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The Optimal Strategic Positioning of Private Hospitals Incorporating Patient's Perspective

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Abstract: Strategic positioning is about how a company positions itself to create value different from competition. The core value is what then the customer consumes. In the health industry it is healthcare. Health care quality comprises of technical and functional components. What is in the purview of the patient is the functional quality. The patient makes a choice of hospital depending on this functional quality. On the other hand, hospital leadership have access to data on technical (clinical) outcomes. The hospital leadership basis of competition tends to be technical quality. This may cause a misalignment between patient's expectation and the basis of competition. Doctors and medical insurance providers influence patient's choice of hospital. The perception of quality from patient's, doctor's and medical insurance provider's point of view was evaluated using a modified SERVQUAL tool, a questionnaire that is based on the identification of the expectation-experience gap. The study, then linked this customer experience to perceived (current) strategy and the customer expectation to anticipated (future) strategy. In doing so, the study defined an optimal strategic position. Michael Porter defined strategic positioning as cost leadership, product differentiation and market focus. Currently, many of the hospital are perceived to be strategically positioned based on product leadership. Nevertheless, shifting the focus to cost leadership and transferring the benefit back to the patients (price leadership) is the most sustainable strategic positioning. This was a perception study. No in-depth attempt was made to explain the reason for the perception of the various customers.

Key words: Strategic positioning, patient's perspective, planned strategy, realised strategy, sustainable, cost leadership

INTRODUCTION

Strategic positioning is about how a company will create value different from competition. Therefore, strategic positioning is defined as a firm's relative position in the industry. It must lead to one of two outcomes lower costs or higher premium. Higher premium can be charged when there is unique focus on either a product/service or the unique needs of a few exclusive customers (niche market). Thus, Michael Porter (1985, 1996, 1998) defined strategic positioning as cost leadership, product differentiation and customer focus.

In the health industry setup, the hospital could be a general hospital that treats most common conditions and covering a wide population base. This would be mass market and the positioning would be that of cost leadership. Alternatively, the hospital leadership may steer the institution in investing in the latest equipment thus aim at attracting doctors who in turn bring in patients. This would be product focus. Lastly, a hospital may focus on a specific population by age such as pediatric or geriatrics by gender such as women and maternity or by disease type such as cardiology, neurosciences, orthopedics and so forth. This would be customer segmentation. An institution may also focus on a specific socio-economic group as an alternative customer focus strategy. Managers must adopt specific tactics commensurate to the selected strategy (Allen and Helms, 2006).

Michael Porter's theory assumes that a deliberate and thought out strategy conceptualization, formulation and implementation process exists. However, others have contended that in increasing competitive environment one tends more to adapt to the environment than having a deliberate planning and execution process, hence, the concept of emergent strategy (Mintzberg and Waters, 1985). Between these two extreme ends of strategy development process deliberate and emergent is a spectrum of strategies that has a mixture of both qualities. This brings in the concept between stated/intended and realized strategiesn where realized strategies tend to be modifications of stated strategies adjusted for the changing

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environment. Whereas, the institutional leadership design the strategy, it is the consumers that perceives the impact of the strategy. In the health care industry in as much as technical quality is mandatory and a pre-requisite to sustainability of an institution, information on it is usually not available to patients or patients are not able to interpret it accurately. Information on functional quality is the only one that informs the patient on the quality of the hospital (Babakus and Mangold, 1992). Patient's intention to re-visit a hospital or to inform others favorably of their experience at a hospital is determined by their satisfaction level. In turn, their satisfaction is determined by the perceived value of care received which in turn is determined by quality of medical care received as perceived by the patient (Kim *et al*., 2008; Kazemi *et al*., 2013; Murti *et al*., 2013).

The institutional leadership makes decisions by crafting products (process and outcomes) that meet the needs of a single customer or optimize the product for most or all of the strategically related interest groups. In the presence of options, customers make a choice to patronize the variously positioned institutions. Both the providers and the consumers have to make decisions. The primary consumer of health care is the patient. If patients choose hospitals on the basis of clinical care, then market based solution imply that competition should drive quality. If hospitals compete on the basis of clinical quality then, this would drive national clinical quality upwards (Romano and Mutter, 2004). The success of this strategy relies on the consumer's ability and willingness to switch health care providers (Varkevisser *et al*., 2010). This implies that the basis of competition is quality.

For the administrators of the hospitals in addition to understanding the voice of the customer, it is even more important to understand which customer they want to prioritize (patients, doctors or medical insurance providers) or to define an optimal position targeting all the three customers. Further, not all satisfiers carry equal weighting. Some attributes delight customers in a manner that is proportional to the magnitude of the attribute. Other attributes cause dissatisfaction in their absence but do not increase the level of satisfaction proportional to the magnitude of the attributes. Lastly, some attributes absence does not cause dissatisfaction but when present, delight the customer in a manner that is far higher than the magnitude of the attribute. Customer may also be skeptical, indifferent or dissatisfied about some attributes (Tan and Shen, 2000).

