Recruitment and Retention of the Health Workforce in Europe

Final Report

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Consumers, Health, Agriculture and Food Executive Agency

EUROPEAN COMMISSION

Directorate-General for Health and Food Safety
Directorate D — Health Systems and Products
Unit D.2. — Healthcare system

European Commission
B-1049 Brussels

2015 EB-02-15-512-EN-C

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Directorate-General for Health and Food Safety
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Luxembourg: Publications Office of the European Union, 2014

ISBN: 978-92-9200-682-2
doi: 10.2818/430223

Printed in Belgium

PRINTED ON ELEMENTAL CHLORINE-FREE BLEACHED PAPER (ECF)

PRINTED ON TOTALLY CHLORINE-FREE BLEACHED PAPER (TCF)

PRINTED ON RECYCLED PAPER

PRINTED ON PROCESS CHLORINE-FREE RECYCLED PAPER (PCF)

Directorate-General for Health and Food Safety
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1 INTRODUCTION

Recruitment and retention of health workers is everybody's business; everybody is a patient at some point in their lives. Patients deserve access to high quality care from a well-qualified workforce. Equally, healthcare staff deserve to work in well-supported environments, with staffing levels that promote safe, high quality care. Many EU countries report difficulties in retaining and recruiting health staff with increasing shortages predicted longer term. This report reviews the existing information and evidence in and beyond the EU to map a wide range of initiatives aimed at tackling problems in recruiting and retaining health staff. It offers a range of case examples with recommendations highlighting key factors to support and optimise the success of recruitment and retention interventions in Europe's health sector.

There are significant economic costs for employers and the public sector in a country when a professional drops out of the health labour market or emigrates. By improving retention, organisations and countries reduce these costs. There is a business case both for more efficient recruitment and retention, and also for safeguarding the quality of health services. A high turnover of staff reduces the availability and continuity of care and is an obstacle to the creation of stable teams of providers, all of which has a negative impact on quality and cost of services.

Mitigating recruitment and retention problems in the healthcare sector is not a free good. It may require salary increases, financial incentives and more training opportunities, information systems, research and development infrastructures and equipment. Also, improved access to doctors and nurses can increase demand for services and health expenditure. The case needs to be made to demonstrate that this is an investment that pays dividends in terms of reduced costs of turn-over, including loss of professionals to other sectors or countries. Improved recruitment and better retention means better access, which in turn means better health outcomes and savings on inappropriate service utilisation. Not doing anything may also have important costs in terms of unmet service needs and poorer health outcomes.

The report is the result of a tender awarded in 2013 by the European Commission to study the various dimensions of recruiting and retaining professionals in the health sector in order to promote an exchange of best practice. It provides possible solutions to recruitment and retention in the health sector and aims to inspire and inform recruitment and retention interventions.

1.1 OBJECTIVES

The objective of the study is to identify and analyse effective strategies for the recruitment and retention of health professionals, mainly focused on physicians and nurses. It aims to provide lessons learnt and inspiration for the development of organisational strategies and human resource policies in Europe.

For the purpose of the study, the following definitions of recruitment and retention were used:

- Recruitment: the demonstrated capacity to attract the professionals with the required skills and qualifications to occupy defined positions in health services in line with the strategic health plan.

- Retention: the capacity to maintain health workers in the health care system, limiting unjustified ("voluntary") losses to other organisations, sectors or geographical areas, within and out of the country.

1.2 POLICY CONTEXT

Most EU countries face the challenge of balancing the right number of healthcare staff with the right skills in the right geographical areas to meet the changing needs of populations and health systems. These problems are becoming increasingly urgent as the health workforce shrinks, with many workers reaching retirement age.

The EU focus on growing health workforce shortages was emphasised by the publication of a Green Paper on the European Workforce for Health in 2008. This was followed by the European Commission Action Plan for the EU Health Workforce (2012) that set out a framework for European cooperation to address health workforce shortages with the sharing of good practices in recruitment and retention as one of the four areas for EU level action. Since 2013, the EU funded Joint Action on Health Workforce Planning and Forecasting has focussed on methodologies and guidelines to support Member States in making decisions on the numbers and kinds of health workers they require.

This study builds on the findings of a series of 3 European research projects on health workforce funded as part of the FP7 research programme[1]. The findings from the EU funded Prometheus Project on health professional mobility in particular showed that the factors influencing mobility were closely linked to the working environment, good management, access to professional development and career opportunities. These conclusions are also reflected in the RN4cast project 'Nurse forecasting in Europe'.

The economic crisis has severely impacted recruitment and retention in healthcare throughout the European Union (EU). Labour market trends and skills forecasts predict skills shortages in the health and social sector in the medium term[2]. At their Council meeting in July 2012, EU health ministers discussed the high employment potential of healthcare and the need for innovative approaches and strategies to attract and equip young people with the right skills in the health sector (European Commission, 2012).

A highly mobile workforce can help balance surpluses or shortages of health professional skills within Europe. However, mobility can also fill skill gaps in one part, while exacerbating undersupply of health professionals in other parts of the EU, leading to geographical imbalances and raising concerns over access to high quality healthcare.

Cost containment measures in response to the economic crisis have exacerbated the situation, with curbs on new recruitment and reductions in salaries leading to increased outflows of health professionals, either to other sectors or to other countries. Retention strategies for the health workforce are therefore receiving increased policy attention as policy makers and healthcare managers look for cost effective ways to attract and retain their health professionals.

Concern about the recruitment and retention of health staff is shared at the EU level by the social partners, the trade unions and hospital employers that participate in the Sectoral Social Dialogue Committee for the Hospital/Health Care Sector. Together, the European Federation of Public Service Unions (EPSU) and HOSPEEM, the European Hospital and Healthcare Employers' Association, are developing a report to provide an overview on a broad range of government-based and social partner-based initiatives at different levels (national, regional, sectoral, workplace level). This report is a follow-up

[1] Three projects on health workforce funded as part of the FP7 research programme were:
PROfessional Mobility in THe European Union Study (PROMeTHEUS)
(http://ec.europa.eu/research/health/public-health/health-systems/projects/health-prometheus_en.html)
Mobility of Health Professionals (MoHProf) (http://www.mohprof.eu/)
RN4CAST (http://www.rn4cast.eu/en/index.php)
2 CEDEFOP (2012). Skills demand and supply forecasts (http://www.cedefop.europa.eu/files/5526_en.pdf)

to their Framework of Actions "Recruitment and Retention" adopted in December 2010 (http://www.epsu.org/a/7158 and http://hospeem.org/our-newsletter/hospeem-epsu-framework-of-actions-recruitment-and-retention/).

1.3 THE STUDY

Launched in January 2014, the study consists of: a mapping and review of recruitment and retention practices for health professionals; eight case studies addressing recruitment and retention of health professionals and policy and management recommendations relevant for policy makers, managers, health professionals, researchers and educators. The findings from the study identified many innovative solutions to the challenges of recruiting and retaining health staff.

The review methodology involved an extensive scoping of the peer-reviewed and grey literature on recruitment and retention of health professionals, supplemented by consultation with informants from each of the EU and EFTA countries and three non-EU countries – Australia, Brazil and South Africa. The literature review identified 121 studies of which 50% were primary studies in peer-reviewed journals, 10% reviews and 40% studies reported in the grey literature. About half of all studies were from EU/EFTA countries.

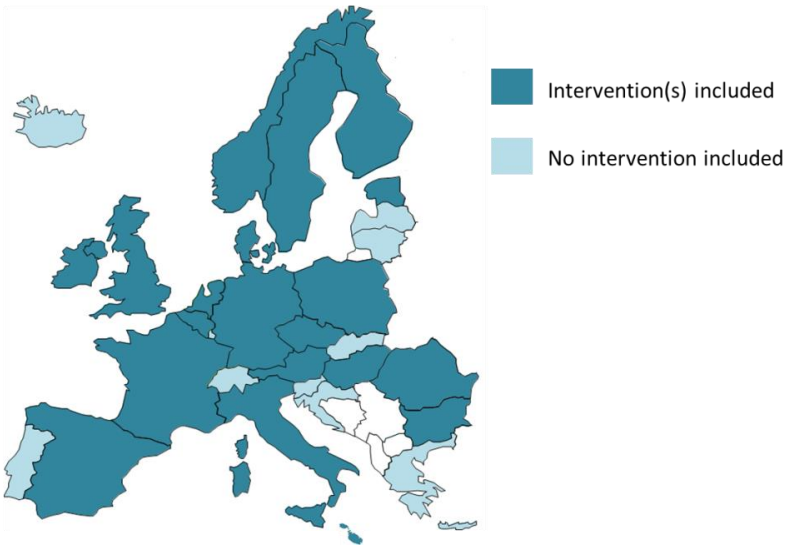
Based on the literature review, input from country respondents and experts on recruitment and retention, eight topics were selected for more in-depth study. These topics cover the trajectory of a health professional career and are:

Eight topics selected for in-depth study
Attracting young people to healthcare
Attracting and retaining GPs to strengthen primary care in underserved areas
Providing training, education and research opportunities for a life-long career
Attracting nurses through the extension of practice and development of advanced roles
Providing good working environments through professional autonomy and worker participation
Making the hospital workplace more attractive by improving family-friendly practices
Return to practice for healthcare professionals
Providing supportive working environments for the ageing workforce

For each topic, multiple cases from multiple countries were included, resulting in a total of 40 interventions from 21 countries (Figure 1). Data was collected via desk research, telephone and/or email interviews and site visits for nine cases. The case study research offers insights into:

- how recruitment and retention interventions are developed and implemented,
- the role of various actors and facilitators and barriers throughout the process, at both policy and organisational levels.

Figure 1 European countries from which recruitment and retention interventions were included in the study



The study was supported by two expert workshops, the first validated the case study themes and the second provided input into the shaping of the recommendations and final report.

Full details of the study methodology are provided in appendix 1.

1.4 DRIVERS OF RECRUITMENT AND RETENTION INTERVENTIONS

Most recruitment and retention interventions, irrespective of differences between the countries, are triggered by similar motivations and objectives including:

- Observed or forecasted shortages of a category of personnel. This is mainly reported in higher-income countries such as Australia, Austria, Germany, Norway, Switzerland and the UK.
- High attrition rates due to career reorientation, (early) retirement or emigration. This is mainly reported in Central and Eastern European countries (e.g. Bulgaria, Hungary, Poland, and Romania) and South Africa and more recently in countries severely hit by the economic crisis such as Greece, Ireland, Portugal and Spain.
- Difficulties in recruiting and retaining personnel in certain professions, specialties or fields of practice, reported in all countries.
- Imbalances in the geographical distribution of health professionals, also reported in all countries.
- Just as they tend to be driven by a set of similar factors in most countries, recruitment and retention interventions also tend to target the same occupational groups and sub-groups, with doctors and nurses most frequently the target groups.

1.5 TYPES OF RECRUITMENT AND RETENTION INTERVENTIONS

Recruitment and retention interventions were classified based on the WHO's (2010) *Global policy recommendations on increasing access to health workers in remote and rural areas through improved retention* – into the following categories:

1.5.1 EDUCATION

Recruitment and retention interventions relating to the education of health professionals include a variety of strategies: clinical rotations; placements in rural regions; coaching or mentoring of students; adaptation of curricula for rural health workers and decentralisation of education institutions or programmes and scholarships in exchange to commitment to work in a rural or remote setting or in certain fields of practice.

1.5.2 REGULATION

Regulatory measures are policy levers less commonly used to recruit and retain healthcare staff as they are more demanding, politically and economically. Examples are changes in the status of nurses or of family physicians, in the revision of scopes of practice, in the management structure, in employment contracts or in remuneration mechanisms. An isolated example from South Africa is the introduction of compulsory community service.

1.5.3 FINANCIAL INCENTIVES

These include salary increases and financial incentives, but also the provision of good working tools such as information and communication technologies and training opportunities, all of which require investment in infrastructures and in technical personnel. Higher-income countries such as Australia and Norway have dedicated substantial financial resources to infrastructures to train students and interns in rural areas, on telecommunication connections to make networking possible and on additional trainers and supervisors. Middle-income ones such as Brazil, Hungary, and South Africa have also made substantial financial efforts, but the literature reviewed and information received tend to indicate that these were not always sufficient to produce the desired results. This indicates that there might be a threshold below which investments are not as productive as desired.

