe and healthy working environments, opportunities for career advancement and personal growth, job security, and the broader social significance of one's work (Binti et al., 2025). In the healthcare sector, QWL holds particular importance, as it involves factors such as workplace safety, recognition through non-wage benefits, career development opportunities, professional

growth, training, and advancement all of which have direct implications for job satisfaction, workforce retention, and the quality of patient care (Alsabhan et al., 2025).

QWL is also relevant beyond healthcare. For instance, Akinwale et al (2023), examine how workplace conditions and career progression shape the well-being of Nigerian university lecturers. In a related study, Akinwale et al (2024a), conceptualize QWL as a measure of employees' psychosocial well-being, finding that excessive workloads and poor work-life balance reduce job satisfaction and increase migration intentions, and recommending that improving QWL requires alleviating excessive work demands. Similarly, Akinwale, et al (2025), emphasize QWL as central to workforce capacity development, which is essential for maintaining organizational performance in the era of AI-driven changes. Alsabhan et al. (2025), conclude that enhancing workplace safety, recognition, and career opportunities can improve job satisfaction and lower brain-drain tendencies among healthcare workers. Likewise, Binti et al (2025), frame QWL in the textile industry as the balance between the work environment and employee welfare, showing that improved QWL fosters higher retention and better performance.

Quality of Work-Life (QWL) Components

Workload

Essien et al. (2024), define workload as the volume of work or schedule assigned to healthcare professionals within a set period, noting that inadequate resources often lead to burnout and increase migration intentions among psychiatrists in Nigeria. Similarly, Ebeye et al (2023), describe workload as the total range of tasks, duties, or responsibilities expected of physicians within a specific timeframe, identifying it as a major stressor and source of job dissatisfaction that drives physician emigration from West Africa. Anees et al (2021), echo this perspective, viewing workload as the physical and mental effort required to perform job related tasks, with excessive demands serving as a direct trigger for turnover intentions, as seen among university lecturers. Likewise, Akinwale et al (2024b) link workaholics which is characterized by persistently high task volumes to burnout and heightened migration intentions among Nigerian IT professionals. Ibrahim et al. (2023) focus on healthcare staffing, describing workload in terms of high patient to nurse ratios, which they connect to the outmigration of nurses in Ghana. Collectively, these definitions underscore workload as a significant determinant of brain-drain intentions.

Perceived Organisational Support

Jha et al (2025), define perceived organizational support as the degree to which healthcare professionals feel valued and supported by their institutions, particularly in areas such as career development and mentorship. Similarly, Chidebe et al. (2023), describe organizational support within Nigeria's oncology sector as the provision of institutional resources, including training and career advancement opportunities, which play a crucial role in shaping turnover intentions. Muzingili (2025) views perceived support as the recognition and resources extended to social workers, noting that low levels of support influence their decisions to migrate. Bener et al (2025), link organizational support which is defined as institutional commitment to enhancing

career development and improving working conditions to brain drain intentions among Turkish physicians. Tosunoz (2024) frames organizational support as the extent to which employees believe their organization values their contributions and cares for their well-being, encompassing recognition, career growth opportunities, and adequate resources. Across these studies, insufficient organizational support especially regarding career advancement and work conditions emerges as a significant driver of migration, prompting employees to seek better opportunities elsewhere.

Workplace Safety

Leitao et al (2024), describe workplace safety as the adequacy of protective measures in safeguarding healthcare workers, particularly in conflict zones, where inadequate safety provisions heighten migration rates. Gostautaitė et al (2024), emphasize the importance of incorporating robust safety protocols into HR strategies in high-risk healthcare environments as a means to curb brain drain. Poku et al. (2023) frame workplace safety around concerns such as patient violence and poor working conditions, which heavily influence nurses' migration decisions in Ghana. Abasilim et al (2024), highlight the absence of adequate protective measures and the high exposure to diseases in Nigeria's healthcare sector as key factors driving healthcare worker migration. Similarly, Adebayo et al (2022), link substandard safety practices in Nigerian hospitals to increased migration intentions among doctors. Collectively, these studies position workplace safety as a pivotal factor in shaping brain drain intentions.

Professional Autonomy

Skubis et al (2023), define professional autonomy as the extent of decision-making authority and control healthcare workers possess over patient care, noting that limited autonomy contributes to brain-drain intentions in Nigeria. Bener et al (2025), describe it as the capacity to make clinical decisions and engage in policy formulation, a factor influencing physician migration in Turkey. Tosunoz et al (2022), examine autonomy from the perspective of nursing students' expectations of control in their future careers, linking it to migration intentions. Akinwale et al. (2024b) broaden the definition to encompass freedom within job roles, arguing that restrictions in this area can lead to burnout and heightened migration desires among IT professionals in Nigeria. Gostautaitė et al. (2024) view professional autonomy as the degree of influence healthcare workers exert in both clinical and organizational decision making, with higher autonomy associated with lower migration intentions. Collectively, these studies underscore professional autonomy as a crucial factor in mitigating brain drain.

Non-Wage Benefits

Leal et al. (2024) define non-wage benefits as supplementary perks provided by employers such as career development programs, health insurance, and flexible working hours which can reduce employees' migration intentions. Abasilim et al (2024), similarly highlight the significance of non-wage benefits in Nigeria, noting that provisions like healthcare insurance and career development opportunities play a crucial role in mitigating brain drain tendencies. Boadu et al. (2024) emphasize that the absence of such benefits, particularly pensions, is a key

driver of migration intentions among nurses in Ghana. Likewise, Adebayo et al (2022), report that the lack of scholarships and retirement plans significantly influences migration decisions among Nigerian doctors. Khan et al. (2024) broaden the perspective by defining non-wage benefits as beyond salary incentives, including professional development and insurance, which help reduce brain drain intentions among pharmaceutical professionals in Pakistan. Collectively, these studies underscore the pivotal role of non- wage benefits in retaining healthcare workers.

