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AHEAD

ACTION FOR HEALTH AND EQUITY
ADDRESSING MEDICAL DESERTS

EU Policy Dialogues
Policy Brief

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Policy Brief

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AHEAD

Action for Health and Equity - Addressing Medical Deserts

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The AHEAD project in brief

The project Action for Health and Equity: Addressing medical Deserts (AHEAD) (April 2021 – May 2023) aims to reduce health inequalities by addressing the challenge of medical deserts and medical desertification in Europe. Our goal is to achieve 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: Italy, Moldova, the Netherlands, Romania and Serbia. This is done by building knowledge, encouraging (digital) innovation in health service delivery and applying a participatory approach to public health policymaking [1].

AHEAD features two unique selling points: a medical deserts diagnostic tool (MDDT) and a consensus building methodology.

1) The MDDT intends to support policy makers in identifying and monitoring medical deserts and areas at risk of medical desertification, by visualising health worker and health services densities on interactive maps. For more information, see: webpage, webinar, explainer slide show.
2) The consensus building methodology aims to bring together a broad and relevant group of stakeholders playing a role in, or affected by, medical desertification. During a series of interactive workshops, they explore the causes and effects of medical desertification, exchange experiences, and jointly develop feasible and context-specific policy solutions. For more information, see: webpage, webinar, explainer slide show.

The list of outputs and results from the project can be found via this link.

Purpose of this document

This policy brief is a document

- outlining the background and rationale for AHEAD project
- summarizing the project's unique selling points, key activities, and how they resulted in country-specific policy options to address medical deserts
- and linking these policy options to a European policy context, as discussed during EU level policy dialogues.

This document will only very briefly revisit the key findings from the in-country research and the in-country developed policy options, as they have been extensively documented elsewhere[2]. It will, however, concentrate on specific sets of (complementary) actions that are required to address medical

[1] For further information, please visit our website: www.ahead.health.
[2] The complete research reports and policy options documents developed in the participating countries will be referenced extensively in the following chapters.

deserts, for different target groups that were identified to have the highest potential for change. Since medical desertification is multi-dimensional in nature, interventions will have the most impact when all target groups implement their actions in concertation and coordination.

The target groups identified are present at local, national and European levels, and include:

- EU level institutions,
- Member States government,
- educational institutions,
- health professionals and their associations and citizens and their associations, including Patients' Advocacy Groups.

This policy brief is meant to not only highlight the technical nature of the medical desertification phenomenon (the policy interventions), but also, and explicitly so, the political nature (the actual commitments for the investments in time, effort and money). This is why we have shaped our recommendations to the different target groups in the form of a Call to Action (see page 11 onwards), which was subsequently discussed during an event in the European Parliament.

Context

In the Spring of 2020, the European Commission launched a call for proposals under the third EU Health Programme[3], with the aim to support reforms in the health workforce field. The background to the call lies in the persistent health inequalities in the European Union. The AHEAD project was co-funded by European Commission under this call and focuses on the causes and risks of medical deserts and medical desertification, and prospective mitigation actions, in an effort to help reduce healthcare inequalities across Europe.

Equity in access to quality and affordable preventive and curative healthcare is one of the key dimensions of resilient, sustainable economies and societies. Still, the health systems in Europe are not yet able to protect and improve each citizen's health. Achieving equal access to modern and efficient healthcare is a challenge, and gaps in healthcare accessibility across countries, regions, population groups exist in each country, affecting mostly the already vulnerable populations.

The national and EU policymakers are confronted with major health-related challenges: an ageing population with a high demand for health and care services, a rising burden of chronic diseases, and persistent underfunding of growing healthcare needs, alongside systematic unresolved challenges in the healthcare workforce. The health and care workforce is ageing, while health workforce shortages, with various mobility and migration patterns, are leading to medical deserts across the world, and the European region is not excluded.

The COVID-19 pandemic has exposed the health systems' weaknesses and vulnerabilities, and the crucial importance of sufficient and well-performing health workers of all cadres, geographically available according to the population's needs, and working in an environment that motivates them. The European Commission and Member States, aiming at a stronger European Health Union, have taken measures to boost the resilience of the health care systems, with substantial EU support, through the Recovery and Resilience Facility.

Still, strengthening the health workforce across Europe remains crucial to ensuring access equity to quality health services in the European Union and beyond. An optimal supply of health workers in each

[3] See here

European country asks for tailored, country specific solutions, based on good quality and comparable data, addressing a variety of topics from shortages of different categories of health professionals, to geographical imbalances, from better planning and retention of the health workforce to modern medical education programmes, adaptable to the changing health needs of the people.

