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Attracting and retaining health workers in the Member States of the South-eastern Europe Health Network

SOUTH-EASTERN EUROPE HEALTH NETWORK

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A policy brief

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Attracting and retaining health workers in the Member States of the South-eastern Europe Health Network

This policy brief has been formulated to help health policy-makers in the countries of the South-eastern Europe Health Network (SEEHN) attract and retain health workers.

What major health workforce challenges do SEEHN Member States face?

What preconditions are needed to make attraction and retention interventions work?

What are some recent experiences that these countries have had with such interventions?

What are some of the key policy options that SEEHN Member States can use to attract and retain health professionals?

Rationale

An equitable distribution of health workers is essential for effective health system performance. Health workforce shortages limit general access to health services, while poor distribution and migration of workers limit such access for people living in underserved communities and rural areas.

In 2010, WHO published global recommendations for retention policies that would improve the availability of health workers in remote and rural areas (WHO, 2010a). WHO complemented these recommendations with the Global Code of Practice on the International Recruitment of Health Personnel (WHO, 2010b), which addresses the challenges of international migration of health personnel. The global recommendations were informed by evidence from retention practices around the world, although there was no information on attraction and retention practices in the countries of SEEHN.

The SEEHN Member States are Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Montenegro, the Republic of Moldova, Romania, Serbia and the former Yugoslav Republic of Macedonia. Their governments are seeking to address the challenges of retaining and equitably distributing their health workforces through a variety of interventions.

This policy brief is designed to inform policy deliberations on how to improve retention of health workers in rural and remote areas of the nine SEEHN Member States.

The policy options outlined here are based on national experiences of SEEHN Member States[1] and the evidence used for the WHO global recommendations.

[1] The experiences were distilled from national health strategies, human resources for health (HRH) country profiles, national health system profiles by the European Observatory on Health Systems and Policies, written case stories on health worker retention experiences, and other relevant materials.

Background

SEEHN is a political and institutional forum set up in 2001 by the governments of Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Serbia and Montenegro (which later became the two states of Montenegro and of Serbia), the Republic of Moldova, Romania and the former Yugoslav Republic of Macedonia. This network seeks to improve health in the region. At the end of the 20th century, the countries in SEEHN entered a period of economic and political transition. The complex transition led to a rise in gross national incomes, although the recent global economic crisis has dampened this growth (Bartlett & Monastiriotis, 2010; World Bank, 2011b). The SEEHN countries are classified as upper-middle income, except for the Republic of Moldova (lower-middle income) and Croatia (high income) (World Bank, 2011a). Table 1 presents some characteristics of the SEEHN countries. Among other things, it shows that SEEHN health systems must contend with lower life expectancy and lower per capita health expenditure than systems in the WHO European Region as a whole (Table 1).

Table 1 Key indicators for national health systems in SEEHN, 2009

Indicator	Albania	Bosnia and Herzegovina	Bulgaria	Croatia	Montenegro	Republic of Moldova	Romania	Serbia	The former Yugoslav Republic of Macedonia	WHO European Region	European Union
Population	3 155 000	3 767 000	7 545 000	4 416 000	624 000	3 604 000	21 275 000	9 850 000	2 042 000	—	—
Gross national income (PPP) per capita (US$)	7 520	8 360	11 370	17 050	13 420	3 270	13 380	10380	9 250	23 636	34 744
Life expectancy at birth, male/female (years)	72/75	73/78	70/77	73/79	72/77	65/73	70/77	71/76	72/76	72/79	77/83
Total health expenditure (PPP) per capita (US$)	582	929	986	1 553	1 231	341	773	836	749	1 969	2 877
Physicians per 100 000 population	115	333	364	259	199	267	192	204	255	333	320
Nurses and midwives per 100 000 population	403	747	472	558	554	665	419	443	434	747	782

PPP: purchasing power parity.

Source: WHO country profiles, available at http://who.int/countries (WHO, 2011).