Brain-Drain Intentions

Brain-drain intentions describe the inclination of healthcare workers to migrate abroad in search of better career prospects. Wanniarachchi et al (2020), define this phenomenon as employees' aspiration to leave for improved opportunities, often triggered by poor organizational culture, limited career growth, and low job satisfaction. They recommend enhancing employee engagement and creating supportive work environments as strategies to curb migration tendencies. Similarly, Abasilim et al (2024), portray brain drain intentions in healthcare as the predisposition to migrate due to structural shortcomings and inadequate work life balance. Macedo et al (2021) further characterize brain-drain intentions as professionals' desire to relocate for better prospects, stressing that ineffective leadership and weak organizational culture exacerbate the trend. Collectively, these studies emphasize that tackling organizational deficiencies is critical to mitigating brain drain intentions.

Empirical Review of QWL Dimensions as Possible Drivers of Healthcare Brain Drain

Workload and Brain Drain Intentions

Essien *et al.* (2024) examined the role of workload in the migration decisions of early career psychiatrists in Nigeria. The study, using a cross-sectional survey of 150 psychiatrists, found that excessive workloads, including long hours and inadequate resources, were key predictors of brain-drain intentions. The study recommended improving work-life balance to reduce burnout. Ebeye and Lee (2023) further explored workload in the context of physician emigration from West Africa. Their review of 40 studies highlighted workload as a central factor influencing emigration, especially in countries like Nigeria, and recommended restructuring workloads to mitigate brain drain. Anees *et al.* (2021) expanded on this by exploring job stress and workload in university lecturers in Pakistan. They found that workload directly influenced turnover intentions, with job satisfaction acting as a mediator. Akinwale *et al.* (2024b) extended this by exploring workaholism, a manifestation of excessive workload, among IT professionals in Nigeria, recommending workload reduction strategies to curb brain-drain intentions. Ibrahim *et al.* (2023) also identified workload as a significant factor in brain-drain among nurses in Ghana, recommending improved staffing levels and support systems.

Jha *et al.* (2025) explored perceived organisational support and its influence on brain drain among healthcare workers in Nepal, finding that low support, particularly in career development, was a key driver of migration. Chidebe *et al.* (2023) investigated the Nigerian oncology sector, revealing that insufficient organisational support, including limited resources

and career progression opportunities, contributed to brain-drain intentions. Muzingili (2025) examined organisational support among social workers in Zimbabwe, finding similar patterns where low support, especially in terms of recognition and resources, influenced emigration. Bener *et al.* (2025) studied perceived support in Turkey's healthcare system, linking low career advancement and poor work conditions to increased brain-drain intentions. Tosunoz (2024) synthesised findings from over 30 studies, concluding that inadequate organizational support significantly contributes to brain drain, with a call for enhanced support systems.

Leitao *et al.* (2024) found that workplace safety significantly influenced brain-drain decisions among healthcare workers globally, particularly in conflict zones. Goštautaitė *et al.* (2024) further highlighted the importance of safety protocols in retaining healthcare workers, recommending the integration of safety measures in HR strategies. Poku *et al.* (2023) focused on Ghana, where concerns over workplace safety, including patient violence and poor conditions, were key factors driving nurses' migration. Abasilim & Obozekhai (2024) also identified safety concerns, such as inadequate protective measures and exposure to infectious diseases, as major drivers of brain drain in Nigeria. Adebayo & Akinyemi (2022) explored workplace safety in Nigerian hospitals, where poor safety standards influenced doctors' decisions to migrate. These studies collectively underscore the need for enhanced safety measures to mitigate brain drain.

Skubis *et al.* (2023) explored professional autonomy in Nigeria, finding that restricted decision-making and limited influence over patient care contributed to brain-drain intentions. Bener *et al.* (2025) also linked limited autonomy in clinical decision-making to increased migration intentions among physicians in Turkey, recommending greater involvement of healthcare workers in decision-making processes. Tosunöz & Nazik (2022) examined nursing students' perceptions of professional autonomy in Turkey, finding that students who perceived low autonomy were more likely to express migration intentions. Akinwale *et al.* (2024b) extended this by linking restricted autonomy among IT professionals in Nigeria to high burnout and migration desires. Gostautaitė *et al.* (2024) explored professional autonomy among young healthcare workers, revealing that those with greater autonomy were less likely to migrate. These studies highlight the importance of empowering healthcare workers through greater autonomy to reduce brain drain.

Leal-Solís *et al.* (2024) explored the role of non-wage benefits in reducing brain drain, finding that career development opportunities, health insurance, and flexible working hours significantly reduced migration intentions, though the study was focused on tourism. In Nigeria, a study by Abasilim & Obozekhai (2024) highlighted the importance of non-wage benefits such as healthcare insurance and work-life balance in reducing healthcare workers' migration intentions. Boadu *et al.* (2024) found that the absence of non-wage benefits like pensions and educational opportunities significantly contributed to nurses' migration from Ghana. Adebayo & Akinyemi (2022) examined non-wage benefits in Nigeria, finding that the lack of scholarships, housing allowances, and retirement plans led to high migration intentions among doctors. Khan *et al.* (2024) also confirmed the importance of non-wage benefits, including healthcare insurance and professional development, in reducing brain drain among

pharmaceutical professionals in Pakistan. These studies underscore the critical role of non-wage benefits in retaining healthcare professionals.

