

Knowledge Sharing on Healthcare Strategic Alliance Value Creation from Dynamic Capabilities Perspective

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Abstract

A strategic alliance is one of the essential pillars for improving the healthcare sector in developing countries. Nevertheless, the available literature reported that most strategic alliances fail to attain the intended objectives due to the contradictory interest of partners' motives and capabilities. Despite, alliance literature has been widely developed, few studies provide a clear understanding of how alliance motives improve alliance dynamic capability and value creation through knowledge-sharing and how they dynamically improve healthcare alliance performance.

Purpose: this study aims to explore how alliance motives through knowledge-sharing influence several aspects of alliance value creation and performance.

Design and Methodology: A qualitative grounded method driven by semi interview was conducted with 25 healthcare project leaders from Abu Dhabi healthcare institutions, meanwhile, the MAXQDA analysis software was used to analyse the data.

Finding: The findings demonstrated that knowledge-sharing between partners about their motives and achievement facilities healthcare alliance dynamic capabilities and performance. Furthermore, the dynamic capability of the alliance is improved through knowledge-sharing about partners' complementary resources, which influences value creation.

Contribution: this study, therefore, bridges the alliance literature gap from three perspectives. First, this study provides effective knowledge-sharing scales that play a major role in healthcare alliance dynamic capabilities and performance. Second, this study provides a good understanding of how knowledge-sharing in alliance motives can strengthen alliance dynamic capabilities and performance.

Originality/value: this study is one of few studies that contribute to the alliance in the healthcare sector generally and in developing countries.

Keywords: Knowledge; Sharing; Healthcare; Strategic; Alliance; Dynamic; Capabilities

Introduction

The world is witnessing an increasing demand for excellent healthcare services, which prompted healthcare institutions to enhance their competitiveness through developing their capabilities in providing integrated health services. Given the diversity of health care and its increasing complexity, providing integrated health services is a challenge, especially in light of the dynamic changes and fluctuations in consumer behavior. This requires the collaboration

and cooperation of health institutions in exchanging knowledge and developing capabilities through the alliance strategy (Moonesar, 2018). Nevertheless, the failure rate and the peculiarities in strategic healthcare alliance remains a critical academic interest (Melas, Subbiah, Saadat, Rajurkar, & McDonnell, 2020). The surge in alliance failures attributed to the lack of partners' commitment and collaboration, which negatively influenced knowledge sharing (Russo & Cesarani, 2017). According to the individual motives of the partner, disagreements with several expectations should be perceived similarly to positive ones (Pelletier et al., 2014; Pera et al., 2016) (Toylan, Semerciöz, & Hassan, 2020). Some alliance parties who have little understanding of the motives and expectations minimally have the tendency to evolve to higher requirements over the alliance's course (de Bakker, Lagendijk, & Wiering, 2020) (Drewniak & Karaszewski, 2020), which create a challenge that scholars struggle to grip (Babu et al., 2020; Bhatti, 2011).

Knowledge sharing in the healthcare sector is highly critical as this business area is characterised by cross-functional dependency, high personal specialisation and qualification requirements (Thrasher, Craighead, & Byrd, 2010). These systems lead to personnel allegiance to a broader professional group instead of within the organisation they work for (Charband & Navimipour, 2018). Partners will get to understand partners' goals in the alliance, share individual goals, and comprehensively discuss how these goals will be attained through knowledge sharing with the pursuit of a common goal to compete with other competitors within the business (Gooch, 2016; Kyongpitzer, 2019)

Knowledge sharing is one of alliance outcome, which plays a crucial role in the development of healthcare capacity knowledge through improving innovation development and learning capacity. The role of knowledge sharing in strategic alliances has been thoroughly debated (Le & Lei, 2019); however, a model of how strategic alliance may be sustained to achieve the individual partners' motives whilst generating the ultimate outcome of competitive advantage, is lacking (Gao, Yang, Yin, & Ma, 2017). This lack of evidence is far from deliberate; the fundamental issue is that defining alliance motives has remained every eluding (Bhatti, 2011). To arrive at a model of how strategic alliance can be sustained, a higher gap needs to be closed on how alliance motives may be aligned. It is in this context that knowledge sharing has played an overarching role in helping arrive at a consensus to warrant the appreciation of partnership differences (Pelletier et al., 2014; Bhatti, 2011). By closing this higher gap, a model of strategic alliance sustainability may be reached. As (Ferreira, Coelho, & Moutinho, 2021) observe, an important consideration must be given to equally well-matched strategic motives nevertheless of the orientation; therefore, while motives may not always be the same or may have good and negative parts, they must be aligned through knowledge sharing. Therefore, this research attempts to develop a scale for measuring knowledge sharing in strategic motives alignment, with attention to the context of healthcare strategic alliance.

Literature Review

Strategic alliances are important for businesses to corporate firms and build up an effective force within any particular industry (Mamédio, Rocha, Szczepanik, & Kato, 2019). Alliances are formed, ranging from local to international partnerships, with the goal of making one or

more achievements in pre-determined focus areas (Drucker, 2001; O'Dwyer & Gilmore, 2018). The prevalence of equally positive and negative results of strategic alliances clearly indicates that alliance drives may differ and sometimes conflict and can be the result of a common external cause that needs cautious management and integration.' (Chang, 2019). According to Link (2015), although significant disputes and inconsistencies develop mainly in terms of partner motives, strategic compatible organisations usually pursue common aims. Rowitz (2014) argued that healthcare alliances might take comparable forms of service, opportunity, or stakeholder coalitions, based on knowledge from mainstream literature on strategic alliances. Other academics, such as Das and Teng (2001), have claimed that administrative and institutional aspects are necessary at all stages of an alliance's life cycle to ensure its success and long-term viability. The degree of ownership-based control has been claimed to be proportionally related to the necessity for knowledge sharing between partners in the attempt to conceptualise alliance control (Bhatti, 2011; Kok, Faems, & de Faria, 2020). Before going into further detail on the importance of knowledge sharing in strategic healthcare alliances, Tjemkes and Burgers (2013) point out that available evidence indicates that more than half of all alliances fail to fulfil their goals. The alliances' purpose failure has been attributed to a number of factors. Nonetheless, the main difficulty is that alliance motivations are frequently divergent, making the achievement of common ground that benefits all parties challenging.

