ANALYSIS OF THE INDUSTRY FORCES AND THE STRATEGIC CHOICES ADOPTED BY PRIVATE HOSPITALS IN NAIROBI

BY

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DECLARATION

This management project is my original work and has not been presented for a degree in any other university

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This management project has been submitted for examination with my approval as the university supervisor.

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DEDICATION

To Joyce, Martin and Dan

ABBREVIATIONS

AIDS:	Acquired Immune Deficiency Syndrome
HMO:	Health Maintenance Organization
GDP:	Gross Domestic Product
NHIF:	National Hospital Insurance Fund
MoH:	Ministry of Health of the Republic of Kenya
NHSSP:	National Health Strategic Sector Plan
GOK:	Government of Kenya
KRAMS:	Kenya Registered Association of Medical Schemes
BMJ:	British Medical Journal

ABSTRACT

This report presents the findings of a survey of the industry forces and the strategic choices adopted by private hospitals based in Nairobi, Kenya. The research was conducted among the 51 private hospitals based in Nairobi.

The study examined the industry structure. 56.4% of the hospitals were found to be recent entrants under 10 years of age. In terms of size, 66.6 % were found to be small hospitals with less than 50 beds. The majority (59.4%) of hospitals were found to be owned by individuals and private companies in equal proportions. The industry is almost equally split between non profit and profit seeking hospitals, with a slight majority of 55.3% being profit seekers. The industry mainly comprises of indigenous firms. An overwhelming majority (86.4%) were found to be locally owned or controlled

The study revealed that the level of competition in the hospital industry is quite high. 68.4% of the respondents rated the level of competition as high to very high while only an insignificant 5.2% rated it as low or very low.

Further, the study examined the impact of the industry forces. The forces were all found to be significant. On a scale of 1-5 each of the forces scored above average. The force with the greatest impact on the hospitals is rivalry/competition from existing hospitals with a score of 3.62. This was followed by the following forces in descending order; bargaining power of customers (3.56), bargaining power of suppliers (3.08), threat of new entrants/upcoming hospitals (3.08) and substitutes (3.05). With the lowest score of 2.95, government was found to have the least

influence in the industry. Given that this should be a highly regulated industry, and the significant influence of government in other markets, this low score was quite unexpected.

The findings revealed that several strategic choices are adopted by private hospitals. While the popularity of each choice differs, none is completely dominant. The most popular is cost leadership with a 56.4% score. This is followed in order of popularity by new product development (43.6%), market penetration (28.2%), market development (28.2%) and focus (18.4%). The least popular is diversification with a 7.7% score. The strategic choices are similar to those adopted by hospitals in the North American market which has the most developed private sector owned hospital industry.

This study raises several questions for further research. Among them is the industry forces and strategic choices selected by hospitals in other parts of the country. The study does not establish a causal relationship between industry forces, hospital characteristics and strategic choice. Such studies would deepen understanding of strategic issues in this poorly researched industry.

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background

Health care was for a long time the preserve of governments and charitable organisations. Health care providers, particularly hospitals, have for many years been internally focused, centrally controlled and operated in a rigid and protected environment. In the early part of the 19th century, the providers of health care were government and church owned hospitals. Both provided free services to the consumers and were funded by taxes and donations respectively. Between the 1940's to the 1970's, community owned hospitals whose mandate was to provide hospital care for community members was founded (MoH-NHSSP).

Independence brought with it an exodus of non-Africans. For the community owned hospitals, this exodus led to reduction in both donations and patients. To survive, the community hospitals had to open their doors to Africans. The Mission hospitals were handed over to the local chapters of the various churches. One of the consequences of "self rule" was reduction in external funding. Due to these developments, community and mission private hospitals were compelled to finance their budgets primarily by charging for their services.

Today, the leading mission hospitals charge as much, if not more, than private profit seeking hospitals. Indeed all-private hospitals seek to make a revenue surplus (profit). The fundamental difference is how the surplus is distributed. In charitable hospitals, the entire surplus is reinvested in the hospital while in profit seeking ones; some of the surplus may be paid out as dividends.

1.2 Definition of Terms

Certain terms and concepts used in this paper require clear understanding and as such, their definition is appropriate. Among the terms are the following;

Hospital

A hospital is defined as any institution providing medical and surgical treatment and nursing care for ill and injured people on both outpatient and inpatient basis.

Environment

This is the pattern of all the external conditions and influences that affect an organisation's life and development

Environmental conditions

Include all important international and domestic conditions of technological, economic, social, political and competitive nature. Changes in the environmental conditions shape a firm's opportunities and challenges.

Competitive forces

These refer to the forces that drive competition in an industry. They include such forces as the bargaining power of suppliers and buyers, potential entrants, substitute products and rivalry among existing firms.

1.3 Global Developments in the Hospital Industry

In their study of international trends in the provision and utilisation of hospital care, Hensher et al (1999), found that despite the great differences in hospital systems world wide, hospitals in all areas have to deal with rising expectations and, more often than not, a need to contain the costs of health care. Outside the developing countries, the generic response to rising costs has been to reduce hospital stays and to improve the efficiency of the system, a strategy that seems to be partially successful. The experience in the health care systems in the United States and the United Kingdom shows that cost pressures and changes in health care delivery mean that this strategy will lead to hospital mergers and closures in the long run.

According the Hensher et al (1999) medical practice, hospital management, and technology have undergone great changes over the last 20 years. This has led to substantial shifts in demand for

secondary care facilities and notable changes in the types of facilities required. Hospital costs are the largest component of health expenditure in most countries in the Organisation of Economic Co-operation and Development (OECD) and they have therefore been a key focus in the drive for increased efficiency in the health sector. While this financial pressure has played a part in the developments in the provision of secondary care, the influence of technology and the ability to treat large proportions of the patients on a day basis have also shaped patterns in the provision and use of hospitals.

The current trends of increased efficiency, substitution between inpatient and outpatient care, and changes in clinical management are likely to continue. Hensher et al (1999) found that there are no comprehensive databases providing detailed comparative data on hospital provision in the developing countries. Although trends indicate a reduction in beds per capita, there has been a general increase in hospital beds in developing countries since the early 1970s but the increase has been at rates lower than the population growth rate. Problems facing hospital systems in developing countries include over concentration in large urban areas and the increasing burden of the hospital system from adults with AIDS.

There are many proposals to reduce health care costs, some of them controversial. Giuffrida & Torgeson (1997) posit that where important individual or external effects are associated with treatment non-compliance, monetary incentives may be relatively cost effective and compliant patients should receive payment. In effect, they recommend that patients should be paid to take their medication. The French government proposes to curb health care costs by fining doctors who exceed budgetary allocations (Bmj, October 1997)

Teisberg et al (1994) argue that the major reason for escalating costs in the United States health care system is because incentives throughout the health care system, reward cost escalating behaviour by hospitals and doctors. The industry forces identified in this market are firstly, pressure to cut costs due to bargaining power of customers particularly insurance companies and large employers. Secondly, declining demand due to new medical technology and initiatives

aimed at keeping patients out of hospitals. Thirdly, new entrants who include for profit providers, medical centres, Health maintenance organisations, home nursing, health clubs and fourthly, alternative or substitute care such as herbal therapy, acupuncture etc. Lastly, there is excess capacity coupled with high fixed costs.

According to Coddington et al (1985), American hospitals have responded to the industry forces through cost cutting while attempting to maintain quality of care, consolidation through joint ventures, strategic alliances, mergers and acquisitions, retrenchment and downsizing through measures such as closure of unprofitable units and reduction of bed capacity, integration in the industry though diversification of hospitals into health insurance to become HMOs or diversification of health insurers into hospitals (mainly through acquisition). Other strategic directions include diversification such as setting up consultant wings on hospital grounds, shift of control of hospitals from doctors to professional managers, market segmentation and development of distinctive competencies/specializations by some of the providers and, for those unable to compete, exit from the industry.

1.4 The State of the Health Sector In Kenya

According to the MOH records, Kenya has 4207 health facilities. Of these, 420 are hospitals, 579 health centres, 3146 health sub centres and dispensaries. There are a total of 52186 beds with an average bed ratio of 1.76 beds per 1000 Kenyans. With the exception of North Eastern, the distribution of the health infrastructure is fairly even. Most of the private hospitals are concentrated in urban centres while mission and government ones are found distributed throughout the country (NHSSP 1999-2000).

The private sector owns 44% of the health care infrastructure with the government owning the remaining 56%. In Kenya, the per capita expenditure has declined from U.S. dollars 9.5 in 1980/81 to 3.4 in 1997. Kenya spends approximately 3.8% GDP on healthcare. In contrast, the

per capita expenditure on health care in the U.S.A. is slightly over 4000 dollars and health care expenditure as a percentage of GDP is approximately 11%.

Health care is financed in several ways. At 47%, the government is the largest financier of health care services, individuals fund 42% while the donor and missions cater for 7%. The NHIF finances a lowly 4.0%. Only 10% of the population are covered by social insurance.

According to NHSSP, 70% of diseases in Kenya are preventable through simple hygiene and environmental manipulation. Malaria accounts for 30% of outpatient cases (NHSSP 1999-2004). Successful public health programs therefore pose a major challenge to hospitals because they would reduce the captive market particularly to private facilities in the health care market.

Health care consumption shows an interesting pattern. A 1994 welfare monitoring survey revealed that 74% of the Kenyans who fall sick used medicines bought from pharmacies, 21% visited health facilities while 1.4% sought care from herbalists. 3.7% took no action (NHSSP1999-2004). Health care consumption is price sensitive particularly in a country where 15 millions Kenyans are estimated to be extremely poor. A study on the implication of the introduction of user fees for health care carried out in 1989 indicated that there was a drop in the number of people seeking healthcare as a result (NHSSP 1999-2004).

By 1998, Nairobi had 51 hospitals (12% of the national total), 36 health centres and 303 health sub centres and dispensaries. The province had 6,691 beds with 3.21 beds per 1,000 population. This number is significantly below the higher income countries' ratio of 7.46 but much higher than the Sub-Saharan Africa ratio of 1.21. It is also almost double the national average of 1.75 beds per 1,000population. The MOH estimates that over 80% of the registered 4,282 doctor's practice in urban centres with 50% based in Nairobi. The government and private sector provide 60% and 40% of health care respectively (MOH).

1.5 Recent Developments in the Hospital Industry In Kenya

Faced with growing demand and deterioration in quality of care, the government has implemented various measures intended to address the problems in the industry. In 1994, the government approved the Kenya Health Policy Framework Paper as the official blue print for the development and management of health services in the country. The paper expanded the scope of private health care provision and recommended privatisation and liberalisation in the industry. In 1999, to address the slow implementation of health sector reforms, the government formulated the National Health Sector Strategic Plan. (NHSSP) to cover the period 1999-2004.

In 1998, Medivac, the second largest managed health care organisation in the country, went into voluntary receivership. Hospitals lost millions in unpaid bills. Members, particularly corporates also lost millions in premiums. The result were calls for legislation to control and regulate the operations of health maintenance organisations.

One of the greatest perceived need in the industry is the creation of sustainable health care financing. Fraudulent claims were identified as a major drain the resources of the NHIF. In 1997, the government carried out an extensive investigation of NHIF claims. At least 30 hospitals were implicated in fraud and over 20 closed apparently because they could not survive without NHIF financing. In 1998, the government repealed the NHIF Act, which converted the NHIF from a department of the Ministry of health to a parastatal with a board comprising of key stakeholders.

To tap the private and self-funded market, the government introduced amenity wards in its provincial and some selected district hospitals. In pursuit of this policy, Kenyatta National Hospital opened a private wing in 1998. This expanded the number of private hospital beds and made the hospital a direct competitor of the private sector hospitals.

These developments have not been without consequences. On 18th July 2000, Hurlingham hospital, one of the entrants within the last five years had its property attached by auctioneers for the non-payment of debts. Within the last one-year, all the leading private hospitals have implemented changes which include employee retrenchment. The leading Health maintenance

organisation has also opted to set up its own provider network instead of outsourcing to existing providers as a way of cutting costs and controlling quality.

By the standards in other industries, these changes are not unusual. However, it is the first time that so many changes are occurring in the hospital industry. Clearly, all is not well within the industry.

1.6 Statement of the Problem

Many countries face serious problems in financing and restructuring their health care delivery systems. Due to the intangible nature of services, health care system problems have to be addressed at the national level. Though patients can and do seek health care services abroad, this is only applicable for non-emergency services only. This means that health care services have a high strategic value. As Coddington et al (1985) note, it is not in the public interest to have a large number of hospitals operating in a weakened financial state, fighting to survive. A thriving, sustainable but efficient private health care system, in which hospitals are a major and essential component, is a matter of national importance.

The Kenyan health care sector is in a dynamic state. On one hand, the government is spearheading fundamental health sector reforms, which will affect financing, service delivery, role of various professionals, review of the legal framework and harmonisation of regulation. On the other, there are signs that all is not well with in the industry. The signs are there and include exit from the industry, financial distress, efforts aimed at cost reduction such as retrenchment of employees and efforts to increase market share such as price competition and advertising. Other signs are development of new markets and products, expansion of capacity and diversification into related businesses.

This strategic repositioning indicates that there are powerful forces at play in the industry. What is not clear is the nature of these forces that are driving change or the bases for the different and

specific strategic choices being pursued by hospital. The aim of this study was therefore to answer two key questions;

1. What are the industries forces influencing strategy formulation and choice in the hospital industry?
2. What are the strategic options adopted by private hospitals in response to forces in the industry?

1.7 Objectives of the Study

The objectives of the study were;

1. To identify the industry forces, which influence the strategies, formulated by the private hospitals.
2. To identify the strategies formulated by private hospitals in Nairobi

1.8 Importance of the Study

Every country requires a vibrant, functioning and efficient health care sector. Hospitals are a key plank in the health care industry. Sustainability of hospitals is therefore a matter of national interest. Specifically, the study will be of interest to:

1. The government because private sector hospitals providers are a key pre-requisite for successful health care delivery. The findings of this study will shed light in this area and assist health planners to formulate and implement policies that will support the government's stated objective and health sector goals. This is particularly pertinent in view of the ongoing health sector reforms.

2. Investors as it will provide them with an overview of the industry dynamics and thus facilitate well-informed entry decisions. It will also assist the investors in the existing hospitals with a basis for strategy formulation and strategic choice. The net result should be less destructive competition, identification of new market niches and ultimately a healthier hospital industry.

3. The public's accessibility to good quality medical facilities is a matter of great public interest. This is because even the best health insurance policy is of no value in the absence of good quality medical facilities.

4. Scholars who wish to do further research in the hospital industry.

1.9 Limitations of the Study

The study was constrained by various factors. The study was limited to hospitals. Inclusion of other health care providers may have enriched the findings

It was not possible to include all hospitals as health care providers in Nairobi and it was also not possible to conduct the research in other parts of the country. This would have facilitated a comparison with practices in both urban and rural settings.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Health Care, A Global Perspective

Provision of health care has serious social, economic, political and ethical implications and repercussions. World wide, for different reasons, countries are grappling with different health care dilemmas. Despite these differences, a number of trends are discernible.