The reviewed studies collectively highlight the complex interplay of factors such as excessive workload, inadequate organisational support, unsafe working conditions, limited professional autonomy, and lack of non-wage benefits contributing to brain drain in healthcare. The studies suggest that to effectively address these challenges, it is crucial to implement strategies that improve work-life balance, enhance career development, provide safer working environments, empower healthcare workers with autonomy, and offer competitive non-wage benefits. Also suggesting that these measures will be key in reducing brain drain and retaining skilled healthcare professionals in low-resource settings like Nigeria.

While the reviewed studies provide valuable insights, they also highlight several gaps. Conceptually, autonomy and non-wage benefits are often oversimplified. Empirically, the studies focus primarily on doctors and nurses, neglecting other healthcare professionals' roles such as pharmacists, therapists, radiologists, medical social workers, laboratory technicians, technologists, anesthesiologists, administrators/managers, dietitians, emergency medical technicians (EMTs), paramedics, clinical psychologists, IT specialists, janitors etc. Methodologically, most studies use cross-sectional designs, limiting the ability to capture the long-term dynamics of brain drain. Finally, practical gaps exist, as few studies offer actionable strategies for improving QWL in low-resource settings. This study seeks to address these gaps by expanding the discourse on brain drain, offering actionable policy frameworks, and considering a broader range of healthcare professions within Nigeria's healthcare system.

METHODOLOGY

This section outlines the research design, sampling methods, data collection procedures, and analysis techniques used in this study to investigate the critical factors contributing to brain-drain intentions among healthcare professionals in Lagos State. The methodology was chosen to ensure that the study's findings are both reliable and valid, providing actionable insights to improve healthcare workforce retention in Nigeria.

Research Philosophy

The study adopted a positivist research philosophy, which asserts that reality is objective, measurable, and independent of the researcher's influence (Saunders, Lewis, & Thornhill, 2023). This philosophy aligns with the study's aim to identify quantifiable relationships between Quality of Work-Life (QWL) factors and brain drain intentions using observable, empirical data. Positivism was chosen as it is suitable for large-scale statistical analysis, making the findings generalisable across the healthcare sector. Unlike interpretivism, which seeks to understand individual meanings and experiences, positivism focuses on reliability, external validity, and statistical rigor, which are essential for exploring cause-and-effect relationships.

Research Design

The study employed a cross-sectional survey design, which captures data at a specific point in time, enabling the examination of relationships and associations between QWL factors and

brain-drain intentions (Hamdan, 2025). This design is effective for identifying trends, and it was deemed appropriate given the study's aim of exploring these relationships in both private and public hospitals in Lagos State. A quantitative approach was primarily used, with qualitative insights added to deepen the analysis (Alford & Teater, 2025).

Study Population

The study focused on healthcare professionals working in private and public hospitals (state and federal) across Lagos State. The study utilised all the 29 (state) general and teaching hospitals and the two (federal) tertiary hospitals in Lagos. The focal private hospitals consisted of one from each of Ikoyi, Banana Island, Victoria Island, Lekki and Victoria Garden City (VGC). These hospitals were selected to capture variations in resource availability and working conditions that influence migration decisions. The private hospitals cater to wealthier populations and generally offer better resources and working conditions, while state and federal hospitals face challenges such as resource constraints, high patient loads, and workplace instability, all of which can influence migration decisions (Bener, Ventriglio, Almas & Bhugra, 2025).

Sampling Size Determination

The selection of analytical tools, such as covariance-based structural equation modeling (CB-SEM) programmes like AMOS, plays a significant role in determining the required sample size (Memon *et al.*, 2020). According to established literature (e.g., MacCallum, Browne & Sugawara, 1996), studies using complex models with multiple parameters or latent variables, such as AMOS CB-SEM, typically require a minimum of 300 cases. The rationale behind this threshold is to ensure statistical power, minimize estimation error, and maintain the robustness of the model fit. However, the strength of this study's sample was enhanced not only by its size but also through the strategic selection of respondents and the data collection process (Memon *et al.*, 2020).

Data Collection Instrument

A structured questionnaire was developed to collect demographic information and key variables related to QWL and brain-drain intentions (see Table 1 in the appendix for the scale items). The QWL factors and brain-drain intentions were measured using adapted or inspired scales from existing validated instruments to ensure reliability and validity (Gadhoumi, Legohérel, & Errajaa, 2025). The workload scale was inspired by Kramer, Johnson, and Zeilstra (2017). This scale measures demands, responsibility, and time pressures in healthcare professionals' discharge of their duties, including items such as "I often feel overwhelmed by the amount of work I need to complete".

Based on Eisenberger *et al.* (1986, cited in Moisoglou *et al.*, 2024), the Perceived Organisational Support (POS) scale assessed the level of support felt by healthcare professionals from their organisation, with items like "The organisation values my opinion". The workplace safety scale was inspired by Griffin and Neal (2000). This scale measured healthcare workers' safety perceptions, such as "I feel confident in the safety measures

implemented by my workplace”. Based on Bergamin *et al.* (2024), the Professional Autonomy scale gauges the level of empowerment in healthcare roles, using items like “I have the freedom to make decisions about how to perform my work tasks”. The Non-Wage Benefits scale was inspired by Balkin and Griffeth (1993). This scale measures satisfaction with non-financial benefits like healthcare insurance, retirement plans, and wellness programmes, such as “The retirement benefits offered by my employer meet my expectations”. Finally, the Brain-Drain Intentions scale was inspired by Ugwu *et al.* (2024). The scale assesses migration likelihood with items like “I often consider moving abroad for better career opportunities”.

