Meeting of the Ad Hoc Working Group on Human Resources for Health in Small Countries in the European Region

Progress, action and next steps

27–28 January 2022 (in-person and online)
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Abstract

Two years into the COVID-19 pandemic, health workforces (HWF) in small countries were faced with huge demands, having to address challenges related to a relatively limited capacity in human resources for health. The need to take small-country specificities into account in planning effective HRH policy responses continues to be highly relevant. The main objectives of the Meeting of the Ad Hoc Working Group on Human Resources for Health in Small Countries of the WHO European Region were to: share information and provide a regional update on policy tools and resources for HWF challenges in a webinar forum open to various WHO networks; understand the impact of the pandemic on HRH planning and development (member-country experiences, and national HWF priorities for the next 2–3 years); discuss the Group’s action plan for 2022–2023 and agree on priorities; and hold on-line consultations with three sub-sets of small countries (island countries, continental countries and city-states). The meeting revealed the importance of collaborative working – both within the health sector and between the health and non-health sectors – to improve health systems in small countries and concluded in proposing areas in which small countries could be supported to this end.

Keywords

Health workforce
Small countries
COVID-19
Policy resources

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Background

In 2018, the need to make a detailed assessment of the health workforce (HWF) challenges relevant to, and potential solutions applicable in, small countries provided the impetus to establish a technical working group on human resources for health (HRH) in small countries in the WHO European Region. In April 2019, the Sixth high-level meeting of small countries held in San Marino on 31 March–2 April 2019 (1) endorsed the establishment of the Ad Hoc Working Group on Human Resources for Health in Small Countries of the WHO European Region (Ad Hoc Working Group on HRH) as a means of fostering cross-country collaboration to strengthen HRH. The aim of the Ad Hoc Working Group on HRH was to enable experts in small countries in the WHO European Region to share experiences in and identify ways of making collective progress in implementing sustainable solutions to their HRH-related challenges. The first meeting of the Ad Hoc Working Group was held in Venice, Italy, on 9–10 December 2019 (2), offering the participants the opportunity to share their experiences related to HRH challenges and consider policy questions and responses in the areas of postgraduate training and monitoring and HWF mobility management in depth. It was also agreed to start the process of commissioning HRH technical briefs on key priority issues identified by the Ad Hoc Working Group on HRH.

With the increasing impact of the COVID-19 pandemic in 2020 and the direct involvement of many members of the Ad Hoc Working Group in HRH responses to dealing with it in their countries, the focus of the second meeting of the Group, held on line in December 2020, was on surge capacity during the pandemic, continuous professional development (CPD) and forecasting linked to HWF retention. The meeting acknowledged that COVID-19 had created a situation in which huge transformations in health systems, once unimaginable, had taken place over the course of only a few months with limited opportunities to cement, mainstream and solidify these, or even small-scale innovations to the health system. The countries agreed on the need to capitalize on the innovations and changes adopted in this period, which would not be possible to sustain long-term going forward.

Two years into the pandemic, the HWFs in small countries were faced with huge demands, having to address the related HRH challenges with relatively limited capacity and resources. The need to take small-country specificities into account in planning effective HRH policy responses continues to be highly relevant.

The Small Countries Initiative Roadmap (in print) (3) acknowledges that the pandemic has heightened the need for united action in a number of areas critical to small countries. It emphasizes the importance of innovation, agile transformation and responsiveness in relation to changing country needs and presents a forward-looking agenda, which considers the key drivers of change, including the strategic direction of the core priorities of the European Programme of Work 2020–2025 (EPW) (4). With regard to specific HRH-related priorities in small countries, the Roadmap endorses the role of the Ad Hoc Working Group on HRH and identifies “the renewed aim of supporting small countries in planning and forecasting critical health-workforce demand, needs and operationalization in the digital world” (3).

This meeting of the Ad Hoc Working Group on HRH was informed by brief updates from the national focal points on the impact of the COVID-19 pandemic on HRH planning and policy responses.