2.1.2 Health care financing

Heath care wants and desires are limitless but the resources to satisfy these wants are not. Scarcity is the imbalance between the desire for goods and services and the means to satisfy them. Scarcity is a universal problem faced by poor and rich nations alike. Health care is an excludable public good. It can be priced easily and can be produced and sold for a fee. It has therefore been possible for private firms to provide the service for a fee, for the government to finance the service through taxes and provide services for free, for government to levy fees through cost sharing or for government to subsidise private firms so as to reduce the price and encourage consumption. Through the price mechanism, it is also possible to ration supply. Kenya is a classic example of the imbalance arising out of lack of purchasing power. While the private hospitals are competing for clients with the purchasing power to pay for their services, the public hospitals cannot cope with the demand. Clearly, a change in health care financing would have the effect of redistributing the demand to the underutilised suppliers.

All countries are dealing with the question of how to finance escalating health care costs against slowed or static economic growth. Europe, excluding the U.K. spends 9.1 of GDP on healthcare. The proportion differs from country to country, for example, healthcare expenditure, as a percentage of GDP is as follows, Sweden 8.6, Germany 10.7, France 9.6, and U.K. 6.7. In 1998, the U.S.A. spent 1.1 trillion dollars or 4094 dollars per person on health care. Between 1993 to

1998, U.S. health care expenditure as a percentage of GDP has ranged between 13.4-13.5(Bmj, January 2000).

The situation in Kenya is substantially different. Not only do we have a much smaller economy but also, health care expenditure as a percentage of GDP is only 3.4%. In 1997, the MOH consumed 9.7% of government expenditure. Although the MOH budgetary allocation has been increasing over the years, it has not kept up with the growth in population. As a consequence, the per capita expenditure has declined from U.S. dollars 9.5 in 1980/81 to 3.4 in 1997(NHSSP 1999-2004).

In every country, health care financing is predominantly a government affair. Private financing sources include health insurers, health maintenance organisations, private donors and individuals. Health care financing is not without risk. In 1999, Harvard pilgrim health care, one of the 10 largest HMOs in America went into receivership after incurring losses that resulted in negative net worth. In 1998, Medivac, the second largest HMO in Kenya, went into voluntary receivership after it was unable to meet its financial obligations. Members were never compensated and had to seek alternative health insurance. Similarly, providers lost millions in unpaid bills. This risk also applies at personal level. Medical bills accounted for 40% of the 500,000 personal bankruptcies filed in the U.S.A. in 1999(Bmj May 2000)

2.1.3 Quality of Care

Despite the technological, clinical and managerial advances in the health care industry, delivery of quality care remains a major concern. It is estimated that 44,000–98,000 Americans die from medical mistakes each year. In Germany, a series of diagnostic errors led to at least 300 women being operated unnecessarily for breast cancer (Bmj March 2000). In Japan, 3 directors of a drug company were jailed for selling untreated blood products that resulted in HIV infection for 1800 patients of whom 500 have died with another 500 developing full blown AIDS. In Australia, 9 patients were exposed to a potentially fatal infection of the brain after surgical equipment was reused without being properly sterilised. While Kenyan statistics are not available, a number of

cases have been reported in the media. It is prudent to presume that mistakes do occur but may remain unreported.

Greater patient empowerment has greatly encouraged malpractice litigation. The threat of malpractice causes doctors to practice defensive medicine. This in turn leads to unnecessary investigations and treatments. In the U.S.A., defensive medicine is estimated to increase overall health care costs by 1% (Porter et al, 1994). Doctors are also leaving high-risk specialities such as Obstretics, Orthopaedics and Neurosurgery. In Canada, medical specialists have threatened to leave Ontario due to the high cost of professional indemnity insurance (Bmj March 2000)

2.1.4 Equity

One of the key questions in health care is how to achieve equal access to healthcare irrespective of social economic status. Equity is a very difficult goal to achieve. The British, Israeli and Kenyan public health care systems have a two-tier system that offers shorter waiting periods for patients willing to pay higher private care fees. When any national health care delivery system is examined, a two-tier system exists. On one hand is the relatively congested and under funded public health care delivery system that provides care for the indigent population. On the other hand is the private health care delivery system which is more efficient and within which the latest treatments are available at a fee. In South Africa, private health care consumes approximately 11 billion rand per year. In developed countries, the key difference between public and private health care is the waiting time particularly for non-emergency services. In developing countries the contrast is so large that in many instances, it may well be a matter of life and death.

2.1.5 Service delivery

Health care providers range from governments, non-profit organisations and for profit firms. Historically, government and non-profits have provided health care services. The concept of for profit seeking providers is fairly recent and controversial. However, in a 1987 study, Herzlinger et al concluded that American non profit hospital chains studied did not provide sufficient charity to warrant their exemption from income taxes. The study concluded that the poor would have

benefited more if the considerable profits made by the non profits had been taxed and the proceeds applied to pay for their care. In 1989, a General Accounting Office study confirmed this controversial conclusion when it reported that 57% of American non profit hospitals examined provided charity whose value was less than the tax benefits they received.

While no similar study has been done in Kenya, it is clear that many of the non-profit hospitals in Nairobi are out of the reach of the majority of Kenyans and do not do any visible charity work. It would be worthwhile to do a comparative study and establish whether the local findings would be similar.

2.2 Competitive Environment in Nairobi

Competition in an industry continuously works to drive down the rate of return on invested capital towards the competitive floor rate of return or the return that would be earned in a "perfectly competitive industry". This competitive floor or "free market" return is approximated by the yield on long term government securities adjusted upward by the risk of capital loss. Investors will not tolerate returns below this rate in the long run because of the alternative of investing in other industries and firms earning less than this return will eventually go out of business. The presence of a rate of return higher than the adjusted free market return serves to stimulate the inflows of capital into an industry either through new entry or through additional investment by existing competitors.

2.2.1 Rivalry among existing competitors

Rivalry among existing competitors uses tactics such as price competition, advertising, product introductions and increased customer service. Rivalry occurs because one or more competitor either feels the pressure or sees the opportunity to improve position. Intense rivalry is the result of; Numerous or equally balanced competitors, slow industry growth, high fixed costs or storage costs, lack of differentiation or switching costs and where capacity is augmented in large increments. Other factors are diverse competitors, high strategic stakes and high exit barriers

due to specialised assets, fixed costs of exit, strategic interrelationships, emotional barriers or government or social restrictions.

It is difficult to measure the extent of rivalry between hospitals. There are some indicators. Against established conventions, one of the leading hospitals hospital placed advertisements in the print media and lowered consultation fees. Two others hospitals followed suit shortly.

On the other hand, hospitals are co-operating to improve their environment. Some of the hospital administrators' routinely share information on the telephone and in meetings. Plans are at an advanced stage to set up an industry association. A different association, the association of private hospitals, nursing home and clinics and has launched a campaign against newly introduced fees by the Medical Practitioners & Dentists Board (Daily Nation, 1/7/2000)

2.2.2 Threat of new entrants

New entrants bring with them additional capacity, desire for market share and substantial resources. Entry may be by acquisition or green site development. Barriers to entry include fear of retaliation by existing players, economies of scale, economies of scope due to shared functions, product differentiation, degree of consolidation/integration, capital requirements, exit barriers and switching costs.

Entry at the top end of the industry is restricted by shortage of suitable locations, high capital costs that runs into billions, high fixed costs, an industry structure that precludes acquisition and the difficulty of building brand recognition due to restrictions on advertising.

Hospital admissions are mostly dependent on consultant referrals from doctors in private practice and consultation. However, many senior consultants have hospital-based practices which increases their switching costs.

As a matter of policy, corporate health care buyers require that a hospital be registered with the NHIF, a process which is cumbersome and may take up to two or more years to complete. Even

without this requirement, new hospitals are faced by a price disadvantage because the NHIF rebate has the effect of reducing the net cost to the payer in accredited hospitals. The NHIF has proposed a mandatory two-year waiting period. This change is coupled with a proposal for wider range of benefits. Such changes if implemented would substantively raise the entry barrier.

Hospitals have specialised assets, which are difficult to sell. Secondly, the largest private hospitals are not profit motivated and are unlikely to exit even in a hostile business environment. These two factors raise the exit barriers. Indeed, for several years, one commercial bank has been trying to sell a hospital to recover debts without success. Entry at the medium size hospital level has lower capital and location barriers. However, most of the other barriers remain. Entry at the low end of the market is relatively easier. Most of the hospitals are in the middle to low income suburban areas, target cash paying clientele and generally operate outside the regulatory framework because they are too small to attract the attention of regulators who are inadequately equipped for the task. A good number are in rented premises that are converted from residential or commercial use.

2.2.3 Pressure from substitutes

Substitutability is possible in terms of the product, process or geographic market boundaries. Substitutes limit the potential returns in an industry by placing a ceiling on the prices firms in an industry can profitably charge. The more attractive the price performance alternative offered by substitutes, the firmer the lid on industry profits. Hospitals face many substitute providers of health care; Hospital outpatient services compete with all other providers of ambulatory services ranging from managed care and health maintenance organisations, doctor owned practices, clinical officer and nurse practitioners, alternative medicine providers such as herbalists and so on.

According to the NHSSP, 70% of Kenyans initially seek assistance from pharmacies when they fall sick (NHSSP). This shows that hospitals also compete with over the counter medicines sold in shops, supermarkets, retail chemists and pharmacies. In theory, prescription medicines should

not be sold over the counter. In practice, this requirement is often ignored and flouted. The use of the title doctor by pharmacists has only served to confuse and aggravate the situation.

One significant, but often ignored substitute is public health. Public health activities endeavour to prevent disease and illness at source. 70% of diseases in Kenya are preventable through simple hygiene measures, environmental intervention and immunisation. If successful, such efforts would drastically reduce outpatient visits and admissions. Such health promotion efforts have successfully been tried elsewhere. Some American companies, in an effort to address the rising cost of healthcare have opted to tackle the problem at source by improving the health of their employees through simple or multifaceted health promotion activities (Herzlinger, 1986).

Health maintenance organisations attempt to cut costs by keeping their clients out of hospitals and thus compete in the same way but more visibly than general public health efforts. Reisler (1995) notes that when a health maintenance organisation enters a community, it quickly evokes competitive responses from other healthcare providers because its prepayment approach upsets the medical profession's fee for service rules and forces providers to become equally cost conscious or lose their market share.

Other generic competitors include hospices and home based care services that encourage home and community based care. Session Paper No. 4 of 1997 on AIDS in Kenya spells out the government's commitment to promote home based care as an intervention to reduce the impact of AIDS. Home based care provides a continuum between the community and health facilities and leads to reduction of hospital based care for the chronically ill.

Day care centers compete with inpatient services. Hensher (1999) notes that advances in technology have enabled more and more procedures and treatments to be provided on an outpatient or day care basis. This obviously reduces the need for hospitalisation and reduces the entry barrier for surgery by making it possible to perform major surgery from doctors' practices. In the U.K., the number of day case admissions as a proportion to total admission has increased from 17.7% in 1985 to 38.9% in 1997. Hensher further notes that from the experience in the United States where approximately 60% of operations are performed on a day care basis, the

actual level of day care surgery in the U.K and continental Europe falls far below the technical potential. While some amount of day care surgery occurs in Kenyan hospitals, it is hampered by lack of supporting infrastructure. The statistics are unavailable.

2.2.4 Bargaining power of suppliers

Suppliers can exert bargaining power over participants in an industry by threatening to raise prices or reduce quality of goods and services. Powerful supplies can squeeze profitability out of an industry unable to recover cost increases in its own prices. Supplier power is high if it is dominated by a few companies and is more concentrated than the industry it sells to, if not obliged to contend with other substitute products for sale to the industry and if the industry is not an important customer of the supplier group. The power is also high if the supplier's product is an important input in the buyer's business, if the supplier's products are differentiated, if it has built in switching costs or the supplier group poses a credible threat of forward integration.

Labour is an important supplier and one that exerts great pressure in many industries. The power of labour depends on its degree of organisation and whether the suppliers of labour can expand capacity. Hospitals are labour intensive. They employ a substantial number of highly qualified and skilled employees. The supply of labour is quite static with long lead times before qualification and registration. This increases the bargaining power of labour.

Consultant doctors qualify as suppliers because they are an important source of referrals. According to a study commissioned by the Nairobi hospital in 1998, patients perceive consultants to be an integral part of the hospital and usually do not differentiate the hospital and consultant fees. The main reason for this is that to the payer or the patient, what counts is the final consolidated bill rather than the parts. High consultant fees restrict the level of fees that hospitals can charge for their services without outpricing themselves out of the market.

Another group is the suppliers of medical equipment, pharmaceuticals and consumables. Medical equipment is generally specialised and expensive. Hospitals have to depend on the supplier for service and consumables. This increases switching costs. Many pharmaceutical

distributors have exclusive territorial rights, patent protection for up to 15 years after introduction of new products and legal protection against parallel importation. As a consequence, despite their duty free status, many products are much more expensive than in the countries of origin. This exclusivity is only mitigated by availability of substitute products after expiration of the patent.

2.2.5 Bargaining power of buyers

According to Porter (1998), a group of buyers is powerful if it is concentrated or purchases in large volumes relative to seller's sales; if the product it purchases from the industry represents a significant fraction of the buyer's costs or purchases; if the products purchased from the industry are standard or undifferentiated; if it faces few switching costs or if earns low profits. Buyer power is also augmented if the buyers pose a credible threat of backward integration, if the industry's product is unimportant to the quality of the buyer's products or if the buyer has full information.

Hospitals are not homogenous. Different services face different buyer pressure. For example, outpatient services are generic with little differentiation between providers coupled with a large fragmented network of providers. Other services such as intensive care and renal dialysis are only available in a few well established hospitals.

Buyer power has been rising due to the organisation of some of the large buyers into a industry group known as KRAMS, the increasing use of health insurance or managed care experts by buyer companies, low switching costs, fragmented provider network for basic services and the risk of backward integration. For example, some HMOs have set up their own outpatient clinics in order to have control over costs and quality of health care delivery. Some large corporations also have their own outpatient clinics such as Barclays Bank, Kenya Airways, and Kenya Brewery.

Declining profits have induced many employers to place limits on health care expenditure and to shop around for cost effective alternatives. Secondly, the bulk of health care purchases are for

junior employees and therefore, for the management, the quality of service is not as serious a consideration as cost.

Private hospitals prefer corporate buyers due to the lower financial risk. At the top end of the market, corporate business may be as high as 80% of turnover. Retrenchment has reduced the corporate buyer market size, leaving hospitals to fight to maintain market share against a declining market. Corporate buyer pressure is therefore expected to be quite significant.

There is a general improvement in health care scheme managerial capability. In an effort to cut costs, many scheme managers and large employers are employing doctors to audit or manage their medical schemes. Others have out sourced the function to managed health care specialists. Some of the local insurance companies have entered into strategic alliances with foreign companies especially from South Africa. The strategic partners bring expertise and experience in health care schemes management. Enlightened buyers are more empowered. These changes have therefore augmented buyer power.

Self-paying patients have always been price sensitive but have become even more so due to economic hardship. Health care is intangible and once consumed, the provider has little bargaining power to enforce payment. Once incurred, healthcare debts are usually interest free and rank quite low in the debtor's financial priorities. Though widely practised, perhaps for want of a better alternative, declining to admit patients on financial grounds is viewed negatively by the public. Detaining those unable to pay is socially unacceptable and is discouraged by the regulator. The high costs of treatment of chronically ill patients, particularly AIDS, aggravates the financial risk associated with self-paying patients.

