




Faith as competitive strategy: The value-based leadership advantage in Christian hospitals



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Background: Christian foundation private hospitals in Indonesia must navigate a challenging healthcare environment characterised by limited resources, regulatory requirements and rising patient expectations while maintaining their religious identity in a non-Christian context.

Aim: This research explores how value-based leadership practices enable Christian foundation private hospitals in Indonesia to construct competitive strengths amid market challenges.

Setting: Researchers conducted the study across 12 Christian foundation private hospitals on Java Island, Indonesia, varying from 120 to 450 beds in size, with histories spanning 45 to over 100 years, covering urban and semi-urban areas across West, Central, and East Java.

Method: Drawing upon the resource-based view (RBV) theory, servant leadership theory, and institutional theory, this research utilises a qualitative multiple case study design based on Gioia methodology. The study analyses 12 Christian hospitals through 35 executive interviews, 48 middle manager perspectives, examination of 144 organisational documents and field observations over 36 days.

Results: Four value-based leadership dimensions contribute to competitive advantage: servant leadership, spiritual stewardship, empathetic management and God-integrated vision through value embodiment.

Conclusion: The results demonstrate that value-based leadership builds enduring competitive advantage while maintaining religious identity amid market forces. The findings provide a workable model for leadership capability development in faith-based organisations.

Contribution: This research extends RBV theory by showing how values function as strategic assets meeting VRIO criteria. The study shows value-based leadership results in sustainable competitive advantage.

Keywords: value-based leadership; competitive advantage; Christian hospitals; healthcare management; faith-based organisations.

Introduction

The global health environment has become increasingly demanding, with organisations confronting systemic issues that threaten operational sustainability. Resource constraints compound stricter regulatory environments, while persistent shortages of skilled labour erode service delivery capacity (Lega & Vendramini 2021). Technological advancements necessarily disrupt traditional healthcare models, presenting both opportunities and implementation challenges for institutions with limited capital resources. Simultaneously, patients increasingly approach healthcare as consumers demanding better service quality, transparency and personalised experiences, placing pressure on already stretched systems to adapt rapidly or risk becoming irrelevant in competitive markets (Gordon et al. 2020).

Research gap and theoretical need

Amid such dynamic change, religious healthcare organisations face unique strategic dilemmas in balancing their essential spiritual mandates with pragmatic marketplace requirements for organisational survival. Despite extensive research on healthcare competitive advantage (Porter & Lee 2020; Treviño-Rodríguez, Chamakiotis & Hernández-Espallardo 2021) and leadership in healthcare settings (Grady & Grady 2020; Mullen & Jarrett 2023), a critical theoretical gap persists: How do value-based leadership practices translate into sustainable competitive advantage in faith-based healthcare organisations operating in pluralistic environments?

This research gap is particularly significant because existing strategic management literature has inadequately addressed the institutional nature of capability development in value-based organisations (Micelotta, Lounsbury & Greenwood 2017). Vu, Wolfgramm and Spiller (2022) specifically call for research into 'leadership as a culturally-embedded phenomenon that shapes organisational capabilities through value-driven practices' (p. 67). Furthermore, while servant leadership theory has established conceptual foundations (Eva et al. 2019), empirical evidence remains scarce regarding the mechanisms through which servant practices build organisational capabilities relevant to competitive positioning in healthcare environments.

The Indonesian context as a critical case

The necessity to maintain financial sustainability while preserving religious values creates constant tension in operational decision-making for faith-based healthcare institutions (Groenewoud & Vollaard 2019). Such organisations must navigate resource allocation decisions that respect their founding missions while investing sufficiently in competitive competencies. The challenge extends beyond financial concerns to involve organisational identity maintenance in the context of professionalisation tendencies that sometimes conflict with traditional care provision and governance structures (Thompson & Miller 2022).

Christian foundation hospitals on Java Island in Indonesia present a particularly compelling context for investigating organisational resilience in plural societies. These organisations operate within a predominantly Muslim cultural environment (comprising over 87% of Indonesia's population) and face increasing competition from subsidised government public hospitals and well-funded corporate healthcare chains (Kuntjoro, Harris & Utarini 2020). Their continued competitiveness contradicts traditional expectations: minority-affiliated organisations in religiously identified markets typically face competitive disadvantages, as alignment with the dominant population would normally confer competitor advantage.

This resilience points to the presence of distinctive capabilities that transcend demographic positioning to create sustainable competitive advantage based on other organisational features (Rahman & Abdullah 2021). The central theoretical puzzle therefore concerns how these organisations develop and sustain competitive capabilities in contexts where their religious identity might reasonably predict disadvantage. This puzzle connects directly to broader theoretical questions about the nature of competitive advantage in service organisations and the role of value-based resources in strategic positioning.

