



**ALLIANCE MOTIVES TOWARDS DYNAMIC CAPABILITIES
AND THE COMPETITIVENESS OF HEALTHCARE
ORGANIZATIONS**



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UNIVERSITI TEKNIKAL MALAYSIA MELAKA

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2023



Institute of Technology Management and Entrepreneurship

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KHALED MOHAMMED RASHED SALEM AL KAABI

**A thesis submitted in fulfillment of the requirements for the degree of
Doctor of Philosophy**



UNIVERSITI TEKNIKAL MALAYSIA MELAKA

2023

DECLARATION

I declare that this thesis entitled “Alliance Motives towards Dynamic Capabilities and the Competitiveness of Healthcare Organizations” is the result of my own research except as cited in the references. The thesis has not been accepted for any degree and is not concurrently submitted in candidature of any other degree.

Signature :

Name : Khaled Mohammed Rashed Salem Al kaabi

Date : 13-2-2023



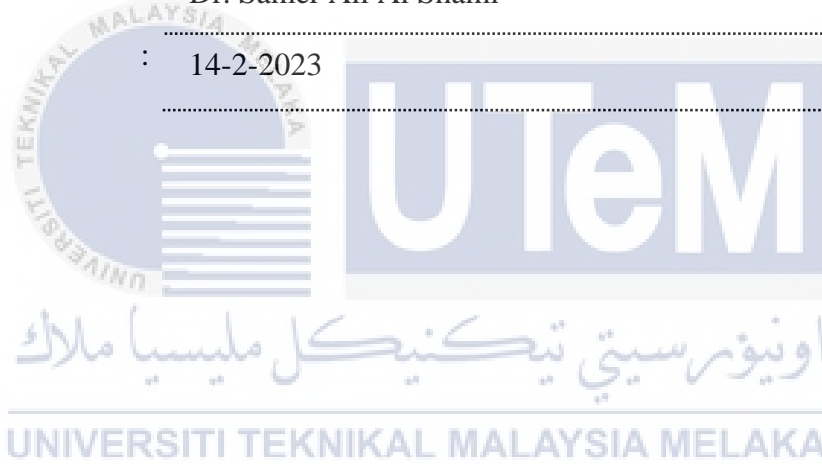
APPROVAL

I hereby declare that I have read this thesis and in my opinion, this thesis is sufficient in terms of scope and quality for the award of Doctor of Philosophy.

Signature :

Supervisor Name : Dr. Samer Ali Al Shami

Date : 14-2-2023



DEDICATION

I dedicate this thesis to my family.



ABSTRACT

Strategic alliance is increasingly gaining attention in healthcare service provision. However, there is a lack of understanding on alliance motives among healthcare institutions and how they affect several aspects of healthcare organizations' dynamic capabilities and competitiveness. The aim of the present study is to identify alliance motives and critically examine how they drive the competitiveness of the UAE healthcare organizations. Contextualised within the UAE healthcare sector, this study adopted a mixed methods research design, which involved two phases. In the first phase, a qualitative research method driven was conducted to identify and describe alliance motives and the dynamic capabilities of the healthcare organizations. For this purpose, a semi-structured interview with 25 alliance project leaders located in the Abu Dhabi and Dubai healthcare organizations was conducted. In the second phase, a quantitative method using a survey was conducted to examine the relationship between alliance motives, value-based dynamic capabilities and healthcare institutions' competitiveness. A sample of 279 employees of healthcare institutions responded to the survey questionnaire and the data were analysed using Amos. The finding revealed that alliance motives driven by transactional cost economy, industry-relationship and partners competencies are important factor for the development of healthcare dynamic capabilities, particularly in coordination, integration and reconfiguration capabilities, which influence healthcare institutions' competitiveness. This research provides an integrative model that explains how to improve alliance motives towards value creation in the dynamic capabilities, which consequently improve alliance competitive performance. This research is one of the few researches explores how knowledge sharing drives strategic alliances practices that contribute to competitive performance of the UAE healthcare institutions.

اونيورسيتي تيكنيكل مليسيا ملاك

UNIVERSITI TEKNIKAL MALAYSIA MELAKA

MOTIF PERIKATAN KE ARAH KEUPAYAAN DINAMIK DAN DAYA SAING ORGANISASI PENJAGAAN KESIHATAN

ABSTRAK

Pakatan strategik semakin mendapat perhatian dalam penyediaan perkhidmatan penjagaan kesihatan. Walau bagaimanapun, terdapat kekurangan pemahaman tentang motif pakatan dalam kalangan institusi penjagaan kesihatan dan bagaimana ia mempengaruhi beberapa aspek keupayaan dinamik dan daya saing organisasi penjagaan kesihatan. Matlamat kajian ini adalah untuk mengenal pasti motif pakatan dan mengkaji secara kritis bagaimana ia memacu daya saing organisasi penjagaan kesihatan UAE. Berdasarkan konteks dalam sektor penjagaan kesihatan UAE, kajian ini menggunakan reka bentuk penyelidikan kaedah campuran, yang melibatkan dua fasa. Pada fasa pertama, kaedah penyelidikan kualitatif yang didorong telah dijalankan untuk mengenal pasti dan menerangkan motif pakatan dan keupayaan dinamik organisasi penjagaan kesihatan. Untuk tujuan ini, temu bual separa berstruktur dengan 25 pemimpin projek perikatan yang terletak di organisasi penjagaan kesihatan Abu Dhabi dan Dubai telah dijalankan. Dalam fasa kedua, kaedah kuantitatif menggunakan tinjauan telah dijalankan untuk mengkaji hubungan antara motif pakatan, keupayaan dinamik berasaskan nilai dan daya saing institusi penjagaan kesihatan. Sampel 279 pekerja institusi penjagaan kesihatan menjawab soal selidik tinjauan dan data dianalisis menggunakan Amos. Dapatan itu mendedahkan bahawa motif pakatan yang didorong oleh ekonomi kos transaksi, hubungan industri dan kecekapan rakan kongsi adalah faktor penting untuk pembangunan keupayaan dinamik penjagaan kesihatan, terutamanya dalam keupayaan penyelarasan, penyepaduan dan konfigurasi semula, yang mempengaruhi daya saing institusi penjagaan kesihatan. Penyelidikan ini menyediakan model integratif yang menerangkan cara menambah baik motif pakatan ke arah penciptaan nilai dalam keupayaan dinamik, yang seterusnya meningkatkan prestasi daya saing pakatan. Penyelidikan ini adalah salah satu daripada beberapa penyelidikan yang meneroka bagaimana perkongsian pengetahuan mendorong amalan pakatan strategik yang menyumbang kepada prestasi kompetitif institusi penjagaan kesihatan UAE.

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LIST OF SYMBOLS

R^2	-	Coefficient of Determination
f^2	-	Effect Size



LIST OF ABBREVIATIONS

DHA	-	Dubai Health Authority
DOH	-	Department of Health – Abu Dhabi
MOHAP	-	Ministry of Health and Prevention
SEHA	-	The Abu Dhabi Health Services Company
SA	-	Strategic Alliance
TCE	-	Transaction Cost Economics
RBV	-	Resource-Based View
CBV	-	Competence-Based View
DC	-	Dynamic Capabilities
IC	-	Integration Capabilities
VRIO	-	Value, Rare, Inimitable, Organisation
NGOs	-	Non-Governmental Organizations
GTM	-	Grounded Theory Method
ML	-	Maximum Likelihood
CMV	-	Common Method Variance



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LIST OF PUBLICATIONS

The followings are the list of publications related to the work on this thesis:

1. Alkaabi, K. M., Al-Shami, S. A., Rafeea, S. J., and Adil, H., 2021. Causes Of Strategic Alliance Failure Among Healthcare Partners: The Role Of Knowledge Sharing In Alliance Performance-A Review Paper. *Journal Of Legal, Ethical And Regulatory Issues*, 24, pp.1-10.
2. Salama Jamal, Samer Ali Al-Shami, Khaled Mohammed Alkaabi, and Nurulizwa Rashid, 2021. "Healthcare Industry Challenges And Potential Opportunities In The Uae. A Review Paper." *Academy Of Strategic Management Journal*, 20, pp. 1-9.



CHAPTER 1

INTRODUCTION

1.1 Background of the Study

Prior to further elaboration on the need for achieving competitiveness in healthcare strategic alliance, it is important to mention that general evidence indicates that over 50% of all alliances fail to achieve the purpose of the alliances (Tjemkes, Vos, and Burgers, 2017; Rajan, Dhir, and Sushil, 2020). A number of reasons have been cited; however, the fundamental concern is that the alliance motives are often different and the achievement of common grounds benefiting to all parties is difficult to attain. It is often difficult to measure the contribution of parties, whilst other parties act as free riders either due to perceived importance over counterparts (Bhatti, 2011; Choi, 2020). Other factors including differences in culture, management values, markets and the lack of clear coordinating mechanisms threaten the success of alliances.

A critical combination of the internal and external environments covering the common and opposing interests at the same time is essential to properly conceptualise this area. In the UAE, strategic alliances are equally new to the healthcare systems and the government has re-emphasized the need to strengthen competition through international alliances between entities within the UAE and other overseas corporations. The trend towards consolidation in the healthcare sector of the UAE has been highlighted in several report forecasts (Gooch, 2016; Kyongpitzer, 2019a; Kyongpitzer, 2019b).

Pursuing this study within the context of the UAE healthcare sector is in the right direction to establish evidence within a context that is still maturing, has proven rather resourceful economically, and is becoming heavily reliant on imported competencies and

international partnerships (U.S – UAE Business Council, 2018). Existing alliances between the local and other international parties have often been considered marginal, invaluable, and cosmetic. They often lack cooperation and experience serious administrative challenges, mainly due to the lack of consensus on how each of the alliance parties will achieve their respective motives with the contribution of the other parties.

1.1.1 Overview of the UAE Healthcare Sector and Policy Structures

As healthcare expenditure continues to expand, it is not unusual that the United Arab Emirates (UAE) and other global economic regions are faced with one or more of challenging situations including the maturing and rising populations, the pervasiveness of chronic diseases, market growth, infrastructure enhancements, and progresses in treatment technologies (Morris et al., 2015). As these factors support growth in the healthcare sector, the UAE has faced its own share of unique challenges including over 30% and 20% of the adults being obese or diabetic respectively (U.S. International Trade Administration, 2018).

The UAE government's focus has been directed at developing a healthcare industry to cater for the growing demand. The formation of alliance healthcare is therefore among some of the most significant objectives of the government of the UAE and, as a result, the sector has witnessed advancement and considerable progress in the past four decades (Koornneef et al., 2017). This has remained evident since the early 2000s; the UAE has been keen on developing the health system (Koornneef et al., 2017). As shown in Figure 1.1, building a competitive healthcare sector is paramount to the very achievement of the UAE Vision 2021 Policy Actions on World Class Healthcare (Patel et al., 2013; UAE Government, 2019).

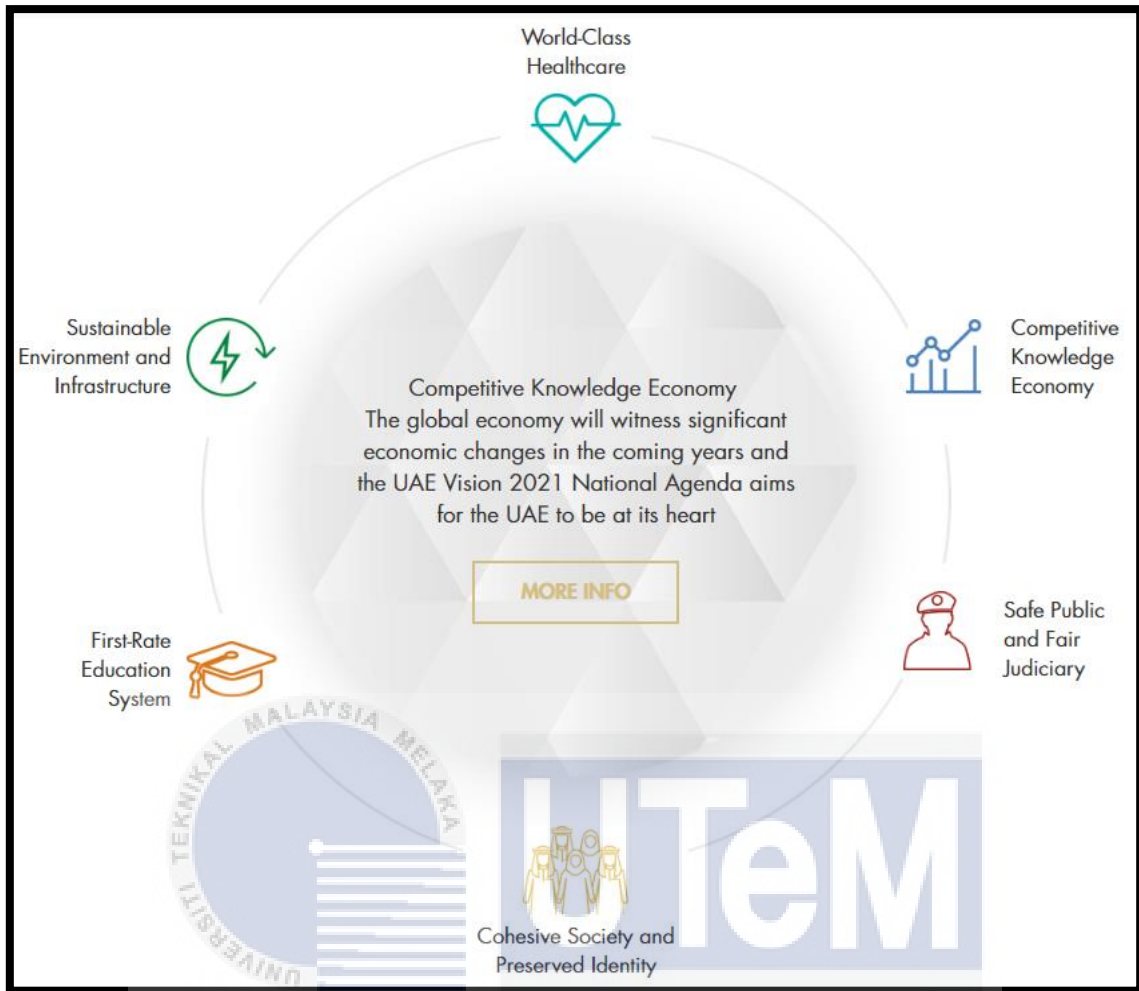


Figure 1.1: UAE Vision 2021 Sectors Source: The UAE Government Report 2019

According to BMI (2018) the UAE healthcare industry is well-established and has an active interplay of public and private investments infused to sustain expenditure over the next decades. These investments support the sector and place it as attractive, with developing opportunities in the areas of medical tourism, international healthcare partnerships and the intrusion of foreign drug makers. In an attempt to meet the rising demand, and to ensure that private healthcare organisations earn their fair share of the expanding demand due to high expatriates and tourist influx, mandatory healthcare insurance, and careful cuts in drug spending have been witnessed in the face of staggering oil and gas economy. The current growth and expected forecast of UAE are presented in Figure 1.2 below.

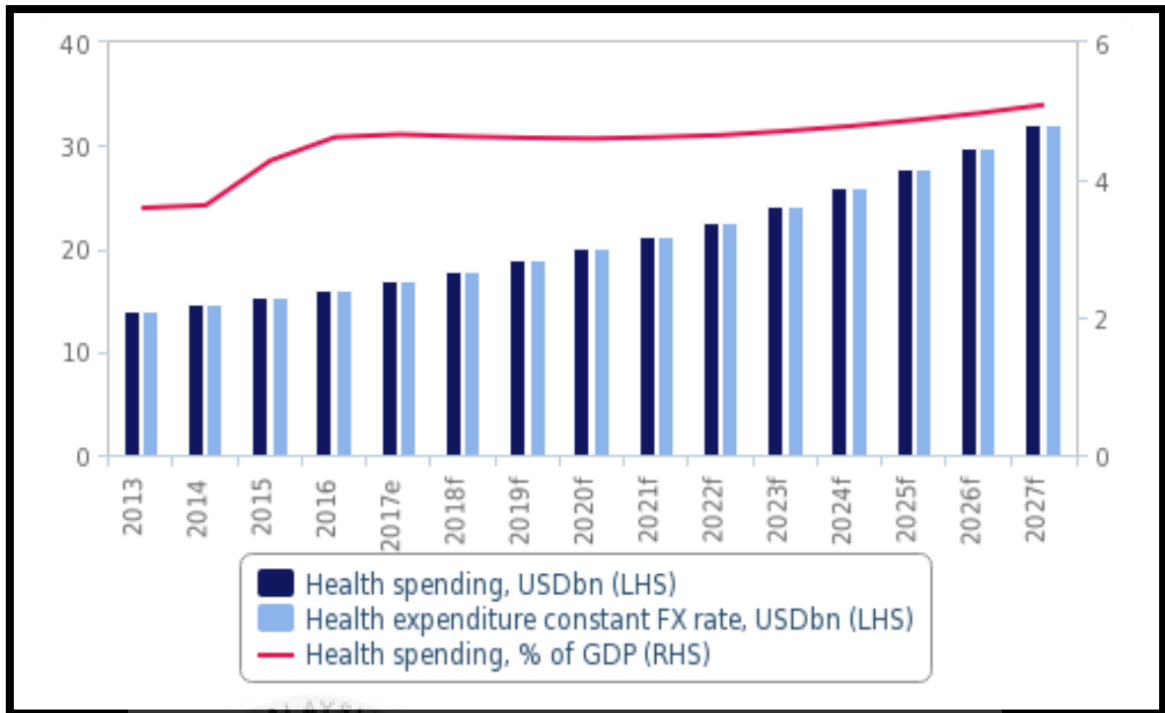


Figure 1.2: Healthcare Market Forecast 2013- 2027 Source: Ministry of Health UAE

Based on Figure 1.2, the current healthcare spending is about USD 20 and forms about 5% of the annual GDP of the UAE. The government is expected to maintain the proportion of investment into this area by reducing government contribution and encouraging private investment to retain this percentage of GDP. The UAE healthcare sector is increasingly becoming integrated with parties and forces external to the UAE. In 2018, Dutch healthcare authority expressed interest to collaborate with the UAE to develop healthcare solutions mainly focused on resolving some of the chronic diseases that have remained rather problematic to the UAE. Other whole government collaboration and partnerships have been received from Korean Healthcare. The government is increasingly committed to national healthcare, to reduce the overall prevalence of chronic diseases, and ensure overall growth and stability by contributing up to 72% of the healthcare expenditure in 2014.

1.2 Problem Statement

Developing the competitiveness of health institutions is one of the most important goals that the UAE government seeks to achieve. This is because the development of health institutions will reduce the cost of health spending abroad, since most of the UAE citizens prefer to travel abroad for treatment, especially in Germany (Alnakhi et al., 2019). In addition, the development of healthcare competitiveness will not only cover local needs, but also become a destination for health tourism, especially in the Middle East Region. Therefore, driven by Vision 2030, the UAE is aspiring to create one of the best healthcare systems in the world by the nation's (Kim and Hyun, 2022). To faster the attainment of Vision 2030, the UAE introduced Tourism, Regional Development, and Public Policy with aiming to maximize the tourism portfolio through diversifying tourism products and at the heart of them is healthcare services (Kim and Hyun, 2022). Therefore, the UAE government allocated 4.65% of the government budget for the healthcare expenditure with about 1% growth over the last decade (BMI, 2018). Despite these major efforts, the UAE healthcare institutions still lack of dynamic capabilities and competitiveness (Alrahbi, Khan, Gupta, Modgil, and Chiappetta Jabbour, 2022).

Strategic alliance has been recognized as an effective strategy to bridge the gap of shorten capabilities, especially in the developing countries (Babu et al., 2020). Therefore, the UAE government adopted strategic alliance to improve the internal dynamic capabilities and healthcare competitiveness. Strategic alliances between the UAE and international firms have witnessed unique approaches with the foreign firm usually providing the reputation of credible experts, and the local intuition providing financial returns to leverage these intangible assets. One such popular alliance is the UAE Telemedicine Centre; an alliance between the UAE Mubadala Group and Switzerland's renowned Telemedicine. This alliance centres around the health services known as Medgate, where Telemedicine is employed to

develop high-quality medical advice through dedicated telephone numbers round the clock (Gohari and Alabdulrazak, 2012).

In another alliance between the UAE's Mubadala Investment Company, Imperial College London Diabetes Centre and others partners such as the US Based Cleveland Clinic Foundation, UK, and Swaziland was formed as an outcome of this alliance.

Through this alliance, healthcare hospitals and centres in the UAE are able to offer unparalleled specialised care not only to clients within the UAE but serving the entire GCC and playing an instrumental role in healthcare tourism (U.S – UAE Business Council, 2018).

Whilst other academic partnerships continue to ensue between academic institutions, and some of these alliances including Cleveland Clinic Abu Dhabi (Mirza el, 2018), one other alliance that has gained popularity in the UAE include that between the very well-known Mayo Clinic and the Houston Methodist Global Health Care Services in an independent partnership agreement. The Houston Methodist Global Health Care Services was first launched by the Dubai-based holding company Meraas.

Despite the development of the alliance's strategy in the health sector, the desired benefit is still limited within the framework of information and expertise cooperation or within alliance the time and type of alliance project rather than developing local partner capabilities and expertise. This however forms a challenge to the UAE healthcare system where about 90% of healthcare expertise and workers are expatriates (Paulo, Loney, and Lapão, 2019).

According to Donbesuur, Zahoor, and Adomako (2021) the success of strategic alliance performance is highly dependent on its dynamic capability in creating value. Therefore, (Klus, Lohwasser, Holotiuk, and Moormann, 2019), argue that it is important to take both partner's motives into account to understand the occurrence and character of alliances. Benefits that one alliance partner can offer the other include "skills, competencies,

capabilities, and knowledge” (Nielsen, 2003), but these can only be fully captured when partners are carefully selected and both sides’ motives are well understood (Yang, 2020). In pursuant of partner’s individual motives, disagreements with set expectations must equally be observed in a similar manner as positive expectations (Toylan, Semerciöz, and Hassan, 2020). Some alliance parties understand very little that their expectations and motives have the propensity to change or evolve to higher needs over the course of the alliance (Drewniak and Karaszewski, 2020). These complexities create an environment which scholars have since struggle to gain a grip (Bhatti, 2011). As Ferreira, Coelho, and Moutinho (2021) observe, attention must be on “mutually compatible strategic interests regardless of the orientation”; thus, interests and motives which would not necessarily be the same or may consist of positive and negative elements, but nonetheless require alignment through capability.

The review of the research on strategic alliances in healthcare has revealed significant gaps as studies have mainly focused on the undefined nature of the motives of the healthcare alliances (Lewis, 2017). This lack of evidence is far from deliberate; the fundamental issue is that defining alliance motives has remained every eluding (Hübel, Weissbrod, and Schaltegger, 2022). In addition, the wide spectrum of motives shows that alliances are becoming an essential feature of companies’ overall organizational structure, and competitive advantage increasingly depends not only on a company’s internal capabilities. However, past studies have not paid enough attention to the conceptualisation of strategic alliance from its endogenous and exogenous perspectives to solve the challenge of defining alliance expectations and motives to improve alliance competitiveness. The alliance formation motives controlled by several factors such as types of alliances strategies and the scope of the relationships with other companies (Christie, Chahine, Curry, Cherlin, and Linnander, 2022). This however influence the gernalizeability of previous studies since they

have mainly focused on the undefined nature of the motives of the healthcare alliances (Lewis, 2017). Therefore, to bridge these gaps this research aims to come out with a model that explains what and how alliance motives can influence several aspects of alliance dynamic capabilities and competitiveness.

1.3 Research Questions

The main research question of the study is, “What is the appropriate model of strategic alliance motives towards healthcare value creation and competitiveness in the UAE? Specific research questions are categorized into two main areas pertaining to the two main phases of the study.

Phase I Research Questions explanatory

In this phase two main research questions are emerged. First, research question was formulated to identify the appropriate dimensions of alliance motives driven by the transactional cost, competence-based view, and industry relationship-based view.

Q1) what are the motives that drive strategic alliances for healthcare firms? To answer this question, the following sub-questions are emerged:-

Q1a. What economic (including financial and transactional) factors compelled alliance healthcare value creation and competitive?

Q1b. What competency-based factors compelled alliance healthcare value creation and competitive?

Q1c. What industry-relationship based factors compelled alliance healthcare value creation and competitive?

Second research question was formulated to identify the appropriate dimensions of dynamic capabilities among healthcare firms.

Q2) what are the dynamic capabilities that create value for healthcare firms?

Q2a. What reconfiguration capabilities are that create healthcare firms' value and competitiveness?

Q2b. What coordination capabilities are that create healthcare firms' value and competitiveness?

Q2b. What integration capabilities are that create healthcare firms' value and competitiveness?

The phenomenon of alliance motives and dynamic capabilities in healthcare strategic alliance will be explored in qualitative research using the multi-case studies strategy. The observed themes of alliance motives and dynamic capabilities within this phenomenon will be empirically developed using the qualitative research strategy to theorize the partners' motives. As a starting point of this Phase of the study, the study relies heavily on the competence-based view, transactional cost, industry relationship-based view and dynamic capabilities view to within strategic alliances.

Phase II Research Questions – Quantitative

In this phase one main questions were formulated, which is what is the appropriate model of alliance motives and dynamic capabilities that influence competitiveness of healthcare firms?

Q3) How does dynamic capabilities influence the relationship between motives and value creation and competitiveness of strategic alliance?

Q4) what is the appropriate model of alliance motives towards healthcare dynamic capabilities and competitiveness in UAE?

The second phase of the study, quantitative research will be built on the findings in the first phase of the study. This quantitative research design will ensure that the findings of the first phase of the study are put to proper empirical validation in an objective, statistical and replicable manner. The second phase is also necessary to encapsulate the entirety of

theoretical perspectives that are considered relevant to strategic alliance within the healthcare context. Even though the first phase of the study will focus on the smaller sample population of healthcare networks alliances due to its inductive nature, the second phase will focus on the larger population of healthcare professionals within the sector.

1.4 Research Objectives

1.4.1 Aim of the Study

The aim of the study is, to come out with strategic alliances model towards competitiveness among the UAE healthcare organizations.

1.4.2 Objectives of the Study

The objectives of the study are presented below. The first four objectives focus on the:

1. To identify alliance motives among healthcare organizations [RQ1].
2. To identify alliance dynamic capabilities through strategic alliances among healthcare organizations [RQ2].
3. To examine the relationship between alliance motives, value-based dynamic capabilities, and strategic competitiveness of strategic alliances within the UAE healthcare sector [RQ3].
4. To validate the appropriate model of strategic alliance towards healthcare competitiveness in UAE [RQ4].

Table 1.1 presents the mapping between the research objectives, research questions and other important aspects of the research methodology.

Table 1.1: Objectives, Questions, and Methodology Interconnections

Objective	Research Questions	Method Design n (strategy)	Source of Data (sample)	Analysis
1. To identify alliance motives among healthcare organizations [RQ1].	Q1) What are the motives that drive strategic alliances for healthcare firms?	Phase I: <u>Explanatory</u> Fieldwork 1: Qualitative multi-case studies research design	<u>Multiple case Studies</u> Sample n1 = 25-30 (Alliance project leaders)	Three steps, which are data reduction; data display; and drawing conclusions.
2. To identify alliance dynamic capabilities through strategic alliances among healthcare organizations [RQ2].	Q2) what are the dynamic capabilities that create value for healthcare firms?			
3. To examine the relationship between alliance motives, value-based dynamic capabilities, and strategic competitiveness of strategic alliances within the UAE healthcare sector [RQ3].	Q3) How does dynamic capabilities influence the relationship between motives and value creation and competitiveness of strategic alliance ?	Phase II: <u>Conclusive</u> Fieldwork 2: Quantitative (survey)	<u>Hospitals (Managers)</u> Sample n2 = 279	AMOS
4. To validate the appropriate model of strategic alliance towards healthcare competitiveness in UAE [RQ4]	4). What is the appropriate model of alliance motives towards healthcare dynamic capabilities and competitiveness in UAE?			

1.5 Significance of the Research

This thesis is expected to contribute to the existing body of literature and knowledge about strategic partnerships in a number of ways. As highlighted by Pelletier et al. (2014) argued that a versatile and mixed research method is essential to observe all the endogenous and exogenous factors that influence “inter-hospital alliances”.

The present study considers the endogenous and exogenous factors to inter-hospital alliances in a mixed sequential mixed methodology to unravel the role of alliance motives in strategic alliance competitiveness.

This is not only essential to the closure of the research gap but will help amass tremendous insight into the conceptualization of strategic alliance and alliance motives within the healthcare sector. Exploring alliance motives of strategic alliance motives will be of tremendous contribution to existing elusive nature of insight on strategic alliance meeting of alliance expectations. The lack of models and empirical insight to explain the motives behind strategic alliances have been registered in the surrounding literature and confirmed in the practice of healthcare alliances. Even though the trend of single hospitals is fading away gradually, giving room to networks of hospitals.

It is important to acknowledge that while hospitals and healthcare facilities have their own agenda in the event of alliances; they also share a common agenda which usually drive them to collaborate and cooperate to achieve these outcomes. However, the improper integration and coordination of alliance motives often inhibit strategic alliances from achieving the collective purpose of the alliance which have a higher implication on the role of the alliance within the industry. The research model of the study will, therefore, help model how partners can improve alliance dynamic capability and competitiveness through alliance motives.

The present study will contribute to the theory of strategic alliances within the domain of healthcare services. This insight will remain critical to the building and establishment of how strategic alliances can be used to add value to the U.A.E.'s healthcare sector. The current scenario of the U.A.E. demands innovation through new idea development, entrepreneurship, organisational structural adjustments, and partnerships to increase its value and overall efficiency (Dosi, 2000).

The present study seeks to enhance the understanding of alliances formed by healthcare organisations within the healthcare sector or with other business outside the sector since the knowledge can be transferred from the healthcare sector and applied to other domains. The study seeks to appeal to both students and professionals in the UAE economic sectors.

1.6 Scope of Research

Strategic alliances between healthcare institutions in the UAE have assumed varied formats. Whereas the distinction between strategic alliances, joint ventures, and mergers and acquisitions (MandA) have remained a subject of criticism (Inkpen and Dinur, 1998), Barringer and Harrison (2000) categorised strategic alliances into three main forms, which are contractual alliance, joint venture and consortia alliance. Considering this scope, it may be argued that other forms of strategic alliances are exempted from the present study; nonetheless, Barringer and Harrison (2000) argue that these alliance formats remain the dominant forms across sectors. Building on these alliance typologies is again essential to encapsulate the key forms of alliances that occur within the UAE healthcare sector. According to BMI (2018) healthcare alliances in the UAE often assume one of these three formats, and other special forms of partnerships. It must also be mentioned that even though a clear scope or headcount of healthcare strategic alliances in the region is not accessible, leading or landmark alliances within the region have been published in numerous news sources and whitepapers including BMI (2018). Key reference was made to these alliances as part of the present study.

1.7 Key Terms

Key terms and concepts within the context of the study are presented in Table 1.2. Even though multiple definitions exist to any of these concepts, these definitions are

carefully selected to enable the achievement of the study aim and optimize the contribution of the literature to the study.

Table 1.2: Definition of Key Terms

Terms	Definition
Strategic Alliance	A term used interchangeably with other terms such as partnerships, collaborations. According to Carnwell and Carson (2008) the term has rendered different meanings in healthcare service provision. In this research joint venture is the type of alliance strategy.
Alliance Motives Transaction Cost (TCE) Economics	Partners are driven into an alliance mainly for the purpose of efficiency and cost minimization. It also entails alliances recognizing the role of the partner motives, nature of investment and nature of the transaction (Williamson, 1991).
Alliance Motives Competence-Based View (CBV)	Alliances with focus on the competence of one or more partners as instrumental to the alliance. The competence-based view (CBV) to strategic alliances argues that institutions may come together to share some form of competence and expertise in their independent fields (Helfat and Peteraf, 2003).
Alliance Motives Industry Relationship-Based View	Alliances formed with partner motives focused on industry positions. The key strategic considerations for firms include structural holes and weaknesses that affect the profitability of the individual firms within the industry (Kuznetsova, 2016).
Dynamic Capabilities	Teece et al. (1997) defined DC as: “A firm’s strategic ability to combine inside and outside competencies to address volatile environments and periods of rapid change” (Teece et al., 1997).
Integration Capabilities	A value creation dynamic capability that entails networking of interactions and establishment of knowledge logic through shared knowledge or learning activities (Okhuysen and Eisenhardt, 2002). Companies differ in integration capability – the ability to absorb and manage business resources on a continuing basis (Jemison and Sitkin, 1986)
Coordination Capabilities	To gain a competitive edge, coordination is important to harness and merge the activities, task, and resources related to the operational capabilities (Iansiti and Clark, 1994; Helfat and Peteraf, 2003). In the alliance, the coordination ability is explained as the ability to orchestrate and deploy tasks, resources, and activities in the new operational capabilities specific to the needs of the alliance (Helfat and Peteraf, 2003).
Firms competitiveness	The ultimate outcome of a strategic alliance for the alliance to perform better than existing industry competitors due to the more effective application of resources of the possession of resources or capabilities unknown to the competition (Tjemkes, Vos, and Burgers, 2017). Competitive is only realized when a firm is able to implement successfully value creation strategy (Hitt et al., 2000).

1.8 Thesis Organization

The remaining part of this thesis will be organised into 5 chapters. An overview of these chapters is presented in Table 1.3 below.

Table 1.3: Overview of Thesis Chapters

Chapter	Overview
Chapter one- Introduction	Introduction. This chapter presents the background of the study, research problems, objectives, scopes, contributions and significance of the research.
Chapter two - Literature Review	The second chapter establishes the theoretical background guiding this study. As part of this chapter, the concept of strategic alliances in the healthcare sector is evaluated. The theories are then linked to the concept of strategic alliances to provide new insights on how healthcare alliances exist within the context of the U.A.E.
Chapter three – research methodology	Chapter three covers the research methodology of the study. As already indicated, a mixed methodology (qualitative and quantitative) has been adopted for this study. The chapter covers in detail why the mixed methodology is considered the most appropriate for this study as well as benefits realised.
Chapter Four – Results	Chapter four presents the qualitative and qualitative results of Phase I. The multi-case studies analytical approach was used together with some narratives to help present the interview data. Quantitative data is obtained from key respondents within the UAE healthcare sector. Amos results are reported
Chapter Five- discussion of result and conclusion	This chapter discusses the integration of quantitative and qualitative methods in line with the available literature on the area of study. The chapter will help observe the empirical findings through the lenses of the available literature on the area. A case study of a healthcare network is discussed in light of the findings to help understand how the findings support a real case application. The theoretical and practical implications of findings within the context of the study are as well be discussed. Presents the conclusions and recommendations of the study.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

This chapter presents a review of theories and recent literature in support of the study. The chapter is separated into four main aspects. The first section considers a review of the underlying themes and context of the study. These include the concept of strategic alliances, healthcare service quality among other key themes that inform the main research gaps. The second section elaborates on the theoretical scope of the study; key theories discussed here include the resource-based view, competence-based view, organizational learning theory, transactional cost and industrial organization. The next section presents the conceptual framework and embedded relationships that support the research questions. The last major section presents an empirical review of literature. A critical discussion of the main research gaps and other issues within the scope of the study are presented. Following this section conclusion to the literature review is presented and the next chapter is introduced.

2.2 Review of main themes and context of the study

Important themes applicable to the study are reviewed in this section of the thesis to help arrive at the fundamental research gap.

2.2.1 The Concept of Strategic Alliances

Different definitions have been offered to explain the concept of alliances within the domain of healthcare; however, conceptual confusion still exists (Taylor and Le Riche, 2006; Carnwell and Carson, 2008; Robson, Katsikeas, Schlegelmilch, and Pramböck, 2019).

More often, the term strategic alliance is used interchangeably with other terms like collaboration, partnerships, joint venture among others as originally specified in the context of the study in Table 2.1 to encompass three main alliance formats including contractual Alliance, joint venture and consortia alliance, as originally adapted from Barringer and Harrison (2000). With no attempt to delve deeper into the definitions offered by the concept of the years, it is important to mention that the present study builds on the definition of alliances offered by Tjemkes et al. (2012) and presented as part of the list of definitions in the earlier chapter of this thesis.

Table 2.1: Strategic Alliances Typologies as considered for present study

Form of Inter-organizational Alliance	Description	Reference Studies
Contractual Alliance	Loose agreements between alliance partners. The partners have an exchange of value but with little commitment or no form of ownership involvement.	Doz and Hamel (1998); Saxton (1997)
Joint Venture	A contractual agreement between parties where parts of the involved ventures are brought together to create a new entity separate in terms of structure and ownership.	Inkpen and Crossan (1995); Garcia-Canal (1996)
Consortia Alliance	Beyond the joint venture created from existing partners, the partners also come together to share technology, RandD and other problem-solving platforms together.	Aldrich and Sasaki (1995); Child and Faulkner (1998).

Tjemkes et al. (2017) definition of strategic alliance originally builds on Gulati (1995) and Ariño et al. (2001). This definition supports the assertion that alliances prior to collaboration or partnership are autonomous and independent. Even though they may not be in the same industry, they must be able to achieve mutual and individual objectives.

This assertion plays a central role in the present investigation as partners must be able to reflect inward on their internal motives and pursue the common agenda of the alliance (Marhold and Kang, 2017). This insight is critical for the present study and efforts made to conceptualize the area of the study.

Prior to other discussions, it is also important to highlight that the lack of a clear consensus regarding the definition of alliances has resulted in disagreement on what partnership or collaboration formats may be classified under the term. An instance is that the present study considers the three main forms of alliances as originally categorized by Barringer and Harrison (2000); Tjemkes et al. (2017) considers that strategic alliances entail a much larger set of alliance formats including co-makerships, co-creation efforts, multi-partner alliances, public-private partnerships and consortia. They also argue that strategic alliance excludes traditional market transactions, and mergers and acquisition. Other studies including Bhatti (2011) on the discussion of knowledge sharing need of alliances have extended the definition of alliances to cover a continuum which includes mergers and acquisitions.

Regardless of the definition and categorization of alliances, one of the most important type of strategic alliances is joint ventures (JVs), which is the central focus of this research. Joint ventures commonly refer to the firms that are autonomously cooperating with each other to achieve some mutual goals (Shi, Sun, Pinkham, and Peng, 2014). Due to the significant advantage of the successful joint venture, they become increasingly prominent, especially to encounter the challenges in globalisation of business and competition (Howell, 2018).

JVs is one of the favourable entrances to international market. It can be described as a participation or collaboration of a separate legal organisational entity, at least two partners that are geographically, economically, and legally independent of each other (Meschi and

Roger, 1994; Yan and Luo, 2016). A large number of multinational and transnational companies employ the IJV as a proxy for entering and penetrating new markets in the emerging countries (Beamish, 2013; Koch and Koch, 2018; Kogut, 1988). JVs have gained popularity as institutional systems selected by the less advanced countries to attract foreign direct investment (Khan et al., 2015). Through alliance with the international venture, knowledge can be transformed. In addition, as a new entity, it is expected to bring additional advantages to hosted countries, such as creation of job opportunities as well as inflow of foreign currencies (Carrillo, 1996). JVs between two or more corporations have many advantages of additional resources and knowledge, as well as minimizing investment risk through capital sharing.

Notwithstanding all the benefits that JVs intend to bring to partner corporations, JV participation might experience unanticipated and unwelcome states and events for companies in an alliance (Chattopadhyay and Bhawsar, 2016; Zineldin and Bredenl w, 2003) and lack of competitiveness (Liow, 2016). In addition, past studies have extensively discussed the terms of JVs in industrial collaboration, yet an important industry such as healthcare has yet to receive adequate attention, especially in the developing countries (van der Kamp, Tjemkes, Duplat, and Jehn, 2022).

2.2.2 Nature and Development Stages of Strategic Alliances

The strategic alliance development stages have been discussed from varied perspectives; one popular model of strategic alliance development stages is presented in Figure 2.1 (Tjemkes et al. 2012). This model builds on earlier observations including Kanter (1994), Das and Teng (2002) Dyer et al. (2008). At each of these stages, particular activities may go into the alliance formation, with unique decision-making rationale and steps to consider.

Tjemkes et al. (2012) argue that the development stages are more of a cycle and not a one-off process event. The cyclical approach indicates that an old alliance may move from termination to re-negotiation, design and management as a new alliance.

The alliance process may not necessarily commence from stage one, as indicated by the presence of broken lines. Stage one and two may be general industry knowledge that does not require thorough consideration; however, stage three, four, five and six follows concurrently as presented with solid lines (Figure 2.1). Skipping any one of these mandatory stages may have negative repercussions to strategic alliances. In addition, it is important to add that the alliances may not necessarily have a point of termination as part of the agreement.

The alliance development stage has been simplified by others including Bhatti (2011) and Russo and Cesarani (2017) to include three main stages of alliance formation, operation and evaluation stages. The remaining discussion of the section is structured in line with the three-stage alliance development process. At the alliance formation stage, which basically covers the initial phase of the alliance's formation. The reasons must be carefully justified, and the selection of partner must be in the good interest in reaching the anticipated objectives.