Public expectation of free services puts a cap on prices that hospitals can charge. It also leads to losses in certain areas like emergency services where service has to be provided first without any financial arrangements. In addition, the concept of a profit seeking hospital is against the prevailing paradigm of hospitals being charitable institutions. Indeed, many private hospitals adopt names, which imply a charitable base and reinforce this paradigm.

Collectively, these factors increase the power of self-paying patients and results in high levels of bad debts. The rural based Kaplong Mission hospital claims that it is suffering from financial distress due to unpaid bills and has asked the government to help it collect (Daily Nation, 14/7/2000)

2.3 Concept of Strategy

Various authors have defined strategy in different ways. Pierce & Robinson define strategy as a game plan, which results in future, oriented plans interacting with the competitive environment to achieve company objectives. Thompson et al (1993) state that managers develop strategies to guide how an organisation conducts its business and how it will achieve its objectives. Johnson & Scholes (1984) define strategy as the direction and scope of an organisation over the long term that ideally matches its changing environment and in particular, its markets and customers so as to meet stakeholder expectations. Porter (1996) defines strategy as the creation of a unique and vulnerable position through trade-offs in competing, involving a set of activities that neatly fit together, that are simply consistent, reinforce each other and ensure optimisation of effort. Ansoff (1965) views strategy in terms of market and product choices. Mintzberg & Quinn (1991) perceive strategy as a pattern or plan that integrates an organisation's major goals, policies and action into a cohesive whole.

From the foregoing, one can conclude that strategy is a unifying pattern of decisions that define an organisation's objectives, and its obligations to its stakeholders through making choices regarding product and market scope and determining how the organisation will position itself within its environment to create sustainable competitive advantage.

2.4 The Strategic Process

Teece (1984) defines strategic management as an ongoing process that ensures a competitively superior fit between the organisation and its ever-changing environment. The relationship between an organisation and its environment is crucial for its survival. Hofer & Schendel (1978) observe that for firms to be effective they should respond appropriately to changes that occur in their respective environment. Porter (1980) states that every firm that competes in an industry must have a competitive strategy. Strategy can be formal or explicit if developed through a deliberate planning process or informal and implicit if evolved through the activities of the various functions of the organisation.

2.5 Conceptual Framework

The forces in the hospital industry will be examined by applying porter's five forces model. The strategic choices made by hospitals will be examined primarily through Ansoff's Product Market Expansion Grid and secondarily, through the Porter's three generic strategies.

2.6 Competitive Strategies

Organisations are environment serving entities. They depend on their environment for inputs and discharge their outputs into the environment. Every organisation whether profit seeking or otherwise is set up to fulfil particular goals and objectives. It is also set up to meet certain societal needs which the promoters of the enterprise believe are unmet or can be fulfilled in a better way than is the case.

Resources are limited while needs and wants are unlimited. New ventures must therefore compete for resources with others. The competition could be for volunteers' time, donations, finances, customers, space stakeholder support etc. To survive, the venture must be deemed to

add value to a society by a large enough group of stakeholders for it to take root and grow. Herein lies the crux of competition. As long as there are alternatives, competition is perhaps the only viable and equitable way of allocating resources.

To succeed, every organisation requires a competitive strategy. Competitive strategy is a combination of the *ends* (goals) for which the firm is striving and the *means* (policies) by which it seeks to get there (Porter, 1998). At the broadest level, formulating competitive strategy involves the consideration of four key factors that determine the limits of what a company can successfully accomplish. These factors are the company's strengths and weaknesses, the personal values of the key implementers, the industry opportunities and threats and broader societal expectations.

According to Porter (1998), competition in an industry is neither a coincidence nor matter of bad luck. It is rooted in the industry's underlying economic structure and depends on five basic forces. These forces are the threat of potential entrants, bargaining power of suppliers, bargaining power of buyers, threat of substitute products and services and rivalry among existing competitors. The collective strength of these forces determines the ultimate profit potential in the industry where profit potential is measured in terms of the long run return on invested capital.

An effective competitive strategy takes offensive and defensive actions in order to create a defendable position against the five competitive forces. There a number of possible approaches which include positioning the firm so that its capabilities provide the best defence against the existing allay of competitive forces, influencing the balance of forces through strategic moves thereby improving the firm's relative position; or anticipating shifts in the factors underlying the forces and responding to them, thereby exploiting change by choosing a strategy appropriate to the new competitive balance before rivals recognise it.

There are three general competitive strategies

2.6.1 Overall cost leadership

Cost leadership requires aggressive construction of efficient scale facilities, vigorous pursuit of cost reductions from experience, tight cost and overhead control, avoidance of marginal customer accounts, cost minimisation in areas like Research and Development, service, sales force, advertising and so on. A great deal of managerial attention to cost control is necessary to achieve these aims. A low cost position defends the firm against all the five competitive forces but requires a relative high market share or other advantages such as favourable access to raw materials and other inputs.

2.6.2 Differentiation

Differentiation involves creating something that is perceived to be unique in an industry. Differentiation takes many forms and can be built on many bases such as design, brand image, technology, customer service, features, distribution network etc. Differentiation sometimes precludes gaining high market share, as it often requires a perception of exclusivity.

2.6.3 Focus

This strategy focuses on a particular group of buyers, geographical market, etc. It aims to serve its chosen market more effectively or efficiently than the competitors. As a result, the firm may achieve differentiation from better meeting the needs of the particular target or lower costs in serving the target market or both. Even if the focus strategy does not achieve low cost or differentiation from the perspective of the market as a whole, it does achieve one or both of these positions vis-à-vis its narrow market segment.

2.7 Competitive Responses in Other Markets

The experience from other industries is that competitive pressures induce change as firms in the industry try to adjust to their new environment. Hospitals would be expected to be no exception to the rule.

That hospitals do respond to industry forces is not in doubt. The experience in other countries seems to bear this out. In china, where health care costs are rising by 30% per year, the government imposed limits on consultation and surgical fees in an effort curb costs. The hospitals' response was to perform more expensive tests, which are paid for separately, and issue more expensive prescriptions (Bmj, Volume August 1997).

The response patterns are also within expectations. The Shouldice hospital based in Ontario, Canada focuses on performing only one type of operation using only one surgical procedure developed by its founder. As a result, it has built a formidable reputation and achieved cost leadership with prices that are usually 50% of those charged elsewhere. The hospital gets referrals from all over Canada and the United States.

The strategies adopted in the other markets and particularly in North American market include;

2.7.1 Downsizing

Downsizing has been achieved through reduction of beds while remaining economically viable. Downsizing may be through reduction of physical infrastructure, number of units or services or reduction in number of employees.

2.7.2 Low cost providers

Coddington et al (1985) note that American hospitals are now viewing themselves in terms of their product lines, and hospital administrators and physicians are now discovering how efficient they can be in production. Many hospitals are busily installing computer based cost accounting systems to track costs.

Coddington et al (1985) further observe that for a low cost strategy to work two things must happen; The medical staff must cooperate by ordering appropriate tests only and carefully monitoring each patient's progress to achieve early discharge. Secondly, hospital management must develop better systems for scheduling nurses and other personnel to control variable costs. Hospital labour typically represents 55-60% of total costs.

2.7.3 Increasing market share

The major elements in this strategy are; Developing a strong physician referral network because doctors control most hospital admissions, increasing direct marketing efforts to consumers through advertisement and developing a convenience oriented feeder system such as a free standing emergency centre. In the U.S.A., efforts to increase market share have at times resulted in retaliatory moves to the extent that no hospital has been able to sustain a market advantage. Strategic efforts to increase market share may pay off for a few well located, aggressively managed hospitals (Coddington et al, 1985).

2.7.4 Focus

Many acute care hospitals have increased specialisation. In a sense, the strategy of specialisation is no different from new product development in a manufacturing company. Innovation is necessary to identify opportunities and carry them through, and products champions should be encouraged (Coddington et al 1985).

2.7.5 Diversification

According to Coddington et al (1985), a strategy of diversification does not conflict with a focus or cost leadership strategy. Hospital executives should develop a strategic framework in which new diversification opportunities, both from inside and outside sources, can be evaluated properly. Hospitals have diversified in various ways; some have developed real estate, others into health maintenance organisations, health management consultancy, etc.

Other strategic directions taken by hospitals include strategic alliances, joint ventures and mergers. By 1985, over 80% of American hospitals were non-profit. Some of the hospitals have joined networks which offer economies of scale, access to capital, management expertise, information sharing, joint marketing, management development and other human resource programs. For example, the voluntary hospitals of America network has 202 hospitals with 20,000 beds.

CHAPTER THREE

3.0 RESEARCH METHODOLOGY

3.1 Research Design

The study was exploratory. It was intended to elicit information on the strategic responses adopted by private hospitals. The objective of the research was to gain insights, better comprehension of the current situation and clarification of concepts. As such, an exploratory study sufficed (Naresh, 1996).

Since the researcher was unable to manipulate the respondents, the research was basically ex-post facto. Emory (1985) argues that investigators have no control over the variables in a sense of being able to manipulate them. They can only report what has happened or what is happening. He goes further to state that it is important that in this design, researchers should not influence the variables, as to do so is to introduce bias.

3.2 Population

The population of interest in this study included all the 51 private hospitals in Nairobi. A list of the hospitals was compiled from the Ministry of Health records and the Kenya medical directory 2000 issue. The concise oxford dictionary defines a hospital as an institution providing medical and surgical treatment and nursing care for ill or injured people. The working definition of a hospital adopted for the purpose of this study is any health care facility that provides inpatient care.

Given that the population size is small, a census study was conducted. Ogutu (1983) observes that for an exploratory study, a census survey provides a more accurate picture.

3.3 Data Collection Method

Primary data was collected through questionnaires with target respondents. The target respondents were the chief executive officers of the hospitals.

Secondary data was also used in the study. Official records of the Ministry of Health were examined as a source of secondary data. The researcher also examined official hospital publications and information accumulated over a period of 5 years in his capacity as chief executive of Metropolitan hospital. The secondary data was used to cross reference the primary data where applicable and in conjunction with the primary data to arrive at conclusions.

The research instrument used to collect data was a questionnaire. To help eliminate the possible non-response rate of the executives and further clarification of issues, the questionnaires were personally administered.

Pre-testing of the questionnaire was done in order to determine its appropriateness before it was administered to the entire population.

3.4 Data Analysis

The data collected was analysed by use of descriptive statistics such as proportions, frequency, and percentages.

As stated by Frankfort (1996), descriptive statistics enable the researcher to summarize and organise data in an effective and meaningful way. They provide tools for describing collections of statistical observations and reducing information to an understandable form.

CHAPTER FOUR

4.0 FINDINGS AND DISCUSSION

4.1 Response Rate

All the hospitals in Nairobi, 51 in total, were considered in the study. However, one of the hospitals was closed due to financial problems before the questionnaire could be submitted. Some of the hospitals failed to complete the questionnaire while in others, the respondents were out of the country. In all, a total of 39 hospitals responded. This gave a response rate of 76.5%

4.2 Industry Characteristics

Industry dynamics affect its attractiveness. This part deals with analysis of the characteristics of the respondents.

4.2.1 Age of hospitals

This question sought to establish the age profile of the hospitals. The hospitals were grouped into three categories namely the young (under 10 years), mature (between 10-20 years) and old (over 20 years). The responses are shown in the table below.

Table 1: Age of respondent hospitals

Age in years	Frequency	Percentage	Cumulative percentage
1 - 10 years	22	56.4	56.4
11 - 20 years	4	10.3	66.7
Over 20 years	13	33.3	100.0
Total		100.0	

56.4% of the hospitals were found to be less than 10 years old. Only 10% were set up in the 1980's while those over 20 years constitute 33% with the majority (25.6%) in this group pre-dating independence in 1963. The oldest hospital became operational in 1901. (Table 1 in Appendix 2).

Due to the wider disparity in age, the old hospitals group is likely to be display more heterogeneous behaviour.

These findings indicate that many of the hospitals are new entrants in the industry. One would therefore expect a lot of strategic activity in the industry. It can also be surmised that the industry has become relative more attractive for it to attract many new players. Further, there must be market niches, which the existing players were not providing for.

4.2.2 Size of the hospitals

The hospitals were asked to state their bed capacity. The number of beds was used to classify hospital size. This is a generally accepted criterion globally. Based on this criteria, the hospitals were classified into four classes namely very small hospitals as those under 25 beds, small hospitals as those with 25-50 beds, medium hospitals as those with 50-75 beds and large hospitals as those with over 75 beds. The results are shown in the table below.

Table 2: Size of the respondent hospitals

No. of beds	Frequency	Percentage	Cumulative percent
0 - 25 beds	13	33.3	33.3
26 - 50 beds	13	33.3	66.6
51 - 75 beds	3	7.7	74.3
Over 75 beds	10	25.6	100.0
Total	39	100.0	

The bed capacity was found to be widely distributed with a range of 5 to 262 beds (see table 2 appendix 2). The most popular class was found to be small and very small categories with 13 hospitals (33.3%) each. The least common were the medium sized with 3 hospitals (7.7%) of the respondents. The large sized hospitals comprised 25.6% of the total. This group is more heterogeneous due to the wider range of respondents in this class.

4.2.3 Ownership of the hospitals

This question sought to establish which types of organisations own hospitals. The responses were classified into common and similar forms of ownership. The results are tabulated below.

Table 3: Ownership of hospitals

Type of ownership	Frequency	Percent	Cumulative Percent
Charitable organisations	9	24.4	24.4
Private companies	22	59.4	83.8
Membership organisations	5	13.5	97.3
Government	1	2.7	100
Total	37	100	

Ownership falls under various categories. The most popular form of ownership is private companies at 59.4%. The least popular is government with one hospital (2.7%).

The low participation of co-operatives is surprising given the significant participation in many other social economic activities. From the above table proportion of hospitals owned by non-profit organisations is approximately 40%, a finding which is close to the 44% of hospitals which classified themselves as non-profits.

The findings indicate that most of the old hospitals are owned by social welfare organisations. In contrast, the young hospitals are commercial entities mainly owned by individuals and private companies. It can therefore by concluded that the new hospitals are mainly motivated by the prospect of providing service at a profit.

4.2.4 Controlling interest

Ownership affects strategy because organisations are likely to pursue the interests of the key stakeholders. One of the most powerful stakeholders is the shareholder with a controlling interest. Diverse ownership leads to diverse strategic objectives and market positioning. All

other factors being constant, it is expected that the industry will manifest diverse strategic directions as each hospital positions itself to fulfil its mission and objectives.

The question sought to establish distribution of ownership and thus whether the locus of control of the hospitals was local or foreign. The results appear in the table below.

Table 4: Distribution of Ownership

Ownership distribution	Frequency	Percent	Cumulative
100% local	33	84.6	86.4
Over 51% local	3	7.7	92.3
Over 51% foreign	2	5.1	97.4
100% foreign	1	2.6	100%
	39	100%	

The results show that the majority of hospitals are indigenous with 92.3% of the hospitals being either wholly locally owned or controlled. Only one hospital is wholly foreign owned and controlled.