As mentioned in the last country reports of the European Semester 2022[4], Italy, the Netherlands, or Romania, are not excepted from the challenges mentioned above. Neither are the EU candidate countries like Moldova or Serbia, all five represented in the AHEAD project consortium.

Italy is facing persistent regional disparities in the quality of and access to services, including in healthcare. Italy has significant regional inequalities in life expectancy with a gap between northern and southern regions of almost three years (before the pandemic). This can be closely related to disparities in access to and quality of care across regions. Residents in poorer regions in the south are more than twice as likely to report unmet medical care needs as those living in wealthier regions in the north of the country.

The Netherlands has a life expectancy higher than the EU average by about one year, a health care service provision well developed, with a strong primary care system. Still, it faces a shortage of certain health workers, and general practices often struggle to find a replacement after retirement. Labour market forecasts point to a continued tight labour market in the future, including in the healthcare sector, and a*ddressing labour and skills shortages in the healthcare sector is included in* the last European Semester country-specific recommendations in 2022.

Romania faces many challenges in health, including access to quality care, outdated health infrastructure, shortages of healthcare personnel, and underdeveloped primary care and prevention. Health spending in Romania increased in the last decade but remains the second lowest among the EU Member States, while life expectancy is significantly lower than in the EU as a whole. With persistent disparities in access to healthcare and an uneven distribution of the workforce across the country, Romania is relying on its recovery and resilience plan to implement structural healthcare reforms.

Republic of Moldova is affected by brain waste[5] and brain drain[6], and by significant geographical disparities in the distribution of health professionals, with severe shortages in rural areas. The access inequalities affect in particular the most vulnerable population groups, especially in remote areas. Health sector inefficiencies are present, even though healthcare delivery is of relatively good quality. Despite a steady improvement in the health indicators achieved in recent years, they remain below the EU averages.

Serbia has self-reported unmet needs for medical examination or treatment almost double compared to the EU average (2021). Inequities in the utilization of health services are widespread, the most disadvantaged people and the uninsured being the most affected. Inadequate health workforce development strategies resulted in an increasing number of unemployed health workers in some areas, in parallel with an insufficient number of some specialists. This, together with low salaries (among other reasons) has created an incentive for doctors and nurses to emigrate.

To read further into the country contexts and the research findings on medical deserts, please see our research briefs via this link.

[4] See here

[5] 'Brain waste' refers to a situation where the skills and qualifications acquired by migrants outside of their country of residence and employment, are not (fully) recognized, which prevents them from fully using their potential (adapted from European Migration Network's Glossary).

[6] 'Brain drain' refers to the loss suffered by a country as a result of the emigration of a (highly) qualified person (adapted from the European Migration Network's Glossary).

Policy options

Bearing in mind the national contexts and the findings from the research on how medical deserts are manifested in each AHEAD country, consensus building methodology was implement in case study areas, to develop context specific, feasible, effective and relevant policy solutions. These policy solutions are discussed in further detail during national policy dialogues, and commitments are made by the various actors and duty bearers to implement them. Because the policy options developed are so context-specific, the policy dialogues yielded a wide variety of policy solutions[7]. For more information, see: webpage or watch this webinar).

From these activities, several common themes of policy solutions can be categorised as:

- Some policy actions are required by Ministries of Health, and need to be implemented on a national level
- Other actions are necessary to establish close collaboration with diverse actors with different perspectives and mandates:
    - From other sectors (e.g. education, infrastructure, digital solutions, finance ministries and/or
    - international entities including other Member States or EU level (e.g. DGs)
    - or with different scopes of actions (such as health professional associations, trade unions)
- Additional actions are needed that focus on empowering local communities, especially from areas that are or could be considered medical deserts (or are at risk of medical desertification). This includes citizens, healthcare providers (e.g. general practitioners in rural areas), or other local actors, including mayors or those in some power position.

Moreover, one cross-cutting theme has also been identified: the governance capacity – which can be interpreted as the availability of technical and physical capacity to:

1. First and foremost, assess the localities that are or could be identified as medical deserts
2. Take action to mitigate them, in a contextually relevant manner, and escalate when needed to national stakeholders

To create such capacity, Member States, the national governing bodies, have the responsibility to allocate appropriate funding via e.g. national domestic funding streams, and/or use the EU level funding mechanisms that are available. This can only be done if there is a political will, beyond the political cycle of the politicians. This funding should be made available, also in light of the ongoing regional developments.

An important advantage of using EU funding to implement the solutions is that it creates a stronger incentive to ensure **accountability** and **sustainability** of the solutions.