Hospital leadership must therefore, prioritize on what quality attributes to focus on and communicate to the customer. In order to do this, the hospital leadership has to understand what the customer wants. Hospital leadership tend to lay emphasis on either technical or functional quality whereas, they should be doing both (Martins and Aspinwall, 2001). SERVQUAL has been found reliable and valid in various industries. It has been adapted and used in various cultures and languages (Rocha *et al*., 2013). SERVQUAL as a tool for assessing quality has been used in Kenya in different industries (Akama and Kieti, 2003; Manani *et al*., 2013; Owino *et al*., 2014).

Objectives: The objective of this study was to determine what quality dimension informs patient's choice of a healthcare provider in the private sector and in doing so, determine the optimal strategic positioning of the private hospitals in Kenya.

Hypothesis: The study aims to test the hypothesis that the hospital leadership has no understanding of patient's perception of quality and that there is no optimal strategic positioning of the hospital in response to patients choice of hospital

Conceptual framework: The conceptual framework showing how the variables relate to each other is illustrated in Fig. 1 and how they have been operationalized (Table 1).

Table 1: Operationalization of key variables

Key variables	Indicators
Interpersonal	1: Doctor listens to patient
	2: Doctors are courteous
	3: Doctors spend enough time with me
	4: Nurses are courteous
	5: Nurses are efficient
	6: Clinical staff are professional
Environment of care	8: Food and catering
and Hospitality services	9: Staff smartly dressed
	10: Privacy
	11: Linen is clean and adequate
	12: Washroom are clean and functioning
	13: Physical facility
	14: Quiet and pleasant
	15: Room temperature
	16: Room cleanliness
	17: Parking
	18: Security
Administrative	20: Admission process
processes	21: Billing process
	22: Discharge process
Access	24: Physically easily accessible
	25: Signage within and around the hospital
	26: Affordability
Clinical outcome	28: Clinical outcome is as acceptable
Strategic positioning	32: Customer intimacy-focus on and meet/exceed needs of patients both clinical and non-clinically
	Product-focus to deliver the most accurate and modern care by acquisition of the latest machines and most qualified personnel
	Price leadership-focus on lowering the cost of care through high level of operational efficiency and transfer the cost benefit to patient in terms of pricing
Future behavioral	34: Intention to refer family and friends
intention	35: First choice for readmission

Number-indicates the question number as it appears in the questionnaire

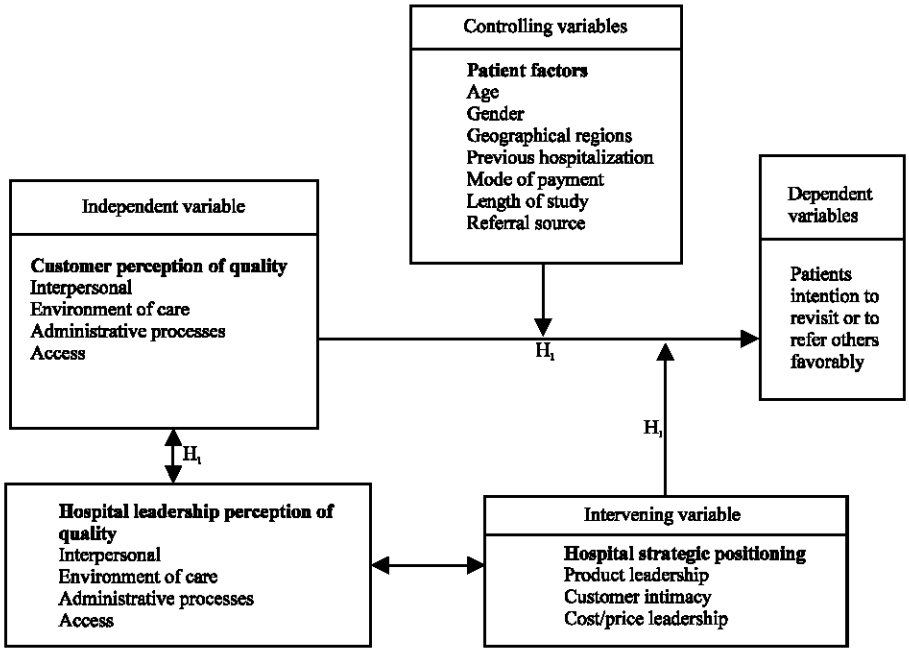

Fig. 1: Graphical presentation of the conceptual framework

MATERIALS AND METHODS

The approach of this research was objectivist (post-positivism). It used a mixed method study design. However, the quantitative study design was predominant and was of the non-experimental method type with aspects of causal-comparative and correlational study. Qualitative data was collected simultaneously with the quantitative one thus making this a convergent parallel mixed method approach. The qualitative data was collected using a structure closed ended questionnaire and the qualitative data was collected as an open ended question after each section.

