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Health Management in South-Eastern Europe: challenges and opportunities

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Editors

George Valiotis, European Health Management Association (EHMA)
Anett Ruszanov, European Health Management Association (EHMA)
Zachary Desson, European Health Management Association (EHMA)
Evelyn Donohoe, European Health Management Association (EHMA)
Emmi Weller, European Health Management Association (EHMA)

Contributors

Austeja Tunaityte, European Health Management Association (EHMA)
Federica Margheri, European Health Management Association (EHMA)
Claudia Granaldi, European Health Management Association (EHMA)

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Executive summary

In 2022, the European Health Management Association (EHMA) set up a Special Interest Group[1] on the South-Eastern European region (SIG SEE), with the aim to:

- Identify the main challenges that health care systems in South-Eastern Europe face and collect and share best practices to increase the resilience of these systems.
- Build on the expertise and insights of leading health experts in the region to spark discussions and brainstorm practical steps countries can take to increase health management capacity and capability.
- Support the efforts of the South-Eastern Europe Health Network (SEEHN) and promote collaboration between SEE countries to foster mutual learning and improve the health of citizens through improved health system functioning
- Mobilise relevant local, national, and regional stakeholders around identified priority reforms to transform healthcare systems
- Raise awareness about the challenges and strengths of the SEE healthcare systems and build commitment to address these challenges at the EU level

Corresponding with the nationalities of current SIG SEE members, the following countries make up SEE for the purposes of this report: Albania, Bosnia and Herzegovina, Bulgaria, North Macedonia, Montenegro, Moldova, Romania, and Serbia. This report presents a brief fiche of the health management landscape in each of these countries, based on the results of a rapid literature review. Based on these country fiches and the expertise of SIG members, five themes for improving health management in the region have been identified:

- Governance
- Health workforce management
- Finance
- Digitalisation and data
- Cross-border communication and collaboration

The SIG is committed to mobilising its resources to address the health management challenges that fall under these themes. As a first step, this report presents several good practices from SEE that have the potential to positively transform the health management landscape in the region.

Overall, this report provides the SIG SEE with a foundation on which they can apply their expertise and insights, allowing them to develop practical steps and solutions that countries can take to build upon their existing health management capacity, promote collaboration, mobilise relevant stakeholders, and implement best practices.

The EHMA SIG SEE is committed to continuing this work into 2023.

[1] A temporary group of experts working on a timely topic of high interest for the health management community.

Introduction

The political and economic crisis arising after the collapse of the Soviet communist regime has left a long-lasting legacy in the healthcare systems of countries in **South-Eastern Europe** (SEE).(1) While many of the healthcare systems in the region have since undergone transitional reforms, this shared legacy continues to present both unique challenges and a strong foundation for collaboration between the SEE countries, which for the purposes of this work include Albania, Bosnia and Herzegovina, Bulgaria, North Macedonia, Montenegro, Moldova, Romania, and Serbia – corresponding to the nationalities of the SIG SEE members.

Figure 1. Countries covered by the SIG SEE

At the moment, the **South-Eastern Europe Health Network** (SEEHN) provides the leading example of a collaborative intergovernmental body for health in the region and has been working on broad initiatives for collaboration between countries since its inception in 2001.(2) However, there is space for further regional collaboration on health issues, particularly to address existing challenges related to health management. For this reason, the European Health Management Association (EHMA) has created a SEE Special Interest Group (SIG) to **support health managers** in the region to address these challenges.

Specifically, health managers are struggling to overcome a **chronic 'brain drain'** of their health workforce, which continues to pull skilled health professionals away from the region and into Western Europe, resulting in **workforce shortages**. Progressive privatisation and spending cuts have further deteriorated healthcare systems in some countries, creating a general shortfall in new equipment and medical supplies. In addition to these wider trends, the Covid-19 pandemic has had a considerable impact on health system capacity to the point that many countries in South-Eastern Europe continue to experience difficulties due to **limited infrastructure, lack of bed capacity, limited testing capacity, low vaccination uptake**, and shortages of health care employees.(2)

Purpose of this paper

Broadly, the SIG SEE aims to **strengthen health management capacity** to create more resilient health systems that deliver **excellent quality care** and **improve health outcomes** for the region's citizens. Achieving this aim involves many interrelated activities, including **dissemination of evidence-based practices** in health management, ensuring that these practices are supported by strong policy, creating a forum for health managers **to exchange knowledge**, supporting the **implementation of lessons learnt** from the COVID-19 pandemic, and helping to **meet the training needs** of the health workforce.

