# FROM MANDATE TO MOTIVATION

## TRANSFORMING JUNIOR DOCTORS' RETENTION STRATEGIES IN EUROPE

EUROPEAN JUNIOR DOCTORS

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**EUROPEAN JUNIOR DOCTORS 2024**



# Executive summary

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As Europe faces the consequences of the health workforce crisis, the issue of retaining junior doctors has become critical. This document explores the challenges and strategies surrounding their retention, focusing on involuntary workforce allocation and its implications. It highlights the growing use of these measures to address staffing shortages in underserved areas, also known as medical deserts. The report examines the trade-offs between compulsory service and incentive-based approaches, advocating for a shift from forced allocation to motivational strategies.

- **What do we define as involuntary workforce allocation? It is an umbrella term which tries to encapsulate a set of mandatory locational workforce retention initiatives. These are instances where a doctor or student is compelled to be employed in a designated location typically under threat of penalties or loss of remuneration.**
- **Legal considerations**: The document discusses conflicts with European Union directives on professional qualifications and citizens' rights. It calls for adherence to these regulations and the avoidance of punitive measures against junior doctors who choose not to comply with compulsory service.
- **Ethical standpoint:** Forcing junior doctors to work in specific locations undermines their autonomy, limiting their ability to make decisions about their professional paths and personal lives. This practice can lead to feelings of resentment and dissatisfaction, negatively impacting their performance and patient care.
- **Strategies to increase retention**: Less favorable practices include mandatory rural service and compulsory public sector employment post-training, which can impose hefty penalties for non-compliance. Best practices involve financial incentives, improved working conditions, and supervised clinical placements in rural areas to attract and retain medical talent voluntarily.

**Recommendations**: **Involuntary allocation strategies which aim at improving workforce shortages may inadvertently aggravate those shortages by promoting distress and dissatisfaction.** Prioritise long-term planning and investment in medical education and training. Create positive and appealing incentives for work in underserved areas, such as higher salaries and better working conditions. Avoid compromising the quality of medical education and training due to workforce planning needs.

**Conclusion**: The report advocates for a shift from mandate-based strategies to motivation-driven approaches that respect the autonomy and career aspirations of junior doctors while effectively addressing the healthcare needs of underserved populations in Europe.

# CHAPTER 1

# Medical workforce challenges and involuntary workforce allocation in Europe

# 1- Introduction

Europe faces a growing problem of healthcare workforce attrition, making it increasingly difficult to retain healthcare professionals, especially doctors. This has contributed, among other issues, to the phenomenon of medical desertification[1], creating critical public health challenges. The European Commission estimates a current shortage of 1 million health workers[2], and the World Health Organisation underscores the urgent need for strategies to retain healthcare workers in Europe[3]. Despite efforts by the European Union (EU) and Member States to ensure universal health coverage while addressing these shortages, challenges with workforce retention persist.

The European Junior Doctors Association (EJD) is concerned by the recent debate and increasing trend of measures aimed at forcibly allocating junior doctors and medical students to underserved areas. **The term involuntary workforce allocation refers to a range of mandatory locational workforce retention initiatives implemented by various healthcare systems. These initiatives compel junior doctors and medical students to work in designated, often underserved and remote areas, far from their preferred places of residence. During Post-Graduate Training (PGT), allocation is frequently justified under the pretext of training, although it often lacks adequate supervision. Non-compliance with these mandates can result in penalties or the loss of remuneration.**

Based on the results published in EJD's report "From tradition to transition: Navigating through the health workforce crisis" we aim at expanding our knowledge on involuntary workforce allocation. In relation to the phenomenon we strongly advocate against the forced allocation of personnel as a solution for workforce shortages. **Based on the available**

[1] Medical deserts are areas where population healthcare needs are unmet partially or totally due to lack of adequate access or improper quality of healthcare services caused by (i) insufficient human resources in health or (ii) facilities, (iii) long waiting times, (iv) disproportionate high costs of services or (v) other socio-cultural barriers

[2] Health-EU newsletter 250

[3] Framework for action on the health and care workforce in the WHO European Region 2023–2030

**literature and the reports from our national medical associations it is clear that involuntary allocation contribute to reduced job satisfaction and a negative work experience, which can result in job abandonment which could further aggravate the problem these measures aim to reduce.**[4] Moreover, some of these initiatives could fall under International Labour Organisation definition of forced labour[5] (Forced Labour Convention, 1930, No. 29): *all work or service which is exacted from any person under the threat of a penalty and for which the person has not offered himself or herself voluntarily*.