Objectives

The main objectives of the meeting were to:

1. share information and provide a regional update on policy tools and resources for HWF challenges in a webinar forum open to various WHO networks;
2. understand the impact of the pandemic on HRH planning and development (member-country experiences, and national HWF priorities for the next 2–3 years);
3. discuss the Group’s action plan for 2022–2023 and agree on priorities;
4. hold on-line consultations with three sub-sets of small countries (island countries, continental countries and city-states).
Session 1. Planning the HWF: new policy tools and resources available

The aim of the first collaborative webinar held in 2022 by the Healthy Settings Programme and the Health Workforce and Service Delivery Programme was to present participants with new policy tools and resources available for HWF planning.

The first-mentioned new resource was the new WHO Health labour market analysis guidebook (5). This resource aims at supporting Member States and other stakeholders in developing a better understanding of the HWF situation and dynamics at the country level, and identifying effective policy planning and response. A health labour market analysis (HMLA) approach should be both interdisciplinary and participatory, gathering input from technical experts in areas, such as HWF, labour and macroeconomics, political economy, education, gender equity and data management. This approach makes it possible to carry out a more extensive and coordinated analysis of all components of the health labour market. The guidebook (5) builds on a unique combination of technical expertise, work experience at the country level, and existing literature. It addresses the questions: “What are the key elements to assess in a HLMA?” and “Who should be involved in this type of analysis?”

An HMLA approach makes it possible to carry out a more extensive analysis of all components of the health labour market. An HLMA for the state of Chhattisgarh, India, was provided as an example, showing that the issues faced by the HWF were a lack of absorptive capacity and misdistribution. While this example is from outside the WHO European Region, the process can be transferred to its context.

The second-mentioned new tool focused on helping Member States to achieve a more effective recruitment and retention of health-care workers in remote, rural areas, and improve access to health services for rural populations. With almost half the world’s population and a little over one in four people in the European Region living in rural or remote areas, the development, recruitment and retention of adequate, appropriate and competent multidisciplinary teams to provide primary health care, based on national priorities and local health needs, are of critical importance. The updated WHO guideline on health workforce development, attraction, recruitment and retention in rural and remote areas (6) address this need. Health workers are often not best located to support population access. In their placement, the social determinants of health and the roles of health systems and the health sector in relation to sustainable economic growth should be taken into consideration. At the same time, some rural settings have the added challenge of improving access to health services for poor rural populations through the delivery of primary health care and universal health coverage. There is also a need to consider the impact of policies on different health workers and sociodemographic characteristics, including gender, age, class, ethnicity, migration status, civic status, language, sexuality, disability and religion.

These updated guidelines (6) draw on 133 studies with 17 recommendations, covering education, regulation, incentives and personal and professional support for health and care workers in rural and remote areas. They emphasize the need for a multipronged approach to addressing the complexity of the issue (what attracts health workers to the area, how attractive it is compared to urban counterparts in terms of regulation and personal and professional support).
Session 2. Understanding the impact of the pandemic on HRH planning and development

In this session, in response to previously administered questionnaires sent to participants, small-country HRH representatives reported to the Ad Hoc Working group on:

- how the pandemic had affected HWFs in the small countries
- what policy responses had been taken
- priorities moving forward
- how best to work together as a network to provide support in these challenging times.

Most participants reported that they had already been faced with shortages before the pandemic and that previous HRH planning had been insufficient to allow for the necessary capacity surge. Countries used a range of interventions to achieve this (if in some cases only temporarily) (Box 1).

Box 1. All hands on deck: small-country strategies to deal with HWF shortages

These included:

- the temporary redeployment of health professionals for specific tasks (paramedics, nursing and medical students, retired health workers, inactive health workers, laboratory technicians);
- calling on general practitioners to help during the most acute phases of the pandemic;
- the use of non-medical personnel, when possible, at testing sites and patient check-in points (police, fire fighters, other civil protection personnel, administrative and clerical staff from other ministries, national armed forces);
- private-sector contributions (such as input from laboratories and pharmacies for COVID testing and from private laboratories for limited periods of time for patient testing and the processing of results);
- the use of tourism infrastructure for patient transportation;
- postponement of some health services;
- HWF training in specific areas, such as, case management, COVID swabbing and vaccination.

Cooperation among institutions and within government was key in some countries, involving close collaboration among the ministry of health and other ministries, chief epidemiologists, civil protection and fire-fighters. Some countries reported patient sharing among hospitals. Flexibility in deployment and ways of working was required with staff being moved between institutions and health centres, especially to fill gaps created when health workers fell ill with COVID. In some cases, governments provided funding for such arrangements. Physical and organizational structures were also adapted: some countries set up mobile vaccination teams and other temporary structures to deal with the high volume of requests. Primary health care saw reorganization, the most vulnerable were prioritized, and doctors were redistributed from capital cities to rural areas.