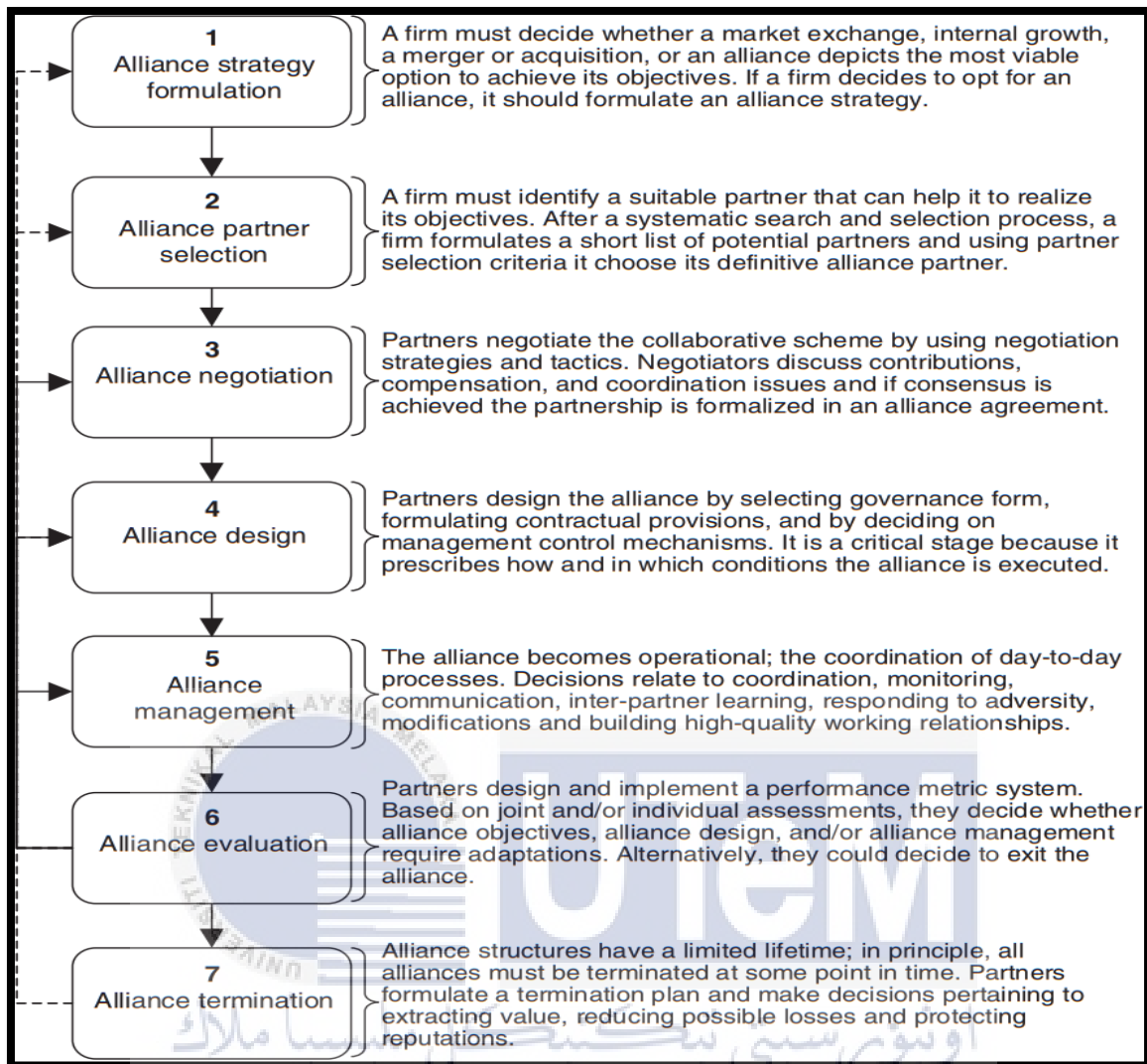


Figure 2.1: Alliance Development Stages by Tjemkes et al. (2012)

Das and Teng (2003) argue that at the formation stage, partner selection and governance specification is fundamental for overall success. The selection of the right partner entails careful matching of resources between partners in terms of resources, goals and strategies (Wang, Nguyen, Le, and Hsueh, 2018). Considered in the seven-stages of alliance lifecycle, firms have to look for a certain degree of fit between partners throughout the alliance development process in a proactive approach (Russo and Cesarani, 2017). In aligning a partner, complementary, congruence and compatibility is critical (Child et al., 2005).

Whereas complementary refers to the very concept of strategic fit, congruence refers to the partner goals and objectives alignment by defining clear and comparable goals (Belgraver and Verwaal, 2018). Finally, partner compatibility represents the overall cultural and organisational fit. Organizational culture is popularly defined as the way things are done in any organisation; strategic alliance implies that the aliened parties do things together in a coherent manner that complements each other's efforts (Hietajärvi and Aaltonen, 2018). Organisational fit, on the other hand, implies that businesses make individual adjustments to accommodate the other partner (Park and Ungson, 1997).

Proper alliance formation behaviour drastically reduces opportunistic behaviour and partners are at liberty to select the format of the corporation they wish to undertake (Kale and Singh, 2009; Russo and Cesarani, 2017). More involved formats such as equity are recommended in cases where the risk of opportunistic behaviour and uncertainty is high (Russo and Cesarani, 2017). On the other hand, contractual provisions are enough in cases where the partners want to define mutual rights, specific contribution and carefully calculated exchanges on how potential conflicts are solved (Kale and Singh, 2009; Bouncken, Fredrich, Ritala, and Kraus, 2020).

Following the formation stage, the operational phase is the phase in which alliance vision is translated in economic reality (Das and Teng, 2003; Al-Tabbaa, Leach, and Khan, 2019). This represents a crossroad where engagement is very high, and conflicts are bound to arise. Partners are forced to take important decisions related to coordination and monitoring of the alliance activities as well as the management of communication. Learning is critical to the operations of the alliances as partners need to share knowledge between themselves to ensure that there are trust, control communication and resolution of conflicts (Varma et al., 2015; Toylan et al., 2020).

Through high-level coordination, partners are able to sustain and ensure overall alliance success. Trust, commitment and strong cooperation are equally critical (Varma et al., 2015; Ali and Khalid, 2017).

It is important that the alliance parties are committed to the alliance and demonstrate readiness to build social capital while promoting a sense of belongingness among partners. If partners feel strong belongingness to the alliance, opportunistic behaviour will be reduced, and partners would not seek to gain an unfair advantage on others (Gulati, 1995). Partners must also set control measures, rules and mechanism throughout the alliance operations (Yang et al., 2011; Yu, Xu, and Dong, 2019). Conflicts are at the peak of occurrence during this period; Khanna et al. (1998) observe that the strategic alliance conflicts arise in three main areas of organisational, managerial and cultural differences among partners.

From another perspective, a difference may exist in terms of the perceptions of partners within the alliance; some partners may feel cheated, but this may only be perceived and not be applicable in reality. The contributions and returns may lead partners to remain committed for all the period; for this reason, frequent communication and interaction to understand the feelings and perceptions of the various partners is critical to achieving a win-win situation (Russo and Cesarani, 2017).

At the final stage of the alliance formation, alliance evaluation represents the point where the alliance matures and realises its full potential including anticipated benefits among themselves and as a whole (Drewniak and Karaszewski, 2020). At this point in the lifecycle, performance can be evaluated, and the partnership exists in its strongest form. Tjemkes et al. (2013) argue that two main factors are of critical importance at this point; the evaluation of performance and whether further alliance development is necessary. In other words, if the alliance objective is achieved and there is no need for further partnership, the alliance may be brought to an end.

Performance evaluation is critical to permit a good understanding of the adaptation or termination required for the alliance future. It also helps evaluate the comic standing of the alliance relationship and whether the anticipated value or competitive performance has been obtained. Moreover, at this stage, it is important internal and external stakeholders of the alliance have to access the necessary information to perform individual evaluation and assessment of the alliance performance. Relational performance entails the comparison of parties' performance to ensure that all parties appreciate their degree of benefits within the partnership.

It is important to add that the alliance development process does not only show the change in the format and composition of an alliance, but it also demonstrates how the alliance evolved over time (Pereira et al., 2021). It indicates that the entire composition of an alliance may change through re-organization, termination or reinstitution. Partners may as well decide to extend, terminate or change the structure of the alliance (Tjemkes et al., 2013). It is also not unusual that one alliance party chooses to take over the incorporated business whilst the other allied party exists the partnership; in such case, the newly established alliance business continues to operate under full ownership of only one alliance party. Premature termination of alliances, however, implies that the objectives of the alliances have not been reached.

Nonetheless, a number of factors may induce premature termination. These factors may occur at any of the stages discussed from alliance formation, operations to evaluation. The expectations of the alliance may be misplaced, or the parties may not possess complementary resources as originally anticipated. It is also not new that parties to an alliance begin to demonstrate opportunistic behaviour, refusal to share knowledge, lack of genuine interest, or even a change in management who do not share the original enthusiasm that went into the creation of the alliance (Russo and Cesarani, 2017; Rajan et al., 2020).

Acquisition of one partner by the other is also one exist strategy that alliance parties could face at any stage of the strategic alliance whether or not the individual objectives or the pair/groups ambition has been met (Tjemkes et al., 2013).

2.2.3 Strategic Alliances in Healthcare Service Provision

After the discussion main themes that underlie the study, the time is right that some attention is directed at how the concepts have been applied within the context of healthcare-related literature; this is fundamental to arrive at contextual gaps which the present study aspires to contribute. Starting from the subject of strategic alliance in healthcare, it must be mentioned that the need for collaboration and strategic alliances in the healthcare industry is not new. A number of studies have tackled this area, and these include (Nyström, Karlton, Keller, and Andersson Gäre, 2018), observation on the concept of partnership and collaboration within the practice of health and social care. Healthcare alliance may be characterised by key attributes such as trust, confidence, teamwork, empathy and other unique principles essential to healthcare partnership and collaborations. The healthcare environment is knitted with a strong urge for a competitive edge. With this, strategic alliance, therefore, offers the chance to go beyond the comfort zones of the firm to reach into areas that redefine ways to meeting consumer taste and create product and service evolution (Van den Bosch et al., 1999; Sarcone and Kimmel, 2021).

In the healthcare sector, constant innovation and technology application is ongoing to make humans healthier and create a better earth for all humans. When technology or some aspect of the environment changes, the firm's products and existing technology capabilities become obsolete (Van den Bosch et al., 1999; Ren and Wang, 2019). There is a need for constant evolution and reconfiguration of assets to remain relevant within the healthcare industry (Moonesar, 2018).

The dynamic nature of the industry also necessitates that key capabilities are within reach to help create value within the technologically and competence is driven sector in efforts to overcome institutional uncertainties (Meira, Machado, and Gomes, 2019). In such an environment, the rate of change is unpredictable and forcefully adapted based on industry-leading trends such as technology and human resource competency requirements.

The reasons that force alliance in the healthcare industry may be similar to that discussed in the earlier sections even though close attention to specific cases is discussed in the later sections of this chapter. It must be mentioned at this point that even though a few studies have been conducted in healthcare alliance including Lewis (1990); Pelletier et al. (2014); McMonagle (2016); Browning et al. (2016); Wu, Wang, and Zhang (2021); Murphy and Wilson (2021) half of these papers are white papers and written in the form of industry reports with little to no empirical support.

McMonagle (2016) assert that strategic alliance in the healthcare is driven by a number of factors including increases negotiation power for insurer-provider contracting, price of healthcare and market power. Through alliances, companies are able to achieve cost savings, improved clinical integration, higher care quality and easier acquisition of advanced technology. It is important to add that strategic alliances may assume the form of alignment of intent, critical tasks, competences, structure control and rewards, leadership or culture (O'reilly, Tushman, 2004; Meadows, Angwin, Gomes, Child, 2020); this is particularly characteristic of the healthcare industry. Even though all areas of the alliance may not be considered compatible, some form of compatibility must be established for alliances to succeed (Gibson and Birkinshaw, 2004; He and Wong, 2004; Andriopoulos and Lewis, 2009). In global regions such as Australia, the Collaborative Framework is overseen by the North-Western Melbourne Government Initiative, the Royal Melbourne Hospital, the Meri Community Health Services, and cohealth; this collaboration is seen as a strategic path

outlining collaboration strategy over a period of 5 years from 2012 to 2017 and subsequently from 2016 to 2020 (Carter et al., 2012). In this strategic document, Carter et al. (2012) assert that the foundation principles of collaboration must be person-centred. Partners must have equal standing and responsibilities, joint learning, have the commitment to participate, possess positive working relationships, complement each other, ensure transparent while remaining independent and focusing on the set outcomes (Figure 2.4).

In addition to the collaboration principles, it is equally important that specific roles of partners are specified, a defined governance structure is installed, and a good market insight is established to guide the alliance. Others including Browning et al. (2016) focused on the unique areas of healthcare leadership key partnership areas peculiar to quality and companionate patient care through collaborative leadership; these principles include collaborative partner care team, resource stewardship, talent transformation, boundary spanning, capacity for complexity innovation and change, and finally engagement and well-being.

2.2.4 UAE Healthcare Sector

From the perspective of dynamic capability, the UAE healthcare sector may be seen from a unique perspective relevant to the present discussion. The development of UAE healthcare firms is part of the UAE healthcare is critical to the development of the sector, to address pertinent challenges and ensure that progress is made to address the regional deficits in healthcare. Knowledge exploitation is part of the government's original agenda as part of the government's Vision 2021 to achieve the SDG of the 2030 Agenda as health is one of the six national priorities of the UAE's Vision (Paulo, Loney, and Lapão, 2019). The Vision of the government to become a knowledge-based economy has key implications on recruitment in the healthcare sector (Alameri, Hamdy, Sims, 2021).

The government through the sector is bent on recruiting and developing world-class talents and pursue the highest level of professionalism and knowledge sharing in the healthcare sector.

According to Alameri et al. (2021) healthcare facilities in the region aspire to establish themselves as well-accepted and professional tertiary care centres with the introduction of new facilities and services originally unknown to the population. In both the private and public sectors, quick advancements continue to be made in the areas of neurosurgery, spine surgery, advanced minimally invasive surgery, cardiac interventions and even open-heart surgery (Al-Neyadi, Abdallah, Malik, 2018). These advancements are as a result of the shift in creating value via strategic alliance mainly with other healthcare facilities and hubs in South America and Europe (Fadol, Sandhu, 2013).

Research per se may be low in the UAE region; however, through alliance joint venture, they are able to adapt the latest technology and accepted procedures whilst employing highly qualified personnel to undertake these processes and impart knowledge. In another critical evaluation by WHO (2013) the UAE is explained to have unique health workforce challenges similar to neighbouring countries such as Bahrain, Kuwait, Saudi Arabia, Qatar and Oman. Whilst common regional challenges include areas of human resource governance, workforce production and the availability, accessibility and quality of healthcare remains key issues of concern (Table 2.3) is particularly characterised by a shortage of health workers, reliance on expatriate staff and limited professional productivity capacity.

Table 2.2: Health Workforce Challenges in the Eastern Mediterranean Region

Health Workforce Challenges in the EMR		
<p><u>Common challenges EMR member states</u></p> <ul style="list-style-type: none"> • Lack of comprehensive national health workforce strategies • Limited health workforce governance and leadership capacities • Suboptimal multi-stakeholder coordination for health workforce • The increasing involvement of non-state actors • Insufficient regulatory frameworks and capacities • Weak human resources for health management systems • The paucity of data and information on the health workforce 		
<p><u>Health workforce production</u></p> <ul style="list-style-type: none"> • Inadequate and/or imbalanced production capacity of health workers • Concerns around the quality and relevance of health professional's education • Availability, accessibility and quality • Overall health workforce shortages • Skill mix and geographical distribution imbalances • Quality and performance concerns • Dual practice • Health worker's safety and security • Inadequate capacity for emergency response 		
<p><u>Attrition</u> Health workers mobility (international and public to private)</p>		
<p><u>Group 1:</u> Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, United Arab Emirates</p> <ul style="list-style-type: none"> • Strong national health workers • High resilience • Limited production capacity • High turnover 	<p><u>Group 2:</u> Egypt, Iran, Iraq, Jordan, Lebanon, Libya, Morocco, Palestine, Syria, Tunisia</p> <ul style="list-style-type: none"> • Critical shortage of health workers • Low production capacities • Limited employment capacities • Geographic imbalances 	<p><u>Group 3:</u> Afghanistan, Djibouti, Pakistan, Somalia, Sudan, Yemen</p> <ul style="list-style-type: none"> • A critical shortage of health workers • Low production capacities • Limited employment capacities • Geographic imbalances

Source: WHO (2017).

These challenges are common in the UAE and other member countries in Group 1 (WHO, 2017). To employ the latest forms of healthcare innovation, Rahma et al. (2020) argue that the region has a high demand for professional expertise as this has picked up significantly in the last couple of years. The inflow of expertise and professionals is gradually positioning the UAE as an emerging leader in the drive for talent. The demand for professional and technical expertise has been specific and urgent, and this does not only apply to the UAE but exists across the region.

There has also been the search for professional leadership positions to drive the new desired corporate culture which relies extensively on knowledge, innovation and professionalism (WHO, 2017; BMI, 2018; U.S-UAE Business Council, 2018; Rafeea, Alshami, Alkaabi, 2021). It is also expected that the leaders of the new institutions have the qualities and skills to manage a diverse work base by working with people of different background; however, this leads to a high turnover rate as one of the main challenges present in the region (WHO, 2017).

The region is also being seen by professionals as the next destination to explore their careers. As mentioned by Bader (2013) medical professionals are increasingly considering UAE as their next career destination. The culture of the UAE and the diversity of the people add to reasons why practitioners consider this region as attractive; it appeals to practitioners who seek to experience different environments. Due to the unique nature of the industry, it is often used as a benchmark for other industries in terms of professionalism and standard of living of healthcare professionals. It is important to add that the UAE leads in the region in diverse areas of professional knowledge and healthcare initiatives. Van Weel et al. (2018) add that whenever knowledge is transferred into the region, specific consideration of the unique attributes of the region and regulations are taken into consideration to result in greater benefits to the system at large.

The sector, therefore, has to battle the talents demand whilst benefiting from the diversified workforce. Significant attempts continue to ensue in these areas to further intellectual property, which is a key driver in medium to long term commitment and highly dependent on the human capital inflow. The race for competitive advantage in healthcare is critically linked with the knowledge-based assets and the institutions within the sector are bent on closing these gaps through alliances to boost the overall competitiveness of the sector.

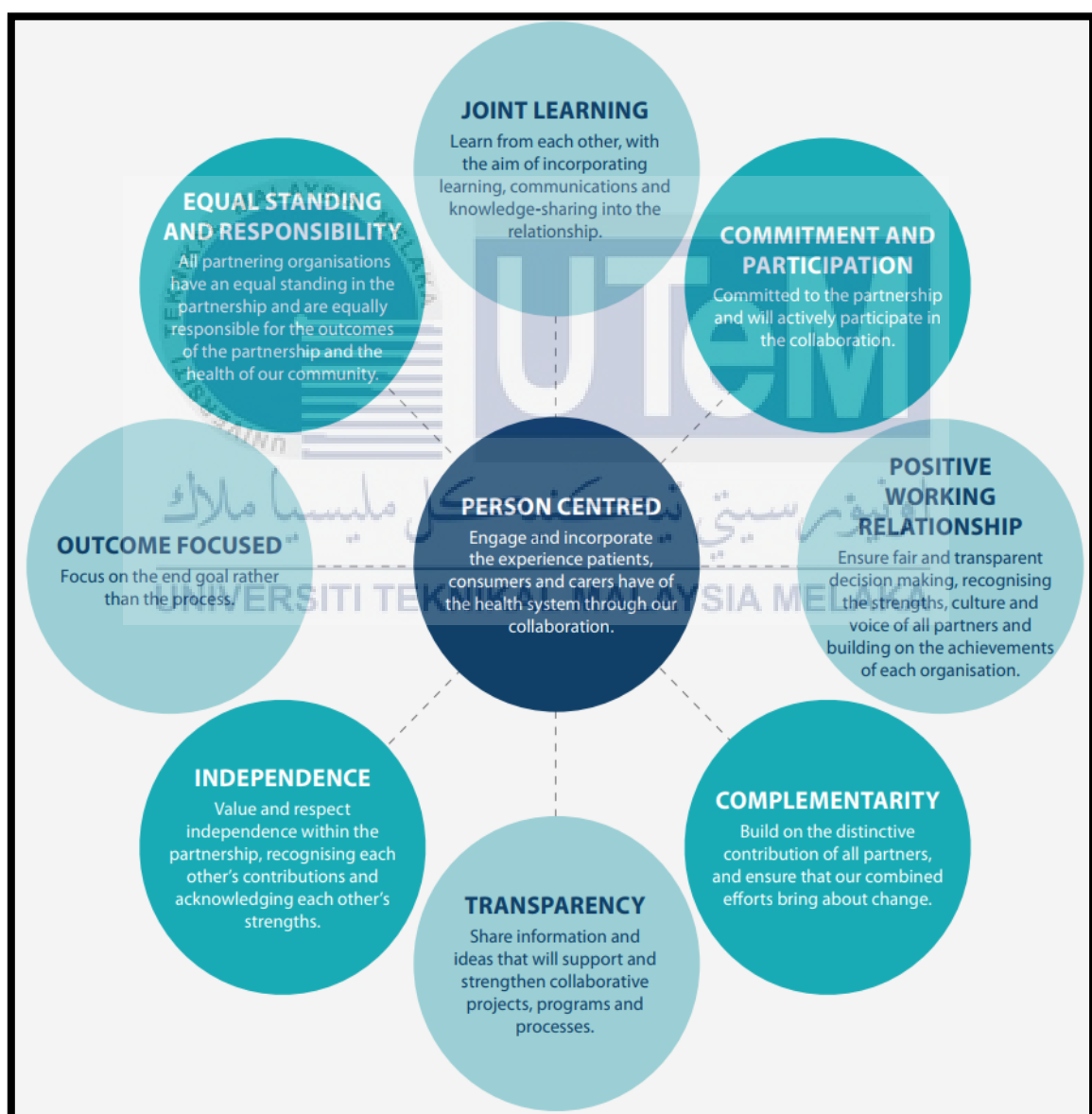


Figure 2.2: Foundation Collaboration Principles by Carter et al. (2012)

Aside from the consideration that neither Carter et al. (2012) Browning et al. (2016) have empirical support for their assertions, it is important to add that these principles are no near exhaustive with regards to the underlying principles of healthcare strategic alliance and collaboration.

2.2.5 Endogenous and Exogenous Components of Strategic Alliances

Competitiveness

One of the main reasons behind the collaboration is to gain the competitive advantages. According to Williamson “Intermediate asset specificity and low uncertainty are conditions that may lead to a preference for hybrid forms of governance structure over both arm’s length transactions and internalization” (Williamson, 1991). One of the main motives to form a relationship with other companies is joint venture where they combine the skills and expertise of the both companies and gain the cooperative venture (Seo, Edler, and Massini, 2022). However, the clear differentiation of the partner and alliance objectives in the strategic alliance has often been overlooked even though the discussion on meeting partnership expectations continue to ensue (Tjemkes et al., 2013)(Hübel, Weissbrod, and Schaltegger, 2022). To ensure that the negative and positive expectations of the alliance are met, it is important to understand the individual partnership and group expectations in a clearly defined fashion. Prior to a critical analysis of the individual alliance components, it is important to re-look at the alliance from the alliance system perspective.

Within any strategic alliance, the alliance level is characterised by the need to pursue specific outcome and processes that will ensure continuity throughout the alliance process (Kumar and Nti, 1998; Belgraver and Verwaal, 2018). At the alliance level, partners may discuss governance structure, the alliance contract, decision-making mechanisms, and performance expectations among others.

Within this system, an endless cycle of learning and adaption ensues (Büchel 2002). At the alliance level, partners must learn about each other’s capabilities and listen to partner’s intention regarding the convergence or diverse. Moreover, resources from both or all parties of the alliance converge, and the partners move away from the “initial motive” stage (Dhaundiyaal and Coughlan, 2020). Likewise, resource divergence is equally important to create a vacuum to be filled by depending on the other partner.

The alliance system originally proposed by Tjemkes et al. (2013) is presented in Figure 2.2. The system indicates that learning and adaptation form the heart of the strategic alliance in an organizational self-renewal or evolution.

The self-renewal only occurs, as a result, the interaction between the partners, which also results in learning and continues adaptation. The larger environment cannot be completely exempted from the alliance system as it informs motives of the alliance itself. Over time, the organisations involved in the alliance build on historic experiences, changing environmental dynamics, and the building of the alliance through learning and adaptation.

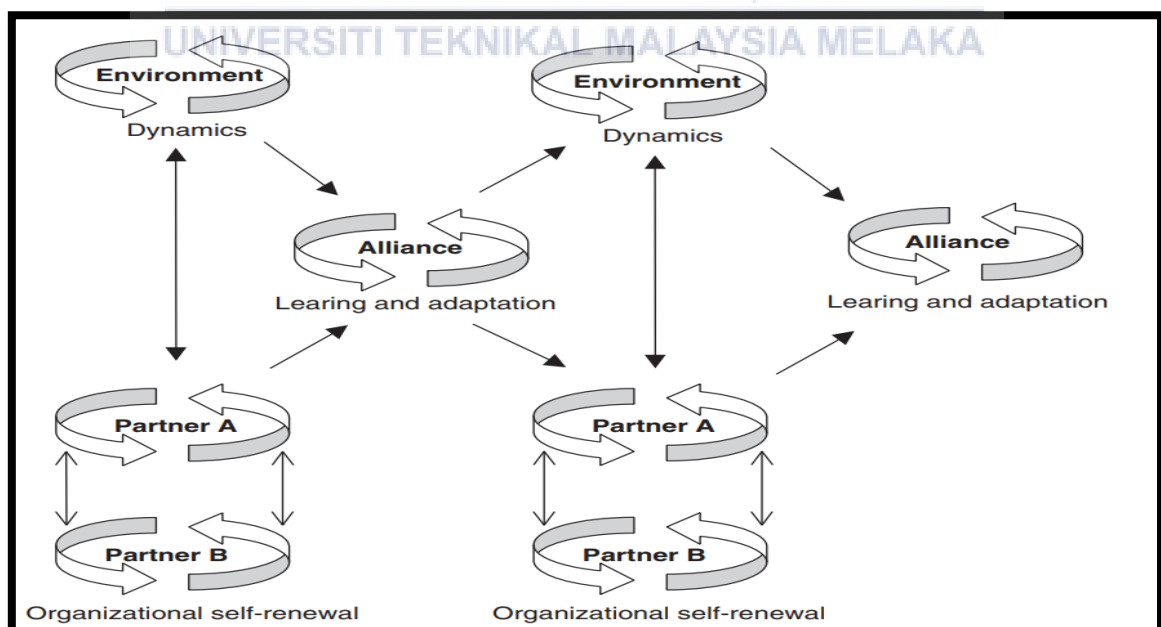


Figure 2.3: Alliance System by Tjemkes et al. (2013)

As established, the linkages between alliance, alliance partner organizations and alliance environment create an alliance system in which alliance co-evolutionary processes occur. This evidence indicates that change occurs at two main levels of the strategic alliance; change occurring at the partner level and change occurring at the level of the alliance (Wilson and Hynes 2009; Bouncken, Fredrich, Kraus, and Ritala, 2020). The dynamic nature of the alliance both within and between various levels creates co-evolutionary alliance processes within which all components and elements of the alliance progress (Bouncken, Fredrich, Ritala, 2020). Tjemkes et al. (2013) emphasise that equilibrium is never achieved owing to the continuance convergent and divergent patterns of mixed expectations and feedback. In this respect, many scholars such as Tjemkes et al. (2013) and Leischnig and Geigenmüller (2020) state that proactive management is difficult for any manager of an alliance and this is due to the fact that the internal components of the alliance lack bounded rationality and cognitive limitations based on which proactive management could be facilitated. Owing to this, a single partner cannot understand all the processes, mechanisms and consequences of the alliance evolution.

When caught within the cycle of self-renewal, firms can have some amount of control only in the event where continuous assessment of efficiency and equity conditions of the alliance is conducted (Tjemkes et al., 2013; Leischnig and Geigenmüller, 2020). In addition, the alliance outcomes must be continuously assessed in addition to the alliance environment which cannot be directly controlled (Marshall et al., 2020). After installing these three mechanisms (organizational self-renewal, dynamic environment and learning adoption), the viability of an alliance can be enhanced by further installing buffering mechanisms and boundary-spanning agents. The buffering refers to the governing of alliance activities, resources and individuals from being affected by the changes within the environment (Lynn, 2005).

2.2.6 Alliance Motives and Value Creation Dynamics in Healthcare Services

Alliance strategy in the healthcare context has been researched by Pentland et al. (2011); Sheng et al. (2013) and Tasselli (2015). There is no doubt that this area remains one of the most under-research areas of administration healthcare studies. Pentland et al. (2011) work on resource exchange in healthcare entailed an integrated review of papers on the area and the results largely consisted of grey literature with four (4) systematic reviews and only nine (9) empirical reviews over the 10-year period preceding 2009. The lack of attention to this area may therefore not be overemphasized.

Building on the sparsely distributed available literature, it must be emphasized that medical knowledge is an essential resource of medical competency (Verhoeven et al., 2002; Hark and Deen, 2017), and as competitiveness increases, medical knowledge has emerged as the most strategically significant resource for healthcare organizations. It must be added that healthcare organisations are becoming increasingly aware of the change in the competitive environment and the need to set aside from the competition by building on capabilities, staff competency and technology through alliance formation (Lewis, Tierney, Colla, and Shortell, 2017).

A number of studies have paid attention to the need to align tangible assets together with intangible knowledge-based assets in healthcare competitive advantage. Riusala and Smale (2007) argue that within the healthcare sector, organisations can attribute their existence to their superiority in terms of rare and valuable external market mechanism. These mechanisms may be used to achieve a competitive edge by internalising intangible assets through transferring and leveraging of knowledge and resources that improve alliance value creation, which are the core for healthcare competitiveness (Vătămănescu, Cegarra-Navarro, Andrei, Dincă, and Alexandru, 2020).

Ansell (2007) argues that the ability to properly use resources in healthcare services require that a good understanding of knowledge sharing exists. Nonetheless, the barriers to knowledge stickiness and knowledge ambiguity are typical challenges within the healthcare domain (Secundo, Toma, Schiuma, and Passiante, 2019). Whereas knowledge stickiness represents the inability or unwillingness to transfer knowledge (Gupta and Govindarajan, 2000; Szulanski et al., 2004; Hoksbergen, Chan, Peko, and Sundaram, 2021), knowledge ambiguity refers to the lack of clear understanding of the relevance or importance or understanding of knowledge as relevant to an alliance party (Ho, Ghauri, and Kafouros, 2019). A number of factors that inhibit healthcare strategic alliances may be considered similar to the main failures of alliance discussed earlier, they include people, structure, culture, alliance process and strategy, communication, among other factors (Spender and Grant, 1996).

Medical service delivery has been viewed as a collaborative process where healthcare providers work together to achieve outcomes in terms of access, quality, and cost that they would find it difficult to accomplish on their own (Sheng et al., 2013; Gao, Wu, and Wang, 2021). Resource sharing is therefore critical to the creation of value in the healthcare service context to help achieve competitive advantage. Sharing knowledge is important to facilitate operational capabilities of the healthcare alliance; in such environment, cross-sharing of knowledge must occur not only within parties but across the alliance.

In a final elaboration, it is not unusual that hospital alliance would consider key factors within their environment in order to better target and build competitive performance needed within the larger context (Pentland et al., 2011). In a typical observation, Carter et al. (2012) in their collaborative alliance blueprint, reveal that an important aspect of the strategic alliance is to map the market conditions to ensure that relevant alliances are targeted at relevant markets.

2.2.7 The Concept of Value Creation Dynamic Capabilities

The direct outcome of strategic capabilities lies in the operationalisation of value creation dynamic capabilities as originally defined by Pavlou and El Sawy (2011); Kurzhals (2016) Starting from the original concept of dynamic capabilities, it is important to explain that the concept has its roots in diverse areas of strategic management including configuration competence (Henderson and Cockburn, 1994), and combinative capabilities (Kogut and Zander, 1992). At the core of the theory “sometimes termed concept or approach” is the need to achieve and sustain competitive advantage through resource and competency of its application (Teece et al., 1997).

Teece et al. (1997) emphasized that the dynamic capabilities approach strategic management is an important model that takes into consideration the sources and creation of wealth within an environment of rapid technological change. Teece et al. (1997) emphasized that this concept is critical to the environment where there is rapid change facilitated by innovation-based competition, price-performance rivalry, the existence of a gap for performance improvement within the company and industry, and the improvements in returns and the existence of what they refer to as “creative destruction” of existing competencies. According to Zollo and Winter (2002) dynamic capabilities represent as a set of complicated routines by and comprises of a variety of managerial and organisational processes employees to create value and achieve competitive advantage.

The managerial and organizational processes capabilities consisting of reconfiguration, leveraging, learning and knowledge creation, integration, and sensing and seizing have all been considered dynamic capabilities by a large number of studies including Bowman and Ambrosini (2003); Helfat et al. (2007) and Teece (2007); Ambrosini et al. (2009), Barreto (2010); Mamédio (2019); Maldonado-Guzmán, Garza-Reyes, Pinzón-Castro (2019); Lin, Sheng, and Jeng Wang (2020).

More often, the dynamic capabilities view has been appraised as more specific and replaceable of its more ambiguous counterpart, the resource-based view (Lin et al., 2020).

Prior to the proposition of the dynamic capabilities view to strategic management, Teece et al. (1997) argued that many of the strategic management models that exist are only surrounded by loosely structured frameworks or paradigms; they lack specificity and often do not provide an avenue for empirical testing.

The dynamic capabilities view to strategic management may be different to research and operationalize; however, it offers key routines that are clearly identifiable and can be used to inform empirical observation in value creation and potential building (Eisenhardt and Martin, 2000).

Originally developed by Pavlou and El Sawy (2011) see Figure 2.3. The model builds on the strategic management continuum that bridges existing operational capabilities with reconfigured operational capabilities. It argues that to reconfigure operational capabilities and arrive at novel recombination of resources where value is optimized, a firm must first and foremost be able to spot, interpret and pursue opportunities defined within its sensing capabilities. The organization must then find ways to combine the sensed opportunities with its existing operational capabilities by utilizing and creating new knowledge.

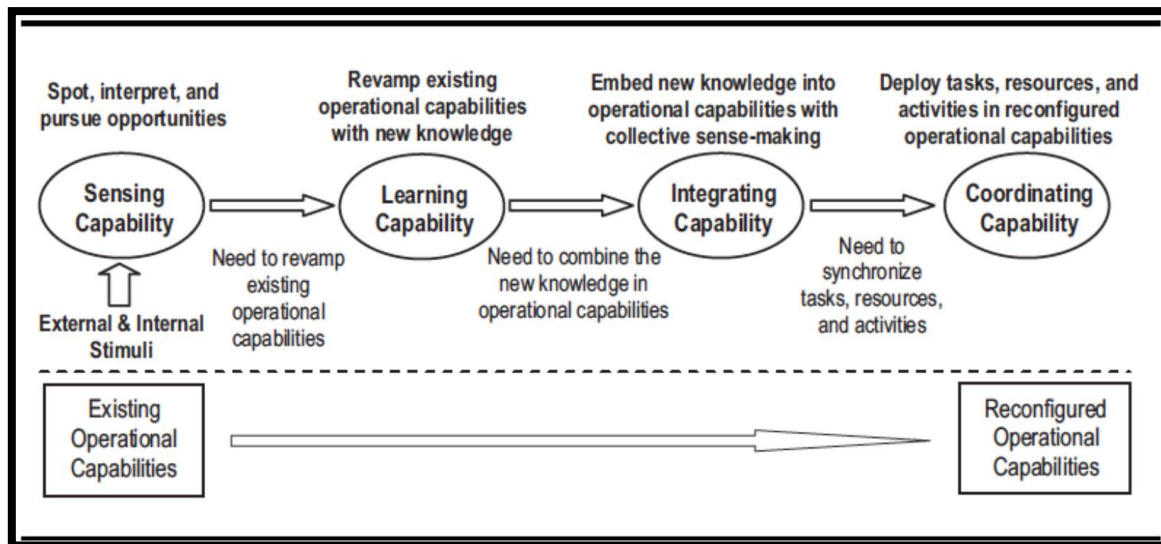


Figure 2.4: Dynamic Capabilities Conceptual Model by Pavlou (2011)

The knowledge created is infused into the existing operational capabilities through the learned experiences in order to make sense of the capabilities within the current operational environment and how it can help achieve competitive advantage. Finally, the deployment of tasks, resources and activities in a reconfigured operational capability is critical in what they finally define as coordinating capability. Since the present study builds on knowledge sharing, which is equally captured by the sensing and learning capabilities, the study builds on the value creation components of the dynamic capabilities model.

According to March (1991), Lin et al. (2020) and the first two aspects of the dynamic capability's continuum applies to potential building or exploration whilst the last two cover exploitation capabilities or value creation capabilities. This aspect was considered most critical to build on the knowledge outcome towards competitive performance. Fundamentally, all models in the area of DC lies between the ends of exploration and exploitation continuum as originally proposed by March (1991); Teece (2007) on the subject, proposed that:

“Dynamic capabilities can be disaggregated into the capacity (1) to sense and shape opportunities and threats, (2) to seize opportunities, and (3) to maintain competitiveness through enhancing, combining, protecting, and, when necessary, reconfiguring the business enterprise’s intangible and tangible assets”. The individual aspects of the value creation capabilities are discussed in more detail in the sections that follow.

2.2.7.1 Integrating Capability

Integration traditionally follows after organisations have sensed and learned on how to revamp existing operational capabilities. Integration capabilities, therefore, represent the embedding of new knowledge and resources to enhance reconfiguration of assets; here, networking of interactions and logic is required (Galunic and Eisenhardt, 2001; Okhuysen and Eisenhardt, 2002; Hernández-Linares, Kellermanns, and López-Fernández, 2021). The knowledge copyright must go beyond the individual level top of the firm or alliance for ownership through integration and reconfiguration of operational capabilities (Teece, 1982). Okhuysen and Eisenhardt (2002) argue that integrating capability possesses the ability to combine individual knowledge with new operational capabilities.

Its routine processes are closely linked to the DC nomenclatures such as collaborative participation of integrating individual inputs within a section for a collection action (Helfat and Peteraf, 2003; Rashidirad and Salimian, 2020). In particular, Teece (2007) views the integration of knowledge as a foundation of DC; this, therefore, plays a fundamental role in the research model as knowledge is transformed into integration and coordination capabilities prior to establishing competitiveness. It must be added that companies differ in integration capability the ability to absorb and manage business resources on a continuing basis (Jemison and Sitkin, 1986; Haspeslagh and Jemison, 1991; Collis and Montgomery, 1998; Helfat and Raubitschec, 2000; Hernández-Linares et al., 2021).

A strategic alliance must, therefore, see to it that both or all alliance parties contribute and complement themselves with regards to the absorption and management of business resources. (Chidlow, Wang, Liu, and Wei, 2021) assert that integrative knowledge is an essential factor in the co-evolution of capabilities of multinational corporations. Zollo and Singh (2000); Leshchinskii (2000) add that explicit codification is critical especially for relatively infrequent tasks, in order to avoid misunderstanding between individuals and sections of the organization. If done properly, integration capability is essential in absorbing the differences among firms in a strategic alliance.

2.2.7.2 Coordinating Capability

Coordination is important to harness and merge the activities, task, and resources related to operational capabilities (Iansiti and Clark, 1994; Helfat and Peteraf, 2003; Chidlow et al., 2021).

The coordination ability is explained as the ability to orchestrate and deploy tasks, resources, and activities in the new operational capabilities (Hernández-Linares et al., 2021). In a strategic alliance, the coherent deployment of tasks and resources is critical to achieving competitive advantage. It is worth mentioning that operational capabilities have also been referred to as functional competencies or ordinary capabilities. According to Collis (1994) operational capabilities are lower-order capabilities which are described as the purposive combinations of resources to permit an organisation or institution to perform functional activities. Functional activities, in this case, include logistics, marketing and sales or manufacturing, and other superior forms of dynamic capabilities that deal with change. It must be mentioned that operational capabilities lead to the achievement, and remains different from, strategic capabilities (Frances and Stephen, 2003; Mikalef, Krogstie, Pappas, and Pavlou, 2020).

According to Tsai-Lung (2005) strategic level activities encompass the overall mobilization of organisational resources of choices, commitment and actions. From this discussion, it may be asserted that the operational make-up of the alliance and the extent to which value is created is a fundamental and instrumental competitive advantage.

2.2.7.3 Reconfiguration

The process of reconfiguration changes the existing configuration of resources into new ones that match the changing environment. Reconfigurability as a capability has been referred to appropriateness (Glaunic and Rodan, 1998), timeliness (Zott, 2003), and efficiency (Kogut and Zander, 1992) by which existing resources are reconfigured into new operational competencies. The process of reconfiguration is cited in the dynamic capability literature through activities such as reconfiguring operational competencies influence competitive advantage (Pavlou and Sawy, 2006), innovative redeployment of existing resources (Helfat and Peteraf, 2003), patching –reconfiguring resources into the right chunks at the right scale to address shifting market opportunities (Eisenhardt and Brown, 1999), attractive new combination of resources (Glaunic and Rodan, 1998), revamping (not destroying) existing operational competencies (Grant, 1996). A closer enquiry with in the literature yield three major mechanisms for reconfiguration. They are reconfiguration as gain or release of resources, reconfiguration as combination of resources, and reconfiguration as redeployment of resources.

The role of dynamic capabilities is to react to crisis situations, sense new opportunities and reconfigure the company base and resources in order to seize any opportunities sensed (Dyduch, Chudziński, Cyfert, and Zastempowski, 2021). Opportunity exploitation during a crisis is understood as the sum of new products and services launched, or new markets penetrated.

2.2.8 Strategic Alliance and Exploitation or Value Creation Capabilities

Upon a critical exploration of the concept of strategic alliances and a more detailed view at the partner and alliance system, closer attention must be directed at how strategic alliance generate the mid-way outcome of “value” for the achievement of competitive advantage (Lin et al., 2020). As modelled in the present study, an alliance may directly imply competitive advantage, but this magnified through value creation elements (Bouncken et al., 2020). Viewed from the perspective of the strategic alliance, firms are able to integrate and coordinate their combined resources to create new ones. These new ones are created by developing high order resources that ensure the overall productivity of basic ones. In a strategic alliance, new forms of resources are created by combining existing resource capabilities (Kwok, Sharma, Gaur, and Ueno, 2018).

It is based on this consideration that (Al-Tabbaa et al., 2019), assert that alliances success does not entirely lie on the relationship between partners, but more importantly, it lies within each firm’s alliance management capabilities readily contributed on board the strategic alliance. Heimeriks and Schreiner (2010) assert that every concept of strategic alliance lies in the theory of dynamic capabilities. In specific terms:

“Alliance management capabilities are a kind of dynamic capabilities, defined as superior firm’s capabilities in managing alliances” (Heimeriks and Schreiner, 2010). Originally, resources are heterogeneously distributed across firms and this justified the need to align strengths so as to pull together these resources to bridge performance differences. Bouncken, Fredrich, Ritala, et al. (2020) emphasize that alliances are successful if the individual partners are able to develop the required value-creating capabilities required for the management of the alliance. Both the dynamic capability and alliance capabilities view identify “alliance management capabilities” as key critical for the success of alliances (Leischnig and Geigenmüller, 2020).