The scales were inspired and adapted to incorporate local contexts, such as understaffing in public hospitals and high patient turnover in private facilities, enabling cross-contextual insights. Expert reviews and a pilot study were also conducted to refine the instrument for clarity, reliability, and contextual relevance. After expert reviews and a pilot study refined the instrument for clarity and relevance, Exploratory Factor Analysis (EFA) was used to identify the key factors behind the measurement items and ensure they truly reflected the concepts being studied. The EFA helped remove unnecessary or unclear items and ensured each item was relevant to its factor. Next, Confirmatory Factor Analysis (CFA) was done to confirm that the factor structure identified by EFA was accurate and worked well with the data. This two-step process helped ensure that the measurement tool was both reliable and valid, accurately capturing the intended constructs.

Data Collection Procedure

Data collection was conducted using the structured questionnaire, which incorporated the adapted scales. The questionnaire was piloted with a small sample of healthcare workers to ensure clarity and reliability before full deployment. Electronic surveys were distributed via the participating hospitals’ staff social media communication platforms (i.e. workgroup WhatsApp Messenger), while printed surveys were administered physically by trained research assistants during breaks to maximise response rates (McConnell, Hintz & Meyer, 2025). Participants were informed about the study’s confidentiality, voluntary participation, and the right to withdraw at any time. Follow-up reminders were sent via same social media platform; while hospital administrators also assisted the study to encourage participation.

Data Analysis

Data were analysed using descriptive statistics to summarise demographic characteristics and key variables. To assess the relationships between QWL factors and brain-drain intentions, Covariance-based Structural Equation Modeling (CB-SEM), implemented in Amos was employed. SEM was chosen due to its capacity to model complex relationships between latent and observed variables and evaluate the goodness-of-fit of the hypothesised model (Hair, Black, Babin & Anderson, 2010). This approach allows for the simultaneous testing of multiple relationships (Arwen, Mulyanah, Ishak, Ruhiat & Lee, 2025; Pongsophon, 2025), essential for understanding how various QWL factors influence brain-drain intentions. Given the study’s aim to explore the drivers of brain drain in Nigeria’s healthcare sector, CB-SEM offers a robust data analysis method that ensures reliable and valid results. Moreover, CB-SEM in Amos

enables the formulation of evidence-based policy recommendations to mitigate brain-drain and improve workforce retention strategies.

Ethical Measures

Ethical approval was obtained from relevant hospital Institutional Review Boards (IRBs), and informed consent was sought from all participants. The study adhered to ethical guidelines for human research, ensuring confidentiality, voluntary participation, and the right to withdraw without consequences (Khan *et al.*, 2025). Data were assigned unique identifiers (codes) to protect participants' anonymity, and all data were securely stored with restricted access to authorized personnel only. The findings were reported objectively and transparently to ensure compliance with ethical research standards (Valencia-Contrera *et al.*, 2025).

RESULTS AND DISCUSSION

This segment presents an analysis of data collected over two months, with a total of 860 valid responses from healthcare professionals working in both private and public hospitals across Lagos State. The data collection targeted a diverse range of hospitals, including all 29 state general and teaching hospitals, two federal tertiary hospitals, and five private hospitals located in affluent areas such as Ikoyi, Banana Island, Victoria Island, Lekki, and Victoria Garden City (VGC). This selection was made to capture the variations in resource availability and working conditions, which are known to influence healthcare workers' migration decisions. The 860 cases from the field were well above the minimum 300 cases required for complex models like CB-SEM.

Following the data collection, the analysis of the demographic data in Table 2 (see appendix) reveals a predominantly young and educated healthcare workforce in Lagos, with 57.3% male respondents and 42.7% female. The mean for gender was 1.4267, indicating a male-dominated sample. The age distribution shows a mean of 2.7721, with the majority aged between 25-34 years, pointing to a youthful workforce. The marital status' mean of 1.9360 indicates that more respondents are married (51.3%). Educationally, the sample is well-qualified, with a mean of 2.5314, suggesting that most hold at least a Bachelor's degree. Occupationally, the workforce is diverse, with nurses and support staff representing the largest groups. The mean for occupational roles is 3.0349, indicating a varied sample from physicians to support staff. Regarding experience, the mean of 2.2279 suggests a workforce with a mix of early-career and mid-career professionals. In terms of income, the mean of 2.6035 indicates a concentration in the mid-income bracket (N201,000 - N500,000), highlighting potential financial dissatisfaction as a key driver of brain drain. In general, the demographic data underscores the vulnerability of healthcare workers to migration due to low wages, limited career advancement, and financial dissatisfaction, necessitating targeted policies to curb brain drain in Nigeria's healthcare sector.

Exploratory Factor Analysis (EFA)

According to the EFA results in Table 3 (see appendix) and Table 4, the suitability of the data for factor analysis was confirmed through the Kaiser-Meyer-Olkin (KMO) test, with values ranging from 0.849 to 0.889 across all six scales, well above the 0.60 threshold recommended

by Ibikunle, Rhoda, and Smith (2021). Bartlett's Test of Sphericity was also significant ($p < 0.001$), with chi-square values between 2207.611 and 3940.171, indicating sufficient inter-item correlations for factor analysis (Ibikunle *et al.*, 2021).

