Competence management framework model in health care

The need for competency management as a tool for the development of Health Visitor Services and services of the health visitors

PhD theses

Anna Perge

Thesis supervisor: Prof. Dr. Mariann Éva Veresné Somosi, professor
Thesis co-supervisor: Dr. Andrea Mária Rucska, associate professor

Head of Doctoral School: Prof. Dr. Géza Tóth, professor

University of Miskolc
Hantos Elemér Business and Regional Sciences Doctoral School
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1. Introduction

The activity of the health visitor can look back on more than a century in Hungary. The Hungarian Health Visitor Service, which is considered to be an internationally unique system, now listed as a Hungaricum according to the Hungarian Collection of Hungaricums-Hungarian Heritage, is extremely diverse in terms of the work of the health visitors employed in the labour market. Having reached the limits of the system's flexibility, the activity of the health visitors has been divided into several branches, all in the service of the community, of the management of public health problems, of prevention. There is a growing tendency for the beneficiaries, the field of care and the co-professions to demand that the health visitor, who has a high degree of autonomy, should have additional competences to those acquired through her higher education, in addition to the knowledge, skills, attitudes and autonomy that she has acquired through her higher education, which also justifies mapping and prioritising the competences of the system and identifying the organisational skills that can contribute to the formulation of proposals aimed at the sustainability of the network. Given the diversity of the network and its sensitivity to social change, there is a strong need for competence management. The definition of competence requirements should be considered both at system level and for individual organisations within the network. In the light of this, exploiting the potential of competency management can help to develop the network and improve its members' employability.

1.1. Aim of the research, research questions, research hypotheses

A coherent, comprehensive study of the health visitors and the Service working in different social systems and organisational forms was not carried out before the research for this dissertation.
In light of this, the main aim of this research is to compile a competency management framework model for the organisation of the Health Visitor Service and the health visitors in the health system.
The research also aims to identify the existing competences at network level and by network elements, and to map the factors that influence them and the weight of the influencing factors. In the light of these important processes, the research aims to identify the points of intervention that will contribute to the development, and where necessary the development and promotion, of the appropriate competences of the health visitor profession, in order to meet the demands of the labour market. It is of particular importance to accurately identify any gaps in network competences and to manage these competences in order to ensure sustainability.
Through literature analysis and primary research, I sought to answer the following questions.
Research questions aimed at examining the network and its elements:

1. Can competence management help sustainability?
2. Can competency management be used to make the career of a health visitor more attractive?
3. To what extent is the expectation of competence in the performance of the duties of a health visitor in

line with the actual competence set of the health visitors?

4. Are the current solutions for competence development satisfactory?

Research questions on the operational efficiency and effectiveness of the network and the competences of its components:

5. How to assess the competences of the network of health visitors?
6. Can competency management be used to support health visitors in the labour market to do their job effectively?
7. What are the strengths and weaknesses of network competences?
8. What are the strengths and areas for improvement of the network components?

For the research for this thesis, I formulated three research hypotheses.

H1: There is a difference in the utilization of network resources and capabilities in the Hungarian Health Visitor Service network in at least three main dimensions for the 4 typical job functions by adapting the VRIO model.

H2: The geographical location of the work activity (centre or periphery) has an impact on the competences and skills of group A. In the dimensions of reputation and human resources, VRIO analysis places at least one element of each of the two dimensions in the ranking A 21-33.

H3: The utilisation of competences and organisational capacities in the network of the Hungarian Health Visitor Service depends on the region, in particular on the number

of municipalities (districts) which are legally classified as beneficiary.

2. Description of research methodology

The research covered four areas. The first element of the research focused on the network of health visitors in the health care system, on the one hand, its positioning in the Hungarian health care system, and on the other hand, it attempted to map the organisational elements and competences of the network.
The primary research is composed of three elements, a district level study, a county level study and a network, national level study.

