

ORGANIZATIONAL AGILITY AND ECONOMIC PERFORMANCE IN THE PRIVATE HEALTHCARE SECTOR: A SYSTEMATIC LITERATURE REVIEW AND FUTURE RESEARCH AGENDA

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ABSTRACT: *Private healthcare organizations operate under persistent technological, competitive, regulatory, workforce, and demand-side pressures. In this environment, organizational agility has become a relevant explanatory construct for understanding how providers sense change, make timely decisions, reconfigure resources, and adapt service delivery. Yet the economic consequences of agility in private healthcare remain less consolidated than its operational, workforce, supply-chain, and resilience implications. This article synthesizes the literature on organizational agility in healthcare through the lens of dynamic capabilities and develops a research agenda centered on economic performance. The review integrates foundational organizational-agility research with healthcare-specific systematic reviews and empirical studies. The synthesis shows that healthcare agility is multidimensional and commonly appears as organizational, workforce, supply-chain, strategic, digital, or treatment agility. Evidence generally associates agility with improved responsiveness, innovation, resilience, employee outcomes, operational performance, and organizational performance, but direct evidence using objective economic indicators in private clinics is scarce. Four gaps are particularly salient: insufficient separation of private from public providers; inconsistent construct measurement; reliance on perceptual performance measures; and limited testing of mediating mechanisms that convert responsiveness into economic value. Building on these findings, the article proposes an integrated framework in which digital capability, leadership, knowledge processes, workforce flexibility, and environmental sensing enable organizational agility; agility then affects economic performance through resource utilization, operational efficiency, innovation, and service responsiveness. The paper concludes with testable propositions and a methodological agenda for future studies using clinic-level financial and operational data.*

Keywords: *Organizational Agility; Economic Performance; Private Healthcare; Dynamic Capabilities; Operational Efficiency; Digital Transformation; Systematic Literature Review.*

JEL Classification: *I11; L25; M10; O33.*

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1. INTRODUCTION

Healthcare organizations increasingly compete and operate in conditions that combine high uncertainty with strong resource constraints. Technological change, digital platforms, labor shortages, volatile demand, rising patient expectations, supply disruptions, and regulatory requirements can alter the economics of service delivery within short periods. These pressures are especially consequential for private providers because the ability to maintain clinical quality must coexist with revenue generation, cost control, capacity utilization, investment recovery, and competitive positioning. In this setting, organizational agility offers a useful theoretical lens for explaining why some providers can respond to change without allowing adaptation costs to erode performance.

Organizational agility is usually understood as an organization-level capability to detect relevant changes and respond rapidly and effectively. The construct is broader than the adoption of agile project-management techniques. It includes sensing environmental developments, making decisions with sufficient speed, coordinating actors, and reconfiguring processes and resources. Walter's (2021) systematic review demonstrates both the importance and the conceptual fragmentation of the field, identifying agility drivers, enablers, capabilities, and dimensions. More recent synthesis work likewise finds a generally positive association between forms of agility and organizational outcomes, while emphasizing heterogeneity in theories, measures, mediators, and moderators.

The healthcare literature has begun to develop a more sector-specific understanding. Sarmiento Falla and Karwowski (2024), in a systematic review of survey-based healthcare studies, identified four recurring clusters: organizational agility, workforce agility, supply-chain agility, and treatment agility. Their review also showed that measurement instruments vary substantially and that organizational and supply-chain agility dominate empirical work. Li and Martins (2024), reviewing leagility in healthcare, similarly concluded that empirical validation remains limited and that applications are dispersed across hospital-wide management, patient flow, pharmacy, technology, laboratories, and supply chains.

These findings reveal an important opportunity for economics-oriented research. Much of the healthcare agility literature asks whether agility improves responsiveness, resilience, employee satisfaction, innovation, or broad organizational performance. Far fewer studies isolate economic performance as the outcome of interest, particularly in private healthcare organizations. Even when 'performance' is included, it is often operationalized through perceptual scales rather than clinic-level financial or productivity indicators. Consequently, the mechanism through which agility creates measurable economic value remains under-specified.

This distinction is not trivial. An organization can respond quickly yet do so at excessive cost. It can invest in digital technologies without improving capacity utilization. It can create flexible work arrangements that improve responsiveness but generate coordination costs. The economically relevant question is therefore not merely whether an organization is agile, but whether its agility improves the allocation and productivity of scarce resources sufficiently to generate superior economic outcomes.

Against this background, the objective of this article is to synthesize the literature connecting organizational agility, healthcare performance, and dynamic capabilities, with particular attention to the private healthcare sector. The article has four aims: to clarify how agility is conceptualized in healthcare; to identify its principal antecedents and dimensions; to examine the mechanisms through which agility may affect economic performance; and to formulate a future research agenda suitable for empirical testing in private clinics and other market-oriented healthcare providers.

The review is guided by four research questions: (RQ1) How is organizational agility conceptualized and measured in healthcare research? (RQ2) Which antecedents and dimensions of agility are most relevant to private healthcare providers? (RQ3) Through which mechanisms

can organizational agility influence economic performance? (RQ4) Which theoretical and methodological gaps should guide future research in private healthcare economics?

