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Cost Leadership Strategies for Sustainable Competitive Advantage Adopted by Selected Private Hospitals in Mombasa County

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Abstract: **As a result of globalization, benchmarking strategies in sustainable competitive advantage are continuously being replicated eliminating the aspect of uniqueness, imitability and rarity. The purpose of the study was to investigate how thirteen private hospitals in Mombasa County in Kenya accredited to the National Hospital Insurance Fund managed to sustain themselves with the costs of medical services tremendously rising. The theoretical framework was based on the resource based, market based and capability based views. The researcher highlighted the cost leadership strategy and used the descriptive research design. A purposeful census cross-sectional sampling of thirty nine managers who took part in strategy formulation and implementation was issued with a questionnaire that used survey technique for data collection. It was found that hospitals' sustainable competitive advantage related positively with cost leadership influencing the level of competitive advantage. The study found that private hospitals in conjunction with insurance firms and non-governmental organizations had managed to retain customers through the reduction of costs, some subsidies, bill waivers and the use of generic drugs in treatment. The findings further revealed that a positive and significant relationship between cost leadership and sustainable competitive advantage contributed significantly to survival in the health sector. Private hospitals that provided services at low cost enabled them to attract more customers therefore increasing revenues.**

Keywords: **Cost Leadership Strategy, Sustainable Competitive Advantage, Private Hospital, Medical Insurance.**

I. INTRODUCTION

Government hospitals introduced cost sharing in the level five hospitals but with challenges such as overcrowding and long lines, clients preferred to seek consultation at private hospitals and if treatment was too expensive, they returned for public hospital treatment as a last resort. Some private hospitals offered a subsidized package for specific services which attracted customers even though the hospital was high cost. Medical insurance had greatly assisted in the cost of treatment and especially the public National Hospital Insurance Fund (NHIF) which was meeting partial or full payment of services for clients for both normal and specialized treatment at some private hospitals. Research was essential on the parameters of this aspect so as to understand how private hospitals would be able to attract and retain clientele from the middle and poor class in the society while still charging medical fees. The trend in Mombasa County was a continuous mushrooming of private hospitals many of which ended up at the brink of collapse or were finally shut down. Other hospitals had survived very well in the long term. This was basically because, realistically the hospital business was very marketable and thrived as there was a demand for medical services every single day in the community. So now the question was, "what were the cost leadership strategies that managers in private hospitals were using to retain sustainable competitive advantage in the long term among their peers".

As per the Mombasa District Strategic Plan (National Coordinating Agency for Population and Development) 2005-2015, majority of health facilities in Mombasa County were small privately owned clinics and the rest were Mombasa County

and Government of Kenya owned. Private hospitals were observed to have filled a large gap in the public health sector which the government had been unable to cope with due to the growing population. This was depicted in the Kenya Economic Report of 2013 which stated that public financing for the health sector (recurrent and development) as a percentage of total government expenditure was only about 2 percent of Gross National Product (GNP). Public per capita health spending was US $12.6 in 2010/2011 which was largely inadequate when compared to the World Health Organization (WHO) recommendation of an average of US $44 per capita on health care. The overall allocations had remained at 6 percent on the overall government budget for the last three years. Further to this, as per the Mombasa County Government 2013-2017 First County Integrated Development Plan, the Coast General Hospital in the county of Mombasa was the only level five hospital and also the only referral hospital serving the entire region. There were two level four hospitals namely Tudor and Port Reitz, over thirty five public dispensaries and health centers, eighteen clinics and four special clinics in existence. The doctor patient ratio of 1:11,875 and the nurse population ratio of 1:18,678 was still higher than the (WHO) recommended doctor patient ratio of 1:600. This shortfall in the public health sector was compensated for by the private hospitals who covered for the shortage of staff, delays, lack of equipment or the manpower to use it and rude treatment from an overworked, stressed labor force at a fee.