In short: many **different actors** are required to **work closely together** and **act now** to tackle medical desertification.

[7] The policy options that were discussed and agreed upon in the policy dialogues of AHEAD countries can be found via this link: https://ahead.health/policy-options/

Key findings from EU level research brief

One of the AHEAD deliverables is an EU level research brief that aimed to understand the different manifestations of medical deserts in the EU, and neighbouring countries, as well as to provide an overview of remedial actions that were initiated by the EU, including EU funded programmes and relevant EU instruments.

The following conclusions were derived:

DG Sante has initiated, funded and stimulated a long chain of projects dealing with the manifold health workforce challenges (see chapter 3.2.1 of the report) throughout the different EU Health Programmes. From research and development side, there have also been funding opportunities to investigate health workforce issues and develop guidelines and recommendations for specific health workforce issues.
Projects involved academia (research & development projects) and national actors (in Joint Actions, SEPEN), and included cross-country learning, exchange of knowledge on technical and managerial aspects of health workforce issues, particularly on the monitoring and planning aspects of national strategies, improving digital skills of health workers, and examples of specific case studies that address these issues.

However, even though the Commission has put in place several initiatives to support Member States in addressing shortages of health workers and skills, it is not the Commission's mandate to make structural change happen. This is up to the Member States themselves (subsidiarity principle). So, even though the 'technical' know-how is there, the implementation of recommendations, the sustainability of policies or ensuring adequate funding for these reforms, is often (still) a challenge in the policy arena.

Even the Covid-19 crisis has not triggered convincing action to build more resilience into our health systems, including in times of extreme external stressors, such as a pandemic. Also, the European health workforce crisis doesn't seem to be regarded by all the Member States as a European crisis that should be tackled collectively, in a process of mutual accountability.

We learnt that there is an awareness issue on both the medical deserts phenomenon and also on the possible solutions and tools to address them. We note several solutions and tools to make better policies (or improve current ones), mostly focusing on addressing health workforce related issues, however, the health workforce crisis is still on-going, as are the associated health inequalities (including unequal access to care, particularly in remote areas). It appears that despite available knowledge and tools, they are not sufficiently utilised by Member States and policy makers.

There is also the issue of (in)availability of funding. This could also be linked to awareness: if the policy makers are not aware of existing funding opportunities, they are less likely to implement the proposed solutions proposed by the programmes that address medical deserts. Additionally, recommended solutions often do not include recommendations for potential funding sources. Addressing this could improve the likelihood of successful implementation of the recommendations.

Click here to read full report.

Policy dialogues

The organisation of policy dialogues has been an integral element of the AHEAD project from the start. Such dialogues aim to discuss feasible and acceptable policy options to address medical desertification, while at the same time elevating the topic on the political agenda and stimulating the political will and action preparedness among policy makers, politicians and other actors.

Policy dialogues have therefore been organised at national level in the project countries. In addition, to foster the notion that medical desertification is a shared concern for all Member States of the European Union (and neighbouring countries) and to emphasise the importance of joint European action, a European policy dialogue was also included in the project plan.

South-eastern Europe Health Network (SEEHN)

The South-eastern Europe Health Network (SEEHN) is a key stakeholder in our project, as 3 out of 5 project countries belong to this region: the Republic of Moldova, the Republic of Serbia and Romania. Sharing knowledge, and discussing our activities and outputs is important to ensure we contribute to solutions to address medical deserts in the South-eastern European region.

Our first engagement with SEEHN was in December 2021, during the 44th Plenary meeting, with several policy makers and stakeholders from the region. It was our first opportunity to showcase the research findings to specific stakeholders and allies on the topic.

On March 16-17th 2023, AHEAD and SEEHN gathered for a two-day roundtable discussion in Tirana (Albania). Attending in-person, AHEAD representative Sergiu Otgon (human resources for health expert, National Agency for Public Health, Republic of Moldova) presented our project findings, Medical Deserts Diagnostics Tool and consensus building methodology to representatives of SEEHN.

The roundtable was a great opportunity to share AHEAD's added value and the results we gained during the last two years, and to foster future collaborations.

AHEAD representative Sergiu Otgon (human resources for health expert, National Agency for Public Health, Republic of Moldova) and SEEHN at the roundtable discussion in Tirana, Albania in March 2023.

