EFFECT OF SOCIAL CAPITAL, KNOWLEDGE MANAGEMENT, ORGANIZATIONAL LEARNING AND RISK CULTURE ON RISK MANAGEMENT CAPABILITY BUILDING OF HEALTHCARE BUSINESS

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Abstract

Given the constant changes and complexity of the current economic, political, and social climate, healthcare business entrepreneurs must confront daily operations risks, especially during the COVID-19 pandemic. In the meantime, the focus on healthcare among customers is increasing leading to high healthcare business and disease prevention service growth. Consequently, the healthcare business needs to consider the factors that help develop and improve the management capability of risk that maybe arise. This research aims to 1) examine the level of social capital, knowledge management, organizational learning and risk culture affecting risk management capability building of the healthcare business, 2) explore the effect of social capital, knowledge management, organizational learning, and risk culture affecting risk management capability of healthcare business, and 3) develop the driving model of risk management capability building of healthcare business. The study used a mixed research methodology that combined quantitative and qualitative methods. The quantitative sample group consisted of 420 owners and entrepreneurs of elderly care business in Bangkok and vicinity, selected based on a multiple-stage sampling process using 20-time criteria of the observed variable. Data was collected through questionnaires and analyzed using structural equation modelling. For the qualitative aspect, in-depth interviews were conducted 17 experts in risk management capability building of healthcare business in Thailand, who had at least 5-year experienced in the field. The findings revealed that 1) social capital, knowledge management, organizational learning, risk culture, and risk management capability of the healthcare business were all at a high level, ; 2) social capital, knowledge management, organizational learning and risk culture affected risk management capability of the healthcare business at statistical significance level of .05, ; and 3) the risk management capability model of healthcare business as developed by the researcher was called SKOR-RM Model (S = Social Capital, K = Knowledge Management, O = Organizational Learning, R = Risk Culture, Risk Management Capability Building in Healthcare Service). Additionally, the qualitative term indicated that to succeed in building risk management capability, entrepreneurs should emphasize the development of healthcare service model by applying management innovation to be in the form of elderly innovation and technology model that now in high demand, i.e., smart hearing aids, power-lift bed, human support robot, elderly walker, StairSteady, liftware spoon for Parkinson patient and food for dysphagia patient, etc. This research can be proposed to concerned authorities for defining their policies for promoting and developing healthcare business entrepreneurs and personnel to upgrade healthcare business and create remarkableness and market positioning at the regional level with sustainable potential in due course.

Keyword: Social Capital/Knowledge Management/Risk Culture/ Risk Management Capability Building.

INTRODUCTION

The continuous waves of change in the economic, political, and social aspects, especially with the ongoing impact of the COVID-19 pandemic, have made the current healthcare service industry complex and constantly evolving. Many entrepreneurs face numerous significant risks in their daily operations. While they are dedicated to providing full-service to users, they may not fully realize the risks they have to confront. Over the past two years, we have seen people worldwide becoming more aware of personal health, and the consequences of COVID-19 have greatly affected the healthcare service industry. Everyone is concerned and needs to take care of themselves, resulting in self-isolation and staying at home. Many people are unable to work or earn a living normally. Numerous businesses have to shut down or operate less efficiently. Trade and investment are severely impacted, and even the global economy is entering an economic crisis largely attributed to COVID-19. The relationship between business and health is unusually difficult. The delays associated with running health-related businesses have long-lasting effects and many causal connections (Park et al., 2022).

Another important impact is on industrial production, leading to shortages of essential products such as medical tools and healthcare equipment, resulting in higher prices for items like face masks and hand sanitizers. There is a problem of profit hoarding, causing increased expenses for Thais. This is not only due to the complexity of the healthcare service industry, which needs to constantly adapt to changes, but also due to the repercussions of the COVID-19 pandemic. Therefore, it is necessary for entrepreneurs in the healthcare industry to change their patterns and working methods to cope with the current situation. They must adapt to respond to the preventive healthcare trend, especially with the entry into Thailand's aging society in the year 2022, where the population aged 60 and above is over 14 million people. This increases the demand for healthcare products and services. Simultaneously, consumer behavior has shifted towards health consciousness. In addition, the COVID-19 pandemic has accelerated further increasing in the demand for health services and disease prevention. As a result, the healthcare service industry is experiencing significant growth.