In some countries, hospitals launched outpatient COVID units and provided services via the telephone. Rural areas used telehealth care to connect with patients. In some small countries, primary-health-care services have been working beyond their usual territorial and administrative delineations, taking care of patients not formally under their jurisdiction.

During the meeting, examples were reported of setting aside existing regulatory or legislative barriers to flexible response to support rapid response to the pandemic. It was clear the small countries hoped that any such unnecessary barriers that had been removed during the acute phases of COVID would remain so in the immediate future.

The intention to set up an interministerial working group involving the ministries of health and education was noted by some countries as a means of bolstering collaboration. Such a mechanism would ensure that their needs regarding the availability and skills of health workers were catered for.

Representatives of small countries with rural areas reported good collaboration between urban and rural settings. Multidisciplinary teams had been set up in the rural areas, resulting in strong communication between different sectors. Networking had been boosted by sharing educational material on line, placing
equipment where it was most needed, and moving physicians from the clinical centres to the general hospitals in smaller cities. When hospitals became full in these areas, patients were moved to smaller hospitals in rural areas. Some countries reorganized primary care, referring a number of family doctors to COVID centres for diagnostics, treatment and home visits. Moreover, new e-health services for consultations, test results, appointments and prescriptions were used more to avoid overburdening the HWF.

Countries highlighted the importance of having a human resources management system that would provide access to all registered health professionals. This can help identify retired workers who could be asked to return to work temporarily though this is not yet possible in all small countries due to varying information systems.

Many small countries rely on foreign-located workforces that they wish to integrate and retain. In some, the pandemic exposed the limitations and risks of reliance on daily cross-border flows of health workers should the borders be closed. Some of the countries held diplomatic discussions on keeping borders open to allow health workers to commute and, in some cases, patients to be transferred from larger to smaller countries.

Some small countries depend on larger neighbouring countries for medical schools and, sometimes, for specialization. Some look to larger countries that can contribute to their HWF supply, a factor to be taken into account in planning.

Digital solutions had been put in place to manage the capacity surge (Box 2). The need for additional health-care workers in extra-hospital sectors, for example, in long-term care centres or nursing homes, was a challenge often met by making a call to nursing and medical students and retired health workers whose data were included in an electronic pool of available health workers. Remote services had been set up by many countries, involving telephone consultations, e-prescriptions and telemedicine.

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Box 2. Platforms for essential services and information

All types of digital technologies had been used to manage the surge. Some countries set up on-line tools for volunteer health workers, which made it possible to create a pool of readily available health professionals. Malta had set up telemedicine systems, enabling patients to access clinical professionals, including doctors, directly from their homes; this will be continued in the future. Iceland also used telemedicine to access remote areas.

Luxembourg had set up a national platform of hospitals to jointly manage the surge and cancel non-urgent activities, as well as a pool of nurses and doctors that can be deployed to areas most in need. Another tool had been developed to collect data on COVID patients in hospitals and nursing homes; data were also collected on COVID-positive or other ill health professionals to help in planning. Latvia had set up an informal platform through which all stakeholders, hospitals, educational institutions, private-sector actors and diaspora HWF could be tracked, making it possible to monitor the situation, raise any issues and find solutions together.
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Some countries had taken the change brought about by COVID as an opportunity to invest in the medical profession at the university level with plans to start new specializations (e.g., in geriatric medicine), set up a new hospital structure, and invest in technology and research (e.g., cancer genomics). Other small countries had introduced changes, such as the development of a new hospital master plan and a new primary-health-care strategy, that take staff availability and needs into account.

