Competitive Strategies in the English National Healthcare System (NHS) - A Case Study of York Teaching Hospital

York Teaching Hospital NHS Foundation Trust

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ABSTRACT

Increased patient choice and competition are well renowned reform strategies in European Healthcare systems. Despite some debate, these strategies are generally felt to improve efficacy and quality of healthcare. The National Health Service (NHS), England’s publicly funded healthcare system, is similarly undergoing significant government reforms as a result of substantial increases in health care spending and an ageing population.

Prior to the reforms, hospitals in England were given a fixed annual budget from the government to treat the patients living in their catchment area and there was no competition and patients subsequently had no choice over where they could have their care.

However the government reforms being rolled out over a ten year period propose the following changes: removal of the annual budgets, split up of care into purchasers and providers of care, allow for negotiation on services, introduce a new payment system based on results, introduce a new system whereby patients are given at least four or more providers to choose from, allow private providers to bid for services, and finally allow primary care doctors to commission out services as required. All these reforms allow for increased patient choice between providers and mean that hospitals will have to develop competitive strategies to meet these challenges.

The aim of our study is to assess what strategies managers in English hospitals can use in order to gain a competitive advantage and meet the challenges posed by the government reforms.

From our literature review we concluded that potential strategies could be either deliberate or emergent and potentially further analysed on a theoretical basis of whether they address the “external” or “internal” frameworks as represented by Porters Theories and the resource based view (RBV) of the firm respectively, as these were felt to be the most applicable to our aims. The SWOT framework was proposed as an appropriate tool as it can be split into these two separate schools of strategy. The first school of strategy characterized by the industrial organization or Porter’s theories is represented by the opportunities and threats and the second school of thought, RBV of the firm, is represented by the strengths and weaknesses.

Based on the explorative nature of our research question, a case study using York District Hospital in England was conducted with the use of semi-structured interviews with key management personnel as well as a survey questionnaire to account for all hierarchies of
management and to establish the resource profile of the hospital. Firstly we established what competitive strategies are currently being used in the hospital and then a SWOT analysis of our primary data was undertaken in order to analyse and suggest competitive strategies utilising the “external” and “internal” theoretical frameworks.

Our results demonstrated that the hospital’s competitive strategies were a mixture of deliberate and emergent strategies. The deliberate strategies predominantly addressed the reforms already in place and focused on improving the quality of essential services in terms of aiming to be the main provider of acute services in the catchment area, attracting standard elective work with existing long waiting times, and expanding non-acute/non-elective care capabilities by forging partnerships and sharing clinical support. As these strategies focus on “where” (acute/elective service) a hospital should be competing they therefore represent the external framework based on Porter’s “positional” approach although there were elements of both schools of thought.

The emergent strategies on the other hand, more specifically addressed the reforms being rolled out and were devised taking into consideration aspects such as size, internal resources and competences and therefore represented the internal framework or resource based view as they all involved service diversification by virtue of using specific internal resources and included: increased recruitment of specialised staff, re-organisation of existing clinical space, updating out-dated technology and promoting formation of new services such as a weight management clinic with integrated bariatric services.

Our study demonstrates that by including important elements from different theoretical perspectives this allows for a greater complexity and a wider scope of analysis when evaluating strategy and enhances our understanding of sustained competitive advantage in the English healthcare system. Based on our study we therefore propose a framework for hospitals in England to use in addressing the competitive challenges posed by the reforms, which consists of two broad but distinct strategies: predominantly deliberate strategies for i) competing on quality of essential services and more emergent strategies for ii) competing on service diversification.

Suggested future research possibilities in this area would include repeating the study once the full government legislation comes into place to assess differences in competition and the impact of our suggested strategies.

**KEYWORDS**: competitive strategy, hospital management, healthcare management
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<tr>
<td>A&amp;E</td>
<td>Accident and Emergency</td>
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<tr>
<td>CDU</td>
<td>Clinical Decisions Unit</td>
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<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
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<td>CT</td>
<td>Computer Tomographs</td>
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<tr>
<td>DH</td>
<td>Department of Health</td>
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<tr>
<td>ENT</td>
<td>Ear, Nose and Throat</td>
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<tr>
<td>GP</td>
<td>General Practitioners</td>
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<tr>
<td>GPSI</td>
<td>GP with special interest services</td>
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<td>IPU</td>
<td>Integrated Practice Units</td>
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<tr>
<td>IT</td>
<td>Information Technology</td>
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<tr>
<td>LOS</td>
<td>Length Of Stay</td>
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<tr>
<td>MRI</td>
<td>Magnetic Resonance Imaging</td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>NYYPCT</td>
<td>North Yorkshire and York Primary Care Trust</td>
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<tr>
<td>PbR</td>
<td>Payment By Results</td>
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<td>PCT</td>
<td>Primary Care Trust</td>
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<td>PPS</td>
<td>Prospective Payment System</td>
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<td>RBV</td>
<td>Resource- Based Views</td>
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<td>SCP</td>
<td>Structure-Conduct-Performance</td>
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<td>STH</td>
<td>Strategic Health Authority</td>
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<td>YHFT</td>
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1. INTRODUCTION

The purpose of this section is to familiarise the reader with the core subject of this thesis. It includes a detailed background to the problem in order to facilitate understanding of the issues that our research question seeks to address. The last part of this section gives an overview of the layout of the rest of the thesis.

1.1 Scope of the Thesis

The manner in which organisations respond to and adapt to changes in the market and new competitive forces is an issue of timeless importance. This thesis seeks to addresses this particular issue in the context of the English healthcare environment. As a result of a number of proposed government reforms leading to an increasingly competitive environment, hospitals have to adapt their strategies to respond to these changes and this is the focus of our study. The ensuing section will serve as an introduction to the English healthcare system, particularly prior to the reforms.

1.2 Background to the English Healthcare System

Healthcare in the UK is managed individually by each of its constituent countries namely: England, Wales, Scotland and Northern Ireland. The focus of our study is the English Healthcare system, the National Health Service (NHS).

The English NHS was founded in 1948 and is essentially a tax-funded health system that is free for the end user. The primary care system in England is centred around general practitioners (GPs) who provide patients with referrals to secondary care.

Historically, secondary care has always been delivered in government-owned NHS hospitals, which were funded by annual budgets set by the Department of Health (Klein, 2006).

Significantly, during this period, patients had little choice over where they received care and they were generally referred by their GP to the hospital with whom their local purchasing body maintained a contract.
1.3 Market changes resulting from Government Reforms

In the traditional NHS structure, described above, it can therefore be seen that there was no competition between hospitals (provider trusts) and patients as a result had very limited choices in deciding where to receive care.

As a result of significant increases in health care spending in England, the government proposed to launch a wave of substantial, market-based reforms to the NHS, to be implemented on a rolling basis over the next decade (Department of Health, 2002). The initial proposed time-line is shown in figure 1 below although in reality the majority of reforms took much longer to implement.

Annual hospital budgets were phased out and the government separated the purchasers of care from the providers of care. This introduced two main kinds of roles in the NHS reflecting purchaser/provider roles; GP led commissioning trusts such as Primary Care Trusts and hospitals that serve as the Provider trusts. Primary care trusts principally examine local needs and negotiate with providers to provide health care services to the local population.

The reforms were designed to give patients a greater choice over where they received care and to introduce competition between hospitals, principally within a market with fixed prices.
(Department of Health, 2004). During this period of austerity, the government began to set in motion a variety of policies designed to foster a more competitive environment. One of these policies included the Department of Health in 2011, introducing a payment system, inspired by the United States existing Medicare prospective payment system.

The new payment system, known as Payment by Results (PbR), paid hospitals a fee determined by the government, based on the diagnosis of the patient, adjusting for discrepancies in local wages, specific characteristics of the hospital and some determinants of illness severity. Apart from this, the government also encouraged new private providers to enter the market and gave hospitals much more control including the ability to retain profits.

The overall aims of these NHS reforms were to give patients a formal choice over where and how they were cared for in the secondary care system. Together with a reimbursement system where money followed patients around the system, the resultant introduction of choice into the system created financial incentives for hospitals to now compete for market share. The government also gave patients who were waiting for over a year for care (later lowered to nine months) the ability to go to an alternative provider with spare capacity. Furthermore from 2006 onwards, the Department of Health required that all NHS patients referred for elective care (routine non-emergency operations and procedures) would need to be offered a choice of at least four or more providers for them to choose from.

This was the first time in the history of the NHS whereby a payment system worked in conjunction with patient choice to create financial incentives for hospitals to attract patients. A new referral system (called choose and book) allowed patients and their referring physicians to search for nearby hospitals and included information on providers’ performance and information on average waiting times at each facility in order to enable them to make an informed choice as to where they wanted to have their care.

Further government initiatives allowed patients the possibility of accessing care in the private sector in order to prompt public hospitals to compete with new private entrants. This program allowed private providers in England who registered with the government quality regulator to provide care to NHS funded patients. There are approximately 162 private hospitals in England offering elective secondary care with overnight beds. The new reforms meant that these were
potentially accessible to NHS-funded patients free of charge, if the hospitals agreed to be paid based on standard NHS tariffs. Apart from this, to increase and facilitate the number of referrals, these hospitals were also included on the NHS ‘Choose and Book’ website and were eligible for paperless electronic referrals from GPs in the NHS (Department of Health, 2008). As mentioned previously, in England, the private hospitals account for only approximately 6.5% of the total hospital beds in the country (Boyle, 2011). In general, these private hospitals are similar to private specialty hospitals in the US. However the private sector hospitals in England have considerably fewer beds, usually less than 50 beds, and thereby delivering elective surgical care is their main focus.

The United Kingdom like most other western countries is facing increasing pressure on its health services as a result of an increasingly ageing population. In addition to this with the results of the economic downturn there have already been hospital closures and reduction of services in poorly performing hospitals (Simonet, 2010).

The Department of Health has published figures to show that the National Health Service has now accumulated record debts over one billion pounds which has put pressure on even the high performing hospitals to find ways of cutting costs (Express Newspaper, 4th August 2013). In an attempt to control these spiralling costs, the government has made further reforms for the NHS including the provision for private organisations to bid for services in poorly performing regions. This is not an entirely alien concept as private provision of welfare services is seen in other “state orientated” systems like in Sweden (Blomquist 2004; Anell 2011)

All these policy reforms, have increased patient choice between hospitals and created more effective competition (Centrepiece, 2009). Commissioning has now also been extended to lower levels enabling ordinary doctors who identify a need in their community to commission services to meet that need.

The coalition government that was elected in the last general elections is planning more reforms to the NHS structure that will further increase this role. The plan is for General Practitioners to be responsible for the NHS budget at each local level, abolishing the need for the current primary care trusts. The GP’s will therefore be commissioning out the required services that they are unable to provide to suitable secondary care providers. This is likely to be mostly
hospital trusts but will also include private entities that are able to provide the same services. Some of the existing provider trusts that manage to meet certain stringent conditions are able to apply to become NHS Foundation Trusts, which allow them more freedom although still monitored (Monitor, 2013).

As a result of all these reforms the NHS is set to become a highly competitive environment.

1.4 Competition and the English Healthcare System

The changes seen in the English NHS with increasing patient choice are representative of changes occurring in many other western European countries. Furthermore, free competition and choice are greatly promoted by the European Union and apart from England; other tax-funded countries like Spain, Italy, Ireland and the Scandinavian countries have all introduced choice. Studies suggest that choice and competition in NHS type systems is a favourable way of increasing user involvement without increasing costs (Bevan and Van De Ven, 2010).

How organisations respond to and adapt to changes in the market are crucial to their survival and are underpinned by sound strategies. The fundamental aim of strategy theory is that it guides an organisation in the direction that it wants to go. In order for an organisation to flourish it must formulate its strategy based on its position in a particular competitive environment whilst taking into consideration aspects such as its size, internal resources, and competences. As a result of the proposed reforms, hospitals in the UK will similarly need to respond and adapt to the changes in the market.

A pivotal component of meeting the challenges posed by the reform and the future health care needs of the UK would be to focus on the implementation of sound healthcare strategies to help hospitals navigate through the effects of these market changes (Zhang et al, 2012). Studies have shown that it is possible to transfer and apply strategic management research from other sectors into the hospital environment and to assess hospital performance in the light of these strategies (Madoran and Val Pardo). However other studies have shown that despite this, there are large discrepancies between hospitals in their competitive strategies and subsequently considerable differences in their performance when evaluated on the same scale as any other corporation (Markota et al). However hospitals with coherent competitive strategies have much better
outcomes in terms of efficiency, compared to those without such strategies thereby highlighting the importance of implementing such strategies (Berkowitz E. N., 1994).

1.5 Justification of Study

The overall justification of this study is based on the need to broaden the scope of research conducted in the English health care sector, specifically in light of the new reforms and with regards to competitive strategy. Our study has both theoretical and practical relevance as discussed below.

The fact that NHS Trusts are struggling to determine a long-term strategic direction for their organizations in response to the competitive pressures generated by the NHS and government reforms has been demonstrated in other studies looking at the UK healthcare market and competitive strategy (Maislela et al, 2012). The authors state that development of long-term strategic direction and the methods to implement this are presenting real challenges to the hospitals which have inherited service configurations based on bureaucratic planning frameworks rather than service configurations suited to a more competitive environment. Similar studies in other countries also claim that the challenge for healthcare organizations is to develop suitable competitive strategies that are geared towards addressing the competitive forces they face in the future, rather than responding with approaches that are rooted in the past (Devers et al 2003). This demonstrates the need for studies into competitive strategies in the UK healthcare market following the reforms, as this has not been specifically addressed in the literature.

The UK healthcare system additionally serves as a unique and ideal setting to analyse the development of competitive strategy for a number of reasons. Firstly as Cabiedes and Guillen point out, the UK serves as a role model particularly to the Southern European countries who look to more advanced EU member states for inspiration but also partly due to the policy-making style and the use of the English language (Cabiedes and Guilleen 2001). In addition to this, the status quo of the healthcare system prior to the reforms was in essence a system devoid of competition and therefore from an analysis point of view a “clean slate” or “forme fruste” from which to begin the analysis. This is in contrast to countries such as the USA, where a significant level of competitiveness is already inherent in the system from the start.
The advent of the government reforms, introduced the need for creation of effective competitive strategies for hospitals to be able to sustain themselves in the new competitive environment. Furthermore as the reforms are being rolled out over a period of years, there is an opportunity to formulate strategies, assess the response and modify them based on the effects, in line with the stepwise introduction of new reforms. From a theoretical perspective this allows for development and analysis of both deliberate/intended strategies to counter the reforms already in place as well as for more emergent strategies to be developed as and when the new reforms are rolled out. We will also aim to analyse these strategies in the context of existing competitive strategy theory. In particular we will analyse the strategies that the hospitals have formulated to counter the external competitive forces referencing to Porter’s theories and how hospitals will use their internal resources to establish a competitive edge as proposed by the resource based view of the firm. This will form the basis of our “internal” and “external” theoretical framework (as will be described later in the thesis) and the relationship between these will also be explored in the context of healthcare in order to contribute to theory. As a result of the study we hope to propose a framework that NHS hospitals can use to develop competitive advantage in the context of the reforms. As the strategies are being formulated in response to the reforms, this serves as an ideal setting to analyse these changes in the context of competitive strategy theory and how the various theoretical viewpoints are being drawn upon in the formulation process (Cabiedes and Guilleen 2001).

