





In today's fast-paced world, we all need a trusted healthcare partner who connects with us and meets our medical needs, however simple, or complex they may be.

United as a team, we share a common purpose, a dedication to secure your well-being.

At Premier Hospital we put in the time, the skill, the smiles, and the will required to transition you and your loved ones into happier and healthier people.

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FORWARD





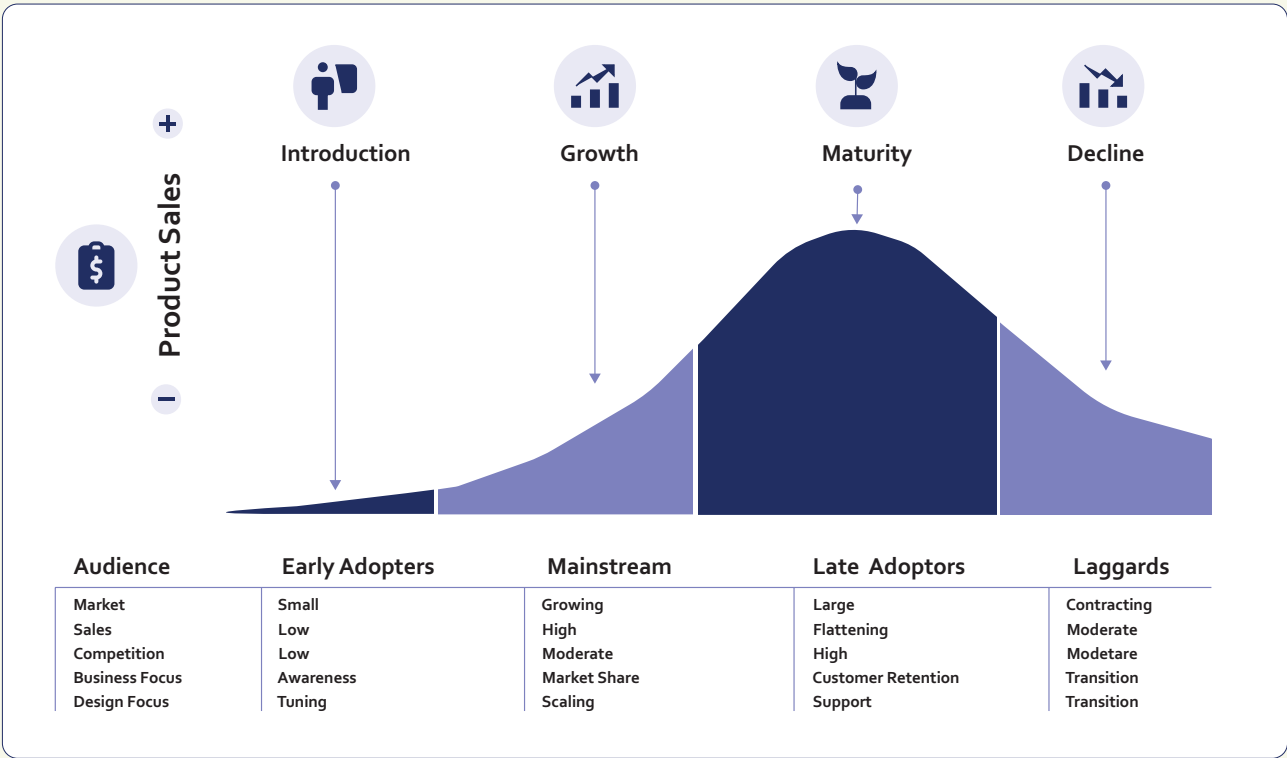
INTRODUCTION

Background

Premier Hospital is an 82-bed private tertiary hospital located in Nyali. Premier Hospital opened its doors in November 2017 and has since grown to become a level 5 healthcare provider offering 24-hour Inpatient and Outpatient services, Accident and Emergency services, Diagnostics services including Lab tests and CT Scans, Maternity, Theatre, Paediatrics, Physiotherapy, Renal Dialysis and ICU/HDU services.

Known throughout the region for its unmatched excellence in customer experience, compassion, care and competence, the hospital is accredited by NHIF and all major Insurances and is a SafeCare Level 4 certified facility.

Figure 1: Phases of the Business Life Cycle



Premier Hospital is currently entering the growth phase as a business hence at an important precipice as it contemplates the following:

- a. Geographical expansion - expansion plans into the greater Coastal region
- b. Increasing the scope of service delivery
- c. Governance transition
- d. Maintaining existing competitive advantages.

This 5-year strategic plan is a culmination of an extensive analysis of Premier Hospital, looking at its strengths, weaknesses, internal priorities with the resulting external interventions and targets. The Strategy provides a yardstick to guide, monitor, measure, and evaluate the future work and progress of Premier Hospital with a view to maximizing its potential for unique value.



METHODOLOGY

A four-phased approach was adopted, guided by the 4 Ds of Change, in the delivery of this engagement as below:

Figure 2: The 4 Ds of Change



STEP 1: Diagnose

This step aimed at identifying opportunities to better and reactivate the organizational purpose. The objectives of this step included:

- Understand the Coastal healthcare ecosystem.
- Identify the key enablers in the ecosystem that impact Premier Hospital policies
- Understand the trends and developments in the industry.
- Conduct SWOT analysis of Premier Hospital and its affiliates

The specific tools for this phase were designed in conjunction with Premier Hospital to be able to gather the greatest insight and ideations to the intended objectives.

Consequently, data was collected from both Premier Hospital and stakeholders in a bid to determine their opinions and standing of Premier Hospital in the Coastal healthcare ecosystem.

Tools

a. Desktop review of literature

An in-depth review of secondary data was conducted on a) the hospital’s operations and systems; b) social determinants of health within the coastal region, the country and at a global scale with a view to identifying trends that lend themselves as opportunities to Premier Hospital, threats that require mitigation, strengths that elevate competitiveness, as well as weaknesses deserving emendation by the management team to enhance competitiveness.

b. Key Informant Interviews

Cognizant of the prevailing COVID-19 pandemic, hybrid interviews (physical and virtual) were held with purposively sampled respondents within the pool of Premier Hospital’s stakeholders. The detailed list of respondents is captured in Appendix 1 and included the following:

Internal Stakeholders

- Hospital Directors
- Hospital Top Management
- Functional Level Management
- Consultants

External Stakeholders

- Suppliers
- Payers
- Corporate clients
- Medical Consultants
- Medical Officers
- Nurses
- Members of general public in Mombasa, Kilifi, Lamu and Diani

c. Online Surveys

To enhance open and unbiased feedback from the internal stakeholders, an anonymous virtual survey was developed and disseminated. This drew valuable feedback from 39 respondents on diverse pillars of the organization’s operations, and brand reputation. A link to the responses is attached in Appendix 2.

d. Reconnaissance & Facility Visits

4 site visits were conducted including Nyali (comprehensive tour of the main facility); Diani and Ukunda (Kwale); Kilifi and Lamu. The visits yielded valuable insights on service and market gaps that lend themselves as opportunities for growth. They also provided more information on existing competitors within the coastal health ecosystem.

e. Participatory Workshops & Focus Group Discussions

2 physical workshops were conducted with the hospital’s senior management team alongside the Chief Operations Officer and the Chief Executive Officer with the aim of drawing collective insights on the current state as well as potential strategic direction.

Targeted discussions with board members and top management were also held in both Nyali and Nairobi to establish the leadership’s assessment of the progress, governance dynamics; and vision and priorities of the founders.

Subsequently, virtual workshops were held with the senior management team with a view to facilitating co-creation of the balanced scorecard.

f. Stakeholder mapping

As part of the field work and desk review, key stakeholders were progressively mapped and emerging data from used to refine the stakeholder matrix.

STEP 2: Design

Using all the data gathered, a synthesis sprint workshop was held to Identify possibilities for strategic direction for Premier Hospital and create several hypotheses or minimally viable products (MVPs) that would eventually determine the direction of the strategic plan.

The objectives at this phase included:

- Identifying the possibilities for Premier Hospital given the findings from the current state/SWOT analysis.
- Engaging employees to create an inventory of potential solutions and initiatives to address the challenges/problems identified in Step 1.
- Development and iteration of a draft strategic plan with the board and SMT.

Consequently, the use of a design thinking workshop for this feedback was employed.

In addition, virtual participatory workshops with the leadership team were held with a view to remotely support the team in their development and refinement of the organization level Balanced Scorecard (BSC). Bi-weekly sessions of this nature were also conducted with a view to mentoring and coaching the senior management team (SMT) on the process to ensure co-creation, ownership of the process as well as capacity development for sustainable cascading of the strategy at functional unit/ departmental level.

