PILLARS OF HEALTH

POSITION PAPER ON HUMAN RESOURCES FOR HEALTH IN ROMANIA

CHALLENGES AND POSSIBLE SOLUTIONS IDENTIFIED IN THE "PILLARS OF HEALTH - TOWARDS SOLIDARITY FOR HEALTH WORKER BALANCE IN EUROPE" PROJECT

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Introduction

To ensure equitable access to healthcare across countries in the European region (not only those in large urban areas, but also those in more remote areas, including rural areas, from all social backgrounds), there is a need for medium and long-term defined human resources for health programmes, sustained and adequate investments, effective training, recruitment and retention strategies, and measures to mitigate any potential adverse effects of labour mobility or migration.

However, to define the most impactful actions at different levels (national, EU, or regional) requires concrete evidence and a thorough revision of data, as well as in-depth knowledge of the challenges and sharing of this knowledge, including cross-country. With this knowledge in hand, the next stage requires public dialogues to explore potential solutions and shape relevant policies, leading to an equitable distribution of healthcare workers across the EU, member countries, and non-member countries alike.

Through "***Pillars of Health - Towards solidarity for health worker balance in Europe***", a three-year programme (2021-2023) focusing on gathering evidence, strengthening dialogue with all stakeholders and carrying out advocacy at national level, in selected countries (Romania, the Netherlands, Germany, France, Serbia) and at EU level, we advocate for policy makers to focus on implementing policies that ensure improved availability and accessibility of health workers for all European citizens, together with all actors in health systems and civil society in the European countries included in the project and at EU level.

Further information about the project and the activities carried out during the project can be accessed on the Pillars of Health website .

Research methodology used in Romania (two research stages)

Along with the benefits of the EU internal market, such as freedom of movement, Member States also encounter challenges arising from imbalanced flows of mobility and migration, which have contributed to an uneven availability of health workers. These discrepancies have led to an unequal distribution of health workers, consequently impacting the quality of healthcare in certain countries and regions adversely. In essence, the mobility of health workers tends to primarily benefit wealthier EU Member States (termed "destination countries"), while the loss of skills and work experience weakens health systems in poorer countries (termed "source countries"), thereby exacerbating the disparity in access to healthcare.

Romania is widely recognised as a "source country", supplying human resources in the health sector to Western European countries. On the other hand, it also serves as a "destination". One example is that of doctors and nurses from the Republic of Moldova who choose to practice in Romania also due to the convenience of sharing the same language.

In order to capture the two facets of the issue of mobility and migration to and from Romania, the project conducted two stages of research, the first focusing on the "source country" model and the second on the "destination country" model.

The study on Romania as "source country" (conducted between September 2021 and April 2022) aimed to identify the factors influencing the migration of Romanian healthcare workers, to analyse their personal work experience, and to present the respondents' solutions that could encourage their retention or return to the country.

The research was based on a desk review and a series of 19 in-depth interviews conducted with health professionals who graduated in Romania and remained to practice in the country, health professionals who graduated in Romania and are currently working abroad, managers from different health facilities in Romania, representatives of professional organisations such as the Romanian College of Physicians and the Order of Nurses, representatives of student associations and, finally, a representative of a diaspora organisation of healthcare workers.

The in-depth interview method was selected in order to collect information about mobility behaviour, respondents' perceptions of it and the push and pull factors, as well as their attitudes towards migration and the potential solutions they foresee, without any limitations that would have been generated by a more controlled research method (such as a written questionnaire).

The analysis revealed that there are two predominant aspects that still foster the migration or mobility of Romanian healthcare workers, despite the significant increase in some of the incomes in the Romanian public healthcare system:

- For doctors, opportunities for professional growth and career development are the main factors influencing their decision to deploy.
- For nurses, finding a better paying job with an appropriate workload still fuels the decision to practice abroad.