1.5.4 PROFESSIONAL AND PERSONAL SUPPORT

These measures include access to telemedicine, to distance learning and virtual networks to reduce isolation and thereby improve retention in rural/remote areas. In the Nordic countries, the Czech Republic and Germany, family-friendly measures such as the provision of childcare support, flexible working hours, part-time contracts, good maternity and annual leave arrangements have been put in place to make workplaces more attractive. Measures such as exemption from night and weekend shifts, part-time work and financial incentives have been introduced to prevent early retirement, or to encourage retirees to continue working.

1.5.5 MIX/OTHER TYPES OF INTERVENTIONS

The most frequently reported types of interventions are educational, followed by professional and personal support. Interventions focusing on financial incentives have been developed in numerous countries, but these appear to be more effective when combined with other measures. Regulatory changes are less often used and recruitment and retention strategies combining a mix of interventions are rare

1.6 USING THIS REPORT

This report brings together case studies and examples of good practices in recruitment and retention. The case studies in Chapter 2 are grouped to reflect the trajectory of a health professional's career and provide detailed examples of what is being done to tackle health professional recruitment and retention problems within and beyond the EU.

The good practices in Chapter 3 describe success factors for the process of implementation and for specific interventions. Using the Knoster model (Knoster, 1991) of change management, it describes how to maximise the impact of recruitment and retention interventions. This section also builds on the 2010 WHO recommendations to identify success factors for different types of interventions.

The recommendations in Chapter 4 focus on common factors found to support or hinder the effective implementation of interventions to tackle recruitment and retention. Each recommendation includes actions for different levels, from EU level actions through to actions for professional' associations and managers at the organisational level.

Throughout this report there are a wealth of examples and approaches to stimulate policy makers, health professional associations, managers and educators seeking solutions to problems of health professional recruitment and retention.

2 FINDINGS FROM THE LITERATURE REVIEW

2.1 TARGETS AND NATURE OF INTERVENTIONS

In many countries, interventions target potential candidates to medicine and nursing as early as secondary school level, particularly in nursing where recruitment is often more difficult. Interventions also aim at attracting students to less prestigious or "difficult" fields of practice, such as family medicine, emergency care, mental health or geriatrics. Others target new graduates, for example to attract them to underserved regions, or to attract specific groups of practitioners, such as female, immigrant or older professionals.

The dimension most frequently targeted by recruitment and retention interventions is the education of health professionals, e.g. the content, structure and the length of the curriculum and continuing education. Another target is the working conditions and environment, including compensation, benefits, work schedules, career progress and management and supervision. The two other dimensions identified in the literature as important are professional and personal support and regulation.

2.2 POLICY RESPONSES FROM ACROSS EUROPE

Responses to recruitment and retention problems show great variation between countries. High-income countries, such as Australia, France, the Nordic countries and the UK have a history going back to the 1990s of efforts to address of large-scale recruitment due to difficulties in recruiting enough nurses and physicians to meet their current and future service needs. Other countries including the Czech Republic, Hungary, Lithuania and South Africa have been more active in improving retention, mainly to stop losing many professionals to emigration.

Recruitment and retention interventions focusing on the education of health professionals include a variety of strategies: clinical rotations, placements in rural regions, coaching or mentoring of students, adaptation of curricula for rural health workers, decentralisation of education institutions or programmes and scholarships in exchange to commitment to work in a rural or remote setting or in certain fields of practice.

Financial incentives and the provision of professional and personal support are also frequently used. Measures such as access to telemedicine, to distance learning and virtual networks have been used to reduce isolation and thereby improve retention in rural/remote areas. In the Nordic countries, the Czech Republic and Germany, family-friendly measures such as the provision of childcare support, flexible working hours, part-time contracts, good maternity and annual leave arrangements have been put in place to make workplaces more attractive. Measures such as exemption from night and weekend shifts, part-time work and financial incentives have been introduced to prevent early retirement, or to encourage retirees to continue working.

Regulatory measures are less frequently used to recruit and retain healthcare staff, possibly because they can be more demanding, politically and economically. Examples include changes in the status of nurses or of family physicians, in the revision of scopes of practice, in the management structure, in employment contracts or in remuneration mechanisms. An isolated example from South Africa is the introduction of compulsory community service.

There are important differences in how policy-makers have responded to recruitment and retention challenges. The literature and informants from some countries (Greece, Italy, Latvia, Portugal, and Slovenia) report few policy interventions. At the other end of the continuum, Australia has been the most active in developing recruitment and

retention strategies to address the issue of unmet needs in rural and curricula reforms, of upgrading the status of nurses, of increasing the intake of students and of decentralisation of education programmes.

Explicit 'human resources for health' policies are not common. In the Netherlands, the Minister of Health issues an annual "health labour market letter" to the Parliament in which the Government's health workforce policy is presented. Austria and Finland have a generic workforce development policy that covers all sectors, including health. In other countries, health workforce issues are addressed in a National Health Plan or equivalent (Australia, Ireland, France, Hungary, Lithuania, Norway, South Africa and the United Kingdom).

2.3 USEFUL LESSONS FROM LITERATURE REVIEW

The findings from the literature review taken together bring useful lessons for policy-makers, planners, managers, educators and leaders of professional associations. The findings are framed in generic terms to enable tailoring to the specificities of a country's needs. All ten are important and complementary. Together they contribute to the success of recruitment and retention interventions:

2.3.1 DIFFERENT FACTORS INFLUENCE RECRUITMENT TO THOSE THAT INFLUENCE RETENTION. POLICIES AND INTERVENTIONS NEED TO BE DESIGNED DIFFERENTLY TO TAKE THIS INTO ACCOUNT

A review of recruitment and retention experiences in OECD countries concluded that interventions to improve recruitment should be different from those targeting retention. The reason is that the decision to choose to practice in a certain location, say a rural area, and the decision to stay there are taken on the basis of different criteria. One takes place outside the practice setting when the future practitioner is still studying, whereas the other is influenced by factors related to the experience of living and working in such a rural area (Forcier et al 2004).

Another study suggests that interventions should be adapted to the different stages of engagement with the "rural pipeline". For example, at stage one, "making career choices", exposing potential students to the possibilities of working in rural areas can be useful and differs from offering incentives once qualified or drawing in recruits from the locality and investing in the workplace and training and development opportunities to support retention.(Mbemba eta l (2013). Viscomi et al (2013) argue along the same lines when they propose that interventions should be designed around the five Life Stages of a family practitioner in rural practice which are: "life before medical school"; "experiences during medical school"; "experiences during postgraduate training"; "recruitment and retention after completion of fellowship qualifications" and "maintenance action plan: remaining satisfied". By analogy, the same argument can be applied to decisions to work in a specific organisation and to stay there.

2.3.2 POLICY STATEMENTS THAT PROPOSE OBJECTIVES AND STRATEGIES TO ADDRESS HEALTH WORKERS RECRUITMENT AND RETENTION CHALLENGES PLAY A CRITICAL ROLE IN GUIDING ACTION AND IN MOBILIZING STAKEHOLDERS

Examples are: the Health Workforce 2025 reports in Australia, the Dutch Minister of Health yearly Labour Market Letter that formulates the government's health workforce development policy directions and the English NHS Plan, which included a commitment to introduce more flexible pathways into nursing education in order to encourage the recruitment of students without traditional qualifications and from under-represented populations.

The literature shows that most recruitment and retention interventions at national level originated from the government or a public agency. These were often triggered by a mix of reports from researchers, professional or provider organisations and education

institutions, alerting actors to deficits in the current or future availability of health workers or to unmet needs in certain fields of activity or geographical regions.

2.3.3 CREATING A FORMAL SUPPORT STRUCTURE (DEPARTMENT, WORKING GROUP, OBSERVATORY) FACILITATES THE DESIGN AND IMPLEMENTATION OF RECRUITMENT AND RETENTION INTERVENTIONS

Such organisations can provide technical support in research, policy analysis and design, planning, monitoring and evaluation and mobilisation of stakeholders. This is critical because of the enduring nature of the process. It also facilitates coordination between the various actors involved in an intervention. Examples are the creation of the former Health Workforce Australia (https://www.hwa.gov.au/), of the Centre for Workforce Intelligence (http://www.cfwi.org.uk/) and Health Education England (http://hee.nhs.uk/) in the UK, and of a network of Human Resources for Health Observatories in Brazil (http://www.observarh.org.br/).

Strong technical capacity helps to avoid issues being addressed in an ad-hoc manner and to focus on the effects rather than on the causes of problems. An organisation mandated to monitor the health workforce situation and dynamics, to propose and later evaluate corrective interventions can help to produce relevant data and intelligence in support of policy-making.

2.3.4 MOBILISING STAKEHOLDERS IS A NECESSARY CONDITION OF SUCCESS, BUT IS NOT SUFFICIENT

Engaging professional councils, unions and associations, employers and local authorities in the design and implementation of interventions builds trust and ownership and increases the probability of success. Effective communication is important in this context. Top-down interventions tend to generate less collaboration and even resistance.

Conversely, engaging stakeholders is conducive to consensus building, providing a solid foundation for successful interventions. Examples include the process of negotiation between unions, employers and government in Belgium that has led to effective recruitment and retention interventions; in the UK, consultation with professional councils is routinely conducted to discuss recruitment and retention problems and possible interventions.

2.3.5 BUILDING THE CASE FOR INVESTING IN RECRUITMENT AND RETENTION IS NEEDED

Mitigating recruitment and retention problems is not necessarily a free good. It may require salary increases, financial incentives and more training opportunities, information systems, research and development infrastructures and equipment. Also, improved access to doctors and nurses can increase demand for services and health expenditure. The case needs to be made to demonstrate that this is an investment that pays dividends in terms of reduced costs of turn-over, including loss of professionals to other sectors or countries. Better retention means better access, which in turn means better health outcomes and savings on inappropriate service utilisation. Not doing anything may also have important costs in terms of unmet service needs and poorer health outcomes.

2.3.6 HEALTH PROFESSIONALS RESPOND TO INCENTIVES; BUT FINANCIAL INCENTIVES ALONE ARE NOT ENOUGH TO IMPROVE RECRUITMENT AND RETENTION. POLICY RESPONSES NEED TO BE MULTI-FACETED

There is ample evidence to suggest that financial incentives, however attractive, are not sufficient in themselves to convince doctors or nurses to settle and stay in underserved and remote areas. Policy-makers and organisation leaders need to consider combinations of interventions rather than isolated ones. This is because

multiple factors influence the decision by a professional to choose a certain specialty or practice location. These factors may vary across settings and time periods and interact differently according to the context. Consequently, a combination of interventions needs to be implemented and monitored to assess effectiveness and identify adjustments as needed. Single interventions have limited effects over time. Bärnighausen, and Bloom (2009) and Misfeldt et al (2014) reviewed the literature on the topic and came to similar conclusions: higher wages appear to have a positive influence on job satisfaction initially. However, there is evidence that the effectiveness of financial incentives on retention declines after five years, compared to other factors such as a positive work environment. A recent OECD paper recommends that policy-makers consider complementary strategies to attract and retain doctors in underserved areas: "adapted selection and education of students; incentive systems and regulatory measures to influence physicians' location choices and service re-design or configuration solutions"(Ono, Schoenstein, Buchan 2014).

2.3.7 INTER-SECTORAL COLLABORATION AT GOVERNMENT LEVEL IS IMPERATIVE

Some recruitment and retention measures fall within the remit of the health sector but others require collaboration from Ministries such as Education (curricular reforms), Public Administration (recruitment, remuneration, career paths) and Finance. There may be legal barriers to certain policy options, like changing laws regulating scopes of practice. Factors that relate to the context, such as limited access to secondary and tertiary education or to social activities in rural regions are not under the control of the health sector, making inter-sectoral interventions necessary.

2.3.8 DIFFERENT SOCIAL CONTEXTS REQUIRE DIFFERENT POLICIES AND INTERVENTIONS

Different underserved regions have different characteristics that affect recruitment and retention. Some are remote, others isolated or simply poor areas, some have specific cultural or ethnic characteristics. Their populations may have different social, economic, demographic and epidemiological profiles. Decentralising education and training programmes and recruiting from local communities helps adapt health professionals to the needs of the population they are expected to serve. Incentives, such as access to housing, may have more impact in certain regions. Financial incentives may need to be calibrated according to the features of the place, the motivations and aspirations of practitioners or the nature of the work.

