AHEAD

ACTION FOR HEALTH AND EQUITY
ADDRESSING MEDICAL DESERTS

NATIONAL POLICY DIALOGUE

SERBIA

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 Serbia, under the responsibility of Media Education Centre. 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, 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 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, policymakers and decision-makers:
    - 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 Serbia

The medical desertification phenomenon in Serbia

Serbia has a Bismarck healthcare system model, with most state-owned healthcare institutions, obligatory health insurance and a highly centralised government. Although all employees and employers are paying each month's health care insurance tax, and all citizens are paying taxes, not all citizens have equal access to public health care in their settlements. Several countermeasures to medical deserts were identified through a policy discussion with patients, providers, and local and national stakeholders. The way forward is to establish the government task force/national body that deals with medical deserts, to include indicators of medical deserts in national and local health information systems of the Health Insurance Fund and Integrated health information system, and that regulatory acts against the development of medical deserts, their roots and consequences are implemented, regularly monitored, the countermeasures success evaluated and acted upon.

Using the AHEAD Medical Deserts Diagnostic Tool (MDDT), adapted to the Serbian context, we diagnosed the potential areas of healthcare-related medical deserts. Some identified medical deserts partially overlap by different MDDT criteria. For example, for accessibility, in total 4-10 districts; while for performance - three districts. In all 25 Serbian districts, the top five districts with potential areas of medical deserts identified according to the MDDT are Mačvanski, Šumadijski, Moravički, Srednjebanatski, and Podunavski district. These districts with potential areas of medical deserts were additionally confirmed by using the Multiple Criteria Scoring System (MCSS) in Serbian districts. MCSS final scores 0 (none) - 100% (score of all indicators).

Our key informants agreed that the term medical desert is not known, but it is appropriate. They suggest that **medical deserts in Serbia can be identified using 5-7 criteria**, including

- whether the area has public transport 24h/7 days to access the healthcare institution**,**
- the distance that a person can travel on foot or travel, alone or with support,
- the accessibility of healthcare workers (number of healthcare workers in relation to the number of users of the service),
- the number of working hours when healthcare workers are available, the waiting time in case of need, and
- duration of service the patient gets.

Health services and health workforce standards should be set up at the local level because of contextual specificity, not on a national level only. For example, the maximum distance:1-5km &<20 min for GP, up to 10km & <30 min (pharmacy), and up to 10km <30 min (emergency care). Workforce and services at the primary level must address the diseases and needs of residents. More "free healthcare" for residents, employed and poor (preventive days) are needed in medical deserts.

Problems related to medical deserts are too few/lack of staff, lack of funds, low earnings of healthcare workers, lack of adequate job posts and inability to advance, poor working conditions, and misunderstanding of state stakeholders (quoting):

- *"The big problem (for the economy and medicine) is migration".*
- *''How to keep a newly educated staff?"*
- *"Physical and temporal distance to medical workers, equality of population health needs and job conditions in health care – are equally important in medical deserts in Serbia".*

Patients view vs providers vs local stakeholders view

Consensus-building sessions were organized in one of the identified medical deserts. Three different groups of stakeholders were included and were given a chance to evaluate a pre-compiled list of potential solutions for medical deserts, based on experiences of other countries, but also to add their own locally informed solutions which could help solve the problem of medical deserts.

The final list of potential solutions included:

- Subsidies for employment in medical deserts
- More places for medical education closer to medical deserts
- Benefits to healthcare workers for employment in medical deserts
- An established body (for example, a working group) that deals exclusively with medical deserts
- Benefits for dual practice in medical deserts
- Increase earnings
- Increase the variety of healthcare professionals' profiles
- Increase the availability of medicines and technologies
- Facilitate the opening of private practice in medical deserts
- Development (education, financing and establishment) of mobile practices
- Increasing the number of employees
- Job Description Revision - Administration Downsizing
- Adapt the profile structure to the needs
- Strengthen home treatment and care services
- Mobile laboratory
- Assessment of working capacity – who works realistically and which job
- Increase the number of services of the chosen doctor

Patients and patient organizations, the first group of stakeholders, proposed subsidies for employment in medical deserts, other benefits to healthcare professionals employed in medical deserts, development of mobile practices, increased earnings of healthcare professionals, and mobile laboratories.