Choice of research method

The functioning, effectiveness and competences of the network as an organisation were examined through interviews. The interview survey was conducted among the chief health visitors of the duchy, the managers who carry out professional management and professional supervision activities for official purposes, in order to get to know the functioning of the health visitor network as an organisation, to identify and examine the competences of the network and the health visitors under their professional supervision.
The interview draft was prepared in two stages. The interview consisted of questions on the operational efficiency and effectiveness of the Hungarian Health Visitor Service, where I interpreted the health visitor service as a network. For the second branch I chose to adapt the questions of the VRIO analysis focusing on

competences. The given items were, on the one hand, questions related to the Hungarian Health Visitor Service (network, national level) and, on the other hand, questions related to the area under the professional direction and professional supervision of the chief health visitor of the county, referring to the health visitors who perform the duties of hospital health visitors and the health visitors of the Family Protection Service (CSVSZ).
I chose the questionnaire method to identify the network competences and to test them by answering the questions of the VRIO analysis. I conducted the online questionnaire survey to identify and examine network competencies among district head health visitors, district health visitors (purely district and mixed district) and school-healthcare health visitors (full-time school health visitors).
The need for representativeness and the consequent need to conduct a nationally extended study justified the online availability.

The sampling procedure

In the interview process, the size and accessibility of the target group had to be taken into account. At the time of conducting the research, two persons were performing the duties of the chief county protection officer in one county and one county had a vacancy for this position. Participation in the research was possible after a formal written invitation to participate, at an agreed time and in a manner that did not interfere with the managerial duties.

When selecting the sample group for the questionnaire survey, I tried to ensure that it adequately models the range

of professionally supervised district-level health visitors in the Hungarian network. When including the district head health visitors in the research sample, I tried to ensure that at least one response from each county would help to obtain more accurate results.

The target groups of the research

To define the target groups of the research, I started from the structure of the network system. To answer the research questions and hypotheses of the thesis, I worked with data collected from the following two groups.

From the group of the chief public health visitors in the duchy, 11 were interviewed. 24 persons from the group of district chief health visitors participated in the questionnaire interview.

How the data is collected

Aspects of interview content

I examined the operational efficiency and effectiveness of the network by adapting questions related to organisational analysis methods and organisational capability analysis methodologies based on the organisational development process model of Veresné (2013).
Selection of organisational analysis methods (and related questions):

1) Analysis of the relationship between the network structure and the environment

2) Examining the factors and organisational characteristics that influence the design of the organisation

Selection of organisational capability analysis methodologies (and related questions):

1) Resource allocation
2) Feasibility
3) Problematic relationships
4) Redundant hierarchy / status of business units
5) Flexibility

Adapting the VRIO model questions

The second part of the interview survey focused on the identification and assessment of competences, using the VRIO model questions used in the primary survey. In relation to the Hungarian Health Visitor Service (network, at national level), 32 competences were identified across the 7 domains. For the questions on the area under the professional direction and supervision of the chief health visitors in the county, 33-33 competences were assessed for the health visitors who perform the duties of hospital health visitors and Family Protection Service (CSVSZ) health visitors. To identify the competencies, the options possess, partially possess or not possess were adapted to fit the items.

Aspects of the content of the questionnaire

The questionnaire for the primary research contains 35 questions, consisting of 3 main blocks of questions.
Outline of the questionnaire:

1) background variables

Elements of the questions on the job under supervision based on professional experience.

2) characteristics of the district(s) under specialised supervision

On the basis of the performance of specialist supervision by district health visitors (purely district and mixed) and/or full-time school-healthcare health visitors (to be completed separately), the question items are:

a) Questions to be answered in the VRIO analysis (by district chief health visitors)
b) VRIO model questions with 5-point Likert scale
c) responses from the supervisor that can be expressed independently (professional help, external support, emphasis on other areas considered important)
d) expanding competence in the field of health visitor: the MSc in professional health visitor

3) the value of the health visitor service in health care

The questions on the services provided by the health visitors, which are directed to health visitors who perform district health visitor duties (purely district and mixed district) and full-time school-healthcare health visitors, were to be completed separately. The questionnaire was designed on Google Drive. The link to the questionnaire was only available to those involved in the conduct of the research, and was sent to 19 county chief health visitors, the public health departments of the county government offices belonging to the counties and the archbishops of 3 county government offices, together with a letter of invitation to participate in the research. The letter of

inquiry and the questionnaire were forwarded to the district chief health visitors with the help of these bodies.

The scope and set of values of competence management in the network of and for the health visitors

Using the VRIO model, the competencies of the organisation - in this case, the network - can be specified in a list format. By rating the competencies, it is possible to identify which areas are fundamental for competitive advantage (Veresné, 2019), in this case, for sustainability. The competences in the network of the Health Visitor Service have been grouped into seven categories: Financial Resources, Material Resources, Technological Resources, Social Acceptance, Organisational Capability, Human Resources and Reputation.

