

Brain Drain Intention: The Role of Improved Standard of Living on Quality of Work-Life among Nigerian Medical Students in Diaspora

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Abstract. This study investigates the determinants of brain drain intention among Nigerian medical students in the diaspora, focusing on how improved standards of living mediate the relationship between socio-economic push factors and the perceived quality of work-life. Using a cross-sectional survey design, data were collected from 428 medical students enrolled in 18 universities across six countries, and analysed using Partial Least Squares Structural Equation Modelling (PLS-SEM). The study examined the influence of high unemployment, poor infrastructure, insecurity, poor pay, and mass poverty on quality of work-life, with improved living standards serving as a mediating variable. The results show that all five factors significantly and negatively affect the perceived quality of work-life, confirming their role as key drivers of brain drain intentions. Moreover, improved living standards fully mediated these relationships, indicating that favourable socio-economic and environmental conditions abroad offset the negative effects of poor domestic conditions and strengthen students' intentions to remain overseas after graduation. These findings suggest that the decision of Nigerian medical students to stay abroad is shaped not only by professional and economic dissatisfaction but also by comparative perceptions of well-being and life quality. The study concludes that tackling brain drain requires integrated national retention strategies that simultaneously enhance professional welfare, living standards, and work-life quality within Nigeria.

Keywords: Brain drain, Diaspora, Unemployment, Insecurity, Nigerian medical students, Poor pay, Poverty, Quality of work-life, Standard of living.

1. INTRODUCTION

To leave or stay in the host country for the majority of Nigerian medical students in the diaspora after completion of their medical study programme has become an issue and a serious agitation in the minds of a multitude of Nigerian medical postgraduate students. This has worsened the albatross of brain drain among Nigerian medical professionals and deepened the challenges in the present time, with a large number of medical students and graduates travelling to nations such as the United Kingdom, Canada, Dubai, the United States, and Australia. This exodus paradigm portends a grave consequence for Nigeria's healthcare system, which hitherto maintains one of the lowest physician-to-patient ratios across the world at a meagre 4 physicians per 10,000 population, which is below the standard and recommendation of the World Health Organisation of 1:600 (Akinwale, Kuye & George, 2024). The mass migration and intention to stay after the completion of their medical study programme is largely influenced by push factors experienced within Nigeria, which are poor remuneration, unhealthy working conditions, poor career growth opportunities, security issues, and inadequate standard of living, among others. Those factors that attract medical professional graduates from host countries are competitive reward systems and compensation packages, healthy and favourable work environments, career growth and capacity development opportunities, enhanced technological growth to work as well as improved quality of work-life (Akinwale & George, 2023).

Present studies indicate that over 65% of Nigerian-trained physicians now practice in foreign countries. Ecosystem, with yearly immigrant dimensions soaring higher following the incidence of pandemic attacks. Currently, this trend is alarming as Nigerians invest substantial resources in medical education, critically subsidising the healthcare systems of developed countries while Nigeria's healthcare system encounters critical workforce challenges (Akinwale, Kuye, & Akinwale, 2024). However, the nexus between improved standard of living in foreign countries as well as perceived quality of work-life indicates an essential trajectory of investigation, as this offers insights into potential policy interventions that could tackle the core underlying elements driving these persistent brain drain intentions. From the foregoing, a clear understanding of the decision-making procedure of Nigerian medical students presently studying in a global environment is largely valuable as this category of people are fundamental points in their careers where interventions may reverse their brain drain pathway and their intentions to further migrate to another destination country.

2. LITERATURE REVIEW

The albatross of brain drain in Nigerian medical students and professionals has attracted significant attention among policymakers and scholars, with research persistently underscoring the link between standard of living disparities and quality of work-life prospects as key influences of migration intentions (Akyeampong *et al.*, 2025). Reports from Akinwale, Kuye and Akinwale (2023) and Stephens (2025) highlighted how Nigerian medical students increasingly nurture migration to foreign nations as a pathway to enhanced working conditions, high compensation and reward, and improved career growth prospects, which are not available in their country of

origin. An empirical investigation by Sharifi, *et al.*, (2025) revealed that views of optimal healthcare infrastructure, technological resources, and medical professional development in the global ecosystem essentially drive brain drain intentions. While (REF) established work-life balance, political stability, and personal security as additional quality of work-life variables influencing brain drain decisions. This mass exodus approach further deepens the issues of Nigeria's healthcare system, as scholars like Shiri *et al.*, (2025) provided links between medical professional migration and worsened patient-to-provider ratios, particularly in rural centres of the country. Remarkably, Bazyar *et al.*, (2025)'s longitudinal evaluation illustrates that students who accomplish foreign electives or clinical rotations demonstrate greater migration intentions, suggesting that exposure to enhanced standards of living strengthens brain drain intentions by offering a latitude to compare the quality of work-life differences between Nigerian and diaspora medical practice ecosystems.

The contemporary studies from extant literature on migration intention and brain drain among Nigerian medical students indicate a compounding relationship between an improved standard of living in foreign nations and quality of work-life perspectives (Rodrigues, 2025). The literature, however, shows a complex association between brain intention, the standard of living aspiration, and the quality of work-life among medical students in international communities. Several studies have indicated the rising paradigm of Nigerian healthcare professionals, especially physicians and medical students, seeking opportunities abroad, with nations such as America, the UK, Canada, and Australia being their destination preferences (Akinwale, Kuye & George, 2024). A recent research by Masoud (2025) discovered that over 75% of medical students in Nigerian universities demonstrated sturdy intentions to practice in an international workspace immediately after completion of their medical programmes, with enhanced living standards persistently occurring as a key driving force. This aligns with the Rico *et al.*, (2025) study outcome that established major variations in compensation, working conditions, and overall standard of living of Nigerian healthcare systems and those in high-income nations. The economic incentive is substantial, with physicians in the diaspora often earning as much as ten times their Nigerian counterparts' salaries while experiencing improved working conditions and career advancement opportunities.

In addition, the quality of work-life elements prominently featured in the decision-making process of the brain drain intention of Nigerian medical graduates in the diaspora. John *et al.*, (2025) established that Nigerian medical students view diaspora opportunities as offering excellent professional career growth, better-equipped facilities, optimised workloads, and a stimulated work environment. Their study on medical students illustrated hindrances in the Nigerian healthcare system, inadequacies, high workloads, restricted dedicated training opportunities, and poor pay that prevented the desirable lifestyles. However, healthcare systems in foreign ecosystems were perceived as providing a workspace where clinical excellence could be accomplished without perennial resource challenges (Küçükkendirci & Yücel, 2025).

In the same line of discourse, the psychological dimension of brain drain intention has been investigated by Doğan and Bekleviç, (2024), whose results indicated that expected improvements in quality of worklife and professional satisfaction meaningfully predicted migration intentions. Their research proved that medical students who perceived many opportunities for a sustainable standard of living in the diaspora showed a higher degree of career growth and reduced stress in the workplace, suggesting the psychological advantages of perceived opportunity (Ahmad, 2025). This again is associated with the study by Jurić (2025), indicating that Nigerian medical experts in the global workspace report progressively greater job satisfaction and work-life balance than their Nigerian counterparts. At the same time, social interactions serve to play a major role in strengthening brain drain intentions among Nigerian medical experts and medical students studying in the diaspora. The recent study by Martella *et al.*, (2025) also established how diaspora triumphant reports circulate among Nigerian medical students, with social media and personal interactions offering palpable examples of an enduring standard of living obtained in a global environment. This study showed that over 70% of students with migration intentions had a direct association with medical experts already practising in the global workplace, showing the strong impact of social interactions and the effect of social media in brain drain decision-making.

While the economic variables remain key contention for brain drain intention, a study by Ozdemir *et al.*, (2024) discovered that standard of living considerations go beyond pay and salary to encompass wider quality of work-life dimensions focusing on personal safety, training opportunities for children, political stability, esteem needs and appreciation for the medical profession. This multidimensional consideration of living standards assists in understanding the rationale for pervasiveness in brain drain intentions even within relatively well-rewarded experts in Nigeria's private healthcare industry. Efforts to solve the brain drain challenge through retention strategies have recorded restricted success. Uzun and Kılıç, (2024) analysis of several retention policies demonstrated that interventions addressing largely compensation improvement without tackling other dimensions of quality of work-life concerns had little or no impact on migration intentions. This study suggests that comprehensive approaches addressing professional growth and development, work environment, and socio-economic elements indicate more promise in solving brain drain tendencies among Nigerian medical students.

2.1. Theoretical Underpinning and Framework

2.1.1. Push-Pull Theory of Migration

The push-pull theory of migration was propounded by Lee (1966) and later transformed by Todaro (1969), provides a solid foundational framework for exploring brain drain intention. The theory advocates that migration intentions are driven by adverse factors experienced as push variables in the home country, and positive factors are described as pull factors in the host countries. In terms of the Nigerian medical context, push factors involve inadequate pay and salary, poor infrastructure, and uproar in political space, while pull factors involve improved reward systems, superior working conditions, and professional advancement opportunities in the international ecosystem. Lee (1966) seminal work on the theory of migration had created the foundation by highlighting four core factors driven migration intentions: factors linked with the origin area, push factors, factors concerning the host nations, pull factors, prevailing challenges, as well as personal factors. This framework has shown an enduring trajectory in brain drain tendencies and migration studies, providing a robust understanding across diverse contexts from rural-urban migration to foreign brain drain.

On the flip side of theory, push elements mirror adverse conditions in the work environment, denoted as originating countries that discourage the individual from migrating to a better and more attractive country. These include economic variables like unemployment, poor pay, and restricted professional growth potentials, while political variables include instability, social unrest, corruption and unethical practices, environmental issues, and resource depletion (Liu, Zhang, & Yang, 2023). Social concerns include discrimination in the workplace, inequality, high crime rates, and infrastructure deficiencies in the healthcare system and public service. The recent study of Saraswati *et al.*, (2025) supported this trajectory and documented how economic push variables predominate African migration contexts, with high levels of unemployment and wage inequality powerfully resonating with migration frameworks from nations such as Nigeria, Ghana, and Kenya. In the same line of thought, Urbanski's, (2022) study evaluation established how political instability provokes significant push effects, perceiving significant migration uprisings following civil conflicts in several regions of the study population.

