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Technical Meeting on Health Workforce Retention in Countries of the South-eastern Europe Health Network

SOUTH-EASTERN EUROPE HEALTH NETWORK

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Bucharest, 28–29 March 2011

ABSTRACT

This report presents the proceedings and outcomes of the Technical Meeting on Health Workforce Retention in Countries of the South-eastern Europe Health Network (SEEHN) in March 2011, organized by the WHO Regional Office for Europe and the Executive Committee of SEEHN. The purpose of the meeting was to share experiences with interventions to improve the recruitment and retention of national health workforces in south-eastern Europe and to identify relevant policy options, and to thereby expand the evidence base for retention strategies in the area. This report includes an executive summary and a presentation of key messages. A policy brief documenting SEEHN retention experiences is being published in parallel with this report.

Keywords

HEALTH MANPOWER
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DELIVERY OF HEALTH CARE
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The WHO Regional Office for Europe and the Executive Committee of the South-eastern Europe Health Network (SEEHN) organized this technical meeting on health worker retention in south-eastern Europe (SEE). The meeting took place in Bucharest in March 2011, and it was facilitated by the experts of the Royal Tropical Institute, a WHO collaborating centre for research, training and development of human resources for health, located in Amsterdam. The Regional Office and the Executive Committee of SEEHN gratefully acknowledge the Institute for its assistance, especially the contributions of Dr Marjolein Dieleman, Dr Ankie van den Broek and Ms Christel Jansen in facilitating the meeting and helping write the report and develop a separate policy brief (WHO Regional Office for Europe, 2011).

The organizers also express their appreciation for the efforts of the meeting participants, for writing country case stories and providing other invaluable input on the policy brief.

The Technical Meeting and the preparation of the report and brief were funded through a joint partnership programme of the Netherlands Ministry of Health, Welfare and Sport and the Regional Office.

Abbreviations

EU	European Union
GP	general practitioner
HRH	human resources for health
RHDC	regional health development centre
SEE	south-eastern Europe
SEEHN	South-eastern Europe Health Network

Executive summary

The Member States of the South-eastern Europe Health Network (SEEHN) are facing increasing difficulties in attracting and retaining sufficient health workers to care for the health needs of their populations, especially in rural areas. SEEHN is a political and institutional forum set up 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.

The SEEHN Member States are facing increasing shortages of workers in most health professions and serious geographic maldistribution of human resources for health (HRH) due to the movement of health professionals to urban areas, to the private health sector, to non-health sectors and to other countries.

In 2010, WHO issued a set of global policy recommendations, *Increasing access to health workers in remote and rural areas through improved retention*, to help provide people who live in remote and rural locations with access to trained health workers. The recommendations were based on a review of evidence relating to health workforce attraction, recruitment and retention in such locations. However, the authors found no publications on relevant practices in south-eastern Europe (SEE) during their literature review.

The WHO Regional Office for Europe and the Executive Committee of SEEHN organized the present two-day technical meeting on health worker retention in SEE. During the meeting, participants made an inventory of retention strategies being used in the area.

The inventory shows that SEEHN governments have been working hard to develop and implement a variety of policies to attract and retain the health workforce in their countries. They use many of the retention interventions described in the WHO global policy recommendations. Interventions they use less often include continuing professional development, professional support and the adaptation of medical curricula. SEE governments do not always monitor and evaluate their programmes, or combine interventions into a comprehensive approach to increase the likelihood of success.

A policy brief documenting SEEHN retention experiences is being prepared and published in parallel with this report. The brief will provide policy-makers with information to improve the retention and distribution of SEE health workers. It will be included on the agenda of the Third Health Ministers' Forum of SEEHN, which is scheduled to take place in Banja Luka, Bosnia and Herzegovina, in October 2011.

Introduction

Equitable access to health workers is a critical determinant of health system performance, and it is central to the right to health. Health workforce shortages, maldistribution and migration impede the access of people to health services, especially people living in remote and rural areas. Policy-makers in SEEHN countries are facing difficulties in achieving health equity and meeting the health needs of their populations, especially disadvantaged groups. However, there has been a dearth of documented evidence on their experiences with health workforce problems and how they are addressing them.