Evaluation criteria for the VRIO analysis

The competences of the network are rated on a scale of 1 to 5 in each area, with 1 being "not at all" and 5 being "completely". For the value of the competence, 1 is "not valuable" and 5 is "very valuable". For rarity, 1 is 'not rare' and 5 is 'very rare'. For replicability, which can be interpreted as imitability, 1 is "easy to copy or imitate", 5 is "very difficult to copy or imitate". To assess organisational capability, the scale ranges from 1 'the organisation cannot exploit its valuable, rare, hard-to-copy competences' to 5 'the organisation can fully exploit its valuable, rare, hard-to-copy competences'. In this light, the maximum score for each competence and organisational capability is 20. No separate categories are defined in the

evaluation - an external scoring system is not used - but the scores of the competences are compared to each other to obtain the strengths and weaknesses of the network.

Ranking of competences

In defining competences and organisational capabilities, I have kept long-term sustainability in mind. Through the analysis I wanted to create two groups, separating strengths within the network and areas for improvement. The analysis will differentiate the strengths that should be further developed. The weaknesses and problematic areas will also become apparent, which need to be revised and modified.

Data processing and analysis

Forms created using Google Drive are well suited for recording data and storing them in Excel spreadsheets. I used descriptive statistics and statistical tests in the analyses. The statistical software used for the calculations is SPSS 22.0. The statistical methods used are the Chi-square test and Pearson's correlation.

3. Results of the primary research

3.1. The operational efficiency and effectiveness of the Hungarian Health Visitor Service

In this branch of primary research, I interpreted the health visitor service as a network.

Impact of environmental (network) uncertainty on the network and critical factors affecting the network

The effects of environmental uncertainty are predominantly negative, affecting employers, health care providers, structure, infrastructure, wages and cash benefits, among others, with financial uncertainty also being a consequence of environmental uncertainty. The impact of this uncertainty is most evident in issues of human resources, covering all members of the network, including the pool of health visitors, as well as professional management and supervision. Overall, the effects of uncertainty can cause significant damage to all members of the network. Network members prefer to operate in a unified system, which is supportive of negative impacts.

Many of the critical factors are the result of the effects of uncertainty. Critical factors can be described as external and internal factors:

- External factors
    - Reorganisation of the network
        - Communication
        - "Dual" leadership, management
        - Structure
        - Damage to cooperation, lack of cooperation
        - Lack of unification
    - Role of local governments, employers
    - Wages and salaries
    - Education
    - Changes that require a rapid response
- Internal factors

- Lack of vision
- Not knowing the care system
- Human resources

The results of the primary research on the effects of environmental (network) uncertainty on the network and the critical factors affecting the network can be considered as new results.

Reflection of the strengths, weaknesses and motivations of the staff (health visitors) in the current organisational structure

In the current organisational structure of the Hungarian Health Visitor Service, some of the senior health visitors of the county partially see the strengths, weaknesses and motivations of the staff, while a significant part of them see a well-functioning system reflected in the current structure: the strengths, weaknesses, motivations and needs of the health visitors can be reflected and monitored in the organisational structure. In the given organisational structure, these can be reflected and professional functioning can be well monitored.
In the current organisational structure, the primary research findings on the strengths, weaknesses and motivations of staff (health visitors) can be considered as a new result in part because the network is aware of some of the identified weaknesses and problematic areas, as well as of the inequalities, including the significant differences in wages.

The tools and methodologies provided by the current organisational structure to deal with problematic, conflictual inter-organisational relationships

At the time of the research, the system's organisational structure was characterised by a detailed elaboration of the management of relations between problematic, conflicting departments, and its operation is appropriate and provides the opportunity to resolve conflict issues. All this is backed up by a continuously updating and development work, the outstanding legal development work of the development advocacy teams, which helps to respond to problematic issues in a rapid and appropriate manner.
The results of primary research on the management of problematic relationships are partly new findings.