These virtual workshops and outputs of this phase set ground for the subsequent stages (Deliver and Discharge). The draft strategic plan was then created and reiterated back to the board and the SMT to validate it.



STEP 3: Deliver

The collected information and feedback were pivoted into a workable plan and final SP, breaking it down into actionable buckets with SMART objectives over the 5 years and beyond. The SMART objectives were coupled to an execution plan and eventual milestones for each.

The main objectives for this step were to:

- Describe the future strategic direction of the organization’s activities in light of step 2 validation.
- Refine and prioritize initiatives to simplify execution.
- Propose strategies for achieving the strategic objectives and key results.
- Identify quick wins.
- Ready the organization

STEP 4: Discharge

At this final step, with the strategic plan in place, the team supported the SMT in development of the execution plan and would subsequently support them in starting off the changes entailed in the SP. These included:

- Review of organizational structure and processes with clear profiles and job descriptions of key staff positions
- Plan and run initiative sprints.
- Describe major tasks and outputs of each department and develop KPIs for each task.

This phase was further bolstered by virtual participatory workshops with respective functional unit heads to refine their key initiatives. Additionally, this phase included a final virtual workshop with a change management specialist (Ms. Sarah Richson) themed Team Spirit to ready and spur the team towards cohesive and collaborative implementation of the strategy.



FINDINGS

Demand Factors

a. Gender and Age as key drivers of demand

Demand for healthcare services in Kenya is largely driven by the female population due to their population size and better health seeking behaviours when compared to men, as well as their focus on maternal and child health. Pediatric care will still continue to be important in Kenya given the rate of infant admissions and deaths. It is expected that this trend will remain unchanged for the foreseeable future.

b. Economic Status

The economic status of clients is also a big driver of demand for healthcare services. According to the 2017 Economic Survey for Kenya, three-quarters of the population are low income earners (KES. 23,670 and below monthly) while about 13% fall into the middle

income earning group (KES. 23,671-119,999 monthly) and less than 12% were high income earners (monthly income above KES. 120,000).

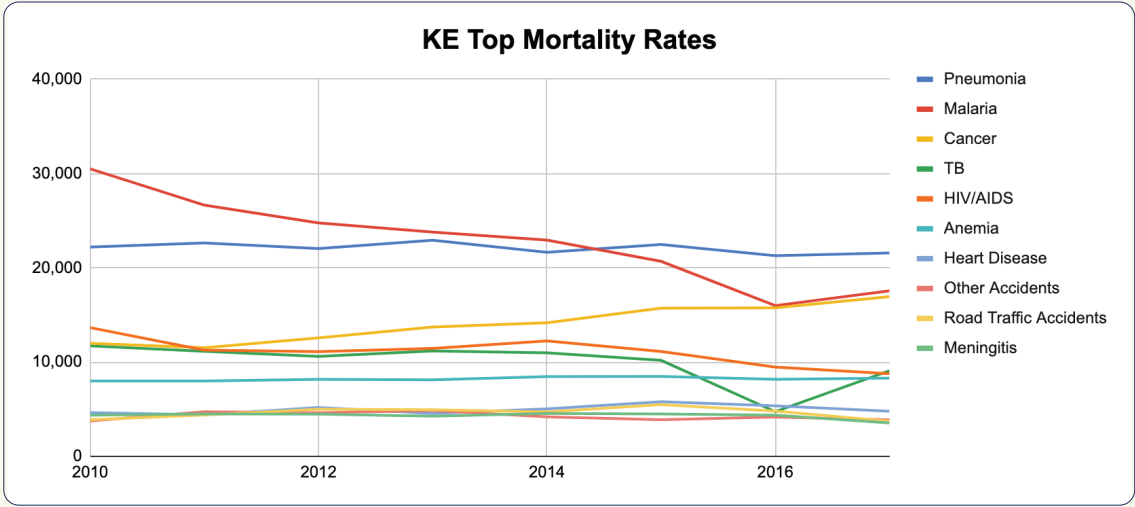
c. Behavioural Factors

Demand for healthcare is also influenced by the health seeking behaviours of the population. While in a given month, about a fifth of the population will either fall sick or suffer an injury, only less than a third of this population will seek for care in a health facility.

d. Disease Factors

Focus diseases remain to be pneumonia and respiratory diseases, malaria, cancer and cardiovascular diseases.

Figure 3: Causes of Mortality in Kenya



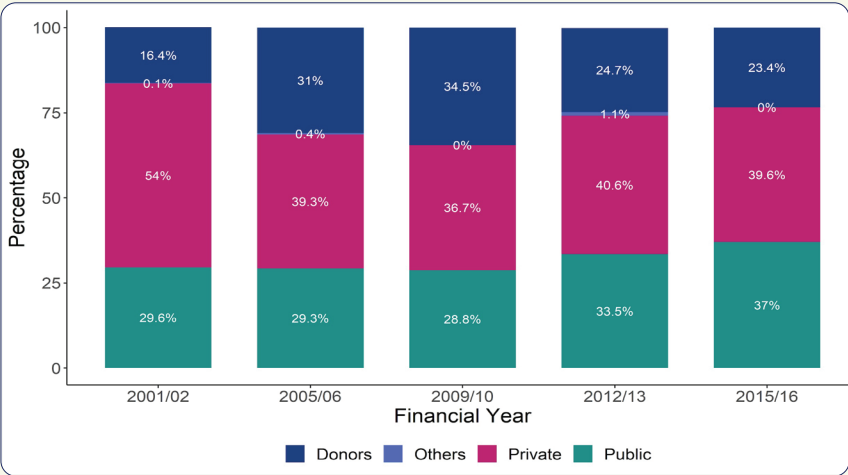
Notably, Cervical, Esophageal, Prostate, Breast and Oral Cancers account for 54% of all cancer burden in Kenya.

e. Healthcare Financing

i.Financing Sources

Households or Out Of Pocket Payments (OOP) are the largest source of revenue for healthcare in Kenya accounting for approximately 40% of the funding (NHA 2015/16). The government's contribution has been progressively increasing and is likely to be the biggest funder of healthcare services in Kenya especially with its focus on provision of universal healthcare in the country. This provides the private sector an opportunity for greater collaboration with the government.

Figure 4: Financing sources as a percent of the Total Health Expenditure (THE)



Source: National Health Accounts (Ministry of Health, 2019)

It is worth noting that Kenyans spend much of their health funds in buying outpatient and inpatient curative services. Businesses in the health sector must therefore be innovative on how to package their offerings to tap into these resources.

ii. Health Insurance

Uptake of health insurance in the country is low, with only 20% (18% in NHIF and 2% in Private Insurance) of the population having some form of health insurance.

Figure 5: Health Insurance Coverage in Kenya

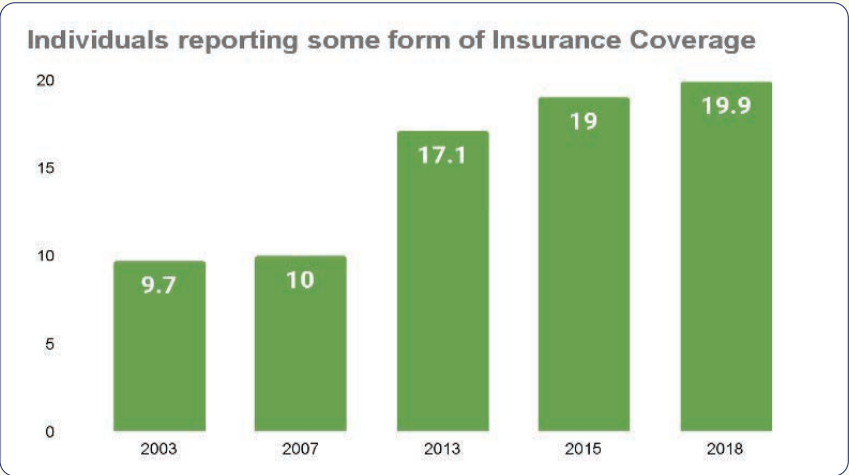


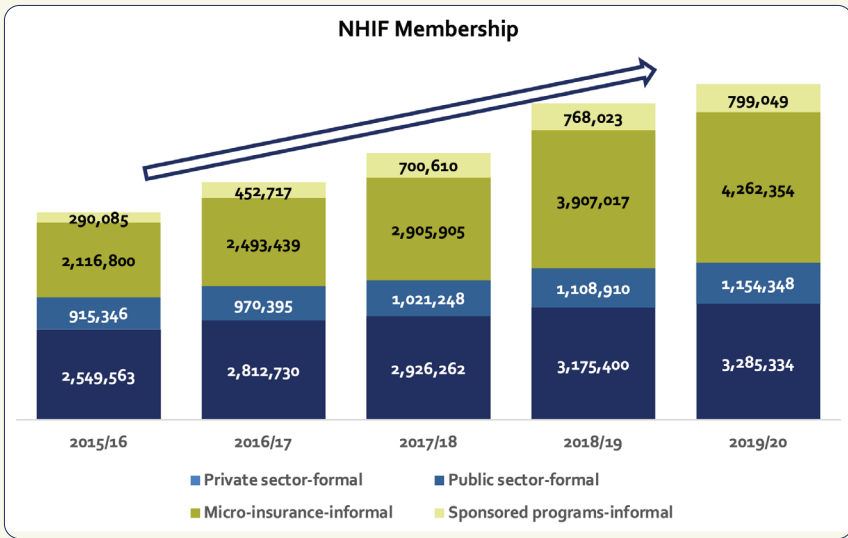
Figure 5: Health Insurance Coverage in Kenya

The National Hospital Insurance Fund (NHIF) is and will remain a key payer of health services in the country, thereby driving demand for services. Since 2016, membership to NHIF has increased by 62%, while its collections and pay-outs during the same period have increased sevenfold from KES. 7 billion in 2016 to almost KES. 50 billion in 2020.