Healthcare in Kenya is provided by either the public sector or the private sector. Hospitals in Kenya are organized in to six levels-level one is the community health center practicing predominantly primary healthcare, level two hospitals continue with promotive and preventive healthcare but begin to undertake curative care of common ailments, mainly on an outpatient basis. By level three, hospitals offer maternity and nursing services. Level four hospitals are secondary care hospitals offering in-patient, outpatient and theatre services. Level five hospitals are regional referral hospital and have the ability to treat acute life threatening illness as well as manage chronic illnesses. Level six are national referral hospital. These have the ability to treat complex illnesses (Muga *et al*., 2015). The current study is limited to level five and six private hospitals. All the private hospitals in Kenya are registered by Kenya Medical Practitioners and Dentists Board and are available on their website (KMPDB, 2015). At the time of the study, there were 2884 registered private health facilities in the country of which 702 admit inpatient. Of these, level five and level six hospitals were 15 (KMPDB, 2015). One hospital did not qualify to participate. Of the 14 eligible hospital, 12 (86%) participated in the study.

The second stage of sampling was that of patients. The discharged patients in each hospital were sampled sequentially until the sample size was reached. Pediatric patients and those under 18 years participated by proxy through their parents or guardians who completed the questionnaire.

The third stage was that of sampling of doctors. The country had 9,734 registered doctors as at the time of the study. Many institutions had a mixed doctor population those employed and those with visiting privileges. Visiting doctors usually have privileges in multiple hospital and make a conscious choice of where to admit patients. This study excluded employee doctors who only work and admit patients in a single institution. All the doctors (840) whose patients had been recruited were approached to enlist in the study. The response of rate of doctors was 10%. Each doctor respondent filled in one

questionnaire for each participating hospital that their patients had been discharged from irrespective of the number of patients discharged by that doctor. This implies that each doctor filled one questionnaire per hospital.

The fourth stage was that of sampling of medical insurance providers. Insurance penetration in Kenya in general was low at 1.8% at the time of the study. There were 22 medical insurance providers in Kenya (TAKI, 2015). There were 15 medical insurance providers of the patients participating in the study which constituted 68% of the target population. Each MIP respondent who participated filled in one questionnaire for each participating hospital that their patients had been discharged from irrespective of the number of patients discharged that they covered for that hospital. This implies each MIP respondent completed a maximum of one questionnaire per hospital.

One institution had three level-five hospitals and had a central command and control structure. Therefore, one administrator representing all the three was enlisted. Therefore, a total of 10 hospital leadership participated which is therefore, a census of the hospital leadership of the participating hospital.

In this study, the researcher used a 95% confidence level, a significance level of <0.05 and a margin of error of <5% and assumed a two tailed normal distribution.

Data was coded and entered in a Microsoft Excel® data sheet at the end of each day and then transferred to the IBM SPSS® Version 24, 2016 data analytics software for processing. In the current study, the scale items and the six dimensions associated with them were extracted and adapted after reviewing and affinity grouping of multiple studies (Parasuraman *et al*., 1985, 1994; Babakus and Mangold, 1992; Esain *et al*., 2008).

Two column questionnaire was used for this study in order to have the paired questions side by side for respondents to compare expected and experienced measures for the each variable simultaneously. This format has been shown to be valid and reliable (Parasuraman *et al*., 1985). At the end of each section there was an open ended section for the respondent to add additional information appertaining to the section. Further, there was an additional three questions two of which assessed future behavioral intention, whether the respondent would wish to be readmitted in the same hospital or whether they would refer a family member to the hospital. The third question assessed perceived strategy. The respondents selected one of the three generic strategies that they felt best described current strategy of the hospital. The paired response for this question assessed what they thought the future strategy should be. All questions were positively worded. A mixture of negatively and positively worded statements creates confusion (Babakus and Mangold, 1992). The questions were put on a 5 point Likert scale of 1-5 where 1 is least likely and 5 most likely.

RESULTS AND DISCUSSION

A total of 1529 questionnaires were administered to respondents with patients respondents constituting 87.6%, doctors respondents 5.5%, MIP respondents 6.6% and hospital leadership 0.7%. The 225 questionnaires had incomplete or outlier data and were removed from analysis. The remaining 1361 were used for further analysis.

The Cronbach alpha was 0.906 which indicates a high level of internal consistency. The researcher adopted exploratory factor analysis. The Kaiser-Meyer-Olkin (KMO) and Bartlett's test for this study meets the criterion set for factor analysis and further analysis.

Principle component analysis for factor extraction showed four latent factors were extracted with the first latent factor "Environmental of Care" dimension explaining 40.1%, followed by "Interpersonal" dimension explaining 8.3%, "Access" dimension explaining 6.7% and "Administrative" dimension explaining 5.2%. Cumulatively, the four latent constructs accounted for 60.3% variance of the extraction.