The Regional Office supports health system strengthening in its Member States in order to help them deliver equitable health outcomes. The WHO Regional Committee for Europe has called on Member States to address health workforce challenges and establish mechanisms to improve and promote their health workforce policies (WHO Regional Office for Europe, 2007, 2009). It is widely recognized that national strategic workforce plans need to include retention strategies to ensure that health workers remain in country and continue to provide services in the least accessible areas. In 2010, WHO published global recommendations for increasing access to health workers in remote and rural areas through improved retention (WHO, 2010a), and the Sixty-third World Health Assembly unanimously adopted the Global Code of Practice on the International Recruitment of Health Personnel (WHO, 2010c).

This report documents the proceedings and outcomes of the Technical Meeting on Health Workforce Retention in Countries of the South-eastern Europe Health Network. Organized by the Regional Office and the Executive Committee of SEEHN, the meeting took place in March 2011 and targeted policy-makers from ministries of health, managers of health institutions and researchers. Participants came from eight of the nine SEE countries and Slovenia, which was invited because of its key role in health worker mobility in SEE.

The purpose of the meeting was to identify policy options and share experiences with interventions that sought to improve retention of the national health workforce, thereby contributing to the evidence base on retention strategies in SEE.

The meeting was funded through a joint partnership programme of the Netherlands Ministry of Health, Welfare and Sport and the Regional Office. WHO's technical partner for the meeting and meeting follow-up was the Royal Tropical Institute in Amsterdam, a WHO collaborating centre for research, training and development of human resources for health.

Background of SEEHN

In 1999, the international community established the Stability Pact for South Eastern Europe as a conflict-prevention and reconstruction framework in the area. In 2001, SEEHN was added to the Pact's social cohesion initiative as a health component, bringing together high-level officials from the health ministries of Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Serbia and Montenegro (which would later become the two states of Montenegro and of Serbia), the Republic of Moldova, Romania and the former Yugoslav Republic of Macedonia. In 2008, responsibility for the Stability Pact was handed over to the Regional Cooperation Council, based in Sarajevo. The Council now provides the political umbrella and leadership for all regional cooperation in SEE, including SEEHN.

Today, SEEHN comprises representatives from the health ministries of its nine Member States. SEEHN also works closely with 12 partner countries (Belgium, France, Greece, the Netherlands, Norway, Hungary, Israel, Italy, Slovenia, Sweden, Switzerland and the United Kingdom) and 7 partner organizations (the Council of Europe, the Council of Europe Development Bank, the European Commission, the International Organization for Migration, the Northern Dimension Partnership in Public Health, the Regional Cooperation Council and the WHO Regional Office for Europe). These partner countries and organizations provide SEEHN with ongoing political, technical and financial support.

For the past decade, SEEHN has been the undisputed vehicle of health development in SEE, covering mental health, communicable diseases, food safety and nutrition, blood safety, tobacco control, information systems, maternal and neonatal health, public health services and health systems.

Bulgaria and Romania are the two SEEHN Member States that are also members of the European Union (EU), which they have been since 2007. The EU has recognized all the other SEEHN countries except for the Republic of Moldova as either official or potential EU candidates. Bulgaria and Romania are also in the process of becoming members of the Schengen Area.

More information on SEEHN can be found on the following web pages:

- http://euro.who.int/en/what-we-do/health-topics/Health-systems/public-health-services/activities/south-eastern-europe-health-network-seehn; and
- http://seehnsec.blogspot.com.