2. THEORETICAL FOUNDATIONS

Agility emerged in management research as a response to environments in which speed, uncertainty, and changing customer requirements weaken the usefulness of rigid organizational routines. Although definitions differ, most contemporary approaches combine two ideas: sensitivity to change and the capacity for timely organizational response. Walter (2021) defines organizational agility as a learned, permanently available dynamic capability that can be performed rapidly and efficiently when required to increase business performance in volatile environments. This formulation is particularly useful because it connects agility to performance while avoiding the reduction of agility to a single practice.

Agility overlaps with flexibility, adaptability, and resilience but should not be treated as synonymous with them. Flexibility generally concerns the range of alternatives available to an organization. Adaptability emphasizes adjustment to changed circumstances. Resilience focuses on the capacity to absorb, recover from, or continue functioning through disruption. Agility includes elements of all three but adds a strong emphasis on sensing, speed, coordinated response, and reconfiguration. In healthcare, a clinic that can extend opening hours is flexible; one that detects a shift in demand, reallocates specialists, changes scheduling rules, expands digital consultations, and modifies its service portfolio before capacity bottlenecks emerge demonstrates a broader form of organizational agility.

Healthcare-specific research confirms that agility operates at multiple levels. Organizational agility concerns the provider as a whole; workforce agility concerns employees' capacity to change roles and behaviors; supply-chain agility concerns the ability to adjust sourcing and flows; and treatment agility concerns adaptive clinical pathways. These dimensions are analytically separable, yet they interact. For example, an agile digital scheduling system may have little effect if workforce rules prevent rapid capacity reallocation.

The dynamic capabilities framework provides the strongest theoretical bridge between agility and economic performance. Teece, Pisano, and Shuen (1997) argued that firms in rapidly changing environments require capabilities that enable them to integrate, build, and reconfigure internal and external competences. Teece (2007) subsequently organized these capabilities around sensing opportunities and threats, seizing opportunities, and transforming or reconfiguring the organization's asset base.

Applied to private healthcare, sensing includes identifying changes in patient demand, referral patterns, competitor behavior, reimbursement conditions, labor availability, technologies, and regulatory requirements. Seizing includes decisions to introduce services, alter pricing or contracting, invest in digital systems, redesign patient pathways, or recruit specialists. Reconfiguration concerns the practical rearrangement of staff, equipment, facilities, data, partnerships, and financial resources.

This perspective explains why agility should be expected to influence economic performance indirectly as well as directly. The economic value of sensing is realized only when information is converted into action; the value of action depends on the efficiency with which resources are reconfigured. Furnival, Boaden, and Walshe (2019) explicitly conceptualize healthcare improvement capability as a dynamic capability, reinforcing the relevance of sensing, seizing, and reconfiguring to healthcare performance. Agwunobi and Osborne (2016) similarly apply dynamic capabilities to hospital competitive advantage.

Economic performance in private healthcare is multidimensional. Profitability is important but insufficient because accounting outcomes are produced by underlying operational and market processes. A clinic's economic performance may therefore be represented by revenue growth, operating margin, cost per patient, revenue per physician, labor productivity,

capacity utilization, equipment utilization, patient throughput, return on invested capital, contribution margin by service line, market share, and revenue diversification.

This multidimensional approach is particularly important for agility research. Some benefits of agility may first appear as operational improvements and only later as financial results. Faster reallocation of appointment slots can reduce idle capacity; better capacity utilization can increase throughput; increased throughput can raise revenue and lower unit cost. Accordingly, the pathway Organizational Agility -> Operational Efficiency -> Economic Performance is theoretically more informative than a simple bivariate association.

Private providers also differ from many public organizations in the strength and immediacy of market signals. Although institutional arrangements vary across countries, private clinics typically face direct consequences from underused capacity, delayed investment decisions, poor service differentiation, weak patient retention, or inefficient labor deployment. This makes the private sector an analytically valuable setting for examining the economic returns to agility.

3. REVIEW METHODOLOGY

This manuscript is structured as a systematic-literature-review article and follows the logic of PRISMA 2020 for transparent identification, screening, eligibility assessment, and synthesis (Page et al., 2021). Because the present document is a manuscript draft prepared before the author's final export from subscription bibliographic databases, it distinguishes between the evidence synthesis already verified for conceptual development and the final PRISMA record counts that must be generated and archived before submission.

The review combines two evidence streams. The first contains foundational research on organizational agility and dynamic capabilities. The second contains healthcare-specific systematic reviews and empirical studies that examine organizational, strategic, workforce, digital, supply-chain, resilience, or performance-related agility. This dual strategy is appropriate because a search restricted to the exact phrase 'organizational agility' would omit conceptually adjacent healthcare studies that operationalize the same sensing-response-reconfiguration logic under different labels.

For the final reproducible search, the following databases should be used: Scopus, Web of Science Core Collection, PubMed/MEDLINE, and EBSCO Business Source Complete. ScienceDirect may be used for supplementary publisher-level searching, while Google Scholar should be reserved for forward and backward citation tracking.

A recommended core Boolean query is: ("organizational agility" OR "organisational agility" OR "strategic agility" OR "workforce agility" OR "supply chain agility" OR "dynamic capabilit*" OR "organizational responsiveness") AND ("healthcare" OR "health care" OR hospital* OR clinic* OR "medical organization*" OR "medical organisation*") AND ("economic performance" OR "financial performance" OR "organizational performance" OR "operational performance" OR efficiency OR productivity OR profitability OR cost* OR resilience OR innovation).

The final search should record the date of each database query, exact syntax, fields searched, language restrictions, document types, and number of records returned. These details are essential for reproducibility.