The focus of NHIF on the informal sector and subsidised healthcare points to the need for affordable packages that can align with this group. Since the government is using NHIF as its vehicle for Universal Health care and given the profile of the population, aligning healthcare services to this imperative will be very critical for healthcare providers.

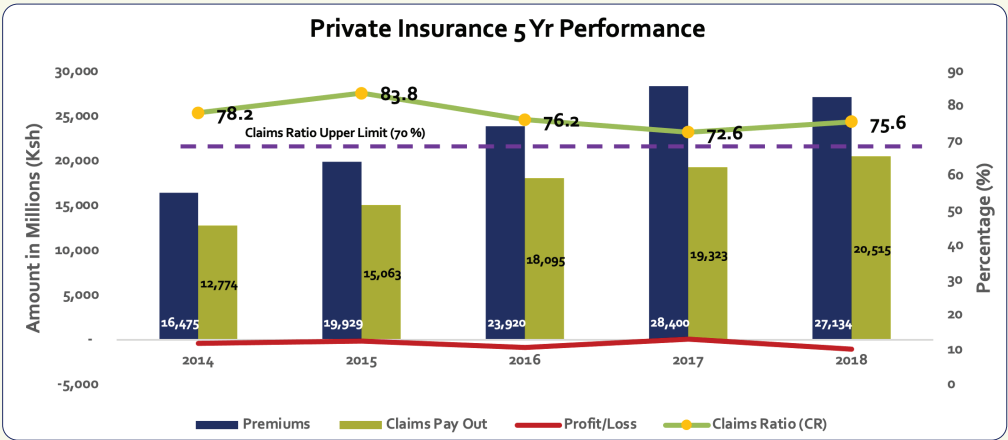
However, private insurance providers will continue to be players in the health sector given the growth in the economic status of individuals who can afford it. They are likely to push for lower prices from the providers since their medical businesses have been underperforming as demonstrated in figure 7.

Figure 6: NHIF Membership



Source: National Health Accounts (Ministry of Health, 2019)

5yr Financial Performance of Private Health Insurance in Kenya



Source: Insurance Regulatory Authority, 2019

There has been a steady rise in spending on private health insurance in Kenya between 2014 and 2018 with an increase in both the premiums collected and medical claims incurred by private medical insurers as shown in Figure 7. The claims-pay-out ratio for private medical insurance has remained significantly high over the five-year period. Additionally, the medical insurance sector recorded significant losses over the five-year period.

Supply Factors

a. Healthcare Providers

Out of 10,535 health facilities in Kenya, half (49%) are public, 38% are private, while 13% are faith-based facilities. Levels 2 and 3 (primary care facilities, dispensaries and health centers) account for about two-third of the facilities while Levels 4 and 5 (Primary & Secondary Referral hospitals) are about 26%. The National Referral and Teaching hospitals which make up the level 6 category of facilities are mainly composed of public facilities.

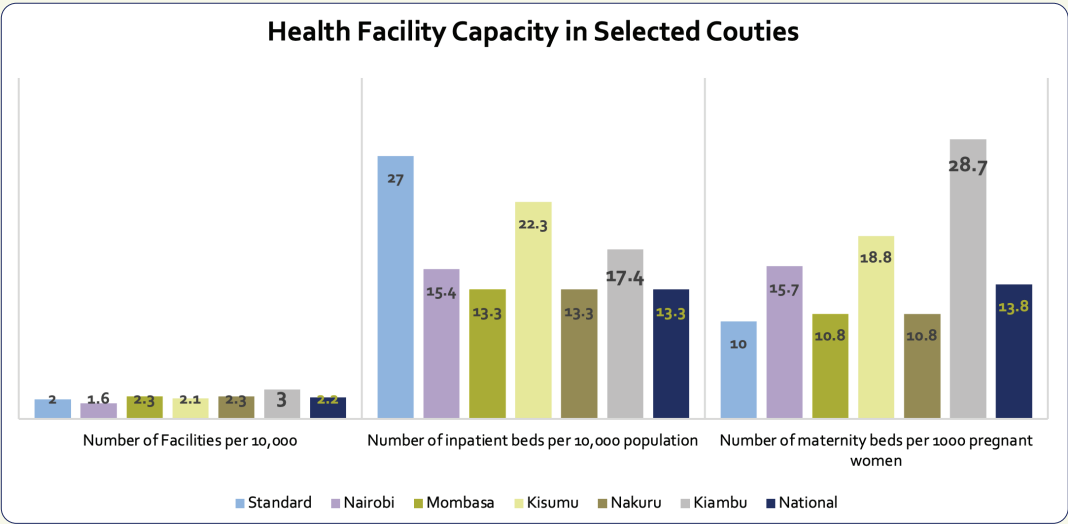
Of the total private health facilities, about one third (31%) are in Nairobi city while only 6% are in Mombasa.

b. Increased Investments in Health

The National Government is making significant investments in expansion of health facilities across the country. Similarly, private providers are investing heavily in their infrastructure to meet the growing demand for health services.

County governments have, since the onset of devolution, have increasingly invested in healthcare, including upgrading some of their facilities to level 4 and 5 status. For example, in Kiambu County, Thika, Kiambu and Gatundu hospitals were upgraded from level 4 to level 5 hospitals. Nairobi County has upgraded over 5 health facilities to level 4 hospitals. It is also upgrading Mbagathi district and Mama Lucy hospitals to level 5 facilities with an aim to decongest Kenyatta National Hospital (KNH) which is the only referral hospital in Nairobi.

Figure 8: Facility Capacity across selected counties in Kenya

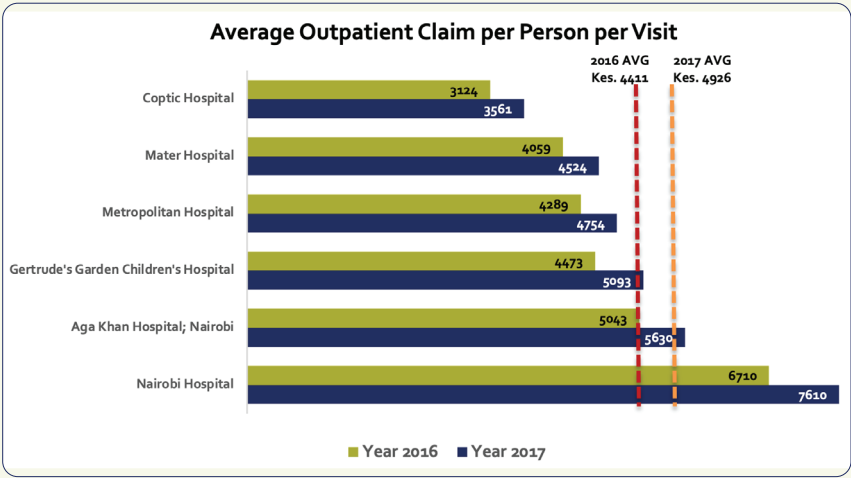


In spite of the significant progress in expanding health access, disparities persist across different counties. The absolute number of facilities per 10,000 adheres to the global recommendation of 2 per 10,000 population. Similarly, the number of maternity beds meets the global threshold of 10 per 1,000 pregnant women. Notably, Kenya and Mombasa still have a limited inpatient bed capacity of 13.3 beds per 10,000 population against a global average of 27 as demonstrated in figure 8.

