TALLINN UNIVERSITY OF TECHNOLOGY
School of Business and Governance
Department of Business Administration

Kadi Tomson

LEADERSHIP COMPETENCIES OF MANAGERIAL HEALTHCARE PROFESSIONALS IN PRIMARY HEALTH CENTRES IN ESTONIA

Master thesis

Programme Entrepreneurial Management

Supervisor: Maris Zernand-Vilson, PhD

Tallinn 2022

I hereby declare that I have compiled the thesis independently
and all works, important standpoints and data by other authors
have been properly referenced and the same paper
has not been previously presented for grading.
The document length is 14351 words from the introduction to the end of conclusion.

Kadi Tomson 10.05.2022

(signature, date)

Student code: 201468MAEM
Student e-mail address: kadi133@msn.com

Supervisor: Maris Zernand-Vilson, PhD
The paper conforms to requirements in force

……………………………………………

(signature, date)

Chairman of the Defence Committee:
Permitted to the defence

…………………………………

(name, signature, date)

TABLE OF CONTENTS

ABSTRACT 5
INTRODUCTION 6
1. THEORETICAL BACKGROUND 9
1.1. Leadership 9
1.1.1 Leadership styles in healthcare 11
1.1.2 Management levels in healthcare 12
1.1.3 Medical leadership 13
1.1.4 Small-enterprise-related managerial competencies 15
1.2. Competency models in healthcare 17
1.2.1 Challenges for healthcare managers 17
1.2.2 Examples of competency models 18
2. RESEARCH DESIGN AND METHODOLOGY 23
2.1. Background to the research 24
2.1.1 Family medicine in Estonia 24
2.1.2 Primary health care centre 25
2.2. Interview design 26
2.3 Defining the research sample 27
2.4 Data analysis 28
3. RESULTS AND ANALYSIS 29
3.1 Results from interviews 29
3.1.1 Managerial skills and leadership style 29
3.1.2 Evaluation 31
3.1.3 Competency importance rank 33
3.1.4 Managerial work organisation in their centre 34
3.1.5 Main challenges for primary health centre leader 37
3.2 Competency model for the health centre leader 39
3.2.1 Comparison with other competency models 40
3.2.2 Practical implications and limitations 42
CONCLUSION 44
LIST OF REFERENCES 45
APPENDICES 49

Appendix 1. Interview questions 49
Appendix 2. Competency list 50
Appendix 3. Leadership styles by Goleman (2000) 52
Appendix 4. Competency rank table 53
Appendix 5. Cloud location link 55
Appendix 6. Non-exclusive licence 56

ABSTRACT

In the complex and multi-level healthcare environment with rapid changes and new challenges in recent years as well as constant battle with lack of financial and human resources, managerial competencies are gaining more importance than ever. In Estonia, primary care, i.e. family medicine services have changed significantly in recent decade where single practices have joined and formed more compact primary health care centres. A bigger team requires new skillset of managerial competencies and effective leadership from its leaders that have specialist background and continue doing clinical work simultaneously with managing their health care centre. Lack of leadership competencies stands as one obstacle against improving medical system. The problem is, that these non-medical competencies needed are not taught at medical school.

The aim of this master thesis is to improve the management quality of primary care services by identifying and listing managerial and leadership competencies that are necessary for health care centre leader. Theoretical framework is supported by empirical research that is conducted by seven qualitative semi-structured expert interviews with family doctors/managers of their health centre from leading pimary care centres of Tallinn, but results can be applicable for other countries with similar management models of primary care. The leadership/management competency model found would provide a useful tool in planning, developing and evaluating management practices for health care centre leader.

The results indicate that there is no universal health care centre leader profile and most important is the will to be one. Strategic competencies in hand with HR related, interpersonal competecies, process management and knowledge of environment are the most important competency groups. All areas need to be covered either by medical manager or outsourced to administrative manager to a lesser or greater extent. To improve leadership quality in primary care management there are two options – either to teach clinicians the necessary leadership and managerial competencies, or – to develop an administrative manager with good managerial and people skills within the system.

Keywords: Healthcare management, medical leadership, primary care management, specialist-manager, family medicine leadership development

INTRODUCTION

In the complex and multi-level world of healthcare administration, one would presume that the best combination would be a physician manager with both medical and administrative skills but by means of resources and effectiveness, it is not always reasonable for all physicians to study parallelly with medicine business administration or management programme. Neither all doctors aspire to be managers. Thus, it would be useful to use competency models that could help identify, develop and evaluate the managerial skills necessary for current management level in healthcare and a good self-analysis tool for managers themselves in order to manage resources effectively.

In Estonia, healthcare services are divided into two distinguished parts with differences in funding and management – primary care and specialized care. The role of family nurse or family doctor cannot be overestimated. Patient's first and most frequent contact regarding issues with health, also preventative medicine, is at the family medicine clinic he or she is enlisted and with each year, the role of primary care becomes bigger as more responsibilites from secondary care move to family practitioners. Well working system solves most of patient's problems before they become more seriuosly ill and need hospital-level treatment. Primary care management has been contracted to family physicians by the state which means they run their private businesses but the funding comes from the state on fee-per-capita system of nationally insured patients (Eesti Haigekassa A, 2022; Eesti Haigekassa B, 2022). For doctors this means more freedom regarding organising their practice's work but also demands more leadership and managerial skills. When the majority of Estonian family medicine providers are single practices consisting of one doctor and one to two nurses, making up 61% of all service providers (Raag, 2021), in recent years yet again the tendency is towards bigger practices and merging into primary health care centres, where teams consist of at least ten people (Eesti Haigekassa B, 2022). On average, one health care centre is responsible of providing medical care to 9628 people and has an average of 23 people in team (Raag, 2021). This puts new challenges to leaders of these merged organisations as the bigger the company grows, generic managerial competencies are needed for its effective functioning (Papulová & Mokroš, 2007). With the family doctor reform in 1997 in Estonia, where change to business model of primary healthcare delivery gave more financial power and independence to family doctors and the right to run their own businesses as private entrepreneurs, it became evident that new skills

like assessing financial data, workforce planning and recruiting, knowledge of jurisdiction etc. needed to be acquired. Similar findings have also been found by researchers Figueroa *et al.* (2019) in UK, where family medicine system is similar to Estonia's (Figueroa *et al.,* 2019).

As by law in Estonia, the owners of family medicine centres can either be family doctors themselves or in rural areas, also local municipality, doctor-managers' position is unique, because they are at the same time clinicians, managers and founders/owners who need to balance between various shareholders. This can be challenging and lots of family doctors struggle without having the right tools and knowledge for managing their practices. With constant discrepancy between healthcare and patients' needs and the available resources regarding financial means and workforce, the clinics that have better organised management, are preferrably coping better and adopting faster with these challenges.

The problem is, that while as doctors they can be really professional and constant training and evaluation to the quality requirements is done on a frequent basis, managerial skills can only be developed through personal experience. At medical school or during family residency program hardly any leadership or managerial skills are taught to clinicians. So far no competency model has been created for medical leadership in Estonia. Among the programs that can be found in Estonian universities, no degree-offering program for healthcare management is available. There is only one five-month development program for health leaders in Estonian Business School (Estonian Business School, 2022). It should be state's priority that healthcare is led by strong leaders which makes it more cost-effective and improves satisfaction level on both parties. Similar suggestions have been made by other researchers (Baker & Denis, 2011; Chen, 2018). Baker and Denis (2011) argue that nothing about medical school prepares a physician to take leadership roles and improve the system and instead, physicians are taught to cope within the system and perfect themselves as individual professionals. But this is not enough for making a better system on whole and other, leadership-oriented competencies are also needed (Baker & Denis, 2011).

This master thesis will be concentrated on identifying necessary leadership competencies in primary care health centres, i.e. family doctor clinics that have at least two doctors and six nurses, a midwife and a fysiotherapist in team, that meet all standards of space and equipment as well as opening times (Eesti Haigekassa B, 2022); how medical professionals in primary care clinics and health centers have developed into managers and, what competencies are needed in order to be a good leader among medical professionals. The compentencies and qualities that are essential for health centre leaders are mapped and a competency model/skillset will be suggested, which could

be useful in developing and evaluating current and future health leaders. These findings will be compared with other researchers' models and also with competencies needed for small enterprise managers. For primary care health centre manager is it actually necessary to have medical background or is it a waste of resources?

In this master thesis terms "manager" and "leader" of the health centre are used as synonyms because being small business owners, they need to have common qualities of a leader and a manager (Papulová *et al.,* 2007; Zaleznik, 1977, 2004).

Main research questions:
1. What is the current situation in primary health care centre management by example of Tallinn's leading health care centres?
2. What are the most important necessary leadership and management competencies for primary health care centre managers?
3. What suggestions can be made to improve the quality of primary care leaders' managerial competencies?

Finding that set of competencies could help select, develop and evaluate leaders that rise from medical professionals or apply for executive positions in healthcare management. It could also give input for medical school or family medicine residency program to help educate future health centre leaders and entrepreneurs. It could be helpful when finding suitable people for managing health centres and start delevoping their managerial and leadership skills from early stages.

The master thesis will be divided into following parts:
1) review of literature and theoretical framework;
2) research methodology - qualitative research method of conducting semi-structured interviews with leaders in this sector and analysing data by its content will be used;
3) results and discussion, possible implications and shortcomings.

For background and theory literature in databases will be researched. Then, seven qualitative expert interviews with primary health care centre leaders in Tallinn will be conducted to gather data and get valuable insight about the topic, that is relevant but has not been researched before in Estonia. In the end, most important data from the interviews will be extracted using content analysis and inductive method and based on the conclusions, competency model of the most important skillset needed to efficiently lead primary health care centres will be created and suggestions for further research as well as limitations to current research will be given.

1. THEORETICAL BACKGROUND

In Estonia, managers and leaders in healthcare are mostly physicians themselves, only at senior level top executives of our bigger hospitals are non-medical professionals - the CEO-s of Estonian three biggest hospitals (Ida-Tallinna Keskhaigla, 2022; Regionaalhaigla, 2022; Tartu Ülikooli Kliinikum, 2022; Lääne-Tallinna Keskhaigla, 2022). The latter is similar all over the world where four out of five senior-level hospital managers are not physicians (Busari, 2012), however, the more junior level of administration to look at, the more its management is organised by physicians themselves. For example, front line managers, who are responsible for operational level of unit, are by rule, physicians themselves because besides managerial skills they need technical expertise and skillset for the work (Adindu & Asuquo, 2013).

In literature, most articles are about leadership competencies needed for hospital-level management. However, healthcare remains to be one of the hottest topics with increasing demand of managing resources effectively and therefore, both primary level and hospital-level healthcare organisation need to run smoothly. More and more research is done and both universal, as well as selective competency models for certain management level have been created in recent years. Some of them will be introduced in the next paragraphs. Most important findings will be emphasized and extracted from the rest of the text by having them written in bold.

1.1. Leadership

Various researches have given their definition to term "leadership" in different meanings, for example Bass (1990), Kotter (1988), and Rost (1993) - simply described, leadership is an influential relationship between the leader and its followers to achieve a mutual goal (Rosari, 2019). Most authors separate leadership from management (Zaleznik, 1977, 2004) omitting different, and sometimes also contrary characteristics to them, however, to run an organisation effectively, qualities of leadership as well as managerial competencies are needed. Most common leadership theories will be introduced in the next paragraphs.

Leadership roles and traits have been researched thoroughly. Top leaders can introduce structural change or policy formulation, mid-level leaders can interpolate structure and improvise, and lower level of leaders can use the formally provided structure to run operations effectively. As with other

leadership skills, abilities and traits, character is also developed over time with practice and motivation (Barlow *et al*., 2003).

Leadership styles are divided by different authors in many ways. Most common divisions are the five types - authoritative (autocratic), participating (democratic), delegative (*laissez-faire*), transactional and transformational leadership. The first three were introduced by psychologist Kurt Lewin in 1939 and the latter by researchers Burns (1978) and Bass (1985) (Bass, 1990; Khan, 2015; Cherry, 2021). By Goleman (Goleman, 2000), who went further with leadership style studies and is one of the most known researches of leadership theories, six main distinctive leadership styles are identified, each representing different emotional intelligence components - visionary, coaching, democratic, affiliative, commanding and pacesetting styles (Goleman, 2000).