Structuring of the current organisational structure in relation to the tasks to be performed

The majority of the opinions consider the current organisational structure to be adequate for the tasks to be tackled. The Health Visitor Service is a pillar of primary health care.
The diversity of employers is the reason for the difference of opinion on the organisational structure in the light of the tasks to be performed. The separation of professions does not lead to overcrowding, but the positive impact of a single employer on the system is questionable in the case of overcrowding caused by many employers. The organisational structure as a whole would also be supported if the role of employer and manager were always filled by a professional with a qualification as a

health visitor, who would be able to interpret problems and difficulties more effectively.
These results of the primary research can be considered as a new finding.

The planned organisational structure

The juxtaposition of the two different systems is visible, the organisational structure and the factors supporting and constraining it are not fully or not at all known. With regard to the organisational structure of the planned system, it is essential that the health visitor can carry out her autonomous tasks.
The results of the primary research describing the planned organisational structure can be considered as a new result.

The role of organisational structure in developing new strategies and ensuring the flexibility needed to adapt to change

On the organisational structure side, opinions are very mixed on how to facilitate the development of new strategies and the flexibility needed to adapt to change. The flexibility required to adapt can be understood as multi-level. In this approach, there is a sense of inflexibility on the part of the organisation and flexibility on the part of those working in it. Inflexibility can be shown in communication and adaptation, flexibility in the ability to adapt to change.
The inflexibility of the organisational structure has implications for the question of innovation, the possibility of innovation, but it must also be taken into account that it

is delimited and uniform. Flexibility is felt by the health visitors working in the system, in which case they are presented with a vision of the future to which it is 'worthwhile' to adapt.
In the approaches that seek to map the rigidity of the system, the weakness in the development of strategies, the "multi-stakeholder" system, the significant regulation of the activities of the advocates (through directives, legislation, professional rules) are reflected.
The research findings on the role of organisational structures in developing new strategies and ensuring the flexibility needed to adapt to change are new findings.

3.2. Network competences and organisational capabilities of the Hungarian Health Visitor Service

The financial stability of the network is judged to be mostly met. The network is able to make partial use of the grants available to support the work of the health visitors. The infrastructure varies in the different areas of the network. The network shows both strengths and weaknesses in terms of technological resources. The interconnection of communication systems at different levels of the network is not uniform. The quality management system is not uniform throughout the network, with most areas having little or no quality management system, and therefore satisfaction measurements are not carried out.
In the relationship between health visitors and cared-for persons, the network mostly has the acceptance, in addition to basic expectations of competence. The network has an open organisational culture. At national level, it is observed that the values regarding the work of the health

visitors are overwhelmingly held by the network members and the network itself. The coordination of activities within the competence boundaries works well. The network is mostly only partially open to change and development. The professional, general/personal, methodological and social competences are not uniformly possessed by the network's health visitors, and there are gaps, particularly in general/personal competences. In many cases, the commitment and identification with the network is only partially felt by the health visitors. Constructive conflict resolution mechanisms are a critical issue in the study area, both within the organisation and among carers. Patron caregivers are mostly partially equipped with conflict resolution mechanisms. The brand of the network is mostly managed appropriately. Despite the often perceived low professional prestige among the network's Health visitors, the health visitors' sense of vocation and loyalty to the health visitor profession is demonstrated to the senior health visitors.

Those working in the network have little or no vision, and those in professional management and supervision have an uncertain vision.

The results concerning the network competences and organisational capacities of the Hungarian Health Visitor Service can be considered as a new achievement.

3.3. Competences and organisational skills among hospital and CSVSZ health visitors

There is a significant difference in the dimension of financial support between the two jobs. In the case of hospital health visitors, both in the county and at national level, financial stability is either met or partially met, as

judged by the head health visitors, whereas in the case of the CSVSZ it is partially met and in many cases not met at all. In this dimension, the element of tenders to support the work of the health visitors is the most critical, mostly partially or not fulfilled for hospital health visitors and almost not fulfilled for CSVSZ health visitors. The lack of a unified IT database is noticeable. In the network at the time of conducting the research, the functioning of the quality management system was mostly absent for CSVSZ health visitors.

In the case of hospital health visitors, the quality management system is implemented or partially implemented, which can be explained by their significantly different working environment and institutional affiliation compared to other jobs.

The relationships that health visitors have beyond their caregivers, which can be understood as socio-economic relationships, are not always able to function properly and fully, which can be influenced by internal and external factors alike. The members of the network in the jobs studied possess almost all these competences, which are part of an open organisational culture. Similar strengths were found in the question of possession of values oriented towards the work activities of the health visitors.