In furtherance of this discourse, pull variables include attractive factors in the possible destination areas that entice migrants. These comprise sustainable economic advantages like competitive pay and salary, employment availability, powerful economic indices, political stability, and good governance. Social benefits and inclusion, such as better healthcare opportunities, education, social care and welfare programs. Also, cultural attractiveness such as fundamental human rights and freedoms, alignment with individual values, and social networks established by prevailing communities that stimulate transformation (Marx, 2025). An empirical study by Yu (2025) showed that wage differentials between countries remain the most consistent determinant of migration flow, with destination countries providing salaries and pay as high as five times that of the country of origin, provoking huge migration pressure.

The relationship between push and pull variables predicts migration intensity and directions, with migration more likely when push elements in the country of origin are strong and pull elements in the host country are gripping and persuasive. Kuditchar (2025) redefined this theoretical framework by establishing that migration intentions include a comparative analysis instead of absolute conditions, observing that perceived relative deprivation often influences brain drain tendencies even when absolute situations in the origin country stabilise. This underscores the contradictory nature perceived where economic development in developing nations initially increases migration rates by raising anticipations and offering resources for flexible movement before reducing migration at a higher development level, an idea described as the migration hump (Berger & Roos, 2025).

However, overriding obstacles represent another set of challenges that prevent migration despite the presence of push and pull variables. These comprise geographical barriers, transportation expenses, legal limitations like immigration policies and visa requirements, cultural and language challenges, and inadequate information about host nations' conditions. Jennath and Paul (2025) established how skill-selective immigration policies in developed countries produce differential mobility issues, enabling migration for highly educated professionals while limiting chances for unskilled migrants. Likewise, Jang, Kim, and Oh (2025) highlighted how transportation costs substantially decreased, overcoming obstacles, considering how steamships, railways, and eventually air travel largely expanded migration possibilities by reducing both time and economic costs of migration.

Also, it is important to explain that personal factors serve as contributory elements to how people respond to push-pull dynamics and overriding obstacles, introducing significant divergence into brain drain and migration dynamics. These involve demographic variables like sex, age, and family status; socio-economic attributes such as education profile, skill set, and financial capacity; psychological traits including risk tolerance and adaptability; as well as the personal link to potential destinations. Ochoa-Moreno, Quito, Del Río-Rama, and Torres-Díaz (2024) recognised how these individual factors provoke migration capability differences, explaining the rationale a similar push-pull conditions offer diverse migration responses among different population segments. Their study indicated that low-income households most time exhibit greater migration tendencies than the poor segments, who lack resources to survive migration barriers despite encountering appalling push factors.

Therefore, contemporary theoretical developments have further stretched the push-pull theory to tackle its

limitations. Carling's aspiration-ability framework presented the concept of involuntary immobility to emphasise conditions where push-pull factors establish migration desires but overriding obstacles prevent movement, creating would-be-migrants who desire yet cannot afford to migrate (Bogdan, 2025). Puchol, Fernandez-Baldor, Lovaton, Rodila, and Botija (2025) offered a capabilities approach to migration, claiming that development intensifies migration capabilities before reducing migration ambitions, explaining why this development initially expedites migration intentions. The recent work of Wallnoefer, Svensson-Hoglund, Bhar, and Upham, (2024), the structure-agency approach further integrates essential perspectives by analysing how global political-economic structures transform the distribution of push-pull factors of migration among the migrant communities, highlighting how colonial chronicles and In modern In power imbalances predict migration trends beyond personal decision-making. Empirical and theoretical applications of push-pull theory span diverse migration contexts. In evaluating labour migration, Kasaaye, Bayiley, and Alemu (2025) established how a wage differential ratio of 15:1 between developing and developed countries introduces stronger economic motivations that overwhelm most policy restrictions. In professional migration studies, Usam, Hasan and Alam (2025) documented the inadequacies of the strict push-pull disparities, indicating how professional labour often makes a tough decision balancing immediate safety concerns with long-term settlement prospects. In a skilled migration study, Docquier and Rapoport (2022) applied the framework to brain drain dynamics, discovering that professional career growth is often a major determinant and central to skilled labourers than pay considerations for highly educated migrants, explaining why nations with relatively low income but poor professionals experience major talent outflows.

Therefore, the push-pull theory has proven essentially valuable in explaining healthcare professional migration from developing to developed nations. The relationship of both push and pull factors offers strong migration pressure that explains the persistent mass exodus of Nigerian medical talent despite several retention strategies. The sustainability of push-pull theory lies in its adaptability across contexts and integration capacity with complementary frameworks. While critics aptly noted its limitations in tackling structural inequalities, historical account dependencies, and migrant agency, the basic insight that migration flows to address the origin and destination conditions remains fundamentally sound.

2.1.2. Relative Deprivation Theory

Relative deprivation theory, propounded by Stouffer, Suchman, DeVinney, Starr and Williams (1949) and later redefined by Merton (1968), explains how perceptions of disadvantage emerge through comparisons with reference groups. Relative deprivation theory emerged as a significant theoretical framework in social psychology during the post-World War II era, with its foundational principles established through Samuel Stouffer and colleagues' groundbreaking research in the American Soldier in 1949. This landmark study documented the counterintuitive finding that soldiers in rapidly promoting units reported lower satisfaction than those in units with limited advancement opportunities, despite objectively better conditions. Stouffer attributed this phenomenon to social comparison processes, wherein individuals evaluate their circumstances relative to reference groups rather than absolute standards. This initial observation crystallised into a powerful theoretical framework that has since been applied across disciplines, including sociology, economics, political science, and migration studies. The theory fundamentally posits that feelings of deprivation arise not from objective conditions but from subjective comparisons between one's actual situation and expectations derived from reference group comparisons.

Merton (1968) formalised these concepts in his theory of reference group behaviour, explaining how individuals adopt reference groups—sometimes outside their immediate social circles—as standards for self-evaluation. Walter Runciman (1966) further advanced the theory by distinguishing between egoistic relative deprivation (comparisons involving personal circumstances) and fraternalistic relative deprivation (comparisons involving group status). This distinction proved crucial for understanding how individual and collective responses to perceived inequalities might differ. Runciman also articulated the four preconditions for relative deprivation: Person A must not possess X, must see that Person B possesses X, must desire X, and must view obtaining X as feasible. This conceptualisation highlighted the cognitive and evaluative processes underlying deprivation feelings rather than objective circumstances alone.

Ted Robert Gurr's influential work "Why Men Rebel" (1970) applied relative deprivation Theory to political contexts, proposing that the gap between value expectations (what people believe they deserve) and value capabilities (what they believe they can attain) creates a "frustration-aggression" dynamic that can fuel collective action and social movements. Gurr distinguished between decremental deprivation (declining conditions while expectations remain stable), aspirational deprivation (stable conditions while expectations rise), and progressive deprivation (the revolution of rising expectations where improvement rates lag behind rapidly rising expectations). This nuanced approach explained how relative deprivation could emerge even during periods of objective improvement, offering valuable insights into the timing and intensity of social protests and political instability (Pan & Yang, 2025).

Empirical research has consistently validated Relative deprivation theory core propositions. Crosby's (1976) studies on workplace satisfaction demonstrated that employees judge their compensation fairness by comparing it

with similar others rather than absolute standards. Subsequent research by Major and Testa (1989) documented how reference group selection significantly influences satisfaction levels, with individuals reporting higher satisfaction when comparing downward (to less advantaged groups) than when comparing upward (to more advantaged groups). Walker and Smith's (2002) meta-analysis of relative deprivation studies confirmed the theory's robust predictive validity across diverse contexts, establishing that perceived relative deprivation correlates consistently with decreased psychological well-being, including higher stress levels, reduced life satisfaction, and increased incidence of depression.

For Nigerian medical students, social media and global connectivity have expanded reference groups to include international peers, heightening awareness of disparities in the standard of living and quality of work-life. Umeh's (2024) study demonstrated that perceived relative deprivation compared to international medical peers significantly predicted brain drain intention, with the standard of living comparisons being particularly influential.

Relative deprivation theory has proven particularly valuable in explaining migration decisions. Stark and Taylor's (1989) seminal research demonstrated that households often engage in international migration not merely to improve absolute income but to enhance relative position within reference communities. Their studies of Mexican migration to the United States showed that households in the middle of village income distributions—experiencing greater relative deprivation than both the poorest and richest households—demonstrated the highest migration propensity. This finding contradicted simpler economic models predicting the highest migration rates among the poorest households, highlighting how the perception of relative position drives mobility decisions. Quinn's (2006) subsequent research across developing contexts confirmed that relative economic position within communities consistently predicts migration intention more accurately than absolute poverty measures.

The globalisation era has dramatically expanded the theory's relevance as communication technologies and media exposure have widened reference group horizons. Appadurai's (2004) concept of the "capacity to aspire" explains how globalisation creates new "imaginaries" that reshape expectations and reference points. Research by Czaika and Vothknecht (2014) demonstrated how international media exposure creates "global reference groups" that intensify relative deprivation by presenting idealised Western lifestyles as comparative standards. Their multi-country analysis revealed that satellite television access significantly increased migration intentions in developing regions, with the effect mediated by heightened perceptions of relative deprivation. This phenomenon helps explain why economic development often initially increases rather than decreases emigration pressures, as rising capabilities enable mobility while global comparisons intensify relative deprivation.

In healthcare migration specifically, relative deprivation mechanisms operate powerfully. Lilly, Sibley, and Osborne (2025) documented how physician emigration from Sub-Saharan Africa correlates strongly with perceived relative deprivation compared to international peers rather than absolute economic conditions. Their interviews with migrating physicians revealed recurring themes of professional comparison, with respondents explicitly referencing income and working condition differentials between their situations and those of colleagues abroad. Similarly, Pak's (2025) study of Nigerian medical students found that exposure to international training standards through educational exchanges significantly increased brain drain intentions by heightening awareness of relative professional deprivation in domestic practice contexts.