Another pool of studies supporting the contribution of strategic alliances to value creation, the subject of innovation has become an important aspect of this discussion (Raghubanshi, Venugopal, and Saini, 2021). Through learning and resource and development, strategic alliance spur innovation and value creation. Others have argued that strategic alliances affect functional departments to generate unique outcome; an instance is that marketing and operational functions combine to create exploitative innovation while research and development functions result in exploratory innovation (Ferreira, Coelho, and Moutinho, 2021). Koza and Lewin (1998) assert that alliance in traditional functional areas lead to scale advantage and expansion of production capacity in combination with knowledge and capabilities.

The exploitative and exploratory capabilities of strategic alliances are comparable to the potential building and value creation capabilities of the dynamic capabilities (Ferreira et al., 2021). The reservation of the exploration capabilities to research and development and learning in strategic alliance maps onto the definition of potential building capabilities as encompassing the firm's sensing and learning capabilities (Pavlou and El Sawy, 2011; Lin et al., 2020). Likewise, the operational and marketing alliance between parties in the strategic alliance represent the exploitative capabilities (Koza and Lewin, 1998) and this term maps onto the value creation capabilities originally conceptualized by Pavlou and El Sawy (2011). The value creation dynamic capabilities entail integration and coordination dynamic capabilities discussed in the earlier sections of the present chapter.

What can be inferred from the blend between strategic alliances and associated immediate outcome of value creation is that, even though exploratory capabilities are instrumental to competitive advantage, it remains an integral aspect of knowledge sharing. Knowledge sharing, as discussed in the context of the present study, and as observed in the earlier sections of the present review, has key similarities with the concept of learning and

exploratory capabilities. Moreover, the traditional dynamic capabilities model conceptualizes exploitative capabilities or value creation capabilities as resulting from exploratory capabilities (Pavlou and El Sawy, 2011). With these observations, the study conceptualizes value creation dynamic capabilities from knowledge sharing towards alignment of partner motives.

2.2.9 Conclusion and Key Research Gaps

Based on the key discussions covering the main and underlying themes of the study, the main research gap of the study may be affirmed. First, the review of the literature indicates that the areas of strategic alliance, motives, and value creation dynamic capabilities have all been offered some amount of attention. Likewise, blending these constructs, the relationship between strategic alliance, value creation dynamic capabilities, and competitiveness, has been covered to what may be considered satisfactory. However, at the centre of these discussions is that studies have not paid enough attention to the conceptualisation of strategic alliance from its endogenous and exogenous perspectives to solve the challenge of defining alliance expectations and motives to improve alliance competitiveness.

Third, a closer look at the context of the study reveals that the area of healthcare services has not gained much attention within the broader scope of literature surrounding strategic alliances, alliance motives and value creation dynamic capabilities. The few areas that have been covered however proved valuable in establishing insight on how these concepts inter-play with the context of the study.

2.3 Theoretical Foundations of the Study

A number of theories have been proposed to explain the underlying elements of strategic alliances and how they can be successfully operationalized. An influential source

in this area is Russo and Cesarani (2017) critical review on the alliance lifecycle towards strategic alliance success. Others that have supported this critical discussion include Bhatti (2011). Barringer and Harrison (2000) model of theoretical foundations of inter-organizational relationships was originally adopted by Bhatti (2011) to explain how strategic alliances transpire between the far ends of economic and behavioural positions (Figure 2.5).

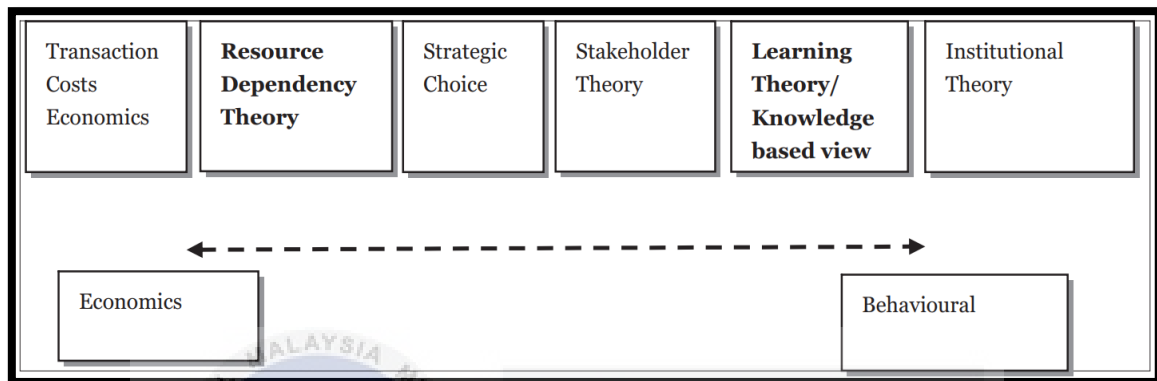


Figure 2.5: Theoretical Foundations of Strategic Alliances by Barringer (2000)

Selecting theories relevant to the context will help arrive at a model that better represents strategic alliances within this context. This will help close the research gap of the study that the expectations, purpose and control of alliances in the healthcare sector are not yet understood (Pelletier et al., 2014; Fuertes, Toporovsky, Reyes, Osborne, 2017).

It is important to mention that one or more of these theoretical perspectives may exhibit features of other theories. An instance is that the resource-based view theoretical perspective is characterised by the ability to create new forms of resources by combining existing resources from the alliance partners; this description is highly similar to that of the resource recombination or resource reconfiguration capabilities from the dynamic capability perspective (Teece et al., 1997; Schreyögg, Kliesch, 2003; Akkaya, Üstgörül, 2020).

As observed in the case of resource recombination, the underlying phenomena of the synergy created through the combination of resources are common to many of the debated theories as highlighted by Russo and Cesarani (2017).

Aside from these observations regarding the shared commonalities across the discussed theoretical perspectives, it must be mentioned that a one-size-fits-all theory may be far from reach. Each of the available theoretical perspectives has their own limitations, strengths, and success criteria; noting these peculiarities is essential for proper adoption of any one of these theories towards purported outcomes (Table 2.3).

Table 2.3: Theoretical Perspectives Strategic Alliances in Healthcare

Theoretical Perspective	Suitable Environment	Predominant Success Criteria	Weaknesses and Critics
Competence-Based View	Competence and expertise as overarching among the pool of resources requires for the strategic alliance	Strong association with knowledge sharing. Without the proper transfer of knowledge and installed mechanisms, competency transfer may be challenged in the alliance	This theoretical composition focuses on competence as the core factor for competitive advantage, without much attention to other resource components
Dynamic Capability View and Alliance management Capability View	The dynamic capabilities perspective is considered in cases where recombination and resource reconfiguration is critical in a more thorough approach than a mere resource-based approach	Core alliance management capabilities must be combined through high order resources in the management of alliance relationships.	The dynamic capabilities view has gained a reputation within the broader scope of strategic management literature. The area is too broad and contains too many sub-constructs
Industrial Organization Theory to Strategic Alliance	Focus on the larger context of the industry rather than on internal factors of the alliance.	The alliance holds the potential of creating a stir or a shift in the industry May or may not entail the shift	The main weakness of the industrial organization is that the alliance may be irrelevant and only considered

		and movement of resources but with emphasis on achieving significant changes in the industry	intimidating to other competitors. In the healthcare context, the alliance may not add to the improvement in the competence and economic benefits of the alliance.
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Source: Tjemkes et al. (2013) and Russo and Cesarani (2017)

2.3.1 Resource-based View

A key issue with the practice of strategic alliances in the business environment is that they are based on the differing and sometimes contradictory explanatory model (He et al., 2020). The resource-based view of organizations strongly focuses on the relevance of resources and assets in achieving competitive advantage (Barney, 1991; Peteraf, 1993). The resource-based theory holds that resources or business assets become beneficial to organizations based on four characteristics; rarity, durability, value, and imitability (Russo and Cesarani, 2017; Donnellan and Rutledge, 2019). Even though firms strive to achieve these qualities, it is not unusual that they find it rather difficult to achieve a perfect mix of qualities in resource acquisition.

This challenge is more daunting for firms that operate in highly uncertain environments (Lioukas et al., 2016; Babu et al., 2020). Beyond the assertion that strategic partnerships involve the integration of resources, and they improve organizational outcomes through the efficient application of shared resources, these forms of alliances mainly transpire due to key individual resource gaps (Martínez-Fierro, 2015). Complementary resources help provide resources that are originally lacking to the aligned institutions (Koroleva, 2014; Chen, Zhou, Zhou, and Xue, 2017' čirjevskis, 2021).

According to Belgraver and Verwaal (2018) complementary resources constitute those resources that a partner can provide to the collaboration and the other partner predominately lacks.

Despite, the importance of RBV, it has its own limitations. According to Valentin (2001) the strengths and weaknesses of the resource-based view are of equal measure. When an organization or a group of organisations anticipate achieving competitive advantage through the combination of resources, the efficiency and effectiveness of the reconfiguration of resources are not always within acceptable constraints. The combination may be costly or lead to a severe loss of other resources. Moreover, other factors may hinder the effectiveness of the combination as the outcome may not essentially be relevant to the competition at the time (Rehm and Goel, 2017). Finally, the increased reliance on the complementary resources of the partner can hinder growth for a particular organization with the other organization benefiting from the alliance; the very understanding of the relevance of the newly created resources is critical to acknowledge and properly implemented (Zubac et al. 2010). It has also been argued that competitiveness goes beyond resource application and involves predominantly other factors, commitments and competencies that do not necessarily entail resource integration. The resource-based view is sometimes (mis-)understood as an inside-out approach. Therefore, RBV is not suitable for this research since the objective of the research is to explore alliance motives that influence firms' competitiveness through dynamic capabilities.

2.3.2 Competence-Based View Perspective

The concept of competence has been used by scholars as firms' main source of competitive advantage (Mills et al., 2002; Prahalad and Hamel, 1990). Competence concerns the sufficient availability of firm-specific resources that will help a firm set adequate strategies (Ray and Ramakrishnan, 2006).

Unlike physical assets, that deteriorate or depreciate over time, competences improve when put into practice. Therefore, at the same time that competences need to be used and developed, they need to be nourished and protected to deliver the expected results (Mills et al., 2002). In general, there are two levels of competence: supportive competence and core competence. Supportive competences (Comi and Eppler, 2014) concern sales, production and logistics activities, which are also known as primary value-creating activities (Kingkaew and Dahms, 2019). Although supportive competences are ordinary resources, they may also play an important role in supporting core competences. Therefore, core competences create potential access to a wide variety of markets, contribute significantly to meeting customers' needs and are difficult to be replicated by competitors (Prahalad and Hamel, 1990). A company will pursue to develop a core competence (Prahalad and Hamel, 1990) once it enables it to gain and sustain competitive advantage over its rivals in the long run both nationally and internationally.

The competence-based view (CBV) to strategic alliances argues that institutions may come together to share some form of competence and expertise in their independent fields (Chen, Zhou, Zhou, and Xue, 2017). This is particularly characteristic of the healthcare sector where expertise and competence are critical for competitive advantage. The core competence approach sheds light on organizations' make alliance decisions by warning against the risk of renouncing key capabilities and competences to the detriment of focusing solely on cost-based competition (Li and Liao, 2007). Since core competences develop through organizational learning processes that generate effective results, competitors may mimic what has already been done, but they will hardly ever replicate what can be done or created in the future (Santos and Batalha, 2022). Competence development, therefore, results from long-term processes of organizational commitment and learning (Baraldi et al., 2012), implying some sort of association with the firm's path dependence (Barney, 1991).

In addition to being considered a source of competitive advantage (Bogner et al., 1999), core competence is also viewed as the root of the alliance process (Fleury and Fleury, 2011). The competence-based view sees competitive advantages as not solely derived “mechanically” from the availability and quality of resources together with how they are efficiently combined. It takes a step further to observe that competitiveness involves the ability to “utilise” these resources more effectively and efficiently towards competitive advantage (Moldaschl, 2006).

In this research, it is argued that competence for healthcare alliance should be understood as a healthcare firms’s ability to organize and coordinate internal resources to a level of sufficiency required to achieve and sustain strategic objectives regarding the alliance expansion process. A healthcare firm can develop core competences for alliance such as joint venture in many areas, depending on the strategy it seeks to pursue (Fleury and Fleury, 2011).

2.3.3 Transaction Cost Theory to Strategic Alliances and Criticisms

Williamson (1991) argue that this theory highlights the logic of cost minimization as the main reason why firms get into strategic partnerships. Firms consider the need to minimise costs when choosing the mode of their transactions when getting into strategic partnerships (Russo and Cesarani, 2017). While TCT has been widely used in research on ‘entry mode choice’, including the choice of IJVs, other studies have extended it to investigate how partners ensure the management of IJVs after their formation (Ali and Larimo, 2016), Zeng, 1998). TCT assumes that opportunism is an inherent factor in IJV partnerships and therefore provides important insights into how partners should structure their IJV to promote effective management (Ali, Khalid, Shahzad, and Larimo, 2021).

The theory is based heavily on the fact that businesses face production and transaction costs in their operations (Madhok et al., 2015; Khalid and Ali, 2017). Production costs refer to expenses associated with the different resources applied in producing a good or service. Transaction costs, on the other hand, arise from the bounded rationality of the actors in the supply chain. The actors involved in the production and operations of a business sometimes engage in opportunism, which significantly affects the markets by introducing friction (Sklavounos et al., 2015; Babu et al., 2020).

According to Linwei, et al. (2017) one key motive of firms in getting into such partnerships is to minimize the costs associated with the firm and its operations. Firms seek to respond to the changes in their industry by developing and taking advantage of opportunities within the larger economic systems. Firms can benefit from cooperative strategies by collaborating with their peers to create more value (Russo, Cesarani, 2017; Babu et al., 2020). By aligning themselves strategically, the firms can develop an effective solution through shared resources and networks that is less costly than the internalization of the functions (Raynard, Greenwood, 2015; Dhaundiyal and Coughlan, 2020). This theory holds that firms seek partners that are most efficient in undertaking other functions that are critical to their survival in the market. Their focus on seeking such partners is to minimize costs and achieve efficiency across their value chains.

Martínez-Fierro (2015) highlights the motive of cost minimization as the main reason why firms choose to engage in strategic partnerships. Firms do not have the resources to engage in all aspects of their value chain. They have to buy raw materials and other items from other firms, including intellectual property. In some cases, firms rely on the networks of their colleagues in order to develop products and get them to the market. These relationships with external stakeholders can be expensive due to the emergent transaction costs (Madhok, Keyhani, Bossink, 2015).

One alternative for addressing them to minimize the transaction costs is through internalisation of all processes. However, this is a costly affair, and it may result in a net negative effect on firms.

As decision-makers, it is not unusual that humans are unable to act optimally in business transactions. Adding to the complex nature of the business environments and to avoid pertinent challenges whilst reducing the resulting transaction costs, firms form entities to internalize key operational functions (Niesten and Jolink, 2015; Aggarwal, 2020). Despite associated benefits, the transaction cost theory application to strategic alliances has the disadvantage of increasing the production costs as the different functions are managed internally. In such a case, the strategic alliance may be directed at bridging the link between the market and the firm. Earlier scholars have highlighted the relevance of strategic alliances as tools for lowering the overall costs incurred by a business in dealing with its partners (Williamson, 1991).

To sum up, strategic alliances in the case of transaction cost theory are tools applied with the motive of lowering costs for implementing operations. The organizations involved engage in a hybrid form of interaction through cooperative and competitive approaches (Sklavounos et al., 2015). Ultimately, this model considers cost as the main indicator of efficiency in the strategic alliance, and strategic alliance is preferred if the cost for the organisation of activities within the firm is lower (Russo and Cesarani, 2017). It must, however, be noted that perfect contracts are impossible to achieve in principle and this implies that strategic alliances are the best alternative for internalizing the conditions and consequences (Kuznetsova, 2016; Yang, 2021).

2.3.4 Industrial Organization to Strategic Alliances

The industrial organization approach to strategic management posits that firms get into alliances with others for strategic reasons. The key strategic considerations for firms

include structural holes and weaknesses that affect profitability (Kuznetsova, 2016). The industrial organization theory originates from Michael Porter within the field of strategic management of firms and how it contributes to profitability (Kuznetsova, 2016). According to the theory, firms have to align their management strategy to the needs of their industry and be dynamic to respond effectively to related changes. This approach plays a beneficial role in ensuring that structural weaknesses and problems do not adversely affect firms. This approach posits that firms gain cooperative outcomes by aligning with the right partners in their industry (Linwei, 2017).

In the industrial organization approach to strategic alliances, success is based on structural characteristics of the alliance. These include issues such as the density of the industry and partnerships, structural gaps, structural equivalence, and centrality. These factors play a major role in affecting the performance and profitability of a firm in the industry. Companies pull back their corporate borders through collaborations and alliances that are meant to enhance how well they can accomplish their non-core activities that are critical to their success. A key element of this approach is to enable companies to access resources that are outside their organizational boundaries (Madhok et al., 2015).

By collaborating with partners to gain a better strategic position, firms are able to improve performance through the enhancement of transaction efficiency. This differs significantly from the resource-based view, which focuses on the acquisition of resources that are difficult to imitate (Lioukas, 2016). As a result, strategic partnerships are ways for organizations to build on their competitiveness by creating effective networks with key players in their industry.

The structures of the industry in terms of the networks developed among the key players are essential in creating competitive advantages for firms. A major aspect of the

theory is that firms and industries become increasingly complex hence they are unable to internalise all aspects of their operations (Ferreira et al., 2014).

Porter argues that the competitiveness of a company is dependent on how it is organized in relation to its industry. Long term and substantial collaboration can be applied by companies as a way of ensuring that they have access to essential resources while at the same time gaining competitive advantages that enhance their survival (Ferreira et al., 2014). The focus of this approach to alliances is that the different firms within an industry are dependent and they can develop a formidable force in the market by collaborating in order to share knowledge and beneficial relationships or networks. In the industrial organization view, strategic alliances involve different collaborative forms such as supplier-buyer agreements, technical collaborations, and joint ventures, shared manufacturing, and shared product development (Lin and Darnall, 2014). The challenge is addressed through efforts to get the resources from external players through mutual collaboration as opposed to internalization or acquisition of such operations and resources.

These approaches have the benefit or consequence of making firms more dominant and effective in their industries (Russo and Cesarani, 2017). Industrial organization alliances may also aid in reducing the opportunities for competition by creating barriers to new entrants. As a strategic motive, this theory holds that strategic alliances focus on developing strategic competencies that make them effective competitors. Firms seek strategic partners that can aid them to compete in their industries by becoming integrated across the entire value chain. In this case, strategic alliances involve firms and partners that allow an organization to compete on the bases of economies of scope (Russo and Cesarani, 2017).

Even though the vertical integration alliance also falls into this category, the form will no doubt be able to internalize all aspects of the value chain from the raw materials to the final consumer. Nonetheless, this may be difficult to achieve because of the resources

required to ensure proper co-operation are usually diverse and usually exist at different levels of the supply chain. As a result, collaborating with other firms along the value chain creates similar competences by providing a collaborative approach for addressing all elements of the value chain. This creates a barrier to entry in the industry and can make the industry highly concentrated since the central players have control over a wide range of players that are central to the industry (Russo and Cesarani, 2017).

Since the internal resources contribute to the potential for firm success, it may be inferred that the characteristics of the alliances formed influence their success. Key factors include the structural holes and structural equivalence of the industry as well as the density of the relationships developed among the different organizations. Focus on the healthcare sector in this area is not new; in a study by Yoo and Kim (2014) structural holes were evaluated in terms of the effect they have on corporate performance and strategic alliances in the pharmaceutical sector. The findings indicated that network density was a key factor in enhancing management performance and competitive advancement of the organizations.

In another observation, the existence of structural holes was found to have an effect on the performance of the firms (Russo and Cesarani, 2017), however, the strategic alliances played a major role in providing alternatives for filling the structural holes that the pharmaceutical companies face in their operations. A major issue with the analysis was that strategic alliances were found to be effective ways of building organizational networks that could address the structural weaknesses facing the different organizations, as argued by Ang and Michailova (2015). In this respect, the effectiveness of the strategic alliance in filling structural holes was a critical element in improving organisational performance.

Finally, it has also been argued that the centrality of the organization in the network remains another critical aspect of increasing the capacity of the firm to respond to opportunities in the industry and gaining competitive advantages (Koroleva, 2014). The

assertion that firms can lose competitiveness if there are structural holes in the different products they develop or the approaches for reaching the market, is therefore plausible. Moreover, strategic alliances for covering structural holes for gaining information would be highly beneficial in responding to the needs of the firm.

2.3.5 Conclusion to Theoretical Perspective to Healthcare Strategic Alliance

It must first and foremost be mentioned that any of these theoretical perspectives may be adapted to explain the context of strategic alliances. Nonetheless, some of these theories better explain the context of the study whilst others are more focused on alliance motives than other broad theories. Starting from the resourced based view (Barney, 1991; Peteraf, 1993; Russo and Cesarani, 2017). It is also important to mention that the resource-based view (Lo et al., 2016; Russo and Cesarani, 2017) and the competence-based view provide a better understanding on the motives of alliance (Helfat and Peteraf, 2003; Hawass, 2010), in the context of healthcare. It is because RBV lays emphasis on the fact that the internal capabilities of a firm make it competitive, mainly entailing the firm's capabilities and different resources (Steiner, Lan, Unterschultz, and Boxall, 2017). Even though, RBV has been widely used as a lens for alliance motives, this theory mainly tries to use the resources available to a firm at a certain point in time to explain firm performance. Looking beyond a firm's resources, the competency based view has undertaken to develop a more comprehensive perspective on firms (Sanchez et al., 1996). The CBV asserts that competences created by adding capabilities, coordination, and strategic targeting to resources are the sources of competitive advantages and enable firms to attain their goals (Viale, Ruel, and Zouari, 2022).

Aside from the appraisal of the competence-based view and resource-based view, the other theoretical perspectives of transaction cost, dynamic capabilities and industrial organization theory cannot be completely ignored.

Bhatti (2011) consider these factors within their proposed research model as integral to the quest to conceptualize strategic alliance control whilst capturing the larger set of factors within the phenomenon of strategic alliance.

The present study explores the key areas of resources, competence, knowledge whilst acknowledging external dynamic factors and other industrial-organizational context in the unique context of strategic alliance. The next section presents the inter-relationships between these constructs with the support of literature on the subject area. This reverts to the original assertion to build on theories that encapsulate the continuum of inter-organizational strategic alliance relationships but with special attention to the context of the investigation.

2.4 Conceptual Framework and Research Questions

The conceptual framework of the study is presented in Figure 2.7. The model builds on the integrated theories relevant to the context of the study.

The model argues that the main antecedents of strategic management control essential to meet the expectations and motives of strategic alliances include resources (cost and economics), competence, and industrial-based relationships.

The conceptual framework is bridged into two main areas of endogenous and exogenous alliance operationalisation. The endogenous section goes a step beyond Bhatti (2011) to consider competence and relationships as different from the resources as a construct. Resources, on the other hand, is limited to the tangible and mainly cost or economic resources that inform individual strategic alliance motives.

Given the three main antecedents of the model, and the role of alliance motives based on transaction cost, industrial relation and resource competencies. Dynamic capabilities sub-constructs of integration, reconfiguration and coordination have been argued as central to competitive advantage in the strategic management literature. Holding these three constructs as mediators of the relationship between alliance motives is critical as alliances move from

existing operational capabilities to reconfigured operational status through the innovative integration and coordination of alliance resources and permit the synchronization of tasks, resources and activities necessary for the strategic alliance (Pavlou and Sawy, 2011; Kurtz and Varvakis, 2016).

On the final aspect of the model, the competitive advantage of the strategic alliance is considered as an ultimate outcome of strategic partnerships as thoroughly discussed in the earlier sections. The individual motives of the alliance are cemented to be achieved at the point of knowledge sharing; however, it is through thorough integration, reconfiguration and coordination that the combined motive of the alliance can be optimized in the form of competitive advantage. The use of the word optimize is due to the consideration that knowledge management may as well induce competitive advantage on its own. Competitive advantage in strategic alliances has been observed as central to alliance outcomes regardless of alliance motives (Ireland et al., 2002; Tjemkes et al., 2012; Lee and Yoo, 2021). The conceptual framework fits the dual methodological orientation and provides an all-inclusive view of strategic alliances by building collectively on underlying theories to achieve competitive advantage. A critical elaboration of the relationships between the construct within the research model is presented in the sections that follow.

2.4.1 The Need to Explore Strategic Alliance Antecedents in the Context of Healthcare Provision

As part of the first three research questions, the study seeks to explore the areas of resource/cost-based alliance, competence-based alliance and industry relationship-based alliance, within the context of healthcare service that help in the achievement of individual strategic alliance motives. The need to explore how alliance partners can achieve their individual conflicting expectations is not new (Bhatti, 2011; Min, 2017). The discussion here, therefore, focuses little on the antecedents of the resource-based, competence-based,

and relationship-based. It focuses attention on why the area of alliance motives or endogenous alliance components must be explored and not conceptualized like the other quantitative components of the study.

Building on earlier discussions on the endogenous aspect of the strategic alliance, it is important to mention that this aspect of the strategic alliance is far from predictable due to the complex nature of how independent systems combine. As explained by Kumar and Nti (1998) at best, control mechanisms may be installed to enable partners to monitor progress emerging outcomes and process discrepancies. Every organization is unique, and no single rule of thumb exists on the exact areas that must be combined first as this depends on the unique interests and needs of the alliance parties. Some alliance may be more interested in starting from the competence sharing whilst others may anticipate the tangible or economic resource sharing from the onset prior to commitment (Chakravarty, Zhou, and Sharma, 2020).

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 resource 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 dynamic alliance motives sharing.

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). To create value in strategic alliance, establishing a common identity is critical to truly exploit operational resources towards competitive advantage (Tjemkes et al., 2013; Bouncken, Fredrich, Ritala, et al., 2020).

The complex nature of endogenous strategic alliance components is due to the assertion that it lacks rational and cognitive boundaries (Koza and Lewin, 1998). At the core of this phase of the alliance is the co-evolutionary alliance processes in which all elements progress with no clear definition of a set path. As put by Tjemkes et al. (2012):

“a state of equilibrium is never likely to be achieved owing to converging and diverging patterns of positive and negative feedback”.

Owing to bounded rationality and cognitive limitations, it is most unlikely that a single alliance could gain the complete knowledge and understand the relationship between diverse of change, intermediary mechanisms and consequences of change across the entire alliance.

These discussions are in support of the need to explore strategic alliance within the healthcare sector due to the lack of a clear form of the endogenous components of strategic alliances. Now, in line with the theories discussed, and other discussions presented in this section, intent for alliance may be broadly categorised into the areas of cost/economics, competence as a vital resource, and relationship building. In combination with the critical review of theories in support of this area, the following research questions were proposed:

RQ1a: What resource (economic) factors contribute to partners strategic motives among UAE Hospitals?

R1b: What competency factors contribute to partners strategic motives among UAE Hospitals?

R1c: What industry relationship factors contribute to partners strategic motives among UAE Hospitals?

To answer these research questions, the qualitative methodology will be employed in an inductive-based empirical observation. This assessment will be conceptualizing the area and help arrive at factors that can be applied that define strategic alliance motives peculiar to the UAE healthcare industry. These factors will then be instrumental in conducting quantitative research that will follow in phase two of the research.

2.4.2 Value Creation Dynamic Capabilities and Competitive Advantage

Here the third group of research questions are introduced involving the contribution of value creation dynamic capabilities to competitive advantage as an ultimate outcome of the strategic alliance. As critical resources get exchanged, firms engaged in alliances grow increasingly dependent on each other to realize both their individual and joint objectives. Ultimately, firms are often encouraged to engage alliance proactively in order to address all conflicts and ensure that efforts are focused on value creation and competitive forces oriented toward value appropriation (Dyer et al. 2008).

Ultimately, competitive advantage results when the firm can implement a value-creating strategy (Hitt et al. 2000), this strategy must be unique, rare, valuable and unmatched by competitors, at least not implemented simultaneously by existing or potential competitors. Overwhelming evidence exists that competitive advantage requires firms to possess valuable, scarce, not imitable and non-substitutable resources (Teece et al., 1997; Saebi, 2011).

The original purpose of the dynamic capability view as proposed by Teece et al. (1997) is how to achieve and sustain competitive advantage. Dynamic capabilities ensure that firms put their resources to use and are able to reconfigure them better their competitors.

The contribution of dynamic capabilities to competitiveness does not only exist in theory but has been established with overwhelming empirical support (Hurley and Hult, 1998; Slater and Narver, 1998; Baker and Sinkula, 1999; Calantone et al., 2002). At the core of dynamic capabilities is the ability to promote changes with the integration, building and reconfiguration of basic resources in matching changing environments.

According to the alliance capability view, even though knowledge sharing is a step in the right direction towards alliance competitiveness, this view stresses that firms with high alliance success rate are those ones with a higher degree of alliance capabilities established through dynamic capabilities (Saebi, 2011). Based on the contribution of dynamic capabilities to competitive advantage, the following research questions were established for empirical assessment:

RQ2d: What is the impact of strategic alliance integration capabilities on strategic alliance competitiveness within the UAE Healthcare Sector?

RQ2e: What is the impact of strategic alliance coordination capabilities on strategic alliance competitiveness within the UAE Healthcare Sector?

RQ2e: What is the impact of strategic alliance reconfiguration capabilities on strategic alliance competitiveness within the UAE Healthcare Sector?

2.5 Hypotheses

Healthcare industry is a complex industry that encompasses a wide range of sectors that provide goods and services to treat patients. This includes things such as treating people, preventing illness, and providing rehabilitative medicine and palliative care. Therefore, strategic alliances is one of the ways healthcare is increasing its survival rates is to partner

with others in the community, or the region, to become stronger. One of the main factors leading strategic alliances in healthcare is managing costs. TCT predicts that when managers perceive growing transaction costs, they should take steps to reduce such costs by moving activities to lower-cost modes of governance (Williamson, 1985). According to (Penney and Combs, 2020) suggests that the managers used alliance integration as a proxy to reduce such costs. Therefore, this research hypothesize that:

H1: Alliance motives based on transactional cost has positive effect on alliance integration

Alliance integration capability emphasizes the processes employed to develop a relational platform for learning. Thus, alliance integration capability references to the firm's ability to integrate strategic alliances by developing both structural and social ties between alliance partners.

The ability of the healthcare firms to integrate strategic alliances is essential to achieve their competitiveness. It is because ability alliance integration has significant effects on value co-creation and capture, innovation, supplier and customer performance (Kohtamäki, Rabetino, and Möller, 2018). Therefore, many healthcare firms seek for developing a relationship structures such as joint alliance development teams, alliance steering groups, integrated working procedures, processes, and IT system (Gao et al., 2021). Therefore, this research hypothesizes that:

H2: Integration Capabilities (AC) has positive and significant effect on Healthcare Organization Competitiveness (HOC)

Industrial relationships are a central construct of competitive advantage in business-to-business (B2B) marketplaces, wherein the market undertakes an exchange between multiple network actors that require constant and continuous management (Kohtamäki et al., 2018). Networks between organisations are formed when multiple organisational actors

collaborate and engage with one another, share intellectual capital, and exchange resources (Faems, Bos, Noseleit, and Leten, 2020). Relational perspectives, therefore, retain a strong influence within B2B organisations (Cartwright, Davies, and Archer-Brown, 2021). While rational partner selection criteria for alliance portfolio reconfiguration are important (Lidström and Vanyushyn, 2022), understand the partners industrial-relations and their effect on alliance reconfiguration is still limited, especially among healthcare industry. Therefore, this research hypothesises that:

H3: Alliance Motives based on Industry Relationship (AMC) has significant and direct effect on Reconfiguration Capabilities (RC)

The process of reconfiguration is cited in the dynamic capability literature through activities such as reconfiguring operational competencies influence competitive advantage (Pavlou and Sawy, 2006), innovative redeployment of existing resources (Helfat and Peteraf, 2003), patching –reconfiguring resources into the right chunks at the right scale to address shifting market opportunities (Eisenhardt and Brown, 1999), attractive new combination of resources (Glaunic and Rodan, 1998), revamping (not destroying) existing operational competencies (Grant, 1996).

2.6 Chapter Summary

The chapter presents a review of literature on the subject area. The chapter commences with an introduction, dashes into the review of important themes covering the concepts of strategic alliance, and other critical discussions surrounding value creation dynamic capabilities and knowledge sharing. The theoretical framework of the study also touched on important theories that explain strategic alliance and are of most relevance to the context of healthcare alliances. The conceptual framework and justifications for the research questions are presented with rich literature support in the section that follows.

Finally, an empirical review is presented. Each of these sections covered has key implications to support the present study.



CHAPTER 3

METHODOLOGY

3.1 Introduction

This chapter aims to address the research paradigm and research design, and explain its relationship with the research philosophy, approach, and the strategy of data collection. The first section is research paradigm which covers the paradigm definition, types of paradigms, assumptions of research paradigm selection, and research strategy. The second section is research design, which is the basic plan that guides the researcher to build his or her research and the plan is derived from the basic and scientific methods and technical tools. Research design must be an effective plan that facilitates the understanding of the research problem and answering its questions. It should also help the researcher to select the appropriate strategy of data collection that interprets the research questions.

3.2 Research Process

Research is often thought as a process which comprises a set of activities unfolding over time (Stone 2002). The first step of research, as shown in Figure 3.1, is to select the target research topic or phenomenon. The research objectives and questions have been introduced and discussed in Chapter One. However, a short introduction to research questions is contained in this chapter to introduce it to research paradigm and discuss it in the research design.

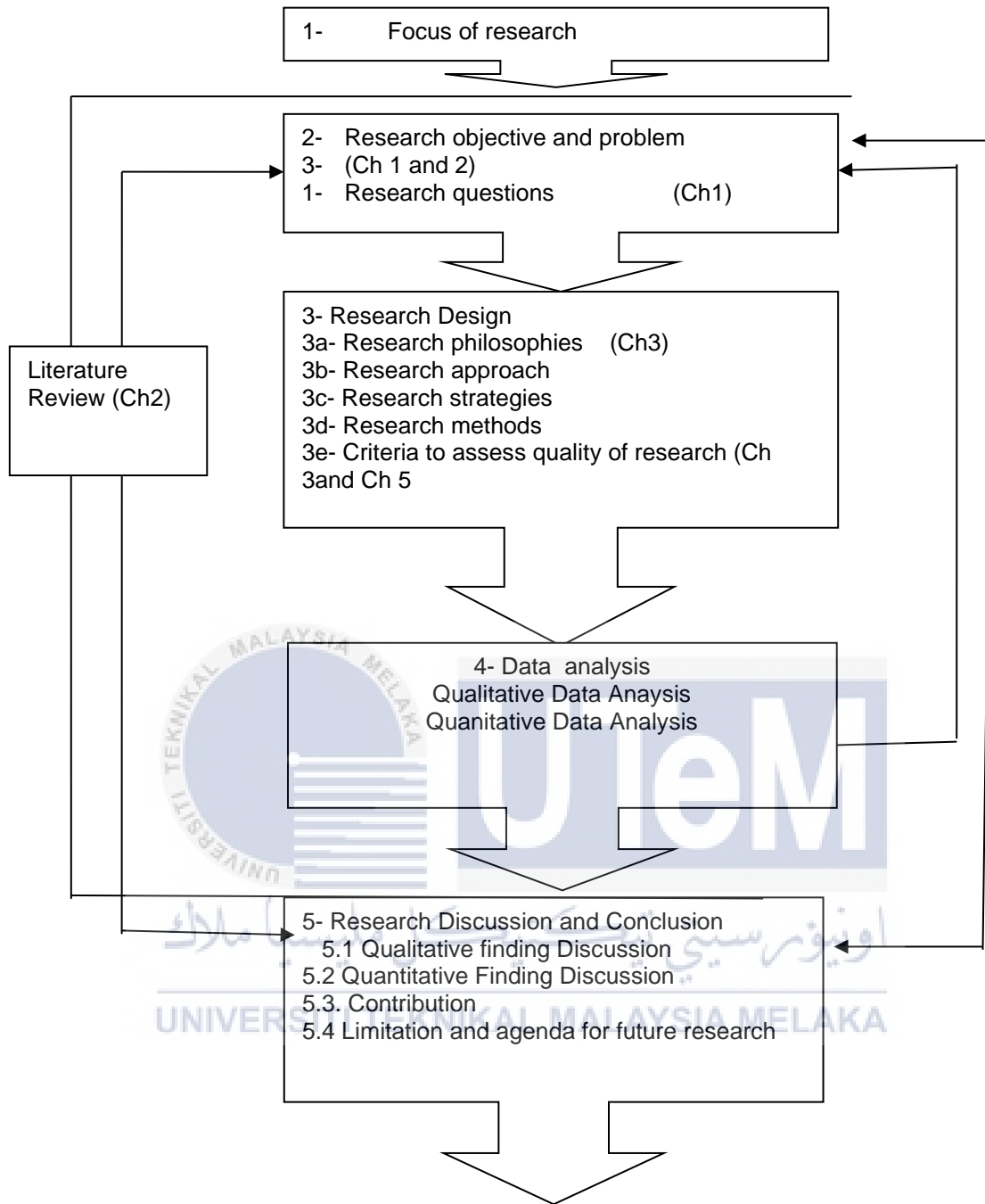


Figure 3.1: The research process

3.3 Research Paradigm

Denzin and Lincoln (2005) defined research paradigm as a basic set of beliefs that guides the action of an individual. The quality of research depends on the relation between idea and theory which has received a wide discussion for a long time.

It also depends on the philosophical thinking of the researcher (Easterby et al., 2012). The arena of business and management research is generally focused on the nature of the reality whether subjective-objective axis (Mangan et al. 2004). For the same axis, researchers have used other terms such as positivist and phenomenological (Gummesson 2000).

The motives and dynamic capabilities of strategic alliance and their effect on firms' competitiveness are defined differently from one study to another and from one context to another. This problem makes it difficult to gain the right and comprehensive knowledge about strategic alliance in the healthcare by using one paradigm solely, either positivist paradigm or phenomenological paradigm. Therefore, in this research, the presence of the phenomenological (exploring the conceptualization) and positivist paradigms (investigating the relationship of factors) is important to explore alliance motives and dynamic capabilities and examine the effect of motives on healthcare firms' competitiveness through mediating effect of dynamic capabilities.

In the phenomenological paradigm, the researcher aimed to gain a good understanding on the motives and dynamic capabilities of alliance strategy in the UAE healthcare institutions. The researcher employed interview with open ended questions. In the positivist paradigm, the researcher aimed to examine the effect of motives on healthcare firms' competitiveness through mediating effect of dynamic capabilities. The researcher used survey to collect the data and was separated from the reality. The value of this research is both value-free through test the collected data and value-laden.

3.4 Mixed Method Research

Mixed methods research has been widely recognized as a crucial approach in the field of social science research and recently it has become a hot topic (Creswell, 2009). Mixed method research is defined as a “research in which investigator collects and analyses data, integrates the findings and draws interferences using both qualitative and quantitative

approaches (Tashakkori and Creswell, 2007). It is a good research design when researchers aim to build on the strengths of both quantitative and qualitative data (Creswell, 2012). There are several advantages of mixed method research, such as build research based on the strengths of both quantitative and qualitative data and overcome the weakness of one method by using the strengths of another method (Creswell, 2012). There are several purposes that motivate the researcher to conduct a mixed method research, which are complementary, completeness, expansion, development, compensation, corroboration and diversity purposes (Venkatesh et al., 2013). For further details see Table 3.1.

Table 3.1: Purpose for Mixed methods

Purposes	Explanation
Complementarily	Mixed methods are used in order to gain complementary views about the same phenomena or relationships.
Completeness	Mixed methods designs are used to make sure a complete picture of a phenomenon is obtained.
Expansion	Mixed methods are used in order to explain or expand upon the understanding obtained in a previous strand of a study
Developmental	Questions for one strand emerge from the inferences of a previous one (sequential mixed methods), or one strand provides hypotheses to be tested in the next one.
Corroboration/ Confirmation	Mixed methods are used in order to assess the credibility of inferences obtained from one approach (strand).
Diversity	Mixed methods are used with the hope of obtaining divergent views of the same phenomenon
Compensation	Mixed methods enable to compensate for the weaknesses of one approach by using the other.

(Creswell, 2012; Venkatesh and Brown, 2013)

In this research, the main objective of this research is to come out with a model that identifies alliance motives and dynamic capabilities and explains how they influence several aspects of healthcare competitiveness. Due to the fact that the motives and dynamic capabilities of strategic alliance and their effect on firms' competitiveness are defined differently from one study to another and from one context to another, conducting either quantitative or qualitative method does not provide a comprehensive understanding of the alliance strategy in healthcare.

To tackle this problem, this research employed a sequential mixed method to gain a greater quality and more robust evaluation and research findings. As shown in Figure 3.2, the sequential mixed method adopted by this research consists of two phases. The first phase was devoted to the conduct of qualitative research method as its focus was to gain an depth understanding of the conceptualization of motives and dynamic capabilities of strategic alliances within the context of UAE healthcare firms. In this context, two research questions were formulated to frame the conceptualisation of the two concepts, which were then used to develop the measurements for the two concepts adopted in development of the questionnaire, the instrument used in the second phase of the research.

The second sequence (phase) of this research was the quantitative research, namely survey research method. In this survey research, questionnaire used to measure three concepts, namely strategic alliance motives, dynamic capabilities of the strategic alliance and competitiveness of healthcare firms. The former two concepts were measured based on the findings derived from the qualitative research conducted in the first phase, while the third concept, competitiveness was measured based on the measurement adopted from the previous peer reviewed studies. The third research question was designed to investigate the influence of the strategic alliance motives and dynamic capabilities on the competitiveness of the healthcare firms in the UAE. Subsequently, framed by the fourth research question, the findings from the qualitative research (interview) used for the development of the measurements of the strategic alliance motives and dynamic capabilities and the findings from the quantitative research that analyse the influence of strategic alliance motives and dynamic capabilities on the competitiveness of the healthcare firms were used to validate the proposed model for strategic alliances for competitiveness of healthcare firms in the UAE.