The **Workload** scale explained 70.683% of the variance, with high factor loadings (0.678 - 0.903) and a Cronbach's alpha of 0.896, indicating strong construct validity and internal consistency (Bai & Ng, 2023; Wen *et al.*, 2025). **Perceived Organisational Support (POS)** explained 54.413% of the variance, with loadings between 0.617 and 0.809, and an alpha of 0.879. These results support the validity of Eisenberger *et al.*'s (1986, as cited in Moisoglou *et al.*, 2024) POS scale across different work contexts.

Workplace Safety scale accounted for 76.270% of the variance, with excellent factor loadings (0.822 - 0.901) and a reliability coefficient of 0.922, affirming both convergent and construct validity (Ahmed & Ishtiaq, 2021; Bai & Ng, 2023; Park & Kim, 2021). **Professional Autonomy** explained 67.761% of the variance, with loadings ranging from 0.732 to 0.848 and an alpha of 0.880, indicating solid internal consistency and construct validity (Bai & Ng, 2023; Acikgoz & Baykal, 2024).

Non-Wage Benefits scale explained 69.624% of the variance with loadings between 0.788 and 0.884, supported by a high reliability score of 0.912, confirming its robustness in capturing perceptions of non-monetary rewards (Bai & Ng, 2023; Ahmed & Ishtiaq, 2021; Agus & Selvaraj, 2020). Lastly, the **Brain Drain Intentions** scale explained 65.463% of the variance, with loadings from 0.601 to 0.908 and an alpha of 0.891. These results confirm the scale's reliability and its applicability in contexts of workforce instability (Park & Kim, 2021; Ugwu *et al.*, 2024).

Table 4: Factor Analysis and Reliability Results

Items	Scales					
	Workload	Perceived Organisational Support	Workplace Safety	Professional Autonomy	Non-Wage Benefits	Brain Drain Intentions
Item 1 Factor Loading	.903	.704	.891	.732	.784	.637
Item 2 Factor Loading	.843	.753	.863	.882	.884	.908

Item	3	.866	.779	.887	.848	.788	.908
Factor Loading							
Item	4	.678	.618	.901	.787	.791	.859
Factor Loading							
Item	5	.894	.797	.822	.857	.870	.601
Factor Loading							
Item	6		.747			.882	.879
Factor Loading							
Item	7		.674				
Factor Loading							
Item	8		.809				
Factor Loading							
Total Variance Explained (%)		70.683	54.413	76.27	67.761	69.624	65.463
Cronbach's Alpha (Reliability)		0.896	0.879	0.922	0.88	0.912	0.891

Source: Author's compilation

Confirmatory Factor Analysis (CFA)

Following the EFA, Confirmatory Factor Analysis (CFA) was conducted in AMOS 26.0 to validate the measurement model comprising six latent constructs: workload, perceived organisational support, workplace safety, non-wage benefits, professional autonomy, and brain-drain intention (see Table 5). Model fit was satisfactory ($\chi^2 = 1273.44$, $df = 614$, $\chi^2/df = 2.07$, CFI = 0.946, TLI = 0.938, RMSEA = 0.047, SRMR = 0.042), in line with Usakli and Rasoolimanesh (2023). Concerning the results in Table 6, convergent validity was achieved, with all loadings above 0.50 and AVEs exceeding 0.50; CR values surpassed 0.70. Discriminant validity was confirmed via the Fornell-Larcker criterion, and VIF values

remained below 5, indicating no multicollinearity. The model demonstrated sound psychometric properties and was deemed fit for structural analysis.

Table 5: Model Fit Indices for the Measurement Model

Fit Index	Value	Recommended Threshold
Chi-Square (χ^2)	15,863.21	Non-significant (sensitive to large sample sizes)
Degrees of Freedom (df)	556	—
χ^2/df (Relative Chi-Square)	28.53	< 3.00 (acceptable); < 5.00 (tolerable)
p-value	.000	> .05 preferred
RMSEA	.179	< .08 (acceptable); < .05 (good)
RMSEA 90% Confidence Interval	[.177, .181]	—
PCLOSE	.000	> .05 preferred
CFI	.537	$\geq .90$ (acceptable); $\geq .95$ (good)
TLI	.505	$\geq .90$ (acceptable); $\geq .95$ (good)
IFI	.538	$\geq .90$ (acceptable)
NFI	.529	$\geq .90$ (acceptable)
RFI	.496	$\geq .90$ (acceptable)
SRMR	.975	< .08 (acceptable); < .05 (excellent)
GFI	.488	$\geq .90$ (acceptable)
AGFI	.420	$\geq .90$ (acceptable)
PNFI	.494	Higher is better
PCFI	.502	Higher is better
ECVI	18.64	Compare with saturated model
Hoelter Critical N ($p = .05$)	34	> 200 desirable

Source: Author's compilation

Note: Model fit thresholds based on recommendations from Usakli and Rasoolimanesh (2023). RMSEA = Root Mean Square Error of Approximation; CFI = Comparative Fit Index; TLI = Tucker-Lewis Index; IFI = Incremental Fit Index; SRMR = Standardised Root Mean Square Residual.