2.3.9 DIFFERENT CADRES, SUBGROUPS AND AREAS OF WORK REQUIRE DIFFERENT INTERVENTIONS

The needs of professionals vary from profession to profession, from one stage of their career to another. Men and women have different needs and may react differently to the same or different incentives. Professionals who have been out of practice, who have emigrated or who are getting older have specific needs and expectations. The literature is abundant on what motivates health professionals: attractive compensation package; access to continuing professional development and to a career structure; a secure and motivating work environment; reasonable workload; work-life balance and, in more isolated regions, support for family needs (accommodation, education of children, work of spouse) (WHO 2010). Depending on the characteristics of the professionals, these factors are likely to have differential weighting that designers of interventions need to take into account. The corollary of this is that interventions need to be co-designed with the target groups concerned as designers and decision makers cannot possibly be expected to know the mind and motivations of the different groups. This is why multi-stakeholder input is crucial in tailoring solutions.

2.3.10 CONCLUSION - THERE IS MUCH WE CAN LEARN FROM EACH OTHER IN THE EU/EFTA AND ALSO FROM OTHER COUNTRIES

The review of literature on Australia, Brazil and South Africa supports the lessons from the literature on EU/EFTA countries. Australia has vast rural areas and an economic status superior to most EU Member States. Brazil and South Africa are two emerging countries, also with vast rural areas, and a level of economic development comparable to Bulgaria and Romania in the case of South Africa and to Lithuania and Hungary in the case of Brazil. Their experiences confirm the need for multipronged and continuous action in tackling recruitment and retention problems. These tend to be recurrent and they cannot be taken off the policy agenda. In the EU, the case of the UK shows that addressing these issues is a long-term process. Poorer EU countries can look at the experience of Brazil and South Africa to pick up ideas and lessons from the strengths and weaknesses of their health workforce policies. But, in the end, each country has to develop policies adapted to its particular set of circumstances.

The full version of the Literature Review is available in Annex 4.

3 CASE STUDIES – INSPIRING SOLUTIONS FROM ACROSS EUROPE

The case studies offer **insights and lessons for good practice** in recruitment and retention of health workers across Europe. They offer policy makers, managers, professional associations, researchers and educators the opportunity to identify possible solutions to the health workforce issues with which they are dealing.

The case studies are organised around eight topics. These topics were selected on the basis of the results of the literature review, consultation with country respondents and experts on recruitment and retention. The eight topics are organised according to the stages of a **professional life cycle**, since the creation of a sustainable health workforce starts with attracting people to education and ends with making sure that an ageing workforce is well supported. Recruitment and retention are relevant throughout a professional's career.

Figure 1 Horizontal theme and eight case study topics

Below, the key findings for each topic are discussed. Per topic, two or three case examples are provided that best illustrate the exemplary features and results for the cases under the particular topic.

3.1 ATTRACTING YOUNG PEOPLE TO HEALTHCARE

Case	Description	Country	Intervention type
1.1. *Pflegeoffensiv Salzburg*	Recruitment campaign	AT	
1.2. *Zorgambassadeur*	Recruitment campaign	BE	
1.3. *Healthcare Academy*	Education as a road to work	UK	
1.4. *Ich Pflege, weil..*	Recruitment campaign	DE	
1.5 *Hvid Zone campaign*	Recruitment campaign	DK	
1.6. *Zorgtrailer*	Recruitment campaign	NL	

Education Regulation Financial intervention Professional and personal support Mix/other

Most of the cases designed to attract young people to education and jobs in healthcare take the shape of **information and promotional campaigns**. They face **few barriers** and are **easier to replicate** in different contexts than most other recruitment and retention interventions, partly because they can operate fairly independently of the policy level. A distinctive feature of the cases on attracting young people to healthcare is their **reliance on external expertise** in designing and/or marketing the recruitment campaigns. For other interventions, internal expertise is often sufficient.

Other cases try to attract young people to healthcare through a focus on education, although some interventions include other aspects as well. For example, the *NHS Tayside Healthcare Academy* in Scotland focuses on attracting young people, but also on supporting people from disadvantaged backgrounds and unemployed people to take jobs in health care.

The potential effects of educational recruitment campaigns will, by definition, have a **medium to long impact lag**. Campaigns first need to be designed and run, students who want to enter education in one of the targeted areas must wait till the beginning of the school year to start. Subsequently, it can take at least two years before they will enter the labour market and the potential impact on workforce numbers becomes visible.

Example from practice: Salzburger Pflegeoffensive (AT)

The *Salzburger Pflegeoffensive* was launched in 2010 to reduce the growing shortage of nurses in the Salzburg area in Austria. It contains a **package of measures** to recruit and retain nurses and social professionals (e.g carers), including:

- Recruitment, such as initiatives to make nursing more visible and popular (e.g. Salzburg nursing days);

- Education, for example the introduction of a *Pflegestiftung* via which unemployed people can follow education course in nursing, which is paid for by the Land Salzburg and the company, where they will do their internship (and hopefully remain working afterwards);

- Retention, including strategies to improve working conditions.

Because of the multi-faceted nature of the intervention **many partners are involved** including the Land Salzburg, city of Salzburg, Diakoniewerk Salzburg (a religious charity and modern service company, providing care to sick people, senior citizens and people with disabilities), the Salzburger Landeskliniken, Arbeitsmarktservice Salzburg, regional healthcare and educational institutions and so on. **All these parties were involved from the start** of the discussion about the *Pflegeoffensive*. It was reported that, next to quasi-bilateral discussions, it was crucial that during important meetings all partners were literally sitting at one table. This **eased the political decision process** and reduced the risk of rivalry and competitive tension.

Not all measures that have been taken in light of the Pflegeoffensive have been evaluated. However, **results that are available are encouraging**. For example, the *"Pflege deinen Traum!"* [in English: "Take care of your dream!"] campaign, organised by the Salzburger Landesklinieken in 2012 and 2013, obtained good results. It consisted of a (social) media campaign and nursing schools presented at high schools and educational fairs. The number of candidates for nursing, mental health and nursing assistants in general health and nursing schools almost doubled between 2012 and 2013, from 217 to 416. Moreover, there are 100 new students per year in nursing education through the *Pflegestiftung* and the Arbeitsmarktservice monitors whether graduates find a job in nursing within 3 months after they graduated. Up to 2014, 197 persons graduated through the Pflegestiftung.

Example from practice: Care ambassador (BE)

The function of 'Care Ambassador' (in Dutch: *Zorgambassadeur*) was introduced in Flanders (BE) in 2010, partly **in response to the action plan** 'To make work of work in the healthcare sector' which was introduced by the Flemish Minister for Welfare, Health and Family (Vandeurzen, 2010). The function also partly resulted from the **individual efforts** of the future Care Ambassador herself to increase the inflow of nurses in Flanders.

The goal of the Care Ambassador was to support the inflow of people to the healthcare sector by running a coordinated campaign for the promotion of healthcare jobs in Flanders, with a particular focus on nurses, carers and nurse auxiliaries. The Care Ambassador was **supported by various partners**, including the Flemish Minister of Health and the Flemish Consultation Platform Healthcare Professions - which developed the Campaign and determined the main messages. Provincial platforms subsequently used the centrally developed campaign and applied and **adjusted the initiatives to their local context**. According to the Care Ambassador, this is one of the reasons for the success of the Campaign. The promotional campaign is supported by **an external commercial communication agency.**

The most important parameters used to measure the success of the campaign were the number of newly enrolled students in care and welfare education and the reduction of vacancy rates in the care and welfare sector. Results are generally positive; a **large inflow of new nursing students** was observed, between 2004 and 2013, with numbers nearly doubling from 1108 to 2253. In the same period the number of

nurse/carer vacancies in Flanders decreased. Process measures, such as the number of Facebook and website visits, show that the **campaign reached its target audience**. However, it remains difficult to establish a causal relationship between the intervention and outcome measures, because of the high number of confounding variables such as the economic situation in the country or other recruitment and retention measures which took place at the same time.

Example from practice: Hvid Zone campaign (DK)

Between 2009 and 2011, a consortium in Denmark ran a three-year recruitment campaign – called *Hvid Zone* – to increase the number of people entering training in nursing, radiography and medical laboratory technology. The **consortium** consisted of the Ministries of Education and Health, Danish Regions, Danish municipalities, professional organisations and University Colleges. Hence, **partners at national and regional policy levels and organisational level** cooperated. Costs were shared amongst the consortium members; the specific amount of financial contribution was based on the staff numbers of each organisation. The campaign **increased the number of people entering training** in the fields of nursing, radiography and medical laboratory technology respectively by 53%, 84% and 81% in three years (Hvid Zone, 2009).

3.2 ATTRACTING AND RETAINING GPS TO STRENGTHEN PRIMARY CARE IN UNDERSERVED AREAS

Case	Description	Country	Intervention type
2.1. *Pacte Territoire Santé*	Package of recruitment and retention measures	FR	
2.2. *Rural Clinical School*	University of Queensland	AU	
2.3. *Financial compensation*	For GPs to work in remote areas	BG	
2.4. *Beginner's allowance young doctors*	Financial incentives	EE	
2.5 *Resident scholarship programme*	Grant system	HU	
2.6. *Finnmark intern support project*	Rural intern support	NO	
2.7 *Framework Contract*	Financial incentives	RO	

Education Regulation Financial intervention Professional and personal support Mix/other

For countries or regions that are struggling with shortages of health professionals in underserved areas, **combinations of measures** to attract and retain health professionals appear most promising. Nonetheless, interventions focusing on attracting and retaining GPs to underserved areas are **often purely financial incentives,** for example providing young doctors with financial benefits if they start working in an underserved area. These types of intervention are also often **situated at policy level** and involve considerable costs, even though purely financial incentives have low proven effectiveness. To increase their potential success, measures that are purely financial incentives need to make sure that the **amount of financial support provided is and remains sufficient**.

The interventions included in our case study are diverse. Three of the seven are purely financial, the other four focus predominantly on providing educational opportunities and professional and personal support to medical students or doctors in rural areas (full details are available in the case study annexed to this report). The one comprehensive package of measures identified was the *Pacte Territoire Santé*, aimed at increasing the number of healthcare professionals, mainly doctors, in underserved areas in France. An advantage of utilising financial incentives to attract GPs to underserved areas appeared to be the **short impact lag**. Once administrative issues have been arranged, a GP can settle in an underserved area thereby immediately increasing the number of available GPs in that area. However, effects may wear off quickly once the financial benefits are over. Educational or support interventions on the other hand may have a slightly longer impact lag, but their **effects may be longer lasting** as they address the intrinsic motivation of professionals.

Interventions focusing on attracting and retaining GPs to underserved areas are **measuring their effects in different ways.** For example in Bulgaria, the National Health Insurance Fund monitors data concerning the number of GPs working in Bulgaria and can establish whether the *GPs financial compensation programme* stops or slows down the decline in number of GPs.

The *University of Queensland Rural Clinical School (AU)* has established an alumni database which tracks graduates' career pathways and vocational choices, with follow-up data collection every 2 years. The results are encouraging. Rural Clinical School (RCS) **graduates were found to be 2.5 times more likely to work in a rural area** than medical school graduates who had not participated in the RCS.

Example from practice: Pacte Territoire Santé (FR)

The *Pacte Territoire Santé* (FR), launched in December 2012, is a **formal agreement** between the **French Ministry of Health and various stakeholders** to attract medical doctors (mainly GPs) to rural and underserved areas in France. It contains 12 specific commitments divided over three packages. While some financial incentives are included, the Pacte also tries to **tap into GPs' intrinsic motivation** by supporting them to function and work in rural areas in the same way as they would in a metropolitan area, for example by developing team work and telemedicine.

The conceptual work and communication around the Pacte takes place at national policy level, but implementation takes place in the regions. **Appropriate action plans**, adapted to the **needs of the local context**, are, for example, developed by the Regional Health Authorities. In developing the action plans there is a lot of **cooperation with the target groups**, i.e. medical doctors, professional medical associations, local GPs, educational institutions etc.

The implementation and working of the **Pacte is constantly monitored** by the Ministry of Health at national and regional level. There are two sorts of measures for the success of the Pacte, some are short term and directly linked to the Pacte, for

example the number of *Maisons de Santé Pluridisciplinaires* (MSPs) in the country. Long term results relate to public health indicators of the population in underserved areas, and they will take more time to become visible. The initial **indicators for the Pacte are positive**. For example, the 200 territorial general practitioner contracts (securing GPs' first two years of work in an underserved area by providing a minimum salary and guaranteeing social protection) offered in September 2013 were taken within four months.