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The study on Romania as "destination country" (conducted between May and September 2023) Given that a significant number of health workers from the Republic of Moldova opted to migrate to Romania, the World Health Organization has conducted a study to explore their motivations, how their professional integration and recognition of their studies is done, but also to estimate their numbers and provide insights for public policies. The study found that the motivations behind the decision to migrate varied, from those centred on the state of the health system in the Republic of Moldova in the first phase of migration of Moldovan medical workers to Romania between 1991 and 1996, to those centred on family needs in the second phase between 1997 and 2006 and finally to those related to the advantages of Romania as a "destination country" in the period after Romania's joining the European Union in 2007 (WHO 2014, p. 62; Cheianu-Andrei 2016). The study also highlighted that the intention to return to the country of origin is not particularly common among health professionals originating from Republic of Moldova who are now working in Romania.

Complementing the WHO study, the second component of the research in Romania conducted as part of the project aimed to delve deeper into the impact of migration experiences on individuals' lives within their personal and social contexts, spanning various stages of life. Rather than focusing on a specific theme, the research took a holistic approach, exploring the individual's life and biography as a whole. This approach allowed for a clearer understanding of how migration experiences intertwine with other life events and how individuals perceive their overall life journey, as well as specific events or experiences at different times. Thus, the main objective of this research was to investigate the profound perceptions of doctors from the Republic of Moldova who migrated to Romania. Given the exploratory nature of this assessment, we conducted and analysed a set of 10 interviews, comprising of 1 nurse and 9 doctors who had emigrated from the Republic of Moldova to Romania.

While the method chosen does not allow for a generalisation of conclusions, it can be said that, at the level of the respondents interviewed for the project reaffirmed the division into "waves of migration" indicated by the WHO study. Moreover, for respondents, the opportunity for more practice-based residency and, after completion, professional and career development, with competitive salaries for doctors in Romania comparable to other Western European Union countries, as well as the existing options for family and a fulfilling social life emerged as key factors contributing to their decision to remain and practice here.

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Policy dialogue on solutions for retaining medical personnel in Romania

The existing literature demonstrates that the successful implementation of health workforce policies involves building consensus among different stakeholders on existing solutions[1].

Based on this model, the findings of the Romania "*source country*" research were presented by the project team in Romania and discussed during a series of events (carried out in Targu Mures, Brasov, Bucharest). These dialogues aimed to identify the most feasible solutions, which could be supported within the framework of national initiatives already launched, or those which can be the focus of future interventions, by a network of advocates working in a variety of thematic areas, promoting changes and reforms at the level of human resources in health in Romania, or at the level of the health system.

The benefits of applying the consensus building method included:

1. Stakeholders have gained a deeper understanding of the factors contributing to mobility and migration (perceived as an effect) and have focused on structural solutions to address the underlying causes.
2. The various stakeholders discussed and gained a better understanding of each other's opinions and interests.
3. All stakeholders have been involved in the process of identifying strategic or tactical measures, which can contribute to a more effective implementation of the solutions identified, through actions to be undertaken and supported by the various entities.

By developing this model to build consensus around the factors driving migration and viable solutions to systemic challenges, we sought to achieve a dual objective:

1. **Identifying practical and feasible solutions for the retention or return of healthcare staff** that can support decision-makers to take action and contribute to increasing the attractiveness of healthcare careers in Romania;
2. **Establishing a network of support and action centered around the measures identified (or other measures currently under public discussion)** that can be

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[1] Hendriks, Carolyn M. 2009. "Deliberative Governance in the Context of Power." *Policy and Society* 28 (3): 173–84.
Innes, Judith E., and David E. Booher. 1999. "Consensus Building and Complex Adaptive Systems." *Journal of the American Planning Association. American Planning Association* 65 (4): 412–23.

leveraged, including through the advocacy component included in the project, to become actively involved in the HRH reform process at national and EU level.

Potential strategic or tactical interventions to retain medical personnel in Romania

Drawing from the research regarding the factors influencing the migration or mobility of Romanian health workers and the respondents' solutions for staying or returning to the country, the most effective interventions were categorised into three categories: **1.** Challenges and recommended changes to the medical education system; **2.** Challenges and recommended changes for the inpatient and ambulatory healthcare system; **3.** Challenges and recommended changes in primary health care.