**Highlights of session 2**

During discussion, the following issues were highlighted as the most important to small countries in relation to HWF:

- **flexibility** within the health system and among actual health-worker roles (quick reaction, often coupled with the rapid acquisition of new skills);
- involvement of workers and resources from other (non-health) sectors to deal with surge;
- the need for cross-government collaboration, networking and the sharing of information beyond that related to the pandemic;
- cross-border cooperation (including cross-border mobility on a daily basis, foreign-trained HWFs, bilateral cooperation) and the need to properly define it;
• the need for **data, specifically for HWF planning**, and an updated HWF registry;
• **demographic challenges**, such as an **ageing health workforce**, especially among general practitioners;
• **digital technologies**, telemedicine and remote services (e.g., telephonic and internet-based services);
• using the opportunity created by the pandemic to put sustained **reforms** (nursing) in place and resolve inequitable health-worker remuneration issues;
• **salary increases** (used in some countries to motivate health workers to stay in the country; in others, the only categories of health workers whose salaries had increased were doctors and nurses);
• mechanisms, such as **legislation**, to help bring retired health professionals on board, and incentives, such as the option to work while receiving a pension;
• available **budget** to expand/move HWF (some countries had access to funding, for example, from the European Union (EU) Directorate-General for Structural Reform Support (DG Reform), for structural mapping and HWF reform);
• WHO support in the form of **webinars and strategic direction**.

Two core groups of issues emerged from the discussion, as well as an understanding of the impact of the pandemic on HRH planning and development, namely short-term (1–2 years) and long-term (up to 10 years) needs and perspectives.

**Short-term action**

1. **Maintaining momentum in surge response**
   Countries reported various means of dealing with the surge (Box 1), noting that such a response needs to be implemented more quickly and effectively than has been the case.

2. **Dealing with HWF burnout**
   The pandemic has had a knock-on effect on health-worker burnout and mental health, resulting in the need for HWF support.

3. **Improving the collection of data and evidence for planning purposes**
   It was clear from the discussions that HWF data are not optimal in all small countries, but that they are necessary to support and inform longer-term planning responses.

**Long-term action**

1. **Strategic approach to planning**. This is necessary not only within the health sector but also with respect to engaging other sectors. Small countries also need to be able to assess resource implications in different scenarios. Within the health sector, investment in all aspects of primary health care (including public health measures) should be a priority. Planning needs to be underpinned by tools, which can make it more effective.

2. **HWF dynamics should be captured**. Accurate data are necessary to allow policy-makers time to react to potential problems.

**Discussion on 2022–2023 action plan of the Ad Hoc Working Group on HRH**

After sharing experiences, the Ad Hoc Working Group on HRH came to an agreement on an action plan for 2022–2023. This would be structured around:

1. how best to support the Ad Hoc Working Group on HRH
2. priorities for a follow-up meeting of the Group (planned for 28–29 April 2022).
3. specific requests for country support.

The following areas were identified as being in need of support.
Data collection

Systems need to be in place to allow small countries a comprehensive picture of the health labour market and the HWF situation. Some small countries expressed the need for support in improving their HWF data-collection systems to better support planning.

HWF planning

Planning the workforce is heavily dependent on the accuracy and availability of data, the collection of which is underpinned by effective tools. There is a need to better understand supply, demand and bottlenecks to enable flexible planning and prepare the HWF for potential problems.

Need to improve recruitment and retention

The challenge for some small countries in this connection is that they are facing an ageing workforce while for others it is that the HWF tends to be concentrated in the capital cities.

Protection of HWF health and well-being

Countries agreed on the need to find ways to sustain a stable, flexible, fairly remunerated, and supported HWF, which is trained to anticipate post-pandemic challenges at the workplace.

Cross-government and/or interministerial collaboration

Small countries had introduced mechanisms of intersectoral collaboration that had made it possible to work across government sectors. To bolster this, it was thought that an HRH management and leadership course, focusing on mainstreaming such collaboration, could help strengthen this governance component.

Cross-border collaboration

Small countries face challenges of dependency on larger or neighbouring countries. The need to improve cross-border collaboration and improve self-reliance was expressed by a number of countries.

Summary of session 2

Session 2 concluded with the question of how the shift from pandemic response to sustainable pandemic control could be made and what kind of human resources would be needed to do so. Factors to consider were: (i) minimum health workforce requirements in the case of another emergency; ii) essential response needs in terms of primary-health-care doctors, nurses, and other auxiliary staff; iii) ways of addressing the two-year backlog in noncommunicable-diseases management, cancer, and other screening programmes. It was important (in the coming months) to keep immediate needs in mind while planning long term. The key policy recommendations needed to advance this work should be further discussed at subsequent meetings.
Session 3. Small-country group discussions: progress, action and next steps

This section was structured around small-country group discussions to identify shared challenges, potential workforce solutions and key issues requiring technical assistance.