The national average inpatient bed occupancy rate is (46%) which is below the target of 80%.

c. Competitor Analysis: Outpatient Average Cost by Hospital

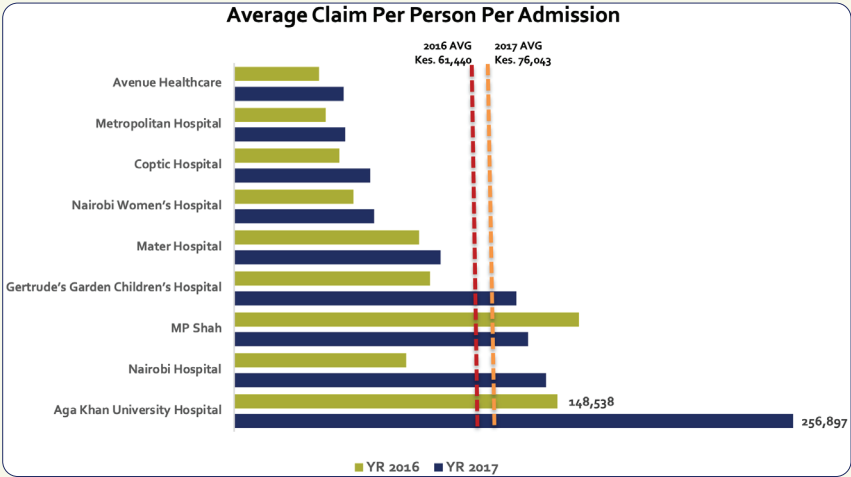
Figure 9: Cost of Outpatient Services



There was an average increase of 12% in the outpatient costs across the sampled level 4 and 5 private hospitals from Kes. 4411 in 2016 to Kes. 4926 in 2017. Nairobi Hospital had the highest outpatient costs at Ksh. 6710 in 2016 & Ksh. 7610 in 2017.

d. Competitor Analysis: Inpatient Average Cost by Hospital

Figure 10: Cost of Admissions



There was an average increase of 24% in the inpatient costs across the sampled level 4 and 5 private hospitals from Kes. 61,440 in 2016 to Kes. 76,043 in 2017. AKUH had the highest average inpatient claims at Kes. 149,000 in 2016 and Kes. 257,000 in 2017.

Enablers

a. Electronic/ Digital Health

Due to the constant advances in technology, digital and E-health emerge as key channels for delivery of health services. The development of e-health policies in Kenya point to the visibility digital health enjoys from the government and key stakeholders and could also point to potential for future investments.

b.Regulations

Compliance risk is going to be a strategic risk for any business operating in the health sector due to the numerous laws and regulations in place. Alignment to existing laws and regulations must be a key focus while crafting the strategic direction.

c. Universal Health Coverage (UHC)

UHC will drive healthcare provision in the country and providers need to align accordingly to ensure they also benefit from the program. The government will mobilize further resources for the UHC scheme through the establishment of a UHC fund to allow for joint pooling. All contributors (statutory and mandated) will be eligible while the poor & vulnerable households will be eligible for government subsidies.

Trends in Healthcare

a. Global

The healthcare space is undergoing disruption globally. Non-traditional players, like Amazon, Apple, Bestbuy, Microsoft, Google etc., are entering the Health sector while the traditional players are making unconventional moves e.g. vertical integration. Some of the emerging global mega trends are:

- 1. Spending on health care is consuming an ever larger share of the GDP, fuelled in part by aging populations, the rise of chronic diseases, inefficiencies in health systems and a growing middle class.
- 2. Consumers today have more information and options and are therefore demanding convenience and transparency.

As a result, the industry is shifting focus from:

- **Volumes to value-driven care:** where focus on patient outcomes outweigh focus on volumes, with stakeholders seeking sustainability.
- **Hospitals to everywhere:** Consumer demand for convenience is driving innovation in the industry, new opportunities and business models. Care, already moving from high to low cost centers will become more “on demand”.
- **From diagnostics to prediction and wellness:** Availability of data and advancement of technology is moving rapidly from diagnostics to prediction, with prevention as the ultimate goal.

Emanating from the megatrends are the evolving trends listed below:

- 1. **Market Consolidation:** Increased intersection of payers and providers and new business entrants, including 100 hospital consolidations annually since 2012.
- 2. **Value-based Care:** Movement to value-based payment systems as providers and patients (out of pocket) face intense cost pressures under healthcare reform.
- 3. **Risk Shift to Providers:** Shift of financial risk from payers to providers is occurring within the industry as a result of reform efforts intended to improve overall healthcare
- 4. **Focus on the Consumer:** Payers are moving from focus on defined contribution to a defined benefit model as consumers become more informed of their health and medical options.
- 5. **Demographic Changes:** An increasingly aging population, rise in chronic diseases, demand for personalized medicine from growing middle class and greater focus on wellness and prevention.
- 6. **Data Analytics:** Reliance on analytics to drive decision making is causing organizations to develop health analytic solutions and engage technology partners.
- 7. **IT and Innovation Optimization:** Rapid technological advancements are driving a digital innovation transformation (e.g., migration of providers to clinical IT platforms EPIC or Cerner).
- 8. **Increased Scrutiny on Cost:** All healthcare players are being challenged as costs continue to grow, especially pharmaceutical companies.

- 9. **Cyber Security and Breaches:** Rise in patient data reliance requires organizations to increase cybersecurity and prevent highly visible data breaches and costly data privacy violations.
- 10. **Telemedicine and Digital Health:** The rise of smartphone apps and intuitive medical devices enable patients to monitor health condition without constant and costly hospital attention

b. Regional Trends

- 1. **Communicable and non-communicable diseases will continue to be a challenge:** By 2050, it is predicted that Sub-Saharan Africa will bear 90% of the world’s AIDS-related deaths, up from 76% today. Progressive aging of populations, increased urbanization, alongside growing middle-class and changing lifestyles, will lead to a rise of lifestyle disorders such as cardiovascular diseases, diabetes, hypertension, obesity, cancer, and respiratory disease. The above will result in requirements for major investments in early diagnosis, treatment and management.
- 2. **Population aging will accelerate in Africa over the next 50 years:** •Projections show that by 2050, the elderly will account for nearly 13% of Africa’s total population. Aging increases personal care needs and is highly correlated with chronic conditions and long-term physical and mental disability. This older age cohort is predicted to account for an increase of 9.5 million people with diabetes in Sub-Saharan Africa between 2010 and 2030. Investment will be needed in human resources that are qualified for the care of the elderly.

- 3. **Africa will increasingly concentrate on value for money to secure efficient and equitable allocation of resources:**•Focus will be on building well-governed, sustainable health systems in which governments are accountable to their citizens. Scarce financial resources in health will force needs-based strategic spending in order to ensure the best value for money. This has necessitated a rise in the use of demand and supply incentives such as conditional cash transfers and results-based financing.
- 4. **Financial Risk Protection:** Strategies to reduce out-of-pocket expenditure levels need will be explored. By 2060, most African countries will be well on the path to providing their citizens with a basic health insurance package, while others will have developed comprehensive social insurance systems. Many countries are also likely to establish micro-insurance coverage, aimed at poorer populations, offering lower premiums and lower coverage.
- 5. **Development of M-health:** •mHealth is the practice of medical and public health supported by mobile devices. The focus remains improving access to basic health care, remote diagnosis, remote monitoring and prevention. mHealth services include text messaging to improve treatment compliance and applications for diagnostic and treatment support, infrastructures that enable remote monitoring and audio-visual communication for real time interaction between patients and providers.

c. Trends in Kenya

Kenya is making slow but meaningful progress towards attainment of Universal Health Coverage (UHC). This has created opportunities for actors within the healthcare ecosystem. However, some of the health indicators including health financing, financial protection and health service availability and outcomes, still suggest that Kenya has more work to do if it is to fully attain UHC.