Medical education: challenges

The main drivers that still generate the outflow of health professionals from Romania are also linked to aspects concerning the medical education system. Thus, the experiences during the educational period may often serve as a decisive factor in the decision to either remain within the Romanian health system or seek opportunities abroad, especially for early-career health professionals. Similarly, the significance of continuous education throughout the career can be a motivating or de-motivating factor, particularly among those with more experience.

In summary, based on the research conducted in the project, the challenges faced by the current medical education system, as well as the needs that, once addressed, could bring improvements have been identified and listed below, categorized separately for doctors and nurses.

For doctors:

1. The need to update the syllabus for certain disciplines (outdated textbooks, information, or bibliography).

2. The need to effectively address social related issues (housing, transport).

3. The need to provide more opportunities for studying or participating in research programmes in other universities during the course of their studies (both physical and online formats).

4. The need to structurally and effectively address the practical training of students and residents which is currently deficient in certain aspects (e.g. not receiving sufficient attention during the training period, guidance or mentoring not being conceptualised

and organised well; practical training not keeping pace with accelerated scientific development, or ICT).

5. Difficulties in changing specialisation during residency.

For nurses:

1. Different educational programs for graduate nurses than for college nurses, resulting in large disparities in training.

2. Low or uneven practical training.

3. Teaching oriented on theoretical knowledge (professors are generally doctors) and too little on practical skills appropriate to the nursing vocation.

4. Lack of opportunities for continuous professional development.

In addition, for both doctors and nurses, continuous medical education is not promoted based on identified needs, but rather on the basis of supply.

Medical education: proposed solutions

The solutions for key directions of intervention in the area of medical education, identified from research and consultation rounds with key stakeholders from the academia, professional organisations, public institutions, employers, health trade unions or international organisations concerned can be categorised into **five strategic objectives (SO)**:

SO 1. Encouraging the autonomy of medical and nursing students and enhancing their motivation through a career guidance counselling programme available from the early years of study. Developing career guidance support services through the introduction of a regular assessment of students' career intentions, providing them with the opportunity to define and commit to a study and career plan.

SO 2. Facilitating the orientation process of medical, nursing or midwifery students and residents in the Romanian health care system by developing and implementing a well-defined mentorship and practice programme based on a set of clear and well-defined procedures. This will be supported by the establishment and implementation of a rigorous training programme for mentors or practice leaders, and their essential role in the education of students or residents will be encouraged and promoted on the basis of a system of rewards and recognition to motivate them to perform. The mentoring (or tutoring) process should be

interactive, based on the principle of mutual engagement, of guiding the development of learning and of taking responsibility for their respective statuses.

SO 3. A better correlation of the theoretical and practical training of medical students, residents and nursing or midwifery students with the requirements of the labour market through: **a.** reviewing the curricula of the training programme, both for doctors and residents and for nurses, and harmonising them, including by establishing a cohesive connection between the theoretical-practical elements; **b.** increasing the use of information and communication technologies and digital technologies in the university education system and in residency, in order to develop practices based on modern teaching methods; **c.** defining a mechanism to ensure continuous improvement of the quality of education.

SO 4. Using available human resources more efficiently through task-shifting: preparing and implementing a model wherein certain tasks are transferred from more skilled health workers to less skilled health workers.

SO 5. Increasing the quality of the continuous medical education system through better (needs-based) structuring and organisation, including by initiating collaborations between universities of medicine and other relevant professional institutions.

Inpatient and ambulatory care system: challenges

The list of motivations for the departure of healthcare professionals from Romania also includes issues related to the organisation and operation of the current system inpatient and ambulatory care.

Briefly, the challenges of the current inpatient and ambulatory care system arising from the research conducted in the project and the elements that, if managed, could bring improvements include:

1. Aspects of investment in hospital infrastructure in all hospitals: the need to invest in modern and functional buildings, in the maintenance and modernisation of existing ones, in up-to-date medical equipment, in the materials necessary for modern practice.

2. Aspects of social nature: a. the need to actively manage tensions, conflicts and ineffective competition at interdisciplinary level or within medical teams comprising doctors and nurses; b.

the need to find mechanisms for training and strengthening the medical team in a system which, on the one hand, nurses see as paternalistic, based on the unquestionable authority of doctors and, on the other hand, in which doctors feel that nurses sometimes fail to adapt to new developments in treatment and procedures and do not comply to their authority.