Organisational stability is characterised by flexibility, both the hospital and the CSVSZ can reorganise their operations to some or all extent, which can be demonstrated by their openness to change and development, i.e. their ability to innovate and renew.

For hospital health visitors and CSVSZ health visitors, the most homogeneous responses for the 7 dimensions examined were for the competences mentioned in the

human resources section. Professional and social competences are fully present in the jobs surveyed, and general/personal and morality competences are almost fully present in the network members surveyed. There are gaps in the ability to deal with conflict problems within the organisation, and difficulties in dealing with conflict situations with the cared-for persons are found among the CSVSZ health visitors.

The 'brand' of the hospital and CSVSZ health visitors within the health visitor network is mostly well managed, but there are areas of perceived undervaluation, which contributes significantly to the negative vision of the CSVSZ health visitors concerned. Hospital-based CSVSZ with a feeling of being undervalued have some degree of vision. Overall, loyalty to the network is overwhelmingly high among hospital and CSVSZ health visitors. The prestige of the profession's particular areas of work is mostly average, with low prestige where the 'brand' has been rated as undervalued. Crucially, higher prestige brings with it a vision, a sense of vocation and loyalty.

The results of the primary research on competencies and organisational skills among hospital and CSVSZ health visitors are a new finding.

3.4. VRIO analysis to assess network competences and organisational capabilities

The VRIO method allowed for the analysis of strengths and areas for improvement to support the sustainability of the network. I conducted an analysis of two groups in the research, importantly, the two groups were formed along the areas under study, so that several district head health visitors could respond to both groups. The two groups

were composed of 24 district head health visitors, group A (NA=24) analysing the range of health visitors providing district health visitors' services and the range of health visitors providing care (purely district and mixed district), group B (NB=22) analysing the range of health visitors and services providing school-healthcare on a full-time basis.

Within the network, the strengths and areas for improvement were separated according to a ranking (1-10, 11-20 and 21-33), which allowed for a differentiation between strengths and weaker rated competences and skills.

The ten highest scoring competencies and organisational skills among district and mixed district health visitors were: professional competencies, acceptance, interconnectedness of communication systems (among district head health visitors), application support, staff commitment, coordination of activities, open organisational culture, knowledge-based organisational relationships, organisational stability and constructive conflict resolution mechanisms. According to the ranking, the professional competences mentioned in the human resources dimension are the strongest. A further two items from the human resources dimension are in the top ten competences and capabilities, with a similar strength of three items from the organisational capabilities dimension. Of particular importance is the second ranked dimension of acceptance of the caregiver-caregiver relationship, which is a fundamental competence and a basic requirement for the delivery of care by caregivers. Employee commitment is seen as a strength within the organisation, with the district head health visitors'

perception of commitment to, identification with and pride in the organisation, quantified as 75.6% (m=80) of the health visitors, and the district head health visitors' self-assessed level of commitment as 83.71% (m=90).

The ranking from 11 to 20 shows the parts of the organisation that are somewhat valuable, rare, more or less replicable and mostly exploitable by the organisation compared to the other elements. Competences and capabilities are not the strongest, but are not explicitly present as acute problems, but gaps are visible and needs for improvement are felt. Among other things, improving the image of professional prestige would contribute significantly to sustainability, which would also lead to an increase in values, professionalism and loyalty.

The analysis identifies six dimensions of competences and skills to be developed. The elements identified under tangible resources - IT databases, systems, the working environment and the infrastructure of the environment - are areas for improvement. Based on the analysis, quality management system is 1.08 points lower than the first competence in the ranking, the explanation for its appearance as the last element is that quality management systems are not in place or are incomplete in several units in the organisation.

The ten strongest competences and skills among full-time school-healthcare health visitors: grant funding available to support the work of the health visitors, general/personal competencies, acceptance, constructive conflict resolution mechanisms, methodological competencies, staff commitment, professional competencies, financial stability of members of the health visitors' services, interconnectedness of communication systems among

district head health visitors, and sense of vocation and loyalty. Human resources appear decisively in the top ten items of the list. Acceptance is the third pillar for the implementation of effective care by the advocate. The strongest element of the ranking is the availability of grant funding, but the availability of the physical resources expected in this context does not follow in the ranking. Infrastructural conditions are at the bottom of the ranking, among the elements to be improved. There is no significant variation between the scores of the elements of the ranking from 11 to 20, but it can be used to indicate the direction of improvement. The perception of the prestige of the profession and the values of the work activity in question are not ranked as the priority areas for improvement, but are given priority for improvement in terms of the values they provide and their impact on the future. Organisational capabilities are identified as an area for improvement. The analysis also shows the shortcomings of the quality management system in this context, with a gap of 1.208 points compared to the strongest item in the list.