The mechanisms of alliance control within the endogenous region are critical for alliance adaptation and development (Koza and Lewin 1998). In a case of an international joint venture discussed by Ariño and de la Torre's (1998) it was recommended that efficiency and equity conditions are aligned first to reduce uncomfortable situations in diverse manners such as governance, contracts, in addition to how the alliance may be terminated. It is not new that in a new alliance, one aspires to explore through knowledge sharing whilst the other seeks to exploit operational and functional capabilities (Koza and Lewin, 1998; Liu, Deng, Wei, Ying, Tian, 2019). The fundamental argument is that the outcome cannot be predicted and only remains artefacts of the given context. Thus, when the outcome is uncertain or unspecified, the alliance must be more receptive to adaptation as managers change their initial conditions once the outcomes become clearer. The change in conditions may not go down well with the other alliance parties as they may see this as a breach of original intent. This does not always represent a change of intent but is rather rational considering the original intent was not well understood by the partners themselves given the lack of knowledge. Knowledge sharing is therefore not just a matter of communicating intent but a critical exchange of insight to nurture and clearly define motives for the alliance (Koza and Lewin 1998; Russo and Cesarani, 2017; Ritala, Husted, Olander, and Michailova, 2018).

From one other major perspective, the relationship between knowledge sharing and value creation capabilities is centred on the relative nature of absorptive capacity among partners. Relative absorptive capacity between partners can hinder the extent to which both parties benefit from knowledge sharing and are able to generate or create value through integration and coordination (Lane and Lubatkin 1998). The test of this relationship is, therefore, a key determinant of the firm's ability to utilise given resources to learn from the alliance and build convergence over time whilst extracting divergent resources from the other partners (Nakamura

et al. 1996). It is important to add that even though a wide relative absorptive capability can jeopardise the alliance success, absorptive adaptation is even more required at the stage of partnership exploration or the endogenous phase of the alliance, however, as observed by Hamel (1991) in exploration alliances, partners' ability to acquire knowledge is critical. For better results or outcome, the strategic alliance must aspire to achieve asymmetry between partners in terms of absorptive capacity; this outcome is more likely to trigger adaptation in exploration alliances to control the emergence of learning races (Hamel, 1991). This strength will again complement integration and coordination capabilities as these constructs step directly from learning in the original Pavlou and El Sawy (2011) model of dynamic capabilities. Based on these discussions, it is proposed that effective knowledge sharing or asymmetry absorptive adaptation will lead to improved alliance integration and coordination capabilities (Al-Shami & Rashid, 2022). Even though, knowledge sharing in strategic alliances has been thoroughly debated (Le and Lei, 2019); understand how strategic alliance may be sustained to achieve the individual partners' motives whilst generating the ultimate outcome of competitive advantage, is lacking (Gao, Yang, Yin, and Ma, 2017).

How can knowledge sharing through strategic alliances drive value creation and competitive advantages among healthcare organizations?

Methodology

This research aimed to explore the factors that drive knowledge sharing in strategic alliances for value creation and competitive advantage among healthcare organisations. A qualitative research method known as the grounded theory method (GTM), proposed by Strauss and Corbin (1998), was adopted to achieve the research aim. The GTM allows an inductive process for gathering, synthesising, and analysing grounded data (Corbin and Strauss, 1998).

In line with the recommendations by Creswell and Poth (2018) and to fulfil the purpose of this study and the GTM, a sample size of 30 alliance project leaders between Abu Dhabi and the United States of America (USA) healthcare was purposively selected. Thirty respondents were initially selected, but the data collection stopped at the 25th respondent (Detailed of the respondents are shown in Table 1). As suggested by (Glaser and Straus, 1968), by Glaser and Strauss (1967) and Taylor and Bogdan (1998) "interviews should be carried out until it reaches theoretical saturation point where an additional interview would no longer provide any new insights about the topic". In this study therefore, after reaching thirty four interviewee, we ended interviewing because of continuous repetition of themes. The purposive sampling was used in respondents' selection according to the following criteria: first, they hold a position in the top management in their institutions and they are policymakers. Second, they have sufficient experience on strategic alliance. Finally, they represent a wide-range of sectorial areas that covers both managerial and specialists departments across different healthcare types.

Semi-structured interview questions were used as the data collection instrument directly in a natural setting. The interviews were conducted between 4th January 2020 and 21st January 2020. The interviews sought to investigate the specific underlying factors that help measure motives-consensus in the strategic healthcare alliance. The original factors of motives-consensus were adapted from existing literature from the resource-based, competency-based

and industry relationship-based views. A pilot interview was conducted to improve the quality of the interview protocol. The participants were contacted privately by the researchers. Each participant was assigned to a specific number (001 to 025) as a specific identifier. The researchers asked the participants about their experience and opinion using the semi-structured interviews after obtaining informed consent. The interviews were conducted face to face with the managers of the healthcare institutions. Each interview lasted for 45 to 60 minutes and was recorded and transcribed. The transcriptions were then verified with the participants to ensure that data validity is obtained.

Data collection and data analysis were conducted concurrently. The interview data were coded, and memos were written to aid the ongoing analysis each time an interview was conducted. Furthermore, constant comparisons were conducted between the interview data in order to identify data saturation. The analysis aimed not to determine specific motives but to identify knowledge sharing cues required for successful motive-consensus. Essentially, the motives cannot be conceptualised because they remain elusive, evolve over time and their specificity remain abstract. Nonetheless, the knowledge sharing cues required for a successful strategic alliance will be instrumental in fulfilling the underlying research gap. A systematic procedure consisting of three layers of analysis, namely open coding, axial coding and selecting coding, were adopted to develop the model.

Thematic analysis was used to develop the list of codes and theme categories that emerge from the data collected (Williams & Moser, 2019). Open coding was conducted with sample statement texts. The conceptualisations and initial conceptualisations of data were outlined. The categorisation was spelt out to the various reference points at the axial coding stage, and the main categories were drawn. This stage is referred to as the 'reassembling of the fractured data' during the open coding. The researchers start to piece together what matters and what happens (Corbin and Strauss, 1998). Subsequently, selective coding entailed drawing out the embedded inter-relationships between the constructs or elements within the data. The model was visually presented in support of the empirical findings. The qualitative analysis was conducted via MAXQDA analysis software.