3. Aspects of psychological nature generated by: a. The need to evaluate and manage effectively the very high workload under extreme pressure, combined with staff shortages, which can lead, in some situations, to exhaustion and burn-out at the workplace; b. the need to analyse and seek solutions to the psychological difficulties associated with the perceived disorganisation of the workplace, the lack of clearly assigned responsibilities and duties or the lack of explicit support from superiors and colleagues, and the absence of more effective management skills and mechanisms; **c.** the need to identify solutions so that staff no longer feel that they are carrying out their work under the constant fear they are liable to prosecution and fines.

4. Aspects of a political or policy nature in the health system arising from the fact that: a. the system is generally perceived as suffering from a lack of transparency, sometimes governed by personal relationships; b. there is a general perception that the promotion system in hospitals is not linked to an individual's level of competence and merit, but rather to their political affiliation; c. there is a perception that the health system has undergone various reforms, not all of which are coherent with each other, is fragmented, does not demonstrate a national and stepwise vision (centred on the patient's pathway through the system, from prevention of illness to recovery or palliative services); d. there is a view that part of these inconsistencies is due to a lack of managerial consistency at the level of the Ministry of Health.

Inpatient and ambulatory care system: proposed solutions

The broad directions of intervention in the area of inpatient and ambulatory care, identified from research and consultation rounds with key stakeholders from academia, professional organisations, public institutions, employers, health trade unions or international organisations concerned, can be categorised into **four strategic objectives (SO)**:

SO 1. Promoting investments designed to ensure better working conditions and improved infrastructure in hospitals and specialised ambulatory care.

SO 2. Developing and organising patient-centred hospital healthcare services by **a.** standardising the quality of healthcare services by continuously updating national standards of treatment (protocols and guidelines) and defining and operationalising effective systems for regular training and monitoring of their implementation; **b.** regular reviews by level and category of service with the aim of monitoring and improving the patient experience in the system; **c.** Easier patient pathway through the system through digitisation, interoperability of applications (e.g. patient medical record); **d.** Development of ambulatory specialist services (in all hospitals) with flexible working system; **e.** Training for medical staff on patient-centred counselling techniques (including how to initiate and maintain conversations about therapeutic conduct, prevention methods and healthy lifestyles and behaviours).

SO 3. Orientating the system towards promoting teamwork (including limiting unhealthy competition) **and enhancing intra- and inter-disciplinary teamwork to increase professional cohesion, motivation and job satisfaction** by: **a.** training courses on communication and interpersonal interaction in hospitals and team training contexts aimed at strengthening the relationship between doctors and nurses or between professionals from different specialities and understanding the position and role of each in relation to the work carried out and in relation to the patient; **b.** developing pilot projects aimed at providing medical staff with support for their physical and mental health, as well as facilitating safe environments for the exchange of experiences and advice. Expansion of the programme if it is proven effective.

SO 4. A focus on high performance management models in hospitals through: **a.** professionalisation of hospital management; **b.** planning and good management of resources in order to cover the shortage of specialties and a good territorial distribution (including through regionally or locally designed measures of incentivisation); **c.** implementation of a national programme of reward or recognition, distinguishing doctors or nurses who provide exemplary care to patients, based on a uniform and transparent system of recognition of merit; **d.** pilot pay-for-performance programmes, which can be further extended.

The primary and community health care system: challenges

The spectrum of reasons justifying the departure of healthcare professionals from Romania also includes issues related to the organisation and functioning of the current primary health care system, as a main pillar of health services at the community level.

In summary, the challenges of the current community health system resulting from the research conducted in the project and the elements that, if properly managed, could lead to improvements include:

1. Aspects related to access to primary or community health care services in disadvantaged or remote areas, including some rural localities: **a.** The need to invest in encouraging medical school graduates to opt for the specialty of family medicine and subsequently to practice it, especially in rural areas; **b.** the need to rethink and reform the services that could be provided in the community by midwives; **c.** the need to build effective relationships and collaboration between members of the primary health care team and those in the community health care team; **d.** the need to provide the necessary infrastructure and funding for primary and community health care at the level of the territorial administrative units.