Tabel 1. Eligibility criteria

Criterion	Operational rule
Inclusion	Peer-reviewed journal articles; healthcare provider or healthcare-organization context; organizational-level

Criterion	Operational rule
	agility or a clearly related dynamic capability; empirical, conceptual, or systematic-review contribution relevant to performance; English-language publication; sufficient methodological or conceptual detail.
Exclusion	Studies using 'agile' solely for software-development methodology without organizational implications; purely clinical treatment studies; papers outside healthcare delivery or healthcare organizations; editorials and non-scholarly commentary; records without sufficient information for synthesis.
Ownership coding	Private, public, nonprofit, mixed, and unspecified ownership should be coded separately. Studies from public settings may inform theory, but findings should not automatically be generalized to private clinics.
Outcome coding	Financial/economic, operational, workforce, innovation, resilience, quality, patient-related, and broad organizational outcomes should be distinguished.

Source: Authors' own elaboration, based on the PRISMA 2020 guidelines (Page et al., 2021) and the methodological and conceptual literature on organizational agility and dynamic capabilities in healthcare (Furnival et al., 2019; Sarmiento Falla & Karwowski, 2024; Li & Martins, 2024).

Screening should be conducted in two stages: title/abstract screening followed by full-text eligibility assessment. Duplicate records should be removed before screening. For stronger methodological quality, a second reviewer should independently screen at least a substantial subsample, with disagreements resolved by discussion.

Data extraction should capture authorship, year, country, healthcare setting, ownership type, sample, method, theoretical framework, agility definition, agility dimensions, measurement instrument, performance measures, mediators/moderators, main findings, and limitations. A narrative thematic synthesis is appropriate because the literature is heterogeneous in constructs and outcomes. Meta-analysis should be attempted only if a sufficiently homogeneous subset of studies reports comparable effect sizes.

The evidence synthesis in this draft prioritizes peer-reviewed sources whose bibliographic details and central findings were verified. The final PRISMA flow diagram must be populated from the author's exported database records rather than reconstructed retrospectively.

4. EVIDENCE SYNTHESIS

The literature reviewed for this manuscript reveals three overlapping streams: general organizational-agility research; healthcare-specific agility and leagility reviews; and empirical healthcare studies linking dynamic capabilities or agility to performance, resilience, renewal, workforce outcomes, innovation, or operational results. Table 1 summarizes representative sources that anchor the synthesis.

Table 2. Profile of the core evidence base

Study	Context	Design	Agility lens	Contribution to synthesis
Walter (2021)	Cross-sector	Systematic review	Organizational agility	Reviews 75 academic papers; identifies agility drivers, enablers, capabilities and dimensions.
Sarmiento Falla & Karwowski (2024)	Healthcare	Systematic review	Organizational, workforce, supply-chain and treatment agility	Reviews 21 survey-based studies; identifies heterogeneous conceptualizations and measurement approaches.
Li & Martins (2024)	Healthcare	Systematic review	Leagility	Synthesizes 24 studies and identifies application areas, implementation factors and gaps in empirical validation.
Furnival et al. (2019)	Healthcare	Conceptual analysis	Improvement capability as a dynamic capability	Connects organizational improvement capability with sensing, seizing and reconfiguring.
Agwunobi & Osborne (2016)	Hospitals	Conceptual framework	Dynamic capabilities	Explains the potential contribution of dynamic capabilities to hospital competitive advantage.
Loureiro et al. (2023)	Healthcare organizations	Quantitative empirical study	Dynamic capabilities	Examines dynamic capabilities and their relationship with organizational performance.
Alhassani & Al-Somali (2022)	Saudi public hospitals	Quantitative study	Dynamic innovation capabilities and organizational agility	Examines how innovation-related dynamic capabilities contribute to agility and organizational performance.
Akkaya & Mert (2022)	Healthcare organizations, Turkey	Quantitative study	Organizational agility	Investigates the mediating role of organizational agility between operational competitive capabilities and organizational performance.
Junaid et al. (2023)	Healthcare supply chains	Quantitative empirical study	Supply-chain dynamic capabilities	Examines relationships among dynamic capabilities, integration, resilience and sustainable performance.
Rosenbäck & Eriksson (2024)	Two Swedish public hospitals	Multiple case study with structured literature review	Dynamic capabilities and crisis management	Explores how sensing, seizing and transformation capabilities supported hospital responses during COVID-19.
Tenggono et al. (2025)	Private hospitals, Indonesia	PLS-SEM	Strategic agility and dynamic managerial capabilities	Examines relationships between institutional pressures, managerial capabilities, strategic agility and strategic renewal.
Aloulou (2025)	174 Saudi private healthcare providers	SEM	Supply-chain integration, digital transformation and resilience	Finds that resilience mediates the relationships between integration, digital transformation and organizational performance.

Study	Context	Design	Agility lens	Contribution to synthesis
Sarmiento Falla et al. (2025)	138 healthcare professionals, Peru	PLS-SEM	Workforce agility	Investigates IT ambidexterity, human-resource practices, workforce agility and job performance.
Mishra et al. (2026)	Healthcare organizations	Quantitative empirical study	Dynamic capabilities, adaptability and resilience	Examines relationships among dynamic capabilities, organizational resilience and ESG performance.
Leng et al. (2026)	Healthcare firms	Time-lagged survey	Organizational agility	Investigates organizational agility as a mediator between digital orientation and digital product and service innovation performance.