HRH priorities identified in session 2, for which collective action and support were possible, were presented. The countries were asked to identify the priorities most relevant to them. These were:

1. HWF strategic planning, taking into account preparedness for future pandemics (including the development and use of relevant tools);
2. improvement of HRH data and human-resource information systems for better policy decision-making (linked to point 1);
3. increased self-sufficiency (e.g., improved recruitment and retention, focus on primary health care, telemedicine);
4. HWF governance (interministerial collaboration and beyond);
5. improved cross-border cooperation and mobility management;
6. health-worker protection and HWF well-being.

Table 1 summarizes the main priorities identified by the small countries during three, one-hour discussion sessions.

Table 1. Most pressing needs in small countries relative to HWF

<table>
<thead>
<tr>
<th>Country</th>
<th>Priorities</th>
<th>Highlights</th>
<th>Ongoing and proposed small-country activities for which the support of the Small Countries Initiative and WHO is requested</th>
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<tr>
<td>Andorra</td>
<td>To improve planning with a clear focus on lessons learned from the pandemic and how to prepare for the next emergency. To strengthen health-information systems and improve data towards better planning and policy-making decisions. Data are currently incomplete or unconnected (hospitals, Ministry of Health and social security do not share their data). To enhance governance through interministerial collaboration, including Ministries of Finance and Education. To enhance cross-border mobility.</td>
<td>Andorra collaborates with medical schools in Catalonia (Spain). In 2021, the country received medical students to complete their degrees and nurses to complete their midwife speciality (Andorra has higher birth rates than neighbouring countries). This mechanism could be used to collaborate with neighbouring countries to bolster HWF.</td>
<td>Andorra proposed the idea of starting an Erasmus exchange among small countries to allow medical or nursing students to become acquainted with work in other countries. In late 2019, the WHO Regional Office for Europe performed an assessment of the health information system in Andorra and provided a list of recommendations on improving them. Due to the pandemic, it has not been possible to implement these. The Regional Office could possibly help in integrating the HRH component into this system and will follow up internally.</td>
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| Cyprus  | To undertake strategic planning and preparedness based on lessons learned from the COVID-19 pandemic.  
To resume data collection according to the health labour market model for nursing and midwifery personnel (paused due to the pandemic).  
To enhance governance through interministerial collaboration (Ministry of Health, Ministry of Finance and Ministry of Education, Culture, Youth and Sports) to promote health professions. | There is a need to examine the necessity for additional reforms. | Cyprus appreciates the ongoing support provided by WHO (Small Countries Initiative, existing and updated literature, etc.) and will submit specific requests in due course. |
| Estonia | To evaluate which types of staff are needed and how best to use all available staff (not only nurses and doctors). Currently, there are some new strategies, such as a master plans for a new hospital and a new primary-health-care strategy. | Cooperation between hospitals and patient sharing are in place, as well as the possibility of calling upon medical schools and voluntary personnel to add to the workforce.  
Family physicians cooperate on administering vaccinations, taking care of those not officially under their care.  
A bilateral agreement with Finland on intensive care units was in place but implementation was unnecessary. | Estonia is considering whether to invest more in primary health care to increase numbers of health workers. |
| Iceland | To enhance flexibility and task-shifting to improve collaboration among health workers.  
To support HWF mental health. | National Council on Health Workforce Recruitment and Education established (Ministry of Health and Ministry of Education).  
The focus has been on improving HRH data, much of which are collected through the health and educational systems.  
Efforts are being made to plan the number of specialists needed, taking Iceland's small population into account. | Collaborative ways of working adopted during the pandemic are being maintained.  
Iceland would appreciate WHO support in task-shifting and teamworking towards helping people work outside their silos.  
Would like to see examples from other countries on how to map the HWF.  
Would like information on skills’ mix and task-shifting that can be used at the country level (e.g., autonomy in nursing). |
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| Latvia  | To introduce strategic direction for human resources, including remuneration and salary issues (would like not only to increase HWF numbers, but also map and plan model for government approval). To find ways of retaining medical personnel (many of whom go to the private sector). To move medical personnel to areas most in need. To work on the availability, quality and compatibility of their data (for example, related to education, hospital settings and qualifications – easier data registration with less bureaucracy). To secure CPD for all (find ways of supporting HWF to this end). | Latvia has created a mapping and planning model, which:  
- is more transparent and acceptable to medical staff;  
- promotes salary increases and self-sufficiency;  
- reflects a Latvian HRH strategy under the EU DG Reform project;  
- will introduce the structural reform of human resources, the main aim being to gain a better understanding of demand. It is planned to submit the model for Government approval. | Latvia would appreciate WHO support in seeking government approval of the mapping and planning model, establishing CPD, and setting up cross-border collaboration on HRH and CPD.                                                                                                                                                                                                 |
