

BUILDING NATIONAL HEALTH WORKFORCES

Academies that build national capability

Launch with partners, keep the platform national

EXECUTIVE SUMMARY

Academies are how health systems turn training spend into a permanent national asset. **The fastest way to launch one is often with an experienced partner. The way to make it last is to keep the curricula, intellectual property, data and long-term ownership national from day one.**

40,000+

trainees enrolled at the SCFHS Health Academy since 2017

SCFHS [1]

32,800+

Health Academy graduates across 78 programmes

SCFHS [1]

87.2%

first-year retention in nurse residency, against a reported 67.2% nationally

AACN / Vizient [2]

693

doctors graduated by Weill Cornell Medicine-Qatar since 2008

Weill Cornell Medicine [3]

The GCC is already building at system scale. Saudi Arabia's SCFHS Health Academy, founded in 2017, has enrolled more than 40,000 trainees and produced more than 32,800 graduates across 78 programmes. It works with 388 training partners and 458 recruitment partners.¹ Dubai Health has brought a university, a philanthropy and six hospitals together into one academic health system.⁴ The question is no longer whether to build academies. It is how to structure partners around national platforms so that capability stays at home.

Why academies: what leading systems and the evidence show

The world's leading health systems train their own people at scale, through dedicated institutions rather than ad hoc courses:

Kaiser Permanente founded its School of Allied Health Sciences in 1989 and added programmes in sonography, nuclear medicine, radiation therapy and medical assisting over the following decades.⁵

Mayo Clinic's School of Health Sciences has more than 1,600 students in more than 200 programmes, within a college of five schools.⁶

Cleveland Clinic's Education Institute records more than 3.5 million education encounters a year for more than 80,000 caregivers.⁷

SingHealth Academy in Singapore is organised as six colleges by profession (nursing, allied health, clinical medicine, dentistry, healthcare administration and leadership, healthcare engineering), plus a simulation institute.⁸

The evidence favours academies that focus on specific professions and the transition into practice. New-graduate nurses in the Vizient/AACN Nurse Residency Program had **87.2%** first-year retention, against a reported national average of 67.2%.² A randomised multisite study found that transition programmes worked best when they had executive backing, trained preceptors, a 9–12 month length and content

tailored to the specialty.⁹ A meta-analysis of 609 studies found that simulation training, compared with no training, has large effects on knowledge and skills and moderate effects on patient outcomes.¹⁰

Regional programmes anchored by partners already deliver national graduates. In 2024, 20 of Cleveland Clinic Abu Dhabi's 22 graduating residents and interns were UAE nationals.¹¹ Weill Cornell Medicine-Qatar has graduated 693 doctors since its first graduation in 2008.³

Four operating models

There is no single right model. The choice depends on how fast the academy must launch, how much faculty already exists at home, and how much control the owner needs from the start.

Model	How it works	Example	Main strength	What to manage
Build and own	The national owner designs, staffs and runs the academy	SCFHS Health Academy; ¹ SingHealth Academy ⁸	Full control of brand, content and data	Slower start; needs senior faculty from day one
Partner operates, then transfers	A partner runs the academy or hospital for a period, then hands over	Johns Hopkins at Tawam Hospital: managed from 2006, now a capability partnership ^{12, 13}	Speed and proven systems	Transfer terms must be written in from the start
National brand, partner delivery	The owner holds the brand and award; contracted partners deliver	NHS Leadership Academy: 1,309 MSc graduates, delivered by a KPMG-led consortium ¹⁴	Brand and credential stay national	Dependence on contract renewal
Institutional affiliation	A long-term partnership between institutions, often with joint funding	Hamad Healthcare Quality Institute with IHI over 10 years ¹⁵	A world-class quality anchor	Clarity on degrees, IP and research from the outset

The models can be combined over time. In the strongest examples, the partner helps launch and the national institution ends up owning the platform. Saudi Arabia now has a legal route for such arrangements. The Private Sector Participation Law came into force in July 2021 and is administered by the National Center for Privatization & PPP.¹⁶ In 2023 the Ministry of Health awarded one of the Kingdom's first healthcare public-private partnerships, a ten-year radiology contract developed with the National Center for Privatization.^{17, 18}