In authoritative or autocratic leadership the manager has much power and decision-making authority and this is good for unstable environments, new employees, crisis management. Participating or democratic style encourages employees to have their opinions and it allows the manager to be a coach who gathers information from the employees before making a decision. This style is effective with highly skilled or experienced employees and resolving group problems and helps everyone be part of a team, however it can be time-consuming and is not suitabe for crisis management. Delegative or *laissez-faire* leadership goes even further with giving freedom to the employees, letting the employees decide on their own and the manager provides little or no direction. It requires team members to have lots of experience and expertise as well as self-discipline in their work. Transformational style has been described as the most effective style in recent years and involves the leader's charisma and ability to inspire and motivate its employees to get the best results for the organisation (Dionne *et al.,* 2004; Khan, 2015). Visionary and coaching leadership are said to be part of transformational leadership as they require clear vision and mission from its leaders so that all employees know their common goal. Coaching leadership has gained more popularity in recent years and it focuses on striving as a team and at the same time encouraging everyone to develop their personal and professional strengths (Dennison, 2021; Sutton, 2021). Transactional leadership is traditional "managerial style" of leadership with clear hierarchy and roles for the leader and its employees and set goal and reward-punishment system. It can stifle creativity and motivation because employees will often feel they are just part of the system and lack authority and engagement in the organisation (Goleman, 2000; Khan, 2015). Affiliative leadership focuses entirely on people and is the type of leadership that sets employees'

emotional wellbeing top priority. It creates a sense of trust and harmony between the team and encourages to express one's feelings (Goleman, 2000).

Among those leadership styles, coercive and pacesetting are the only ones that have negative impact on group climate. However, they still have their role in certain circumstances like undeveloped workers or critical situations (Barlow *et al.,* 2003; Al-Khaled & Fenn, 2020; Chapman *et al.,* 2014). Regarding organisational constraints, there is a negative correlation between authoritative (visionary) and coaching style and the amount of organisational constraints, i.e. the more these styles were used, the better the employee performance in these organisations (Drzewiecka & Roczniewska, 2018). However, leadership is always situational, as a good leader should vary its leadership style according to circumstances, current situation and its team's qualification and morale. For highly qualified and motivated team, democratic and delegative (*laissez-faire*) style are the best, while for undeveloped people autocratic and transactional leadership is good. Coercive (commanding) leadership is mostly used in solving crisis situations or in military (Chapman *et al*., 2014; Khan, 2015).

1.1.1 Leadership styles in healthcare

In healthcare, a doctor may have two different leadership roles –

1) as a senior clinician being part of a team with responsibilities of patient care, and
2) as part of a management team in a healthcare organisation

In either roles the doctor may exhibit different leadership styles. In a study by Chapman *et al.* (2014) a study of leadership styles used by hospital managers in administrative role was conducted. The findings suggested that there was no one single leadership style used by a medical leader and all styles were used by current leaders. The predominant styles were overall the authoritative or visionary, democratic and affiliative styles. Coaching, commanding and pacesetting styles were used less frequently (Chapman *et al.*, 2014).

In medicine, there is also literature about most effective leadership styles with transformational style beating transactional styles in job satisfaction of the staff. Job satisfaction is critical to maintain low employee turnover (Alloubani, 2014). Kleinman (2004) indicated that there was important relation between nurse administration leadership styles and nurse staff job satisfaction and retention. Similar results were found by Taunton (1997) that manager's characteristics facilitate job satisfaction, commitment and positive working environment as well as better

perception of the organisation. Transactional leadership can help healthcare organization meet its financial and operational targets, but does not improve its quality or patient care standards (Kumar, 2013). One study examined leadership competencies and leadership styles' effect on healthcare quality for twenty-first century healthcare organisations (Alloubani, 2014). The findings concluded that leadership quality is one of the most crucial factors of success in healthcare management and identified **six transformational leadership competencies and values**:

1. Change management – how organisations cope with change as opportunity to find new alternatives and calculated risk taking
2. Systems thinking: the capacity to understand and solve complex problems in healthcare
3. Shared vision for the organisation
4. Continuous quality improvement
5. Redefining healthcare and constant innovation
6. Serving public/community i.e. social capabilites (Alloubani, 2014).

1.1.2 Management levels in healthcare

Traditionally, management hierarchy is divided into three levels: senior or executive level, middle-management and first line manager. In medicine, the latter is also called front line manager or supervisory manager. Top level management is responsible for strategic management, middle level is responsible for tactical management and first line or operative level is responsible for daily activities (Adindu & Asuquo, 2013; Lumen, 2022). First line or front line managers are often skilled specialists who are responsible for operational level, they ensure that all daily work is running smoothly according to directions from upper management level and according to quality standards, they organize, coordinate and control work at their unit level. These managers are usually doctors responsible for their clinic or unit and they give directions, coordinate and supervise other workers in their team. They are also liaison officers who communicate workers' problems or operational issues to senior management. Effective service delivery depends on operational managers. A front line manager needs to have t**wo distinctive skill sets**: the **interpersonal** competencies to manage people - communicating, observing and listening skills, giving and receiving feedback, prioritizing, organizing processes and tasks, aligning resources - as well as the **technical expertise** or professional competencies to be among the front lines actively executing functional tasks. Front line managers are often tasked with hiring, assessing performance, providing feedback, delegating functional tasks, identifying gaps, maximizing efficiency, scheduling, and aligning teams, understanding employee needs and delivering these to

the upper management, removing blockers, and optimizing performance (Adindu & Asuquo, 2013; Lumen, 2022).

Tactical or middle level management in healthcare institution consists often of healthcare professionals who are heads of department with many units and manage large numbers of health workers and resources. Their main objectives are **translating strategic health objectives** and orders from senior management into tactics and execution plan for their department. Planning, organizing, coordinating, monitoring and evaluating work of its units among its department is the main responsibility of this management level (Adindu & Asuquo, 2013). Middle-level and front line managers can often be inefficient and overwhelmed by workload due to lack of defining clear managerial work distribution within organisations and lack of leadership training. Despite this, they are also often very little involved in strategic decision-making (Figueroa *et al.*, 2019).

Strategic health managers at the highest level or healthcare executives are typically responsible of **developing vision and strategy** of the healthcare organisation, managing and structuring the organisation, developing policies and values within the organisation, managing partner and public relations, recruitment and employee policies, managing financial resources of the organisation, initiating change management. The senior level management in healthcare is normally the director of the hospital, the primary health care coordinator, minister of health (Adindu & Asuquo, 2013). On senior level, most often the leader is not a physician anymore (Busari, 2012) and more generic competency models for executive level leadership are needed. The higher the execution level, the more important role plays the character and persona of the leader (Barlow *et al.,* 2003).

1.1.3 Medical leadership

When historically, healthcare organisations have been developed from guild-oriented management of specialists into bureaucratic organisations with divided administrative and clinical management, the tendency over the last decades is towards combined medical leadership with close collaboration of non-clinical and clinical managers. Busari (2012) states that medical personnel and management are not on the same page in healthcare and do not have the same targets and this leads to conflicts and stagnation in healthcare management. The majority of physicians are stuck on the frontline and therefore there is a big gap between understanding of "true value" and quality and misinterpretation of goals between stakeholders. They suggest that it is essential to teach physicicians the necessary management and leadership skills because only then these medically-trained managers could help create effective health systems (Busari, 2012). Edwards *et al.* (2003)

addresses in the article “Doctors and managers – a problem without solution?” (Edwards *et al*., 2003) the main paradox of clinicians, whose primary objective is patient care, and managers, whose main objective are smoothly running systems and patient experience overall. Patients receive best outcome by a balance between these two. Wysocka *et al.* (2017) argues about the dilemma between specialists and non-medical managers in healthcare, saying, that only medical professionals might lack the strategic vision and that they also hire other specialists preferrably (Wysocka *et al.,* 2017). Edwards *et al.* (2003) suggest three main ways to solve the problem: 1) denying any management in clinical issues; 2) improving the quality of health managers; 3) making managers think like doctors and vice versa in order to create common values and goals (Edwards *et al.*, 2003).

Medical leadership has been seen as a key ingredient in merging the clinical and managerial world of healthcare organisation. It involves senior doctors to participate in developing and executing strategy to improve organisational and healthcare system performance and requires teaching new skills to medical professionals. Medical leadership is now defined as the improvement of health care systems, not solely as the practice of individual professionals (Baker & Denis, 2011). One of the findings based on Alloubani (2014) research was that leadership development programs should involve training, coaching and mentoring from early stages of professional career development and be an integral part of it. It must not be limited only to senior staff, but potential junior staff should also be encouraged to take up these types of sessions. It has been stated that compared to other leadership development programs and competency frameworks, in health sector it is important to recognize the wide range of leadership skills for effective operational leadership to avoid mechanistic and unnatural approach (Alloubani, 2014; Chen, 2018). These findings are confirmed by Adindu and Asuquo (2013), who examine additional competencies regarding leadership and management that clinicians need to have in order to bridge the gap of knowledge of healthcare professionals to perform managerial functions effectively. They suggest that every clinician should receive leadership and management competency training in addition to clinical training (Adindu & Asuquo, 2013). In the renowned Mayo clinics, that is lead by medical professionals, teaching leadership and managerial skills from the beginning of medical career has been implemented into their agenda since the clinic has existed. This policy ensures that the doctors who will become executives, have already developed good leadership skills (Peters, 2014).

1.1.4 Small-enterprise-related managerial competencies

As managers of health care centres need to run their companies and operate the centres also financially, general competencies related to small business management are relevant.

In his 1977 article (and repeatedly in 2004), Zaleznik argued that managers and leaders in organization are not the same and the difference lies very deep in their way of thinking, their influence on other people and their work organisation. Managers seek order and control in work and are "problem solvers". Leaders, in contrast are more creative types who seek new opportunities, tolerate chaos and lack of structure and sometimes even create it, but inspire and motivate other people to make their vision come true (Zaleznik, 1977, 2004). Organizations need both managers and leaders, but their development processes are rather opposite. In small businesses, the one leading the organization often has to have more qualities presenting as leader to attract people to work with them and as company grows, more managers who can take charge of the processes, are needed (Zaleznik, 1977, 2004). There is also a distinction between a functional and a general manager. General managers are most commonly referred to as executives with overall responsibility of company's cost and revenue elements of income statement, they oversee most financial, marketing and sales functions as well as daily operations. General managers are also responsible of strategy, planning, delegating, coordination, staffing, decision making. A functional manager is a person who makes decisions about one organizational unit, such as department within a business (Papulová *et al.,* 2007; Lumen, 2022).

By the studies of Castanias and Helfat (1991) there are four types of managerial skills – 1) generic skills, that are transferable across organizations and different sectors; 2) sector-related skills; 3) organization-specific skills; 4) industry-related skills. However, nine skills are characteristic of successful leaders: cleverness (intelligence), conceptual skills, creativity, diplomacy and tact, fluency in speaking, knowledge about group tasks, organizing skills (administrative ability), persuasiveness, and social skills (Carmeli & Tishler, 2006). Manager of the small enterprise should be a generalist and have basic knowledge and skills in managerial functions such as planning, organizing, leading, controlling, financial and marketing knowledge, recruiting. However, as companies grow, one person is not capable of handling all these issues and more responsibilities need to be delegated to avoid the failure of the enterprise (Papulová *et al.,* 2007). According to Baldwin's research (1995) Baldwin summarized these areas, that should be in attention for the small enterprises: insufficient use of consultancy services and outsourcing, lack of quality,

unwillingness to delegate responsibilities, key personnel leaving the enterprise, personal issues concerning the owner/manager (Baldwin, 1995; Papulová *et al.,* 2007).

Factors that affect business can be divided into internal and external. External factors are "outer factors" that the company owners cannot control – political, demographic, legal, economic, social and technical factors. The internal environment is associated with internal factors that can be controlled by businesses themselves and are mostly related to human resource management and business organization (Dragnić, 2014). Manager's personal features, vision and strategy and organization culture are also part of internal factors (Kotey *et al*., 1997). Management's choice of strategy will be influenced by three basic factors – management itself, internal factors and external or environmental factors. It has been found by researchers Montanari (1978), Kotey *et al.* (1997) that the greater the influence of environmental variables on business strategy, the less impact the management has (Kotey *et al*., 1997). According to Baldwin (Baldwin, 1995), internal factors, such as managerial skills and entrepreneurial values are most impotant success factors for small enterprises (Baldwin, 1995).