Applications of Relative Deprivation Theory extend beyond migration to numerous domains. In consumer behaviour research, Sharma and Alter (2012) documented how relative deprivation influences consumption patterns, with individuals experiencing higher relative deprivation demonstrating greater preference for conspicuous consumption. In health research, Wilkinson and Pickett's (2009) influential work on inequality demonstrated that relative socioeconomic position predicts health outcomes more powerfully than absolute income, suggesting physiological consequences of perceived relative deprivation. In educational contexts, Lynch and O'Riordan (1998) showed how working-class students' awareness of relative disadvantage affects educational aspirations and persistence. This theoretical versatility highlights the framework's enduring relevance across disciplines.

Contemporary research continues expanding relative deprivation theory in promising directions. Technological advancements have enabled more sophisticated measurement approaches, with Walker *et al.* (2015) developing validated scales distinguishing cognitive (perceived disadvantage) and affective (emotional response) components of relative deprivation. Koehler's (2025) research on temporal comparison processes demonstrated how individuals compare present circumstances not only with others but with their past or anticipated future conditions, expanding the theory beyond purely social comparisons. Increasingly, researchers recognise the dynamic interplay between absolute and relative considerations, with Pettigrew's (2016) integrated model proposing that absolute needs establish minimum thresholds while relative comparisons drive aspirations above these thresholds.

The theory's enduring value lies in its capacity to explain seemingly paradoxical human behaviours across diverse contexts. It helps explain why objectively improving conditions sometimes coincide with increasing dissatisfaction, why middle-income rather than lowest-income groups often drive social movements, and why global inequality awareness complicates development outcomes. In an increasingly interconnected world where

reference horizons continually expand, Relative Deprivation Theory provides crucial insights into the subjective evaluation processes that ultimately drive human decision-making across economic, social, and political domains. These theoretical frameworks collectively illuminate the multifaceted nature of brain drain intention among Nigerian medical students, highlighting how the standard of living aspirations and quality of work-life considerations interact within broader economic, social, and psychological contexts to shape migration decisions.

2.2. Conceptual Review and Hypotheses Development

2.2.1. High Unemployment Rate and Quality of Worklife

The effect of high unemployment rates on the quality of work-life among medical professionals and medical students in the diaspora illustrates a complicated intersection of economic variables, expert development, and individual well-being. Studies indicate that medical professionals who move to international work environments frequently encounter major challenges in foreign market integration despite their educational background, which is an additional benefit to their quality of worklife (Akinwale, Kuye, & Doddonavar, 2025). Petreska, Prodanova, and Kocarev (2025) demonstrated that medical graduates who trained in the global work environment often encounter issues in employment, including qualification recognition challenges, language proficiency requirements, and discriminatory hiring practices. These challenges often provoke protracted periods of high incidence of unemployment or underemployment, where physicians work in positions lower than their qualifications. Issues abound that lead to brain drain intention among medical graduates in the diaspora. A high level of unemployment in the country has activated the intentions of several medical graduates to study in international institutions. The study by Berşe *et al.* (2025) demonstrated that the majority of medical students and graduates in the UK, Canadian and American universities never wanted to return to their country of origin due to the high level of unemployment experienced before migrating for the medical postgraduate program. Thus, the huge unemployment in the African continent has exacerbated persistent brain drain decisions among the medical graduates' community in the diaspora. These unemployment challenges have been associated with heightened psychological distress, diminished overall life satisfaction and poor quality of work-life (Vega-Muñoz *et al.*, 2025).

In the same vein, Kacani *et al.* (2025) established that medical graduates studying in a global community have an understanding of high unemployment incidence in their intended originating countries or upon return to their home countries, always create anticipatory anxiety and low-quality work-life. The longitudinal study of Rukema and Nkoko (2024) also established that this understanding frequently affects educational experiences, with medical postgraduates reporting low morale and heightened competitive behaviour when met with employment prospects uncertainty. Hence, the challenges to obtaining residency positions or job placement in competitive employment markets always affect the quality of work-life. In the same line of discourse, economic barriers worsen these issues of brain drain into the global market. A recent study by Stephens (2025) documented that the mass exodus of healthcare experts from economically dwindling regions always creates a medical brain drain and unexpectedly exacerbates unemployment in parts of the national economy of the originating countries while creating shortages in other areas. This often affects the quality of work-life of both medical experts and medical graduates studying in the diaspora. Therefore, this study hypothesises that:

H: High Unemployment rate negatively affects the Quality of work-life.

2.2.2. Poor Infrastructure and Quality of Worklife

Inadequacy and paucity of medical facilities and infrastructures have worsened the brain drain challenge among medical professionals in low-income and developing nations. This has a negative effect on their quality of work-life across professional settings, generating adverse effects on productivity, job satisfaction, and overall well-being (Oke, 2025). Studies persistently establish a robust association between a lack of medical infrastructure and negative work experience for medical professionals. In the healthcare ecosystem, inadequacy in medical facilities creates immediate issues for medical professionals. REF (2025) established how deteriorating medical equipment and facilities, as well as poor clinical spaces, directly affect both healthcare delivery and workforce quality of work-life. These limitations provoke brain drain decision-making from medical professionals from time to time, as it leads to professional frustration. Medical postgraduates in the diaspora studying have decried poor and inadequate medical equipment and facilities in their country of origin, which always prevent them from functioning effectively (Akyeampong *et al.*, 2025). It has given the majority of medical professionals serious concerns about the quality of their preparation. The study by REF () reported that restrictions in access to simulation laboratories, inadequate clinical exposure opportunities, and obsolete learning resources provoke brain drain intention among medical students receiving training in the diaspora. This has affected their future competence and the quality of their work-life. REF () discovered that medical postgraduates obtaining training in medical facilities-deficient institutions and countries reported reduced self-efficacy and increased concerns regarding their competitiveness in the global job market. REF () argued that the link between medical infrastructure and quality of worklife appears bidirectional. Inadequate infrastructure reduces professional satisfaction and retention, creating a brain drain gap that further strains the existing medical facilities. Breaking

this cycle requires coordinated investments in both physical resources and capacity development. Hence, this study hypothesises that

H₂: Poor Infrastructure adversely impacts on Quality of Worklife.

2.2.3. Insecurity and Quality of Worklife

Insecurity in the workplace has deeply shaped the quality of work-life of medical experts and medical postgraduates, manifesting through several dimensions including job insecurity, physical safety and psychological imbalance (Taylor *et al.* 2025). The extant literature shows a complex interaction between these insecurity components and professional well-being outcomes. Job insecurity, characterised by issues regarding employment instability and career progression lopsidedness, consistently occurs as a major issue affecting the quality of work-life of medical professionals and medical students in diaspora (Yuan, 2025). A study by Özbilgin *et al.* (2025) established that prolonged job insecurity provokes cumulative negative impacts, with professionals reporting progressive deterioration in work engagement and increasing cynicism from time to time. Also, physical security issues represent another significant dimension negatively impacting the quality of work-life. Healthcare professionals experience increased risks of workplace harassment and medical insecurity, with emergency and mental health professionals reporting particularly high incidences of exposure rates. The research by Khaliq *et al.* (2025) established how safety concerns change clinical decision-making, with the management of healthcare recognising defensive practices adopted to reduce confrontation risks rather than optimise care. These incidents provoke moral distress when they conflict with professional values. Another study by Cojocaru *et al.* (2025) documented that medical professionals and medical students in the diaspora decried insecurity from their home country as well as conflicts and political instability as part of the factors that determine their mass exodus decision, which largely creates severe quality of work-life issues.

Also, psychological insecurity originating from organisational dynamics offers additional concerns. Hierarchical medical cultures characterised by bullying, intimidation, and harsh criticism create environments where professionals and early-career professionals encounter consistent psychological insecurity (Alhebshi *et al.*, 2025). Kelman (2025) discovered relationships between work environment insecurity and quality of work-life. This anxiety-based limitation of professional behaviour undermines medical professionals' engagement and satisfaction dimensions of quality of work-life. Financial insecurity also introduces another layer of complication to the brain drain challenge. Sbaa *et al.* (2025) study indicated that financial insecurity has been discovered to be a challenging situation and justification for brain drain intention among medical professional communities, which affects their quality of work-life. These issues distract from learning engagement and create early disappointment with the professional. Therefore, this study proposes a hypothesis that:

H₃: Insecurity has a negative impact on the Quality of Worklife.

2.2.4. Poor Pay and Quality of Worklife

The relationship between poor compensation, brain drain intentions, and quality of work-life has presented a grave challenge in healthcare workforce sustainability, especially affecting medical professionals and students in resource-constrained ecosystems. Studies persistently demonstrate a significant association between this factor that drives employee career decisions and larger healthcare system outcomes. Poor pay among the healthcare workforce stands as a core predictor of reduced quality of work-life among medical experts. The study by Xu *et al.*, (2025) indicated that the healthcare workforce who discovered that their pay and salary were inadequate reported lower job satisfaction, lower commitment, and poor quality of work-life. The psychological effect of poor pay has moved beyond financial concerns, with most medical professionals expressing feelings of undervaluation and poor recognition when salary and pay fail to reflect their expertise, responsibility level, and societal contribution. The study by Okpalauwaekwe *et al.*, (2025) also affirmed that brain drain intention, its contemplation and active planning of migration to regions providing better professional opportunities occur as a popular solution to poor salary and pay structures. Büyükbayram & Çiçekoğlu, (2025) argued how persistent compensation inequalities between countries create large pull factors drawing healthcare professionals from developing nations to higher-resource nations. This decision to migrate, even before the main relocation occurs, significantly affects the quality of work-life. Medical professionals anticipating migration frequently nurture a mental state of *already having a foot out the door*, coupled with reduced investment in local professional associations, decreased engagement with work environment enhancement ideas and diminished psychological connection from the immediate work environment. Therefore, the relationship between compensation, migration intention, and quality of worklife appears to be independent and self-sustaining. Watson and Howells, (2025) discovered that healthcare professionals reported poor quality of work-life demonstrated greater migration intentions, while those actively preparing to migrate indicated quick declines in work engagement and job satisfaction. This provides feedback loops where workplace dissatisfaction drives brain drain intention, which further reduces workplace engagement, and potentially increases actual migration intentions. Thus, this study proposes that:

H₄: Poor Pay has a negative impact on the Quality of work-life.