Source: Authors' own elaboration based on the 15 studies included in the evidence synthesis (Agwunobi & Osborne, 2016; Furnival et al., 2019; Walter, 2021; Akkaya & Mert, 2022; Alhassani & Al-Somali, 2022; Junaaid et al., 2023; Loureiro et al., 2023; Li & Martins, 2024; Rosenbäck & Eriksson, 2024; Sarmiento Falla & Karwowski, 2024; Aloulou, 2025; Sarmiento Falla et al., 2025; Tenggono et al., 2025; Leng et al., 2026; Mishra et al., 2026).

The first consistent finding is conceptual fragmentation. General agility research uses multiple labels and levels of analysis, while healthcare adds sector-specific constructs. Walter (2021) shows that this fragmentation is not merely terminological: studies emphasize different combinations of drivers, enablers, capabilities, and dimensions. Sarmiento Falla and Karwowski (2024) reach a similar conclusion in healthcare, where multiple survey instruments are used and no single measurement model dominates.

At the same time, convergence is visible beneath the terminology. Most definitions contain three recurring elements: awareness of change, speed of coordinated response, and the ability to alter resources or routines. This common core is compatible with the sensing-seizing-reconfiguring structure of dynamic capabilities. For private healthcare research, this convergence supports the construction of a multidimensional agility measure while cautioning against simply importing scales from manufacturing without validation.

Healthcare agility depends heavily on human and managerial capabilities because clinical service production is knowledge-intensive and coordination-intensive. Research in intensive care units has linked leadership and high-performance work practices to organizational agility and employee outcomes. More recent workforce-agility research identifies self-organization, collaboration, and iteration as relevant dimensions and suggests that information-technology ambidexterity and human-resource practices can improve job performance through workforce agility.

These findings matter economically because labor is both a major cost component and a critical capacity constraint in private healthcare. Workforce agility can affect the ability to match staffing to demand, use cross-functional teams, extend service hours, introduce new services, and reduce bottlenecks. However, excessive flexibility may also generate burnout, coordination costs, or quality risks. Future economic research should therefore estimate net effects rather than assume that greater flexibility is always beneficial.

Digitalization appears repeatedly as an enabling condition for agility, but the literature cautions against treating technology adoption as equivalent to organizational transformation. Information systems can improve sensing by providing timely demand and capacity data; they can support seizing by accelerating analysis and decision-making; and they can facilitate reconfiguration through integrated scheduling, telemedicine, customer relationship management, and workflow automation.

Empirical work in private healthcare strengthens this argument. Research on Saudi private healthcare providers reports that supply-chain integration and digital transformation enhance resilience, which in turn improves provider performance. Research on healthcare firms published in 2026 similarly finds that organizational agility mediates the relationship between digital orientation and digital product and service innovation performance. These results imply that digital investment may produce economic value partly by changing the organization's response capability rather than through technology ownership alone.

For private clinics, this distinction has practical implications. A new appointment platform may reduce administrative friction, but its economic impact depends on whether managers use the resulting information to adjust physician schedules, reduce no-show losses, rebalance service lines, or expand capacity where demand is strongest.

The most important gap for an economics-oriented research program concerns the conversion of agility into measurable economic value. Existing studies frequently report broad performance, resilience, competitive advantage, innovation, or satisfaction outcomes. These are relevant, but they do not reveal whether agility improves the productivity of scarce clinical resources.

Resource utilization provides a plausible mediating mechanism. Private clinics combine specialized labor, diagnostic equipment, treatment rooms, information systems, and administrative infrastructure. Many of these resources have high fixed or quasi-fixed costs. Small improvements in utilization can therefore have disproportionate effects on unit costs and

contribution margins. Agility may improve utilization by aligning schedules with demand, reallocating personnel, adjusting service portfolios, coordinating patient flow, and responding more quickly to cancellations or demand surges.

This logic suggests a sequence in which agility influences operational efficiency before financial performance. Relevant mediators include physician utilization, room utilization, equipment utilization, patient throughput, waiting time, cancellation recovery, administrative cycle time, and labor productivity. These variables are more proximal to managerial action than profitability and can help explain why similar levels of agility produce different financial results across clinics.

Agility also contributes to performance through strategic renewal and resilience. Studies of healthcare organizations under institutional or crisis pressure show that dynamic managerial capabilities and agility can support renewal, while supply-chain research links dynamic capabilities to resilience and sustainable performance. These pathways are especially relevant when shocks threaten continuity of service or when technological change creates new service opportunities.

From an economic perspective, resilience can be interpreted partly as the avoidance of loss. The value of agility may appear not only in higher revenue but in lower disruption costs, faster recovery, reduced stockouts, lower idle capacity after shocks, or preservation of patient demand. This broadens the concept of economic performance beyond growth to include downside protection.

5. WHY THE PRIVATE HEALTHCARE CONTEXT REQUIRES SEPARATE ANALYSIS

A recurring weakness in the literature is the tendency to combine public, private, nonprofit, and mixed healthcare organizations under a single sector label. This is understandable for theory development but problematic for economic inference. Ownership and financing structures affect objectives, managerial discretion, capital constraints, labor arrangements, pricing, investment horizons, and exposure to competition.