As a first step in this work, the SIG SEE requires a **strong understanding of the issues faced by health managers** across the region. This paper aims to provide this understanding through a comprehensive literature review covering the current health management challenges present in each country in the region. Rather than presenting data and statistics on health systems and health outcomes, which is already widely available through national government sources and organisations like the World Health Organization, this review will focus specifically on outlining the landscape for each country specifically from the health management perspective, including **workforce, policy and economic considerations**.

This mapping of the health management landscape in SEE involves an exploration of the available academic and professional literature on health management in the selected countries, allowing for the creation of a 'snapshot' of the situation in each country as well as an identification and preliminary discussion of common trends. To further support this exercise, potential **best practices** for addressing the identified challenges will also be included in this report.

Overall, this report provides the SIG SEE with a foundation on which they can apply their expertise and insights, allowing them to develop practical steps and solutions that countries can take to build upon their existing health management capacity, promote collaboration, mobilise relevant stakeholders, and implement best practices.

1. The health management landscape in SEE: literature review

This section presents a brief fiche for each country represented in the SIG SEE. The country fiches have been developed following a rapid literature review that relied upon a combination of grey literature (government reports, statistics, conference papers), peer-reviewed publications, and practical guidance provided by SIG SEE members. To achieve the most accurate and up-to-date picture, the most recent available sources were included, with critical attention paid to any information published before 2010. The literature search for each country was conducted to find health management information using a range of indicators including the political situation, health system governance, health workforce, and economic situation. The fiches were also reviewed by relevant SIG experts to ensure that they reflect a good approximation of the real health management context in each country.

Country fiches are available below for (in alphabetical order): Albania, Bosnia Hercegovina, Bulgaria, Moldova, Montenegro, North Macedonia, Romania and Serbia.

1.1. Albania

Albania's health system remains in a **period of transition**, with numerous initiatives for reform and modernisation underway. One of the most significant initiatives is the establishment of a more sustainable health financing insurance system, which is to be supported by improved management and administration capacities at all levels of government.(3) Although there is substantial work to be done before all of the planned reforms are implemented, Albania finds itself in a favourable demographic situation compared to its regional neighbours, as it has a much **lower rate of population aging**.(4)

Despite ongoing reforms, many aspects of Albania's health care system remain rooted in the Semashko model[2] developed during the Soviet era. As is typical for systems that developed using this model, this includes **a high level of centralisation**, with the national Ministry of Health exercising a high level of control of regional and local health services, from primary care clinics to hospitals.(5) The legacy of this hierarchical approach to health management remains present to some extent, with many health management roles being filled by doctors or nurses who are provided with **limited management training** and are expected to simply **follow top down instructions**.(5)

In an effort to improve the system's health management capacity, the country's first Master of Public Health was developed and launched in 2001 at the University of Tirana, although further specialised training and education programmes are required to meet the needs of the workforce.(6) As in many SEE countries, a lack of training opportunities is not the only pressing concern with regards to the health workforce. There are **significant inequalities in access to care and quality of care between different regions** in Albania, in large part due to

[2] The Semashko model, named after Nikolai Semashko (a Soviet Union Commissioner for Healthcare), is a single-payer healthcare system where healthcare is free for everyone. In this model, medical services are provided by a hierarchy of state institutions under the oversight of the Health Ministry and are financed from the national budget.

shortages of general practitioners.(7) Geographical coverage for secondary care and specialty services is also highly variable, with only a third of district hospitals able to provide all of the outpatient, hospital, and pharmaceutical services included in the basic national coverage package.(8)