At the start of the **health sector reforms** that formed part of the broader political and economic reforms during the transition period, countries in SEEHN inherited health care systems with centrally planned universal health coverage, extensive infrastructure and a large number of salaried health professionals (Council of Europe Development Bank & WHO Regional Office for Europe, 2009). Resource allocation had been directed largely towards secondary and tertiary curative services. The countries **shifted the focus of health services to primary care** and began training general practitioners to provide primary care and act as gatekeepers for secondary and tertiary care. They also **decentralized national health systems**, delegating health service responsibility and management to regional and local authorities. This change took a variety of forms in the different countries. The **legalization of private practice** in the health sector led to an increase in private general practitioners,

dentists and pharmacists. However, private practices are often not fully integrated into the health system. For instance, sometimes they do not provide a comprehensive package of services that includes preventive interventions and 24-hour emergency care, nor do they always provide sufficient health data to the central authorities. With the introduction of **health insurance schemes**, payment mechanisms in SEEHN health sectors shifted away from salaried public employees to contractual relationships between health insurance funds and health care providers, both public and private.

The health sector reforms of the past two decades have started to bring about positive changes in SEEHN countries, e.g. by increasing access to primary care and improving the financial sustainability of health systems. Yet challenges remain, notably in providing populations with access to human resources for health (HRH).

Health workforce challenges

Countries in the SEEHN report a **lack of qualified HRH in rural and remote areas** and other underserved communities, a lack that negatively affects the accessibility and quality of health services. The tendency of health professionals to locate and practise in urban areas due to better **living and working conditions** is a challenge for policy-makers worldwide (WHO, 2010a).

In SEEHN Member States, the availability of physicians in rural and remote areas is closely linked to physicians' specialty mix. One legacy of a system with an imbalance that favoured hospital care over primary care is **a workforce with many medical specialists** and few general practitioners. This situation has been reported for instance in Albania, the Republic of Moldova and Serbia. Medical specialists work mainly in secondary or tertiary care hospitals, which are predominantly located in urban and suburban areas. Although the health policies of SEEHN Member States now emphasize primary care strongly, it has proven difficult for patients and physicians to adapt. Service users tend to bypass general practitioners in order to visit specialists directly, while medical graduates are still not sufficiently drawn to the profession of general practitioner in some countries due to the relatively **low status of general practice** among medical doctors.

The **skewed distribution of health personnel** by level and type is also seen in other types of health workers. Some countries have reported that few nurses have higher educational backgrounds (Bosnia and Herzegovina), or that nurses have limited opportunities to upgrade their academic qualifications (Bosnia and Herzegovina and the Republic of Moldova). These dynamics contribute to the low status of nurses (Bosnia and Herzegovina and the Republic of Moldova). Some countries in SEEHN report a surplus of nonmedical staff members, such as administrative and technical personnel (Montenegro and the former Yugoslav Republic of Macedonia).

Overall, health workforce **salaries are relatively low**, though they vary considerably among SEEHN countries. For instance, the monthly salaries of general practitioners range from €135 (Republic of Moldova) and €310 (Albania) to €1000 (Bosnia and Herzegovina) and €1300 (Croatia). Moreover, career opportunities are often lacking, and formal opportunities to upgrade knowledge and skills through continuing professional development are limited for the health workforce in some countries (Albania, Bulgaria and the Republic of Moldova). That impedes health worker motivation, encouraging their **movement to the private sector and abroad**. In turn, that diminishes the numbers of health workers in the public sector, while demand for them is simultaneously increasing due to **ageing populations and ageing health workforces** in SEEHN countries.

Private practice is increasingly common in many SEEHN countries, sometimes **leading to dual practice**, in which a public health worker has two positions, with the second typically in the private sector. Since the private sector is more difficult to monitor, the growth in private practice has also made HRH data less dependable, hampering effective planning (Albania, Bosnia and Herzegovina, Montenegro and the former Yugoslav Republic of Macedonia).

SEEHN countries indicate an increase in **migration flows** of health workers within south-eastern Europe and to other European countries, particularly the migration of young health professionals, although exact numbers are limited and national data are often neither comprehensive nor comparable (Buchan, 2007; WHO Regional Office for Europe, 2009).