The results indicate that hospitals are likely to implement strategies, which are home-grown and driven by prevailing local industry circumstances instead of strategy transplants from abroad. The local locus of control is thus likely to lead to homogenous rather than heterogeneous strategic activities.

4.2.5 Financial Objectives

Profit is a major driving force in competitive strategy. It is the fuel that drives the rivalry among firms in an industry. Traditionally, many hospitals were founded as social welfare organisations whose brief was to provide health care to members. Financially, they were only required to break even and any surpluses were incidental. Indeed, in return for services rendered, the members would underwrite capital costs and any operating budgetary shortfalls. Profit seeking hospitals are a new phenomenon globally.

This question therefore attempted to establish the financial objective and motivation of the respondents.

Table 5: Financial objectives

Financial objective	Frequency	Percentage
For profit	21	55.3
Non profit	17	44.7
Total	38	100

The 55.3% of the respondents are profit seeking. This is 6 % lower than the number, which are registered as ordinary commercial entities. It is possible that some hospitals did not wish to be seen to be profiting from illness and the suffering of others. Further questioning revealed that 92.3% of the hospitals are entirely dependent on patient fees. The remaining 7.7% only benefit from capital expenditure subsidies with no recurrent expenditure support. This shows that even the non-profit hospitals are wholly consumer dependent and in this respect, are no different from the profit seeking ones.

4.2.6 Premises ownership

This question was meant to establish the ownership of hospital premises. Hospitals generally comprise of expensive buildings, plant, equipment and infrastructure. This therefore constitutes a major entry barrier into the industry and should decrease rivalry in the industry. However, it is also a major exit barrier whose effect is to keep poorly performing hospitals in the industry due to the difficulty in selling plant and equipment. This should have the opposite effect of increasing rivalry.

Table 6: Premises ownership

Premises status	Frequency	Percent
Owned	24	61.5
Rented	15	38.5
Total	39	100.0

The results show that 61.5% of the hospitals are in own premises while the rest, 38.5% are tenants. Most of the large and older hospitals are in own premises while a large number of the younger and small hospitals are renting premises.

From the findings, it is clear that renting may be a strategy used to lower the capital requirement to set up a hospital and has thus lowered the entry barrier. The lowering of this major barrier may partly explain the high influx of new players within the last 10 years.

4.2.7 NHIF Registration

NHIF registration is a potent entry barrier because without it, hospitals are unable to access lucrative corporate and insurance business. The waiting period is usually 2 years. Secondly, the rebate constitutes a subsidy to the client's bed charges, the effect of which is to lower the medical bill. The level of subsidy varies from hospital to hospital. Registered hospitals can therefore charge more for bed and still have a lower net daily bed charge. This places the non-registered hospitals at a serious competitive disadvantage. Non-registered hospitals are therefore expected to come up with strategies to reduce the impact of this barrier.

Table 7: Registration with NHIF

Registered with NHIF	Frequency	Percentage
Yes	28	71.8
No	11	28.2
Total	39	100.0

The finding revealed that 71.8% of the respondents were registered with the National Hospital Insurance Fund. The daily rebate on bed charges was found to vary between 120 to 650 shillings.

Further questioning revealed that most of the non-registered hospitals, charge lower bed fees that compensate clients for the lack of NHIF subsidy. Others agree to give a discount equivalent to the rebate or target self-paying clients who do not qualify for the NHIF subsidy.

4.3 Analysis of Industry Forces

Most strategic efforts are reactive rather than pro-active. Organisations are forced to act as a result of changes in their competitive environment. The degree of strategic activity should therefore bear some correlation with the level of turbulence in the environment. Secondly, the interaction between the environment and specific organisations is dynamic. As a consequence, the same environmental forces will have different impacts on different organisations. The extent of strategic efforts will therefore be dependent on the level of environment turbulence, the impact on the organisation and the organisation's internal dynamics.

4.3.1 Level of Competition

The level of strategic activity depends on top management's perception of the degree or level of competition. This question sought to elicit top management's perception and assessment of the level of competition in the industry. The results are shown in the tables below.

Table 8: Analysis of Level of Competition

Competition	Frequency	Percent	Cumulative percent
Very high	11	28.2	28.9
High	15	38.2	68.4
Moderate	10	25.6	94.7
Low	1	2.6	97.3
Very low	1	2.6	100.0
Total	39		

From the findings, 68.41% rated competition as high to very high. Only 5.2% rated it as low or very low. 26.3% rated it as moderate. The industry is therefore quite competitive. Based on these findings, a high level of strategic activity is expected.

Table 9: Age Versus competition

Age		Level of competition					Total
		Very high	High	Moderate	Low	Very low	
Young	Count	8	9	4	-	-	21
	Percentage	38.1%	42.9%	19.0%	-	-	100%
Mature	Count	-	3	-	-	-	3
	Percentage		100.0	-	-	-	100%
Old	Count	3	3	6	1	1	14
	Percentage	21.4%	21.4%	43.0%	7.1%	7.1%	100%
Total	Count	11	15	10	1	1	38
	Percentage	29.0%	39.5%	26.3%	2.6%	2.6%	100%

17 out of 21 (81%) of the young hospitals rated competition as high to very high with the rest rating it as moderate and none rating it as low. All the mature hospitals rated competition as high and none as moderate or low. The old hospitals have a more widespread distribution. 42 % rated competition as high to very high, 43% as moderate and 14% as low to very low.

Table 10: Size versus Level of Competition

Size of hospital		Level of competition					Total
		Very high	High	Moderate	Low	Very low	
Very small	Count	5	4	3	1	-	13
	Percentage	38.5%	30.8%	23.0%	7.7%	-	100%
Small	Count	3	6	3	-	-	12
	Percentage	25%	50%	25%	-	-	100%
Medium	Count	-	3	-	-	-	3
	Percentage		100%	-	-	-	100%
Large	Count	3	2	4	-	1	10
	Percentage	30%	20%	40%		10%	100%
Totals	Count	11	15	10	1	1	38
	Percentage	28.9%	39.5%	26.3%	2.6	2.6	100%

The different classes rated competition as high to very high in the following proportions: 100% of the medium sized hospitals, 75% of the small hospitals, 69.5% of the very small hospitals and 50% of the large ones.

Table 11: Ownership versus Level of Competition

Ownership		Level of competition					Total
		Very high	High	Moderate	Low	Very low	
Local	Count	9	15	9	1	1	35
	Percentage	25.7%	42.8%	25.7%	2.9%	2.9%	100%
Foreign	Count	2	-	1	-	-	3
	Percentage	66.7%		33.3%			100%
Totals	Count	11	15	10	1	1	38
	Percentage	28.9%	39.5%	26.3%	2.6%	2.6%	100%

The analysis shows that there is no major difference in the level of competition experienced by local and foreign hospitals. 68.5% of the locally controlled and 66.7% of the foreign controlled hospitals experience a high to very high level of competition. 27.5% of locally controlled and 33.3% of foreign controlled hospitals experience a moderate level of competition. 5.8% of the locally controlled experience a low level of competition.

The wider distribution among the locally controlled hospitals is not significant and may be accounted for by the fact that there are more in number..

Table 12: Financial objective versus Level of Competition

Financial objective		Level of Competition					Total
		Very high	High	Moderate	Low	Very low	
For profit	Count	8	13	5			26
	Percentage	30.8%	50.0%	19.2%			100%
Not for Profit	Count	3	2	5	1	1	12
	Percentage	25.0%	16.7%	41.7%	8.3%	8.3%	100%
Total	Count	11	15	10	1	1	38
	Percentage	29.0%	39.5%	26.3%	2.6%	2.6%	100%

80.8% of the for profit hospitals rate competition as high to very high as opposed to 41.7% of the non profits. This difference in perception and assessment may be due to several reasons. There is lower pressure on non-profits to operate profitably. The non-profits are older and may therefore be more immune to competitive pressure due to factors such as client loyalty, better financial resources and stronger branding.

4.3.2 Analysis of the Impact of the Industry Forces

Industry forces have different impacts among industry players depending on their market position and internal organisation dynamics. The purpose of this section is to assess the perceived impact of the industry forces on the respondents.

Impact of Industry Forces

In order to establish the strength of the various forces, the respondents were asked to rank the industry forces on a scale of 1-5. The mean score and the standard deviation were then computed for all the respondents. The mean and standard deviation were then applied to rank the forces. Based on this ranking, the forces were arranged from the highest to the lowest. The results are tabulated below.

Table 13: Ranking of forces

	N	Minimum	Maximum	Mean	Std. Deviation
Impact of Competitors/existing hospitals	39	1.00	5.00	3.6154	1.3301
Impact of Upcoming/New hospitals	39	1.00	5.00	3.0769	1.3453
Impact of Substitute products/services	39	1.00	5.00	3.0513	1.3169
Impact of Customers	39	1.00	5.00	3.5641	1.1875
Impact of Suppliers	39	1.00	5.00	3.0769	1.3838
Impact of Government policies	39	1.00	5.00	2.9487	1.4681

On a scale of 1 to 5, the lowest ranked force scored 2.95. This shows that all scored above the median 2.5. Each of the forces therefore has an above average impact in the industry. The two most significant forces in the industry are competition from existing hospitals (rivalry) with a score of 3.62 and bargaining power of customers with a score of 3.56. The least significant is the threat of substitutes with a score of 3.05 and impact of government policies with a score of 2.95.

Impact of Competition from Existing Hospitals

Rivalry is one of the industry forces. It is the jostling for market share amongst existing players in an industry. It is usually high when there are large players of equal strength, a dwindling market, slow industry growth, high fixed costs and lack of differentiation among other variables. This question sought to establish the impact of rivalry on the respondents

Table 14: Impact of Competition from existing hospitals (Rivalry)

	Frequency	Percentage	Cumulative percent
Very high	10	27.0	27.0
High	15	40.6	67.6
Moderate	9	24.3	91.9
Low	1	2.7	94.6
Very low	2	5.4	100.0
Total	37	100.0	

67.6% rated the impact of competition from existing hospitals as high to very high. Only 8.1% rated it as low to very low. This finding implies a higher degree of rivalry in the industry. Possible explanations include the high number of recent entrants who have brought extra capacity and increased customer choice, the decline in effective demand due to economic recession plus corporate retrenchment and the resulting reduction in demand in this key market.

Table 15: Age versus impact of competition from existing hospitals

Age		Impact of competition					Total
		Very high	High	Moderate	Low	Very low	
Young	Count	8	7	5			20
	Percentage	40%	35%	25%			100%
Mature	Count	1	2	1			4
	Percentage	25%	50%	25%			100%
Old	Count	1	6	3	1	2	13
	Percentage	7.7%	46.1%	23.1%	7.7%	15.4%	100%
Total	Count	10	15	9	1	2	37
	Percentage	27.0%	40.5%	24.3%	2.7%	5.4%	100%

The impact of rivalry is most felt by mature and young hospitals (75%) followed by the old (53.8%) as shown by the proportions who rank it as high to very high.

Table 16: Size versus impact of competition from existing hospitals (rivalry)

Size of hospital		Impact of Competition					Total
		Very high	High	Moderate	Low	Very low	
Very small	Count	5	4	3	-	1	13
	Percentage	38.5%	30.8%	23.0%		7.7%	100%
Small	Count	3	3	5	-	-	11
	Percentage	27.3%	27.3%	45.4%			100%
Medium	Count			3			3
	Percentage			100%	-	-	100%
Large	Count	2	5	1	1	1	10
	Percentage	20.0%	50%	10%	10%	10%	
Totals	Count	10	15	9	1	2	37
	Percentage	27.0%	40.5%	24.3%	2.7%	5.1%	100%

The highest impact is experienced by the large hospitals with 70% rating of high to very high. This is followed by the very small hospitals with 69.3% rating. In third position is the small hospitals at 54.6%. The impact is least on the medium sized hospitals who rate the impact as moderate. A significant 20% of the large hospitals rate the impact as low or very low compared to none of the medium and small hospitals and 7.7% of the very small.

The lower impact on the medium sized hospitals may be due to the relatively fewer numbers competing for market share in this niche. Due to the high numbers, there is likely to be intense competition among the small and very small hospitals. The wide distribution among the large hospitals may be due to the relatively heterogeneous nature of this group. While some face intense competition, others may, due to the nature of their clientele, location, branding and financial strength be more immune to the impact of competition.

Table 17: Ownership Versus impact of competition from existing hospitals

Ownership		Impact of competition					Total
		Very high	High	Moderate	Low	Very low	
Local	Count	9	14	8	1	2	34
	Percent	26.5%	41.2%	23.5%	2.9%	5.9%	100%
Foreign	Count	1	1	1			3
	Percent	33.3%	33.3%	33.4%			100%
Total	Count	10	15	9	1	2	37
	Percent	27.0%	40.5%	24.3%	2.7%	5.4%	100%

91.2% and 100% of local and foreign hospitals respectively rate the impact as above moderate. The wider distribution among the local hospitals is possibly due to the higher number of hospitals in this group.

Table 18: Financial objectives versus impact of existing hospitals

Financial objective		Impact of competition					Total
		Very high	High	Moderate	Low	Very low	
For profit	Count	8	11	6	-	-	25
	Percentage	32.0%	44.0%	24.0%			100%
Non profit	Count	2	4	3	1	2	12
	Percentage	16.7%	33.3%	25%	8.3%	16.7%	100%
Total	Count	10	15	9	1	2	37
	Percentage	27.0%	40.6%	24.3%	2.7%	5.4%	100%

The for-profits indicate a higher impact with 76% rating it as high or very high and 24% rating it as moderate. In contrast, only 50% of the non-profits rank it as high or more with 25% ranking it as low or less. This finding may be as a result of the lower pressure on none profits to perform well financially. The non profits are also generally older and may thus be less susceptible to rivalry.

Competition from New Or Upcoming Hospitals

Over 50% of the hospitals are less than 10 years old. One would therefore expect them to have a significant impact on existing industry players.

Table 19: Impact of Competition from upcoming/New hospitals

Impact	Frequency	Percentage	Cumulative percent
Very low	4	10.5%	10.5%
Low	8	21.1%	31.6%
Moderate	11	28.9%	60.5%
High	8	21.1%	81.6%
Very high	7	18.4%	100%
Total	38	100%	

Only 39.5% rate the impact of competition from new hospitals as high to very high. A significant 31.6% rate it as low to very low while 28.9% rank it as moderate. The impact of new hospital is therefore generally low. This finding may be explained in several ways. The hospitals may be underestimating the impact of new entrants. They may also not be aware of the existence of new players. Thirdly, it is possible that the new entrants are small and therefore have not had much of an impact beyond their immediate neighbourhood.

Table 20: Age versus Impact of new/upcoming hospitals (New entrants)

Age		Impact of New/upcoming hospitals					Total
		Very high	High	Moderate	Low	Very low	
Young	Count	6	4	7	2	2	21
	Percentage	28.6%	19.0%	33.3%	9.5%	9.5%	100%
Mature	Count		1	1	1	1	4
	Percentage		25%	25.0%	25.0%	25.0%	100%
Old	Count	1	3	3	5	1	13
	Percentage	7.7%	23.1%	23.1%	38.5%	7.7%	100%
Totals	Count	7	8	11	8	4	38
	Percentage	18.4%	21.1%	28.9%	21.1%	10.5%	100%

The greatest impact is on the young hospitals of which 47.6% rate it as high to very high. This is followed by the old hospitals with 30.8%. These findings may be because new entrants are likely to enter at the lower end of the market where barriers are least.