1.2. Bosnia and Herzegovina

Bosnia and Herzegovina contain two main government entities: the Federation of Bosnia and Herzegovina (*Federacija Bosna i Hercegovina*) and the Republika Srpska, as well as the independently administered district of Brčko – over which neither Republika Srpska nor the Federation of Bosnia and Herzegovina have jurisdiction. Each of these entities has its own responsibility for health care financing, management, organisation and provision, resulting in a highly fragmented system with centralised governance in Republika Srpska and decentralised subnational governance in the Federation, with no overarching national mandate.(9) This fragmented decision-making context adds additional complications for health system reform, policy development and workforce strategy.

Unsurprisingly given this context, there is a general lack of integration across services, which is exacerbated by a lack of communication protocols and procedures. This has created a silo effect in many care settings, especially for specialised disciplines; expertise in cardiology is concentrated in Tuzla Canton while oncology expertise is clustered in Sarajevo. Primary health clinics and hospitals also suffer from a lack of cohesive clinical practice guidelines and pathways which could otherwise improve coordination across the health system.(10)

These issues are exacerbated by the lack of a systematic, strategic workforce plan, which contributes to a general scarcity of human resources in health settings, especially in public health and epidemiology contexts. The availability of health professionals also varies greatly between regions, which can affect access to certain services based on geographic location.(11) A lack of training for health managers also contributes to workforce challenges across the country, as many lack training in strategic planning, information management and technology integration.(12)

1.3. Bulgaria

In Bulgaria, post-Semashko health system reform has been hampered by political instability. Successive coalition and minority governments have not had the political capital to implement long-term detailed strategic programs related to health, making health policy vulnerable to special interests. The centralised nature of the health system also gives the Minister of Health significant influence over the system's governance, but between July 2001 and July 2020 the position has been held by 14 different people, further challenging the government's ability to enact meaningful reform.(13)

An example of the type of policy capture by special interests that has occurred in the absence of sustained political stability is the lack of effective control mechanisms on hospital establishment and operation, leading to an oversupply of beds driven by the creation of superfluous private hospitals which nevertheless qualify for funding from the National Health Insurance Fund.(13) The issue of oversupply also extends to pharmaceutical pricing and procurement. Despite several adjustments to the purchasing scheme,

pharmaceuticals and medical goods account for **44% of total health expenditure in Bulgaria**, compared to the EU average of 20%.(14)

1.4. Moldova

Health management culture in Moldova is often **autocratic and top-down**, presenting a barrier to corporate and managerial transformation within the health system. This culture is reinforced by a **high degree of centralisation** that leaves local authorities dependent on higher levels of government for logistical, managerial, and technical support. However, **training in management principles**, **economics** and **finance** for health managers has been well-developed in recent years and is having a positive impact on shifting this systemic legacy. (15, 16)

There is **no functional central mechanism for human resources** planning based on the real health needs of health workers. In 2016, the 2016-2024 **Strategy for the development of human resources in the health system** (17) was approved. However, due to a lack of resources, capabilities and political instability, the needs of health workers have been largely addressed only through **salary increases**. There is also no strategic plan that takes into consideration the needs of health workers in the context of demographic evolutions, educational institution capacity, and population-level shifts in morbidity factors. Combined with the limited ability of local authorities to manage health services in their areas leads to significant **regional inequalities in access to care**, specifically regarding family medicine in rural areas. Chronic emigration of the health workforce remains a challenge that exacerbates this issue.(18)

An interrelated challenge that represents a further burden on the health workforce is the general **lack of health information resources and technology**. The Moldovan health information system has evolved in a fragmented manner under the National Centre of Health Management, and **data currently collected** on health status, care quality and health system performance **do not match the needs of care professionals**, **health managers**, or **decision-makers**, preventing the creation of evidence-based policy initiatives.(18)

1.5. Montenegro

Montenegro's health system governance is **relatively centralised** within the Ministry of Health, with little involvement from local government authorities in healthcare provision and planning. In addition, many **critical health manager positions are filled through political channels**, including the director of the Clinical Centre of Montenegro and the director of the Institute for Public Health.(19)