Example from practice: Internship support project Finnmark (NO)

A primary care internship support project was launched in 1998 in Finnmark a remote area of Norway with shortages of GPs and nurses. Interns were offered tutorials in groups that, amongst other benefits, provided **opportunities to overcome professional and social isolation** by networking with peers from neighbouring municipalities. The groups meet 3 times for 1-3 days during the 6-month period of their Primary Care internship.

The intern support project mainly resulted from the concerns and efforts of the then Chief County Medical Officer of Finnmark, who proved an **individual change agent** in obtaining **political commitment** and funding from the Ministry of Health to solve the primary health workforce problems with which the region was dealing. Ms Straume, currently the Chief County Medical Officer of Finnmark, came up with the idea of working with the interns and led the groups, as she had **prior experience** with this. The costs of the intern support project are relatively low compared to other interventions. The project is **financed by the national Ministry of Health** and Care Services/Directorate of Health. This funding was important; it was stated that 'we could not have done it without that'.

From January 1999 until August 2006, data was collected from graduates who had conducted their primary care internship in Finnmark and an evaluation was conducted. Since no baseline data was available, the results from Finnmark were compared with the results from interns in Nordland, the second most remote county in Norway. It was found that **significantly more interns took their first fully licensed physician job in the north of Norway**, compared to what could be expected from their origin, although causality cannot be proven. Another finding was that **significantly more interns from Finnmark chose general practice as their specialisation** (34%) compared to the national gain in the same period (15%). Again, however, causality could not be proven.

3.3 PROVIDING TRAINING, EDUCATION AND RESEARCH OPPORTUNITIES FOR A LIFE-LONG CAREER

Case	Description	Country	Intervention type
3.1. *Bridging courses*	Professional training to Bachelor training to bachelor level	PL	
3.2. *Graduate Nurse Programme*	Calvary Health ACT	AU	
3.3. *Research opportunities*	Research as a form of CPD	SE	

Case	Description	Country	Intervention type
3.4. *Flying Start NHS Scotland*	Development programme for newly qualified staff	UK	
3.5. *Flying Start Queensland Health*	Development programme for newly qualified staff	AUS	

Education Regulation Financial intervention Professional and personal support Mix/other

Interventions providing training, education and research opportunities for a life-long career can **produce effects within a relatively short period of time** (after all, just offering the possibility for training/research can already have an effect), especially when compared to other recruitment and retention interventions. However, it is difficult to say how long the effects last. For all the interventions in our study that provide training, education or research opportunities, the **day-to-day responsibilities are at organisational level**, but there is a variation in the way the programmes were staffed. The *Graduate Nurse Programme (AU),* for example, created new roles in order to achieve the goals of its programme, whereas the *Flying Start Programmes* (UK and AU) rely on the time and capacity available within existing roles. This may be less resource intensive, but can be a barrier in the implementation of programmes. In general, the costs of interventions providing training, education and research opportunities are considerable, but these **costs often do not have to be fully borne by organisations** that provide or run the interventions. Usually, some funding is obtained from European or national policy levels.

To increase the potential success of training, education and research interventions, **sufficient time needs to be made available for professionals to participate.** Many cases reported the need for improvement in this area. The effects that these types of interventions have on recruitment and retention numbers are largely unknown. Often, there are too many variables involved to determine a causal relationship between the interventions and recruitment or retention numbers of health professionals, or recruitment and retention are not key outcome measures. Yet, **process measures can provide valuable insights** in issues related to recruitment and retention. For example, a survey on graduates of the Polish *bridging courses* – offering nurses and midwives the possibility of obtaining a Bachelor degree – showed that 85.4% of the graduates had increased motivation for career development and further development of their professional qualifications.

Example from practice: Flying Start NHS Scotland (UK)

Flying Start NHS is a national web-based development programme, introduced in 2006, for newly qualified nurses, midwives and allied health professionals entering employment with NHS Scotland. The programme is delivered through a dedicated website comprising 10 learning units. Newly qualified practitioners undertaking the programme decide which activities **fulfil their individual learning needs** and learning style. Those undertaking the Flying Start NHS programme receive **support from mentors**, whose role is to offer a light-touch approach to guide new entrants through the programme and lead them to completion.

The programme was developed by NHS Education for Scotland, in partnership with NHS Scotland and the Higher Education Institutions (HEIs). **Implementation and day-to-day running are the responsibilities of individual NHS Boards across Scotland**, supported by national funding. As responsibility for the implementation lies with the

individual Boards, the extent to which the programme has been adopted and promoted varies across the country; in some areas participation in the programme is mandatory for new staff, in others it is not.

The Scottish Government finances Flying Start NHS. In 2010 the intellectual property rights of the programme were protected, which resulted in the successful branding of Flying Start NHS®. The purchase of a licensing agreement to use the Flying Start programme by NHS England (in 2010) and Queensland Health (in 2011, see below) yielded considerable benefits for NHS Education for Scotland.

The effects of the Flying Start programme on recruitment and retention of newly qualified staff within the NHS are not fully measured, mainly because data of adequate quality are not available. However, survey results showed that most newly qualified professionals **considered participation a positive experience**, particularly in relation to clinical skills development and confidence.

Example from practice: Flying Start Queensland Health (AU)

In 2009, Queensland Health was confronted with a similar problem to NHS Scotland. A **needs-analysis survey** showed that support for new starters, including new graduates, was needed across most disciplines. After identifying this, Queensland Health had to make the choice between developing its own support programme or using an existing one. An **investigation into existing new starter/induction programmes** revealed Flying Start NHS as an option. It stood out because it was structured and had been **trialed and evaluated**. Once Queensland Health had decided that the Flying Start program would fulfil their needs, they contacted NHS Education for Scotland who were supportive of transferring the programme to Queensland. Both organisations then started drafting a **license agreement to secure the cooperation**. This process took much longer than expected, but in 2011 the licensing agreement was established and Queensland Health was licensed to use the Flying Start resource, which remains the intellectual property of NHS Scotland. In 2012, Flying Start Queensland Health started operating.

In **transferring the intervention from one context to another**, it proved easy **to adapt the content** of Flying Start NHS Scotland to the local Queensland context. The shared language and very similar professional curriculum probably facilitated this process. Moreover, both organisations benefit from each other's experiences with the programme.

What was very difficult was negotiating a contract or a license agreement that would meet both the legislative needs of the Queensland Government and the NHS Scotland/Scottish Government. Yet overall, Queensland Health felt that the time and costs of the licensing agreement were relatively cheap compared to the costs of developing (the content) of such a resource themselves, stating that: **"Despite the challenges, it was worth it."**

In implementing Flying Start in Queensland, the Cunningham Centre (a Registered Training Organisation (RTO) for Queensland Health) cooperated with lead **contacts in each of the local hospitals and health services** throughout the state. Moreover, **workshops were provided** to future users of the programme and these workshops were rated as highly relevant by participants. In the day-to-day running of the programme, there is a **clear division of responsibilities** between the Cunningham Centre, the website hosting company and support contractor and the local health services.

Retention was never a key effect measure for Flying Start Queensland Health. Even though it is important, the number of confounding variables in establishing whether the

programme has contributed to retention is too high. However, the programme is constantly being monitored and evaluated. Access to resources, **ease of use and support for supervision practices** are rated as the most useful aspects of Flying Start Queensland Health.

3.4 ATTRACTING NURSES THROUGH THE EXTENSION OF PRACTICE AND DEVELOPMENT OF ADVANCED ROLES

Case	Description	Country	Intervention type
4.1. *Huhtasuo Haltuun-project*	Nurse-oriented care provision	FI	
4.2. *Extension of nurses' roles and functions*	In various states	AU	
4.3. *Subsidszed education*	RNs can become nurse specialists	CZ	
4.4. *Advanced Nursing Practice*	Task substitution/new roles	FR	
4.5 *Nurse specialist*	Introduction of new function	NL	

Education Regulation Financial intervention Professional and personal support Mix/other

Interventions involving advanced practice roles for Registered Nurses (RNs) can have a **long impact lag**, but also **long-lasting or permanent effects** on health workforce issues. Implementation processes can take years; often legal changes are required, RNs then need to acquire the necessary competencies, special training may need to be developed and, subsequently, the advanced practice/new roles need to be introduced and grounded in practice. Once nurses or nurse specialists are allowed to prescribe medicines, they will be able to perform this task for the rest of their professional careers, thus creating a positive investment for the future.

Interventions involving advanced practice roles for RNs often encounter **legal barriers**, as the scope of practice for health professionals is often enshrined in law. However, where legal barriers have been found, these seem **not to prevent the introduction** of interventions. What appears to be more common is that the introduction of measures becomes delayed (where legislation changes are required) or that the measures themselves are adjusted to fit within the legal framework. Hence, **taking into account the local legal framework** right from the onset of an intervention may reduce these barriers and shorten the process.

The interventions that were included in our study are diverse. All involve either the extension of nurses' roles or task substitution, but they are situated at different levels and aim to do so in different ways. The factor that all of them have in common is the **further education of nurses**, often **combined with other elements** such as changing regulations or personal and professional support. One important facilitating

factor amongst the interventions is the need for political commitment. Countries or organisations that want to introduce task substitutions and/or extend nurses' roles need to **create political goodwill** for the proposed changes and gather a substantial amount of support, both among nursing stakeholders and medical stakeholders. Task reallocations are a sensitive topic in healthcare and need a **broad coalition of support** if they are to be successful.

As noted above, the effects of changes in (legal) regulations for task substitution and/or advanced practice are generally permanent, but can take considerable time to impact. This is one of the reasons why it is **difficult to establish a direct link** between the extension of nurses' practice and roles, and recruitment and retention rates. It is also probably why, if we look at the included interventions, monitoring or evaluation of the measures barely takes place.

Example from practice: Huhtasuo Haltuun- project (FI)

The *Huhtasuo Haltuun*- project [in English: Huhtasuo Take-over- project] started in 2012. The Huhtasuo health centre, offering primary care in the Huhtasuo neighbourhood in Jyväskylä (FI), had experienced a shortage of doctors and nurses for over a decade. The health centre staff had pleaded for years to hire more nurses to fill the gaps because the centre was unable to attract more GPs. By doing this they were acting as **individual change agents**. However, the municipality would not give permission to do this. This is because in Finland, the 'cultural' idea that doctors should provide all care is very strong. Yet in 2012 the situation became so critical that the municipality agreed to spend the money that was earmarked for GPs in a different way.

After gaining municipal approval, the **staff composition was changed**: 4 additional RNs were hired, a social worker (½ FTE) was added to the staff, a substance abuse nurse (⅔ FTE) was added, 'half' a physiotherapist was added (bringing the total number of physiotherapists to 1½ FTE) and the working time of the nurse specialising in the treatment of depression was increased.

At the same time as the change in staff composition, the care pathway was changed and the **health centre became nurse-led**. The assessment of patients need is made by registered nurses, who have undergone extensive training. They decide whether a patient should come to the health centre and, if so, whether they should see a GP or a nurse. Now, most patients are only seen by nurses. For example, the first contact for all patients with chronic conditions is with a nurse..

Important facilitators in the operation of the new way of working were that the nurses were experienced and well-educated. Other important factors were that the **project was developed bottom-up** by staff, with a **united understanding and sharing of the vision** of the project and a good working atmosphere in the organisation.

The *Huhtasuo Haltuun project* was implemented by the staff of the Huhtasuo Health Centre. There was **almost no extra money spent** or available to support the project. The four additional nurses were paid with the money that was 'saved' by the two unfulfilled GP vacancies. The additional education – a prescribing course – was paid (€5.000) by the employer who also reimbursed 20 school days (i.e. nurses continued receiving salary).

The project was **deemed a success from the staff point of view**. Nurses felt that their skills and capabilities were better used, which **contributed to job satisfaction**. The overall patient perception was also positive and patients felt that services had improved. Moreover, **process and patient outcomes have improved** significantly. For example, the scores for the health centre on the Assessment of Chronic Illness Care

evaluation increased on all evaluation items between 2012 – before the project started – and 2013 – when the project was running.