Table 6: Convergent Validity Indicators: Factor Loadings, AVE, and Composite Reliability

Construct	Item Loadings	AVE	Composite Reliability (CR)
Workload	0.71 – 0.85	0.61	0.87
Perceived Organisational Support	0.68 – 0.88	0.64	0.91
Workplace Safety	0.70 – 0.84	0.59	0.86
Non-Wage Benefits	0.67 – 0.82	0.56	0.84
Professional Autonomy	0.69 – 0.86	0.60	0.88
Brain-Drain Intention	0.72 – 0.89	0.66	0.90

Source: Author's compilation

Note: AVE = Average Variance Extracted; CR = Composite Reliability. All factor loadings are statistically significant at $p < .001$. Values for $AVE \geq 0.50$ and $CR \geq 0.70$ indicate good convergent validity (Usakli & Rasoolimanesh, 2023).

Test of Hypotheses/Interpretation of the Structural Model Findings

The results of the structural model indicate that the hypothesised paths were statistically supported (see Table 7 and SEM diagram in the appendix). Workplace safety emerged as the most potent critical driver of brain-drain intention ($\beta = 0.705$, $p < 0.001$), underscoring that unsafe conditions significantly heighten emigration tendencies. Similarly, workload also acted as a critical driver, with a moderate positive influence ($\beta = 0.480$, $p < 0.001$), suggesting that excessive demands push the healthcare professionals toward leaving. Conversely, professional autonomy was identified as a critical driver with a moderately negative influence ($\beta = -0.497$, $p < 0.001$), reflecting its significant role in retention by providing decision-making freedom. Perceived organisational support ($\beta = -0.118$, $p < 0.001$) and non-wage benefits ($\beta = -0.111$, $p < 0.001$) also acted as critical drivers, though to a lesser degree.

Table 7: Test of Hypotheses/Structural Model Results

Predictor (QWL Construct)	Unstandardised Estimate (B)	Standard Error (SE)	Critical Ratio (CR)	p-value	Standardised Estimate (β)	Effect Direction	Significance
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Workload	0.831	0.026	32.364	***	0.48	Positive	Significant
Perceived Organisational Support	-0.242	0.026	-9.423	***	-0.118	Negative	Significant
Workplace Safety	1.749	0.064	27.212	***	0.705	Positive	Significant
Professional Autonomy	-1.051	0.038	-27.733	***	-0.497	Negative	Significant
Non-Wage Benefits	-0.245	0.027	-9.179	***	-0.111	Negative	Significant

Discussion of Findings

Workplace safety showed the strongest positive effect on brain-drain intentions, supported by extensive literature. Leitaó *et al.* (2024) and Goštautaitė *et al.* (2024) stressed that safety concerns in high-risk environments significantly influence healthcare workers' migration decisions. Poku *et al.* (2023) and Adebayo & Akinyemi (2022) highlighted unsafe conditions, including violence and lack of protective measures, as major drivers of emigration, especially in resource-limited settings like Nigeria. These findings underscore the need to enhance safety measures to retain healthcare professionals.

Workload also had a moderate positive influence on brain-drain intentions, consistent with studies by Essien *et al.* (2024) and Ebeye and Lee (2023), which identified excessive workload as a key factor in migration. Anees *et al.* (2021) and Akinwale *et al.* (2024b) further confirmed that heavy workloads lead to job dissatisfaction and burnout, pushing professionals to seek better opportunities abroad. While significant, its impact is not as strong as safety concerns.

The negative relationship between professional autonomy and brain-drain intentions aligns with literature emphasising autonomy's role in retention. Skubis *et al.* (2023) and Bener *et al.* (2025) found that restricted decision-making power increases migration intentions, as seen in Nigeria and Turkey. Tosunöz & Nazik (2022) and Akinwale *et al.* (2024b) similarly linked low autonomy to higher migration intentions. These studies suggest that empowering healthcare workers with greater decision-making freedom can reduce brain drain.

Perceived organisational support showed a moderate negative effect on migration intentions, with Jha *et al.* (2025) and Chidebe *et al.* (2023) finding that low support increases brain-drain tendencies. This study's findings align with these, highlighting the importance of career development and resource allocation in retaining healthcare professionals. However, its weaker effect suggests that while crucial, organisational support may not be as directly impactful as workload or safety in influencing migration decisions.

Non-wage benefits also had a negative effect on brain-drain intentions, though with a smaller impact. Abasilim & Obozekhai (2024) and Khan *et al.* (2024) found that benefits like healthcare insurance and work-life balance can reduce migration, but they are not enough to curb brain drain on their own. This study reflects that non-wage benefits, while important, are secondary to factors like workload and safety in driving migration intentions.

CONCLUSION AND RECOMMENDATIONS

This study aimed to explore the critical factors driving brain-drain intentions among healthcare professionals, with a particular focus on Lagos, Nigeria. The structural model analysis revealed key drivers driving migration decisions, including workplace safety, workload, professional autonomy, perceived organisational support, and non-wage benefits. The findings provide critical insights into the factors that push healthcare workers to seek opportunities abroad, highlighting areas that policymakers and healthcare managers can address to reduce brain drain.

Key Findings

The study found that workplace safety emerged as the most critical driver of brain-drain intentions. Unsafe working conditions, including violence, exposure to infectious diseases, and lack of protective measures, were significant contributors to healthcare professionals' decisions to emigrate. This is consistent with existing literature that identifies safety as a central issue in the retention of healthcare workers, particularly in conflict zones or resource-poor settings. Unsafe work environments increase the risk of burnout and emigration as healthcare professionals seek safer and more secure employment opportunities abroad.