The awakening of the global population's interest and efforts in seeking better, faster, and more affordable healthcare, along with the increasing convenience of travel to various locations, as well as improved communication and networking through the internet (Garba, Maiwada & Nourah, 2022). These have led to a continuous growth trend in the health-oriented economy, particularly evident in the Asia-Pacific region, presenting opportunities for countries in this area to generate income, jobs, and careers in the healthcare service industry. Consequently, many countries are striving to position themselves as medical hubs by creating unique strengths and market positioning to attract service users to their nations .Key countries in the Asia-Pacific region, potentially competing for the Medical Hub of Asia, include Singapore, Malaysia, South Korea, India, and Thailand (Castaneda, 2010; Smith, 2008).

The study focuses on examining the patterns of capabilities in managing business risks in the healthcare service industry and the influence of social capital, knowledge management, organizational learning, and risk culture on building capabilities in managing risks for healthcare businesses.

This aligns with the strategic goal of developing Thailand into a central medical service hub. The researchers conducted a review of research documents and literature relevant to the topic over the past five years, from the year 2016 to 2021. The findings indicate that there has been extensive research on each of the five variables of interest in various businesses and healthcare services. However, there is a lack of studies that comprehensively explore the relationships among all five variables in the context of the healthcare service industry, particularly in Thailand. Therefore, this study aims to address this gap in the existing research landscape.

LITERATURE REVIEW

Social Capital

Social capital is challenging to define, whether at the individual or group level. It arises when individuals actively participate in groups. Comparing social capital to financial capital may lead to misunderstandings because it differs from financial capital, which is the resource owned by individuals. Social capital is the benefit derived from the patterns of social organization, not belonging to any specific individual but rather resulting from the collective participation of a group of individuals who benefit from their collaboration (Elahi, 2013). However, defining, establishing groups, and measuring social capital pose philosophical and linguistic challenges. The term "capital" generally refers to resources used for investment. Financial capital includes fixed assets, and human capital is akin to financial capital, encompassing specific types of skills as a form of assets. Nonetheless, social capital, generated by social interactions, does not aggregate resources owned by individuals or groups because it is a process of social interactions that results in created entities (Fox, 1996; Elahi, 2013).

Knowledge Management

Knowledge management is a comprehensive process involving various tasks managed in an integrated manner to generate the anticipated benefits. It is the holistic concept of managing knowledge resources within an organization (Elahi, 2013). According to Kucza (2001), knowledge management is an activity related to organizing processes of knowledge creation, storage, and sharing. In general, it encompasses identifying the current state, determining needs, and refining processes to enhance knowledge management for better outcomes to meet the requirements. Goswami and Agrawa (2019) define knowledge management as a system of asset management. The organizational knowledge includes both explicit and tacit knowledge. This system is associated with knowledge classification, knowledge audit, storing audited knowledge, preparing knowledge filtering, and providing access to users (Kucza, 2001). The underlying principle is to ensure that knowledge is applied, adapted, and elevated. Grant (1996) explains knowledge management for organizations, comprising activities that gather knowledge from individuals' experiences and others to apply in fulfilling the organization's mission. It relies on integrating acquired knowledge to align with organizational technology infrastructure and formulating strategies using wisdom (Kucza, 2001). This is all underpinned by utilizing knowledge to generate new knowledge.

Organizational Learning

Organizational learning is a perspective within organizational studies and a sub-discipline of organizational studies. In the organizational context, organizational learning is the process of generating, maintaining, and transmitting knowledge (Argote & Ingram, 2000). It involves knowledge creation, knowledge retention, and knowledge transfer (Cyert & March, 1992). These processes are considered adaptive processes that are the responsibilities of experience (Argote & Ingram, 2000). Experience is knowledge that leads to understanding through participation or disclosure in the process. Internal research on organizational learning is applied specifically to the characteristics and behaviors of this knowledge. It examines how this knowledge brings about changes in the organization's understanding, routines, and behaviors. Most people perceive it as a mechanism for organizational learning by creating knowledge through experiences (Argote & Ingram, 2000; Cyert & March, 1992).

The knowledge of each individual facilitates learning within the organization as a whole. However, if there is a lack of knowledge transfer, individuals may inhibit the transfer of knowledge or exit the organization. Knowledge embedded in the organization can be retained even if individuals leave. Organizations can store knowledge in various forms beyond individual retention, including using knowledge repositories such as communication tools, processes, learning routines, tasks, networks, and transaction memory systems (Argote, 2014; Argote & Ingram, 2000; Walsh & Ungson, 1991).