This document aims to explore the problems associated with involuntary workforce allocation and its connection to medical deserts within the healthcare sector, particularly focusing on junior doctors. It seeks to dissect the intricate balance between the need for effective healthcare distribution and the well-being of healthcare professionals subjected to such reassignments. In this regard, it will showcase a spectrum of initiatives, both positive and negative, that have been implemented to address these challenges. In this regard, this comprehensive approach aims not only to highlight the pressing issues but also to spur dialogue and action towards sustainable solutions that prioritise both healthcare accessibility and the professional satisfaction of the workforce.

[4] European Junior Doctors 2023. From Tradition to transition. Navigating trough the health workforce crisis.

[5] International Labour Organisation's definition of forced Labour.

# 2- Current scenarios of involuntary allocation

Throughout the continuum of medical education, including both undergraduate and postgraduate training, we have identified instances of involuntary allocation. These instances reflect a concerted effort to address healthcare disparities, particularly in underserved areas.

### During Higher Education

In certain countries, such as Germany, there are specific programs where acceptance into a higher education institution is contingent upon the applicant's commitment to serve in an underserved area. This early-stage intervention aims to direct upcoming healthcare professionals towards regions most in need, even before their formal medical training commences. In Austria, some undergraduate medical students are required to work in underserved areas during their medical studies, specifically during the Clinical Practical Year (KPJ). Additionally, some federal states in Austria offer scholarships or study places to applicants for medical studies if they commit to working in the public healthcare system. Some medical schools throughout Europe have mandatory rotations in rural areas during undergraduate training.

### During Postgraduate Training (PGT)

Involuntary workforce allocation during PGT manifests in several forms:

- **Based on a service delivery rationale**: In this scenario, allocation is driven by immediate healthcare needs, occasionally at the expense of the quality and outcomes of the training provided. This approach prioritises addressing urgent staffing shortages over the educational needs of the trainees and raises concerns about the quality of healthcare that patients will receive in the future.
- **Foundation years in medical deserts**: Establishing foundation years specifically in medical deserts aims to immerse trainees in high-need environments. However, these placements are often not based on attaining competencies or an educational rationale, potentially compromising the standard of training received.
- **Mandatory placements in underserved areas**: In the latter stages of PGT, some initiatives mandate placements in underserved areas. While these are intended to provide future doctors with experience in diverse

settings, they often follow a service delivery rationale rather than an educational one, potentially affecting the quality of training and overall educational experience.

**After completing the specialization (early-career specialists)**

After completing their postgraduate training, early-career specialists often face contractual obligations as measures of forced retention, requiring them to remain and work in a designated area or specific segment of healthcare for an established period of time. This phase creates a scenario where the specialist's ability to advance in their career or specialize further is tied to their service in underserved regions, potentially leading to a different career path than they might have chosen independently. In countries like Croatia, Latvia, and Slovenia, there are mandates that bind specialists to work in the public healthcare system for up to six years following government-funded postgraduate training. Non-compliance with these mandates can result in junior doctors being required to pay a fine.

These involuntary allocation initiatives, spanning from higher education to the early stages of a doctor's professional career, reveal a mandate based approach to mitigating healthcare workforce shortages. However, they also raise important considerations regarding the impact on training quality, personal choices, and career development of healthcare professionals.

# 3 - Measures to improve retention and tackle workforce shortages

## SUBSTANDARD PRACTICES

### Undergraduate Level

- **Work in underserved areas:** In some medical schools throughout Europe, undergraduate students are required to work in underserved areas. This practice can be substandard when implemented without proper planning and resources, and solely aimed at addressing staffing shortages. Underserved areas frequently lack qualified teachers, further compromising the educational experience. Such initiatives require adequate support and well-structured programs. If not implemented properly, they may fail to provide the necessary educational benefits and could undermine the quality of training and patient care.

### During Postgraduate Training

- **Compulsory rural service:** There are initiatives that mandate service in rural areas, often involving sending junior doctors to understaffed hospitals and clinics. These measures aim to address immediate staffing needs but can place significant strain on the trainees and potentially compromise both their education and personal safety. In Turkey, this practice extends to sending trainees to war zones.
- **ER Department work requirement:** Initiatives for ER department exposure during training regardless of speciality or training outcomes to cover for personnel shortages.

### After Postgraduate Training

- **Mandatory public service:** In Croatia, Latvia, and Slovenia, mandatory employment in the public health care system is required for up to six years after the completion of government funded postgraduate training. Failure to comply may lead to a fine which is justified under the pretext of *training and administrative costs* from junior doctors, amounting to up to €5,000-10.000€ per year of training.

## BEST PRACTICES

### Undergraduate Level

- **Sponsor a designated number of medical student positions to incentivise work in underserved regions.** Some medical schools across Europe, such as those in Ireland, Norway, and the United Kingdom, have developed specialized programs that are carefully structured and supported to ensure students receive a high-quality education and making a positive impact in areas with critical healthcare needs.

### During Postgraduate Training

- **Financial Incentives**: Better salary or one-time starting allowance for those who work in underserved areas (Czech Republic, Finland, Latvia).
- **Training-focused supervised rural placements**: An initiative of rotations focusing on effective supervision in underserved areas (Estonia, Hungary, Portugal, the United Kingdom).
- **Diverse hospital choice**: An initiative with varied hospital selections during PGT for a trainee to choose from (Lithuania).
- **Improved labour contracts**: An initiative for better working conditions in underserved areas (Spain).
- **Underserved area prioritisation for better opportunities**: An emphasis on promoting internships and PGT in these areas (Sweden).

### After Postgraduate Training

- **Employment Incentives**: some regions in Spain have introduced initiatives to incentivise junior doctors to remain in underserved areas, enhancing their attractiveness (i.e. long term contracts, flexible working schemes). The United Kingdom offers financial incentives to encourage taking up GP posts in less populated areas. Estonia has a financial incentive in the form of a one-time payment for specialists who decide to start work in a rural area after PGT and stay there for at least 5 years.
- **Financial incentives:** The United Kingdom offers financial incentives to encourage taking up general practitioner posts in less popular areas. Estonia has a financial incentive in the form of a one-time payment for specialists who decide to start work in a rural area after PGT and stay there for at least 5 years. Financial incentives in Lithuania include one-time payments, increased salaries, and reimbursements for travel costs and accommodation in rural areas.

- **Working conditions and social support:** Improvements in Lithuania include flexible working hours, additional holidays, support for research or voluntary work, assistance for young families in finding good educational opportunities for their children in remote areas. Spain introduces multiple initiatives to incentivise junior doctors to remain in underserved areas, enhancing their attractiveness.
- **Mentorship and career opportunities**: Mentorship programs and career advancement pathways are tailored to attract and retain young doctors in rural areas. In Lithuania, junior doctors are attracted to rural areas by opportunities for early career advancement and the encouragement to improve the quality of care, particularly in managerial roles. Additionally, the provision of time and financial support for continuous education further enhances the appeal for young specialists to work in these regions.

# 4 - Involuntary workforce allocation and legal implications

Involuntary workforce allocation of a worker has a significant **impact on their personal life and work-life balance**. Such interventions create additional stress, conflicts in personal life and family planning, and reduce workplace satisfaction. Many of the aforementioned initiatives prioritise the involuntary relocation of doctors to address medical workforce shortages, rather than implementing proactive measures to attract and retain professionals in underserved areas. Similarly, involuntary relocation of medical students during their undergraduate training has also been described.

Involuntary relocation of junior doctors in the EU includes sending them to underserved areas and medical deserts during foundation years before postgraduate training, potentially compromising the quality of education. Additionally, some countries also allocate junior doctors during their training, disregarding its impact on their personal lives and professional autonomy.

Furthermore, certain EU Member States have implemented initiatives where **involuntary allocation is a possibility up to five years after postgraduate training once a doctor has achieved the status of specialist.** In these scenarios failure to comply could result in fines for junior doctors. Such measures effectively sanction doctors for exercising their right to move and reside freely within the EU, which contravenes The Citizens' Rights Directive 2004/38/EC and the principles of the Recognition of Professional Qualifications (RPQ) Directive 2005/36/EC. The RPQ directive facilitates the free movement and professional mobility of workers within the EU, aiming to remove barriers that impede their ability to choose their place of work and residence.

In certain European countries, regulations mandate compulsory employment or specific contracts for medical graduates and early-career specialists after postgraduate training. While others offer reimbursement systems for non-compliance with these requirements. Countries with enforced work allocation vary in legal authority, with some governed by national laws (Croatia, Latvia, Slovenia), local governance (the UK), or educational institutions (Greece). In Germany and Italy, individual contracts

following postgraduate training can determine a junior doctor's placement after the certification exam, given variations in certifications across regions. In Croatia, Latvia, and Slovenia, national laws require junior doctors to work in their specialised field within the public health care system for up to six years after completing their training.

The principle of proportionality, fundamental to EU law, mandates that measures by Member States must be appropriate, necessary, and not excessively burdensome. Involuntary allocation, especially when coupled with sanctions such as fines for specialists, is a disproportionate measure, restricting professionals' freedom and failing to be the least restrictive means to address workforce shortages. **These penalties place specialists at a disadvantage by limiting their mobility and career opportunities, a restriction that is uncommon in the majority of other countries where such fines do not exist.**

Moreover, the RPQ directive emphasises non-discrimination in accessing employment, ensuring consistent and high standards of professional practice across the EU. Involuntary allocation can disproportionately affect professionals from other Member States, creating indirect discrimination and potentially compromising the quality of education and professional practice by placing junior doctors in less resourced areas without adequate support.

By undermining professional autonomy and disrupting career planning and development, involuntary allocation contradicts the directive's goals of supporting professional development and autonomy. It hinders the pursuit of specialised training and continuous professional development, essential for maintaining high professional standards.

Legal interpretations and European Court of Justice rulings consistently support the free movement of professionals and the recognition of qualifications across Member States. Inconsistencies in the implementation of involuntary allocation across Member States undermine the harmonisation goals of the RPQ directive, highlighting the need for a more balanced and compliant approach to addressing medical workforce shortages.

# 5 - Recommendations

- Governments should focus on long-term strategic planning to address workforce shortages in the healthcare sector, including investing in training programs, expanding medical education opportunities, and creating positive incentives for professionals to work in underserved areas.
- Each European country should create as many medical study places as needed to cover its own demand, in order to avoid *brain drain* effects from other countries and to comply with the Ethical recruitment standards of WHO's Global Code of Practice on the International Recruitment of Health Personnel.
- European countries should adhere to the EU directive (2004/38/EC) on the right of citizens and their families to move and reside freely within the EU.
- Solutions for medical desertification cannot compromise the education and training of junior doctors, as well the quality of care provided for patients.
- Forcing specialist to stay in the region they did their PGT subject to fines to compel postgraduate trainees to address medical workforce gaps can exacerbate inequalities and must be avoided.
- Junior doctors, regardless of their training level, must not face sanctions for exercising their rights and prioritising their personal lives.
- Initiatives should be monitored, their effectiveness evaluated on a regular basis and results of the evaluations should be publicly available.
- Transparency and communication between stakeholders, including junior doctors, regarding workforce policies and expectations are crucial for maintaining a supportive and sustainable healthcare system.
- Implement financial incentives such as higher salaries for junior doctors who choose to work in underserved areas to attract and retain talent.
- Develop incentives which include improved working environments to encourage junior doctors to start their careers in underserved areas.

# Chapter 2.
# Country case studies

# CROATIA

The introduction of the **new Law on Healthcare in Croatia** marks a significant milestone in the country's healthcare system. With the law being in place since April 2, 2024, a comprehensive framework has been established to regulate medical residencies in a more transparent and standardised manner. Under the provisions outlined in the law, medical doctors are now permitted to take the European specialty exam from the European Union of Medical Specialists (UEMS), aligning Croatia's healthcare standards with international practices. Furthermore, the law stipulates that medical professionals must complete their entire medical residency program, with competencies confirmed by a chief mentor. **This emphasis on mentorship ensures that aspiring specialists receive proper guidance and support throughout their training.**

One of the key aspects addressed in the law is the contractual relationship between healthcare workers and their employers. Notably, **the law prohibits healthcare institutions, particularly those established by the national or regional government, from imposing additional financial obligations on residents and specialists beyond what is legally prescribed.** This measure aims to protect the rights and well-being of medical professionals, preventing exploitative practices that may hinder their career advancement or personal growth.

Additionally, the law introduces a structured process for residents seeking to terminate their contracts and transition to a new healthcare facility. In these instances, Ministry approval is required, and strict criteria are considered to ensure that the resident's specialised skills align with the needs of the new healthcare institution. Provisions are also in place for reimbursement of specialisation costs, emphasizing financial transparency and accountability within the system. **A fine ranging from 660 to 1,320 euros will be imposed on the director of a healthcare facility for violations, such as concluding a contract with a resident that contradicts the provisions governing residency expenses.**

Article 191 outlines the detailed breakdown of specialisation costs, including expenses related to mentors, healthcare facilities, and final exams, setting clear guidelines on financial responsibilities and funding allocation. Ultimately, the law's meticulous approach to residency regulation, coupled with stringent penalties for violations, underscores the Croatian government's commitment to fostering a fair, supportive, and high-quality healthcare system for both practitioners and patients alike.

# GREECE

The **Greek Ministry of Health**, aiming to upgrade the clinical education received by medical graduates, introduced a reform of the compulsory rural service for PGT trainees. This reform entails a **preliminary clinical practice of six months in a secondary or tertiary regional hospital, followed by the six-month compulsory rural service,** effectively introducing a foundation year for medical graduates before entering PGT programs[6]. This change was first announced in 2021 and is still undergoing a pilot phase, however **without a clear plan on the logistics or the timeline** of implementation and no clear provisions for the compensation/salaries of junior doctors within the foundation year. This reform, although supported by the Panhellenic Medical Association (PhMA), has not been well received by Greek trainees due to its many inconsistencies.

In both February and April of 2023, new legal provisions[7] were enacted delineating the curriculum and logistics for the pilot phase implementation (ministerial decrees Γ5α/Γ.Π. 11606/2023 and Γ5α/Γ.Π. 19246/2023) nationwide. Among its provisions is the **introduction of an official Trainee Logbook, serving as both a curriculum adjunct and assessment tool**. Regarding the legal status and responsibilities of PGT trainees during the foundation year, it stipulates similarities to those of resident doctors in specialty training. Their salary will mirror that previously provided to compulsory rural service doctors (€1160 gross). This awaited legislation since 2021 has been warmly received by both the Panhellenic Medical Association (PhMA) and PGT trainees.

[6] https://www.in.gr/2021/11/25/greece/ti-einai-foundation-year-giati-antidroun-giatroi-kai-foitites-iatrikis/

[7] https://www.kodiko.gr/nomothesia/document/863486/yp.-apofasi-g5a-g.p.oik.11606-2023

# LATVIA

In **Latvia**, PGT is overseen by the Ministry of Health and is primarily government-funded, although there are also privately funded positions available. While there are more government-funded positions available, there are legal requirements for doctors who choose this option. Upon graduation, **junior doctors must commit to working full-time in a government or municipality hospital for up to three years within a five-year period**. **Failure to comply results in sanctions** imposed by the Ministry of Health, with administrative costs of approximately 5000 EUR per year of training. Recently, changes to the law[8] have allowed for PhD studies and work in other government healthcare institutions. This strict system has been identified by junior doctors as a contributing factor to why many choose to migrate to other countries within the European Union. Notably, privately funded positions disrupt the state's healthcare workforce planning by providing unrestrictive opportunities to choose any specialty, thereby creating disparities in career paths and increasing inequalities.

[8] https://likumi.lv/ta/id/235421-rezidentu-uznemsanas-sadales-un-rezidenturas-finansesanas-kartiba

# LITHUANIA

Starting from January 26, 2023, **Lithuania** revised the implementation of PGT by introducing a new provision requiring a portion of residency to be completed in non-university hospitals or clinics. **The minimum duration for PGT training in these settings will gradually increase from 15 percent to 35 percent of the total PGT duration between 2023 and 2027**. This requirement, however, does not apply to specific PGT programs like genetics, clinical toxicology, laboratory medicine, neurosurgery, cardiac surgery, and cardiac and thoracic surgery. **Residents can choose the medical facility where they complete part of their training, and this change is seen as a positive step to address the shortage and uneven distribution of medical professionals in Lithuania**.

PGT in Lithuania can be state-funded or self-funded. For self-funded spots, regional hospitals or clinics in need of specialists often cover the residency costs, with the resident agreeing to work there for several years in return. After completing PGT, junior doctors are not required to work in remote areas or the public sector, although such proposals occasionally surface. Instead, motivational incentives are used to attract and retain junior doctors.

These include financial incentives like one-time payments, increased salaries, and reimbursements for travel and accommodation in underserved areas.Moreover, improvements in working conditions, such as flexible hours, additional holidays, support for research or voluntary work, and assistance in finding good educational opportunities for doctors' children, make these positions more appealing. **Opportunities for early career advancement and continuous education support further enhance the attractiveness of working in rural areas for young specialists.**

# PORTUGAL

In **Portugal**, addressing the challenges posed by medical deserts and involuntary workforce relocation has led to the implementation of various strategic measures aimed at improving healthcare accessibility and retention in underserved areas. Initiatives such as the Medical Service in Peripheral Areas program, which began in 1975, incorporated mandatory service years in remote locations into the career paths of medical professionals. This encouraged the provision of essential health services in the country's peripheries. The program played a crucial role until the establishment of the National Health Service (NHS) in 1979, which integrated primary healthcare. Recently, discussions have been ongoing regarding strategies for enforced retention in the NHS following specialised training, but these are yet to be put into action. The rationale behind this is to ensure a return on the public investment made in medical education and post-graduate training. One of the strategies implemented to tackle medical deserts and healthcare workforce shortages was the utilisation of contracts for service provision, particularly in emergency services. However, this has raised concerns about the qualifications and pay conditions of contracted doctors. Furthermore, **geographical areas identified as deprived are being targeted with national and municipal incentives for mobility. These include significant salary boosts, additional vacation days, and local benefits such as financial aids and subsidies. All these measures are designed to attract and retain medical professionals in these critical regions** (Decree-Law No. 15/2017, enacted on January 27th). The legislation prioritises spouses or partners in de facto unions in cases of equal ranking in candidate selection. Additionally, it **offers financial incentives, sometimes amounting to 40% of the base salary for the initial remunerative position within the medical career.**

# ROMANIA

In **Romania,** junior doctors are confronted with a challenging decision after successfully passing the National Residency Exam. **They have the option to choose between enrolling in a residency program, which offers them temporary employment for the duration of their residency, or pursuing a highly competitive post that ensures a permanent position after their residency concludes.** Unfortunately, these permanent posts are exceedingly rare, with less than 10% of residents securing such positions. This scarcity reflects the intense competition and extremely limited availability of long-term employment opportunities in the Romanian healthcare system. The situation places significant pressure on junior doctors to not only excel in their immediate medical training but also to strategically plan and position themselves in the few available permanent roles. Success in securing these positions requires foresight, meticulous preparation, and often, a degree of professional networking to navigate the highly competitive landscape of Romania's medical employment market. To make matters more difficult, the remaining 90% of the residents, upon graduation, cannot apply for a job in a public hospital or clinic because most of the positions are taken. They now have two options: either start their practice in a private hospital or begin another residency program in the hope that one day they will be able to work in the Public Hospital Network.

# SLOVENIA

In **Slovenia**, PGT for doctors is governed by the Medical Services Act and is primarily funded by the government, although some privately funded positions exist. PGT positions are categorised into two types: national and institution-specific. **Doctors completing government-funded training must work in the public health care system for a period equivalent to their training duration** (four to six years depending on the specialty). For national positions, they can work at any public institution with vacancies, while institution-specific positions require employment at the designated institution unless no positions are available. **Failure to meet these conditions necessitates reimbursement to the government, which can be up to 30,000 EUR.** Recently, the government has focused on opening positions for specific institutions to better plan public health networks, despite a lack of incentives for young doctors in underserved areas. The Slovene Medical Chamber and junior doctors advocate for more national positions and positive incentives to retain doctors. Additionally, **since 2021, those in family medicine PGT receive financial incentives but face longer mandatory service periods in the public system or penalties for non-compliance.** Despite potential reimbursements, many doctors still leave for better opportunities in the private sector or abroad.

# SPAIN

In response to the growing challenge of medical deserts, **Spain** has implemented comprehensive measures to attract and retain healthcare professionals in underserved areas. The 'Desiertos Médicos en España' report[9], developed by the Junior Doctors' Section of the Spanish General Medical Council (CGCOM) in 2023, highlights these efforts. To make underserved areas more appealing to junior doctors, the Spanish and regional governments have introduced a range of initiatives. These include **improved labour contracts with competitive salaries and benefits in rural and remote regions and specialised training opportunities in rural medicine**. Furthermore, there has been an **emphasis on mentorship programs and career advancement pathways** tailored to attract and retain young doctors in these areas. **The report emphasises the importance of creating sustainable solutions that not only address immediate workforce shortages but also contribute to the long-term stability and effectiveness of healthcare services across Spain**, thereby mitigating the issue of medical deserts and ensuring equitable healthcare access for all citizens.

[9] Desiertos Médicos en España. Domingo A. Sánchez et al. (2023). Consejo General Colegios Oficiales de Médicos. España. link: https://www.cgcom.es/media/4625/download

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