European integration is expected to increase the mobility of HRH to other countries. For instance, immediately after acceding to the European Union in 2007, Romania reported over 6000 requests for certificates recognizing the Romanian diplomas of doctors, dentists, pharmacists and nurses for use elsewhere in the Union. Integration implies educational harmonization and mutual recognition of professional qualifications in the European Union and its single market. It would allow free movement of health professionals among countries, to the detriment of health workforces in the countries with the least favourable working conditions.

The **limited availability and scattered nature of HRH data** is relevant not only for tracking HRH migration and movement to the private sector; it is also a general health workforce management challenge. Data on e.g. unemployment, attrition rates and training institutions are lacking in both the public and the private health sectors, hampering effective stock-taking and planning for HRH. Other health workforce management challenges include a **lack of skills** in analysing data, managing health services, making health policy, planning, managing HRH performance and overseeing contracts (Dubois, McKee & Nolte, 2006).

Preconditions to make attraction and retention interventions work

Good attraction and retention strategies are crucial for addressing health workforce challenges in rural and underserved areas, but certain preconditions are also needed to make success more likely. They include a national HRH strategy, reliable HRH information, a broad focus on all health workers and attention to management issues.

A national HRH strategy

A full set of attraction and retention interventions should be part of a comprehensive national HRH strategy, based on the national health plan. The interventions should address the specific HRH challenges that arise in the country from the needs of health workers and the general population. It is important to involve a broad selection of stakeholders in developing the HRH strategy; besides the health ministry, they could represent private and public training institutions, the finance ministry, the education ministry, professional associations, patient groups, health insurance institutes, public health institutes, etc. Given the challenges posed by workforce flows between SEEHN countries and other parts of the European Region, the strategy should address international and regional collaboration on health workforce mobility and joint interventions to manage it.

An HRH information system

Effective planning and prioritization of HRH requires insight into health workforce needs and dynamics. Evidence-based insight can be provided by a comprehensive situation analysis and a good HRH information system. These elements will facilitate the development of appropriate interventions by taking into account factors such as labour market characteristics, new expertise requirements, the changing competences needed by different types of health care providers, demands for new technologies, and shifting international conditions (see Box 1 below). An HRH information system should include data on the health workforce in public and private facilities and training institutions, its geographical distribution and demographic characteristics. Appropriate regulations are also necessary to ensure that the private sector supplies full information on its health workers.

Including all workers in the health sector

HRH planning should focus on not only general practitioners, specialists, dentists, pharmacists, nurses and midwives, but also other health workers, including administrative and support staff members and facility managers. Interventions should address the number and distribution of these workers too, for instance through continuing professional development, career development and adapting the scope of responsibilities as needed.

Management capacity

Changes in health service delivery, management structures and payment mechanisms should all to be accompanied by adequate managerial training and support for national and local health authorities. For instance, primary care practices often consist of a team of a general practitioner and a nurse or two, or a group practice with several general practitioners and nurses. The changes mentioned require the authorities to practice human resource management, taking into account the performance and motivation of all the types of health workers involved in these practices. They also require health authorities to recruit different

types of professionals – such as information technology specialists, economists, managers and statisticians – to provide competencies relating to organization and management.

Box 1 The Medical Worker Registry in Croatia

The Croatian National Institute of Public Health set up the Medical Worker Registry in 1991. The goal of the Registry is to identify the number of physicians, particularly medical specialists, who leave the medical service or start specialty training each year, and to monitor their age distribution. Health institutions in Croatia are obligated to report any changes in their workforces. In this way, the Institute maintains basic demographic data on health workers, as well as data on professional status, level of education, type of employment, activities and workplace for each worker.

The Medical Worker Registry gives Croatian policy-makers immediate, accurate insight into the state of employment in the health sector, particularly for medical specialists. The Registry has helped stabilize the health workforce in Croatia, e.g. by demonstrating the need for the Ministry of Health to finance specialization training of physicians, given the fact that in 1999, 29% of the physicians aged 35–44 years did not possess a specialty degree. Registry data also informed a decision to raise the national *numerus clausus* for medical students from 240 to 300, beginning in 2008.