Montenegro has received substantial amounts of financial aid from the EU and the World Bank, with €15 million earmarked for a 2004 Health System Improvement Project to stabilise health financing and strengthen institutional capacity for health policy, planning, regulation and management to improve care delivery.(20) Further reforms were implemented in 2022, when Montenegro switched to a **fully tax-funded health insurance system**, linking health benefit entitlement to residency rather than a direct payment of premiums. It remains to be seen if this system change will result in improvements to health

system financing, as international observers have already noted concerns about a lack of clarity in its implementation.(21)

Financial challenges have also led to challenges with **workforce retention**, particularly for physicians. The possibility of higher earning potential abroad, a lack of standardised protocols and work standards, and the absence of continuous medical education have all been cited as factors causing an exodus of care professionals. 'Dual practice' is also common in Montenegro, with many care professionals working extra hours in private care settings to supplement their wages from public institutions.(22)

1.6. North Macedonia

The North Macedonian health system is **highly centralised**, with minimal delegation of decision-making or budgetary authority. For the most part, the Ministry of Health and the central Health Insurance Fund are responsible for all policymaking, health system organisation, and monitoring of health system performance.(23)

Reform of primary care remains a priority, with part of this reform aiming to improve the scope of nurses' practice and provide expanded training opportunities.(24) The privatisation of a significant areas of primary care (family medicine, general medicine, primary paediatric and gynaecology specialist services) all working under same conditions implemented by the central Health Insurance Fund, has proven to be very effective, although has had some negative implications. One such implication has been the **fragmentation of primary care services**, which in some cases means that patients need to consult with multiple care professionals before they can receive adequate services. This fragmentation may contribute to a **limited availability of preventative care** such as immunisations and basic diagnostic tests, and difficulties obtaining prescriptions for routine medications like insulin and statins.(24) The management of **prescribing is poorly organised** in some areas, with no logical pattern for covering costs by the Health Insurance Fund, and with **imposed prescribing restrictions for primary care physicians**. The prescribing policy tends to burden the secondary healthcare with unnecessary time-consuming interventions.

Alongside this focus on the health workforce, **health sector wages** in North Macedonia have **grown by 35.51%** over the past decade, significantly more than wages in other sectors of the economy. (25) Despite this, the country continues to face challenges with **recruitment** and **retention** of the health workforce, with shortages of doctors' specialists, patronage nurses [3] and midwives reported. The age of practicing doctors who work in public healthcare institutions is shifting rapidly towards older age groups especially general and family practitioners with limited interest by young doctors to replace them. A contributing factor to these ongoing challenges could be that **professional development and training** for care professionals is largely underfunded. (24) Also, investment in public healthcare infrastructure is needed.

[3] Community nurses and midwives (so-called 'patronage nurses') perform home visits and provide care for new-borns and their families, and also have a role in care for older people in some areas.

One area of the health system that has received significant investment is digital transformation, and the **comprehensive electronic health record system** *MojTermin* is accessible for most care providers.(26)

1.7. Romania

The Romanian health system is **organised at two levels, national** and **district**. The national level is responsible for setting general objectives and the districts are responsible for ensuring service provision that meets these objectives. Despite this division, the system remains **highly centralised**, with the Ministry of Health exerting indirect control over some functions that have technically been devolved to the districts and independent institutions such as the National Authority for Quality Management in Health Care.(27)

The Romanian health system is also struggling to retain its health workforce, given strong incentives for migration to jobs in Western European countries. These retention issues, combined with high levels of migration, complicate efforts to provide basic care services for rural, underserved, and marginalised populations.(28) The widespread practice of **informal payments to physicians** within the Romanian health system may create further complications for workforce management, as these payments can create additional imbalances in access to care.(29) Hospital management is usually filled by medical professionals. (30)