Meeting opening and introduction

At the opening session, **Dr Raed Arafat** (Ministry of Health, Romania) highlighted the very serious health workforce shortage and maldistribution in Romania and the need for education, health, labour and finance ministries to cooperate to address this threat to the health of the population. Dr Arafat underlined the interdependence of European countries, and the fact that policies in one country can affect the number and distribution of HRH in other countries.[1]

Dr Galina Perfilieva (Regional Office) outlined the WHO Global Code of Practice on the International Recruitment of Health Personnel, which WHO Member States adopted in May 2010 at the Sixty-third World Health Assembly (WHO, 2010c). The Global Code articulates ethical norms, principles and practices needed to address the challenges associated with the international recruitment and migration of health personnel. The challenges include self-sustainability of national health labour markets; formulation and implementation of evidence-based policies to address health workforce shortages; sharing of information; and cooperation to address global shortages in HRH.

WHO provided several resources to participants to help countries implement the Global Code, including:

- *Increasing access to health workers in remote and rural areas through improved retention: global policy recommendations* (WHO, 2010a);
- *Innovations in cooperation: a guidebook on bilateral agreements to address health worker migration* (Dhillon, Clark & Kapp, 2010);
- *Models and tools for health workforce planning and projections* (WHO, 2010b); and
- *Draft guidelines for monitoring the implementation of the WHO Global Code* (WHO, 2011).

Yet many policy-makers in SEE still do not have the national and regional evidence they need to formulate policies that will effectively improve the retention of health personnel in their own countries. Fortunately, as individuals they have a great deal of information they can share about the experiences, practices, challenges and successes they have had in attracting and retaining HRH. The goal for this two-day technical meeting was therefore to describe retention practices in SEEHN countries in order to inform a policy brief on retention practices and challenges in the area.

[1] Participants discussed the EU directive on working time as an example. The directive requires EU Member States to ensure that every worker does not work more than an average of 48 hours a week and restricts excessive night work, for the purpose of protecting people's health and safety. The EU formulated the directive during a period when it had no shortage of health personnel. However, seven years later, as shortages of health personnel are emerging in all Member States, such policies are increasing health worker shortages and encouraging more recruitment of foreign health personnel.

SEE experiences with health workforces and retention

The participants made poster presentations of their national experiences with HRH, including challenges and policies. Despite the fact that most SEE countries have seen their numbers of health workers increase in recent years, they all face serious shortages of health personnel. These shortages are attributable to several types of health worker mobility.

- *Movement towards urban areas and away from rural or underserved areas:* some countries face a shortage of health workers in rural areas and, at the same time, health worker unemployment in urban settings.
- *Movement to the private health sector and out of the public health sector:* some countries allow dual practice in order to prevent health workers from moving entirely to the private sector.
- *Movement to other sectors and out of the health sector:* health workers may move to related sectors such as the pharmaceutical sector.
- *Movement into secondary and tertiary forms of health service delivery and out of primary care service delivery.*
- *Movement to other countries:* there is significant mobility of health workers among SEEHN countries. The extent of this mobility is affected by factors such as language barriers, dual citizenship and bilateral agreements (such as the agreement between the Republic of Moldova and Romania). The recent global economic crisis has also encouraged health workers to leave their native countries, for instance by forcing the Romanian government to make deep cuts in public sector salaries. Health workers move from the former Yugoslav Republic of Macedonia (where a doctor's monthly salary averages €600) to Slovenia (where doctors earn as much as €2500 monthly). Health workers living in Bulgaria take the ferry to Romania to work night shifts there. Romania in turn faces the same phenomenon with health personnel migrating temporarily to Hungary. All SEEHN countries face migration of health workers to European countries outside SEE, such as France, Germany and Italy.

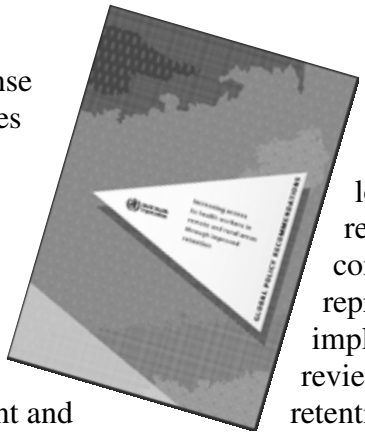
Throughout the area, the mobility of health workers within and between countries creates similar concerns about multisectoral cooperation, data collection, planning, attracting students to health education, the adequacy of training, and retention. Box 1 elaborates on the definition and concept of HRH retention.