Using factor rotation and creating the unobserved (Latent) variables using varimax rotation, 22 unobserved or latent or unmeasured factors/constructs were formed using regression scores of each observed variable retained in EFA.

The variables realigned and some were dropped off. "Parking for family/myself and friends", "Nurses are efficient" and "Medical and Diagnostic Equipment" were dropped off as they scored <0.5. Clinical outcomes realigned itself to "Interpersonal" dimension. The latent variables were evaluated for quality by performing exploratory data analysis. The data was subjected to normality, missing data, multivariate outliers, linearity, multi-collinearity and influential statistical analyses. None was of critical significance

Respondent's characteristics: Almost two in every three patient respondents were female and for every one female doctor respondent there were 6.6 male doctor respondents. All the hospital leadership respondents

Table 2: Summary of regression in current strategy with maximum payout mapped (shaded)

	Independent variables					
Dependent variables	EoC and hospitality	Interpersonal	Access	Administrative	R^2	Model Sig.
No specified strategy	0.24***	0.28***	0.11***	0.14***	0.15	0.000***
Customer intention to refer or recommend	**0.32*** **	**0.32*** **	0.05	**0.13** **	**0.16**	0.000***
product cost	0.17***	0.24***	0.20***	0.13**	0.13	0.000***
	0.21**	0.31***	0.07	0.12*	0.15	0.000***
Customer intention to readmit	**0.30*** **	**0.30*** **	0.08	0.09	**0.13**	0.000***
product cost	0.20***	0.20***	**0.23*** **	0.13**	0.13	0.000***
	0.12*	0.16*	0.20**	**0.17** **	0.10	0.000***

Table 3: Summary of regression in future strategy with maximum payout mapped (shaded)

Dependent variable	EoC and hospitality	Interpersonal	Access	Administrative	R^2	Model Sig.
No specified strategy	0.24**	0.28**	0.11**	0.14**	0.15	0.000**
Customer intention to refer or recommend	0.23*	0.23***	0.07	0.13**	0.12	0.000***
product cost	0.18*	**0.39*** **	**0.18***	**0.16***	**0.22**	0.000***
	0.28* **	0.29***	0.12**	0.14***	0.15	0.000***
Customer intention to readmit	**0.24*** **	0.21***	0.15***	0.13*	0.10	0.000***
product cost	0.22***	0.22***	**0.19*** **	0.12**	0.13	0.000***
	0.13	**0.32*** **	0.11	**0.26** **	**0.17**	0.000***

***Significant at<0.001, ** at <0.01 and * at <0.05 level of significance; EoC = Environment of Care

were males. Three quarters of the patient respondents were below 45 years old whereas 70% of the doctor respondents were above 45 years. Indeed, over 90% of the doctors were older than 35 years.

There was a predominance of females in the child bearing age of 15-45 years almost three of every four patients. Outside the child bearing age, there was a predominance if males.

The doctors were experienced with majority (about 70%) having being in practice for more than 10 years. Most (76%) doctors admitted on an average less than one patient per day.

Majority (63%) of the patients were admitted for the first time and stayed in the general wards and majority (88%) of all patients stayed <6 days. The predominant payers of the patients respondent was medical insurance provider (81%) and an additional 4% that were partially paid for by the MIP. Even though the majority (62%) of the patient respondent's referral to hospital was self-referral, the main source of admission was from the clinics (70%).

Optimal strategic positioning of the hospital in response to patients choice of hospital: This analysis is of the total combined data base of all respondents patients, doctors and medical insurance providers and it focused on the current perceived (realized) strategy as well as future (intended) strategy. The strategies are also compared against the baseline that includes all respondents without defining the strategy (Table 2 and 3). Of the 10 hospital leaders that participated in the study, 40% felt their current strategy was customer intimacy, another 40% felt it was product leadership and 20% felt it was price leadership. The 40% of the same hospital leadership felt that their future strategy should be customer intimacy and 60% felt that this should be product leadership. None felt the future strategy should be cost leadership.

Intention to refer or recommend the hospital to family and friends current perceived (realized) strategy: When the variable for hospital current strategy is not included in the equation, all the four constructs are statistically significant. This data is controlled for gender and age of respondent which were not statistically significant.

To compare the effect of hospital current strategy, three regression equations are run with a reduced (Model 1) and controlled model (Model 2). What is depicted here is the controlled model. For the model where the current strategy is customer intimacy, only access is not statistically significant. All the four constructs are statistically significant in the model where current strategy is product. For the model where the current strategy is cost leadership, all the four constructs are statistically significant except for access. This is an implication that for maximum output in the equation, the regression where the current strategy is product is more robust.

Intention to come back for readmission-current perceived (realized) strategy: Table 2 also shows where the dependent variable is the respondent's intention for readmission and the independent variables are the four

constructs of interpersonal, environment of care and hospitality, access and administrative and separately adding the control variables.