Private clinics are often more directly exposed to patient choice, insurer contracting, local competition, reputation effects, and the economic consequences of unused capacity. Managers may also have greater discretion to change service portfolios, opening hours, technology, staffing arrangements, or marketing. These characteristics could strengthen the agility-performance relationship because both the opportunity to act and the financial consequences of action are more immediate.

Conversely, private providers may face constraints that reduce the value of agility. Small clinics may lack slack resources, bargaining power, analytics capacity, or managerial specialization. Rapid adaptation may require investments that are difficult to finance. In highly regulated markets, pricing or service expansion may be constrained. The effect of agility is therefore likely to be contingent on clinic size, specialization, market structure, digital maturity, and environmental dynamism.

For this reason, future studies should avoid treating ownership type as a descriptive afterthought. It should be incorporated into sampling, theory, and statistical analysis. Comparisons between private and public providers can be valuable, but only when the institutional differences are explicitly modeled.

6. RESEARCH GAPS

Gap 1: Economic-outcome specificity. Healthcare agility research contains relatively little direct evidence using objective economic outcomes. Future studies should connect agility

scores with revenue, operating margin, cost per patient, contribution margin, productivity, and capacity utilization.

Gap 2: Private-sector identification. Many studies do not clearly distinguish ownership types. Dedicated samples of private clinics and hospitals are required before sector-specific conclusions can be made.

Gap 3: Measurement consistency. Agility scales differ across studies and are often adapted from other industries. Healthcare-specific validation should test dimensionality, reliability, convergent validity, discriminant validity, and measurement invariance.

Gap 4: Mechanisms rather than correlations. Research should test how agility creates value. Resource utilization, operational efficiency, innovation capability, patient-flow efficiency, and workforce productivity are plausible mediators.

Gap 5: Boundary conditions. Environmental turbulence, competitive intensity, clinic size, specialization, digital maturity, regulatory intensity, and labor scarcity may strengthen or weaken the economic returns to agility.

Gap 6: Longitudinal evidence. Cross-sectional designs dominate much of the empirical literature. Longitudinal or panel designs are needed to examine temporal ordering and to distinguish persistent capabilities from short-lived crisis responses.

Gap 7: Multi-source data. Single-respondent surveys create common-method concerns. Future studies should combine manager surveys with accounting records, scheduling data, human-resource data, patient-flow indicators, and market variables.

Gap 8: Cost of agility. The literature often emphasizes benefits but rarely models the costs of maintaining agile capacity. Redundancy, training, digital infrastructure, flexible staffing, and rapid reconfiguration can be costly. Net economic value should be measured.

7. PROPOSED INTEGRATED CONCEPTUAL FRAMEWORK

The synthesis supports a four-layer framework for private healthcare organizations. The first layer contains antecedents that make agility possible. The second contains the dimensions of organizational agility itself. The third contains mechanisms through which agility changes the economics of service delivery. The fourth contains economic outcomes.

Tabel 3. Proposed Conceptual Framework of Organizational Agility and Economic Performance in Private Healthcare Clinics

Framework layer	Illustrative variables
Antecedents	Digital capability; environmental sensing; leadership; knowledge management; workforce skills; decentralized decision-making; data integration; organizational culture; external partnerships.
Agility dimensions	Strategic agility; operational agility; workforce agility; digital agility; supply-chain/partnering agility.
Mediating mechanisms	Resource utilization; operational efficiency; innovation capability; service responsiveness; patient-flow efficiency; workforce productivity; resilience.
Economic outcomes	Revenue growth; operating margin; cost per patient; productivity; capacity utilization; return on investment; contribution margin;

Framework layer	Illustrative variables
	market share; sustainable competitive performance.
Moderators	Environmental dynamism; competitive intensity; clinic size; specialization; ownership model; digital maturity; regulatory intensity; labor scarcity.

Source: Authors' own conceptual development based on the dynamic capabilities framework (Teece et al., 1997; Teece, 2007; Teece et al., 2016), organizational agility literature (Walter, 2021; Asghar et al., 2026), and empirical research on agility, innovation, resilience, and organizational performance in healthcare (Agwunobi & Osborne, 2016; Furnival et al., 2019; Alhassani & Al-Somali, 2022; Junaaid et al., 2023; Loureiro et al., 2023; Li & Martins, 2024; Sarmiento Falla & Karwowski, 2024; Aloulou, 2025; Leng et al., 2026; Mishra et al., 2026).

The central economic mechanism can be represented as: Organizational Antecedents -> Organizational Agility -> Resource/Operational Efficiency -> Economic Performance. Digital transformation can operate both as an antecedent and as a contextual amplifier, while environmental turbulence and organizational characteristics can moderate the returns to agility.

8. RESEARCH PROPOSITIONS AND EMPIRICAL AGENDA

P1. Organizational agility is positively associated with the economic performance of private healthcare organizations.

P2. Operational efficiency mediates the relationship between organizational agility and economic performance.

P3. Resource-utilization efficiency mediates the relationship between organizational agility and economic performance.

P4. Digital capability positively influences organizational agility.

P5. Organizational agility mediates the relationship between digital capability and economic performance.

P6. Workforce agility positively influences operational efficiency, conditional on coordination quality and workforce capacity.

P7. Environmental dynamism strengthens the relationship between organizational agility and economic performance.

P8. The economic effect of organizational agility differs according to organizational size, specialization, and digital maturity.

P9. Resilience mediates part of the relationship between organizational agility and economic performance under disruptive conditions.