Table 1: Demographic information about of the respondents

Participants	Sector	Position	Age	Experience	Education
Participation No: 1	Public Hospital	Top Manager	48	18	Postgraduate
Participation No: 2	Public Hospital	Top Manager	45	17	Postgraduate
Participation No: 3	Public Hospital	Top Manager	53	21	Postgraduate
Participation No: 4	Public Hospital	Top Manager	51	19	Postgraduate
Participation No: 5	Public Hospital	Top Manager	39	17	doctorate

Participation No: 6	Public Hospital	Top Manager	51	21	Postgraduate
Participation No: 7	Public Hospital	Mid-Manager	38	14	doctorate
Participation No: 8	Public Hospital	Mid-Manager	42	15	Postgraduate
Participation No: 9	Public Hospital	Mid-Manager	48	19	Postgraduate
Participation No: 10	Public Hospital	Managerial level	46	16	completed colleage
Participation No: 11	Public Hospital	Managerial level	44	15	completed colleage
Participation No: 12	Public Hospital	Managerial level	34	7	completed colleage
Participation No: 13	Public Hospital	Managerial level	37	9	completed colleage
Participation No: 14	Private Hospital	Mid-Manager	52	15	Postgraduate
Participation No: 15	Private Hospital	Mid-Manager	52	17	doctorate
Participation No: 16	Private Hospital	Mid-Manager	48	14	doctorate
Participation No: 17	Private Hospital	Mid-Manager	47	18	Postgraduate
Participation No: 18	Private Hospital	Mid-Manager	44	15	Postgraduate
Participation No: 19	Private Hospital	Mid-Manager	39	9	doctorate
Participation No: 20	Private Hospital	Managerial level	37	8	completed colleage
Participation No: 21	Private Hospital	Managerial level	41	11	completed colleage
Participation No: 22	Healthcare Centre	Top Manager	49	19	doctorate
Participation No: 23	Healthcare Centre	Top Manager	44	14	Postgraduate
Participation No: 24	Healthcare Centre	Mid-Manager	36	6	Postgraduate
Participation No: 25	Healthcare Centre	Managerial level	39	8	completed colleage

Data Analysis and Discussion

The data analysis for the model development involved three stages of analysis as presented below.

Open Coding

The summary of all the general codes was organised into categories. In this coding phase, the exercise was conducted with the help of two other researchers to settle any disagreements with the codes' categorisation and essentially avoid bias (Malis et al., 2017). If a disagreement occurred, the three researchers discussed resolving the inconsistencies and reached a consensus. Unrelated content was deleted, whereas the rest of the content was organised into themes. Through the open coding, 588 reference points were categorised into unique conceptualisations and categorisations shown in Table 1.

Table 1. Analysis of open coding with sample statement texts

Statement Text	Conceptualisation	Categorisation
Motives that Drive Alliance Formation		
001: I believe when we improve the quality, we will detect our operational cost leakage and deficiencies.	Quality service, operational cost leakage (overcome), deficiencies (overcome), better management, cost reduction profit etc.	Economic motives (resource Cost Motivation)
025: the most concern in our health care organisation is providing best quality of service, but also, we concern minimising operation cost, high profit, and better management to perform better.		
002: that cost reduction is important. For example, reduce manpower, case that avoiding losing employees that you spent cost to hire, train and develop theory skills.		
006: motives declaration, opportunities for both parties, cooperation areas and outcomes expectations.	Motives declaration, openness, committees follow up, cost of knowledge transfer, conflict management, good faith, etc.	Knowledge support for economic motives
025: to avoid going through conflict during the agreement and therefore avoiding any circumstances which will reflect negatively.		
016: Usually any conflicts are taken under the legal terms and conditions of the partnership contract. Committees from both parties would form and investigate the incident and decision.		
Statement Text	Conceptualisation	Categorisation
Motives that Drive Alliance Formation		
001: Where getting in affiliation with well-known healthcare institute give the healthcare organisation more reputation.	Specialist and subspecialty shortage,	Competency-based motives

011: It became more attractive for patients and get more respect among other entities.	attractive patients, more respect, integrated services competencies, etc.	
018: Complementary exchange of alternative competences yes! Imagine that I can operate my staff where I have strength on this.		
009: If I become a decision maker, I will not go with alliance without putting clear map and roles and create channels.	Map, roles, channels, learn from experiences, exchange of expertise, share skills, KPIs, etc.	Knowledge support for competency-based motives
012: “Need them [employees] to learn from other experiences who was in the field for long time and face many issues and I don’t want my people to start from scratch.”		
003: Dashboards and KPI’s and individual motives are discussed always as apart of agreement.		
008: Well! I believe our organisation sometimes do not want to invest in some technology for example.	Technology investment, market reputation, value, specialty infrastructure, training, improve weakness, etc.	Industry relationship motives
014: What they do is getting alliance with well-known institutions who has strong reputation in the market.		
014: This add value to our organisation in only a part of its operation. This apply for also specialty infrastructure IT and training.		
Statement Text	Conceptualisation	Categorisation
Motives that Drive Alliance Formation		
003: supervised by steering committee with regular meeting where clear data is shared for both sides will avoid many conflicts with alliance.	Committee with regular meetings, long-term relations, partner commitment, financial status, relational priorities.	Knowledge support for industry relationship motives
003: and that will lead to long-term relation with all data and outcomes will be shared, challenges will start small and will sorted out.		
017: long-term relation with all data and outcomes will be shared, challenges will start small and will sorted out before it grows and become bigger.		
Dynamism Agenda		

001: Using technology for example systems, network, other equipment with better technology, 020: Imagine that my organisation want to do transformation from using paperwork to digital system.	Technology/ systems/network equipment expertise human resource transformation from using paperwork to digital systems etc.	Integration
020: Imagine that my organisation want to do transformation from using paperwork to digital system.		
011: “I believe listing my strength and weaknesses with honesty and same I’m expecting from my partner.” 002: the need to make it a priority, provide incentives, create a space for sharing to happen, and invest in a long-term strategy.	Acknowledging expectations including strengths and weaknesses, clear motives and communication of prioritised areas.	Knowledge sharing for integration
018: Exchanging programs where our professional can be trained at our partner health institution and gain more skills and knowledge.		
Statement Text	Conceptualisation	Categorisation