Our unit of analysis will be the hospital, rather than for instance the patient (end-user). We will specifically be looking at how hospital managers can ensure that they are able to maintain a competitive advantage which will in turn ensure that commissioners will choose their hospital over their competitors when commissioning out various healthcare services on tender as per the reforms.

1.6 Problem Formulation and Purpose

In this study we will therefore assess healthcare competitive strategies that hospitals can use in order to obtain a competitive advantage in the context of the reforms. We will do this by using a representative UK hospital as a case study using an exploratory research approach. We will aim to analyse our results in the context of existing competitive strategy theory, in particular with reference to Porter’s theories and the resource based view of the firm.
Consequently from our discussion above it can be seen that the main objective of our exploratory study is to answer the principle research question below:

*What strategies can managers in English hospitals use in order to gain a competitive advantage in the English healthcare system following the government reforms?*

In order to effectively answer this research question, we have devised the following subordinate research propositions:

1.) *How important do hospital managers perceive competitive strategies to be in the context of the new reforms?*

2.) *What competitive strategies have hospitals formulated to counter the effects of the reforms? Are they deliberate or emergent strategies and are they primarily based on a specific type of strategy (eg cost leadership strategy, differentiation strategy etc) and how do they relate to competitive strategy theory in general?*

3.) *With reference to competitive strategy theory, in particular Porter’s theories and the resource based view of the firm, how well do the existing strategies address a hospital’s position in the new competitive environment whilst taking into consideration aspects such as its size, internal resources, and competences? Based on the above, what further strategies can be formulated to help hospitals meet the future challenges that the National Health Service will face?*

*1.7 Limitations and De-limitations*

Our study is limited in that we are focusing on one hospital and then extrapolating the data from there and as such the healthcare strategies of the chosen hospital may not be representative of other hospitals in the country.

The fact that our chosen trust is a Foundation trust (see section 1.3) and therefore has more freedom in management may slightly skew our results when compared to other hospitals in England that have not attained foundation status.
Due to the diversity of hospital performance, the health care service is a complex system, which is composed of multiple subsystems of different disciplines. Our unit of analysis is the hospital only whilst this topic could also be investigated from several other perspectives including the patient’s perspective or the government perspective, which is beyond the scope of this thesis. Furthermore specific details regarding the strategy formulation and operation within the hospital were not available to us and therefore are again beyond the scope of this study. Each specialized subject in different departments handles the cost and performance in different ways and therefore cost and performance in relation to strategy is not considered in this study. Similarly measurement of efficiency and strategy outcomes is also beyond the scope of our study.

In summary, although the implementation of strategic management at the hospital has some limitations, a clearly stated competitive strategy can make the hospital understand its own advantages and weaknesses, which can reduce the cost of consumption of the hospital business activities and increase the performance of hospital staff, thus allowing people to enjoy the quality and excellence of low-cost health services. Hospital competition can be achieved simultaneously by increasing both the social and the economic benefits.

1.8 Thesis Structure

The components and structural layout of this paper are illustrated in Figure 2 and described below:

Chapter One – Introduction: this chapter focuses on the general background, problem formulation, the purpose of the research & research questions. It also outlines the expected contents of the chapters that ensue.

Chapter Two – Theory: this section focuses on the literature available on competitive strategy and linking it to available hospital management theory. It also highlights the main theoretical concepts to be used to answer the proposed research questions and as a framework for the thesis. It concludes with a case description of our chosen hospital.

Chapter Three -Method: this section illustrates how the study was conducted as well as justifying the chosen research methodology and method of data analysis.
Chapter Four-Empirical Findings and Analysis: This section presents the summary of our results from the data collected and undertakes an analysis related to our case study.

Chapter Five -Discussion: This section focuses on analysing the data presented in the previous section in relation to our theoretical framework and extrapolating from the results of the case study to attempt to find solutions to the proposed research questions.

Chapter Six-Recommendations and Conclusions: This section summarises our principle findings and presents the recommendations resulting from our analysis. This section concludes by making recommendations for further research.

Figure 2- Logical flow of the thesis
2. THEORETICAL BACKGROUND

In this section we will establish the theoretical framework that will be used to answer our research questions. We will start by introducing the term strategy, different types of strategy, competitive strategy theory and relationship with SWOT analysis, the hierarchical levels of strategy and finally we will incorporate all this into healthcare competitive strategy and outline a theoretical framework for our study.

2.1 Strategy

It was Chester Barnard (1938) who first introduced the strategy term into the discipline of business management and he proposed to provide a comprehensive theoretical system to guide the corporate behaviour of enterprises or other formal organizations (Barnard 1938). This is then evolved further in the 1950’s, when Selznick introduced the need to bring an organization’s “internal state” and “external expectations” in order to consolidate and thereby implement an effective policy into the organization’s social structure (Kong, 2008). This perspective was then further developed in 1982 by Weihrich who conceptualized the internal and external analysis into a structured matrix known as the SWOT framework, which will be discussed in detail in the ensuing sections (Kong, 2008).

2.2 The Concept of Deliberate and Emergent Strategies

Strategies are generally thought of as formal plans that have been intentionally devised in advance to achieve some specific goal. Historically many theorists defined strategy in this manner. However it soon became clear that strategies that had been formally planned were not realised as per the initial specific intention and were influenced by other forces that came into play.

Henry Mintzberg has contributed significantly to the concepts of strategy, strategic planning and strategy formulation. Mintzberg (1987), propagated the possibility of strategy being crafted’ rather than planned and proposed that (a) strategies are a result of plans for the future and patterns from the past (b) strategies don’t have to be deliberate; they can also emerge, (c) effective strategies can develop in all kinds of ways, (d) strategic reorientation can happen in
brief but quantum leaps and (e) to manage strategy is to craft thought and action, control and learning, stability and change. Mintzberg therefore defines strategy as a pattern in a stream of actions over time (Mintzberg, 1992). He described “emergent strategy” as something that emerges over time as an organization learns what works in practice. Figure 3 depicts his view of emergent strategy as a set of actions, or behaviour, consistent over time, “a realized pattern [that] was not expressly intended” in the original planning of strategy (Mintzberg, 1992). On the other hand, the strategies that were not achieved according to initial plans are classified as unrealized strategies.

2.3 Planned vs Unplanned Strategies in Unstable Environments

As discussed previously, external forces can come into play in modifying intended strategies. Ansoff (1991, 1994) argues for the need for effective planning in unstable environments just as much as it is a requirement in stable ones. In contrast, Mintzberg stresses the importance of learning, particularly in unstable environments. Mintzberg sees formal planning as flawed in what he refers to as a “change pitfall” which is rigid by its very nature and which has the potential to create what he refers to as “change opposition” (Mintzberg, 1994). A more neutral view is proposed by Steiner and Kunin (1983) who argue, “plans are sometimes useless but the planning process is always indispensable.” Formal planning that is so rigid that it does not allow room for adjustments or strategies without any formalised structure will both lead to ineffective implementation of strategies. Therefore from a pragmatic viewpoint, managers should plan
ahead before executing a strategy but at the same time need to be ready to learn from whatever materialises in reality and adapt to it.

2.4 Competitive strategies

Competition can be defined simply as the fight for market share between two or more firms. Competitive strategy on the other hand has numerous definitions. It can be described as an integrated and coordinated set of commitments and actions designed to exploit core competencies and gain a competitive advantage (Hitt et al, 2003). Porter (1985) on the other hand, defined competitive strategy as the activities a company undertakes to gain a sustainable competitive advantage in a particular industry. Although there exists numerous theories on competitive strategy in the literature, the focus is on how a firm can create and sustain competitive advantage. As such the contributions of Porter (1985; 1996; 2001), Barney (1991), Wernerfelt B (1984) and Hamel & Prahalad (1994) are the most prominent theorists that deal precisely with this issue.

These theorists’ viewpoints are often split into two schools of thought based on their main area of focus and corresponding to the external vs internal analysis of the SWOT framework as will be discussed in detail later. The first school of strategy is the Industrial Organization school of thought such as seen with Porter’s theories, which is represented by the opportunities and threats and the second school of thought is the RBV of the firm represented by the strengths and weaknesses (Kong, 2008).

2.5 Industrial Organisation and Competitive Advantage

The Industrial Organisation school of thought is generally considered to be the most dominant in strategic management where the relationship between the firm and industry is essential. The most prominent model in the literature in relation to this school of thought on competitive strategy is that of Michael Porter (1980). He proposed some generic strategies that, regardless of industry context, organisations can choose from to compete at the business level. The term strategy has various interpretations dependent on the field in question. However Porter’s original definition (1985, p. 47) ‘positioning a business to maximise the value of the capabilities that distinguish it from its competitors’ gives us a broad definition and stresses the essence of strategy which is to
achieve a competitive advantage.’ His approach is therefore often termed the “positional” approach to competitive strategy. His approach essentially emphasises “where” a company should be competing and what the important considerations are when it competes. Porter's five forces and Value Chain concepts comprise the main externally based framework referred to earlier. The value chain is a systematic way of analyzing the full spectrum of activities a firm performs and how they interact. It scrutinizes each of the activities of the firm (e.g. development, marketing, sales, operations, etc.) in an attempt to identify a potential source of advantage. Further details regarding Porter’s five forces and generic strategies will be dealt with in the ensuing sections.

2.6 Resource-Based view and Competitive Advantage

The alternative approach is what is termed the resource-based strategy or the internally based framework. An approach to achieving competitive advantage that emerged in 1980s and 1990s, after the major works published by a number of authors including Wernerfelt, B. (“The Resource-Based View of the Firm”), Barney, J. (“Firm resources and sustained competitive advantage”), Prahalad and Hamel (“The Core Competence of The Corporation”), and others. Proponents of this view argue that organizations should look inside the company to find the sources of competitive advantage instead of looking at the competitive environment for it. Prahalad and Hamel in 1990 used the term "core competencies" which refers to the activities, knowledge and internal organisational structure that a firm is better at than its competitors. These core competencies which are not always visible at first glance are deeply rooted in the firm and provide a basis from which successful product can be developed and allow the firm to compete in a diverse range of markets. This approach is sometimes described as ‘inside-out’ because you look inside the organisation and then decide what strategies to pursue outside it. Proponents of this framework emphasize the importance of a dynamic strategy in today's more evolving business environment where positional strategies are not suited. For instance Prahalad and Hamel (1990) present the concept of “core competencies” as the collective learning in the organization, specifically in how to coordinate diverse production skills and integrate multiple streams of technology. These skills underlie a company's various product lines, and determine how easily successful competitors are able to enter new and seemingly unrelated businesses.
Like the frameworks of core competence and capabilities, firms have varying collections of physical and intangible assets and capabilities, which are referred to as its resources. Competitive advantage is thereby ultimately attributed to the ownership of a valuable resource. Resources can be of various types including physical (e.g. property rights, capital), intangible (e.g. brand names, technological know how), or organizational (e.g. routines or processes like lean manufacturing). Whereas Barney focuses on internal resources as the key to sustained competitive advantage, Hamel & Prahalad (1994) focus on core competencies and argue that a firm’s sustained competitive advantage is to be found in its core competencies. In order for a competence to be a core competence, three criteria have to be met: the competence has to 1) provide access to more than one market, 2) give a significant contribution to the end product/products and 3) be difficult for competitors to imitate (Hamel & Prahalad, 1994).

2.7 Industrial organisation vs Resource Based view

Most resource based view authors recognize that the resource-based perspective and industrial organization tools, such as Porter’s five forces model, complement each other in explaining the sources of firm performance. Foss (1996, p. 19) summarises some of the complementary aspects of Porter’s framework and the resource-based view. The resource-based is more oriented towards the longer run and may allow more fine-grained competitor analysis, it may, for example, be helpful in ascertaining the dangers of future competitive imitation through an analysis of the resources and capabilities of competitors. Porter, in turn, may add an understanding of the external environment in terms of the short run with concepts such as commitment, signalling, the role played by exit barriers etc.

Despite the complementary aspects of the resource-based view (RBV) and Porter’s (1980) framework, some important differences must also be acknowledged. First, arguably, Porter’s (1980) framework and the RBV do not have the same unit of analysis (industry versus firm or individual resource). In fact, Porter (1980) only identifies and discusses industry determinants of competitive advantage; he does not analyse the underlying resource endowments that allow firms to carry out their strategic ploys (Foss, 1996).

Another difference is with regards to articulation among competitive environment, resources and strategy; Porter’s five forces framework builds on the structure-conduct-performance
(SCP) paradigm. In Porter’s framework, the accumulation of resources is part of the implementation of the strategy dictated by conditions and constraints in the external environment. In opposition, the resource-based view suggests that firm resources provide the basis for strategy: strategy should allow the firm to best exploit its resources relative to the competitive environment.

The application of theses competitive strategies in the healthcare market will be discussed further on in this chapter.

2.8 The SWOT Analysis

The essence of developing a corporate competitive strategy is to ensure that the organization’s capabilities fit the competitive market environment. And the proposed corporate competitive strategy shall also adapt the marketing change in the foreseeable future. The organisation's resource profile (often referred to as its strengths and weaknesses) is one of the most critical parts of the corporate competitive strategy (Hooley, 2004).

SWOT method distinguishes T (Threats) and O (Opportunities) as the external environmental factors, and evaluates W (Weakness) and S (Strengths) as internal factors as shown in figure 4.

The SWOT analysis forms effective strategic plan for enterprises. The SWOT analysis helps to match the enterprises' resources and strengths to the competitive environment, and to formulate or select proper strategies.
As strategic management has evolved, the SWOT framework has been split into two separate schools of strategy. The first school of strategy is the Industrial Organization school of thought such as seen with Porter’s theories, which is represented by the opportunities and threats and the second school of thought is the RBV of the firm represented by the strengths and weaknesses (Kong, 2008). The strengths of an enterprise are the internal resources and capabilities, which can be utilized to develop competitive advantage. This reflects the resource-based strategy or the internally based framework that is less based on industry structure and more in specific business operations and decisions. On the other hand the lack of certain strengths is the weakness of the enterprise. The external environmental analysis can also show some new opportunities for enterprise’s growth. This reflects Porter’s focus on an “external” analysis of economics perspective of industry structure, and how a firm can make the most of competing in that structure. On the other hand some external environmental changes can also threaten the enterprise’s survival as a whole.

2.9 Hierarchical level of strategy

An organisation’s strategy can be normally divided into three levels of strategies: corporate unit level, business unit level and the operational level, shown in figure 5. A brief introduction to these levels is helpful for clarifying and estimating the scope of strategy.
Figure 5: Three hierarchical levels of strategies

The corporate level strategy reviews the whole corporation as a whole, and aims to set the big missions of the corporation. Corporate level strategy analyse the similarities among different business units and work to add value to all participating business units. The corporate level strategy generally reflects the stakeholder’s values, expectations, and their overall vision of the organization. The actions such as new products introduction or new market or segments expansion all belong to the corporate level strategy.