According to [1] health services are provided over a network of more than 5000 health facilities countrywide. The public sector holds 51 percent of the facilities and the rest is supplemented by non-governmental, private clinics and faith based organizations meaning that half the health facilities are privately owned. Private hospitals capitalize on this disadvantage to compete for clients by providing quality, professional, efficient, excellent service and facilities commensurate with the costs that they charge. This calls for the management of such hospitals to come up with the right sustainable strategies over their competitors. Private hospitals are diverse and dynamic making the study of their management strategies for (SCA) interesting. The study will analyze what cost leadership strategies managers adopt, what competitive advantages they possess and how they sustain these competitive advantages. This study is vital in enlightening both the existing and prospective hospitals' management on cost leadership strategies that ensure sustainable competitive advantage.

1.1 Research Objective:

The objective of the study was to determine the influence of cost leadership on the sustainable competitive advantage of selected private hospitals in Mombasa County.

1.2 Cost Leadership Strategy:

According to [2] banks in Kenya are very innovative but with the competition, new products can be duplicated even before they are launched such as agent banking. There was also the need to ensure that new projects were properly pre-planned before being introduced to eliminate any failures before they were fully implemented. It was necessary to ensure that the new products fitted the niche that they were required to operate in. Banks in Kenya poached staff from each other by offering competitive packages that attracted the executives. This beats the element of confidentiality on competitive advantage of peers and therefore knowledge transfer of insider strategies. Identification of customers, a good customer base of loyal people and training of staff on customer service was important. Market intelligence on other firms was also important so as to counter their moves quickly.

[3], in their study found that the cost leadership strategy was used by some firms to develop cost advantage over the competition in the market and this led to growth in the market share associated with large businesses that had standard products which were different from competitors targeting a wider group of customers. But looking closely the true picture was not reflected by these findings because the products being sold at a lower price were similar to those of the competitor in all aspects except that the competitor's price was higher. The argument that low cost did not always lead to low price came about because producers could price at competitive parity, exploiting the benefits of a bigger margin than competitors. Multinational Corporations used price reduction strategies by constantly reviewing operations and related costs so as to set a price which could give a competitive advantage to the multinational.

In findings by [4] the current National Hospital Insurance Fund (NHIF) act number 9 of 1998 had the provision of both in-patient and out-patient care. They were of the opinion that the government should shift from out-of-pocket payments in hospitals to tax financing and or social health insurance as well as community based health insurance (CBHI). The Fund has successfully offered in-patient cover by providing a comprehensive cover through the Government of Kenya (GoK) hospitals, faith-based hospitals and low-cost privately owned hospitals, and paying specific rebates to high cost private hospitals. The maternity benefit package was also enhanced to cover both normal and caesarean delivery with no

additional cost. Finances that went towards this fund were deducted from the salaries of employed people at a monthly rate that was topped up to pay for their inpatient bills at the hospitals. This fund incorporated small and medium sized entrepreneurs and anybody else who was capable of paying a set amount towards their personal accounts with the fund through mobile money transfer. For (GoK) hospitals if one had an (NHIF) card, they did not pay for admission and in the private hospitals, a fixed amount per day was paid for the bed. It further encompassed other services such as magnetic resonance imaging, CT scan, outpatient services, dialysis and chemotheraphy services for active contributing members.