Example from practice: Subsidised education for RNs to become nurse specialists (CZ)

In 2008, the Czech **Ministry of Health conducted a study** to identify the needs across all nurse specialist areas to identify which ones should be given the most support. In 2009, as a reaction to nursing shortages in different fields, the Czech government decided to subsidise a number of education courses for nurse specialists. Hence, this is an **educational intervention with financial incentives**; it offers RNs fully subsidised educational courses to become specialist nurses. There are 7 specialist courses for nurses (intensive care, intensive care in paediatrics, perioperative care, nursing care in paediatrics, nursing care in psychiatry, community nursing care, organization and management of health services). To replicate a similar programme, key requirements are to have **political goodwill** and **financial resources**.

The subsidy programme is a general programme available to all healthcare professionals. In 2014 there were 600 places available for all non-medical health care professionals with a total budget of about €2.200.000. Three hundred of these places were allocated for nurses. Employers can use the subsidy they receive per individual nurse for covering the costs of the specialist course, the wages of the participating nurses, their travel and food costs and wages for extra personnel (to replace nurses in school).

The subsidy for the specialised education is the responsibility of the Ministry of Health (MoH). However, **various actors are involved in the day-to-day running** of the programme.

Employers (usually health care facilities) apply at the MoH for the extra financial resources to train more specialist nurses. The MoH distributes the finances, checks the data and organises the meetings of an expert group that decides how to and where to allocate the available finances. After the requested number of places is approved by the MoH, employers have to announce the opportunities to their employees and they can sign up. The **external administrator** (IPVZ; Institute of Postgraduate Medical Education) performs daily administrative tasks, which improves the speed and quality of administrative processes. The institute for health care education (NCONZO- National Centre of Nursing and Non-medical Health Care) controls whether the individual health care professional is fulfilling the requirements of her/his specialist education.

Since 2009, between 485 and 694 training places have been approved on an annual basis. Unfortunately, there are **no follow-up data available** about the recipients of the subsidies, so it is not clear how many of them actually stay in the nursing profession

3.5 PROVIDING GOOD WORKING ENVIRONMENTS THROUGH PROFESSIONAL AUTONOMY AND WORKER PARTICIPATION

Case	Description	Country	Intervention type
5.1. *Buurtzorg*	Autonomous working in home care	NL	

Case	Description	Country	Intervention type
5.2. *Self-managing teams*	Autonomous working in home care	BE	
5.3. *We Care Teams*	Autonomous working in home care	BE	
5.4. *Grannvard Sverige*	Autonomous working in home care	SE	

The topic of providing good working environments provides insights on how a successful intervention can be transferred from one context to another. The Dutch home care organisation *Buurtzorg* was established in 2006. This **successful way of working** has since then been **replicated by home care organisations** in Sweden and Belgium. For these organisations, it was helpful to look at the methodology, philosophy and experience of *Buurtzorg*. None of them had to reinvent the wheel, as they could **learn from the pioneer work** that *Buurtzorg* had done. It was also useful to have a successful example to **convince people of the added value** of the new way of working. The results of Buurtzorg Netherlands prove that it works.

When introducing the 'Buurtzorg way of working', other organisations had to **take into account their legal and financial policy frameworks**. The self-managing way of working in home care was originally developed for the Dutch context. When *Grannvård Sverige* in Sweden and the *WGK Oost-Vlaanderen* and *Vlaams-Brabant* in Belgium wanted to introduce the Buurtzorg way of working, they were faced with different policy and financial contexts. This resulted in a **trade-off between sticking to the original concept and adapting it** to the specific requirements of the legal and financial context. This adaptation seemed to impact on their results. When transferring the autonomous way of working in home care, the following factors should be taken into account:

- Legal system around home care
- Financing system around home care: who is providing the reimbursement? What costs are being reimbursed (e.g. direct costs, indirect costs)?
- Knowledgeable people: to introduce the self-managing way of working, people are needed who understand the Buurtzorg way of working and who have knowledge of the context and the system in which it needs to be introduced.
- Similar IT-system to the one that Buurtzorg is using
- Cultural differences: the Dutch culture has a more open feedback culture than many other countries and this influences how self-managing teams operate.
- Support of an external adviser with expertise in work organisation and change processes can be useful.

- Substantial additional financing is required, although the precise amount is dependent on whether autonomous working is introduced in a new organisation or within an existing organisation.

Example from practice: Buurtzorg (NL)

Buurtzorg was established in 2006. It introduced a new way of working in which nurses provide home care in self-directed teams, supported by new technology, minimal managerial oversight and a flat network organisation. Buurtzorg home care teams work autonomously and divide tasks among themselves. They are responsible for office accommodation, planning, work schedules, holiday planning, administration, hiring new colleagues, calculating the team results etc. Since 2008, all Buurtzorg teams are connected with the IT-system *Buurtzorgweb,* which supports the Buurtzorg way of working and was **developed by the external ICT-company Ecare**.

Buurtzorg was not explicitly introduced as a recruitment and retention intervention, but proved to be very successful in this respect. This is shown by the **growth in number of staff** (from 100 in 2007 to 8.000 in 2014), **high staff turnover resistance** (9,3 in 2013) and **low sickness absence level** (< 2% compared to the average of 6,5% in the branch). Moreover, *Buurtzorg* was awarded 'Best Employer of the Netherlands' in 2011, 2012 and 2014.

Buurtzorg received **no funding from third parties**. It started with one small team and grew gradually. The start-up costs for a new Buurtzorg team are approximately €25.000. These costs are financed out of the financial surplus of already existing Buurtzorg teams. Buurtzorg in the Netherlands also established a number of subsidiary companies, such as 'Buurtzorg Advice', which **advises other organisations** that are interested in making (parts of) the 'Buurtzorg model suitable for their own organisation. In 2011, Buurtzorg founder Jos de Blok stated in an interview that: "It is not very effective for organisations if they only do ICT or only take over the model. (..) There is flexibility, in that sense that you can adapt the model to the circumstances of the organisation. But the ingredients need to be there, otherwise you shouldn't do it."

Example from practice: self-managing teams WGK Oost-Vlaanderen (BE)

In Belgium, the home care organisation *Wit-Gele Kruis Oost-Vlaanderen* is currently in the first stages of a phased implementation strategy to introduce self-managing teams within the organisation. It developed this new way of working in **close cooperation with Buurtzorg** the Netherlands and tries to resemble the Dutch example as closely as possible, albeit taking into consideration the limitations that an existing organisation raises. Hence, it has taken **Buurtzorg as an example, but not as a blueprint**, because the Belgian context differs considerably from the Dutch context in terms of financing of home care, different labour laws etc..

While *Buurtzorg* was a major support to the WGK Oost-Vlaanderen, preparation also included **literature research** and visits to other organisations with self-managing ways of working. The **directors also took specific courses**, such as unifying leadership, and an **external consultant in innovative work organisation** provided the WGK Oost-Vlaanderen with help to develop and introduce the self-managing teams.

As the introduction of a new way of working to an existing organisation is disruptive, the WGK Oost-Vlaanderen decided not to implement this change all at once. They started a first **'test phase' with six 'expedition teams'** that would be the first ones to start self-managing work. Subsequently, more teams followed and in 2015, preparation sessions will be organised for all teams to prepare them to start working as self-managing teams.

To introduce the new way of working, **funding was partly provided** by the European Social Fund and Flemish Co-financing Fund (VCF). However, this was not even close to the costs that an organisation the size of WGK Oost-Vlaanderen has when introducing a fundamentally new way of working. Hence, considerable **financial resources from the organisation's own budget** were invested as well.

The implementation strategy that WGK Oost-Vlaanderen is using for the introduction of self-managing teams within the organisation is characterised by its phased approach.

Working with self-managing teams was not introduced with the primary aim of increasing recruitment and retention of staff. At this moment, it is too early to report any results.

3.6 MAKING THE HEALTH WORKPLACE MORE ATTRACTIVE BY IMPROVING FAMILY-FRIENDLY PRACTICES

Case	Description	Country	Intervention type
6.1. *Kindergarten*	General University Hospital Prague	CZ	
6.2. *Kindergarten*	Thomayer Hospital Prague	CZ	
6.3. *Dr DOC programme*	Support for rural doctors	AU	
6.4. *Health and wellbeing programme*	Nottingham University Hospitals	UK	

Education Regulation Financial intervention Professional and personal support Mix/other

Perhaps not surprisingly, the interventions that focus on making the hospital workplace more attractive by improving family-friendly practices are more often situated at organisational level, compared to recruitment and retention interventions on other topics. The interventions face **relatively few barriers in transferring** to different organisational contexts, although the costs involved and impact lag of effects are highly **dependent on the nature of the intervention**. Having a Kindergarten, for example, is expensive and is usually only an option to introduce for fairly large organisations. Having or not having a Kindergarten produces **immediate but short-term effects for individual workers** with children in the appropriate age group. However, continuously running a Kindergarten may have long-term effects for the organisation. Health and well-being programmes for staff, on the other hand, can be **introduced in organisations of any size**, although **economies of scale** should be taken into account. Organisations can for example develop their own programme or 'outsource' parts of the programme (e.g. memberships for fitness schools), depending on their size. The upfront costs are fairly limited and the **effects can be long lasting**. Moreover, measures taken under these programmes can be continued even after the programme itself has ceased to exist.

None of the organisations in our study is monitoring the effects of their family-friendly practices on recruitment and retention of staff. This is mainly related to the **difficulties in establishing a causal link** between a certain intervention and recruitment and retention rates of the larger organisation in which the intervention is embedded.

Example from practice: Dr DOC programme (AU)

The *Dr DOC programme (AU),* instigated in 2000 by the Rural Doctors Workforce Agency (RDWA) in South Australia, is a health and well-being programme for rural GPs. It works across the full spectrum of health care, from prevention through early intervention to acute or chronic situations. Examples include an emergency support line, health check-ups and mental health support.

The programme was developed with **significant input from an individual change champion,** Dr Roger Sexton. At the time he was a practising GP in a rural town in South Australia with an interest in doctors' health. Together with Dr Sexton, the RDWA was able to develop his ideas by supplying basic funding and applying for extra funding. This **strong partnership** was one of the key things that made the Dr DOC programme work in the early stages; having an individual champion, well known and respected in the GP community, who is passionate about the programme and wants to work for it, combined with an **organisation champion**, the RDWA.

The RDWA is funded via a contract with the Commonwealth Government to provide recruitment and retention support so the continued existence of the Dr DOC program also depends on commitment at national policy level. The **costs are relatively limited** though this varies according to what an organisation is doing with the programme, but having a list of GPs doesn't cost an organisation very much.

There are no results available - and there is no monitoring or tracking of the influence that the Dr DOC programme has on retention of rural GPs in South Australia. However, the programme was extensively evaluated. A survey found significant **improvements in the level of feeling of social support** for GPs working in rural practice in South Australia. There were also **decreases in GPs feeling unsupported**, in crisis with no help and GPs feeling that their mental health was suffering.

Example from practice: Health and Wellbeing programme (UK)

The *Nottingham University Hospitals NHS Trust (NUH) Health and Wellbeing programme (UK)* for hospital staff was introduced in 2009. The programme was introduced for several reasons, including the publication of the **Choosing Health White Paper** in the UK and to improve staff satisfaction, recruitment and retention. The programme has multiple aims including improving the physical and emotional wellbeing of staff. It offers a **wide variety of activities**, from weekly fitness classes to quarterly health checks to coping-with-stress workshops. In 2009, a **Health & Wellbeing strategy** was written for Nottingham University Hospitals NHS Trust demonstrating **high-level commitment**. NUH embedded the programme into the organisation through **ongoing funding** of the Health & Wellbeing Coordinator post. While there is no structural operating budget, additional funding for specific activities is sought through various routes, for example the Hospital Charity staff lottery.

Partnership working has been a key success element of the programme. There is a Health & Wellbeing coordinator post and some of the programme activity is delivered in partnership with other departments in the Trust, most notably the Occupational Health nurses. There are also **external partnerships**, for example with Sustrans, a national sustainable transport charity. A health and wellbeing **steering group** was set up to **oversee the implementation of the strategy and action plans**. The group reviews sickness monitoring data, evaluation of programme activities and provides direction.

The programme has established a good profile within the hospital through a robust communications plan.