Value-based leadership as a theoretical bridge

Leadership practices employed in these Christian foundation hospitals appear fundamental to their competitive sustainability, characterised by distinctive integration of

professional healthcare management norms with values formally rooted in their Christian foundations (Hendriks, Prabowo & De Vries 2022). Such leadership systems balance complex stakeholder dynamics within religiously diverse patient populations, employees and local communities while promoting organisational cohesion. These leaders demonstrate excellence in integrating faith-inspired care components into contemporary healthcare delivery models without compromising clinical excellence or operational efficiency.

This dual-synthesis model creates distinctive patient experiences that differentiate such hospitals in competitive markets. Theoretically, this suggests that faith-based leadership models might offer broader lessons for healthcare administration regardless of religious affiliation (Widiyanto & Setyowati 2023). By examining how value-based leadership operates in this challenging context, this research can illuminate mechanisms through which values function as strategic resources – extending resource-based view (RBV) theory beyond its traditional focus on tangible assets to encompass values as sources of sustainable competitive advantage.

Research objectives

This research primarily examines how value-based leadership assists Christian foundation private hospitals in Java in developing and maintaining competitive advantages in their operating environment. Specifically, the study aims to:

- Identify and explain the distinctive dimensions of value-based leadership practised in these hospitals, moving beyond generic descriptions to specify concrete leadership behaviours and their theoretical foundations.
- Examine organisational processes through which leadership dimensions translate into competitive strengths, thereby addressing the 'black box' problem in strategic management research regarding how leadership practices become organisational capabilities.
- Develop a conceptual framework explaining the connection between value-based leadership behaviours and competitive advantage outcomes, grounded in RBV theory, servant leadership theory and institutional theory.
- Provide practical insights to healthcare leaders interested in integrating values into organisational leadership initiatives while maintaining competitive viability.

By addressing these objectives, this research contributes to both theoretical understanding and practical application of value-based leadership in complex organisational environments.

Literature review

Value-based leadership in healthcare contexts

Value-based leadership is a type that consists of leaders' shaping organisational action through the expression of

explicitly and regularly applied values (Kempster, Jackson & Conroy 2019). Health care environments have accorded value-based leadership growing interest, as organisations attempt to balance clinical, fiscal and ethical demands (Grady & Grady 2020). It is argued that value-based leadership comprises ethical decision-making, authentic communication and purposeful planning aimed at linking organisation actions to mutual principles (Stouten, Rousseau & De Cremer 2021).

In religious healthcare organisations, value-based leadership typically incorporates spiritual elements that shape organisational culture and strategic priorities (Adawiyah et al. 2023). Chaston and Lips-Wiersma (2020) found that religious healthcare organisation leaders often utilise spiritual traditions to inform their leadership philosophy and practices. According to Krakowiak, Fryc and Modlinska (2020), for the Polish Journal of Management Studies, value-based leadership in health organisations constructs 'meaningful organisational stories that tie daily activities to higher-order purpose, and thereby improving employee commitment and service quality'.

Shen et al. (2023) suggests that value-based leadership enhances sustainable organisational cultures via the congruence of organisational and individual values, while Karakas, Sarigollu and Manisaligil (2021) found that benevolent leadership in health care settings drives employee well-being and organisational performance. New evidence by Mullen and Jarrett (2023) affirms that compassionate leadership in health care settings constructs robust organisational cultures for resilience against industry disruption.

Competitive advantage in healthcare

Healthcare competitive advantage is the distinct capabilities that enable a business firm to outperform rivals in attracting patients, recruiting talent, acquiring assets and better outcomes (Porter & Lee 2020). Location, speciality services, technology, cost leadership and reputation are traditional sources of competitive advantage (Trevinyo-Rodríguez et al. 2021).

Competitive advantage for faith hospitals is typically founded on special dimensions of community embedding, perceived legitimacy and mission commitment (Groenewoud, Mallidou & Kemperman 2022). Indonesian Christian hospitals once established competitive advantages upon quality leadership, service excellence and value-aligned practices that distinguished them within the marketplace (Kuntjoro et al. 2020).

More recent research by Dźwigoł, Dźwigoł-Barosz and Zhyvko (2022:165) in the Polish Journal of Management Studies emphasises that 'sustainable competitive advantage in healthcare increasingly depends on value-creation systems that integrate technical competence with humanistic approaches to care'. This perspective suggests that value-based organisations could enjoy inherent strengths in healthcare markets more oriented towards end-to-end patient experiences.