Table 21: Size versus impact of new/upcoming hospitals

Size of hospital		Impact of the Upcoming Hospitals					Total
		Very high	High	Moderate	Low	Very low	
Very small	Count	3	1	6	1	2	13
	Percentage	23.0%	7.7%%	46.2%	7.7%	15.4%	100%
Small	Count	3	4	1	2	2	12
	Percentage	25%	33.3%	8.3%	16.7%	16.7%	100%
Medium	Count			1	2		3
	Percentage			33.3%	66.7%		100%
Large	Count	1	3	3	3	-	10
	Percentage	10%	30%	30%	30%		100%
Totals	Count	7	8	11	8	4	38
	Percentage	18.4%	21.1%	28.9%	21.1%	10.5%	100%

Based on the rate of high to very high the impact is greatest on the small (58.3%) followed by the large (40%) very small 30.7% and least on the medium sized ones (0%). Overall the majority 28.9, rate the impact as moderate.

Table 22:Ownership versus impact of New/Upcoming hospitals

Ownership		Impact of Upcoming hospitals					Total
		Very high	High	Moderate	Low	Very low	
Local	Count	7	6	11	8	3	35
	Percentage	20%	17.1%	31.4%	22.9%	8.6%	100%
Foreign	Count		2			1	3
	Percentage		66.7%			33.3%	100%
Total	Count	7	8	11	8	4	38
	Percentage	18.4%	21.1%	28.9%	21.1%	10.5%	100%

Whereas the impact among local hospitals is well distributed, the foreign ones are skewed towards high (66.7%).

Table 23: Financial objectives versus impact of new entrants

Financial objectives		Impact of Suppliers					Total
		Very high	High	Moderate	Low	Very low	
For profit	Count	5	3	11	5	2	26
	Percentage	19.2%	11.5%	42.3%	19.2%	7.7%	100%
Not for profit	Count	2	5	1	2	1	11
	Percentage	18.2%	45.5%	9.0%	18.2%	9.0%	100%
Total	Count	7	8	12	7	3	37
	Percentage	18.9%	21.6%	32.4%	18.9%	8.1%	100%

There is no significant difference in impact between the for profit and non profit hospitals.

Bargaining Power of Customers

Table 24: Impact of Customers

Impact	Frequency	Percentage	Cumulative percent
Very high	10	26.3	26.3
High	10	26.3	52.6
Moderate	14	36.8	89.4
Low	3	7.9	97.3%
Very low	1	2.6	100%
Total	38	100.0	

52.6% rated the impact of customers as high to very high, 36.8% rated it as moderate and only 10.5% rated it as low to very low.

Table 25: Age Versus impact of customers

The impact is almost inversely proportional to age. It is most felt by mature hospitals (61.5%) and least felt by the young hospitals (45.5%).

Age		Impact of customers					Total
		Very high	High	Moderate	Low	Very low	
Young	Count	6	4	8	3	-	21
	Percentage	28.6%	19.0%	38.1%	14.3%		100
Mature	Count	1	1	2			4
	Percentage	25%	25%	50%			100%
Old	Count	3	5	4		1	13
	Percentage	23.0%	38.5%	30.8%		7.7%	100%
Total		10	10	14	3	1	38
		26.3%	26.3%	36.8%	8.0%	2.6%	100%

Table 26: Size versus impact of customers

Size		Impact of Customers					Total
		Very high	High	Moderate	Low	Very low	
Very small	Count	5	1	3	3	1	13
	Percentage	38.5%	7.7%	23.1%	23.1%	7.7%	100%
Small	Count	2	3	7	-	-	12
	Percentage	16.7%	25%	58.3%			100%
Medium	Count	-	2	1	-	-	3
	Percentage		66.7%	33.3%			100%
Large	Count	3	4	3	-	-	10
	Percentage	30%	40%	30%			100%
Totals	Count	10	10	14	3	1	38
	Percentage	26.3%	26.3%	36.8%	8.0%	2.6%	100%

Impact is generally high in all classes but inversely proportional to size with 100% of the large and medium sized hospitals rating it as above moderate compared to 70% of the very small hospitals.

Table 27: Ownership versus impact of customers

Ownership		Impact of Customers					Total
		Very high	High	Moderate	Low	Very low	
Local	Count	10	8	13	3	1	35
	Percentage	28.6%	22.9	37.1%	8.5%	2.9%	100%
Foreign	Count		2	1	-	-	3
	Percentage		66.7%	33.3%			100%
Total	Count	10	10	14	3	1	38
	Percentage	26.3%	26.3%	36.8%	7.9%	2.7%	100%

Impact of customer bargaining power is greater on foreign controlled hospitals with 66.7% ranking it as high. However, a significant 28.6% of the locally controlled hospitals rank the impact as very high.

Table 28: Financial objective versus impact of customers

Financial objective		Impact of Customers					Total
		Very high	High	Moderate	Low	Very low	
For profit	Count	6	7	11	2	-	26
	Percentage	23.1%	26.9%	42.3%	7.7%		100%
Non profit	Count	4	3	3	1	1	12
	Percentage	33.4%	25%	25%	8.3%	8.3%	100%
Total	Count	10	10	14	3	1	39
	Percentage	25.6%	25.6%	35.9%	7.7%	2.6%	100%

Over 80% of both groups rate the impact as moderate to very high. The non-profits display higher impact.

Impact of Bargaining Power of Suppliers

Table 29: Impact of suppliers

Impact	Frequency	Percentage	Cumulative percent
Very high	7	18.9	18.9
High	8	21.6	40.5
Moderate	12	32.4	72.9
Low	7	18.9	91.8
Very Low	3	8.1	100.0
Total	37	100	

40.5% rated the impact of the suppliers as high to very high. 27% rated the impact as low to very low while 32.4% rated it as moderate. This assessment may be due to several factors:

- The supplier industry is fragmented and the hospitals therefore have choice.
- Many products have manufacturer recommended prices thus reducing suppliers' bargaining power.
- Many manufacturers retain the most marketing functions and are therefore able to monitor market responses and respond appropriately.
- Many of the supplies have substitutes

However,

- Some goods and services are only available from particular suppliers thus giving them bargaining power.
- Specialised equipment is in many instances manufactured as proprietary systems closed. Once purchased, hospitals cannot switch suppliers for consumables and maintenance, thus giving the suppliers leverage.

Table 30: Age Versus impact of suppliers

Age		Impact of Suppliers					Total
		Very high	High	Moderate	Low	Very low	
Young	Count	6	3	6	4	2	21
	Percentage	28.6%	14.3%	28.6%	19.0%	9.5%	100%
Mature	Count	1		3			4
	Percentage	25%		75%			100%
Old	Count	-	5	3	3	1	12
	Percentage	-	41.7%	25%	25%	8.3%	100%
Total	Count	7	8	12	7	3	37
	Percentage	18.9%	21.6%	32.4%	18.9%	8.2%	100%

Based on ranking of high to very high, most of the impact is felt by the young hospitals (42.9%) followed by the old hospitals (41.7%). Possible explanations are low bargaining power, which in young hospitals may be due to financial constraints and in old hospitals, may be due to the high level of closed specialised equipment. This ties the old hospitals to long term supply contracts with very high switching costs.

Table 31: Ownership Versus impact of suppliers

Ownership		Impact of Suppliers					Total
		Very high	High	Moderate	Low	Very low	
Local	Count	7	6	11	7	3	34
	Percentage	20.6%	17.6%	32.4%	20.7%	8.8%	100%
Foreign	Count		2	1	-	-	3
	Percentage		66.7%	33.3%			100%
Total	Count	7	8	12	7	3	37
	Percentage	18.9%	21.6%	32.4%	18.9%	8.2%	100%

The impact is well distributed among the local hospitals. 66.7% of foreign controlled hospitals rank it as high compared to only 38.2% of the local ones. The impact is most felt by foreign hospitals.

Table 32: Size versus impact of suppliers

Size of hospital		Impact of Suppliers					Total
		Very high	High	Moderate	Low	Very low	
Very small	Count	6	1	3	1	2	13
	Percentage	46.1%	7.7%	23.1%	7.7%	15.4%	100%
Small	Count	1	3	4	3	1	12
	Percentage	8.3%	25%	33.4%	25%	8.3%	
Medium	Count			2	1		3
	Percentage			66.7%	33.3%		100%
Large	Count		4	3	2		9
	Percentage		44.4%	33.3%	22.3%		
Totals	Count	7	8	12	7	3	37
	Percentage	18.9%	21.6%	32.4%	18.9%	8.2%	100%

A ranking of above moderate impacts for all classes is 60-70%. Size does not seem to offer any advantage probably because each class has to deal with the same group of suppliers with most supplies being offered at recommended prices. The second possibility is that each class will deal with suppliers of its own size thus maintaining the same level of bargaining power.

Table 33: Financial Objectives versus suppliers

Financial objective		Impact of Suppliers					Total
		Very high	High	Moderate	Low	Very low	
For profit	Count	5	3	11	5	2	26
	Percentage	19.2%	11.5%	42.3%	19.2%	7.7%	100%
Non profit	Count	2	5	1	2	1	11
	Percentage	18.2%	45.4%	9.1%	18.2%	9.1%	100%
Total	Count	7	8	12	7	3	37
	Percentage	18.4%	21.1%	31.6%	18.4%	7.7%	100%

Over 60% rank the impact as moderate to high in both groups. However, only 29.6% of the for-profits rank it as high or very high compared to 58.3% of the non-profits. Possible explanations

are greater awareness of supplier power, higher proportion of proprietary equipment and possible vested interests in the supply chain.

Competition from Substitutes

Table 34: Impact of Substitute products and services

	Frequency	Percentage	Cumulative percent
Very high	6	15.8	15.8
High	9	23.7	39.5
Moderate	11	28.9	68.4
Low	8	21.1	89.5
Very low	4	10.5	100
Total	38	100.0	

The impact is generally ranked as low. 39.5% rate the impact of substitute products and services as high to very high. 31.6% rate it as low to very low with 28.9% rating it as moderate.

The comparative lower assessment may be as a result of the

- Lower visibility of substitutes.
- Poor appreciation of the impact of substitutes. 39.5% of respondents indicated that they were not ware of any substitutes to their services.

Table 35: Age Versus impact of competition from substitutes

Age		Impact of Substitute product/services					Total
		Very high	High	Moderate	Low	Very low	
Young	Count	4	3	8	4	2	21
	Percentage	19.1%	14.3%	38.1%	19.1%	9.4%	100%
Mature	Count		1		1	2	4
	Percentage		25%		25%	50%	100%
Old	Count	2	5	3	3	-	13
	Percentage	15.3%	38.5%	23.1%	23.1		100%
Total	Count	6	9	11	8	4	38
	Percentage	15.8%	23.7%	28.9%	21.1%	10.5%	100%

Mature hospitals indicate the lowest impact with 75% rating it as low to very low while the whole of this group rates it as moderate or below. The old hospitals have the highest impact with 53.8% rating it as high or above. This may be due to greater awareness of substitutes, greater competition from private clinics and other medical facilities. For example, some of the alternative providers are tenants within the hospital premises.

Table 36: Size versus Impact of competition from substitutes

Size of hospital		Impact of Substitute products/services					Total
		Very high	High	Moderate	Low	Very low	
Very small	Count	4	2	4	2	1	13
	Percentage	30.8%	15.4%	30.8%	15.4%	7.6%	100%
Small	Count	1	2	4	3	2	12
	Percentage	8.3%	16.7%	33.3%	25%	16.7%	100%
Medium	Count	-	-	1	1	1	3
	Percentage			33.3%	33.3%	33.4%	100%
Large	Count	1	5	2	2	-	10
	Percentage	10%	50%	20%	20%		100%
Totals	Count	6	9	11	8	4	38
	Percentage	15.8%	23.7%	28.9%	21.1%	10.5%	100%

Medium sized hospitals indicate the lowest impact with 66.7% rating it as low to very low. The whole group rates it as moderate or below. The large hospitals have the highest impact with 60% rating it as high or above.

Table 37: Ownership versus impact of substitutes

Ownership		Impact of Substitute products/services					Total
		Very high	High	Moderate	Low	Very low	
Local	Count	6	8	9	8	4	35
	Percentage	17.1%	22.9%	25.7%	22.9%	11.4%	100%
Foreign	Count		1	2	-	-	3
	Percentage		33.3%	66.7%			100%
	Count	6	9	11	8	4	38
	Percentage	15.8%	23.7%	28.9%	21.1%	10.5%	100%

The 3 foreign hospitals rank the impact as moderate or above with 33.3% ranking it as high. In comparison, 65.7% of locals rank it as moderate or high with 34.3% ranking it as low. Possible explanations are lower level of substitute awareness among local hospitals and the greater heterogeneity of the local group of hospitals.

Table 38: Financial objectives versus impact of substitutes

Financial objective		Impact of Substitute					Total
		Very high	High	Moderate	Low	Very low	
For profit	Count	3	5	9	6	3	26
	Percentage	11.5%	19.2%	34.6%	23.2%	11.5%	100%
Non profit	Count	3	4	2	2	1	12
	Percentage	25.0%	33.3%	16.7%	16.7%	8.3%	100%
Total	Count	6	9	11	8	4	38
	Percentage	15.8%	23.7%	28.9%	21.1%	10.5%	100%

The impact is evenly distributed among the for-profits with approximately 30% in each category in contrast to the more skewed distribution among non-profits. The non-profits may have a wide distribution in terms of size and age thus leading to the wider disparity of responses.

Government Policy

Government policy affects all the industry forces and my augment or lessen competition. For example the enactment of the bill legalising parallel importation of essential medicines has led to a tremendous decrease in affected medicine prices.

Table 39: Impact of Government Policies

	Frequency	Percentage	Cumulative percent
Very high	8	21.6	21.6
High	6	16.2	37.8
Moderate	9	24.3	62.1
Low	10	27.0	89.1
Very low	4	10.8	100.0
Total	37	100.0	

The impact of government is well distributed amongst the respondents. 37.8% rated the impact as high to very high. Another 37.8% rated it as low to very low. 24.3% rated it as moderate.

Table 40: Age versus impact of government policy

		Impact of Government policies					Total
		Very high	High	Moderate	Low	Very low	
Young	Count	6	4	6	3	2	21
	Percentage	28.6%	19.1%	28.6%	14.3%	9.4%	100%
Mature	Count	1		1	2		4
	Percentage	25.0%		25.0%	50.0%		100%
Old	Count	1	2	2	5	2	12
	Percentage	8.3%	16.7%	16.7%	41.7%	16.7%	100%
Total	Count	8	6	9	10	4	37
	Percentage	21.6%	16.3%	24.3%	27.0%	10.8%	100%

Impact is proportional to age with 45.5% of the young hospitals rating it as high to very high in comparison to 25% and 23% respectively for the mature and old hospitals respectively. This may be explained by greater government policing of this group and more recent interaction with statutory bodies in the course of registration and acquisition of hospital licences.