Although extensive data on the functioning of the health system and on population health status are collected, the information systems currently suffer from **a high degree of data fragmentation and duplication**, and the use of existing data to create evidence-based policy remains rare.(27) Issues with data consistency also present a challenge for the integration of health technology assessment (HTA) into the Romanian health system, although HTA capacity building through additional educational opportunities and the establishment of a national HTA body are also important steps towards this goal.(31)

1.8. Serbia

Serbia's health system is characterised by **centralised state governance** alongside a growing private sector. Prior to 2019, the national government transferred ownership of primary care facilities and equipment to local authorities, along with responsibility for the management, capital investment, and development of specific care plans and local public health programmes. Despite this, the Health Care Law passed in 2019 aims to re-centralise the system by transferring ownership back to the national government.(32) Regardless of which level of government has ownership for care institutions, the health system retains the need for patients to have a 'chosen doctor' who acts as their primary care provider and as a gatekeeper to other levels of care.(32)

Serbia has a multisectoral approach that **lacks** a single coordinating governing entity to take overall responsibility for **effective and coordinated health labour market evaluation** and an integrative **health workforce planning, management and development education,** and **deployment**. There is also limited development of a long-term strategy for health. This contributes to a wide variation in accessibility to certain health specialties between regions, which spans from 26% more access to care providers in the best-served region compared

to the national average, to 34% less access in the worst-served region.(33) The lack of attention to the health workforce also directly affects health managers themselves, with 39.5% experiencing high-very high work pressure, 51.2% being dissatisfied with their work, and 23.7% having the intention to leave for a different sector of the economy. These trends are particularly acute among nurse managers, women, and managers in secondary and tertiary care centres.(34)

1.9. Review limitations

While a wide range of resources and research exists about demography, disease prevalence and healthcare systems in the SEE countries, this review was limited by a lack of available resources in English concerning the capacity, strengths, and areas of growth for health management. The SIG confirmed that many management practices are available in unofficial internal documents, but unfortunately the majority of these have not been published or made otherwise available. Considering the lack of available research and evidence related to health management in the region, opportunities for future work may involve developing comprehensive profiles in collaboration with national and local governments, care professionals, and SIG experts.

2. Common challenges to quality and accessibility of care

Following a broad analysis of the SEE country fiches for health management, there appear to be several **common challenges** faced by health managers in their endeavour to improve the quality and accessibility of healthcare. These common challenges represent potential **opportunities for meaningful engagement by the SIG** moving forward with their activities in 2023. The challenges can be clustered under five main themes. These thematic groupings are intended to provide a simplified overview of the core challenges to be addressed but are of course all highly interrelated. In the development of solutions to address any one of these themes, the others should also be considered to identify opportunities for cross-cutting impact.

The common challenges cover governance, health workforce management, finances, digitalisation and data and cross-border communication and collaboration.

2.1. Governance

Many of the health systems in SEE remain in transition to some degree, with the legacy of the Semashko model continuing to impact the way these systems function. Many of these health systems have a highly centralised governance structure, with most **decisions about health service delivery made at the national or regional level**, rather than at the local level where the services are actually being provided. This can make it difficult for health managers to respond to the specific needs and challenges of their communities and can prevent them from implementing locally adapted models of care that could improve service delivery.

Centralised governance can also lead to a **lack of accountability and transparency** in these health systems, as decision-makers may be less accountable to local communities and may not be required to provide regular reports on the performance of the health services they oversee. This lack of local accountability can exacerbate regional **inequalities, increase vulnerability** to system capture by special interests, and negatively impact the data available to health managers, preventing them from identifying and addressing problems related to workforce challenges, care quality, and finance.

2.2. Health workforce management

Many health systems in SEE do not have effective strategies in place to **train, develop, and retain their health workforce**. This can lead to **inadequate staffing** levels and **poor working conditions** as care professionals are asked to work longer hours with fewer resources. Many care professionals in SEE also have relatively **low wages** and limited access to professional development and training opportunities. In combination, these factors create high rates of burnout of care professionals, with many choosing to emigrate and work in health systems in Western Europe.