Healthcare workers proposed an increase in earnings, and in the number of employees (revising standards for the number of different healthcare professionals), benefits for healthcare professionals employed in medical deserts, adapting the profile of healthcare workers to the population needs, and strengthening home treatment and care services.

Finally, *local stakeholders* proposed subsidies for employment in medical deserts and other benefits for healthcare professionals employed in medical deserts, increase in earnings, adapting the profile of healthcare workers to the population's needs, and increasing the number of employees.

Policy solutions to mitigate medical deserts

Government-level

Structural support to improve access to quality health care in medical deserts

- Establishing the task force/national body to combat medical deserts' roots and consequences.
- Regular monitoring of indicators of medical deserts using national and local information systems for population health, health workers and health care.
- Implement regulatory acts to combat the development of medical deserts, including:
    - Building a supply of competent and motivated health workers in medical deserts – accomplishing social equity in access to healthcare:
        - More subsidies and incentives for health workers (benefits and higher salaries) for employment and dual practices in medical deserts.
        - More jobs for board-certified health workers in medical deserts.
        - Mandatory health worker practice in medical deserts (e.g. 1-3 months) during fellowship, internship and residency programmes in medicine.

- Modernization of healthcare delivery in medical deserts – promoting efficiency in healthcare delivery**:**
    - Enable contracts for mobile healthcare practices (mobile doctors and diagnostics, mobile nurse and home care, mobile labs, mobile pharmacies, mobile therapy and surgical clinics)

Government-level and local-level

- Health worker competency building and assurance - improving healthcare effectiveness:
    - Assurance that more places for health worker training are closer to the medical deserts.
    - Developing training curricula for rural health.

- Creating health worker professional networks for e-consultation and e-teamwork.
- Coaching health workers for telemedicine (e.g. mobile pocket-size ultrasound)

- Working conditions improvement - improving healthcare quality:
  - Increase of availability of medicines.
  - Increase of availability of modern healthcare technologies in medical deserts.
  - Implement digital medical documentation.
  - Build fieldwork with equipment for mobile healthcare practice.
  - Establish mandatory peer - supervision, and visitations of health workers.
  - Support (financially and regulatory) mentorship in healthcare in medical deserts.

Conclusions

Medical deserts and **medical desertification are new terms** in the Serbian context, but represent phenomena which are already recognized and the name is considered adequate by Serbian stakeholders. The main issues identified as related to these phenomena include the **lack of medical doctors and nurses in specific areas**, their availability only on specific days, or their low number, a **large number of patients per healthcare provider**, **and less time available** per patient and potentially lower quality of service, as well as **long travel times** to general practitioners or other healthcare services.

Policy solutions were recommended to the government level and local levels. At the government level, stakeholders underlined the need to **establish a task force** which would monitor and propose solutions for medical deserts, using available **national and local information systems** for decision making, and implementing **regulatory mechanisms** to prevent the development of medical deserts, including **retaining and training** competent and motivated health workforce in medical deserts and modernization of healthcare delivery in medical deserts. On the local level, the identified priorities would be **creating more places** for healthcare worker training closer to (potential) medical deserts and at-job training, participating in the development of **training curricula for rural health**, and strengthening health worker professional **networks**, while at the same time **improving working conditions** and healthcare quality.

Useful resources

Mandić-Rajčević S, Šantrić-Milićević M. Linking health system inputs, processes and outputs to identify medical deserts in Serbia: Stefan Mandić-Rajčević. European Journal of Public Health. 2022 Oct;32(Supplement_3):ckac131-284.

Medical Deserts Diagnostic Tool and Index calculation: https://ahead.health/methodological-approach-for-medical-desertification-index-calculation/

Media Education Centre: https://www.mediaeducationcentre.eu/eng/