Dynamism Agenda

009: I believe working in health information system has many areas for reconfiguration.	Health information system, financial leakages, claim detection, create new resources.	Reconfiguration
010: Also, focusing in research and developing in healthcare will lead for new breakthrough.		
002: To transfer resources to and from one target to create new resources.		
011: I believe clearing everything in the table will be the best idea before getting in alliance especially in financial proper configuration.	Clearing the table, proper financial configuration in agreement, clear information, owner of new capabilities, dashboards, KPI's.	Knowledge sharing for reconfiguration
014: If that is stated in the agreement is perfect.		
014: “But if it’s not, I believe it should be attached later to the agreement and both sides should agree on it.”		
020: coordination capabilities in human resources, technology and equipment as well as financial coordination is essential in coordination capabilities.	Human resources, technology, equipment, market behaviour, quantity of available market	Coordination
014: there is the need to consider market behaviour and consider dealing with quantity of available market information.		

004: We share same system in case of disaster to coordinate all patients and critical cases suitable hospital.	information, employees etc.	
015: developing new standard of procedure focusing on sharing information roles and responsibilities and sharing information process for both parties.	Financial coordination, developing new standards, information sharing roles, medical field by investment in resource and partner.	Knowledge sharing for coordination
024: well from my field there is many coordination capabilities between our organisation and other organisation in the medical field inside Abu Dhabi or alliance among UAE or USA.		
Statement Text	Conceptualisation	Categorisation
Dynamism Agenda		
005: better through connect every level of the organisation in operation, management and leadership level connect them together.		
Strategic Alliance Competitive Performance		
015: I think when you ally with well-reputable organisation that will increase your quality and reputation which will consequently affect all aspects of performance.	Financial, reputation, stronger market, position, technology achieve goals.	Integration for competitiveness
013: "But if we look in negative perspective, that's right if I share knowledge with partner that will cost me time and efforts."		
019: in our culture its fundamental assumption that union is a strong force no one can debate.		
003: reconfiguration the operation cost that I spend in my organisation will reduce defiantly as well as increase quality of services.	Long-term alliance, building trust, continuity strength of the individual and businesses, operation cost etc.	Reconfiguring for competitiveness
003: we will attract new clients that was not from their list before.		
014: new product or service that make you in better position in case of competitiveness. Adding to that cost that you saved, time and efforts.		
001: contribute to solve many issues that can appear during alliance as well as building trust.	Problem-solving, trust-building, organisational indexing, cost reduction quality of healthcare services etc.	Coordination for competitiveness
014: Strategic competitiveness is the ultimate goal of creating all these alliances, where local capabilities can compete with international capabilities.		
018: that coordination will help measure partner performance and outcomes being sought.		
Statement Text	Conceptualisation	Categorisation

Strategic Alliance Competitive Performance		
013: I believe level matching in alliance. That means design way of communication with all organisation level.	Level matching, sharing data, meetings, committees, discussions, communication, KPI's etc.	Knowledge sharing
004: data should be shared, daily meeting between different committees and top of this steering committees should be addressed to drive this alliance to the goals.		
016: the use of meetings, direct discussions, emails, sessions, conferences, and seminars.		
001: I say on this that the UAE market, in general, is attractive for investment, where in healthcare sector, in particular, is more attractive.	Attractive market, goals specification, investment interest declaration, consensus building, etc.	Knowledge sharing for competitiveness
003: knowledge share can draw short and long-term goals. In specific words.		
004: Quality is of high demand, and hence multiple strategic alliances were formed at the level of highly esteemed facilities like Johns Hopkins, Mayo Clinic, Cleveland, and many others.		

*Note: Abbreviation = KPI – Key Performance Index

Axial Coding

Based on the open coding analysis, a summary of key categories within the data are presented in Figure 1 according to the proportion of reference points within the data. A total of 17 categories were observed, including economic motives, knowledge support for economic motives, competency-based motives, knowledge support for competency-based motives, industry relationship motives, knowledge support for industry relationship motives, integration, knowledge sharing for integration, reconfiguration, knowledge sharing for reconfiguration, coordination, knowledge sharing for coordination, integration for competitiveness, reconfiguring for competitiveness, coordination for competitiveness, knowledge sharing, and knowledge sharing for competitiveness. Some categories were combined due to the intrinsic relationship between the categories at the conceptual level. For example, knowledge sharing that facilitates motives and value creation capabilities was repetitive in terms of conceptualisation. Moreover, the repetition was similar to knowledge sharing as a category. Contrastingly, knowledge sharing towards competitiveness denoted the overall contribution of this dimension to the outcome of competitive advantage. Other code themes under the same categories and conceptualisations could be combined under an overarching code. The outcome after categories and codes were combined is presented in Table 2.

