AHEAD

ACTION FOR HEALTH AND EQUITY
ADDRESSING MEDICAL DESERTS

NATIONAL POLICY DIALOGUE

ROMANIA

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 Romania, under the responsibility of the Center for Health Policies and Services. 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 Romania

The current status of medical desertification in Romania

The AHEAD project actions in Romania aim to **(1) analyse the medical desertification and (2) identify strategic measures and solutions to inform the public policies designed to reduce the health inequalities across the country**.

To this end, we ensured that:

(1) The access to health services is defined objectively, using the national regulations, sound data sources, and the project research methodology;

(2) The consensus on local and national solutions to increase access to health services and counteract medical desertification considers both supply and demand.

To study the medical desertification in Romania, we followed the project research methodology comprising an extensive literature review, our own quantitative and qualitative studies, and constructing a desertification index - a mix of normative, relative/statistical and consensual approaches regarding healthcare delivery. The project consensus-building model was adapted to the local context and used around the identified strategic measures and solutions. The research findings and identified measures were discussed and disseminated through various public dialogues at the local and national levels.

The research carried out in Romania examined the extent to which the medical desertification issue is featured on the public agenda and in what way, how respondents define it and what criteria is being used. More specifically, after analysing the extent to which desertification is considered an issue, we questioned what a decent access to medical services entails. In addition, we asked about the extent to which the lack of access to primary health care, pharmacies or inpatient care is considered a sign of medical desertification and defined as a healthcare delivery problematic issue.

The main research conclusions are as follows:

1. The “medical desertification” term is rather unknown in Romania, suggesting a low level of awareness and concern regarding the issue.

2. The evaluations of the Romanian healthcare system and its problems are rather broad. Medical desertification is seen as a consequence of public policies based on economic

reasoning - an underfunded health system, with low and hospital-focused public health expenditure. The patients' needs remain unmet, and the present public health system set up encourages the private one to grow, but only for those who can afford it.

3. Medical desertification is seen as closely related to the health workforce planning, supply and distribution, and their mobility and migration. Since, for instance, many family doctors (GPs) are soon to be retired and have no replacement, medical desertification is expected to worsen in the coming years.

4. Access to health services is essentially viewed as curative care rather than preventive services.

5. At the national level, some areas are evaluated (without difficulty) as medical deserts, such as the Danube Delta and the Apuseni Mountains regions, where communities are isolated, scattered and hard to reach.

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

Strategic measures and interventions to counteract the medical desertification process in Romania include:

A. Reforms and measures related to medical education (for GPs, primary health care nurses, community health nurses, and midwives):

1. Ongoing update of graduate, post-graduate (residency) curriculums and continuous medical education programmes. A higher share of practical activities, adjusted to the new medical and digital technologies – e.g. by setting clearer procedures for the practical work (traceability of individual, practical activities).
2. A continuous medical education system that balances the supply with the demand and the needs, e.g. one that considers a regular individual development needs assessment for each category of professionals (physicians, nurses etc), as well as the public health priorities.
3. The need to bring curricular changes that account for the rural area practice for family medicine residents (more courses and seminars, early exposure to practice in rural areas).
4. Extending practical activities, including practical training in the community, and implementing a recognition system for practical training supervisors. Organising internships in the rural practices accredited for this purpose (and adequately incentivised) for GP residents and medical students (to understand area specifics, develop empathy for the local community patients and enhance this activity's appeal). The model may be customised for nurses as well.
5. Vocational guidance mentorship and counselling strategies during medical education, accompanied by adequate information, throughout the study period, of all health professional categories, to create accurate career expectations. Regular assessment of students' career goals.

6. Promoting GP residency among students, including in rural areas, by granting scholarships as well as other incentives.
7. Providing education for nurses from communities at risk of desertification to determine them to follow their studies with a career in these administrative territorial units threatened by desertification. The model may be considered for midwives as well (as a way to restore this profession within community health care).