For the model where the current strategy is customer intimacy, only access is not statistically significant in both reduced and controlled model. All the four constructs are statistically significant in the model where current strategy is product. For the model where the current strategy is price leadership, all the four constructs are statistically significant except for access. This is an implication that for maximum output in the equation, the regression where the current strategy is product is more robust.

Intention to recommend the hospital-future intended strategy: Table 3 shows a summary of the analysis where the dependent variable is recommendation of the hospital to family and friends and the four constructs are used as independent variables (only results of the model with control variables is shown in the Table 3).

When the variable for hospital future strategy is not included in the equation, all the four constructs are statistically significant in both reduced and controlled. To compare the effect of hospital future strategy, three regression equations are fit with a reduced and controlled model. For the model where the future strategy is customer intimacy, only access is not statistically significant in both reduced and controlled model. All the four constructs are statistically significant in the model where future strategy is product and price leadership. For maximum output in the equation, the regression where the current strategy is cost leadership is more robust.

Intention to come back for readmission-future perceived intended strategy: Table 3 also shows where the dependent variable is whether the respondent has intention for readmission and the independent variables are the four constructs of environment of care and hospitality, interpersonal, access and administrative.

To compare the effect of hospital future strategy, three regression equations are run with a reduced and controlled model. Only the control model is shown in the Table 3. For the model where the future strategy is customer intimacy and product all the four constructs are statistically significant in both reduced and controlled model. For the model where the current strategy is price leadership, all the four constructs are statistically significant except the access. This is an implication that for maximum output in the equation, the regression where the current strategy is cost leadership is more robust.

Current perceived realized strategic positioning looking at maximizing future behavioral intentions (both Intention to recommend the hospital to family and friends and intention to come back for readmission), the regression equation where the current strategy is product leadership is more robust.

Future intended strategic positioning looking at maximizing future behavioral intentions (both intention to recommend the hospital to family and friends as well as Intention to come back for readmission) the regression that maximizes output is either product or cost leadership.

Within these information, one can tease out different components to prioritize (Table 2). Current strategy priority should be environment of care and very closely followed by Interpersonal, followed by access and lastly administrative

Future strategic prioritization in order should be interpersonal, environment of care, followed by administrative processes and lastly access (Table 2).

Whereas the current perceived strategic positioning on the ground factoring patients, doctors and MIPs (realized strategy) is customer intimacy yet only 40% of the hospital leaders felt their current deliberate strategic positioning was that of customer intimacy. The rest felt it is was product leadership (40%) and price leadership (20%). The optimal future strategic positioning that maximizes future behavioral intention is Product or cost leadership yet none of hospital leadership intended to pursue cost leadership in the future. The 40% of the hospital leadership felt that their future intended strategic positioning should be customer intimacy and 60% felt that this should be product leadership.

The details of the contribution of the individual components that the customers (patients, doctors and MIPs) feel require to be prioritized are illustrated in the four quadrant analysis (Fig. 2). A four quadrant is a scatter plot with the axis of the two measures (in this case expectation and experience) crossing at the means. The priority areas include discharge process, admission process, affordability and perhaps nurses efficiency. This is more in keeping with operations related processes and affordability.

Hypothesis conclusion: The null hypothesis that there is no optimal strategic positioning of the hospital in

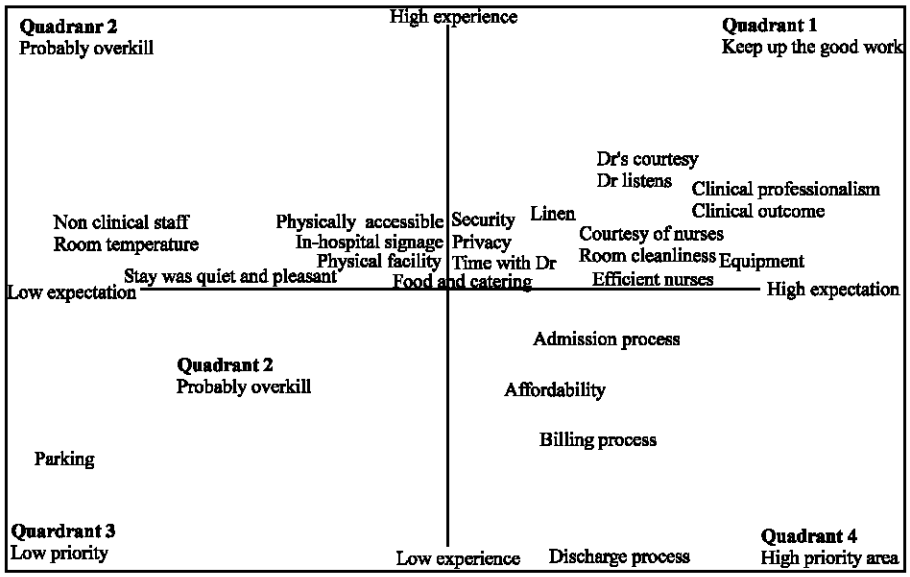

Fig. 2: Four quadrant of expectation-experience matrix

response to patients choice of hospital cannot be accepted and the alternative hypothesis that there is an optimal strategic positioning of the hospital in response to patients choice of hospital is accepted.