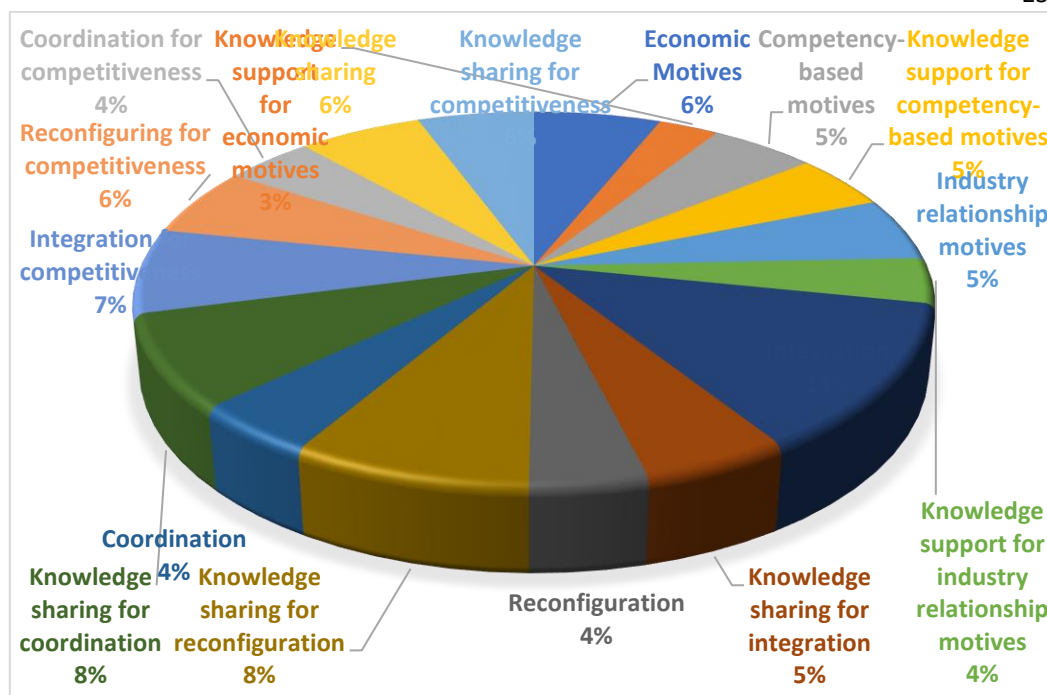


Figure 1. The proportion of reference points for free nodes

Besides knowledge sharing, pre-alliance motives were grouped into economic, competency, and industry relationship motives. These motives were distant from the alliance or modified into value creation capabilities after the alliance. Additionally, the motives serve as the originating factors that motivate health organisations to venture into alliances but merely serve as face value or temporal motives. Subsequently, the motives evolve into more complex alliance motives necessary to run the alliance and ensure the operations' efficiency. The value creation motives come in steps at this point. Integration, reconfiguration, and coordination after the alliance have been formed is deemed essential to catalyse progress and ensure the alliance's success. Beyond these observations, knowledge sharing complements the motives necessitating alliances and motives facilitating alliance continuity towards competitiveness. Knowledge sharing could be defined independently or engineered to contribute critically to the competitive performance of strategic healthcare alliances. The selected coding analysis was conducted as per these axial coding. The coding is presented in Table 2.

Table 2. Axial coding

Main Categories	Categorisation	Reference Points	Implication of Categories
Motives necessitating alliance formation	Economic motives	36	Economic-based motives in their raw states that drive the need for an alliance among healthcare
	Competency-based motives	30	Competency-based motives in their raw states that drive the need for an alliance among healthcare

	Industry relationship motives	32	Industry relationship-based motives in their raw states that drive the need for an alliance among healthcare
Motives dictating alliance value creation/success	Integration motives	75	Integration agenda that drives the success of strategic alliances after partners come together
	Integration for competitiveness	43	The degree to which integration facilitates competitiveness in the strategic healthcare alliance by creating value
	Reconfiguration motives	24	Reconfiguration agenda that drives the success of strategic alliances after partners come together
	Reconfiguring for competitiveness	35	The degree to which reconfiguration facilitates competitiveness in the strategic healthcare alliance by creating value
	Coordination motives	26	Coordinating agenda that drives the success of strategic alliances after partners come together
	Coordination for competitiveness	25	The degree to which reconfiguration facilitates competitiveness in the strategic healthcare alliance by creating value
Knowledge sharing to facilitate competitiveness	Knowledge support for economic motives	17	The degree to which knowledge sharing help achieve economic-based motive-consensus at the formation of the alliance
	Knowledge support for competency-based motives	28	The degree to which knowledge sharing help achieve competency-based motive-consensus at the formation of the alliance
	Knowledge support for industry relationship motives	23	The degree to which knowledge sharing help achieve industry relationship-based motive-consensus at the formation of the alliance
	Knowledge sharing for integration	30	The degree to which knowledge sharing help integrate resources and motives after alliance formation to help create value
Main Categories	Categorisation	Reference Points	Implication of Categories
	Knowledge sharing for reconfiguration	49	The degree to which knowledge sharing help reconfigure resources and motives

			after alliance formation to help create value
	Knowledge sharing for coordination	47	The degree to which knowledge sharing help coordinate resources and motives after alliance formation to help create value
	Knowledge sharing	35	Knowledge sharing in its simplest format within the strategic alliance
	Knowledge sharing for competitiveness	33	The ultimate contribution of knowledge sharing to competitive performance

Selective Coding and Theoretical Model

Selective coding is the process of constructing theoretical models by extracting core categories from main categories and other categories and analysing the correlation paths between the core categories and other categories through the original interview materials. According to Guan et al. (2020), selective coding constitutes the process of constructing theoretical models from the conceptual themes by extracting the underlying categories from the main categories under axial coding. During the selective coding, the correlations and other associations between the categories were highlighted. A model of knowledge sharing for strategic alliance competitiveness is presented in Figure 2. According to the model, knowledge sharing remains the most versatile and critical element for the success of strategic alliance competitiveness.

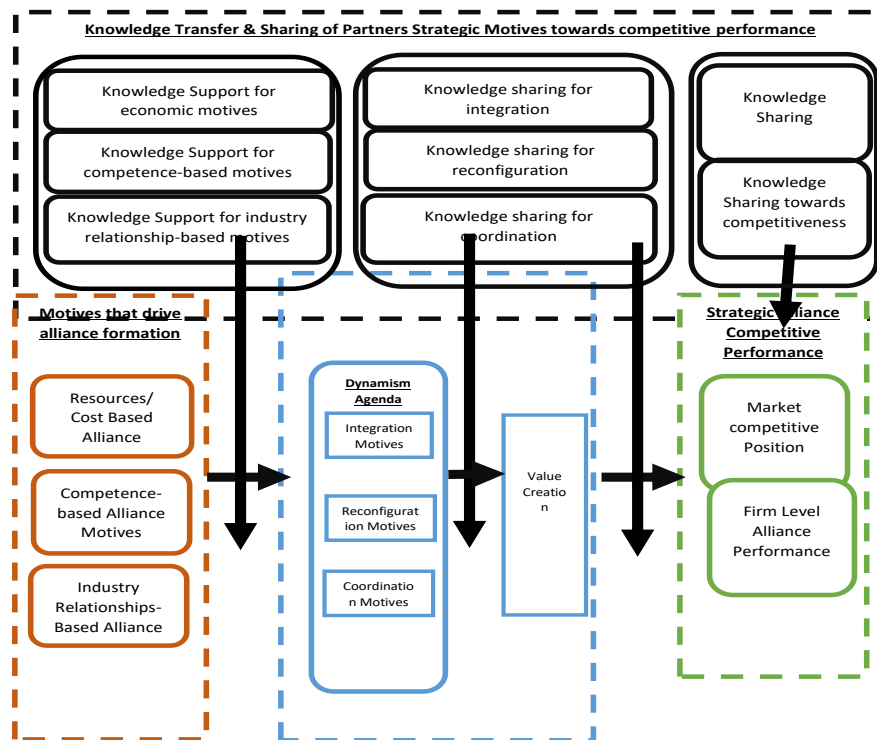


Figure 2. The model of knowledge sharing for strategic alliance competitiveness (Source: Author)