Box 1 Definition of worker retention

Retention of employees is "a systematic effort to create and foster an environment that encourages employees to remain employed by having policies and practices in place that address their diverse needs" (Employee Retention Workgroup, 2002). HRH retention is also defined to include the attraction and recruitment of health workers, whether they are recent graduates, unemployed, employed in other sectors or retired. Once health workers are recruited, retention becomes important in ensuring that health workers wish to remain in their positions. There is no international standard for the duration of successful retention in the health sector, but three to five years is often used.

The WHO global policy recommendations on retention

Dr Marjolein Dieleman (Royal Tropical Institute) introduced the WHO global policy recommendations for increasing access to health workers in remote and rural areas through improved retention (WHO, 2010a).



WHO developed the recommendations in response to requests from government and civil society representatives in Member States who faced difficulties in achieving health equity and in ensuring that people living in rural and remote locations had access to trained health workers. The recommendations were formulated by a group of experts comprising researchers, policy-makers, donors, representatives from professional associations and programme implementers from all six WHO regions. The expert group reviewed evidence related to health workforce attraction, recruitment and retention in remote and rural areas and considered how context may determine an intervention's success. However, the group found no publications on any practices in SEE during its literature review.

Table 1 lists major types of intervention for improving the attraction, recruitment and retention of health workers in remote and rural areas, as classified in the global recommendations.

Table 1 Types of retention interventions for health workers in remote and rural areas

Category of intervention	Intervention emphasis
A. Education	A1 Support for students from rural backgrounds
	A2 Health professional schools located outside major cities
	A3 Clinical rotations in rural areas during studies
	A4 Curricula that reflect rural health issues
	A5 Continuing professional development for rural health workers
B. Regulation	B1 Broader scope of practice
	B2 A new type of health worker
	B3 Compulsory rural service
	B4 Subsidized education in exchange for service
C. Financial incentives	C1 Appropriate financial incentives
D. Professional and personal support	D1 Better living conditions
	D2 Safe, supportive working environments
	D3 Outreach support
	D4 Career development programmes
	D5 Professional networks
	D6 Public recognition

Source: WHO, 2010a.

Mapping of retention policies in the SEE area

As mentioned, little published evidence or documentation on retention practices in SEE countries have been made available to the international public. To start identifying retention practices in the area, as well as to familiarize participants with the WHO global retention recommendations, Dr **Ankie van den Broek** (Royal Tropical Institute) facilitated a mapping exercise. Table 2 shows the retention policies that participants identified as being implemented in SEE to increase access to health workers in rural and underserved areas.

Table 2 SEE retention policies, by category

Country	Education	Regulation	Financial incentives	Professional and personal support
Albania	—	Bonding contracts for doctors to provide 5 years of public sector service	Financial incentives for GPs working in rural areas	—
Bulgaria	The training of mediators to provide access to ethnic minorities (e.g. the Roma)	Introduction of the health assistant as a new profession and change in the scope of practice for feldshers; physicians allowed to work for multiple employers	Financial compensation through the National Health Insurance Fund for GPs working in remote areas	Improved access for nurses to medical universities, to encourage more nurses to pursue professional training
Croatia	—	Raising of the pension age	—	—
Montenegro	—	Dual practice allowed Bonding contract of 3–5 years between physicians and employers	Lower number of patients per physician for those practising in rural areas	—
Republic of Moldova	Special admissions quota for students from rural areas	Bonding contracts for 3 years of public health services	Financial incentives for GPs, specialists and nurses in rural areas	Locally varying reimbursement for housing, gas and electricity
Romania	—	—	Financial incentives for GPs working in rural areas	Varying forms and degrees of housing and personal support from local authorities
Serbia	Placement of health education facility in non-urban area	Bonding contracts	Increased salaries for health workers	Improved housing and living conditions
Slovenia	—	—	General public sector salary raise	Housing support, varying by locality
The former Yugoslav Republic of Macedonia	Special admission quotas for students from minority ethnic groups	Dual practice allowed	Physician salaries based on performance, with added compensation for rural work	Increased health ministry investments in public health facilities and equipment