2.2.5. Mass Poverty and Quality of Worklife

Poverty adversely influences individual mindset, reduces productivity, promotes anxiety and psychological breakdown, and increases susceptibility to poor quality of worklife. This largely affects the economic progress of any nation and decreases the rate of the active working population (Kirvalidze *et al.*, 2025). Poverty in any country significantly shapes brain drain decisions and the quality of work-life among medical professionals, creating dynamics that impact employee career trajectories. Extant literature has revealed multifaceted links between economic deprivation, professional migration considerations, and work environment sanctity (Al-Ali *et al.*, 2025). Individual economic challenges in the healthcare workforce create present pressures that reduce the quality of work-life and increase migration decisions. The study of Sun *et al.* (2025) addresses this foregoing discourse, revealing that several migrating healthcare professionals indicate a preference for remaining in their home countries if economically stable and attractive. Besides employee financial circumstances, operating in poverty-based nations introduces a peculiar quality of work-life issues. The medical workforce in impoverished populations often experiences resource limitations that constrain clinical effectiveness. The study by Gao *et al.*, (2025) documents the relationship between national poverty rates and healthcare employee distress, with medical professionals in critical resource-constrained settings reporting higher psychological exhaustion and derealisation disorder. This finding indicates that experiencing poverty's health consequences without sufficient means to tackle it provokes mental distress that reduces the quality of work-life perceptions.

Thus, the link between poverty exposure and brain drain intentions appears to be mediated by several elements. Professional mission orientation and individual connection to less-served regions demonstrate protective effects against migration intentions despite economic issues. Vega-Muñoz *et al.*, (2025) discovered that healthcare professionals exhibiting a strong sense of purpose in responding to healthcare inequities showed greater resilience to economic dissatisfaction and reduced migration consideration degree. Brain drain decisions emanating as a result of poverty exposure create more workplace challenges that further weaken the quality of work-life. Thus, this study hypothesises that:

H₂: Mass Poverty has an adverse impact on the Quality of Worklife.

2.2.6. Mediating Impact of Improved Living Standard Between High Unemployment and Quality of Worklife

The association between a high unemployment rate and quality of work-life is significantly moderated by enhanced living standards, showing a compound relationship of economic, mental, and social elements that drive medical professionals' welfare among medical students in the diaspora (Rukema & Nkoko, 2025). It has been established that improved living standards can critically ameliorate the adverse impact of high unemployment on the quality of work-life through the lens of several pathways (Meo & Sultan, 2025). An enhanced living standard creates financial strength that moderates unemployment-associated concerns. The research by Kavas *et al.*, (2025) has highlighted that medical professionals with persistent financial stability, such as diversified sources of income and family wealth, indicate significantly reduced mental challenges linked to the job market ambiguity compared to those lacking the resources. This financial security allows professionals to make employment decisions with higher selectivity and decreased distress, maintaining professional standards and limitations that will enhance the quality of work-life even in highly competitive job markets.

In addition, housing security occurs as a specific influential element of the standard of living that intervenes in employment insecurity issues. Riyath (2025) established how medical professionals with stable, comfortable housing reports maintained mental well-being inspite of unemployment challenges, while those encountering housing issues face complex challenges that reduce their professional productivity and quality of work-life. It is the sustainable living standard that can only solve these colossal issues between the high incidence of employment and the quality of work-life (Kacani *et al.*, 2025). Therefore, for medical students in the diaspora, the study by Petreska *et al.*, (2025) demonstrated that accomplishing housing security in the destination country largely optimizes professional integration achievement and work environment progress irrespective of employment status, indicating sustainability in basic standard conditions which offers the mental background needed for efficient professional acclimatization and transformation (Usman *et al.*, 2025).

In another dimension, the standard of living enhancement also involves social integration and community belonging, demonstrating a significant mediating impact. Jahić *et al.*, (2024) underscored the essence of medical professionals trained in foreign countries, established a significant social interconnectivity and social community involvement, reported a sustained professional identity and purpose inspite employment barriers. This social embeddedness provides emotional support, networking opportunities, and identity affirmation that preserve professional self-concept during periods of unemployment or underemployment. It has been discovered that sustained living standard often mediates the interactions between a high incidence of employment uncertainty and quality of work-life. Thus, this study hypothesises that:

H₃: Improved Living Standard mediates the relationship between High Unemployment rate and quality of work-life.

2.2.7. Mediating Impact of Improved Living Standard Between Poor Infrastructure and Quality of Worklife Quality of Worklife

Poor infrastructure in healthcare systems has been a growing concern among medical experts and professionals for time immemorial. It has affected their productivity and ability to compete globally. The connection between poor medical infrastructure and quality of work-life may be essentially intervened by a sustained living standard, showing a pertinent cushioning mechanism that can mitigate negative workplace influence in the face of unending medical infrastructural issues (Samuel & Haruna, 2025). The study of Isah *et al.*, (2025) explored the mediating link of a standard of living between medical facilities and nurses' job satisfaction, providing valuable insights for understanding the healthcare resilience workforce and efficiency in resource-limited ecosystems. Individual conditions of living that have a divergence route with workplace infrastructural limitations produce mental respite that promotes general well-being (Kalu, 2025). Demirkaya *et al.*, (2025) established that medical experts who maintained comfortable, suitable homes after work in depleting facilities indicated a decrease in stress and improved quality of work-life compared to their counterparts experiencing similar medical facilities challenges in both home and work environments. This compensatory contrast appears particularly significant for aspects like reliable power supply, access to clean water systems, efficient climate control, and accessibility to basic needs of life that will make life bearable. Thereby, a sustainable standard of living will often act as a buffer between poor infrastructure and quality of work-life in the healthcare work environment. Also, financial stability emanating from sustained living standards provides a practical mitigation framework for workplace facilities and infrastructure lack. The study by Gangadevi *et al.*, (2025) established how the healthcare workforce with discretionary salary frequently supplies few equipment items, reference materials, as well as technological solutions that fulfil certain workplace infrastructural deficiencies. This is done in a bid to address the challenges of living standards. Thus, this study hypothesises that

H₁: Improved Living Standard mediates the relationship between poor infrastructure and quality of work-life.

2.2.8. Mediating Impact of Improved Living Standard Between Insecurity and Quality of Worklife

Workplace insecurity has been a consistent issue of concern to all members of the organisation in the corporate work environment. However, the adverse interaction between this terrible workplace insecurity and the quality of work-life of employees may likely be intervened by a sustained living standard (Akinwale, Asonye, Durojaiye, & Jogunomi, 2025). This demonstrates a possible positive relationship that strengthens medical professionals well-being. Extant literature has established that improved individual living conditions may essentially boost the adverse impact of several insecurity variations experienced in the workplace via diverse means of protective mechanisms (Joonaghani *et al.*, 2025). Sustainable living standard occurs as a strong mediating variable between workplace security and quality of work-life. The study of Ossai *et al.*, (2020) argued that medical experts who derive stable, safe housing in a secure environment, along with possible financial stability, report an overall significant decrease in workaholicism despite encountering workplace insecurity. Workplace insecurity largely reduces the quality of work-life of professional employees via several mental, physical, and social pathways that hinder professional effectiveness and personal well-being. These mental disturbances create psychological interference that prevents individuals from committing to work as well as impair decision-making quality, and creative problem-solving capabilities significant for professional satisfaction and efficiency. Also, workplace physical security issues further complicate these challenges, with individuals reporting cognitive distress responses when working under perceived threat conditions (Ossai & Azuogu, 2018). Therefore, it is believed that sustainable living standards will assist in managing the negative effects of workplace insecurity and the quality of work-life experience in the work ecosystem.

The persistent extra-consciousness and vigilance for every form of workplace insecurity diminish cognitive resources required for optimal functioning and capabilities, establishing cycles of reduced productive work behaviour among the members of the organisation, and rather promoting an error rate that further diminishes work quality perceptions. Also, social aspects of workplace insecurity significantly affect interactional quality, with the study of Ali *et al.*, (2025) demonstrating increased competitive behaviours, low knowledge sharing, and poor collegial trust among employees in insecure work environments. These turbulent professional interactions eradicate major social support that would otherwise moderate workplace burden and reduce a sense of professional community that significantly contributes to the quality of work-life. Therefore, sustainable standards of living significantly mediate all possible challenges experienced from the workplace insecurity dimensions. Jun (2025) established that improved living conditions will moderate the negative relationship between workplace insecurity and quality of work-life by creating a springboard that will offer resilience against occupational challenges and uncertainties. Hence, the diverse dimensional safety created by a sustainable standard of living functionally promotes cognitive, physical and social cover that promote the psychological and emotional resources needed for professional work engagement despite workplace insecurities, suggesting essential pathways for encouraging healthcare workplace resilience through the lens of an improved standard of living that will complement workplace insecurity. Hence, this study hypothesises that

H₂: Improved Living Standard mediates the relationship between insecurity and quality of work-life.

2.2.9. Mediating Impact of Improved Living Standard Between Poor Pay and Quality of Worklife

The interaction between salary/pay and quality of worklife has on employee wellbeing, is significantly established in the literature. Therefore, the opposite of it is adversely detrimental to organisational progress and individual accomplishment in the workplace. Largely, the relationship between poor pay and quality of work-life is significant in organisational behaviour and human capital development (Andrade, 2025). The living condition involves multifaceted dimensions of employee well-being, including financial stability, availability of resources, and general satisfaction may likely contribute as an essential mediating trajectory between inadequate pay and poor quality of worklife (Ononye, 2023). Inadequate salary and pay package indisputably affect the quality of work-life of individuals in the workplace, potentially leading to reduced work satisfaction, as well as demotivation. Meanwhile, the individual living standard may drive the extent of this impact. An improved living standard, characterised by economic stability and access to essential resources, may prevent the adverse impact of poor pay on the quality of work-life, likewise offering individuals a sense of stability and control despite their inadequacies in pay (Reade *et al.*, 2019). In other words, a poor living standard may increase the negative impact of inadequate compensation on the quality of work-life, producing a vicious cycle of financial depression and poor well-being. A member of the organisation experiencing challenges to fulfil basic needs of life may likely realise strains, reduced access to healthcare, restricted opportunities for career growth, and further worsen the quality of work-life. Therefore, the link between inadequate compensation and quality of worklife is intervened by enhanced living conditions, showing nuanced relationships that impact professional medical wellbeing. The recent study of Siziba and Barnard (2023) demonstrates that sustained personal standard of living can significantly mitigate the adverse effects of inadequate remuneration via diverse compensation mechanisms.