Notably, before forming strategic alliances, little exists in the form of knowledge sharing as the alliances are motivated by the parties' own interests. Alliance interests may be categorised into three main independent areas: economic, competence, and industry relationship motives. The individual and distinct motives do not drive value. These motives are often surface values of deep-rooted alliance agenda that could be either known or unknown to both parties in the strategic alliance. Nonetheless, knowledge sharing should be introduced during the alliance formation to share these motives between alliances and facilitate the transition to dynamism. The alliance parties need to set value-driven motives in integration, reconfiguration, and coordination areas at the dynamism stage. Knowledge sharing needs to be introduced for these motives to be optimised towards value creation. The direct role of knowledge sharing on value creation dynamism after the alliance formation is explained, as presented in Figure 2. In addition, knowledge sharing serves as a critical moderator of the transition from value creation to strategic alliance competitive performance. The alliance is able to channel the value creation efforts to sustain the competitive performance of the new alliance through more advanced forms of knowledge sharing, including Key Performance Index (KPIs), committees, benchmarking, among others. An overall representation of the relationships between the data is presented in Table 3

Table 3. Categories of typical relational structure

Relational Structures	Connotation of Relational Structure
<p><u>Three-way relationship</u></p> <ul style="list-style-type: none"> Independent: Partner motives pre-alliance formation Dependent: Dynamism post alliance formation Moderator (facilitator): Knowledge sharing 	<p>1) Alliance individual motives that are seen from the outside and motivate the individual partners to initiate the alliance formation process in the healthcare sector.</p> <p>2) These motives must align in the alliance formation stage through knowledge sharing. This step is essential to higher the immediate value outcome within the operational space, achievable through dynamism (integration, reconfiguration, and coordination).</p> <p>3) The transition from independent partner motives to value creation should be noted as not possible without proper knowledge sharing.</p>
<p><u>Three-way relationship</u></p> <ul style="list-style-type: none"> Independent: Dynamism agenda (for integration, reconfiguration, and coordination) post alliance formation Dependent: Value creation alliance operational efficiency Moderator (facilitator): Knowledge sharing 	<p>1) After alliance formation, the individual motives must be relegated to make room for dynamism agenda through integration, reconfiguration, and proper coordination of affairs. These motives or activities may drive value creation better when facilitated using knowledge sharing.</p> <p>2) Knowledge sharing facilitates the transition of integration agenda, reconfiguration agenda and coordination agenda towards value creation. Traditionally, integration, reconfiguration, and coordination capabilities are value creation capabilities according to Teece's (2018) dynamic capabilities model. However, unique to the newly formed strategic alliance relationship, knowledge sharing becomes</p>

	paramount for proper dynamism of the extent to which the partners work together more efficiently in terms of their operations.
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Relational Structures	Connotation of Relational Structure
<u>Three-way relationship</u> <ul style="list-style-type: none"> • Independent: Value creation dynamism post strategic alliance formation • Dependent: Strategic alliance competitive performance • Moderator (facilitator): Knowledge sharing 	1) Following the achievement of operational value through optimal dynamism, the internal efficiency must be directed at the strategic purpose of competitive performance. Competitive performance within the market cannot be achieved without an observable positive performance outlook for the organisation. In other words, achieving competitiveness through negative profits are unsustainable. 2) Value creation capabilities must be channelled towards competitive performance by operationalising advanced knowledge sharing at the strategic level of the strategic alliance to achieve competitiveness.
<u>Two-way relationship</u> <ul style="list-style-type: none"> • Independent: Knowledge sharing • Dependent: Strategic Alliance competitive performance 	1) In the absence of all the other antecedents, knowledge sharing has a significant and independent impact on strategic alliance competitive performance. 2) The ability of knowledge sharing to act as a stand-alone construct goes beyond the confines of strategic alliance literature to encompass the broader scope of literature that surrounds how knowledge sharing may be used as a core competence in competitive business environments.

Theoretical Saturation

Data saturation has to be given attention during data collection. Data saturation is considered as the point where any new respondent would not contribute additional new data to the interview results (Saunders, Lewis & Thornhill, 2016). Initially, 30 respondents were targeted as a population sample. Nevertheless, data saturation was achieved after 25 respondents, implying that no further data collection was required. The theoretical model presented in Figure 2 is saturated and complete, in line with Guan et al.'s (2019) observation for qualitative research that adopted the grounded theory research strategy.

Factors of Knowledge Sharing in Healthcare Strategic Alliance

The final aspects of this analysis necessitated that key factors and indicators are proposed to arrive at a crucial measurement construct. A tri-dimensional construct was proposed, with six indicators under each sub-dimension (Refer to Table 4). A total of 18 item scales for the measurement of knowledge sharing in strategic healthcare alliances was proposed. Literature support for these indicators is thoroughly discussed in the discussion section of the study.