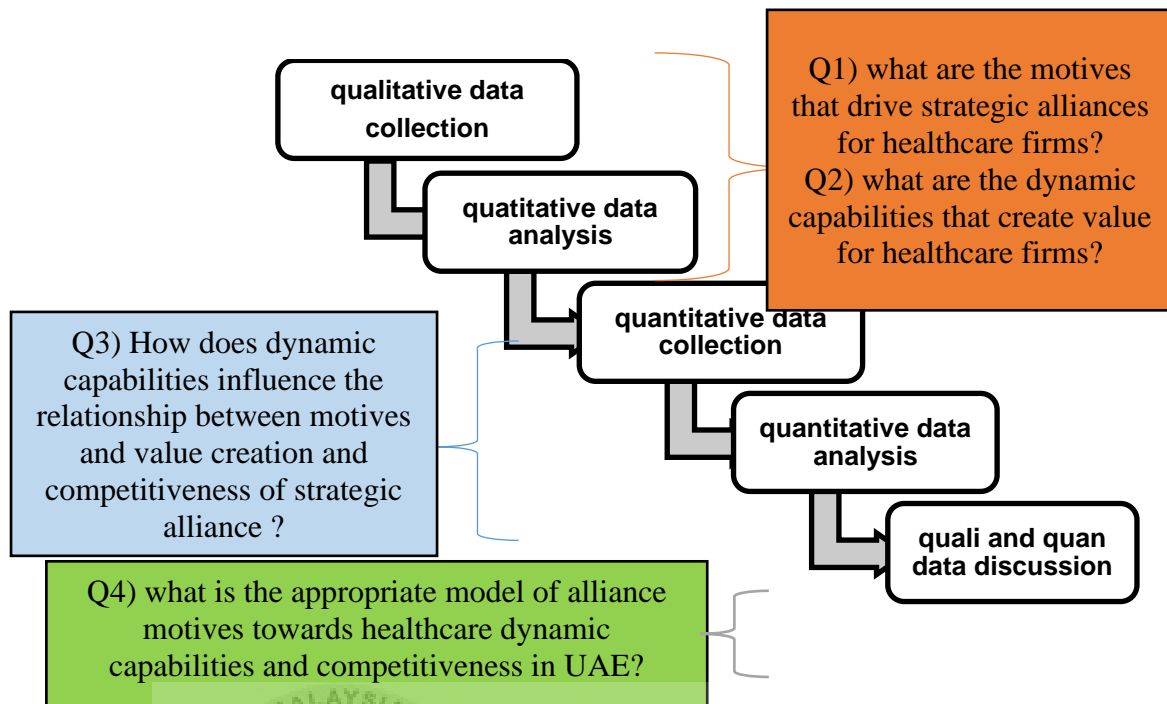


Figure 3.2: Sequential Mixed Method Design (Creswell, 2012)

Phase 1: Qualitative Research (Interview)

As mentioned earlier, the qualitative research was guided by two research questions aiming to conceptualise two concepts, namely the strategic alliance motives and dynamic capabilities within the context of healthcare firms in the UAE. In this case, qualitative research approach was considered the most appropriate approach to capture rich empirical data contextualised within a specific socio-cultural environment, which is the UAE context. Interview was used as the instrument to collect the qualitative data.

The following describes the sample selection, data collection procedure and data analysis involved in this qualitative research phase.

3.4.1 Selection of Respondents (Interviewees)

According to Sekaran (2003), target population refers to all the eligible subjects for participation in the study. In this research, the targeted population refers to alliance projects in the UAE healthcare firms.

According to the statistics in the International Cooperation and Development Department in the Ministry of Health, UAE, there were approximately 79 registered alliance project, in which 57 alliance projects were joint venture and 22 alliance projects were cooperation. In this case, this research selected the respondents from those who involved in joint venture, considering joint venture is the main alliance projects in the healthcare firms of the UAE. According to the statistics, the 57 alliance joint ventures were among three types of institutions, which are 32 public hospitals, 17 private hospitals and 8 Healthcare Centre. These joint ventures were located at two big cities in the UAE, namely Abu Dhabi and Dubai. The criteria for the selection of the respondents is presented in Table 3.5. Based on Table 3.5, four criteria were imposed for the selection of the respondents, which are location, types of alliance, types of institutions and the respondent's length of experience in alliance project. The alliance project must also be ongoing.

Table 3.2: Selection criteria

Selection criteria	Description of criteria
Location	Abu Dhabi and Dubai
Type of alliance	Joint Venture
Type of institutions	General Hospitals, Private Hospital and Healthcare centre
Experience	More than one year
Involvement	On-going project

To collect rich data for inductive analysis, this research purposely selected respondents based on the criteria stated in Table 3.2. The purposive sampling technique entails the identification and selection of subjects who are well-informed and have sufficient experience on the strategic alliance of joint ventures being researched. This leads to rich and vivid insights for more precise research results.

In this case, the respondents who have more than one year experience participating in an on-going joint venture strategic alliance in healthcare firms located in Abu Dhabi or Dubai were purposively selected. It is because the majority of active alliance project are

located in these two cities. It is expected that respondents with more than one year experience in joint venture strategic alliance have sufficient experience to construct meaning on the conceptualization of strategic alliance motives and dynamic capabilities. Additionally, those who are participating in the on-going strategic alliance joint venture project were purposely selected. The purposive sampling allows the researcher to understand the real practice of alliance management from the managers, who are involved in alliance development at different levels. In this case, the primary unit of analysis is the managerial level, which can be the manager or chief executive director (CEO). In this research, based on the 57 joint ventures alliance, only 25 respondents match the criteria for the respondent selection, and all the 25 respondents have agreed to be interviewed.

3.4.2 Data Collection Method

Interviews are considered the best method of gathering large amount of in-depth data in a short time span (Marshall and Rossman, 1995; Easterby-Smith et al., 2002; Yin, 2003). Depending on the purpose of the research, the interview may take a structured format with specific questions for the interviewee or it can be a semi-structured, open-ended type to enable interviewees to expand on the topic they consider as important and to frame those issues in their terms to open up new lines of enquiry (Meredith et al., 1989; Barnes, 2001; Yin, 2003; Ates, 2008).

In this present research, 25 semi-structured interviews were conducted. The position of the interviewees ranged from CEO level to middle level management. Shop-floor employees were excluded from the interview process as the focus of the research was more on the alliance management, which includes alliance motives, dynamic capabilities and competitiveness. Semi-structured interviews were the preferred method over the structured interviews to enable the generation of new ideas and leading questions through open discussion with the interviewees.

Due to the complexity of ensuring the right criteria of the respondents in this research, the interviewees were contacted through the researcher's professional and personal connections. The interviews were conducted through a combination of face-to-face, telephone and Skype-mediated methods to ensure convenience and optimize response rates. The data collection and reporting process followed due steps to address ethical issues and to ensure confidentiality and anonymity of interviewees. On average, each interview took between one hour to one hour and thirty minutes. Several respondents agreed for the interview to be recorded, while others opted for non-recording of the interviews for professional reason. For the interview session without the permission for recording, the research seek permission to make notes during the interview.

Prior to the interview, the researcher explained to the respondents the purpose and the scope of the interview and seek their consent to participate in the interview. The researcher also seek permission from the respondents to record their conversation and make notes during the interview. All respondents were completely aware of the purpose and scope of the research. Appropriate measures were adopted to create a two way, open communication atmosphere for the respondents to feel at ease.

During the interview session, the interviewer (researcher) created a non-threatening and comfortable environment for the respondents to uncover the best possible details from them. He also made sure the confidentiality of the responses provided by the interviewees. Guided by the interview protocol, the interviewer asked questions and jot down important notes. During the interview, the researcher focused on the 5-wh questions, to capture vivid and rich description and gain in-depth understanding of the conceptualization of the concept. Nevertheless, the researcher kept an open mind and applied probing supplementary questions to explore deeper in sights. Data collection and data analysis were conducted concurrently. All interviews were transcribed. The interview data were coded, and memos

were written to aid the ongoing analysis each time an interview was conducted. Each participant was assigned to a specific number (001 to 025) as a specific identifier. The transcriptions were verified with the respondents to ensure that data validity is obtained.

3.5 Interview protocol – An operational action plan

Semi-structured interviews (at the company site) were used as the primary data collection method. The research questions and findings from the literature review facilitated in developing the interview protocol (with established themes) for conducting semi interviews. According to Yin (2017) protocols act as an instrument that supports in operationalising the research, acting as an action plan, and setting rules and regulations by which data can be gathered. Following Yin ((2003), the interview protocol includes information on the purpose of the conducting the interview, data collection procedures and the topics to be interviewed. As shown in Table 3.2, the protocol which includes the topics to be interviewed are divided into two main topics which are the strategic alliance motives and the strategic alliance dynamic capabilities of the healthcare firms. In this research, the topics identified in the literature provided initial guidance for interview protocol.

Table 3.3: Interview Protocol

Topics	Determined by literature and further explored during interview
Understanding alliance motives	• industrial Relation
	• transactional cost (economic)
	• Partner competency
Understanding alliance Dynamic capabilities	• reconfiguration
	• integration
	• co-ordination

Consistent with the interview protocol, the interview questions are categorized into three sections: i) Demographic background; ii) alliance motives; and iii) alliance dynamic capabilities. The list of the interview questions is presented below.

SECTION 1: Participants' demographics and background 1.

Q1. Could you please tell us about your age and educational background?

Q2. Could you please tell us about your employment in terms of institution, position and the main responsibilities?

Q3. How long are you working in this institution?

SECTION 2: Alliance Motives

What are the motives that drive strategic alliances for healthcare firms?

Q1. What economic (including financial and transactional) resource factors compelled your healthcare organization to venture into strategic alliances?

Q2. What competency-based factors compelled your healthcare institution to venture into strategic alliances?

Q3. What industry-relationship based factors compelled your healthcare institution to venture into strategic alliances?

SECTION 3: Alliance Dynamic Capabilities

What are the dynamic capabilities that create value for healthcare firms?

Q4. What areas in your alliance do you consider the integration of capabilities?

Q5. What areas in your alliance do you consider reconfiguration capabilities?

Q6. What areas in your alliance do you consider co-ordination capabilities?

3.6 Qualitative Data Analysis

Data analysis is the process of making sense of the data collected (Merriam, 2009; Holliday, 2007). Qualitative data analysis could be linked to completing a jigsaw puzzle in which the pieces represents the data (Saunders et al., 2007). Analysis of large amount of

information gathered through interview is the biggest challenge in qualitative research (Yin, 2003; Eisenhardt, 1989). The challenge faced by the researcher is how to condense the rich data into a format that could be convincingly comprehended by a target audience (Easterby-Smith et al., 2002).

As stated by Eisenhardt (1989) “Analyzing data is the heart of building theory from case studies but it is both the most difficult and the least codified part of the process”. Several methods for qualitative data analysis have been proposed to date that includes content analysis, grounded theory, cognitive mapping, repertory grid, protocol analysis, pattern matching, critical incident techniques to name a few (Easterby-Smith et al., 2002; Miles and Huberman, 1994; Yin, 2003). A common method of data analysis used in qualitative work is the thematic content analysis, rooted from the grounded theory approach (Braun and Clarke, 2006; Burnard, Gill, Stewart, Treasure and Chadwick, 2008; Cresswell, 2009). The general process of thematic analysis is done in a recursive process, involving analysing the transcripts to extract the codes which are then transformed into themes (Javadi and Zarea, 2016).

There are several software packages such as NVIVO, NUD.IST, CAQDAS, which has also become popular for coding, generating patterns from large amount of narrative texts collected from open-ended interview or from historic documents (Yin, 2003). However, this research conduct the data analysis manually.

In this present research, the process of data analysis for the qualitative data was conducted adapted from Braun and Clarke (2006). In this research, the six-step thematic proposed by Braun and Clarke (2006), was adapted into four steps only, which are 1) familiarizing the data, 2) generating codes for labeling; 3) search and determining themes, and 4) using the themes for questionnaire development). In this research, the three steps for developing the themes proposed by Braun and Clarke (2006) were combined into one step

that is searching and determining themes, while the presentation of the result was adapted to using the themes for developing the items of measurement for the constructs. Figure 3.3 shows the four steps of data analysis adopted by this research, which starts from 1) familiarizing with the data; 2) Coding for labeling data, 3) searching for and determining themes, and 4) using the themes for construct measurement. Considering the purpose of the analysing of the qualitative data was to design the construct measurements for the three motives (economic, competency and industry-relationship) of strategic alliances with partners and dynamic capabilities that create values, the final report of the analysis is the themes to be used to develop the questionnaire for the second stage of the research, which is the survey research.



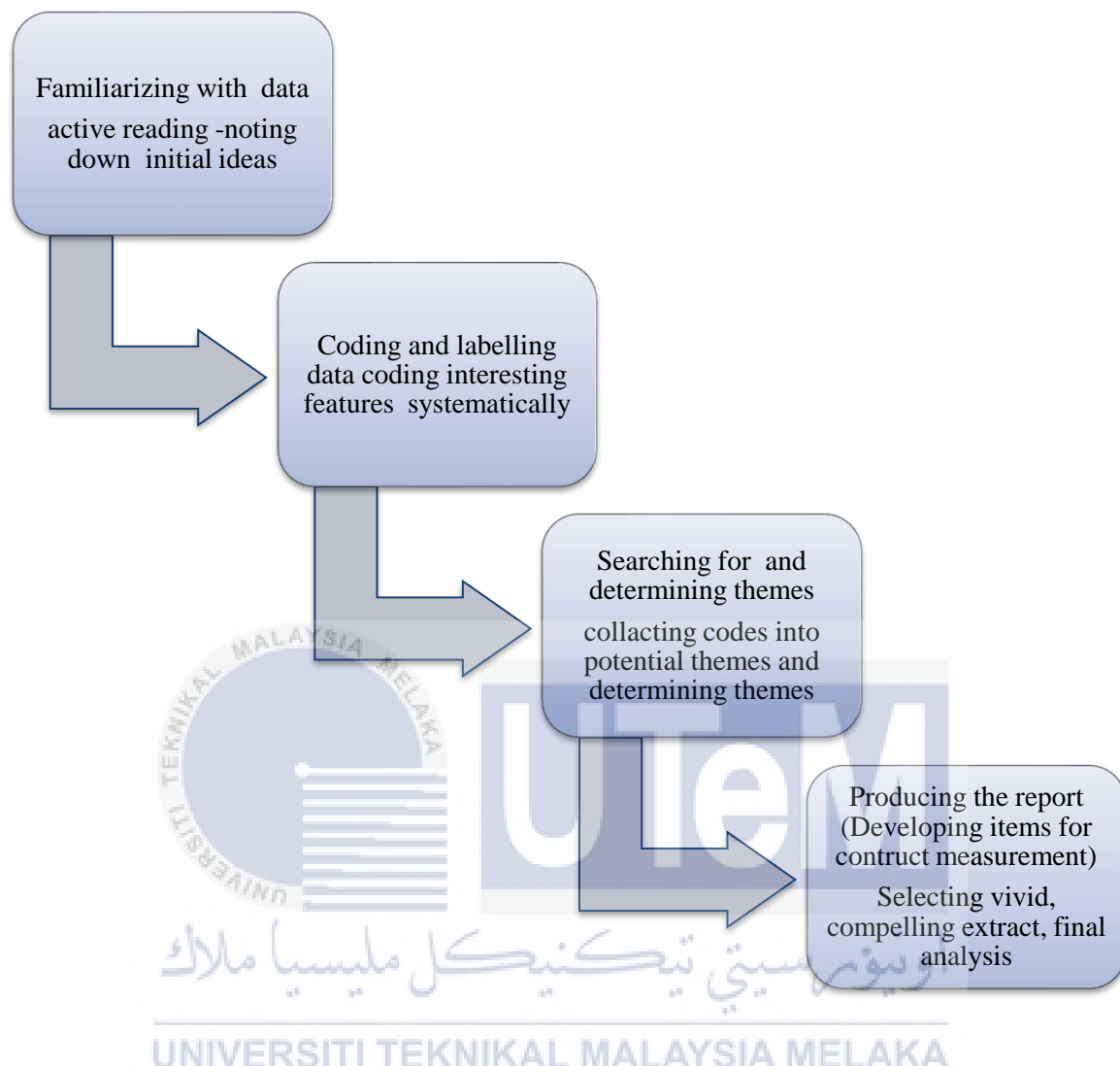


Figure 3.3: Analytical process of thematic analysis (Adapted from Braun and Clarke, 2006)

The following describes the stages involved in the data analysis. Prior to the analysis, the recorded data were transcribed verbatim, while the unrecorded data were based on the notes taken during the interview. A total of 25 data were analysed and the transcribed data were more comprehensive than the notes-based data.

3.6.1 Familiarizing with the data

The analysis began with the process of familiarizing and making sense of the data. It is important to read the whole set of data before coding in order to obtain an overall

understanding. At this stage, the researcher interacted with the data in order to construct meaning. This is also one of the ways to bracket the researcher's subjectivity, in order to gain understanding of the meaning constructed by the respondents. For this purpose, active reading was conducted to ensure the familiarity of the data. The text was read several times and while reading the text, memoing were made to gain overall understanding of the data. To gain understanding of the text, the memoing was done through the comments features in the Word guided by wh-questions and how questions (what, who, where, when why and how strategic partners were selected). Figure 3.4 shows the sample of memoing conducted to one of the transcriptions (Interview 001). As shown in the sample, the memoing includes the additional explanations (comments) of the researcher.

Economic (including financial and transactional) factors compelled alliance healthcare value creation and competitive

Based on your opinion, what are the economic factors that lead to strategic alliance project in your company?

... Basically in our alliance project we are trying to achieve win to win goal whereby both parties can get a benefit of the alliance.

To ensure that, we tried to equally collaborate and participate to alliance commitment.

How did you do that?

We share equity balance between the partners, either positive or negative is one of our organization strategy to select our partners.

Did you experience any challenges?

Our organization has bad experience with some of alliance partners because they used to take advantage from us. For example, some of alliance partners are not opened enough with their resources and knowledge. This because the top management were reluctant to make a decision. This cost us a lot. Therefore. We are eager to select the right partner, who can mitigate the risk of opportunistic behaviour through talk a walk.

May I know how did you select your partner?

As we know, our hospital provide a high quality services, but the associated cost is high, especially when it comes to hiring specialists, who can only visit our hospital in limited time. Therefore, we used to select our partner who can help us in optimizing our value and reduce transaction cost through complementary resources.

Utem07
Reasons for alliance – win-win goal., This seems to be the common explanation given by the respondent.

Utem07
How – equality seems to be the most important consideration in alliance. Here, equal collaboration and participation, the statement seems to be quite general, will seek further info regarding this Commitment is also an issue- are there a lot of instances that alliance not sustainable.?

Utem07
How equal – either positive or negative Here another comments about collaboration- not necessary positive- they share both positive and negative

Utem07
Challenges – take advantage by partners – any effort to rectify this? What do you normally do? When you discover this? at what stage did you normally this happen and what kinds of advantage did the partner take?

Utem07
How .. and why Types of risk.? What do you mean through talk a walk- any example?

Utem07
Who and what – example.???

Figure 3.4: Sample of comments by researcher to familiarize with the transcript

3.6.2 Coding for labelling data

After gaining sufficient understanding of the data, the data were coded and labeled according to categories. Guided by Braun and Clarke (2006) and King and Horrocks (2010), coding and categorising the data involved two stages: a) developing a coding index, and b) coding the transcripts based on the coding index. The coding index represents the thematic structure (King and Horrocks, 2010) that serves as a general template to code and categorise the data into meaningful units for interpretation. It was developed based on axial coding (Corbin and Strauss, 2007) in which a general coding index was constructed based on the research questions, conceptual framework and relevant literature. In this case, explicit rather than implicit meaning of the text were emphasized as the main purpose of the qualitative analysis is to design the questionnaire for the second stage of the research. The general categories and sub-categories were assigned with each code (as shown in Table 3.3) for easy reference and coding. Additionally, for each category, 'others' was also included for any data that cannot be classified by the identified sub-categories, resulting in four sub-categories for each of the two categories (Alliance motive (AM) and Alliance dynamic capabilities (ADC))

Table 3.4: Categories and sub-categories for coding and labelling

General categories (code)	Sub-categories (codes)
Alliance motives (AM)	Transactional cost (AM-TC)
	Partner competencies (AM-PC)
	Industrial Relation (AM-IR)
	Others (AM-O)
Alliance dynamic capabilities (ADC)	Reconfiguration (ADC-R)
	Integration (ADC-I)
	Co-ordination (ADC-C)
	Others (ADC-O)

3.6.3 Searching and defining themes

The next stage is to search and define the themes. A thematic approach to organising the data was employed, wherein data was re-arranged under themes or categories (Creswell, 1998; Holliday, 2007; Merriam, 2009; Schwandt, 2001) Using inductive analysis, the possible patterns, themes and categories were discovered by looking for key phrases, terms and practices that are particular to the people in the setting. The themes were determined based on the codes produced in the earlier stage. The codes were used as guidance to label the key words under each sub-code and there are instances whereby, the text can be classified as two different codes. The labelling of the text according to the codes were done by highlighting the key words and classifying them under specific categories. Figure 3.5 shows two samples (Data 001 and Data 003) of the highlighted key words related to sub-category (Alliance motive –transaction cost: AM-TC).

Sample 1: interviewee 001

Based on your opinion, what are the economic factors that lead to strategic alliance project in your company?

.... Basically in our alliance project we are trying to **achieve win to win goal** whereby both parties can **get a benefit of the alliance**.

To ensure that, we tried to **equally collaborate and participate to alliance commitment**.

How did you do that?

We **share equity balance between the partners**, either **positive or negative** is one of our organization strategy to select our partners.

Did you experience any challenges?

Our organization has bad experience with some of alliance partners because they used to **take advantage** from us. For example, some of alliance partners are **not opened enough with their resources and knowledge**. This because **the top management were reluctant to make a decision**. This **cost us a lot**. Therefore. We are eager to select the right partner, who can **mitigate the risk of opportunistic behaviour** through **talk a walk**.

May I know how did you select your partner?

As we know, our hospital **provide** a high quality services, but the **associated cost is high**, especially when it comes to hiring specialists, who can only visit our hospital in limited time. Therefore, we used to select our partner who can help us **in optimizing our value** and **reduce transaction cost** through **complementary resources**.

Figure 3.5: Sample 2: Interviewee 003

Based on your opinion, what are the economic factors that lead to strategic alliance project in your company?

We look for partner who can help **to reduce operational costs**, as reducing the cost of transactions can **improve the efficiency of operations**. In addition, we seek for **alliance partner** who can play an important role in **mitigating transactional costs** by **establishing trust** and **promoting active engagement** among cooperative employees. When trust is high, partners are more likely to **openly share resources and information**, leading to **greater efficiency** and **reduced costs**.

Our organization also attempts to **mitigate transactional costs** and **limit opportunistic behavior**. It is because the opportunistic **behavior** can increase transactional costs by leading to **disputes, renegotiations, and other inefficiencies**. Therefore, we used to select a partner whose **top management team** has a **strong sense of justice** to **mitigate transactional costs** and **limit opportunistic behaviour**.

Our organization often seek alliance partners who can **optimize our organization value** while reducing transactional costs. It is because by optimizing value and reducing transactional costs, our partnership can **create a mutually beneficial relationship** and **achieve a competitive advantage** in the market. In this way, both parties can **achieve the goals** and **achieve greater success** through alliance partnerships.

Figure 3.6: Samples Of The Highlighted Key Words For Sub-Category AM-CT

Next, the highlighted keywords were classified under specific categories that guide the construction of items of the questionnaire.

3.6.4 Reporting

The final stage is the reporting, which focuses on reporting the development of items related to the constructs measured in the questionnaire survey. The process of transforming the key words into the items in the survey is as illustrated in Table 3.XX. As shown in Table 3.5, the key words extracted from the data were categorized according to broad themes: reason for alliance and criteria for selecting partners. constructions of the items of the questionnaire for ‘transaction cost’ is as shown in Table 3.5.

Table 3.5: The development of the measurement transaction cost as sub-dimension of alliance motive.

Phrases /words from data	Extracted key words based on frequency	Theme	Constructed items of the questionnaire
Strategic alliance Reduce cost Operation cost Transactional cost Improve quality	Alliance Reduce Operation Cost Quality	cost	In our organization, the main reason for opting strategic alliance is to reduce operation cost
Win-win goal Equally collaborate and participate Equity balance between partners Positive or negative Does not take advantage Create a mutually beneficial relationship Take advantage (neg)	Partners Equity balance Positive or negative Win-win goal	Equal balance	We always look for partners that emphasise on equity of balance, either positive or negative to achieve win-win goal
Establish trust Open with resources and knowledge Openly share resources and information Promote active engagement	Trust Active engagement Share resources and knowledge	Trust and active engagement	We look for project partner who is trustworthy, promote active engagement and willing to share resources and knowledge
Mitigate the risk of opportunistic behaviour Walk the talk Limit opportunistic behaviour Disputes, renegotiations and other inefficiencies (negative) Top management reluctant to make decision (neg) Strong sense of justice	Top management Strong sense of justice Opportunistic behaviour	Top management	We look for partners whose top management team has a strong sense of justice to limit opportunistic behaviour
Optimise organization values complementary resources Improve efficiency of operations	Optimise organization values Complementary resources Efficiency of operations	Complementary resources	We look for partners who have complementary resources to improve efficiency of operations and

Phrases /words from data	Extracted key words based on frequency	Theme	Constructed items of the questionnaire
Greater efficiency Buy new resources			cost of buying new resources that optimizes company's value

3.7 Quantitative Method

3.7.1 Phase II Research Strategy – Survey

For the second phase, survey research was conducted. According to Saunders et al. (2012) the survey questionnaire is suitable for data collection in the survey research strategy. The strategy is popular in both academic and industry research as it gives researchers an authoritative way to establish empirical evidence (Saunders et al., 2012). This comes from the ability to use a large sample size with the survey strategy to enhance the generalizability of the study. The survey strategy is an important strategy used by this study to conduct the conclusive phase in order to close the main research gap by arriving at a model of strategic alliance sustainability.

3.7.2 Phase II Population (Quantitative Methods)

Despite clearly defining the sampling techniques, the correct sample size (Saunders et al. 2009) determination is considered as the heart of contributing to the increasing level of precision and confidence of data generated. There are different sampling size requirements between probability and non-probability sampling size as the latter rests on smaller sample size from $n = 12$ respondents respectively for the equally consistent group (Guest 2006). However, for the probability sampling techniques, the calculation for business research is based on Roscoe (1975). The rule of thumb to calculate the sample size in this research is applicable as (i) sample size between 30 to 500 is adequate for most research as supported by Stutely (2003) which indicated that the minimal sample of $n = 30$ is sufficient to represent

the normal distribution. Furthermore, as discussed in Kumar et al. (2013) the increase of sample size is useful to reduce sampling error.

However, as argued by Sekaran and Bougie (2009) too large sample size may incur the type II error especially if $n > 500$ respondent. The decision to choose the correct sample size is based on Saunders et al.'s (2009) requirements which is following the requirement of analysis carried out. Thus, due to the fact that this research applied SEM as part of the data analysis, the determination of sample size will be following the SEM requirement. The sample size chosen according to Hair et al. (2010) is in Table 3.6. (ii) Sample size of $n = 30$ is required for the sub-samples as recommended by Roscoe (1975) and Stutely (2003). This is due to this research that is based on the multistage cluster, minimal requirements are needed to increase the level of precision (Sekaran and Bougie 2009).

Table 3.6: Summary of the suggestions for minimum sample size

Model characteristics	Minimum sample required	Item Community
Five or less latent constructs. Each latent construct has more than three items.	100 sample	0.6 or higher
Seven or less latent construct. Each construct has more than three items.	150 sample	0.5 or higher
Seven or less latent construct. Each construct has less than three items (just identified model).	300 sample	0.45 or lower
More than seven latent constructs. Some constructs have less than three items (just identified model).	500 sample	0.45 or lower

Adapted from Hair et al. (2010) and Awang (2012).

In this research, a survey was distributed to thirteen hospitals that have alliance strategy with international partners. Of them eight general hospitals and five private hospitals. The managerial units were selected as a unit, which includes research and development (R and D), marketing and sales, operation and other.

Due to the fact that there is no exact size of population since the research focuses on unit level, this research follows Stutely (2003) in which sample size between 30 to 500 is adequate for most research.

This indicates that the minimal sample of $n = 30$ is sufficient to represent the normal distribution (Stutely 2003).

In Jun 2020, surveys sent to selected participants together with a supporting letter from the hospitals and alliance project support. The surveys were developed in English because all workers in alliance project have the ability to speak in English. In the early of Jun 2020, the respondents were randomly selected from the list that provided by human resource departments. After selecting the respondents, the survey then was distributed to 60 units in 13 hospitals, of them eight public hospitals and five private hospitals as shown in the Table 3.7. The online survey was used as a tool for data collection, which was more active because it minimizes the outliers and missing value rate. A total number of 459 surveys were distributed to 134 unit directors and 325 employees. The data collected was finished in March 2021 with a total number of 292 respondents of them were 87 surveys from unit leader's positions (30%) and 205 surveys from employees (70%).

Table 3.7: Data Distribution and Collection Rate

Level	8 Public Hospitals			5 Private Hospitals			Total Received
	Distribution	Received	%	Distribution	Received	%	
Unit Level	80	55	69 %	54	32	59 %	87
RandD	18	11		13	8		19
Sales and Marketing	16	13		14	9		22
Operation	20	13		12	7		20
Others	36	18		16	8		26
Employees Level	181	120	66 %	144	85	59 %	205
RandD	45	29		36	19		48
Sales and Marketing	41	28		33	21		49
Operation	46	29		36	20		49
Others	49	34		39	25		59
Total	261	175	67 %	198	117	59 %	292

3.7.2.1 The Survey Questionnaire

The questionnaire in phase II will consider the items as resulting from the qualitative grounded theory research strategy. The items resulting from the survey, will be combined and measured on a five (5) point Likert scale for validation within the case study institution. The structure of this questionnaire is presented in Appendix D of the present report. The questionnaire will help measure the lower or exogenous aspect of the conceptual framework; this is critical to investigate how knowledge sharing contribute to competitive performance through value creation dynamic capabilities in an all-inclusive model of healthcare strategic alliance sustainability.

In addition to the use of key measurement of variables presented in the earlier section of the methodology, the questionnaire collects data on key demographics including the age, gender, public/private and job position. The collection of data on these demographics as part of the survey will be critical to observe the inclusive nature of the results or outcome. The diverse nature of responses will support the randomness of the sampling approach and add to the overall generalizability of the study.

3.8 Measurement of the Study Variables

The study mainly consists of seven (7) main variables; three variables within the endogenous areas and three other variables within the exogenous zone, with knowledge sharing being shared between the endogenous and exogenous zones. For the qualitative phase covering the endogenous aspect of the model, no specific variable definitions will be used as characteristic of qualitative research. The factors of the transactional cost economy, competence-based view and industry relationship-based view factors that contribute to partners strategic motives among parties within the case study hospital will be observed. Second, three factors represent alliance dynamic capabilities, which include integration, reconfiguration and coordination capabilities.

These factors were also generated from the interview, which discuss in CH 4.

Finally, healthcare competitiveness were adopted from study by.

Table 3.8: Measurements Strategic Alliance Competitive Performance

Strategic Alliance Competitive Performance	
1	Our healthcare alliance often form competitive expectations at alliance formation
2	Process and relational measures of strategic alliances are often up to global industry standards
3	Strategic goals fulfilment is often within clear reach in our healthcare alliance
4	Strategic and operational satisfaction is often achieved in our healthcare alliance
5	Financial performance of our healthcare alliance are often satisfactory (overall profitable outlook)
6	In our healthcare alliance, new emergent goals add to the overall competitiveness of the alliance within the market
7	Our healthcare alliance has demonstrated stability in operations and competitiveness
8	Our healthcare alliance is able to remain competitive throughout the duration of the alliance
9	Our healthcare alliance is usually terminated on satisfactory and successful terms of outcomes
10	Overall market performance of strategic alliances are encouraging within our healthcare alliance

3.9 Data Collection Methods

Every study that requires primary data also requires a sample (Etikan et al., 2016). Data collection is a critical step in research as it provides enhanced understanding regarding the conceptual framework of the study. Due to this, careful attention needs to be paid to how data is obtained and from where data is obtained. Importantly, the choice of data source must be free of bias and in the best interest of the accuracy of the research being conducted. The data collection phase is highly critical since it is impossible to correct improperly collected data through analysis. The questionnaire will be administered with the help of Microsoft Forms Online Data Collection Platform. This was to ensure that challenges associated with data entry are removed.

It also helped alleviate errors that occur in the event of data entry. Online data collection of responses from survey ensure efficiency in data management as data is simply downloaded after data collection and uploaded into the SPSS and Office Excel analyses software. The official email address of the researcher was used to send the questionnaire and accompanying information sheets and consent form to all participants. With regards to the interview discussions, the data will be collected from the offices and convenient locations as agreed with the study participants.

3.10 Pilot Study, Reliability and Validity Assessment

Research credibility will be achieved in two main areas of validity and reliability. Validity is achieved by ensuring that all theories and concepts are defined based on established theories and empirically tested constructs. Reliability pertains to how the methods observed specifically answers the questions and objectives at hand (Saunders et al., 2012). All constructs were tested for internal consistency with the help of Cronbach Alpha test in SPSS.

To ensure that all the constructs used in the study were valid, all constructs of the study are either acquired from the literature using reputable journal articles or validate in the first phase of the study. The items used were selected on the basis of being empirically tested and evaluated. Where the constructs were only acquired after the qualitative stage of the study, the qualitative stage of the study was used systematically to explore those constructs before their inclusion on the quantitative stage. For each of the data collection instruments, the following pilot observations was conducted prior to main or actual data collection (Table 3.9). For the qualitative research, it is important that all areas of research credibility, transferability, dependability and confirmability are strictly maintained as recommended by Cope (2014).

Table 3.9: Measurement of Variables - DC

S/N	Instrument	Pilot	Validity and Reliability Measurement
1	Interview Guide – Phase I	<ul style="list-style-type: none"> • Expert Opinions • 1-5 Pilot respondent 	Credibility/trustworthiness Transferability Dependability Confirmability
3	Survey Questionnaire – Phase II	<ul style="list-style-type: none"> • Expert Opinions • 40-50 Pilot respondent 	Construct validity, Discriminant Validity, Composite Reliability, AVE etc

3.11 Pre-test

3.11.1 Exprts' Validation

The validity of an instrument or questionnaire measurement is the level to which it measures what it intends to measure (Bordens and Abbot, 2011). Validity is concerned with how properly the construct is defined by the measures, and the two most commonly accepted and used validity tests are face or content validity, and construct validity (Bordens and Abbot, 2011). Content validity or face validity deals with the subjective agreement among professionals that a scale logically reflects exactly what it is contend to measure and the content of the scale appears to be adequate (Zikmund, 2003). Although it is a weak form of validity, content or face validity might be important in a way that it gives certain assurance to the researchers and the study as a whole. If the respondents did not see the instruments as valid, they might build a negative attitude about its effectiveness (Cohen and Swerdlik, 2010). In this study five experts were contacted for a discussion session in order to make clear the contents of the questionnaire. Table 3.10 shows a list of experts who were consulted and given the questionnaires for their reviews. They were to verify if respondents have any complexity in understanding the questionnaire, or whether there exists any uncertainty or bias in the questions.

These experts were also asked to critique and give suggestions in order to improve the questionnaire. During the session, they were encouraged to give their input on the design of the questions, wording of the questionnaire, and any improvement that they might think is appropriate. These experts examined each item or question in the questionnaire to ensure that they satisfactorily measured the research concept. Their comments were noted, and some questions were reworded and revisions were made to remove certain ambiguities. The objective was to improve the content and the face validity of the questionnaire.

Table 3.10:List of Content Validity Experts

Institution	Department	Expert Area
Associate Professor Dr. Ahmed Jaber	Research and Development Dijlah University	Business management
Associate Professor Dr. Mohammed Ali	Sana'a University	Law and Governance
Dr. Qusi Hayder	Bagdad University	Information Technology
Dr. Shiek Salem	Dubai University	Management
Mohamed Abudullah	Healthcare industry Abu Dhabi	Management

Construct validity is another form of validity test. Construct validity “measures the extent to which the scale correctly measures what it is intended to measure, that is, the items in the scale all measure the same construct”. Construct validity is established during the statistical analysis of the data. Using Smart PLS construct validity is assessed through convergent validity and discriminant validity. Convergent validity “assesses the degree to which measures of the same concept are correlated. When the scores obtained from two or more different questionnaires measuring the same concepts are correlated, then convergent validity is established (Sekaran and Bougie, 2013). Discriminant validity is the “degree to which two conceptually similar concepts are distinct. Each instrument is unique or distinct,

and that the measurement scale of a particular construct should not be highly correlated with the measurement of another construct (Zikmund et al., 2013).

3.11.2 Pilot for Survey Questionnaire

The reliability of a measure concerns its capacity to create similar results when repeated measurements were made under identical conditions (Bordens and Abbot, 2011). Reliability is also considered as the scale to which the observed variable measures the “true” value and is “error free” (Hair et al., 2010). To determine the reliability of the measurements used, internal consistency check was conducted which applied to the consistency amongst the variables in a summated scale (Hair et al., 2010). The reason for applying internal consistency is that the individual terms or indicators of the scale should all be measuring the same construct and hence be extremely intercorrelated (Nunnally, 1978; Churchill, 1979). The most common measures of reliability employed in many studies is the reliability coefficient that evaluates the consistency of the entire scale, with the most commonly used Cronbach’s alpha (Cronbach, 1951; Nunnally, 1978; Churchill, 1979). It is suitable for instruments that use Likert scale and dichotomous scales. An alpha value of 0.7 and above is regarded as reliable. The closer the value to 1 means that the instrument is more reliable and shares a high internal consistency.

A pilot study is significant because it improves the questionnaire and is used to identify weaknesses in the instrumentation and design, and to give proxy data for the selection of a probability sample (Cooper and Schindler, 2014). Pilot test would involve respondents from the same pool of the study, and its purpose is to ensure the reliability, readability, wording, format and sequencing and clarity of questions or items in the questionnaire. Pilot test is also used to determine the length of time required for completion as it also establishes the accuracy and appropriateness of the research design and instrumentation.

According to Emory and Cooper (1991) respondents of 25 to 100 are appropriate for a pilot study. A set of questionnaires were distributed randomly to 35 unit leaders and employees who are engaged in alliance management in Dubai and Abdu Dhabi hospitals. Data collected was coded and entered into SPSS to test the reliability by using alpha scores for each of the construct variables. Cronbach's Alpha consistency coefficient was used to measure the reliability consistency of the collected data (Straub, 1989). The results of the pilot are presented in Table 3.11 below shows that the Cronbach alpha score is more than 0.70, indicating that the internal consistency of the measurements are reliable and explained the constructs.

Table 3.11: Pilot Study Results

S/N	Construct/ Factor	Number of Items	Alpha (Cronbach) Score
1	Transactional Economic Cost	3	.864
2	Alliance Partners' Competencies	3	0.912
3	Industry-relationship	3	0.817
4	Reconfiguration Capabilities	5	0.903
5	Coordination Capabilities	7	.829
6	Integration Capabilities	6	0.873
7	Healthcare Competitiveness	8	.892

3.11.3 Exploratory Factor Analysis

A total of 100 questionnaires were administered to employees in alliance project in the UAE healthcare institutions, both face to face and online. Cronbach Alpha and EFA were used to analyse the data in IBM SPSS version 23. In the context of this study, EFA can be used to examine the construct's unidimensionality. EFA is effective at the early stages, according to Hoque and Awang (2016) and Hoque et al. (2018), and is judged appropriate when there is a requirement to evaluate the unidimensionality of the components measured. Furthermore, EFA is a valuable method for studying the links between observable variables and a small number of underlying factors, according to Hoque and Awang (2016), which

may be applicable in this study. A component analysis is used to decrease the number of variables utilised to explain a relationship or to establish which variables have a link. Factor analysis is a multivariate analysis process that tries to find any underlying "factors" that are responsible for the covariant among a set of independent variables.

As a result, by examining all of the elements at the same time to prevent biases and preferences, this study is declared adequate and appropriate. Kaiser (1974) advises a minimum of 0.5 (KMO value) (just acceptable levels between 0.7-0.8 are acceptable, and values over 0.9 are excellent).

Table 3.12: Exploratory Factor Analysis

	Component						
	1	2	3	4	5	6	7
AT1						0.725	
AT2						0.774	
AT3						0.773	
AM1					0.853		
AM2					0.84		
AM3					0.794		
AI1							0.814
AI2							0.809
AI3							0.733
AC1		0.661					
AC2		0.614					
AC3		0.655					
AC4		0.71					
AC5		0.658					
AC6		0.666					
RC1			0.51				
RC2			0.579				
RC3			0.736				
RC4			0.767				
RC5			0.798				
CC1				0.533			
CC2				0.576			
CC3				0.497			
CC4				0.634			
CC5				0.685			

CC6				0.589			
CC7				0.579			
HOC1	0.718						
HOC2	0.734						
HOC3	0.707						
HOC4	0.721						
HOC5	0.748						
HOC6	0.777						
HOC7	0.726						
HOC8	0.746						

3.11.4 Ethical Considerations

To make sure that the study was ethical, key ethical considerations were followed. The adherence to ethical considerations ensures that the study is credible, and the results were not achieved through unacceptable means. Therefore, all areas of the study were completed with a focus on research ethics and acceptable practices. As argued by Saunders at al. (2012) all researches that involve human participants must be completed with the permission of those participants; this was followed strictly. In addition to this, other ethical standards for conducting research were inferred from the UK Data Protection Act (1998). Participants were given prior information in written form.

This information contained the names and contacts of the research and institution to which the researcher belonged. It also contained the purpose of the investigation and the reason why the participants were being asked to participate. A form of informed consent was also given to participants. The form detailed all the requirements to acquire full permission for the participants' input. It informed the participants regarding their confidentiality and reserved right to withdraw their participation in the research. Both the information sheet and informed consent form are provided in the appendices of the study (Appendix A and Appendix B).

3.12 Quantitative Data Analysis

3.12.1 Structure Equation Model (SEM)

The strength of SEM techniques relies on the confirmatory techniques (hypothesis testing) (Byrne 2010) with the ultimate aim to measure the outcomes of data collected that will replicate the underpinning theory (Lei and Wu 2007). Furthermore, SEM is capable of assessing, specifying, and calculating the measurement error (Oke et al. 2012) while efficient in searching for the “best fitting model” that made this technique more robust as compared to conventional techniques (Byrne 2010). Next, the simplicity of SEM techniques depends on the capabilities of measuring the entire relationship simultaneously (Oke et al. 2012) by integrating the measurement model and structural model (hypothesised causal path) and it is useful to resolve the complexity in managerial and behavioural research.

Lastly, under the umbrella of SEM application, the research can apply this technique under several conditions; experimental-non experimental data and cross-sectional data or longitudinal data (Lei and Wu 2007) and practical to be used (Oke et al. 2012) in management, administration (Gefen and Rigdon 2011; Shah and Goldstein 2006) operation management and clinical research (Tomarken and Waller 2005). Therefore, SEM techniques provide a convenient and effective usage depending on its approaches (Gefen and Rigdon 2011) and this research employed SEM to robust the analysis with taking into consideration research its objectives, application, and assumption.