Innovation seems to play a mediating role between the human, social and financial capital of entrepreneurs and entrepreneurial success and could be used as a useful construct in utilizing these resources effectively (Omri *et al.,* 2015). Innovative R&D activites, accessing new markets and using new technology differentiate the less successful from more successful SME-s. While large companies have more financial capital to invest in innovative technologies, innovation is also key to success for SME-s (Baldwin, 1995).

It has also been noted by researchers Miller (1983), Kotey *et al.* (1997) that managers have greater influence on business strategy in small firms where manager is also the owner of the firm, than in large firms (Kotey *et al*., 1997). It can be related to the personal relationship through ownership, the power they have through that ownership on company's face and also direct contact with employees. Successful owners/managers have been identified as entrepreneurial types by numerous researchers and tend to place high value on ambition, achievement, reliability, responsibility, hard work, competence and professionalism, optimism, innovation, honesty and integrity, creativity, social recognition and growth, aggressiveness. These high performers also tend to be proactive in their strategic orientation in contrast to lower performers who are reactive in strategic orientation and tend to exhibit conservative personal values. Conservative managers may also struggle managing growth. However, most owners/managers adopt combinations of both proactive and reactive strategies (Kotey *et al*., 1997).

As primary health centres are mostly small businesses consisting of 10-40 employees, their management is primarily personalized (owner = manager) and the "face of an owner", they are more sensitive to external environment influences (for example state directions or legal constraints), resources are limited in finance, management and human resources and the structure is more shallow, spontaneous and flexible. This, on the other hand, gives opportunity to be more flexible, adaptive and innovative in business and give its employees a better sense of team and belonging (Dragnić, 2014; Sepp, 2015).

1.2. Competency models in healthcare

Hollenbeck *et al.* (2006) have argued that leadership competency models are useful for outlining and summarizing leadership framework, specifying a range of useful leader behaviours and can be used as a tool that individuals can use for their self-development as well as selecting and evaluating leadership effectiveness (Hollenbeck *et al*., 2006). For organizations it is useful because it helps to openly communicate which leader behaviours are important, to link leader behaviour to the strategic directions and goals of the business, and to provide an integrative model of leadership that can be reliably used across many positions. The problem with competency models is, that the higher the executive level and complex job, the less reliable one single set of competency model becomes, as leader's personal characteristics, also situational variables start to gain more importance and there is no "one way" of doing things. Then, also universal managerial competencies - persuasiveness, administrative skills, fluency in speaking, knowledge about group tasks, diplomacy and tact, social skills, creativity, conceptual skills, and cleverness as well as universal leadership behaviours are relevant to top management team in all sectors and firm sizes. Human resource capabilities, however, are found to be more important than intellectual capabilites (Carmeli & Tishler, 2006). In healthcare, sector-specific competency models can effectively be used for first line or middle management levels, but for picking a top executive, these universal models may not be so well suitable.

1.2.1 Challenges for healthcare managers

Figueroa *et al.* (2019) addresses the biggest challenges and emerging needs in health leadership and workforce management in recent years (and that was even before COVID-pandemic) at macro (international, national and societal), meso (organisational), and micro (individual health manager) levels. The **biggest challenges are HR related problems** – lack of qualified specialists, changes

in healthcare situation (aging population and its growing needs), rise of expectations by the patients and increase in private sector importance. Thus, the role of healthcare manager is becoming more important and global but as healthcare systems are so complex and multi-level, **no universal competence model** is introduced, but it rather suggests that key issues like efficiency savings, change management and human resource management need to be handled differently at different levels and that health managers need their transnational and interpersonal skills to be educated professionally in order to be successful in changing healthcare environment (Figueroa *et al*., 2019). Since March, 2020, when the world has battled with COVID-19 pandemics, lack of resources and managing these resources effectively in the turbulent environment has become even more relevant. Exhaustion and shortage of healthcare personnel available has been one catalyst of developing AI techologies to use resources more effectively (Efthymiou, 2020). Communication skills, empowering and motivating team and quick adaption to changing environment have become even more important leadership skill during the COVID-19 pandemic (Mishra, 2021).

As primary health care centres that are the focus of this thesis, are mostly single units with teams of 10-40 members, the managers there are most often also first line managers who give direct orders to their team and are responsible of operational level of the health centre. At the same time, as these centres are all separate businessses and there is little standardization among different centres, the managers are also middle managers and CEO-s of their health centres who create strategy and vision to the centre and who are responsible for partner relations, recruitment and salary policies and control mechanisms as well planning and managing finances. The Estonian ministry of Health and state insurance fund Haigekassa who is the supervisor of the health care centres, gives a lot of freedom for family medicine companies to decide their strategy and work organisation, working culture and ethics etc, as long as the norms related to opening times, space and equipment requirements, personnel requirements and quality standars are met. Being most often business owners themselves, the primary health care centre leaders are overall managers, i.e. general managers and the CEO-s of their health centres (Papulová *et al.,* 2007; Lumen, 2022).

1.2.2 Examples of competency models

As most competency models created are meant for universal use or do not distinguish between leadership levels, some research has been specifically done on creating competency model for executive-level health manager. As health care centre managers in Estonian primary care centres are also executives of these centres, the same core competencies could be applicable.

Liang *et al.* (2018) identified **six core management competencies** (competencies related to evidence, operations, knowledge, communications, leadership, change) and created an assessment tool by this framework to distinguish superior and average performers among managers in healthcare organisations. It provides opportunity for the HR to identify managerial competencies already when recruiting or picking healthcare executives and also to train and assess healthcare managers accordingly (Liang, 2018).

Howard *et al.* (2018) used best-fit method to identify and map competencies needed in healthcare management to validated management competency assessment program (MCAP). The new competency model includes the following **seven core leadership and management competencies**: evidence-informed decision-making, operations, administration and resource management, knowledge of healthcare environment and the organization, interpersonal, communication qualities and relationship management, leading people and organisation, enabling and managing change, and professionalism. However, this new proposed framework does not clearly differentiate the variation of required competence level between sectors, management levels and positions in healthcare management (Howard *et al.,* 2018).

Stefl (2008) discusses how five-competency-model created by Healthcare Leadership Alliance – a consortium of major professional membership organizations in the USA – can be used in combination with the Dreyfus model presented by Dreyfus *et al*. in 1980 (Maddy & Rosenbaum, 2018). The five-competency model was composed of the following competency areas: 1) **communication and relationship management**, 2) **professionalism**, 3) **leadership**, 4) **knowledge of the healthcare system**, and 5) **business skills and knowledge**. Dreyfus model of skill acquisiton is a five-step model of how new skills are developed from novice to expert and what kind of instruction and practice is needed at each level. Stefl (2008) argues that this together could serve as a framework for developing individual competency areas, because some areas in competency directory created by the HLA were general, and some more specific (Stefl, 2008).

In Leotsakos *et al*. (2014) research for creating competency model for healthcare leaders three main competency domains were identified: 1) **personal characteristics of a leader**, 2) **core leadership competencies,** like creating strategy, leading transformational change and communicating effectively, 3) **executive or *mise-en-place* competencies** – ability to create working systems and run people, human resource management and financial competencies (Leotsakos *et al.,* 2014).

Lin *et al.*'s (2011) research focused on creating a competency model for executive-level health manager and found that **management** and **marketing** competencies were most significant because without proper managerial skills the co-operation and communication of teams in this healthcare institution suffered and overall efficiancy of the healthcare institution suffered (Lin *et al*., 2011).

A systematic review of literature about the subject published between 2000 and 2020, conducted by Kakeman *et al.* (2020) created a competency model for hospital managers that is still applicable to different healthcare context.

Figure 1. Competency model for hospital managers

Source: Kakeman *et al.* (2020)

Wysocka *et al.* (2017) introduce a good overview of what competency models for healthcare managers have been created so far and analyse their limitations and applicability. In their research, where they compare literature findings with survey amont Polish healthcare managers, **strategic thinking, human resource management skills, delegation and responsibility skills, team building and management skills** seem to be the most important, together with **knowledge of the environment**. At the same time, the biggest competency gaps were also identified in those areas (Wysocka *et al.,* 2017).

An overview of the most relevant competency models and skillsets according to theoretical research introduced previously will be presented in the next table. These competency areas are used to help create the empirical part of the study.

Figure 2. Table of main competencies for healthcare managers according to literature.

Management level	Competency	Sources
Executive	**Personal characteristics**	Lin *et al.* (2011), Leotsakos *et al.* (2014)
Executive, universal	**Interpersonal skills and HR**	Howard et al. (2018), Lin *et al.* (2011), Kakemam *et al.* (2020), Leotsakos *et al.* (2014), Liang *et al.* (2018), Stefl (2008), Wysocka *et al.* (2017)
Executive, universal	**Managerial skills/operations**	Howard *et al.* (2018), Lin *et al.* (2011), Kakemam *et al.* (2020), Leotsakos *et al.* (2014), Liang *et al.* (2018), Wysocka *et al.* (2017)
Executive	**Marketing**	Lin *et al.* (2011)
Executive, universal	**Evidence-informed decision-making**	Howard *et al.* (2018), Kakemam *et al.* (2020), Liang *et al.* (2018)
Executive, universal	**Resource management, finances**	Howard *et al.* (2018), Kakemam *et al.* (2020), Leotsakos *et al.* (2014), Stefl (2008)
Executive, universal	**Knowledge of healthcare environment and organisation**	Howard *et al.* (2018), Kakemam *et al.* (2020), Liang *et al.* (2018), Stefl (2008), Wysocka *et al.* (2017)
Executive, universal	**Change management**	Howard et al. (2018), Kakemam *et al.* (2020), Leotsakos *et al.* (2020), Liang *et al.* (2018)
Executive, universal	**Professionalism**	Kakemam *et al.* (2020), Stefl *et al.* (2008)
Executive	**Strategic competencies**	Leotsakos *et al.* (2014), Liang *et al.* (2018), Wysocka *et al.* (2017)
Executive, universal	**Core leadership competencies**	Kakemam *et al.* (2020), Leotsakos *et al.* (2014), Liang *et al.* (2018), Stefl (2008), Wysocka *et al.* (2017)

Source: Author's summary based on literature review

According to theoretical research, healthcare management is complex due to various reasons: high quality requirements for the service and the personnel, lack of resources and increasing health needs, constantly changing healthcare environment and the need to make compromises between different shareholders and resources available. Human-resource related problems – shortage of qualified personnel remains one of the biggest challenges for the growing and aging population. Healthcare management is complex also partly because of high bureaucracy level in the system

and low agility for medical specialists are often resistant to change, especially when it is initiated from outside organization or from a manager with non-clinical background. Therefore, medical leadership with managerial skills taught to all clinical professionals to close the gap between clinicians and managers and to create shared leadership and joint management, is a trend that becomes more important than ever. Various competency models, both for universal use and for different executive level in healthcare management, have been created. Most of them can be grouped into three main groups – 1) strategic (executive) competencies, 2) human resources related (interpersonal) competencies, 3) professional competencies. With this theoretical knowledge in mind, the next chapter will research how and to which extinct these competency areas are expressed among Estonian family medicine health centre expert managers and the last part of study would discuss what could be a possible competency model for this type of healthcare manager and give suggestions about practical use and further research as well as its limitations.

2. RESEARCH DESIGN AND METHODOLOGY

To find answers to current research questions and support theoretical background with empirical study, qualitative semi-structured expert interviews were carried out with seven physician managers – already their own primary health care centre leaders. Qualitative method was used because there were no similar studies carried on in this field previously and no working model had been made that could be used to design a quantitative study. Qualitative interviews with experts enabled to collect valuable data and get insight of the real world and then to use the inductive method to draw basic conclusions and create framework for the topic. The use of semi-structured interviews gave opportunity to ask open-ended questions and additional questions derived from the answers helped go in-depth with understanding of the topic and the respondants' real opinions (Õunapuu, 2014). The interviews were carried out in Estonian languages, as this was the managers' mother tongue. All of them were experienced clinicians but also long-term managers with managerial and entrepreneurial experience between 15-30 years. The aim of the interviews was to find answers to research questions about current situation in Tallinn primary health care centres regarding management competencies, identifying the most important necessary leadership and managerial competencies of primary health care centre managers and eventually, to find whether these competencies can be formed into one competency model to be utilised for finding, developing and evaluating health centre leaders/managers. More detailed interview target questions thematically were following:

1) How have the current healthcare centre leaders become managers and how have they developed themselves regarding leadership and managerial competencies?
2) How is management and administrative work organised in their healthcare centres?
3) What are their biggest strengths and weaknesses as leaders-managers and what is their leadership style?
4) What are the most important necessary leadership and management competencies for primary health care centre managers in their opinion?
5) What are main challenges for health care centre managers in Estonia in their opinion? How do they evaluate the current management level in Estonian health centres?