Table 4. Dimensions of knowledge sharing in strategic alliance, and indicators for measurement

SUB-DIMENSIONS	INDICATORS
Knowledge sharing essential for the transition of strategic alliance motives into dynamic agenda	<ul style="list-style-type: none"> • Agenda and motive declaration/ setting • Contractual (regulatory and relationship) regulation • Clarity (openness/ good faith) • Committee/meetings/ resolution strategy • Role definition (including conflict resolution) • KPIs for alliance formation
Knowledge sharing essential to operationalise strategic alliance dynamism towards competitive performance efficiently	<ul style="list-style-type: none"> • Acknowledgement of individual strengths and limitations • Incentive-driven • Leadership commitment • Technology and Innovation adoption • Long-term strategic orientation • KPIs for alliance operational success
Knowledge sharing factors essential for strategic alliance competitive performance	<ul style="list-style-type: none"> • Strategic alignment (common grounds, vision, mission and others) • Innovative communication using versatile media and channels • Close (daily/ frequent) relationship building • Documentation of all encounters • Balancing short and long-term goals/agenda • External marketing (including government support and external opportunities sensing)

*Note: Abbreviation = KPI – Key Performance Index

Motives that Drive Healthcare Strategic Alliance Formation and Facilitates the Operational Success of Alliances

The motives for alliance formation was observed as a by-product of the present phase. Motives can be grouped into two main areas: (1) motives that drive alliance formation and (2) motives that drive operational success. Sub-dimensions were proposed for each of these constructs, as presented in Table 5:

Table 5. Dimensions and indicators of motives that drive strategic healthcare alliance

Motives	Sub-dimensions	Indicators
Motives that Drive Alliance Formation	Economic	<ol style="list-style-type: none"> 1. Service quality 2. Minimise operational cost 3. Profit maximisation 4. Capital and financial support 5. Access to resource

		6. Management economic know-how
	Competency	<ol style="list-style-type: none"> 1. Access to healthcare specialist 2. Competency affiliation and reputation 3. Competency attractiveness to patients 4. Service competency integration/synergy 5. Achieving a global (international) standard 6. The attraction of management competency
	Industry relationship	<ol style="list-style-type: none"> 1. Access to technology (patented or ownership by partner) 2. Reputation improvement in the industry 3. Incentives from government and regional economic blocks 4. Quality perception improvement (care) 5. The attraction of international investors 6. Reduce market/industry weaknesses and tap into other markets/industry strengths
Motives that Drive Alliance Operational Success	Integrating	<ol style="list-style-type: none"> 1. Economic integration (financial, cost, profit allocation and others) 2. Technology integration 3. Management integration 4. Workforce integration 5. Efforts, goals, agenda and other integration 6. Operational performance integration
	Reconfiguration	<ol style="list-style-type: none"> 1. Long-term re-orientation of efforts 2. Trust-building 3. Optimisation of strengths 4. Innovation solutions and outcomes 5. Newmarket/product targeting 6. New technology development
	Coordinating	<ol style="list-style-type: none"> 1. Financial coordination (costs and capital) 2. Scopes (coordination of different partner scopes of operations) 3. Problem-solving 4. Service quality 5. International coordination 6. Performance coordination (measuring performance outcomes)

Discussion

The phenomenon of knowledge sharing in healthcare strategic alliances is explored in qualitative research using the grounded theory research strategy. Purposive sampling was used and an open interview was conducted with 25 alliance project leaders of X hospital within Abu Dhabi and the USA healthcare industry between the 4th and 11th of January 2020. The open and axial codes were used and study the competence-based view, resource-based view, and industry relationship-based view were used to facilitate the understanding of the interrelation between knowledge sharing within strategic alliances. Knowledge sharing in this research was found to have an influence on strategic alliance in three main perspectives, which are resources, first, competencies and industry-relationship motives, second, knowledge sharing fuelling integration, coordination and reconfiguration capabilities in strategic alliances and third, value creation and knowledge sharing to fuel competitive advantage in strategic alliances. To investigate the resources, competencies, and industry-related motives that inspire alliance motives-consensus, a total of six (6) questions were asked; two questions each on economic, competencies, and industry-related motives. Whilst the first question asked for resource, competency, and industry relationship factors, the second question for each motive category requested information on share knowledge between the alliance to address agreements and conflicts that arise from competency motives.

The responses collected from professionals were showing different perspectives related to knowledge sharing and factors of the healthcare system for driving this opportunity. The financial and transactional resource factors have indicated the requirement of quality improvement that is joined with the sharing of fees, and charges. It is explored that for the improvement in the quality, one can easily detect deficiencies and operational cost leakages. Partnerships allow sharing of the financial perspectives that designates the financial resources excess at one facility can be shared with others through alliance (Schumpeter, 1934). Knowledge sharing in the UAE hospitals is considered mostly for finance. Partners supporting one another can result in better budgeting options and the alliance formation can benefit society by improves service quality (Schumpeter, 1934). This happens due to the presence of effective resources. Economic motive-consensus in the strategic alliance can have dual results as the current responses are showing how the study participants were merging their needs and improvements that were sighted in the responses correspondingly. Motives to have an alliance are of great importance and these are important to sign before the alliance. The private sector in the UAE is observed to develop alliances to ensure business continuity as the respondents were sharing their perspective of alliance in the economic motive. The deviation of the respondents regarding business continuity is presenting the sharing of resources by the hospitals to reduce the risk of future problems regarding financial gains.

The finding of this study shows that from 30 motives of competency-based consensus in strategic alliance, 28 were based on knowledge sharing. The shortage of specialists is one of the dilemmas in the UAE as the knowledge sharing process also requires proper skills that can help to establish a centralized system between two partners for sharing information. The competency of the staff is an important aspect in the competency-based consensus for driving alliance motives. Due to a shortage of skills and competencies in sub-specialities, the hospitals

in remote areas want to have an affiliation with well-known healthcare to improve their reputation (Zahra & George, 2002; Rohani&Asadi, 2020). The professionals were preferring multiple expertise at one setup through partnerships. A lot of UAE hospitals were lacking sub-speciality that was possible by keeping skills and knowledge at once by sharing knowledge among two types of organizations. The professional reviews were straightforward regarding the exchange of skills, expertise, and competencies.

Key performance indicators (KPI's) were found to be the main instruments to develop consensus in an alliance. The defects were rectified in the UAE hospitals with the help of procedures that were developed to minimize the challenges and to explore the solutions for conflicts. The competency motives were also required by having an alliance with a similar level or with a higher level to support one another to integrate services of both specialities. Partner competencies are used to develop staff skills, operational performance, and performance management showing a strengthening and advantageous behaviour of healthcare partners.