Corporate level strategy establishes the mainstream of the strategic decisions, so it gives dominated influence to all succeeding strategies in the cooperation. Bowman and Ambrosini (2007) examined Corporate level strategy and discussed the concept of an organization’s set of businesses. They demonstrated that corporate strategy plays two roles in organizations through the enhancement of value via astute decision-making and through the establishment of appropriate processes to effect the required degree of coordination between value activities.

The business unit level strategy deals with how the companies tend to secure their own identity and market position. The aim of the business level strategy is to increase the company's business value by increasing brand awareness and customer’s product value expectation. In general, there are two ways to increase the perceived customer value, pricing or product differentiation.

The operational level strategy includes the detailed implementation of the strategic decisions on the two upper levels. This level of strategy will translate the higher-level strategies into the detailed business processes, in order to optimize the resources and competencies relocation.

All three levels of strategy have a role to play in the effective functioning of an organization.
2.10 Competition in Healthcare – Theory and Evidence

The concept of health care management was introduced around 30 years ago and has undergone significant changes during these years. The underlying assumption is that the higher rate of competition leads to improved outcomes in provision of public services. Patients’ as consumers have greater freedom to choose between various health care providers and therefore have become more sensitive to the brand and service quality of health care providers. Healthcare management although having become more complicated is now accepted as being essential to succeed.

It is however clear from previous studies that the balance between choice and competition is highly sensitive and healthcare policies do not always generate the desired results (Propper et al 2006). Even in instances when results show improvement in services there is controversy (Cooper et al 2012).

It is generally reported that choice policies exert an influence on the way services are run primarily through incentives for improved performances whereby the money follows the patient’s choice resulting in some type of competition (Propper et al 2008). Evidence from the US suggests that it makes a difference whether prices are fixed or variable, and hence whether providers are competing only on quality or also on price. The evidence suggests that the outcomes are better with fixed price (Shen 2003), as variable prices tend to have a negative effect on quality (Gowrisankaran and Town 2003). Bloom et al reported that increased hospital competition resulted in higher management quality and higher management quality was associated with lower mortality from heart attacks (2010). Cooper et al also demonstrated that competition increased hospital efficiency without compromising patient outcomes (Cooper et al 2010). Gaynor et al also demonstrated that hospitals in more competitive markets had lower all cause mortality and shorter length of stay.

As can be seen the potential costs and benefits of free market competition within the healthcare field have been a source of intense debate. Those who advocate market competition in healthcare stress numerous benefits, which include reduced costs, increase quality, improved efficiencies and incentives to innovate. Others argue that distinct differences exist between hospital markets and other markets and caution against the use of basic economic models when drawing...
conclusions concerning improving the health care delivery system. The opposing view however is that without the existence of a competitive market, individuals lose the freedom to choose and continue to consume medical care for free therefore the market cannot learn what it is an individual values most.

As described there is significant evidence in the literature for introducing competition between health care providers to improve efficiency, and in a number of countries which have introduced market-based reforms designed to create financial incentives for health care providers, improvements in their performance have been reported (Gaynor and Town, 2011). As some studies showed that price competition could have a negative effect on quality of care, the studies by Gaynor and Town explored this further and concluded that this could happen and therefore as a result advocated non-price competition and thereby greater patient choice based on factors other than price. This is consistent with the NHS reforms that also advocate non-price competition based predominantly on quality of services.

The government’s stance on competition in the case of the NHS is clear as they feel it will improve efficiency and offer more choice to the patients. The NHS market is likely to support the pursuit of hospital efficiency, since there is evidence that strong commissioning arrangements, an element of competition, and case based payment system such as England's payment by results are positively associated with hospital efficiency.

How to measure efficiency in the healthcare environment is another challenging point. Common measures of efficiency and quality effects is predominantly based on technical indicators such as mortality or morbidity (Cooper et al 2012) and provide important insights into the possible changes in health outcomes resulting from choice and competition policies. Several studies in the literature use length of stay (LOS) of patients in hospital as a measure of efficiency. In isolation, the new payment system in England should reduce length of stay. The new hospital reimbursement system in England is a per-case, prospective payment system that resembles the US Medicare Prospective Payment System (PPS) introduced in 1983 (Frank and Lave, 1985). Prospective payment should reduce patients’ LOS because under this type of payment system, a hospital’s net revenue per patient decreases with each additional day of care provided (Cutler, 1995). Consistent with the theoretical literature, there is evidence from various countries that has
found that the introduction of case-based, prospective payment systems has led to a reduction in LOS. However measurement of efficiency and strategy outcomes as discussed in the limitations, is beyond the scope of our study and in this thesis we will be primarily focusing on identification of competitive strategies in the light of the reforms.

2.11 Porter’s Theories and Healthcare

Porter’s work is considered by many to be seminal for an analysis of healthcare competition and the general framework suggested by Porter for competitive analysis has been applied in the hospital industry for a long time because it captures the essence of the strategy formulation process (Autry and Thomas, 1986).

Strategies that are able to gain an advantage from the achievement of distinctive value in the marketplace are termed position strategies. As per Porter, distinctive value can be achieved by pursuing the following the “generic strategies” shown in figure 2.

Porter claimed that these strategies were mutually exclusive or “at least non-complementary” and referred to firms that attempted to pursue more than one generic strategy as “stuck in the middle.” Although in the corporate world being stuck in the middle and trying to focus on all the below strategies does not generally work, in healthcare focusing on just one strategy such as cost leadership alone at the expense of patient outcomes will clearly not work. A few studies have shown that a stuck in the middle approach may still work well in the healthcare industry (Kumar et al, 1997).
Porter’s model of generic strategies has still been found to be very useful in analysing the hospital industry as it deals with the strategy formulation process itself, particularly in the US (Autry and Thomas, 1986). The study of Kumar et al. (1997) also examined the application of Porter’s generic strategies (1980) to the US hospital industry and concluded that the five main strategy types (focused cost leadership, cost leadership, stuck in the middle, focused differentiation, and differentiation) were present and consistent with Porters theories.

However, such studies are not readily available for UK hospitals and therefore we propose to use Porter’s model as one of the basis for analysing the existing strategies within our chosen UK hospital.

Porter and Elizabeth O. Teisberg (Porter and Teisberg, 2006) have also emphasized the inherent conflict between the hospital’s fundamental values (delivering health care to the patients) and their economic incentives especially in the current health care system. The authors hold the view that health care providers compete with each other in order to shift costs, accumulate bargaining power, and restrict services, rather than the main aim of creating value for patients. These observations although made in the US healthcare system, which is considerably different from that in the UK, are still likely to be very relevant. In his recent article in the Harvard Business Review, Porter further emphasis that the main aim of any strategy should be to maximize value for patients and sets out ways to do this (Porter and Lee 2013).
Furthermore, it has been observed that health insurance has a relatively large impact on the equilibrium in the market for health care service, which manifests itself as follows: A: The negative impact prior to the treatment: With complete health insurance, the consumer’s incentives for disease prevention will be reduced, thereby increasing the probability of morbidity. So the medical expenditure is increased as a whole. B: Negative impact after the treatment: With health insurance the consumer pays less for the medical treatment, therefore the medical demand will definitely increase. C: Dynamic negative impact on the treatment: Consumers covered by health insurance do not bear the entire cost of medical services with higher quality; therefore there will be a strong demand which can enable the health care providers to provide high quality medical services with high-tech medical equipment, which will cause medical expenses to continue to rise.

2.12 Porter’s Generic Strategies within the Healthcare Industry

In the following sections, Porter’s generic strategies will be briefly presented with reference to the healthcare industry.

2.12.1 Cost Leadership Strategy within the Healthcare Industry

In the current environment one of the most used strategies among hospital managers is that of cost control measures in order to protect themselves from competitive forces arising in the industry as well as to cope with the regulatory changes described earlier. Examples of cost control strategies used by hospitals include reducing quantities of waste, improving coordination between different departments, income generation by selling or renting unused capacity, and of course as demonstrated most recently also reducing staff and eliminating unprofitable services. Using a tight cost control strategy, hospitals have attempted to demonstrate efficiency in use of allocated resources to the resource providers.

Companies pursuing a low-cost strategy will typically employ one or more of the following factors to create their low-cost position, (Porter, 1980):

1) Accurate demand forecasting combined with high capacity utilization

2) Economies of scale
3) Technological advantages

4) Outsourcing

5) Learning/Experience effects

2.12.2 Differentiation strategy within the healthcare industry

There are also hospital activities that fall under the category of differentiation strategy as outlined by Porter. Examples of such generic strategies include utilisation of the latest technologies (e.g. computer tomographs (CT) and magnetic resonance imaging (MRI) scanners), differentiation by types of technology used (e.g. laparoscopic surgery), by emphasising the perceived quality of medical staff (e.g. famous university professors leading the care process), provision of “hotel” services, provision of patient support services, provision of services not commonly offered (e.g. burn units, trauma centres, transplant units, and preventive care). By demonstrating competence and high proficiency, hospitals particularly in the US have attempted to create institutional loyalty and hence price inelasticity.

2.12.3 Focus Strategy within the Healthcare Industry

A focus strategy involves hospitals pursuing a cost leadership or differentiation strategy but competing in a narrow segment – a specific type of medical patient. Focus principles can drive the emergence of a new type of healthcare service organization—specialty hospital (Herzlinger, 1999) or focused care unit (Peltokorpi el at., 2010). The focus strategy can be either low cost or a differentiation strategy.

The UK hospitals do form certain degree of differentiation for their service to please a particular guest segment, by offering a unique service for the chosen market segment. Examples of focus include obstetrics and gynaecology, geriatrics, paediatrics.

Some of the other factors that have also been shown to indirectly affect a hospital’s strategy include things like environmental location and operational technology.
2.13 Porter’s Five Forces and the Healthcare Industry

Any industry has a certain industrial structure. Similarly the health care industry structure refers to the competition between health care industry and other industries as well as competition between the various hospitals.

As per Professor Michael Porter’s model, the healthcare industry is also susceptible to the five competitive forces, shown in figure 3 (Porter, 1980):

![Figure 7 - A graphical representation of Porter's five forces](image)

In comparison to some other industries, the level of competition within the health care industry may not seem as intense. However as will be illustrated below all the five forces still play a significant role in the health care industry.

**The Healthcare Industry Structure Analysis:**

These aforementioned five forces will determine the competitive intensity, and therefore the attractiveness of the health care market. Each of the 5-forces are explained and analysed as below:

a) **Threat of New Entrants**

The new competitor means any organization that is not in the health care industry, but has the capital and power to enter the health care industry. The new competitors bring health care
industry new medical capabilities and resources but will simultaneously gain market share in the health care industry.

New competition has become an increasingly great threat to the health care industry in the UK, despite the relatively high entry barriers. Most recently, very large supermarket chains have started GP clinics within the supermarket so that patients can visit their doctor and do their shopping at the same time. There are also fully stocked pharmacies manned by qualified pharmacists in these shopping centres allowing them to even pick up their medications after the consultation. This threat is likely to increase with further government reforms where services will be commissioned out by GP’s to whoever can provide the cheapest and most efficient service (pulsetoday.co.uk, 2011).

b) Competition among hospitals - Internal or External Rivalry

There is always competition among hospitals in various forms and the degree of competition is mainly determined by the following factors (Porter, 1980):

A: When there are several hospitals in one city or district, some hospitals might feel the pressure of competition in order to obtain higher benefit.

B: Health care market growth rate: Rapid health care market growth rate gives more space for the development of the hospital as well as more resources to access and utilize to meet the rapid growth. When the Health care market grows slowly, the room for hospitals to grow is small. For those hospitals that want to gain a competitive advantage, they have to compete with peer hospitals for increasing market share, which will intensify the competition among hospitals.

c) Substitute Products or Services - Threat of Substitutes

Just like many industries, the hospitals are also facing the competition from alternative health care providers. The so-called alternative health care services provide medical products and service from outside of the hospitals.

The alternative health care services include at least: the clinics, community pharmacies, community health services, and others disease prevention and control services providers. In an
extended definition, the alternative health care services also include healthy lifestyle and habits, sports, health promotion programs, health literacy, herbal treatments, acupuncture, reflexology and other commercial consumer health care products.

The alternative health care services will inevitably raise the level of promoting population health and reduce the total social cost of medical services. Of course hospitals should welcome these ’competitors’, however, the hospital managers would need to consider and adapt to those potential changes when developing the hospital strategies.

d) The Bargaining Power of Medical Suppliers:

Medical supplies constitute a large proportion of the hospital’s budget. The medical supplies needed include pharmaceutical, medical equipment, medical test kits as well as the maintenance materials from the manufacturers. Hospitals will always strive to obtain these products from a supplier with low prices, high quality, and convenient products. In most cases, the hospitals in negotiations with suppliers are usually in an advantageous position as the supplies are usually available from a wide range of suppliers. However there are certain niche items such as certain stents (tubes used in procedures like angioplasties) that are very specific and made only by a particular supplier in which case the monopoly results in a reduction in the bargaining power of the hospital.

e) Patients’ attention to the price -The Bargaining Power of the Patients

This is more directly relevant to private practice in the UK as most treatments on the NHS are free for the patient as they pay mandatory tax and national insurance contributions, which fund their treatments. The patients’ attention to the prices in private practice does however indirectly affect the profitability of the hospital. If a patient perceives the benefit of getting seen earlier privately, because of long NHS waiting lists, to be more than the cost of paying for the treatment then the hospitals will lose out on income as a result of poor efficiency. The hospitals can sometimes recuperate some of this income by allowing their premises to be used for private practice and charging a fee for this to the provider.
2.14 The Ideal Healthcare Strategy as per Porter

In Porter’s recent article in the Harvard Business review (October 2013), which he has perhaps rather arrogantly called “The Strategy That Will Fix Healthcare” he sets out what he believes to be the solution to competitive healthcare strategy (Porter and Lee 2013). He proposes that healthcare organizations appear to have lost focus by concentrating on activity and cost reduction individually. He feels that the core aim should be maximizing value for the patient, namely achieving the best outcomes at the lowest costs. Although this on its own is not a new idea, despite him referring to it as a fundamentally new strategy, it would seem highly pertinent in the current healthcare environment with commissioning of services sometimes being based solely on cost.
Porter, in his article, proposes six ways, which are not mutually exclusive but work together, in which to achieve this ultimate goal of maximizing value for the patient:

1.) **Organize into Integrated Practice Units (IPUs):** Here porter is referring to the problems caused by super-specialisation as it is occurring within the field of medicine, resulting in patients with one disease condition having to attend several departments to see different specialities. While super-specialisation can be a good thing for patient care it also can be a frustrating experience for a patient with multiple problems caused by one disease condition. The most apt example of such a condition would be diabetes, which is increasing in incidence and causes significant mortality and morbidity. Diabetes affects multiple organs including the eyes, the kidneys and nervous system. A patient often has to go and see an ophthalmologist, a renal physician, and a neurologist at different times and different locations, which does not provide a favourable patient experience. Porter instead advocates setting up integrated units such as a Diabetes centre where all the problems can be managed in a more holistic way, under one roof, significantly improving the patient experience and value. This is increasingly being done in the UK.