Promising practices: SEE retention strategies

From the experiences they shared during the first day of the technical meeting, participants selected retention strategies that would provide interesting material for in-depth case stories. A case story was defined as a communication product that describes an activity, a process or a strategy, together with its impact, results and lessons (Monville Oro & Baltissen, 2009). The purpose of gathering SEE retention case stories was to generate evidence for SEE and to share successful experiences in retaining health workers in remote, rural and underserved areas.

The following paragraphs provide an overview of the strategies they selected. Full case stories can be downloaded from the Royal Tropical Institute web site[2].

Albania – encouraging GPs and medical specialists to work in rural areas and district hospitals

In response to the process of urbanization during the previous 20 years, and to the fact that many district hospitals did not have the medical specialists they needed, the Albanian Ministry of Health assembled data on health centres and hospitals that were not adequately staffed by specialists or GPs. Then it joined forces with the Ministry of Education, the Ministry of Finance and other stakeholders. The strategies they developed included providing financial support to GPs and medical specialists working in rural areas, based on the distance from their homes. As a result, an anaesthesiologist who decides to work in a rural district hospital rather than an urban hospital can earn almost twice as much. Another strategy has been to bond medical doctors to specific districts for five years. However, some difficulties have arisen in enforcing these bonding schemes.

Bulgaria – changing the scope of practice for feldshers

In 2011, Bulgaria had 2500 feldshers, who worked mainly in rural areas providing emergency care. Since 2008, Bulgaria has expanded their scope of practice, giving them the right to prescribe medicines and to prescribe and carry out treatments. The goal was to replace physicians in remote areas because of the difficulty of retaining physicians there. Expanding feldshers' job definition will help ensure access to health services. A feldsher is supervised by a GP from a nearby area, and part of the remuneration the GP receives from national health insurance serves as the feldsher's salary. Challenges in this new strategy include training and continuing professional development for feldshers, as well as quality assurance for the services they deliver. It is unclear yet whether, in the long term, Bulgaria will upgrade the feldshers and make them formally regulated health professionals, or replace them with such professionals. The upgrade option faces difficulties in gaining support from professional associations. If they do achieve more professional recognition, the country will have to address the issue of attracting and retaining them in rural areas.

Croatia – improving the registration of medical specialists to monitor current and future availability

In 1991, Croatia noticed a decrease in the number of physicians in the country, but it had no information system that could tell policy-makers the exact number of physicians, the number

[2] The cases will be available from http://www.kit.nl/-/INS/2018/Royal-Tropical-Institute/KIT-Development-Policy-and-Practice--/DEV-Research-and-Advisory-services/Health---/Human-resources-for-health?tab=1.

of new graduates who had entered the health system or doctors' attrition rates. It therefore decided to establish the Medical Worker Registry at the Croatian National Institute of Public Health, initially to provide information on the number of medical specialists leaving the medical service each year and their distribution by age. Today, every health institution is obligated to submit information at the end of each year on all health workers, including name, age, profession, entry or departure from service, and change in position or professional level. This information is analysed and then published in a health services yearbook, with special analyses performed on request. The Registry is an important HRH planning tool that reveals trends and points to areas where additional effort is needed. The information is used mainly by the Ministry of Health and Social Welfare and the Croatian Health Insurance Institute. The main challenges in maintaining the Registry are ensuring that staff and information technology are available to keep it up to date, and that health institutions provide the requested data. The private sector is not involved in the Registry yet, so there is no record of medical graduates who do not enter the public sector.