Current practices to attract and retain health workforces in SEEHN

Governments from the SEEHN region have developed a variety of strategies to attract and retain health professionals, especially in areas outside major cities. They are presented below, using the four retention intervention categories that WHO uses: education, regulation, financial incentives and professional and personal support (Box 2).

Box 2 Four types of HRH attraction and retention interventions

1. *Educational interventions* relate to the selection of students, since students from rural or remote areas are more likely to practise in those areas. Others interventions are curricular, e.g. using locations and methods that match or might influence the choice of future practice locations, or offering continuing professional development for health workers in rural and isolated areas.
2. *Regulatory interventions* involve governmental control, including legislative and administrative measures. They also include policies that expand the scope of health worker responsibilities, introduce a new type of health worker or make a rural service commitment a prerequisite for a practice licence, specialization or scholarship.
3. *Financial incentives* provide extra benefits to health workers to entice them to work in rural or remote areas.
4. *Professional and personal support* include interventions that relieve the sense of personal and professional isolation experienced by HRH in rural and remote areas. They may address living conditions, infrastructure, social interaction, schooling and employment for relatives. Equally important are the promotion of contacts and consultations with other professionals, e.g. through professional networks, and public recognition of services provided.

Source: WHO, 2010.

Education

SEEHN Member States have implemented several types of educational strategies to attract and retain health workers. Most of them have introduced family medicine or general practice as specializations in their professional health training to prepare graduates to work as family doctors or general practitioners. Serbia has set up a nursing school that lies outside its major cities, which has increased the number of nurses working outside urban areas (Box 3). Preliminary results have also shown an increase in patients' satisfaction with primary care and in nurses' job satisfaction.

Albania and the former Yugoslav Republic of Macedonia have organized continuing professional development for general practitioners, in family medicine and primary health care, respectively. Preliminary results from the former Yugoslav Republic of Macedonia show that job satisfaction and performance improved as a result. The country has also been awarding health training scholarships to students from the underserved Roma population. The Republic of Moldova is funding health training for students from rural areas. Its intention is to improve access to care, since these students are required to go back and work in their areas of origin, although the results of this initiative are not known yet. Romania developed distance-learning modules in emergency care to train physicians and nurses working in ambulance services and hospital emergency departments. There are indications that the

modules have led to improved use of equipment and better patient care, suggesting the potential benefits of offering distance education to health workers in rural and remote areas. Bulgaria and Romania have established chairs in the discipline of family medicine at their main medical universities.

Box 3 A Serbian nursing college that is not in a city

In 1998, the Serbian Government decided to found the Nursing College in Ćuprija, 38 kilometres from the nearest university. The only public college for nurse specialist education outside the capital, the Nursing College offers further education to nurses who graduate from the local nursing school. By improving access to continuing professional development, the Nursing College may be indirectly promoting local interest in nursing and encouraging nurses to work and stay in non-urban areas. In addition, the presence of locally trained and employed health professionals is increasing client utilization of local health care providers.

Regulation

SEEHN countries have experimented with different statutes and policies to redefine the roles of health workers and improve attraction and retention. For instance, Bulgaria, Romania and the former Yugoslav Republic of Macedonia have all passed regulations to train and recruit Roma health mediators to facilitate access to care and raise health awareness in the underserved Roma population (Box 4). Romania has also expanded general practitioners' scope of activity and given them more responsibilities in primary care, including the monitoring of diabetes patients. Bulgaria has tried enhancing health assistants' scope of practice.