<p>| Luxembourg | To strengthen HWF planning. To improve HWF data. To increase self-sufficiency. To improve HWF governance. To increase cross-border mobility.                                                                                                                                                                                                                                                                                                                                                   | Work is underway on policy reform related to increasing collaboration between different health professionals (nurses, doctors, etc.). There is a wish to give nurses greater autonomy. Large campaign to recruit health professionals; wish to increase number of nurses trained in Luxembourg. Single register set up for the collection of health data for planning (interministerial committee, including representatives of the Ministry of Family Affairs, Integration and the Greater Region, the Ministry of Finance, the Ministry of Education, Children and Youth, the Ministry of Social Security and the Ministry of Health). | Luxembourg is currently considering how activities can be shared among health professionals, and ultimately with other small countries. Would appreciate WHO support in strengthening teamwork and efforts to break down silos in ways of working.                                                                                                             |</p>
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<td>Malta</td>
<td>To plan strategic workforce (top priority). To improve data collection (difficult to obtain data from educational institutions regarding HWF supply and skills). To establish a closer relationship with the Ministry of Education (data held by the Professions Council are outdated) and change system of registering health professionals to on-line system accessible to Ministry of Health, as employer. To manage mobility to deal with exodus of non-EU nurses to UK. To address HWF burnout.</td>
<td>Draft HWF planning strategy underway (with WHO technical support). Malta is continuing work on strategic planning tool and follow-up regarding data-planning systems.</td>
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<td>Montenegro</td>
<td>To find an approach to strategic HRH planning (current strategic plan expires in 2022). This planning needs to be flexible not only in the pandemic but also in other emergencies. To strengthen and develop HWF capacity and competencies. To improve HRH data (currently the country is in the process of establishing HRH registries). To improve recruitment and retention and provide internal workforce mobility. To create an integrated health-care system (better organization of existing resources is needed as well as the reorganization of internal workforce mobility to provide integrated care). To strengthen HWF governance (recognize, underpin and justify shortage of certain health-care workers’ specialities and profiles).</td>
<td>Montenegro wishes to continue working on improving primary health care. Not possible to solve all issues through telemedicine as some patients need direct contact. Montenegro would like WHO support in: setting up registries of human resources and health facilities (currently, only annual statistical reports on resources and health-care facilities are available and the HRH picture is incomplete); creating new models for preparing health professionals for times of uncertainty; and establishing cross-border care (the country is in the EU accession process wishes to avoid losing HWF as a result of accession).</td>
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| San Marino| To increase the number of health workers (doctors and nurses) with direct experience in pandemic response.  
To strengthen telemedicine with a view to helping reorganize primary health care.  
To strengthen cross-border collaboration with neighbouring countries. | San Marino is introducing a new professional course for nurses with specific experience in primary care and family support. This will create a new category of professional support in the health system. | San Marino proposes holding a policy dialogue to address issues of cross-border HWF.                                                                                                                                                                                                                                                     |
| Slovenia  | To tackle the challenge of accessibility to family medical doctors.  
To address the decrease in number of health workers due to the Omicron variant of COVID-19.                                                                                                                | Slovenia has sought support from health-science, medical and nursing students.  
Mobile vaccination teams have been in use.  
Doctors’ and nurses’ salaries have been increased (no increase for other health workers). | The support of WHO, specifically the Small Countries Initiative, in creating strategies to strengthen primary health care is needed.                                                                                                                                                                                                                                                                  |
Conclusions and next steps

The meeting revealed the importance of collaborative working – both within the health sector and between the health and non-health sectors – to improve health systems in small countries. On the one hand, small countries would like to become more self-sufficient and improve their internal governance systems to help them manage future emergencies; on the other, they need to avoid isolation. They expressed the importance of bilateral relations and cross-border collaboration. The meeting concluded that it would be important to help small countries to:

1. improve high-level governance, set up/maintain multisectoral platforms, involving non-health ministries (e.g., those for education, finance, social security, etc.), and continue intergovernmental collaboration;
2. conduct workforce planning, including a preparedness component, and enable flexible deployment;
3. improve HWF data for use in planning and policy-making (linked to improved governance);
4. implement innovative approaches and solutions that can be scaled up, including task-shifting and teamwork, to allow for mobility within the health system, flexible ways of working that break down barriers, and horizontal ways of working;
5. strengthen primary health care, teamwork, and health-worker competencies;
6. further define what cross-border collaboration means for small countries and their HWFs.

In addition, it was agreed to:

- formulate strategic/political key HWF recommendations to take forward at the 8th high-level meeting of small countries in Montenegro (2–3 June 2022);
- organize a face-to-face meeting of the Ad Hoc Working Group on HRH to discuss the top three priorities identified by the group;
- provide support in strengthening communication and outreach.
References


1 All URLs accessed 6 April 2022.
Annex 1. Programme

Day 1: 27 January 2022

Planning health care workforce: which new policy tools and resources are available? (Zoom meeting)

Introduction (Natasha Azzopardi-Muscat, Director, Division of Country Health Policies and Systems, WHO Regional Office for Europe)

Welcome speech (Bettina Maria Menne, Coordinator, European Office for Investment for Health, Division of Country Health Policies and Systems, WHO Regional Office for Europe)

Regional update (moderated by James Buchan, Senior WHO Consultant, Health Workforce and Service Delivery Programme, Division of Country Health Policies and Systems, WHO Regional Office for Europe)

• Regional Committee update (Tomas Zapata, Unit Head, Health Workforce and Service Delivery Programme, Division of Country Health Policies and Systems, WHO Regional Office for Europe)
• New health labour market analysis guidebook (Pascal Zurn, Unit Head, Health Labour Market and Partnerships, Universal Health Coverage and Life Course, WHO Headquarters)
• New WHO guidelines on health workforce development, attraction, recruitment and retention in rural and remote areas (Michelle McIsaac, Economist, Health Workforce Department, WHO Headquarters)
• Open discussion (moderated by Tomas Zapata)

Impact of pandemic on HRH planning and development (moderated by James Buchan)

Summary/synthesis of Member States’ updates (Zoom meeting)

Round table (brief summaries of countries’ responses to questionnaire distributed prior to the meeting, including national HWF priorities for the next 2–3 years): Cyprus, Iceland, Malta, Andorra, Luxembourg, Monaco, San Marino, Estonia, Latvia, Montenegro, Slovenia

Synthesis of all country reports (Leda Eugenia Nemer, WHO Consultant, European Office for Investment for Health, Division of Country Health Policies and Systems, WHO Regional Office for Europe)

Open discussion (moderated by: James Buchan)

Action plan 2022–2023 (Tomas Zapata/Bettina Maria Menne)

Priorities/next steps for meeting scheduled for 28–29 April 2022

Day 2: 28 January 2022

Three on-line consultations (Zoom meetings)

1. Small group consultation with island-countries cluster (Cyprus, Iceland, Malta): focused discussion on one-to-one or cluster-based HRH priorities and country support (Tomas Zapata/Jim Buchan, Leda Eugenia Nemer/Crispin David Paul Scotter).

2. Small group consultation with city-countries cluster (Andorra, Luxembourg, Monaco, San Marino) focused discussion on one-to-one or cluster-based HRH priorities and country support (Tomas Zapata/Jim Buchan, Leda Eugenia Nemer/Crispin David Paul Scotter).

3. Small group consultation with continental-countries cluster (Estonia, Latvia, Montenegro, Slovenia) focused discussion on one-to-one or cluster-based HRH priorities and country support (Tomas Zapata/Jim Buchan, Leda Eugenia Nemer/Crispin David Paul Scotter).
Annex 2. Participants

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Universal Health Coverage and Life Course

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Universal Health Coverage and Life Course
The WHO Regional Office for Europe

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Estonia
Finland
France
Georgia
Germany
Greece
Hungary
Iceland
Ireland
Israel
Italy
Kazakhstan
Kyrgyzstan
Latvia
Lithuania
Luxembourg
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