Montenegro – allowing public sector physicians to practise in the private sector too

Montenegro has practically no unemployed doctors, and the small size of the country means that retaining health professionals in rural areas is not much of a problem. The largest problem in Montenegro is keeping skilled health professionals in the public sector. Dual practice is not uncommon in the country, and a network of health institutions has therefore been created to enable physicians working for participating public institutions to work for private institutions as well, once they receive approval from the director of their public institution. So far, only public institutions are part of the network; the aim is to involve private institutions as well. Not all doctors can work in the private sector, and it is believed that allowing dual practice will help keep doctors in the public sector while ensuring a more equitable distribution of salaries.

Republic of Moldova – combining interventions to retain doctors and nurses in rural areas

National differences between working and living conditions increase the mobility of health workers, and as the poorest country in the WHO European Region, the Republic of Moldova has found that they migrate in only one direction: out of the country. To increase the national retention of health workers, the Ministry of Health, with support from the government, has developed a set of interventions to attract young specialists and retain all medical staff members, especially in rural and remote locations. It modified legislation to ensure that graduates from public nursing and medical colleges who agree to work for three years anywhere outside the two largest cities can access financial incentives and compensation for the costs of renting an apartment, including gas and electricity expenses. In rural areas, this initiative has succeeded in increasing the number of nurses and halting a decline in the number of doctors.

Romania – increasing access for the underserved Roma population

Cultural and language barriers, as well as the fact that a part of the Roma population is not documented, have impeded the access of Roma to health services, leading to significant inequities. In 2002, the Romanian Ministry of Health initiated a national programme to establish the new occupation of Roma health mediator. The purpose of training this new cadre of health workers was to promote interactions between Roma communities and health

services, particularly for maternal and child health. In three years, 2000 female Roma health mediators were trained, leading to higher vaccination coverage of Roma children and an increase in the number of Roma registered with family doctors. One unintended consequence has been that the number of Roma registered with the authorities has also increased. Political parties have also used Roma health mediators as electoral agents. The main challenges include aligning the project with the current process of health sector decentralization; some Roma health mediators lost their jobs when local councils became responsible for financing and filling their positions. To ensure the sustainability of the programme, a new project is underway to retrain the health mediators for certification.

Serbia – nursing education in a small town in central Serbia

To produce more nurses to provide health services in central Serbia, a state nursing college was established in a small town there, with curricula adapted to local health needs. This institution has increased the population's access to nursing education and increased the employment of nurses in primary health care centres, the district public health institute, general hospitals and clinics. However, since this nursing college and the private nursing colleges in major cities have not aligned their enrolments with the HRH absorption capacity of the health system, one unintended consequence has been the overproduction and subsequent unemployment of nurses. The Serbian experience highlights the importance of strategic HRH planning and of aligning HRH production with the labour market and national health needs.

Slovenia – giving nurses new responsibilities in primary health care

Faced with shortages of physicians and an ageing population, Slovenia is piloting the introduction of nurses in general practices to take over some of the tasks and responsibilities previously handled by GPs, e.g. in providing care for patients with chronic illnesses such as diabetes and chronic obstructive pulmonary disease. This move should reduce the workload of GPs while increasing career opportunities for nurses. This policy was introduced following demand from GPs, and it will be accompanied by clinical guidelines and additional training for nurses.

The former Yugoslav Republic of Macedonia – Roma medical education

In the former Yugoslav Republic of Macedonia, the Ministry of Health, the Ministry of Education and the Open Society Institute signed a memorandum of understanding, overseen by the Minister on Roma Issues, on scholarships for medical students who are Roma. The memorandum's five-year plan is designed to build Roma capacities, ease Roma unemployment, attract additional health workers to the National Health Service and make health services more accessible to an underserved population. After medical training, the graduates are obligated to work for five years in a Roma community. Previously, health worker positions in these communities often went unfilled.