Overall, health workforce management challenges in SEE can have a negative impact on the **quality and accessibility of healthcare** in the region. Without sufficient numbers of specialised care professionals to meet demand, tertiary care capacity can develop in silos,

leading to regional inequalities in access to different types of care. This environment can also open the door to factors that distort the labour market even further, such as informal payments to care providers and competition for care professionals between the public and private sectors.

2.3. Finances

One of the main challenges for health managers in SEE is that many countries have **limited financing** available for their health systems. This is further complicated by the ongoing transition from Semashko systems of financing towards more market-oriented models in many countries, and the lingering presence of informal payments, poor governance, transparency and accountability in some contexts. Without **adequate training in financial and economic concepts**, health managers may find it difficult to navigate newly implemented health insurance schemes and make cost-effective decisions. Capacity for implementing evidence-based methods of health decision-making is also limited, and tools like health technology assessment (HTA) are not fully integrated into health systems in the region, creating additional barriers to the adoption of sound financial management practices.

2.4. Digitalisation and data – evidence for policymaking

Due in part to health system transition and limited resources, **digital transformation** within health systems in SEE has been inconsistent. Some countries and regions have been able to install modern health data systems while others struggle with fragmented methods and systems for data collection, leading to a general **lack of data interoperability and reporting standards**. At the macro level, this presents challenges for health managers related to performance monitoring, research initiatives and the development of evidence-based policy. At the micro level, this can exacerbate existing health workforce challenges, as data and information systems that may help to reduce the workload of care professionals cannot be implemented effectively due to limited financial resources and a limited capacity to provide the up- and reskilling opportunities required for the introduction of new technologies into care settings.

2.5. Cross-border communication and collaboration

The importance of communication for health management capacity-building in the region is an area of significant relevance. Issues and barriers to communication between countries, experts and professionals present challenges to strengthening the resilience of health systems and impact the perception of managers and leadership at the organisational level.

Outside of the high-level meetings of the SEEHN, there are few formal channels through which health managers in SEE can collaborate across borders, and informal collaboration is complicated by language barriers, health system differences, and variances in population health needs. Communication is also complicated within countries due to political instability, stakeholder ideological differences and inconsistent availability and reliability of technology and infrastructure between regions, particularly in rural or remote areas. These challenges can make it difficult for health managers to effectively communicate across

geographical and professional divides and are exacerbated in many cases by centralised health systems that discourage horizontal integration.

To support all actions to address the challenges identified in this report, formal and informal communication channels between governments, health managers, and care providers in SEE must be established. Effective communication is critical to the sharing of important information and resources, such as public health guidelines and best practices. Access to established communication channels can also facilitate collaboration and coordination between different stakeholders and across borders, while building trust and transparency between governments, health managers, and care providers. This can help to ensure that the public has confidence in the actions of health managers while also supporting them to develop the essential soft skills required for organisational and team management.

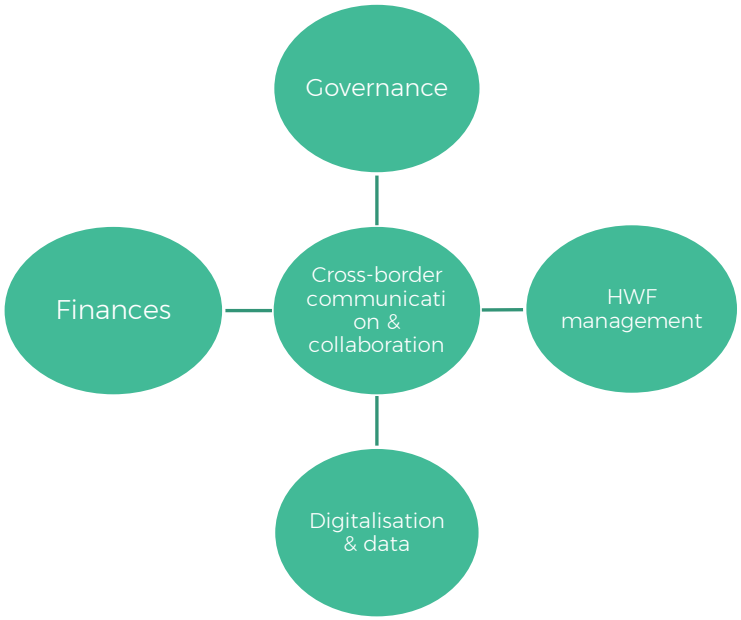

Figure 2. Common health management challenges shared by the SEE countries to quality and accessibility of care