This study utilised SEM statistical package, AMOS 18 and IBM SPSS 19 to conduct and analyse its data. SEM has become a popular multivariate approach in social sciences recently and it is known by many names such as (i) analysis of covariance structures, (ii) latent-variable analysis, (iii) analysis of moment structure, (iv) linear structural relationship, and (v) causal modelling (Cunningham, 2008; Hair et al., 2010). SEM provides advantages over other multivariate analysis techniques: it is easy to use for visual SEM, modification,

viewing of the model, and it produces quality graphics for publication purpose. Moreover, SEM is also able to determine measurement error and test measurement model through CFA and structural model through path analysis simultaneously (Kline, 2011). As SEM allows researchers to estimate parameters and test hypotheses, this statistical package has been widely applied in the engineering and management field in areas. SEM is also utilised in this study on the basis of its rigorous approach in conducting multivariate analysis (Kline, 2011).

The primary purpose of choosing SEM compared to the factor analysis or multiple regression analysis in SPSS is because this method is more precise.

Thus, choosing an appropriate approach is seemed as crucial for the researchers who use the SEM application. In one hand, Karl Jöreskog that comprises specific software such as Lisrel, Mplus, EQS established the covariance-based SEM, and Amos works well for confirmatory research design. Meanwhile, variance-based SEM introduced by Wold, namely Smart PLS, PLS graph, and GeSCA rest on exploratory research design (Kumar and Deregowska 2002). Further, the cutting edge to differentiate both applications relies on the theory testing procedure with strong theoretical background for covariance-based while variance-based is more suitable for causal predictive assessment with weak theoretical base (Gefen and Rigdon 2011).

The other point of departure relies on the sample size requirement (Oke et al. 2012) depending on the complexity of the model (Kumar and Deregowska, 2002) as the covariance-based requires more respondents compared to variance-based. Furthermore, the quality of assessment under covariance-based is more rigorous based on the established goodness of fit (GOF) measurement and directly increase the validity of measurement evaluation (Tomarken and Waller 2005).

3.12.2 Assessment of Statistical Fit

Good of Fit (GOF) is considered as part of critical techniques on approving the “superior” of the proposed model as this analysis recognises how well the predicted model measures the observed covariance matrix in the data compared to the proposed model (Ho 2006) or how well the similarity of the estimated covariance matrix (theory) to reality (the observed covariance matrix) (Hair et al. 2010) through several cut of values. Byrne (2010) and Hair et al. (2010) proposed three major indicators to measure model fit, namely (i) absolute fit indices, (ii) incremental fit indices, and (iii) parsimonious fit indices.

However, there are differences in terms of practical usage mainly in the cut off values and the main function for each dedicated formula as described below.

a) Absolute fit indices: This measurement is called **model fit** because the ultimate aim of the assessment relies on measuring the degree to which the sample variance-covariance data fit the structural equation model (Schumacker and Lomax 2004).

b) Incremental fit indices: This indicator is recognised as **model comparison** as the main function of the evaluation is comparing the proposed model with the null model (alternative model) (Schumacker and Lomax, 2004).

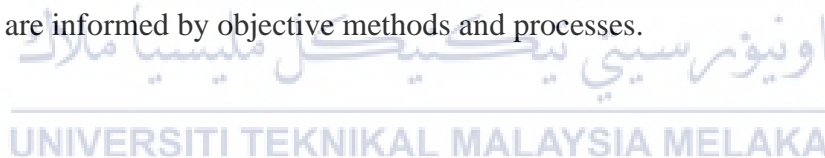
c) Parsimonious fit indices: In this indication, it mentions the number of estimated parameters required to achieve a specific level of fit (Schumacker and Lomax 2004).

There are many arguments on the GOF application in terms of the correct indicator to represent the model fit and suitable cut off values. The aforementioned indicators can be specifies based on Hair et al.’s (2010) proposal of GOF measurement and cut off values based on the sample sizes, complexity, and degree of error in model specification. Furthermore, Bagozzi and Yi (2012) and Oke et al. (2012) proposed that X^2 , RMSEA, non-normed fit index (NNFI/TLI), CFI, and SRMR are crucial indicators to measure model fit. Kline (2011) indicated there are several indicators that are important for model fit such as

RMSEA, GFI, CFI and SRMR. However, as opposed to the Oke et al.'s (2012) argument, there are no issues on selecting the best indicator to represent the model fit as the indicator is sensitive to the sample size, type of data, and number of variables. Hair et al. (2010) in the rule of thumb highlighted that by comparing that the complex model and larger size ($n = 250$), simpler model and small sample size ($n < 250$) required a stringent model fit evaluation.

3.13 Chapter Summary

The present chapter summarizes the research methodology in a detailed fashion. In summary, the study entails a two fieldworks research strategy where the first phase entails building a measurement scale of knowledge sharing of strategic alliance partner motives using grounded theory, and the second phase entails the use of this scale to develop a model of strategic alliance sustainability. For these methods to be executed successfully towards the observation and recommendation of authentic conclusions, it is important that all areas of the study are informed by objective methods and processes.



CHAPTER 4

QUALITATIVE RESULTS AND FINDINGS

4.1 Introduction

The main analysis is categorised into three main sections or parts. The first part focus on the qualitative analysis, which answers two main question, which are: Q1) what alliance motives are that influence alliance among the healthcare firms? Q2) what are the dynamic capabilities that create value for healthcare firms? The second section focuses on how the interaction between alliance motives and dynamic capabilities influence alliance competitiveness among healthcare institutions. This section answer three main questions, which are: Q3) Does alliance motives positively influence the dynamic capabilities and competitiveness of the UAE healthcare firms? Q4) Does alliance dynamic capabilities influence the competitiveness of the UAE healthcare firms? Q5) What is the appropriate model of alliance motives and dynamic capabilities that influence competitiveness of healthcare firms?

4.2 Qualitative Data Analysis

Prior to conducting the interviews, the researcher obtained full permission from the Health institutions (general and private hospitals as well as healthcare centres). This section outlines the answers for the first research question or phase I of the research study, which was carried out through qualitative research (multiple case studies). The data were gathered using the Semi-interview guide as a data collection instrument. The interviews sought to investigate the specific underlying alliance motives and dynamic capabilities the UAE healthcare institutions. As shown in Table 4.1, there are three original groups represent alliance motives and were derived from the literature, which are the transaction cost,

competency-based view and industrial-organization relationship based view. In addition three main group represent alliance dynamic capabilities were derived from the literature, which are alliance integration, coordination and reconfiguration.

Table 4.1: Research Questions and the Groups

Main Question	Sub-Questions	Group
Q1) what alliance motives are that influence alliance among the healthcare firms?	Q1a. What economic (including financial and transactional) factors compelled alliance healthcare value creation and competitive?	Economic Motives
	Q1b. What competency-based factors compelled alliance healthcare value creation and competitive?	Competencies Motives
	Q1c. What industrial-organization relationship based factors compelled alliance healthcare value creation and competitive?	Industrial-organization relationship
Q2) what are the dynamic capabilities that create value for healthcare firms?	Q2a. What reconfiguration capabilities are that create healthcare firms' value and competitive?	Reconfiguration
	Q2b. What coordination capabilities are that create healthcare firms' value and competitive?	Coordination
	Q2b. What integration capabilities are that create healthcare firms' value and competitive?	Integration

The first section elaborates on an overview of the results including overall responses. The rest of the analysis follow the two of the other most commonly used and cited techniques for qualitative data analysis are - a three step proposal by Miles and Huberman (1994): data reduction; data display; and drawing conclusions; and a two step process proposed by Eisenhardt (1989): within- case analysis and cross-case analysis.

4.2.1 Background of the Respondents

In this research 25 participants consented to, and successfully participate. An overview of the data is presented in Table 4.2. The respondents were coded 001 to 025. Given this outcome, a total of 25 interview transcripts were therefore analysed and presented in the present chapter. The interviews were conducted between 4th January 2020 and 21st January 2020, meanwhile each interview took between one to one and half hour.

Over the 2 and a half weeks period, 1-3 interviews were conducted on selected days. Eleven respondents were from public hospitals with about 40% followed by nine respondents from private hospitals with about 36% and finally six with about 24% of the respondents were from health centres. Regarding respondents position, thirteen of the respondents were from middle and top management, meanwhile twelve respondents were from senior managers. The average age of the respondents were 44.4 years old and their experience range from 4 to 15 years with about average of 11 years. This indicates that the respondents have a good experience. Finally, most of the respondents have master with about thirteen respondents equivalent to 52%, followed by seven who have degree about 28% and finally five of the respondents have doctorate with percentage of 20%. This indicates that all respondents have high education, which indicates that they have a good knowledge about alliance strategy in healthcare institutions.

Table 4.2: Overview of Respondents for Qualitative Data

<i>Participants</i>	<i>Date</i>	<i>Time</i>	<i>Sector</i>	<i>Position</i>	<i>State</i>	<i>Age</i>	<i>Experience</i>	<i>Education</i>
<i>No: 001</i>	4 th January 2020	9:00 AM	Public Hospital	Senior level management	Abu Dhabi	48	11	Master
<i>No: 002</i>	4 th January 2020	1:00 PM	Public Hospital	Senior level management	Abu Dhabi	45	12	Master
<i>No: 003</i>	6 th January 2020	3:00 PM	Public Hospital	Senior level management	Abu Dhabi	53	21	Master
<i>No: 004</i>	6 th January 2020	8:00 PM	Public Hospital	Senior level management	Dubai	51	13	Master
<i>No: 005</i>	8 th January 2020	10:00 AM	Healthcare Centre	Senior level management	Abu Dhabi	39	9	doctorate
<i>No: 006</i>	8 th January 2020	2:00 PM	Public Hospital	Senior level management	Dubai	51	14	Master
<i>No: 007</i>	8 th January 2020	3:00 PM	Public Hospital	Mid-level management	Abu Dhabi	38	14	doctorate

No: 008	9 th January 2020	5:00 PM	Public Hospital	Mid-level management	Abu Dhabi	42	15	Master
No: 009	11 th January 2020	11:00 AM	Healthcare Centre	Mid-level management	Dubai	48	12	Master
No: 010	11 th January 2020	4:00 PM	Public Hospital	Managerial level	Dubai	46	9	Degree
No: 011	11 th January 2020	11:00 PM	Private Hospital	Managerial level	Abu Dhabi	44	9	Degree
No: 012	14 th January 2020	10:00 AM	Public Hospital	Managerial level	Abu Dhabi	34	7	Degree
No: 013	14 th January 2020	3:00 PM	Healthcare Centre	Managerial level	Dubai	37	9	Degree
No: 014	15 th January 2020	12:00 PM	Private Hospital	Senior level management	Dubai	52	11	Master
No: 015	15 th January 2020	11:00 PM	Private Hospital	Senior level management	Abu Dhabi	52	12	doctorate
No: 016	16 th January 2020	1:00 PM	Private Hospital	Senior level management	Abu Dhabi	48	14	doctorate
No: 017	16 th January 2020	7:00 PM	Healthcare Centre	Mid-level management	Abu Dhabi	47	11	Master
No: 018	17 th January 2020	7:00 PM	Private Hospital	Mid-level management	Dubai	44	12	Master
No: 019	18 th January 2020	9:00 AM	Private Hospital	Mid-level management	Dubai	39	6	doctorate
No: 020	20 th January 2020	9:00 AM	Private Hospital	Managerial level	Dubai	37	8	Degree
No: 021	22 th January 2020	9:00 AM	Private Hospital	Senior level management	Abu Dhabi	46	12	Master
No: 022	22 th January 2020	3:00 PM	Private Hospital	Managerial level	Dubai	33	4	Degree
No: 023	23 th January 2020	9:00 AM	Public Hospital	Managerial level	Dubai	35	6	Degree

No: 024	23 th January 2020	3:00 PM	Public Hospital	Senior level management	Abu Dhabi	53	12	Master
No: 025	24 th January 2020	3:00 PM	Healthcare Centre	Senior level management	Abu Dhabi	48	12	Master

4.2.2 Transactional Cost, Competencies and Industrial-organization relationship

Motives

Based on the research problem, alliance strategy works differently from one industry to another, and the literature still lacks of a clear understanding about alliance motives (Hübel, Weissbrod, and Schaltegger, 2022). This affects the generalizability of previous studies since they have mainly focused on the undefined nature of the motives of the healthcare alliances (Lewis, 2017). Therefore, to bridge this gap, the following question was emerged, which is “what alliance motives are that influence alliance among the healthcare firms?”. Based on the literature review three main themes were shown to be the most common motives, which are transactional cost, competencies, and industry-related motives. Yet, the factors of each category are vary and understand which factors influence alliance motives in the healthcare institution need further exploring based on actual practice. Therefore, driven by economic, competencies and industrial-organization relationship motives, three questions were asked as shown in the following:

4.2.2.1 What economic (including financial and transactional) factors compelled alliance healthcare value creation and competitive?

Regarding economic resource factors that compelled the healthcare organisation to venture into alliance, special responses were sought in the areas of financial and transactional resource factors such as the sharing of bills, fees, and profit motives among others. In the original situation, both the principal and the healthcare alliance faced the

real risk that the alliance of healthcare firms might run into trouble as the project progressed. Therefore, the balance of the equity in alliance project, either positive or negative forms an incentive for both alliance partners to use their competences with dedication and benevolence, rather than trying to offload risks onto each other.

Respondent

001 mentioned “the equity balance, either positive or negative is one of our organization strategy to select our partners. This help to mitigate the risk of opportunistic behaviour’.

The other responses were largely in consensus, **004 emphasised** on the need to make partner motives known ahead of the alliance formation. He explained in detail that: “I believe that partner **motives to go with alliance is very important before sign the agreement**. How that is can be done? Well! I worked in this organization for more than 10 years. The majority motive for my organization focus on how to be stronger among other organization. The most concern in our health care organization is not only improving service quality but also **minimizing operation cost through equity sharing**. Therefore, the partner with strong equity position is important to ensure the fulfilment of its duties and minimize the opportunistic behaviour. This is in line with **five interviewees such as 011, 015,009, 012 and 025**.

This supports by **interviewee 001**. The finding of this research is in line with study by Ali, Khalid, Shahzad, and Larimo (2021) in which equity sharing between IJV partners facilitates minimizing opportunistic behaviour and positively associated with IJV performance. This was supported by other six **interviewees namely 024, 020, 0.18, 006,008 and 014**.

Many joint venture tends to produce behaviours that contradict what is required in a cooperative relationship. While the initial alliance conditions may bring about legitimate

levels of distrust on the principal's side, due to the opportunities and incentives for healthcare firms to claim for extra work, to shirk on quality or to hide mistakes, the ways adopted for monitoring may worsen relationships, since they tend to become self-fulfilling prophecies. That is, closely monitored partners, feeling that they are not treated as equals, may reciprocate by behaving in just the way the principal organizations are trying to protect themselves against. This may lead to the potential costs of endangering their relationship, which is seen as outweighing any short-term advantages gained through opportunistic behaviour. Therefore, efficiency managing internal alliance is one of the motives to overcome this problem. **Interviewee 023** states that “**our organization ensure the efficiency of managing alliance and we select the appropriate project partner, who share trust and make substantial efforts in engaging cooperative employees, who are accommodated rather than opportunistic attitudes**”. This is in line with study by (Huo et al., 2015) in which partner trust is important to achieve a long term collaboration. This supported by interviewee 022.

The alliance's strategy in the health sector, like any vital sector, is witnessing a dramatic changes over time, especially in the era of digital transformation. This results a challenge to the partners, especially in how to take advantage from this change and maintain competitive and maintain competitive. One of the key solution is providing a good quality with minimum cost, especially in developing countries where cost is the driver for competitive advantage. In this regard, **Respondent 021** confirmed that our organization prefer a partner who have **complementary resources** that facilitates providing **a good quality services with minimum cost**. This also supported by **respondents 020**, who stated that “**optimize value** through controlling the resources cost is one of the most important areas where our organizations are always looking for alliance partner, who have

complementary resources to reduce transaction cost of buying new resources”. This in line with **two interviewees**

This also supports by Ali et al. (2021) in which optimize value through resource complementary and minimize the opportunism behaviour between IJV partners are important incentives that facilitate value creation in the IJV. This supported by **four interviewees 003, 005, 007, 016 and 021**.

The common issue in strategic alliance is how to minimize opportunistic behaviour among the partners. This can be achieved through top management support for justice and KPI control. In this regard, respondent 0.002 stated that: **“our organization used to select the partner whose top management team has a strong sense of justice to limit the opportunistic behaviour”**. This supported by **two interviewees namely 001, 010 and 012**.

Table 4.3: Alliance Economic Motives

Economic Motives					
	Operation cost	Equity Balance	Cooperative employees	Limit opportunistic behaviour	Optimize value
Groups	The most concern in our health care organization is not only improving service quality but also minimizing operation cost	The equity balance, either positive or negative is one of our organization strategy to select our partners.	our organization select the appropriate project partner, who has a good record in sharing trust and make substantial efforts in engaging cooperative employees	our organization used to select the partner whose top management team has a strong sense of justice to limit opportunistic behaviour”	our organizations are always looking for alliance partner, who can optimize our value and reduce transaction cost through complementary resources”.
1		✓		✓	✓
2		✓		✓	
3		✓			✓
4	✓		✓		
5					✓
6		✓		✓	
7	✓	✓			✓
8		✓		✓	

9	✓	✓			✓
10			✓	✓	
11	✓		✓		
12	✓		✓		
13	✓	✓			✓
14		✓			
15	✓		✓	✓	
16		✓			✓
17	✓	✓			✓
18		✓			
19	✓	✓			✓
20	✓	✓	✓		✓
21	✓	✓			✓
22	✓	✓		✓	
23			✓		✓
24		✓			✓
25	✓			✓	✓
Total	14	18	7	8	14
%	23%	29.50%	11%	13%	23%

To sum up, as shown in the Table 4.3, the majority of the interviewees suggested that sharing equity is the most important motive for alliance formatting following by the partners who can minimize the operation cost and optimize the value creation equally with 23%. This indicates that the UAE healthcare institutions are economically motivated in alliance based on economic value creation, operation cost minimization and most importantly balance equity sharing. This because with sharing equity, the opportunistic behaviour will be reduced. However, the limit opportunistic behaviour and cooperative employees scored the lowest value with 13% and 11% respectively.

4.2.2.2 What competency-based factors compelled alliance healthcare value creation and competitive?

The success of strategic alliance goes beyond achieving specific performance to include achieving the competitiveness. This depends on partners' competency in managing

the strategic alliance. In this regard, Respondent 011 stated that: “Our **organization tend to select competent partners who know-how to articulate, codify, share and internalize healthcare experience**”. This also supported by 001.

Teece, Pisano, and Shuen (1997) emphasize that competencies can generate competitive advantages and profitability as long as they are based on a collection of routines, skills and other resources that are difficult to imitate. In this regard, **Respondent 012 added:**

“If you look in the UAE healthcare sector and MENA sector there is shortage of specialist and subspecialty in the healthcare. Where getting in affiliation with well-known healthcare institute give the healthcare organization more reputation. Therefore, one of our priorities for forming alliance is to have a partners who have **substantial experiences and skills in healthcare services at different levels, which was supported by interviewee 025.**

Getting into a strategic alliance with a recognized and a good experience partner can assist in creating a favourable efficient and effective health distribution systems. This supported by **Respondent 013**, who stated that:

“I 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, but I want them to start where other ended. I want them to learn from other and start to gain more knowledge that helps to put this organization on the top list”. This also supported by interviewee 015.

Respondent 024 was straight forward on competency-based motives, stating that the main competency-based motive for getting into alliance is: “Exchange of expertise, Share skills and Share competency”. To address consensus in competency motives, 002 added that: “we set **KPI's to measure the performance in alliance.** We see any defects; we use the process that we created to ease challenges and find solution for conflicts. .”

Respondent 009 elaborated in detail, the need for competence motives in alliances:

“if partner that I’m going alliance with have competency similar to my level or higher and supporting me when I need on our operation level which will lead **to integrated services** that we both provide. to elaborate more, if we go to our staff competencies and skills, operation performance, management performance, therefore, we can use our **partner competencies to perform better** and our **partner can do same of using strengthen competencies** that we have to add advantages for their organization. This supported by interviewees 021, 023, 019 and 007.

The researcher asked if the competency-based motives did benefit the alliances, mainly highlighting on *complementary exchange of alternative competences*.

Respondent 018 mentioned that:

“Yes! Imagine that I can operate my staff where I have strength on this. My staff are qualified and well trained. On the other hand, I have lack of experience on managing my equipment and technology where my partner is qualified. Therefore, both parties will get benefit”.

According to Respondent 003:

Respondent 013 also added that management competency is another key driver of strategic alliances. “the most need for our company from my perspective is **management**. I will not go with new established organization who have no **experience with management**. At this stage my management team will avoid and mistake by learning from my well expert partner who will help to avoid making mistakes from experience and reduce risk factors in management”. In further elaboration on the alignment of competence motives, 014 highlighted on the conflicts surrounding competencies sharing that: “it’s important to know my partner competency motives before or after getting in alliance, and I believe it is important before getting in alliance. For example, to overcome my internal weaknesses, I always prefer a partner with complementary resources”.

For Respondent 004, competencies must exist in the areas of: “Delivering a **Global class healthcare system** and given the current circumstances and the numbers of people specialized in the healthcare sector, it was mandated that we attract and retain well reputable firms and organizations that **satisfy our patients**. This requires advanced technology since healthcare became more complex and rapidly witnesses changes. Therefore, the local expertise will **integrate and learn from international expertise technology use** which will eventually unify the practice of the two parties and enhance the healthcare sector. Therefore, I can conclude that our organization prefer partner with a unique **technological knowledge and resources** that can bring **competitive advantage** to our healthcare market.”

Respondent 010 added that:

“**Enhancing quality of care through exchanging expertise** where knowledge will be shared, and professionals well **gain more technology and learn** from each other experiences. To achieve alliance in competency-based motives, 020 added that:

“Let’s talk about technological and knowledge competency where in **alliance partner sharing knowledge** and technology and **learn from other partner**. It’s important to set that in the agreement, but I believe partnership based on competency motives is challenging while for example partner X want to use partner Y to train professional in its hospital.

Where partner Y does not want to share all knowledge with X partner professional. That was not clear in the agreement. **Where agreement should state all training needs and motives that bring this agreement on the table**”. Interviewees 017, 014 and 008, added that the technological and knowledge competencies are very important motives for alliance.

Based on competence-based theory (Hunt et al., 2002), successful alliances are achieved based on the development of specific competences that lead them to succeed. Competence is defined as ‘an ability to sustain the coordinated deployment of assets in a

way that helps a firm achieve its goals’ (Heene and Sanchez, 1997). Therefore, an alliance competence is connected with partners’ resources as well as partners’ capability of using these resources in attaining their strategic goals. In this regard, respondent 017 stated that: “We always looking for a partner who has **separate abilities** that, when combined together, enable our healthcare to **achieve goals**.”

Table 4.4: Alliance Competencies Motives

Competency Motives					
Groups	Healthcare Specialist	Healthcare service capability	Technological resources	Complementary healthcare skills	Experience in Management
Item	Our organization tend to select competent partners who know-how to articulate, codify, share and internalize healthcare experience	One of our priorities for forming alliance is to have a partners who have substantial experiences and skills in healthcare services at different levels.	our organization prefer partner with a unique technological knowledge and resources that can bring competitive advantage to our healthcare market.”	We always looking for a partner who has separate skills that, when combined together, enable our healthcare to achieve its goals	Our organization prefer partner with a good management experience in alliance to minimize the risk
1	✓				✓
2	✓		✓		✓
3		✓		✓	✓
4	✓		✓		
5			✓		✓
6		✓	✓	✓	✓
7			✓	✓	
8	✓		✓		
9				✓	✓
10			✓		
11	✓			✓	✓
12	✓		✓		✓
13		✓	✓	✓	✓
14			✓	✓	✓
15		✓			
16	✓		✓	✓	✓
17			✓		

18		✓		✓	✓
19				✓	
20	✓		✓		✓
21		✓	✓	✓	
22	✓		✓	✓	✓
23		✓		✓	
24		✓	✓		✓
25	✓		✓	✓	✓
Total	10	8	17	14	16
%	15%	12%	26%	22%	25%

To sum up, as shown above at the Table 4.4, partner competencies are important motives for alliance creation. The majority of the interviewees about 26%, prefer alliance partner who have technology and knowledge competences in the healthcare. This is important to many developing countries including UAE since the development of technological healthcare industry is dominated by developed countries. Followed by 25% of alliance management experience. This is indeed important to limit alliance termination before achieving the targeted goals.

The interviewees also suggested that complementary healthcare skills are important motives for alliance development with about 22%. Finally, healthcare Specialist and healthcare service capability got the minimum score with about 15% and 12% respectively.

4.2.2.3 Alliance Motives based on Industrial-organization relationship

Q3. What industry-relationship based factors compelled your healthcare institution to venture into strategic alliances?

The healthcare industry witnesses a dynamic transformation and rapidly changes in the process of delivering its product and services. This create an opportunity to healthcare organization that has capability to change. However, in developing countries adopting with technological and work environmental changes is always challenging organizational change.

This because most of the firms there still rely on western and developed countries technical support.

Thus, alliance strategy is a bridge that many UAE healthcare institutions used to form. The industrial-organization relationship strategy is one of the effective motives to achieve alliance competitive where partners can gain advantage of more flexibility and better responses to the changing situation (Migdadi, 2022). Regarding healthcare alliance, the integration of technology in health industry forced many healthcare institutions to establish alliance with a pioneer technological industry to achieve their competitiveness. For this area **Respondent 008** observed that factors that drive industry relationship include:

“Well! I believe our organization use to select alliance partners who are well known by our organization or other organizations whom we have **a good cooperation with, especially in investing in some technologies**”. This also confirms by interviewees 001, 004 and 009,

The Industrial Organization theory shows not only what resources that are needed by alliance, but how to gain the resources. In this respect, **respondent 014 added that:**

“What they do is getting alliance with well-known institutions who has strong reputation in the market. This add value to our organization in only a part of its operation. This apply for also specialty infrastructure IT and training”. This supported by 016 and 017.

In what may be considered as largely in consensus **with 014, Respondent 002** and 007 added that: “This make our **organization stronger** from the perspective of turn my weaknesses to strength by allaying with partner who can help to **improve these weaknesses**.”

Respondent 003 explained that consensus may be established by forming committees.

“I believe establishing committees supervised by **steering committee with regular meeting**, where clear data is shared for both sides will avoid many conflicts with alliance.

Respondent 017 also stated that our organization prioritise a long term relationships in **knowledge sharing** for industry relationship: **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 and it would be difficult to be solved.”

For Respondent 003, industrial-organization relationships are essential to support businesses in a complex and unstable business world: “Our organization prefers the partner who has **strong market position** and can aid in reducing the opportunaities for competition by creating barriers to new entrants”.

Indeed many firms in developing countries are struggle hard to penetrate new markets or somehow protect their local markets not only because of the operational capabilities, but **also network. According to interviewee 015, our alliance has strong network with government agencies. This** facilitates resource mobility and fasten the achievement of our activities. In addition, interviewee 010, stated that our organization put priority on alliance partner who has good network with healthcare suppliers. It is because it facilitates knowledge and **resources sharing**, which help in increasing the **capacity of our healthcare services and respond to market opportunities**”. **This confirms by respond 011, 013, 021 and 022.** The network intensity with other leading industries is an important competency that many corporations seek for: **In this regard, interviewees 005 and 010 stated that** our health centre is dealing with diabetes which is the most common disease in the UAE and we prefer partner who has network density and agreements with good healthcare suppliers and experts. Interviewees 023 and 024, added that our alliance partner has good network with health international organizational agencies. This improve our image.

Table 4.5: Alliance Motives based on Industrial-organization relationship

Category	Reputation	Market Network and Control	Network
Code	Our organization prefer alliance with well-known institutions who has strong reputation in the market.	We prefer the partner who have market network and can control market competition by creating barriers to new entrants	Our organization prefer partner who has network density to facilitate our knowledge and resources sharing, which help in increasing the capacity of our healthcare services and respond to market opportunities”.
Re001	✓	✓	✓
Re002	✓		
Re003		✓	
Re004	✓		✓
Re005	✓	✓	✓
Re006			
Re007	✓	✓	✓
Re008	✓		✓
Re009	✓		✓
Re010	✓		✓
Re011			✓
Re012	✓	✓	
Re013		✓	✓
Re014	✓	✓	
Re015		✓	✓
Re016	✓	✓	
Re017	✓	✓	✓
Re018		✓	✓
Re019		✓	
Re020	✓		✓
Re021	✓	✓	
Re022		✓	✓
Re023	✓	✓	✓
Re024			✓
Re025	✓	✓	✓
Total	16	16	17
%	33%	33%	34%

To sum up, the interviewees suggested that industry relationship is an important motives for alliance formation in the UAE healthcare industry. The interviewees suggested that the partner who has earlier collaboration with them is more preferable with about 34% followed by alliance partner with a good reputation as well as has a good market network, which can help in market control with about 33% respectively.

Alliance motives have been regarded as an important factors for alliance competitiveness and value creation. A total of 25 interviewees with about 175 suggested that economic motives, partners' competencies and partner with industrial-organization relationship are important motives for alliance competitiveness. As shown in Figure 4.1, the majority of the interviewees emphasised to the important of partner competencies with about 37% following by alliance with economic motives 35 and finally alliance with industrial-organization relationship with about 28%.

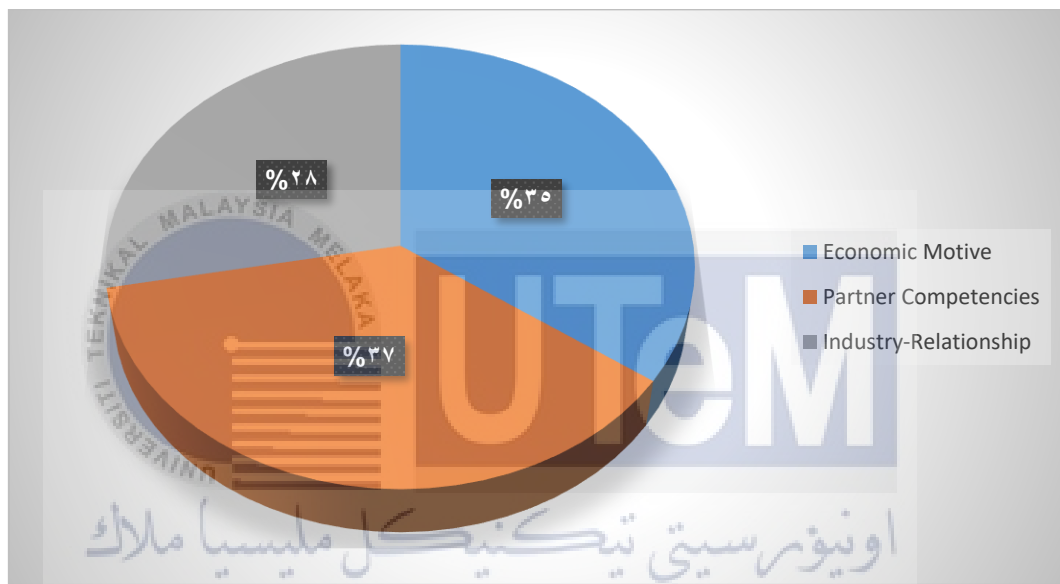


Figure 4.1: Summary Alliance Motives

4.2.3 Value Creation to Fuel Competitive Advantage In Strategic Alliances

The last part of interviews considered value creation; and the extent to which they add to competitiveness in strategic alliances. A total of five (5) questions were asked in this area. It mainly targeting how integration, reconfiguration, coordination contributes to competitiveness.

4.2.3.1 Integration Capabilities to Healthcare Competitiveness

For the first research question, the researcher sought to observe the contribution of integration capabilities to competitive advantage. Respondent 012 mentioned that “our

organization contributes in an **integrated manner knowledge** to the alliance integration is essential to **achieve goals** and **provide efficient capabilities** that inform better competitiveness. Respondent 002 added that our organization shares understanding of tasks, responsibilities to facilitate duties achievements and operational cost reduction through an integrational system.

Respondent 013 emphasized to the importance of communication within alliance partners saying that “Our organization have demonstrated **connectedness in communication** towards **value creation**”.

Some alliance partners are able to squeeze more benefits than others due to power differences from expertise or differences in intra-alliance value capture strategies (Bouncken, Fredrich, Kraus, and Ritala, 2020). This may affect long term alliance collaboration. In this regard, Respondent 015: stated that ‘our organization sought out to attend **collective intra-alliance activities** to create value in our healthcare alliance’. In a similar vien, respondent 021 stated that “I think when you ally with well-reputable organization, we consider partner with collective **intra-alliance** activities which will consequently affect all aspects of performance, including but not limited to **contracts with insurance companies** where you can ask for **better reimbursement factor**.”

For Respondent 019, integration: “In our culture its fundamental assumption that **union** is a strong force no one can debate. Therefore, if two partners integrate their capabilities, both can reach **level of performance that can be noticed among other competitors**.”

In addition, respondent 0122, indicates that our healthcare pays a great attention on **inter-connectedness** to external **value channels to improve alliance operations**. This requires alliance integration capabilities to ensure that both alliance parties are jointly committed to the achievement of their intra-alliance activities. For example, respondent 009

stated that “Collective **intra**-alliance activities (activities within the newly formed alliance) is considered important to create value in our healthcare alliance”. This also helps in value creation, especially in exploiting external opportunities. In this regard, respondent 010 stated that “**Adaptation and inter-connectedness to external value channels is an essential aspect of alliance operations in our healthcare alliance**”.

Table 4.6: Integration Capabilities

Group	knowledge	shares understanding	communication	intra-alliance	inter-connectedness	integrate their capabilities
Code	“Our organization contributes in an integrated manner knowledge to achieve goals and provide efficient capabilities ”	Our organization shares understanding of tasks, responsibilities to elimination of duties and reduction of operational costs	Our organization demonstrates connectedness in communication towards value creation.	Our organization sought out to attend collective intra-alliance activities to create value in our healthcare alliance’	Our organization pays a great attention on inter-connectedness to external value channels to improve alliance operations	Our organization and its partner integrate their capabilities to reach level of performance that can be noticed among other competitors.
Re001	✓		✓	✓		
Re002		✓		✓		✓
Re003	✓		✓		✓	✓
Re004		✓			✓	
Re005	✓	✓	✓		✓	✓
Re006						
Re007			✓		✓	
Re008	✓			✓		✓
Re009		✓				
Re010			✓	✓		✓
Re011	✓	✓			✓	
Re012	✓		✓		✓	
Re013	✓	✓	✓	✓	✓	

Re01 4			✓	✓	✓	✓
Re01 5	✓	✓	✓	✓		
Re01 6		✓	✓	✓	✓	
Re01 7	✓	✓			✓	✓
Re01 8		✓	✓	✓	✓	
Re01 9	✓	✓				
Re02 0			✓	✓		
Re02 1	✓	✓				
Re02 2	✓	✓			✓	✓
Re02 3	✓	✓		✓		
Re02 4	✓				✓	
Re02 5	✓		✓			
Total	15	14	13	11	13	8

4.2.3.2 Reconfiguration Capabilities to Healthcare Competitiveness

During rapidly changing market conditions, a firm's ability to reconfigure its alliance portfolio becomes more valuable. In a dynamic market, building unrelated alliances with partner firms that are distantly related provides a firm with the opportunity to learn about changing market conditions and the ability to discover new insights about the uncertain environment. In this respect, respondent 0123 states that ‘Our organization has the **ability to reconfiguring operational competencies to achieve competitiveness in the new markets, especially internationally**’.

Respondent 021 mentioned that contribution may be realised in the main areas of **long-term alliance, building trust, continuity** and the **strength of the individual businesses**. The deynamic change in the environment requires strong dynamic capability in reconfrating the resources to attract market opportunities through maximizing the benefit and minimizing the cost. In this regards, respondent 0124, states that ‘our team management

and employees in alliance project have the skills to **innovative redeployment of existing resources** to cope with healthcare market changes and achieve **competitiveness**'. This requires also efficiency managing the resources to switch the cost. According to respondent 013, "reconfiguration the **operation cost** that I spend in my organisation will **reduce defiantly** as well as **increase quality of services**. This is a **new solution for our clients** that other competitors cannot provide, which can be **new management concepts**, or **developed technology** or even **developed process**. Therefore, we will **attract new clients** that was not from their list before. That definitely will appear after getting in alliance and that will lead to increase our competitiveness capability."

In dynamic market environment, innovation in healthcare service is the most important factor to drive healthcare competitiveness. Yet, in many developing countries including the UAE, it is difficult to independently develop innovation. Therefore, the capability of the partner in reconfiguration resources is important. In this respect, respondent 025 explains the strength of its alliance project saying that 'our organization has the capability to **evolve intra firm resources**, which we used different methods such as **imitation** and **experimentation**'.

Respondent 014 and the others did not have much insight into the role of reconfiguration capabilities; however, 006 emphasized the area of innovation: "new product or service that make you in better position in case of competitiveness. Adding to that cost that you saved, time and efforts. However, it requires the ability to **acquire complementary resources** and **employ** them **horizontally** that ensures the achievement of alliance **competitiveness**". Adding to what reported by respondent 014, respondent 016 stated that, "our healthcare alliance has capability in **patching reconfiguring resources into the right chunks at the right scale to address shifting market opportunities**"

Organizational change is one of the most difficult strategies to implement, especially when it includes a change in operation, restructuring operations, teams, layoffs, new technologies, collaborations, rightsizing, or even new programs. Some specialists submit to organizational alterations. Therefore, to sustain change, the structures of the organization itself should be modified, including strategic plans, policies and procedures. In this regard respondent 010 reported that **“Our alliance organization offers an immediate and strong response to environmental change”**. This is indeed important to ensure the healthcare firm competitiveness, especially when the new alliance project has the **“capability to evaluate and continuously improve alliance processes and tasks”**, which was reported by the respondent 012. This is in line with study by (Hu, Hao, and Wang, 2022).

Table 4.7: Reconfiguration Capabilities (RC)

Group	reconfiguring operational Competencies	innovative redeployment	reconfiguration the operation cost	evolve intra firm resources	acquire and use complementary resource	patching reconfiguring resources	response to environmental change
Items	Organization has the ability to reconfiguring operational competencies to achieve competitiveness in the new markets,	our team management have the skills to innovative redeployment of existing resources	Our organization has the capability to reconfigure the operation cost quality of services..	our organization has the capability to evolve intra firm resources, which we used different methods such as imitation and experimentation’	Our organization has the ability to acquire complementary resources and employ them horizontally that ensures the achievement of alliance	Our organization has capability in patching reconfiguring resources into the right chunks at the right scale to address shifting market opportunities?	Our alliance organization offers an immediate and strong response to environmental change
Re001	✓			✓		✓	
Re002		✓					✓
Re003			✓	✓		✓	
Re004	✓	✓			✓		✓
Re005	✓	✓		✓	✓		✓
Re006			✓	✓	✓	✓	

Re007	✓	✓		✓			✓
Re008		✓	✓	✓	✓		
Re009	✓	✓			✓	✓	✓
Re010		✓	✓	✓	✓		
Re011	✓	✓					
Re012			✓	✓			✓
Re013	✓	✓					
Re014	✓	✓			✓	✓	
Re015	✓	✓		✓			✓
Re016	✓			✓	✓		✓
Re017	✓		✓			✓	
Re018		✓		✓		✓	✓
Re019		✓				✓	✓
Re020	✓		✓			✓	
Re021	✓	✓		✓			✓
Re022		✓	✓	✓	✓		
Re023	✓	✓					✓
Re024		✓	✓	✓	✓		
Re025		✓				✓	✓
Total	14	18	9	13	11	11	13

4.2.3.3 Coordination Capabilities and Competitive Advantage

The health organization capability to deliberate and orderly align partners' actions to achieve jointly determined goals is important to achieve alliance competitiveness (Gao, Wu, and Wang, 2021). In this regard respondent 010 added that “**our organization has the capability to effectively coordinate and redeploy internal and external competences**”. This also confirms by respondent 005, who stated that the success of alliance strategy is not

in signing the contract, but most importantly in managing and coordinating the construct. Therefore, we **systematically coordinate our strategies across different alliances**. The key driver for effectively and efficiency coordinating alliance activities relies on the knowledge. This was supported by respondent 006, who confirmed that “Our organization have the **capability to manage and create synergies across our alliances** and ensure the **systematic processes of transferring the knowledge across alliance partners**. This because it helps to improve the quality of work performance, which results significantly on alliance competitiveness”.

Organizations engage in coordination efforts to manage the task interdependence that can flow from a given division of labour or from the production technologies in use, and to manage uncertainties arising from internal tasks or the external environment.

In this regard **respondent 017** confirms that “**when we design our alliance tasks we set with our partner and ensure the compatibility of the employees’** expertise with the work processes they are assigned to”. This indeed important to ensure the alliance competitiveness through efficiency utilizing the resources, which is in line with (Nieves and Haller, 2014).

The coordination of capabilities was also observed as leading to competitiveness through allocating the needed resources. Respondent 001 highlighted that “As we know, the appropriate and necessary resources are important determinants for alliance efficiency and effective operation. Therefore, we **are keen to allocate the appropriate resources such as information, time, reports and etc.**, to the activities of the alliance project”

Appointing the right employee to do the specific job is important for alliance competitiveness, especially in the rapid changes in the business environment. In this regarded respondent 018 added that “one of the most common challenge in strategic alliance is to maintain competitiveness. This requires improve employees productivity. Thus, we

always assign the tasks of our employees that are commensurate with their experts and knowledge". Respondent 014 added that the benefits go beyond local and national levels to international capabilities. In specific words, they added that:

“Strategic competitiveness is the ultimate goal of creating all these alliances, where local capabilities can compete with **international capabilities**. **Thus we select employees who are competent to carry alliance at diversity culture**”.

Table 4.8: Coordination Capabilities

Group	redeploy internal and external competencies	Transfer knowledge	employees compatibility	allocate the appropriate resources	Staff and task	Employees selection	Coordinate strategy
Items	our organization has the capability to effectively coordinate and redeploy internal and external competences	Our organization have the capability to manage and create synergies across our alliances to transfer the knowledge across	Our organization ensures the employees compatibility with alliance tasks	Our Organization keeps to allocate the appropriate resources such as information, time, reports and etc., to the	Our organization always assigns the tasks of our employees that are commensurate with their experts and knowledge	Our organization selects employees who are competent to carry alliance at diversity culture”	Our organization has the capability to systematically coordinate its strategies across different alliances
Re001	✓			✓		✓	
Re002		✓					✓
Re003			✓	✓		✓	
Re004		✓	✓		✓		✓
Re005	✓	✓	✓	✓			✓
Re006				✓	✓	✓	
Re007		✓	✓				✓
Re008		✓	✓	✓	✓		
Re009	✓				✓	✓	✓
Re010		✓	✓		✓		
Re011	✓						
Re012			✓	✓			✓

Re013	✓	✓					
Re014	✓		✓		✓	✓	
Re015	✓	✓		✓			✓
Re016	✓				✓		✓
Re017	✓		✓			✓	
Re018		✓		✓		✓	✓
Re019		✓				✓	✓
Re020	✓		✓			✓	
Re021	✓	✓		✓			✓
Re022			✓	✓	✓		
Re023	✓				✓	✓	✓
Re024		✓	✓	✓	✓		
Re025			✓	✓		✓	✓
	12	12	13	12	10	11	13

4.2.4 Summary of Qualitative Section

This chapter presents the findings of the study. The results are mainly presented towards the achievement of the two research questions, which are:

- Q1) what alliance motives are that influence alliance among the healthcare firms?
- Q2) what are the dynamic capabilities that create value for healthcare firms?

The finding of this chapter shows that alliance among healthcare institutions are driven by three major motives, which are transactional cost, industrial relationship and alliance partners competencies. In addition, the dynamic capabilities of alliance among healthcare institutions are driven by three major competencies, which are alliance reconfiguration, integration and coordination capabilities. The next section explains how the interaction between alliance motives and dynamic capabilities influence several aspects of alliance competitiveness among healthcare institutions.

4.3 Quantitative Data Analysis

4.3.1 Introduction

The objective of this research was to examine the relationship between alliance motives and Healthcare Organization Competitiveness through mediating effect of alliance dynamic capabilities.

This chapter includes statistical data analysis to conclude findings of the present study. For this purpose, structural equation modeling (SEM) has been used for empirical analysis. This chapter aims to examine the relationship between alliance motives, value-based on dynamic capabilities, and alliance effectiveness within the UAE healthcare sector. This study has three endogenous constructs in the model namely, Alliance transactional cost (ATC), alliance motive competencies (AMC) and alliance industrial-organization relationship (AIR). The model also has three mediator constructs namely, Alliance integration capabilities (AC), reconfiguration capabilities (RC) and coordination capabilities (CC). As for the endogenous construct, the model has one endogenous construct which is healthcare organizational competitiveness (HOC). The research framework of this is presented in Figure 4.2.

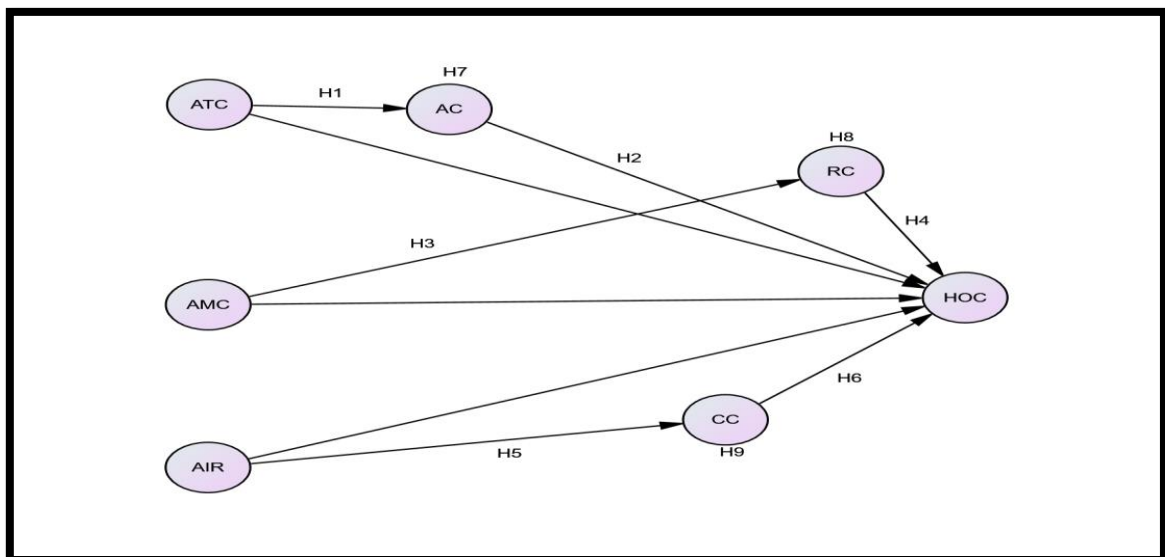


Figure 4.2: The framework of study

4.3.2 Exploratory Factor Analysis

Prior to conducting field study, the researcher conducted pilot study to explore the usefulness of the adapted and modified items and to determine the number of components emerged (if any) for every construct. The Exploratory Factor Analysis (EFA) results showed every construct is measured using few items respectively (Yahya et al., 2018; Awang et al., 2019; Bahkia et al., 2019; Shkeer and Awang, 2019; Alias et al., 2019; Muda et al., 2020; Ehido et al., 2020; Baistaman et al., 2020, Fitriana et al., 2022). The items that have been retained by EFA procedure for each construct in the framework is presented in Figure 4.3.

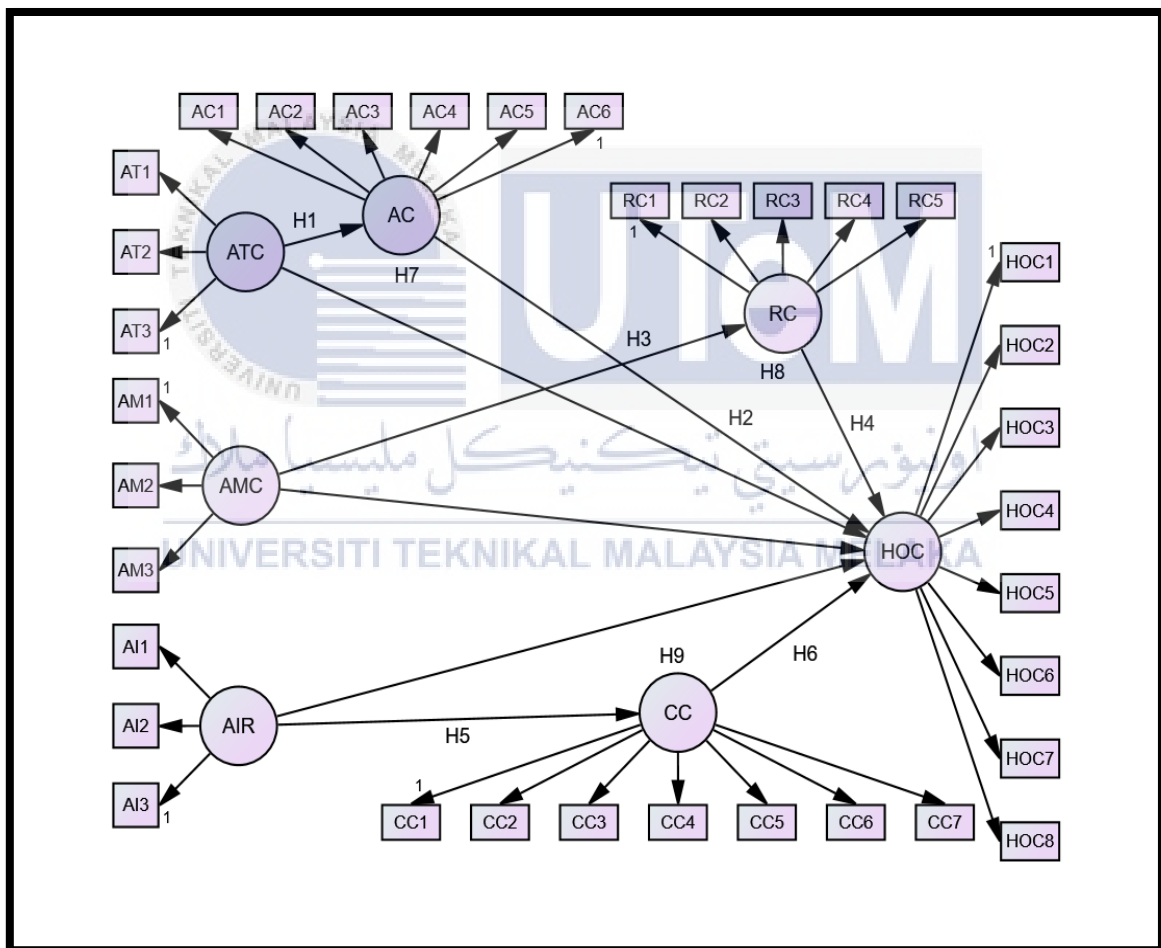


Figure 4.3: The framework of study with the measuring items for every construct.

From Figure 4.3, there are three exogenous constructs in the model namely, ATC, AMC and AIR and three mediator constructs namely, AC, RC and CC. The framework has one endogenous constructs namely, HOC. The construct and its respective measuring items are listed below.

1. ATC is measured with three items (AT1, AT2 and AT3)
2. AMC is measured with three items (AM1, AM2 and AM3)
3. AIR is measured with three items (AI1, AI2 and AI3)
4. AC is measured with six items (AC1, AC2, AC3, AC4, AC5, AC6)
5. RC is measured with five items (RC1, RC2, RC3, RC4 and RC5)
6. CC is measured with seven items (CC1, CC2, CC3, CC4, CC5, CC6 and CC7)
7. HOC is measured with eight items (HOC1, HOC2, HOC3, HOC4, HOC5, HOC6, HOC7 AND HOC8).

As has been stated in Figure 4.2 and Figure 4.3, there are few research hypotheses that has been put forward regarding the inter-relationships among the constructs to be tested in this study. The hypothesis statements and method of analysis are shown in Table 4.9.

Table 4.9: The hypothesis statement and method of analysis

	Hypothesis statement	Statistical Analysis to employ
H ₁	Alliance Motives based on Transactional Cost (ATC) has positive and significant effect on Integration Capabilities (AC)	Path Analysis in SEM
H ₂	Integration Capabilities (AC) has positive and significant effect on Healthcare Organization Competitiveness (HOC)	Path Analysis in SEM
H ₃	Alliance Motives based on Industry Relationship (AMC) has significant and direct effect on Reconfiguration Capabilities (RC)	Path Analysis in SEM
H ₄	Reconfiguration (RC) has significant and direct effect on Healthcare Organization Competitiveness (HOC)	Path Analysis in SEM
H ₅	Alliance Motives based on Industrial-Relationship (AIR) has significant and direct effect on Coordination Capabilities (CC).	Path Analysis in SEM
H ₆	Coordination Capabilities (CC) has significant and direct effect on Healthcare Organization Competitiveness (HOC)	Path Analysis in SEM
H ₇	Integration Capabilities (IC) mediates the relationship between Alliance Motives based on Transactional Cost (ATC) and Healthcare Organization Competitiveness (HOC)	Path Analysis in SEM and Bootstrapping

H ₈	Reconfiguration Capabilities (RC) mediates the relationship between Alliance Motives based on Industry Relationship (AMC) and Healthcare Organization Competitiveness (HOC)	Path Analysis in SEM and Bootstrapping
H ₉	Coordination Capabilities (CC) mediates the relationship between Alliance Motives based on Industrial-Relationship (AIR) and Healthcare Organization Competitiveness (HOC)	Path Analysis in SEM and Bootstrapping

4.3.3 Common Method Variance

Before proceeding with the Confirmatory Factor Analysis (CFA) to validate the measurement model and develop the structural model assessment, the study ensured the dataset is not contaminated due to the measurement instrument used in this study. This study performed Harman's single-factor test. The measuring items for latent constructs are loaded into a single factor extraction using SPSS.

This is to test whether the majority (50%) of the variance can be accounted for by one general factor (Podsakoff et al., 2003). Table 4.10, presents the result of Harman's One-Factor Solution. The results indicate variance accounted by one general factor is 39.751 per cent, which is lower than the 50 per cent threshold. Therefore, the issue of Common Method Bias or Common Method Variance does not affect the data of this study (Fuller et al., 2016).

Table 4.10: The Harman's One Factor Solution

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	13.913	39.751	39.751	13.913	39.751	39.751
2	2.339	6.682	46.433	2.339	6.682	46.433
3	1.862	5.319	51.752	1.862	5.319	51.752
4	1.723	4.924	56.676	1.723	4.924	56.676
5	1.597	4.562	61.239	1.597	4.562	61.239
6	1.112	3.178	64.416	1.112	3.178	64.416
7	1.044	2.697	67.113	1.044	2.697	67.113

Once the dataset is free from Common Method Variance, the study can proceed into further analysis. The data analysis for this study begins with Confirmatory Factor Analysis (CFA) to be followed by Structural Equation Modelling (SEM). The results of SEM procedure would be used for testing the hypothesis. Based on the framework in Figure 4.1 and Figure 4.2, the study has six direct effect and three mediation effect hypotheses.

Prior to analysing the data measuring every construct in the model, the study needs to validate these latent constructs for validity and reliability (Awang et al., 2018; Muda et al., 2018). The validation procedure for latent constructs is termed as Confirmatory Factor Analysis (CFA).

4.3.4 Respondents' Demographic Characteristics

Table 5.2 includes demographic information of the respondents such as in what Emirate is your institution located? How long has your organisation remained in operation? Does your origination fall into the private or public sector? What is your current position in the healthcare facility you are representing? And Under what category does your organisation fall? Classification of respondents based on in what Emirate is your institution located? Was 41.6 percent located in Abu Dhabi? Respondents were asked how long has your organisation remained in operation? Belonged to group of 11-15 years and 6-10 years with 27.6 percent, with regard to Does your origination fall into the private or public sector? Highest number belongs to group of Private sectors with 63.1 present. However, regard to what is your current position in the healthcare facility you are representing? Most of the respondents were Administrative Staff with 32.3 percent. Lastly, under what category does your organisation fall? Highest respondent belongs to group Private hospitals with 21.5 present.

Table 4.11: Respondent's Background

Demographic Variables		Frequency	Valid (%)
In what Emirate is your institution located?	Abu Dhabi	167	60 %
	Dubai	112	40 %
How long has your organisation remained in operation?	0-5 years	19	6.8
	11-15 years	77	27.6
	16-20 years	39	14
	20 years and above	67	24
	6-10 years	77	27.6
Does your origination fall into the private or public sector?	Public	166	59 %
	Private	113	41 %
What is your current position in the healthcare facility you are representing?	Head of unit	85	30 %
	nurse	81	29 %
	physician	72	26 %
	Support Staff	41	15 %
Under what category does your department fall?	RandD	87	31 %
	Sales and Marketing	62	22 %
	Operation	67	24 %
	Others	69	25 %

In what Emirate is your institution located?

In what Emirate is your institution located is one of the characteristics of academic surveys. The features have two categories, Abu Dhabi and Dubai. The majority of the respondents were belonging to the Abu Dhabi group with a percentage of 60% with frequency of 167 compared to 40% from Dubai with frequency of 112. The numerical results are proposed in Table 5.2 and an Infographic representation of in what Emirate is your institution located distribution is proposed in Figure 4.4.

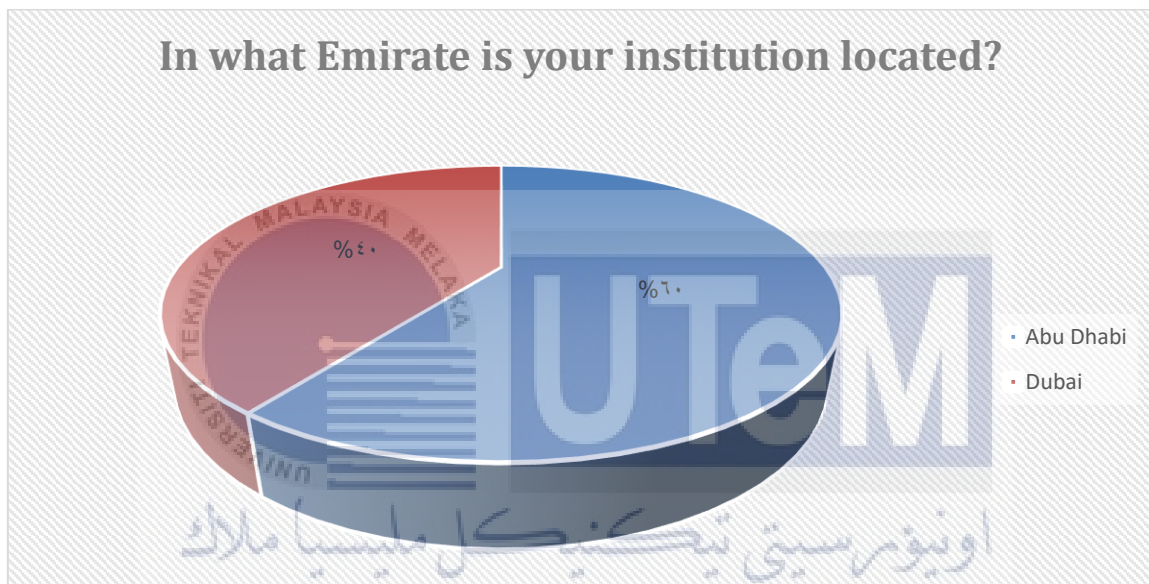


Figure 4.4: Location

How long has your organisation remained in operation Distribution?

How long has your organisation remained in operation group is another common characteristic of academic surveys. The feature has five categories, 0-5 years, 6-10 years, 11-15 years, 16-20 years and 20 years and above. The majority of the respondents were belonging to 11-15 years group and 6-10 years Group with percentage of 27.6% and Frequency of 77. Followed by 20 years and above group with percentage of 24% and Frequency of 67. Followed by 16-20 years group which had a percentage of 14% and Frequency of 39. Followed by 0-5 years group which had a percentage of 6.8% and

Frequency of 19. The distribution of feature, the majority were between 11-15 years group and 6-10 years Group is normal in the society because of the normal age distribution. The numerical results are proposed in Table 4.1 and a graphic representation distribution is proposed in Figure 4.5.

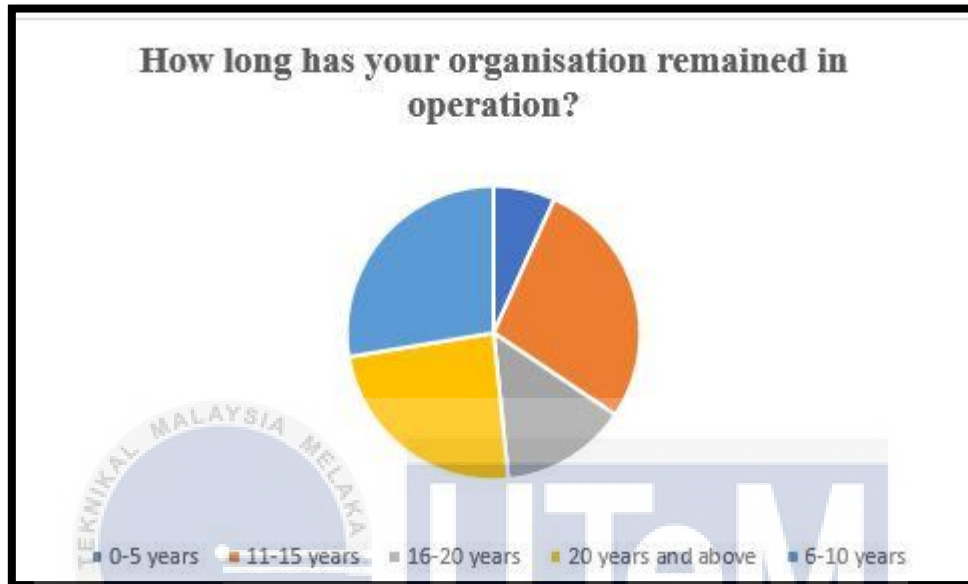


Figure 4.5: Respondents Experience

Does your origination fall into the private or public sector Distribution?

Does your origination fall into the private or public sector is another common characteristic of academic surveys? The features have two categories, Private and Public.

The majority of the respondents were belonging to public hospitals group with a percentage of 59 % and frequency of 166. Followed by the private hospitals group with a percentage of 36.9% and frequency of 113. The numerical results are proposed in Table 5.2 and a graphic representation distribution is proposed in Figure 5.3.

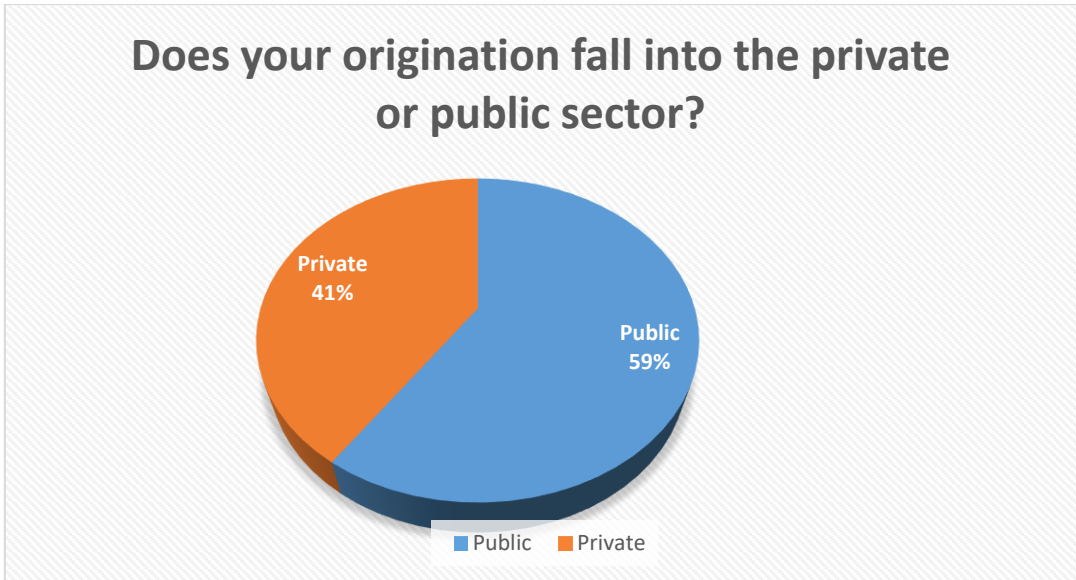


Figure 4.6: Respondents Sector

What is your current position in the healthcare facility you are representing?

The respondents in this research were gathered from four main clusters as shown in Figure 5.4. The majority of the respondents with 30% and frequency of 85 respondents work as a head of unit, followed by 29% with frequency of nurse. The respondents from physicians was 26% with frequency of 72 respondents and finally the respondents from staff support was 15% with frequency of 41.

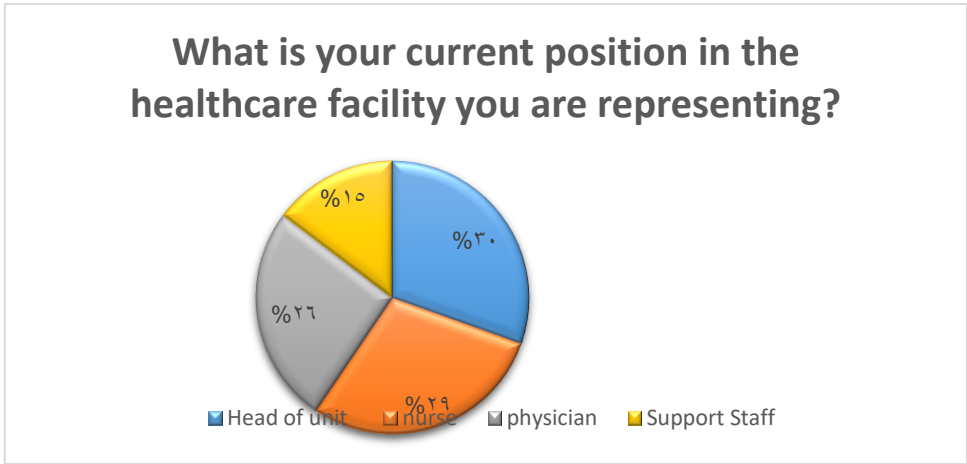


Figure 4.7: Respondents Position

What category does your department fall?

The respondents in this research were gathered from four main departments namely RandD, operation, sales and marketing and others. As shown in Figure 5.5. The majority of the respondents with 31% and frequency of 87 respondents were gathered from RandD. This important because alliance strategy deals with knowledge sharing and innovation development. The second department with majority of respondents was others with 24% and frequency of 69 respondents. This because alliance strategy in hospitals projects involve many staffs from different departments at different levels. The third category was gathered from operation department with 23% and frequency of 67 respondents and finally 22% with frequency of 62 were gathered from sales and marketing department.

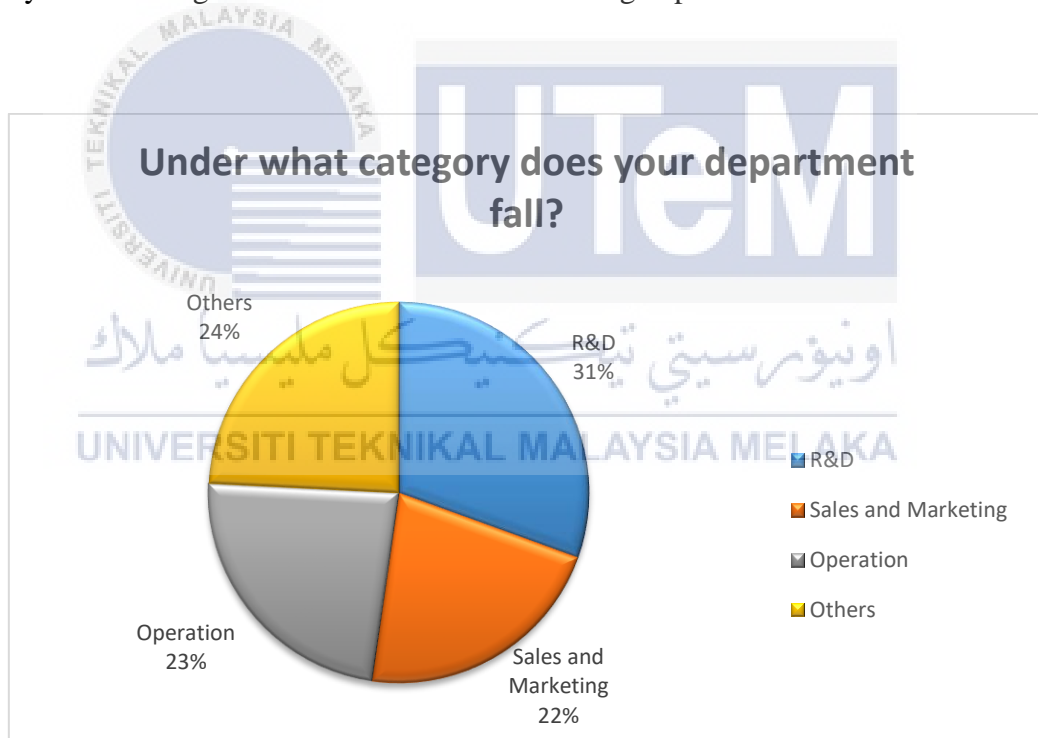


Figure 4.8: Respondents Departments

4.3.5 Descriptive Analysis

4.3.5.1 Alliance Transactional Cost

To address the alliance transactional cost in Healthcare Strategic Alliances (ATC), three items were designed using the 5-point scale ranging from (1) strongly disagree to (5) strongly agree. Based on Table 4.11, the overall mean of all the indicators is 3.95 which shows that the level of strategic alliance motives is higher than the median of scale (3). As shown in Table 5.3, the highest mean belongs to “Our organizations are always looking for alliance partner, who can optimize our value and reduce transaction cost through complementary resources” with (M=3.99, S.D=0.791), followed by “Minimizing the operational cost is one of the main reasons of forming alliance.” with (M=3.96, S.D=0.757) and finally “The equity balance, either positive or negative is one of our organization strategy to select our partners” with (M=3.91, S.D=0.725).

Table 4.12: Descriptive analysis Alliance Transactional Cost

Code	Items	Mean		Std. Deviation
		Statistic	Std. Error	Statistic
AT1	Minimizing the operational cost is one of the main reasons of forming alliance	3.96	0.045	0.757
AT2	The equity balance, either positive or negative is one of our organization strategy to select our partners.	3.91	0.043	0.725
AT3	Our organizations are always looking for alliance partner, who can optimize our value and reduce transaction cost through complementary resources”.	3.99	0.047	0.791
	Overall	3.95		

4.3.5.2 Alliance Motives Competencies

To address the alliance competencies in the healthcare strategic alliances (ATC), three items were designed using the 5-point scale ranging from (1) strongly disagree to (5) strongly agree. Based on Table 4.12, the overall mean of all the indicators is 3.15 which shows that the level of strategic alliance motives is higher than the median of scale (3). As shown in Table 5.3, the highest mean belongs to “Our organization prefer partner with a good management experience in alliance to minimize the risk ” with (M=3.29, S.D=0.811), followed by “One of our priorities for forming alliance is to have a partners who have substantial experiences and skills in healthcare services at different levels.” with (M=3.14, S.D=0.773) and finally “Our organization tend to select competent partners who know-how to articulate, codify, share and internalize alliance management in healthcare” with (M=3.03, S.D = 0.824).

Table 4.13: Descriptive analysis Alliance Motives Competencies

	Items	Mean		Std. Deviation
		Statistic	Std. Error	Statistic
AM1	Our organization tend to select competent partners who know-how to articulate, codify, share and internalize alliance management in healthcare	3.03	.049	.824
AM2	One of our priorities for forming alliance is to have a partners who have substantial experiences and skills in healthcare services at different levels.	3.14	.046	.773
AM3	Our organization prefer partner with a good management experience in alliance to minimize the risk	3.29	.049	.811
	Overall	3.15		

4.3.5.3 Alliance Motives Industrial-organization relationship

To address the Industrial-organization relationship in Healthcare Strategic Alliances (ATC), three items were designed using the 5-point scale ranging from (1) strongly

disagree to (5) strongly agree. Based on Table 4.13, the overall mean of all the indicators is 3.88 which shows that the level of strategic alliance motives is higher than the median of scale (3). As shown in Table 5.3, the highest mean belongs to “We prefer the partner who can aid in reducing the opportunities for competition by creating barriers to new entrants” with (M=3.92, S.D=0.708), followed by “Our organization prefer alliance with well-known institutions who has strong reputation in the market” with (M=3.87, S.D=0.768) and finally “Our organization prefer partner who has network density to facilitate our knowledge and resources sharing” with (M=3.86, S.D=0.735).

Table 4.14: Alliance Motives Industrial-organization relationship

	Items	Mean		Std. Deviation
		Statistic	Std. Error	Statistic
AI1	Our organization prefer alliance with well-known institutions who has strong reputation in the market.	3.87	.046	.768
AI2	We prefer the partner who can aid in reducing the opportunities for competition by creating barriers to new entrants	3.92	.042	.708
AI3	Our organization prefer partner who has network density to facilitate our knowledge and resources sharing	3.86	.044	.735
	Overall	3.88		

4.3.5.4 Alliance Integration Capability (AC)

To address the integration capabilities in Healthcare Strategic Alliances (ATC), six items were designed using the 5-point scale ranging from (1) strongly disagree to (5) strongly agree. Based on Table 4.14, the overall mean of all the indicators is 3.72 which shows that the level of strategic alliance motives is higher than the median of scale (3). As shown in Table 5.3, the highest mean belongs to “Our organization pays a great attention on inter-connectedness to external value channels to improve alliance operations” with (M=3.87, S.D=0.652), followed by “Our organization and its partner integrate their capabilities to

reach level of performance that can be noticed among other competitors.” with (M=3.8, S.D=0.641), following by “Our organization contributes in an integrated manner knowledge to achieve goals and provide efficient capabilities” with (M=3.76, S.D=0.658) and then “Our organization sought out to attend collective intra-alliance activities to create value in our healthcare alliance” with (M=3.73, S.D=0.637), and finally “Our organization demonstrates connectedness in communication towards value creation.” with (M=3.52, S.D=0.729).

Table 4.15: Alliance Integration Capability (AC)

	Items	Mean		Std. Deviation
		Statistic	Std. Error	Statistic
AC1	“Our organization contributes in an integrated manner knowledge to achieve goals and provide efficient capabilities	3.76	0.039	0.658
AC2	Our organization shares understanding of tasks, responsibilities to elimination of duties and reduction of operational costs	3.65	0.042	0.694
AC3	Our organization demonstrates connectedness in communication towards value creation.	3.52	0.044	0.729
AC4	Our organization sought out to attend collective intra-alliance activities to create value in our healthcare alliance’	3.73	0.038	0.637
AC5	Our organization pays a great attention on inter-connectedness to external value channels to improve alliance operations	3.87	0.039	0.652
AC6	Our organization and its partner integrate their capabilities to reach level of performance that can be noticed among other competitors.	3.8	0.038	0.641

4.3.5.5 Alliance Coordination Capability (CC)

To address the coordination capabilities in Healthcare Strategic Alliances (ATC), seven items were designed using the 5-point scale ranging from (1) strongly disagree to (5) strongly agree. Based on Table 4.15, the overall mean of all the indicators is 3.72 which shows that the level of strategic alliance motives is higher than the median of scale (3). As shown in Table 5.3, the highest mean belongs to “Our organization always assigns the tasks

of our employees that are commensurate with their experts and knowledge” with (M=3.89, S.D=0.667), followed by “Our organization selects employees who are competent to carry alliance at diversity culture”with (M=3.88, S.D=0.687), following by “our organization has the capability to effectively coordinate and redeploy internal and external competences” with (M=3.8, S.D=0.662) and then “Our organization ensures the employees compitability with allince tasks” with (M=3.75, S.D=0.754), and finally “Our organization has the capability to systematically coordinate its strategies across different alliances” with (M=3.47, S.D=0.834).

Table 4.16: Alliance Coordination Capability (CC)

	Items	Mean		Std. Deviation
		Statistic	Std. Error	Statistic
CC1	our organization has the capability to effectively coordinate and redeploy internal and external competences	3.8	0.04	0.672
CC2	Our organization have the capability to manage and create synergies across our alliances to transfer the knowledge across alliance partners	3.55	0.048	0.802
CC3	Our organization ensures the employees compitability with allince tasks ’	3.75	0.045	0.754
CC4	Our Organization keens to allocate the appropriate resources such as information, time, reports and etc., to the activities of the alliance project	3.7	0.044	0.732
CC5	Our organization always assigns the tasks of our employees that are commensurate with their experts and knowldge	3.89	0.04	0.667
CC6	Our organization selects employees who are competent to carry alliance at diversity culture”.	3.88	0.041	0.687
CC7	Our organization has the capability to systematically coordinate its strategies across different alliances	3.47	0.05	0.834

4.3.5.6 Alliance Reconfiguration Capability (RC)

To address the reconfiguration capabilities in Healthcare Strategic Alliances (ATC), five items were designed using the 5-point scale ranging from (1) strongly disagree to (5)

strongly agree. Based on Table 4.16, the overall mean of all the indicators is 3.72 which shows that the level of strategic alliance motives is higher than the median of scale (3).

As shown in Table 5.3, the highest mean belongs to “Our organization has the ability to acquire complementary resources and employ them horizontally that ensures the achievement of alliance competitiveness with (M=3.8, S.D=0.618), followed by “Our organization has the ability to reconfiguring operational competencies to achieve competitiveness in the new markets, especially internationally” with (M=3.67, S.D=0.674) and “our organization has the capability to evolve intra firm resources, which we used different methods such as imitation and experimentation” and “with (M=3.76, S.D=0.676), and finally “our team management have the skills to innovative redeployment of existing resources” with (M=3.56, S.D=0.746).

Table 4.17: Alliance Reconfiguration Capability (RC)

Items	Mean		Std. Deviation	
	Statistic	Std. Error	Statistic	
RC1	Our organization has the ability to reconfiguring operational competencies to achieve competitiveness in the new markets, especially internationally”.	3.76	0.04	0.674
RC2	our team management have the skills to innovative redeployment of existing resources	3.56	0.045	0.746
RC3	Our alliance organization offers an immediate and strong response to environmental change	3.63	0.038	0.631
RC4	our organization has the capability to evolve intra firm resources, which we used different methods such as imitation and experimentation’	3.76	0.04	0.676
RC5	Our organization has the ability to acquire complementary resources and employ them horizontally that ensures the achievement of alliance competitiveness	3.8	0.037	0.618

4.3.5.7 Healthcare Organizational Competitiveness (HOC)

To address the Organizational Competitiveness among Healthcare firms, eight items were designed using the 5-point scale ranging from (1) strongly disagree to (5) strongly

agree. Based on Table 4.17, the overall mean of all the indicators is 3.72 which shows that the level of strategic alliance motives is higher than the median of scale (3).

As shown in Table 4.18, the highest mean belongs to “Our organization is satisfied with its alliance in achieving its goals (M=3.99, S.D=0.660), followed by “Our alliance is usually terminated on satisfactory and successful terms of outcomes” with (M=3.98, S.D=0.719) and “Our market performance of strategic alliances are encouraging within UAE healthcare strategic alliances” and “with (M=3.95, S.D=0.674), and “Our organization operation cost and service cost are low” with (M=3.89, S.D=0.652), Our organization respond flexibly to its volatile customers’ needs” with (M=3.84, S.D=0.679).

Table 4.18: Healthcare Organizational Competitiveness (HOC)

	Items	Mean		Std. Deviation
		Statistic	Error	Statistic
HOC1	Our organization operation cost and service cost are low	3.89	0.039	0.652
HOC2	Our organization respond flexibly to its volatile customers’ needs	3.82	0.04	0.66
HOC3	Our organization customize the services according to customers’ needs	3.8	0.043	0.71
HOC4	Our organization provide accurate information to its customers	3.84	0.042	0.697
HOC5	Our organization can create new opportunities through the value of alliance joint venture	3.94	0.039	0.659
HOC6	Our organization is satisfied with its alliance in achieving its goals	3.99	0.039	0.66
HOC7	Our alliance is usually terminated on satisfactory and successful terms of outcomes	3.98	0.043	0.719
HOC8	Our market performance of strategic alliances are encouraging within UAE healthcare strategic alliances	3.95	0.04	0.674
		3.901		

4.3.6 The Confirmatory Factor Analysis (CFA)

The study adopted the two-steps approach of modelling and analysing the structural model namely, Confirmatory Factor Analysis (CFA) and Structural Equation Modelling (SEM) as proposed by Awang (2012, 2014, 2015), Awang et al. (2018) and Muda et al. (2018). Thus, prior to modelling the structural model and executing Structural Equation Modeling (SEM), the study needs to validate all measurement models of latent constructs for Unidimensionality, Validity, and Reliability (Awang et al., 2018; Asnawi et al., 2019; Mahfouz et al., 2019; Rahlin et al., 2019a, 2021; Raza and Awang, 2019, 2020, 2020a; Sarwar et al., 2020; Fitriana et al., 2022; Rahlin et al., 2023).

According to Awang (2014, 2015), Awang et al. (2015, 2018), Yusof et al. (2017), Mohamad et al. (2016, 2017, 2018, 2019), Afthanorhan et al. (2020, 2020a), Alown et al. (2021) and Dani et al. (2022), the measurement model of latent constructs needs to pass three types of validity namely Construct Validity, Convergent Validity, and Discriminant Validity. The Construct Validity is assessed through the Fitness Indexes of the Measurement Model, the Convergent Validity is assessed through computing the Average Variance Extracted (AVE), and Discriminant Validity is assessed through developing the Discriminant Validity Index Summary.

As for the reliability, it is adequate for the study to assess the Composite Reliability (CR) since it replaced the traditional method of computing the Cronbach Alpha for analysis using Structural Equation Modeling (SEM) (Kashif et al., 2015, 2016; Noor et al., 2015; Yusof et al., 2017, Aziz et al., 2016; Asnawi et al., 2019; Rahlin et al., 2019a, 2021, 2022).

The particular latent construct is considered valid if its fitness indexes achieved the three Model Fit categories namely Absolute Fit, Incremental Fit and Parsimonious Fit (Mahfouz et al., 2019, 2020; Afthanorhan et al., 2020, 2020a; Sarwar et al., 2020, Alown et

al. (2021), Fitriana et al., 2022; Abdul Rahim et al., 2022). The index fit categories and their respective thresholds for fitness indexes are given in Table 4.19.

Table 4.19: The three categories of model fit and their level of acceptance

Name of category	Name of index	Level of acceptance
Absolute Fit Index	RMSEA	RMSEA < 0.08
	GFI	GFI > 0.85, Ideal if > 0.90
Incremental Fit Index	AGFI	AGFI > 0.85, Ideal if > 0.90
	CFI	CFI > 0.85, Ideal if > 0.90
	TLI	TLI > 0.85, Ideal if > 0.90
	NFI	NFI > 0.85, Ideal if > 0.90
Parsimonious Fit Index	ChiSq /df	Chi-Square/ df < 5.0, Ideal if < 3.0

The indexes in bold are recommended since they are frequently reported in literatures

Source: Awang (2015) and Awang et al. (2018)

4.3.6.1 The Pooled-CFA for all Measurement Model of Constructs

The pooled construct is presented in Figure 4.9. The reason for running the pooled-CFA for all constructs together is to assess the Discriminant Validity among constructs in the model (Mohamad et al., 2016, 2017, 2018, 2019; Alown et al., 2021; Fitriana et al., 2022; Dani et al., 2022). The pooled-CFA procedure to assess all latent constructs at once is shown in Figure 4.9.