Literature indicates various avenues through which value-based leadership can create competitive advantage, including heightened employee commitment (Thompson & Zolnierrek 2020), improvement in patient experience (Sumner & Townsend 2023), greater innovation capability (Lee et al. 2020) and stronger community relations (Nyame-Asiamah, Ghulam & Mediavilla 2021).

Faith-based healthcare organisations

Faith-based healthcare institutions exist at the nexus of religious mission and health provision, producing unique organisational identities and operational styles (Olivier & Wodon 2021). These institutions generally have religious governance systems in place while offering services to wider communities irrespective of religious affiliation (Groenewoud & Vollaard 2019).

Literature on Christian healthcare organisations across the world has also pointed to shared features such as mission-oriented strategy, value-based organisational culture, integration of spiritual care, and community service orientation (Adawiyah et al. 2023). Christian hospitals in Indonesia have historical origins in missionary work but have become professional healthcare providers with faith-based identities serving plural communities (Hendriks et al. 2022).

Research on faith-based healthcare organisations indicates that they tend to build unique organisational competencies through their value commitments, such as increased focus on holistic care, greater employee loyalty and more profound community connections (Olivier, Tsimpo & Gemignani 2021). These institutions also have specific challenges such as mission-market tensions, identity maintenance in the face of professionalisation and managing religiously diverse stakeholder expectations (Groenewoud et al. 2022).

Chen, Zhou and Zhu (2023) provided a systematic review of religious healthcare institutions in Asia and determined their key roles in healthcare systems with the views of challenges facing them in terms of sustainability and integration into public health programmes. Richardson and Howcroft (2022) analysed the increasing role of spiritual care in hospitals with the observation of the distinctive placement of religious institutions in meeting these aspects of patients' needs.

Theoretical framework

Theoretical foundation for this research incorporates three interconnected perspectives that collectively provide insights into the way religious healthcare organisations develop distinct competitive advantages via their leadership behaviours. Resource-based view theory serves as the central analytical theory, emphasising the manner in which organisations achieve enduring competitive advantage through capabilities that are valuable, rare, inimitable and organisationally embedded (VRIO) (Barney & Harrison 2020). Within healthcare settings, the RBV methodology is particularly helpful in understanding how abstract assets like ideology of leadership, organisational culture and

systems of values develop a performance differentiation beyond material resource advantage (Ferlie et al. 2015). In application to Indonesian Christian foundation hospitals, it helps identify how value-driven leadership approaches become institutionalised as organisational routines hard to imitate by competitors despite having similar form or technology (Kraatz, Flores & Chandler 2020).

Servant leadership theory possesses the second theoretical basis, offering conceptual models for analysis of the distinctive leadership styles prevalent in religious healthcare organisations. Current servant leadership literature has shifted away from simplistic definitions to construct robust theories of leadership to describe how leader behaviours grounded in follower development, community building and moral stewardship become organisational competencies (Eva et al. 2019). This leadership model has particular applicability to healthcare settings where professional norms are skewed towards service orientation, and religious organisations where servant leadership aligns with religious teachings (Iliffe & Manthorpe 2020). The theory provides analytic frames for examining how Christian hospital leadership behaviour formulates theological underpinnings while simultaneously fulfilling practical management needs, crafting leadership styles to reconcile spiritual values with professional competency (Parris & Peachey 2013).

The third theoretical element is institutional theory that provides frameworks for analysing how organisations achieve legitimacy and maintain distinctive identities within pluralistic environments. This perspective illuminates processes through which Indonesian Christian hospitals navigate complex legitimacy demands by various stakeholders without compromising their anchor missions (Kraatz et al. 2020). Institutional theory is helpful in shedding light on how these organisations navigate institutional complexity—aligning clinical, financial, regulatory and faith-based logics that sometimes present conflicting expectations (Thornton, Ocasio & Lounsbury 2022). The recent theoretical developments in institutional theory focusing on institutional leadership and identity work are particularly helpful to study how hospital leaders undertake mindful actions to maintain organisational distinctiveness while adapting to changing environmental demands (Greenwood et al. 2021).