3.7 RETURN TO PRACTICE FOR HEALTHCARE PROFESSIONALS

Case	Description	Country	Intervention type
7.1. *Return to Practice course*	Northumbria University	UK	
7.2. *Midwifery Refresher Programme*	Mater Misericordiae Mothers' Hospital	AU	
7.3. *Return to Nursing Practice*	Various programmes	IE	
7.4. *Return to practice*	Various measures	MT	
7.5 *Return to Practice course*	Teesside University	UK	

Education Regulation Financial intervention Professional and personal support Mix/other

Return to Practice (RTP) courses can be a helpful tool for organisations in all countries that are facing shortages of particular groups of healthcare professionals, such as nurses or midwives. When establishing a RTP course, a number of crucial factors need to be taken into account. Most RTP courses encompass **educational measures, supported by attractive financial conditions**, to support nurses, midwives and/or health visitors to re-enter their profession. Most of them are **funded by national policy bodies** and are free of charge for participants. Often participants receive additional financial benefits for attending and/or finishing the course. Costs are fixed upfront as most programmes have a maximum capacity. Given the high costs of educating new healthcare professionals, it is likely that the benefits of recruiting former professionals will more than **outweigh the costs of educating new staff**.

Partnership working between educational institutions and clinical placement partners is essential and a clear division of responsibilities contributes to the smooth running of the course. The **important role of mentors** in clinical practice to turn the courses into a success clearly distinguishes RTP courses from the other recruitment and retention interventions in the study. It is important to **ensure that mentors feel rewarded**, especially as they take on this role on a voluntary basis. If financial compensation is not possible, efforts should at least be made to guarantee mentors designated time and a private space on the ward to fulfil their mentoring duties. Finally, as many RTP participants will be (female) adults with family responsibilities, **courses need to be designed in a flexible way** so that they fit participants' other responsibilities in life.

Not all RTP courses are following up their graduates to see whether they have secured employment after finishing the course. If they do so, data quality is often sketchy. However, the *Midwifery Refresher Programme at Mater Hospital (AU)* is considered a

successful recruitment strategy with an **employment rate of approximately 90%** following completion of the programme, and in general there is a high level of satisfaction among participants with the RTP courses.

Example from practice: Midwifery Refresher Programme at Mater Mothers' Hospital (AU)

Despite the implementation of a range of recruitment and retention strategies, the Mater Mothers' Hospital continued to experience an acute shortage of midwives. **Based on a situational analysis**, it became apparent that offering a midwifery refresher programme could be an effective recruitment strategy. To design an effective programme, the Hospital **reviewed midwifery refresher programmes** to identify key elements and issues. In **collaboration with the Australian Catholic University**, a programme with an evidence-based framework, within contemporary midwifery contexts, was developed and in 2002 the first course was run. Resources to develop and implement the Midwifery Refresher Programme were readily available internally at the Mater Mothers' Hospital and through its existing **collaborative partnership** with the Australian Catholic University.

No records have been kept of the precise numbers of attending nurses, but there were approximately 10 midwives in each year that the programme was run. Based on the success of the 2002 venture, the programme was offered again in 2003, 2004 and 2005 and then ceased running as it appeared the market was saturated and there were no further midwives looking to refresh their practice. The programme is considered quite a successful recruitment strategy with an **employment rate of approximately 90%** following completion of it. However, no follow up data was available to determine how long midwifes remained in practice afterwards.

Example from practice: Return To Practice (RTP) course at Northumbria University (UK)

In the late 1980s, the **Department of Health, England, recommended** that all nurses returning to practice after they had been away for three years, should undertake a return to practice programme. After this recommendation and the decision by Northumbria University to establish a RTP course, it found that one of the hospitals in the region (Alnwick Infirmary) had already established such a programme. This **existing programme was used as an inspiration and basis** and then further developed by Northumbria University. Both organisations cooperated on an informal basis of mutual exchange for mutual benefit. Northumbria University provides the RTP Programme **in partnership with local Health Trusts** who provide the placements for students. The curriculum of the course is currently being rewritten on the basis of the national toolkit for the content of RTP courses that has been developed by Health Education England. Funding for the programme is **entirely provided by Health Education North East** (HENE), a regional NHS training body, while uniforms are provided by the University. Northumbria University is **tracking graduates with a questionnaire** to establish if they have secured employment. However, the quality of this data is sketchy. Recent discussions with HENE have identified a possible solution to this. HENE can track the students' employment in local Trusts' employment databases through their Nursing and Midwifery Council PIN (Personal Identification Number) number. It is hoped that in the future this will improve the tracking of employment for those who have completed the RTP programme. In the course evaluation of 2013/2014, there was **good overall satisfaction** with the quality of the programme (average of 4.2 on a scale of 5 – definitely agree –to 1 – definitely disagree).

3.8 PROVIDING SUPPORTIVE WORKING ENVIRONMENTS FOR THE AGEING WORKFORCE

Case	Description	Country	Intervention type
8.1. *PAIME programme*	Promotion and protection of physicians' health	ES	
8.2. *Wir sind älter als 50, na und?*	Health and age management policies Sozial-Holding der Stadt Mönchengladbach	DE	
8.3. Improve the working conditions of the aging workforce	Various measures	IT	
8.4. *Livsfasepolitik* [Life stage policy]	Implementation at Aalborg Hospital	DK	

Education Regulation Financial intervention Professional and personal support Mix/other

Interventions to support the ageing workforce are characterised by their diversity. Yet they also share a number of crucial characteristics. All encompass elements of professional and personal support and all are **built up of multiple measures**, or at least multiple 'options' in supporting the ageing workforce. For example measures focusing on the organisation of work, education/competencies and/or changes in working hours. For interventions aiming to support the ageing workforce, a **fair amount of financial resource** is indispensable. Moreover, the organisational interventions in our study – the *PAIME programme (ES)* and the measures taken by the *Sozial-Holding (DE)* –require a **large organisational framework**.

Measures to support the ageing workforce frequently touch on issues of working conditions and working time. Often, these stand in close relationship with **labour laws and labour conditions** in place. Hence, these factors should be taken into consideration. In principal, however, these sorts of measures can be **useful for organisations of any size**, although the consequences of, for example, having to replace the night shifts for a senior employee may be different for larger organisations (with lots of manpower available for substitution) and smaller organisations. In general, the interventions included under this topic have a medium to long-term impact lag.

Example from practice: PAIME programme (ES)

The *PAIME programme* was established in Spain in 1998 to promote and protect the health of physicians. It is available to medical doctors from all ages, but it is predominantly used by older doctors (> 51 years). PAIME consists of **various tailored clinical programmes**, including, for example, for doctors with mental health problems or addictive disorders. It is run by the 'Colegio de Médicos' (Medical Associations) of each Spanish region and each of them offers a PAIME outpatient service to their registered physicians. The programme is **financially supported by various partners**, including the Colegios de Médicos, the Foundation Board and Social Protection of the

Spanish Medical Colleges Organisation and the health authorities of most Spanish regions.

The *PAIME programme* has **helped more than 3.500 physicians** since its inception. Of the doctors that have been treated by the programme, **close to 90% have recovered** and been rehabilitated back into medicine and retained for medical practice, while it is certain that without the PAIME programme, a substantial percentage of this group would have been forced to leave the profession.

Example from practice: Health and age management policies; Sozial-Holding der Stadt Mönchengladbach

Since the beginning of the 2000s, the *Sozial-Holding der Stadt Mönchengladbach GmbH* has increasingly focused on its ageing workforce and is taking measures to support and retain the workforce in its homes for the elderly. According to the Sozial-Holding, when the ability to work of older employees needs to be maintained, **investments need to be made at an early point in time** in the area of further education, prevention and health promotion. It offers a **variety of measures** to support the ageing workforce, ranging from further education/CPD, to flexible work arrangement to positive images of ageing in the company, among others through the communication of the motto '*Wir sind alter als 50, na und?*' (we are older than 50, so what?). Most of the measures were developed by the *Sozial-Holding* itself. In **implementing the measures, there is cooperation with various partners**, including the Agency for Employment and educational institutions. The measures taken require considerable financial resources, but in the end the Sozial-Holding believes it is **more cost-efficient**.

The *Sozial-Holding* does not gather information on recruitment and retention, but process measures show a high success rate for the individual measures that it has taken. For example, by introducing free mental health support for its employees, the *Sozial-Holding* was able to **halve the number of mental health illness days** since May 2012.

4 SUCCESS FACTORS FOR THE DIFFERENT TYPES OF RECRUITMENT AND RETENTION INTERVENTION

The study identified a number of success factors, which are particularly relevant for specific types of recruitment and retention interventions. Throughout the study, interventions were categorised according to a framework adapted from the WHO's *'Global policy recommendations on increasing access to health workers in remote and rural areas through improved retention'* (World Health Organization, 2010). Below, a number of good practices, based on established success factors with particular relevance for each of the intervention types, are presented.

Education:

- Offer (time for) Continuous Professional Development (CPD), education and research opportunities to professionals as a mechanism for career progression.
- Provide training and job opportunities in healthcare for young people from deprived areas and/or the unemployed, providing mutual benefit for both the beneficiaries and the healthcare sector struggling with staff shortages.
- Make use of the expertise of a commercial marketing or communication agency when implementing promotional campaigns to attract youngsters to healthcare education.
- Designate sufficient time and space to mentors to fulfill the duties of their role in educational interventions.

Regulation:

- Change the scope of practice of healthcare professionals. Allow them to take on more extended roles and enable task substitution to increase the attractiveness of a profession (most applicable to the nursing profession).

Financial incentives:

- Combine financial incentives with other types of recruitment and retention measures, for example educational interventions and opportunities for career progression underpinned by good working environments, as financial incentives on their own are rarely sufficient to improve recruitment and retention.
- Offer financial benefits that are both convincing and attractive when using financial stimuli to attract professionals to underserved areas.

Professional and personal support:

- Create supportive working environments to improve recruitment and retention, preferably tailored to individual employees' life stages (e.g. specific measures for employees with young children, the ageing workforce, etc.)
- Implement activities to support the physical and emotional wellbeing of staff and make protected time available to enable staff to participate in these activities.
- Provide childcare facilities and services to support staff in combining their work and care responsibilities.

Mix/other types of interventions:

- Include measures from different domains in recruitment and retention packages, for example combining education with professional support measures.

4.1 GOOD PRACTICES: CONDITIONS FOR SUCESS

Recruitment and retention interventions are highly context-specific and their features need to be adapted if transferred to different organisations and countries. To support policy makers, health managers and health professionals in decision-making in recruitment and retention, the good practices for successful recruitment and retention interventions have been categorised according to the Knoster model (Knoster, 1991). This model sets out the five necessary elements for successful change to take place. These are: vision, skills incentives, resources and action plan. A change process has to cover all elements for change to take place. If one element is missing, the result is likely to be confusion, anxiety, resistance, frustration or a false start.

Building on the Knoster model we have grouped the different good practices identified through the literature review and case studies as an aide memoire to support the implementation of recruitment and retention interventions. All the good practices are relevant for:

- Recruitment interventions as well as retention interventions
- All categories of recruitment and retention interventions
- All professional groups targeted
- Both 'source' and 'destination' countries

4.2 GOOD PRACTICES FOR SUCCESSFUL RECRUITMENT AND RETENTION INTERVENTIONS

Framework for good practices for Recruitment and Retention interventions	
Vision – essential to avoid confusion	
Obtain political commitment and/or executive commitment	Policy statements, explicit value choices and/or clear objectives can trigger recruitment and retention interventions. At organisational level, executive commitment can prove beneficial in making funds and time available for recruitment and retention interventions.
Identification of main stakeholders	Mobilise stakeholders around a common project and strategy.