2. Aspects concerning the role of the family doctor and his/her role in society and the health system: a. the need to increase the status and social role of the family doctor within the society (*one of the issues intensively discussed in the study was the fact that the decisions taken at central level regarding the COVID-19 pandemic and the image portrayed by the media have deeply affected the image and credibility of family doctors in the eyes of society and caused a lack of trust even among their patients, a situation that cannot be left to rectify itself*); b. the need to increase the role of the family doctor in the structure of the health care system in Romania (*another element discussed in the study was that the family doctor is often forced to refer patients to specialist doctors, even for basic procedures; routine actions such as patient evaluation and prescribing treatment are nowadays outside the responsibilities of the family doctor in Romania, a situation that transfers most cases to ambulatory care and hospitals*).

3. Aspects regarding the organisation of the primary health care system and reducing bureaucracy: the need for an accurate and efficient information system, based on case studies carried out in the field in model family doctor offices, which are then extended through clear regulatory frameworks. (*Healthcare organisations usually generate patient data for internal purposes. However, the views expressed in the research indicated that there are no standardised data collection forms, measurement tools or unique reporting systems in primary care. Interventions are needed to end the excessive bureaucracy generated by burdensome processes, redundant requests for information and unclear accountability structures. In most cases, the sheer volume of paperwork that has to be carried out does not enable doctors to*

focus on their patients. In addition, recent initiatives aimed at reducing the number of documents required have not had a positive impact).

4. Aspects related to the promotion of prevention: The need to design the system of supporting and promoting prevention through primary care in such a manner that it remains a priority for the family doctor, regardless of the number of patients on the list or other formal considerations (*for instance, the research indicated a certain reluctance to prescribe preventive procedures due to the system in place at the time of the study, which "punished" the family doctor for this activity, in the sense that if the patient to whom the doctor recommended a set of medical tests did not return to the family doctor's office with the results, the family doctor could not claim reimbursement for this service*).

The primary and community healthcare system: proposed solutions

The main directions for action around the primary and community healthcare, identified from the research and consultation rounds with key stakeholders from academia, professional organisations, public institutions, employers, health trade unions or international organisations concerned, can be classified into **five strategic objectives (SOs)**:

SO 1. Increasing the attractiveness of family medicine specialisation for rural practice by: **a.** Developing an in-depth urban vs. rural business case analysis that explores three elements: predictable career path, predictable income and structuring a training model, using international and European examples, but adapted to the Romanian context, to help rethink the family doctor's career plan; **b.** training, organising and stimulating accredited practices to attract students and residents, with the objective of motivating them to choose and favour the specialty of family medicine, listing and promoting them; **c.** the need for curricular changes tailored to rural practice for family medicine residents (courses, seminars, early exposure to rural practice); **d.** the organisation of internships for medical students in rural practices accredited for this purpose in order to understand the particularities of medical practice in rural communities, increase its attractiveness, including through exposure to the relationship with patients of these practices and the development of links with their patients; **e.** promotion of family medicine studies for rural students through granting scholarships; **f.** regulations to encourage the association of family doctors at large, while also considering measures to encourage multi-generational practices through the association of family doctors and group practices that will support the integration of young specialists.

SO 2. Increasing the attractiveness of the roles of nurses working in family medicine practices, community nurses and midwives by: **a.** specialising some nurses, with the aim of encouraging them to practise in primary health care. As part of the model, rethinking the career path of nurses employed in family doctors' offices; **b.** organising internships for nurses in primary care offices accredited for this purpose (and appropriately incentivised) in order to increase the attractiveness of these jobs; **c.** the model of stimulating community practice can also be designed for midwives, so that this profession can be revived within community medicine; **d.** recognising the importance of nurses in family doctors' offices who provide exemplary care to patients, based on a uniform and transparent system; **e.** defining a viable model, stimulating and enhancing the independent practice of nurses and midwives.