2.1. Background to the research

Here, the family medicine organisation in Estonia will be introduced and the system will be compared to some other countries to give additional information about the family medicine management in Estonia that is one of the main influencers of the respondants' answers.

2.1.1 Family medicine in Estonia

Estonian primary care system, or family doctor system, dates back to 1991, when Estonian Family Medicine Association (EPS) was formed and new speciality was recognised by officials. However, until 1997 no changes in legislation were done and only after making regulation for creating family medicine practices, defining their job descriptions and regulating funding, family medicine practices were created as we know (Maaroos & Kalda, 2017). Family doctors make the biggest group of specialized doctors in Estonia. Family doctors can work with their own patient list or work as a substitute doctor with some other family doctor's patient list. There are currently 735 family doctors with their own patient list (Eesti Haigekassa B, 2022). When first, single practices prevailed mostly, in the last decade, the tendency is once again towards merged practices – and more specifically primary health care centres. Its main benefit is better quality in medical services and for family doctors, that also means better funding compared to single practices. When no longer a single doctor and nurse make up the team, but a minimum of 10 people, it demands another approach and managerial skills from the team leader. It requires new competencies regarding human resources, interpersonal skills and teamwork, organisation management, strategic and financial competencies, change and conflict management. Currently there are 56 primary healthcare centres in Estonia (Eesti Haigekassa B, 2022). All of them are managed by family doctors themselves, who normally parallelly do clinical work and clinic's administration and, as being owners of the clinic, also managing and developing their businesses.

Besides fee per capita and services provided, there is bonus funding for family doctors who meet quality system indicators each year (Sadrak, 2021). However, the quality indicator system that was created by family doctors themselves in 2009 and focuses mainly on evaluating quantitave criteria of the medical and preventative services provided, does not take into account any quality indicators regarding managerial or leadership competencies (Ingerainen, 2021). Last year, 2021 when data about 2020 was published, out of 420 GP practices in Estonia, 43% met the criteria of A+, A, B+ or B which meant the indicators were met at least 80%. 17% of the practices got evaluation for grade F which meant they were not "quality" clinics (Sadrak, 2021). In her research, a family

doctor, owner and manager of her health care centre that is responsible for its 20 000 patients, Ingerainen (2021), researches the current family doctor quality system and gives her suggestions about improving it, emphasising the importance of implementing strategical management tools and holistic view to quality management in family doctor offices and suggests using EFQM model for improving current quality evaluation system (Ingerainen, 2021).

Estonian primary care system has similarities with some other family medicine systems, for example United Kingdom and Australia. In the UK, taxpayers' money is given via NHS (National Health Service) to Family Doctors who run their practices or healthcare centres, money is divided according to capitation principle (like in Estonia) to provide free healthcare access to everyone. In the UK, family medicine healthcare centres are similar to Estonia, providing a large variety of services, comprising of 4-6 doctors, nurses, social workers and administrative personnel (Sepp, 2015). In Australia, the system is more combined, where Medicare (national social care provider) pays for the GP (general practitioner = family doctor) services directly to the GP according to their bill, the fees are per service, not per capita. In Australia, there is also combination of patient's self payment and private medicine. In Australia, GP offices are organised more like private practices (Davies *et al.,* 2009). In Finland, in contrast, the primary care is divided into three parts: 1) public health care centres - run by local government, 2) occupational health - run by private companies – contracts with employers, takes care of their workers in all family medicine related issues, 3) private clinics - lots of people have private insurance to ensure their access to private healthcare services (Sepp, 2015).

2.1.2 Primary health care centre

Primary health care centre with its family nurses and family doctors is usually the patient's first contact with medical services and patients tend to have long-term relationship with their family doctor or family nurses. Acutely ill patients are headed directly towards emergency room and hospitals but to planned visits to specialist doctors and exams the family doctor has a ”gatekeeper” function and many patient's health needs are actually met in the health centre with help of other healthcare personnel like fysiotherapist, psychologist, midwife (Eesti Haigekassa B, 2022). This means that lots of health care centre's functions is to identify patient's needs and to be a consultative organ. For that, it is vital that the system is running smoothly and patient experience is insatiable.

To create a competency model for healthcare centre leaders, it is necessary to identify their job-related tasks and assess, which of them are essential for the manager, which can only be performed by clinicians and which tasks can be delegated. In Estonia, currently majority of health care centre leaders are also its owners. As discussed before in previous paragraphs, it is essential for the small business owner to start delegating as soon as the enterprise starts growing (Papulová *et al.* 2007). Therefore it will be researched how much administrative work the current owner-managers delegate and what responsibilites can be delegated. As health centres receive their funding from the state, one obstacle for not delegating enough can be due to lack of funding for administrative or assisting personnel from the state. According to current financing model, there is only funding for one clinical assistant with a salary making up only 59% of the average salary in Estonia (Statistikaamet, 2021; Eesti Haigekassa, 2022). There is no funding for hiring an administrative manager nor COO for the clinic. With so scarce resources, no competent manager can be hired. This is also one of the reasons health care centres are mostly led by its owners who, at the same time, do their clinical work with their patients. Besides core managerial competencies of running their businesses, they are also in charge of partner relations with their contractor and funding provider state insurance fund (Haigekassa), Health Board, quality control of patient care, producing and presenting reports to authorities and statistics. All these tasks can lead to overwhelming workload of the manager and therefore uneffective management of the health care centre.

2.2. Interview design

Before the interviews, participants received questions created by the author. The questions were designed to cover the range of subjects and questions the author was trying to find answers to according to research questions based on theoretical background and author's empirical evidence. The questionnaire consisted of 14 questions. 12 questions were open-ended questions and two questions consisted of a list/selection to choose answers from using rank order rating method (Õunapuu, 2014). In addition to predefined questions, extra questions were asked following logical sequence of respondants' answers to go in-depth with the understanding about the subject. The questionnaire is presented fully in appendix 1. Interview transcriptions as well as audio files and coding table are retrievable from a cloud location presented in appendix 5. The questions with optional choice are presented separately in appendix 2 and appendix 3. In question number 9 (see appendix 2) a list of competencies (30) was created based on competency models and

competencies presented in the theoretical part. The respondants were asked to choose and rank these competencies according to their importance for health care centre managers in their opinion (see appendix 4). Competencies were grouped into following groups: **strategic and executive competencies**, **“soft” or human related (interpersonal) competencies, professional competencies**. In question number 10 six main leadership styles by Goleman (Goleman, 2000) was shown to participants (see appendix 3) and they were supposed to choose one style that is most common to them and explain why they use this style and how and whether it has changed over the course of their time as manager. All interviews were done as face-to-face interviews, that allowed to ask further detailing questions related to the answers given. Interviews were carried out in March, 2022. By that time, Estonia was just coming out of its recent COVID-19 pandemic crisis. Interviews were recorded live and the official length of the interviews was between 32 to 49 minutes. However, part of the interviews was off-record because it involved delicate data but was important for the author to understand the context and background of the experts’ opinions. Interviews were then transcribed manually and the location of transcribed files is presented in appendix 5.

2.3 Defining the research sample

Working experience of the expert respondants as healthcare managers as well as entrepreneurs was ranged between 15-30 years. All of them were practicing medicine simultaneously. Some of the participants had years of experience from Finland, where they also had clinical as well as managerial positions. 6 out of 7 were females. All participants were approached by e-mail or via social media platform. The author was acquainted with some of the participants before. However, the participants were selected by their vast experiene in family medicine and were considered as experts on the field, they all had leadership experience by managing their own primary care centres, some had also participated in Estonian Family Doctor Association’s (EPS) management work or even lead the association and helped create the family medicine organisation from a clinical and quality control perspective. The participants were all physician managers/owners of primary health centre in Tallinn municipality and its premises with employees from 20 to 70 people in their organisation, average amount of employees was 42. All managers except one were specialized in family medicine, one manager had speciality in paediatrics.

The table of participants will be presented below and the results of the interviews will be discussed in next paragraph.

Figure 3. Table of participants

Symbol	Patients in centre	Subordinates of the manager	Managerial experience since	Interview time	Interview length (h:m:s)
INT 1	28607	65	1992	3 March 2022	00:42:02
INT 2	12130	25	1999	18 March 2022	00:49:52
INT 3	14809	42	1998	14 March 2022	00:32:19
INT 4	15264	70	2007	14 March 2022	00:33:55
INT 5	9009	20	2001	22 March 2022	00:33:13
INT 6	7975	36	2010	14 March 2022	00:35:20
INT 7	7691	42	1996	31 March 2022	00:36:34

Source: created by author based on interviews and Raag (2021)

2.4 Data analysis

Qualitative interviews were transcribed and then analysed using content analysis to go in-depth with deeper understanding of the context and then inductive method was used to draw conclusions and formulate framework for the competency model. Interview recordings were listened repeatedly and compared to transcriptions to replace missing words, find keywords and most important inferences. Then, most often used phrases and topics were extracted and compared with other participants' answers (see coding table in appendix 5). Inductive content analysis was used because it is best suitable where there are no previous studies dealing with the phenomenon or when data is fragmented. With the use of content analysis replicable and valid inferences from data can be made, with the purpose of providing knowledge, new insights, representation of facts and a practical guide to action (Elo & Kyngäs, 2007). The answers from the interviews were categorized according to the research questions and interview target questions and the answers were compared with other respondants' answers. The answers to question number nine ("What competencies are most important for the healthcare manager? Name five and rank them with number one as the most important one") were coded using rank order rating method and then competencies were sequenced according to their rank (see rank table in appendix 4). The diagram is shown on figure 4 (p 34).

3. RESULTS AND ANALYSIS

In this chapter the results of the interviews will be discussed and analysed how they correlate with other findings in literature. Thereafter a competency model for the healthcare manager will be suggested according to the literature cohesion and the research on Estonian primary care management based on health centre management.

3.1 Results from interviews

Here, the results from the interviews will be presented, most important data has been extracted by using content analysis and inductive method. The findings will be then compared with findings from theoretical part and conclusions and suggestions will be given.

3.1.1 Managerial skills and leadership style

All doctors-managers had a managerial and entrepreneurial experience between 15 to 30 years. It most oftenly dated back to 1997-1998 when family doctor system as we now know was created in Estonia and which enabled family doctors to start their own family medicine practice and business on a contract basis with the funding that the state provided. After that, it has been a constant development of their clinic from a single practice to health care centre with maximum of 70 employees. Most leaders started out as single practices that has grown and developed into health centre over the years. One of the current doctor-manager was asked to become leader of a family medicine clinic with former experience in healthcare management of over a decade. One other doctor-manager had previous leadership experience of approximately 10 years before he started more serious entrepreneurship by creating his private primary care clinic.

Most managers had trained their leadership skills either by taking short courses from the universities in economics or finance planning, healthcare management, three doctors also had done a further complete non-medical degree – one doctor had a PhD in medical technologies, one doctor had a MBA degree in business administration, and one doctor a MA in organization psychology. One doctor had completed the 5-month development program for healthcare leaders in EBS (Estonian Business School) and graduated Estonian Diplomacy School. Some had also participated in coaching/mentorship programme and they valued highly the gains and insight it gave them and how it helped them grow as a leader. One of the reasons that coaching was named as an effective tool for the healthcare manager in Estonia, was this position’s uniqueness – to have competencies

of a doctor, a leader and a manager is not so widelyspread and therefore these competencies cannot be taught to bigger audiences. The differences between clinics and their operational style also varied a great deal and often resembled the face of its owner-manager. This correlates with the findings of Kotey *et al.* (1997) that small companies are most oftenly the face of their owners-managers (Kotey *et al*., 1997). Some of the doctors were also mentoring other doctors or managers-to-be. Personal role models/close people as mentors were also named. Three of the doctor-managers relied on themselves in making managerial decisions and trusted their "gut".