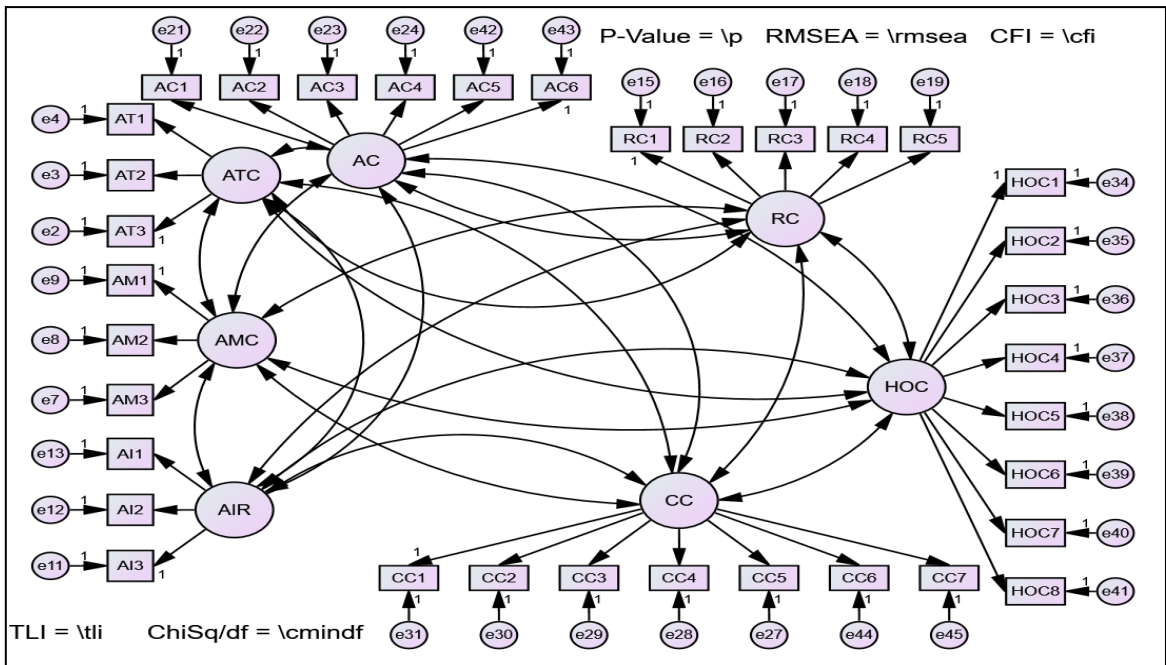


Figure 4.9: The measurement model for every construct is set for pooled CFA.

The result for CFA pooled is presented in Figure 4.10.

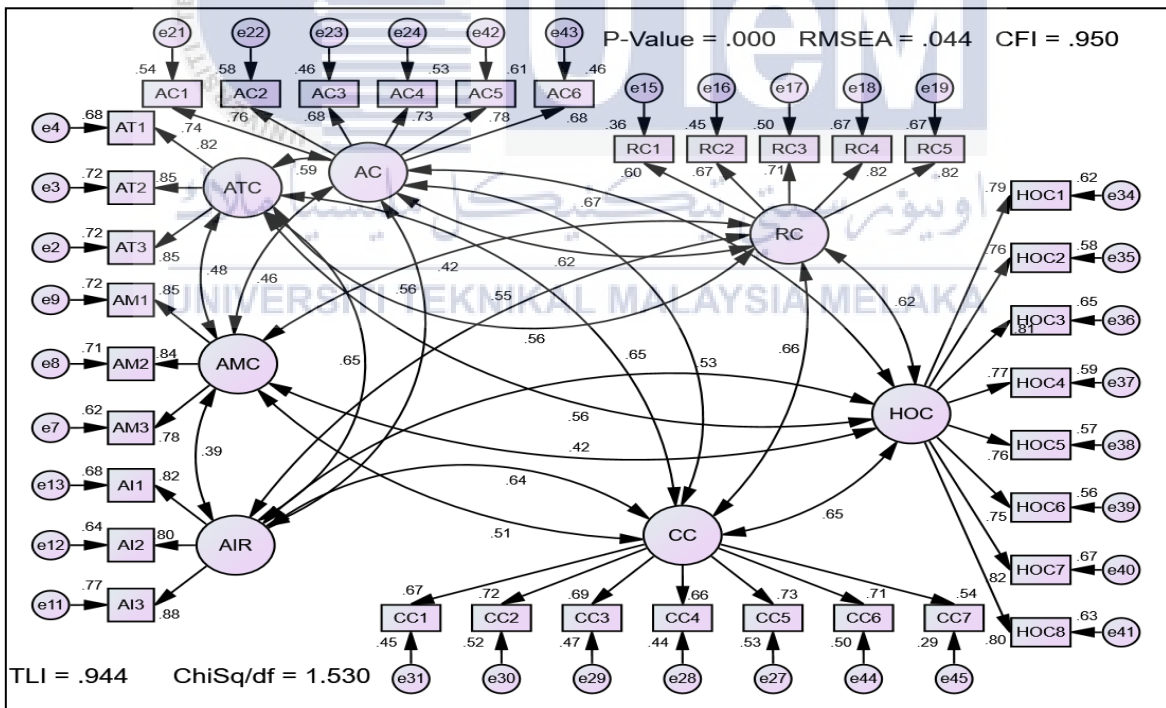


Figure 4.10: The results of CFA pooled for all constructs.

The deleted items based on CFA results

The study needs to delete two items based on the following reasons:

- i. Item CC7 from construct CC is deleted due to factor loading less than 0.6 (Awang, 2014, 2015; Awang et al., 2018 and Muda et al., 2018).
- ii. Items CC6 from construct CC is also deleted due to redundancy with other items as shown by the Modification Index (MI) below.

Item with the measurement error (e27) has correlated with item with measurement error e44 needs to be removed due to redundancy with other items measuring the same construct (Awang, 2014, 2015; Awang et al., 2018 and Muda et al., 2018).

			M.I.	Par Change
e27	<-->	e44	25.061	.073

The final measurement model for the study resulted from the pooled CFA procedure is presented in Figure 4.11.

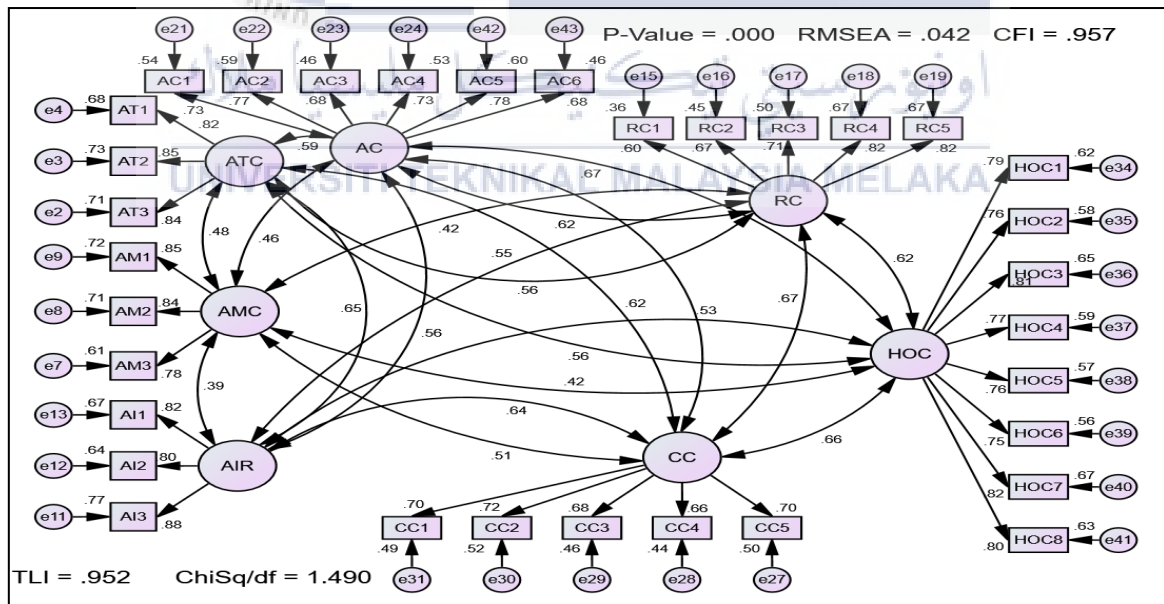


Figure 4.11: The final results of CFA pooled after removing poor loading and redundant items.

The study can use the results in Figure 4.5 to assess the validity and reliability for all latent constructs in the model. The first validity assessment is Construct Validity, to be followed by Convergent Validity and Discriminant Validity. As for reliability, the study needs to assess the Composite Reliability for all constructs in the model.

4.3.7 The Assessment for Construct Validity

The fitness indexes in Figure 4.5 have met the threshold values as stated in Table 4.3. The Absolute Fit category namely RMSEA is 0.042 (achieved the threshold of less than 0.08), the Incremental Fit category namely CFI is 0.957 (achieved the threshold of greater than 0.90), and the Parsimonious Fit category namely the ratio of Chisq/df is 1.490 (achieved the threshold of 3.0). Thus, the measurement model of all constructs have achieved the requirement for Construct Validity (Awang et al., 2018; Mohamad et al., 2018, 2019; Raza and Awang, 2019, 2020, 20201; Bahkia et al., 2019; Afthanorhan et al., 2020, 2020a; Alown et al., 2021; Fitriana et al., 2022; Abdul Rahim et al., 2022; Dani et al., 2022).

4.3.7.1 The Assessment for Convergent Validity and Composite Reliability

For the assessment of Convergent Validity, the study needs to compute Average Variance Extracted (AVE). The construct achieved Convergent Validity if its AVE exceeds the threshold value of 0.5 (Afthanorhan et al., 2017, 2017a, 2018, 2019, 2020, 2020a; Rahlin et al., 2019a, 2021, 2022, 2023; Mahfouz et al., 2019; Sarwar et al., 2020; Bahkia et al., 2022). As for assessing the Composite Reliability, the study needs to compute the CR and its value should exceed the threshold value of 0.6 for this reliability to achieve (Awang, 2014; 2015; Awang et al., 2018; Fitriana et al., 2022; Abdul Rahim et al., 2022; Dani et al., 2022). The Average Variance Extracted (AVE) and Composite Reliability (CR) for exogenous constructs are computed and presented in Table 4.20.

Table 4.20: The AVE and CR for three exogenous constructs in the model.

Construct	Item	Factor Loading	CR (Above 0.6)	AVE (Above 0.5)
ATC	AT1	0.82	0.875	0.700
	AT2	0.85		
	AT3	0.84		
AMC	AM1	0.85	0.864	0.679
	AM2	0.84		
	AM3	0.78		
AIR	AI1	0.82	0.873	0.696
	AI2	0.80		
	AI3	0.88		

With reference to the Average Variance Extracted (AVE) and Composite Reliability (CR) values in Table 4.4, the study found all AVE and CR exceed their threshold values of 0.5 and 0.6 respectively (Kashif et al., 2015, 2016; Noor et al., 2015; Yusof et al., 2017, Aziz et al., 2016; Mohamad et al., 2016, 2017, 2018, 2019; Sarwar et al., 2020). Thus, the study can conclude that the Convergent Validity and Composite Reliability for all latent constructs in the model have been achieved. The Average Variance Extracted (AVE) and Composite Reliability (CR) for three mediator constructs are computed and presented in Table 4.21.

Table 4.21: The AVE and CR for three mediator constructs in the model

Construct	Item	Factor Loading	CR (Above 0.6)	AVE (Above 0.5)
AC	AC1	0.73	0.872	0.582
	AC2	0.77		
	AC3	0.68		
	AC4	0.73		
	AC5	0.78		
	AC6	0.68		
RC	RC1	0.80	0.876	0.588
	RC2	0.67		
	RC3	0.71		
	RC4	0.82		
	RC5	0.82		
CC	CC1	0.70	0.882	0.602
	CC2	0.72		
	CC3	0.88		
	CC4	0.86		
	CC5	0.70		

With reference to the Average Variance Extracted (AVE) and Composite Reliability (CR) values in Table 4.5, the study found all AVE and CR exceed their threshold values of 0.5 and 0.6 respectively (Kashif et al., 2015, 2016; Noor et al., 2015; Yusof et., 2017, Aziz et al., 2016; Mohamad et al., 2016, 2017, 2018, 2019; Sarwar et al., 2020). Thus, the study can conclude that the Convergent Validity and Composite Reliability for all latent constructs in the model have been achieved. The Average Variance Extracted (AVE) and Composite Reliability (CR) for the endogenous construct is computed and presented in Table 4.22.

Table 4.22: The AVE and CR) for the endogenous constructs in the model

Construct	Item	Factor Loading	CR (Above 0.6)	AVE (Above 0.5)
HOC	HOC1	0.79	0.929	0.621
	HOC2	0.78		
	HOC3	0.81		
	HOC4	0.77		
	HOC5	0.78		
	HOC6	0.75		
	HOC7	0.82		
	HOC8	0.80		

With reference to the Average Variance Extracted (AVE) and Composite Reliability (CR) values in Table 4.6, the study found all AVE and CR exceed their threshold values of 0.5 and 0.6 respectively (Kashif et al., 2015, 2016; Noor et al., 2015; Yusof et., 2017, Aziz et al., 2016; Mohamad et al., 2016, 2017, 2018, 2019; Sarwar et al., 2020). Thus, the study can conclude that the Convergent Validity and Composite Reliability for all latent constructs in the model have been achieved.

4.3.7.2 The Assessment of Discriminant Validity among Constructs

The study needs to assess another type of validity for the model namely, Discriminant Validity. The Discriminant Validity assessment is to ensure that no redundant constructs occur in the model. Redundant construct occurs when any pair of constructs in the model are highly correlated. For assessing the Discriminant Validity, one needs to

develop the discriminant validity index summary as shown in Table 4.22. The diagonal values in bold are the square root of the AVE of the respective constructs while other values are the correlation coefficient between the pair of the respective constructs.

Table 4.23: The Discriminant Validity Index Summary for all Constructs

Construct	ATC	AMC	AIR	RC	AC	CC	HOC
ATC	0.84						
AMC	0.48	0.82					
AIR	0.65	0.39	0.83				
RC	0.57	0.42	0.55	0.76			
AC	0.59	0.46	0.56	0.62	0.77		
CC	0.53	0.51	0.51	0.67	0.53	0.78	
HOC	0.56	0.42	0.42	0.62	0.67	0.66	0.79

Referring to Table 4.7, the Discriminant Validity of the respective construct is achieved if the square root of its AVE exceeds its correlation value with other constructs in the model Awang, 2014, 2015; Awang et al., 2015; Awang et al., 2018; Bahkia et al., 2022; Fitriana et al., 2022). In other words, the Discriminant Validity is achieved if the diagonal values (in bold) are higher than any other values in its row and its column. The tabulated values in Table 4.7 meet the threshold of Discriminant Validity. Thus, the study concludes that the Discriminant Validity for all constructs is achieved.

4.3.7.3 The Assessment of Normality for all constructs

Finally, the study needs to assess for normality distribution of all items measuring the construct before modeling the structural model and executing SEM. Since SEM employs the parametric statistical approach of modeling, the study needs to assess the normality distribution of all items measuring their respective constructs. According to Awang (2015), Awang et al. (2015, 2018), Kashif et al. (2015, 2016), Mohamad et al. (2016, 2017, 2018) and Yusuf et al. (2017), the study only needs to show that the values of skewness for all

items do not depart from normality. Thus, the skewness values should fall within the range of -1.5 to 1.5 is acceptable. The assessment of normality distribution for all items is presented in Table 4.24.

Table 4.24: The Assessment of normality for all items of the constructs

Variable	min	max	skew	c.r.	kurtosis	c.r.
CC7	1	5	-0.116	-0.788	-0.408	-1.392
CC6	2	5	-0.045	-0.305	-0.434	-1.481
CC5	2	5	-0.017	-0.119	-0.42	-1.432
CC4	2	5	0.157	1.074	-0.559	-1.907
HOC8	2	5	-0.361	-2.459	0.333	1.135
HOC7	2	5	-0.375	-2.555	0.023	0.078
HOC6	2	5	-0.215	-1.464	-0.022	-0.076
HOC5	2	5	-0.158	-1.075	-0.101	-0.343
RC5	2	5	-0.123	-0.842	0.007	0.023
RC4	2	5	-0.37	-2.526	0.251	0.857
AC6	2	5	0.036	0.247	-0.344	-1.174
AC5	2	5	-0.252	-1.719	0.205	0.697
AC4	2	5	-0.036	-0.245	-0.199	-0.677
HOC4	2	5	-0.096	-0.654	-0.308	-1.051
HOC3	2	5	-0.121	-0.822	-0.267	-0.909
HOC2	2	5	-0.017	-0.113	-0.306	-1.045
HOC1	2	5	-0.349	-2.377	0.433	1.476
CC1	2	5	-0.378	-2.58	0.323	1.1
CC2	1	5	-0.149	-1.014	-0.231	-0.788
CC3	2	5	-0.064	-0.436	-0.444	-1.515
AC3	2	5	-0.041	-0.277	-0.281	-0.958
AC2	2	5	-0.238	-1.62	-0.07	-0.24
AC1	2	5	-0.011	-0.075	-0.269	-0.916
RC3	2	5	-0.042	-0.288	-0.225	-0.765
RC2	2	5	-0.294	-2.001	-0.232	-0.792
RC1	2	5	0.454	3.095	0.391	1.334
AI1	2	5	0.295	2.008	0.265	0.904
AI2	2	5	0.197	1.342	0.267	0.91
AI3	2	5	0.313	2.136	0.065	0.221
AM1	1	5	0.098	0.671	0.273	0.932
AM2	1	5	0.029	0.195	0.202	0.689
AM3	1	5	0.324	2.21	0.404	1.379
AT1	1	5	0.625	4.264	0.963	3.282
AT2	1	5	0.494	3.37	0.662	2.258
AT3	1	5	0.73	4.976	1.121	3.821

Multivariate					67.851	11.135
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The values of skewness for all measuring items in the model fall within the range between -1.5 and 1.5 which means their distribution does not depart from normality (Awang, 2015; Awang et al., 2018; Muda et al., 2018). Thus, the data distribution meets the requirement of normality distribution for employing the parametric statistical analysis.

Once the CFA has completed and the requirement for Validity, Reliability, and Normality distribution have been satisfied, the study can proceed into modeling the structural model. The structural model for the study is shown in Figure 4.7.

4.3.8 The Structural Model and Structural Equation Modeling (SEM)

Once the CFA report is completed and all values meet the required thresholds for validity and reliability, the researcher can conclude that the measurement models for all latent constructs involved in the model have been validated (Awang, 2015; Yusuf et al., 2017; Awang et al., 2018; Mohamad et al., 2018, 2019; Sarwar et al., 2020; Afthanorhan et al., 2020, 2020a). Then, the next step for the researcher is to assemble these constructs into the structural model in order to execute Structural Equation Modeling (SEM). The constructs should be arranged from left to right, beginning with the exogenous constructs at far left, followed by the mediator constructs in the middle, and the endogenous construct at the far right (Awang, 2015; Awang et al., 2018; Muda et al., 2018; Bahkia et al., 2022). Then, based on the direction of hypothesis, the researcher links the exogenous construct to its respective endogenous construct using the single headed arrow. Lastly, all exogenous constructs are linked using the double-headed arrow as presented in Figure 4.12.

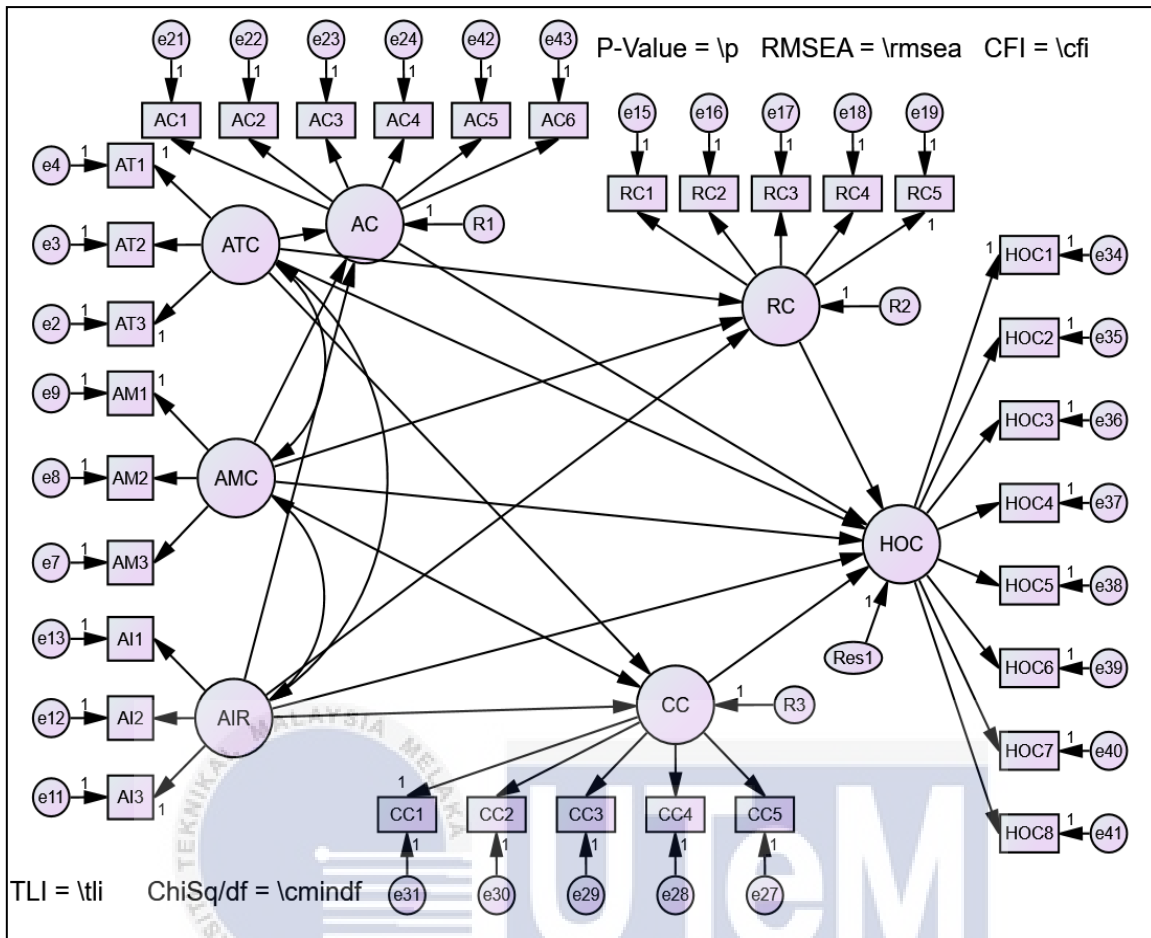


Figure 4.12: The Structural Model of this study in IBM-SPSS-AMOS

The single headed arrow (Figure 4.12) indicates the causal effects of an exogenous construct on the respective endogenous construct being estimated. If the structural model consists of more than one exogenous construct, the double headed arrow should be employed to estimate the correlational effects between all exogenous constructs. The study needs to assess the strength of correlation between the exogenous constructs in order to avoid the multi-collinearity problem in the model where the two exogenous constructs are highly correlated. The correlation between a pair of exogenous constructs higher than 0.85 indicate that constructs are highly correlated and the multi-collinearity problem exists in the model (Raza and Awang, 2020, 2020a; Sarwar et al., 2020; Afthanorhan et al., 2020, 2020a; Bahkia et al., 2022).

The output resulted from executing SEM is given in Figure 4.8 for the Standardized Regression path coefficients and in Figure 4.9 for the Regression path coefficients between constructs.

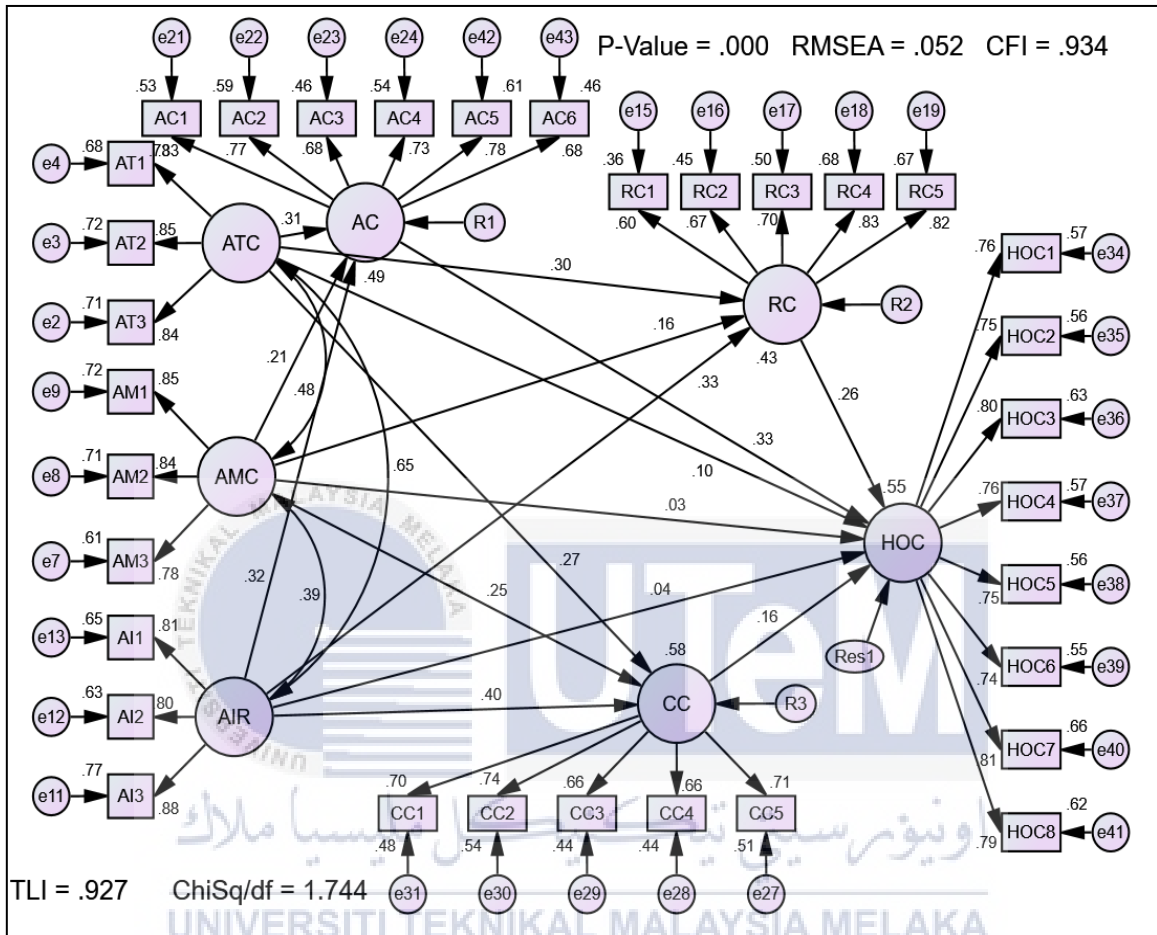


Figure 4.13: The Standardized Regression Path Coefficient

The explanation regarding the performance of R^2 (coefficient of multiple determination) of the model (obtained from Figure 4.9) is explained in Table 4.25.

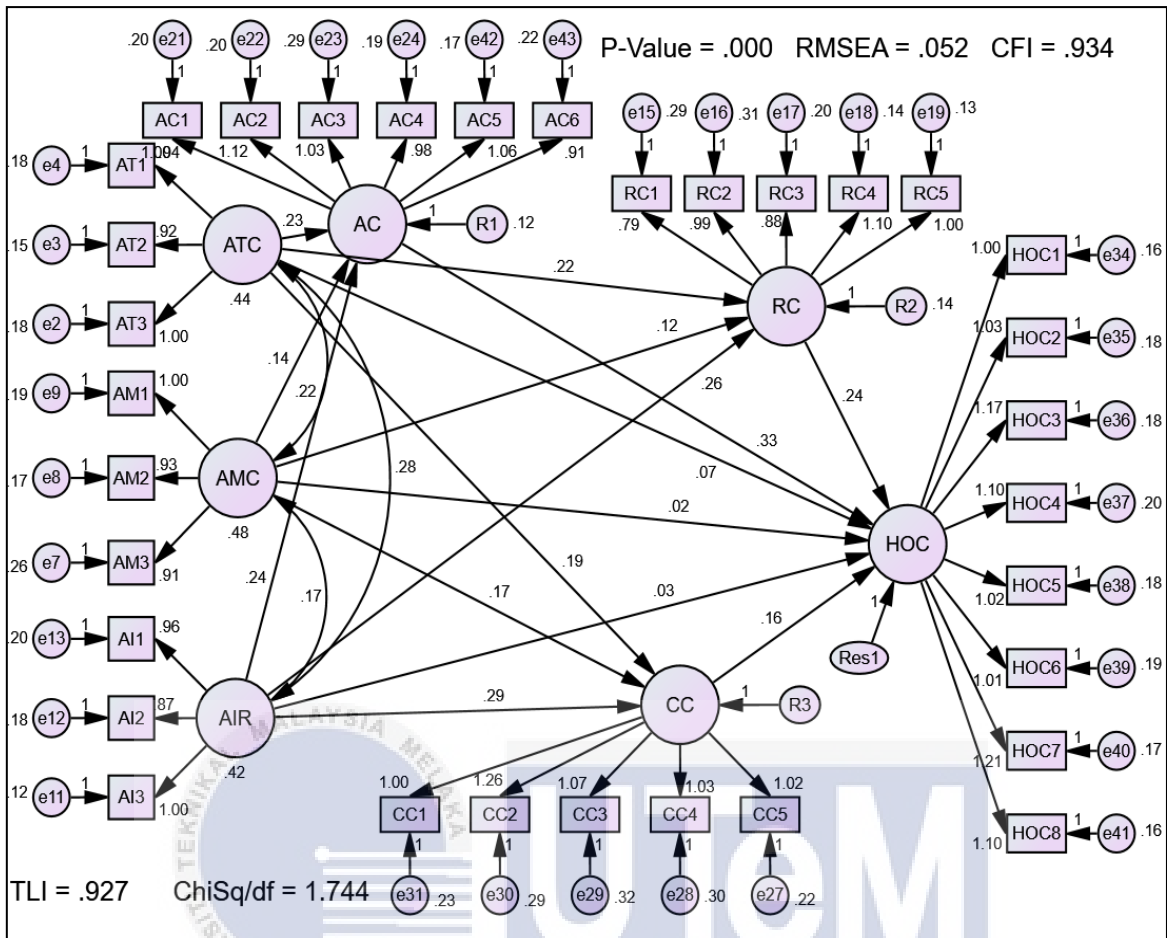


Figure 4.14: implication in this study

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Table 4.25: The R² and its implication in this study

Endogenous Construct	R ²	Conclusion
HOC	0.49	The exogenous constructs in the model RC, AC, CC, ATC, AMC and AIR contribute about 49 percent of endogenous construct HOC.

The regression path coefficients for all independent constructs are shown in Figure 4.15.

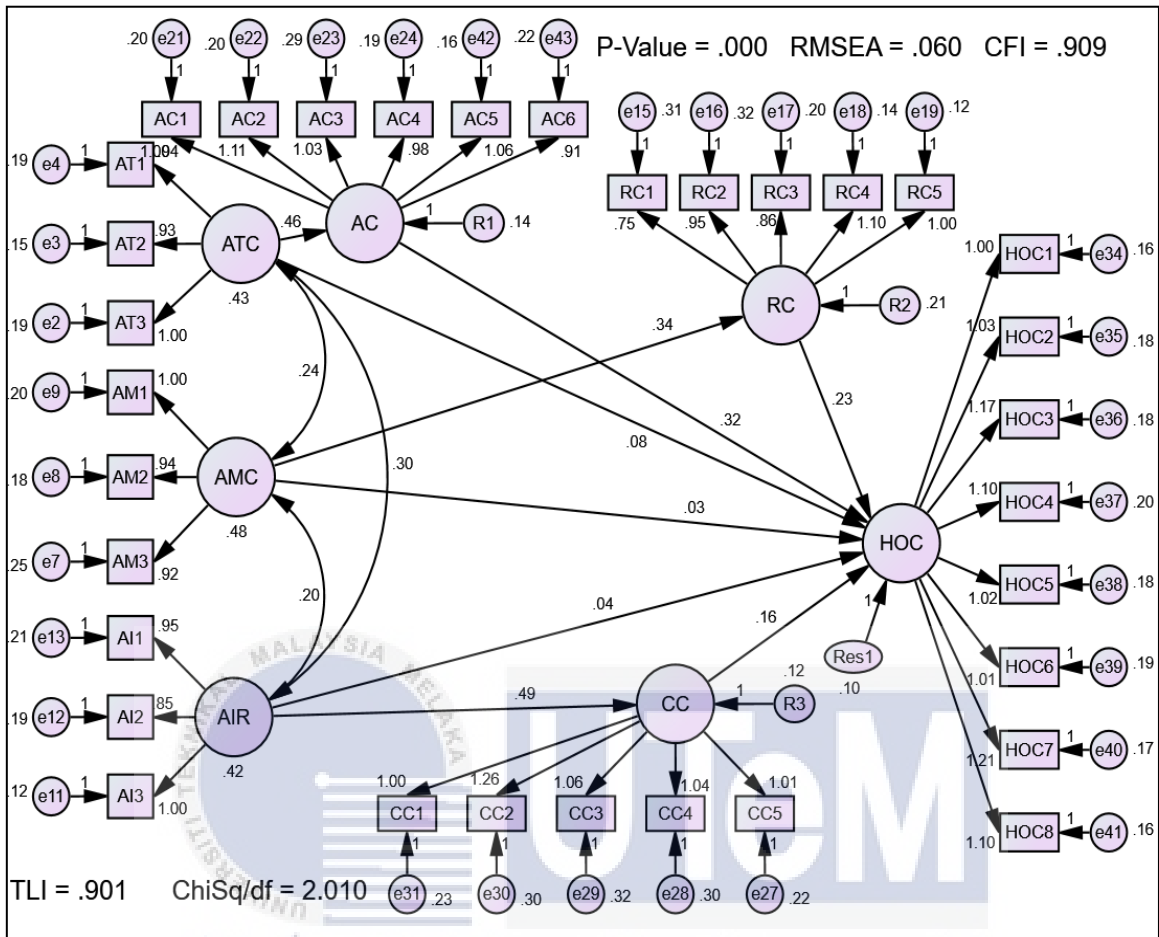


Figure 4.15: The Regression Path Coefficient among the constructs

The output for regression path coefficient (beta) for the effects of every independent construct on dependent construct extracted from Figure 4.8 is shown in Table 4.25.

Table 4.26: The Regression Path Coefficient

Exogenous	Endogenous	Beta	Explanation
ATC	AC	0.48	When ATC goes up one unit, AC goes up 0.48
AMC	RC	0.34	When AMC goes up one unit, RC goes up 0.34
AIR	CC	0.49	When AIR goes up one unit CC goes up 0.49
AC	HOC	0.32	When AC goes up one unit, HOC goes up by 0.32
RC	HOC	0.23	When RC goes up one unit, HOC goes up by 0.23
CC	HOC	0.16	When CC goes up one unit, HOC goes up by 0.16

The regression equation obtained in this study is presented in Table 4.26.

Table 4.27: The Regression Equation for the model in this study

Endogenous Construct	Regression Equation
HOC	$= 0.23.RC + 0.32.AC + 0.08.ATC + 0.03.AMC + 0.04.AIR + 0.16.CC$

The regression path coefficient between latent constructs and its significance is tabulated in Table 4.28.

Table 4.28: The regression path coefficient and its significance

			Estimate	S.E.	C.R.	P	Label
AC	<---	ATC	.226	.060	3.743	***	par_25
RC	<---	AMC	.120	.049	2.460	.014	par_28
CC	<---	AIR	.292	.058	5.005	***	par_30
RC	<---	ATC	.225	.066	3.410	***	par_39
CC	<---	ATC	.190	.058	3.252	.001	par_40
AC	<---	AMC	.144	.045	3.233	.001	par_41
CC	<---	AMC	.168	.044	3.818	***	par_42
AC	<---	AIR	.237	.058	4.068	***	par_43
RC	<---	AIR	.255	.064	4.003	***	par_44
HOC	<---	AC	.330	.077	4.290	***	par_26
HOC	<---	ATC	.074	.060	1.231	.218	par_27
HOC	<---	AMC	.018	.045	.397	.691	par_29
HOC	<---	CC	.163	.090	1.798	.072	par_31
HOC	<---	AIR	.026	.064	.402	.688	par_32
HOC	<---	RC	.238	.066	3.605	***	par_36

4.3.9 Summary of Hypotheses Testing

The hypothesis testing for direct effect is carried out in Table 4.28

Table 4.29: The hypothesis testing for direct effect

	Hypothesis statement	P-Value	Result
H ₁	Alliance Motives Transactional Cost (ATC) has positive and significant effect on Healthcare Organization Competitiveness (HOC)	.218	Not Supported
H ₂	Alliance Motives competencies (AMC) has significant and direct effect on Healthcare Organization Competitiveness (HOC)	.691	Not Supported
H ₃	Alliance Motives Transactional Cost (ATC) has positive and significant effect on Healthcare Organization Competitiveness (HOC))	.218	Not Supported
H ₄	Alliance Motives Industrial-Relationship (AIR) has significant and direct effect on Integration Capabilities (AC)	0.000	Supported
H ₅	Alliance Motives Transactional Cost (ATC) has positive and significant effect on Reconfiguration Capabilities (RC)	0.000	Supported
H ₆	Alliance Motives Transactional Cost (ATC) has positive and significant effect on Coordination Capabilities (CC).	.001	Supported
H ₇	Alliance Motives competencies (AMC) has significant and direct effect on Reconfiguration Capabilities (RC)	.001	Supported
H ₈	Alliance Motives competencies (AMC) has significant and direct effect on Integration Capabilities (AC)	.001	Supported
H ₉	Alliance Motives competencies (AMC) has significant and direct effect on Integration Capabilities (AC)	.001	Supported
H ₁₀	Alliance Motives Industrial-Relationship (AIR) has significant and direct effect on Integration Capabilities (AC)	.001	Supported
H ₁₁	Alliance Motives Industrial-Relationship (AIR) has significant and direct effect on Reconfiguration Capabilities (RC)	.001	Supported
H ₁₂	Alliance Motives Industrial-Relationship (AIR) has significant and direct effect on Coordination Capabilities (CC).	.001	Supported
H ₁₃	Integration Capabilities (AC) has positive and significant effect on Healthcare Organization Competitiveness (HOC)	.001	Supported

H ₁₄	Reconfiguration (RC) has significant and direct effect on Healthcare Organization Competitiveness (HOC)	.001	Supported
H ₁₅	Coordination Capabilities (CC) has significant and direct effect on Healthcare Organization Competitiveness (HOC)	.688	Not-Supported

4.4 Chapter Summary

This chapter presents the findings of the study. The results are mainly presented towards the achievement of the first research question. Even though the core of the research question was covered in Part One, Part two and Part three further elaborate on the areas of knowledge sharing, as fundamental to introduce contextual elements into the definition, as relevant to the present study.

The integration of findings was tabulated and analysed following the grounded theory analytical technique. This entailed open, axial, and selective coding. Towards the end of the selective coding, a theoretical model was presented based on the data underpinnings. Following the coding processes, the data was synthesized to reveal the specific items to be used for the subsequent phase of the study. Mainly, the items pertaining to knowledge sharing remain essential to completion of the survey questionnaire for the next phase of the research. The next chapter therefore present the results of the quantitative study after completing the quantitative data collection process.

CHAPTER 5

DISCUSSION, CONCLUSION AND RECOMANDATION

5.1 Intro Introduction

A strategic alliance is considered an effective driven vehicle for the competitiveness of any firm in the arena of international business. Therefore, many firms, especially in developing countries struggle hard to form alliance strategy with a success international partners. The literature suggests that alliance motives play a major role on alliance success through improving partners' dynamic capabilities and competitiveness. Yet, understand what alliance motives are and how they influence several aspects of alliance dynamic capabilities and competitiveness is not well documented, especially among healthcare institutions. To bridge this gap, the following research question was addressed:

Q1) what alliance motives are that influence alliance among the healthcare firms?

Q2) what are the dynamic capabilities that create value for healthcare firms?

On the other hand, a quantitative method driven by a survey was conducted with a large sample size to address three questions, which are:

Q3) what is the appropriate model of alliance motives and dynamic capabilities that influence competitiveness of healthcare firms?

This chapter presents the key finding of both qualitative and quantitative methods and discusses the results finding with past studies. This chapter also discusses the research implication and limitation and summary with a conclusion.

5.2 Alliance Motives

What alliance motives are that influence alliance among the healthcare firms?

Even though strategic alliance has widely perceived as an effective driven vehicle for the improvement of firm competitiveness, it depends on the motives and dynamic capabilities, which are vary from one industry to another industry. In addition, alliance strategy works differently from one context to another and based on the type of industry and its preferences. This however leaves a gap on understanding what alliance motives and dynamic capabilities are (Nsanzumuhire and Groot, 2020).

To bridge these gaps, qualitative research using multiple case studies were used to identify alliance motives and dynamic capabilities from the perspective of UAE healthcare institutions.

Purposive sampling was used and an open interview was conducted with 25 alliance project leaders at the UAE healthcare institutions between the 4th and 11th of January 2020. The open code was used and study the transactional cost, competence-based view, and industry relationship-based view are the major groups, which facilitate the understanding of the interrelation between knowledge sharing within strategic alliances.

In this research, the results show that alliance motives among healthcare institutions are driven by three main groups' namely transactional cost, industry-relationship and partner competencies and they influence the competitiveness of the UAE healthcare institutions.

Second, this research finds that alliance motives are important for developing alliance dynamic capabilities. It is because the dynamic change in the market environment influence the motives of alliance partners to commensurate with their dynamic capabilities. In this research, qualitative research driven by multiple case studies were conducted to identify the dynamic capabilities from the perspective of healthcare institutions, which were described based on three main groups namely, integration, and coordination and

reconfiguration capabilities. Third, to investigate the relationship between alliance motives and healthcare dynamic capabilities that influence healthcare competitiveness and generate alliance motives model, a quantitative research method was designed, which answered question 3.

5.2.1 Transactional Cost Motive

The finding of the qualitative research shows that economic motives (transactional cost) is important motives for forming alliance. Three main transactional cost indicators were confirmed in quantitative, which are minimizing the operational cost, equally equity sharing either positive or negative and optimizing value. The transactional cost got the highest score compared to other motives with 3.95. This indicates that the UAE healthcare firms emphasizes more to partner with capability to maximize their profits from providing advanced and affordable health services.

The transactional cost factors have indicated the requirement of equally equity sharing because it helps to maintain the alliance through minimizing opportunistic behavior of the partner that may rise during transferring the goods and services, where information is imperfect. Or because the parties have asset-specific investments, or either party may seek to promote its own interest at the expense of the other by engaging in strategic or opportunistic behaviour. Therefore, sharing equity is important to minimize the opportunistic behaviour, which is in line with study by Hu, Jain and Delios (2021). This is important to healthcare institutions because healthcare transactions are exceedingly complex; they involve physical, mental and even spiritual aspects on the buyer's side and technological, regulatory, medical and financial aspects on the supplier's side (Kros, Kirchoff and Falasca, 2019). One of the major motives is improving operational efficiency with the help of minimizing the cost and improving alliance value creation.