Box 4 Roma health mediators in Romania

In 2002, in line with the national health strategy, the Romanian Ministry of Health used a ministerial order to introduce a new type of worker, the health mediator, to improve the health of the Roma population. The main role of the health mediators, who are themselves Roma, is to facilitate communication between Roma communities and the health system. The mediators' main activities include:

- supporting Roma in obtaining identity documents so they can use health insurance;
- scheduling medical examinations for pregnant and postpartum women and accompanying them to these examinations;
- explaining the advantages of family planning in the context of Roma traditions and culture;
- encouraging Roma to register infants, and accompanying them during registration;
- supporting other health workers in promoting and tracking infant immunizations; and
- identifying cases of tuberculosis and other infectious diseases under the guidance of family doctors and medical personnel in the public health directorates.

In 2011, the Ministry has been employing 250 Roma health mediators on fixed-term contracts. District public health directorates coordinate their activities. In areas where the mediators are active, improvement in Roma access to public health care services has been reported, as has increased awareness among Roma of the importance of good health.

Bulgaria, Montenegro and the former Yugoslav Republic of Macedonia allow health workers to engage in dual practice and work for multiple employers.
In Croatia, the government responded to an ageing workforce by raising the pension age and allowing general practitioners to work under special contract until the age of 70. Rural general practitioners in both Croatia and Montenegro receive higher capitation fees, based on patient populations that are smaller than they are in more densely populated areas. In Montenegro, general practitioners in rural areas receive the same remuneration as their urban counterparts for working with fewer patients. Albania and the Republic of Moldova have established bonding contracts requiring health workers to practise for three to five years outside major cities, although how effective and how well enforced these schemes are remains unclear. In Montenegro and Serbia, the health institutions that finance physicians' specialty training also use bonding schemes, regardless of institutional location.

None of these regulatory interventions have been formally evaluated yet.

Financial incentives

Almost all SEEHN countries provide financial incentives to health workers who work in rural or remote areas, such as higher salaries or higher fees (Box 5). In the Republic of Moldova, family doctors also receive bonuses when they meet certain quality standards. For the most part, incentive payments for rural postings apply mainly to general practitioners, specialists and, in some countries, nurses. While these incentives have not been evaluated systematically, the results appear to be mixed: some areas have increased the number of general practitioners and nurses, whereas others still face shortages, suggesting that income is not the only contributing factor.

Box 5 Raising the salaries of general practitioners in rural Albania

The Albanian Health Insurance Institute has sought to make working in rural and remote areas more attractive by significantly increasing the salaries of general practitioners posted in these locations. The salary difference is substantial: general practitioners working near cities receive approximately €210 per month, while those working in remote rural areas receive at least €490 per month. When the additional salary fails to attract the needed personnel to remote facilities, then general practitioners from neighbouring areas are sent in to provide regular medical services.

Professional and personal support

Most support efforts for health workers concentrate on providing better working and living conditions. Rural doctors and nurses in the Republic of Moldova receive free housing, heat and electricity (Box 6); in Romania and Serbia doctors also receive housing and better living conditions. In the former Yugoslav Republic of Macedonia, the Ministry of Health invests in improved health facilities and equipment. Bulgaria provides career development by waiving entry exams to school graduates wishing to enter nursing school, and by providing postgraduate education young general practitioners. Albania has organized outreach support to address a shortage of anaesthesiologists, periodically assigning anaesthesiologists to work in district hospitals that lack them for several weeks or months. In Croatia, telemedicine allows medical providers in remote locations such as islands to consult with experts about diagnoses and treatment.

None of these initiatives have been evaluated.

Box 6 Subsidizing living expenses for Moldovan health workers

Moldovan health workers who are required to work in rural areas for at least three years receive several benefits:

- an allowance for house rental, or free housing from the local government authority;
- a supplement of 30 000 Moldovan lei (€1800) for doctors and pharmacists and 24 000 lei (€1450) for nurses, spread over three years;
- a monthly reimbursement for up to 30 kWh of electricity and an annual reimbursement for heating costs.

If the worker does not remain for a full three years, he or she must repay the above benefits.

Overview of HRH interventions in SEEHN countries

SEEHN countries have been undertaking many efforts to correct the rural–urban imbalance in their health workforces and improve access to high-quality primary care services. Many of these interventions are also described in the WHO global policy recommendations and have met with varying levels of success in other contexts (WHO, 2010a). Often they are implemented in packages combining all four types of intervention.