AREA	MOST RECENT DATA	KENYA 2030 TARGET
Health Financing	\$44 Total Health expenditure per capita, 2017	\$357 Total Health expenditure per capita, 2030 Target
Financial Protection	19.9% Percentage of population covered by insurance, 2018	\$85 Total Health expenditure per capita, 2030 Target
Health Service Availability	80% Percentage of population within 5km of a health facility, 2018	100% Percentage of population within 5km of a health facility, 2030 Target
Health Outcomes	52 Under-five mortality rate (per 1,000 births, 2018)	24 Under-five mortality rate (per 1,000 births, 2030 Target)

SWOT Analysis

Table 2: Internal and External Assessment

STRENGTHS	WEAKNESSES
- Progressive growth since inception - Faster decision making - lean hierarchy - Strong culture on customer satisfaction - Awareness & desire to grow business while strengthening governance - High working capital - Goodwill from directors and staff - Conducive location away from bustle	- Nascent systems, policies and processes - Low staff motivation and high staff turnover - Non-integrated IT systems which do not support business decisions and increases pain points along customer journey - Large accounts receivables and payables - Weak communication pathways internally and externally - High cost of care - Weak patient referral systems across specialties
OPPORTUNITIES	THREATS
- Government prioritization of UHC - Large untapped markets - oncology, ophthalmology, obstetrics, interventional medicine - Market need for services still exists - Goodwill from internal and external customers - Increased govt investment in infrastructure across Coastal region - Outsourced services	- COVID-19 - Impact of pandemic on purchasing power - Reliance on few revenue streams - Strong value proposition by competitors - Negative brand perception on high cost of care - Scarcity of talent - Raised customer awareness and expectations

Risks and Mitigation

Table 3: Risks and Mitigation Strategies

RISKS	MITIGATION
Slow adaptation to technology & emerging trends.	Keep abreast with technological advances. Take a proactive approach to embracing technology.
Rapid expansion	Well-thought out, market informed expansion plan while maintaining versatility in responding to trends.
Poor understanding and ownership of key vision and core values leading to weak and misaligned corporate culture.	Staff involvement in understanding and driving the hospital mission and core values.
Reliance on few services (e.g., COVID-19 care) as critical profit drivers.	Diversify and grow revenue streams leveraging competitive advantages.
Lean pool of medical specialists	Create an environment that not only attracts specialists and other staff but also supports PH's values and strategic aspirations.
Low staff engagement and loyalty	Create an environment that not only attracts specialists and other staff but also supports PH's values and strategic aspirations.
Low customer loyalty	Customer centric service design and delivery coupled to strategic marketing.
Lack of HR and Operational Tools and Policies	Develop strategy aligned governance & operational tools.



A. Stakeholder Voices

External Stakeholders: Competitor Review & Perspectives

HOSPITAL	HEALTH WORKERS	MEMBERS OF THE PUBLIC
Aga Khan Mombasa	Compensation: Good pay; Timely Payment; Welfare Equipment: Available, Variety & Quality equipment; Working Environment: Easy staff to work with; Well organized; Good staff with great customer care; Easy organisation to work with. Governance: Good management, well paying, considers welfare, Job security. Service Factors: High quality health services; Adequate bed capacity, Variety of services hence more learning.	Service Factors: Good services; Timeliness of services; Variety; Specialists available; ISO certified
Mombasa Hospital	Compensation: Good pay; Timely Payment; Job Security; Further Studies Working Environment: Good Working Environment; Great customer care; Friendly Professionals. Service Factors: Excellent services; High quality health services; Preparedness	Service Factors: Variety of Services; Quality services; Available specialists
Pandya Hospital	Governance: Good management relationship with staff; Good managerial system. Service Factors: Good customer care; Variety of services thus lots of exposure. Equipment: Modernized equipment for health care services. Working Environment: Motivated staff	Service Factors: Quality services; Timeliness of services; Well Equipped.
Coast General Hospital	Service Factors: Variety of services; Affordable services.	Service Factors: Cheap Services; Available specialists
Bomu Hospital	Good working environment: Affordable rates. Well paying. Sponsors for further studies. Job security	Service Factors: Friendly, Quality services, Affordable

B. External Stakeholders: Service Gaps

GAP	PROPOSED SOLUTIONS
- Information & communication to patients on what is ailing them and what treatment they are receiving. - Affordable healthcare. - Trustworthy Providers - Sufficient numbers of competent health workers	- Proper communication on patient care - Considerate pricing of services

C. External Healthcare Workers

CHALLENGES AT PREMIER HOSPITAL	POSSIBLE SOLUTIONS
- Staff harassment and disrespect in front of patients - Micromanagement - Job insecurity, staff dismissals, confusion	- Listen to staff complains - Work to ensure job security - Work on the management; management has to improve on how they handle the staff - Work on retaining staff; reduce staff turnover as this brings a lot of confusion especially during rounds.

d. Vendors (Private Health Insurers and Suppliers)

PH still has untapped potential for growth. Is strategically located and could expand further into other parts of the coastal region.

PH is largely known for great customer experience. Onus is to maintain high quality services.

Current shortcomings: Lean pool of consultants. Currently losing out on patients since some of the well-known consultants in town are not working with the hospital.

This lends itself as an opportunity for Premier not only hire full time consultants but also to engage existing consultants within the coastal town to deliver care at Premier.

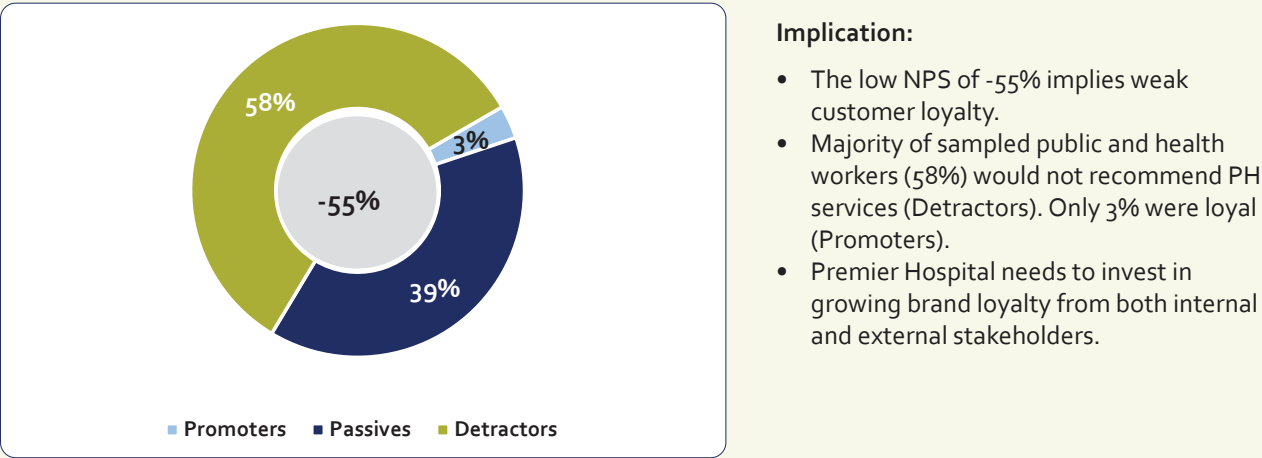
High staff turnover: Address high staff turnover especially of key medical personnel

Delayed payments of suppliers: Pay suppliers on time. PH is known within the supply circles to be a ‘stubborn’ customer. Suppliers have to follow up for payments for long, sometimes resorting to withholding of further supplies before due payments are made.

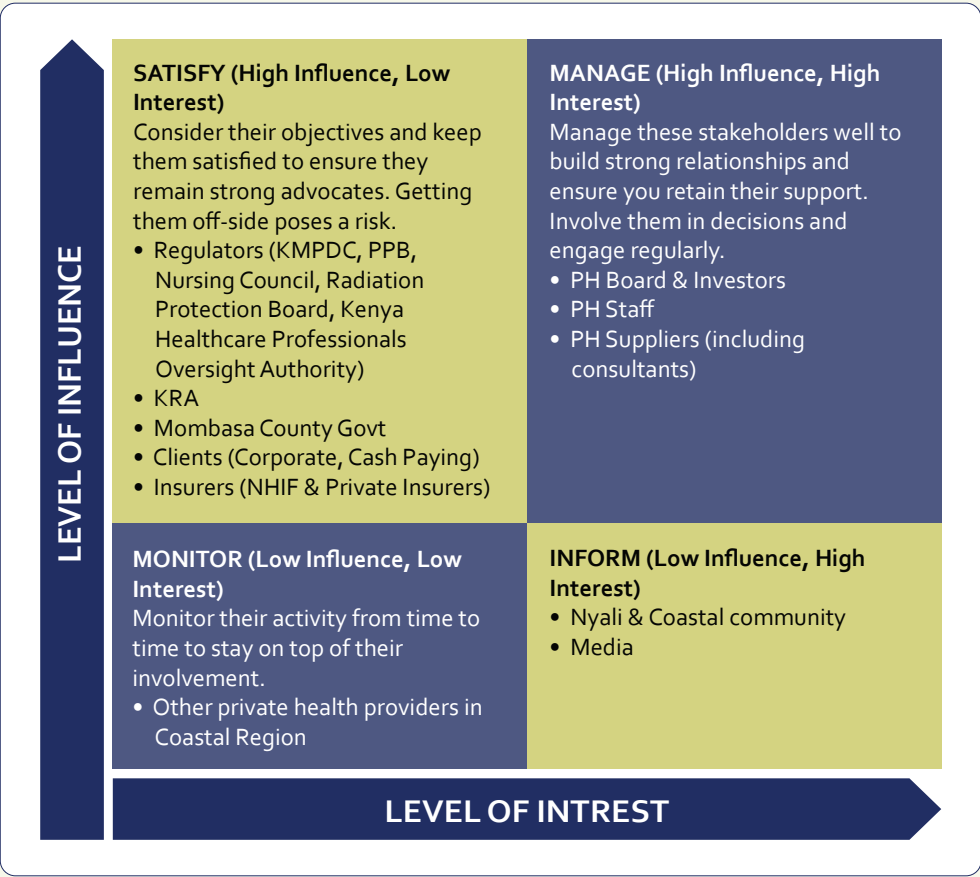
Net Promoter Score

The **Net Promoter Score (NPS)** assesses how loyal clients are to your brand and services. The score ranges from **-100% to 100%**. The higher the score, the stronger the loyalty. Promoters are considered loyal, Passives are neutral, and Detractors are not loyal, and may discourage others from using your services. The assessment established an NPS of **Negative Fifty-Five (- 55%)** as shown in figure 3.