In the same vein, cost of living optimisation emerges as a particularly powerful mediator. Studies by Parviniannasab *et al.*, (2025) show that healthcare professionals who successfully negotiate favourable housing arrangements, efficient transportation options, and strategic consumption patterns report significantly higher satisfaction with objectively low salaries. This purchasing power enhancement effectively increases the functional value of compensation, allowing professionals to maintain lifestyle quality despite income limitations. For medical students and early-career professionals specifically, research by Emery *et al.*, (2025) documents how those mastering cost-optimisation strategies report lower financial stress and greater career optimism despite awareness of suboptimal compensation structures in their chosen fields. These approaches recognise that absolute compensation represents only one factor in financial well-being, with living standard optimisation offering complementary pathways to professional satisfaction. Therefore, the study hypothesises that:

H₆: Improved Living Standard mediates the relationship between poor pay and quality of work-life.

2.2.10. Mediating Impact of Improved Living Standard Between Mass Poverty and Quality of Worklife

The relationship between mass poverty in practice environments and quality of work life among medical professionals is significantly mediated by improvements in personal living standards, revealing complex interactions that influence professional wellbeing and effectiveness. Research demonstrates that enhanced individual living conditions can substantially tackle the negative effects of working amidst widespread poverty through multiple protective frameworks.

Physical separation between work and living environments emerges as a particularly powerful mediator of poverty exposure effects. Research by Adebayo (2023) document how healthcare professionals maintaining residences in areas distinct from impoverished practice communities report significantly better psychological recovery and maintained professional empathy compared to colleagues living within the same impoverished areas they serve. This residential boundary creates psychological respite that enables emotional replenishment and perspective maintenance despite daily exposure to poverty-related suffering. For international medical professionals serving in resource-constrained settings, this psychological commute appears especially protective against compassion fatigue and burnout. Another critical paradigm to this is resource sufficiency in personal life, which significantly moderates the stress of practising amid resource scarcity. Research by Abikenova *et al.*, (2023) demonstrates that medical practitioners who maintain adequate personal supplies of essentials frequently lacking in their work environments—including reliable electricity, clean water, and basic commodities - report reduced overall stress and greater work engagement despite practising in severe resource-constrained settings. This personal resource security reduces cognitive load related to basic needs fulfilment, preserving psychological resources for professional challenges.

Also, financial security independent of local economic conditions shows substantial mediating effects. Studies by Chen and Williams (2020) reveal that healthcare workers with income stability, particularly through internationally benchmarked salaries or supplemental foreign income sources, maintain higher job satisfaction despite serving communities experiencing economic collapse or extreme poverty. This financial insulation appears to reduce personal anxiety that would otherwise compound the psychological challenges of witnessing poverty daily, allowing a maintained focus on service provision rather than personal economic vulnerability. Access to international travel opportunities shows unexpected but significant mediating effects. Studies by Çiçekoğlu (2025), document how healthcare professionals who periodically leave highly impoverished practice settings for international conferences, family visits, or strategic respite demonstrate better-sustained empathy

and lower burnout rates compared to colleagues without such intermittent departures. These periodic boundary crossings appear to prevent psychological habituation to poverty conditions that can lead to hopelessness or cynicism, restoring perspective on both challenges and progress that maintains professional purpose.

Healthcare access security represents another significant mediator between mass poverty exposure and work-life quality. Research by Fernandez and Kumar (2020) reveals that medical professionals who maintain guaranteed access to quality healthcare for themselves and their families—often through private insurance, international evacuation coverage, or dedicated provider arrangements—report reduced anxiety despite working in settings with compromised healthcare infrastructure. This personal health security appears particularly important during disease outbreaks or in regions with endemic health threats, enabling continued professional functioning without overwhelming personal vulnerability concerns. Awareness of these intervening relationships offers valuable insights for organisations deploying healthcare workers to impoverished regions. Comprehensive support packages addressing multiple living standard dimensions show greater effectiveness in maintaining workforce well-being and retention than salary-focused approaches alone. Strategic investments in living condition enhancements that create sustainable boundaries between professional exposure to poverty and personal life quality may provide cost-effective approaches to supporting sustained humanitarian service while preventing the psychological deterioration that undermines both provider well-being and care quality. Hence, this hypothesis is inevitable:

H₁₀: Improved Living Standard mediates the relationship between mass poverty and quality of work-life.

3. RESEARCH METHODS

3.1. Research Design

This study adopted a diagnostic research design in that it enables the researcher to estimate the additional contribution above the test outcome in establishing the presence of a particular event (Creswell & Creswell, 2018). The justification for employing a diagnostic research design is that it stimulates evaluation of the multivariate diagnostic prediction of this study (Hunziker, 2019). Moreover, the study evaluates factors that determine brain drain intention in relation to the quality of work-life among the medical students in diaspora. Thus, the design has robust predictive ability.

3.2. Study Population and Sample Size

The study population for the study comprises medical students and medical postgraduates studying in foreign countries. The study will decipher four regions and locations of the global world: United Kingdom, Canada, the United States of America, Ireland, Australia, UAE/Qatar. However, since the population is spread across several countries, it is considered an infinite population. The study cannot highlight the definite figures of all the medical students and postgraduate medical students in diaspora. Thus, the sample size is determined following the suggestion of Cochran (1967) with a sample size formula:

$$n_o = \frac{Z^2 * P * q}{e^2}$$

where n_o = Sample Size

Z = Z-value (1.96), denoted as a 95% confidence interval

P = Estimated population, taking a choice expressed as a decimal ($P = 0.5$)

e^2 = Margin of error (eg 0.04 +/-4%)

Hence, the sample size for the study is obtained through the above formula for geographically dispersed medical students and postgraduate students in diaspora, whose extent of variability is unknown. Therefore, the estimate for the sample size is:

$$n_o = \frac{(1.96)^2 (0.5) (0.5)}{0.04^2} = 0.9604/0.0016 = 600.25.$$

3.3. Sample Strategy

The sampling technique for the study is stratified probability sampling, which assists in choosing a concise sample from an infinite population by categorising it into distinguished subgroups, strata, according to shared features and then randomly choosing the medical students and postgraduates within each stratum. The justification for using this strategy is the ability to ensure representation of diverse segments within the population, and it helps to enhance the accuracy of the results compared to other probability techniques (Qing & Valliant, 2025). The study utilised online survey method through Qualtrics to administer the instrument to Nigeria medical students studying in 18 Universities in abroad which cut across 6 countries (USA, UK, Canada, Australia, Germany and UAE). The rationale for choosing those Universities is that they are considered top best medical programme University globally. Taken 3 University from each identified most migrated countries in the world.

3.4. Measurement Scale and Data Collection Instrument

A combination of scales was adapted to investigate the constructs and dimensions of what provoked brain drain intention among the medical students community in diaspora. The scales were put together as one single research instrument.

High Unemployment Rate: The employed extensively utilised scale on the High incidence of unemployment. It adapted Mylonas *et al.*'s (2013) unemployment scale, measuring explanations for a high incidence of unemployment in eight countries. The original scale consisted of 12 items with a 5 Likert scale and explored two core unemployment dimensions: inflationary trend and high rate unemployment, with a reliability coefficient of $\alpha = 0.72$. This study utilised 6 items of the scale relevant to the high unemployment rate.

Poor Infrastructure: The measurement scale for poor infrastructure was adapted from Monsen, Bekemeier, Newhouse, and Scutchfield (2012), which measures the development of public health care nursing data infrastructure with 10 items addressing the ineptitude nature of nursing in inadequate healthcare facilities to work in the healthcare environment. The Cronbach alpha of this scale was 0.74, and this study modified the items to 6 on a 4-point Likert scale.

Insecurity: The scale of measurement for insecurity at work that determined the intentions of Nigerian medical students, as well as the medical postgraduates in diaspora, is adapted from the study of Tomsik *et al.* (2014), understanding and measuring healthcare insecurity scale. The original scale was on 5 5-point Likert scale, but was modified to 4 4-point Likert scale. The reason is that it is easy to report the results in such a way that underscores the split between agree versus disagree, and takes away the issue of neither there nor here for the respondents. The scale had a coefficient reliability score of 0.78, which shows a robust consistency, with 16 items. It is, however, modified for this study, while the research utilised 7 items relevant for the Nigerian medical students and postgraduates in diaspora.

Poor Pay: For the pay and remuneration scale, this study adapted a measuring instrument from the study of Ozaki, Matsumura and Bito's (2005) study; the scale was the job satisfaction scale (JSS) from the Japanese business ecosystem. The scale has 13 dimensions, which are autonomy, patient care challenge, global job satisfaction and pay. This study only modified the pay/remuneration of the scale, as this is the only pivot aspect of the measure relevant for this research. This study only utilised 7 items of the scale, and the internal consistency of the scale is considered valid and reliable with an alpha score of 0.81.

Poverty: For poverty measurement scale, a short scale was adopted from a previous study of Valdiva (2004) called the poverty, health infrastructure scale (PHIS) of Peruvian children, with 7 items assessing the poverty estimates among the children in the Peruvian community. The short scale PHIS measures the impact of the expansion in health infrastructure and the rate of poverty among the citizens. The Cronbach's alpha for the scale was 0.70, which indicates a powerful reliability coefficient.

Living Standard: To measure the standard of living of Nigerian medical students and postgraduates studying in diaspora, a scale was adopted from the study of Topp, Østergaard, Søndergaard, and Bech (2014) known as the WHO-5 well-being index scale and personal well-being scale. The scale had 5 items that measured participants' feelings about dimensions of healthy living on a 6-point Likert scale. Thus, WHO-5 has been reported to be reliable and valid in a systematic review of 213 studies that utilised the instrument in various environments, with a reliability coefficient score of 0.86 and 0.75, respectively. The personal well-being Index is an eight-item scale with a dimension of satisfaction with life, health, life achievement, relationships, safety, standard of living, and future security on an 11-point Likert scale. The study utilised the life achievement dimension, which is relevant to the affordable social status of this study. 4 items were modified therein, and 5 items of the healthy living to measure basic affordable living of this study, all on a 4-point Likert scale.