The blend of these three theoretical frameworks completes gaps in existing literature highlighted by different scholars. This structure responds directly to Vu et al.'s (2022:165) call for research into 'leadership as a culturally-embedded phenomenon that shapes organisational capabilities through value-driven practices'. It also responds to Greenwood et al.'s (2021) complaint that strategic management research is prone to neglecting the institutional nature of capability development in value-based organisations. By connecting competitive performance to leadership actions through precise value mechanisms, this research assists in theory building at the edge of leadership research and strategic management in healthcare settings (Shin et al. 2020). The theoretical synthesis proposed in this article enhances

comprehension of how religious healthcare organisation leadership styles are translated into distinctive capabilities that lead to sustainable competitive advantage in plural societies where marketplace pressures and mission-driven demands foster sustainable tensions (Tracey 2020).

Methods

Research approach

This study employed an interpretivist paradigm that acknowledges the socially constructed reality of organisational values and leadership, seeking to uncover how organisational members and leaders perceive their value-driven strategies and understand them in connection with competitive outcomes. A qualitative research method was found to be best positioned to explore rich social processes in their native environments, delivering a richness of knowledge of organisational dynamics and leadership processes that cannot be accessed using quantitative methods (Gioia et al. 2023).

Research strategy

The research employed a systematic qualitative multiple case study strategy consistent with Gioia et al.'s (2023) robust methodology in exploring value-based leadership and competitive advantage in and across several companies. The design was employed to enable within-case examination of the leadership dynamics and cross-case analysis for pattern detection and contextual determinants of competitive performance. The multi-stage structure involved exploratory interviews, in-depth case studies, and cross-case analysis to arrive at a conceptual framework based on sound empirical evidence.

Research method

Research setting

Researchers conducted the study across 12 Christian foundation private hospitals on Java Island, Indonesia. These settings provided rich contexts to observe value-based leadership in action, as these institutions openly assert Christian values yet operate in a predominantly Muslim country (87% Muslim population) and within a competitive health sector. The hospitals ranged from 120 to 450 beds in capacity, with histories spanning 45 to over 100 years, and served urban and semi-urban settings across West, Central and East Java.

Entrée and establishing researcher roles

The research team obtained permission to access research sites through official application to hospital management, supplemented by endorsement from the Christian Hospital Association of Indonesia. The lead researcher, with previous professional experience in healthcare management, built rapport with participants while maintaining reflexivity regarding potential preconceptions. Research team members assumed the role of knowledgeable outsiders in that they acknowledged their understanding of healthcare contexts but entered each site with openness to site-specific dynamics and practices.

Research participants and sampling methods

Researchers applied purposive sampling to select 12 diverse Christian hospitals in Java based on governance structure, operational status, organisational age and competitive success indicators such as growth, financial success and industry awards. Theoretical sampling guided the recruitment of 35 executive leaders (e.g. CEOs, medical directors, and board members) and 48 middle managers to garner differing opinions from informants with experiential knowledge in leadership plans and competitive positioning. Participants averaged 12.4 years of healthcare leadership experience, with 64% having experience in more than one Christian healthcare organisation.

Data collection methods

Data collection drew upon four complementary methods to yield rich triangulation across sites:

Semi-structured interviews: Researchers conducted 60–90-min interviews with hospital CEOs exploring leadership philosophy, values, competitive strategy and relationships between perceived market position. Data collection took place over March 2024 – June 2024, with 3-day site visits for each institution.

The research team conducted six focus groups, with each group consisting of 6–10 middle managers. A structured protocol was followed throughout the focus group process. Each session commenced with an ice-breaking activity, through which rapport was established and a comfortable environment for open discussion was created. Discussions were guided by a trained facilitator using a semi-structured interview guide, whereby themes of value implementation, leadership practices and competitive positioning were covered. Detailed notes were taken by a co-facilitator, who also managed the audio recording equipment. Sessions were held for 90–120 min, during which sufficient time was allowed for in-depth exploration while participant engagement was maintained. Probing questions and reflective listening techniques were employed by researchers to encourage elaboration on key themes. At the conclusion of each session, key points were summarised by facilitators and participant validation was invited. Through these focus groups, the operationalisation of values in practice and their contribution to organisational capability were investigated.

A total of 144 organisational documents were reviewed by researchers, which included strategic plans, annual reports, policy documents and public communications. Through this documentary analysis, insight was gained into the formal statements of institutional values and strategies. The documents were systematically examined to understand how values were articulated and communicated within official organisational materials.

Observational studies were conducted by the research team over a period spanning 36 days across the 12 hospital sites, whereby firsthand insights into leadership behaviour,

organisational culture, and value expression in day-to-day operations were provided. These observations encompassed leadership meetings, patient rounds, staff-to-staff encounters and community outreach efforts, through which direct exposure to the practical operation of values was given to researchers. A rich, multidimensional dataset was provided through the combination of interview data, focus group results, document analysis and field observation, by which the complex interplay between faith-based leadership styles and competitive positioning could be grasped.