However, there are some forms of support that are relatively rare in SEEHN countries, including career development programmes, professional networks and initiatives to improve the status of rural health workers and primary care providers. And despite the increasing importance of private practices in the (primary) health care systems of south-eastern Europe, members of SEEHN have not introduced very many regulations that address dual practice or improve information on HRH in the private sector. Moreover, most attraction and retention efforts are geared only to the medical profession. A general lack of evaluation and the recency of many of these initiatives also mean that it is hard to gauge their effectiveness in SEEHN.

Policy options for attracting and retaining health workforces in SEEHN

The reforms of the transition period brought important changes to the health systems of SEEHN countries. However, they still face HRH challenges that they need to address to improve access to health services. The following policy options are for the specific consideration of these countries. Their suitability of individual interventions will vary by country, and selection should be based on situational analysis, stakeholder consultation and financial feasibility. Because of limited evidence about which interventions work in SEEHN countries, why they work there, and how cost-effective and sustainable they are, these policy options are based on anecdotal evidence from SEEHN and the WHO global recommendations.

Increase health workers' willingness to work in rural areas and with underserved populations

- Provide students in the health professions who come from underserved populations and rural areas with preferential access to scholarships (education).
- Incorporate rural health issues and social determinants of health, including minority status, in health worker training (education).
- Establish health training schools outside urban areas (education).
- Set up clinical internships in health facilities outside major cities (education).
- Use distance education to expand access to continuing professional development (education).
- Establish bonding contracts to work in rural areas or with underserved populations and combine these with professional and personal support (regulation, support).

Create financial incentives to work in rural and remote areas

- Develop financial incentives for remote postings and tie the payment of these incentives to performance and quality indicators (financial incentives).
- Combine such incentives with appropriate regulation and professional and personal support (financial incentives, regulation, support).
- Develop financial incentives and support for primary care teams (financial incentives, support).

Address the role of the private sector in HRH

- Regulate dual and multiple practice (regulation).

Raise the profile of primary care providers

- Introduce continuing professional development for general practitioners and other primary care providers, to encourage the primary care workforce to adapt to new roles and to increase the credibility of primary care reforms among patients and the medical profession (education).
- Expand the scope of general practice to include the monitoring of chronically ill patients (regulation).

- Improve the status of primary care by forming primary care networks for professional exchange on e.g. diagnosis, treatment and care; establishing university chairs in general practice; and developing primary care research programmes (support, education).
- Raise the profile of primary care facilities among patients (support).
- Publicly recognize medical and paramedical personnel working in primary care, especially in rural or remote areas, through awards, media attention and publicizing the results of patient satisfaction surveys (support).

Raise the profile of nurses and midwives

- Increase the status of nurses and midwives, e.g. through establishing a university programme in nursing sciences and a university chair in nursing (support, education).

Create health professionals who will work with underserved populations

- Establish the profession of health mediator to facilitate underserved populations' access to health care (regulation).

Increase or maintain the number of health workers

- Increase the pension age (regulation).
- Make the health sector more attractive to young secondary-school graduates through a combination of financial and non-financial incentives (financial incentives, support).
- Establish international and regional collaborations to manage health worker migration, e.g. through bilateral agreements with destination countries (regulation).

The development of an effective retention strategy

The key to a successful health worker retention strategy is to develop a combination of different retention interventions based on thorough situational analysis, good health workforce data, and intersectoral and interdepartmental collaboration. To increase the success of the retention strategy, the interventions should be gender-sensitive, costed and sustainable, and there should be adequate capacity to implement, enforce and manage them. In general, the WHO global recommendations provide valuable guidance on selecting effective interventions (WHO, 2010a). There is very limited evidence at present on which interventions work in south-eastern Europe and why. Operational research and intervention monitoring and evaluation are crucial in establishing a common evidence base, which will facilitate the future development of effective HRH policy in SEEHN countries.

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