Quality of Worklife: The quality of the work-life scale was measured following the suggestions of Walton (1975) on doctors' work-related quality of life (WRQoL), a dimension of participation, social integration, growth and development, supervision, pay and workplace benefits. The original scale was 14 items on a Likert scale and further modified to fit into the Nigerian medical students and postgraduates in diaspora. 6 items were modified and utilised from the scale, and overall, all the scales were brought together to form a single instrument for this study. The adopted scales with respective question items were combined as one with a total number of 37 question items for this study to measure all the established constructs and variables responsible for brain drain intention of Nigerian medical students and postgraduates studying in diaspora.

3.5. Data Analysis

The data analysis method employed for the study is the structural equation model (SEM) to examine the variables of interest, latent constructs and observable items of brain drain intention, improved living standard and quality of worklife. A partial least squares (PLS) variance-based SEM was employed to investigate the obtained data from the participants. The essence of employing SEM using PLS is due to its robust nature and capacity to explore the connections among the latent constructs of this research in a large data group and analyse data with a vast pool of multicollinearity (Batra, 2025). The justification for using PLS-SEM is due to its ability to integrate complex models with multiple constructs, indicators and relationships into the analysis. It includes reflective and formative measurement models, mediation and even second-order factors found in the living

standard of this research. Therefore, PLS-SEM enables more complex relationships to be investigated at once (Legate, Ringle & Hair, 2024).

4. RESULTS AND DISCUSSION

4.1. Participants' Demographic Profile

Table 1: Respondents' Demographic Characteristics.

Respondent Profile	Frequency	Percentage (%)	Profile	Frequency	(%)
428					
Sex			Universities of Study		
Male	210	49.1	University of Glasgow	25	5.8
Female	218	50.9	King's College, London	20	4.7
			University of Edinburgh	30	7.0
Age			University of Alberta	22	5.1
20 – 25 years	80	18.7	University of Calgary	28	6.5
25 – 30 years	75	17.5	McGill University	41	9.6
30 – 35 years	60	14.0	Monash University	39	9.1
35 – 40 years	110	25.7	Deakin University	41	9.6
40 – 45 years	55	12.9	University of Adelaide	42	9.8
45 years and above	48	11.2	Johns Hopkins University	26	6.1
Academic Level			Yale University	20	4.7
First Year	48	11.2	Stanford University	15	3.5
Second Year	55	12.9	Abu Dhabi University	18	4.2
Third Year	65	15.2	Gulf Medical University	12	2.8
Fourth Year	70	16.3	American University of Sharjah	10	2.3
Fifth Year	60	14.0	University of Munich	16	3.7
Six Year	55	12.9	University of Hamburg	14	3.3
Medical Postgraduate	75	17.5	Heidelberg University	9	2.1
Countries/Destinations					
USA	80	18.7			
UK	85	19.9			
Canada	70	16.3			
Australia	70	16.3			
UAE	65	15.2			
Germany	58	13.6			
Study Programme					
MBBS	170	39.7			
MD	120	28.0			
MBBCH	80	18.7			
Staatsexamen	58	13.6			

Table 1 illustrates the participants' demographic features, showing their age, gender, the academic status, they are countries of destination in diaspora, and their study programme. Their various Universities in all six regions of the world, the United States, the United Kingdom, Canada, Australia, the United Arab Emirates and Germany. The medical programme indicates that in diverse countries there is a peculiar name called medicine as a study, some countries name it Bachelor of Medicine and Bachelor of Surgery (MBBS), some call it a medicine degree, while in Germany it is called Staatsexamen, and the United Arab Emirates calls it MBBch.

Table 2: Inter-Item Correlation Analysis and Discriminant Validity.

Constructs	HUR	PINF	INSEC	MP	PP	IMSL	QWC
HUR	0.74						
PINF	0.72	0.70					
INSEC	0.68	0.68	0.72				
PP	0.71	0.64	0.70	0.71			
MP	0.65	0.62	0.68	0.69	0.74		
IMSL	0.72	0.76	0.76	0.61	0.56	0.76	
QWC	0.66	0.62	0.59	0.59	0.71	0.64	0.78
Mean	4.8	4.2	3.6	4.5	4.4	4.3	4.1
SD	0.6	0.8	0.7	0.5	0.7	0.8	0.9

Note: $P < 0.05$, HUR = High Unemployment Rate; PINF = Poor Infrastructure; INSEC = Insecurity; PP = Poor Pay; MP = Mass Poverty; IMSL = Improved Living Standard; QWC = Quality Worklife; Standard Deviation = SD. Average Variance Extracted (AVE) values are in bold diagonal form; AVE for individual constructs is higher than the corresponding inter-correlation construct square, indicating that discriminant validity is achieved.

Table 2 indicates the discriminant validity of the instrument, indicating a measure of the elements of the scales, meaning that they are unrelated. This shows a fit of the research instrument as it measures what the study intends to measure appropriately. Also, the average variance extraction (AVE), which is in bold in Table 2, means that all the square roots of the respective AVE are above the correlation values with other constructs in the model (Mohd Dzin & Lay, 2021). Hence, the intercorrelation items also demonstrate that the model is fit and discriminant validity is achieved.

Table 3: Reliability and Validity Fit Indices for Estimating Brain Drain Intention, Improved Living Standard and Quality of Worklife (Convergent Validity and Composite Reliability).

Constructs	Indicators	λ	α	AVE	rho A
High Unemployment Rate	HUR1	0.824	0.818	0.740	0.922
	HUR2	0.814			
	HUR3	0.846			
	HUR4	0.802			
Poor Infrastructure	PINF1	0.844	0.904	0.700	0.914
	PINF2	0.862			
	PINF3	0.817			
	PINF4	0.848			
	PINF5	0.838			
Insecurity	INSEC1	0.789	0.942	0.721	0.925
	INSEC2	0.810			
	INSEC3	0.828			
	INSEC4	0.849			
	INSEC5	0.861			
Poor Pay	PP1	0.896	0.910	0.710	0.900
	PP2	0.824			
	PP3	0.760			
	PP4	0.782			
Mass Poverty	MP1	0.912	0.894	0.740	0.915
	MP2	0.840			
	MP3	0.825			
	MP4	0.804			
Improved Living Standard <i>Basic Affordable Living</i>			0.849	0.760	0.922
			0.886	0.714	0.879
	BAL1	0.762			
	BAL2	0.789			
<i>Affordable Social Status</i>	BAL3	0.760			
	BAL4	0.766			
	ASS1	0.786	0.789	0.725	0.725
	ASS2	0.766			
	ASS3	0.844			
	ASS4	0.828			
Quality of Worklife	Qual_Work_Life1	0.818	0.924	0.780	0.780
	Qual_Work_Life2	0.746			
	Qual_Work_Life3	0.825			
	Qual_Work_Life4	0.849			
	Qual_Work_Life5	0.801			
	Qual_Work_Life6	0.812			

Note(s): λ = Factor loading, α = Cronbach alpha, AVE = Average Variance Extracted, rho_A = Composite Reliability.

Table 3 illustrates convergent and composite validity, the analysis and the instrument revealed a satisfactory convergent validity for ethical leadership, sustainable work environment and quality of work-life construct with an Average Variance Extration (AVE) of 0.70 above the threshold of 0.50, and acceptable composite reliability of 0.90, showing that the items measuring this constructs are internally consistent and adequately captured the underlying concept.

4.2. Analysis of Data and Test of Hypotheses

Table 4: PLS-Structural Equation Model (SEM) Path Analysis Result.

Hypotheses	Path Description	Estimates (β)	SE	CR	P	Acceptance Level
H ₁	HUR → QWL	0.105	0.311	2.322	0.010	Accepted/Significant
H ₂	PINF → QWL	0.130	0.263	2.153	0.010	Accepted/Significant
H ₃	INSEC → QWL	0.120	0.225	2.975	0.001	Accepted/Significant
H ₄	PP → QWL	0.105	0.332	3.411	0.007	Accepted/Significant
H ₅	MP → QWL	0.141	0.428	2.572	0.001	Accepted/Significant

Note: P-Value = 0.05.

NB: HUR = High Unemployment Rate; PINF = Poor Infrastructure; INSEC = Insecurity; PP = Poor Pay; MP = Mass Poverty; QWC = Quality Worklife.

Table 5: Mediating Analysis Results – (Bootstrapping) of Brain Drain Intention, Improved Living Standard on the Relationship Between Dimensions of Brain Drain and Quality of Worklife.

Hyp.	Path	D-Effect	In-Effect	T-Effect	P-Value	LLCI	ULCI	Mediation Type
H ₆	HUR → IMSL → QWL	0.105	0.243	0.270	0.000	0.556	1.719	Full Mediation
H ₇	PINF → IMSL → QWL	0.130	0.196	0.286	0.000	0.446	1.405	Full Mediation
H ₈	INSEC → IMSL → QWL	0.120	0.199	0.208	0.000	0.595	1.963	Full Mediation
H ₉	PP → IMSL → QWL	0.105	0.166	0.273	0.001	0.615	1.452	Full Mediation
H ₁₀	MP → SWE → QWL	0.141	0.170	0.251	0.001	0.815	0.622	Full Mediation

Note: NB: HUR = High Unemployment Rate; PINF = Poor Infrastructure; INSEC = Insecurity; PP = Poor Pay; MP = Mass Poverty; IMSL = Improved