Data recording

With participants' consent, researchers audio-recorded interviews and focus groups and had them professionally transcribed verbatim. The research team documented field observations using detailed field notes that recorded both descriptive observations and reflective commentary. Researchers noted document analysis findings in systematic templates identifying key themes and corresponding illustrative examples. The team coded and stored all data using NVivo 14 qualitative data analysis software with appropriate security arrangements to maintain confidentiality.

Strategies employed to ensure data quality and integrity

Multiple strategies were employed to ensure maximum trustworthiness throughout the research process. Methodological triangulation was achieved through the employment of diverse data collection methods that enabled cross-validation of findings across different sources. Source triangulation was accomplished by incorporating perspectives from various organisational levels, ensuring that multiple viewpoints informed the analysis. The coding process involved three independent researchers who reviewed subsets of data separately, thereby strengthening the reliability of interpretations. Preliminary findings were validated through member checking procedures whereby key informants reviewed and confirmed the accuracy of interpretations. Additionally, peer debriefing sessions were conducted with healthcare management academics who had not been involved in data collection, providing external scrutiny of the analytical process. Throughout the study, reflexivity journals were maintained in which potential biases were documented alongside the strategies adopted to address them. Finally, thick description was provided through detailed documentation of contextual data, enabling readers to assess the transferability of findings to other settings.

Data analysis

Data analysis followed Gioia's approach to methodological rigour in qualitative research. The coding process proceeded systematically:

The data were independently reviewed by two researchers, and initial codes were generated using participants' own terms and language, whereby proximity to the data was maintained

without theoretical structures being imposed. Through this open coding process, 187 first-order codes were produced. Inter-coder reliability was assessed using Cohen's kappa, through which $\kappa = 0.82$ was achieved, indicating substantial agreement. Discrepancies were resolved through discussion, and consensus was reached between the researchers.

These initial codes were then categorised by researchers into 28 abstract conceptual constructs representing emerging themes through constant comparison among data and categories. During this phase, data sources were weighted by the research team according to several considerations. Primary emphasis was given to executive leader interviews for strategic-level constructs, such as competitive positioning and strategic vision, while middle manager focus groups were given primary emphasis for operational-level constructs, including daily implementation of values and management practices. Validation and historical context for both strategic and operational constructs were provided through document analysis, whereas observational data were employed to triangulate and validate themes emerging from interviews and focus groups. When conflicting perspectives were provided by data sources, precedence was given by researchers to triangulated findings, whereby themes supported by multiple data sources were prioritised over single-source evidence. These weighting decisions were documented by the team in analytical memos so that transparency in the analysis process was maintained.

Second-order concepts were incorporated by the research team into seven aggregate theoretical dimensions, through which the conceptual framework was formed. Finally, patterns, similarities and contextual factors influencing leadership and competitive results were revealed through systematic cross-case comparison of the 12 hospitals.

NVivo 14 proved valuable throughout data analysis and management, enabling coding, memo creation and framework development throughout the research process. The analysis proceeded iteratively with constant comparisons between emerging constructs and raw data to ensure that findings remained rooted in participants' realities. This structured yet adaptive analytical process allowed researchers to develop a robust conceptual understanding of the complex relationships between faith-based leadership styles and competitive positioning in Christian hospitals in Java.

Reporting style

This study presents its discoveries through a blend of narrative and visual representations that capture the depth and context of the research journey while offering clear conceptual frameworks. Participant voices emerge through carefully selected quotations that bring key themes to life, complemented by thoughtful explanations that connect real-world observations to theoretical understanding. The research team distilled insights into accessible tables and a visual model that makes complex relationships easier to

grasp, while preserving sufficient rich contextual detail for readers to consider how findings might apply to other settings.

Ethical considerations

This study obtained ethical clearance from Karya Husada University, Research Ethical Committee (approval no: 017/KEP/UNKAHA/SLE/II/2024). Written informed consent was obtained from all participants before participating. Anonymity of all data and codes being used for naming individual hospitals and participants ensured confidentiality. Data were kept on encrypted servers that had access restricted to the research team. Direct patient contact was not involved in the research, but organisational leadership and management practices were used.

Results

The study revealed four key components of value-based leadership that develop competitive advantage among private Christian-founded hospitals in Java: servant leadership orientation, spirituality-based stewardship, compassion-guided management practices, and faith-based strategic vision. These dimensions take form through concrete actions and give rise to different competitive strengths in these organisations.