Figure 3: Premier Hospital Net Promoter Score



Stakeholder Analysis



Business Model Canvas

KEY PARTNERS a. Payers - NHIF, PHIs b. Corporates - KRA, KPA c. Specialists d. Govt (national & County) e. Suppliers	KEY ACTIVITIES a. Customer relationship management. b. Talent management. c. Expansion (service and location) d. Brand building e. Marketing f. Key stakeholder engagement	VALUE PROPOSITIONS a. a. Highest quality healthcare, b. b. Accessibility, c. c. Superior customer experience d. d. Convenience	CUSTOMER RELATIONSHIPS a. Personalized care is expected b. Integration to the business model c. Pricing of this in the model	CHANNELS • Hospitals • Network of clinics • Telemedicine a. No integration of channels b. Need to find best integrations and most cost-efficient c. Consider patient routines in integration.
MOTIVATIONS FOR PARTNERSHIPS Resources from partners - licensing, financial, commodities				
COST STRUCTURE Direct costs, CAPEX, working capital, Most expensive - OPEX Value driven	KEY RESOURCES a. Human Capital b. b. Winning Culture, c. Financial (expansion, OPEX, working capital), d. IT (telemedicine, integrated ERP)	REVENUE STREAMS Fee for service, packaged/bundled services		

Financial Performance

a. Understanding Financial Performance

Figure 12 below outlines critical components in the appraisal of financial performance.

Figure 12: Dimensions of analysis of Financial Performance

FINANCIAL PERFORMANCE		
REVENUE GENERATION	OPERATIONAL EFFICIENCY	WORKING CAPITAL
Total Revenue and Revenue Growth	Direct Costs	Aged Creditors
Revenue by Key Business Lines	Operating Costs	Aged Debtors
Revenue By Payers	Units Performance	Provision Coverage Ratio

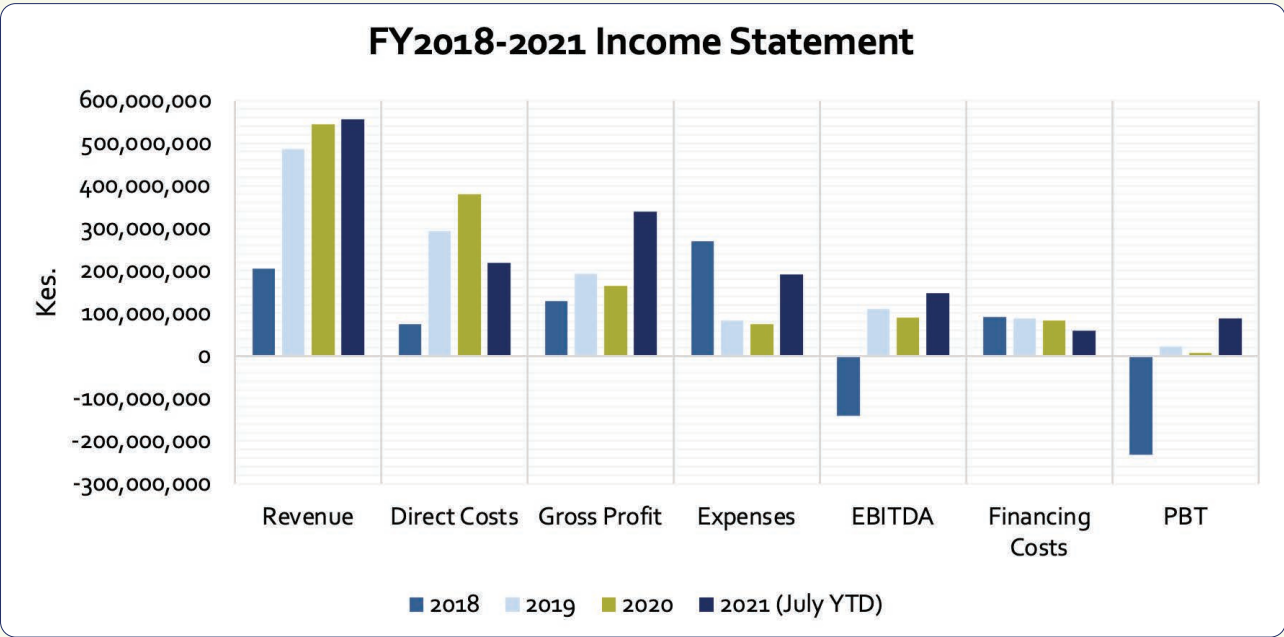
b. Income Growth

Table 1: FY2018-2021 Income Statement

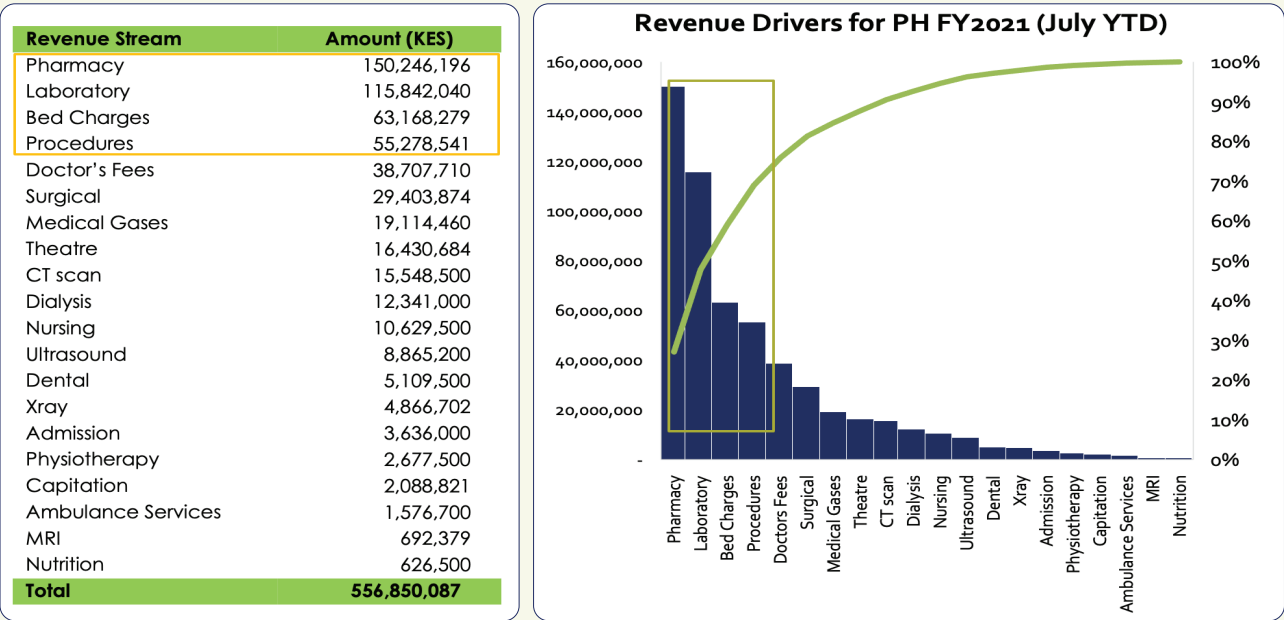
	2018	2019	2020	2021 (YTD July)
Revenue	204,350,679	486,824,584	544,247,521	556,924,993
Direct Costs	74,754,567	293,534,005	380,311,796	217,958,828
Gross Profit	129,596,112	193,290,579	163,935,725	338,966,166
Gross Margin	63%	40%	30%	61%
Expenses	269,972,941	83,646,437	74,241,990	191,062,766
EBITDA	(140,376,829)	109,644,142	89,693,735	147,903,400
EBITDA Margin	-69%	23%	16%	27%
Financing Costs	92,283,396	88,192,958	82,860,234	59,303,521
PBT	(232,660,225)	21,451,184	6,833,501	88,599,879
PBT Margin	-114%	4%	1%	16%