2.) **Measure Outcomes and Costs for Every Patient:** Here Porter is referring to the importance of measuring outcomes relevant to the patient rather than generic targets and also working out costs in a similar way. Taking the example of the diabetic patient again, instead of just monitoring blood sugars and cholesterol in order to meet specific targets, the patient is likely to be more keen on knowing how likely he is to go blind or develop kidney problems, which are better outcome measures. Once we know what outcomes are important we are then able to work out where costs can be reduced. Porter feels this is the single most important step in improving healthcare.

3.) **Move to Bundled Payments for Care Cycles:** Here Porter states that neither of the two main payment models currently in use, global capitation or fee-for-service, directly reward creating value for patients. He therefore advocates a move to a bundled payment within a specific time interval. For instance with the diabetic patient, calculating the costs for each patient encounter with a different speciality is not sensible and Porter suggests it would be
better to calculate the cost for all the services and resources used for the diabetic patient in a year for example.

4.) **Integrate Care Delivery Systems**: Porter states that we should aim to integrate care so as to avoid fragmentation and duplication of care. This includes streamlining current services and concentrating volume in fewer locations, but at the right locations and with the right calibre of staff. This will help to optimise the level of care being provided.

5.) **Expand Geographic Reach**: This is quite self intuitive and refers to increased patient value and experience created by ensuring that services that provide high quality care are accessible to a larger proportion of patients within a geographical area thereby improving the patient experience. One way is by using a hub and spoke model with one main hospital as a base with links to smaller surrounding hospitals which is something seen in quite a few UK hospitals at present.

6.) **Build an Enabling Information Technology Platform**: Here Porter is referring to the problem of individual departments and hospitals not having an easy and accessible IT system. Porter feels that in order to achieve the above five points effectively, it is required to have a good integrated IT system. Unfortunately this is one of the more frustrating problems experienced by clinicians trying to provide holistic care of patients. For instance doctors in the hospital while have a different system from the GP in the community and will therefore not be able to access or share information from one platform to the other, to the detriment of patient care. Porter rightly advocates using the same IT platform to improve this problem and thereby improve patient care.

Porter in his article appears to provide very relevant points and measures for developing a successful competitive strategy all of which seem to be highly relevant to the UK healthcare system.

### 2.15 RBV and healthcare

The resource-based view (RBV) is one of the most utilized theoretical frameworks in the strategic management literature. Despite this, there are very few studies of its application in
healthcare management and even less so in terms of healthcare competitive strategy. The RBV approach propagates that organisations comprise a mix of tangible and intangible resources, including physical, human and organisational capital. The ‘imperfect distribution’ of these resources across firms within a similar market is thought to account for variation in performance. RBV focuses on resources that have Value, Rarity, are difficult to Imitate, and are Non-substitutable (VRIN) and explain an organisation’s competitive advantage relative to others.

Whilst the application of the RBV to healthcare has been the focus of theoretical evaluation, its empirical application is limited. However its use as a theoretical lens to investigate quality improvement within healthcare has been investigated in one study and found to it to be applicable in this scenario (Burton et al, 2014). A study by Kash et al comparing a children's health and a multi-hospital system located in two competitive metropolitan markets in the US aimed to gain a better understanding of the role of resource based view (RBV) in healthcare strategic management. They conducted semi-structured interviews with healthcare administrators. The two health systems had very similar pursuits in terms of top initiatives, thus indicating that both utilize an externally oriented method of strategy formulation. However the relevance of the RBV became apparent during resource deployment for strategy implementation showing its relevance to the healthcare environment.

We will investigate the use of RBV in competitive strategies in further detail in English hospitals.

2.16 Previous studies in healthcare strategy

The topic of healthcare strategies was explored by Wells et al (2004) through investigating hospital CEOs and their views on how their strategy emerged. Wells et al. (2004) determined that most strategic ideas came from CEOs and their key managers in conjunction with governing boards and medical staff. It is apparent from the above that key managerial levels in health care organisations play an important role in hospital strategy development. Therefore, in order for successful strategies to be developed the CEO, their key managers, in conjunction with the organisation’s board and medical staff, need to be involved. However, the studies discussed above have focused on the overall strategy of organisations, while competitive strategy
development has been explored to a lesser extent, particularly in the UK as most studies in this regard have been conducted in the US.

There is very little known about competition in the English healthcare system in the literature (Propper, 2012). The majority of studies relate to the US healthcare system, which was also noted by Propper. However one previous study into the UK healthcare system showed that some organizations simply follow market trends with little innovation for differentiation or making use of their internal resources (Richardson 2002). However the results of studies looking at healthcare competitive strategies elsewhere (Hopper 2004; Pride & Ferrell 2003) indicate that hospitals were focused on differentiating their services from those of their competitors. These findings shed further light on the aspect of hospitals’ competitive strategies. In particular, that the higher management gave their attention to the activities of competitors, as they deemed that it was important to be aware of what competitors were doing, to monitor the external environment (of which competitors are a part), to determine the capabilities and strengths of the hospitals and to market these accordingly. Competitive marketing strategies in these hospitals were therefore focused on competitor knowledge and monitoring. We will assess whether this holds true in the English healthcare system in the context of the reforms.

The topic of changes in the healthcare environment has been addressed by Ashmos et al (2000), who examined how health care organisations’ respond to dynamic, complex and turbulent environments through assessing goal complexity, strategic complexity, interaction complexity, structural complexity and financial performance. Results appeared to indicate that when operating in a complex environment, hospitals that had a greater internal complexity outperformed those with less internal complexity. The notion that the health care environment is dynamic, complex and highly uncertain is further endorsed by Begun and Kaissi (2004), who associated dynamism in the health care environment with frequency of change and the predictability of change. The health care environment complexity refers to the number of elements in the environment, their dissimilarity and the degree of interconnectivity between them. Complexity absorption and its relationship with organisational performance has been explored by Walters et al (2004), with complexity absorption being the degree to which an organisation responds to increases in environmental dynamism through complicating themselves internally. It was determined that acute care hospitals that undertook complexity absorption
practices experienced a higher level of organisational performance, endorsing the previously discussed findings of Ashmos et al (2000). Wilson and Gilligan (2005) illustrated how dynamic and complex an environment English hospitals are forced to function in, as shown in figure 9.


Figure 9 – Health Care Environment Uncertainty

The topic of emergent and deliberate strategies in health care was explored by Mason et al (2004) by examining health service trusts and investigating the strategies that management and trade unions adopted in their approach towards social partnerships. They found that health care organisations that used a deliberate top-down approach to strategy produced sustainability in both employment and industrial relations whilst on the other hand, health care organisations that implemented emergent strategy that was highly constrained did not move beyond the survivability approach. The studies concluded that the use of emergent and deliberate strategies
in organisations can produce different results. The studies suggested that information technology management can be associated with an emergent strategic approach rather than a deliberate one. Additionally, it can also be seen that both autocratic decision-making and emergent strategy positively affect performance but in different ways. Resource allocation and emergent strategy were also shown to assist in resource decision-making. Interestingly, the studies suggested that a highly constrained approach to emergent strategy in health care did not yield overwhelming positive results. Thus, the use of emergent strategies in organisations, when not highly constrained, positively affects information technology management, performance and resource decision-making. While emergent and deliberate strategies have been explored from the overall organisational point of view, the competitive strategy of the organisation and its linkage with emergent or deliberate strategy has not been investigated to the same degree. Thus, this research will explore the emergent or deliberate nature of competitive strategy with particular focus on the English healthcare system.

2.17 Theoretical Framework Summary

In our thesis we are particularly concerned about how a firm can create and sustain competitive advantage and as such we have chosen to use the contributions of the Industrial organisation school of thought and the resource based view of the firm for our study, for the reasons outlined below.

When applying competitive strategy theory to a particular situation that an organisation finds itself in, it is often difficult to apply the theoretical methods directly and it is therefore accepted that the general framework of theses theories should be used. In this context it is often regarded that the frameworks can be analysed as having two components, namely, external and internal. This lends itself nicely to our chosen theorists as the Industrial Organisation including Porter’s theories focus on an “external” analysis of economics perspective of industry structure, and how a firm can make the most of competing in that structure whilst “internal” analysis, like core competence for example, is less based on industry structure and more in specific business operations and decisions. In the health care environment, the internal environment is considered in terms of staff, patients and resources and the external environment is considered in the form of customers, competitors, private health insurance, staff recruitment, government and policy changes, and public hospitals.
Furthermore as mentioned previously, Porter’s work is considered by many to be seminal for an analysis of healthcare competition and the general framework suggested by Porter for competitive analysis has been applied in the hospital industry for a long time (Autrey and Thomas, 1986). We have also therefore chosen to principally use Porters theories for our analysis as it seems to be the favoured approach in the literature when analysing competition in healthcare and also because some of the fundamental differences highlighted earlier appears to be more pertinent to the NHS. In a taxpayer funded system such as the NHS, hospitals have to be able to offer all services expected of a hospital’s status to a minimum standard and their resources have to be modified accordingly: i.e. a more “outside-in” approach. We will aim to conduct an analysis taking into account Porters generic strategies, Porter’s five forces framework as well as the ideas from his paper entitled “The Strategy That Will Fix Healthcare” (Porter and Lee 2013).

However we postulate that once services expected of a hospital are met, the hospital could focus on its more valuable resources to extend its competitive advantage, which is where RBV comes into play. We further postulate that the RBV perspective may play in new strategy formation based on internal resources given that external resources could become more constrained with the reforms. It therefore becomes important that hospitals leverage relevant internal resources as per the resource-based strategy or the internally based framework in the identification of competitive advantages and effective execution of strategic initiatives.

We will therefore be using the SWOT framework to split and gain insight into the two separate schools of strategy as explained in the theory section. The first school of strategy or the external/positional approach as explained earlier, school of thought, is represented by the opportunities and threats and the second school of thought of ten referred to as the “internal” approach such as the RBV of the firm, is represented by the strengths and weaknesses.

On one hand, Porter’s school of thought regards firm resources as being homogeneous and therefore they see the concept of competitive advantage as being ascribed to external characteristics. On the other hand, the RBV is based on the idea that firm resources are heterogeneous, and therefore views competitive advantage from the perspective of the distinctive competencies and resources that give a firm an edge over its competitors. When focusing only at
the industry/firm level or only at the resource level, the firm will be missing out important insights from each theoretical perspective.

As per our theoretical discussion we will also analyse whether competitive strategies being used are deliberate or emergent and if there are specific instances when one is better than the other.

As discussed, the overall strategy of a firm can be normally divided into three levels of strategies: corporate unit level, business unit level and the operational level and we will be seeking to target all three levels in determining the strategies relevant to the above theoretical frameworks. Further application of our theory to our study will be discussed in the methodology section.

2.18 Case Description- York Teaching Hospital

York is a historic city with a very rich cultural heritage and a popular tourist destination situated in the north of England in the county of North Yorkshire (see map below). York Hospital is the main hospital providing care for approximately 350,000 people living in and around York and also a range of specialist services over a wider catchment area of around 500,000 people in North Yorkshire, and is initially thought to have been founded in April 1740, as a charity hospital. Since inception it has grown rapidly and is now a dedicated teaching multi-speciality hospital. It was given Foundation trust status on the 1st of April 2007 and hence become York Teaching Hospitals NHS Foundation Trust. The creation of the Foundation Trust (see introductory chapter) apart from resulting in greater independence has led to significant changes to the overall governance of the organisation as well as increasing the links with the local community through the appointment of governors and members. (York Hospital 2013).
The Trust provides health care services from its main site York Hospital along with two community rehabilitation hospitals at St Helen's and White Cross Court, and now has a total of 1127 beds.

In addition to this, the hospital also manages satellite renal dialysis units based at Acorn Court, Easingwold and in Harrogate District Hospital. Outpatient services are also provided from premises operated by the North Yorkshire and York Primary Care Trust including Selby War Memorial Hospital. Sexual health services are based at Monkgate Health Centre and School Health Services are provided across York and Selby. The trust employs in total over 8000 staff working across the hospitals and in the community. More than 92 per cent of the Trust's clinical income arises from contracts with the North Yorkshire & York Primary Care Trust. The trust’s current annual turnover is over £400 million and the income plan for 2009/10 was approximately £235m. (York Hospital, 2011)
In terms of geographical competition, the main competitive threats to York Hospital’s services geographically (see map) would be as follows:-

1.) **Harrogate and District NHS Foundation Trust:** Harrogate is another Foundation Trust hospital that has a reputation for effective delivery of services and accessibility for patients on the west side of the York Hospital patch.

2.) **Hull and East Yorkshire NHS Trust:** This is another hospital in the region and although not having attained foundation status yet, still poses a threat to York’s catchment population on the east side of its patch and to the north.

3.) **Nuffield Hospital**: This is the local private hospital situated in York and is an existing competitor for services but which has the potential to become even more so once the new government legislation comes into practice.

4.) **Ramsay Treatment Centre:** Currently the Trust provides staff to enable this private Centre based in York to function on a secondment basis and there are caps on activity and income that the Ramsay Organisation (which currently operates a contract for the NYYPCT) can deliver and obtain. This centre deals primarily with elective surgical procedures.
2.18.1 Hierarchical level of strategy at York Hospital

As described in the previous section, the corporate strategy can be normally divided into three levels of strategies: corporate unit level, business unit level and the operational level. At York Hospital the corporate level strategy is principally formulated by the Director of Strategy in conjunction with the Managerial Head of Medical Specialties and the Chief Executive and board of directors. The business unit level strategy and the operational level strategy at the hospital are both dealt with by the individual managers of each of the 34 departments (Table 1).

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<tr>
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<th>York Hospital Departments list</th>
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<td>1</td>
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<td>2</td>
<td>Upper GI Surgery</td>
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<td>Sexual Health</td>
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<td>Ear, Nose &amp; Throat</td>
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<td>16</td>
<td>Maxillofacial Surgery</td>
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<td>17</td>
<td>Orthodontics</td>
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3 METHOD

In this section the methodology used in this study will be discussed. We will initially justify the selection of the research methods in relation to theory and then will discuss the most appropriate way to collect data and the reasons for our selection. As we as explaining why we have chosen particular methods we will also discuss the limitations of these. We will conclude the section by a brief discussion on the reliability and validity of our data.

3.1 Research Method

In order to identify an appropriate methodology for our study, we need to consider both the nature of the research question as well as the salient aspects of our study conditions.

Yin (2003) proposes that the following three conditions need to be assessed when deciding what type of research method to use in a research study: (a) the type of research question posed, (b) the extent of control an investigator has over actual behavioral events and (c) the degree of focus on contemporary as opposed to historical events.