Most healthcare managers from the interviews described their leadership style as "democratic" or "coaching". "Affiliative" and "visionary" style were also named. This indicates that the leaders were working with independent specialists who required less direct commanding and more of motivating and inspiring towards shared goal and teamwork. This also correlates with leaders' responses to question number nine ("What competencies are most important for the healthcare manager?" – see appendix no 1) where mission and vision received most points. When practising coaching or visionary style, it is essential that all team members know the mission of the organisation and have shared vision about team's goals. This is part of transformational leadership's main qualities (Bass, 1990; Dionne *et al.,* 2004; Al-Sawai, 2013). No leader admitted the use of commanding style apart from only in situations where it was essential to follow orders now and without objection (for example during some of the most hectic times of COVID-19 pandemic crisis). One leader called his preferred leadership style "servant leadership", that was not in the list by Goleman (Goleman, 2000). Servant leadership by definition (Greenleaf, 1997) differs from other leadership styles by "serving its employees", this means when other leadership styles prioritize organizational well-being, servant leadership genuinely puts employees first and provides them with structure and necessary tools so that employees can focus on their job. It comes closest to affiliative leadership by Goleman's typology (van Dierendonck, 2011).

The above findings correlate with findings of Goleman (2000) and Chapman (2014) that a good leader should use a range of leadership styles according to situation and its team and that there is no universal leadership style for medical leader. However, democratic, coaching, affiliative and authoritative (visionary) were among the most frequently and effectively used styles (Goleman, 2000; Alloubani, 2014; Chapman *et al.,* 2014).

3.1.2 Evaluation

When it came to evaluating their work as a leader or defining success in leading their health centre, there was a variance between feedback frequency and methods. However, everyone defined their success as a good manager through their employees. To some, it meant that employee turnover was low, to one leader it meant that even when she had moved on to a new company, her employees followed her.

> "*When I have had one employee who has followed me for different organizations for 15 years, it probably means, I have done great job as a manager*" (INT 1).

Regarding feedback to their work as a leader, no one used the 360-degrees feedback system. Some of the leaders already used feedback questionnaires and developmental interviews from twice a year to every three years. One leader had started to use personal coach to implement feedbacking system in the healthcare centre and to get anonymous feedback to manager's work. When some of the managers asked direct feedback from their employees during developmental interviews, others were keen on asking about their employees' wellbeing and suggestions about work every week. Noticing their employees' emotional health and preventing burnout was very important to them. These leaders were also the ones who named affiliative leadership style as one of the styles besides democratic or coaching leadership that they used most frequently. Their centres, however, were not so big (25-36 employees), which means it is still possible to use this style in this middle-sized centre. It can be time-consuming to advocate each employee individually and in bigger centres the leaders used mostly their head nurses or assistants to get feedback from their employees. One centre used a professional human resource company to ask feedback from employees, using SWOT analysis was also one method named. Open and honest communication and constructive critizisim were perceived as one indicator for the manager's job. It came out clearly from the answers that some centres had a more personal approach to their employees, the team had regular events together and the manager saw their employees as their "family" to take care of but the bigger the centre was, the more distant was its leader to each employee and employee satisfaction was measured mainly through manager's closest employees and low employee turnover rates. In bigger centres though, employee turnover rate was approximately 10% while in smaller centres it was 0% in the course of last three years. On average, in healthcare according to US data, employee turnover rates are 3,2% and during the first 8-month COVID-19 pandemics peak in 2020, the number was 5,6% which after that recovered to 3,7% (Van Beusekom, 2022). This means that even during COVID-19 times, the managers of smaller Estonian health centres were able to prevent their employees from leaving with their motivational and leadership skill exhibited.

In one question, biggest strengths and weaknesses as a leader was asked from the respondants. **Strengths** that were named by the leaders themselves, can be grouped into three distinguish competency areas: **people skills**, **strategic skills** and **general leadership skills**. Two of the leaders named motivational and inspirational skills, employee engagement and enlightment as their main strengths and these qualities can be seen as ones that are also characteristic to transformational leadership. Honesty and standing out for their employees were one of the strengths this manager possessed. Teamwork skills and "(…) *picking the right people, not the brightest people separately, but "best fits" for the team* (…)" were also one of these leader's skills (INT 3). Two of the leaders named human resources and people skills – communication and public relations as their most important strengths. The ability to see the bigger picture, patterns and vision and strategy creation, self-analysis skills, calmness and professionalism were also named.

When it comes to **weaknesses**, the leaders were more aware of them or at least named more of their weaknesses than strengths. **Personal characteristics**, such as stubbornness, strong-headedness and lazyness were named. **Taking too many responsibilities** and difficulties in saying no or difficulties in giving negative feedback or dismissal messages were also one area of improvement. Being too emotional and idealistic in their vision was also named by one of the leaders. This leader, however, knew it well and compensated this weakness by using the right people in her team to keep her on the grounds and setting realistic goals for the organisation. **Lack of systematicity and organisational skills** regarding process management were also named, these were the leaders who were "people leaders" meaning their main focus was on their employee satisfaction and organisation structure and system creation was not their top priority. **Weak financial knowledge** or low interest in IT and detail management were also named by one leader who possessed characteristics of a visionary leader and had the ability to see the bigger picture as her strength. One leader who was very good in creating a vision and seeing patterns and bigger picture, said he struggled in communicating and delivering his vision to his employees and saw this as his biggest weakness. He had dealt already with his other weakness – to tell people what to do and instead, let them to find out themselves and by this he had stepped more towards coaching style of leadership. Interestingly, to "compensate" the weakness or perhaps just to organise processes more effectively, this leader had found a middle management team of five people to communicate his messages and execute his vision into strategy to his 70-people organisation. **Communication skills,** i.e. lack of delicacy or too direct/indiscrete communication especially in written communication was one of the weaknesses of a transformational leader who also exhibited entrepreneurial and proactive character. Being too busy was often named as one of the weaknesses.

Here, assumption can be made, perhaps “being busy” was actually the weakness of micromanaging or taking too much responsibilites and delegating too little by not clearly defining managerial job description and role?

Good management is not a one-size-fits-all approach and leaders come in all shapes and sizes. There are, however, some traits, that make a good manager – clarity in expectations to the team and their tasks, trust and openness to listen and give honest and regular feedback (Kralova, 2022).

3.1.3 Competency importance rank

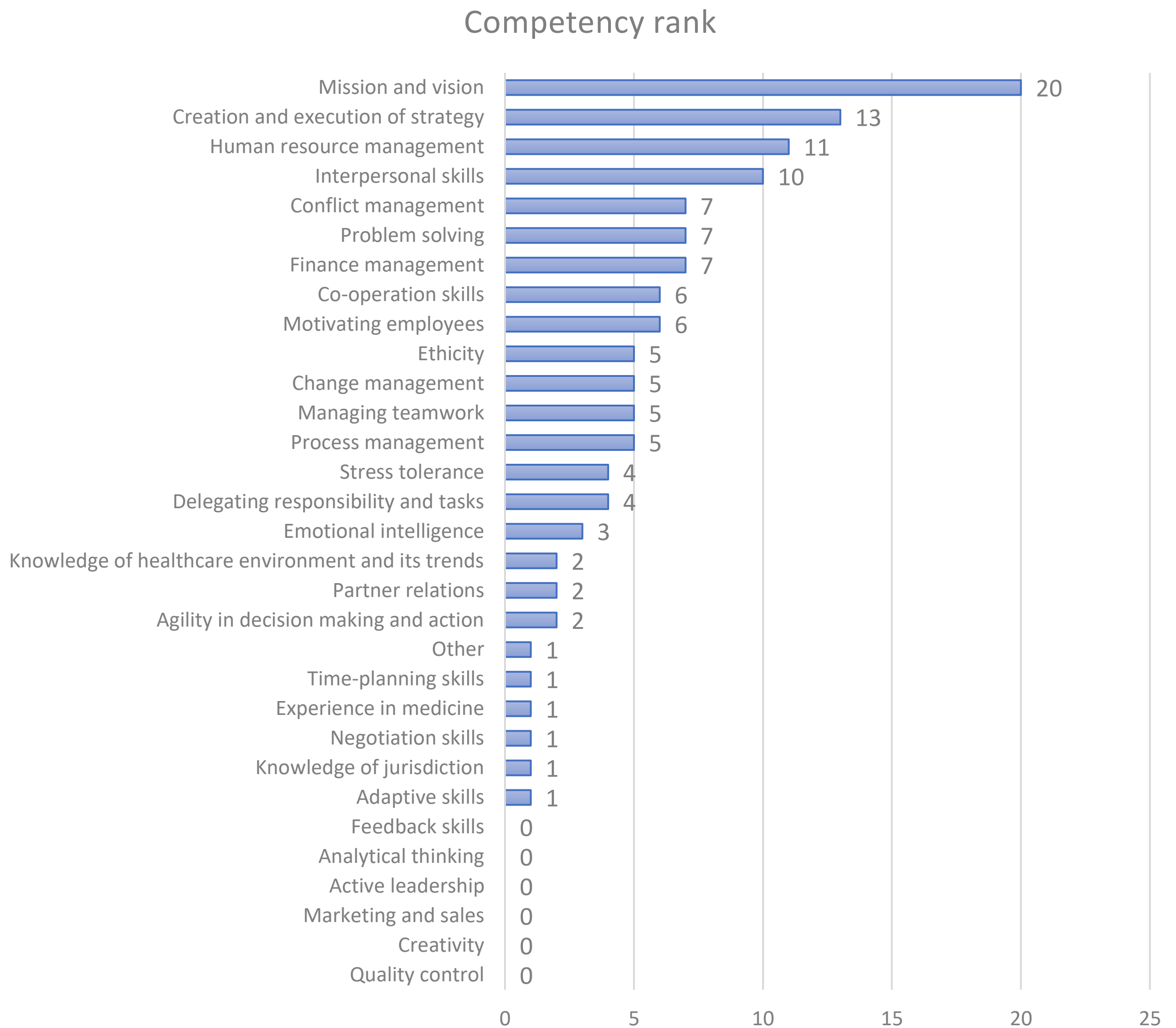
Competencies that were named and ranked by the participants were given points to find out the most prevailing ones according to their importance using rank order rating scale. The competency that was placed first, received 5 points; competency that was placed second, received 4 points; competency that was placed third, received 3 points; competency that was placed fourth, received 2 points; and competency that was placed 5th, received 1 point. In case the participant chose more than five competencies, the excessive competencies also received 1 point.

The competencies that got points from the respondants came in the following rank:

1. Mission and vision
2. Strategy creation and execution
3. Human resource management
4. Interpersonal skills
5. Problem solving and conflict solving, finance management
6. Motivating employees and co-operation skills
7. Ethics; change management and managing teamwork
8. Stress tolerance and delegating responsibilities
9. Emotional intelligence
10. Knowledge of healthcare environment and its trends; agility in decision making and action; partner relations
11. Experience in medicine; time-planning skills; negotiation skills; adaptive skills; knowledge of jurisdiction; other

See appendix 4 for a more detailed table of answers.

Figure 4: Competency importance rank diagram by answers to question number 9



Source: Created by author based on interview responses

3.1.4 Managerial work organisation in their centre

From the interviews came out that the structure of the healthcare centre management is quite flat. In two centres, there was only the manager or management team to whom all staff was responsible to directly, there was no leading nurse and the responsibility was shared between different nurses mutually. One health centre with 42 employees had three head nurses who served as middle managers between front liners (family nurses) and management team. Most centres had one head nurse who, at the same time with managerial work, was doing patient work as a family nurse in the same clinic. Besides head nurse, administrative non-clinical positions were present in four of the centres. The biggest health care centre (70 employees) had administrative operations manager

who was with non-medical backround (originally human resources manager) and the smallest clinic (20 employees) was currently training one part-time clinical assistant into COO of the centre. The doctor leaders-owners and current managers of the latter two organisations had opinions that a good healthcare manager does not necessarily need to be a physician oneself, but it is important to know the environment that surrounds them and to have good managerial skills. The head of one smaller family centre with 20 employees (INT 2) named that one reason for hiring an administrative manager who is not one of their doctors or owners, was the desire to do more clinical work. She also emphasized that the most important competency of the non-medical manager was not knowledge of the healthcare environment, but the wish to work and administrate the clinic and to be the true leader who motivates and engages its employees. This correlates well with the fact that in many healthcare organisations the managers are willing, not wanting to do the job which leads to stagnation in these organisations (Kumar, 2013).