[5], divided hospital market structure dimensions into three, namely, managed care (MC) penetration, managed care plan concentration and hospital market competition. They were of the opinion that the strongest markets had health plans with the strongest bargaining power in the insurers and hospital negotiations and were measured as high MC penetration and concentration and yet had limited hospital market power which was measured as low hospital concentration. Among their findings was the fact that hospital utilization did not increase during their period of study which was indicatively not recent or short term in per capita demand for hospital services and would have been caused by the latest expensive medical technology that shortened hospital admissions or eliminated them altogether. MC plans reduced the use of direct controls but increased cost sharing and case management programs but the hospital bed capacity remained fixed partly because of the shortage of nurses. They found that much of the spending growth was due to higher revenue per unit of the output not taking into consideration whether the market was strong or not meaning that in the strongest markets prices rose more than twice as fast as their utilization. They were of the opinion that the position of bargaining by insurers in health plans had weakened when it came to the hospitals and changes in treatment and modern technology increased hospital spending. Better quality management improved both public and private quality improvement efforts. Further to the above, the results showed that hospital care spending rose substantially due to increase in pricing and the health care market had lost the competitive excitement that would have maintained constant pressure on prices and regulatory bodies needed to come in to protect and retain price stability. This also called for the private hospitals to do more innovations.

[6], in their study found that there was a relationship between cost leadership and the performance of hospitals and that cost leadership affected the performance of the hospitals by maximizing on the lean staff capacity to improve on the quality of services through the use of better working ethics and procedures. Focus was laid on the purchase of cheaper equipment and constant change of suppliers to hedge on the exploitation of costs by constant service providers. The hospital practiced cross selling where they had an advantage as they were in a rural setting, were the only large hospital and the community around depended on them for services such as family planning, maternal care, delivery and child immunization. The low cost strategy also encouraged patients from outside the community because of quality of services provided and the fact that all services were under one roof.

[7], highlighted customer satisfaction, sales revenue, trust and investment output whereby trust was the most important. Therefore serious attention to customer requirements and the necessary tools that would enhance customer understanding such as knowledge management. Integration of the strategic organizational plans with the company vision and mission and customized training courses for staff on how to undertake continuous customer surveys and measurements was found to be important.

II. RESEARCH METHODOLOGY

The study population included thirteen private in-patient hospitals within Mombasa County which were registered under the National Hospital Insurance Fund by first July 2016 and the respondents were thirty nine senior managers of these hospitals (hospital administrator, human resource manager and finance manager). According to [8], a study that seeks to find out what, where and how of a phenomenon is a descriptive study therefore this study used a descriptive research design which was both quantitative and qualitative because the analysis required reporting. The researcher used a census of the whole population incorporating survey techniques that used questionnaires to collect data the focus of which was on the research questions bringing out a comparison between the dependent and independent variables that were to test the hypothesis and give a solution without bias. The likert rating scale tool quantified opinion based findings as either very good or very poor due to the closed-ended questioning format. Primary data was collected through questionnaires using both the ‘drop and pick’ and ‘face-to-face’ techniques of obtaining data because of convenience both to the researcher and the respondents. Secondary data was collected through analysis of past research studies, government reports, the internet and other documented data that could be verified and incorporated into the literature review. Table 1below depicts the population size:

TABLE I: POPULATION SIZE

NO.	PRIVATE HOSPITALS	SAMPLE
1	Alfarooq Hospital	3
2	Bakarani Maternity and Nursing Home (Mombasa)	3
3	Bomu Medical Centre	3
4	H H Aga Khan Hospital Mombasa	3
5	Jocham Hospital	3
6	Mainland Health Centre	3
7	Marie Stopes Hospital (K) (Mombasa)	3
8	Mewa Medical Centre	3
9	Mombasa Hospital Association	3
10	Nairobi Homes Nursing Home	3
11	Pandya Memorial Hospital	3
12	Sayyid Fatmah Hospital	3
13	Tudor Healthcare	3
	TOTAL SAMPLE SIZE	**39**

III. RESULTS AND DISCUSSION

TABLE II: RESPONSE RATE

Category	Number Issued	Percentage %
Number of questionnaires returned	30	76.9
Number not returned	09	23.1
Total number of questionnaires	**39**	**100**