3. Best practices for health management capacity building

This section presents some examples of good practices from SEE that have the potential to address some or all of the identified challenges to improving health management capacity in the region. The examples presented are not meant to be an exhaustive account of all of the good practices that exist in the region, but rather to serve as a starting point for further discussion about the transferability, mutual learning and regional collaboration.

The practices highlighted include some examples of regional collaborative initiatives some individual, country-specific practices, to offer a breadth of perspective about the work that is currently ongoing in SEE. The SIG SEE intends to use these examples as a baseline for considering investment into further research in 2023 and setting priorities for their scope of work in 2023.

Identified practices are grouped below based on the identified thematic challenge areas from this report.

Cross-border communication and collaboration, health workforce management

Mental health and resilience training – Regional Initiative

The Mental Health and Resilience Training for HCWs responding to COVID-19 in SEE Region project developed and implemented by the SEEHN Secretariat aims to support efforts to **improve the well-being of health professionals** by providing deeper knowledge and basic tools and techniques to **build more personal resilience** and, consequently, to **achieve the systemic resilience** that health systems critically need. This project brings together National Focal Points and Mental Health experts from Albania, Bosnia and Herzegovina, Moldova, Montenegro, North Macedonia, Serbia and Kosovo to improve the well-being of health workers. The project is expected to reach up to 8000 healthcare workers in the SEE region with training sessions addressing key concepts of stress, trauma and resilience.

Actions of the project include:

- Involvement of local health authorities and institutions.
- Adaptation of HERO-NY training materials to the local context of target project participants by local mental health experts and local health workers.
- Strengthening the capacity of health workers using HERO-NY adapted material and the Train the Trainers (ToTs) approach to create a group of trainers.
- Providing cascading sessions to other health workers.

Digitalisation and data – evidence for policymaking

Reducing harmful use of alcohol - Moldova

Harmful alcohol use is a major public health concern in Moldova, not only among adults but also among children and adolescents. Alcohol accounts for over half of deaths from liver cirrhosis, half of violent acts, including road traffic accidents, and unintentional injury and a quarter of death from cardiovascular disease. To tackle

the harmful use of alcohol in the country, Evidence-informed Policy Network (EVIPNet) Europe developed and refined an evidence brief for policy, to reduce alcohol consumption with support from the Ministry of Health to establish an intersectoral working group to prepare an evidence brief for policy (EBP).

Following the presentation of the first draft to key stakeholders the focus of the EBP was redirected to specifically advocate for the amendment of alcohol control legislation. Despite, the range of systemic challenges encountered by the group, such as weak capacity of institutions to develop evidence-informed policy, limited reliable local evidence, a lack of cooperation between policymakers and the research community, and slow coordination between ministries, the final brief directly contributed to the Parliament of the Republic of Moldova introducing changes to the alcohol control legislation in September 2017. Beer, which was previously categorised as food, is now legally recognised as an alcohol product.

The work of the team helped the Republic of Moldova build capacity and increase awareness among key stakeholders of the overall importance of and need to strengthen evidence-informed policy related to alcohol consumption in the country. The published EBP is now being used to support policymakers in their endeavours to further strengthen alcohol control policies.

Moj Termin – North Macedonia

In 2011, a health information system, Moj Termin was introduced as a pilot in three tertiary care facilities in North Macedonia. The purpose of this system was to **improve strategic planning, scheduling** and waiting times for clinical appointments and diagnostic tests. Moj Termin is a cloud-based system that is managed centrally. It has several modules that can be integrated with one another and with other health-care applications. These modules include a **digital scheduling** system; an **electronic health record** (EHR); e-referrals; the ordering of laboratory and imaging services; and e-prescriptions.