Highlights

- PH has experienced year-on-year growth on its total revenue and Profit Before Tax (PBT)
- PH's revenue has been growing in the past 4 years since 2018 at a Compound Annual Growth Rate (CAGR) rate of 40%
- Direct costs have been growing faster than the revenue at CAGR at 43%
- 2021 YTD margins have been the best since 2018 with an EBITDA margin of 27%; Likely but precariously driven by COVID-19 care hence unsustainable.
- 21% of admissions are cash payers and 79% are by corporates
- Shareholder contributions cost may account for the declining trend in financing costs.



c. Revenue by Key Business Lines

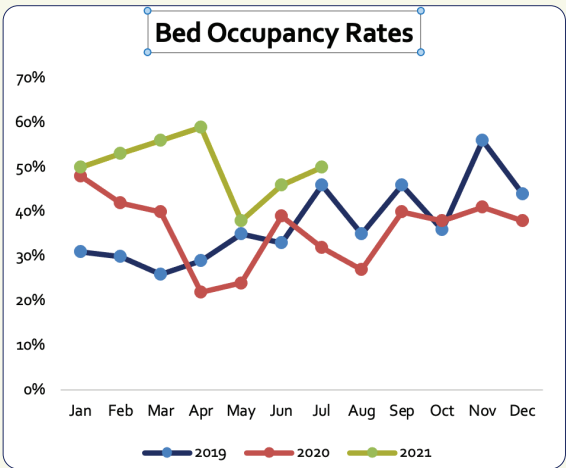


Highlights

The key revenue streams are the Pharmacy, Laboratory, Bed Charges and Procedures which contributed approximately 70% of the total revenue for FY 2021 (July YTD).

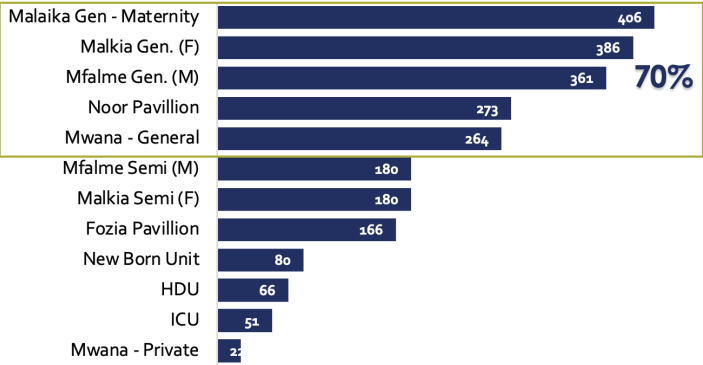
High contribution of bed charges to revenues could be a pointer to the perception of expensive services among the public.

d. Hospital Admissions



Bed Occupancy Rates were notably higher in 2021 (Average 50%) compared to 2020 (36%) and 2019 (37%).

Distribution of Admissions in PH



Highlights

Malaika Maternity Ward has highest admissions (17% of all admissions). Maternity, General Female, Male, & Pediatric wards, & Noor Pavillion account for 70% of all admissions.

e. Direct Costs by Key Business Lines

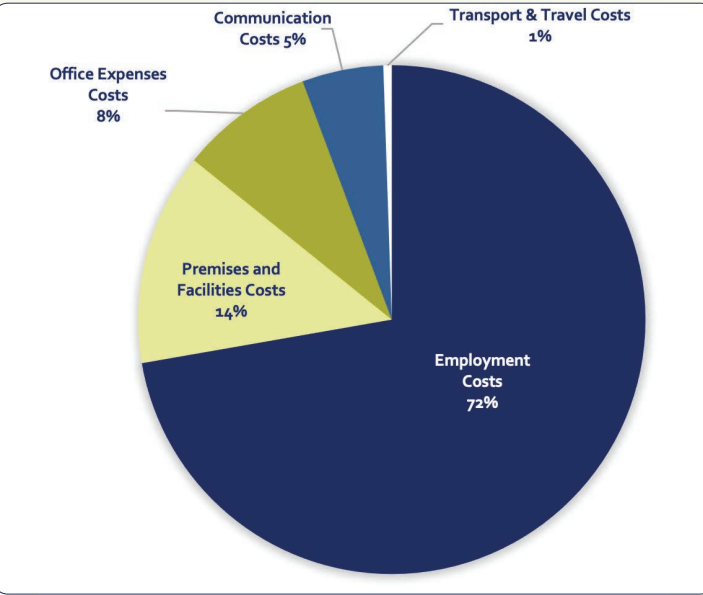
Direct Costs	Amount (KES)	Proportion
Pharmacy	-102,972,287	47.32%
Surgical	-40,376,917	18.55%
Laboratory	-38,266,972	17.58%
Medical Gases Cost	-12,342,861	5.67%
CT Scan	-6,876,675	3.16%
Dialysis	-4,811,039	2.21%
Food And Beverage	-4,391,775	2.02%
Dental	-4,431,120	2.04%
Xray	-1,084,352	0.50%
Theatre	-1,110,123	0.51%
Ultrasound	-701,066	0.32%
Inventory Adjustment	254,651	-0.12%
MRI Revenue	-299,100	0.14%
Echo	-115,000	0.05%
Physiotherapy	-19,800	0.01%
Ambulance Running Cost	-79,079	0.04%
Total	-217,623,515	100%

Highlights

Over 80% of the direct costs are accounted for by Pharmacy, Surgical, and Laboratory Costs. Pharmacy Costs are the greatest drivers of the direct costs (47%).

Highly likely that the lab is the most profitable functional unit at Kes. 77.5M (Revenue Kes. 115M vs Direct Costs Kes. 38M)

f. Operating Costs

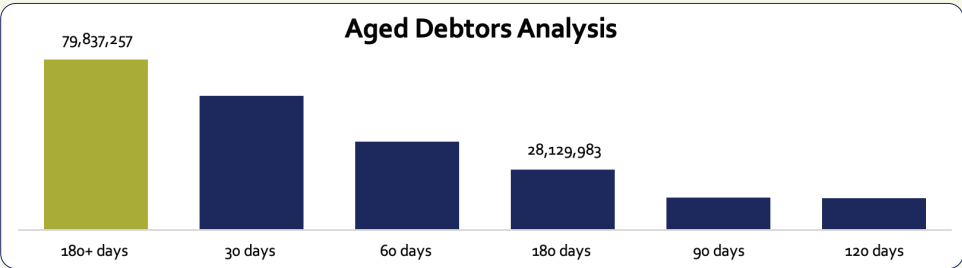


Highlights

Employment costs contributed 72% of total operating costs.

A compelling Employee Value Proposition (EVP) should be a critical priority as employees are the most expensive resource and bear highest responsibility for PH's returns.

g. Working Capital: Debtor Analysis

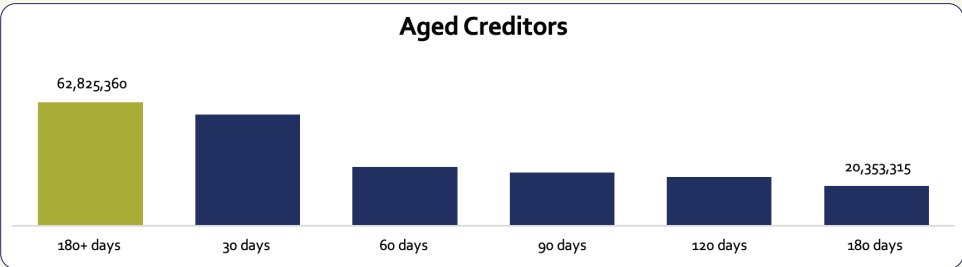


Most debtors are over 180+ days, raising concerns on liquidity and debt collection. NHIF is the largest debtor comprising 44% of total debt as shown in the table below.

DEBTORS	AMOUNT (KES)	PROPORTION
NHIF	106,305,193	44%
JUBILEE INSURANCE KENYA LIMITED	26,724,843	11%
SELF PAY DEBTORS	19,060,478	8%
KENYA PORTS AUTHORITY	14,168,237	6%
KENYA DEFENCE FORCES	8,583,581	4%
TOTAL DEBTORS	242,139,247	

Notably, NHIF report to owe Premier Hospital less the half the stated sum. This heightens the need for robust claims management within Premier Hospital.

h. Working Capital: Creditor Analysis



Majority of the creditors are beyond 180 days while others average at 30 days.

CREDITORS	AMOUNT (KES)	PROPORTION
DOCTORS	91,463,675	41%
SURGIPHARM LIMITED	14,423,293	7%
KETON CONSULTING LIMITED	13,205,888	6%
SCIENCESCOPE LTD	7,007,014	3%
NAIROBI ENTERPRISES LIMITED	6,896,000	3%
TOTAL CREDITORS	130,215,678	

Doctors account for 41% of creditors. This elevates the need for Premier Hospital to develop a structured payment plan as part of the value proposition for the doctors.