Servant leadership orientation

Servant leadership emerged as a central leadership approach across the researched hospitals, characterised by leader humility, focus on others, and commitment to employee development. As one participant articulated:

'Our leadership model begins with the understanding that we are here to serve, not be served. That principle draws directly from Christ's life and teachings. When our leaders approach their work with genuine humility and a desire to serve others, it transforms the way we deliver healthcare.' (CEO, hospital E, 45-year-old male)

This orientation manifested itself through four specific leadership practices. Firstly, visible commitments to service were demonstrated through regular participation in direct patient care activities by chief executives. Secondly, open decision-making processes enabled frontline workers to play active roles in improvement initiatives. Thirdly, empowerment structures facilitated the delegation of appropriate authority to the clinical level. Fourthly, recognition mechanisms acknowledged excellence in service delivery, thereby reinforcing desired organizational behaviours.

Analysis indicated that servant leadership contributed to competitive advantage through enhanced employee commitment and turnover rates well below regional industry norms, patient satisfaction scores well above national averages on standardised measures, and service innovation emerging from frontline empowerment. One participant described how servant leadership transforms organisational culture:

'When leaders genuinely model servanthood, it shifts the entire work culture. Staff feel valued and consequently value patients differently. This represents something competitors cannot simply copy by adjusting policies—it requires authentic values lived out over time.' (Nursing director, hospital J, 42-year-old female)

Spiritual stewardship

Spiritual stewardship characterised leaders' organisational resource management style through long-term orientation, resource respect, and accountability beyond financial metrics. This dimension manifested through four interconnected elements: legacy consciousness reflected in decision-making that considers multi-generational impact, conservative resource use characterised by avoiding waste as a spiritual value, transparent financial practices demonstrated through open reporting on resource allocation, and balanced success measures that incorporate holistic organizational performance indicators.

Hospital records commonly employed the language of stewardship principles:

'We are custodians of resources ultimately belonging to God and the people we serve. This sacred trust demands that we make decisions that fulfil this duty with integrity, sustainability, and advancement of mission.' (Strategic Plan, Hospital C)

This stewardship emphasis contributed to competitive advantage through multiple strategic outcomes, including financial stability demonstrated by positive operating margins across all investigated hospitals during COVID-19 pandemic disruptions, enhanced community trust that translated into substantial philanthropic support funding most capital improvements through voluntary contributions, and patient-centered strategies that enabled the development of long-term therapeutic relationships prioritizing holistic care over transactional services.

Compassionate management practices

Compassionate management practices infused empathy and care into standard management processes and systems through multiple interconnected approaches, including human-oriented policies that created space for individual needs within organizational systems, forgiveness practices that focused on restoration rather than punishment after errors, whole-person assessments that incorporated holistic considerations in performance development, and care-based workflow design that balanced operational efficiency with meaningful human connection.

Middle managers particularly emphasised how compassion impacted daily operations:

'We've designed management systems that don't force individuals to trade effectiveness for empathy. Our processes systematically accommodate human connection. Our metrics encompass both productivity and relational quality. This integration distinguishes our approach.' (Operations Director, hospital H, 38-year-old male)

These practices established competitive advantage through multiple strategic pathways, including the creation of distinctive patient experiences that generate service differentiation, the cultivation of psychological safety that enhances error reporting and quality improvement processes, and the development of adaptive capacity that builds resilient relational infrastructure essential for organizational performance during crisis situations.

Faith-integrated strategic vision

Faith-integrated strategic vision articulates the manner in which Christian values inform organizational direction, priorities, and innovation through four strategic dimensions: value-based growth decisions characterized by the evaluation of expansion opportunities according to mission fit, community-need identification leveraging faith networks to discover unmet needs, distinctive service development focused on designing programs that address spiritual dimensions of health, and faith-compatible partnerships involving the selection of collaborative relationships congruent with core organisational values.

Strategic reports consistently confirmed this integration:

'Our strategic directions emerge from prayerful discernment about where God calls our organisation to serve. We pursue growth, not for its own sake, but to extend our healing ministry to others who need it most.' (Annual Report, Hospital K)

This approach facilitated competitive advantage through multiple strategic pathways, including differentiated market positioning that clearly distinguished organisations from secular competitors, network connectivity leveraging religion-associated networks to provide patient referrals and talent pipelines, and innovative service lines supporting holistic patient needs unaddressed by competitors.

Integration into competitive advantage framework

Analysis of the interrelation among these leadership dimensions and competitive performance yielded the integrated framework shown in Figure 1. The framework reflects how value-based leadership dimensions establish organisational capabilities that result in targeted competitive benefits.