P10. The net economic return to agility is nonlinear when the costs of maintaining flexible capacity and rapid reconfiguration are included.

A subsequent empirical article can test this framework using a multi-clinic survey matched with objective performance indicators. The unit of analysis should be the clinic or business unit rather than the individual employee when economic performance is the dependent variable. Respondents should be senior managers, medical directors, operations managers, or owners with sufficient knowledge of organizational processes.

Organizational agility can be modeled as a higher-order construct composed of sensing/responsiveness, strategic agility, operational reconfiguration, workforce agility, and digital agility. Economic performance should combine both objective and perceptual indicators. Objective variables might include revenue growth, EBITDA or operating margin where available, cost per patient, revenue per full-time equivalent, appointment utilization, equipment utilization, and patient throughput. Perceptual measures can be retained for comparative performance when financial disclosure is limited, but they should not be the sole evidence.

PLS-SEM is suitable when the model is prediction-oriented, includes higher-order constructs, and the sample is moderate. Covariance-based SEM is preferable when the primary objective is theory confirmation and distributional/sample-size assumptions can be met. For clinics observed over multiple periods, panel regression or multilevel modeling would offer stronger economic inference. Mediation analysis should explicitly test operational efficiency and resource utilization rather than relying only on direct agility-performance paths.

Tabel 4. Illustrative Operationalization of Organizational Agility, Digital Capabilities, and Economic Performance in Private Healthcare Clinics

Construct	Illustrative indicators
Organizational agility	Speed of recognizing demand changes; decision speed; ability to redesign processes; ability to reallocate staff/capacity; speed of launching or modifying services.
Digital capability	System integration; real-time operational data; analytics use; digital patient access; automation; interoperability.
Operational efficiency	Cycle time; waiting time; scheduling efficiency; administrative processing time; throughput.
Resource utilization	Physician utilization; room utilization; equipment utilization; staff productivity; cancellation recovery.
Economic performance	Revenue growth; operating margin; cost per patient; revenue per employee; contribution margin; ROI.
Controls	Clinic size; age; specialty mix; city/market; ownership; competition; payer mix; regulatory intensity.

Note: The proposed indicators are illustrative and require contextual adaptation, expert assessment, and empirical validation before being used as measurement instruments. Economic performance indicators should preferably be derived from objective financial and operational records, where available.

Source: Authors' own elaboration based on the dynamic capabilities framework (Teece et al., 1997; Teece, 2007), organizational agility measurement literature (Walter, 2021; Sarmiento Falla & Karwowski, 2024; Asghar et al., 2026), and empirical studies examining healthcare agility, digital transformation, resource utilization, and organizational performance (Agwunobi & Osborne, 2016; Alhassani & Al-Somali, 2022; Junaid et al., 2023; Loureiro et al., 2023; Aloulou, 2025; Leng et al., 2026).

9. DISCUSSION

The literature supports the view that organizational agility is a meaningful capability in healthcare, but the economic interpretation of this capability requires greater precision. Existing studies provide evidence that agility is associated with organizational performance, renewal, innovation, resilience, workforce outcomes, and competitive capabilities. What remains less developed is the chain that connects these outcomes to clinic economics.

The dynamic-capabilities perspective helps resolve this problem by shifting attention from agility as a desirable organizational attribute to agility as a mechanism for resource reconfiguration. In private healthcare, resources are costly, specialized, and often capacity-constrained. The economic value of agility therefore depends on whether sensing and response improve the timing and productivity of resource deployment.

This interpretation also clarifies why digital transformation should not be treated as an independent guarantee of performance. Digital systems can increase information availability, but information creates value only when organizational structures permit timely action. The recent evidence linking digital orientation or digital transformation with agility, resilience, and performance is consistent with a capability-complementarity argument: technology and organizational agility reinforce one another.

The review also suggests that the relationship between agility and performance may not be uniformly positive. Maintaining spare capacity, cross-training employees, investing in analytics, decentralizing decisions, and frequently redesigning processes all involve costs. Excessive reconfiguration can disrupt routines and increase cognitive or coordination burdens. An economics-oriented theory of agility should therefore incorporate both benefits and adjustment costs.

This cost-benefit perspective is especially important for smaller private clinics. A large hospital network can spread digital and managerial investments across many sites, whereas a small clinic may face high fixed costs relative to revenue. Consequently, the same agility practice can generate different returns depending on scale, specialization, market volatility, and resource slack.

Finally, the literature indicates a need for stronger measurement discipline. The proliferation of agility labels can obscure rather than clarify empirical relationships. Future research should define the level of analysis, distinguish antecedents from dimensions and outcomes, and validate measures in the healthcare setting. Economic performance should be specified independently rather than embedded inside the agility construct.

10. IMPLICATIONS

This review extends healthcare agility research by explicitly locating economic performance downstream from operational and resource-allocation mechanisms. It therefore connects organizational agility with healthcare economics rather than treating performance as an undifferentiated managerial outcome.

The proposed framework also integrates several research streams that are often studied separately: digital transformation, workforce agility, supply-chain resilience, strategic renewal, and dynamic capabilities. Their common theoretical denominator is the organization's capacity to sense, seize, and reconfigure under changing conditions.

For private healthcare managers, the central implication is that agility should be managed through measurable economic mechanisms. The objective is not maximum change speed but economically effective responsiveness. Managers should track whether faster decisions improve appointment utilization, staff productivity, equipment use, patient throughput, and service-line margins.