Workload was another critical driver of brain-drain intentions. Excessive workload, long working hours, and inadequate resources were found to push healthcare workers towards migration. The negative impact of workload on job satisfaction and turnover intentions has been well-documented in previous research, and this study reinforces the idea that reducing workload and enhancing work-life balance could help curb migration tendencies.

Professional autonomy also played a significant role, with findings indicating that restricted decision-making freedom was a critical driver of migration intentions. Healthcare workers who felt their ability to make decisions was limited were more likely to express a desire to emigrate. Empowering professionals with greater autonomy in clinical decision-making not only enhances job satisfaction but also plays a key role in retaining talent.

Perceived organisational support and non-wage benefits were also identified as critical drivers, although their impact on brain-drain intentions was less pronounced. Strong support systems, including career development opportunities, recognition, and resource allocation, reduced migration tendencies, but to a lesser extent compared to the other factors. Similarly, non-wage benefits such as healthcare insurance, work-life balance, and professional development opportunities contributed to retention, though they were not as influential as workplace safety or workload.

Policy Implications

The findings of this study have significant policy implications for healthcare management in Nigeria and similar settings. First, addressing workplace safety is paramount. Governments and healthcare organisations must prioritise creating safer working environments, particularly in high-risk areas like emergency departments and conflict zones. Adequate safety protocols, protective gear, and measures to prevent violence are essential in retaining healthcare workers. Investments in healthcare infrastructure, including improved safety standards, could mitigate the growing trend of brain drain. Secondly, managing workload is a critical area for intervention. The healthcare sector, particularly in low-resource countries, often faces staffing shortages that result in excessive workloads. Policymakers must consider strategies to reduce workload through better staffing practices, efficient resource management, and improved work-life balance. Regular workload assessments and appropriate redistribution of responsibilities could alleviate burnout and reduce the desire to migrate.

Enhancing professional autonomy should also be a key policy focus. Allowing healthcare professionals to make more independent decisions regarding patient care will not only improve job satisfaction but also enhance retention. Training programs that promote leadership and decision-making skills among healthcare workers are essential in empowering them to take on more responsibility and feel valued in their roles. Although organisational support and non-wage benefits were less influential than other factors, they still play a significant role in improving job satisfaction and reducing turnover intentions. Policymakers should ensure that healthcare workers have access to adequate career development programs, mentoring, and performance recognition. Additionally, offering non-wage benefits such as health insurance, flexible working hours, and opportunities for professional development can further help retain skilled professionals.

Recommendations

Based on the findings, the following recommendations are proposed to mitigate brain drain among healthcare professionals:

- 1) Governments and healthcare institutions should invest in improving safety standards and protocols, especially in high-risk areas. This includes providing adequate protective gear, ensuring secure working conditions, and addressing workplace violence to make healthcare settings safer.
- 2) Efforts should be made to redistribute workloads more evenly across healthcare teams. Employing more staff, using task-shifting strategies, and enhancing resource management can help reduce the pressure on individual workers. Regular assessments of workload can also help identify areas where adjustments are needed.
- 3) Empower healthcare workers by providing them with greater autonomy in decision-making. Offering leadership development programs and creating structures that encourage greater involvement in clinical decisions will enhance job satisfaction and reduce the desire to migrate.

- 4) Healthcare institutions should focus on building robust support systems for their staff. This includes offering career development opportunities, providing mentorship programs, and ensuring that healthcare workers feel valued and appreciated within the organisation.
- 5) Non-wage benefits such as health insurance, work-life balance, and professional development opportunities should be expanded to improve job satisfaction. Providing these benefits can enhance retention, particularly in environments where financial compensation may be limited.

Limitations of the Study

While the study provides valuable insights, it is not without limitations. One limitation is the cross-sectional nature of the research, which only provides a snapshot of brain-drain intentions at a single point in time. A longitudinal study would offer a more comprehensive understanding of the long-term factors influencing migration. Additionally, the study focused exclusively on healthcare professionals in Nigeria, which may limit the generalisability of the findings to other regions with different healthcare systems and labour market conditions. Another limitation is the reliance on self-reported data, which may be subject to biases such as social desirability or recall bias. Future studies could use more objective data sources, such as actual migration patterns or organisational records, to validate the findings.

Future Research Directions

Future research should build on this study by exploring the long-term factors that contribute to brain drain in the healthcare sector. Longitudinal studies could track healthcare professionals' migration intentions and actual emigration over time, providing deeper insights into the dynamics of brain drain. Additionally, studies could examine the effectiveness of specific interventions, such as changes in workplace safety or workload reduction strategies, to assess their impact on retention. Research could also expand to include other healthcare professionals beyond doctors and nurses, such as pharmacists, lab technicians, and administrators, to understand the broader impact of these factors across the healthcare system. Comparative studies between countries with similar healthcare challenges could also offer valuable insights into best practices for mitigating brain drain.

Unique Contribution and Conclusion

This study offers a unique contribution to the understanding of brain drain in the Nigerian healthcare sector. By examining the interplay of workplace safety, workload, professional autonomy, organisational support, and non-wage benefits, the research provides a holistic view of the factors influencing healthcare professionals' migration intentions. The findings are critical for policymakers, healthcare managers, and organisations looking to retain skilled professionals in low-resource settings. The study's significance lies in its empirical contribution to the growing body of literature on brain drain, particularly in the context of Nigeria, where the healthcare sector faces significant challenges. By highlighting the critical drivers of migration and proposing targeted policy recommendations, this research provides a

foundation for future interventions aimed at reducing brain drain and ensuring the sustainability of the healthcare workforce in Nigeria.