B. Reforms and measures in support of primary health care regulation and practice:

1. Reviewing the regulations on GP practice; simplifying those measures currently perceived as bureaucratic or restrictive in terms of the work of GP practices.
2. Regulations encouraging GP association/group practice (including multi-generational practice).
3. Cooperation between the speciality boards and the Romanian College of Physicians or other competent entities towards rethinking the GP's duties (the need to enhance their role). Setting up expert committees tasked with providing decision-makers with concrete proposed legislative changes (e.g. the procedures, complementary studies and prescriptions that can be made by a GP, based on the practice used in other European countries).
4. Encouraging and supporting GPs' and GP university departments' linkages to the European and international networks (developing and valuing the profession, research and practical guidelines).
5. Recognising the GP's importance at the community level by establishing a national awards programme which singles out the GPs or the nurses in the GP practices who provide outstanding care to patients, using a unitary and transparent system.
6. Continuing the development and updating of practical guidelines, protocols and work procedures for GPs, in sync with the progress of new medical and digital technologies, and in line with the European and international guidelines and standards (adapted to the Romanian context). For instance, supporting cooperation with the European General Practice Research Network (the European medical research network within WONCA Europe), to provide a relevant setting for discussions and development of research in primary care.
7. Developing a primary care telemedicine programme (including standards and practical guidelines), along with developing related digital knowledge and skills, as well as the infrastructure required to deliver remote quality, safe services. Reviewing the provisions on malpractice. Including health education as a common practice among the medical services delivered remotely in primary care.

C. Reforms and measures supporting the cooperation between the primary health care GP and the community health care GP:

1. Valuing the GP profession, as the paradigm changes from "primary health care" (currently associated with the GP's practice) to primary health care team (which would include the GP, the GP's practice nurse, the midwife, and the community health nurse).
2. Identifying clear primary care duties that may be assigned to other team members, including the community health nurse hired by the municipality/town hall.

3. Integrating/establishing a procedure for the cooperation between the GP and the community health nurses hired by town halls and developing the community health care network in rural areas, primarily in the rural municipalities at risk of desertification.
4. Encouraging the use of nurses and midwives as independent service providers, when revisiting the primary health care team roles and tasks.
5. Close multidisciplinary cooperation in the first line of primary care and an adequate legal framework, as well as physical settings/spaces in place that facilitate interaction, creating a sense of common purpose within the team, effective communication and organisation models that reflect team objectives and activities.
6. Rethinking the organisation and financing of primary care public health, prevention, and health education priority actions: (1) the role of the physician/nurse/midwife/community health nurse; (2) performance-based financing; (3) the possibility of territorial definition in rural communities; the role of the MDs who do not enrol in a medical residency programme for at least one year (duties, connection with the GP and other professionals; income and funding sources).

D. Reforms and measures that increase access to health care in communities at risk of medical desertification, by involving the local authorities:

1. Improving accessibility of general practice in rural, disadvantaged or hard-to-reach areas, by boosting local government involvement in underserved areas, having the administrative territorial units offer incentives and develop the infrastructure, especially by drawing on the existing funding opportunities (European funds) in a way that ensures the sustainability of interventions.
2. Motivating physicians to work in rural areas, by providing the aid they require to set up practice in rural areas and to furnish their practices with the equipment that would enable optimal work; providing accommodation and medical equipment, including via the National Recovery and Resilience Programme.
3. Fostering the GP – administrative territorial unit (commune/town/municipality) relationship and ensuring a clearer involvement of the administrative territorial unit.
4. Interventions and practical measures to increase the administrative territorial unit representatives' awareness of the importance of health, prevention, health education, and the local authorities' role and contribution in ensuring their community members' good health and access to health services. Using good practice examples of communities whose local authorities demonstrate proactive involvement.
5. Wider use of mobile medicine, to provide medical services in rural areas.
6. Setting up integrated community centres by rehabilitating and adapting certain buildings in rural localities.
7. Analysing the possibility of employing medical graduates who do not enter a residency programme in the rural integrated community centres, using state budget funding (piloting this via European funded projects).

Conclusions regarding the medical desertification status and public policy options in Romania

The discussion regarding the "medical desertification" phenomenon initiated at the national level is an important step towards an assessment/evaluation that is focused on equitable

access to health services and towards the identification of solutions that would lead to the deceleration of the phenomenon and to finding viable alternatives, involving the most relevant institutional actors. However, to make progress towards counteracting the phenomenon, the research should be carried out recurringly, while the priority solutions should be turned into measures which have a practical and case-specific application.

An effective counter measure to the "medical desertification" phenomenon in Romania is about:

I. The health human resources: training, work regulation, role redefining and the cooperation of professionals acting within the affected communities;
II. Local government proactive involvement in developing and supporting local health services; promoting good practice models;
III. Changing the paradigm promoted by the health care system, as well as the cultural model, from focusing on the illness to focusing on preserving one's good health or quality of life.