Risk Culture

Risk culture is another perspective in risk perception theories, standing out among two other prominent theories. The first theory, rooted in the theory of reasoned action, considers risk perception as a rational weighing of costs and benefits by individuals. Sonnentag (2002) as well as Douglas and Wildavsky (1982) criticized this approach in their book "Risk and Culture: An essay on the selection of technical and environmental dangers," arguing that it overlooks the role of cultural lifestyles in determining which risks individuals find acceptable (Douglas & Wildavsky, 1982).

The second standout theory, based on social psychology and behavioral economics, asserts that individuals' risk perceptions have prevalent patterns and are often distorted by behavior and bias (Kahneman, Slovic & Tversky, 1982). Douglas confirmed that psychometrics, a discipline studying psychological measurements, including knowledge, abilities, attitudes, and personalities, has attempted to eliminate political bias in risk perception by identifying beliefs influencing perception. This reflects the dedication of individuals to competitive cultural frameworks (Douglas, 1997).

Risk Management Capability

Risk management capability has implications for various aspects of business. Zhang (2019) argue that even though a company's characteristics have significant influence, the use of derivatives reflects the integrated risk management capabilities of a company, indicating the company's holistic management power, influencing financial derivatives usage. Managing

risks in business operations can lead to various financial benefits. Therefore, it is essential to incorporate risk management as part of the business management strategy. Ahmed et al. (2021) state that managing risk as a business process creates a competitive advantage for the insurance sector. Elahi (2013) suggests that when companies seek risk management capabilities from a strategic perspective, these capabilities can be utilized to enhance competitiveness. Furthermore, Kwak et al. (2018) express that the ability to manage risk supports a competitive advantage in business competition.

Gatzert and Schmit (2016) recommend several crucial concepts when integrating reputation risk management into the organizational risk management framework. These include identifying and understanding the primary objectives of stakeholders, recognizing the value of multidimensional and multilevel impacts on the organization's reputation, and monitoring the influence of technological advancements. Walsh, Bolivar and Ecuador (2012) likewise reveal that reputation positively affects spending and wallet share. According to Kaho (2021), companies can employ team-coaching methods to build risk management team capabilities. A systematic and comprehensive approach is necessary for enhanced effectiveness in dealing with future flexibility and business continuity. Organizations consider developing risk management capabilities to increase preparedness, whether in terms of business flexibility, disaster recovery, or project and operational conditions. The aim is to enhance business flexibility and continuity. Buttigieg et al. (2019) also mentioned that management should respond to employees' risk awareness by allocating organizational resources, such as time, personnel, training, and equipment. When employees receive adequate guidance on safety importance, understanding safety can be improved.

METHODOLOGY

This research employed a mixed methods approach, integrating quantitative research and qualitative research in an explanatory sequential mixed methods design. This design prioritized quantitative research as the primary method. After processing and obtaining results from the quantitative research, the study proceeded to conduct qualitative research with key informants for providing in-depth insights to confirm the quantitative findings and further explain the quantitative research. For the quantitative research, a literature review was conducted on social capital, knowledge management, organizational learning, risk culture, and risk management capabilities in healthcare businesses. The researchers synthesized this information to formulate research terminology definitions, establish variable indicators based on the research framework, and create a questionnaire following Likert's five-level approximation method. The validity and reliability of the measures were tested before collecting data from owners or entrepreneurs of healthcare businesses catering to the elderly in Bangkok and its surrounding areas. The collected data were then statistically analyzed using Structural Equation Modeling (SEM). As for the qualitative research, in-depth interviews were conducted with knowledgeable individuals who had expertise in organizational risk management within the healthcare industry in Thailand or those who had experience in risk management of healthcare businesses operating in Thailand for not less than 5 years. From the research question to find information that respond to research

objectives, the qualitative research to complement the results of quantitative research to provide additional knowledge and understanding about variables affecting building risk management capabilities in healthcare businesses, in addition to the variables that the researchers used in quantitative research studies, was conducted (Suchat Prasitratsin, 2012). Moreover, it allowed the researchers to bring qualitative data to confirm the findings in this research by using data from many sources and many types to drive quantitative research and support it with qualitative research (Tashakkori & Teddlie, 1998). These data developed the model to increase the efficient risk management capability of the healthcare business which could be used in personnel improvement to increase potential and opportunities in international competition in quality, safe and acceptable healthcare business.