Discussion of the mapped retention strategies

The mapping of different practices (Table 2) showed that the provision of **financial incentives** to health workers (Intervention C1 in Table 1) has been implemented in different forms in most SEE countries, including Albania and the Republic of Moldova, albeit with different rates of success. The Moldovan approach combines a financial incentive scheme with **compulsory service** in rural or remote areas for a certain period (Intervention B3). On

the basis of current evidence, the WHO global policy recommendations describe this combined strategy as likely to yield results, though they say success is more likely when accompanied by improved working conditions and professional support. The Moldovan strategy has turned out to be better for retaining nurses than physicians. The creation of this multipronged approach may well be attributable to the fact that it was created by a multisectoral process supported by both the prime minister and president.

Bulgaria and Slovenia **expanded the scope of practice** for existing professions (Intervention B1) to relieve health worker shortages and improve access to health services. Health workers serving rural and remote communities may often be pressed to provide services beyond the remit of their formal training, due to the absence or shortage of more-qualified workers. According to the global policy recommendations, it is unclear from current evidence whether this intervention actually contributes to the retention of health workers, although evidence does show that it can lead to greater job satisfaction.

The Romanian introduction of the Roma health mediator as a **new type of health worker** can be considered a way to increase the number of health workers serving underserved populations (Intervention B2). These peer providers are able to provide services to a hard-to-reach population that has proved inaccessible to non-peer providers. Bulgaria has also introduced a new kind of health worker. Both interventions also contribute to a **more supportive working environment** for physicians (Intervention D2).

Intervention A1 in the global recommendations, encouraging **rural inhabitants to study the health professions** to increase the chance that graduates will choose to practise in rural communities, is supported by compelling evidence from high-, middle- and low-income countries. It resembles the former Yugoslav Republic of Macedonia strategy to increase the number of Roma medical students. Serbia located a **school for health professionals outside of major cities** (Intervention A2) to help attract non-urban students, in this case to nursing education.

Montenegro made regulatory changes **allowing dual practice**, and Croatia improved its monitoring and evaluation system by establishing a national **health workforce registry**. Local authorities throughout SEE established undertook various measures to provide **better living conditions for health professionals**.

In conclusion, the strategies being used in the SEE area show that the governments there have been working hard to develop and implement a variety of different policies to attract and retain health workers. Many of the interventions described in the WHO global retention recommendations can be found there, although interventions involving medical curricula and continuing professional development and support appear to be less common than other types. In addition, the retention programmes are not always monitored or evaluated, and interventions are sometimes introduced in isolation, rather than being developed as part of a comprehensive approach that would increase the likelihood of success.

Way forward

Often, policy-makers do not have access to the national or regional evidence they need to formulate the policies that will best attract and retain health personnel in their countries. That appears to be the case in SEE. There is much more information that SEE policy-makers could share with each other about retention experiences, practices, challenges and successes. It would support the development of better policies for retaining health workers and managing health workforce mobility. Meeting participants proposed several activities to expand the evidence base on HRH in SEE, in order to help health policy-makers in the area. The technical meeting itself was designed to generate evidence for a policy brief on health workforce retention there. Participants also suggested creating a regional health development centre (RHDC) on HRH and incorporating the results of the present meeting in other area health initiatives.

Policy brief

The strategies identified in the mapping exercise were intended for elaboration as case stories. The case stories will be available later in 2011 at the Royal Tropical Institute web site, www.kit.nl, or on request from the Regional Office. The stories were intended to provide anecdotal evidence for a policy brief to be published at the same time as this report (WHO Regional Office for Europe, 2011). This policy brief will also make recommendations for policy-makers in SEE health ministries, to help them formulate interventions that will improve the retention and distribution of health workers in their countries.

Participants expressed concern about the sensitivity of certain terminology, singling out the negative political implications of the term "retention" in SEE languages. Replacing it with a term such as "attraction and maintenance" was suggested as a better reflection of SEE regional sensitivities, but given the widespread use of the term "retention" in publications by WHO and other international organizations, it will be used in the brief.

It was agreed that the policy brief should contain a simple evidence-based message about the need to attract and retain health personnel in SEEHN countries in order to achieve better health outcomes. The formulation of retention strategies could also serve as a way to implement the Global Code of Practice and should clearly signal the challenges faced by countries whose health workers are recruited by other countries. Participants also agreed that the brief should outline terms and the subject at hand, as well as detailing the issues and strategies specific to SEE. In addition, it should address what can be done, what has been done and what can be learned from other experiences in the area.