Framework for good practices for Recruitment and Retention interventions	
Create a support base for the intervention, from its inception onwards	To achieve this, communication and consultation with all relevant stakeholders is a crucial factor. Several of the cases included in the study showed that involvement of relevant stakeholders at the beginning of an intervention facilitates smooth implementation and uptake of the intervention during later stages. Stakeholders are aware of the intervention, can participate in the decision making process and feel valued. These factors facilitate the processes that will follow.
Communication	Without timely and good communication about interventions with relevant stakeholders and target groups, the potential success rate of an intervention may decrease. There are two main reasons for this: stakeholders may feel left out, resulting in a lack of commitment and secondly, for an intervention to gain traction people first need to be aware of the intervention.
Appropriate framework	Interventions developed at organisational or local level need to take into account the obstacles that regional or national legal and financial frameworks can raise.
Skills – essential to avoid anxiety for change	
Individual change champions	Especially in the developmental phase of interventions, individual champions are of crucial importance. The case studies showed that individual champions share a number of strengths; their passion, their credibility as (former) healthcare professionals and their ability for coalition building and developing a platform to embed the intervention in a wider context.
Institutionalisation of support to health workforce development	To continue a recruitment and retention initiative on a long-term basis, it is important that support to health workforce development is institutionalised.
Sufficient internal technical expertise, supplemented by external professionals when required	Recruitment and retention interventions sometimes hinge heavily on the skills of professionals from other sectors (e.g. promotional campaigns often hire professional marketing/communication agencies for developing the campaign).
Incentives – essential to avoid resistance	
Financial incentives	Financial incentives are important, but their effectiveness is

Framework for good practices for Recruitment and Retention interventions	
	limited if they are not combined with other measures.
Non-financial motivational drivers for change addressing intrinsic motivation	Drivers for change that address the intrinsic motivation of health professionals can play an important role in recruitment and retention interventions, especially when financial incentives are not available or not sufficient. A good example is the motivation of GPs in France to function and work in rural areas in the same way as they would in a big city. The *Pacte Territoire Sante* responds to this by incorporating telemedicine as one of its measures.
Resources – essential to avoid frustration	
Resource management	Time resources need to be thoroughly managed. In the case studies there were examples where too little time was made available (from managerial or policy level) to implement and run interventions. In some cases administrative processes were made too complex and hence time-consuming.
Sufficient financial resources	For most interventions, financial resources are indispensable for making success possible. Almost all cases included in the study received funding to cover start-up costs and kept receiving funding afterwards, sometimes from different sources. Some interventions were functioning sub-optimally because of a lack of financial resources.
Action plan – essential to avoid sense of a never ending treadmill	
Action plan	To have an action plan from the start, including some well-defined targets, ensures a smoother implementation of the intervention.
Incremental process	Pilot experiments can be helpful in preventing problems during later stages of an intervention. An incremental step-by-step implementation allows for subtle adjustments along the way and may prevent bigger problems in later stages.

5 RECOMMENDATIONS TO OPTIMISE IMPACT

The Recommendations are based on a comprehensive review of the literature, eight case studies on recruitment and retention – covering 40 interventions from 21 countries – and two workshops involving experts and stakeholders in the recruitment and retention of health workers as specified by the Tender specifications for this study (EAHC/2013/Health/08). The findings show that recruitment and retention interventions are characterised by their high context specificity and can lack a sound evidence base.

Our study identified a number of success factors and good practices that recurred across many of the interventions in Europe. These recommendations, identify facilitators and barriers for maximising the impact of recruitment and retention interventions.

Most of the recommendations are relevant for recruitment as well as retention interventions whether from 'source' or 'destination' countries.

It is important to emphasise that there is much more helpful detail in the body of the report and its annexes. Policy makers and managers can optimise recruitment and retention results by using these recommendations to design interventions that meet their distinctive, context-specific needs.

5.1 CHOOSING THE RIGHT INTERVENTIONS

The success of recruitment and retention interventions depends to a large extent on partnership working and the fit with local economic, political, legal, cultural and organisational environments. A key challenge is mobilising stakeholders in a collective strategy to generate action. Stakeholder dialogues and consultations can be a useful lever to engage people and begin conversations from an early stage. Dealing with the complexity of healthcare environments can mean that multiple measures need to be taken at the same time, and multi-faceted interventions are more effective than single interventions[3]. In adapting an intervention it is important that a workable trade-off is made to adapt it to the specific requirements of its new legal and financial context.

- Scan the environment and clearly define the problem to be solved before developing an intervention – does the proposed solution fit the context?
- Organise working groups to bring together relevant representatives of governments, social partners and other stakeholders to develop a collective recruitment and retention strategy.
- Develop interventions as coherent packages of measures that cross different sectors such as education, health and employment.
- Design and implement interventions in accordance with the characteristics of the target group (for example medical interns require a different approach than older nurses).
- Look to other sectors to stimulate innovation in recruitment and retention in the healthcare sector.
- Stimulate "out-of-the-box" thinking by supporting interdisciplinary approaches in the design of interventions.
- Blend recruitment and retention measures, and review and adapt this mix over time, depending on the particular setting, time period and early results.

[3] Grol, R., Eccles, M., & Wensing, M. (2005). *Improving patient care: the implementation of change in clinical practice*. Butterworth-Heinemann. Where does this fit?

5.2 IMPLEMENTING RECRUITMENT AND RETENTION INTERVENTIONS

For most recruitment and retention interventions currently, change processes are complex, highly dependent on context and supported by little evidence. In such a dynamic environment small-scale pilot studies can provide valuable lessons. They can serve as living labs providing knowledge and insights about an intervention, its impact on different actors and the likely requirements for organisational and policy measures.

- Offer interventions with enough freedom to allow different actors to select the elements that suit their needs and skills set, but with sufficient structure to ensure that all actors work towards a common goal.
- Design interventions with enough flexibility to be customised to different local contexts within country.
- Use the 'framework of good practices' in the report as an aide memoire to monitor the implementation of interventions.
- Before implementing interventions with little established evidence, conduct a pilot study or small-scale experiment to check, change or enhance the working of the intervention.
- Align regulatory frameworks and policies with organisational priorities and timescales to support organisational adoption.

5.3 MONITORING AND EVALUATING RECRUITMENT AND RETENTION INTERVENTIONS

Too often, recruitment and retention interventions take place as a crisis response to a staff shortage. Perhaps a result of this the vast majority of recruitment and retention interventions do not use an explicit definition of effectiveness and do not propose measurable objectives. This results in a lack of available evidence to judge the success of interventions. While policy and managerial monitoring and evaluation on the basis of the 'framework of good practices' are important, a more robust evidence base to underpin the recruitment and retention of health workers is required. Formal evaluation designs, suitable for complex interventions and allied to long term monitoring, are needed.

- Formulate concrete objectives and time frames for interventions to facilitate monitoring and evaluation.
- Invest in longstanding monitoring systems to establish the long-term effects of a recruitment and retention intervention. Indicators may include: employment status; staff stability index; staff turnover rates; vacancy rates and/or time taken to replace staff; student enrolment numbers and job satisfaction levels.
- Employ multi-method evaluation designs to evaluate interventions and to build a robust evidence base.
- Develop a flexible web-based reporting platform to allow users to filter resources by level (policy, organisational), professional group (nurses, GPs).

5.4 ACTIONS AT EUROPEAN LEVEL ON RECRUITMENT AND RETENTION

The study identified a wealth of learning and inspiration available in Europe on the recruitment and retention of health professionals. Yet European-wide cooperation or knowledge exchange in this area is underdeveloped given the national, local and organizational context. To support learning and cooperation, good practices in recruitment and retention need to be disseminated and shared through different channels and at different levels. EU investment in research and dissemination could help support innovation in health staff recruitment and retention.

- Share Good Practice in the EU through building a European repository of good practices to facilitate, and increase the success of, recruitment and retention in the health sector.

- Promote and disseminate monitoring and evaluation toolkits, including sets of standard indicators that countries can use as a reference for the development of their own strategies.
- Support active cross country learning and dissemination of recruitment and retention good practices.
- Activate existing networks, collaborations and Joint Actions at the European level to involve and mobilise governments, social partners,including the Sectoral Social Dialogue Committee for Hospital Sector, and other relevant stakeholders to 'jump start' recruitment and retention strategies and facilitate cross-border cooperation.
- Promote support for Research & Development in the funding of recruitment and retention interventions, particularly the evaluation of the effectiveness of recruitment and retention interventions and the development of innovative working practices.

6 CONCLUSION

Recruitment and retention is not an abstract challenge: it is an immediate and urgent problem and it is also everyone's problem. As the population in the EU ages, many citizens will either already be patients or are likely to become patients in the near future. All of us have an interest in making sure the lessons of this report are learned, so that, when we seek health care, there are well-trained, well-supported health professionals there to treat us.

This report provides examples of good practice, insights and lessons for the development of policy, organisational strategies and human resource policies from the European Union and European Free Trade Association (EU/EFTA) countries that could help solve the challenge of the recruitment and retention of health staff.

Urgent problem

Ensuring that there are enough health staff, with the right skills in the right places is an urgent problem across and beyond the EU. It is important to see problems in recruitment and retention in context. Shortages of staff highlight areas of weakness in our healthcare systems. These can be unattractive jobs, due to lack of support or poor management, or lack of opportunities for CPD or promotion, through to staffing levels that staff believe are too low to be able to provide safe quality healthcare. All of these factors and more can push staff to move countries or leave the health sector. The recruitment and retention crisis should trigger a sense of urgency and willingness to intervene. Doing nothing has an enormous cost in terms of wasted resources, such as in the loss of highly-qualified professionals. Above all it means that people may not get the quality of healthcare to which they are entitled.

The need for a policy framework underpinned by political support is clear from our study. It is equally clear that there needs to be flexibility in design and implementation of interventions. This does not mean policy makers need to endorse a huge number of different approaches but it requires a recognition that each intervention needs to be adapted to local circumstances. As Management Guru Peter Drucker is credited with saying, 'culture eats strategy for breakfast' and failure to take account of local contexts can jeopardise the success of interventions. The good practices identified within the report will aid both policy makers and organisations in implementing recruitment and retention interventions that will work for them.

Long-term vision

Tackling recruitment and retention requires both short-term action and longer term planning. In times of plenty when there are few staff shortages, work needs to be in place to ensure that there are no future shortages. While crises can foster innovation, recruitment and retention needs to stay on the policy agenda over the long term. The time scales involved in training health professionals mean that it can take up to 5 to 10 years to make an impact on any shortage. Recruitment and retention requires long-term political commitment and room for flexible adjustments along the way.

Include all relevant actors at policy and organisational level

Action to tackle recruitment and retention often requires policy action beyond the Health Ministry. However, which Ministries should be involved depends on the nature of the intervention, the professional group targeted and the local context in which an intervention is developed and implemented. Many interventions focus on education,

which involves the Education Ministry and resources are needed to support work in recruitment and retention and that involves the Ministry of Finance.

The causes of shortages and imbalances of healthcare staff result from a combination of different factors that vary across countries. Many of the solutions need thoughtful action across the system, recognising that a fix in one part of the system may well have an impact on other parts. For example, a successful campaign to recruit more people onto nursing courses can have knock-on effects into an already pressured system. An influx of students puts additional pressure on already busy clinical teams and can militate against every student getting the right level of experience and practice on a clinical placement.

The potential complexity could lead to paralysis. However, the case studies demonstrate that interventions both large and small can work and that a combination of actions across different dimensions has a much higher chance of success than isolated interventions. Establishing opportunities and platforms for formal and informal dialogue with key stakeholders, from the design of an intervention through to implementation, and acknowledging their particular issues can maximise their impact.

Context-sensitivity

While no "one size fits all" solution can be found to problems in recruitment and retention, the good practices outlined in the report highlight the key factors that maximise the chances of success. Success is not just dependent on the intervention itself, but also on other factors, including economic, political, legal, cultural and organisational feasibility - recruitment and retention interventions are highly context-specific.

Influence of management

The implementation of interventions is the greatest challenge. Technical and managerial capacity is a key ingredient in the success or failure of implementation. It is clear from other EC reports such as RN4CAST, the Prometheus project and MOHPROF (all projects funded by the EC under the FP7 research programme) that improving the quality of the everyday working life of staff is just as, if not more, important as paying staff more.

Key to this is the quality of management and leadership that staff experience and yet there is a lack of research evidence to inform management on what is needed for the development of a competent and stable health workforce. Evidence is needed on which managerial and organisational arrangements are more likely to achieve recruitment and retention objectives, what data needs to be available for managers to monitor and anticipate recruitment and retention problems and which competencies managers need.

Need for more evidence

In many countries strategic decisions have been made after reviewing evidence and assessing past experiences. However the study shows that there are still knowledge gaps to be filled. Given the limited amount of rigorous evaluation in recruitment and retention, the need for research to support this work is clear. There is a need for more evaluative research to assess the effectiveness of recruitment and retention interventions. But research to provide tools, definitions and advice on processes is just as much needed.