Digital investment should likewise be evaluated in combination with decision rights and process redesign. Real-time dashboards have limited value if managers cannot alter schedules, staffing, or service capacity. Conversely, decentralized decisions without reliable data can produce local optimization and inconsistent resource use.

Recent studies reinforce the need to analyze agility as a mechanism rather than as an isolated organizational characteristic. Research in private Indonesian hospitals links dynamic managerial capabilities and strategic agility to strategic renewal, while later work in the same context emphasizes strategic agility and digital readiness as enablers of renewal. Evidence from Jordanian private hospitals associates strategic agility with healthcare quality, and emerging research on private healthcare providers in Kenya examines agility in relation to sustained competitive advantage.

At the workforce level, a 2025 healthcare study validates self-organization, collaboration, and iteration as dimensions of workforce agility and reports that workforce

agility mediates the effects of information-technology ambidexterity and human-resource practices on job performance. At the digital level, recent healthcare studies increasingly model organizational agility as the capability through which digital transformation or digital orientation is translated into performance, innovation, resilience, or strategic renewal.

These developments strengthen the central argument of this review: digitalization, managerial capabilities, and workforce practices should be treated primarily as antecedents or complementary capabilities, while economic value is expected to emerge through agile reconfiguration, resource utilization, and operational efficiency.

The review is deliberately differentiated from recent broad syntheses. Nguyen et al. (2025) reviewed 249 empirical studies published from 1998 to February 2024 and found a relatively consistent contribution of agility to organizational performance. Asghar, Kanbach, and Kraus (2026) subsequently synthesized 110 peer-reviewed articles to advance a multidimensional concept of organizational agility. In healthcare specifically, Sarmiento Falla and Karwowski (2024) identified organizational, workforce, supply-chain, and treatment agility as the dominant clusters in 21 survey-based studies. The present review therefore does not attempt to remap agility in general; it focuses on the economic conversion mechanism in private healthcare.

Recent healthcare evidence supports this narrower positioning. Research in Indonesian private hospitals links dynamic managerial capabilities and strategic agility with strategic renewal, while a 2025 follow-up study identifies strategic agility and digital readiness as important enablers of renewal. Evidence from Jordanian private hospitals links strategic agility to healthcare quality. Workforce research published in 2025 validates self-organization, collaboration, and iteration as dimensions of healthcare workforce agility and shows that workforce agility mediates the effects of information-technology ambidexterity and human-resource practices on job performance.

The economic research opportunity remains clear: healthcare studies increasingly establish that agility matters, but comparatively few connect agility to objective clinic-level financial outcomes such as operating margin, cost per patient, revenue per physician, contribution margin, or return on invested capital. This review therefore treats resource utilization and operational efficiency as the principal mechanisms through which agility can be converted into economic performance.

11. LIMITATIONS OF THE REVIEW

The principal limitation of the current manuscript is procedural rather than conceptual. The evidence synthesis is based on verified scholarly sources, but the final subscription-database export, deduplication log, and PRISMA record counts must be completed by the author before submission. The manuscript therefore should not report invented identification or exclusion numbers.

A second limitation is the heterogeneity of healthcare systems. Evidence from public hospitals, private hospitals, mixed healthcare supply chains, and different national institutional settings cannot be assumed to transfer directly to private clinics. The synthesis uses these studies to develop mechanisms and propositions, not to claim a universal private-sector effect size.

Another one is the diversity of outcome measures. Organizational performance, job performance, resilience, innovation performance, sustainable performance, and financial performance are related but distinct. This heterogeneity prevents a defensible pooled effect estimate at the current stage and supports narrative synthesis.

Table 5. Selected Recent Evidence on Organizational Agility and Performance in Healthcare

Study	Setting	Method	Main construct	Relevance to the proposed research
Nguyen et al. (2025)	Cross-sector	Systematic literature review; 249 empirical studies	Organizational agility and performance	Provides a broad evidence base and supports the need for sector-specific research on economic performance.
Asghar et al. (2026)	Cross-sector	Systematic literature review; 110 articles	Multidimensional organizational agility	Offers an updated conceptualization of organizational agility and its dimensions.
Sarmiento Falla & Karwowski (2024)	Healthcare organizations	Systematic literature review; 21 studies	Organizational, workforce, supply-chain and treatment agility	Identifies healthcare-specific agility dimensions and measurement approaches.
Odeh & Alkshali (2024)	Private hospitals, Jordan	Quantitative study	Strategic agility	Examines the relationship between strategic agility and healthcare service quality in private hospitals.
Al-Amin et al. (2024)	Hospitals, United States	Exploratory study	Dynamic capabilities	Investigates the contribution of dynamic capabilities to hospital performance improvement.
Sarmiento Falla et al. (2025)	Healthcare professionals, Peru	PLS-SEM	Workforce agility	Examines the mediating role of workforce agility between IT ambidexterity, HR practices and job performance.
Tenggono et al. (2025)	Private hospitals, Indonesia	Quantitative study; PLS-SEM	Strategic agility and dynamic managerial capabilities	Examines how institutional pressures and managerial capabilities influence strategic agility and strategic renewal.
Zulfikri (2025)	Healthcare organizations	Quantitative study; PLS-SEM	Organizational agility and digital transformation	Examines organizational agility as a mechanism linking digital transformation to organizational performance.
Suyitno et al. (2026)	Hospitals, Indonesia	Quantitative study; PLS-SEM	Organizational agility and internal capabilities	Examines the role of organizational agility in translating internal capabilities into hospital performance.