SO 3. Improving the accessibility of family medicine in rural, disadvantaged or hard-to-reach areas, by **a.** raising awareness among the representatives of TAUs of the importance of health, prevention, health education, and on their role in ensuring community health in the modern society as well as how they can contribute to it by cultivating the relationship between the Ministry of Health representatives in the counties from the Public Health Directorates, family doctors (through their organisations) and associations of TAUs, to promote successful models and learn from positive examples; **b.** Stimulating the involvement of local authorities in developing the necessary infrastructure (equipping practices with the necessary equipment for optimal practice conditions; providing accommodation and medical equipment) and giving incentives to family doctors to attract them to practice in these areas, using existing funding opportunities (including European funds) and taking into account the sustainability of the interventions; **c.** each TAU to effectively promote the strengths of its community and to work systematically to attract medical personnel (promoting the advantages: why should they come to work in that community and not in the hospital?, what are the community's development prospects, how does the community support health service providers, etc.); **d.** wider use of mobile medicine to provide health services in rural areas, involving the TAU in needs analysis and planning of the interventions; **e.** exploring the possibility of employing medical school graduates who do not enter residency in integrated community centres in rural areas, based on clearly defined competences, with funding from the state budget (testing through European funded projects); **f.** promoting the use of telemedicine by family doctors wherever possible and appropriate, including for health education.

SO 4. Increasing the role of the family doctor in society and in the health system by: **a.** rethinking the family doctor's duties (the need to increase his/her role) through cooperation

between the competent bodies; **b.** supporting the standardisation of primary health care practice by continuing to develop and update national standards (protocols and practice guidelines, working procedures), following international and European standards, adapted to the Romanian context; **c.** developing research in primary health care by supporting collaboration with the European General Practice Research Network (the European medical research network within WONCA); **d.** recognising the importance of the family doctor in the community by establishing a national award programme, which distinguishes family doctors who provide exemplary patient care, based on a uniform and transparent system; **e.** reviewing the regulations on family doctor practice (case studies), in order to simplify measures perceived as restrictive and bureaucratic.

SO 5. Defining and operationalising collaboration between primary and community health care by: **a.** Establishing an appropriate legal framework for close multidisciplinary collaboration at the frontline of primary and community health care through clearly defined mechanisms that facilitate the creation of a common purpose within the team, the existence of organisational models that reflect the team's objectives and activities, and effective training, monitoring and reporting/interaction mechanisms; **b.** assigning clear tasks in the primary health care area to other team members, including the community health nurse employed by the municipality; **c.** establishing separate contracts for nurses in primary care practices with the national health insurance house, e.g. for public health activities in priority areas.

Conclusions

While the analysis reinforces a widely acknowledged truth, namely that freedom of mobility is a cherished European value in itself, allowing people to take access more attractive employment opportunities in other Member States, it must also be recognised that, over time, the brain drain exacerbates health inequalities.

In addition, the analysis of other "destination countries" included in the *Pillars of Health* project, along with the research on health worker migration from Republic of Moldova to Romania, reveals that despite the significant mobility within the EU and from neighbouring countries to member countries, this has not systematically addressed the shortage of health workers in these countries who have been absorbingtrained health workers from other countries.

In the post-pandemic Europe, marked by a substantial number of unmet (physical and mental) health needs, we call for improved monitoring of these trends and for greater accountability

regarding the systemic drivers of health workforce mobility and unequal access to health services.

Ideally, healthcare workers should be able to expect similar career prospects and working conditions across the EU, allowing them to contribute with their skills where they are most needed.

In addition, migration from neighbouring EU countries should be addressed responsibly by "destination countries", to prevent the transfer of inequality of access to the area.
Finally, the mobility of health workers within the EU is not a problem in itself, but rather should be viewed as a symptom of wider issues that need to be addressed within the European health systems.

The new threats posed to the health system, including geopolitical challenges, are sounding the alarm and signalling the urgency of joint action: without adequate supplies of skilled healthcare workers, the resilience of health systems cannot be achieved, solidarity remains an unattainable dream, and the cost of inaction is simply too high to overlook.

Useful resources
Detailed information about this initiative and the research results can be found on the project website: https://pillars-of-health.eu/