Although only one doctor described herself as "*a true entrepreneur by soul*" (INT 7), all interviewed leaders were satisfied with the freedom the system enabled them in organising and managing their work and their clinics. To a greater and lesser extent, all doctor-managers were actively engaged in managing their clinics, but some of them also pointed out the desire to be more of an owner than manager of the clinic. This, by their opinions, was perhaps possible in the future when a strong COO would be in charge. In most health centres the management did not consist of one single manager but managerial tasks were also divided by owners. The ownership of clinic was often divided between 2-3 doctors but mostly only one of them carried leading managerial role. One clinic had one owner-manager as CEO, but the executive team was formed of three persons to help make organisational, process-related and clinical decisions together. This "shared" management could also be particularly useful because in healthcare organisations independent and highly educated medical professionals can be sometimes barrier to change, it can be difficult to lead them from above and key to effective leadership in this case is empowering its individual team members to participate in decision making, acquiring leadership behaviours and emphasizing teamwork and team's shared goals (Al-Sawai, 2013; Kumar, 2013).

It was stated by several doctor-managers in the research that managing a health centre is almost a full-time job, besides managerial work the participants were all active doctors, with clinical-administrative work relation ranging from 25/75 % to 75/25%. It was also emphasized that the relationship between administrative and clinical work depended on the current situation in primary care – during COVID-19 pandemic peaks the amount of clinical work was bigger.

The leader of a centre responsible for 15 000 patients' care (INT 3) compared managing a healthcare centre with conductor's work –

> "*A good conductor cannot play all the instruments simultaneously and conduct the orchestra, it is important to find good players, good fits for the each instrument and harmonize the orchestra*" (INT 3).

However, none of the doctor-managers had stopped doing clinical work entirely, they emphasized the importance to preserve their clinical skills and also because maintaining clinical knowledge and patient contact was a satisfactory part of their career. This confirms findings of Figueroa *et al*. (2019) that the number of hybrid managers, i.e. managers performing clinical and managerial work parallelly, is increasing in developed countries, thus improving the governance of this clinical organisation (Figueroa *et al.,* 2019). On the other hand, what came out from the interviews, was that doing too much clinical work may lead to exhaustion and loss of bigger picture and vision. According to Baldwin (1995), it is essential to delegate responsibilites and outsource consultancy services as much as possible, to avoid burnout of the manager and key personnel leaving the enterprise and find balance between the specialist and managerial roles (Baldwin, 1995).

The leaders in these interviews named agility and adaption in changing healthcare environment as one big factor impacting their relationship between clinical and administrative work. Adaption and change management are also part of core transformational leadership competencies and part of health leadership competencies according to various researchers (Leotsakos, 2014; Howard *et al.*, 2018; Liang *et al.*, 2018; Kakemam *et al*., 2020).

Most doctor-managers had an assistant. To some, it was a part-time nurse or a former nurse, in other organisations assistants had either economic background being developing director or administrative manager, in some organisations assistants' primary role was to do non-clinical assisting work like directing patients to right places or registrating patients. Respectively, in organisations where assistants had more responsibility, they participated in management meetings or served as a right hand to the manager. Different tasks were also delegated to more experienced nurses and most centres had one position for a person who was dealing with technical maintenance or other miscellaneous non-medical tasks. Most managers were satisfied with the delegation level they had in their organisation. As delegation is part of leadership's core competencies, this gives hint that they were good managers, but as all of them had managerial experience for over 15 years minimum, it remained unclear whether and how this competency had developed over time.

3.1.5 Main challenges for primary health centre leader

The answer to the question "What do you think are the main challenges for primary healthcare centre leader? Should the person in charge be a specialist (clinician), entrepreneur or a manager?" also brought out different views among the experts.

Main challenges were related to **managing people and teamwork**, **managing finances** and **keeping the balance** between managerial and clinical work. People and teamwork were clearly the most important challenges for the leaders. One manager argued that when during the 2000s the biggest challenge was to manage finances, the shift has been towards people and evaluating them as biggest asset (INT 5). This goes well in hand with the transformational leadership style becoming more popular among leaders in healthcare. Lack of financial resources and administrative personnel was one of the key obstacles of preventing the owners to focus solely on clinical work for those who wanted to to be more doctors. Those who enjoyed entrepreneurship and managing their clinic, still admitted that the resources were limited to hire enough assistants or other people to delegate responsibilites. A manager from smaller centre who did not have an assistant (INT 2) admitted that it was very complicated to balance between managerial and clinical work and especially during recent turbulent years when COVID-19 crisis was holding healthcare in its grasp, it was mainly about managing processes and motivating her employees. This leaves less time to do clinical work because managing your organization is already a full-time job. Other managers also admitted that it was dificult to stay up-to-date with latest clinical discoveries and guidelines when everyday work consisted of too much bureaucracy and paperwork.

Opinions about whether the manager should be a doctor or not, separated between the respondants. One leader of a clinic with 42 employees (INT 3) said that all the necessary functions were to be fulfilled and as an owner-manager you also had to have managerial competencies as well as entrepreneurial savvyness and if you were not interested in these subjects as a doctor, you had to outsource all the competencies. This opinion was shared by several respondents. Another manager (INT 5) stated that as long as the manager was interested in her work, it was not actually relevant whether it was a specialist or purely administrative manager. She gave examples of how family medicine clinics have declined very quickly when their owner-manager was for example on maternity leave and therefore suggested that there should be one passionate and charismatic leader within the organization. This leader does not necessarily had to be the owner, but until now, in Estonia, they usually have been. The leader of a big healthcare centre with 70 employees (INT 4) pointed out that because doctors as independent specialist are normally not very obeying and

dislike authority, the manager should practice servant leadership and to support all systems so that clinicians can do their work smoothly. In that case the leader does not have to be with medical background. He also admitted that although the reknown Mayo clinics have clinician-background managers, it is not possible in Estonia because there are very few doctors with good managerial competencies.

Owner-manager of an average size centre (36 employees, INT 6) voted for specialist to be the manager. She prioritized her employees and good working climate over financial benefits. She argued that if you hired COO outside your organization who is not a doctor, your main values and family feeling with your employees will suffer.

"Only doctor can have enough empathy for your colleagues, not just seeing numbers or profit." *(*INT 6)

This could be arguable because health centres are not non-profit organisations, but stable financing by the state gives them certain financial security though. A manager who coordinated work of 42 employees and care of 7700 patients (INT 7) admitted that it was very difficult for the outside and solely administrative manager to understand the specifics of our family medicine system and it would take years to understand and manage the system effectively for a manager with non-medical background.

Overall, what came out was, that when ideally the manager could have a clinical background, it could be compensated with manager's communication and people skills and organizing non-medical work smoothly so that doctors and nurses can do their work.

All participants admitted that there was a big gap between managerial competencies among Estonian healthcare centres. Some practices were managed brilliantly whereas some practices were not managed at all and this also reflected on their reputation and quality reviews. The main problem about family care centre management is that clinicians are good specialists, but lack managerial competencies and the stable financing system that the state provides and that does not differentiate clinics with good or bad management financially, enables some clinics to exist years without proper management.

3.2 Competency model for the health centre leader

Based on findings in literature and the empirical part, the following competency model would be suggested for the health care centre leader. Similar competencies that belong to one competency area are grouped into one competency group to make the model more easily readable and applicable.

1) **Strategic competencies**, including mission and vision, strategy creation and execution, finance management
2) **Human resources management related competencies** like problem solving, conflict management, managing teamwork, motivating employees, employee retention policies
3) **Interpersonal skills** like communication, emotional intelligence, co-operation and negotiation skills, ethics
4) **Process management related competencies** like delegating responsibilites, agility in decision making and action, adaptive skills, knowledge of jurisdiction

Knowledge of healthcare environment is essential for the health centre leader to orientate and manage health centre effectively.

Figure 5: Competency domains in competency model

Source: Created by author

This means that there are two major competency areas for the manager of the healthcare leader – strategic competencies and people skills. All these are actually trainable and non-medical competencies. According to INT 3, however, all competency areas must be covered equally and parallels can be made with McKinsey 7S theory (Faridun & Naveen, 2012) where all the competencies for your business to succeed need to be acquired. However, out of these competencies in the model, only knowledge of the healthcare environment is not so easily attainable and can be time-consuming for a non-medical manager. One possible option is to use this competency model as direction indicator for the current physician manager so that the manager could delegate purely administrative tasks, time-consuming tasks or these competency areas that the manager is not competent or interested to, to non-medical manager and then the owner can still do executive tasks she or he is interested in, like creating vision and strategy to the health centre or perhaps people managing, if this is one of his or hers strengths.

3.2.1 Comparison with other competency models

Comparing these findings with literature, mission and vision that was placed first in current research, is also one competency that 21st century transformational healthcare manager should have, according to Trofino (1992) (Alloubani, 2014). Parallels can be made with Wysocka *et al.* (2017) competency model for Polish healthcare management. According to their research, key competencies are knowledge and management of human resources. However, when in Wysocka (2017) research knowledge of medical environment and professional skills was another set of key competencies, in this research that did not turn out to be the most important competency area for health centre manager (Wysocka *et al.,* 2017). Instead, vision and strategy creation and execution topped over professional skills. Finance management was also one competency area that was not among top twelve competencies needed for health care manager in Wysocka research (2017) but were important to Estonian primary care centre managers. Perhaps this is because of the relative independence in financial decision making and budgeting of the health centres and running their own businesses as manager-owners.

"*When I realized I will not get to buy yachts and take million euros as dividends every year as health care centre owner, the focus shifted from managing finances to managing people"* (INT 6)

People skills like communication and problem solving, turned out to be equally important competency area between Polish and Estonian healthcare leaders. The competencies that ranked highest according to respondants, are similar to these that were found in Wysocka *et al.*'s (2017)

research: **strategic thinking, human resource management, team building and interpersonal skills**.

The competency model that Lin *et al.* (2011) created for executive-level health manager, included four competency areas like personal characteristics, interpersonal skills and relationships, management, and marketing. According to interview respondants, marketing is not important at all for health care centre leader. Personal characteristics did not also seem to be important for Estonian health care centre manager although according to literature its role in small firms is vastly important (Kotey *et al.,* 1997).

In comparison with the competency model for hospital managers by Kakeman *et al.* (2020), the importance of interpersonal, communication qualities and relationship management, leading people and organisations, change management and operations management also came out with this study (Kakemam *et al.,* 2020).

Liang *et al.* (2018) identified six core management competencies - competencies related to evidence, operations, knowledge, communications, leadership, change were the most important ones. In this research according to the respondants communications, leadership, change, and operations were also named but the competency model of Liang *et al.* (2018) does not fit so well for the Estonian health centre manager (Liang *et al*., 2018).

In the research by Leotsakos *et al*. (2014) and the competency model that was created, leader's personal characteristics and leadership style were placed in top three along with core leadership competencies like stategy creation and change and communication management with executive and process management as well as HR management and financial competencies, these competency areas are correlating with skills that came out in current study (Leotsakos *et al.,* 2014).

In Stefl's research (2008) where she argued how five-competency-model created by Healthcare Leadership Alliance can be used in combination with the Dreyfus model, three competency areas in the list (communication and relationship management, leadership, business skills and knowledge) also ranked top in this current study (Stefl, 2008).

According to Alloubani (2014) findings about key competencies for transformational leadership, shared vision, change management and systems thinking as well as innovation correlate with findings of the current study (Alloubani, 2014). The ability to see a bigger picture and align all

team members towards a shared goal, was seen as one of key competences according to the transformational leader of 42 people in team in Estonian health centre (INT 3).

Interestingly, none of the interview respondants named leader's own personal characteristics as main competency area for leading and managing a primary care centre successfully. Also, professional competencies did not rank high in the current research. This can be due to reason that health care centre leaders who already are very experienced doctors and train their clinical knowledge on a routine basis, do not have to think more about being better in their professional or clinical competence in order to be a good manager. The health centre leaders who considered a non-clinical manager to lead their centre, were interestingly not emphasizing knowledge of environment as top qualities for the manager. When other researches have stated leader's personal characteristics and leadership style among top competencies, it did not come out from this research. All managers in the current research interviewed were considered to be successful but differed from each other in large amount and their leadership styles were also different. This did not seem to affect managing healthcare centre neither positively nor negatively.