Table 41: Size versus Impact of government policy

Size of hospital		Impact of Government policies					Total
		Very high	High	Moderate	Low	Very low	
Very small	Count	5	3	2	1	2	13
	Percentage	38.5%	23.1%	15.4%	7.6%	15.4%	100%
Small	Count	2	1	5	2	2	12
	Percentage	16.7%	8.3%	41.7%	16.7%	16.7%	100%
Medium	Count	1	1		1		3
	Percentage	33.3%	33.3%		33.4%		100%
Large	Count	-	1	2	6	-	9
	Percentage	-	11.1%	22.2%	66.7%		100%
Totals	Count	8	6	9	10	4	37
	Percentage	21.6%	16.3%	24.3%	27.0%	10.8%	100%

The large hospitals report very low impact with only 11.1% rating it as high or above and a total of 33.3% ranking it as above moderate. The above moderate range is 60-70% for the rest.

From the findings, it can be concluded that large size therefore protects hospitals from the impact of government policies. It is possible that these hospitals have the resources and connections to bargain with government or that government adopts a hands off policy towards them. They are also likely to be older and thus are unaware of the bureaucracy involved in setting up a hospital or dealing with government. Self-regulation and higher standards may also reduce the need for government intervention.

Table 42: Ownership versus government policy

Ownership		Impact of Government policies					Total
		Very high	High	Moderate	Low	Very low	
Local	Count	7	6	8	9	4	34
	Percentage	20.6%	17.6%	23.5%	26.5%	11.8%	100%
Foreign	Count	1	-	1	1		3
	Percentage	33.3%		33.3%	33.3%		100%
Total	Count	8	6	9	10	4	37
	Percentage	21.6%	16.3%	24.3%	27.0%	10.8%	100%

Both classes are well represented in all categories. Similar proportions in both groups rank the impact as high or above and also as low to very low. The findings indicate that no group is favoured by government policy.

Table 43: Financial objective versus impact of government policies

Financial objective		Impact of Government					Total
		Very high	High	Moderate	Low	Very low	
For profit	Count	6	5	8	4	3	26
	Percentage	23.2%	19.2%	30.8%	15.4%	11.5%	100%
Non profit	Count	2	1	1	6	1	11
	Percentage	18.2%	9.1%	9.1%	54.6%	9.1%	100%
Total		8	6	9	10	4	37
		21.6%	16.3%	24.3%	27.0%	10.8%	100%

There is a significant difference in impact. 66.7% of non profits rate it as low to very low while 73.2% of for profits rank it as moderate to very high. Possible explanations include the fact that government sees non profits as an extension of own services and gives them certain concessions

such as tax breaks and for some, staff on secondment. They may also be less supervised due to being better established, more service quality oriented with laid down self regulation guidelines.

4.4 Strategic Choices Adopted by Hospitals

To determine the strategic choices made by hospitals, the respondents were given choices clustered into the common aspects of each of the broad strategic options. The two models applied are Ansoff's product market expansion grid and Michael Porter's generic strategic choices. These choices are market penetration, market development, product development, diversification, cost leadership and focus.

The choices were scored and any score over 50% was taken as positive response. Hospitals with a score over 50% were considered to be pursuing the particular strategic alternative.

There are many factors that affect strategic choice among them ownership, financial goals, organisation size, age, culture, structure, management practices etc. For the purpose of the study, four key hospital characteristics were identified and compared to the strategic choices to establish their relationship to the strategic choices adopted.

4.4.1 Ranking of Strategic Choices

Table 44: Ranking of Strategic Choices

Strategic Choices	Frequency	Percentage
Cost Leadership	22	56.4
New product development	17	43.6
Market penetration	11	28.2
Market development	11	28.2
Focus	7	18.4
Diversification	3	7.7

The able shows the strategic alternatives adopted by the respondents. Cost leadership is the most popular with a score of 56.5% and diversification the least popular with a score of 7.7%.

4.4.2 Analysis of the Strategic Choices

Market penetration

Table 45: Analysis of Hospitals Practising Market Penetration

	Frequency	Percentage
No	28	71.8
Yes	11	28.2
Total		100.0

The majority of hospitals (71.8%) do not pursue a market penetration strategy. A significant minority of 28.2% do.

Table 46: Age versus Market Penetration

Age		Market Penetration		Total
		No	Yes	
Young	Count	17	5	22
	Percentage	77.3%	22.7%	100%
Mature	Count	3	1	4
	Percentage	75%	25%	100%
Old	Count	8	5	13
	Percentage	61.5%	38.5%	100%
Total	Count	28	11	39
	Percentage	71.8%	28.2%	100%

Market penetration is more popular among the old hospitals with 38.5% as opposed to 22-25% for the rest. These hospitals may have greater resources for strategy implementation. They may also be seeking to maintain and protect market share against the onslaught of new competitors. Market penetration may also assist them to achieve economies of scale and scope.

Table 47: Ownership versus Market Penetration

Ownership		Market Penetration		Total
		No	Yes	
Local	Count	28	8	36
	Percentage	77.8%	22.2%	100%
Foreign	Count		3	3
	Percentage		100%	100%
Total	Count	28	11	39
	Percentage	71.8%	28.2%	100%

All the foreign hospitals practice market penetration as opposed to only 22.2% of the locally owned ones, which are the majority. The 71.8% that do not practice market penetration comprise of the locally owned hospitals. This may be explained by the smaller sizes, relatively younger age, lack of managerial skills and financial resources in many local hospitals. Being small, the hospitals may also only be targeted at niche markets in their neighbourhoods.

Table 48: Size versus Market Penetration

Size		Market Penetration		Total
		No	Yes	
Very small	Count	10	2	12
	Percentage	83.3%	16.7%	100%
Small	Count	12	2	14
	Percentage	85.7%	14.3%	100%
Medium	Count	1	2	3
	Percentage	33.3%	66.7%	100%
Large	Count	5	4	9
	Percentage	55.6%	44.4%	100%
Totals	Count	28	10	38
	Percentage	73.7%	26.3%	100%

Of the 26.3% that practice market penetration, 10.5% comprise of the large hospitals. Two thirds of the medium sized hospitals practice market penetration compared to only a third of the total hospital population. This may be due to several factors. The medium sized hospitals may be most vulnerable to competitive pressure. They face competition from both the smaller hospitals,

which may have lower charges, and the larger ones with better brand recognition. They have higher capacity to utilize but may not have the brand recognition and larger markets of the large hospitals.

In general, there is a relationship between hospital size and market penetration as a strategy. The medium and large hospitals tend to use this strategy more as opposed to the small and very small hospitals, which do not.

Table 49: Financial Objectives versus Market Penetration

Financial objectives		Market Penetration		Total
		No	Yes	
For profit	Count	15	6	21
	Percentage	71.4%	28.6%	100%
Non profit	Count	12	5	17
	Percentage	70.6%	29.4%	
Total	Count	27	11	38
	Percentage	71.1%	28.9%	100%

There seems to be no relationship between financial objectives and a market penetration strategy. This may be explained by the fact that 92.3% of the hospitals are entirely dependent on the fees paid by their customers and will therefore be equally aggressive in protecting market share.

New product development

Table 50: Analysis of Hospitals practising Product Development

	Frequency	Percentage
No	22	56.4
Yes	17	43.6
Total	39	100%

New product/service development is the second most popular strategy. It is practised by 43.6% of the respondents. This strategy may be demand driven as customers increasingly looking for the convenience of one stop medical facilities.

Table 51: Age versus Product Development

Age		Product Development		Total
		No	Yes	
Young	Count	15	7	22
	Percentage	68.2%	31.8%	100%
Mature	Count	1	3	4
	Percentage	25%	75%	100%
Old	Count	6	7	13
	Percentage	46.2%	53.8%	100%
Total	Count	22	17	39
	Percentage	56.4%	43.6%	100%

The most active practitioners are mature hospitals with 75% of the hospitals practising product development. This is followed by the old hospitals of which 53.8% of the hospitals practice product development. In contrast, less than half of the young hospitals use this strategy.

These findings may be explained by several factors; The young hospitals may lack the resources for new product development with most of their efforts going towards nurturing existing services and surviving. The mature hospitals are at a stage where pursuing economies of scope and broadening their service proposition is important. On the other hand, the old hospitals may have developed many of the basic services and may therefore not be under intense pressure to increase their scope of services.

Table 52: Ownership versus Product Development

Ownership		Product Development		Total
		No	Yes	
Local	Count	20	16	36
	Percentage	55.6%	44.4%	100%
Foreign	Count	2	1	3
	Percentage	66.7%	33.7%	100%
Total	Count	22	17	39
	Percentage	56.4%	43.6%	100%

The local hospitals are more active practitioners of product development. A possible explanation is that the local hospitals have a higher proportion of the mature hospitals, 75% of which have been observed to be expanding their scope of services.

Table 53: Size versus New Product Development

Size		Product Development		Total
		No	Yes	
Very small	Count	9	3	12
	Percentage	75%	25%	100%
Small	Count	9	5	14
	Percentage	64.3%	35.7%	100%
Medium	Count		3	3
	Percentage		100%	100%
Large	Count	3	6	9
	Percentage	33.3%	66.7%	100%
Totals	Count	21	17	38
	Percentage	55.3%	44.7%	100%

In general, the analysis shows an inverse relationship between size and product development as a strategy. However, the leading practitioners are the medium sized hospitals (100%) followed by the large, small and very small hospitals respectively. These findings may be explained by: availability of resources, differential impact of competitive pressures, and the pursuit of economies of scope.

Table 54: Financial Objectives versus Product Development

Financial Objective		Product Development		Total
		No	Yes	
For profit	Count	13	8	21
	Percentage	61.9%	38.1	100%
Non profit	Count	8	9	17
	Percentage	47.1%	52.9%	100%
Total	Count	21	17	38
	Percentage	55.3%	44.7%	100%

52.9% of the non-profit seeking hospitals as opposed to 38.1% of the non-profits use a product development strategy. This may be explained by the fact that these hospitals are better represented in the medium and large hospitals. A higher proportion of these hospitals has been observed to be practising product development as a strategic choice.

New market development

Table 55: New market development practice

	Frequency	Percentage
No	28	71.8
Yes	11	28.2
Total	39	100.0

This is the third most popular strategic option. Practiced by 28.2% of the respondents.

Table 56: Age versus market development

Age		Market Development		Total
		No	Yes	
Young	Count	19	3	22
	Percentage	86.4%	13.6%	100%
Mature	Count	2	2	4
	Percentage	50%	50%	100%
Old	Count	7	6	13
	Percentage	53.8%	46.2%	100%
Total	Count	28	11	39
	Percentage	71.8%	28.2%	100%

Most popular among the mature hospitals with 53.8% followed by the old hospitals with a 50% application rate. It is least popular with young hospitals with a 15% utilisation rate.

The mature hospitals may have opted to seek growth through new markets instead of augmenting capacity. The old hospitals may already have high capacity at existing sites and may thus prefer other strategies such as market penetration, which is highest among them in order to utilise this capacity. The young hospitals may be constrained by lack of resources and may be focused on survival rather than growth.

Table 57: Ownership versus product development

Ownership		Market Development		Total
		No	Yes	
Local	Count	26	10	36
	Percentage	72.2%	27.8%	100%
Foreign	Count	2	1	3
	Percentage	66.7%	33.3%	100%
Total	Count	28	11	39
	Percentage	71.8%	28.2%	100%

Ownership does not seem to have any substantial impact of market development although it is marginally higher among the local hospitals. The practice levels for local and foreign hospitals are 38 % and 33% respectively.

Table 58: Size versus market development

Size of hospital		Market Development		Total
		No	Yes	
Very small	Count	11	2	13
	Percentage	84.6%	15.4%	100%
Small	Count	10	3	13
	Percentage	76.9%	23.1%	100%
Medium	Count	1	2	3
	Percentage	3.3%	66.7%	100%
Large	Count	6	4	10
	Percentage	60%	40%	100%
Totals	Count	28	11	
	Percentage	71.8%	28.2%	100%

Most popular with medium sized hospitals with 66.7% utilisation followed by large ones at 40%. It is least popular with the very small hospitals at 15.3%. The medium sized hospitals may see this as the best alternative for gaining market share without expanding capacity in one location. The large hospitals have to contend with existing large capacity at existing facility and therefore pursue this alternative less aggressively.

Table 59: Financial Objectives versus market development

Financial Objective		Market Development		Total
		No	Yes	
For profit	Count	19	8	27
	Percentage	70.4%	29.6%	100%
Non profit	Count	9	3	12
	Percentage	75%	25%	100%
Total	Count	28	11	39
	Percentage	71.8%	28.2%	100%

18.4 % more popular with for profits than non profits. This may be due to the greater pressure on for profits to achieve a good return on investment.

Diversification

Table 60: Hospitals that practice diversification

	Frequency	Percentage
No	36	92.3
Yes	3	7.7
Total	39	

Only 7.7% of the respondents practice diversification. This may be due to the high cost of setting up new facilities, the lack of managerial skills to manage diversification or limited diversification opportunities. It may also be due to stakeholder vision and aspirations.

Table 61: Age versus Diversification

Age		Practice diversification		Total
		No	Yes	
Young	Count	21	1	22
	Percentage	95.5%	4.5%	100%
Mature	Count	4	-	4
	Percentage	100%	-	100%
Old	Count	11	2	13
	Percentage	84.6%	15.4%	100%
Total	Count	36	3	39
	Percentage	92.3%	7.7%	100%

15.4% of old hospitals practice diversification compared to none of the mature hospitals and 4.5% of the young ones. The old hospitals may be looking at new ways to enhance their market position. They may also have better resource bases for diversification.

Table 62: Ownership Versus diversification

Ownership		Practice Diversification		Total
		No	Yes	
Local	Count	34	2	36
	Percentage	94.4%	5.6%	100%
Foreign	Count	2	1	3
	Percentage	66.7%	33.3%	100%
Total	Count	36	3	39
	Percentage	92.3%	7.7%	100%

Diversification is more popular with foreign hospitals with 33.3% utilisation compared to 5.6% utilisation among local hospitals. The foreign hospitals may have the advantage of better resources to implement a diversification strategy.

Table 63: Size versus diversification

Size of hospital		Practice Diversification		Total
		No	Yes	
Very small	Count	12	-	12
	Percentage	100%	-	100%
Small	Count	14	-	14
	Percentage	100%	-	100%
Medium	Count	2	1	3
	Percentage	66.7%	33.3%	100%
Large	Count	8	1	9
	Percentage	88.9%	11.1%	100%
Totals	Count	36	2	38
	Percentage	94.7%	5.3%	100%

Most popular with the medium sized hospitals (33%) of which practice diversification compared to 11% of the old ones. The small and very small hospitals do not practice diversification. This finding may be due to the small number of medium sized hospitals. It may also be due to the stiff competition these hospitals face from the smaller and larger hospitals.

Table 64: Financial Objective versus diversification

Financial Objectives		Practice Diversification		Total
		No	Yes	
For profit	Count	25	2	27
	Percentage	92.6%	7.4%	100%
Non profit	Count	11	1	12
	Percentage	91.7%	8.3%	100%
Total	Count	36	3	39
	Percentage	92.3%	7.7%	100%

9.5% of the for- profits practice diversification as opposed to 5.9% of the non-profits. This is expected given the pressure on the for profits to operate profitably.

Cost Leadership

A cost leadership strategy is the most defensible of all strategic choices and the basis and foundation for other strategic choices.