What partners bring, and what stays national

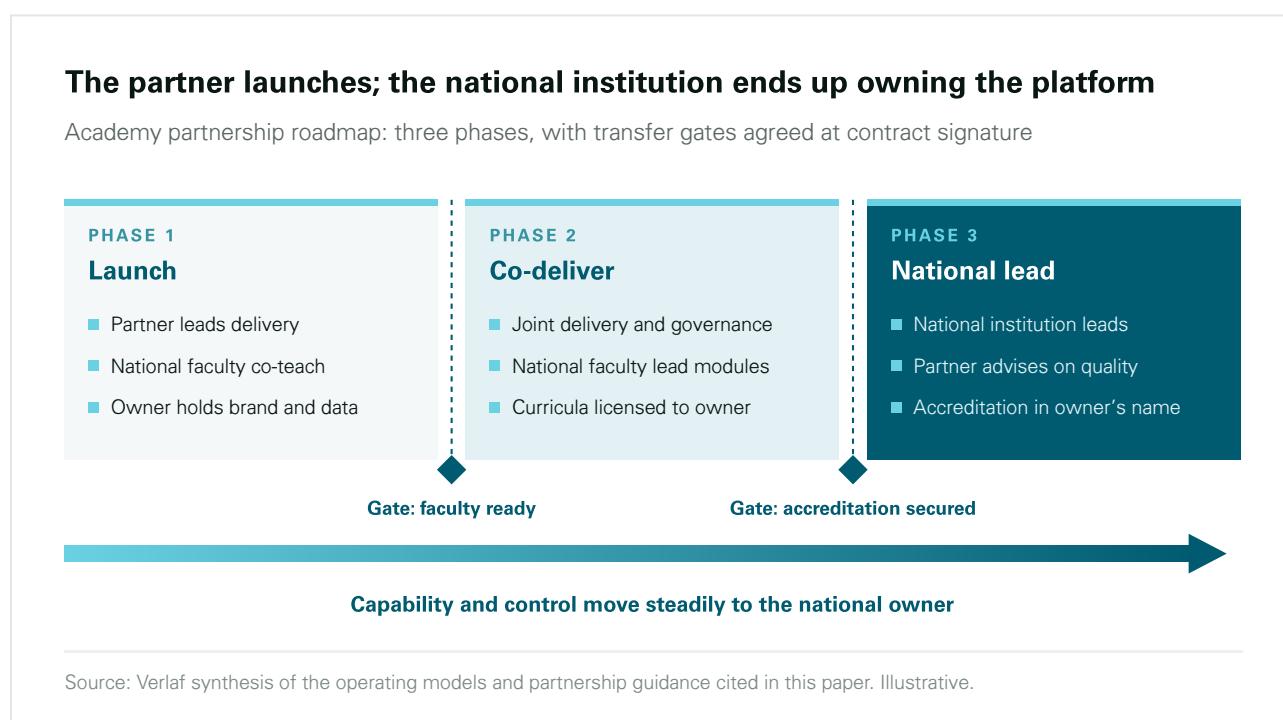
A good partner brings things that take years to build: proven curricula, experienced faculty, accreditation know-how, simulation expertise and an international reputation. Those are worth paying for. What the owner should not give away is the platform itself.

International practice points the same way. The OECD/UNESCO guidelines on cross-border education ask foreign providers to respect the receiving country's quality assurance and accreditation system.¹⁹ WHO's Twinning Partnerships model stresses co-development and spreading the learning across the national system.²⁰ Experienced partnership managers advise settling intellectual property, teach-out and exit at the start, and entering "the partnership expecting it to end".²¹

We recommend six essential conditions for any academy partnership:

- 1 Branding is a deliberate choice.** A partner's name can help at launch, but the national institution should own the academy and its credential over the long term.
- 2 Curricula and IP are owned, or perpetually licensed.** Materials developed for the academy remain usable after the partnership ends.
- 3 Data stays with the owner.** Learner, assessment and outcome data are owned by the national institution and held in line with national data rules.
- 4 Capability transfer is contracted, with milestones.** Examples include the share of national faculty, accreditation held in the owner's name, and national leaders in key roles by set dates.
- 5 Exit is planned from day one.** Teach-out, handover of systems and protection of learners are agreed before launch.
- 6 Commercial terms do not lock the owner in.** Avoid open-ended exclusivity and state-backed revenue guarantees that outlast the transfer.

From launch to transfer



Each phase ends at a gate that is agreed when the contract is signed, so the transfer depends on evidence rather than renegotiation. The Johns Hopkins relationship at Tawam Hospital shows the end state: from operating the hospital to supporting specialist capability, such as a cancer centre of excellence and a medical oncology fellowship.¹²

The partner helps launch; the national institution owns the platform.

FOR LEADERS

Questions for leaders

Six questions can test an academy plan before any contract is signed:

1. **Purpose:** which roles and which service gaps will the academy close, and how many graduates a year does the workforce plan need from it?
2. **Model:** given the faculty available at home today, which operating model fits, and when should it change?
3. **Ownership:** does the draft agreement give the owner long-term ownership of the academy, the curricula (or a perpetual licence) and the data?
4. **Transfer:** are the transfer gates measurable (for example national faculty, accreditation in the owner's name, national leaders in post), and tied to dates?
5. **Focus:** is the academy organised by profession, with transition-to-practice and simulation built in rather than added later?
6. **Exit:** if the partnership ended tomorrow, could the academy keep teaching next month?

SOURCES

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All sources were opened and checked in October 2026. This paper uses publicly available information only; no client material is used.

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Discuss how these ideas apply to your organisation

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