The finding of this paper reveals that the factors driving industry relationships are due to the technical help that the healthcare organizations seek from those having a strong reputation in the market. The technical support from a reputed organization was only a source of support for one operation and applies for only training and speciality infrastructure IT. Another important point noted was to minimize the weaknesses of the organization by having an alliance with a stronger organization. Agreement through committees is steered up by reducing conflicts (Gibson & Birkinshaw, (2004). This leads to developing a fruitful and long-term relationship between organizations. Industry-based relationships are important for supporting the business during complex and unstable situations. This is said to be the vehicle of choice to have a competition in the complex business world.

Control and maximization of the environment was another requirement for making alliances in the industry. Social barriers are needed to be identified for the elimination of the maximal number of individuals through incentives (Gaskin, 2012). These incentives should be based on the improvement in the knowledge sharing with teams, groups, and institutions for overcoming the existing barriers. Diverse factors are of value to depend on the partners for minimizing costs and providing with the competencies for meeting opportunities (Bhatti, 2011). The industry-based consensus was mostly related to the benefits that organizations were trying to achieve through already established competencies. Alliances were also said to be benefit-based partnerships in the industry-based consensus. Knowledge sharing is essential to address industry relationships; experts trust it will make decisions based on processes among firms.

The responses collected for the integration, coordination, and reconfiguration have explored that expertise is important to establish a knowledge-sharing mechanism. Honest has been measured as an important element whole fuelling integration capability between two partners. Both partners expect a high level of trust before integrating the capabilities based on one motive. Expectations and outcomes are met by these organizations by keeping such a trust-based environment (Tjemkes, Vos & Burgers, 2012). Clear situation and right information sharing develop trust among partners otherwise the alliances were failed. Integration was required at two main areas as observed from the primary data and these were technology

systems and networks (Dosi, 2000). By making it a priority, provision of incentives, creating a space to share and happen, and investing over long-term strategy were primary sources to align knowledge sharing with integration capabilities.

The primary data collected has explored that reconfiguration in situations where the combination of resources from the alliance parties go beyond integration to create new units that are different from both partners. The reconfiguration areas in the medical field are the development of healthcare information that can detect financial leakage regarding claims and coding. Research and development in healthcare can be a different sort of success for healthcare as per the present focus of research in the UAE. While configuring with the organization, it is necessary to develop a clear table as the organization's success is based on clear standards developed at the time of alliance (Ellis, 196). Clear information requires to be incorporated in the agreement form before the alliance of reconfiguration and these agreements with vibrant ideas can be shared between owners to have a mutual strategic agreement on shared policies. Clear information is a way to share the reconfiguration capabilities (Tjemkes, Vos & Burgers, 2012). It is not only implemented for the reconfiguration of capabilities but for avoiding future conflicts regarding information sharing. The data has disclosed the reconfiguration in the knowledge sharing is progressed for transferring the resources and creation of new resources based on the information between two partners.

Integration and reconfiguration led to achieving the goals in healthcare as these led to minimizing the operational costs. Partnership goals are achieved from the reconfiguration of capabilities as the professional's response is showing development in the healthcare alliance is not possible without this action of reconfiguration. Complete required information and validation will help the pharmaceuticals to work on drugs and to sell these drugs. Organizations cannot continue with breaking down information to deliver new prescriptions and accordingly firms cannot offer this drug to patients where one may execute them or cause them with pollution issues and hence lose standing and that driving entire accomplices to insolvency. Thus, we can see this is an over the connection, and reconfiguration abilities imply getting the right data from the right source and utilizing the right devices for the right approval to fabricate the accurate item.

Contribution

This paper contribute to the dynamic capabilities theory through developing knowledge sharing scales that play a major role on the success of alliance performance in value creation. knowledge sharing in this research was found to have an influence on strategic alliance in three main perspectives, which are resources, first, competencies and industry-relationship motives, second, knowledge sharing fuelling integration, coordination and reconfiguration capabilities in strategic alliances and third, value creation and knowledge sharing to fuel competitive advantage in strategic alliances. First, Motives to have an alliance are of great importance and these are important to sign before the alliance. Experienced professional's responses have verbalized the lack of proper motives understanding towards a strategic alliance of healthcare have ended with a failure. The motives were to find reasons to be stronger among competitive organizations. Most of the partners have a focus to be financially stronger by keeping the

alliance and they do not get any experience ahead. The leaders focusing on their financial improvement can increase money by putting hidden costs as they want to be paid more. In this paper knowledge sharing is shown to be important at the start of the alliance that clarifies to the partners either the knowledge sharing is beneficial or not as it is a source to minimize the chances of conflict during the agreement. In addition, knowledge sharing is taken as a solution for the conflicts between two parties as it acts to resolve the conflicts based on the facts and figures. Committees are a great source to resolve the conflict between two partners in an alliance by looking into the facts. Second, knowledge sharing improves the integration capabilities between partners. Clear situation and right information sharing develop trust among partners otherwise the alliances were failed. By making it a priority, provision of incentives, creating a space to share and happen, and investing over long-term strategy were primary sources to align knowledge sharing with integration capabilities. Third, knowledge sharing robust the reconfiguration capabilities. The finding of this paper shows that a clear information requires to be incorporated in the agreement form before the alliance of reconfiguration and these agreements with vibrant ideas can be shared between owners to have a mutual strategic agreement on shared policies. Clear information is a way to share the reconfiguration capabilities (Tjemkes, Vos & Burgers, 2012; Veisi&Karini 2021). It is not only implemented for the reconfiguration of capabilities but for avoiding future conflicts regarding information sharing. The data has disclosed the reconfiguration in the knowledge sharing is progressed for transferring the resources and creation of new resources based on the information between two partners.

Limitation

Despite the critical results on supporting strategic alliances in the healthcare sector, this study has several shortcomings. First, the scope of this paper is narrowed to the strategic alliance in the UAE healthcare firms instead of extending to other countries. Thus, the generalisation of the finding is not possible since strategic alliance works differently according to countries, industries and various considerations, such as resources and organisational culture. Thus, future research is recommended to extend the study to include healthcare firms in other countries within the Arab region. Second, this study was conducted through a qualitative research method driven by grounded theory with a small size of the population from the managerial perspective. Although the discussion was in-depth and provides rich information about managing alliances in healthcare, understanding how knowledge sharing influences several aspects of alliance motives and dynamic capabilities towards value creation from the customers' perspective is essential. Therefore, future researchers can extend this study by targeting patients with a large sampling size.

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