3.1 Response Rate:

The number of targeted respondents was thirty (30) managers from (thirteen) 13 private hospitals that were NHIF accredited and had in-patient facilities. A total of thirty (39) questionnaires were issued out to the hospital administrators, chief finance managers and human resource managers in the hospitals. The 30 questionnaires which were collected from 10 hospitals were used for analysis. This translated to 76.9% return rate as shown in Table II. The 76.9% return rate was achieved due to the consistent follow-up made by the researcher to the offices of the hospital managers. Three hospitals did not respond, two turned down the survey request one for fear of highlighting their strategies as they would be duplicated and the other was not sure how far the research would expose them even after explanations and much cajoling. This reflected the lack of understanding on the part of the hospitals on what a research entailed. The third hospital was a branch with the headquarters being in Nairobi. The branch had recently stopped admitting patients and withdrawn from the NHIF Insurance Scheme partly due to the fact that it was a non-governmental organization (NGO) which was already offering services at a subsidized price.

TABLE III: DURATION RESPONDENTS HAD WORKED IN THE HOSPITAL

Duration	Frequency	Percent	Valid Percent
Less than 5 years	15	50	50
5-10 years	09	30	30
More than 10 years	06	20	20
Total	**30**	**100**	**100**

3.2 Duration Respondents Had Worked at the Hospital:

The duration respondents worked in the hospital was grouped into three categories: less than 5 years, 5 to 10 years and more than 10 years. Based on the result in Table III, a majority of respondents (50%) had worked for less than 5 years, and this were followed by those who had worked for between 5 to 10 years at (30%). Therefore the opinions of both the new and the old managers in the hospital were captured in the study. This meant that the job turnover was high with over half the population being less than 5 years on the job. This was reflected by [2] who found in her study that banks in

Kenya had the culture of poaching staff, especially the executives, from each other through enticing them with competitive packages. Therefore this habit beats the element of confidentiality on competitive advantage of peers by unwillingly transferring insider knowledge from one employer to the other and therefore leaking secrets.

TABLE IV: HIGHEST LEVEL OF EDUCATION OF THE RESPONDENTS

Education	Frequency	Percent	Valid Percent
Diploma	15	50.0	50
Degree	05	16.7	16.7
Post Graduate	10	33.3	33.3
Total	**30**	**100**	**100**

3.3 Highest Level of Education of the Respondents:

Table IV shows that a diploma was the highest education level attained by half of the hospital managers (50%) in the selected hospitals. Postgraduate holders were (28.9%) and slightly more than a quarter of the respondents (21.1%) were degree holders. This meant that hospitals recruited managers of diverse educational levels and therefore the opinions of respondents from various levels of education were taken to compose this study. This depicted that many managers in hospitals were promoted gradually to these levels. This is because most hospitals are medium sized organizations and cannot afford to employ executive managers who demand for excessive salaries. The managers were trained or trained themselves further while on the job. The post graduate managers were further either owners or part owners of the hospitals or affiliated through religious or community membership. [7], was of a similar opinion that the integration of strategic plans with the vision, mission, customized staff training courses, strategic management tools to use and customer survey training were an essential part of staff education.

TABLE V: MEAN AND STANDARD DEVIATION OF COST LEADERSHIP IN HOSPITALS IN MOMBASA COUNTY

	N	Mean	Std. Dev.
Insurance scheme has reduced cost	30	4.71	4.60
There are effective cost cutting measures in place like subsidies and waiver	30	.21	.991
We have low cost services than hospitals of our class	30	4.16	.789
Low costs generics are commonly used here in treatment	30	3.89	1.181

3.4 Cost Leadership:

Table V shows the mean and standard deviation of the respondents. The mean of the responses on a scale of 1 (strongly disagree) to 5 (strongly agree) were more than 4, that is, agree. According to the respondents therefore, insurance schemes had reduced hospital cost greatly (m=4.71, SD=.460), the mean for subsidies and bill waivers was very low due to the fact that they depended on outside sources such as donors to pay for the services (m=.21, SD.991), hospitals charged lower costs than hospitals of their class for similar services (m=4.16, SD=.789) and used low cost generic drugs used in treatment (m=3.89, SD=1.181). Therefore most of the hospitals surveyed provided services that aimed at minimizing the cost of treatment by targeting low income earning members of the society and tailoring their services and efforts to provide what was considered the most critical service to them. It was found that the hospitals provided only the essential services with minimum fringe benefits. [7] Agreed in their study which stated that the government should shift from out of pocket payments in hospitals to tax financing and social health insurance as well as community based health insurance to assist in cases such as dialysis and chemotheraphy treatment. The luxurious services were provided for the rich who could afford them.