European Parliament event

This ambition materialised in the organisation of a policy dialogue event in the European Parliament on April 27, 2023. To put our call for multi-stakeholder involvement in addressing medical deserts into action, we invited panelists with different and complementary backgrounds:

- Katarzyna Ptak-Bufkens, **DG Sante**
- Paolo Michelutti, Coordinator of the new **Joint Action** on Health workforce planning and forecasting (HEROES)
- Dr John Wynn-Jones, **EURIPA**, the European Rural and Isolated Practitioners Association
- Tomas Zapata, **WHO European Regional office** (pre-recorded intervention)
- Dorota Tomalak, **Committee of the Regions**
- Marina Royo de Blas, **DG AGRI**

The event was hosted by Member of European Parliament Beatrice Covassi (Group of the Progressive Alliance of Socialists and Democrats (S&D), Italy), and moderated by Mariam Zaidi.

As a preparation for the event, a Call to Action was developed, summarising the most important action points to be undertaken by different actors. This Call to Action formed the basis for the discussions. This call to action was open for finetuning and endorsements until the project's end (May 31, 2023), after which it was finalised and re-shared with the public as a final version.

The discussions of the event included reflections on the current situation of medical deserts and medical desertification across the EU Member States and beyond, and the need for action. The panellists expressed their views and interests in undertaking action in their own institutional capacities, to act now, and prevent further aggravation of medical desertification in the region.

The expert panel during the AHEAD organised European Parliament event, 27th of April 2023.

Call to Action: Let's go AHEAD and tackle medical deserts!

We call on **European institutions** to:

- Elevate the problem of medical deserts on the political agenda and make medical desertification a top priority throughout the next Commission's mandate – and beyond.
- Encourage Member States in the use and application of available data and tools to identify medical deserts and areas at risk of medical desertification.
- Improve data availability, preferably through Eurostat, by requesting countries to report on health workers and health services densities at local (municipal / district) level, for key categories of health and care workers and services.
- Further improve information and dissemination about, and access to the different funding instruments (e.g. Recovery and Resilience Funds, Cohesion Funds, etc.) that can be used for investments in health, education, economy and connectivity in areas with vulnerable populations and remote/rural communities.
- Map and report how many of the NextGenerationEU resources allocated to Member States in National Recovery and Resilience Plans have been dedicated to directly tackling medical desertification.
- Support Member States in digital health innovation in support of (not instead of) innovations in health and care service delivery.

We call on **Member States** to:

- Improve the quality, systematic collection and analysis of data related to health workforce, health services, and related indicators to medical desertification.
- Create a dedicated taskforce that focuses on the identification, mitigation and prevention of medical deserts.
- Use and apply available data and tools to identify and monitor medical deserts and areas at risk of medical desertification.
- Create a sustainable national strategy that addresses medical deserts and desertification, as a long-term plan.
- Recognise citizen participation as a founding principle of the national health system and apply a multi-stakeholder dialogue model/methodology – such as AHEAD's consensus building methodology – to increase the context-sensitivity, applicability, acceptability and feasibility of policy solutions to medical deserts and medical desertification.

- Increase investments in health, education, economy, and digital infrastructure in areas with vulnerable populations and those in rural, remote and underserved communities, particularly targeting medical desert areas, and making use of EU Cohesion Policy Funds.

We call on **education institutes** to:

- Continuously adapt the education of health and care professionals to population needs and health service requirements, especially for the most vulnerable, and with specific attention to people in rural and remote areas.
- Implement or improve task shifting into the curriculums across the cadres.
- Update the digital skills of healthcare personnel.
- Ensure continuous education and professional development, with particular attention to those practising in rural and remote areas.
- Reconsider policies that impact the admission to training institutions for all types of health professionals, including those that limit the number of students per year.

We call on **health professionals and their associations** to:

- Participate in the co-creation of policy solutions to ensure that they are created as contextually relevant and include effective incentives to work in areas that could be deemed as medical deserts.
- Fight for the right to health for all, especially people in areas with limited or difficult access to health services, both in rural and remote areas, as in urban areas.
- Create further awareness on the needs of the most vulnerable, including populations in medical deserts.
- Include, in professional standards and values, the moral duty to cater for the needs of the most vulnerable.

We call on **citizens and their associations, including Patients' Advocacy Groups (PAGs)** to:

- Advocate their right to health.
- Call for multi-dimensional actions by duty bearers to improve their health and well-being, especially for the most vulnerable.
- Initiate and/or participate in multi-stakeholder, co-creation processes for the development of context-sensitive, applicable, acceptable and feasible policy solutions to health and care access challenges.

Endorsers:

Cittadinanzattiva (Italy)

VU Athena Institute (The Netherlands)

National School of Public Health Management – NSPHM (Moldova)

Media Education Center – MEC (Serbia)

Center for Health Policies and Services – CHPS (Romania)

Wemos (The Netherlands)

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