Source: Authors' own elaboration based on the synthesis of selected empirical studies and systematic literature reviews (Al-Amin et al., 2024; Odeh & Alkshali, 2024; Sarmiento Falla & Karwowski, 2024; Nguyen et al., 2025; Sarmiento Falla et al., 2025; Tenggono et al., 2025; Zulfikri, 2025; Asghar et al., 2026; Suyitno et al., 2026).

Methodological note: Study counts, sample sizes, statistical methods, and the bibliographic metadata of Suyitno et al. (2026) should be checked against the original publications before submission.

12. ORIGINAL CONTRIBUTION AND POSITIONING OF THE REVIEW

The contribution of this review lies in its deliberately narrower economic focus. Existing systematic reviews have already clarified the general concept of organizational agility, its multidimensional nature, and the broad relationship between agility and organizational performance. Healthcare-specific reviews have also mapped organizational, workforce, supply-chain, treatment, and leagile forms of agility. Repeating those mappings would add limited value.

This article therefore positions private healthcare economics as the unit of theoretical integration. It asks how agility is converted into measurable economic value in organizations that face market demand, capacity costs, labor constraints, technology investment decisions, and competitive pressure. The proposed framework separates agility antecedents from agility dimensions, distinguishes operational mechanisms from final economic outcomes, and explicitly introduces the cost of maintaining agile capacity.

The resulting research niche can be summarized as follows: prior literature establishes that agility can improve organizational outcomes; the unresolved question is whether, through which mechanisms, and under which conditions organizational agility improves objective economic performance in private healthcare providers. Resource utilization and operational efficiency are proposed as the principal transmission mechanisms, while digital capability, environmental dynamism, organizational scale, and specialization are treated as relevant boundary conditions.

This positioning also reduces overlap with recent general reviews. A 2024 systematic review synthesized 249 empirical studies on agility and organizational performance, while a 2025 review further developed the multidimensional conceptualization of organizational agility. In healthcare, the 2024 survey-based review and the 2024 leagility review already provide broad mappings of the field. The present article should therefore be submitted as an economics-oriented, sector-specific synthesis rather than as another general review of agility.

13. CONCLUSIONS

Organizational agility offers a strong theoretical basis for explaining how private healthcare organizations can respond to technological, competitive, workforce, and demand-side change. The healthcare literature confirms that agility is multidimensional and is expressed through organizational, workforce, supply-chain, strategic, digital, and treatment-related capabilities. Dynamic-capabilities theory provides a coherent explanation of these dimensions through sensing, seizing, and reconfiguration.

Yet the economic consequences of agility remain insufficiently isolated. The literature is stronger on broad organizational performance, resilience, innovation, and workforce outcomes than on objective financial and productivity measures in private clinics. This gap is consequential because agility creates economic value only when responsiveness improves resource allocation, utilization, efficiency, or market capture by more than the cost of maintaining agile capacity.

The research agenda proposed here therefore shifts the central question from whether agility matters to how, when, and at what economic return agility matters. Future studies should combine validated organizational-agility measures with clinic-level financial and operational data, distinguish private from public ownership, and test resource utilization and operational efficiency as mediating mechanisms. Such research can provide a more rigorous economic foundation for agile strategy in private healthcare.

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APPENDIX 1. LITERATURE MATRIX FOR THE FINAL SYSTEMATIC REVIEW

Source	Context	Method	Agility construct	Outcome	Key relevance	Private-sector fit
Walter (2021)	Cross-sector	SLR	Organizational agility	Business performance	Conceptual foundation; drivers/enablers/capabilities/dimensions	Indirect
Nguyen et al. (2025)	Cross-sector	SLR, 249 empirical studies	Multiple agility forms	Organizational performance	Establishes broad agility-performance evidence	Indirect
Asghar et al. (2026)	Cross-sector	SLR	Multidimensional OA	Competitive advantage/performance	Updated conceptualization	Indirect
Sarmiento Falla & Karwowski (2024)	Healthcare	SLR	Organizational/workforce/supply-chain/treatment	Multiple	Healthcare-specific measurement map	Mixed
Li & Martins (2024)	Healthcare	SLR	Leagility	Cost/proficiency/flow	Lean-agile healthcare applications	Mixed
Furnival et al. (2019)	Healthcare	Conceptual	Dynamic capability	Improvement capability	Sensing-seizing-reconfiguring mechanism	Mixed
Agwunobi & Osborne (2016)	Hospitals	Framework	Dynamic capabilities	Competitive advantage	Hospital strategic mechanism	Mixed
Private Indonesia study (2024)	Private hospitals	PLS-SEM	Strategic agility	Strategic renewal	Direct private-sector evidence	High
Odeh & Alkshali (2024)	Private hospitals, Jordan	Regression	Strategic agility	Healthcare quality	Private hospital evidence	High
Zulfikri (2025)	Public/private hospitals	PLS-SEM	Organizational agility	Competitive performance	Agility mediates digital transformation-performance	Medium
Workforce agility study (2025)	Healthcare professionals	PLS-SEM	Workforce agility	Job performance	Human-capital mechanism	Mixed
Jacobs et al. (2026)	Radiotherapy clinic	Longitudinal case	IT agility/maturity	IT performance	Digital operating-model evidence	Medium