The opinions of Romanian policy dialogue participants regarding:

The importance of examining the medical deserts and the usefulness of the tools used in researching medical desertification in Romania

"Congratulations on your research topic. It is a very interesting topic. It will become more and more relevant and interesting, not only to Romania but to everyone out there. I believe the methodology is for the long-run and it should be used again in a few years, say every 3 years". (University professor, University of Medicine and Pharmacy "Carol Davila" Bucharest)

These discussions somehow open up in each of us a thought. I don't know if they actually lead to solving the problem, but I think it's very important to be exposed to the problem, whether it is the College of Physicians or the Health Insurance House, all actors, at all levels should be exposed to the problem. Otherwise, the issue is far from you, when you say disadvantaged areas, that's so remote, so not related to you. When you hear the word desertification instead, it's like picturing a fire that burns everything in sight. It's a word that makes you think of an emergency. I think it's very well chosen. (Assistant professor, The Faculty of Medicine, Transilvania University of Brasov, GP in an urban area)

Usefulness of health public policy consensus building tools in Romania

"As far as we are concerned, we consider ourselves lucky to have been a part of this project, it was a great gain. Both the initial discussions and the national-level ones meant a great deal to us. They motivated us and we hope to achieve as much as possible.... This project was an eye-opener, we learned what could be done, how we as mayors could help, how the Public Health Directorate could help us, what medical services actually mean and what needs to be done to benefit the community of Păulești". (Mayor, rural municipality of Vrancea County; medical desert)

"There were these consensus building sessions in Vrancea county with locals and local authorities and I found that a very good idea, just maybe broaden the local coverage of such sessions, because desertification issues or causes differ from one region to another and from one locality to another." (The Romanian College of Physicians, GP)

Commitment towards initiating and supporting the discussed measures for counteracting Romania's medical desertification

(after participating in the consensus building sessions) *Just as we discussed at the event, we started to look for solutions, to try to implement what is feasible for us and what was proposed to us. We intend to bring at least one community health nurse into the locality. We already started all the necessary procedures and we also initiated a dialogue with the Romanian Association of Communes, just as we discussed at the local consensus building sessions, aiming to identify solutions to improving access to local services in the area… It's already on the table, we have also run it by Vrancea County Public Health Directorate and received feedback. So things have really been set into motion after participating and engaging in the project. It's already one step forward… This project has definitely motivated me a great deal, it was a project in which I witnessed people set their minds to something and actually putting words into action. It is probably one of the very few projects in which I participated where people genuinely wanted to do something to make a difference, to bring about change.* (Mayor, rural municipality of Vrancea County; medical desert)

"The HRH policies should consider the outcomes and the outcome dynamics. If we refer strictly to Romania, the training of medical human resources requires a great deal of work, they are the most valuable item of the health system. We all know that to train a medical doctor, after 12 years of basic education, you need another 10-12 years of higher education and specialisation, and only then, they can start treating patients on their own. Medical work is teamwork. If you miss certain team elements, the team won't work. The health system is facing ever more challenges, e.g. Covid, the war in Ukraine, which have led to all kinds of public health threats to which the health system is required to respond". (University professor, University of Medicine and Pharmacy "Carol Davila" Bucharest)

"I believe more [local and national] focus groups should be organised to identify more tailored solutions for the future. The reason for that and one of the conclusions stemming from these consensus building sessions is that we cannot come up with solutions that are of the past, that worked in the past. Just as it was concluded at the event, the solutions need to be tailored, on the one hand, to the expectations of the human resources we currently have and, on the other hand, to the needs of the students, the graduates of vocational schools and midwives' programmes. We need to understand their needs. Right now, it's difficult to aim to develop a programme that provides housing to the GPs who would go to rural areas, when you have enough means of transportation to ensure a transfer to the county seat or an urban nearby locality, just to somehow meet this need for social security that a graduate feel. For instance, I would find it very important to understand my students' needs and I myself have

started doing this, I've started to discuss with my students to understand their point of view or the barriers that they perceive to their going to work in rural areas or in small-size towns. Everyone wants to be a university professor, in the county seat, in major cities and towns. Everyone wants to go abroad to make a better life for themselves. Clearly, there is a certain course these people are pursuing when it comes to their prospects, and we should not tend to correct or adjust this course. We should just tailor the proposed system solutions to meet their expectations and draw them one way or another, towards working in disadvantaged areas... The medical desertification issue is quite serious, and it will impact government policies for a very long time from now on. We need to avoid reaching that point where we collapse an entire system that will then have to be rebuilt. We need to take preventive action so as not to reach that point." (The Romanian College of Physicians, GP)