The first condition relates to our proposed research question and the subordinate questions which all relate to the “what” and “how” categorisation schemes, which according to Yin (2009) are therefore exploratory in nature. In terms of the second condition we obviously have no control over the behavioural events being studied and finally given we are investigating the effects of the new reforms the degree of focus is on contemporary events. Therefore the most appropriate method in these circumstances, according to Yin, is to use a case study, given that our study is exploratory in nature and examining contemporary events were behaviors cannot be manipulated.

The purpose of our research is therefore principally exploratory and descriptive. A case study is defined as research “involving a detailed description of the setting or individuals, followed by analysis of the data for the themes or issues” (Maylor and Blackmon, 2005, p. 191). Within the scope of design-oriented research, a case study is an important research method. Yin (2003) defines a case study as: ‘a case study is an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon
and context are not clearly evident, which relies on multiple sources of evidence.’ Using a case study, allows for reviewing an organization over an extended time period of time as opposed to alternative methods (Maylor and Blackmon, 2005). There are however accepted shortfalls associated with the case study method that are often related to the external validity and the generalization aspect of the findings. Nevertheless, it remains as one of the most popular research methods and many important management concepts have been developed by using a case study approach. As case studies are used to provide an in-depth study of a phenomenon, this approach was considered as the most suitable for this study. It is also important to note that when designing a case study there are two general approaches that can be used, namely the single-case design and the multiple-case-design. Yin (2009) describes the multiple-case -design as more compelling and robust but has the disadvantage of requiring extensive resources and time when comparing with a single-case-design. When selecting a case for a case study, the investigator requires sufficient access to the potential data, whether it’s interviewing people, reviewing documents or records, or making observations in the “field.” Due to these problems with extensive resources and time only having one hospital accessible to us where we had sufficient access, we had to adopt a single-case-design for our study. In addition to this, as per Yin, our hospital was also felt to be “representative” or “typical” case in terms of its size, resources and catchment area making it suitable for a single-case-design.

In terms of selection of an appropriate research approach, different methods have different strengths. Quantitative research, according to Malhotra (2006, p. 137), is focused on quantifying data and applying a form of statistical analysis. Qualitative research on the other hand involves the collection, analysis and interpretation of data that cannot be summarised in the form of numbers (Parasuraman et al, 2004). As our research questions seek to explore, interpret and analyse information regarding the hospitals management strategies, it was apparent that the data would have to be qualitative, since the questions could not be answered with numbers and statistical data. Qualitative methods were adopted since it facilitates data. The advantages of qualitative research are that it requires in-depth data, which gives descriptions and explanations about a particular context. Furthermore, besides answering the initial research questions, qualitative research can provide answers to research questions not originally asked.
There are a number of reasons that justify the use of qualitative methods in this research study. First, the research question is primarily exploratory, in that there is little known about the influence that the reforms have had on competitive strategy in English hospitals. Second, in addressing the research question and its exploratory nature it is important to note that qualitative investigations are situation-oriented and explore unexpected outcomes (Stake 1995). Finally, the exploratory nature of the research question has assisted in the development of further propositions that are explored by qualitative methods, as opposed to the testing of hypotheses in quantitative research methods (DeRuyter & Scholl 1998).

Qualitative research is occasionally referred to as “soft research” but despite this, studies have shown that qualitative research is of no less value than quantitative research (Parasuraman et al, 2004). According to Yin (2003), by using a case study method the researcher can directly interview people involved in the events being studied, and also examine a large range of evidence including documents, articles, interviews and observations. This indicates, therefore, a great depth of information being obtained about each particular case. According to Marshall and Rossman (1999) there are four key characteristics of qualitative research: (a) takes place in the natural world, (b) uses multiple methods that are interactive and humanistic, (c) is emergent rather than tightly prefigured and (d) is fundamentally interpretive. These characteristics are seen in this research as the case studies were conducted in the hospital’s natural environment and the interviews were interactive and humanistic. Emergence was also evident as the case study analysis and interview protocol allowed for the participants’ ideas to surface and generate information throughout the entire process. Interpretation was used through the researcher interpreting the information obtained from a variety of sources within the hospital.

Despite the above advantages, the qualitative approaches still have their weaknesses. The qualitative approaches can have the tendency of departing from the original objectives of the research in response to the changing nature of the context (Cassell & Symon, 1994). There is the possibility of having different conclusion from the same research by different researchers. Other weakness of the approach include, the inability to clearly explain the differences in the quality and quantity of data collected from different respondents, the high level of expertise required by researchers to extract the relevant information from respondents, and the application of different probing techniques by different researchers and the tendency of
respondents to present their thoughts in different ways to different researchers which poses consistency reliability issue to the qualitative approach.

Apart from our chosen exploratory study type, which is used when the problem is unclear, not well known or unstructured, there are two other ways of approaching research questions: descriptive and casual (Ghauri and Gronhaug, 2005). Descriptive type, contrary to exploratory, is used when the problem is already known and well structured. Casual type is also used when the problem is structured but deals with the relation between cause and effect, separating causes then reporting whether and to what extent causes result in effect and therefore again is not suitable to our study.

3.2 Data Collection

3.2.1 Primary and Secondary Data

The data collection process can utilize various different sources and can by definition consist of either primary or secondary data. Primary data relates to gathering information from various forms of observation, surveys, focus groups and interviews. Secondary data on the other hand relates to the use of previously collected data that has been collected for some other reason and is reanalyzed (Saunders 2007). Our study will make use of both types of data although it will be predominantly primary data with the use if some secondary data predominately used to check the validity of our primary data.

In terms of our study and the focus on strategies, our literature review supports the need of all levels of management to be included in strategy making within an organization, and therefore need to be accounted for in our data collection process (Divanna & Austin 2004; Ketokivi & Castaner 2004; O‘Shannassy 2003; Porter 2005). The literature also suggests that there has been little attention devoted to managers in the middle ranks that plays vital roles in strategy (Huy, 2001a, 2002b). Mid-level managers are known to be great contributors to firm innovation especially in strategy processes (Kanter, 1983). As there are several managers dealing with various components of the hospitals strategy, we would require a data collection methodology that would aim to cover each of the steps in the hierarchy outlined in our theoretical framework.
3.2.2 Theoretical Literature Survey

First of all, extensive literature reviews on the topic was undertaken to clarify and develop the effective research question under the enterprise strategies for hospital industry. This research approach includes the extensive collection of hospital strategic management theory and strategy of ecological system theory, including laws, regulations, policies, and rules.

Study and analysis of these documents lead to the understanding of the historical and current situation of hospital strategic management nature, characteristics, principles and processes. Through publications in professional journals, government policy documents, the Internet, books and other data we were able to gain an in depth understanding of hospital competitive strategies and the key points that needed to be brought up in our interviews and questionnaires.

3.2.3 Semi-Structured Interviews

The corporate level strategy at York Hospital as with any corporation establishes the mainstream of the strategic decisions, so it gives dominated influence to all succeeding strategies in the cooperation. At York Hospital the corporate level strategy is principally formulated by the Director of Strategy in conjunction with the Managerial Head of Medical Specialties based on the Chief Executive’s and board of director’s values, expectations, and their overall vision of the organization. In order to get detailed and accurate ideas of the corporate level strategy including the current competitive strategies of the hospital as a whole it was decided that the most appropriate methodology would be to conduct interviews with the principle managers involved in this facet of strategy, namely, the Director of Strategy and the Managerial Head of Medical Specialties. In terms of choice of interview style, it was suggested that having an unstructured interview technique would mean that large amounts of non-specific general data would be obtained which would make it difficult to address our specific questions regarding the current competitive strategies. However on the other hand using a structured interview technique would make it difficult to address the second part of our research questions regarding ways of improving and expanding on the current strategies as we would need a large amount of non-specific information regarding the general functioning of the hospital as a baseline. It has been recommended by Yin (2003) that some case study interview questions be open-ended, allowing for the opportunity to ask respondents both facts and opinions about a specific event or matter. Therefore a semi-structured interview technique was chosen with
specific pre-determined topics that needed discussion with a mixture of open and closed questions to supplement data. (Research Methods for Business Students, p 318 -360 Mark Saunders, Philip Lewis, Adrian Thornhill). Furthermore, semi structured interviews allow the interviewee to express their opinions, concerns and perception as well as offers the interviewer the opportunity to explore areas which may cause problems or confusions thus ensuring a good understanding of the responses.

As suggested above the use of semi-structured interviews with additional probing questions was felt to be the best way of obtaining data regarding the hospital corporate competitive strategy. We therefore conducted semi-structured interviews of the top-level managers involved with competitive strategy, namely:

1.) Mr Neil Wilson, Director of Strategy and Marketing.

2.) Mr Mike Harvey, Managerial Head of Medical Specialties.

The interviews were conducted in one-hour appointment slots and were recorded for ease of transcribing. It has been suggested by Eisenhardt (1989) that case study write-ups (pure descriptions of the case organisation) assist in the generation of insight and allow the researcher to cope with the volume of data collected from each case organisation. In addition to this, the interviewer being a medical doctor with some knowledge of healthcare marketing and competitive strategy aided the flow of the interview and choice of open and closed questions. The interviewing questions covered several aspects of hospital competitive strategy management including strategy level points of view, the three levels of strategy, current competition, Porter’s forces, overall trust SWOT analysis and specific strategy questions as seen in Appendix B.

3.2.4 Survey Questionnaire

The business unit level strategy and the operational level strategy at the hospital are both dealt with by the individual managers of each of the 34 departments in the hospital based on the ethos of the established corporate level strategy. Due to the large numbers of managers involved in this aspect of the hospital strategy it was decided that a survey approach with the help of a questionnaire would be the most beneficial methodology to use in order to get maximal
information but at the same time taking into consideration the time restraints of our thesis deadline.

A survey is a useful research method to collect specific information from a focused group. It is very common to use standardized questionnaires as the format for a survey. Theoretically a standard survey includes several parts, such as requiring selected populations for inclusion, pre-testing the instruments, determining survey delivery methods, checking survey validity, and analysing survey results.

Generally a survey is a method of continuous performance enhancement, in another word; the results of survey analysis will generate the improvement mechanisms, which will lead to better results in the next survey. Therefore an information flow loop is issued for continuous performance improvement.

As explained earlier, due to the large numbers of managers involved in this aspect of the hospital strategy it was decided that a survey approach with the help of a questionnaire would be the most beneficial methodology to use in order to get maximal information but at the same time taking into consideration the time restraints of our thesis deadline.

A SWOT analysis was deemed to be the best basis for our questionnaire for two main reasons: Firstly it would allow us to establish the resource profile at a departmental level (business and operational unit level) and secondly this would provide valuable data for us to look at ways of improving the existing strategies and for developing new ones.

As the Director of Strategy and Marketing was very keen on reviewing the outcome of our study he too supported us performing the SWOT analysis with the various department heads. In addition to this he also wanted to collect additional information for his own purposes to help him with other strategic concerns beyond the scope of our study. The questionnaire was therefore formulated in conjunction with him and was made generic for mutual benefit. The added advantage from our study’s point of view was that as the survey was sent through official channels the response rate was likely to be very high as it was deemed mandatory for the benefit of the trust. Poor response rate is generally considered to be one of the biggest drawbacks of the survey method and this approach therefore eliminated this drawback. Each
and every head of department were summoned to their monthly managerial meeting and the purpose of the questionnaires were explained to them at the meeting in order to facilitate ease of filling it in, as there are no specific instructions on the questionnaire itself. They were all given two weeks to fill in the questionnaires and it was explained that the results would be confidential and only accessible to us and the Director of Strategy and Marketing. The questionnaire, which is included in the appendix, is attempting to give an insight into the current hospital strategy management from each department manager or clinical lead. Based on these results we propose to develop effective strategies for the hospital management system.

Having completed the SWOT Matrix, the strengths and weaknesses as well as the opportunities and threats would give us an idea of how well the current strategies are being implemented as well as give us data to help formulate further competitive strategies. The S-O strategies will be utilized to enhance the hospital’s ability to pursue external opportunities, which are matched to its strengths. The purposes of W-O strategies are to pursue opportunities by overcoming weaknesses. In order not to be susceptible to certain external threats the W-T strategies generate a defensive plan nullifying the hospital’s weakness. The S-T strategies describe how to utilize the hospital’s strength to be less vulnerable to any external threats.

### 3.2.5 Review of Internal Documents related to Competitive Strategy

Access was granted to the hospitals internal documents outlining various strategic plans, cost reduction strategies, differentiation strategies as well as competition and market share and this constituted our secondary data. The annual report and accounts documents were also analysed as well as a departmental breakdown of costs, expenditures and profits. This was used in order to triangulate the results from our other sources.

So in summary the principal methods used in data collection were:

1) Theoretical literature survey

2) Semi-structured interview with the Director of Strategy and Planning as well as the Managerial Head of Medical Specialties at the Hospital

3) Survey questionnaire sent out to all department heads in the Hospital
4.) Review of internal documents related to management strategy

3.3 Data Analysis and Presentation

Qualitative data analysis is carried out on the collected data generally through content or thematic analysis, which essentially involves examination of the data for recurrent instances of some description. Considering we are using existing theory and concepts in the process of our qualitative research, we have decided to rely on the theoretical propositions in the analysis of the data we will be collecting. These theoretical propositions obviously formed the basis for the literature reviews we did and the interview and survey questions that were drafted. Yin similarly states that ‘the proposition helps focus attention on certain data and ignore other data, the proposition also helps to organize the entire case study and to define alternative explanations to be examined’ (Yin R. 2003 pg. 112). In terms of qualitative research, data interpretation is based on a process of inductive inference (Tashakkori and Teddlie 2003b), which essentially details the need to create meaningful and consistent explanations, understanding, conceptual frameworks, and/ or theories drawing on a systematic observation of phenomena, developing data-driven hypothesis and new theoretical perspectives and understanding of the phenomena under investigation (Gelo et al, 2008).

Presenting qualitative results in essence relates to a discussion of the evidence for the emerged themes and perspectives. The purpose of this is to build a discussion that persuades the reader that the identified categories and dimensions are effectively grounded in the observed data, and not imposed by the researcher. Figures, maps or tables may be utilized to present these data effectively.

3.4 Validity and Reliability

In order for a research study to be of value, it must conform to certain principles. Validity in the context of a research study is defined as “the correctness or credibility of a description, conclusion, explanation, interpretation, or other sort of account” (Maxwell 2005, p. 106). Reliability on the other hand refers to “the extent to which your data collection techniques or analysis procedure will yield consistent findings” (Saunders 2007, p149). Validity and reliability are usually seen as closely related.
Yin subdivides validity further and states that there are therefore essentially four tests that can be used to test the quality of a case study which are: construct validity, internal validity, external validity and reliability (Yin 2009). He who ever also clarifies that the concept of internal validity does not apply to explorative studies like ours as it deals with the effects of false assumptions about casual relationships.