The results presented with the VRIO analysis are considered a new result.

No significant correlation was found between the number of health visitors performing district patronage activities and the number of health visitors performing full-time school activities ($p > 0.05$) when calculated using chi-square test. In the analysis of regions, the more economically developed areas showed a lower demand for the provision of health visitors than peripheral areas, but no significant correlation was found using Pearson's chi-square test ($p=0.36$), although it can be said that the vision

is less positive in each region. There is a significant correlation of medium strength (r=0.4) between the prestige of the profession and employee commitment (p=0.04). Furthermore, the prestige of the profession is significantly correlated with the region (p=0.028). No significant difference was found between staff engagement (p=0.8) when calculated by Chi-square test, however, it is important to note that between the two job areas, regional health visitors appear to be more engaged in terms of staff engagement, i.e. commitment to the organisation, identification with the organisation, pride in the organisation.

3.5. Factors affecting competences and skills

These results of the primary research can be considered a new finding.

Differences between the districts under the professional supervision of district chief health visitors

There is not always a perceptible difference between districts under the professional supervision of the district head health visitor.
The differences are mainly along the lines of the care population: education of the care population; people in need of increased care; population composition; higher unemployment in the district to be developed; more social problems; different population composition; different housing conditions; employment opportunities; motivation; geographical structure; population size; social situation; health status; high turnover of care staff in the

summer; more vulnerable care staff in the district to be developed with a complex programme.
Differences in health care (health care assistants): accessibility of the districts; access to primary care in the municipalities; differences in human resources; large number of municipalities in a district (4-9); number of health care assistants; proximity to the capital.

Essential issues related to the provision of gynaecological services, based on the opinion of the district chief gynaecologist

Both external and internal factors determine the effectiveness and quality of the care provided by the services. These can interact and often manifest themselves as complex tasks or problems.
Employers' attitudes towards the service and the health visitors who provide it contribute to the quality of care, including the positive benefits of employer standardisation.
An important task of professional management and supervision, in addition to professional supervision, would be to provide a form of ongoing assistance, support for appropriate teamwork and, in addition to linking up communication systems, continuous monitoring of work performance.
Maintaining the quality of professional work should be a priority for all members of the network.
The key issues in the work of the health visitors have always been professionalism, coping with a heavy workload, and constantly increasing professional knowledge and skills. This raises the question of raising

competence levels, which is not new, given the profession's ability to adapt to the changing needs of both the health sector and the people it cares for.

Expanding and developing health visitors' competences through education

From the point of view of the profession of health visitor, the MSc in professional health visitor is perceived favourably. On a five-point Likert scale, with 1 being "not at all" and 5 being "completely", the importance of the training was described by district head health visitors (N=24) with an average score of 3.95. Three of the three main district head health visitors were not aware of the training.

Outside professional help to support maternity services

There is a uniformly high demand for professional support in protective services, the effectiveness of which is influenced by the quality of the linkages between communication systems and knowledge-based organisational relationships.
The interconnection of communication systems needs to work well, both on the side of professional management and supervision, and among the working protection workers.
Professional management and supervision staff have a key role to play in 'signposting' the process of professional assistance. The need for external support can manifest

itself at any time and in any work area, regardless of the work area.

3.6. The value (or competitive advantage?) of the health visitor service in health care

Given the uniqueness of the health visitor service in the world, a comparison with other services would not be feasible, or only partially feasible. Against this background, the research aims to illustrate the value of the service in the network's own context, the health care system.
The services provided by those who perform the role of district health visitor are characterised by the fact that their value is known in the wider district, that the resources they provide are necessary for the people they care for and that the services they provide are not dispensable. The services provided by those who perform the role of school-healthcare health visitor on a full-time basis are characterised by the fact that they are necessary and not dispensable.