RESULTS

The normal distribution of the 21 observed variables studied in the structural equation model was examined, using the chi-square test (χ^2). The statistical significance at the .05 level represented non-normally distribution of such variables. On the other hand, if it was found to be not statistically significant (P-value > .50), it revealed normal distribution of such variables.

Table 1: Mean (M), Standard Deviation (SD), percent coefficient of variation (%CV), skewness (Sk), kurtosis (Ku) and P-value of the chi-square test (χ^2) of the empirical variables (n=420)

Variable	M	S.D.	%CV	Sk	Ku	χ^2	P-value
TRST	4.10	.85	20.78	-2.754	-1.364	9.446	.009
NEWK	4.17	.93	22.37	-3.269	-3.566	23.402	.000
NORM	4.09	.88	21.49	-2.916	-1.551	1.909	.004
SFRG	4.13	.99	24.18	-3.340	-3.357	22.424	.000
ACLRN	4.25	.69	16.30	-3.095	-3.955	25.219	.000
PRAS	4.21	.74	17.66	-3.334	-3.713	24.900	.000
AFARW	4.26	.65	15.37	-2.831	-2.663	15.104	.001
APCI	4.23	.65	15.55	-2.707	-2.616	14.171	.001
EXPL	4.11	.82	20.05	-2.837	-1.735	11.061	.004
INTGO	4.01	.94	23.42	-2.809	-3.430	19.657	.000
EPLRN	3.99	.96	24.11	-2.712	-2.836	15.401	.000
EPOPO	4.06	.93	23.00	-3.385	-3.218	21.819	.000
SGSTG	4.12	.64	15.54	-1.618	-.200	2.658	.265
RSIDF	4.15	.67	16.22	-1.915	-2.454	9.691	.008
RKASM	4.02	.74	18.49	-1.904	-.949	4.524	.104
RKRPS	4.05	.68	16.91	-1.841	-.991	4.371	.112
MOTR	4.14	.67	16.40	-1.534	-1.296	4.034	.133
FNCL	4.19	.59	14.22	-1.318	.139	1.757	.415
REPT	4.16	.65	15.66	-2.819	-2.587	14.639	.001
CNTS	4.20	.62	14.82	-1.899	-1.031	4.668	.097
SAFT	4.24	.65	15.51	-2.610	-2.536	13.242	.001

Note: chi-square (χ^2) with statistical significance (P-value <.05) indicates a non-normal distribution

The researchers have checked the quality of the variables studied in the model by testing construct validity of each latent variable using the Confirm Factor Analysis technique by considering the greater than .30 factor loadings to confirm a good observed variable.

It is considered from the R^2 to check reliability of the empirical variables as well as directly examining the Construct Reliability (ρ_c>.60) of the latent variables and Average Variable Extracted, ρ_v>0.50) (Diamantopoulos and Siguaw, 2000), as detailed as follows.

Table 2: Factor Loadings (n = 420)

| Variables	Factor Loading (λ)	Error (θ)	t	R^2
Social Capital (SCPT)				
Trust (TRST)	.82	.33	19.78	.67
Network (NEWK)	.85	.27	21.14	.73
Social Norm (NORM)	.83	.31	20.29	.69
Common Goal (SFRG)	.85	.27	21.12	.73
Knowledge Management (KNMNG)				
Active Learning (ACLRN)	.84	.30	19.55	.70
Peer Assist (PRAS)	.81	.34	19.48	.66
After-action Review (AFARW)	.82	.33	19.61	.67
Appreciative Inquiry (APCI)	.85	.28	19.98	.72
Organizational Learning (ORGLN)				
Experiential Learning (EXPL)	.79	.38	18.83	.62
Integrating Knowledge in Organization (INTGO)	.84	.30	20.79	.70
Exploratory Learning (EPLRN)	.91	.17	23.78	.83
Exploring External Opportunities (EPOPO)	.90	.19	23.22	.81
Risk Culture (RSKCL)				
Strategy Setting (SGSTG)	.84	.30	20.01	.70
Risk Identifying (RSIDF)	.77	.41	17.71	.59
Risk Assessment (RKASM)	.41	.83	8.22	.17
Risk Responsiveness (RKRPS)	.79	.38	18.42	.62
Monitoring (MOTR)	.80	.36	18.75	.64
Risk Management Capability of Healthcare Business (RMCHT)				
Financial Aspect (FNCL)	.89	.20	22.15	.80
Reputation (REPT)	.77	.41	17.04	.59
Continuous Services (CNTS)	.87	.25	21.18	.75
Safety (SAFT)	.79	.37	18.77	.63
ρ_c= .90 ρ_v = .69				
Chi-Square=0.00, df=0, P-value=1.00000, RMSEA=0.000				