Living Standard; ; QWL = Quality of Worklife

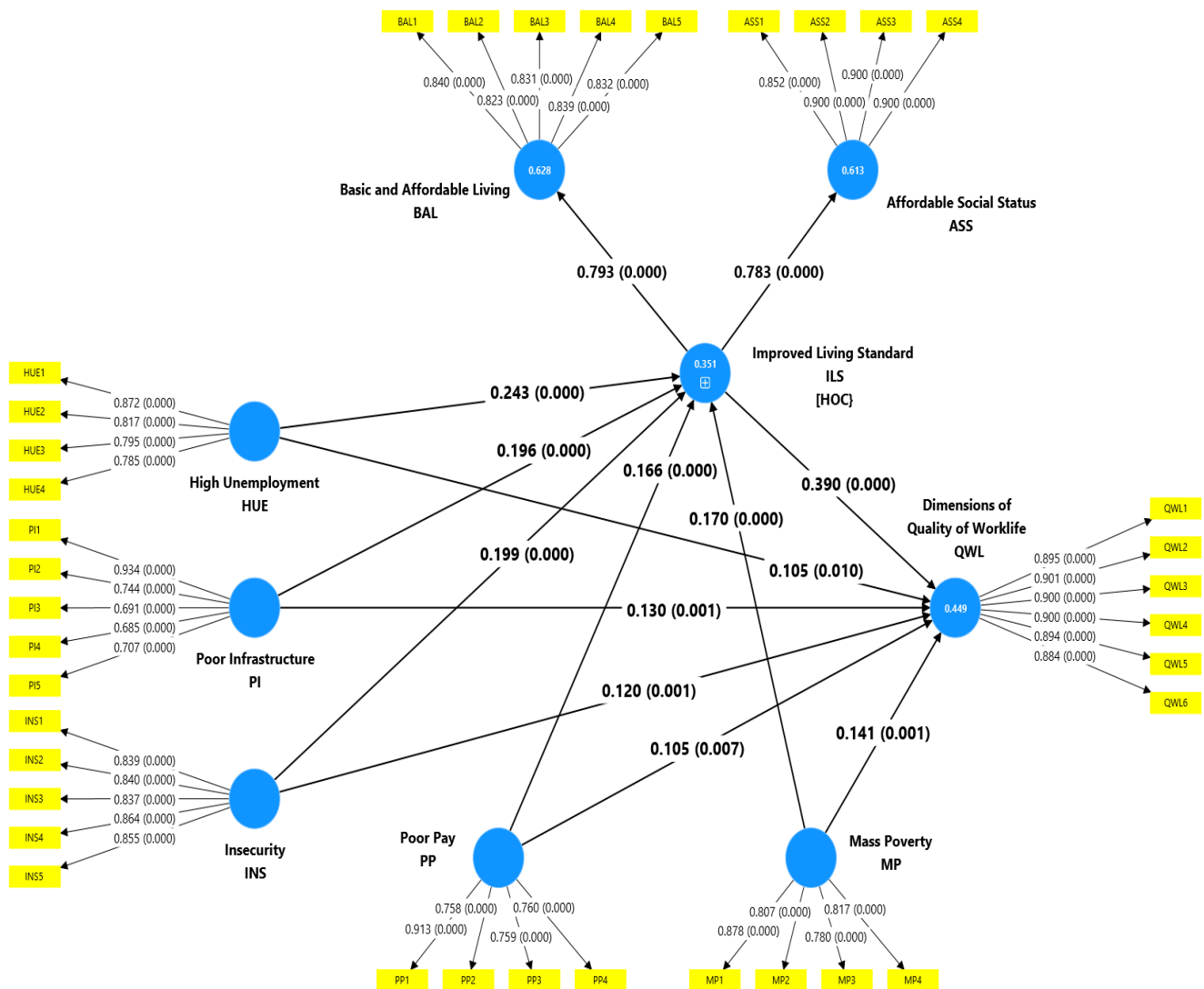


Figure 1: Partial Least Squares (PLS) Structural Equation Model (SEM) Analysis.

The hypotheses are indicated in Table 4, which depicts the direct relationship between determinants of brain drain intention and its possible effect on medical students in diaspora. Hypotheses 1–5 examined what predicts/provokes brain drain decisions among Nigerian medical students studying in foreign Universities. H1 investigates that high unemployment rate is part of what led to the brain drain decision and is essentially significant to the poor quality of work-life among Nigerian medical students and postgraduates in diaspora. The outcome of this study illustrates that a high unemployment rate is a factor responsible for brain drain intention and, as such, affects the quality of work-life with a regression value of ($\beta = 0.105$, $p = 0.010$). These results confirm the hypothesis that a high unemployment rate negatively affects the quality of work-life of Nigerian medical students in diaspora.

The second hypothesis, H_2 , poor Infrastructure adversely impacts on Quality of Worklife with a regression value of ($\beta = 0.130$, $p = 0.010$), which signifies that 13% weak relationship exists between poor infrastructure and quality of worklife. The result shows that poor infrastructure is another determinant of brain drain decision, which adversely affects medical students' quality of work-life in diaspora. This implies that there is a link between poor infrastructure and the quality of work-life. Poor infrastructure is a largely predictor of brain drain intention among the Nigerian medical student community in foreign Universities.

The third hypothesis, H_3 , is an indication that insecurity has a negative impact on the quality of work-life of Nigerian medical students in diaspora, with a regression score of ($\beta = 0.120$, $p = 0.001$). This indicates that insecurity in Nigeria's socio-political landscape is another key factor responsible for the brain drain decision of Nigerian medical students in diaspora. It further shows that a 12% weak relationship occurs between insecurity and quality of work-life, showing a very abysmally low degree of security in Nigeria, which provokes brain drain decisions among the students studying in diaspora. The fourth hypothesis, H_4 , poor pay has a negative impact on the quality of work-life with a regression weight of ($\beta = 0.105$, $p = 0.007$), indicating.

A feeble connection with the quality of work-life among Nigerian medical students community in the diapora. This means that poor pay/salary offering to physicians in Nigeria is also part of what discourages Nigerian

medical students on medicine programme in the diaspora. It shows that 10.5% relationship with the quality of worklife. The fifth hypothesis, H_5 , mass poverty has an adverse impact on the quality of Worklife with a regression weight of ($\beta = 0.141$, $p = 0.001$), which depicts that mass poverty in Nigeria depleting the living standard of the citizens encourage Nigerian medical students to stay back after completion of their medical programme in foreign Universities. The results show that 14.1% weak relationship occurs between mass poverty and quality of worklife among the medical students community in diaspora.

Hypothesis six, H_6 , improved living standard mediates the relationship between high unemployment rate and quality of work-life plays a core role in intervening on the adverse effect of unemployment rate and quality of work-life among the medical students in diaspora. The finding as evidence in Table 5, establishing mediating analysis showing mediating impact on both direct and indirect relationship between high unemployment rate and quality of worklife with a score of ($\beta = 0.105$, $p = 0.010$), and indirect connection score shows ($\beta = 0.243$, $p = 0.000$) with total effect showing ($\beta = 0.270$, $P < 0.000$). The results illustrate that there is a full mediation of improved living standard on the relationship between high unemployment rate and quality of worklife. It shows a full mediating role of improved living standard on the relationship between high incidence of unemployment rates and quality of work-life.

Hypothesis seven, H_7 , improved living standard mediates the relationship between poor infrastructure and quality of work-life. The outcome of this investigation shows a positive interaction between poor infrastructure and quality of worklife, illustrating that an enhanced living standard plays a pivotal role in this trajectory. A direct relationship showing significant effect of ($\beta = 0.130$, $P < 0.001$), with indirect impact between the two variables on the regression weight of ($\beta = 0.196$, $P < 0.000$), and a total effect regression weight ($\beta = 0.286$, $P < 0.000$), this implies that improved living standard has both direct and indirect relationship with poor infrastructure and quality of worklife and impact full mediating role between poor infrastructure and quality of worklife in the medical students' community in diaspora.

The eighth hypothesis, H_8 , improved living standard mediates the relationship between insecurity and quality of work-life. This finding indicates that there is a mediating connection between insecurity and quality of work-life. The direct relationship exists between insecurity and quality of work-life, depicting a regression score of ($\beta = 0.120$, $P < 0.001$), and an indirect relationship was observed to be ($\beta = 0.199$, $P < 0.000$), as evidenced in both Figure 1 and Table 5. The total effect is to be significant ($\beta = 0.208$, $P < 0.000$). Therefore, this study concluded that there is both a significant direct and indirect relationship between insecurity and quality of worklife; thus, improved living standard maintains a full mediating role on the relationship between the two variables.

Hypothesis nine, H_9 , improved living standard mediates the relationship between poor pay and quality of work-life. The finding indicates that an improved standard of living has a full mediating impact on the relationship between poor pay and quality of work-life. The finding shows a significant direct relationship between poor pay and quality of worklife ($\beta = 0.105$, $P < 0.007$), an indirect effect ($\beta = 0.166$, $P < 0.000$), and a total effect ($\beta = 0.273$, $P < 0.000$). Thus, improved standard of living plays a full mediating role, emphasising its impact in sustaining quality of work-life among the Nigerian medical students in diaspora.

The last hypothesis, H_{10} , improved living standard mediates the relationship between mass poverty and quality of work-life. The outcome highlights a direct significant relationship between mass poverty and quality of worklife ($\beta = 0.141$, $P < 0.001$), and a significant indirect effect of ($\beta = 0.170$, $P < 0.000$) with a total effect of ($\beta = 0.251$, $P < 0.001$). Therefore, this study concludes with this evaluated hypothesis that an improved living standard fully mediates the relationship between mass poverty and quality of work-life in the Nigerian medical students' community in diaspora.

5. DISCUSSIONS

This study has established that certain factors provoke brain drain intentions among Nigerian medical students in diaspora. The research has shown that the high unemployment rate in Nigeria has pushed several Nigerian medical students to stay back in the international community and secure better job opportunities. The study has demonstrated that the high incidence of unemployment in Nigeria has discouraged Nigerian medical students in diaspora from picking up jobs in Nigeria. The implication of this is that it has equally affected the quality of work-life of the graduated medical professional, and therefore, when leaving for medical postgraduate programmes in foreign nations, they have it in mind since there is a dearth of employment opportunities in Nigeria to remain in their various countries of medical programmes. This study takes a similar position to the study of Berşe *et al.* (2025), whose findings discovered that unemployment issues among citizens have provoked medical doctors to make migration decisions into the global job market.

The second hypothesis demonstrated that poor infrastructure has determined brain drain decisions among Nigerian medical students studying in diaspora. This has led to a poor quality of work-life for medical students. It further implies that poor infrastructure observed in the country is one of the major factors that predict medical students' brain drain intentions. It has affected their quality of work-life. This finding takes a symmetrical position with the study of Oke (2025), whose analysis highlights that decayed healthcare facilities have been a significant challenge that pushed the majority of medical professionals into the international labour market.