4. Answering research questions and formulating research findings, confirming or rejecting hypotheses

Q1 Research Finding: competence management requires the use of an elaborate model in order to make the network sustainable in the long term. It is essential that sustainability should also aim at quality.
In addition to the classification and decomposition described in the literature, the VRIO model used to interpret competence management has been enriched with additional elements adapted to the specificity of the network or organisation.

From the perspective of competence management, the VRIO model needs to be constructed in such a way that it is sensitive and that even the smallest deficiency is revealed. Competences and organisational capabilities that are considered essential and considered indispensable for the organisation may appear less prominent (when almost all opinions are of similar value in the VRIO), but they are necessary for ranking purposes on the one hand, but at the same time they give a sense of their role in the functioning of the organisation.
The VRIO analysis is not sensitive enough to answer some of the questions and it was therefore necessary to add further questions to the survey to obtain more precise answers. It should be noted that VRIO does not necessarily give a complete picture of the functioning of a network as a whole, but with additional research elements (questions) it can be very well applied to other organisations.

Q2 Research finding: holistic thinking is needed to make the career of a health visitor more attractive/attractive. The elements of several dimensions of the VRIO model need to be examined in terms of value, rarity, replicability and utilisation. It is important to look at this from the perspective of the members of the network, and to consider the sustainability of the network as a secondary objective. Of course, it is possible that, beyond the elements selected in the thesis, the members of the network (and the patrons who are not members of the network) see the positive perception of the field in the existence and functioning of different competences and organisational skills.

Q3 Research finding: the expectation of competence related to the performance of the duties of a health visitor is not always in line with the actual competence set of the health visitor. There are differences in the competencies along the different job functions studied (hospital, CSVSZ, district, school-healthcare health visitors).

Q4 Research finding: the current solutions for competence development in the Health Visitor Service are not satisfactory, competence development needs to be supported both at network and individual level. The success of competency management can be achieved by building on the strengths of the network to support areas for development.

Q5 Research finding: in terms of examining the competences and organisational capacities of the network of health visitors, it is important to note that there are two ways of examining the whole network: as a unit (in which case results are obtained for everyone) or as a sub-network (which gives a comprehensive, analysed picture of the network). A holistic approach is supported by a sub-analysis.

Q6 Research finding: competence management contributes to efficiency and effectiveness. In this case, the uniform competence management of the network, extended to all, will only be partially successful, therefore the development and management of competences can be effective if broken down into sub-elements.

Q7a Research finding: the provision of IT databases and systems is identified as an area for improvement in the network of health workers. At the time of the research, the network did not have a unified IT system covering all. There is a need to improve the infrastructure of the working environment and environment. There is no single quality management system in the network. The perception of the network's "brand" is mostly appropriately managed, but where it is undervalued, it implies a lack of vision, with a perceived loss of prestige for the profession.
The strengths of the competences of the network of health visitors are most evident in the dimensions of Social acceptance and Human resources.

Q7b Research finding: in terms of competencies in the network of health visitors, those that can be linked to the members of the network (the health visitors themselves), such as interpersonal, professional, social and methodological competencies, deserve special attention. These are the strongest and can be developed to increase the stability of the organisation.

Q8 Research finding: the individual sub-elements show a correlation with areas for improvement and strengths that are evident in the network as a whole. It is essential, however, that the jobs should be considered separately, with their specificities determining the direction of development in a sustainable manner.

To confirm or reject hypotheses

H1 Thesis: health visitors who carry out health visitoring activities possess or partially possess the competences according to the training and output requirements and the expectations of the profession, but the utilisation of the competences of health visitors who carry out different health visitoring activities shows a variation, which determines their success in the workforce. The hypothesis is partially confirmed. In each of the seven dimensions studied, differences are evident in the utilisation of network resources and skills across job functions, which should be taken into account in all cases.

H2 Thesis: Geographical location matters for the work of district health visitors. This is reflected in the fact that the social needs, the competencies of the health visitors and their utilisation vary from one area to another, in accordance with the specificities of the area.

H3 Thesis: No correlation was found between the regions in terms of the use of competences, but they do have an impact on the prestige of the profession and on the future outlook. However, it is essential that the working environment has an impact on work activity.