Focus must be directly on the patient as 62% of patients are self-referrals. Service quality is assessed by patients along the dimensions of interpersonal quality, technical quality, environment quality and administrative quality. Service quality is very strongly associated with future behavioral intension, more so than satisfaction (Dagger *et al*., 2007). In a study looking internally at organizations characteristics, communication, cost, facility, competence and demeanor were found to be significant predictors of patient's satisfaction (Andaleeb, 1998).

Prior experience in a hospital and reputation of that institution outweighs quality information when making a choice of a hospital (Ketelaar *et al*., 2014). Consumer start with lower order attribute to infer quality. Lower order attributes are those experienced by the five senses. These tend to be product specific. Thereafter, consumers rely on intrinsic attributes. These are industry specific and include reliability, empathy, assurance, responsiveness and tangibles. In the absence of these, patient attribute quality based on extrinsic attributes. These are universal and include price, brand name and advertising (Zeithaml, 1988). In the hospital set-up, the intrinsic attributes are most important as they also constitute search parameters during the pre-purchase phase. The lower order attribute are experienced at the time of consumption and are over shadowed by the intrinsic attributes at that time. The impact of extrinsic attributes is attenuated in influencing future behavioral intension (intension to inform others favorably or intentions to return) if not in alignment with intrinsic attributes. Therefore, the intrinsic attributes of reliability, empathy assurance, responsiveness and tangibles are the most important aspects that infer quality to the patient. The administrator must ensure appropriate positioning of his/her institution in the mind of the patient.

Even though the primary consumer of hospital services is the patient, there are important influences and indeed determinants of where patients go for care. Physicians are key in hospital competition as they determine where 31% patients will be admitted.

Physician reputation is a determinant of patients patronizing the hospital. In order to improve revenue return, hospital leadership will invest in equipment to attract physician. Secondly, administrator may invest for reputation rather than for return. Hospital may transfer increase price because of the third party payer may not be immediately sensitive to price change. Physicians are a scarce resource. It is therefore important to understand what attracts and retains physicians to an institution. Relationship with the hospital and especially that with the leadership is important. Work-life balance, economic reward and job security did not play a significant role (Trybou *et al*., 2014). Doctor's reputation is a determinant of patients patronizing the hospital. In order to improve revenue return, hospital leadership will invest in equipment to attract physician (Lee, 1971). This then implies that the dominant strategy will have to be that of

product leadership. This is what the researcher finds in the current study that the reigning strategy that maximizes patient's future behavioral intention is that of product leadership. This makes hospitals very capital intensive and adds to the cost of care.

Even though, Medical Insurance Providers (MIPs) contribute only a modest amount of patient referral at this time, they constitute 80% of payers. Medical insurance is a loss making business (TAKI, 2015). There is intense industry and regulatory pressure to change this. It is only a matter of time before the MIPs start influencing operations of the hospital and demanding for accountability. The administrators must use the economies of scale and scope to bundle complimentary services to make it cost efficient for the MIP. Medical insurance providers are looking for cost effective business that is financially viable. Even though over 80% of the patients were funded by Medical insurance providers, they still remained price sensitive. This may be related to limited insurance cover and multiple conditions are excluded especially chronic conditions. It may also be related to co-payment policy that is common in most insurance covers. It is therefore, not surprising the desired (future) strategy that will maximize future behavioral intention is related to cost leadership whose benefits will translate to the patients through price leadership.

In addition to what patients want, attention must be paid to the other two players in a sustainable manner. These players have a significant influence on where patients seek medical care. Their perception of quality may be different from those of patients. The patient is not always the decision maker because it is the physician and/or the Medical Insurance Provider (MIP) who often recommend specific hospitals to the patients who mostly follow the advice. This intra-related group is not only interested in the final clinical outcome but in the process that this outcome is reached as well (Dijkstra and Van, 2002). The needs of the strategic related groups may vary and on occasion, contradict each other. Focusing on any one member of the strategically related interest groups may be at the expense of losing custom of another. In understanding customer needs and wants, all players need to be considered (Gremyr and Raharjo, 2013). In this context, the term "customers" refers to patients, clinicians and third party payers (Padma *et al*., 2009).