3.2.2 Practical implications and limitations

The competency model introduced can be used in evaluating and improving managerial skills for current leaders of the primary care centre but also as a selection and development tool for the owners of health centre who want to find managers for their centres either outside or by training them internally. For health centre owners there should be an option to either be the leader and manager of the centre parallelly with clinical work or to be a doctor but to have a good administrative manager in charge. Current leaders could assess their strengths and weaknesses and accordingly, outsource the areas of their weaknesses. The competency model can also be used as a tool to help select which competency areas are wise to delegate so that the CEO could concentrate more on his or hers work and health centre operations would run smoothly. As no other competency models in Estonia have been created so far for health care centre leaders or primary care management on the whole, this could be the first pioneer and leave further researchers to validate and improve the model using quantitative and combined methods. The competency model is rather universal and similar with other competency models created for healthcare manager before and therefore it can be applicable also in other context, not only in Estonian healthcare environment. However, it should best suit for healthcare organisations that are rather independent (separate clinics or independent units) with quite flat management hierarchy, are small or medium size and where the manager needs to be general manager. This could also give input for universities

for medical leadership development module/programme and for family residency programme so that all clinicians could receive basic leadership and managerial skills and for those interested in combined medical leadership or entrepreneurship, leadership and managerial competencies could be taught in hand with clinical skills.

More research needs to be done whether this competency model is equally applicable to newly established or already fluently operating health centre, with different leadership styles of its managers and how the ownership of the clinic affects the competency model. Also, whether there are differences between health centre management in rural or municipal areas. This competency model should be validated by quantitative research among a bigger group of health managers and in different locations and also among their subordinates in health centres which enables to get more adequate view of leadership and management quality in primary care and to create a more usable and validated model for primary care centre managers.

CONCLUSION

In health management practices, where new leadership skills and managerial competencies are required to battle between increasing demands by patients, rapid changes and lack of resources, competency models have been created to find the optimal skillset for the health care manager who could manage these resources effectively. Poor leadership competencies, especially in primary care, that has the most frequent and close relationship with patients, stands as one obstacle against healthcare quality improvement. The author hereby researched managerial competencies among health centre leaders in Tallinn, who until now, are most often also clinicians, and manager-owners simultaneously. The aim of this master thesis was to identify leadership and managerial competencies needed for the health centre manager and to get valuable insight from current leaders in order to improve the quality of primary care management. The results of the master thesis are based on literature review and qualitative research method of semi-structured interviews with board of experts – experienced family medicine health centres in Tallinn, Estonia. The main findings are presented as follows:

1) Primary care health centre leader competency model can be divided into four distinctive skillsets: strategic competencies, human resources, interpersonal skills, process management competencies. All competency areas need to be covered - either by medical leader, outsourced to administrative manager or in combination of these two. Knowledge of environment is essential
2) Manager with medical background would be ideal. Basic leadership and managerial skills should be taught parallelly with clinical skills to all clinicians and more thoroughly to those interested in medical leadership as separate career path
3) Lack of resources and competent managers prevents hiring administrative managers
4) Teamwork and well-harmonizing teams to align towards shared goal is key to success
5) There is no universal health care centre leader profile – most important is the will to be one

The above findings can help owners to find or develop managers to their health centres or provide an evaluation tool for themselves or their current managers and for development of health managers in residency program. More research needs to be done whether this competency model is equally applicable to already established and new health care centre and its members and to different leadership styles. Further studies should validate the model using quantitative method and also financial modelling of health care centre's effective management should be done.

LIST OF REFERENCES

Adindu, A., & Asuquo, A. (2013, September). TRAINING HUMAN RESOURCE FOR 21ST CENTURY NIGERIAN HEALTH SECTOR. *Global Journal of Human Resource Management*, pp. 1-11.

Al-Khaled, A. A., & Fenn, C. J. (2020). THE IMPACT OF LEADERSHIP STYLES ON ORGANIZATIONAL PERFORMANCE. *BERJAYA Journal of Services & Management*.

Alloubani, A. M. (2014). REVIEW: EFFECTS OF LEADERSHIP STYLES ON QUALITY OF SERVICES IN HEALTHCARE. *European Scientific Journal, ESJ, 10(18)*, p. https://doi.org/10.19044/esj.2014.v10n18p%p.

Al-Sawai, A. (2013). Leadership of Healthcare Professionals - where do we stand? *Oman Medical Journal*.

Baker, G. R., & Denis, J.-L. (2011). Medical leadership in health care systems: from professional authority to organizational leadership. *Public Money & Management*.

Baldwin, J. R. (1995). *Innovation: the key to success in small firms.* Statistics Canada Working Paper 76.

Barlow, C. B., Jordan, M., & Hendrix, W. H. (2003). CHARACTER ASSESSMENT: AN EXAMINATION OF LEADERSHIP LEVELS. *Journal of Business and Psychology*.

Bass, B. M. (1990). From transactional to transformational leadership: Learning to share the vision. *Organizational Dynamics*.

Busari, J. O. (2012). Management and leadership development in healthcare and the challenges facing physician managers in clinical practice. *The International Journal of Clinical Leadership*, 17:211–16.

Carmeli, A., & Tishler, A. (2006). The relative importance of the top management team's managerial skills. *International Journal of Manpower*.

Chapman, L. A., Johnson, D., & Kilner, K. (2014). Leadership styles used by senior medical leaders: : Patterns, influences and implications for leadership development. *Leadership in Health Services*.

Chen, T.-Y. (2018). Medical leadership: An important and required competency for medical students. *Tzu Chi Medical Journal*.

Cherry, K. (2021). *Leadership Styles and Frameworks You Should Know*. Retrieved from verywellmind.com: https://www.verywellmind.com/leadership-styles-2795312 [Accessed 12.02.2022]

Davies, G. P., Perkins, D., McDonald, J., & Williams, A. (2009). Integrated primary health care in Australia. *International Journal of Integrated Care*.

DeChurch, L. A., Hiller, N. J., Murase, T., Doty, D., & Salas, E. (2010). Leadership across levels: Levels of leaders and their levels of impact. *The Leadership Quarterly*.

Dennison, K. (2021, May 27). *Why Traditional Leadership Styles May Become Irrelevant With The Rise Of The Coaching Leadership Style*. Retrieved from Forbes: https://www.forbes.com/sites/karadennison/2021/05/27/why-traditional-leadership-styles-may-become-irrelevant-with-the-rise-of-the-coaching-leadership-style/?sh=129727667e9e [Accessed 30.03.2022]

Dionne, S. D., Yammarino, F. J., Atwater, L. E., & Spangler, W. D. (2004). Transformational Leadership and Team Performance. *Journal of Organizational Change Management*.

Dragnić, D. (2014). IMPACT OF INTERNAL AND EXTERNAL FACTORS ON THE PERFORMANCE OF FAST-GROWING SMALL AND MEDIUM BUSINESSES. *Management – Journal of Contemporary Management Issues*.

Drzewiecka, M., & Roczniewska, M. (2018). The relationship between perceived leadership styles and organisational constraints: An empirical study in Goleman's typology. *European Review of Applied Psychology*.

Edwards, N., Marshall, M., McLellan, A., & Abbasi, K. (2003). Doctors and managers: a problem without a solution? *BMJ Clinical Research*.

Eesti Haigekassa. (2022, April 1). PA_rahastusmudelid_al_apr_2022. Estonia: Eesti Haigekassa.

Eesti Haigekassa A. (2022, 04 15). Retrieved from Lepingud üldarstiabi rahastamiseks: https://www.haigekassa.ee/partnerile/raviasutusele/perearstile/lepingud [Accessed 12.04.2022]

Eesti Haigekassa B. (2022, 04 15). Retrieved from Esmatasandi teenuste arendamine: https://www.haigekassa.ee/haigekassa/strateegiad-ja-arengusuunad-0/esmatasandi-teenuste-arendamine [Accessed 22.04.2022]

Efthymiou, I. P. (2020). AI transforming Healthcare Management during Covid-19 pandemic. *HAPSc Policy Briefs Series*, pp. 130-138.

Elo, S., & Kyngäs, H. (2007). The qualitative content analysis process. *Journal of Advanced Nursing*.

Estonian Business School. (2022). Retrieved from Tervishoiu valdkonna juhi arenguprogramm: https://ebs.ee/en/node/242 [Accessed 12.02.2022]

Faridun, D., & Naveen, U. (2012). *Developing leadership capabilities*. Retrieved from McKinsey&Company: https://www.mckinsey.com/business-functions/operations/our-insights/developing-leadership-capabilities [Accessed 02.04.2022]

Figueroa, C. A., Harrison, R., Chauhan, A., & Meyer, L. (2019). Priorities and challenges for health leadership and workforce management globally: a rapid review. *MBC Health Services Research*.

Goleman, D. (2000). Leadership that Gets Results. *Harvard Business Review*, pp. 82-83.

Hollenbeck, G. P., McCall Jr., M. W., & Silzer, R. F. (2006). Leadership competency models. *The Leadership Quarterly*.

Howard, P. F., Liang, Z., Leggat, S., & Karimi, L. (2018). Validation of a management competency assessment tool for health service managers. *Journal of Health Organisation and Management*.

Ida-Tallinna Keskhaigla. (2022, 04 15). Retrieved from Juhtimine - haigla nõukogu: https://www.itk.ee/haiglast/haigla-juhtimine [Accessed 22.02.2022]

Ingerainen, D. (2021). Eesti perearstipraksiste kvaliteedijuhise täiendamine EFQM näitel. Tartu, Estonia.

Kakemam, E., Liang, Z., Janati, A., Arab-Zozani, M., Mohaghegh, B., & Gholizadeh, M. (2020). Leadership and Management Competencies for Hospital Managers: A Systematic Review and Best-Fit Framework Synthesis. *Journal of Healthcare Leadership*, pp. 12: 59–68.

Khan, M. S. (2015). The Styles of Leadership: A Critical Review. *Public Policy and Administration Research*, *5(3),* pp. 87-92.

Kotey, B., & Meredith, G. G. (1997). Relationships among Owner/Manager Personal Values, Business Strategies, and Enterprise Performance. *Journal of Small Business Management*.