Construct validity on the other hand, refers to the potential bias from subjective judgments and involves identifying correct operational measures for the concepts being studied and is relevant to a case study. Yin proposes a few methods to increase construct validity including using “multiple sources of evidence,” “chain of evidence,” and to have the case study report reviewed by key informants. These approaches were used in our study. Firstly we used triangulation to establish multiple sources of evidence. The process of triangulation ensures that data is cross examined or double checked and so in order to support any conclusions that are made. (Saunders et al, 2009). In our study we utilised both data triangulation by gathering information from several sources as well as methodological triangulation by using multiple methods (interviews/survey) for gathering data as discussed earlier (Turner and Turner 2009). We also conducted a review of hospital internal documents to supplement the information gained from our interviews and survey. These documents were predominantly acquired from the Director of Strategy with the remaining being publicly available documents related to the hospitals expenditure and business plans.

External validity refers to the degree to which the results from the case study can be generalized to other situations or in other words defining the domain to which a study’s findings can be generalized. In a single-case case study, such as ours, this condition is satisfied by using theory whilst in the case of multiple-case studies replication logic is used. We have however discussed the limitations of generalizing from our case study in the limitations part of our theory section.

Reliability as defined earlier is more to do with demonstrating that specific operations of the study such as the data collection procedures can be repeated, yielding the same results. Due to the drawbacks with an explorative approach particularly using a semi-structured interview (different conclusions can be drawn by different researchers) this is more difficult to prove as when compared to a quantitative study. As both validity and reliability concern measurement to some degree, qualitative researchers have raised the issue of relevance of these two terms to
qualitative methods of research. For instance trustworthiness and authenticity have been suggested as potential terms taking the place of validity and reliability in the assessment of qualitative research (Bryman 2004).

3.5 Methodological framework summary

The methodology for out study has been described above. Figure 12 illustrates our methodological framework in the form of a flowchart.
Figure 12- Methodological Framework
4.0 EMPIRICAL FINDINGS AND ANALYSIS

The findings from our study will be illustrated below in different sections corresponding to our subordinate research propositions and theoretical principles, which will ultimately seek to answer our principle research question. An analysis of our findings and research proposition in relation to our case study hospital will also be undertaken.

4.1 Current and Future Perception of Health Care Competitive Strategy

In this section we address our first research proposition:

_How important do hospital managers perceive competitive strategies to be in the context of the new reforms?_

We firstly noted that all the hierarchies of management were aware of the implications of the government reforms and the need for competitive strategies. In addition all the managers were familiar with the current competitive strategies being used in the hospital as they seem to have been communicated down well throughout the hierarchies of management. The managers interviewed also all agreed wholeheartedly on the importance of competitive strategy particularly in the current environment.

The managers did however concede that they felt that some the current strategies in the hospital were lacking and out-dated and in need of updating due to the on-going changes. The main reason they suggested for the deficiencies in the current competitive strategies were that historically the trust has not been focused on competing with other trusts and services as prior to attaining Foundation status and the introduction of the government reforms this was not on the top of the trust’s priorities.

In terms of the importance of competitive strategy going forward, again the managers were unanimous in their feelings that in the next few years with the new government reforms and GP commissioning the increasing competition with their local rivals will make their competitive
strategy pivotal for the trust in the future. They were all therefore very encouraging of our study as the benefits to the trust were very apparent.

4.2 Current Competitive Strategies

In this section we address our second research proposition:

*What competitive strategies have hospitals formulated to counter the effects of the reforms? Are they deliberate or emergent strategies and are they primarily based on a specific type of strategy (eg cost leadership strategy, differentiation strategy etc) and how do they relate to competitive strategy theory in general?*

The main competitive strategies that we were able to identify from our study are discussed below.

1.) **Aim to be main provider for acute services to local community:** As mentioned previously in the introduction the two main competing hospitals in the area that provide acute services (Accident and Emergency Services) are Harrogate and Hull and therefore the trust is actively trying to ensure that the do not lose acutely unwell patients to these competing trusts. They have several initiatives in place to improve the function of their Accident and Emergency services that have been previously accused of being slowly and not meeting their maximum four-hour wait targets. The principle means by which they have done this is to increase the capacity of their nursing staff and employing more non-training doctors as well as a recent new Consultant appointment with a special interest in paediatric emergencies.

This was a deliberate strategy formulated to compete on essential services. As it is dealing with a particular segment of healthcare (acute services), it could be classified as an example of focus strategy with emphasis on differentiation to stand out from its competing hospitals.

2.) **Aim to develop “Secondary Care Plus” services for wider North Yorkshire population:**

The trust’s main function is to provide secondary care and in order to increase their appeal to patients they have attempted to add some services (therefore the plus) that are usually provided by big specialised tertiary centres, in this case Leeds. The two specialties in which
they have managed to do this are in providing invasive vascular services as well ENT (Ear Nose and Throat) services. As York is a considerable smaller hospital when compared to Leeds they are not able to take over all the work being undertaken by Leeds and so they have managed to form clinical alliances in these fields with Leeds and so are able to profit share as well as improve the quality of the services provided.

This was considered to be a more emergent strategy in response to the government reforms resulting in patient’s having a choice of provider via the “choose and book” system. By providing these additional services the trust is aiming to make itself more attractive to patients choosing a provider by diversifying their services.

3.) **Aim to attract additional elective work from neighbouring providers to enhance service capability, quality and income:** Here again the trust is aiming to take some work away from the bigger tertiary centre at Leeds. The specialty in focus on this occasion is Cardiology with them attempting to carry out elective (routine) angioplasties that are on the waiting list in Leeds. This therefore enhances services by allowing patients quicker appointments and of course enhances the trust’s income and image in the region.

This was another deliberate strategy formulated to compete on essential (routine) services. The main focus with this strategy is to improve the capability and quality of essential services allowing for patients to choose York Hospital rather than the larger centres due to reduced waiting times and reputation of the hospital.

4.) **Aim to provide clinical support services to NHS / non NHS neighbour providers:** The trust provides additional NHS services to more rural parts of their catchment area through community rehabilitation hospitals, mentioned in the introduction, at St Helen's and White Cross Court thereby increasing their presence in the region. In terms of non NHS work, the Ramsay Centre which is another private centre referred to in the initial section which provides private surgical procedures is actually staffed by York Hospital staff and this in turns allows the trust the privilege of using this facility to shorten NHS waiting lists by carrying out NHS procedures at an additional site.
This was another very deliberate and clever strategy formulated to not only counter the threat of private providers as a result of the reforms but also at the same time improve the quality of the existing essential services by reducing waiting times through the use of an additional site.

5.) **Aim to expand non-elective care capability:** Here the trust here is referring to patients that are somewhere in between acutely unwell and elective, such as Elderly and Walk-in-Centre patients. The trust has an out-of-hours general practice facility within the Accident and Emergency Department which allows for patients with minor ailments to be reviewed and treated without affecting the Casualty departments waiting time.

This was another deliberate strategy formulated to compete on essential services by improving the capability and quality of services offered allowing for patients to choose York Hospital rather than the larger centres due to reduced waiting times and reputation of the hospital.

**4.3 Quality of Competitive Strategies in relation to theoretical framework and formulation of future strategies**

In this section we address our third research proposition:

*With reference to competitive strategy theory, in particular Porter’s theories and the resource based view of the firm, how well do the existing strategies address the hospital’s position in the new competitive environment whilst taking into consideration aspects such as its size, internal resources, and competences? Based on the above, what further strategies can be formulated to help hospitals meet the future challenges that the National Health Service will face?*

In order to answer this question, we first need to analyse the results of our SWOT analysis in order to relate it to our theoretical framework as per the flowchart in figure 3 in our theory section with the strengths and weaknesses representing the internal framework or Resource Based view of the firm and the opportunities and threats representing the external framework or Industrial organisation’s or Porter’s theories.
4.3.1 SWOT Questionnaire Results

Due to our chosen method of sending out the questionnaires via official links we were able to get a 100% response rate to our survey. As a result, a substantial amount of data was obtained from our 36 departmental questionnaires and table 2 below is an extract of our principle findings excluding any repetitive comments. In the interest of confidentiality the comments have not been linked with the departments. In addition to this the results of the SWOT analysis at the corporate strategy level are also included here from our semi-structured interviews. The comments are further substantiated below.
Table 2: SWOT four block results (Sample Raw data)

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Experienced teams with specialisation</td>
<td>× Theatre capacity and staffing</td>
</tr>
<tr>
<td>✓ Cohesive working</td>
<td>× Staff working for specialty not employed by specialty.</td>
</tr>
<tr>
<td>✓ Modern practice/innovative/proactive</td>
<td>× Junior Doctors: Availability/shortage</td>
</tr>
<tr>
<td>✓ Flexible workforce</td>
<td>× Lack of protected time for training</td>
</tr>
<tr>
<td>✓ Well trained workforce and good retention</td>
<td>× Lack of electronic data systems/computerisation/information/report</td>
</tr>
<tr>
<td>✓ Strong relationships delivering excellent inter-specialty working</td>
<td>× Out-dated systems</td>
</tr>
<tr>
<td>✓ Areas of excellent environment</td>
<td>× Shortfall in secretarial support</td>
</tr>
<tr>
<td>✓ Good audit</td>
<td>× Lack of clarity about acute medical service model</td>
</tr>
<tr>
<td>✓ Clinical alliances with other hospitals</td>
<td>× Single handed practitioners/specialists</td>
</tr>
<tr>
<td>✓ Partnership working with Hull-York Medical School, University of York, University of Leeds and mental health</td>
<td>× Lack of rehab facilities</td>
</tr>
<tr>
<td>✓ Good communication within teams and across Trust</td>
<td>× Primary care lack of standards and pathways</td>
</tr>
<tr>
<td>✓ Growing research and academic links</td>
<td>× Increasing acuity and dependency of patients</td>
</tr>
<tr>
<td>✓ Strong relationships with managers</td>
<td>× Lack of Pharmacy cover on wards</td>
</tr>
<tr>
<td>✓ Well organised services and consultant rotas</td>
<td>× Lack of services for dementia patients</td>
</tr>
<tr>
<td></td>
<td>× Sub-specialisation of consultants</td>
</tr>
<tr>
<td></td>
<td>× Small number of clinical trials</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Opportunities</th>
<th>Threats</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Laparoscopic training centre</td>
<td>➢ Cherry picking/fragmentation of services by Commissioners</td>
</tr>
<tr>
<td>o Specialist centre for Bariatrics</td>
<td>➢ Commissioner triage schemes and exception panel processes diverting work away</td>
</tr>
<tr>
<td>o Re-designation of spare capacity</td>
<td>➢ Commissioners choosing alternative providers – other Trusts, primary care, private sector</td>
</tr>
<tr>
<td>o Vascular development – Harrogate and Scarborough</td>
<td>➢ Private sector providers cheaper</td>
</tr>
<tr>
<td>o Additional work from periphery of catchment</td>
<td>➢ PCT funding issues</td>
</tr>
<tr>
<td>o Tertiary work - secondary care plus</td>
<td>➢ Tooling up of tertiary centres</td>
</tr>
<tr>
<td>o Improved efficiency in outpatients</td>
<td>➢ Leeds/Hull Cancer centre</td>
</tr>
<tr>
<td>o Service development/specialisation</td>
<td></td>
</tr>
<tr>
<td>o PCT takes more of simple work freeing up capacity</td>
<td>➢ Hull cardiac centre</td>
</tr>
<tr>
<td>o GP with special interest services</td>
<td>➢ Hull/Leeds Endocrinology Centres</td>
</tr>
<tr>
<td>o Community Geriatrician</td>
<td>➢ National drive for centralisation – affecting critical mass of services provided locally</td>
</tr>
<tr>
<td>o Academic posts</td>
<td>➢ PCTs reluctant to support patient – led referral (loss of control)</td>
</tr>
<tr>
<td>o Allergy services</td>
<td>➢ Recruitment to posts may be difficult where specialist work is moved to tertiary centres</td>
</tr>
<tr>
<td>o Chest Pain service for North Yorkshire</td>
<td>➢ More career opportunities for community Pharmacists given imminent legislative changes</td>
</tr>
<tr>
<td>o Harrogate sexual health services managed by York</td>
<td>➢ Other Trusts offering more competitive employment packages</td>
</tr>
<tr>
<td>o Walk in centre</td>
<td>➢ Impact of Screening Programmes – workload and governance implications</td>
</tr>
<tr>
<td>o Clinical Decisions Unit in A&amp;E</td>
<td>➢ Dependency on Social Services supporting effective/efficient discharge</td>
</tr>
<tr>
<td>o Children’s A&amp;E</td>
<td>➢ Uncertainty of impact of changes to tariff</td>
</tr>
<tr>
<td>o Private provision of some services</td>
<td></td>
</tr>
<tr>
<td>o Self referral of patients</td>
<td></td>
</tr>
<tr>
<td>o Radiotherapy service</td>
<td></td>
</tr>
<tr>
<td>o Expanding role of cancer centre</td>
<td></td>
</tr>
</tbody>
</table>
Due to the large amount of data generated, we have further summarised the top responses in the following table:

### SWOT Analysis Summary (Top Responses)

<table>
<thead>
<tr>
<th>Internal Strengths</th>
<th>Internal Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Quality of staff</td>
<td>1. Lack of space</td>
</tr>
<tr>
<td>2. Strong partnerships with external organisations</td>
<td>2. Lack of staff</td>
</tr>
<tr>
<td>3. Well organised services</td>
<td>3. Poor IT system</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>External Opportunities</th>
<th>External Threats</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Innovative/new services</td>
<td>1. Commissioning bodies</td>
</tr>
<tr>
<td>2. Improving existing acute services</td>
<td>choosing alternative provider</td>
</tr>
<tr>
<td>3. Extending services geographically</td>
<td>2. Threat from larger hospitals and organisations</td>
</tr>
<tr>
<td>4. Introduction of academic posts</td>
<td>3. Competitors offering better employment packages</td>
</tr>
</tbody>
</table>

Table 3: SWOT Summary

As discussed in the theory chapter, the internal framework corresponding to the resource-based view is represented by the strengths and weaknesses and the external framework by the opportunities and threats. We will now delve into more detail with regards to the top responses corresponding to each of the sections above from the SWOT analysis of the questionnaire and then relate it to our theoretical framework.
4.3.2 Practical and Theoretical relevance of the “Internal” Framework perspective

Internal Strengths:

As can be seen from figure 8 below, the majority of managers felt that the strengths of the individual business and operational units are the quality of the staff in the departments. Several questionnaires mentioned the strengths of the staff in terms of specialisation, communication between members, quality of practice and growing research and academic links. This was again supported by our interviews as the overriding strength of the trust was felt to be the quality of the staff employed even at a corporate level. The strength of alliances between the different regional hospitals was also brought up as a strength suggesting that the corporate strategy (points 2 and 3) is being well implemented at the departmental level.