Whereas the current strategic positioning on the ground as perceived by patients, doctors and MIPs (realized strategy) is product leadership yet only 40% stated that they felt their current strategic positioning was product leadership. All the hospital leadership affirmed that their strategy development process was planned and deliberate and they confirmed the presence of a defined strategy development role in an individual, committee or department. Michael Porter's theory assumes a deliberate and thought out strategy conceptualizing, formulation and implementation process. However, Mintzberg and Waters (1985) contended that in increasing competitive environment one tends more to adapt to the environment than a deliberate planning and execution process, hence, the concept of emergent strategy. In this study it seems that the strategy starts as a deliberate process but evolves with time. It is important for the hospital leadership to realize and be cognizant that the strategy is no longer as per the original plan and has evolved to be out of synch with the environment thus risk strategic drift and loss of competitive advantage (Zafirova, 2014).

Further and most critical is that none of the hospital leadership intended to focus on strategically positioning their institutions as cost leaders in the future yet this was the most optimal future strategic positioning.

Michael Porter affirms the importance and criticality of patient centered care in his writings of value based approach to transforming the healthcare industry in the USA. However, his discussions are predominantly on technical quality and tying in technical quality to unit costs (Portera, 2010). There is very little discussion on functional quality in driving quality in healthcare.

CONCLUSION

Perception of quality by the patient is affected by four dimensions that are hierarchical interpersonal attributes, environment of care and hospitality, administrative and access in descending order. This enables prioritization of actions. Hospital leaders appear aligned to the needs of the principal stakeholders.

There is a clear priority strategy that should be the focus. The hospital leadership may position their institutions based on either product based strategic positioning or cost based strategic positioning. The indication is that the hospital leadership should choose to either focus on the doctors who will bring the patients or to focus on mass market. However, one has to remain cognizant of regional differences and take this in to consideration. This implies that they cannot be a universal recommendation on or "one size fits all" strategic positioning. Both deliberate and emergent strategy processes may co-exist (Esain *et al*., 2008). In spite of this, the current perceived dominant strategy is that of product leadership and the desired future strategy should include the option of cost leadership. The quality of care factors that influence patient's choice of hospital and their hierarchy of importance.

RECOMMENDATIONS

To the administrators, they must also include direct patient input (voice of the customer) when developing their strategy. The focus on equipping the hospital with latest machines in order to attract the doctors who in turn it is hoped that they will bring in the patient's needs to be tempered by the finding of this study. Majority of patients are self-referred rather than referred by doctors.

The study would have been enhanced by increasing the sample size of the doctors and hospital leadership. The fact only the senior most leadership of the participating hospital were used implies they were only 10 hospital leaders sampled. Doctor response rate was very low.

SUGGESTIONS

With rapidly increasing competition among healthcare providers as well as standalone laboratory and pharmacy services in Kenya the agency problem at the hospital management and governance level is likely to get even worse and introduce a different dynamic of patient referral to hospital. Rooted in this agency theory clinician interaction with patients and hospitals can be aligned with value based incentive that delivers better quality and efficient service (Conrad, 2016). This would be an area of further research.

It is important to consider major influencers of patients when undertaking research on patient's perception. Most studies have directly looked at patients only. The significant influence of doctors and medical insurance providers role is crucial to study. This is an area open to further studies. It would be useful to explore the determinants of quality perception among doctors and medical insurance providers.

The ultimate reason patients go to the hospital is to seek healthcare. The outcome measurements of healthcare are part of technical quality. The process of delivery of this healthcare and its outcome measures are part of functional quality. In order to drive quality, functional quality must be linked to technical outcomes. Important research would be to link functional and technical outcomes. This would a worthwhile area of further research.

REFERENCES

Akama, J.S. and D.M. Kieti, 2003. Measuring tourist satisfaction with Kenya's wildlife safari: A case study of Tsavo West National Park. Tourism Manage., 24: 73-81.

Allen, R.S. and M.M. Helms, 2006. Linking strategic practices and organizational performance to Porter's generic strategies. Bus. Process Manage. J., 12: 433-454.

Andaleeb, S.S., 1998. Determinants of customer satisfaction with hospitals: A managerial model. Int. J. Health Care Q. Assur., 11: 181-187.

Babakus, E. and W.G. Mangold, 1992. Adapting the SERVQUAL scale to hospital services: An empirical investigation. Health Serv. Res., 26: 767-786.

Conrad, D.A., 2015. The theory of value-based payment incentives and their application to health care. Health Serv. Res., 50: 2057-2089.

Dagger, T.S., J.C. Sweeney and L.W. Johnson, 2007. A hierarchical model of health service quality: Scale development and investigation of an integrated model. J. Serv. Res., 10: 123-142.

Dijkstra, L. and D.B.H. Van, 2002. Quality function deployment in healthcare: Methods for meeting customer requirements in redesign and renewal. Int. J. Qual. Reliab. Manage., 19: 67-89.

Esain, A., S. Williams and L. Massey, 2008. Combining planned and emergent change in a healthcare lean transformation. Public Money Manage., 28: 21-26.

Gremyr, I. and H. Raharjo, 2013. Quality function deployment in healthcare: A literature review and case study. Intl. J. Health Care Qual. Assur., 26: 135-146.