Three primary mechanisms whereby competitive advantage was generated through value-based leadership were revealed by the model. Value embodiment was identified as the first dimension, whereby values were lived by leaders through authentic demonstration through consistent behaviour, and organisational cultures that could not be replicated by competitors were created. As was attested by one respondent, 'Our values live in leadership behaviours that define the entire organisation' (CEO, hospital G, 52-year-old female). The second dimension, value integration, was characterised by the organisational embedding of values through deliberate systems, policies and procedures, through which

organisational infrastructure that sustained unique approaches despite personnel changes was developed. The third dimension, value innovation, was observed where values served as generative assets for developing new services and approaches that met needs overlooked by competitors who focused solely on technical or financial considerations. Cross-case analysis discovered that hospitals demonstrating greater consistency across all four leadership dimensions achieved stronger competitive positioning in their markets in terms of growth metrics, financial performance, and stakeholder perception.

Discussion

Overview of the results

The findings depict how Christian foundation private hospitals in Java apply value-based leadership practices to build distinct competitive advantages in challenging healthcare markets. The four identified dimensions of value-based leadership – servant leadership orientation, spiritual stewardship, empathetic management practices, and faith-based strategic vision – function through value embodiment, integration, and innovation processes to generate organisational capabilities that competitors find difficult to imitate.

These leadership dimensions function synergistically, ensuring an integrated organisational response grounded in Christian values while remaining sensitive to contemporary healthcare demands. Most importantly, the research suggests that faith values do not constrain organisational effectiveness but rather constitute strategic assets when genuinely infused into leadership practice and organisational systems.

The research indicates that competitive advantage stems not from the mere presence of stated values but from their actual manifestation in leadership conduct, formal inclusion in organisational designs, and application as generative

resources for responding to patient and community demands. Consequently, adopting the lexicon of values or isolated practices does not translate into the same competitive benefits realised in organisations with values deeply embedded in leadership agendas.

Theoretical implications

This study makes fundamental theoretical contributions in the area where strategic management, leadership and healthcare administration converge.

Firstly, the research extends RBV theory by illustrating how values function as strategic assets that meet VRIO criteria (valuable, rare, inimitable and organisationally embedded). Barney and Harrison (2020) explain that resources not easily imitated by competitors constitute requirements for building sustainable competitive advantage. The study identifies how values, when embedded authentically in leadership, create composite social resources immune to imitation because of their tacit, historically situated, and socially complex nature.

Secondly, the study contributes to servant leadership theory by establishing mechanisms through which servant practices build organisational capabilities relevant to competitive positioning. While Eva et al. (2019) established conceptual foundations, this study offers empirical evidence of how servant leadership principles bring about competitive results in healthcare environments. That servant leadership enhances employee commitment and patient experience suggests unique usefulness in service organisations with intensive human interaction.

Thirdly, this study contributes to institutional theory by showing how religion-based organisations gain distinctive identities with legitimacy in professional healthcare environments. Kraatz et al.'s (2020) study suggested mission-driven organisations experience distinctive tensions in balancing founding values and adaptation imperatives. This study demonstrates how Christian hospitals resolve these tensions through leadership practices that integrate professional approaches with faith values rather than abandoning either dimension.

Finally, the study presents a theoretical model connecting leadership values to competitive advantage through specific organisational mechanisms, addressing Vu et al.'s (2022) call for research examining leadership as a culturally-embedded phenomenon that affects organisational capabilities. The model provides a foundation for future research examining how different value systems may generate distinct capabilities in various organisational contexts.

Practical implications

The research demonstrates important practical implications for healthcare organisations and their leaders. Value-based strategies can create sustainable competitive advantage, dispelling the myth that mission-orientation and market

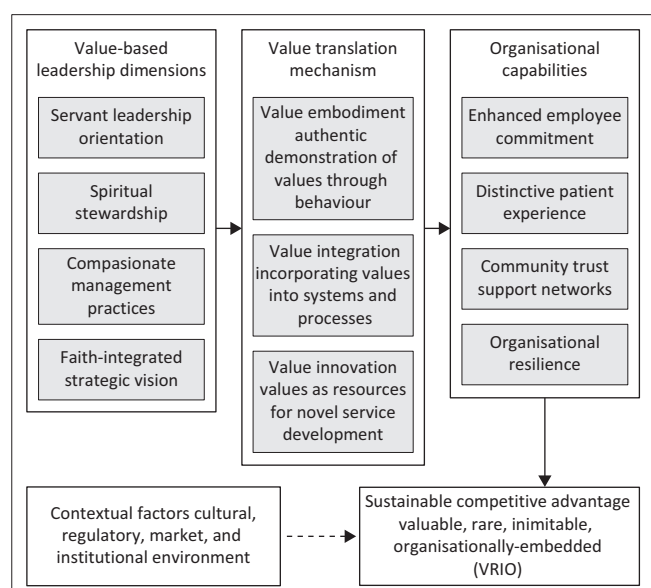


FIGURE 1: Value-based leadership and competitive advantage framework of Christian foundation private hospitals in Indonesia.

success prove incompatible, thereby allowing healthcare leaders to maintain core values while remaining competitive.