Internal Weaknesses:

The weakness conversely appears to be mostly concerned with actual numbers (quantity and not quality) of available staff being inadequate. This was particular highlighted in terms of number of junior doctors, nurses, pharmacists and secretarial staff. This was also reflected by our interviews indicating that the corporate level unit are also aware of this problem. There was also
repeated mention of a lack of working space including theatre availability and rehab facilities. Inadequacies in research in some departments were also felt to be a problem as there were not many active on-going clinical trials. Furthermore there were concerns regarding the new models in dealing with acute services and this seems to be a reflection on the corporate strategy with regards to becoming the main provider of acute services (point 1). Another point that was raised was that a lot of the IT systems currently in use were felt to be out dated and needed replacing.

Figure 14: Main weaknesses based on SWOT responses

As described earlier, this perspective represented by the Resource Based View, argues that organizations should look inside the company to find the sources of competitive advantage instead of looking at the competitive environment for it. This can be analysed by addressing the components of the SWOT framework, which address this aspect, namely, the strengths and weaknesses of the organisations as shown above.

The main strengths were felt to be the quality of the staff in the departments. Several questionnaires mentioned the strengths of the staff in terms of specialisation, communication between members, quality of practice and growing research and academic links. This was again supported by our interviews as the overriding strength of the trust was felt to be the quality of the staff employed even at a corporate level. The strength of alliances between the different regional
hospitals was also brought up as a strength suggesting that the corporate strategy is being well implemented at the departmental level. We can therefore see the influence of the resource-based view in the two existing strategies (no 2 and 4) below:

2.) **Aim to develop “Secondary Care Plus” services for wider North Yorkshire population**- here the trust are making use of their strength of alliances between the different regional hospitals by managing to form clinical alliances with the larger hospitals in Leeds and so are able to profit share as well as improve the quality of the services provided.

4.) **Aim to provide clinical support services to NHS / non NHS neighbour providers**- here again the trust are making use of their strengths by utilising their existing links with the community rehabilitation hospitals, at St Helen's and White Cross Court thereby increasing their presence in the region. In terms of non NHS work, they are also making use of the Ramsay Centre which is another private centre referred to in the initial section which provides private surgical procedures staffed by York Hospital staff and allows the trust the privilege of using this facility to shorten NHS waiting lists by carrying out NHS procedures at an additional site.

These strengths will also serve as further basis for the formulation of future strategies as will be discussed in the next section. The weaknesses can be seen as ideal starting points to initiate new competitive strategies that will raise the profile of the hospital and allow it to compete using its internal resources. Meanwhile, the S-O strategies can be utilized to enhance the hospital’s ability to pursue external opportunities, which are matched to its strengths. Furthermore, W-O strategies are used to pursue opportunities by overcoming weaknesses, while in order not to be susceptible to certain external threats the W-T strategies generate a defensive plan nullifying the hospital’s weakness. The S-T strategies describe how to utilize the hospital’s strength to be less vulnerable to any external threats. Our suggested competitive strategies based on the internal resources are:

1.) **Improve Staffing Levels:** This was raised as a problem in several of the trust departments and appears to be significantly affecting performance. In particular junior doctors, nurses, pharmacists and secretarial staff were felt to be lacking. Possible causes for this also become apparent from our study. It appears some of the competing trusts are providing better employment contracts tempting staff to leave York for these more favourable prospects. In addition to this pharmacists working in the community have better opportunities due to recent
government legislation consequently reducing the numbers staying in hospital. It would appear that the trust is suffering from previous cost leadership strategies that have reduced staff numbers for increased profits. However as can be seen this reduction appears to be affecting the running of several departments and a balance needs to be drawn as once services are affected this will result in patients deferring elsewhere ultimately resulting in bigger losses. Possible solutions to the problem, which would mean hiring new staff, may appear expensive to the trust but would be better in the long run. Our study also shows that several departments felt that there was a lack of clinical research being performed and one way to possibly solve both problems may be to advertise part-time academic/part-time clinical posts. This would mean the additional workforce, who may be research nurses, doctors and pharmacists could enhance the clinical side as well as being involved in clinical research, which would bring money in through research grants as well as make the trust stand out as a provider of research excellence.

2.) **Increase Hospital Space:** On the whole there were several departments complaining of a lack of clinical space with the exception of three departments situated in the old part of the hospital who felt that large parts of the old wing were not being utilised as they had been shut down a while ago. Clearly it would be a difficult task and expensive for the hospital to acquire new clinical areas, but it would appear that the trust would benefit from re-organising the currently available space based on clinical needs and opening up the old wing that has been shut. In addition to this, in return for staffing the Ramsay Centre they should consider using some of the theatre space available there to perform NHS procedures that have been waiting for a long time due to a lack of operating space. Here again sharing some of the services they provide with their competitors may be a last resort cost leadership strategy, as this would be better than losing out on the services completely due to inefficiencies resulting from a lack of clinical space.

3.) **Update Out-dated Technology:** Several responses to our survey hinted at the use of out-dated technology being one problem affecting clinical effectiveness. The investment required to acquire more state of the art technologies may be hefty but the benefits could be rewarding. Secretarial staff is probably likely to stay on if there are good IT facilities such as digital dictation for example. Clinical staff would probably find that they would be more efficient in managing their daily tasks if the computer systems were upgraded and the trust went paperless, as would the management staff. All this would certainly have a favourable effect on the patient’s perception of the care they are receiving, thereby increasing popularity of the hospital. Good
technology would probably also have favourable effects on waiting times for procedures and the enhanced patient experience would increasing the bargaining power of the trust as a supplier. In terms of Porter’s ways of maximising value to the patient, this could also be seen as an ideal example of Porter’s emphasis on building an enabling information technology platform.

4.3.3 Practical and theoretical relevance of the “External” Framework perspective

External Opportunities:

The managers of the various departments identified a variety of different opportunities, as shown in figure 10 below. Most of these were in the form of the trust seeking to provide new services not currently being offered. The ones that were mentioned a few times include: offering laparoscopic training for doctors from other regions to increase revenues, development of bariatric services given the large increase in the prevalence of obese patients, working on the success of the vascular service sharing with Leeds (corporate strategy point 2) to start partnerships with other regional hospitals, General Practice with special interest services (GPSI), chest pain services, allergy and radiotherapy services. Furthermore opportunities were identified to improve the trust acute services as per the corporate strategy point 1 by way of introducing a clinical decisions unit (CDU), which increases capacity, as well as having a dedicated children’s Accident and Emergency department. Also suggestions were made to introduce academic posts so that people are explicitly employed to increase the research capabilities of the trust. Along with the current trust strategies, also backed up at the interviews, opportunities were also seen in taking work from peripheral catchment areas as well as by providing services in the community from the hospitals such as community geriatrics for older patients who cannot travel to the hospital.
External Threats:

The main threat identified by all the managers was that of the current commissioning bodies not purchasing the services of the trust but going elsewhere for cost or other reasons as shown in figure 11 below. The feedback from the interviews were that with the expected new government reforms where the GP’s will be commissioning services this is going to become an increasing threat unless the trust markets itself in a manner which makes them more attractive when compared to their competitors. Another threat was the fact that other hospitals have joined together to provide some services making them more attractive. Another threat perhaps linking in with the weakness identified in terms of inadequacy of staff numbers was that other trusts are offering more competitive employment packages to staff and that pharmacists working in the community have more opportunity therefore prompting hospitals pharmacists to leave.
The existing competitive strategies are analysed below in relation to the “external” framework approach and Porter’s theories.

1.) **Aim to be main provider for acute services to local community:** This strategy addresses the problem of external rivalry as proposed by Porter, by accounting for the threats of new entrants and also increasing the bargaining power of the trust as a supplier when the buyers, the commissioning groups, approach them regarding services. The manner in which the trust is executing this strategy is by introducing several initiatives to improve the function of their Accident and Emergency services that have been previously accused of being slow and not meeting their maximum four hour wait targets as well not catering specifically to paediatric emergencies. The principle means by which they have sought to address this is to increase the capacity of their nursing staff and employing more non-training doctors as well as a recent new Consultant appointment with a special interest in paediatric emergencies. So it would seem that the trust is trying to implement this strategy quite well although our SWOT analysis from the departments involved in acute care suggests there are ways this can be improved. There were some concerns that some of the initiative models that had been introduced had not been done so in a systematic manner and is causing some degree of confusion in the acute service provision.
In terms of ways in which this can be further improved, one way that was proposed by some of the managers was introducing a Clinical Decision Unit (CDU) that is present in several other acute hospitals. The function of this would be to have beds were patients can be observed to see whether they will require further acute care under different specialities or whether they can be discharged thereby eliminating some of the confusion with the current model. Another suggestion that was presented by some of the managers is introducing a dedicated Children’s Accident and Emergency section, which could perhaps be done in conjunction with the recent appointment of the new consultant with an interest in paediatrics. In terms of Porters strategies the introduction of a CDU would be an example of improving the co-ordination between departments and would therefore effectively be a cost leadership strategy. The introduction of a separate Children’s Accident and Emergency department on the other hand would be an example of a differentiation strategy that would make York Hospital stand out when compared to their local competitors without such a facility.

In terms of Porter’s “Strategies that will fix healthcare” article and ways to maximise value to the patient, this could be seen as a way to integrate care delivery systems by bringing all the acute services together. Rather than just looking at numbers of patients, measuring outcomes such as patient satisfaction, waiting time, and quality of service would further enhance value to the patient.

2.) **Aim to develop “Secondary Care Plus” services for wider North Yorkshire population:** This appears to be another strategy that is being implemented very well as this was mentioned several times as a strength in several of the departments. The two specialties in which they have managed to do this so far are providing invasive vascular services as well ENT (Ear Nose and Throat) services taking work away from the big teaching hospital in Leeds. As York is a considerable smaller hospital when compared to Leeds they are not able to take over all the work as mentioned earlier and several of the managers in our survey suggest that the trust compete with some of the other similarly sized regional hospitals and also try to expand this to other specialities such as Cardiology. In terms of Porters strategies, sharing the workload with another hospital would be seen as a cost leadership strategy. However focusing on just one speciality, like cardiology, would be an example of a focused differentiation strategy. This strategy of course also addresses the problem of external rivalry as proposed by Porter, by
accounting for the threats of new entrants and also increasing the bargaining power of the trust as a supplier when the buyers, the commissioning groups, approach them regarding services.

In terms of Porter’s ways of maximising value to the patient, this could be seen as a way to integrate care delivery systems by streamlining services but also an opportunity to Organize into Integrated Practice Units (IPUs). Again measuring outcomes such as patient satisfaction, waiting time, and quality of service would further enhance value to the patient and make it more attractive to commissioning groups.

3.) **Aim to attract additional elective work from neighbouring providers to enhance service capability, quality and income:** In this case, the trust appears to be performing well according to our data. The managers are quite keen on this being further expanded and some of the areas they have suggested is offering laparoscopic training for doctors from other regions to increase revenues, development of bariatric services given the large increase in the prevalence of obese patients and allergy and radiotherapy services. This therefore enhances services by allowing patients quicker appointments and of course enhances the trust’s income and image in the region. Our survey and review of internal documents both showed that the new services that had recently been set up were performing very well. As per Porters strategies, sharing the workload with another hospital would be seen as a cost leadership strategy. However setting up niche services not available in the region would be an example of a differentiation strategy making the trust very competitive and reduce the threats of new entrants and also increasing the bargaining power of the trust as a supplier.

Again in terms of Porter’s ways of maximising value to the patient, this could be seen as a way to integrate care delivery systems by streamlining services. There is also an opportunity to Organize into Integrated Practice Units (IPUs), for example a weight management service including doctors from a number of specialties including diabetes and endocrinology, cardiology, dietetics and surgeons providing bariatric surgery. Again measuring outcomes such as patient satisfaction, waiting time, and quality of service would further enhance value to the patient and make it more attractive to commissioning groups. This would also be a way to expand geographic reach as per Porter and would stand out as a service not being offered elsewhere.
4.) **Aim to provide clinical support services to NHS / non NHS neighbour providers:**
The trust provides additional NHS services to more rural parts of their catchment area through community rehabilitation hospitals, mentioned in the introduction, at St Helen's and White Cross Court thereby increasing their presence in the region and increasing the bargaining power of the trust as a supplier. In terms of non NHS work, the Ramsay Centre which is another private centre referred to in the initial section which provides private surgical procedures is actually staffed by York Hospital staff and this in turns allows the trust the privilege of using this facility to shorten NHS waiting lists by carrying out NHS procedures at an additional site. This was one of the strategies that did not seem to be being implemented very well as several responses suggested that there were a variety of more ways this could be done. Furthermore it was felt that staffing the Ramsay Centre with York Hospital staff was counterproductive as this reduced hospital staffing levels, which were already low and also gave away the profit to a private competitor. Here again setting up support services not available in the region would be an example of a differentiation strategy making the trust more competitive and making the barrier for threats from external private entities much higher.

Again in terms of Porter’s ways of maximising value to the patient, this could be seen as a way to integrate care delivery systems by streamlining services as well as a way to expand geographic reach improving patient value.

5.) **Aim to expand non-elective care capability:** As mentioned previously the trust here is referring to patients that are somewhere in between acutely unwell and elective, such as Elderly and Walk-in-Centre patients. They trust has an out-of-hours general practice facility within the Accident and Emergency Department which allows for patients with minor ailments to be reviewed and treated without affecting the Casualty departments waiting time. This was one of the strategies that seem to have been implemented very well based on the results of our interviews and survey. One way in which it may be improved according to our results is by possibly trying to increase rehabilitation capacity for patients. In terms of Porters strategies the introduction of the walk-in services is an example of improving the co-ordination between departments and would therefore effectively be a cost leadership strategy. The introduction of a separate rehabilitation department on the other hand would be an example of a differentiation
strategy that would make York Hospital stand out when compared to their local competitors without such a facility again increasing the bargaining power of the trust as a supplier.

As can be seen from the analysis above, the current strategies appear to be very robust and incorporating aspects of cost leadership strategy, differentiation strategy, maximising the value for patients and trying to organise care into Integrated Practice Units.

In terms of our final part of the research question and ways to develop further strategies to combat the reforms, we can see there are several avenues to become more competitive utilising the information on threats and opportunities as follows.

**Possibility of offering new services:** This is an area where there is a huge scope for expansion and where differentiation strategies would greatly increase the trust’s competitive edge. Suggestions for several new services have been suggested but from our review of internal documents and general disease prevalence statistics, offering bariatric services at York would appear to be very lucrative. This is because there is a huge increase in the number of obesity related diseases and complications and a lot of the patients are ending up being referred to competing trusts, which do offer these services. As York also possesses the necessary skill mix to set up such a service this would appear to be the most logical choice to start with. Setting up a weight management clinic including doctors from a number of specialties including diabetes and endocrinology, cardiology, dietetics and surgeons providing bariatric surgery would seem the most logical step. Again measuring outcomes such as patient satisfaction, waiting time, and quality of service would further enhance value to the patient and make it more attractive to commissioning groups. This would also be a way to expand geographic reach as per Porter and would stand out as a service not being offered elsewhere. Other new services that could be considered periodically would be things like chest pain follow up services, allergy and radiotherapy services once again increasing the bargaining power of the trust as a supplier.