Kralova, U. (2022, March 14). *Ask an Expert: What Skills Do I Need to Become a Great Manager?* Retrieved from Harvard Business Review: https://hbr.org/2022/03/ask-an-expert-what-skills-do-i-need-to-become-a-great-manager?utm_campaign=hbr&utm_medium=social&utm_source=facebook&fbclid=IwAR2T60RANk-6Ngym1E5S1ErwUdOEaT8WLH43V6q8_9fjA7o2f_vtMPZJQMI [Accessed 01.04.2022]

Kumar, R. D. (2013). Leadership in healthcare. *Anaesthesia and intensive Care Medicine*.
Leotsakos, A. P. (2014). Leadership Competencies Framework on Patient Safety and Quality of Care (DRAFT). Geneva, Switzerland: World Health Organization.
Liang, Z. H. (2018). Development and validation of health service management competencies. *Journal of Health Organization and Management*.
Liang, Z., B. F., Howard, P. F., Briggs, D. S., Leggat, S. G., Wollersheim, D., Rahman, A. (2018). An evidence-based approach to understanding the competency development needs of the health service management workforce in Australia. *BMC Health Services Research*.
Lin, Y.-J., Chiang, P.-S., Liao, Y.-W., Wang, S.-J., & Li, A.-T. (2011). Constructing Executive-level Health Manager ' s Competency Model ─ A Case Study of the Health Examination Center at a Teaching Hospital in Central Taiwan. *2nd International Conference on Education and Management Technology.* Singapore: IACSIT Press, Singapore .
Lumen. (2022). *Lumen Learning*. Retrieved from Boundless Management: https://courses.lumenlearning.com/boundless-management/chapter/management-levels-and-types/ [Accessed 10.03.2022]
Lääne-Tallinna Keskhaigla. (2022, 04 15). Retrieved from Juhatus: https://www.keskhaigla.ee/haiglast/juhtkond/ [Accessed 22.02.2022]
Maaroos, H.-I., & Kalda, R. (2017). Peremeditsiin Eesti tervishoiukorralduses. *Tartu Ülikooli ajaloo küsimusi XLV*.
Maddy, L., & Rosenbaum, L. (2018). Determining leadership levels with the Dreyfus model. *Journal of Workplace Learning*.
Mishra, A. e. (2021). LEADERSHIP COMPETENCIES AND COVID-19: EMERGING CHALLENGES AND OPPORTUNITIES. *SHODSHAMHITA*.
Omri, A., Frikha, M. A., & Bouraoui, M. A. (2015). An empirical investigation of factors affecting small business success. *Journal of Management Development*.
Papulová, Z., & Mokroš, M. (2007). IMPORTANCE OF MANAGERIAL SKILLS AND KNOWLEDGE IN MANAGEMENT FOR SMALL ENTERPRENEURS. *e-leader*. Prague.
Peters, D. e. (2014). The Evolution of Leadership: A Perspective from Mayo Clinic. *Physician Executive*.
Raag, M. (2021). *Perearsti nimistute ülevaade.* Retrieved from Eesti Haigekassa: https://app.powerbi.com/view?r=eyJrIjoiMTliZGFkNjMtZTUwYi00MDhiLWEzMWYtNTgwZmQ1MDJkMDMzIiwidCI6IjJiMWJmNzQ4LWZmMGMtNGU5ZC1hZDMzLTBiMzkwMzEzYWIxMyIsImMiOjh9&pageName=ReportSection0996adac74e51bb96ba0 [Accessed 01.05.2022]
Regionaalhaigla . (2022, 04 15). Retrieved from Juhtimine: https://www.regionaalhaigla.ee/et/agris-peedu-cv [Accessed 22.02.2022]
Rosari, R. (2019). LEADERSHIP DEFINITIONS APPLICATIONS FOR LECTURERS' LEADERSHIP DEVELOPMENT. *Journal of Leadership in Organizations*.
Ryan, C. (2012). Field Guide to Case Study Research in Tourism, Hospitality and Leisure. In *Advances in Culture, Tourism and Hospitality Research. Volume 6* (pp. 543-558). Emerald Group Publishing Limited.
Sadrak, E.-M. (2021). Ülevaade Eesti Perearstide kvaliteedisüsteemidest. *Eesti Arst*, 100(2): 122-125.
Sepp, V. K. (2015). *Uuring esmatasandi tervishoiuteenuste geograafilise kättesaadavuse vajaduse hindamine ja esmatasandi tervishoiuteenuste optimaalse korralduse mudeli loomine. Osaraport 5. Esmatasandi tervisekeskuste organisatoorsed mudelid.* Tartu: Tartu Ülikool.
Skorková, Z. (2016). Competency models in public sector. *3rd International Conference on New Challenges in Management and Organization: Organization* . Dubai, UAE: Procedia - Social and Behavioral Sciences.

Statistikaamet. (2021). *Keskmine brutokuupalk*. Retrieved from Statistikaamet: https://www.stat.ee/et/avasta-statistikat/valdkonnad/tooelu/palk-ja-toojoukulu/keskmine-brutokuupalk [Accessed 23.03.2022]

Stefl, M. E. (2008). Common competencies for all healthcare managers: the healthcare leadership alliance model. *Journal of Healthcare Management*.

Sutton, J. P. (2021, July 12). *What Is the Coaching Leadership Style?* Retrieved from positivepsychology.com: https://positivepsychology.com/coaching-leadership-style/ {Accessed 30.03.2022}

Zaleznik, A. (1977, 2004). Managers and Leaders: Are they different? *Harvard Business Review*.

Tartu Ülikooli Kliinikum. (2022, 04 15). Retrieved from Juhatus: https://www.kliinikum.ee/haiglast/struktuur/juhatus/ [Accessed 22.02.2022]

Van Beusekom, M. (2022, April 8). *Healthcare workers report high job turnover amid pandemic*. Retrieved from CIDRAP Centre for Infectious Disease Research and Policy: https://www.cidrap.umn.edu/news-perspective/2022/04/healthcare-workers-report-high-job-turnover-amid-pandemic [Accessed 01.05.2022]

van Dierendonck, D. (2011). Servant Leadership: A Review and Synthesis. *Journal of Management*.

Winters, R. C., Chen, R., Lal, S., & Chan, T. (2022). Six Principles for Developing Leadership Training Ecosystems in Health Care. *ACADEMIC MEDICINE - Journal of the Association of American Medical Colleges*.

Wysocka, M., & Lewandowski, R. (2017, December). Key Competences of a Health Care Manager. *Journal of Intercultural management*.

Õunapuu, L. (2014). *Kvalitatiivne ja kvantitatiivne uurimisviis sotsiaalteadustes.* Tartu Ülikool.

APPENDICES

Appendix 1. Interview questions

1. How big is your team that you manage on a daily basis?
2. How long have you been a manager? Was it your own desired career path or was it a coincidence or other reason?
3. How big is the relationship between clinical and administrative part of your work? Are you satisfied with this relation?
4. Do you use feedback tools or questionnaires for your work as a leader among your employees? How do you measure personnel satisfactory and human resources management in your organization?
5. How big is employee turnover in one year in your health centre?
6. Do you have an assistant? To whom do you delegate tasks and responsibility?
7. How is the manager's substitution during vacation/illness organised? Do you delegate your work and to which extent?
8. What are your biggest strengths/weaknesses as a leader in your opinion?
9. What competencies are most important for the healthcare manager? Name five and rank them with number one as the most important one. See appendix 2 for the list of competencies.
10. What kind of leadership style do you use mostly? Has it changed over course of time and your development as a leader? See appendix 3 to pick from leadership styles by Goleman (2000).
11. Do you actively develop your leadership and managerial competencies? Have you done this before? How?
12. Have you received enough mentorship/coaching as a leader yourself or are you someone's coach/mentor?
13. What do you think are main challenges for primary care centre leader? Should the person in charge be a specialist (clinician), entrepreneur or a manager?
14. How do you personally evaluate leadership quality in Estonian health care centres?

Appendix 2. Competency list

List of competencies created by author based on literature on health leadership competencies and empiric evidence (interview question number 9).

No	Competency name
1.	Delegating responsibility and tasks
2.	Mission and vision
3.	Creation and execution of strategy
4.	Process management
5.	Marketing and sales
6.	Finance management
7.	Human resource management
8.	Active leadership
9.	Problem solving
10.	Agility in decision making and action
11.	Partner relations
12.	Adaptive skills
13.	Analytical thinking
14.	Feedback skills
15.	Motivating employees
16.	Managing teamwork
17.	Interpersonal skills
18.	Knowledge of healthcare environment and its trends
19.	Knowledge of jurisdiction
20.	Negotiation skills
21.	Co-operation skills
22.	Experience in medicine
23.	Conflict management
24.	Change management
25.	Time-planning skills
26.	Emotional intelligence

28.	Quality control
29.	Stress tolerance
30.	Creativity
31.	Other

Source: created by author based on theoretical part research

Appendix 3. Leadership styles by Goleman (2000)

Interview question number 10: Which is your preferred leadership style? Whether or how has it changed over time?

Figure of leadership styles by Goleman was shown and explained to participates:

Leadership style	Main characteristics	Leadership phrase
Coercive (commanding)	Demands immediate obedience, does not let workers take their own initiative, works well in crisis	“Do what I tell you”
Authoritative (visionary)	Mobilizes people towards shared vision about future	“Come with me”
Affiliative	Concentrates on harmony and emotional bonds, “family feeling”	“People come first”
Democratic	Encourages teamwork and participation of all team members’ input, looking for consensus, works well in developed teams consisting of experts	“What do you think?”
Pacesetting	Sets high standards for employees and replaces those who do not meet them, good for competent people	“Do it as I do, now”
Coaching	Focuses on developing each employees’ personal strengths and talents, internally motivating	“Try this”

Source: modified by author, based on Goleman’s (2000, typology)

Appendix 4. Competency rank table

Answers to interview question number 9

Competency rank of the interview respondents.

Participant	INT 1	INT 4	INT 3	INT 6	INT 2	INT 5	INT 7	
Competency								Points together and rank
Delegating responsibility and tasks					2. (4 points)			4 **(=8.)**
Mission and vision	1. (5 points)	3. (3 points)	1. (5 points)	4. (2 points)		1. (5 points)		20 **(1.)**
Creation and execution of strategy	2. (4 points)	4. (2 points)	3. (3 points)			2. (4 points)		13 **(2.)**
Process management	4. (2 points)					3. (3 points)		5 **(=7.)**
Marketing and sales								
Finance management	5. (1 point)				3. (3 points)	3. (3 points)		7 (=**5.**)
Human resource management	3. (3 points)	2. (4 points)	7. (1 point)			3. (3 points)		11 (**3.**)
Active leadership								
Problem solving				2. (4 points)	4. (2 points)	7. (1 point)		7 (=**5.**)
Agility in decision making and action					4. (2 points)			2 **(=10.)**
Partner relations			4. (2 points)					2 **(=10.)**
Adaptive skills			6. (1 point)					1 **(=11.)**
Analytical thinking								
Feedback skills								
Motivating employees			5. (1 point)	5. (1 point)	5. (1 point)	6. (1 point)	4. (2 points)	6 (=**6.**)
Managing teamwork			2. (4 points)		5. (1 point)			5 **(=7.)**
Interpersonal skills		1. (5 points)		1. (5 points)				10 (**4.**)
Knowledge of healthcare environment and its trends					6. (1 point)		5. (1 point)	2 **(10.)**
Knowledge of jurisdiction					6. (1 point)			1 **(=11.)**

Negotiation skills					7. (1 point)			1 **(=11.)**
Co-operation skills			2. (4 points)		7. (1 point)	7. (1 point)		6 **(=6.)**
Experience in medicine					8. (1 point)			1 **(=11.)**
Conflict management					7. (1 point)	7. (1 point)	1. (5 points)	7 **(=5.)**
Change management						8. (1 point)	2. (4 points)	5 **(=7.)**
Time-planning skills					9. (1 point)			1 **(=11.)**
Emotional intelligence				3. (3 points)				3 **(9.)**
Ethics					1. (5 points)			5 **(=7.)**
Quality control								
Stress tolerance					9. (1 point)		3. (3 points)	4 **(=8.)**
Creativity								
Other		5. (1 point) - Giving opportunities to employees						1 **(=11.)**

Appendix 5. Cloud location link

Cloud location for interview transcriptions, audio files and coding table.

The following cloud link is available until 30.06.2022:

https://1drv.ms/u/s!AjQ9cxHVMnfeg2Cm7CkNZHB8scob?e=HTWMmK

Appendix 6. Non-exclusive licence

A non-exclusive licence for reproduction and publication of a graduation thesis[11]

I, Kadi Tomson

1. Grant Tallinn University of Technology free licence (non-exclusive licence) for my thesis

LEADERSHIP COMPETENCIES OF MANAGERIAL HEALTHCARE PROFESSIONALS IN PRIMARY HEALTH CENTRES IN ESTONIA

supervised by Maris Zernand (PhD),

(*supervisor's name*)

1.1 to be reproduced for the purposes of preservation and electronic publication of the graduation thesis, incl. to be entered in the digital collection of the library of Tallinn University of Technology until expiry of the term of copyright.

1.2 to be published via the web of Tallinn University of Technology, incl. to be entered in the digital collection of the library of Tallinn University of Technology until expiry of the term of copyright.

2. I am aware that the author also retains the rights specified in clause 1 of the non-exclusive licence.

3. I confirm that granting the non-exclusive licence does not infringe other persons' intellectual property rights, the rights arising from the Personal Data Protection Act or rights arising from other legislation.

10.05.2022

[1] *The non-exclusive licence is not valid during the validity of access restriction indicated in the student's application for restriction on access to the graduation thesis that has been signed by the school's dean, except in case of the university's right to reproduce the thesis for preservation purposes only. If a graduation thesis is based on the joint creative activity of two or more persons and the co-author(s) has/have not granted, by the set deadline, the student defending his/her graduation thesis consent to reproduce and publish the graduation thesis in compliance with clauses 1.1 and 1.2 of the non-exclusive licence, the non-exclusive license shall not be valid for the period.*