Table 3: Direct, indirect and total effects from the adjusted structural equation model (n=420)

Dependent variables	R²	Effect	Independent Variables			
			Organizational Learning (ORGLN)	Risk Culture (RSKCL)	Social Capital (SCPT)	Knowledge Management (KNMNG)
Organizational Learning (ORGLN)	.65	DE	-	-	.76*(15.09)	.70*(6.41)
		IE	-	-	-	-
		TE	-	-	.76*(15.09)	.70*(6.41)
Risk Culture (RSKCL)	.64	DE	.61*(6.63)	-	.60*(5.42)	.79*(14.60)
		IE	-	-	.29*(4.62)	.13*(3.41)
		TE	.61*(6.63)	-	.89*(10.39)	.92*(14.83)
Risk Management Capability of Healthcare Business (RMCHT)	.71	DE	.58*(5.25)	.41*(6.19)	.46*(5.96)	.48*(6.89)
		IE	.32*(4.55)	-	.37*(6.30)	.33*(5.86)
		TE	.90*(6.48)	.41*(6.19)	.37*(6.10)	.80*(15.65)
χ²= 292.28 df =164 p-value = .00000 , χ² / df = 1.78, RMSEA = .048, RMR = .035, SRMR = .048, CFI =.98, GFI = .92, AGFI = .91, CN = 299.86						

*statistical significance at the .05 level

Note: In parentheses, they were the t-value. If the value was not between -1.96 and 1.96, it was statistically significant at the .05 level. DE=Direct Effect, IE=Indirect Effect, TE=Total Effect
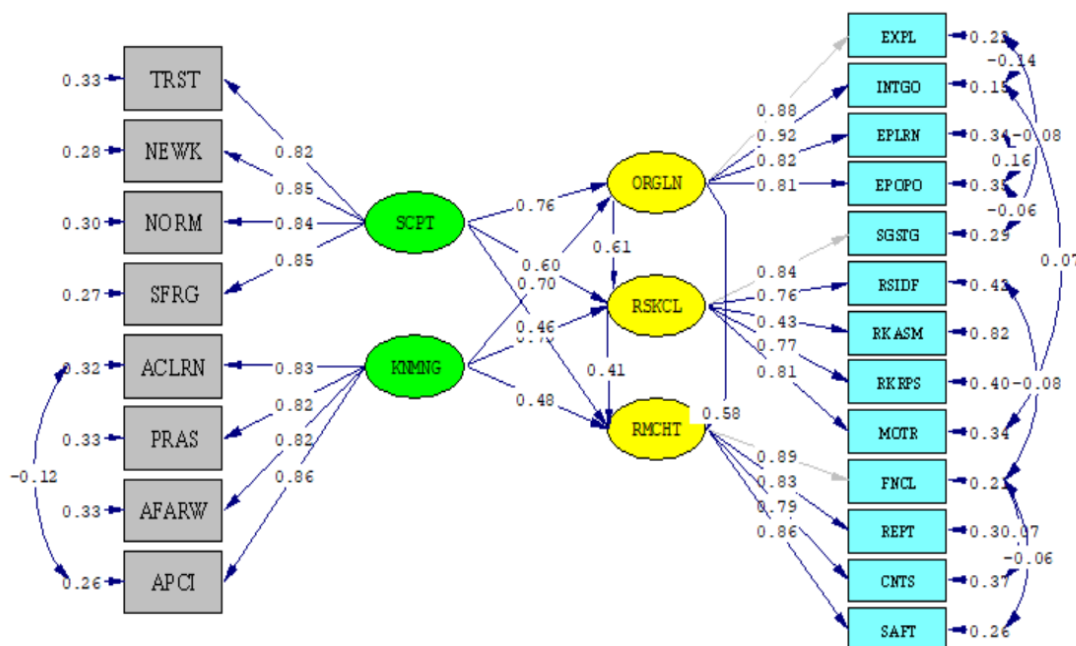
Chi-Square=292.28, df=164, P-value=0.00000, RMSEA=0.048

Figure 1: Adjusted Model (n=420)

The hypothesis-based model demonstrated a goodness of fit with the observational data by allowing the standardized error variance (θ) of 15 pairs of the observed variables to be interrelated (df for the hypothesis-based model and the adjusted model is 179 and 134, respectively). The adjustments made to the model resulted in a fitting adjusted model, as indicated by the fit indices: χ^2= 292.28, df =164 p-value = .00000, χ^2 / df = 1.78, RMSEA = .048, RMR = .035, SRMR = .048, CFI =.98, GFI = .92, AGFI = .91, CN = 299.86.