5. Summary

During the research, I set up a competence management framework model that was suitable for studying a greater network. The dissertation examined the network of the Hungarian Health Visitor Service operating within the healthcare system both on network level and broken down to the network's components, including health visitors' working positions. The research focused on the network's

operational efficiency, effectiveness, network competences and organizational skills. The VRIO-model found in the literature can be applied for the examination of network competences and organizational skills very well, but the model's sensitivity had to be increased which was achieved by adding more components besides saving the VRIO approach, adapting to the network's characteristics. Over the identified and examined components, the model can also be used in other concepts, depending on which field is intended to be studied. My research was performed in the spirit of sustainability. Regarding that the network is unique as a 'Hungarikum', its certain components were compared during the analysis, thus, the strengths of the components and fields to be developed in the network occurred differentially. On the issue of the network's values, it is important that the study results prove the network's acknowledgement among the wider society. In the health visitors' network, the strengths of the competences occur mostly in the dimensions of Social Acceptance and Human Resources. In the health visitors' network, cooperation obligation with the associated professions is outstanding and the relationship with the representatives of associated professions is specific. In the health visitor network, those competences deserve special attention that are discussed by the Human Resources dimension relatable to the network's members, such as cooperation skills and professional, social and methodological competences. They are the strongest ones and the organization's stability can be increased by their improvement.

Among the examined dimensions, the weaknesses of network competences manifested in the Material

Resources, Technological Resources and Reputation dimensions. Supply with IT databases and systems, the improvement of working environment and environmental infrastructure, and the uniform quality control system for the network occur as fields to be develop in the health visitors' network. The network's "brand" is addressed mostly properly, this results in the lack of a future vision in the underestimated fields together with the decrease of the profession's prestige.

Based on the analyses, it is typical for health visitors on a network level that they own or partly own the competences needed for their work; additionally, the employment of employees with nearly the same competences and the identity of the relating motivation system can be realized mostly partly within the network. The competence expectations necessary for completing health visitors' tasks do not always match with the health visitors' existing competences, and differences can be detected in the possession of competences among the typical working positions.

Competence development should be supported in the Health Visitor Service both on network and individual levels. It is important that as the changes occurring in the network influence the smaller units of the system - thereby both leading and working health visitors -, the mechanism has the same effect in reverse as well. Health visitors leaving the career and the lack of leader health visitors influence the whole network.

References

Hungarikumok Gyűjteménye-Magyar Értéktár. Magyar Védőnői Szolgálat, mint nemzetközileg is egyedülálló, tradicionális ellátási rendszer

Veresné, S. M. (2019) Kockázatmenedzselés az ellátási láncok működésében, az élelmiszer-kereskedelem kockázati modellje. In: Sikos T. (ed.) Az élelmiszer ellátási láncok sérülékenysége. Budapest, Dialóg Campus Kiadó, 201-218.

Veresné, S. M. (2013) Teljesítményalapú szervezetalakítás elmélete és módszertana. Miskolci Egyetem, Gazdaságtudományi Kar

List of publications on the topic

Perge, A. (2021)
Kompetenciák súlya a hátrányos helyzetű településeken élők egészségmutatóinak javítására történő törekvésekben Multidiszciplináris Tudományok: A Miskolci Egyetem Közleménye 11:2 pp. 334-340.

Perge, A.; Rucska, A.; Kiss-Tóth, E. (2020)
A védőnői ellátottság jellemzői és az arra hatást gyakorló tényezők a vizsgált települések vonzásában. In: Kiss-Tóth, Emőke (ed.) Abaúj térség 14 év alatti gyermeklakosságának egészségmagatartása és fejlesztési lehetősége. Miskolc-Egyetemváros, Magyarország: Miskolci Egyetemi Kiadó, pp. 19-35.

Perge, A. (2018)
Hátrányos helyzetű települések a védőnői alapellátásban

In: Koncz, István; Szova, Ilona (eds.) A 15 éves PEME XVII. PhD-konferenciájának előadásai. Budapest, Magyarország: Professzorok az Európai Magyarországért Egyesület, pp. 24-29.

Perge, A. (2021)
A kompetenciamenedzsment értelmezési tartománya és értékkészlete a Védőnői Szolgálatban
Hantos Periodika 2: Klnsz., pp. 145-154.

Perge, A.; Rucska, A.; Kiss-Tóth, E. (2019)
Health education as a possible intervention in the child population living in disadvantaged settlements. In: Karlovitz, Tibor János (ed.) Theory and Practice: Lifelong Experiences. Grosspetersdorf, Ausztria: Sozial und Wirtschafts Forschungsgruppe, pp. 65-70.