The use of the system by primary care clinics to schedule all additional secondary/tertiary appointments is mandatory by law. Citizens can access part of their e-health records as a standalone mobile app and through the web. A **telemedicine** platform and **digital vaccination records** were added to ensure maintenance of essential health services during the COVID-19 pandemic. Data collected by the system can provide a summary of the daily activity of providers and providers' capacities. Since its implementation, significant reductions in waiting times for diagnostic imaging and clinical appointments have been recorded.

Health workforce management

Several capacity-building initiatives - Moldova

Despite being one of the poorest countries in Europe, Moldova was one of the first countries to receive **refugees from Ukraine**. To date, it has welcomed the highest number of refugees per capita of any receiving country. In response to this sudden increase in Moldova's population, the School of Public Health Management of the

Republic of Moldova (SPHM) launched several new initiatives including **training and support materials targeting authorities, refugees, and the general population**. Guides such as "The organisation and operation of temporary camps for disaster victims" and "The management of medical staff in crisis situations" were published and disseminated to all the public health authorities within the country.

It is hoped that these publications will inform future health policy decision making in relation to the health outcomes of refugee populations. Additionally, to better manage the new arrivals health needs SPHM in collaboration with the Ministry of Health and with support from the Swiss Agency for Development and Cooperation in July launched a **national training programme for health managers** to manage non-communicable diseases at local level. Training includes representatives from regional local authorities and focuses on supporting multisectoral and intersectoral collaboration within the entire health system.

Finally, a new initiative in the pipeline is the development of a National Health Communication Platform by the SPHM. Using their unique, neutral, position within the health ecosystem SPHM's will use to **platform to facilitate dialogue between all health stakeholders from across the health spectrum**. The goal of this platform is to provide a This platform aims a transparent, professional, apolitical, and equidistant dialogue with all institutions in the public health system to provide decision-making support to managers and health authorities at all levels, including in emergency situations.

Governance

COVID-19 caravan going local – North Macedonia

Just over 40% of North Macedonia's population has been vaccinated with two doses of the COVID-19 vaccine. Identifying the need for a tailor-made approach specific to the needs of local populations for **accessing to COVID-19 vaccines,** the Ministry of Health launched the COVID-19 caravan with support from United States Agency for International Development (USAID), World Health Organization (WHO) and United National Children's Fund (UNICEF). Medical teams, together with Red Cross volunteers and students from medical associations provided local communities with trusted information on the COVID-19 vaccination, including the benefits and risks of delay. Information also shared about the locations and working hours of the nearest health centres where vaccines are available for everyone. Within two weeks of its launch, Caravan staff vaccinated over 200 people vaccinated. In total, the caravan visited a total of 14 urban and rural areas throughout the country and contributed to with health to a **11% increase in daily average vaccinations at healthcare facilities**.

Conclusions and next steps

The preliminary mapping of the health management landscape in South-Eastern Europe conducted in this report highlights several important considerations. It is clear that health managers in SEE countries face a wide range of challenges, from legacies of structural and systemic challenges to more recent developments such as digital transformation. While the literature review conducted for this report represents only a partial picture of the current situation, it has allowed for the identification of thematic challenges, under which future activities for strengthening health management in the region can be organised.

Despite the identified challenges, there is also a considerable **willingness to tackle challenges in SEE health systems**, as evidenced by the good practices highlighted in this report. **Opportunities** exist for health managers to make lasting changes and to positively impact healthcare delivery and population health. However, in the absence of targeted, sustainable investments in the region's health systems, health managers face a difficult road towards effective systemic change.

> Considering health management's role in the development and implementation of strategies, policy, and the roll-out of new programs and initiatives, educational, financial, and structural investment to enhance health management capacity should be prioritised to ensure that health managers can meet the needs of their healthcare organisations and the communities they serve.

To that end, the EHMA SIG SEE is committed to continuing its activities in 2023 and continuing to improve health management capacity in the region.

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