Table 65: Analysis of cost leadership strategy

	Frequency	Percentage
No	17	43.6
Yes	22	56.4
Total	39	100

This is the most popular strategy. Of the 39 respondents, 22 or 56.4 were found to be pursuing a cost leadership strategy. Cost leadership is a very effective and defensive strategy. The fact that it is the most popular may be due to high levels of inefficiency in industry, declining margins and high level of rivalry.

Table 66: Age versus Cost Leadership

Age		Cost Leadership		Total
		No	Yes	
Young	Count	11	11	22
	Percentage	50%	50%	100%
Mature	Count	1	3	4
	Percentage	25%	75%	100%
Old	Count	5	8	13
	Percentage	38.6%	61.5%	100%
Total	Count	17	22	39
	Percentage	43.6%	56.4%	100%

The mature hospitals were found to be the most active (75%) practitioners of this strategy followed by the old hospitals (61.5%). However, even among the young hospitals, which are the least active, 50% pursue a cost leadership strategy.

The mature hospitals may be more vulnerable to price competition because they lack the brand recognition and customer loyalty of the older ones. The young hospitals tend to be smaller with fewer opportunities for reducing costs and probably without the managerial and other resources required for the exercise. Large hospitals may be better protected from price competition by brand recognition and loyalty.

Table 67: Ownership versus Cost Leadership

Ownership		Cost Leadership		Total
		No	Yes	
Local	Count	17	19	36
	Percentage	47.2%	52.8%	100%
Foreign	Count	-	3	3
	Percentage	-	100%	100%
Total	Count	17	22	
	Percentage	43.6%	56.4%	100%

All foreign controlled respondents pursue cost leadership. This may be explained by their lower numbers and therefore greater homogeneity of strategic choice. It may also be due to better

access to financial, managerial and other resources required for strategy selection and implementation.

Table 68: Size versus Cost Leadership

Size of hospital		Cost Leadership		Total
		No	Yes	
Very small	Count	7	5	12
	Percentage	58.3%	41.7%	100%
Small	Count	8	6	14
	Percentage	57.1%	42.9%	100%
Medium	Count	-	3	3
	Percentage	-	100%	100%
Large	Count	2	7	9
	Percentage	22.2%	77.8%	100%
Totals	Count	17	21	38
	Percentage	44.7%	55.3%	100%

100% of the medium sized respondents pursue cost leadership followed by the large hospitals 77.8%. The small and very small hospitals have no significant difference. This may be as a result of lack of resources, less competitive pressure in niche markets, an existing low cost strategy and lack of a growth oriented vision.

Table 69: Financial Objectives versus Cost Leadership

Financial Objective		Cost Leadership		Total
		No	Yes	
For Profit	Count	12	15	27
	Percentage	44.4%	55.6%	100%
Non Profit	Count	5	7	12
	Percentage	41.7%	58.3%	100%
Totals	Count	17	22	39
	Percentage	43.6%	56.4%	100%

No material difference observed between for profits and non-profits.

Focus Strategy

Table 70: Analysis of the hospitals that practice Focus strategy

	Frequency	Percentage
No	8	20.5
Yes	31	79.5
Total	39	100.0

Only 20.5% of the respondents practice a focus strategy while the majority, 79.5% do not.

Table 71: Age versus Focus Strategy

Age		Practice Focus Strategy		Total
		No	Yes	
Young	Count	16	6	22
	Percentage	72.7%	27.3%	100%
Mature	Count	3	1	4
	Percentage	75%	25%	100%
Old	Count	12	1	13
	Percentage	92.3%	7.7%	100%
Total	Count	31	8	39
	Percentage	79.5%	20.5%	100%

The analysis shows that the old hospitals are the least active practitioners at 7.6% compared to 20.5% of all respondents. The young and mature hospitals show a proportion of 27% and 25% respectively.

The broad differentiation strategy practised by the older hospitals may be explained by the customer demands for a broad range of services, the cost and other implications of divesting from certain activities, economies of scope and the competitive advantages arising out differentiation.

The young hospitals may on the other hand be attempting to concentrate their limited resources on a few services, which they can then provide competitively.

Table 72: Ownership versus Focus Strategy

Ownership		Focus Strategy		Total
		No	Yes	
Local	Count	29	7	36
	Percentage	80.6%	19.4%	100%
Foreign	Count	2	1	3
	Percentage	66.7%	33.3%	100%
Total	Count	31	8	39
	Percentage	79.5%	20.5%	100%

The analysis shows that 33.3% of the foreign controlled respondents pursue a focus strategy as opposed to 19.4% of the local ones. Possible explanations include the low number of foreign owned respondents, importation of strategies applied in other markets and better managerial skills.

Table 73: Size versus Focus Strategy

Size of hospital		Focus Strategy		Total
		No	Yes	
Very small	Count	8	4	12
	Percentage	66.7%	33.3%	100%
Small	Count	11	3	14
	Percentage	78.6%	21.4%	100%
Medium	Count	3	-	3
	Percentage	100%	-	100%
Large	Count	8	1	9
	Percentage	88.9%	11.1%	100%
Totals	Count	30	8	38
	Percentage	78.9%	21.1%	100%

Focus is most popular among the small hospitals with 21.4% utilisation. It is least popular among the medium sized hospitals with zero utilisation. The large and very small hospitals have almost the same level of utility at approximately 10%.

These findings may be the result of several possibilities. The very small hospitals may be providing a very limited range of services and thus have no need to take measures geared

towards focus. The small hospitals may find it necessary to focus in order to compete more effectively. The medium sized hospitals have been found to be aggressively pursuing product and market development strategies, which preclude focus. Secondly, to compete effectively with large hospitals a wider repertoire of services is essential. The large hospitals may be enjoying economies of scope or may find it too expensive to outsource services. Customer demands for a broad range of services also makes focus an unattractive strategy.

Table 74: Financial objectives versus focus

Financial Objective		Focus Strategy		Total
		No	Yes	
For profit	Count	19	2	21
	Percentage	90.5%	9.5%	100%
Non Profit	Count	12	5	17
	Percentage	70.6%	29.4%	100%
Total	Count	31	7	38
	Percentage	81.6%	18.4%	100%

This strategy is more popular with the non profits with utilisation of 29.4% compared with 9.5% for the for profits. The non profits may be serving specific market segments and may thus find focus attractive. The drive for growth may also not be as high as the non profits.

CHAPTER FIVE

5.0 CONCLUSIONS AND RECOMMENDATIONS

5.1 Conclusions

This study had a number of objectives. One was to identify the strategic options adopted or practised by private hospitals in Nairobi. The second was to identify the dominant industry forces, which influence the strategies formulated and selected by the hospitals. In order to conduct a comprehensive analysis, the study examined various key industry characteristics, which are known to affect strategic choice. The characteristics examined include age, locus of control, financial objectives, form of ownership, and corporate structure,

5.1.1 Industry Characteristics

The study established that the hospital industry is heterogeneous with several characteristics distinguishing the industry players.

Age

The majority of the hospitals (22 or 56.7%) of hospitals were found to be less than 10 years old. New entrants usually bring with them additional capacity, desire for market share and new resources. This in turn increases rivalry as competitors take both offensive and defensive moves to protect and build market share. The high degree of entry would indicate improved industry attractiveness and unmet demand. This additional demand for private health care providers is likely to have been triggered by the government's ability to meet the demand of a growing population. Another possibility is that with declining purchasing power, the existing hospitals were beyond the financial ability of many customers thereby creating a niche for new lower cost providers. This is further buttressed by the fact that many of the new entrants are small, profit seeking enterprises.

Very few hospitals (4 or 10.3%) entered the market the 1980's. This may be attributed to the fact that at this time government was still able to provide a reasonable level of service. The old hospitals comprise 33.3% of the population. Detailed analysis shows that many were founded as community and mission hospitals primarily aimed at providing health care to particular groups

Size

The majority of the respondents (66.7%) were found to be small businesses. This may be explained by the fact that the majority of the hospitals are young, the high cost of capital, lack of venture capital finance and ownership structure that precludes the possibility of broader equity participation.

Ownership

Individuals and private companies own most of the hospitals (22 or 59.4%) in equal proportions. These hospitals may lack the resources to expand particularly in a market where the cost of capital is very high. The industry may therefore remain fragmented into the foreseeable future.

The overwhelming majority 97.4% of the hospitals are locally owned or controlled.

Financial objectives

The majority of hospitals were found to be profit seeking. This is unlike the American Market where 82% of hospitals are not for profit. It is also unlike the developed countries where hospitals operate mainly as taxpayer funded governmental or quasi government organisations. However, globally, there is a new trend towards privatisation of hitherto public owned and operated services such as health care, mass transport and even penal institutions.

This significant difference may be accounted for in several ways; Governments and not for profit hospitals cannot cope with demand, giving rise to entrepreneurs willing to take the investment

risk in return for the chance of earning a profit. Kenya may also lack the kind of charitable infrastructure required to finance new hospitals thus leaving demand to be met by private individual and companies.

5.1.2 Competitive Environment and Dominant Industry forces

The research established that a high degree of competition exists in the industry. Over 68% of the respondents classified it as high or very high. Another 25.6% of the respondents classified the level of competition as moderate. Overall, 94.7% perceive the level of competition as average or above.

The impact of the industry competitive forces is high. The major competitive forces are rivalry and the bargaining power customers. On a scale of 1-5, these two forces had a score of 3.61 and 3.56 respectively. These findings are supported by the several factors; Over 55% of the players have entered the industry within the last 10 years bringing with them extra capacity and a desire to take market share from existing players. The prolonged economic recession has reduced the bargaining power vis-à-vis customers who not only have more providers to choose from but also have the incentive and motivation to seek the best value proposition.

The least significant forces are substitutes and government policy. This is unexpected. According to the NHSSP, 70% of Kenyans first seek medical assistance from pharmacies and other providers. Secondly, it is also known that 70% of the disease burden can be eliminated through preventive public health interventions. An active and effective public health program would therefore lead to a drastic drop in demand for hospital based care. The respondents therefore seem to underestimate the role and danger of substitutes and a properly functioning government health care policy. This may be explained by the fact that over 38% of repondents are not even aware of the existence of substitutes. This would seem to indicate lack of strategic management skills and capacity among the top management of many of the hospitals.

Government is both a buyer and a regulator in many industries. The poor rating of government is unlike developed markets where government plays a key role in health care using purchasing and

regulating levers. This may be due to the fact that the government does not purchase much health care from private providers. Government has also been a weak regulator.

5.1.3 Strategic Options Identified

The following strategic options were identified:

1. Cost leadership
2. New product development
3. Market penetration
4. Market development
5. Focus
6. Diversification

The study established that hospitals apply different strategic alternatives to protect and build market share. It was also established that the popularity of the different strategic options differs. Cost leadership was found to be the most popular strategic choice. It is practised by 56.4% of the respondents. There are several possible reasons for this finding. Cost leadership is the most defensible option. It allows those who practice it a base to select and practice various strategic options. It particularly allows hospitals to compete on price. The prolonged economic recession may have placed a ceiling on prices that hospitals can charge for their services, thus necessitating focus on costs. According to Michael Porter, rivalry tends to compete away profits until the economic rate of return or entry barring price is reached. The high level of competition, high number of entrants, and the significant bargaining power of customers makes cost leadership a very prudent strategic choice.

New product development is the second most popular strategic alternative practised by 43.6% of the respondents. New products and services enable the hospitals to offer a broader, more comprehensive and more convenient scope of services. It protects the hospitals from substitutes who will usually only provide one type of service. It may bestow economies of scope due to use of common skills and processes. The service industry is notorious for copying, as patent or copyright does not protect most services. Research and development, which constitutes a major barrier to a product development strategy, is therefore not a major impediment in the service

industry. Hospitals may therefore find it necessary to constantly develop new products and services in order to stay ahead of the competition. The popularity of this strategy may be driven by the fact that the many young hospitals find it necessary to broaden their service offers due to customer demands.

New market development is the third most popular strategic choice practised by 28.2% of the respondents. In the service industry, access and convenience are important. New market development, is therefore, a prudent strategic choice. It may provide the hospitals with wider geographical coverage. Hospitals are quite dependent on referrals. Larger market coverage may therefore bestow economies of scope and scale due to use of referral facilities and enable the hospitals to compete more effectively with other providers. A well-distributed provider network is also a potent tool for procuring corporate business particularly from large organisations with a large branch network. New market development may also be motivated by the desire to counter the impact of the many recent entrants through establishment of branches near their facilities. Another possibility is a response to the competition posed by the branch networks set up by some of the leading health maintenance organisations.

Market penetration is also in third place with 28.2% of the respondents practising it. Market penetration is common where goods or services are perishable, or where there is surplus capacity in an industry. With a declining corporate clientele due to retrenchment, declining purchasing power by self-paying clients, this strategic choice is not only expected but also necessary.
Focus holds fourth position with 18.4% of the respondents practising it. Several factors may contribute to this. The market may not be sufficiently developed to support specialised units. A focus strategy also runs counter to the need for customer convenience. Focus also exposes the practitioner to competition from substitutes such as private doctors, pharmacies, clinics and other health care facilities. The focused facility may also suffer from diseconomies of scope. Hospitals are known for providing various health care services under one roof. They also have economies of scope. A focus strategy would therefore not be very prudent and may only appeal to hospitals without the resources to compete on a broad differentiation basis.

Diversification is the least popular strategic option with only 7.7% of respondents practising it. Diversification requires new skills, competencies and substantial resources. Most of the hospitals are not only young but are also small businesses. They do not have the resources and skills required to diversify. The lack of venture capital financing mechanisms in Kenya may also prevent entrepreneurial hospitals from diversifying. Opportunities for related or unrelated diversification may not be readily available. This lack of resources may explain the poor ranking of this strategic alternative. Indeed, with the advent of health maintenance organisations, It is the HMOs' which usually acquire hospitals in their bid to reduce costs. This trend may become common in the country.

5.2 Recommendations for Further Research

The study only covered private hospitals in Nairobi. It is highly recommended that similar studies be done in other parts of the country.

The study was limited to hospitals. A study including other significant health care providers such as doctors, pharmacies would enrich the results.

The study does not establish causal relationship between industry forces and impact on hospitals and strategic choice. Further research in this direction would deepen understanding of strategic management in hospitals.

Research should also be conducted in other industries particularly in those like social services such as education in which the government was until recently the major or only service provider. This would deepen understanding of the dynamics underlying these industries and the basis for strategic choice.