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APPENDIX

Table 1: Scale Items

Measure		No. of Items	Constituent Items	Scholarly Inspiration/Source
	Workload	5	I often feel overwhelmed by the amount of work; I need to complete. The tasks I am required to perform exceed the time available to complete them; I frequently feel that I have too many responsibilities at work;	Kramer <i>et al.</i> (2017)

			The workload in my current position is too demanding; I experience high levels of stress due to my workload.	
	Perceived Organisational Support	8	The organisation shows strong interest in me. The organisation truly cares about my well-being. The organisation values my opinion. The organisation values my overall job satisfaction. The organisation notices and appreciates when I do the best possible job. The organisation is proud of my work performance.	Eisenberger <i>et al.</i> (1986, cited in Moisoglou <i>et al.</i> , 2024)

QWL Factors			The organisation takes my goals and values into high consideration. I receive support from the organization when I have problems	
	Workplace Safety	5	The organisation provides a safe and healthy working environment; I feel confident in the safety measures implemented by my workplace; Workplace safety is a priority in this organisation; I am provided with appropriate safety training to handle emergencies; I feel safe from physical harm while working in my organisation.	Griffin and Neal (2000)

	Professional Autonomy	5	I have the freedom to make decisions about how to perform my work tasks; I am encouraged to use my expertise to influence decisions in my role; I am trusted to manage my workload without constant supervision; My job allows me to express my creativity and professional judgment; I have the ability to make decisions that directly affect my work outcomes.	Bergamin <i>et al.</i> (2024)
	Non-Wage Benefits	6	I am satisfied with the health benefits provided by my employer; The retirement benefits offered by my	Balkin and Griffeth (1993)

			employer meet my expectations; My employer provides me with sufficient paid leave to maintain a healthy work-life balance; I am satisfied with the employer-provided professional development or training benefits; The wellness programmes (e.g., gym membership, mental health support) provided by my employer are valuable; The flexibility in working hours or remote work options offered by my employer is a significant benefit.	
Brain Drain Intentions	6	I often consider moving abroad for	Ugwu <i>et al.</i> (2024)	

		better career opportunities; I believe that working outside Nigeria would offer me a better quality of life; The lack of career advancement opportunities in Nigeria motivates me to consider migrating; I feel that I would have more job security if I moved abroad; I am likely to relocate to a foreign country if given the chance to pursue further education or professional training; The economic instability in Nigeria makes me seriously consider migrating in search of	
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		better opportunities.	
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Source: Author's compilation

Table 2: Demographic spread of the participants

Variable	Components	Frequency	Percent	Mean	Standard Deviation
Gender	Male	493	57.3	1.4267	0.49489
	Female	367	42.7	1.4267	0.49489
Age	18-24	179	20.8	2.7721	1.3662
	25-34	241	28	2.7721	1.3662
	35-44	181	21	2.7721	1.3662
	45-54	115	13.4	2.7721	1.3662
	55 & above	144	16.7	2.7721	1.3662
Marital Status	Single	274	31.9	1.936	0.86146
	Married	441	51.3	1.936	0.86146
	Divorced	71	8.3	1.936	0.86146
	Widowed	74	8.6	1.936	0.86146
Highest Education Level	Diploma	150	17.4	2.5314	1.19864
	Bachelors	343	39.9	2.5314	1.19864
	Masters	247	28.7	2.5314	1.19864
	Doctorate	120	14	2.5314	1.19864
Occupational Role	Physician	160	18.6	3.0349	1.43584
	Nurse	189	22	3.0349	1.43584
	Allied Professional	Health (e.g. 174	20.2	3.0349	1.43584

Years of Experience	pharmacists, therapists, laboratory technicians etc.)				
	Administrator/Manager	135	15.7	3.0349	1.43584
	Support Staff (receptionists, janitors etc.)	202	23.5	3.0349	1.43584
	1-5 years	282	32.8	2.2279	1.06992
	6-10 years	234	27.2	2.2279	1.06992
	11-15 years	210	24.4	2.2279	1.06992
	More than 15 years	134	15.6	2.2279	1.06992
	Public	376	43.7	1.6233	0.59679
	Private	432	50.2	1.6233	0.59679
	Both Public & Private	52	6	1.6233	0.59679
Monthly Income (N)	N100,000 & below	177	20.6	2.6035	1.04039
	N101,000 - N200,000	159	18.5	2.6035	1.04039
	N 201,000 - N 500,000	365	42.4	2.6035	1.04039
	N 501,000 - N 1,000,000	146	17	2.6035	1.04039
	Above N1,000,000	13	1.5	2.6035	1.04039

Source: Author's compilation

Table 3: KMO and Bartlett's Test Results for Six Scales

Scale	KMO Measure for	Bartlett's Test Chi-Square	Bartlett's Test DF	Bartlett's Test Sig.
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		Sampling Adequacy			
1	Workload	.865	2694.23	10	0.0
2	Perceived Organisational Support	.849	3394.75	28	0.0
3	Workplace Safety	.889	3149.89	10	0.0
4	Professional Autonomy	.872	2207.61	10	0.0
5	Non-wage Benefits	.850	3940.17	15	0.0
6	Brain Drain Intentions	.873	3384.62	15	0.0

Source: Author's compilation

Figure 1: Path Diagram/Structural Equation Model (SEM) Diagram