The third finding of this study indicated that insecurity in Nigeria's socio-political environment has impacted the brain drain decisions of Nigerian medical students studying in global communities. The study has shown that a large incidence of insecurity across all six geopolitical regions in Nigeria has been perceived to be a core determinant of the brain drain intentions of medical students studying in diaspora. The study demonstrated that medical students and professionals in regions experiencing armed conflict, terrorism, and high violent crime rates often seek a safer environment to practice after the completion of their medical examination. Targeted attacks on the healthcare workforce in some regions in Nigeria discouraged Nigerian medical students in diaspora, as medical professionals face peculiar threats based on their profession. This finding maintains a similar position with the study of Cojocar *et al.*, (2025), whose result argued that insecurity, such as economic insecurity, professional insecurity, social insecurity and political insecurity, has led to poor quality of work-life and migration intention of professional physicians across the globe.

The fourth hypothesis also established that poor salary and pay are another contending issues that determine the brain drain intention of Nigerian medical students. The study demonstrated that poor salary and compensation structures are one of the most powerful determinants driving brain decisions among medical students and healthcare professionals. The economic inequality between Nigeria and destination countries creates a compelling push-pull dynamic that significantly influences migration decisions among Nigerian medical students in diaspora. However, this outcome takes a balanced view with the study of Akinwale and George (2023), whose findings showed that inadequate reward systems and compensation structures are the two key frameworks affecting the quality of work-life of doctors in developing countries.

The fifth hypothesis also indicated that mass poverty in Nigeria has an adverse impact on the quality of work-life, as well as influencing brain drain intentions among Nigerian medical students studying in a global ecosystem. This research showed that mass poverty within Nigeria creates a pervasive environment that significantly encourages medical students' brain drain decisions while at the same time affecting their quality of work-life. The complicated relationship extends beyond personal economic issues to affect the entire healthcare environment. Mass poverty offers a certain challenging psychological environment for the healthcare workforce, and this, by extension, affects the Nigerian medical students' community studying in an international environment. This outcome is also similar to the study of Kavas, *et al.*, (2025), whose research indicates that inequality among citizenry has been one of the notable issues that affect the quality of work-life of professional people in a work environment.

The sixth hypothesis further established that an improved living standard mediates the inadequacies in high unemployment and quality of work-life among the Nigerian medical students in diaspora. The finding illustrates that an enhanced living standard will bolster the adverse effect of high unemployment on the quality of work-life among the medical students community studying in a foreign ecosystem. This finding takes a similar position to the study of Demirkaya *et al.*, (2025), whose outcome declared that the global index on enhanced standard of living is an intervening factor for all inadequacies perceived in both the corporate work environment and social context.

The seventh hypothesis demonstrated that enhanced standard of living mediates the relationship between organised poor infrastructure and inadequate quality of work-life experienced by Nigerian medical students in diaspora. This study established that the mediating mechanism assists in highlighting why some nations with infrastructure challenges still retain medical talent while others encounter severe brain drain issues. An enhanced living standard will cushion the negative effects of poor infrastructure and quality of work-life. The outcome of this finding illustrates that medical professionals and Nigerian medical students in diaspora may likely tolerate infrastructural inadequacies when living standards are highly enhanced or improved. The study further explains that poor infrastructure may be condoned when there is an avoidable and comfortable living standard in the country, yet it is found elusive in Nigeria's socio-economic environment. The outcome of this study is in line with the study of Akinwale (2025), whose research discovery established that sustainable living standards discouraged physicians and nurses from migrating to the global economy in search of a better life and sustainable quality of worklife.

The eighth hypothesis of the study shows that improved living standard mediates the relationship between insecurity and quality of work-life. It shows that robust and optimised living standard serves as a critical intervening mechanism between insecurity and quality of work-life for Nigerian medical students studying in diaspora. This is what may discourage them from staying in foreign nations after the completion of their medical studies. This outcome further explains why insecurity possibly drives retention differently across contexts and reasons some healthcare workforce remain in an objectively insecure operating environment due to high enhanced living standards. The result established that when living standards are well maintained and improved despite insecurity in the workplace, brain drain intentions reduce. The result emphasised that the medical workforce in an insecure area shows higher retention when the living standard is protected and stable. Therefore, this finding is similar to the study of Jun (2025), whose finding also argued that living standards suggest a direct security interventions are not always efficient than mechanisms that preserve living standards despite insecurity in the workplace. The study further highlights that security-driven interventions often fail to decrease brain drain if they do not translate to enhance daily living experiences.

The ninth hypothesis demonstrated that living standards serve as a crucial mediating variable between poor pay/salary and quality of worklife observed and perceived by Nigerian medical students in diaspora. This further explains why the degree of compensation and pay alone do not perfectly determine brain drain intentions and why salary and pay strategies must be explored through the lens of their impact on the core standard of living. The study demonstrated that pay and salary packages that directly solve living standard components such as transportation, food and housing, enhanced purchasing power outperform equivalent cash only. Therefore, an environment with reduced compensation but increased relative purchasing power frequently shows better retention and prevents brain drain decisions. Thus, this finding also maintains a symmetrical position with the study of Parviniannasab *et al.*, (2025), whose findings declared that living standards often intervene in poor compensation and reduce brain drain intention among professionals in South Africa.

The last hypothesis of this research also established that improved living standard mediates the relationship between mass poverty and quality of work-life. The study indicates that enhanced standard of living functions as a prominent mediating structure between societal mass poverty and the quality of work-life perceived and observed by Nigerian medical students. This mediation path underscores why the effect of widespread poverty on healthcare employees' job satisfaction and retention varies significantly across contexts with the same poverty levels. This implies that when medical experts can sustain adequate personal living standards despite practising in impoverished environments, the adverse effects of mass poverty on their quality of worklife are largely buffered. Another implication of this is that enhanced living standards offer psychological distance between medical expert challenges and personal wellbeing, enabling healthcare employees to perceive poverty-related healthcare problems as work-related challenges rather than existential threats. This finding maintains a balanced view with the study of Büyükbayram and Çiçekoğlu, (2025), whose findings indicated that the living standard illuminates some obscured variables, such as insecure work environment, poverty, and impoverished situations of professionals. The study further shows that adequate living standards offer necessary recovery spaces where professionals can expand from the emotional toll of practising in a resource-constrained setting.

6. CONCLUSION AND RECOMMENDATIONS

This study has established that some factors are attributes of brain drain intention among Nigeria medical students currently taking their medical programme abroad. Thus, the persistent brain drain of Nigerian medical students and professional signifies a complex issues that need immediate, coordinated attention across multiple stakeholders. At its peak, this situation is influenced by a complicated interactions of workplace insecurity, social insecurity, poor salary, inadequate infrastructure, and widespread poverty, with living standards playing a cogent mediating role that largely informs brain drain, migration intentions among Nigerian medical students studying in abroad. This evidence suggests that when Nigerian healthcare professionals and who-would-be medical experts can experience acceptable living standards inspite of challenges, their quality of worklife and dedication in remain in Nigeria significantly stimulated. Also, after completion of Nigeria medical student in diaspora they would like to come back to Nigeria and benefit their country. In view of this, this study suggests the following recommendations to better enhance quality of worklife in Nigerian medical industry and discourage brain drain decisions:

- i. Government should be create a dedicated medical professional retention fund with competitive compensation structure corresponding to living costs.vernment
- ii. Government should ensure there is employment opportunities for medical professionals with enabling work environment from time to time.
- iii. Government should ensure the is dedicated and sustainable infrastructure in the country that will motivate medical professionals to work in Nigeria public healthcare industry
- iv. Security to life and property should be provided for every citizen, and par excellent secure work environment should be made available for medical professionals in Nigeria
- v. Government should establish fast-track specialist training pathways within Nigeria through international partnerships, establishing foreign rotation programs that will allow for periodic skill improvement in an international clime without permanent migration.
- vi. The government should create protected centres of excellence within the Nigerian healthcare system where medical experts can practice advanced medicine despite huge resource challenges.
- vii. Government should execute and implement all these intervention with high degree of transparency and sincerity of purpose, and consistency to rebuild trust in the healthcare system's dedication to its medical professionals.
- viii. Government should focus on preserving and improving the living standards of medical professionals while addressing systemic healthcare issues ravaging the sector. This will go a long way to decrease brain drain intentions and entrench rebuilding its significant healthcare workforce.

7. THEORETICAL IMPLICATIONS

The pervasiveness brain drain incidence among the healthcare workforce in Nigeria as well as the medical students provide an essential insights that extend and improve relative deprivation theory and the push-pull

theory of migration is numerous substantial ways. The Nigeria brain drain context establishes that relative deprivation theory functions not merely through direct social comparison with peer locally, but increasingly via global professional identity development, where medical students form comparative assessments through foreign clinical rotations, social media exposure to international practice standards, and virtual professional communities that goes beyond national boundaries. This transnational comparative dynamism heightens observed disparities, as Nigerian medical students in diaspora analyse their potential opportunities against global reference group than domestic standards alone, establishing what might be referred to international relative deprivation. Also, on push-pull theory, the Nigerian context signifies a more nuanced interaction where push-pull variables does not only function as discrete drive but via multifaceted mediating pathways premised on standard of living. The study demonstrates the push factors peculiar to Nigeria medical students in diaspora as poor infrastructure, insecurity, poor compensation package, mass poverty, provoke differential migration decisions irrespective of how individual can manage acceptable and existing living standard despite these challenges. This portends a significant theoretical modification where standard of living play a crucial mediating role in which push and pull factors largely determine brain drain intentions. Thus, these theoretical implications suggest that effective brain drain prevention strategy requires intervention that address not just objective conditions but subjective comparative analysis, create feasible pathways for professional identity accomplishment within resource constraints, and create mechanism for significant transnational professional engagement that enable contribution without multiple migration intentions.

8. IMPLICATIONS FOR PRACTICE

The persistent mass exodus of Nigeria medical students and professionals require urgent practical attention across multiple industry. Medical education institutions must revise and reform medical programme curricula to balance global standards and practices with context appropriate training for Nigerian healthcare realities, integrating resilience building, resource optimisation skills. Healthcare financing demands immediate restructuring through committed retention funds, public private collaborations, and enduring compensation mechanisms that bridge the foreign wage disparities while offering career improvement incentives. Healthcare management must prioritise work environment improvements within resource constraints, emphasizing on enhanced workflow design, professional autonomy, and tactical resource allocation to major clinical capabilities.

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