**Dealing with the threat of Geographical Competitors**

From our discussion above it is also possible to see how the trust can effectively deal with their local geographical competitors mentioned earlier in the thesis and to expand geographic reach as per Porter, will be discussed below:
1) **Harrogate and District NHS Foundation Trust:** Harrogate has a reputation for effective delivery of services and accessibility for patients on the west side of the York Hospital patch. York hospital needs to implement its marketing strategy with regards to becoming the main provider of acute care in this region, as Harrogate would be its main competitor. As it does not offer dedicated children’s Accident and Emergency department this could be one way in which York could stand out. In other areas where York is struggling to compete the aspirations and plans of the two organisations are currently managed in a mutually beneficial way through the Clinical Alliance arrangement with sharing of services.

2) **Hull and East Yorkshire NHS Trust:** The organisation is seeking to maximise its recently expanded teaching hospital capacity through its new Cancer and Cardiac/Critical Care Units. This has implications for York’s catchment population on the east side of its patch and to the north. York should strive for a clinical alliance arrangement so that they can also benefit from this new unit in Hull.

York hospital also needs to implement its competitive strategy with regards to becoming the main provider of acute care in this region as Hull would be its main competitor on the east and north side. As it does not offer dedicated children’s Accident and Emergency department this could be one way in which York could stand out again.

York hospital is seeking to manage this situation through mutual top team dialogue with Hull and participation in the Scarborough Review process to bring about networking arrangements with Scarborough alone or jointly with Hull.

3) **Nuffield Hospitals:** A potential squeezing of the local private market due to the impact of the recession could encourage the Nuffield to compete more aggressively for NHS business. The Trust will maintain a dialogue with the North Yorkshire and York PCT (NYYPCT) to ensure that both organisations’ desire not to destabilise the local health environment and that is not compromised by the Nuffield being awarded new NHS business. As mentioned this has the potential to become a significant threat once new government reforms come into place and so this needs to be watched carefully.
4) **Ramsay Treatment Centre**: Currently the Trust provides staff to enable the Centre to function on a secondment basis and there are caps on activity and income that the Ramsay Organisation (which currently operates a contract for the NYYPCT) can deliver and obtain. However, as the trust is using its already depleted staff numbers to run this centre without any huge benefits this needs to be amended. The Trust has therefore expressed an interest in submitting a bid for the operation of the contract for the centre (both on its own and in partnership with an Orthopaedic collaborative) when the current contract expires.

4.3.4 Summary of proposed further Strategies

As seen from the analysis of our results in relation to the theoretical framework above, we were able to identify further competitive strategies that the hospital can use to counter the reforms and as can be seen these were predominantly emergent strategies. Although there was influence from both the internal and external theoretical frameworks, the majority of influence for these future emergent strategies actually came from the internal framework with the internal resources and specific competencies of the hospital being the key as suggested by the Resource Based View of the firm. The strategies are summarised again below:

1.) Increased Specialised Staff Recruitment

2.) Re-allocation of current hospital clinical space

3.) Updating Current Technology

4.) Introduction of initiatives that aim to offer new services: Weight management clinic with bariatric services.
5. DISCUSSION

The empirical results of our research propositions described in the previous section has given us valuable insight into ways to answer our principal research question: What strategies can managers in English hospitals use in order to gain a competitive advantage in the English healthcare system following the government reforms?

This will be discussed in greater detail below in terms of relevance to English healthcare system as a whole (rather than just our case study as above) as well as in relation to our theoretical framework.

5.1 Managerial Awareness and Consensus on Reforms and Strategy

Firstly our results demonstrate that all the hierarchies of management were aware of the implications of the government reforms and the need for competitive strategies. In addition all the managers in our study were aware of the current competitive strategies being used in the hospital. There is good evidence for the need for each level of management to be consistent and unanimous in the acceptance of competitive strategies for them to be effective. This topic has been addressed by Dooley, Fryxell and Judge (2000), who explored the effects that strategic decision consensus and commitment in United States hospitals have on decision implementation speed and success. It was established that the level of consensus associated with a strategic decision will increase the level of commitment to the decision in the decision team, that the level of decision-team commitment to a strategic decision will increase the likelihood of successfully implementing the decision and that the relationship between the level of consensus associated with a strategic decision and implementation speed will be mediated by the decision team’s commitment. This therefore would be an important consideration even in the English healthcare system.

In terms of the awareness of the market changes brought on by the reforms, Wilson and Gilligan (2005) illustrated how to manage a dynamic and complex environment, such as that in which English hospitals are forced to function. This description of how to best manage the environment was broken down into aim, methods and dangers (Wilson & Gilligan 2005). A manager’s sensitivity to change was discussed in relation to methods in dynamic market conditions (ibid). The findings of our study makes it clear that the senior management as well as
the middle management of hospitals are aware of the environmental conditions in which they operate. They therefore demonstrate flexibility and willingness to change the strategic direction of the organization quickly, illustrating their sensitivity to the need to change in a dynamic environment. It can be inferred from the above studies that effective strategy implementation relies on structure, teamwork, management style, information gathering and processing, and communication. While the success of these concepts has been investigated in the literature, the application of this success in health care competitive strategy has only been briefly examined prior to our study.

Furthermore it was clear that from our empirical results that throughout the levels of management, there was good awareness of what potential competitors are doing. Higher management gave their attention to the activities of competitors, as they deemed that it was important to know what their competitors were doing, to monitor the external environment (of which competitors are a part), to determine the capabilities and strengths of the hospitals and to market these accordingly which is in keeping with studies conducted in the healthcare environment in the US (Aaker and Mills, 2005).

5.2 Analysis of Competitive Strategies in terms of practical and theoretical relevance

Closer examination of the competitive strategies that our study identified to counter the reforms, shows that they can be broadly divided into to two main categories in terms of practical and theoretical relevance.

As suspected from our theoretical analysis these strategies were a mixture of deliberate and emergent strategies. However from a practical perspective it became clear that the deliberate strategies including: aiming to be the main provider of acute services in the catchment area, attracting standard elective work with existing long waiting times, and expanding non-acute/non-elective care capabilities by forging partnerships and sharing clinical support were all basically focusing on competing on quality of essential services. This is because all of these services are basic requirements for any hospital and therefore the only way in which a hospital can gain an advantage by virtue of these would be to improve the quality of these. Furthermore, as these strategies focus on “where” (acute/elective service) a hospital should be competing they
therefore represent predominantly the external framework of our theoretical background, based on Porter’s “positional” approach and were predominantly focused on differentiation strategies with some limited cost leadership elements although as seen from the discussion there were elements of the internal framework as well. Deliberate strategy therefore appears to produce sustainability as proposed in the literature (Mason et al, 2004).

The emergent strategies on the other hand, were practically focused on addressing further competitive reforms and were devised taking into consideration aspects such as size, internal resources and competences and all involved diversification by virtue of using specific resources and included: new secondary care plus services, increased recruitment of specialised staff, re-organisation of existing clinical space, updating out-dated technology and promoting formation of new services such as a weight management clinic with integrated bariatric services. From a practical viewpoint these strategies are all essentially focusing on service diversification. From a theoretical perspective the service diversification is based predominantly on the internal resources and therefore represent the internal framework of our theoretical background as represented by the Resource Based View of the firm, although as seen from the discussion there were elements of the external framework as well. It would therefore seem like emergent strategy can assist in decision-making especially in the context of a dynamic environment as demonstrated in the literature (Carr, Durant & Downs 2004).

In terms of Mintzberg’s types of strategy (deliberate and emergent) discussed in the theory section, our study showed that the majority of the pre-existing strategies not specifically related to the reforms were predominantly deliberate strategies. The reaction to the circumstances (Fuller-Love & Cooper 2000) caused by the reforms, can be seen through the hospitals’ abilities to change and adapt to current situations, thus indicating an emergent strategic approach that is not constrained, as was suggested by Mason, Heaton and Morgan (2004). These abilities were achieved through keeping the overall goals of the organisation constantly in mind and monitoring government activities and legislative changes. While emergent and deliberate strategies have been explored from the overall organisational point of view, the competitive strategy of the organisation and its linkage with emergent or deliberate strategy has not been investigated to the same degree. Thus, this research contributes to this by exploring how emergent or deliberate competitive strategies may also be dictated by the external competitive
environment in terms of government activities and legislative changes. This also provides further endorsement to the notion that the health care environment is dynamic, complex and highly uncertain as suggested by Begun and Kaissi (2004), who associated dynamism in the health care environment with frequency of change and the predictability of change.

Our results would also seem to be in keeping with Wilson (1999) who explored strategy development processes in conditions of environmental volatility, based on informal and formal approaches to strategy development. The study determined that competitive marketing strategy can be viewed as an organizational response to competitive threats in the environment; that when conducting a competitive assessment and analysis, focus should be given to the perceptions and paradigms of those involved, and be conducted at various hierarchical levels in the organization; and that when facing a competitive threat, focus should be given to fresh systems and approaches.

In terms of the types of strategies being used as per our theoretical framework, as seen in our empirical analysis there was a number of different types being used including cost leadership, differentiation, focus and diversification. Porter suggests that firms that pursue more than one generic strategy are “stuck in the middle.” Although in the corporate world being stuck in the middle and trying to focus on multiple strategies does not generally work, in healthcare focusing on just one strategy such as cost leadership for example, at the expense of patient outcomes will clearly not work. A few studies have therefore demonstrated that a stuck in the middle approach can work well in the healthcare industry (Kumar et al, 1997). Hopper (2004) similarly reported that Australian hospitals actively pursued pricing, positioning, differentiation, growth and general competitive strategies all at once. However our results also indicate that English hospitals are limited in terms of their pricing strategies. Most stakeholders indicated that the hospitals are required to set their prices according to health fund and government regulation requirements. The qualitative findings from examination of internal documents also emphasize the importance of health funds, government policies and regulations in hospitals in terms of influencing the hospitals’ income. Pricing strategies are therefore largely beyond the control of the organizations which again has been shown in the literature (Hopper 2004).

Regarding the use of differentiation and service diversification strategies in hospitals (Hopper 2004; Kotler et al. 2001; Pride & Ferrell 2003), the literature findings provided quite diverse
viewpoints. These indicated that the hospitals were more inclined to concentrate on focusing their services to more than one specific group of customers within the total market. However, this inclination towards such a differentiation strategy was only slightly more pronounced than the strategy of focusing services to the whole market. The notion of directing services to the whole market was reinforced continuously throughout the qualitative results of this study with management continually making the point that they were focused on the community as a whole and strived to service the needs of the community in which the hospital operated. Different types of differentiation strategies are therefore used in hospitals, thus indicating diversity; however, they are all focused utilizing the strengths of the hospital to serve the whole market.

As mentioned previously, the fact that hospitals are focused on differentiating their services from those of their competitors demonstrates the importance of the hospital management knowing what their competitors are doing, and monitoring of the external environment (of which competitors are a part), to determine the capabilities and strengths of the hospitals and to market these accordingly. Competitive strategies in English hospitals should therefore be focused on competitor knowledge.

6. CONCLUSION AND RECOMMENDATIONS

Our study offers new insight into the competitive strategies of English hospitals in the new competitive environment. The findings of our study have also provided new insights into the relationship between Porter theories and RBV in healthcare competitive strategy. Our study demonstrates that by including important elements from different perspectives this allows for a greater complexity and a wider scope of analysis when evaluating strategy and enhances our understanding of sustained competitive advantage.

The flowchart on the next page (figure 17) gives a schematic of our study approach and the conclusions.
Figure 17-
Overview of study approach and conclusions

EXPLORATIVE CASE STUDY

Semi-Structured Interviews
Questionnaire
Review of Internal documents

Primary Data
Triangulation
Secondary Data

Covering all hierarchies of management

SWOT ANALYSIS

Strategies in-line with hospital resources/characteristics

Existing Competitive Strategies

Strengths Opportunities
Weakness Threats

Internal Theoretical Framework
External Theoretical Framework

New Strategies

Deliberate Emergent

Quality of essential services Service Diversification

Framework for hospital managers to gain competitive advantage following government reforms
Based on our study we therefore recommend a framework for hospitals in England to use in addressing the competitive challenges posed by the reforms, which consists of two distinct strategies:

i) **Competing on quality of essential services** - As shown these were predominantly found to be deliberate strategies and focused on improving acute services like emergency care, which is a strategy often referred to in the literature and used a lot in hospitals in the US. Although just the presence of these services do not give a hospital a direct competitive advantage over another, the quality of these services could potentially help commissioners determine whether to go ahead with a hospital contract. There is good evidence in the literature for this strategy being used in a number of healthcare systems (Berry et al, 2004).

ii) **Competing on service diversification** - These on the other hand were predominantly emergent strategies with services being developed based on the resources of the hospital and according to the demands of the area and being influenced by the various reforms as they are being rolled out. Examination of the literature also shows that this strategy has been previously suggested as a very appropriate strategy in response to market reform in the US (Estaugh, 2011).

The framework proposed highlights the diversity of theoretical concepts that exert an influence on competitive strategy and provides a depth of information about hospital competitive strategy in England, which previously had not been available. We believe that managers by focusing on these two broad but distinct strategies will be able to deal with the competitive environment resulting from the government reforms.

Future research possibilities in this area will be vast once further reforms come into place and bidding for services commences, thereby increasing competition. It would be interesting to conduct a similar study once the reforms are fully in place and to compare the development of the trusts competitive strategies as well as to measure the outcomes of their current strategies as well as the strategies that we have suggested.
7. REFERENCES


56. O'Shannassy, T 2003, 'Modern Strategic Management: Balancing Strategic Thinking and Strategic Planning for Internal and External Stakeholders', *Singapore Management Review*, vol. 25, no. 1, pp. 53-68.


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APPENDIX A: Survey Questionnaire

CLINICAL/ MANAGEMENT STRATEGY DEVELOPMENT

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APPENDIX B:

Interview Questions

How would you rate the importance of competitive strategy in York Hospital’s current priorities? How about in the future?

Marketing organization

- Do you consider competitive strategy at York Hospital to be organized in a satisfying manner?

- Do you favour a centralized marketing organization or do you prefer a decentralized marketing organization?

- Do you consider York’s current competitive competence, organization and efforts to be adequate or is there room for improvement?

- Please roughly describe what York’s most important competitive strategies are and should be?

- Would you consider economic incentives to key individuals or organizational units (such as bonuses or result-based salaries) as a mean to achieve increased sales?

Accounting:

- Do you feel that York Hospital has routines and systems to provide reliable calculations of costs, pricing and results of individual products/services?

- Do you have knowledge of the estimated results of current sales?

- Would you consider investing in a high-risk project to possibly gain profit?

Legislation and regulation in regard to marketing management:

- Do you consider York’s health care competitive strategies to be consistent with regulations and regulations applicable to a publicly owned health care organization?

SWOT Analysis:

- Could you please tell me what you think the strengths, weaknesses, opportunities and threats are of York Hospital?

- Who deals with the corporate level, business level and operational level strategies in your hospital? Can you tell me about your current strategies in these regards?
Spontaneous comments:

Feel free to explore any key opinions about York’s health care competitive strategy: