ACTION FOR HEALTH AND EQUITY ADDRESSING MEDICAL DESERTS

NATIONAL POLICY DIALOGUE

REPUBLIC OF MOLDOVA

POLICY OPTIONS FOR ADDRESSING MEDICAL DESERTS

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Introduction

The project AHEAD addresses the challenge of medical deserts and medical desertification in Europe in an effort to help reduce health inequalities. The project is carried out in Italy, Moldova, the Netherlands, Romania and Serbia, with the aim to benefit health policymakers, patients' organisations, health professionals' organisations, affected communities and other relevant stakeholders. Further information about AHEAD's teams, mission and goals, and the activities conducted over the duration of the project can be found via the abovementioned links.

Our ultimate intended impact at society and EU level is better access to health services, especially in underserved areas, and more equitable access to sufficient, skilled and motivated health workers, starting with the countries involved in the project.

Purpose of this document

This policy brief is compiled on the basis of the activities carried out in the Republic of Moldova, under the responsibility of the National School of Public Health Management. This document is based on the ideas, opinions and suggestions collected during the process. It does not represent an official position of any institution or person taking part in the process, but contains recommendations for decision makers, who are in a position to implement policies for human resources for health and improve the national legislation regarding its governance, with the aim to address medical desertification.

The AHEAD country teams have compiled five of these policy briefs, one for each country. Every brief provides a short overview of medical desertification in each country, information regarding the adaptation of our consensus building methodology for each context (see next page), and the specific policy options, categorised where possible. The briefs include quotes from the national level events, conveying some opinions voiced by the participants and where acknowledged, their commitment to address this issue in their national contexts.

Methodology

Each country team organised one or more national policy dialogues, with key stakeholders from national and local levels, discussing the validated, context-specific, and feasible policy measures, thereby building momentum for actual policy change and effective action, and encouraging cross-fertilisation.

Policy dialogue can be valuable input on the demand side of health services and systems, depending on the degree to which it is truly participatory and inclusive, bringing enormous advantages to policy implementation and increasing the chances for positive results. Through policy dialogues, different stakeholders can better examine each other's perspectives whilst improving the general understanding of these policies and their impact

in different frameworks. It promotes involvement in the policy-making process, can boost commitment and lead to more responsive policies, engages diverse stakeholders from various sectors and gives people a say in the choices that will influence their lives and health.

Organizing policy dialogues: from the local to the national

Participation in policy dialogues is a win-win situation for both the community and policy makers. The process gives opportunity to the representatives of consensus building sessions to have direct access to the top decision makers. The dialogue gives opportunity to the decision makers to get input from people with lived experiences, and insights from experts like academics, health advocates and civil society members. The policy options discussed during the policy dialogues are not only backed by evidence but also represented by people who are affected by medical desertification in their daily lives.

Each member of the consortium has mapped and identified key stakeholders and actors at the national level, such as civic and patient organisations, healthcare providers and other health professionals (e.g. primary care physicians and specialists, paediatricians, nurses, pharmacists, etc.), and other relevant stakeholders, such as community representatives, trade unions working in the health sector, directors of health districts, etc. Project partners have conducted in-depth interviews with key stakeholders regarding the issue of medical desertification in their context, to gather experiences, perceptions and (possible and existing) measures to address the phenomenon of medical desertification.

In addition, each organisation's team conducted an analysis to identify key policy-makers involved in decision-making at the local level (e.g. local aldermen, mayors, regional council members, and actors standing for both majority and opposition groups). These key actors were invited to the consensus building sessions that aimed to discuss the most relevant issues about medical desertification in their local context and to build consensus on existing and possible new policy measures to prevent and mitigate medical desertification.

Our consensus building methodology

It is known from literature that successful implementation of health workforce policies requires strong inter-sectoral governance and consensus building among the different stakeholders involved. As a consortium, we have therefore set out to draft, test and validate a consensus building (CB) methodology, in order to increase the chances of successfully counteracting medical deserts.

The aim of this methodology is twofold:

- Implemented in the AHEAD partners' countries, it contributes to the identification and development of practical, feasible and context-specific policy options, that will support policy makers in their decisions on health workforce issues.

- Implemented, contextualised and evaluated across the AHEAD partners' countries, it will result in a validated methodology, that we will share in a practical guidance document, so that other organisations (outside the consortium, and beyond the project timeline) can apply the same methodology in their own context.

This participatory consensus building method consists of two phases at local level and one at national level, all with facilitated dialogues. Further details about this methodology can be found via this link.

It is important to note that the methodology was contextualised to each country, following an extensive series of discussions with the country teams, to ensure its cultural and wider contextual appropriateness, tailoring it to the needs of the facilitators and participants.

Stakeholders

Very often, political representatives operating at the local level also play a role in national politics, and similarly, politicians operating at the European level also play a role at the national level. This means that many of these figures can be involved at multiple levels of the policy dialogue.

This is also true for other key stakeholders affected by the different phases of the project, e.g. a health worker may also be a spokesperson for a particular category at the national level. Or, the same civic or patient association may operate at both the local and national levels.

For this reason, it was very important to select the different stakeholders carefully and in advance in order to avoid their over-engagement.

The national consensus building session, also described as the policy dialogues, form the last phase of the AHEAD consensus building methodology. This step provides opportunity to ensure that the policy options developed in the multi-stakeholder consensus building sessions are carried forward and find their way in the menu of policy options to be implemented in each country.

The range of participants

The range of potential participants in the policy dialogues include the following:

- Politicians and policymakers:
    - Local level politicians, such as local aldermen, the Mayor, Council members as well as opposition leaders
    - National level politicians
    - Members of national Parliament and Members of European Parliament who are also active at national level

- Regional level politicians
  - High level civil servants

- Representatives from the consensus building sessions
  - Participants in earlier CB sessions, including those at local level
  - Health advocates
  - Academics
  - Civil society members and other stakeholders

What are medical deserts?

In the initial stages of the AHEAD project, we carried out a literature review to better define the concept of 'medical desertification'. Based on a thorough review of scientific studies, we have concluded that the complex concept requires an elaboration of definitions to understand its multidimensional perspective. From the literature review, we derived a working definition to inform the development of research tools and validated this definition through the results of research tools. We also discussed this definition during the national dialogues.

Below is our final working definition of medical desertification.

A medical desert is the ***end point*** *of a complex* ***process*** *called 'medical desertification', that implies continuous and increasing inability of a given population to access health services in a timely and contextually relevant manner.*

An elaborate explanation of the definition can be found on the AHEAD website.

Potential solutions for counteracting medical deserts in the Republic of Moldova

The AHEAD project implementation team in the Republic of Moldova organized and conducted several round tables and discussion panels in an extended format with the local authorities involved in the management of human resources in health. The meetings took place in three successive steps, according to the consensus building methodology. At first phase, there were identified 3 areas of potential "medical desert" in the Republic of Moldova: the Criuleni, Hincesti and Telenesti rayons. Subsequently, several rounds of dialogue were performed in each of the given regions and a multi stakeholder meeting was conducted. As the final stage, a national level dialogue on the topic of medical deserts was organized and successfully completed.

During the round tables held, the participants' knowledge regarding the topic, the attitude of medical professionals towards medical desertification and the factors that determine it and the current policies in human resources in health were explored. At the local level, during the consensus building sessions, several solutions have been generated, all of them potentially effective on mitigating the phenomenon of medical desertification in the Republic of Moldova. In order to ensure that these proposals were evaluated according to the proposed eligibility criteria (political, social, technical, administrative and economic) a workshop involving participants from potential medical desert areas and representatives of academia was organized. At the end of this exercise, all of the proposals to mitigate the medical deserts in the Republic of Moldova were systematized and a set of the best ones were put on the table for discussions at national level.

In December 2022, a national dialogue on medical deserts in the Republic of Moldova was successfully conducted with the involvement of several decision-makers from local and central levels, representatives of the academia environment, along with representatives of government structures responsible for developing and promoting health policies. After reaching a consensus among the participants, a set of recommendations on the mitigation of medical deserts in the Republic of Moldova was finalized and is planned to be transmitted to the central health authorities in the nearest future.

The medical desertification phenomenon in Moldova

In the Republic of Moldova, one of the most urgent problems regarding the human capital in the health system is the inefficient territorial distribution of the medical staff – more

precisely the discrepancy in the absolute number of medical professionals in rural and urban areas:

“We cannot say that we have an absolutely insufficient number of medical staff. The biggest problem is their uneven distribution in the country. We have too many doctors in the municipalities and a severe shortage of health professionals in rural localities” said one of the participants to the discussion.

According to the available data, the chronic shortage of health care specialists is recorded especially in the primary health care sector (PHC). The availability of family doctors and general practitioners, especially in rural localities is decreasing: in 2003, in the Republic of Moldova there were 2,112 family doctors, in 2012 there were 1,853, and in 2021 only 1,656 specialists remained (source: Statistical yearbook of the Moldavian health system, 2020-2021).

In the current conditions, the work of the family doctor requires a sustained effort and special dedication from specialists. According to the established norms, a family doctor should manage the health of at least 1,500 people from his district (Order of the Ministry of Health no.100/2008 *regarding the Norms of medical personnel*), while in reality, a family doctor has at least 1,900 population registered in his district, and in some localities even can achieve up to 3,000 people to care about. The population of dozens of localities in the country has access to a family doctor at best for once or twice a week. Even when they arrive at the reception, they are forced to stand in line for hours. In total, in the Republic of Moldova there are about two hundred health centers where there is a shortage of at least one family doctor. According to the needs declared by health institutions from Moldova in 2022, at least 215 family doctors were requested to ensure the access of citizens to primary health care services (source: Department of analysis, planning and integration of services and resources in health, National Agency for Public Health).

According to another opinion expressed during the consensus building exercises, the issue of medical deserts in PHC is a serious one: *“How are the open vacancies in the health system covered? With what we have, and if we do not have enough doctors, with regret, the population does not have access to medical services, in the end, their rights are violated.”*

The data from the Trade Union Federation “Sănătatea” show that in 2020, every fourth doctor was at retirement age and almost 17% of other medical workers were at retirement age also (source). Students and residents partially compensate for the lack of medical staff in the country, but, according to the report, only a third of them remain in the medical system in Moldova after completing their studies, moreover, an imposing number of doctors from the national health system have the temptation to realize their intention to leave the country.

To better illustrate the phenomenon and the research undertaken in the Republic of Moldova, please refer to the research report and the locality-level medical deserts visual maps: MDDT | AHEAD.

Policy solutions to mitigate medical deserts

Following the consensus building methodology, a set of recommendations on HRH policies have been developed. The final beneficiaries of the project deliverables will be the decision makers responsible for developing health policies, patient associations and the associations of medical professionals, public health specialists and communities affected by the phenomenon of medical deserts. The expected major impact of the project at the level of the countries involved in the project and at the level of the European Union is the facilitation of better access to health services, especially in rural areas, and a fair access of the population to sufficient, well-trained and motivated medical staff.

Thus, the participants from the areas of potential medical desert, by mutual agreement and consensus, proposed a number of solutions to mitigate the phenomenon of medical desertification in the Republic of Moldova:

1. To establish a council of experts under each director of the institution;
2. To establish a free-for-all mechanism for displaying open vacancies in the health system;
3. To increase the technical base of and equipment distribution to the health service providers;
4. To increase and optimize the allowance (financial incentives) for young specialists;
5. Overall significant increase of salaries for health care professionals;
6. More flexibility, autonomy and independence in decisions at the level of the medical institution regarding the instruments of financial and non-monetary motivation of workers;
7. Transparency of long-term development priorities of the health system;
8. Review the concept of Continuous Medical Education and allow more e-learning;
9. To increase the role of the doctor in society and the prestige of the medical profession;
10. To keep a better eye on the psychological climate in the health institutions.

The arguments invoked by the participants during the discussions were expressed on condition of anonymity and allowed sincere opinions to be collected. Thus, during the dialogues, several remarks were highlighted, including:

a) *"The feeling of satisfaction of the worker that he enjoys the time when he carries out his activity in a repaired medical institution and equipped with all the necessary instruments for the daily professional activity is a very important factor in the motivation of the health workforce and can lead to a higher level of retention of medical workers in health institutions in the country, including in the countryside";*
b) *"The allowance for young specialists must be increased and oriented primarily to the purchase of a house or a flat in the locality chosen for the professional practice. The provision of temporary housing for specialists and only during the exercise of professional activity remains an ambiguous mechanism of motivation of young specialists";*
c) *"The linkage of the monthly wages of the HWF to the national average salary on economy would allow maintaining the incomes of health professionals several steps higher than the average monthly income per country per capita. Thus, the establishment of doctor's salary of up to 5 average salaries on the economy (45-50 thousands lei/2500*

Euros) was accepted by mutual agreement as one worthy and capable of retaining in the long term the health professionals in the system";

d) *"Raising the salaries of medical workers up to the salary levels of neighboring countries or those with high recruitment potential, using a coefficient of 0.6-0.7 of the corresponding salaries in Romania, Germany, Italy or the United Kingdom (for example) could be a solution."*

e) *"Monitoring the psychological climate in the HWF teams and the level of stress that occurs during the exercise of the profession, can serve as tools for motivating the workers. Increasing the confidence of one's own forces in the medical service provided, would have as final beneficiary the population served and will increase the achievements of HRH".*

Conclusions

1. The phenomenon of medical deserts remains a common problem for all health systems, although at this moment a consensus could not be reached regarding the definition or indicators associated with medical deserts at national or regional levels in Moldova;

2. The factors leading to medical desertification are very different and largely depend on the national context: the distance and waiting time, the differences between urban and rural areas in access to health services, the availability of family doctors or general practitioners and their age, insufficient medical professionals and their uneven distribution;

3. The rural population has low access to the family doctor's office: in some villages the availability of medical professionals has reached critical levels, both because of the low attractiveness for young specialists and because of the lack of financial incentives and opportunities for continuous professional development in these areas;

Policy recommendations

1. The phenomenon of medical deserts must be infiltrated on the political agenda of central and local authorities. More information, more involvement, more options of policies are needed in order to be able to identify and mitigate medical deserts in the Republic of Moldova;

2. Improving the level of knowledge of policy makers in the field of human resources management, including strengthening the skills to attract, retain and motivate medical staff, will facilitate to increase the degree of the available HWF in health institutions;

3. The optimization of the allowances allocated to young specialists: it must be diversified, not only financial motivation, but also other non-material benefits, such as mortgage loans at preferential rates, reimbursement of transport costs, granting various annual bonuses for any specialist who opts for professional practice in rural or remote areas;

4. Development of the local infrastructure, the improvement of the psychological climate in health institutions, the endowment with equipment of the medical service providers, all can help to reduce the phenomenon of medical deserts, especially in the surgical specialties, where it is very important to have in place laparoscopic devices, functional diagnosis, etc.;
5. The gradual increase in salaries in the health system must go side by side with the increase in the skills of medical specialists. To fill in an open vacancy in healthcare must become competitive with open information about tasks, working conditions, salaries and other benefits related to become accessible to the general public, thus helping cover the needs of HWF in several specialties that are at the highest demand in the national medical system.