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APPENDIX I

LIST OF RESPONDENT HOSPITALS

1. The Aga Khan Hospital, Nairobi
2. Avenue Hospital
3. City Nursing Home
4. Comprehensive Medical Services
5. Eastleigh Community Clinic &
6. Maternity Nursing Home
7. Genesis Nursing & Maternity Home
8. Guru Nanak Ramgarhia Sikh Hospital
9. Huruma Nursing Home
10. Inder Nursing Home
11. Kasarani Maternity & Nursing Home
12. Kilimanjaro Nursing Home
13. Lions Sightfirst Eye Hospital
14. Madina Nursing Home
15. Masaba Hospital
16. Menelik Medical Center
17. Mother & Child Hospital
18. The Nairobi Hospital
19. Ngara Nursing Home
20. Nyina wa Mumbi Maternity Home
21. Prime Care Hospital
22. St James Hospital
23. South 'B' Nursing Home
24. Westlands Cottage Hospital
25. Kiambu Cottage Hospital
26. Kikuyu Nursing Home
27. Nazareth Hospital
28. Kenyatta National Hospital
29. Apha Maternity Home
30. Chiromo Lane Medical Center
31. City Park Hospital
32. Coptic Church Nursing Home
33. Equator Nursing Home
34. Getrude's Garden Children's Hospital
35. Hurlingham Hospital
36. Ideal Nursing Home
37. Jamaa Home & Maternity Hospital
38. Kayole Hospital
39. Komarock Nursing Home
40. M P Shah Hospital
41. Maria Maternity & Nursing
42. The Mater Hospital
43. Metropolitan Hospital, Nairobi
44. The Nairobi Hospice
45. Nairobi West Hospital
46. Ngong Hills Hospital & Nursing
47. Park Road Nursing Home
48. Radiant Health Nursing Home
49. St James Medical Center Ltd
50. Umoja Nursing Home
51. Kijabe Medical Center
52. Limiru Nursing Home
53. PCEA Kikuyu Hospita
54. Vicky Medical Clinic & Maternity

UNIVERSITY OF NAIROBI
FACULTY OF COMMERCE
MBA PROGRAMME - LOWER KABETE CAMPUS

Telephone: 732160 Ext 208
Telegrams: "Varsity", Nairobi
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P.O. Box 30197
Nairobi, Kenya

DATE: 28/08/00

TO WHOM IT MAY CONCERN

The bearer of this letter: Gakomba K.I.

Registration No: D61/P/7837/98

is a Master of Business & Administration student of the University of Nairobi.

He/she is required to submit as part of his/her coursework assessment a research project report on some management problem. We would like the students to do their projects on real problems affecting firms in Kenya. We would, therefore, appreciate if you assist him/her by allowing him/her to collect data in your organization for the research.

Thank you

M. B. A. OFFICE
P. O. Box 30197.
NAIROBI.
FACULTY OF COMMERCE

DR. MARTIN OGUTU
LECTURER & CO-ORDINATOR, MBA PROGRAMME

MO/ek

QUESTIONNAIRE

HOSPITAL NAME.....(optional)

1. Which year was the hospital opened.....
2. What is the bed capacity of the hospital.....
3. How many permanent employees does the hospital have.....
4. Are you registered with the National Hospital Insurance Fund(NHIF)

   Yes [ ] No [ ]
5. Who owns the hospital? Tick as appropriate.

   Religious organization [ ]
   Private company [ ]
   Association of members [ ]
   Public company [ ]
   Trust [ ]
   Non government organization [ ]
   Individual [ ]
   Co-operative society [ ]
   Other (Please specify).....
6. How would you classify the ownership of your hospital? Tick as appropriate

   100% locally owned [ ]
   Over 51% locally owned [ ]
   100% foreign owned [ ]
   Over 51% foreign owned [ ]
7. Are the hospital premises. Tick as appropriate

   Owned [ ]
   Rented [ ]
   Other (specify).....
   .....
8. Is the hospital part of any industry grouping or association.

   Yes [ ] No [ ]
9. How would you classify your hospital's financial objective?

   For profit [ ]
   Non profit [ ]
10. Does your hospital depend entirely on fees charged for services?

    Yes [ ] No [ ]

    If no, what percentage of your recurrent budget is funded through donation?.....

11. How many outpatients did you attend to in 1999.....

12. How would you rate the competition your hospital faces? Tick in the appropriate box.

Very High [ ] Moderate [ ] Low [ ]

High [ ] very Low [ ]

13. How would you rate the impact of the following forces on your hospital?

	Very Low	Low	Moderate	High	Very High
Competitors(existing hospitals)	1	2	3	4	5
Upcoming (New) hospitals	1	2	3	4	5
Substitute products/services	1	2	3	4	5
Customers	1	2	3	4	5
Suppliers	1	2	3	4	5
Government policies	1	2	3	4	5

14. What is the extent of satisfaction with the hospital regulatory framework in terms of the following? Circle the appropriate number against each statement.

	Very high	High	Moderate	Low	Very Low
Registration procedure for hospitals	1	2	3	4	5
Regulation of pharmacists	1	2	3	4	5
Regulation of doctors	1	2	3	4	5
Regulation of nurses	1	2	3	4	5
Restriction on importation of medicines	1	2	3	4	5
NHIF registration procedure	1	2	3	4	5
NHIF rebate level	1	2	3	4	5
Enforcement of quality standards	1	2	3	4	5

15. Indicate the extent of your satisfaction with each of the following by circling the appropriate number against each statement.

	Very high	High	Moderate	Low	Very Low
Staff costs	1	2	3	4	5
Fees charged by consultants	1	2	3	4	5
Availability of consultants	1	2	3	4	5
Prices of pharmaceutical supplies	1	2	3	4	5
Prices of medical & surgical supplies	1	2	3	4	5
Prices of medical equipment	1	2	3	4	5
After sales support	1	2	3	4	5
Cost of borrowing	1	2	3	4	5

16. How would you rate your ability to influence the following? Circle as appropriate number against each of the statements.

	Very Low	Low	Moderate	High	Very High
Staff costs	1	2	3	4	5
Fees charged by consultants	1	2	3	4	5
Availability of consultants	1	2	3	4	5
Quality of clinical/Medical practice	1	2	3	4	5
Prices of pharmaceutical supplies	1	2	3	4	5
Prices of medical & Surgical Supplies	1	2	3	4	5
After sales support	1	2	3	4	5
Cost of borrowing	1	2	3	4	5

17. How would you rate each of the following factors as they relate to the environment in which hospital operate? Please circle the appropriate number against each of the statements.

	Very low	Low	Moderate	High	Very High
Barriers to setting up a new hospital	1	2	3	4	5
Barriers to purchasing an existing hospital	1	2	3	4	5
Competition among existing hospital	1	2	3	4	5
Profitability	1	2	3	4	5
Growth potential	1	2	3	4	5
Barriers to selling hospital	1	2	3	4	5

18. How would you rate the extent to which you have difficulties in dealing with customers in terms of the following?

	Very High	High	Moderate	Low	Very Low
Quality of medical care	1	2	3	4	5
Quality of nursing care	1	2	3	4	5
Catering	1	2	3	4	5
Quality of accommodation	1	2	3	4	5
Range of services offered	1	2	3	4	5
Price of services	1	2	3	4	5
Collecting payment	1	2	3	4	5
Credit control	1	2	3	4	5
Litigation risk	1	2	3	4	5

19. How would you rate the extent of change of the following within the last 5 years? Circle as appropriate against each statement.

	Highly Decreased	Decreased	Not changed	Increased	Highly Increased
No. of admissions	1	2	3	4	5
No. of outpatients	1	2	3	4	5
No. of operations	1	2	3	4	5
Bed of occupancy	1	2	3	4	5
Revenue	1	2	3	4	5
Staff costs	1	2	3	4	5
Cost of medical supplies	1	2	3	4	5
Cost of borrowing	1	2	3	4	5
Outstanding debts	1	2	3	4	5
Bad debts	1	2	3	4	5

20. Are you aware of any substitute/alternatives to your services?

Yes [ ] No [ ]

21 On a scale of 1-5, how would you rate the impact of the following service providers on your hospital?

Circle the appropriate number against each statement .

	Very low	Low	Moderate	High	Very High
Home nursing care	1	2	3	4	5
Private doctors clinics	1	2	3	4	5
Private diagnostic centers	1	2	3	4	5
Nursing practitioners	1	2	3	4	5
Clinical officers practitioners	1	2	3	4	5
Herbalists & alternative therapies	1	2	3	4	5
Retail pharmacies/Chemists	1	2	3	4	5
Day care surgery centers	1	2	3	4	5
Public hospitals & Health centers	1	2	3	4	5
Primary public health activities	1	2	3	4	5

22. How would you rate the impact of government policies, legislation and regulation on your hospital's operations? Tick in the appropriate box

Very High [ ] Moderate [ ] Low [ ]

High [ ] Very Low [ ]

23. On a scale of 1-5, please rate the impact of the following on your hospital's operations

	Very Low	Low	Moderate	High	Very High
Water Supply	1	2	3	4	5
Telecommunications	1	2	3	4	5

Electricity supply	1	2	3	4	5
Road network	1	2	3	4	5
Security	1	2	3	4	5

24. How do you handle the government on issues that affect your hospital?

Lobby through the appropriate channels [ ]

Approach the government individually [ ]

Do nothing [ ]

Others(please specify).....

.....

25. Has the ownership changed since the hospital was opened? Tick in the appropriate box

Yes [ ] No [ ]

If yes, how many changes in ownership have occurred in the last 5 years.....

26. Is the hospital part of a hospital or health provider network? Tick in the appropriate box

Yes [ ] No [ ]

If yes, please specify the nature of the network.....

.....

27. Has your hospital opened branches inside or outside Kenya?

Yes [ ] No [ ]

28. In the last five (5) years, has the hospital done any of the following?

	Yes	No
Reduce the number of beds	[ ]	[ ]
Closed poorly performing units	[ ]	[ ]
Stopped offering some services	[ ]	[ ]
Reduced the average length of stay	[ ]	[ ]
Implemented measures to reduce doctor's fees	[ ]	[ ]
Implemented measures to reduce medicine costs	[ ]	[ ]
Reduced the number of employees	[ ]	[ ]
Introduced performance linked pay	[ ]	[ ]
Installed computerized hospital management systems	[ ]	[ ]
Implement measures to reduce the costs of surgical supplies	[ ]	[ ]
Reduced interests on overdraft or loans	[ ]	[ ]
Implemented measures to improve credit control	[ ]	[ ]
Reduced capital expenditure	[ ]	[ ]
Contracted out non-core services or activities	[ ]	[ ]

29. In the last five (5) years has the hospital experienced senior management changes in the following areas/posts.

	Yes	No
Chief Executive	[ ]	[ ]
Administrator	[ ]	[ ]
Finance/Accounts	[ ]	[ ]
Matron/Chief Nurse	[ ]	[ ]
Marketing/Customer Service	[ ]	[ ]
Information system	[ ]	[ ]

Others (please specify).....

30. Has the hospital done any of the following within the last five (5) years?

	Yes	No
Reduced bed fee	[ ]	[ ]
Reduced outpatient consulting fee	[ ]	[ ]
Reduced the fees charged for any other services	[ ]	[ ]
Advertised in the media	[ ]	[ ]
Employed marketing or customer services personnel	[ ]	[ ]
Set up a marketing or business development department	[ ]	[ ]
Actively promoted existing services	[ ]	[ ]
Expanded existing consultant offices	[ ]	[ ]

31. Within the last 5 years, has the hospital done any of the following

	Yes	No
Started a private wing/rooms	[ ]	[ ]
Started x-ray services	[ ]	[ ]
Introduced funeral services	[ ]	[ ]
Started day care surgery	[ ]	[ ]
Set up intensive care	[ ]	[ ]
Launched an ambulance services	[ ]	[ ]
Upgraded existing accommodation facilities	[ ]	[ ]
Upgraded key equipment	[ ]	[ ]
Introduced any other major service	[ ]	[ ]

32. Has the hospital closed any department or contracted third parties to provide any of the following services?

	Yes	No
Laundry service	[ ]	[ ]

Catering	[ ]	[ ]
X-ray	[ ]	[ ]
Ultrasound	[ ]	[ ]
Laboratory	[ ]	[ ]
Pharmacy	[ ]	[ ]
Mortuary	[ ]	[ ]

Others (please specify).....

.....

33. In the last 5 years, has the hospital taken over any services that were previously contracted to third parties such as

	Yes	No
Laundry service	[ ]	[ ]
Catering	[ ]	[ ]
X-ray	[ ]	[ ]
Ultrasound	[ ]	[ ]
Laboratory	[ ]	[ ]
Mortuary	[ ]	[ ]

Others (please specify).....

.....

34. Within the last 5 years, has the hospital stated, acquired or got involved in any of the following activities?

	Yes	No
Purchase any hospital	[ ]	[ ]
Set up new hospital	[ ]	[ ]
New service delivery points outside the hospital	[ ]	[ ]
Built doctors offices	[ ]	[ ]
Health insurance business	[ ]	[ ]
Health maintenance organization	[ ]	[ ]
Pharmaceutical or medical supplies distribution	[ ]	[ ]
Home nursing	[ ]	[ ]
Joined or set up joint purchasing group	[ ]	[ ]
Merger with local or foreign company	[ ]	[ ]
Joined or set up a hospital association	[ ]	[ ]
Joined any business alliance or joint venture	[ ]	[ ]
Any other related health care business	[ ]	[ ]
Any other business outside health cares	[ ]	[ ]

THANK YOU VERY MUCH FOR YOUR COOPERATION.

APPENDIX II

Table 1: What is the bed capacity of the hospital

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	5.00	1	2.6	2.6	2.6
	10.00	3	7.7	7.9	10.5
	12.00	1	2.6	2.6	13.2
	14.00	1	2.6	2.6	15.8
	15.00	2	5.1	5.3	21.1
	20.00	2	5.1	5.3	26.3
	22.00	1	2.6	2.6	28.9
	24.00	1	2.6	2.6	31.6
	27.00	1	2.6	2.6	34.2
	28.00	2	5.1	5.3	39.5
	30.00	1	2.6	2.6	42.1
	32.00	2	5.1	5.3	47.4
	34.00	1	2.6	2.6	50.0
	35.00	3	7.7	7.9	57.9
	40.00	2	5.1	5.3	63.2
	45.00	1	2.6	2.6	65.8
	46.00	1	2.6	2.6	68.4
	60.00	1	2.6	2.6	71.1
	68.00	1	2.6	2.6	73.7
	70.00	1	2.6	2.6	76.3
	85.00	1	2.6	2.6	78.9
	94.00	1	2.6	2.6	81.6
	140.00	1	2.6	2.6	84.2
	150.00	1	2.6	2.6	86.8
	187.00	1	2.6	2.6	89.5
	200.00	1	2.6	2.6	92.1
	240.00	1	2.6	2.6	94.7
	250.00	1	2.6	2.6	97.4
	262.00	1	2.6	2.6	100.0
	Total	38	97.4	100.0	
Missing	System Missing	1			
	Total	1			
Total		39			

Table 2: Year of establishment

NAMES	YEAR
1. Komorock	2000
2. Melc	2000
3. Kilimanjaro	1999
4. Emmaus	1999
5. SinaI	1998
6. Kiambu cottage	1998
7. Right med	1998
8. Chiromo	1997
9. Prime care	1997
10. Comprehensive	1996
11. Eastliegh rep	1996
12. Umoja nursing	1996
13. Kayole	1996
14. St James	1995
15. Mother &	1995
16. Metro	1995
17. Mid hill	1995
18. Madina	1994
19. Eastliegh	1994
20. Equator	1994
21. Unity	1994
22. St. Anne	1991
23. Nairobi West	1987
24. Guru na nak	1986
25. Masaba	1980
26. Westland	1976
27. Avenue	1976
28. Huruma	1976
29. Jamaa	1971
30. Nyina wa	1963
31. Mater	1962
32. Parkroad	1962
33. Nazareth	1960
34. AKH	1958
35. Gatrudes	1957
36. Nairobi hos	1950
37. MP shah	1933
38. Kikuyu	1908
39. KNH	1901