The finding of this research shows that, the UAE healthcare institutions seek for alliance partners with capacity that improves operational cost. This is indicating the status of the economic efficiency aspect developed through the assessment of alliances and their functions in healthcare. The healthcare institutions in the UAE are 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.

5.2.2 Competency-based Consensus in Strategic Alliances

Driven by competency theory, partners are more likely to form alliance with other partners if they have skills, knowledge, attributes and behaviours that enables their firms to perform a task or an activity successfully within a given job. This research also find that the UAE healthcare institutions are more likely to form strategic alliance with partners who know-how to articulate, codify, share and internalize alliance management in healthcare. It is because it helps healthcare institutions to distinguish its products from it's rivals as well as to reduce its costs than its competitors and thereby attain a competitiveness. It a;so helps in creating customer value. Also, core competencies help in creating and developing new goods and service. Second, the finding of this research also shows that the UAE healthcare institution used to select their alliance partner, who have substantial experiences and skills in healthcare services at different levels, a good management experience in alliance to minimize the risk. This faciliates their capabilities to improve value add in specific tasks in healthcare services, which may help to consolidate their competitiveness through enabling local health institutions to provide services that can only provide in foreigner countries such as Germany. Finally, this research conformed that the UAE healthcare institutions are more likely to form alliance to partner who has competencies in management experience in

alliance to minimize the risk. This because healthcare business requires a huge investment in both technology and human resources development. Thus, managing alliance is one of the major issue that UAE healthcare institutions and many firm s in developing countries are looking for.

5.2.3 Industry-Relationship based Consensus in Healthcare Alliances

Healthcare organizations are targeted for this question to assess the industry-relationship-based factors. 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 qualitative finding of this research shows that the partner with industrial motives, particularly in its capability to exert an influence on the external environment (structure), and thus, impact the performance through their strategies are more likely to be selected by the UAE healthcare institution. This because they can create monopoly and reduce the opportunities for the competitors through creating barriers. This in line with study by Nayak, Bhattacharyya and Krishnamoorthy (2022): The finding of this research also emphasized that healthcare institution in the UAE are more likely to select alliance partner, who have a good industrial reputation and have network density. This facilitates the development of inter-organizational network, which improves market integration. This is important when business models are conceptualized within ecosystems, acknowledging the interdependency and alignment between a firms (Kohtamäki et al., 2019). The technical support from a reputed organization was only a source of support for one operation and applies for only training and specialty infrastructure. Another important point noted was to minimize the weaknesses of the organization by having an alliance with a stronger organization. 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).

5.3 Dynamic capabilities

Q2) what are the dynamic capabilities that create value for healthcare firms?

Although the past studies have concluded that dynamic capabilities are a set of complexed routines (Nieves and Osorio, 2019)(Liu and Zhao, 2018), it is also contended that their emergence is taken as a given without implying the exact methods that shape these capabilities (Eisenhardt, 2000). Responding to such a criticism, (Eisenhardt, 2000) The authors state that dynamic capability processes are made up of "specific and recognisable procedures" that have been widely investigated. They specifically suggest that several processes, such as product development (combining various skills in cross-functional teams), strategic decision making (pooling of diverse business, functional, and personal expertise), alliance and acquisitions procedures (new resources, pre- and post-acquisition routines), and many others, can be used as examples of dynamic capabilities. To investigate the impact of dynamic capabilities on firm performance in a comprehensive manner, it is necessary to move beyond specific routines and processes and consider broader composite measurements. In this research, it was argued that dynamic capabilities can be well understood based on the firm practices. This because each firm is vary from other in their strategy and operation. Based on the finading of the interview, three major groups were identified, which are intrgration, reconfiguration and coordination capabilities.

5.3.1 Integration

The finding of this research shows that integration is one of the important capabilities that practices by the UAE healthcare institutions. The importance of integration capabilities lies on the healthcare institution capability in integrating the knowledge into the services and products design of value creation in comparison with direct competitors.

The integration capabilities in the UAE healthcare institutions were recognized through the ability to integrated manner knowledge to achieve goals and provide efficient capabilities, shares understanding of tasks, responsibilities to elimination of duties and reduction of operational costs. It also shows that the capability of the institution to create communication and collective intra-alliance activities towards value creation are important. In addition, the finding of this research shows that healthcare institutions have the capability of to manage inter-connectedness and integrate partners' capabilities to reach level of performance that can be noticed among other competitors.

3. To examine the relationship between alliance motives, value-based dynamic capabilities, and strategic competitiveness of strategic alliances within the UAE healthcare sector [RQ3].

5.4 Motives on Healthcare Competitiveness

H1: Alliance transactional cost has significant positive relationship on healthcare competitiveness

The literature suggests that alliance motives driven by transaction costs are necessary to govern ongoing alliance relationships, which influence firm performance (Lee, 2019). Yet, the finding of this research shows that alliance transaction costs p. value is 0.218, which is more than 0.05 indicating that there is no direct relationship with alliance competitiveness. This may because the transaction cost is more likely to improve healthcare dynamic capabilities healthcare institutions.

H2: Alliance transactional cost has significant positive relationship on dynamic capabilities (reconfiguration, coordination and integration)

To measure this hypothesis, the following three sub-hypotheses need to be measured:-

H2a Alliance Motives Transactional Cost (ATC) has significant and direct effect on Integration Capabilities (AC)

H2b Alliance Motives Transactional Cost (ATC) has positive and significant effect on Reconfiguration Capabilities (RC)

H2c Alliance Motives Transactional Cost (ATC) has positive and significant effect on Coordination Capabilities (CC).

For example, as shown in Chapter 4 Table 4.28, the transaction costs is significantly associated with the improvement of firms' dynamic capabilities coordination, integration and reconfiguration. This shows that reducing transaction cost facilitates alliance value creation through improving the dynamic capabilities of healthcare institutions in terms integration capabilities by 0.226. The increase in transaction cost by one increases healthcare firms capability in combining individual knowledge and tasks with new operational capabilities by 22.6%. In addition, alliance motives transactional cost has positive and significant effect on reconfiguration capabilities .225. This indicates that he increase in transaction cost by one increases healthcare firms capability in reconfiguring the resources into new operational competencies by 22.5%. Finally, alliance motives transactional cost has positive and significant effect on coordination capabilities by 0.190. This shows that increase transaction cost improve the ability to orchestrate and deploy tasks, resources, and activities in the new operational capabilities by 19%.

H3: Alliance competencies has significant positive relationship on healthcare competitiveness

Even though, the literature suggests that partner with competencies is significantly and positively influenced firms competitiveness (Bicen, Hunt and Madhavaram, 2021), the finding of this research shows no relationship. It is because alliance competencies motive can be only materialized when it create value and improve firms' dynamic capabilities.

H4: Alliance competencies has significant positive relationship on dynamic capabilities (reconfiguration, coordination and integration)

To measure this hypothesis, the following three sub-hypotheses need to be measured:-

H4a: Alliance Motives competencies (AMC) has significant and direct effect on Reconfiguration Capabilities (RC)

H4b: Alliance Motives competencies (AMC) has significant and direct effect on Integration Capabilities (AC)

H4c: Alliance Motives competencies (AMC) has significant and direct effect on integration Capabilities (AC)

The finding of this research shows that alliance competencies motive is significantly influenced value creation through improving firms' dynamic capabilities, particularly integration, reconfiguration and coordination capabilities. This because the core competences facilitate generating effective results through organizational learning processes, which influence healthcare long term business competitiveness. This is in line with study by (Santos and Batalha, 2022). The majority of healthcare in developing countries are suffering of sophisticated skills in healthcare services. This because the healthcare knowledge is more likely to be tacit knowledge that hardly to be transferred or reconfigured. Thus, the healthcare institutions and elsewhere used the alliance strategy as bridge to transfer alliance competencies, particularly in healthcare services. This in line with studies by Cambra-Fierro et al., (2011) and Bouncken et al., (2020), who confirms that partners need

to have collaborative know-how, cumulative alliance experience and dedicated and focused alliance managers to channel their synergy to customer value creation.

Learning from other's experiences is a developmental perspective and adopted by the UAE healthcare in local regions where managerial perspectives are of importance to learn from others. Hospitals are also considering management as a competency-based alliance as newly established organizations usually have greater experience of management. Management teams found opportunities by minimizing the mistakes by learning from well-expert partners. Understand managing equipment and using the technology of expert management is a strategy in most UAE hospitals to avoid mistakes and to minimize the risks related to management. This shows the goal of the alliance is already aligned in the hospitals to deliver a world-class healthcare system in the UAE. The outcomes of such alliances are showing a huge development in the specialization with the UAE due to the international expertise.

H5: Alliance industrial-organizational organization has significant positive relationship on healthcare competitiveness

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. However, in this research, the direct relationship between alliance industry-relationship and healthcare firms' competitiveness was not supported. This may be because the industrial-organizational factors such as reputation, competition control and skills influence healthcare dynamic capabilities in their ability to integrate the resources, reconfigure the process and coordinate alliance activities.

H5a: Alliance Motives Industrial-Organization Relationship (AIR) has significant and direct effect on Integration Capabilities (AC)

H5b: Alliance Motives Industrial-Organization Relationship (AIR) has significant and direct effect on Reconfiguration Capabilities (RC)

H5c: Alliance Motives Industrial- Organization Relationship (AIR) has significant and direct effect on Coordination Capabilities (CC).

The UAE economy is steady, and medical care framework is appealing for investment in the medical services where associations can see just competing to upgrade nature of care to be listed on the top medical services supplier is a typical explanation either from medical care supplier to be motivated to go with worldwide. It is additionally needed to set up expectations before getting an understanding.

What is the appropriate model of alliance motives towards healthcare dynamic capabilities and competitiveness in UAE?

Strategic alliances are formal agreements developed between partners for various internal and external needs (Bader, 2013). The motives for a strategic alliance between the healthcare sector are diversification of resources imitation of resources, expansion of resources, and disposal of resources. Strategic alliances are also associated with various other functions in an organization including knowledge sharing, values-based dynamic capabilities, and competitiveness of the organization as the research objective question is developed to understand the relationship among these factors within the healthcare sector.

The value dynamic capabilities are related to resources and renewal through reconfiguration into competence and new capabilities (Argote and Ingram, 2000). Dynamic capabilities are linked with the resource-based view due to its focus on the development of rare, valuable resources that are difficult to imitate (Andriopoulos and Lewis, 2009).

The literature review has also revealed that organizational competitiveness is also influenced by the renewal of capabilities and competencies that are also a subset of the value-

based dynamic capabilities (Ansell, 2007). The quantitative survey collected from hospital has determined various useful results including alliance motives.

The firm's aim and its capability of learning competition are achieved through cooperative agreements. Results determined from the quantitative data have indicated that new competencies are acquired through organizational learning and agreements like alliances.

Further, it is also noted that the competitiveness of the organization is based on new competencies gained. The professionals through surveys have expressed that managers take help of these competencies and they do grow after learning about new processes and approaches. It is revealed from the literature that learning is improved when organizations become process-oriented to develop effective operations leading to reduce future costs. It is known that healthcare competitiveness cannot only be achieved by resource planning and provision at a workplace especially in the healthcare industry because specialities are required such competencies to utilize the provided resources. This competencies should be unique and the international partner has strong industrial relationship to facilitate value creation and reconfiguration capabilities among healthcare institutions. The finding of this research is in line with study by (Melas et al., 2020) in which alliance partner with transaction cost and competencies motives are important to facilitate the development of reconfiguration and integration capabilities, which are associated with the learning and adoption of specialities and sub-specialities. In the UAE healthcare firms, the integration capabilities are identified as a key driver for advancing their competitiveness. The findings of the quantitative analysis have disclosed how the integration is being fulfilled at the hospitals in Abu Dhabi and other UAE regions. The results of quantitative data have revealed that coefficient capabilities and goal achievement are directly linked with integration that is a way to keep effective competition among rivals. The finding of this research shows that

minimization the operational costs is one of alliance motives, which influence the outcomes of healthcare capabilities through integration. This happens due to the elimination of duties and mitigation of operational costs in a facility.

The alliances based on the speciality and sub-speciality in various medical fields have given an approach to the UAE hospitals for achieving success regarding competitiveness. The UAE hiring policy for specialists and sub-specialists can be observed from the last two decades that are developed to fulfil the vacant position with competent staff. The alliances with other partners are successful to complete each other through providing motives that improve other partner dynamic solutions (Yang, 2020).

When considering the competitiveness of the UAE hospitals, the basic aspect has met that is of performance in the operations hospitals. Many insurance companies are also assisting the UAE healthcare and it has revealed how these companies for better reimbursement (UAE Government, 2019). These companies are implementing standard procedures through alliances with insurance companies to provide the patients with better reimbursement plans. This is also a way to assess the performance of healthcare facilities because it allows making cost-effective decisions. Therefore, transactional cost economy is important to facilitate alliance value creation driven by reconfiguration, integration and coordination capabilities. Two partners in the UAE from the health sector also enjoy department-based agreements (Yasin Fadol and Sandhu, 2013).

The literature review has uncovered that the level of performance is reached by partners meeting their need-based alliances. By reconfiguring the capabilities, the healthcare setups are gaining a competitive advantage in the UAE as the inter-department agreements are developed not only for the competitiveness but the efficiency of the operations (Barringer and Harrison, 2000). Partners are driven towards alliances for the sake of efficiency and cost reduction. This is also based on recognition of roles, motives, and transactions between

partners as explained by Williamson (1991). The competition can be assessed from the motives that are the basic aspect of hospitals as partners. The responses collected from primary data have provided the information that capabilities are reconfigured to bring a competitive advantage in the healthcare sector of the UAE. Reconfiguration plays a vital role in establishing a competitive advantage of the organization.

Long-term alliances are based on trust, continuity, and strength in healthcare whereas, in the case of research projects and specific plans these are also developed for a short period (Bentler and Bonett, 1980). New management concepts and technology are developed to attract new clients because clients in the UAE are becoming health-conscious due to high technology private sector interventions. Implementation and development of processes attract more customers indicating the benefit of processes alliance between partners.

This is a way to increase the capability of competitiveness. Time, cost, and efforts are protected through the latest technology implementation. Healthcare innovation is of great importance to access competitiveness. A few respondents have stressed on the function like Innovative processes management by the healthcare organizations demonstrates the alliance motives while an agreement is established.

Primary data has also revealed that capabilities and competitive advantage coordination indicate the presence of a highly developed system in healthcare. Moreover, the data results have designated that the contribution of technology in healthcare is to build trust for effective outcomes in diagnostics. The finding of this research is in line with Varma, et al. (2015) and Sklavounos et al. (2015) in which healthcare firms can gain client trust through creating value that saves time required for the diagnosis and treatment. This can be met through alliance competencies.

Competitiveness in the alliances is also achieved through long-term and short-term goals. The professionals have disclosed that if the short-term goals are of importance, it explores the needs of the organization for healthcare service providers or through technology share. The alliances based on short-term goals are found to be stronger and these cannot be easily broken down.

The hypothesis developed indicating the significant positive relationship between alliance motives and healthcare value creation, which indirectly influence healthcare competitiveness. The dynamic capabilities were determined to have a significant positive relationship with a competitiveness. The significant value of the hypotheses is determined through true data and showing a valuable role of a strategic alliance of the healthcare sector in the UAE.

The government of the UAE is concerned with the healthcare infrastructure. Therefore, serious actions are sought to cater to the needs and demands of the growing competitiveness. The literature review has revealed that the UAE government is keeping the healthcare infrastructure as the most important factor therefore advanced structure and progress is observed in the healthcare facilities. Officials in the healthcare sector are implementing various strategies to develop the healthcare system for the last two decades.

5.5 Research Implication

The implications of these emerging trends (discussed above) are highly significant for strategic alliance in the healthcare firms. New modes of collaboration and models of strategic alliances are emerging quickly. Motivations, incentives and mechanisms of strategic alliances collaboration will be very different from those of previous decades. This research highlights the need for theoretical development to catch up with fast-emerging healthcare alliance in developing countries and argue that for strategic alliances research to continue to advance, researchers need to both reflect on existing perspectives and pay greater

attention to the different changes driven by healthcare in developing countries such as the UAE. Traditional theoretical perspectives of strategic alliances will still be of value going forward, but new theoretical perspectives and new conventions for applying and combining existing perspectives (very likely to be multidisciplinary) will need to be developed to better explain the emerging phenomenon. This research discusses the implication of these changes for future strategic alliances research under four headings: boundaries of strategic alliances, what the alliance motives are, what the dynamic capabilities are and what the appropriate model for healthcare competitiveness is. Boundaries of alliance motives Existing theories, such as transactional cost economy, competencies based and industry relationship provide explanations relating to the alliance value creation and competitiveness. However, Detail here each motives what new. However, future SAs are likely to be more dynamic and exhibit non-linear trends due to radical technological changes (Kohtamäki, Rabetino and Moller, 2018; Todeva and Knoke, 2005), with the competitive edge of firms, as well as boundaries of SAs, being more ad hoc and blurred than ever before (e.g. linked to wider adoption of open innovation and cooperative relationships). TCE, for example, does not take account of the strategic value of alliances, such as in fostering innovation, which has become a key competitive factor. Alternative explanations are needed to explain and explore emerging dynamic and flexible SA relationships, cooperative relationships, SAs within interfirm networks and SA ecosystems. These alternative perspective explanations need to consider new driving forces behind dynamic relationships, and the cost–benefit balance between switching to new alliances and alliance clusters driven by new opportunities and the maintenance of relationships (Kohtamäki, Rabetino and Moller, 2018). In this vein, game theory (Parkhe, 1993) and the DCV (Teece, Pisano and Shuen, 1997), or the combination of the two, may bring important explanations to future understanding of the dynamic process of alliances and the relational equilibrium. Similarly, the expansion of network-based

cooperation is rendering agency relationships more complex and presents a greater challenge to alliance governance. This calls for an extended review of agency theory. Moreover, the relevance and contribution of institutional theory has also grown as (i) politics is superseding economics as a driving force in the new global order and (ii) an increasing number of alliances are located in, or involve firms from, emerging and former transition economies

The finding and results of the data collected from the UAE healthcare have provided with key implications has been drawn from the current study based on strategic alliances. First of all, the alliance is an instrument to achieve the objectives through partnership and to develop a system where competitiveness can be met in healthcare.

Organizational independence is an important factor for the development of an alliance because it is based on common objectives and flexibilities are required to keep both parties at the same level. The healthcare system can take advantage of the knowledge sharing only in case of proper knowledge sharing based on the prior contract agreement. Clear goals indicate the clarity of future results as the healthcare system integrating the entire information is a way to be competitive by sharing resources and technology instruments (Gimeno, 2004).

Competitive advantage can only be developing by the organizations by meeting the entire information agreement in healthcare (Peteraf, 1993). A non-competent healthcare facility develops a strategic alliance with competent one can bring effective results due to integration and reconfiguration. This is also argued by (Tjemkes, Vos and Burgers, 2017) common objectives in the alliances are based on the flexibilities that these organizations show while having a strategic alliance.

The flexibility in the goals to hide important information by strong organization results in confusion as the current study has provided the organizations that are not sharing complete information with partners in the medical field like the international organizations

in an alliance with the UAE local healthcare facilities (García-Canal, 1996). Healthcare systems are dependent on each other for the sake of technology, resources, and skills. These three important things are highlighted from the findings that are about the facts of partnership and future risks related to the goals.

Clarity of the goals at the time of agreement can minimize future issues related to sharing of resources. Alliances can be managed with the help of KPI as the healthcare sector can improve the strategic alliance purpose and establishment. This is also an example of a proactive strategy that helps to attain the objective. Committees are also developed in the UAE to develop KPIs that can be implemented for ensuring the strategic alliance based on effective future results and clear goals. These committees also help the healthcare organizations to achieve their rights of knowledge sharing and meeting future objectives. The current study has added valuable information about these aspects.

Cooperative strategies and goals can also be developed by organizations to meet the desired results of competitiveness in alliances (Ferreira, Storopoli, and Serra, 2014). The study has highlighted the weaknesses that can be present in a healthcare system while sharing resources, technology, skills, capabilities, and specialities. Financial motives and industry-based motives are of value among the healthcare sector in the UAE. The strategies like recruitment, hiring, selection, and training can also be implemented by sharing knowledge and by developing a single platform that will lead to minimizing the future expenses for hiring (Ferreira, Storopoli, and Serra, 2014). The healthcare in the UAE is struggling to adopt digitization for the last two years and the medical organization is developing a relationship with the international healthcare system to increase the impact of sub-speciality and technology (Gauer, 2013). Lack of healthcare facilities and limited workforce governance is a basic issue that has been identified in the UAE healthcare sector. The alliances between healthcares are being developed to keep these resources up to the mark and to improve the

research-based capabilities. The alliances usually end up in the UAE due to a lack of common goals in the healthcare sector. Competitive advantage is also gained by most of the local healthcare in the UAE indicating the strategic alliance purpose for sharing the resources that staff cannot use effectively due to lack of training (Peteraf, 1993). The competitive advantage is taken by having an alliance with international healthcare to increase the competencies of staff with the facility (Peteraf, 1993).

Knowledge integration and reconfiguration with strategic alliances for resources and competencies are also observed in the UAE, indicating an ideal approach by healthcare professionals. The findings have also highlighted the UAE hospitals can adopt more alliances by keeping a complete check as alliances have been imported the situation from the last two decades about drugs research.

The study was collected information from the project managers indicating the credibility to reach actual results of knowledge sharing, competitiveness, and value-based dynamic capabilities (Spender, 1996). The study is useful due to its exploration of the appropriate model as an objective. The results were able to provide the view of the appropriate model of the strategic alliance towards healthcare competitiveness in the UAE. Another implication found from the current study is the identification of policy development. Policies are developed in the medical organization in the UAE regarding transformation and knowledge sharing as the medical organizations are welcoming the change by applying various techniques within healthcare facilities like the application of new protocols that help to reduce the risks related to injuries in the healthcare system.

Information sharing in the UAE clinics is thought about generally from a financial perspective. Partners supporting each other can result in better planning choices and coalition development can profit society by improves administration quality. This occurs because of the presence of successful assets. Financial rationale agreement in the essential partnership

can have double outcomes as the current reactions are showing how the investigation members were consolidating their necessities and upgrades that were located in the reactions correspondingly.

Thought processes to have an alliance are of incredible significance and these are imperative to sign before the failure. Encountered proficient's reactions have expressed the absence of genuine intentions understanding towards an essential partnership of medical services have finished with a dissatisfaction. The supposed processes were to discover motivations to be more grounded among serious organizations. The majority of alliances have a concentration to be monetarily more grounded by keeping the partnership and they do not advance any insight beyond. The pioneers on their monetary improvement can expand financial status by putting covered up costs as they need to be paid more. This is supposed to be a leadership failure as featured by respondents.

Simultaneously, the subsequent alliance might not have comparable goals of union authority that are a need comprehension of the genuine intentions in the alliance. While a significant concern was featured for operational proficiency with the assistance of value that was hard to decide because of practices and transparency of the accomplices with each other. They do not get open even toward the start of the understanding bringing about a disappointment of union. Participants were additionally dedicated to offering excellent support in the alliance emergency clinics by limiting the operational expense, better administration, and high benefit to perform productively.

Agreements can act completely in a similar field as it is an approach to open up with each other toward the start of the understanding. Information sharing is supposed to be significant toward the beginning of the union that explains to the accomplices either the information sharing is helpful or not as it is a source to limit the odds of contention during the arrangement.

The UAE medical services associations have likewise evolved various assemblies to follow up the operational efficiencies and to drive the partnership. This is showing the situation with the monetary proficiency viewpoint created through the evaluation of alliances and their capacities in medical services.

The private area in the UAE is seen to foster collusions to guarantee business progression as the respondents were sharing their point of view of the union in the financial thought process (UAE Government, 2019). The deviation of the respondents in regards to business coherence is introducing the sharing of assets by the medical clinics to lessen the danger of future issues concerning monetary profits (Tjemkes, Vos and Burgers, 2017). Key impacts are significant for those with an absence of assets and to help each other. Cost decrease is discovered to be a significant component in the financial intention that is to limit the expense of recruiting, preparing, and creating representative abilities. Immediate and aberrant expenses require information partaking in the UAE clinics because the accomplices need to bear these expenses (UAE Government, 2019). The information is additionally moved as an additional expense and the two associations stay near share information and familiarity with extra financials assists the associations with spending viably (Stein, 2002). Information sharing was likewise seen as a viewpoint for the quality and execution between the UAE clinic as a couple of the respondents were contradicting the monetary and value-based variables. The thought process of experts in UAE medical care was likewise to give top-notch administrations to the UAE residents (UAE Government, 2019).

The experts in the UAE clinics serving people, in general, were featuring value-based and monetary variables were of least significance, as quality and execution were the essential intentions to share information and to have the essential partnership (Stein, 2002).

5.6 Research Limitation

The limitations of a study are the flaws and shortcomings in a study that can be lack of resources, short sample size, time constraints, and flawed methodology (Creswell, 2009). All types of researches face some challenges and limitations. Therefore, it is important to add limitations in a study to be open and transparent about troublesome issues. Rectification of these issues is also mentioned in the research to develop an understanding for the readers that how the researcher has faced challenges and what appropriate strategies are implemented to minimize these challenges in the whole research development process (Saunders et al., 2012). Study limitations also describe how the author has developed an understanding of key challenges faced during the study and how the author has a holistic understanding of various facts (Creswell, 2009).

The research is based on both qualitative and quantitative techniques for analysis but the study was incompetent for researchers due to the lack of freedom given to the respondents for sharing hidden areas in the strategic alliance (Yoshino, 1995). Interviews were collected to support the limitation. Another limitation was associated with the methodology implemented and the display of knowledge that was extracted from theories and data. The methodology limitation was unavoidable due to the efforts of the researcher for minimising the impact of data and theory conversion. Time was one an expected limitation in the current study development due to the research types. Primary and secondary data consideration for the study requiring more time, but the time given was not short.

The limitation was found due to the full-time job of the researcher. A strict timetable was drawn to implement different activities according to the time. For this, the researcher has adhered to scheduled activities strictly. Key milestones were also showing continuous progress in the work. Population selection and sampling strategy were also challenging for the current study as the data was required from all types of workers in healthcare to

understand facts of knowledge sharing, competitiveness and healthcare alliances. Equal distribution of the sample was a major concern as it was required to minimize future challenges of ethics to select the population size.

The equal presentation was acquired by making a complete difference in employees like nurses, physicians, administrative staff, and support staff. study credibility was achieved by setting population-based and sample-based challenges effectively. One research question was limited to qualitative analysis and for this interviews were conducted whereas, the other part was developed with quantitative analysis. This was creating trouble because for one section it was coding the responses and for the other section, the requirement was SEM, and data was analyzed through Smart PLS software. Due to the need for SEM and PLS, I have learned to implement this software using data.

The study has exposed the future results through qualitative and quantitative analysis. The limitation is the implementation of the quantitative analysis on basic objectives. The limitation was rectified by adding facts about the qualitative data and using tools to improve the reliability and credibility of the study.

5.7 Summary with Conclusion

The chapter of the discussion has enclosed the facts collected by the researcher through proper research methodology. These facts are elaborated by three key highlighting objectives of the study. The data has provided a clear understanding of various motives that are leading to the strategic alliances and the facts that are of value to develop an alliance in the healthcare sector of the UAE. The economic motive, financial motive, and competency-based alliances. Different types of data were observed to bring the discussions for three objective studies. It has been identified that the UAE healthcare is having a strategic alliance based on various motives of knowledge like technology, financial aspect, economic development, and competencies (U.S – UAE Business Council, 2018).

The UAE healthcare sector is not only developing alliances with local and private hospitals to meet resources and standards but actions are also taken to improve the quality of functions. Healthcare is a fertile sector where the local hospitals need to have alliances with huge setups only for the sake of the growth of technology. Other aspects that are important to have alliance are the provision of better services and reducing costs of internal operations by the healthcare (Tjemkes, Vos and Burgers, 2017). The financial motive of healthcare is related to growth and development as hospitals can have the alliance to minimize costs and improve their financial position in the industry.

The alliances based on some clear standards are successful in any case as these alliances between healthcare are usually based on the transparency of the partnerships. However, a few alliances were failed due to a lack of transparent goals and clear standards. Competency-based alliances are developed between most of the UAE hospitals to reduce internal hidden costs, to share knowledge, to train the workers, and to get the benefit of resources perfectly. The alliances in the healthcare sector are developed to share knowledge as indicated in the current study about integration and reconfiguration requirement for knowledge sharing. One department alliance is also observed in the healthcare sector to establish competitiveness in the market. Alliances are also followed by the hospital for self-renewal (Slater and Narver, 1998).

The UAE health sector has been improved to establish technology and instruments and the state-of-the-art hospitals are constructed to meet the future demands of the population (U.S – UAE Business Council, 2018). Another reason to construct such hospitals is to welcome healthcare tourism and international clients to some for the sake of treatment. The study has revealed the authentic efforts by the healthcare authorities and government to seek the opportunity related to healthcare.

The development of cancer hospitals, the addition of technology for chemotherapies and radiotherapies have indicated how the healthcare sector is willing to add more specialities for entertaining its clients effectively. It can be observed from the last two decades that how healthcare functions are improved due to the mutual efforts of the government and healthcare authorities. International talent and organizations are welcomed with flexible agreements to establish high quality and performance in healthcare. The qualitative and quantitative data are managed for the current study to keep the study valid and reliable.



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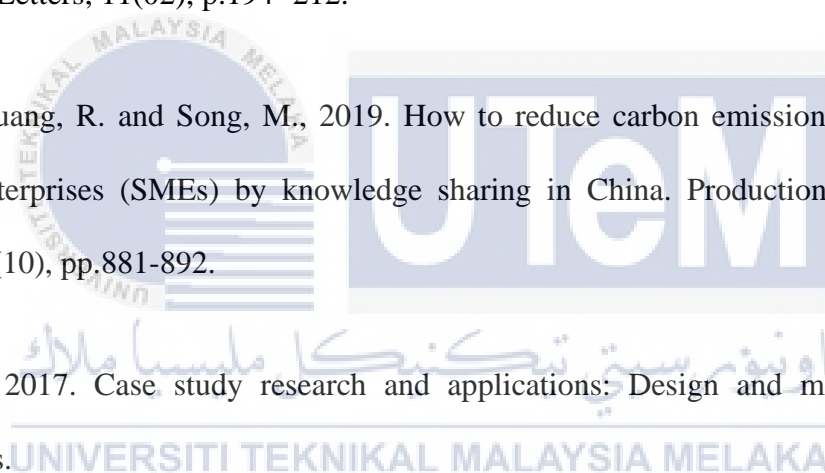
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APPENDICES

Appendix A List of Survey



UNIVERSITI TEKNIKAL MALAYSIA MELAKA

Dear Respondent (healthcare organisation):

This survey is being undertaken as part of an investigation/research into *“the key drivers for the enhancement of Strategic Alliance Value Creation: A model from the UAE Healthcare Industry*. Essentially, it is designed to gather information on key areas such as factors of strategic alliances, healthcare quality and competitive advantage. Please note that this questionnaire is not for promotional or appraisal purpose. Any information provided is strictly confidential and will not be traced or used against you in any way. Data gathered is for the purposes stated only.

For further clarification, please contact:

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Email:

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Supervisor: Dr. Samer Ali Al-shami

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Section A: Demographics / Organisational Characteristics

1. In what Emirate is your institution located?
 Abu Dhabi
 Dubai

2. What type of your healthcare institution?
 General hospital
 Private Hospital

3. How long has your organisation remained in operation?
 0-5 years
 6-10 years
 11-15 years
 16-20 years
 20 years and above

4. What is your current position in the healthcare facility you are representing?
 physician
 nurse
 Support Staff
 Administrative Staff

5. Under what category does your organisation fall?
 Research and Development Department
 Sales and Marketing Department
 Operation Department
 Others

For the remaining aspect of the study, please indicate the number that best shows your LEVEL OF AGREEMENT to the statements, where: 1=Strongly disagree, 2= Disagree, 3= Neither disagree nor agree, 4=Agree and 5 = Strongly Agree. Your responses apply to your knowledge about healthcare alliances in the UAE; whether or not including your organization.

Section B – Knowledge Sharing in Healthcare Strategic Alliances

Sub-Constructs	S/N	Items	1	2	3	4	5	6	7
Industry Relationships-Based Alliance	KSR1	Agenda and Motive declaration/ setting is an essential aspect of UAE healthcare strategic alliance (including alliances my company go into)							
	KSR2	Contractual (regulatory and relationship) regulation (and documentation) has evolved as one of the essential aspects of the UAE healthcare alliances.							
	KSR3	Clarity (openness/ good faith) is often considered an essential part of an alliance in the healthcare sector of the UAE.							
	KSR4	Committee/meetings/ resolution strategy is strongly installed in UAE healthcare B2B alliances							
	KSR5	Role definition (including conflict resolution) is always set up at the beginning of a strategic alliance in the UAE healthcare sector							
	KSR6	Long term strategic orientation are often prioritized at all times in a strategic alliance in the UAE healthcare sector							
	KSR7	Close (daily/ frequent) relationship building drives competitive performance in UAE healthcare strategic alliances							
Resources/ Cost Based Alliance (Economic)	KSC1	Key Performance Indicators (KPIs) are essential principles before alliance formation in the UAE							

	KSC2	Acknowledgement of organisational strengths and limitations is important to succeed as a healthcare alliance in the UAE							
	KSC3	Employees in the UAE healthcare alliance are often motivated through monetary band non-monetary incentives.							
	KSC4	Technology and innovation adoption is essential for the smooth operationalisation of a healthcare strategic alliance in the UAE							
	KSC5	Proper documentation of all encounters is important for competitive performance in UAE healthcare strategic alliances							
	KSC6	External marketing (including government support and external opportunities sensing) are instrumental for healthcare alliance success in the UAE.							
Competence-based Alliance	KSC1	Leadership commitment to UAE healthcare strategic alliance success is important for operational success after alliance formation							
	KSC2	Key performance indicators are introduced to govern for alliance operational success (after formation) in the UAE healthcare sector.							
	KSC3	Strategic alignment (common grounds, vision, mission, etc.) must be encouraged at all times for healthcare strategic alliances to succeed in the UAE healthcare market							
	KSC4	Innovative communication using versatile media and channels play an important role in how a UAE healthcare alliance can make a difference in the market							

	KSC5	Balancing short- and long-term goals/agenda in a careful and innovative manner is instrumental for healthcare alliance success in the UAE healthcare market.							
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Section C – Dynamic Capabilities Integration

S/N	What is the level of integration between alliance parties in the UAE healthcare sector?	Code	1	2	3	4	5	6	7
1	Our healthcare alliance often create value by contributing (in an integrated manner) knowledge to the alliance.	DCI1							
2	Our healthcare alliance often create value through shared understanding of tasks, responsibilities etc.	DCI2							
3	Our healthcare alliance have demonstrated connectedness in communication towards value creation.	DCI3							
4	Collective intra -alliance activities (activities within the newly formed alliance) is considered important to create value in our healthcare alliance	DCI4							
5	Collective inter -alliance activities (activities between the original alliance parties) is considered important to create value in our healthcare alliance	DCI5							
6	Adaptation and inter-connectedness to external value channels is an essential aspect of alliance operations in our healthcare alliance	DCI6							

Section D – Dynamic Capabilities Coordination

What is the level of coordination between alliance parties in the UAE healthcare sector?	Code	1	2	3	4	5	6	7
Appropriate allocation (and coordination) of alliance resources is essential for value creation in our healthcare alliance	DCC1							
Coordination in our healthcare alliance ensures that the assignment of tasks to corresponding strengths.	DCC2							
Alliance synchronisation of all resources, competences, management etc. is an important aspect of our healthcare alliance success	DCC3							
The synergy between group members are often encouraged in our healthcare alliance (alliance strength is higher than a sum of both parties' strength)	DCC4							
Leveraging resources to exploit new ideas is typical of our healthcare alliance	DCC5							
Alliance business coordination is an instrumental success determinant of our healthcare alliance.	DCC6							
Appropriate allocation of alliance resources is often properly conducted in our healthcare alliance towards overall value creation.	DCC7							

Section E – Dynamic Capabilities Configuration

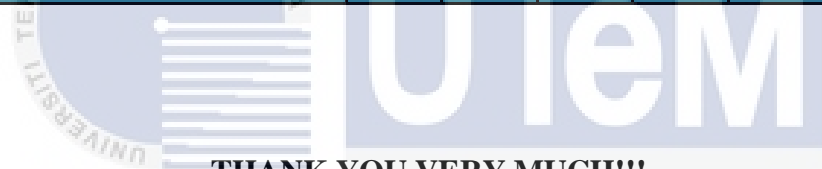
What is the level of reconfiguration between alliance parties in the UAE healthcare sector?	Code	1	2	3	4	5	6	7
Reconfiguring operational competencies influence competitive advantage	DCR1							
Innovative redeployment of existing resources	DCR2							

Evolving intra firm resources through imitation and experimentation	DCR3							
Patching –reconfiguring resources into the right chunks at the right scale to address shifting market opportunities	DCR4							
Resource redeployment following horizontal acquisition	DCR5							
Attractive new combination of resources	DCR6							
Combining resources into new combinations	DCR7							
Revamping (not destroying) existing operational competencies	DCR8							
Experimentation creating multiple alternatives in decision making	DCR9							
Need for internal and external transformation	DCR10							
Reconfiguring firm’s asset structure	DCR11							
Architectural innovation	DCR12							

Section F –Alliance Competitive Performance

S/N	What is the overall level of competitive performance of healthcare alliances in the UAE?	1	2	3	4	5	6	7
ACP1	In the UAE, healthcare alliances often form competitive expectations at alliance formation							
ACP2	Process and relational measures of strategic alliances are often up to global industry standards							
ACP3	Strategic goals fulfilment is often within clear reach in UAE healthcare strategic alliances							
ACP4	Strategic and operational satisfaction is often achieved in UAE healthcare strategic alliances							
ACP5	Financial performance of UAE healthcare strategic alliances are often satisfactory (overall profitable outlook)							

ACP6	In UAE healthcare strategic alliances, new emergent goals add to the overall competitiveness of the alliance within the market							
ACP7	UAE healthcare strategic alliances have demonstrated stability in operations and competitiveness							
ACP8	Healthcare alliances in the UAE are able to remain competitive throughout the duration of the alliance							
ACP9	UAE healthcare alliances are usually terminated on satisfactory and successful terms of outcomes							
ACP10	Overall market performance of strategic alliances are encouraging within UAE healthcare strategic alliances							



THANK YOU VERY MUCH!!!

اونيورسيتي تيكنيكل مليسيا ملاك

UNIVERSITI TEKNIKAL MALAYSIA MELAKA

Appendix B Information Sheet and Informed Consent Form

Alliance motives towards dynamic capabilities and the competitiveness of healthcare organizations

Dear Respondent,

You are being asked to take part in a research study on “Alliance Motives towards Dynamic Capabilities and the Competitiveness of Healthcare Organizations”. Before you decide, it is important for you to understand why this study is being done and what it will involve. Please take time to read the following information carefully and decide whether or not you wish to take part. Kindly reply email and ask me if there is anything that is not clear or if you would like more information.

Who is doing this study and why?

I am a student and am doing this study for my thesis as part of the requirement for the PhD Thesis.

Why have I been chosen?

I am inviting you to take part in this study as someone who I think would be able to provide some valuable opinions on the area of investigation.

Do I have to take part?

It is up to you to decide whether or not you want to take part. You do not have to give a reason for participation or in the event of unwillingness to participate.

Participants' Rights

You may decide to stop being a part of the research study at any time without explanation. You have the right to ask that any data you have supplied to that point be destroyed. You have the

right to omit or refuse to answer any question that is asked of you. You have the right to have your questions about the procedures answered. If you have any questions as a result of reading this information sheet, you should ask the researcher before the study begins.

What happens next if I agree to take part in this study?

You will need to complete the questionnaire online / consent to participate in the interview. The survey will not take any longer than 15 minutes to complete / the interview will last between 30 to 45 minutes max.

Confidentiality/anonymity

Any information you supply to me will be treated confidentially in accordance with the regulations of United Arab Emirates data protection act which is also consistent with the UK Data Protection Act 1998: your name and identifying affiliations will be anonymized in the analysis and any resulting publications. Any information you provide will not be given to anyone else.

What are the benefits of taking part in this study?

There is no payment for taking part in this study. The results preceding data collection can be shared with you upon request.

Are there any risks in taking part in this study?

Measures have been taken to ensure that there are no risks in taking part in this study.

FOR MORE INFORMATION

Student: Khaled Al Kaabi

Address: Al Ain, UAE

Telephone: +971 50 339 7770

Email: khaledkbi@googlemail.com

B. Informed Consent Form

Alliance Motives towards Dynamic Capabilities and the Competitiveness of Healthcare Organizations

Please consent to the following statements:

- I confirm that I have read and understood the Participant Information Sheet dated
- All the questions that I have about the research have been satisfactorily answered
- I understand that my participation is voluntary and that I am free to withdraw from the study at any time, without giving a reason
- I understand that in case I do not reply consent and proceed to data collection, then I have fully agreed to participate in the study through implied consent

I agree to participate

I do not wish to participate

Date: _____

C. Interview Guide – Phase I

Date: _____

Alliance Motives towards Dynamic Capabilities and the Competitiveness of Healthcare Organizations

**This interview is being undertaken as part of an investigation/research into the
“Alliance Motives towards Dynamic Capabilities and the Competitiveness of
Healthcare Organizations”**

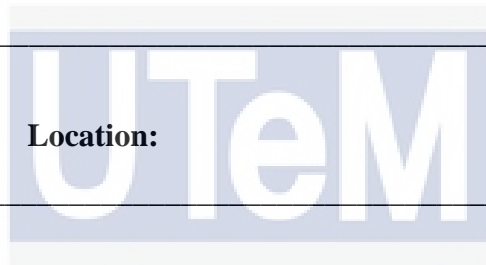
**”. Any information provided is strictly confidential and will not be traced or used
against you in any way. Data gathered is for the purposes stated only.**

Number/Code:

Time:

Respondent:

Location:



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**Question 1: What economic (including financial and transactional) resource factors
compelled your healthcare organization to venture into strategic alliances?**

.....
.....
.....

**Question2. What competency-based factors compelled your healthcare institution to
venture into strategic alliances?**

.....
.....
.....

Question3. What industry-relationship based factors compelled your healthcare institution to venture into strategic alliances?

Question4. What areas in your alliance do you consider the integration of capabilities?

Question5. What areas in your alliance do you consider reconfiguration capabilities?

Question6. What areas in your alliance do you consider co-ordination capabilities?