What the EU can do

There is a huge opportunity for the EU to add value to this area of work. The nature of the challenge, and the need to tailor solutions to different contexts, means that frequently used means of EU wide dissemination such as websites and databases alone are going to be of limited value. The case studies are a rich source of ideas and inspiration, but policy makers, health professionals and managers need to be able to talk to their counterparts in other countries and observe interventions in practice. EU funded learning visits and the development of mentoring and communities of interest would help support the widespread adoption of the approaches found in this report.

The future is now

It is crucial to look to the future as well as considering current problems. What do we want our health systems to do for whom and what kind of health professionals do we want? Inevitably when looking at examples of good practice across the EU, the focus is on the past – on what has been done. However they can help inform this debate and, as the case studies show, there are many examples of what can be done and opportunities to develop the future workforce. This report is an important contribution to the debate.

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8 APPENDIX A: METHODOLOGY

Overview

The study consisted of a review of the evidence of effective measures to recruit and retain health professionals and eight case studies on recruitment and retention interventions.

The review involved an extensive scoping of the peer-reviewed- and grey literature on recruitment and retention of health professionals, and consultation with informants from each of the EU and EFTA countries as well as three non-European countries – Australia, Brazil, and South Africa. The objective was to identify "effective" interventions to improve the recruitment and retention of health workers which can provide lessons and inform policy decisions in EU/EFTA countries.

Based on the literature review, input from country respondents and experts on recruitment and retention, eight topics were selected for the case study research. The case study research offered more insight into a series of recruitment and retention dimensions such as how recruitment and retention interventions are developed and implemented, under which conditions, what the role of various actors is and what facilitators and barriers throughout the process are, at both policy and organisational levels.

Methodology for the literature review

The aim of the review was to identify and categorise measures to improve the recruitment and retention of the health workforce in the EU/EFTA countries and the three other countries. The review was guided by the question: What are the facilitators and obstacles of interventions to improve the recruitment and retention of health workers?

The review identified relevant published literature on policies and practices in EU Member States, EEA/EFTA countries and three non-EU countries (Australia, Brazil, South Africa).

The review and analysis involved 5 steps: (1) planning of the review, including agreement of scope and development of search terms; (2) search of documents meeting selection criteria in reference bases and relevant websites; (3) first screening, based on titles and abstracts, for inclusion in the list of documents for review; (3) second screening, based on reading documents, for final decision on inclusion; (4) data extraction and contents analysis and (5) reporting.

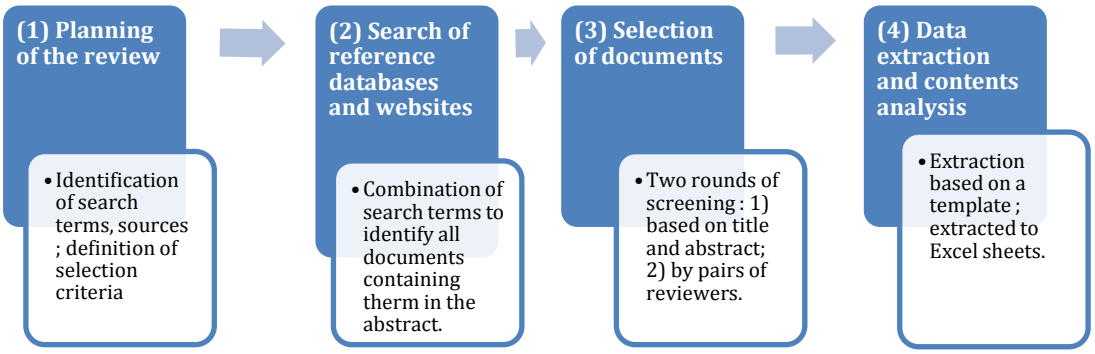
The planning of the review included the definition of inclusion/exclusion criteria, the listing of search terms, and the identification of information sources. Criteria for selection of literature for further analysis were defined by consensus among members of the Consortium. It was agreed to include articles and other documents published since 1993 (since the World Development Report 1993- Investing in Health) to date, in English, French, Portuguese and Spanish. It was also agreed to exclude, at the stage of the first screening, documents whose title or abstracts did not mention recruitment or retention human resources for health intervention/policy/strategy in one or more of the selected countries.

An initial list of search terms was drafted with the inputs of all partners, and using MESH (Medical Subject Headings) terms, the National Library of Medicine's controlled vocabulary used for indexing articles, which is standard practice for a literature search on health related topics. Selected information sources comprised two major databases covering the published literature in the field of health services research: Pubmed and BVS (Biblioteca Vitual em Saúde), which includes literature in Portuguese and Spanish. A selection of relevant websites was also identified for inclusion among sources.

In addition country informants were identified in each of the 35 countries (Appendix 3). They were asked to identify the following: documents on recruitment and retention problems in the country (principally for physicians and nurses) and interventions to improve them; relevant policy documents such as national or organisational strategies, laws, decrees, administrative decisions, etc.; other relevant documents, such as research or administrative and evaluation reports, statements by professional associations and the like and the best sources of data on the health workforce (stock, geographical distribution, etc.) as well as information on how to access them.

The figure below gives an overview of the search and selection process.

Figure 1: Steps of review of published literature



The extensive literature review resulted in 121 studies of which 50% of the studies were primary studies in peer-reviewed journals, 10% reviews and 40% studies reported in the grey literature. About half of all studies were from EU/EFTA countries, half from non-EU countries.

The methodology implied limitations, which were taken into account in discussing the findings. First, there is a language bias in restricting the search to documents published in four languages. Publications in other languages used in the target countries were not retrieved; in fact, they may not always be indexed in the searched databases. This limitation was addressed by using native speakers to identify relevant documents, but time and financial constraints meant that full translation of relevant documents was not possible.

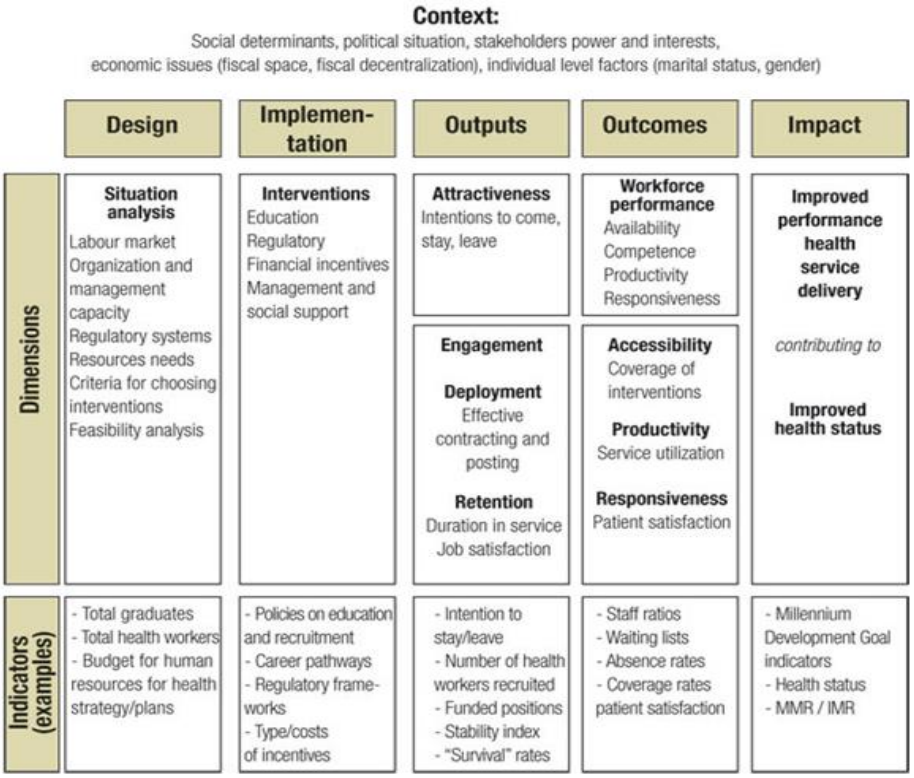
Secondly, although they included description of the interventions, most studies provided little or no information on the implementation process, on the period of the intervention (when it started and ended), on actors involved (who commissioned, who implemented, who evaluated the intervention), or on costs. Since the review was done by desk work, it was not possible to fill in those gaps.

Thirdly, the extensive networks of the Consortium members to select specialised country informants were used. Time constraints meant that it was not possible to set up a procedure to validate the contents or the completeness of the information received for each country. For some countries, in particular more decentralised countries, additional experts were asked to complement the available information.

The analysis in the review was based on a framework, adapted from the one designed to evaluate the impact of the WHO (2010) Global policy recommendations on increasing access to health workers in remote and rural areas through improved retention (Figure

2). These Recommendations were based on an extensive consultation and on a broad review of literature (up to early 2010).

Figure 2: Conceptual framework for measuring efforts to increase access to health workers in underserved areas



(Source: Huicho, L., Dieleman, M., Campbell J., Codjia, L., Balabanova, D., Dussault G., Dolea C., 2010 Increasing access to health workers in underserved areas: A conceptual framework for measuring results, Bulletin of the World Health Organisation, 88 (5) : 358)

Methodology for the case study research

The case studies built on the multi-country literature review by providing an in-depth analysis of how recruitment and retention measures have been implemented. The case study team designed a protocol for preparing and implementing the case studies in advance of actual selection. The protocol included the rationale for case selection, data collection methods and a work plan. This protocol was presented, reviewed and agreed during the first interim meeting with the European Commission.

A pilot case study was conducted to allow for further improvement of the research protocol. During the Expert Meeting in May 2014 a number of themes and selection criteria were discussed, with the pilot study giving insights into what implementation might look like.

In selecting the eight topics for the case studies, a stepwise selection procedure was performed. First, all recruitment and/or retention topics identified in the peer-reviewed and grey literature, in the country reports (WP2/3) and as brought forward by experts were categorised according to the type of intervention:

- education;
- regulation;
- financial incentives;

- professional and personal support
- mix/other types of interventions.

These categories were agreed with the Consortium and European Commission. Secondly, subgroups or topics of interventions were distinguished. So, for example, under the intervention type 'Education', interventions were further grouped under the topic headings attracting young people, CPD etc. This enabled the case study team to decide which topics provided sufficient and promising interventions to explore further in the case studies.

The eight selected topics take approximately the trajectory of a health professional career and are:

1. Attracting young people to healthcare
2. Attracting and retaining GPs to strengthen primary care in underserved areas
3. Providing training, education and research opportunities for a life-long career
4. Attracting nurses through the extension of practice and development of advanced roles
5. Providing good working environments through professional autonomy and worker participation
6. Making the hospital workplace more attractive by improving family-friendly practices
7. Return to practice for healthcare professionals
8. Providing supportive working environments for the ageing workforce

During the Expert Workshop that was conducted in May 2014, experts suggested choosing one overarching theme for all eight case topics. Based on the findings from the literature, country correspondents and experts on recruitment and retention, a clear horizontal theme for the case studies emerged: "Context specific recruitment and retention: matching professional needs and health system priorities". This theme draws attention to the context-specific nature of recruitment and retention interventions, relevant for both source and destination countries, and points out the significance of recruitment and retention interventions in contributing to the sustainability of healthcare systems.

For each of the eight selected topics, case sites in multiple countries were included. Again, a multi-step selection process was applied. A first step in the selection of case sites was to assess the effectiveness and runtime of each of the interventions. Secondly, interventions needed to have high transferability potential, key actors had to be available and the intervention had to be practically feasible (e.g. language issues). In a few cases, interventions were included that had run for a substantial period but did not prove to be effective, as they could also provide valuable learning.

For each of the eight topics, multiple cases from multiple countries were included, resulting in a total of 40 interventions from 21 countries. Data were collected via desk research (n=40), telephone and/or email interviews (n=31) and nine site visits were conducted to obtain more detailed and concrete information.

Data were analysed on the basis of the recruitment and retention dimensions that are the focus of the study (main characteristics of interventions, actors involved, finances, facilitators and barriers and the effects of interventions). The analysis began with within-cases analysis. This involved detailed case study write-ups and individual case reports for all interventions (included as Appendices to this report). The second step in the data analysis process involved cross-case analysis. For each topic, multiple case sites from multiple countries were included. Cross-case analysis was performed by

identifying similarities and differences between the cases within the relevant recruitment and retention dimensions that are the focus of this study.

While this study cannot present an exhaustive overview of all interventions currently taking place across the Member States the findings are a significant contribution to the knowledge base on the recruitment and retention of health professionals.

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2015 EB-02-15-512-EN-C