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Strategic Management in the Healthcare Sector: The Debate About the Resource-Based View Flourishes in Response to Recent Commentaries

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There is increasing interest in – and debate about – the extent to which key concepts from the resource-based view (RBV) of the Firm school of strategic management can be usefully applied to study knowledge mobilization (KM) processes in healthcare and other public services settings.[1-3] This transfer process is an interesting example of how a school of thought originally developed in private sector settings helps in understanding how publicly funded healthcare organizations behave, although its concepts may still require adaptation as they cross-sectoral boundaries.

We here comment on two recent contributions to this debate published in this journal. Burton and Rycroft-Malone[4] raise the intriguing 'co-production' perspectives or the extent to which patients and publics can become partners in healthcare service delivery, for example, in the self-management of long term conditions. Their move from the linear models of knowledge diffusion and implementation still too dominant in health policy texts (eg, the Time 2 'translation gap' outlined in Cooksey[5]) and much of the evidence-based medicine (EBM) and implementation science movements towards more recursive and dialogic models is to be welcomed. Such non-linearity has sharp consequences for the (re)design of KM strategies in healthcare settings. A co-production orientation might well lead to efforts to ensure the better handling of emergent dialogue between different holders of types of knowledge, including between formal scientific knowledge and the more tacit experiential knowledge held by patients and carers.

There is now a strong tradition of patient and public involvement (PPI) in health services research. Drawing on their national (English) evaluation of Collaborations for Leadership in Applied Health Research and Care (CLAHRCs) which can be defined as network-based organizations dedicated to the promotion of evidence-based change and systemic knowledge mobilisation in regional patches, Burton and Rycroft-Malone[4] suggest that such PPI informed approaches could now be usefully extended to the domain of 'implementation.'

But we ask: PPI involvement could contribute to the implementation of *what*? There appears here to be an attachment to an evidence-based healthcare (EBHC) agenda – as indeed CLARHCs are mandated to pursue – that may be rather narrow in current policy terms[6] which now emphasises the more rapid diffusion of value creating innovations and wealth enhancement. Traditional forms of PPI which have grown up around front line National Health Service (NHS) service delivery may have to be rethought within a more marketised and firm-based policy arena.

In a second commentary, Harvey and Kitson[7] usefully explore three general themes in the RBV debate: (*i*) how do we define 'competitive advantage' in healthcare?; (*ii*) the contribution of macro level theory to understanding of KM; and (*iii*) the need to align theory across different analytic levels. Harvey and Kitson[7] argue firstly that 'competitive advantage' is not easy to define in healthcare settings, although they also acknowledge that market or quasi market reforms in many health systems have eroded the traditional boundaries between public and private sectors. In the American healthcare system, for example, some academic strategists now see the weakness of healthcare organizations in lying in a failure to embrace conventional private sector models of strategy sufficiently.[8] Harvey's own prior work[9] suggests achieving a level of health agency 'performance' regarded as adequate by sector regulators may act as a powerful proxy measure of competitiveness, at least in the English healthcare system. But they are right to draw attention to the importance in this sector of quality-based indicators of performance and the danger that they will be marginalized by easier to measure financial indicators.

The contribution of more macro level RBV theory is the second issue raised by Harvey and Kitson.[7] They suggest this focus on the macro or systemic level helpfully complements the usual micro/team-based orientation EBM implementation research. Empirically, however, recent evaluations of the case of the English CLAHRCs suggest that their systemic effects may have so far been weak. They argue RBV theory can suggest reasons for lack of impact (eg, poor absorptive capacity; weak dynamic capabilities) which may help national policy-making. We here suggest sustained recent English attempts to elaborate a broader national institutional architecture in healthcare KM – including but going well beyond CLAHRCs – can usefully be understood from this macro as well as a micro level.[10] The need to align different levels of analysis better is the third point raised by Harvey and Kitson,[7] drawing attention to the established Promoting Action on Research Implementation in Health Services (PARIHS) model which

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moves across macro, meso, and micro levels of analysis. Clearly their argument that RBV is but one theoretical strand which can be used to study KM processes in healthcare is a valid one: we should not claim too much for it. One broader point is that RBV is one school of strategic management originally developed in the private sector which now appears to be transferring inter sectorally into the health management domain, thereby usefully broadening the field's theoretical repertoire. We ask: are there other schools of strategic management which might now also usefully be brought in and if so, which and why?

Ethical issues

Not applicable.

Competing interests

Authors declare that they have no competing interests.

Authors' contributions

EF acted as coordinating author but consulted with other members of the team on an earlier draft and received and incorporated comment.

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