TABLE VI: MEAN AND STANDARD DEVIATION OF COMPETITIVE ADVANTAGE IN HOSPITALS IN MOMBASA COUNTY

	N	Mean	Std. Dev.
There is steady increase of customer base	30	3.79	.528
We have exceptionally motivated staff than our competitors	30	3.76	.431
We have skilled employees than our competitors	30	3.50	.507
We have a constantly investment in essential equipment	30	3.47	.647
There is steady increasing revenue streams over time	30	3.34	.847

3.5 *Competitive Advantage in Hospitals in Mombasa County:*

Table VI shows the mean and standard deviation of competitive advantage items in private hospitals in the county. The competitive levels in a majority of the private hospitals in the county were found to be challenging. There was a challenge in maintaining steadily increasing revenue streams (m=3.34, SD=.847) and this was due to the continuous increment in hospital pricing. [8], were of the opinion that hospital care spending rose substantially due to increase in pricing and the health care market had lost the competitive excitement that would have maintained constant pressure on prices and regulatory bodies needed to come into protect and retain price stability. Investing in essential hospital equipment was not easy because most of it is very expensive both to purchase and maintain (m=3.47, SD=.647). But there was a steady increase in the customer base because of the collaboration between hospitals and the insurance firms for services such as dialysis, magnetic resonance imaging and chemotherapy increasing the customer base and sustainable competitive advantage (m=3.79, SD=.528). Motivated staff are receptive and hardworking therefore enticing customers and bringing in more customers (m=3.76, SD=.431). Skills are essential for an effective and efficient staff making them swifter in their operations and further providing perfect service that all customers appreciate. This brings in more clients (m=3.50, SD=.507). There was a need for private hospitals to package their services in unique differentiated ways in order to attract and maintain a reliable customer base that would be able to afford the services provided within the facilities for continuous operation.

IV. RECOMMENDATIONS

Voluntary organizations, companies and hospital management should come with similar packages equivalent to those given by the National Hospital Insurance Fund to help alleviate the suffering of those within the society with chronic illnesses. Private hospitals in the County of Mombasa should have a centralized medical training center where the medical fraternity can go for customized training courses that will enhance their skills and these trainings could be paid for privately by the individuals, be sponsored for by their hospitals or other institutions such as non-governmental organizations, international bodies like the World Bank and World Health Organization and they should be short term and of flexible timings for ease of scheduling for the employed medical personnel.

V. CONCLUSION

The study found that private hospitals used cost leadership strategies to enhance their competitiveness. Cost reduction measures included the use of generic drugs, affordable equipment, charging lowest cost possible and sometimes offering bill waivers. The National Health Insurance Fund collaborated with the private hospitals to implement customized services to the community at cheaper prices such as dialysis, magnetic resonance imaging and chemotheraphy. Staff were exceptionally motivated, highly skilled, increasing the customer base and therefore the retaining sustainable competitive advantage. Bill waivers and subsidies were only functional where outside parties like clubs, foreign specialist doctors volunteering their services and the government participated. The expensive medical equipment was a challenge to the hospitals although it was a source of attraction to customers when they had it such as the magnetic resonance imaging machines. Revenue was continuously rising due to increase in other factors in the economy making it difficult to retain costs and therefore there had to be continuous innovation of new cost leadership strategies for sustainable competitive advantage.

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