Finally, the policy brief should call for leadership and multisectoral and regional cooperation. It will be shared with health ministers and other high-level policy-makers, e.g. when attending meetings relating to HRH topics.

The following schedule for development of the policy brief during 2011 was presented:

- end of April: participants' case stories sent to the Royal Tropical Institute
- May: online sharing, discussion and finalization of the case stories
- end of May: draft policy brief sent to participants
- June 15: draft policy brief discussed at the SEEHN preparatory meeting in Sofia
- summer: finalization of brief and beginning of formal dissemination.

A regional health development centre (RHDC) on HRH

Meeting participants expressed a need for establishing an RHDC on HRH as a centre of expertise for all SEE countries. At present, SEEHN has established five RHDCs, addressing respectively public health services, mental health services, blood safety, human organ and tissue transplantation, and communicable diseases. An RHDC on HRH would enable countries to join forces in researching and exchanging knowledge about HRH dynamics and policies, while taking into account the specific characteristics of the SEE area. The centre could support local implementation of relevant global and European recommendations and serve as a focal point for reliable data collection on HRH. It could take a valuable first step in encouraging SEE countries to cooperate more closely on HRH by developing a common glossary and set of indicators for issues such as rural retention, workforce shortages and unemployment.[3]

Incorporating retention in current SEE initiatives

The case stories were scheduled to be drafted by the end of April 2011, and the draft policy brief to be distributed at the June meeting of SEEHN in Sofia. The brief should be finalized in time to be placed on the agenda for the third forum of SEE health ministers in Banja Luka in October 2011. It is expected that the Banja Luka Pledge the ministers sign will address health workforce issues and place these issues high on the public health agenda of SEE collaboration in public health. Addressing health workforce needs will bring SEEHN in line with the European Commission initiative on the European workforce for health and the Belgian EU Council Presidency Conclusions of 2010.

The Regional Office informed meeting participants about its continuing collaboration with Eurostat and the Organisation for Economic Co-operation and Development to establish a joint HRH database. The Regional Office planned to hold a meeting in Summer 2011 for the non-EU countries in SEEHN, on a joint data collection system for health workforces. This meeting could provide input for the proposed RHDC on HRH.

It was suggested that participants from SEE countries could become experts for the RHDC, as well as designated national authorities for the implementation and monitoring of the Global Code. Participants agreed to prepare a SEEHN contribution to the WHO consultation in late March 2011 on a guide for implementing and monitoring the Global Code.

[3] The Moldovan health ministry offered to host the centre, and a RHDC on HRH was approved at the SEEHN meeting in June 2011 in Sofia, based on a proposal and action plan supported by the Regional Office.

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Further reading

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Annex 1 Programme

28 March 2011

08:45 Registration

09:00 Opening of the technical meeting
Introduction of participants and programme

10:00 Exploration of existing challenges and "real" opportunities for retention

10:45 Poster presentation on country experiences with retention strategies

12:00 Summary of experiences and plenary discussion of additional actions that could be taken to improve retention

13:30 WHO global policy recommendations on increasing access to health workers in remote and rural areas through improved retention

14:30 Question-and-answer session on the global recommendations

15:15 Group work analysis of current strategies in light of the WHO global recommendations: key issues for retention policies in SEEHN countries

29 March 2011

09:00 Summary of Day 1 and introduction to Day 2: expected outcomes of the technical meeting

09:45 Health workforce retention: discussion of topics for case stories

10:45 Explanation of case stories
Preparation of case story outlines
Plenary presentations and feedback

13:30 Plenary presentation and feedback
Discussion of issues to be emphasized in the policy brief

15:30 Definition of learning path and action plan on the process

16:30 Technical meeting wrap-up and evaluation

Annex 2 List of participants

Albania

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The WHO Regional Office for Europe

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