The examination of the goodness-of-fit indices revealed χ^2= 292.28, df =164 p-value = .00000, which did not meet the statistical significance criterion (P-Value > .05). However, χ^2 was sensitive to the sample size, so the researchers also considered χ^2/df, which was 1.78 (<2.00), indicating a good fit. Other fit indices, including RMSEA (.048<.050), RMR (.035<.050), SRMR (0.48<0.50), CFI (.98>.90), GFI (.92>.90), AGFI (.91>.90), and CN (299.86>200.00), also met the specified criteria. In conclusion, the adjusted model fitted with the observational data, and the parameter estimates in this model were considered acceptable.

CONCLUSIONS

The adjusted structural equation model of the influence of social capital, knowledge management, organizational learning and risk culture that affect the risk management ability of healthcare businesses was fit with the empirical data at an acceptable level, which was considered from the fit Indexes as follows: χ^2= 292.28 df =164 p-value = .00000, χ^2 / df = 1.78, RMSEA = .048, RMR = .035, SRMR = .048, CFI =.98, GFI = .92, AGFI = .91, CN = 299.86. The estimation was found in the structural equation model as follows.

1) Social Capital (SCPT) has a positive direct influence on Risk Management Capability of Healthcare Businesses (RMCHT) with a standardized coefficient of .46*(5.96) at a statistically significant level of .05, supporting Hypothesis 1 (H1): social capital positively influences risk management capability of healthcare businesses.

2) Knowledge Management (KNMNG) has a positive direct influence on Risk Management Capability of Healthcare Businesses (RMCHT) with a standardized coefficient of .48*(6.89) at a statistically significant level of .05, supporting Hypothesis 2 (H2): knowledge management positively influences risk management capability of healthcare businesses.

3) Organizational Learning (ORGLN) has a positive direct influence on the Risk Management Capability of health service businesses (RMCHT) with a standardized coefficient of .58*(5.25) at a statistically significant level of .05, supporting Hypothesis 3 (H3): organizational learning positively influences risk management capability of health service businesses.

4) Risk Culture (RSKCL) has a positive direct influence on the Risk Management Capability of health service businesses (RMCHT) with a standardized coefficient of .41*(6.19) at statistically significant level of .05, supporting Hypothesis 4 (H4): Risk Culture positively influences risk management capability of health service businesses.

5) Social Capital (SCPT) has a positive direct influence on Risk Culture (RSKCL) with a standardized coefficient of .60*(5.42) at a statistically significant level of .05, supporting Hypothesis 5 (H5): social capital positively influences risk culture.

6) Knowledge Management (KNMNG) has a positive direct influence on Risk Culture (RSKCL) with a standardized coefficient of .79*(14.60) at a statistically significant level of .05, supporting Hypothesis 6 (H6): knowledge management positively influences risk culture.

7) Organizational Learning (ORGLN) has a positive direct influence on Risk Culture (RSKCL) with a standardized coefficient of .61*(6.63) at a statistically significant level of .05, supporting Hypothesis 7 (H7): organizational learning positively influences risk culture.

8) Social Capital (SCPT) has a positive direct influence on Organizational Learning (ORGLN) with a standardized coefficient of .76*(15.09) at a statistically significant level of .05, supporting Hypothesis 8 (H8): social capital positively influences organizational learning.

9) Knowledge Management (KNMNG) has a positive direct influence on Organizational Learning (ORGLN) with a standardized coefficient of .70*(6.41) at a statistically significant level of .05, supporting Hypothesis 9 (H9): knowledge management positively influences organizational learning.

10) Integrated Prediction Model: Organizational Learning (ORGLN), Risk Culture (RSKCL), Social Capital (SCPT), and Knowledge Management (KNMNG) collectively predict 71% of the variance in the Risk Management Capability of health service businesses (RMCHT).

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