The study provides a concrete model for building value-based leadership competencies through four established dimensions, enabling organisations to benchmark current practices and define focused areas for improvement in servant leadership, stewardship practices, caring management systems or value-integrated strategic planning. Additionally, the findings offer religious health organisations guidance for negotiating the protection of identity from market pressures by suggesting entry points to promote distinctive identity and competitive advantage concurrently through leadership efforts that express fundamental values in contemporary practice.

The research also provides valuable lessons for healthcare policymakers regarding the unique value added by faith-based providers to healthcare systems. These institutions develop specialised competencies that complement public and for-profit providers, thereby increasing system diversity and resilience. The distinctive leadership approaches identified in the research enable these institutions to deliver care addressing aspects often overlooked in purely market-driven or bureaucratic systems.

Policy interventions that recognise and support this distinctive function can enhance overall healthcare system performance by maintaining diverse organisational arrangements that give rise to holistic and responsive healthcare delivery, particularly in pluralistic societies where diverse models for care delivery can more effectively serve heterogeneous populations.

Limitations and recommendations

This research acknowledges several important limitations. Its focus on Christian hospitals in Indonesia restricts generalisability to organisations with different faith traditions or cultural contexts, and the cross-sectional design prevents comprehension of how value-based leadership evolves over time and adapts to changing market needs. Additionally, while the research outlines associations between leadership dimensions and competitive outcomes, researchers cannot establish causality between particular leadership styles and competitive outcomes. The research also notably gathers perspectives from leaders and managers with limited direct input from patients, thereby potentially overlooking important conceptions of how leadership tactics impact patient care experiences.

Follow-up research should consider whether similar dynamics emerge in healthcare organisations affiliated with other faiths (e.g. Muslim, Jewish or Buddhist) and from other regions. Long-term longitudinal designs would prove invaluable for understanding the dynamic aspect of these styles and whether they remain sustainable across different market cycles and organisational fluctuations. Mixed methods approaches would also

extend research on leadership style and competitive outcomes through quantitative modelling alongside qualitative examination. Additionally, the inclusion of patient perspectives would more effectively inform understanding of how value-based leadership influences care experience and shapes market preference in competitive healthcare environments.

Conclusion

This study provides qualitative evidence of the contribution of value-based leadership to creating competitive advantage in Java's Christian foundation private hospitals. Findings demonstrate that servant leadership orientation, spiritual stewardship, empathetic management practice and faith-infused strategic vision create distinctive organisational capabilities enhancing competitive standing. These leadership dimensions function through embodiment, integration and innovation of values to create competitive advantages resistant to imitation by competitors lacking similar foundational values and leadership stability.

The research demonstrates that organisational values, when deeply rooted in leadership practice, constitute strategic assets that build sustainable competitive advantage. For religious healthcare organisations, the research suggests that distinctive identity and competitive viability reinforce one another through leadership strategies that render core values compatible with existing healthcare practices. Under pressures towards standardisation in the healthcare field, these hospitals suggest value-based strategies as an alternative path towards organisational sustainability and distinctiveness.

By documenting the process of translating values into competitive advantage through leadership practices, this research adds theoretical insight and practical guidance for organisations seeking leadership strategies that balance purpose and performance. At a time when healthcare systems around the world seek models that balance quality, accessibility, and sustainability, the experiences of these organisations offer lessons applicable to both theory and practice in healthcare administration.

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Competing interests

The authors declare that they have no financial or personal relationships that may have inappropriately influenced them in writing this article.

CRedit authorship contribution

Kristiana Susilowati: Conceptualisation, Formal analysis, Investigation, Methodology, Writing – original draft. Lieli Suharti: Conceptualisation, Methodology, Supervision, Validation, Writing – review & editing. Agus Sugiarto: Formal analysis, Investigation, Writing – review & editing.

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Data availability

The data that support the findings of this study are available from the corresponding author, Kristiana Susilowati, on reasonable request and in accordance with privacy restrictions for research participants.

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