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International
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Health Care Management Competencies

- Global Accreditation: Why the CAHME Model is Important in Healthcare Management Education
- Credentialing for Healthcare Executives: Advancing the Profession through the FACHE Credential
- The Case for Healthcare Leader Competencies: Exploring the Evidence
- Emerging Roles in Healthcare: a New Approach Based on Managing Competencies
- Competencies of Hospital Managers: Iran's Case Study
- Public-Private Partnerships (PPPs) in Healthcare: Gauging Leadership Competencies of Hospital Managers
- The Competency-Based Management Model as a Springboard for Transformation in Health Care and Social Care Organisations
- CBEXs Futuro - Brazilian Program for International Leadership in Health
- Competencies for Future Healthcare Managers in Europe (FHME)

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Health Care Management Competencies

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The articles in this issue of the World Hospitals and Health Services (WHHS) Journal of the International Hospital Federation (IHF) showcase recent trends in competencies in health care management training and accreditation programs.

There was a time when the vaunted qualifications of hospital directors were to be respected clinicians well-liked by their peers (few women made it into this select and exclusive club). Usually, Physician-Directors continued with clinical practice, maintained their dual function as medical directors and spent little time on their management duties. They relied on their administrative staff to manage the hospital or health services for which they were responsible– department heads, director of finance, facilities manager, head nurse and others. These leaders were also often politically active, splitting their medical and management duties with political careers as community leaders and even as members of parliament and national political leaders. Invariably, their health care management duties were often neglected.

Those times are over. In most OECD countries, having a medical license and clinical training as a specialist alone is no longer considered an acceptable qualification to be a health care or hospital manager, although remnants of the old system are still seen throughout the world, especially in developing countries.

As highlighted in the lead article on the "Commission on Accreditation of Health Management Education (CAHME)", health care management today is an independent professional tract that usually requires a Master's degree or even a PhD in a related discipline.

Health care management today has evolved into a "hybrid discipline" where training is provided by a diverse range of institutions, such as public health programs, MBA programs, financial institutions and others.

This has led to the need for a framework that will assess which institutions, programs, teachers and students meet certain criteria in terms of performing their health care management duties. This being a nascent field, countries, training institutions and health care providers have approached it differently, which has led to a lack of clarity in setting minimal "acceptable" standards as well as "best practice" gold standards.

The Commission on Accreditation of Health Management Education is one among many organizations that have tried to come up with a standardized approach, becoming increasingly influential in the process, both in the USA and elsewhere.

A major challenge remains in striking an appropriate balance between breadth and depth. A health care manager really needs to be a "renaissance" man/woman. Academic and practical training has to lead to an understanding of topics as diverse as politics, policy making, leadership, government/public functions, private sector/market functions, communications, finance, accounting, human behavior, negotiations, dispute resolution as well as at least some technical knowledge of health systems, health care structure/function, epidemiology, social determinants of health and illness, diseases, treatment, rehabilitation, etc. The list is extensive.

Not surprisingly, many existing training programs like public health programs, MBAs and clinical specialization fall short of these goals. Increasingly specialized health care management programs have been set up to address these shortcomings, cutting across disciplines and reaching out to applicants that have much more diverse backgrounds than the historical focus on life science and medicine.

The IHF is committed to working with its members in moving beyond Minimal Standards and reaching Gold Standards in health care management competencies.

A major landmark was achieved in 2015 with the adoption of the global competency directory for healthcare leadership and management, thus building the foundation for an international approach in support of professionalization in the field of healthcare management.

Since 2015, significant progress has been made in defining and requiring a competency-based approach in both graduate education and continuous professional development. The IHF works with academic institutions and professional associations to promote the use of a competency-based approach. It makes this available through its online, multi-language, self-assessment tools on core competencies (https://healthmanagementcompetency.org/base).

For some countries and institutions, the journey ahead may be long but worth the effort. By striving to reach best practice standards in training, licensing and the assessment of competencies in healthcare leadership and management, different countries and institutions have an opportunity to learn from the experience of others, while adapting the details to their own needs and capacities. Over time, such a continued development process in leadership and management practices will translate into improved performance in the delivery of health services.

The IHF has been supporting its members in this process by acting as a catalyst and a convener. As an international membership organization, it is the natural home for such action. It acknowledges that the positive results achieved so far over the last 5 years are largely due to the commitment and action of its members from around the world representing most influential academic institutions and professional associations.

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Global Accreditation: Why the CAHME Model is Important in Healthcare Management Education

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ABSTRACT: Global accreditation was approved by the Commission on Accreditation of Health Management Education (CAHME) in November 2018. A Global Advisory Council was created along with three sub-committees to implement global accreditation. Strategies have been discussed to organize a process of global accreditation as a "backbone" of professionalism in healthcare management. Recognition is given to the International Hospital Federation (IHF) Competency Platform that provides domains and sub-domains along with specific competencies. Accreditation is important because it validates quality education to various publics; assures relevance of program goals to the professional health care community; provides an opportunity for consultation and feedback from colleagues; underscores the importance of continuous improvement using a competency model; and helps students quality health management education programs. Education and training health care executives remains a priority for university based graduate programs.

Introduction

Throughout the world there has been a major effort to provide and develop efficient and effective healthcare leadership. There has been a strong concern over patient safety, quality of care, governance of healthcare organizations and having competent managers. The need to establish competency models has been advanced by the International Hospital Federation through the development of the Competency Directory. This directory was designed to enhance the professionalism of management in healthcare organizations. Competency models have been developed and implemented in Europe, Asia, North America and South America. Healthcare programs have also emphasized the importance of health management education in training leaders and managers to successfully run organizations. Finally, there is a strong need for practitioners and academics to work together to make sure that overall health system performance improves through strengthening managerial competencies and professionalism. This essentially means that the applied professions and university graduate program faculty must work closely together to produce competently trained health care managers.

Background

For 50 years, the Commission on Accreditation of Health Management Education (CAHME) has sought to advance the quality of healthcare management education by establishing standards and criteria based on academic and practitioner input. CAHME has been a force to ensuring that healthcare administration programs prepare candidates with the ethics, medical knowledge and technical skills required for exercising compassion and overcoming the challenges that existing in today's healthcare industry. CAHME accredits 104 graduate health management education programs in the United States and Canada.

Since its founding in 1968, CAHME recognized the importance of including programs outside of North America. In 2010, the generosity of an outsourced supplier to the industry, Philadelphia, PA based Aramark, enabled the organization to conduct research and map out a strategy to meet its vision. Support for the development of global accreditation has been a topic of discussion through the Association of University Programs in Health Administration (AUPHA) and has received considerable attention from the American College of Healthcare Executives (ACHE). A white paper was developed by CAHME and presented at the ACHE annual meeting in March 2016. This has been augmented by the Strategic Issues Committee of CAHME developing a 3-year strategic business planning process. In November 2017, the Board of Directors of CAHME endorsed a strategic imperative to identify global opportunities consistent

with CAHME's mission and to work with a limited number of global programs to begin the process. The 2020 strategic business plan of CAHME continues to advance the goal. This idea of implementing accreditation policy and procedures necessitates a broader collaboration and cooperation with many national and international health care organizations.

Mission and Vision

The CAHME mission is to "serve the public interest by advancing the quality of health care management education". The values that CAHME holds firmly includes integrity, excellence, transparency, fairness and recognition. The CAHME corporate members, the academic community (accredited graduate programs), and volunteer practitioners ensure that graduate health care management curricula reflect the needs of the profession. The mission and vision necessitate that the accreditation model set and establish measurable criteria for excellence; support, assist and advice programs so that they can meet or exceed criteria; accredit graduate programs that meet or exceed the established accreditation criteria; and making accreditation information relatively available to various constituencies and public groups.

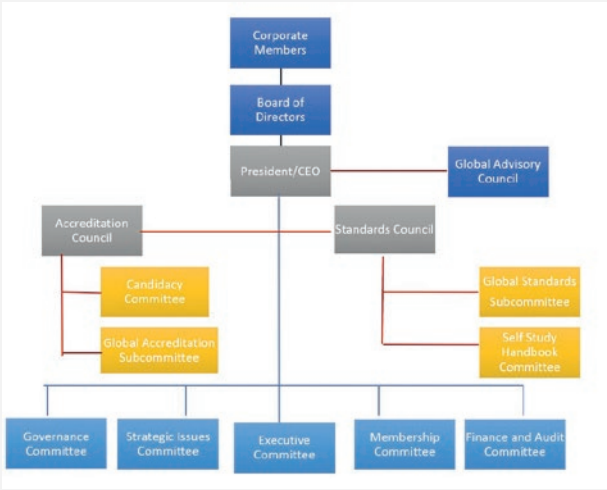
Since the beginning of the planning process, CAHME has worked with other established organizations such as the International Hospital Federation. CAHME is actively seeking to expands its a global network engaging the Society for Health Administration Programs in Education (SHAPE); the European Health Management Association (EHMA); the Association of Schools of Public Health in European Regions (ASPHER); and the Latin American Council of Management Schools (CLADEA), and the Association of University Programs in Healthcare Administration (AUPHA) through faculty forums and meetings around global initiatives. The vision of offering global accreditation necessitates that the CAHME Standards and Criteria retain a basis in competency accounting for global application and cultural relevancy.

Organization and Structure

Global accreditation will utilize the current 2017 CAHME Accreditation Standards and Criteria. CAHME created a structure that would work directly with the President and Chief Executive Officer through the Global Advisory Council (Figure 1). This council also has three sub committees including a sub-committee on Accreditation, subcommittee on Standards, and a subcommittee for Network Expansion. CAHME accreditation seeks to work with select universities who embrace the need for accreditation and are interested in a process of quality improvement guided by academic peers and practitioners in the health care profession. The CAHME model also utilizes a university-based partnership model where current CAHME accredited programs who have international partners can also try to involve others in the accreditation process. The CAHME model is a peer reviewed, voluntary and public process model. The 2017 CAHME Criteria and Standards are used for the accreditation process. These standards are broken down into several domains that examines 1) mission and vision; 2) students and graduates; 3) curriculum and competencies; and 4) faculty teaching, scholarship and service. Specific eligibility criteria must be met in the application phase prior to an actual accreditation site visit.

Figure 1 outlines the structure CAHME implemented to accommodate Global Accreditation in CAHME Governance. (See Figure 1)

FIGURE 1: CAHME STRUCTURE INCORPORATING GLOBAL ACCREDITATION COUNCIL IN CAHME GOVERNANCE



Source: CAHME, 2017. "Global Accreditation in Health Management Education: Concept Paper".

CAHME Design Considerations

Moving forward with global accreditation requires certain flexibility and innovation. CAHME has developed a Candidacy process that is valuable in working with new programs who have a desire for program specific accreditation in health management education. In this candidacy phase, specific information is provided along with feedback to programs as it relates to review criteria. Also available is information in a process known as "enhanced benchmarking" that provides data for accredited programs to access for a process of self-improvement. The accreditation process embraces a concept of "mentoring" which again provides for a "twinning" concept to be implemented between existing accredited programs and non-accredited programs. Accredited programs who accept this challenge are recognized by being named in the CAHME Mentorship Circle.

CAHME also has a very strong Fellowship program whereby professionals in academic settings can apply to be a "CAHME Fellow" to learn the accreditation process, procedures, policies and criteria. Finally, the CHAME model has a training process known as the "CAHME Boot Camp." The training program is an opportunity for new programs and existing programs to acquire the necessary knowledge and understanding of the competencies, process of accreditation, and quality improvement using outcome data. These trainings are supplemented with live and recorded webinars available on the web.

Sustainability

There is an interest among CAHME accredited program

faculty for involvement in the global community. Working with the International Hospital Federation has become extremely important in the development of new approaches for improved quality in higher education. The International Hospital Federation has supported the CAHME model because it recognizes a competency-based process coupled with quality improvement. The CAHME model also has a strong partnership model between academia and the applied professions. The IHF Competency Directory provides a framework for graduate programs globally to identify competencies that are needed to produce qualified and professional leaders in the health care profession. The competency model selected must relate to the mission and vision of the graduate program.

Conclusion

The creation of global networks among universities is not new. The Magna Charta Universitatum is a document that was signed by 388 rectors (university presidents) from all over Europe and beyond on September 18, 1988, also known as the Bologna Accord. It contains principles of academic freedom and institutional autonomy as a guideline for good governance and self-understanding. Today there are 805 universities from 85 countries. The concept endorses the importance of collaboration in study, teaching and research. Other strategic initiatives include Faculty Fulbright Scholars, study abroad programs, language immersion programs, faculty directed research and public-private university-based partnerships.

Global competitions among universities is further noted in the Global Community Ranking System created in 2003. More countries are becoming "viable players" on the global higher education stage. Increasing global competitiveness was discussed by Portnoi and Bagley (November-December 2015) in Academe, and stressed the strategies being used: 1) building "World-Class" universities, 2) merging universities, 3) making quality assurance a priority, 4) increasing cross-border higher education, 5) internationalizing universities, and 6) forging regional alliances.

CAHME's execution of an appropriate and realistic strategy for accrediting programs globally can serve to advance the importance of professional management necessary to lead healthcare systems which have become increasingly complex and politically charged. Program specific accreditation can supplement country-specific national accreditation. Eligibility standards and criteria must be attuned to accommodate culture specific adaptations and realities.

CAHME and its partners have accepted the difficult challenge of advancing world-wide accreditation. We choose to leverage best management practices world-wide, to question established behaviors, and to create a generation of leaders with the skills, knowledge, ethics and commitment to be part of a large group of healthcare professionals that seek to ensure the health of communities throughout the globe.

Biographies

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Portnoi, L.M. & Bagley, S.S. 2015. "The AAUPs Role in a Globalized, Competitive Higher Education Landscape." *Academe*, 101(6): 26-31.

Credentialing for Healthcare Executives: Advancing the Profession through the FACHE Credential

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ABSTRACT: In today's dynamic and ever-changing healthcare environment, proven leaders who are prepared to take on the challenges of healthcare management are in demand. The American College of Healthcare Executives meets this need by offering the FACHE® credential. Members who attain this respected designation benefit from an increased professional credibility. Healthcare organizations benefit by providing confirmation that an individual brings the necessary knowledge, skill, and ability to their role as a healthcare leader.

Introduction

For over 85 years, the American College of Healthcare Executives (ACHE) has focused on its' mission to advance leaders and the field of healthcare management excellence. ACHE is the professional home to more than 48,000 healthcare executives who are committed to integrity, lifelong learning, leadership, and diversity and inclusion.

In today's rapidly changing healthcare environment, ACHE is committed to being the preeminent professional society for healthcare leaders. Members look to ACHE to help them gain valuable knowledge and access proven resources directed at improving health for their patients and their communities. In addition, through an established network of 78 chapters, members have access to networking, education and career development at the local level ("About ACHE", 2019).

As a professional society that welcomes qualified individuals to join, ACHE aims to improve the healthcare management field and support Members with achieving professional goals related to education, networking, and professional development. One of the ways that ACHE aids members in achieving these goals is by offering the Fellow of the American College of Healthcare Executives (FACHE) designation. Much like doctors and other clinical professionals can earn board certifications, healthcare executives have the opportunity to earn the prestigious gold standard, the FACHE credential, signaling board certification in healthcare management.

With over 9,175 Fellows, 125 working outside of the United States (*Regent Area Monthly Census Report*, ACHE, April 2019), the FACHE is an indication that a professional in healthcare management meets the educational, professional, and personal requirements to attain board certification. Achieving Fellow status and earning the FACHE is beneficial to an individual's professional and personal life.

Overview of the FACHE Program

The FACHE credential is based on multi-faceted criteria culminating with the successful completion of a 200-question examination, the Board of Governors Examination in Healthcare Management. Each of the criteria has a purpose in contributing to the meaning and rigor of the credential. The following criteria must be met before the candidate may sit for the Exam.

Requirement	History and Intent
Current ACHE member with three (3) or more years of tenure (acquired as a member, faculty associate or international associate)	Demonstrates commitment to the healthcare management profession and to ACHE.
Master's or other post-baccalaureate degree (documented with diploma or final transcript)	Provides a minimum level of education needed to be certified.
Five (5) years of executive-level healthcare management experience (documented with current job description, organizational chart, and resume)	Provides a minimum standard of practical experience needed to be certified.
Two (2) professional references, one from a current Fellow, as a structured face-to-face or phone interview; one written from a senior-level (VP or higher) executive in the candidate's organization, or a second Fellow	Provides candidates the opportunity to network among their Fellow peers. Provides attestation that a candidate holds the professional attributes required of Fellow status.
Thirty-six (36) hours of healthcare-related continuing education within the last three (3) years: twelve (12) hours must be ACHE Face-to-Face Education. The balance of 24 hours may be additional ACHE Face-to-Face Education or Qualified Education from other related organizations.	Professional development is a hallmark of ACHE. Face-to-Face education is important because it exposes participants to content, as well as, growing their peer network. It reinforces collegial interaction, particularly with junior to senior executives.
Two (2) healthcare-related volunteer activities and two (2) community/civic volunteer activities completed/participated in during the previous three (3) years.	Contributing to the industry and one's local community has been a hallmark of ACHE since its foundation. It is believed that healthcare executives should be part of their community in order to grow in their leadership positions and understand the needs of the community they serve.
The final step in obtaining the FACHE credential is passing the Board of Governors Examination in Healthcare Management. Candidates must meet all of the above requirements prior to obtaining eligibility to sit for the Examination.	Provides a valid and reliable program for candidates to demonstrate their education, knowledge, and professional expertise with the body of knowledge based on a job analysis survey. Attests to minimal competence as a healthcare executive.

Once a candidate attains the FACHE credential they must recertify every three (3) years by maintaining thirty-six (36) hours of healthcare-related continuing education within the last three (3) years: twelve (12) hours must be ACHE Face-to-Face Education. The balance of 24 hours may be additional ACHE Face-to-Face Education or Qualified Education from other related organizations, and demonstrating two (2) healthcare-related volunteer activities and two (2) community/civic volunteer activities completed/participated in during the previous three (3) years. An alternate recertification option is to retake and pass the Board of Governors Examination along with demonstrating the aforementioned volunteer activities.

It is important to note that all members of ACHE agree to abide by the *ACHE Code of Ethics*. By completing the FACHE requirements and recertifying every three (3) years, the candidate demonstrates professionalism, ethical decision-making, competence, leadership skills, and a commitment to lifelong learning.

Development and Maintenance of the Board of Governors Examination

ACHE contracted with the Human Resources Research Organization (HumRRO) to develop the Board of Governors Examination. HumRRO is a nonprofit organization with more than 60 years of solving challenging problems in the areas of human capital management, education, credentialing, policy analysis, program evaluation, and training ("Who We Are – HumRRO", 2019).

The development of a valid examination for the FACHE certification, the Board of Governors Examination, began with a clear and concise definition of the knowledge, skills, and abilities needed for competent job performance. Using interviews, surveys, observation, and group discussions, HumRRO worked with healthcare executives and the ACHE Examination Committee, a group of subject matter experts from diverse backgrounds and work settings, to define critical job components, knowledge, and skill required for competent performance in the field. This study, or job analysis, is the foundation for the questions on the multiple-choice examination.

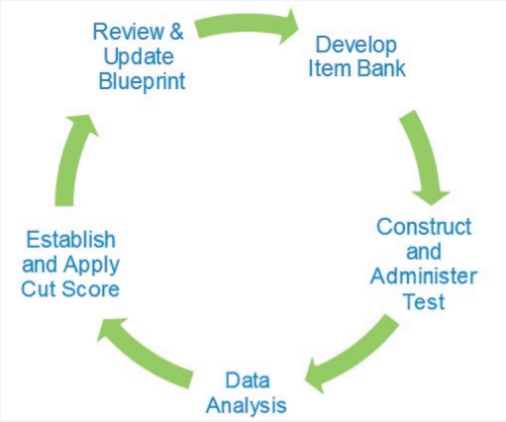
ACHE conducts a job analysis study every five (5) to seven (7) years to ensure that the content of the Board of Governors Examination is relevant to current professional practice and reflects the opinions and expertise of a diverse group of stakeholders. The most recent job analysis study for ACHE was conducted in 2017. The approach involved gathering and integrating multiple sources of data about the profession. The results of this study form the basis of the Board of Governors Examination specifications (test blueprint) and establish its content validity. To keep the survey at a reasonable length, the information was split into two surveys, a "task" survey and a "knowledge, skill, and ability" (KSA) survey. Survey invitations were sent to over 8,000 people (approximately 4,000 per survey). The survey sample yielded 1,059 usable responses for the task and KSA surveys, allowing for a statistically powerful sample.

Steps in Developing the Board of Governors Examination

Once the job analysis study is complete, there are five (5) general steps in the development and maintenance of the Board of Governors Examination.

1. **Review and Update Blueprint** – In this phase, the job analysis work is conducted within the field. This is also the first step in assuring content validity.
2. **Develop Item Bank** – Each item takes the form of a multiple-choice question. The item is made up of: 1) the question, called the "stem", 2) a single correct answer, and 3) a set of plausible, possible answers called "distracters". There are four choices, one correct and three plausible distracters.
3. **Construct and Administer Test** – Pilot testing is an important step in the development of the Examination. Through this process, criterion related validity for each item is generated.
4. **Data Analysis** – During the data analysis phase, each item is reviewed in terms of structure, response, and fit in relationship to the rest of the Examination. Through data analysis, a level of reliability validation can be obtained.
5. **Establish and Apply Cut Score** – The data analysis will reveal items that are not working as expected. Those items will either be eliminated or rewritten. The test form is calibrated to previous test forms and the cut score is set for the total number of correct questions needed to pass the Examination.

FIGURE 1: BOARD OF GOVERNORS EXAM PROCESS CYCLE



Source: HumRRO

The Board of Governors Examination is evaluated on an annual basis to ensure that it remains a relevant and accurate measure of candidates' expertise in the field. As in early stages of the exam development process, ACHE works with HumRRO and the ACHE Examination Committee to consider performance discrepancies and assess issues such as the fairness, reliability, and validity of test items to determine whether adjustments to the test or cut score are necessary.

Credentialing and Its Importance to Healthcare Professions

The purpose of credentialing in any profession is to protect the public and to assure that an individual who holds the credential has met a minimum standard for competency. Additionally, credentials demonstrate a commitment to the profession and a commitment to ongoing continuing education required for maintenance of the credential. Many employers prefer and often require employees to obtain certifications. Certification indicates that an individual has met a certain standard of competence. Achieving certification may give individuals a competitive advantage, more job opportunities, a higher pay scale, or job security.

According to a 2005 survey conducted by the American Health Information Management Association (AHIMA):

- Employers think favorably overall of industry credentials with 83% of executive respondents and 80% overall, reporting them to be 'favorable' to 'very favorable'.
- Credentials influence hiring and promotion practices. With all other things being equal, 68% of employers report choosing a credentialed candidate over one who is not and 53% prefer credentials when promoting their employees.
- Credentialed employees are rewarded financially. 67% of respondents report that they earn more than their non-credentialed peers do.

Source: (American Health Information Management Association, 2005)

Association members participating in the 2016 ASAE Foundation study, *The Benefits of Credentialing Programs to Membership Associations* reported that they experienced the following benefits from certification:

- Are the leaders in their field
- Are more likely to comply with standards
- Have a competitive market advantage
- Are economically more successful
- Have more opportunities to network and socialize

Source: (Tschirhart & Travinin, 2016)

According to a 2016 survey conducted by ACHE and HumRRO, the primary reason members seek board certification from ACHE is to maximize an individual's professional potential. Earning the FACHE credential as a healthcare executive demonstrates to employers a commitment to the healthcare field. Additionally, it validates the knowledge and skills of individuals that provide ongoing benefits to an organization.

In 2016, two respected credentialing firms were contracted to research the Fellow program. Research done by Knapp and Associates, conducted in March 2016, provided feedback on the value of the credential. Then in summer 2016, HumRRO conducted focus groups, interviews, and surveys that provided findings that are more robust.

Findings from the focus groups indicated that the FACHE holds intrinsic value for Fellows. They describe the credential as "an investment in myself" and as "validation" in one's career. Findings from the interviews indicated that when the FACHE credential is mentioned words that come to mind are "expertise," "professionalism," and "competence." Finally, findings from the surveys indicated that the criteria for FACHE enhance the

value of the credential "to a great or very great extent" (Sinclair & Smith, 2016).

The 2016 Credentialing Task Force reviewed the purpose of the Fellow program and agreed that as a profession, healthcare leaders believe in the core tenets of becoming a Fellow of ACHE, which include:

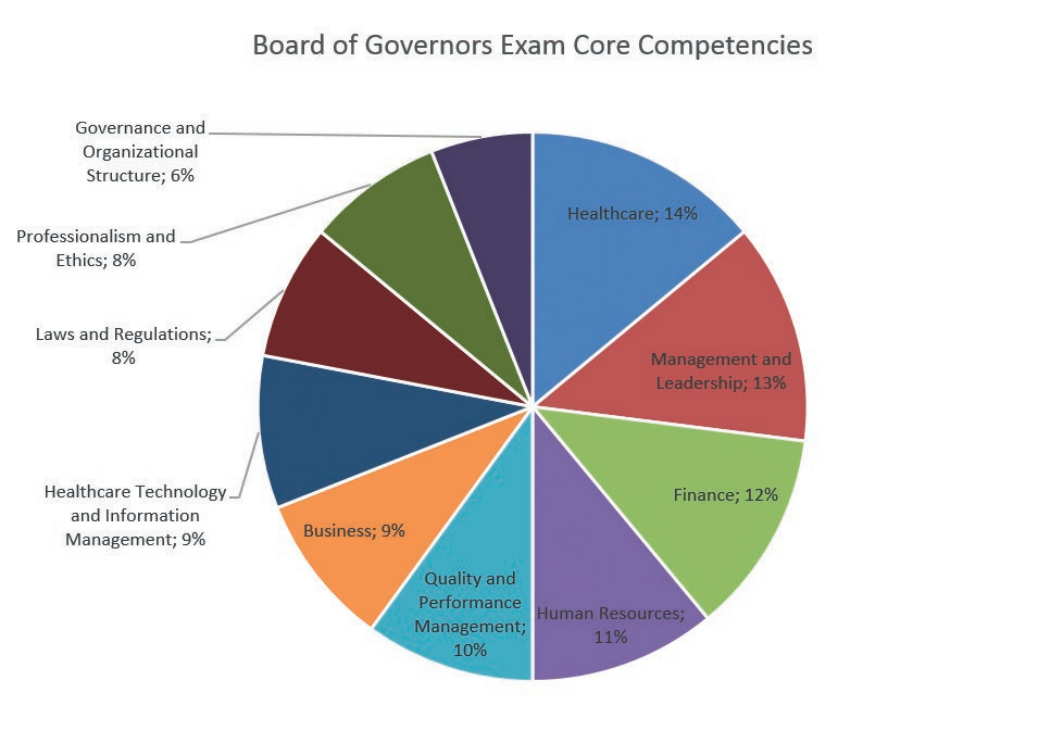
- Demonstrated commitment to professionalism and the field of healthcare management
- Demonstrated commitment to the core values of ACHE
- Demonstrated commitment to continuing education
- Peer perspective as evidenced by references and shared learning

ACHE's mission is to "advance our members and healthcare management excellence." Given the importance of the evolving leadership roles in healthcare, the FACHE credential is important to demonstrate one's knowledge of and commitment to the profession of healthcare management. Traditional as well as non-traditional entrants to the field, including clinicians, should seek the credential to distinguish themselves as "board certified in healthcare management" (HumRRO, 2016).

Transforming the Workforce through Knowledge and Competencies

The FACHE credential is the gold standard for excellence in healthcare leadership. Holding the FACHE credential signals a high level of knowledge and achievement, and elevates and establishes an individual throughout their career. The FACHE credential provides proven evidence that an individual has met rigorous standards. It also demonstrates competency in all areas of healthcare leadership, from strategy and community outreach to financial management, talent management, governance, professionalism and ethics. ACHE has identified ten (10) core competencies as essential to proficient performance in healthcare leadership.

FIGURE 2: BOARD OF GOVERNORS EXAM CORE COMPETENCIES



Source: "Board of Governors Exam Outline", 2019

The FACHE credential allows individuals to stand out within their healthcare organization. The skills developed while earning the FACHE strengthens adaptability as a successful leader in the ever-changing challenges of the healthcare industry. The ongoing requirements to continue professional development reflect a commitment to lifelong learning, innovation, and self-improvement. The FACHE credential is a tangible way individuals can publicly demonstrate positive impact a leader has on patient care and community health.

Conclusion

In an increasingly complex healthcare system, credentialing ensures that leaders in healthcare organizations and other arenas of healthcare management practice have the skills needed to be effective in their profession. Credentialing provides breadth and depth in the knowledge base that forms the foundation of competent performance. Healthcare

organizations may use credentialing to evaluate management teams for hiring purposes. In addition, educators may use the test blueprint to design curriculum for university healthcare management programs. The FACHE credential is a proven standard to validate the knowledge, skill, and ability of management professionals, and ensure the advancement of healthcare management as a profession. It also signals better working environments for professionals and care delivery for patients. These are the essential goals of the FACHE program and for those who achieve this valued recognition. To learn more about the FACHE credential and recertification process, visit the "FACHE" area of ache.org.

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The Case for Healthcare Leader Competencies: Exploring the Evidence

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ABSTRACT: This article explores the relationship between competent management of healthcare organizations and its effect on performance. Despite the fact that excellent management is essential to creating high performing healthcare organizations, there are still many parts of the world where the manager's role has not been adequately recognized or professionalized. We discuss how preparation for these roles can be attained and how support for this type of learning can improve healthcare management competencies and practices, which in turn can improve healthcare organizational and system performance. We conclude with a call to improve and extend the healthcare management evidence base.

A growing body of work explores the relationship between competent healthcare leaders of hospitals as well as other healthcare organizations and how effectively these organizations provide health services. These studies provide evidence of the value competent leadership and management provide in insuring cost effective, quality care for the populations they serve. The contributions of competent leaders have been documented in countries across the economic spectrum, from those with developed economies to those that are much less developed. We would like to share with you some of the evidence we have found about these important contributions.

Performance: Outcomes at the Individual, Team, Organizational, and System Levels. When we talk about competent leaders, we are concerned with individuals that have the knowledge, skills and abilities to engage in actual behaviors that can drive performance outcomes. Research has been conducted on the associations between leadership and management competence or behavior and outcomes at the individual, team, organizational, and system level.

Individual outcomes. There was only one study that suggested a link between leadership behaviors and individual performance; an Iranian study of health care executives in an academic medical center that used a survey to capture self-rated leadership attributes and leadership effectiveness data. Both transactional and transformational leadership attributes were correlated significantly with self-rated leadership effectiveness (Ebadifard Azar & Sarabi Asiabar, 2015).

Team outcomes. A relationship between management and leadership competence or behaviors and outcomes at the team or unit level has been documented. A Swedish study examining leadership styles on leadership effectiveness was conducted on 38 cross-professional health care teams. Vertical leadership (representing hierarchical, directive and participative leadership) was negatively associated with performance on a team case simulation, while more democratic and collaborative leadership styles were positively associated with all measured outcomes, including case quality. The highest team performances on case quality were leaderless and self-managed teams (Ingela Emma Christine & Persson, 2014). A Dutch study of nursing leadership effectiveness found that effective nurse leaders had lower incidence and duration of nurse absence due to short-term sickness in their units (Schreuder et al., 2011a). In the same study population, high-relationship leadership styles

were associated with fewer episodes and days of short-term illness absences. Conversely, low-relationship oriented styles were associated with more sick days due to short-term illness (Schreuder et al., 2011b).

Organizational outcomes. Eight recent research articles have identified implications of leadership competencies for performance at the organizational level. Six of these found that leadership or management practice or competence was associated with better performance. Another found that leadership competence was associated with better staff attitudes but not better organizational performance. An additional study found that poor management and leadership was cited as the main reason for massive performance problems, including employee strikes that caused a number of hospitals to close. These studies are described below.

The three large studies found a strong and positive link between leadership and management practice and hospital performance. The first was a UK study of 86 hospitals and over 17,000 employees that examined the relationship between leadership effectiveness and hospital performance in terms of patient complaints and rating agency scores. Leadership effectiveness (measured by a six-item scale) was significantly associated with better performance on patient complaints and rating agency evaluations, and quality climate mediated this relationship (Shipton, Armstrong, West, & Dawson, 2008). A 2010 study across 1,200 hospitals, in the US, Canada, France, Sweden, UK, Germany and Italy, found that better management practices were significantly associated with better clinical and financial performance. A one-point increase in management score was associated with lower C-section length of stay, a 6-7% decrease in 30-day heart attack mortality and a greater likelihood of adopting clinical best practices. A one-point increase in management score was also associated with a 33% increase in income per bed and a 14% increase in EBITDA per bed. Additionally, better management was associated with significantly better patient ratings of the hospital (Dorgan et al., 2010). A 2015 study found that both board and management practices in over 1,000 hospitals in the US and UK were associated with better clinical outcomes. A one standard deviation increase in management practice was associated with a 20 percent increase in the probability of being a high-performing hospital (Tsai et al., 2015).

Several studies explored the association between executive behavior in the U.S. and hospital performance. One study of top executives found that leaders typically had positive attitudes towards using evidence-based management techniques, which corresponded to the percentage of decisions made using an evidence-based practice approach at the organizational level (Guo, Hermanson, & Farnsworth, 2016). This suggests that it is not only the ability held by managers, but also their attitudes towards a practice that affects a behavior. Another study examined the relationship between physician leadership styles and leadership effectiveness. Transformational leadership was associated with greater leadership effectiveness measured by perceived effectiveness, extra effort of subordinates, subordinate satisfaction with the leader and performance of clinical goals (Xirasagar, Samuels, & Stoskopf, 2005). Another group of researchers examined the relationship between leadership and the success of a strategic implementation in terms of patient satisfaction and access, including the effects of three levels of leadership (CEO, Center Leadership, Department Leadership) on the outcomes of interest. They found that individual leadership effectiveness at one level was not significantly associated with better performance, but that leadership effectiveness across all levels was (O'Reilly, Caldwell, Chatman, Lapiz, & Self, 2010). This highlights the importance of understanding and fostering management and leadership competence across levels.

In contrast to the studies above, one study examined the relationships between the competence of governing board members and hospital performance affecting quality outcomes and found inconsistent or no significant relationships. A UK-based study of 334 board members in 95 hospitals examined board competencies and their relationship to both staff attitudes toward quality and safety and overall organizational performance. Though board competencies were related to improved staff attitudes, there were no consistent statistically significant relationships between board competencies and overall performance linked to quality and safety outcomes (Mannion et al., 2017).

An interesting study identified how ineffective management might be associated with negative outcomes. Hospital workers in parts of Nigeria were on strike for three years, resulting in some hospital closures. The most common cause (92%) and most important reason (43.3%) given for participating in a strike was poor health care leadership and management (Oleribe et al., 2016). This lends support to the importance of better management practice, and also highlights the potential negative impacts of poor management practice. Improving management not only represents an opportunity to excel but may save an organization from failure.

Systems outcomes. A study by Fetene and Colleagues (2019) examined the relationship between better management (management capacity) and primary health care system performance in Ethiopian woredas (administrative divisions). Management capacity was assessed for each woreda health office as a percent of the 26 woreda management standards (WMS) that were completely met. The 26 WMS are embodied within the five domains of 1) governance and organizational capacity, 2) service delivery, 3) collaboration with other sectors, 4) community engagement and 5) performance management.

Health center performance was measured by a key performance indicator (KPI) summary score based on five indicators: 1) antenatal care coverage, 2) contraceptive acceptance rate, 3) skilled birth attendance rate, 4) percentage of 1-year-olds receiving all recommended immunizations and 5) essential drug availability.

In their adjusted models, the researchers found that, in woredas at above median management capacity, health center management capacity was statistically related to better KPI performance ($p = 0.03$); however, this relationship was not observed in woredas characterized by low health center management capacity ($p = 0.96$). They also found greater

staffing levels to be related to higher KPI performance, but this relationship was only observed in those woredas with management capacity levels above the median (p = 0.01) (Fetene, Canavan, Megentta, Linnander, Tan, and Bradley, 2019).

Toward Improving Healthcare Management Practice

These research studies demonstrate the positive relationships observed between strong health care management and performance outcomes in healthcare settings at the individual, team, organizational, and system levels. These results provide support for the assertion that better management can lead to better performance in health care settings. Despite the fact that excellent management is vital to high performing healthcare organizations, due to the front-line visibility and absolute necessity of clinical roles, these frequently eclipse those in management in providing high quality patient care, which frequently results in inadequate attention being given to healthcare management. Moreover, there exists a traditional and inherent conflict between medicine and management (Hoff, 2000; Kippist & Fitzgerald, 2009; Whitman et al., 2010), with physicians often viewing managers and their practices as hampering their clinical work, as opposed to facilitating and supporting their efforts. However, better management can challenge these norms as improvements are generated along multiple dimensions.

Each country will need to determine when and for whom healthcare management education should occur and which modality is best suited to developing competent managers in that country. In countries where healthcare management is professionalized, there is a segment of the healthcare workforce that is specifically educated in management and enters the workforce as full-time healthcare managers. Such professionals, with extensive management education, are also needed in areas of the world where the healthcare management role has not yet been professionalized. The preparation for these management roles can be attained through a variety of formats, but the most comprehensive of these can be found in master's level (Master of Health/Hospital Administration, Master of Business Administration, Master of Public Health, etc.) degree programs available around the world. For example, the United States and Canada master's programs accredited by the Commission on Accreditation of Healthcare Management Education (CAHME) are each required to develop a competency framework that derives from the mission and goals of the program and relates to the type of jobs taken by graduates. Students and graduates can use the management competency frameworks as a development tool for continuously improving their professional growth over the course of their careers. Generally, these program-specific competency frameworks share ample similarity with the IHF Global Competency Directory. In addition to the CAHME-accredited master's programs of North America, examples of comprehensive master's programs can be found in Europe (Italy's Master of International Health Management, Economics and Policy program at Bocconi University), Asia (China's Doctor of Public Health in Healthcare Management and Leadership at the Tsinghua University Institute for Hospital Management), Australia (Australia's Master of Health Administration at La Trobe University), Africa (Ethiopia's Masters in Hospital and Healthcare Administration program at Jimma University), Latin America (Colombia's Master in Health Administration program at Javeriana University) and the Middle East (Lebanon's Master of Public Health in Health Management and Policy program at the American University of Beirut). As completing a full-time master's degree can be time and cost prohibitive for many–especially those from Low- and Middle-Income Countries (LMIC)–alternative educational opportunities are available through online degree programs, workshops, short courses, etc. In addition to the training and development of the professional healthcare manager, physicians, nurses, and other clinicians can also benefit from exposure to management principles. Support for such educational programs needs to be intentional and ongoing. According to Bradley and Colleagues (2015), "Ministries of health supporting such programs and requiring some management education to perform key health management positions (in hospitals, health centers, and districts or regions) would go a long way to improving management capacity …" (p. 413).

Expanding the Health Care Management Evidence Base

Although an evidence base does exist that supports the role of management as an important catalyst in leveraging the performance of health care organizations, it needs to be expanded through rigorous research studies in several areas. First, rigorous research and measurement are needed to evaluate health care performance improvements on multiple dimensions of importance and within a variety of contexts. Second, performance improvements resulting from strengthened management can emerge slowly over time. For example, which competencies provide the greatest performance return on management competency investment? Moreover, as Bradley and Colleagues (2015, p. 44) note, "… we still know very little about how management practices become integrated into organizational routines, which is fundamental to sustainability."

Biographies

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- Best practices for preparedness and responses to disasters, outbreaks and cyberattacks
- Mitigating consequences of conflicts and terror attacks to continue serving all especially vulnerable groups
- Operating under severe resource constraints
- Leading practices reflecting systematic approaches to learning from crises and trauma
- Violence in the workplace

Health investment for prosperity

Well spent resources on health can be an engine of social development and economic growth but heath service providers and especially hospitals will have to revise their delivery models to serve people according to their needs. All the following topics will help better understand how it is possible to gain more prosperity while responding to growing health needs under financial constraints.

- Exploring governance practices driving better efficiency and relevance
- What management and leadership can do for increased efficiency and outcomes
- Inter-professional leadership for cost effectiveness and quality improvement
- What are the impacts of hospitals in the local and national economy
- Future of hospitals in an economically constrained world

Innovation for health impact

Turning prospective benefits into health gain will happen only if appropriate mechanisms are in place to implement and scale up as quickly as possible benefits of meaningful innovations. It is also a game changer when innovation is driven by people's needs as they are recognized in health services with industry providing solutions upon request of health providers. The 4th industrial revolution is on its way and health services are powering this change by accelerating utilization of digital services on all fronts.

- Removing barriers to innovation with change management
- Hospital Technology Assessment to speed up innovation adoption
- Embedding collaboration with industries for health innovation
- Procurement to accelerate and develop innovation
- Enhancing digital health services in the virtual space

Emerging Roles in Healthcare: a New Approach Based on Managing Competencies

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ABSTRACT: The need to provide integrated patient-centered care is causing a large-scale re-configuration of healthcare systems worldwide and prompting policy makers and managers to question deeply ingrained ideas about how a healthcare system should be managed. In this evolving scenario, there is an impressive number of new professional profiles emerging in hospital and primary care settings. In order to face the challenge of managing new professional figures, this article proposes the adoption of a "Competencies Dictionary". This dictionary provides a list of key professional competencies in addition to their definitions and level ranges. Applied to the Italian LHA coordinator role, the dictionary provides a clear description of its characteristics.

Introduction

It is well known that our healthcare organizations (HCOs) are extremely complex. The evolution of patients' needs, the progressive ageing of the population and vast technological innovations are some of the main factors exerting a great degree of pressure on HCOs, requiring increasing standards of care and stringent cost constraints [1,2]. Moreover, the need to provide integrated and patient-centered care is causing a large-scale re-configuration of healthcare systems worldwide, prompting policy makers and managers to question deeply ingrained ideas about how a healthcare system should be managed [3]. In this evolving scenario, an there is an impressive number of new professional profiles emerging. Practically all the typical professional figures that belong to the system are affected by change, to a greater or lesser extent, which means they also must change. HCO Managers face greater levels of organizational accountability, physicians are frequently required to re-think their role in less individualistic and more team-oriented ways, other healthcare professionals (e.g., nurses) are urged to take on new managerial and coordination tasks [4, 5]. Moreover, not only does the above hold true for hospitals, often considered focal actors" in patients' clinical pathways, but also for primary care settings, which are increasingly required to provide integrated and efficient care. As a matter of fact, many managerial tools adopted by secondary and tertiary care organizations may be very useful in primary care settings as well, which would lead to a homogeneous and coherent approach to the whole healthcare system.

Therefore, there is an urgent need to design effective ways of managing HCOs, and it is even more so when it comes to managing human resources. A structured approach to managing competencies may make a big difference, at both the organizational and policy levels.

Methodological Approach

This article proposes the adoption of a "Competencies Dictionary". This tool, which consists of a list of key competencies along with a specific definition for each (*hence the term dictionary*), was introduced in the 70s by D.C McClelland [6] and further developed in the 90s by Spencer and Spencer [7]. Nevertheless, its structured adaptation to managerial roles in the healthcare sector is very recent and, in Italy, it has been carried out by the European Institute of Oncology (IEO) in Milan. IEO made a thorough review of the crucial key competencies for the area in question.

IEO re-configured the dictionary with two types of competencies: technical and behavioral. These are listed along with their definitions. For each competency, the dictionary also provides a numerical level range. These ranges may vary from 0-4 to 0-5 and 0-6 depending on the competency. The list of competencies and their respective level ranges are shown below in Table 1.

TABLE 1: DICTIONARY LIST OF TECHNICAL AND BEHAVIORAL COMPETENCIES

Technical competencies	**Range**
Computer skills	0-5
Linguistic skills	0-4
Managerial techniques and models	0-4
Knowledge of organizational procedures	0-4
Knowledge of organizational structure	0-4
Theoretical knowledge	0-4
Dexterity skills	0-4
Knowledge of specialistic terminology	0-4
Behavioral competencies	**Range**
Accuracy and quality of work	0-4
Self-control	0-4
Communication and listening abilities	0-5
Organizational awareness	0-5
Self-confidence	0-4
Identification with the organization	0-4
Impact and influence	0-5
Managerial attitude	0-6
Goal-oriented attitude	0-6
Service attitude towards stakeholders	0-6
Proactivity	0-5
Propensity to change	0-4
Propensity to develop collaborators	0-5
Team leadership	0-6
Teamwork mentality	0-5

Source: Authors

The approach adopted here consists in the selection of all the technical and eight of the behavioral competencies for each professional profile analyzed. Selecting eight competencies per type seems a reasonable compromise between exhaustiveness and manageability [8]. Each competency must then be assigned a level, ranging from *best possible scenario to minimum requirements* to carry out a specific role effectively.

Finally, developing a competency profile is based on the job's description and followed by an assessment of the person's performance (through the design and application of a well-balanced profile scorecard).

Pilot study

A pilot study was conducted by the Local Health Authority (LHA) of Parma, located in the Emilia Romagna region of Italy. The LHA of Parma, which assists 432,438 patients, is one of the best performing LHAs in Emilia-Romagna. The Emilia Romagna region provided a propitious setting for our study because of its long tradition of innovative managerial and organizational models for improving primary care processes and outcomes [9]. A recent reform led to the creation of a new organizational model for the delivery of primary care together with the introduction of new, well-defined roles to improve the integration and coordination of patient services. The new model fosters the integration of departmental areas (prevention, primary care and specialistic care) together with a multi-professional and multi-disciplinary approach to health care. Two salient characteristics of the new model are the adoption of a team-based approach and the geographical co-location of clinicians (GPs, specialists, nurses, psychologists, rehabilitators, etc.) who are typically involved in primary care operations. Three types of "integrator" roles were adopted to facilitate the implementation of the new model: pathway facilitators (care and case managers), coordinators and other professional roles. As competency profiles emphasize technical skills, professional roles were clearly defined, while the profiles of care and case managers and coordinators had to be (re)defined. In this article, we will not go into all the competency profiles, choosing instead to focus on the behavioral competencies of coordinators. Please see Baraldi et al., 2015 [5] for further details about other roles and profiles.

Coordinators are responsible for important activities insofar as the model we adopted: i) they are in charge and take responsibility of chronic patients by facilitating the integration of the varied settings involved in treatment and assistance, ii) they contribute to the integration of social and health services that multi-professional teams continuously provide to patients iii) and they are involved in the planning and implementation of self-management initiatives benefiting the patients and their families. Several meetings with all members directly and indirectly involved in the activities mentioned above were organized to identify the most relevant competencies for the coordinator role. Participants were asked to select 8 out of the 15 behavioral competencies included in the dictionary, and to provide an assessment of the desired level for each competency. The competencies and scores identified as a result of these brainstorming sessions are illustrated in Figure 1.

FIGURE 1: COMPETENCIES OF THE NEW COORDINATOR ROLE IN THE LHA OF PARMA

Source: Baraldi S., Cicchetti A., Cifalinò A., Mascia D. 2015.

Figure 1 shows that the most important competencies defined for this role are the following: integration (with a score of 4 out of 5 – this competency was added to the dictionary for this specific role), accuracy and quality of work (score 3), communication and listening abilities (score 4), organizational awareness (score 3),

goal-oriented attitude (score 3), proactivity (score 3), propensity to change (score 3) and teamwork mentality (score 4). Integration, communication and teamwork are the three main competencies identified for this role. All participants involved in the definition of the new role agreed that lateral coordination, effective interpersonal communication and ability to work as a team with other clinicians are of quintessential importance to the functioning of the new model and the overall ability to work as a coordinator. Integration refers in particular to the capacity to plan and support work activities including multi-disciplinary teams, which are collectively responsible for the provision of care and therapy to the patient. The ability to communicate is also important, especially with regard to the feedback that coordinators have to provide. The capacity to adapt one's communication style to the characteristics of other actors, especially under conditions of stress, has been emphasized during the brainstorming sessions. Coordinators who identify with their organization become goal-oriented and contribute by proposing new goals with specific targets and strategies. Proactivity and a positive attitude towards change are two competencies that emphasize the role of coordinators as "agents of change" – who will be asked to foster innovation and the implementation of novel behaviors for the new multi-professional models.

Conclusion

The evolution of healthcare organizational models towards a patient-centered care paradigm requires the development of new professional skills and the integration of care management processes. This is not only true at the hospital level, but also in primary care settings, which are responsible for providing an integrated care continuum. A crucial role emerging among many, in both settings, is that of the LHA coordinator, responsible for providing a linear pathway in the non-acute phases of the disease. In light of the increasing complexity of their role, coordinator competency profiles must be re-thought, both in terms of technical-professional and behavioral competencies. In this paper, we highlight the desirable behavioral competencies of this figure, as well as its desirable competency level. Because developing an effective patient-centered culture is a worldwide issue, this profile developed in Italy has the potential of meeting the needs of a high number of international healthcare systems.

Not only has this experience allowed us to test the validity and applicability of a competencies dictionary in a primary healthcare setting, but it has also produced food for thought in terms of which professional traits to look for in healthcare coordinators. Such awareness is fundamental in the recruitment/selection phase. In addition to the traditional *Curriculum Vitae* and previous experience approach, this sensitive task should consider new ways of assessing competencies that go beyond mere knowledge. This new awareness has important consequences in terms of designing training pathways and career ladders. The former should include ways of developing such competencies, while the latter should foster ways of linking them to specific positions within an organization.

Finally, it is our opinion that such an approach may be of paramount importance in the definition of numerous professional profiles at both organizational and regional/national levels. Some countries have invested in the definition of standard professional profiles, fostering a truly coherent healthcare labor market.

Biographies

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Competencies of Hospital Managers: Iran's Case Study

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ABSTRACT: In the Islamic Republic of Iran, the Ministry of Health and Medical Education (MOHME) is taking universal health coverage (UHC) very seriously. Access to quality health services is at the heart of achieving UHC and improving hospital performance is an important entry point. To achieve this goal, hospitals need managers with competencies. In this study, 303 hospital managers filled out a questionnaire that had two areas (relevance and score). The purpose of this study was to determine the relevance of competencies and assess the capability of hospital managers by self-assessment.

Background

According to the World Health Organization (WHO), the management of health systems interventions is as critical as their implementation to sustain improvements of public health outcomes (1-2). Capacity building of health managers in low-income countries receives relatively little attention. Management structures and competencies at the district or subnational level do even worse (3-4). Health managers must possess specific characteristics. However, there is currently little information available regarding such characteristics (5). Managerial competencies are "sets of knowledge, skills, behaviors and attitudes required for a person to be effective in a wide range of managerial jobs and various types of organizations" (6). In the Islamic Republic of Iran, the MOHME is taking UHC very seriously. Access to quality health services is at the heart of achieving UHC and improving hospital performance is an important entry point. To achieve this goal, hospitals need managers with competencies. The purpose of this study was the self-assessment of the competencies required for and by hospital managers.

Method

We used a valid, reliable questionnaire designed by the International Hospital Federation[1] to collect the data. This had been translated and adapted by 30 experts and hospital managers after downloading it from the IHF website. We requested hospital managers to fill out the questionnaire. The questionnaire contained five domains with 80 competencies including the following: (1) Business with eleven sub-domains (General Management, Laws and Regulations, Financial Management, Human Resource Management, Organizational Dynamics and Governance, Strategic Planning and Marketing, Information Management, Risk Management, Quality Improvement, Systems Thinking, Supply Chain Management); 31 competencies (2) Communication and Relationship Management with three subdomains (Relationship Management, Communication Skills and Engagement and Facilitation and Negotiation); and 11 competencies (3) Health and Healthcare Environment with four subdomains (Health Systems and Organizations, Health Workforce, Person-Centered Health and Public Health); and 13 competencies (4) Leadership with four subdomain (Leadership Skills and Behaviors, Engaging Culture and Environment, Leading Change and Driving Innovation) and nine competencies; and finally, (5) Professional and Social Responsibility with five subdomains (Personal and Professional Accountability, Professional Development and Lifelong Learning, Contributions to the Profession, Self-Awareness and Ethical Conduct and Social Consciousness) and 15 competencies. In total, we surveyed 303 hospital managers, the questionnaire are broken down into two areas (relevance and score) by which they self-assessed their managerial competencies and characteristics on a 5-point Likert scale ranging from 1 to 5. The first part of the questionnaire inquired about demographic and personal data such as gender, age, institution, years of employment, years of employment in a leading position and level of education.

1 https://healthmanagementcompetency.org/base

Findings

Our findings show that 89% of the participants were male, 50% were between 40-50 years of age. About 41% of the participants had master's degrees. About 24% had worked for less than two years in their current position and 84% of them had worked for more than 10 years, with 89% of the participants being hospital managers (Table 1).

Relevance of Competencies

The most relevant competencies (Table 2) are listening and communication skills (90.1%), followed by competencies 13 (88.4%), 77 (88.4%), 20 (88.1%), 64 (88.1%), 60 (87.8%), 39 (85.1%), 21 (84.8%), 73 (84.8%), 57 (84.2%), 2 (83.5%), 6 (83.5%), 22 (83.2%), 42 (83.2%), 44 (83.2%), 61 (82.5%), 74 (82.5%), 76 (82.5%), 46 (82.2%) and 62 (82.2%).

TABLE 1: DEMOGRAPHICS AND PERSONAL DATA OF PARTICIPANTS

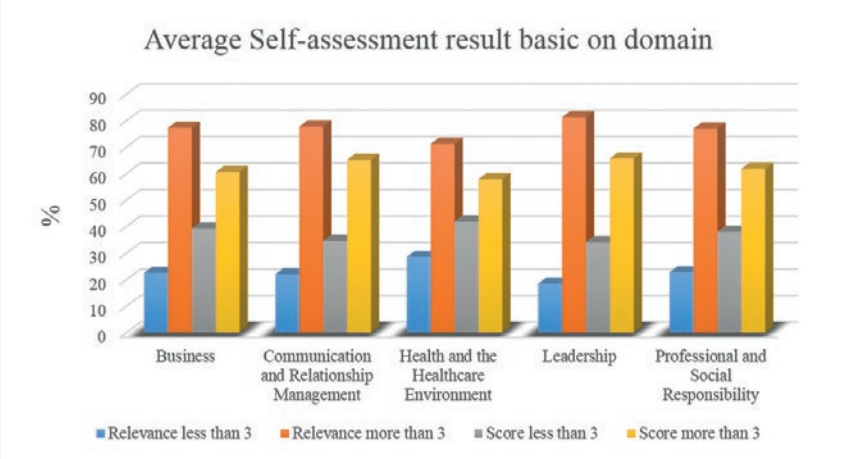
Variable	number	%
Gender		
Male	269	89
Female	34	11
Age		
50-60	96	32
40-50	153	50
30-40	46	15
20-30	8	3
Education		
Bachelor	112	37
Master	124	41
MD	52	17
PhD	15	5
Qualification		
Nurse	80	26
Physician	52	17
Health care Management	49	16
Not mentioned	149	49
Job position		
C-suite member (COO, CFO, CNO, CMO,CIO, etc.)	82	26
Top executive (CEO, President)	190	63
other	33	11
Position Length		
Less than 2 years	74	24
2 to 5 years	78	26
5 to 10 years	71	23
More than 10 years	80	27
Work Length		
Less than 2 years	7	2
2 to 5 years	7	2
5 to 10 years	34	11
More than 10 years	252	84

Source: Adapted from IHF data

The results (Figure 1 and Table 2) show that relevance and score percentages rating over three are, respectively, more than 70% and more than 58%.

The twenty most relevant competencies rating equal to or under 3 are 47 (46.9%), 55 (44.6%), 23 (42.9%), 19 (38.9%), 14 (38.6%), 9 (38%), 35 (37.3%), 25 (36.3%), 1 (34.7%), 51

FIGURE 1: AVERAGE SELF-ASSESSMENT BASED ON DOMAIN



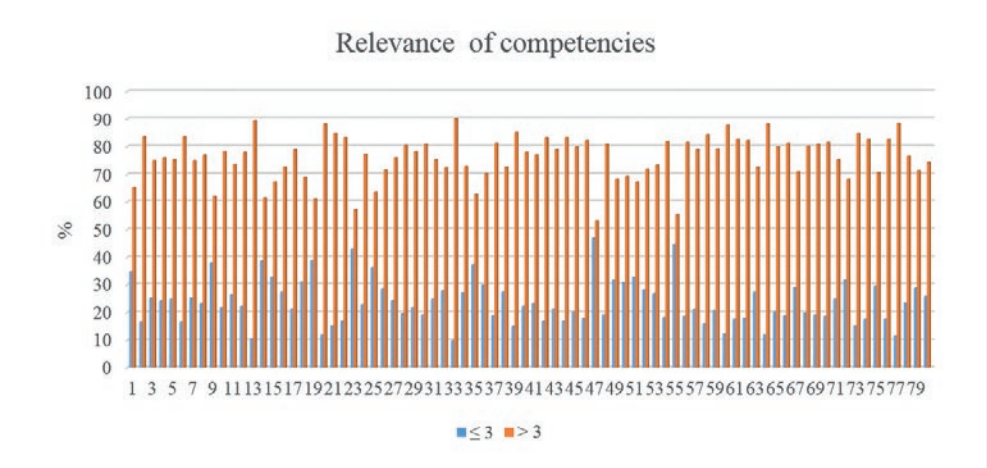
Source: Adapted from IHF data

(32.7%), 15 (32.7%), 49 (31.7%), 72 (31.7%), 18 (31%), 50 (30.7%), 36 (29.7%), 75 (29.4%), 67 (29%), 79 (28.7%) and 26 (28.4%).

Scoring of Competencies

The twenty highest scoring competencies rating over three are (Table 2) 33 (74.9%), 60 (72.6%), 40 (70.6%), 42 (70.3%), 2 (70%), 73 (68.6%), 62 (68.3%), 17 (68.3%), 13 (67.77%), 74 (67.3%), 43 (67.3%), 69 (67%), 20 (66.7%), 61 (66.7%), 76 (66.7%), 65 (66.3%), 28 (66%), 68 (66%), 57 (66%) and 41 (66%).

FIGURE 2: RELEVANCE OF COMPETENCIES



Source: Adapted from IHF data

Twelve out of the twenty highest performing competencies rating over three are shared by both areas (demonstrate strong listening and communication skills; abide by laws and regulations applicable to the work of the organization; develop and implement quality assurance and patient satisfaction and safety programs according to national initiatives on quality and patient safety; hold self and others accountable for surpassing organizational goals; advocate for rights and responsibilities of patients and their families; encourage diversity of thought to support innovation, creativity and improvement; ensure that applicable privacy and security requirements are upheld; demonstrate effective interpersonal relationships and the ability to develop and maintain positive stakeholder relationships; analyze problems, promote solutions and encourage decision making; commit to competence, integrity, altruism and the promotion of the public good; articulate, and communicate the mission, objectives and priorities of the organization to internal and external entities).

The twenty highest scoring competencies rating equal to or under 3 are 55 (52.1%), 47 (51.8%), 5 (51.2%), 23 (49.2%), 1 (48.2%), 9 (46.9%), 7 (45.9%), 25 (44.9%), 72 (44.9), 53 (44.9%), 27 (44.9%), 18 (44.2), 19 (43.6%), 14 (43.6%), 49 (43.6%), 52 (43.6%), 36 (42.9%), 26 (41.9%), 66 (41.9%) and 15 (41.6%).

Thirteen among the twenty highest performing competencies rating equal to or under three are shared by both areas (relevancy and score). These include the following:

- recognize the local implications of global health events to understand global interconnectivity and its impact on population health conditions;
- apply marketing principles and tools to develop appropriate marketing strategies to the needs of the community; manage within the governance structure of the organization;
- interpret public policy, legislative and advocacy processes within the organization;
- demonstrate knowledge of basic business practices, such as business planning, contracting, and project management;
- practice cultural sensitivity in internal and external communications; evaluate whether a proposed action aligns with the organizational business/strategic plan;
- ensure optimal use of information and trend analysis within the organization through the use of business intelligence, information management and clinical/business systems;
- Create and maintain a system of governance that will ensure appropriate oversight of the organization;
- Demonstrate the ability to optimize the healthcare workforce around local critical workforce issues, such as shortages, scope of practice, skill mix, licensing and fluctuations in service;
- Advocate for and participate in healthcare policy initiatives, effectively apply knowledge of organizational systems theories and behaviors;
- Prepare and deliver business communications such as meeting agendas, presentations, reports and project communication plans;
- Lead the development of key planning documents, including strategic plans, business service plans and business cases for new services.

FIGURE 3: SCORING OF COMPETENCIES

Source: Adapted from IHF data

Competencies and Length of Position

The following Table shows that "communication skills and engagement" rate the highest for relevance and score over three. Also, the three following competencies--promote the establishment of alliances and consolidation of networks, apply marketing principles and tools to develop appropriate marketing and ensure optimal use of information and trend analysis within the organization through the use of business intelligence, information management and clinical/business systems--rate the highest of all groups for relevance and score under 3.

Competencies and Work Duration: (84% of them have worked longer than 10 years)

The following table shows that "demonstrating strong listening and communication skills" and "holding oneself and others accountable for surpassing organizational goals" perform the highest as far as relevance and score over 3. In addition, five competencies rate the highest of all groups for relevance and score under 3, as follows:

TABLE 3: COMPETENCIES AND LENGTH OF POSITION

	range	Competency number				
		less than 2 years	2 to 5 years	5 to 10 years	more than 10 years	common
Relevance	> 3	13, 73, 33, 2, 20, 60, 21, 74, 65, 22, 6, 42, 10, 65, 39, 46, 66, 61, 28, 37	77, 64, 20, 33, 39, 60, 21, 44, 45, 76, 13, 22, 46, 56, 66, 73, 6, 58, 61, 2	58, 33, 13, 64, 77, 60, 46, 54, 74, 6, 56, 48, 20, 37, 70, 76, 30, 57, 43, 2	13, 33, 39, 20, 77, 60, 62, 64, 21, 17, 44, 42, 22, 69, 37, 61, 74, 6, 70, 30	33, 13, 20
	≤ 3	47, 23, 55, 49, 9, 50, 35, 19, 36, 15, 1, 72, 18, 26, 14, 51, 79, 11, 75	19, 55, 47, 9, 35, 1, 23, 34, 51, 15, 25, 14, 49, 52, 67, 72, 36, 75, 79, 17	47, 55, 14, 19, 23, 25, 35, 15, 18, 9, 1, 38, 16, 75, 32, 50, 51, 79, 4, 26	79, 80, 14, 23, 47, 55, 35, 1, 51, 25, 9, 72, 16, 53, 49, 26, 63, 50, 19, 3	47, 23, 55, 9, 35, 19, 1, 14, 51, 79
Score	> 3	60, 17, 2, 33, 58, 42, 73, 62, 40, 6, 43, 71, 30, 65, 13, 74, 32, 28, 57, 61	33, 2, 40, 20, 60, 73, 69, 13, 73, 37, 16, 28, 41, 61, 62, 8, 42, 44, 74, 76, 4	60, 39, 33, 62, 65, 40, 13, 76, 77, 17, 6, 2, 42, 68, 57, 54, 3, 22, 37, 74	42, 33, 40, 64, 60, 43, 41, 73, 74, 28, 17, 57, 61, 69, 68, 62, 76, 51, 34, 65	60, 33, 62, 40
	≤ 3	5, 36, 9, 47, 1, 53, 55, 45, 25, 19, 7, 10, 26, 23, 38, 18, 15, 29, 3, 52	55, 47, 23, 14, 5, 9, 1, 7, 18, 72, 11, 27, 36, 3, 22, 52, 76, 24, 26, 35	23, 25, 5, 52, 49, 48, 55, 47, 9, 1, 19, 66, 16, 27, 51, 28, 7, 24, 35, 53	47, 55, 5, 23, 1, 7, 72, 27, 49, 37, 14, 53, 25, 18, 4, 56, 9, 45, 19, 70	47, 1, 55, 7, 23

Source: Adapted from IHF data

- promoting the establishment of alliances and consolidation of networks to expand social and community participation in health networks, both nationally and globally;
- advocating for and participating in healthcare policy initiatives;
- recognizing the local implications of global health events to understand global interconnectivity and its impact on population health conditions;
- managing within the governance structure of the organization:
- demonstrating knowledge of basic business practices, such as business planning, contracting, and project management.

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TABLE 4: COMPETENCIES AND WORK DURATION

	range	Competencies' number		
		under 10 years	over 10 years	common
Relevance	> 3	76, 74, 64, 73, 62, 39, 42, 46, 69, 40, 33, 60, 13, 77, 21, 58, 2, 78, 75	33, 13, 20, 77, 60, 64, 21, 22, 39, 58, 2, 12, 6, 44, 73, 61, 42, 54, 56, 70	64, 73, 39, 42, 33, 60, 13, 77, 21, 58, 2
	≤ 3	47, 55, 25, 1, 19, 15, 49, 9, 50, 3, 18, 11, 23, 72, 26, 52, 35, 51, 7, 5	47, 23, 55, 14, 19, 35, 9, 25, 1, 51, 15, 72, 75, 18, 49, 36, 67, 50, 38, 79	47, 55, 25, 1, 19, 15, 49, 9, 50, 3, 18, 72, 35, 51
Score	> 3	33, 60, 73, 13, 40, 2, 69, 32, 51, 75, 17, 62, 41, 8, 43, 68, 77, 16, 42, 74	33, 60, 42, 40, 2, 17, 61, 62, 74, 43, 46, 65, 13, 20, 28, 39, 57, 64, 69, 68	33, 60, 40, 2, 69, 17, 62, 43, 68, 42, 74
	≤ 3	47, 72, 24, 27, 55, 7.52, 66, 1, 4, 5, 15, 19, 25, 46, 63, 9, 10, 11, 14	55, 5, 47, 23, 1, 9, 53, 7, 25, 18, 27, 72, 14, 49, 36, 52, 19, 26, 38, 79	47, 72, 27, 55, 7, 5, 19, 25, 9, 14

Source: Adapted from IHF data

Conclusion

The results of our study point out that Iranian hospital managers need to improve in the two domains of business and healthcare environmental services. Also, almost 30% of hospital managers need to improve all their competencies, especially the following three: recognizing the local implications of global health events to understand global interconnectivity and its impact on population health conditions, promoting the establishment of alliances and consolidation of networks and effectively using key accounting principles and financial management tools, such as financial plans and measures of performance, which are rated lowest for relevance.

Biographies

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TABLE 2: HEALTH CARE MANAGEMENT COMPETENCY

Subdomain	Competencies	relevance		score		NO
		≤ 3	> 3	≤ 3	> 3	
Information Management	Ensure optimal use of information and trend analysis within the organization through the use of business intelligence, information management and clinical/business systems	34.7	65.3	48.2	51.8	1
	Ensure that applicable privacy and security requirements are upheld	16.5	83.5	30.0	70.0	2
	Promote the effective management, analysis and communication of health information	25.1	74.9	38.9	61.1	3
	Use data sets to assess performance, establish targets, monitor indicators and trends and determine if deliverables are met	24.1	75.9	39.6	60.4	4
Financial Management	Effectively use key accounting principles and financial management tools, such as financial plans and measures of performance (e.g., performance indicators)	24.8	75.2	51.2	48.8	5
	Plan, organize, execute and monitor the resources of the organization to ensure optimal health outcomes and effective quality and cost controls	16.5	83.5	36.0	64.0	6
	Use principles of project, operating and capital budgeting	25.1	74.9	45.9	54.1	7
General Management	Collate relevant data and information, and analyze and evaluate this information to support or make an effective decision or recommendation	23.1	76.9	39.3	60.7	8
	Demonstrate knowledge of basic business practices, such as business planning, contracting, and project management	38.0	62.0	46.9	53.1	9
	Seek information from a variety of sources to support organizational performance, conduct needs analysis and prioritize requirements	21.8	78.2	40.9	59.1	10
Human Resource Management	Effectively manage departmental human resource processes, including scheduling, performance appraisals, incentives, staff recruitment, selection and retention, training and education, motivation, coaching and mentoring and appropriate productivity measures	26.4	73.6	40.9	59.1	11
	Provide leadership in defining staff roles and responsibilities, developing appropriate job classification/grading systems and workforce planning	22.1	77.9	38.9	61.1	12
Laws and Regulations	Abide by laws and regulations applicable to the work of the organization	10.6	89.4	32.3	67.7	13
Organizational Dynamics and Governance	Interpret public policy, legislative and advocacy processes within the organization	38.6	61.4	43.6	56.4	14
	Create and maintain a system of governance that will ensure appropriate oversight of the organization	32.7	67.3	41.6	58.4	15
	Demonstrate knowledge of governmental, regulatory, professional and accreditation agencies	27.4	72.6	37.0	63.0	16
	Demonstrate knowledge of the role of leadership within governance structure	21.1	78.9	31.7	68.3	17
	Effectively apply knowledge of organizational systems theories and behaviors	31.0	69.0	44.2	55.8	18
	Manage within the governance structure of the organization	38.9	61.1	43.6	56.4	19
Quality Improvement	Develop and implement quality assurance and patient satisfaction and safety programs according to national initiatives on quality and patient safety	11.9	88.1	33.3	66.7	20
	Develop and track indicators to measure quality outcomes, patient satisfaction and safety, and plan continuous improvement	15.2	84.8	38.9	61.1	21
Risk Management	Effectively use risk management principles and programs, such as risk assessment and analysis and risk mitigation	16.8	83.2	39.3	60.7	22
Strategic Planning and Marketing	Apply marketing principles and tools to develop appropriate marketing to the needs of the community	42.9	57.1	49.2	50.8	23
	Develop and monitor strategic operating-unit objectives that are aligned with the mission and its strategic objectives	22.8	77.2	41.6	58.4	24
	Evaluate whether a proposed action aligns with the organizational business/ strategic plan	36.3	63.7	44.9	55.1	25

Strategic Planning and Marketing	Lead the development of key planning documents, including strategic plans, business service plans and business cases for new services	28.4	71.6	41.9	58.1	26
	Plan for business continuity in the face of potential disasters that could disrupt service delivery	24.1	75.9	44.9	55.1	27
Supply Chain Management	Adhere to procurement regulations in terms of contract management and tendering guidelines	19.5	80.5	34.0	66.0	28
	Effectively manage the interdependency and logistics of supply chain services within the organization	21.8	78.2	38.9	61.1	29
	Effectively manage the supply chain to achieve timelines and efficiency of inputs, materials, warehousing and distribution so that the supplies will reach the end user in a cost-effective manner	19.1	80.9	38.6	61.4	30
Systems Thinking	Connect the interrelationships among access, quality, cost, resource allocation, accountability and community need	24.8	75.2	38.9	61.1	31
	Demonstrate an understanding of the interdependency, integration, and competition among healthcare sectors	27.7	72.3	35.3	64.7	32
Communication Skills and Engagement	Demonstrate strong listening and communication skills	9.9	90.1	25.1	74.9	33
	Demonstrate understanding of the function of media and public relations	27.1	72.9	37.6	62.4	34
	Practice cultural sensitivity in internal and external communication	37.3	62.7	40.3	59.7	35
	Prepare and deliver business communications such as meeting agendas, presentations, reports and project communication plans	29.7	70.3	42.9	57.1	36
	Present results of data analysis in a way that is factual, credible and understandable to the decision makers	18.8	81.2	38.3	61.7	37
Facilitation and Negotiation	Build and participate in effective multidisciplinary teams	27.4	72.6	41.3	58.7	38
	Demonstrate problem-solving skills	14.9	85.1	34.7	65.3	39
	Manage conflict through mediation, negotiation and other dispute resolution techniques	22.1	77.9	29.4	70.6	40
Relationship Management	Demonstrate collaborative techniques for engaging and working with stakeholders	23.1	76.9	34.0	66.0	41
	Demonstrate effective interpersonal relationships and the ability to develop and maintain positive stakeholder relationships	16.8	83.2	29.7	70.3	42
	Practice and value transparent shared decision making and understand its impacts on stakeholders	21.1	78.9	32.7	67.3	43
Health Systems and Organizations	Assess the performance of the organization as part of the health system/ healthcare services	16.8	83.2	38.0	62.0	44
	Balance the interrelationships among access, quality, safety, cost, resource allocation, accountability, care setting, community needs and professional roles	20.1	79.9	41.6	58.4	45
	Demonstrate an understanding of system structures, funding mechanisms and how healthcare services are organized	17.8	82.2	39.3	60.7	46
	Promote the establishment of alliances and consolidation of networks to expand social and community participation in health networks, both nationally and globally	46.9	53.1	51.8	48.2	47
	Use monitoring systems to ensure legal, ethical, and quality/safety standards are met in clinical, corporate and administrative functions	19.1	80.9	39.9	60.1	48
Health Workforce	Demonstrate the ability to optimize the healthcare workforce around local critical workforce issues, such as shortages, scope of practice, skill mix, licensing and fluctuations in service	31.7	68.3	43.6	56.4	49
Person-Centered Health	Effectively recognize and promote patients and their family's/caregiver's perspectives in the delivery of care	30.7	69.3	40.3	59.7	50
	Include the perspective of individuals, families and the community as partners in healthcare decision-making processes, respecting cultural differences and expectations	32.7	67.3	37.6	62.4	51

Public Health	Establish goals and objectives for improving health outcomes that will incorporate an understanding of the social determinants of health and of the socioeconomic environment in which the organization functions	28.1	71.9	43.6	56.4	52
	Evaluate critical processes connected with the public health surveillance and controls systems and communicate relevant surveillance information to increase response to risks, threats, and damage to health	26.7	73.3	44.9	55.1	53
	Manage risks, threats, and damage to health during disasters and/or emergency situations	18.2	81.8	36.0	64.0	54
	Recognize the local implications of global health events to understand global interconnectivity and its impact on population health conditions	44.6	55.4	52.1	47.9	55
	Use vital statistics and core health indicators to guide decision making and analyze population health trends to guide the provision of health services	18.5	81.5	40.3	59.7	56
Driving Innovation	Encourage diversity of thought to support innovation, creativity and improvement	21.1	78.9	34.0	66.0	57
Engaging Culture and Environment	Create an organizational climate built on mutual trust, transparency and a focus on service improvement that will encourage teamwork and supports diversity	15.8	84.2	35.0	65.0	58
	Encourage a high level of commitment from employees by establishing and communicating a compelling organizational vision and goals	20.8	79.2	37.6	62.4	59
	Hold self and others accountable for surpassing organizational goals	12.2	87.8	27.4	72.6	60
Leadership Skills and Behavior	Analyze problems, promote solutions and encourage decision making	17.5	82.5	33.3	66.7	61
	Articulate and communicate the mission, objectives and priorities of the organization to internal and external entities	17.8	82.2	31.7	68.3	62
	Incorporate management techniques and theories into leadership activities	27.4	72.6	40.3	59.7	63
Leading Change	Promote ongoing learning and improvement within the organization	11.9	88.1	35.0	65.0	64
	Respond to the need for change and lead the change process	20.1	79.9	33.7	66.3	65
Contributions to the Profession	Contribute to the advancement of the healthcare management profession by sharing knowledge and experience	18.8	81.2	41.9	58.1	66
	Develop others by mentoring, advising, coaching and serving as a role model	29.0	71.0	39.3	60.7	67
	Support and mentor high-potential talent within both one's organization and the profession of healthcare management	19.8	80.2	34.0	66.0	68
Ethical Conduct and Social Consciousness	Demonstrate high ethical conduct, commitment to transparency and accountability for one's actions	19.1	80.9	33.0	67.0	68
	Maintain a balance between personal and professional accountability, recognizing that the central focus is the needs of the patient/community	18.5	81.5	38.9	61.1	70
	Use the established ethical structures to resolve ethical issues	24.8	75.2	36.0	64.0	71
Personal and Professional Accountability	Advocate for and participate in healthcare policy initiatives	31.7	68.3	44.9	55.1	72
	Advocate for rights and responsibilities of patients and their families	15.2	84.8	31.4	68.6	73
	Commit to competence, integrity, altruism and the promotion of the public good	17.5	82.5	32.7	67.3	74
	Demonstrate an ability to understand and manage conflict-of-interest situations as defined by organizational bylaws, policies and procedures	29.4	70.6	38.6	61.4	75
	Practice due diligence in carrying out fiduciary responsibilities	17.5	82.5	33.3	66.7	76
	Promote quality, care safety and social commitment in the delivery of health services	11.6	88.4	35.3	64.7	77
Professional Development and Lifelong Learning	Demonstrate commitment to self-development, including continuing education, networking, reflection and personal improvement	23.4	76.6	40.3	59.7	78
Self-Awareness	Be aware of one's own assumptions, values, strengths and limitations	28.7	71.3	40.9	59.1	79
	Demonstrate reflective leadership by using self- assessment and feedback from others in decision making	25.7	74.3	38.6	61.4	80

Source: International Hospital Federation - https://healthmanagementcompetency.org/base

Public-Private Partnerships (PPPs) in Healthcare: Gauging Leadership Competencies of Hospital Managers

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ABSTRACT: Public Private Partnerships (PPPs) are a growing worldwide strategy that promotes private sector investment to support health sector reform initiatives. Our research on healthcare management competencies in Mexico involves diagnosing strengths and weaknesses of healthcare professionals and ultimately helping develop competency-based educational training programs that increase mastery of competencies to improve health systems and outcomes. In the two previous phases of this research, we developed, administered, and analyzed a survey for managers within hospital-based PPPs–principally in Mexico–to identify challenges and what capacity-building resources exist. The current phase of research described in this paper is focused on studying healthcare management competencies of hospital managers from these two sites in Mexico. In October 2017, we followed up with managers from these sites to share our results and to conduct the current survey based on the new International Hospital Federation (IHF) healthcare management competency tool. We will be working with these partners on determining next steps for closing gaps in various competencies identified through the surveys.

Introduction

Several co-authors of this paper began two years ago to study public-private partnerships (PPPs) as a means of developing and strengthening health system capacity in low resource settings. The PPP model brings together private investors, governmental agencies responsible for providing health and hospital services to a defined population, and professional management companies. Based upon a negotiated three-party agreement among the entities, hospital facilities can be constructed or renovated to improve the population's access to care.

However, the perceptions of the joint effort can vary significantly among the PPP participants thereby potentially complicating the effort. The investor will be looking for preservation of capital and a return on investment, the governmental agency will be looking to satisfy political expectations of the sponsoring government, and the professional management company will be seeking to manage the provision of hospital services within budgeted parameters.

A questionnaire to study these challenges was piloted previously for managers of a tertiary Mexican hospital developed on the PPP model. That survey confirmed known challenges including difficulties in interpersonal communication and gaps in participant training, which underscored the need for effective health management training and mentoring systems in the required competencies.

Approximately one year later, several of the co-authors conducted a Phase II validation study to determine the effectiveness of the original questionnaire in capturing participants' perceptions of selected managerial issues. The Phase II study included 29 survey responses from Mexico as well as one each from Kenya, the Republic of Georgia, the Czech Republic, and Slovakia. This Phase II study included representatives of the three elements of a PPP: investors, governmental representatives (i.e., the client), and managers/operators.

After becoming familiar with the perceived needs as identified

by the participants from the three groups, the authors proposed using International Hospital Federation (IHF) Leadership Competencies for Health Services Managers as the basis for further diagnostic and educational efforts for PPP participants (IHF-2016).

This paper describes the findings of the Phase III study to gauge leadership competencies of hospital managers at two sites in Mexico where Phase I and II questionnaires were previously administered. A brief review of (1) the relevant literature regarding PPPs and (2) leadership competencies and training for healthcare managers are provided as context to better understand the findings presented.

What are Public-Private Partnerships (PPPs)?

The term PPP was first used to describe the relationships behind health improvement and infrastructure projects in the United Kingdom in the late 1970's (Stevenson-2016; Taylor, Nalamada ,& Perez-2017). Ormsbee (2017) and Taylor, Nalamada, and Perez (2017), however, argue that the concept of public and private entities partnering on projects dates back to ancient times as governments developed basic partnerships to "achieve public goals…" while allowing "…private actors to benefit as well" (Ormsbee-2017: 237). Ormsbee also notes that PPPs have gained popularity and value in municipal projects over the last few decades. One must look even more recently (in the 1990's) to see the influence of PPPs in healthcare and related industries as they became essential funding sources in the fight against airborne and bloodborne diseases (Barr-2007; Caballer-Tarazona & Vivas-Consuelo-2016).

A time gap exists between the growth of PPPs in municipalities and their use in financing healthcare projects. However, PPPs grew in popularity throughout that time and continued to thrive since. Two common features of PPPs help drive their growth and highlight their continued use. The first is a collaborative, contractual, risk-sharing agreement that outlines responsibilities in order to capitalize on the various parties' strengths (McClure, Ryder, & Devita-2017; Ormsbee-2017; Stachelski-2017). The second is a tendency toward greater project efficiency and higher quality results (Larsen, Aust, & Hogelund-2017; Ormsbee-2017).

The remainder of this brief review of PPPs will concentrate on recent literature that highlights the success of PPPs in healthcare or on successful practices that could be utilized by healthcare entities. Imtiaz et al. (2017) found encouraging results stemming from the formation of the People's Primary Health Care Initiative (PPHCI), a Pakistani government and private partner PPP, and its application to maternal and child health services. Data reviewed from the pre-PPHCI and post-PPHCI periods revealed a significant increase in utilization of key services. In addition, the authors note their findings are consistent with research done in other low- and middle-income countries that show a marked improvement in services after the involvement of PPPs. They further noted that the improvement was not dependent on PPP model but was greater when the contract covered full service delivery as opposed to only management contracts.

Hellowell (2016) and Ormsbee (2017) discuss the successful use of PPPs for acquisition of new technology; however, they do so from divergent perspectives. Hellowell (2016) makes the economic case for PPP formation and investment in new technology in healthcare. He notes that pre-PPP financial concerns stifled innovation and limited technology growth. However, post-PPP involvement saw a rise in financial understanding, and innovation and technology growth increased sharply.

Ormsbee (2017) reviewed one of the first applications of PPPs to the U.S. military as the Air Force has increased utilization of partnerships with private entities in order to maximize acquisition of new technology. He emphasizes that structural differences are not as important as transparency throughout the contractual stage of the relationship, especially in the understanding of the risk and responsibilities involved. Transparency leads to "A reliable legal framework…" (246) that, as Ormsbee argues, is essential to a successful partnership. He also suggests the importance of managerial understanding of the contractual relationship.

Similar to Ormsbee's emphasis on understanding the contractual relationship behind a PPP is the work completed by Iyer et al. (2017). The primary reason for their work was to examine the characteristics of facilities collaborating with obstetricians in Gujarat, India in order to facilitate higher quality childbirth. Their research revealed select "…facility characteristics that predicted participation" (1). However, they also emphasized the importance of the remuneration package within the agreement, as it was successful in accomplishing one of the program goals: to reduce unnecessary cesarean procedures through unique disincentives.

Transparency is also emphasized by Vian, McIntosh, & Grabowski (2017), albeit for a different reason. The authors note a high level of perceived corruption in healthcare. They quote World Health Organization figures that estimate $415 billion in healthcare expenditures lost as a result of fraud and abuse. They also reference various articles that examine the depth and effects of corruption in healthcare. Vian et al. argue that the development and implementation of written policies and procedures and other changes in structure and operations common to PPPs positively influence transparency, which helps to deter corruption. Through interviewing leadership of a hospital in Lesotho, Africa one and a half years after the hospital transitioned from a government run facility to a new PPP-based facility, they determined that an increase in managerial discretion, transparency, accountability, and detection were important drivers in reducing corruption.

Another important factor to PPP success is the partners themselves. Through research aimed at investigating the source of improvement in benefit case management in Denmark, Larsen, Aust, and Hogelund (2017) found that the PPP-driven intervention was not as important as the partners. The same intervention that focused on improving quality and efficiency was applied across six municipalities. The authors determined that the intervention had a negligible effect while the differences in municipalities had an important role in improving outcomes. They suggest further research to examine which factors within the municipalities were driving the change.

The importance of the actors in the success of PPPs in healthcare is further exemplified by research completed in the Bagamoyo district of Tanzania by Kamugumya and Olivier (2016). The reluctance of local entities, both individuals and organizations, to partner with outside entities combined with weak government oversight hindered the formation of PPPs to provide reproductive

and child health services. The authors state the importance of changing those social contracts that fail to support collaborative efforts with outside entities.

In order to fully understand how to drive successful PPPs, it is important to look beyond healthcare for characteristics that could be ported to healthcare and related industries. McClure, Ryder, and DeVita (2017) examined the use of PPPs created by three public research universities to manage student housing. Each of the three institutions embarked upon strategic initiatives to, as noted by the authors, "…reposition [themselves] for improved national reputation…" (87) and respond to competition. These strategic decisions motivated the institutions to seek partners for the initiative.

The authors found select profile characteristics, shared by the institutions, which are strikingly similar to the factors driving healthcare PPPs. Each of the institutions was facing the loss of funding sources and needed to rebrand itself or redesign portions of the organization. The importance of communication in understanding the relationship and building trust between all parties during both the contracting and operational stages was emphasized. Another key characteristic of these relationships was the need to navigate the cultural differences between public and private organizations to get to a shared vision. The last factor was the need to remain customer-friendly. Even though each institution structured the PPP relationship differently, each of the factors noted were vital to success. In fact, one PPP relationship failed as the parties could not navigate these factors effectively.

Hurk (2016) and Stachelski (2017) stressed the importance of patience and flexibility in designing and redesigning PPPs. Hurk explored the 'learning curve' experienced by Belgian governmental entities as they undertook four different infrastructure projects. Each contract was different as all parties found required changes as their experience with PPPs developed. Stachelski (2017) traced the evolution of an economic development association in the city of Arvada, Colorado designed to provide development services to businesses in order to spark innovation and growth. He referred to PPPs and their formation as "…a labor of love and innovation, often taking years of painful trials to shape into effective models" (31) necessary to realize a common vision.

Methods and Results

The survey we adapted to administer for this study was developed by the IHF and its associated partners, and it is available online in Spanish at: https://healthmanagementcompetency.org/base. A full description and list of the 80 leadership competencies for healthcare services managers are available in English through the IHF (IHF- 2016). Our modifications to the survey included the following:

- Balancing the rating scales, for instance so that "Not Relevant" in Part II of the survey corresponded to a zero and so that the median "Relevant" option corresponded to 50% of the maximal rating value (i.e. 2 of 4).
- Adding a "Not Clear" option so that the respondents could select an alternative to the rating scale in the event that a competency was not sufficiently intelligible to them.
- Editing the language of the competencies to ensure clarity and that they were entirely in Spanish. There were some English words retained originally in a few of the IHF competencies.
- Incorporating a survey item strictly for quality control purposes. Interspersed among the competencies, one of the items explicitly instructed respondents to select a specific value (i.e. "1").

The version of the survey that was administered is available upon request. The survey was approved by the administrations of both study sites (designated as "Site 1" and "Site 2" for the purposes of masking the identities of the institutions). Participants were informed verbally and in writing that their participation in the survey was voluntary.

The survey was adapted from the original online version to be administered on paper and consisted of three parts. Part I asked questions to collect basic information for categorizing responses without compromising the privacy of respondents. The results from Part I of the survey are summarized in Table 1. We were able to survey managers representing all PPP roles (i.e. client, investor, and operator) and management levels (i.e. high-level, middle-level, and supervisor) at both sites. The duration of time each manager had been involved in the PPP project was reported as short as 0 months up to 15 years, with an average of 4.5 years.

TABLE 1: DESCRIPTIVE SUMMARY OF RESPONSES TO PART I OF SURVEY

Role in PPP	Site 1 (count)	Site 2 (count)	Combined (count)
Client (Hospital)	3	25	28
Investor	6	1	7
Investor & Operator	0	3	3
Operator	15	6	21
Management Level	**Site 1 (count)**	**Site 2 (count)**	**Combined (count)**
High-level	8	17	25
Middle-lev	13	15	28
Supervisor	3	3	6
Years in Project	**Site 1 (years)**	**Site 2 (years)**	**Combined (years)**
Minimum	0.6	0.0	0.0
Maximum	10.0	15.0	15.0
Average	4.3	4.7	4.5
Standard Deviation	2.5	2.5	2.5

Source: authors

For Part II of the survey, participants were instructed in writing to indicate the relevance of each competency to their present role using the scale provided. The scale ranged from 0 ("Not Relevant") to 4 ("Very Relevant"), with the intermediate option at 2 ("Relevant"). They were also informed that if a competency was

not written clearly, they should select the "Not Clear" option to the far right of the scale.

For Part III of the survey, the respondents were again presented with the 80 competencies and were asked to indicate their level of competency using a similar scale as in Part II. The scale ranged from 0 ("Not Competent") to 4 ("Expert"), with the intermediate option at 2 ("Competent"). As in the original IHF online survey, the order of the competencies was rearranged compared to Part II.

Table 2 includes a brief descriptive summary of the ratings (averages and modes) for Parts II and III. For Part II, the general trend for both sites was that respondents found most competencies to be relevant to their roles, as indicated by the mode of 4 ("Very Relevant") and the average rating of 3.1. The competencies considered least relevant among respondents had a modal rating of 2 ("Relevant"), and they were largely from the categories of "Communications and Relationship Management Competencies" and "Professional and Social Responsibility Competencies." For the self-evaluation in Part III, the ratings were lower than for Part II, with a mode of 2 ("Competent") and average rating of 2.6. The competencies with the highest self-evaluation ratings (i.e., mode of 3 or 4 and average of 3 or above) were generally from the "Leadership Competencies," "Communications and Relationship Management Competencies," and "Professional and Social Responsibility Competencies" categories.

TABLE 2: DESCRIPTIVE SUMMARY OF RESPONSES TO PARTS II AND III OF SURVEY

Part II: Relevance to Role	Site 1	Site 2	Combined
Rating on 0-4 Scale (Average)	3.1	3.2	3.1
Rating on 0-4 Scale (Mode)	4.0	4.0	4.0
Part III: Self-Evaluation	**Site 1**	**Site 2**	**Combined**
Rating on 0-4 Scale (Average)	2.6	2.7	2.6
Rating on 0-4 Scale (Mode)	2.0	2.0	2.0

Source: authors

Note that the results of the survey have been reported in aggregate to protect the anonymity and privacy of respondents. Also, we note that the results of the survey are largely consistent between the two sites, and we have not explicitly made comparisons regarding minor differences between the responses from the two sites here to avoid overinterpreting the data and the possibility of inadvertently misrepresenting the performance of one hospital in comparison with another.

Discussion

We report here our findings from the current phase of our research on leadership competencies of healthcare managers in PPPs, focusing on high specialty hospitals in Mexico where we have previously collaborated to explore the benefits and challenges of the PPP model. We were able to survey 59 managers in total, 24 at Site 1 and 35 at Site 2, representing a wide range of roles within the PPP, management levels, and duration of experience with PPPs. For both sites, respondents identified most competencies as being highly relevant to their roles (Part II of the survey) yet reported lower ratings in their self-evaluation (Part III of the survey), indicating that there is awareness of the need to further develop competencies. Interestingly, the categories of competencies that were ranked the lowest in terms of relevance were also ranked among the highest in terms of self-reported competence. This is an unexpected observation that will require further investigation.

A significant limitation of the self-evaluation methodology used to measure competency levels in Part III of the survey is that it is not possible to distinguish whether a respondent is accurately gauging their own competency nor whether they fully understand what each competency entails. Future work should be directed at designing evaluation methods (such as simulations, peer evaluations, or validated examinations) that can more objectively measure competency levels and proficiency.

We were pleased with the ease of use of the IHF survey and would recommend that the modifications we made be implemented in the future for administering a survey like this. For instance, the "Not Clear" option turned out to be unexpectedly useful because it led to the rapid identification of a minor typo in the survey that was corrected before the survey was administered at the second hospital. This option was also helpful in identifying competencies that are either worded ambiguously or are intrinsically more challenging for respondents to understand.

Future Directions: Education, Training, and Development

The IHF competency model identifies the key competencies needed for healthcare executives. Using the IHF model as the framework guiding our research, specific competencies have been identified and validated as relevant for health executives to lead successful PPPs throughout the world. The question still remains as to the most appropriate venue(s) for training and education to occur that provide opportunities for health executives to develop these competencies.

Situational context becomes a critical factor when determining educational venue. If healthcare managers are currently serving in an executive role at an operational hospital or other facility, on-site learning can be highly effective. There are many factors that may influence the venue such as current educational status, level of professional experience, technological capabilities, cost, accessibility, and other situational attributes. With better tools to identify gaps in competencies, we hope to work with PPP stakeholders to identify appropriate training and educational venues for current health leaders and future health executives in their organizations to help them continue to improve patient care and achieve worthwhile institutional goals.

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The Competency-Based Management Model as a Springboard for Transformation in Health Care and Social Care Organisations

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ABSTRACT: Health care organisations operate in a constantly changing environment. After identifying and prioritizing future healthcare trends and challenges, a competency-based model can help shape leadership management. The competency-based model starts with an analysis and definition of the optimal competencies for each job, based on an association's organisational culture and environmental evolution and opportunities. Organisations can adopt specific measures to meet these challenges through the competency-based managerial model. This will help shape HR policies with a more flexible and coherent approach. Adopting this model is a strategic decision that requires senior management and governance commitment to the professionalisation of the management team.

Introduction

Social and health care organisations operate in a constantly changing environment (increasing demand, social and cultural changes, competition to attract and retain talent, impact of new technologies, new organizational models, ageing population, etc.), so it is vital for these organisations to proactively anticipate these changes, if they are to meet them successfully. The current HR managerial methods are not up to the task, whereas a competency-based model would offer better resources to improve the roles of health care managers and therefore improve the quality of management in these organizations, which would then be better prepared to adapt to the new challenges.

Identifying needs

To this end, La Unió Catalana d'Hospitals (an association of hospital, health and social services providers) set up the project +FUTUR, a prospective exercise carried out in collaboration with our members and the participation of different agents of the social and health care areas, with the purpose of promoting actions to help organisations and professionals anticipate future needs and improve care and assistance.

The +FUTUR project has identified three broad areas of transformation which affect our organisations: the digital transformation, the continuous evolution of care models and humanisation; in this article, we will explain why we are convinced that these are challenges which can only be successfully met through a change of paradigm in HR management, moving from a hierarchical system to a competency-based model.

The competency-based model as a response to these challenges

First of all, it is necessary to briefly summarise the concept of competency-based managerial model within an organisation; this is a model that aims to optimise staff adequacy and defines and shapes recruitment, training, and development policies, as well as capability assessments,

remuneration and numerous other changes in the culture of an organisation. Competencies are "individual (inborn or acquired) characteristics with a causal link with excellent job performance". As an example, consider the personal qualities that distinguish an excellent nurse from one that is only average (motivation, empathy, assertive communication skills, capability for anticipating a patient's needs and so on). If we can define what makes an excellent professional, we can then try to encourage these characteristics or competencies, so that all the professionals of every category can aim for excellence.

First formulated in the 1970s, this notion has been taking on new relevance in recent years in the health and social care areas, as efforts are being made worldwide to professionalise healthcare management. To this end, the Global Consortium for the Professionalisation of Healthcare Management created a Directory of Competencies with the support of the International Hospital Federation. The Healthcare Management Institute of Ireland has also been making remarkable efforts, espousing the use of the Directory and trying to weigh in on European legislation in favour of professionalisation by adopting a formally recognised frame of competencies for careers and educational resources. The Pan-American Healthcare Association is also in the process of formulating a framework graduate and undergraduate education programme for healthcare managers, which includes mechanisms for professional certification and accreditation. Similar efforts are being made in Chile, Costa Rica, Jamaica and other countries.

How to approach a competency-based managerial model

The competency-based model starts off with an analysis and definition of the optimal competencies for each job, based on an association's organisational culture (the same professional may be considered excellent by one association but mediocre by another, depending on cultural criteria, strategy and values). This will shape **recruitment policies**–professionals will be selected not only on the basis of education, training, and experience required for a position, but also on the basis of the competencies the organisation has defined for it. It will have an impact on **training policies**–focusing also on developing competencies for each professional category, along with their potential and performance. It will influence **promotions**–emphasis will be placed on advancing professionals who possess or are able to **develop** the required **competencies** for senior positions. It will affect **remuneration policies**–objectives can be established and performance can be assessed not only from a standpoint of quantity (what) but also quality (how); a variable remuneration system can be established based on both criteria. All the above will nurture the competencies representative of an organisation's culture and values and help share them with the world at large.

Most immediate challenges

The usefulness of this model really comes to shine in the changing environment referred above, with the three broad transformation areas identified by the +FUTUR project (digital transformation, continuous evolution of the care model and humanisation); we will establish that organisations can adopt specific measures to meet these challenges through the competency-based managerial model.

The digital transformation and continuous evolution of the care model pose a great challenge; organisations will need to adapt to the opportunities emerging from new technologies and new treatment models or risk becoming obsolete. A well-implemented competency-based model can help an organisation promote an internal cultural change which values innovation and flexibility, both closely related to the digital transformation and changing care models. When recruiting new staff, competency-specific questions based on previous experience can be prepared, and/or specific tests can be established, indicating whether the candidate has the required personal characteristics; these can also be used to detect and emphasise the presence or lack of competencies when deciding on promotions for senior positions. Essentially, an organisation must attempt by various means to steer its staff towards a culture that fosters change, together with the adoption of new technologies, new therapies, new organisational models, etc. A competency-based model can be of great help to inject this culture in an organisation.

Humanisation poses a challenge in the sense that, as society progresses, so do quality standards for health and social care organisations, which should ensure that their staff is committed to caring for each patient as an individual. A competency-based model can help promote a culture which puts quality and patient care at the centre of a staff's daily priorities and focus, through recruitment, training and development policies, capability management, etc. Also, organisations could benefit from the derived impact on the variable salaries of professionals, by establishing both quantitative (for example, admission/readmission figures) and qualitative objectives (for example, degree of patients' satisfaction), creating a balance between the short and the long term, increasing staff awareness of importance of humanisation and nurturing customer loyalty.

The competency-based managerial model is a strong asset when tackling the challenges facing health and social care organisations today, but it requires several conditions without which it cannot succeed. First of all, the organisation's management should be persuaded of the usefulness of this model, committing to it because it should inform every action and policy undertaken by the organisation.

Adopting this model is a strategic decision. It is implemented in stages (starting by defining culture and values, followed by competency transformation, profile configuration, establishing procedures, etc.) and led by HR management with the support of the organisation's senior management. The whole staff should be engaged in this cultural change through consultation and involvement, if they are to understand and embrace the new model. Also, it is crucial to clearly distinguish between scientific and

technological knowledge and competencies; these are different aspects and need to be analysed independently through selection processes, career assessments and other means so as to correctly identify deficiencies as well any potential for improvement and promote adequate training initiatives. Last, but certainly not least, is the fact that a competency-based management model, by itself, does not necessarily guarantee improved global results; it should go hand in hand with resources and staff adequate enough to meet organisational demands.

Conclusion

We believe that what we discussed in this article makes a strong case for the competency-based model being the most responsible and effective HR policy for organisations and professionals in the health and social care area in this time of constant change and new challenges. Management training and development is key, as well as a comprehensive outlook encompassing the full range of leadership competencies, skills, and capabilities. **Leadership competencies** will help push forward the required changes, favouring innovative and transformational leaderships in this increasingly flowing, more flexible society, fully in the process of changing paradigms, in which the drive for change lies with senior management action. New processes and tools need to be explored to design new solutions to current problems, thus increasing the value of organisations through the promotion of **management and transformation competencies**; these in turn will lead to choosing management mechanisms which facilitate process implementation, organisational efficiency, resource management, planning and more. To make this possible, high-performance, fully committed teams should be built, while expanding the concept of "team" to collaboration and cooperation between organisations and staff, through the development of **relational competencies**.

Biographies

Main authors

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CBEXs Futuro - Brazilian Program for International Leadership in Health

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ABSTRACT: CBEXs has created a low-cost, high-impact leadership development program for younger professionals. In this article, we explore how the program came to be, how it was based on the IHF's leadership competencies for healthcare managers and how its format was created and adapted.

CBEXs

CBEXs - the Brazilian College of Health Executives is an association for professionals in executive positions throughout the health industry in Brazil. It was founded in 2015 and currently counts nearly 500 professionals. CBEXs works along 3 different lines of activity: Education and Certification, Networking and Relationship Building and Representation. In order to join CBEXs, an executive must have management experience in the health industry value chain.

Definition and Diagnosis

CBEXs Futuro is a leadership development program for young healthcare leaders that utilizes the IHF's Global Directory of Leadership Competencies for Healthcare Services Managers as a basis for discussion and development.

The program was created upon a diagnosis of the current state of leadership in the health sector in Brazil. The vast majority of established industry-leaders are over 50 years old, with a significant portion being over 60. Healthcare, however, is going through profound changes, and will need capable leaders to manage organizations effectively–even in the very near future.

Though often very well-trained academically, emerging leaders find few avenues in the hierarchical structure of health organizations to try and develop softer leadership skills, network with their peers and established leaders and gain insights on leadership practices.

At a result, the goal of CBEXs Futuro has been to reduce the distance between emerging leaders and senior, established leaders. On the one hand, this gives the younger group the ability to talk openly to industry leaders outside their organizations, on the other hand, it allows industry leaders to have insights into the challenges faced by the talents emerging in their organizations.

It has also had an effect of building broader, industry-wide networks for the younger leaders, hopefully helping reduce the fragmentation of the health sector in the future.

The International Health Leadership Training Program

Since the beginning, we sought to develop a global program that could possibly be replicated on other scales. Brazil has seen increased globalization in healthcare, and many of the companies doing business in Brazil are parts of larger global conglomerates. As such, we felt that the competencies that leaders needed to develop should also refer to a global framework that would empower them to work as competent managers in an international setting.

The *Leadership Competencies for Healthcare Services Managers* of the International Hospital Federation (IHF) presented us with this opportunity to use a broad, internationally validated and highly utilized directory on which to base our program. We were aware that many of the applicants would not be from healthcare services (see Figure 1) but decided that the Directory was broad enough to accommodate learning objectives for students from other parts of the health industry.

Due to time constraints–this will be a yearly program and it needed to happen within 12 months–the program was based upon competency subdomains, 27 in total, some of which were merged to obtain a total of 20 topics. Once the topics were finalized, interviews were conducted with selected CBEXs executives in order to choose established leaders who would act as mentors for each of the topics.

TABLE 1: CBEXs FUTURO PROGRAM–BASED UPON IHF'S DIRECTORY

Competency Domains	Sub-domains
1. Leadership	1.A. Leadership Skills and Behavior 1.B. Engaging Culture and Environment 1.C. Leading Change 1.D. Driving Innovation
2. Communication and Relationship Management	2.A. Relationship Management 2.B. Communication Skills and Engagement 2.C. Facilitation and Negotiation

3. Professional and Social Responsibility	3.A. Personal and Professional Accountability 3.B. Professional Development and Lifelong Learning, Contributions to the Profession and Self-Awareness. 3.C. Ethical Conduct and Social Consciousness
4. Health and the Healthcare Environment	4.A. Health Systems and Organizations 4.B. Health Workforce and Person-Centered Health 4.C. Public Health
5. Business	5.A. General Management and Organizational Dynamics and Governance 5.B. Laws and Regulations 5.C. Financial Management 5.D. Human Resource Management 5.E. Information Management 5.F. Risk Management and Quality Improvement 5.G Supply Chain Management 5.H. Systems Thinking, Strategic Planning and Marketing

Source: CBEXs

Once each topic had its chosen mentor, the mentors was personally invited to a one-on-one meeting with either Project Leader Eduardo Santana or CBEXs CEO Luiz Felipe Costamilan or both, in which the project was explained and a formal invitation to take part in it was extended. The mentors were invited at least 6 months before the date of their lecture and some over a year in advance. The lectures last 3 hours and occur twice a month either on Wednesday evenings or Saturday mornings.

The mentors were told that there was no compensation involved and also that it was important for young leaders to know the different corporate environments in which healthcare takes place in Brazil; thus, they were asked to deliver their lectures at their places of work. All of the mentors accepted the invitation. After the lecture, the mentors receive a box of chocolates and a handwritten thank you letter.

One month before the designated date for their lecture, the mentors are contacted by CBEXs' education director, in order to set up the methodology and structure of the lecture. The mentor has full control of the lecture, but 4 different standard structures are offered, which may be combined: standard, world café methodology, role-playing and group interview.

Selection Process

After drawing up the program, a selective process was developed to choose the participants: 39 executives up to 39 years old.

Discussions on age initially revolved around selecting 30 under 30. The reality of the healthcare sector, in which many go through very long academic training in a technical profession before undertaking the management path, dictates that only very few people under 30 would have actual leadership experience. 40 under 40 would be the other, more traditional approach, but some of the CBEXs executives interviewed thought that the number 40 would not relay the idea of young leadership. which was a cornerstone of the program.

The program was to be offered for free for CBEXs members, in order to drive up membership and not restrict participation due to economic reasons. At least 100 new CBEXs members can be directly attributed to participation in CBEXs Futuro.

The following were the prerequisites for participation in the selection process:

- Be a CBEXs member;
- Work in a management position in the health sector
- Be no more than 39 years old by 2018
- Send a CV
- Provide a letter of recommendation from a leader in the healthcare field
- Write an essay on the following topic: The future of health in Brazil.

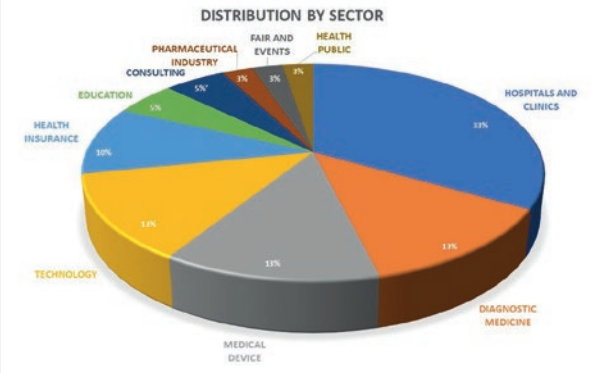
Letters of recommendation were fundamental to generate leadership awareness of the project; asking for two letters as a prerequisite is being considered in this year`s process. 118 students applied, 92 of which fully completed the initial application process. An analysis of the documents submitted allowed the field to be reduced to 65 participants, who were interviewed.

The interviews were conducted by CBEXs Chairman of the Board of Francisco Balestrin, CBEXs Futuro Project Leader Eduardo Santana and CBEXs CEO Luiz Felipe Costamilan. The vast majority of the participants was interviewed by two of the interviewers together.

The interviews lasted 10 minutes and were held by videoconference. All the candidates were asked the same 5 questions, one for each of the competency domains. Their answers were rated objectively on a ten-point scale, and any significant discrepancy in interviewer evaluation was discussed among the interviewers.

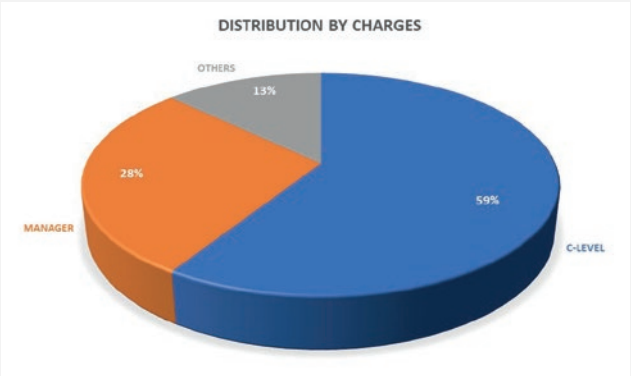
Student Profile

FIGURE 1: DISTRIBUTION OF STUDENTS BY SECTOR



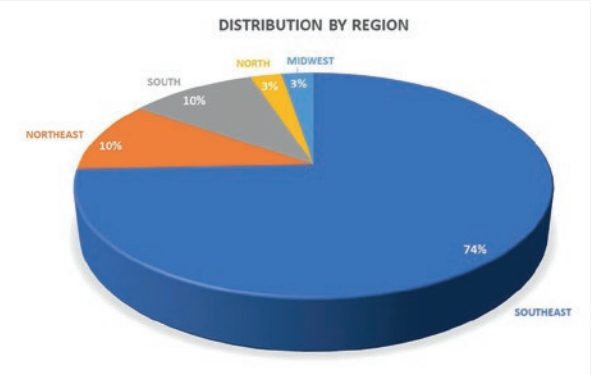
Source: CBEXs Student Files

FIGURE 2: DISTRIBUTION OF STUDENTS BY SENIORITY LEVEL



Source: CBEXs Student Files

FIGURE 3: DISTRIBUTION OF STUDENTS BY REGION



Source: CBEXs Student Files

Program Development

At the beginning of the program, students are made aware that they will need to:

1. Attend at least 50% of the lectures.
2. Watch any lectures they may have missed (the lectures are all recorded, and most of them are transmitted live as well, depending on the infrastructure).
3. Deliver a project for the improvement of the Brazilian Health System. This could be anything from an article to a start-up company, an App, a process improvement or some other idea. The idea must be pre-approved by the project team before development.

Though not a mandatory part of the program, students are also expected to take part in an international training program, which is not free. They are offered 2 options: they can either join a CBEXs delegation to the IHF 's world hospital congress or enroll in a week-long program in the United States. CBEXs has partnered with the American College of Healthcare Executives to develop a training program for young leaders which includes site visits and structured lessons on healthcare leadership.

There has been an enthusiastic response from students. In the first few months, they have already built business relationships, created active discussions on relevant healthcare topics and engaged with established healthcare leaders both inside and outside the lecture spaces.

Financing

The program is relatively inexpensive to run, since the mentors are not compensated and provide the lecture spaces. CBEXs is sometimes expected to provide food and beverage, which is the single biggest expense. The course administration uses CBEXs' facilities. The lectures are recorded and transmitted by cell phone and student interactions and communications all occur on free platforms, such as WhatsApp and YouTube. Membership fees for new CBEXs members (approximately US $300 per year) more than cover the program's expenses. CBEXs' travel expenses for the international programs are included in the student`s packages. Efforts are still ongoing to find sponsorships for the program, which would be an important driver for CBEXs' sustainability.

Conclusion

CBEXs Futuro has proven to be a sustainable way to foster young leadership across the health sector. Though heavily reliant on the goodwill of industry leaders, which donate their time and expertise, the project has proven to be engaging for both students and mentors. There is an ongoing attempt to replicate it at the subnational level, in one of CBEXs' chapters, which might help establish the degree to which the formula can be reproduced. 2019 will see the refinement of the program and student selection process. CBEXs Futuro has also demonstrated the viability of using the IHF's directory of Leadership Competencies for Health Services Managers as a basis for a structured leadership development program.

Biographies

Eduardo Santana is a health care professional with a Master's Degree in Health Politics, Planning and Management from the Federal University of São Paulo. He is the CEO of Nobre Saúde, a long-term care hospital, and a Director of COMSAUDE of the Federation of Industries of the State of São Paulo. He is also the creator and coordinator of CBEXs Futuro within CBEXs.

Luiz Felipe Coutinho Costamilan is the CEO of CBEXs and a Business Administration Graduate from the Catholic University of Rio de Janeiro (PUC-Rio). He has served as National Health Councilor and has advocated for hospitals on issues such as hospital quality, outcome measurement and value-based care. He is also a certified Healthcare Compliance professional.

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Competencies for Future Healthcare Managers in Europe (FHME)

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ABSTRACT: European health systems are facing unprecedented challenges such as ageing population, decreasing budgets, changing societal values and new medical and digital technologies. A collaboration of academic institutions and healthcare providers has developed a frame of reference for healthcare executives and senior managers to help them develop competencies in innovation, leadership, entrepreneurship and management and deal with current and future challenges. The Future Healthcare Manager in Europe (FHME) provides a set of future-focused competencies for senior managers, complementary with existing models, and a set of cases and teaching materials specifically created for developing these new and emerging competencies in healthcare management training programs.

Introduction

Studies of health systems and hospitals in Europe predict a challenging scenario. For instance, European hospitals will be facing changes as far as decreasing budgets, an ageing population with increasing prevalence of chronic diseases and changing societal values (Storey 2013, Ribera 2015). Add to this the tension from introducing new medical technologies and digital transformation; the managers of hospitals and healthcare organizations in general will be required to develop new competencies and capabilities to lead their organizations towards sustainability and value creation (Guerrero 2016, Savage 2017).

Existing competencies and skills models, such as the directory of Leadership Competencies for Healthcare Services Managers (Global Healthcare Management Competencies Directory GHMC 2015), and other references are highly useful and applicable to the development and assessment of managers' competencies. However, executives and managers need points of reference to develop new and emerging competencies that will help them tackle their challenges as leaders (Mascia 2013, Herd 2016, Hernandez 2018). These competencies include incorporating artificial intelligence in healthcare, adapting services to new patient values, agile project management and organization models, designing customer centric services and organizations.

Some academics have worked in the field of innovative competencies for healthcare managers (Lega 2013, Pillay 2016, and have come up with, for example, design thinking, bootstrapping and opportunity assessment and recognition, although without a clear link to the challenges that motivate a need to acquire these competencies.

Moreover, healthcare management associations and medical societies around Europe recognize there is still a large gap between required and realized healthcare executives' and managers' competencies (Lockhart 2009, Lin 2012). Although healthcare management associations at the regional, national and European level are exerting great efforts to generate awareness and develop knowledge through activities such as conferences, seminars and publications, the gap in healthcare management competencies -required versus acquired competencies- is growing due to the large tension created by new technologies and challenges and the fact that training programs are not being updated at the same pace (see Figure 1) (Stefl 2008, West 2015).

Approach

The Future Healthcare Management in Europe (FHME) is a collaboration project that started in 2017 led by five academic institutions: IESE Business School, Karolinska Institutet and University Grenoble-Alpes, and later joined by Ghent University and Medical University of Lodz. Healthcare management associations such as IHF, EAHM, EHMA, HOPE and healthcare providers around Europe have also participated.

The starting aim for this collaboration was to answer the following three questions:

- What type of leaders will be required to manage future hospitals in Europe?
- Which competencies will be required to lead the transformation of hospitals and healthcare in Europe?
- How can these competencies be acquired by current or

FIGURE 1: THE COMPETENCIES GAP OF HEALTHCARE MANAGERS

Source: FHME, https://fhme.eithealth.eu/

future managers?

This collaboration project focused then on the discovery of new and emerging competencies for healthcare managers in Europe and validation of these competencies and their applicability in training programs in Barcelona, Stockholm and Grenoble.

FHME project is an EIT Health education activity (http://eithealth.eu). EIT Health is an alliance of over 140 leading health companies, research institutions, universities and healthcare providers. EIT Health aims to accelerate entrepreneurship and innovation in healthy living and active ageing of people across Europe. The EIT Health campus fosters excellence and innovation in health and business education, to develop novel and unique education programs tailored to create future healthcare leaders and entrepreneurs.

The methodology for developing the FHME competencies included the following steps:

1. A review of the existing literature on healthcare management challenges and models and directories of skills and competencies for healthcare management
2. A series of workshops with the participation of executives and managers from different organizations around Europe
3. An analysis of contributions in different activities and synthesis in a set of definitions
4. A validation of competencies proposed through an online survey

As the goal of the FHME competency model is to provide a set of references for healthcare managers, two additional activities were carried out in 2018 to promote training using the FHME competency model:

5. The development of cases and materials for teaching some selected emerging competencies
6. Training programs to present and validate the FHME model and test the new materials for teaching the competencies.

FHME competencies

FHME aims to be complementary with existing models and will be curated in an open and collaborative way; contributions from any association or organization in Europe will be integrated.

The main purpose of the FHME model is to foster innovation by helping to update training programs and improving the capabilities of healthcare executives and managers. The target of this competency model are chief executives and senior managers; its applicability to middle managers or unit managers may not be as valid, as many competencies describe an integrative mindset required at high organizational levels that are not as relevant for heads of units and other middle levels.

FHME competencies are defined to be flexible and change as the challenges of the health systems evolve. Therefore, these competencies may not be adequate for assessment or self-assessment nor for the comprehensive planning of a management position.

The development and validation counted on the participation of more than 180 participants from various backgrounds (see Figure 2) and included more than 80 experts in face-to-face interactions (workshops, interviews, meetings) and more than 150 online participants. Participants came from many countries in Europe: Andorra, Austria, Belgium, Denmark, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Lithuania, Luxemburg, Netherlands, Norway, Poland, Portugal, Spain, Sweden, Switzerland and the United Kingdom.

In order to identify and develop competencies, the following healthcare management challenges were identified and classified:

1. **Building networks for integrated care** with health and social care providers.
2. **Engaging clinicians** and other healthcare professionals as 'partners'.
3. Promoting models **for patient empowerment** and home care.

FIGURE 2: PARTICIPANTS AND STAKEHOLDERS IN THE ROLE OF FUTURE HEALTHCARE MANAGER

Source: FHME, https://fhme.eithealth.eu/

4. Facilitating **access to new health technologies** and aligning with public priorities.
5. Adapting the **organisational structures** to focus on care processes and patient needs.
6. Promoting **value-based health care** and combining diverse reimbursement models.
7. **Aligning education, research and care** activities as a knowledge-based organisation.
8. Implementing methods for **improving quality, safety and patient experience.**
9. Participating in the **health system change** with regulators and policy makers.
10. **Open collaboration** in the health ecosystem: industry, associations, providers, etc.
11. Transforming processes and systems to leverage **digital technologies** and data.
12. Improving **performance monitoring** and sustainability and involving the public in setting priorities.

These challenges were validated in an online survey of more than 150 participants that considered the most relevant challenges for healthcare managers to be, "Building integrated care networks with health and social care providers" and "Engaging clinicians and other healthcare professionals as 'partners'" (see Figure 3), although there were significant differences in the relevance of these challenges in various countries in Europe.

The resulting model included 30 competencies organized in 6 areas that describe the main initiatives of healthcare leaders in Europe (see Figure 4):

A. Enabling health and social care networks
B. Adapting healthcare services to new models and roles
C. Engaging healthcare professionals as 'internal partners'
D. Transforming the healthcare organization
E. Improving operations towards excellence
F. Strengthening growth and sustainability

An important consideration on the FHME model is that each competency developed was linked at least with one healthcare management challenge.

The current list of FHME competencies is shown in Table 1. The updated list of FHME competencies and their definitions can be viewed at http://fhme.eithealth.eu

The competencies prioritized in the validation were (in this order): Empathic and positive leadership, Collaborative network leadership, and Develop shared organizational vision.

The relevance of some competencies varies significantly amongst countries (see Figure 5), however, all competencies were considered in average very relevant within a scale of 1 (not relevant) to 5 (very relevant).

After the competencies were defined, two faculty development programs for educators in healthcare management, leadership and innovation were organized to present and test new materials for teaching these new and emerging competencies. These programs were implemented in October 2018 at Karolinska Institutet (Stockholm) and in November 2018 at IESE Business School (Barcelona) with more than 60 participants; they combined the case method and discussions on relevant topics in healthcare management education. A set of teaching materials was developed to facilitate teaching some competencies including the following topics: Digital transformation, Leadership and implementation of improvement efforts towards efficiency in times of constraints, Implementation of LEAN and process improvement in a large complex hospital, Compassionate leadership in the ICU, Adapting organizational structures to become more patient centric, Changing the health insurance model and new healthcare business models, Setting innovation priorities in a hospital for the health continuum, New business models in digital health and artificial intelligence and The Patient as a healthcare resource.

Conclusion

Developing competency references for healthcare executives and senior managers is critical for the improvement and sustainability of health systems.

Competency models need to be augmented in order to consider the current and future needs of healthcare leaders, so they can become useful tools for managers and help them plan their professional development and also for academic institutions to update healthcare management and innovation training programs.

Healthcare leaders are highly interested in acquiring these new competencies and educators are encouraged to use the new materials and training methods provided by FHME.

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TABLE 1: FHME - FUTURE-FOCUSED COMPETENCIES FOR HEALTHCARE EXECUTIVES AND MANAGERS

	Competency label	Competency definition
1	**Collaborative network leadership**	Exemplify collaborative leadership by sharing authority and responsibilities and balancing the motivations of network stakeholders and develop clinician leaders that exhibit the same style.
2	**Integrative health ecosystem thinking**	Consider the complex dynamics of the health and care ecosystem and devise actions that integrate all care network stakeholders with special emphasis on leveraging the participation of all actors involved.
3	**Anticipatory business vision**	Anticipate and prepare for possible changes that may impact the role of the healthcare organization in the care network and understand challenges and opportunities of health reforms, policies and other external pressures that may influence the provision model.
4	**Ensure patients and public involvement**	Ensure that the voice of patients is consistently heard at every level of the organization and their needs and preferences considered, including their needs and experiences.
5	**Develop shared organisational vision**	Develop a shared organizational vision that considers professional values, beliefs and motivations and aligns units with the plans of the organization and considers the larger care network and healthcare ecosystem.
6	**Foster patient empowerment and health promotion**	Promote models for the empowerment of patients and citizens, fostering lifestyle counselling interventions and recommendations at all levels of the organization and in the care network.
7	**Develop services adaptability and responsiveness**	Implement models and approaches to facilitate rapid adaptation of healthcare services in response to advances in knowledge and technologies, and changes in patients' and community needs.
8	**Communicate with the public and engage patients' associations**	Communicate with passion and pedagogy with the public, patients and their families and other associations in the health ecosystem and involve them in the co-creation and review of healthcare services.
9	**Develop new professional roles**	Observe changes in health care needs, current professions and boundaries, facilitate development of new roles in the healthcare organization and influence regulators to accept and sustain new professional arrangements.
10	**Promote digital and human-friendly health care models**	Understand and leverage digital technologies for adapting care models to improve access and optimize resource utilization, such as telecare and home care, while considering the 'human' dimension in all interactions and process activities.
11	**Develop models for participatory management**	Develop models for engaging clinicians at all levels of management that foster their involvement in various activities such as planning, directing, organizing, decision-making, monitoring and control.
12	**Unity in top management teams**	Develop "teamness" in top management teams that exhibit a collaborative behaviour, a high level of information exchange and joint-decision making.
13	**Empathic and positive leadership**	Develop active listening and empathy with professionals and demonstrate coherence through conscious empowering and enabling actions that focus on individual needs for meaning and membership.
14	**Multidisciplinary negotiation and compensation systems**	Manage and control the dynamics of negotiation in a complex organization with multidisciplinary professionals, and implement compensation systems that combine economic incentives, professional recognition and development and prosocial contributions.
15	**Foster clinician intrapreneurship**	Foster intrapreneurship by sponsoring opportunities for clinicians to develop their professional projects within the organization and their sense of control over external variables.
16	**Develop transformational leaders**	Develop leaders that communicate and generate trust in change, inspiring optimism and demonstrating honesty and openness in all interactions.
17	**Apply emergent change management**	Apply emergent change approaches for less prescriptive transitions where professionals become change leaders towards new models of care, and provide them with guidance, alternatives and support in decision making.
18	**Organizational ambidexterity**	Balance activities for improving operational excellence with activities that will explore new opportunities for innovation and value creation; to facilitate sustainability, growth and professional satisfaction.
19	**Design patient centric organizational structures**	Apply organizational design towards a more patient-centric model according to grouping patient tracks or needs (such as pathology units, thematic lines or clinical directorates) and removing silos of knowledge or medical specialties.
20	**Agile strategic project management**	Apply agile iterative models for implementing strategic changes and for process improvement to deliver goals in a system where changes happen with increasing speed.

21	**Access to and adoption of new technologies and health innovations**	Anticipate benefits and challenges of new technologies such as genomics, biomics, nanotechnologies, robotics and prosthetic implants for precision medicine and improving clinical processes.
22	**Develop capabilities for adopting external innovations**	Develop capabilities for integrating and scaling external innovations (new drugs, medical technologies, digital and so on), and plan for their potential impact on people, resources, processes and alliances.
23	**Foster collaboration in interdisciplinary and virtual teams**	Foster collaboration and coordination in virtual teams made from diverse specialties, disciplines, units and settings for integrated care.
24	**Resilience and flexibility in performance management**	Maintain focus on goals and persist with efforts in achieving them with a strong need for achievement yet having the capability to adapt and be flexible with new situations that may arise.
25	**Lead comprehensive performance management systems**	Lead the development of models and systems for planning, monitoring, and measuring health, safety, quality and financial outcomes, and their implementation at all levels of the organization, with special emphasis on the individual and team level and with the involvement and consideration of professionals linked to reward models.
26	**Promote responsible and sustainable research and innovation**	Promote research and innovation to respond to the real needs of society, ensuring that integrity, ethics, and risk analysis are considered with transparency and openness of methodology and results.
27	**Develop effective and transformational governance**	Develop effective governance boards and mechanisms that will contribute to the assurance and improvement of organizational performance such as quality, patient safety and efficiency, while energizing initiatives for transformation.
28	**Develop contracting models with focus on value and reported outcomes**	Understand and implement various contracting models with special emphasis on those that are value based, in combination with capitation, packaged services and traditional reimbursement models, and promote evaluations and measures for patient reported experiences and outcomes.
29	**Orchestrate sustainable innovation in the ecosystem**	Orchestrate sustainable initiatives for change and innovation in the care and health network and well-being ecosystem, developing awareness of ecosystem dynamics, assessing the capacity and readiness for change and innovation and building up ecosystem health and resilience.
30	**Detect and assess opportunities for innovation and growth**	Identify changes in the ecosystem that would lead to new opportunities for the improvement of services and make quick evaluations with risk-taking propensity and need for achievement.

Source: FHME, https://fhme.eithealth.eu/

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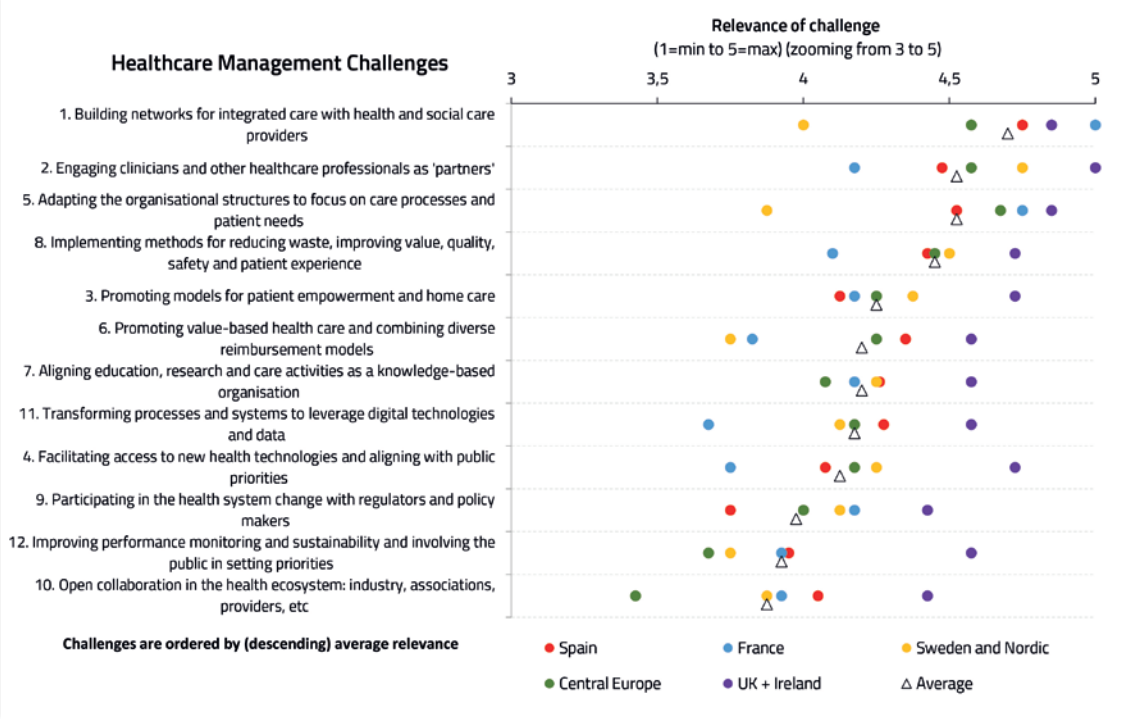
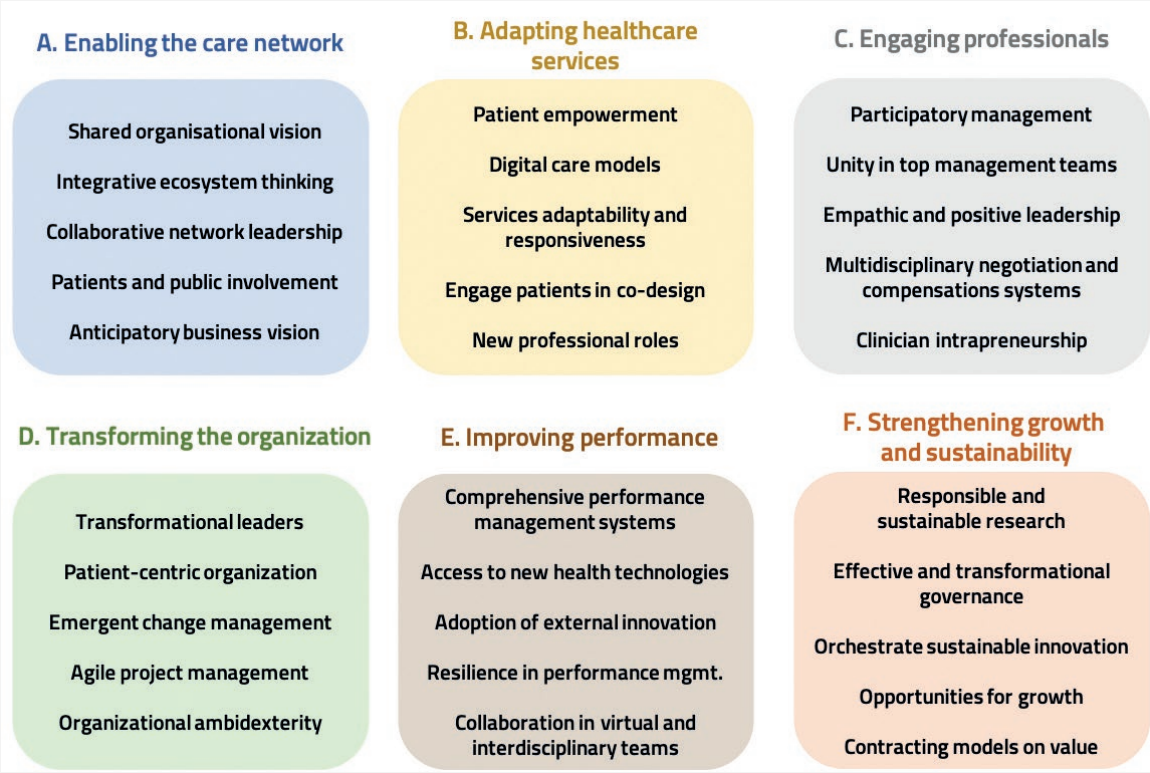
FIGURE 3: VALIDATION OF HEALTHCARE MANAGEMENT CHALLENGES



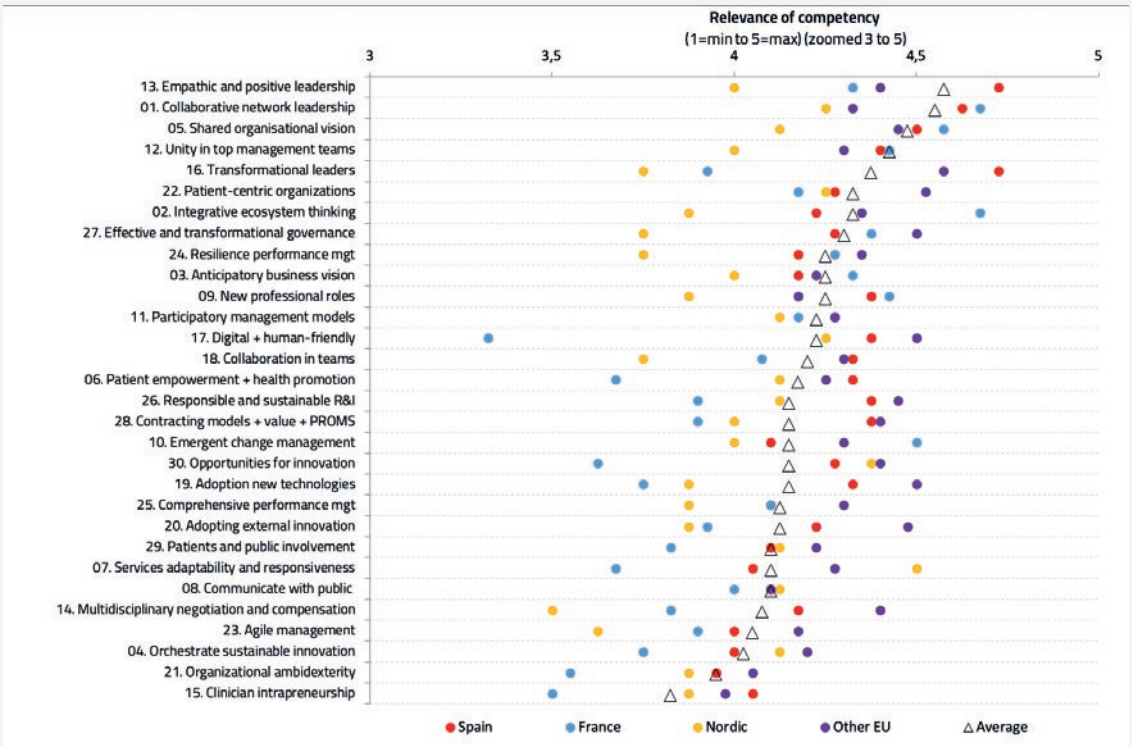
Source: FHME, https://fhme.eithealth.eu/

FIGURE 4: AREAS OF FHME FUTURE-FOCUSED COMPETENCIES



Source: FHME, https://fhme.eithealth.eu/

FIGURE 5: VALIDATION OF COMPETENCIES BY EXPERTS IN 2018



Source: FHME, https://fhme.eithealth.eu/

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Health Care Management Competencies Volume 55 Number 2

Résumés en Français

Accréditation mondiale : Pourquoi le modèle CAHME est important dans l'enseignement de la gestion des soins de santé

L'accréditation mondiale a été approuvée par la « Commission on Accreditation of Health Management Education » (CAHME) en novembre 2018. Un Conseil consultatif mondial et trois sous-comités ont été créés pour mettre en œuvre l'accréditation mondiale. Des stratégies ont été discutées pour organiser un processus d'accréditation globale en tant qu' « épine dorsale » du professionnalisme dans la gestion des soins de santé. La plate-forme de compétences de l'International Hospital Federation (IHF) est reconnue pour ses domaines et sous-domaines ainsi que pour ses compétences spécifiques. L'accréditation est importante parce qu'elle valide la qualité de l'enseignement auprès de divers publics, assure la pertinence des objectifs du programme pour la communauté des professionnels de la santé, offre une occasion de consultation et de rétroaction des collègues, souligne l'importance de l'amélioration continue au moyen d'un modèle de compétences et aide à offrir des programmes de formation en gestion de la santé de qualité aux étudiants. L'enseignement et la formation des cadres en soins de santé demeurent une priorité pour les programmes universitaires d'études supérieures.

Accréditation des cadres supérieurs en soins de santé : Faire progresser la profession grâce au certificat FACHE

Dans l'environnement dynamique et en constante évolution des soins de santé d'aujourd'hui, les leaders éprouvés qui sont prêts à relever les défis de la gestion des soins de santé sont en demande. L'American College of Healthcare Executive répond à ce besoin en offrant la certification FACHE®. Les membres qui obtiennent cette certification reconnue bénéficient d'une crédibilité professionnelle accrue. Les organisations de soins de santé en tirent avantage en confirmant qu'une personne apporte les connaissances, les compétences et les aptitudes nécessaires à son rôle de leader dans le domaine de la santé.

Arguments en faveur des compétences des leaders en matière de soins de santé : Exploration des données probantes

Cet article explore la relation entre la gestion compétente des organisations de soins de santé et son effet sur les performances. Malgré le fait qu'une excellente gestion est essentielle à la création d'organisations de soins de santé hautement performantes, il existe encore de nombreuses régions du monde où le rôle du manager n'est ni suffisamment reconnu ni professionnalisé. Nous examinons la façon dont la préparation à ces rôles peut être réalisée et comment le soutien à ce type d'apprentissage peut améliorer les compétences et les pratiques de gestion des soins de santé, ce qui peut à son tour améliorer le rendement de l'organisation et du système de santé. Nous concluons par un appel à l'amélioration et à l'élargissement des données probantes en matière de gestion des soins de santé.

Rôles émergents dans les soins de santé : une nouvelle approche fondée sur la gestion des compétences

La nécessité de fournir des soins intégrés centrés sur le patient entraîne une réorganisation à grande échelle des systèmes de santé dans le monde entier et incite les responsables politiques et les managers à remettre en question des idées profondément ancrées sur la manière dont un système de santé devrait être géré. Dans ce scénario en évolution, un nombre impressionnant de nouveaux profils professionnels apparaissent dans les milieux hospitaliers et de soins primaires. Pour faire face au défi de la gestion de nouvelles figures professionnelles, cet article propose l'adoption d'un « Dictionnaire des Compétences ». Ce dictionnaire fournit une liste des compétences professionnelles clés ainsi que leurs définitions et leurs niveaux. Appliqué au rôle de coordinateur des autorités sanitaires italiennes, le dictionnaire fournit une description claire de ses caractéristiques.

Compétences des managers en milieu hospitalier : l'étude de cas de l'Iran

En République islamique d'Iran, le Ministère de la santé et de l'éducation médicale (MOHME) prend très au sérieux la couverture maladie universelle (CMU). L'accès à des services de santé de qualité est au cœur de la réalisation de la CMU et l'amélioration du rendement des hôpitaux est un point d'entrée important. Pour atteindre cet objectif, les hôpitaux ont besoin de managers compétents. Dans cette étude, 303 managers en milieu hospitalier ont rempli un questionnaire qui comportait deux volets (pertinence et score). L'objectif de cette étude était de déterminer la pertinence des compétences et d'évaluer la capacité des managers par auto-évaluation.

Partenariats public-privé (PPP) dans les soins de santé : Évaluer les compétences en leadership des managers en milieu hospitalier

Les partenariats public-privé (PPP) sont une stratégie mondiale croissante qui encourage l'investissement du secteur privé pour soutenir les initiatives de réforme du secteur de la santé. Notre recherche sur les compétences en gestion des soins de santé au Mexique consiste à diagnostiquer les forces et les faiblesses des professionnels de la santé et, par la suite, à élaborer des programmes de formation axés sur les compétences qui permettent d'améliorer les systèmes et résultats dans ce domaine. Au cours des deux phases précédentes de cette recherche, nous avons élaboré, géré et analysé un

sondage à l'intention des managers des PPP hospitaliers - principalement au Mexique - pour identifier les défis et les ressources de renforcement des capacités existantes. La phase actuelle de la recherche décrite dans le présent document est axée sur l'étude des compétences en gestion des soins de santé des managers en milieu hospitalier de ces deux sites au Mexique. En octobre 2017, nous avons effectué un suivi auprès des managers de ces sites afin de partager nos résultats et de mener l'enquête actuelle basée sur le nouvel outil de gestion des compétences en soins de santé de l'International Hospital Federation (IHF). Nous travaillerons avec ces partenaires afin de déterminer les prochaines étapes pour combler les lacunes dans les diverses compétences identifiées dans les enquêtes.

Le modèle de gestion par compétences comme tremplin pour la transformation des établissements de santé et d'aide sociale

Les établissements de santé opèrent dans un environnement en constante évolution. Après avoir identifié et déterminé les tendances et les défis futurs en matière de soins de santé, un modèle axé sur les compétences peut aider à structurer la gestion du leadership. Le modèle basé sur les compétences commence par une analyse et une définition des compétences optimales pour chaque fonction, sur la base de la culture organisationnelle de l'entreprise, de son évolution et des opportunités environnementales. Les entreprises peuvent adopter des mesures spécifiques pour relever ces défis grâce au modèle de gestion basé sur les compétences. Cela contribuera à façonner les politiques de RH avec une approche plus souple et plus cohérente. L'adoption de ce modèle est une décision stratégique qui exige l'engagement de la haute direction et de la gouvernance envers la professionnalisation de l'équipe de management.

CBEXs futuro
Programme brésilien pour le leadership international dans le domaine de la santé

CBEXs a créé un programme de développement du leadership à faible coût et à fort impact pour les jeunes professionnels. Dans cet article, nous examinons comment le programme a vu le jour, comment il était basé sur les compétences en leadership de l'IHF pour les managers de la santé et comment son format a été créé et adapté.

Compétences pour les futurs managers de soins de santé en Europe (FHME)

Les systèmes de santé européens sont confrontés à des défis sans précédent tels que le vieillissement de la population, la diminution des budgets, l'évolution des valeurs sociales et les nouvelles technologies médicales et numériques. Une collaboration entre les établissements universitaires et les fournisseurs de soins de santé a permis d'élaborer un modèle de référence pour les dirigeants et les cadres supérieurs du secteur de la santé afin de les aider à développer leurs compétences en innovation, leadership, entrepreneuriat et gestion et à relever les défis actuels et futurs. Le futur manager de soins de santé en Europe (FHME) fournit un ensemble de compétences axées sur l'avenir pour les cadres supérieurs, en complément des modèles existants, ainsi qu'un ensemble de cas et de matériel didactique créés spécifiquement pour développer ces compétences nouvelles et émergentes dans les programmes de formation en gestion des soins de santé.

Health Care Management Competencies Volume 55 Number 2

Resumen en Español

Acreditación internacional: por qué el modelo CAHME es importante en la educación en administración sanitaria

La acreditación internacional fue aprobada por la Comisión de Acreditación en Educación de Administración de Salud (CAHME) en noviembre de 2018. Se creó un consejo asesor internacional junto a tres subcomités para implementar la acreditación global. Se han debatido estrategias para organizar un proceso de acreditación global como "eje" del profesionalismo en la administración sanitaria. Se reconoce la plataforma de competencias de la International Hospital Federation (IHF) que proporciona dominios y subdominios junto con competencias específicas. La acreditación es importante porque valida la educación de calidad para diferentes públicos, garantiza la pertinencia de los objetivos del programa a la comunidad de profesionales sanitarios, ofrece una oportunidad de consulta e interacción entre colegas, subraya la importancia de la mejora continua usando un modelo de competencias y ayuda a los estudiantes con programas de educación en administración sanitaria de calidad. La educación y la formación para ejecutivos en el área sanitaria sigue siendo una prioridad en los programas universitarios para graduados.

Acreditación para ejecutivos del área sanitaria: avances en la profesión gracias a la credencial FACHE

En el entorno del sistema sanitario actual, dinámico y siempre cambiante, se requieren personas con un liderazgo comprobado, que estén preparadas para afrontar los retos de la administración sanitaria. El American College of Healthcare Executives cubre esta demanda ofreciendo la credencial FACHE®. Los miembros que consiguen esta respetada distinción se benefician con una mayor credibilidad profesional. A su vez, las organizaciones sanitarias se benefician otorgando la confirmación de que una persona aporta el conocimiento, las habilidades y capacidades necesarias para su rol como líder sanitario.

El caso para las competencias del líder en la atención sanitaria: exploración de la evidencia

Este artículo explora la relación entre la gestión competente de las organizaciones de atención sanitaria y su efecto en el desempeño. A pesar del hecho de que una excelente administración es esencial para crear organizaciones de salud altamente eficientes, todavía hay muchas partes del mundo donde el papel del administrador no ha sido adecuadamente reconocido ni profesionalizado. Debatimos cómo se puede lograr la preparación para estos roles y cómo el apoyo a este tipo de aprendizaje puede mejorar las competencias y las prácticas de gestión en la atención sanitaria, que a su vez puede mejorar la eficiencia organizacional y del sistema de salud. Concluimos con un llamamiento para mejorar y ampliar la base empírica de gestión en el sistema sanitario.

Roles emergentes en el sector sanitario: un nuevo enfoque basado en las competencias de administración

La necesidad de proporcionar atención integral centrada en el paciente está ocasionando una reconfiguración a gran escala de los sistemas de salud a nivel mundial e impulsando a los políticos y administradores a cuestionarse ideas profundamente arraigadas acerca de cómo se debe administrar un sistema sanitario. En este escenario en evolución, existe un notable número de nuevos perfiles profesionales que están surgiendo en los hospitales y en los centros de atención primaria. Con el fin de afrontar el reto de gestionar las nuevas figuras profesionales, este artículo propone la adopción de un «Diccionario de competencias». Este diccionario proporciona una lista de competencias profesionales claves además de sus definiciones y niveles. Aplicado al papel del coordinador de la unidad local de salud en Italia, el diccionario proporciona una clara descripción de sus características.

Competencias de los administradores de los hospitales: estudio de caso de Irán

En la República Islámica de Irán, el Ministerio de Salud y Educación Médica (MOHME, por sus siglas en inglés) está abordando seriamente el tema de la cobertura de salud universal (UHC, por sus siglas en inglés). El acceso a servicios de salud de calidad es un aspecto clave de alcanzar la UHC y mejorar la eficiencia de los hospitales es también un importante punto de entrada. Para alcanzar este objetivo, los hospitales necesitan administradores con competencias. En este estudio, 303 administradores de hospitales cumplimentaron un cuestionario que tenía dos áreas (pertinencia y puntuación). El objetivo de este estudio fue determinar la relevancia de las competencias y evaluar la capacidad de los administradores de los hospitales mediante la autoevaluación.

Colaboraciones entre el sector público y privado en el sector sanitario: medición de las competencias de liderazgo de los administradores de hospitales

Las colaboraciones entre el sector público y privado (PPP; por sus siglas en inglés) son una estrategia que crece en todo el mundo y promueve la inversión en el sector privado para apoyar las iniciativas de reformas en el sector sanitario. Nuestra investigación sobre las competencias de administración en el sector sanitario en México involucra las fortalezas y debilidades de los profesionales de la salud y, finalmente, ayudarlos a desarrollar programas educativos basados en competencias que incrementen el dominio de competencias para mejorar los sistemas sanitarios y los resultados. En las

dos fases previas de esta investigación, hemos desarrollado, administrado y analizado una encuesta para administradores en hospitales de gestión cooperativa entre sector público y privado (principalmente en México) para identificar qué retos y qué recursos existen para la creación de capacidades. La actual fase de la investigación descrita en este artículo se enfoca en el estudio de las competencias de gestión sanitaria de los administradores de hospitales de estos dos sitios en México. En octubre de 2017, realizamos un seguimiento con administradores de estos sitios para compartir nuestros resultados y llevar adelante la encuesta actual basada en la nueva herramienta para competencias en administración sanitaria de la International Hospital Federation (IHF). Estaremos trabajando con estos colaboradores para determinar los próximos pasos necesarios para cubrir lagunas en diferentes competencias identificadas a través de las encuestas.

El modelo de gestión basado en las competencias como un impulso para la transformación en las organizaciones sanitarias y de asistencia social

Las organizaciones sanitarias operan en un entorno en constante cambio. Tras identificar y priorizar las tendencias y los retos futuros en el área de la atención médica, un modelo basado en las competencias puede contribuir a crear un liderazgo en la administración. El modelo basado en las competencias comienza con un análisis y una definición de las competencias óptimas para cada trabajo, basado en la cultura organizacional y la evolución ambiental y las oportunidades de una determinada asociación. Las organizaciones pueden adoptar medidas específicas para dar respuesta a estos retos a través del modelo de administración basado en las competencias. Esto contribuirá a generar políticas de RR. HH. con un enfoque más flexible y coherente. Adoptar este modelo es una decisión estratégica que requiere una administración superior y un compromiso de gobernanza con el profesionalismo del equipo de gestión.

CBEXs futuro

Programa brasileño para el liderazgo internacional en salud

CBEXs ha creado un programa de desarrollo del liderazgo de alto impacto para jóvenes profesionales. En este artículo, exploramos cómo surgió el programa, cómo se basó en las competencias de liderazgo de la IHF para administradores en el área de la salud y cómo se creó y adaptó su formato.

Competencias para los futuros administradores sanitarios en Europa (FHME, por sus siglas en inglés)

Los sistemas sanitarios europeos están enfrentando retos sin precedentes, tales como envejecimiento demográfico, presupuestos cada vez menores, cambios en los valores sociales y nuevas tecnologías médicas y digitales. Una colaboración entre las instituciones académicas y los proveedores de salud ha creado un marco de referencia para los ejecutivos en asistencia sanitaria y los administradores superiores para ayudarlos a desarrollar competencias en innovación, liderazgo y gestión y afrontar los retos actuales y futuros. El FHME proporciona un conjunto de competencias centradas en el futuro para gerentes superiores, complementarias de modelos existentes y un conjunto de casos y materiales de aprendizaje creados específicamente para desarrollar estas nuevas y emergentes competencias en los programas de formación para administradores sanitarios.

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Health Care Management Competencies Volume 55 Number 2

中文摘要

全球鉴定：为什么CAHME模式对卫生保健管理教育很重要

2018年11月，卫生保健管理教育鉴定委员会（CAHME）批准了全球鉴定事宜。 他们设立了一个全球咨询理事会及其三个分组委员会来实施全球鉴定。 委员会已经讨论出了一些策略来组织一项全球鉴定程序，作为卫生保健管理专业的支柱。 他们向提供了范围和下属范围以及具体能力的国际医院联合会（IHF）能力平台授予了认可。鉴定的重要性在于，它为各项公共事业验证高质量的教育；为专业卫生保健团体确保项目目标的相关性；为咨询和同仁反馈提供机会；强调通过能力模型不断改进的重要性；以及有助于学生质量卫生保健管理教育项目。教育和培训卫生保健管理人员对于大学内的研究生课程而言仍然是优先事项。

对卫生保健管理人员进行资格认证：通过FACHE认证来推进这一行业

在当今千变万化的动态卫生保健环境中，那些准备接受卫生保健管理挑战并得到公认的领导者十分抢手。 美国医疗保健管理人员大学通过提供FACHE®认证来满足这一需求。 获得这一殊荣的成员将因其更高的职业信誉而获益。 卫生保健组织则受益于可以确保作为一名医疗保健领导者的从业人员有必要的知识、技能和能力来履行他们的职责。

卫生医疗领导能力的案例：探寻证据

本文探索了医疗机构能力管理与它对绩效影响之间的关系。卓越的管理对于创办高绩效医疗组织而言很关键。但在世界许多地区，仍然存在管理员的作用没有得到充分承认或专业化这样的情况。本文讨论怎样为这些角色来作好准备，以及怎样支持这些类型的学习能够提升卫生保健管理的能力和实践，从而反过来提高医疗机构和系统的绩效。作为结论，我们呼吁改善和扩大卫生保健管理的证据基础。

卫生保健的新职责：一种基于管理能力的新方法

提供以患者为本的综合护理这一需求正在迫使全球范围的医疗保健系统进行大规模重新配置，并促使政策制定者和管理人员对怎样管理医疗保健系统这一深层次的根本问题提出质疑。在当前不断变化的环境中，医院和初级保健领域出现了大量新的专业。为更好地面对管理新专业数据的挑战，本文提议采用“能力字典”的方法。除了各个专业的定义和水平范围以外，这本字典还提供了一个各项主要专业能力的清单。具体到意大利LHA协调员的职位上，该字典明确地描述了其各种特征。

医院管理人员的能力：伊朗的个案研究

伊朗伊斯兰共和国的国家卫生与医药教育部（MOHME）非常重视全民医疗保健（UHC）。获得高质量医疗卫生服务的途径是实现全民医疗保健的核心，而提高医院的绩效则是重要切入点。为实现这一目标，医院需要有能力的管理人员。在本研究中，303名医院管理人员填写了一份包括两个领域的调查问卷（相关性和得分）。本研究的目的是确定各项能力的相关性，以及通过自我评估的方法来评估医院管理人员的能力。

医疗保健的公私合作（PPPs）：衡量医院管理人员的领导能力

公私合作（PPPs）是一项日益增长的全球战略。它通过促进私人领域的投资来支持卫生领域的改革计划。我们对墨西哥卫生保健管理能力的研究涉及：诊断医疗保健专业人员的长短所在，并最终有助于发展基于能力的教育培训计划，加强对能力的掌握，从而提供卫生系统和最终结果。在本研究的前两个阶段，我们主要为墨西哥的医院公私合作项目制定、实施并分析了一项管理人员调查，来发现挑战和业已存在的能力建设资源。本文所描述的当前阶段的研究侧重于研究墨西哥这两个地方的医院管理人员的卫生保健管理能力。2017年10月，通过国际医院联合会（IHF）的卫生保健管理能力工具，我们通过对这几个地方管理人员的随访，分享我们的研究结果并进行目前的调查。我们将通过与这些单位的协作，来确定为缩小在这些调查中所发现的各项能力之间的差距而需要采取的后续步骤。

作为医保社保机构改革跳板的能力本位管理模型

卫生保健组织运营的环境处在不断的变化中。在确定了今后卫生保健的趋势和挑战并根据优先级将其排序之后，可以采用能力本位模型来协助领导管理。能力本位模型根据某个协会的组织文化、环境发展和机遇等条件，从分析和规定每项工作的最佳能力开始。组织机构可以通过能力本位管理模型来采取具体措施，以满足这些条件。这将有助于以更为灵活一致的方式来制定人力资源政策。采用这种模式是一项战略性的决定，它需要高级管理和机构治理以管理团队的专业化为目标而努力。

CBEXs FUTURO
在卫生方面居于领先地位的巴西项目

CBEXs为年轻的专业人士启动了一个成本低、影响力大的领导开发项目。我们将通过本文来探讨该项目是怎样形成的、它如何在国际医院联合会（IHF）的保健管理人员领导能力的基础上形成、以及它的形式是怎样创建和采用的。

欧洲未来卫生保健管理人员（FHME）应具备的能力

欧洲的卫生系统正面临着前所未有的挑战，比如人口老龄化、财政预算减少、社会价值观的改变和新的医疗数字技术。学术机构和医疗服务供应商之间的协作，已经为卫生保健管理人员和高级管理人员开发出了一个参考框架，来帮助他们发展创新、领导、企业经营和管理以及处理当前和未来挑战等各项能力。欧洲今后的卫生保健管理人员（FHME）为高级管理人员提供了一系列与现有模型相辅相成而又专注于未来的能力，和一组专门为在卫生保健管理培训项目中发展这些新能力而收集的案例和教学材料。

Meet the IHF Award Sponsors

IHF/Dr Kwang Tae Kim Grand Award

Dr. Kwang Tae Kim is a surgeon with immense contributions to the healthcare sector both nationally and internationally. He was President of the International Hospital Federation from 2013 to 2015, President of the Asian Hospital Federation in 2008-2009 and President of the Korean Hospital Association in 2003-2004. He has been the Chairman of Daerim Saint Mary's Hospital in Seoul, his own hospital, since 1969.
As a strong advocate of excellence in clinical governance, leadership, quality and safety, Dr Kim initiated and generously donated to set up the IHF Awards Program during his presidency to promote IHF's visibility and its role as a knowledge hub. Because of this, the Grand Award, the most prestigious among all the IHF Awards, was aptly named after him.
The IHF/Dr Kwang Tae Kim Grand Award will be bestowed to health system, healthcare organisation or facility which achieves excellence in multiple areas including, among others, quality and patient safety, corporate social responsibility, innovations in service delivery at affordable costs, healthcare leadership and management practices. This Award is only open to healthcare service provider organisations which are either IHF Full or Associate Members.

IHF Excellence Awards Sponsors

Austco is the sponsor of the Excellence Award for Quality & Safety and Patient-centered Care
Austco Communication Systems is a global manufacturer of Nurse Call and Clinical Workflow solutions for hospitals and aged-care facilities.
Austco's flagship solution, Tacera, is an integrated IP-based Critical Communication System that delivers safety solutions for patients. By linking nurses and patients in real-time, Tacera enhances the quality of information available to caregivers, enabling them to provide immediate assistance and measurable improvements to patient's quality of care.
Pulse Mobile is the newest component of Austco's innovative Tacera Pulse software suite of next generation clinical business intelligence solutions. Pulse Mobile enhances staff efficiency and caregiver response times, which help improve patient/resident outcomes.
More information about Austco: www.austco.com

Bionexo is the sponsor of the Excellence Award for Corporate Social Responsibility
Bionexo is a technology company that offers digital solutions for purchasing, sales and process management in healthcare. In the healthcare supply chain, there has never been a greater need to reduce costs and operate more efficiently. Through high performance digital solutions, Bionexo offers process automation, increasing the visibility and transparency of information for faster and more intelligent decision making.
More information about Bionexo: bionexo.com/en/

EOH is the sponsor of the Excellence Award for Leadership and Management in Healthcare
EOH provides the technology, knowledge, skills and organisational ability critical to Africa's development and growth. Following the Consulting, Technology and Outsourcing model, EOH provides high value, end-to-end solutions to its clients in all industry verticals. Listed in 1998, EOH attributes its 36% compounded annual growth to a culture of remaining prudent, and not just meeting, but exceeding, customer expectations. More information about EOH: www.eoh.co.za

IHF events calendar

2019

IHF

43rd World Hospital Congress
November 6-9, Muscat, Oman
For more information, contact
congress@ihf-fih.org

2020

IHF

44th World Hospital Congress
November 3-5, Barcelona, Spain
For more information, contact
congress@ihf-fih.org

IHF members' events

ARGENTINA
XXV International Congress "Health, Crisis and Reform"
Camara Argentina de Empresas de Salud (CAES)
October 10, City of Córdoba
http://www.caes.com.ar/index.php/noticias/institucionales/147-cordoba-sera-la-sede-del-xxv-congreso-internacional-caes

AUSTRIA
European Health Forum Gastein
October 2-4, 2019, Bad Hofgastein
https://www.ehfg.org/

BELGIUM
36th Congress Hospitals.be
Belgian Hospital Association
June 19, 2019, Brussels, Belgium
https://www.hospitals.be/events/16806

BRAZIL
13th Brazilian Convention of Hospitals
Brazilian Federation of Hospitals
August 1-2, 2019, Salvador, Bahia
https://www.convencaofbh.com.br/
* Event in Portuguese only

CANADA
National Health Leadership Conference
Healthcare innovation: Advancing better outcomes and economic growth - Healthcare*CAN*
June 10-11, 2019, Toronto, ON
http://www.nhlc-cnls.ca/

COLOMBIA
Colombian Hospitals and Clinics Association
VI Forum for Successful Solutions and Innovation in Health
(VI Foro de Soluciones Exitosas e Innovación en Salud)
August 15-16, 2019, Bogotá
https://achc.org.co/foro-nacional-de-soluciones-exitosas-e-innovacion-en-salud/

XIV International Congress for Hospitals and Clinics
(XIV Congreso Internacional de Hospitales y Clínicas)
July 24-25, 2020
https://achc.org.co/congreso-internacional-de-hospitales-y-clinicas/

JAPAN
69th Congress of Japan Hospital Association
Japan Hospital Association
August 1-2, 2019, Sapporo, Hokkaido
http://www.hospital.or.jp/gakkai.html
Event in Japanese only

SWITZERLAND
H+ Congress 2019
H+ The Hospitals of Switzerland
October 31, 2019, Bern
https://fr.hplus-kongress.ch/

UNITED KINGDOM
Annual Conference and Exhibition 2019
NHS Providers
October 8-9, 2019, Manchester Central
https://nhsproviders.org/courses-events/annual-events/annual-conference/annual-conference-and-exhibition-event

UNITED STATES
ASHRM 2019 Annual Conference
American Society for Healthcare Risk Management (ASHRM)
American Hospital Association (AHA)
October 13-16, 2019, Baltimore, MD
https://annual.ashrm.org/2019/index.cfm

IHF webinars

To register to a webinar, click here: http://bit.ly/ihfwebinars

July 24, 2019
Incentives from the authorities on quality improvement in Belgium
Time: 11:00 UTC
Presenter: Dr Marc Geboers, Director General Hospitals, Zorgnet Icuro, Belgium

August 22, 2019
Effectiveness of Nurse-Led clinics and outreach service at Royal Hospital, Sultanate of Oman
Time: 13:00 UTC
Presenter: Fatma Al Masroori, Director of Nursing Affairs, Royal Hospital, Sultanate of Oman

September 25, 2019
England's new National Health Service (NHS) Long-term Plan: Helping health services deliver integrated care.
Time: 12:00 UTC
Presenter: Matthew Swindells, Deputy Chief Executive, NHS England, UK

For further details contact the: IHF Partnerships and Project, International Hospital Federation, 151 Route de Loëx, 1233 Bernex, Switzerland; E-Mail: info@ihf-fih.org or visit the IHF website: https://www.ihf-fih.org

IHF Hospital & Health Executives Study Tour

16 to 20 SEPTEMBER 2019
PARIS | FRANCE

International Hospital Federation

FHF
FÉDÉRATION HOSPITALIÈRE DE FRANCE

PARIS 2019
IHF HOSPITAL AND HEALTH EXECUTIVES STUDY TOUR

"Health Innovation and Neighborhood: Towards New Health Service Models"

This is an opportunity to learn about current French projects and initiatives aimed at improving the health system and the delivery of hospital and health services.

- Hear from French health system reform that addresses, among others, health professionals recruitment, access to care and telehealth.
- Visit Institut Curie where key representatives of the French private hospital sector will explain the role of private hospitals in France.
- Attend a roundtable discussion with experts in health and innovation on the challenges of innovation.
- Discover initiatives to support companies in terms of innovation in the Île-de-France region, and exchange on health as attractive element of the region.
- Explore health system financing and discuss opportunities to integrate quality funding measures into volume-based (activity-based) financing.
- Join representatives from Paris region and French Hospital Federation who will address the potential of health neighborhoods, a way to re-organize care provision including how home care will be a game changer.

Participation
IHF C-Suite members US$ 1,200
Non IHF members US$ 1,700

What the fees include
Participants will have an in-depth insight into innovations in care delivery models developed in France by engaging in meetings and presentations with senior health officials, as well as site visits. The fees cover lunches, one dinner and local transportation costs. Travel to Paris and accommodation are not covered.

FEATURED SPEAKERS INCLUDE

Zaynab Riet
Director General
French Hospital Federation

Cédric Lussiez
Director General
Hospital Group Nord-Essonne

Stephane Roques
CEO
Medicen

Lise Rochaix
Professor
Pantheon-Sorbonne University

Pascale Flamant
CEO
Unicancer

Jacques Lewiner
Professor
ESPCI ParisTech

SITE VISITS INCLUDE

- The National Assembly, whose role is to debate, propose, amend and pass laws, and monitor the Government's action, adopted in September 2018 the "Ma Santé 2022" bill, a major health reform aimed at improving access to care.
- Longjumeau Hospital, at the center of a project to merge three hospitals together with an innovative reorganization of the delivery of care at the local level.
- The 'Lab Santé', which supports all innovative project leaders in health, mainly by bringing together public and private actors. Its relationships with the health ecosystem make 'Lab Santé' a key player in the health innovation sector.

For more information on the 2019 Study Tour program including all speakrs and site visits, & to register, click here: http://bit.ly/ihfstudytour

Registration ends 31 July. Places limited to 15 participants.
Contact the IHF Secretariat: ihf.secretariat@ihf-fih.org
or +41 22 850 94 20