KMPDB., 2015. Licenced health facilities. Kenya Medical Practitioners And Dentists Board, Nairobi, Kenya. http://medicalboard.co.ke/online-services/licensed-health-facilities/.

Kazemi, N., P. Ehsani, F. Abdi and M. Bighami, 2013. Measuring hospital service quality and its influence on patient satisfaction: An empirical study using structural equation modeling. Manage. Sci. Lett., 3: 2125-2136.

Ketelaar, N.A., M.J. Faber, G. Elwyn, G.P. Westert and J.C. Braspenning, 2014. Comparative performance information plays no role in the referral behaviour of GPs. BMC. Family Prac., 15: 146-154.

Kim, Y.K., C.H. Cho, S.K. Ahn, I.H. Goh and H.J. Kim, 2008. A study on medical services quality and its influence upon value of care and patient satisfaction focusing upon outpatients in a large-sized hospital. Total Qual. Manage., 19: 1155-1171.

Lee, M.L., 1971. A conspicuous production theory of hospital behavior. South. Econ. J., 38: 48-58.

Manani, T.O., R.B. Nyaoga, R.M. Bosire, T.O. Ombati and T.O. Kongere, 2013. Service quality and customer satisfaction at Kenya airways Ltd. Eur. J. Bus. Manage., 5: 170-179.

Martins, A. and E.M. Aspinwall, 2001. Quality function deployment: An empirical study in the UK. Total Qual. Manage., 12: 575-588.

Mintzberg, H. and J.A. Waters, 1985. Of strategies, deliberate and emergent. Strategic Manage. J., 6: 257-272.

Muga, R., P. Kizito, M. Mbayah and T. Gakuruh, 2015. Overview of the health system in Kenya. Demographic Health Surv., 1: 13-26.

Murti, A., A. Deshpande and N. Srivastava, 2013. Patient satisfaction and consumer behavioural intentions: An outcome of service quality in health care services. J. Health Manage., 15: 549-577.

Owino, E., F. Kibera, J. Munyoki and G. Wainaina, 2014. Service quality in Kenyan Universities: Dimensionality and contextual analysis. Eur. J. Bus. Manage., 6: 180-194.

Padma, P., C. Rajendran and L.P. Sai, 2009. A conceptual framework of service quality in healthcare: Perspectives of Indian patients and their attendants. Benchmarking: Int. J., 16: 157-191.

Parasuraman, A., V.A. Zeithaml and L. Leonard L. Berry, 1994. Alternative scales for measuring service quality: A comparative assessment based on psychometric and diagnostic criteria. J. Retail., 70: 201-230.

Parasuraman, A., V.A. Zeithaml and L.L. Berry, 1985. A conceptual model of service quality and its implications for future research. J. Market., 49: 41-50.

Porter, M.E., 1985. Competitive Advantage: Creating and Sustaining Superior Performance. The Free Press, New York, USA., ISBN:9780029250907, Pages: 557.

Porter, M.E., 1996. What is Strategy?. Harvard Business School Publishing, Brighton, Boston, Massachusetts, USA.,.

Porter, M.E., 1998. On Competition. Harvard Business School Press, Boston, Massachusetts, USA., ISBN:9780875847955, Pages: 485.

Porter, M.E., 2010. What is value in health care?. N. Engl. J. Med., 363: 2477-2481.

Rocha, L.R., D.F. Veiga, P.R.E. Oliveira, E.H. Song and L.M. Ferreira, 2013. Health service quality scale: Brazilian Portuguese translation, reliability and validity. BMC. Health Serv. Res., 13: 24-28.

Romano, P.S. and H. Zhou, 2004. Do well-publicized risk-adjusted outcomes reports affect hospital volume?. Med. Care, 42: 367-377.

Romano, P.S. and R. Mutter, 2004. The evolving science of quality measurement for hospitals: Implications for studies of competition and consolidation. Intl. J. Health Care Finance Econ., 4: 131-157.

TAKI., 2015. Insurance industry annual report 2015. The Association of Kenya Insurers, Nairobi, Kenya.

Tan, K.C. and X.X. Shen, 2000. Integrating kano's model in planning matrix of quality function deployment. Total Qual. Manage., 11: 1141-1151.

Trybou, J., P. Gemmel, Y.V. Vaerenbergh and L. Annemans, 2014. Hospital-physician relations: The relative importance of economic, relational and professional attributes to organizational attractiveness. BMC. Health Serv. Res., 14: 232-240.

Varkevisser, M., S.A.V.D. Geest and F.T. Schut, 2010. Assessing hospital competition when prices don't matter to patients: The use of time-elasticities. Intl. J. Health Care Finance Econ., 10: 43-60.

Zafirova, T., 2014. Strategic drift and strategic crisis management of organization. China USA. Bus. Rev., 13: 486-494.

Zeithaml, V.A., 1988. Consumer perceptions of price, quality and value: A means-end model and synthesis of evidence. J. Market., 52: 2-22.