Market Entry Analysis

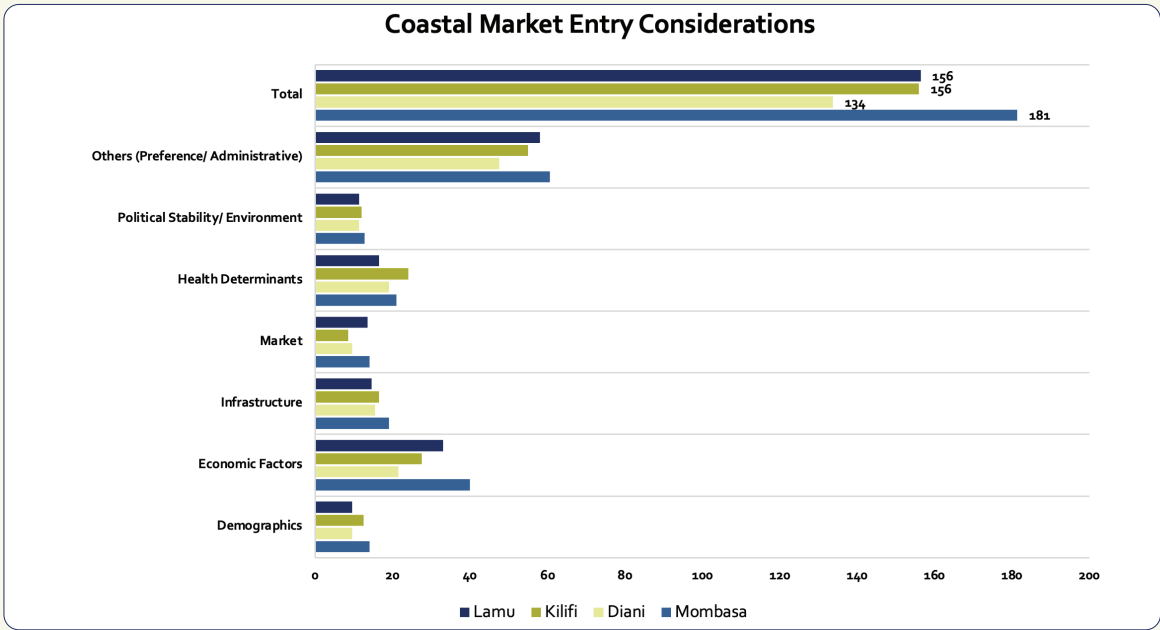
Findings from the market entry analysis are as the table below:

Dimension	Mombasa	Diani/Kwale	Kilifi	Lamu
Demographics	a. 2nd largest population in coastal region (1,208,333). b. 36% of the population are above 30 Years. c. 47% aged between 25 and 44 years. d. 49.5% Female. e. 24% Population reside in urban slums. f. Population Density: 5495/ km2; Highest in Coast.	a. 3rd largest population in coastal region (866,820). b. 29% of the population are above 30 Years. c. 31% aged between 25 and 44 years d. 51% Female e. 85% Rural Population f. Population Density: 105/km2	a. Largest population in coastal region (1,453,787) b. 29% of the population are above 30 Years. c. 32% aged between 25 and 44 years d. 52% Female e. 73% Rural Population f. Population Density: 116/km2	a. a. Smallest population in coastal region (143,920) b. 33% of the population above 30 Years. c. 35% aged between 25 and 44 years d. 47% Female e. 73% Rural Population f. Population Density: 23/km2; Largely concentrated around Lamu Island
Economic Factors	a. Poverty Index: 35% poverty rate; 3rd highest after Taita/ Kwale. b. GDP/Capita: Kes.170,821; Highest in the entire coastal region. c. Economic Activities/ Drivers: Shipping/ Logistics/ Tourism/ Manufacturing/ Refinery/Fishing.	a. Poverty Index: 47% poverty rate; 2nd highest after Taita. b. GDP/Capita: Kes. 53,267; 3rd highest among the focus counties in the coastal region. c. Economic Activities/ Drivers: Tourism/ Extractive Industry/ Fishing/ Agriculture/ Manufacturing.	a. Poverty Index: 31% poverty rate; 4th highest after Taita/ Kwale/Mombasa b. GDP/Capita: Kes. 45,661; Lowest among the focus counties in the coastal region. c. Economic Activities/ Drivers: Tourism/ Robust Extractive Industry/ Fishing/ Agriculture/ Manufacturing.	a. Poverty Index: 28% poverty rate; Lowest in the coastal region b. GDP/Capita: Kes. 98,117; 2nd highest in the entire coastal region. c. Economic Activities/ Drivers: Tourism/ Shipping/Logistics (LAPPSET)/ Fishing/ Agriculture.
Infrastructure	Transport: ~257 km bitumen surface; Highest paved in coastal region; International Airport; Ferries. Electricity Connectivity: ~59% of households connected to the national grid. Highest among coastal counties. Literacy/Education: 57%; Lowest among focus counties. Water Access: 74% have access to piped water; Highest in coast.	Transport: ~213 km bitumen surface; 3rd highest paved in coastal region; Local Airstrip Electricity Connectivity: ~20% of households connected to the national grid. Lowest among coastal counties. Literacy/Education: 57%; Lowest among focus counties.	Transport: ~219 km bitumen surface; 2nd highest paved in coastal region; Local Airstrip. Electricity Connectivity: ~21% of households connected to the national grid. 2nd highest among coastal counties. Literacy/Education: 68%; Highest among focus counties. Water Access: 60% have access to piped water; 2nd highest in coast.	Transport: ~6 km bitumen surface; Lowest paved in coastal region; Local Airstrips. Electricity Connectivity: ~20% of households connected to the national grid. Lowest among coastal counties. Literacy/Education: 67%; 2nd Highest among focus counties.
Market	Target Population: Literate, Economically Empowered. Competition: Robust Competition (Aga Khan, Mombasa Hospital, Pandya Hospital, Coast General Hospital)	Target Population: Large lower income population base. Small base of mid and high-income population. Competition: Fair potential competition (Diani Beach Hospital and Clinic, Palm Beach Hospital, Aga Khan Clinic Ukunda)	Target Population: Large lower income population base. Moderate base of mid and high-income population. Competition: Fair Potential Competition (Aga Khan-Bofa), Others (Mephi, Khairat)	Target Population: Small but literate, economically empowered. Tourist Population in Shela/Manda. Competition: Limited Competition.

Dimension	Mombasa	Diani/Kwale	Kilifi	Lamu
Health Determinants	Health Burden: Relatively low mortality rates (NMR-11 per 1000; IMR-57 per 1000; U5MR-32 per 1000; MMR-195 per 100,000) Facility-Population Ratio: ~ 1:4000 Health Financing: NHIF~18%	Health Burden: Moderate mortality rates (NMR-25 per 1000; IMR-44 per 1000; U5MR-57 per 1000; MMR-98 per 100,000) Facility-Population Ratio: ~ 1:5000 Health Financing: NHIF~9% (low)	Health Burden: High mortality rates (IMR-71 per 1000; U5MR-132 per 1000; MMR-488 per 100,000) Facility-Population Ratio: ~ 1:4200 Health Financing: NHIF~18%	Health Burden: Moderate mortality rates (NMR-25 per 1000; IMR-76 per 1000; U5MR-57 per 1000; MMR-676 per 100,000) Facility-Population Ratio: ~ 1:2600 Health Financing: NHIF~8% (low)
Political Factors	High Prioritization of Health by County Government. City Status. Military Bases	High Prioritization of Health by County Government. Dongo Kudu Road opening up opportunities and access. Terrorism threats	High Prioritization of Health by County Government.	Elevated priority for government investment (LAPPSET). Administrative expansion into Mokowe, Hindi Military Base Terrorism Threats (Boni)
Others (Preference/ Administrative)	High Preference Moderate Administrative requirements to expand.	Lowest Preference Moderate Administrative requirements to expand	Moderate Preference Least Administrative Requirements to expand	High Preference High administrative requirements to expand

Summary of Entry Considerations

Highlights on Potential Outpatient Clinics



While all sites have potential for viable investment, the analysis suggests:

1. Mombasa bears the greatest potential for early expansion.
2. Lamu and Kilifi may bear comparative potential hence can be considered in a phased expansion after Mombasa.
3. Diani may be considered as the last site for expansion.
4. The high demand for maternal and child health services and the high burden of NCDs imply potential value in integrating the general outpatient centers with some specialist clinics (Obstetric/Gynaecology, Pediatric and Physician) in the satellite clinics.



STRATEGIC DIRECTION

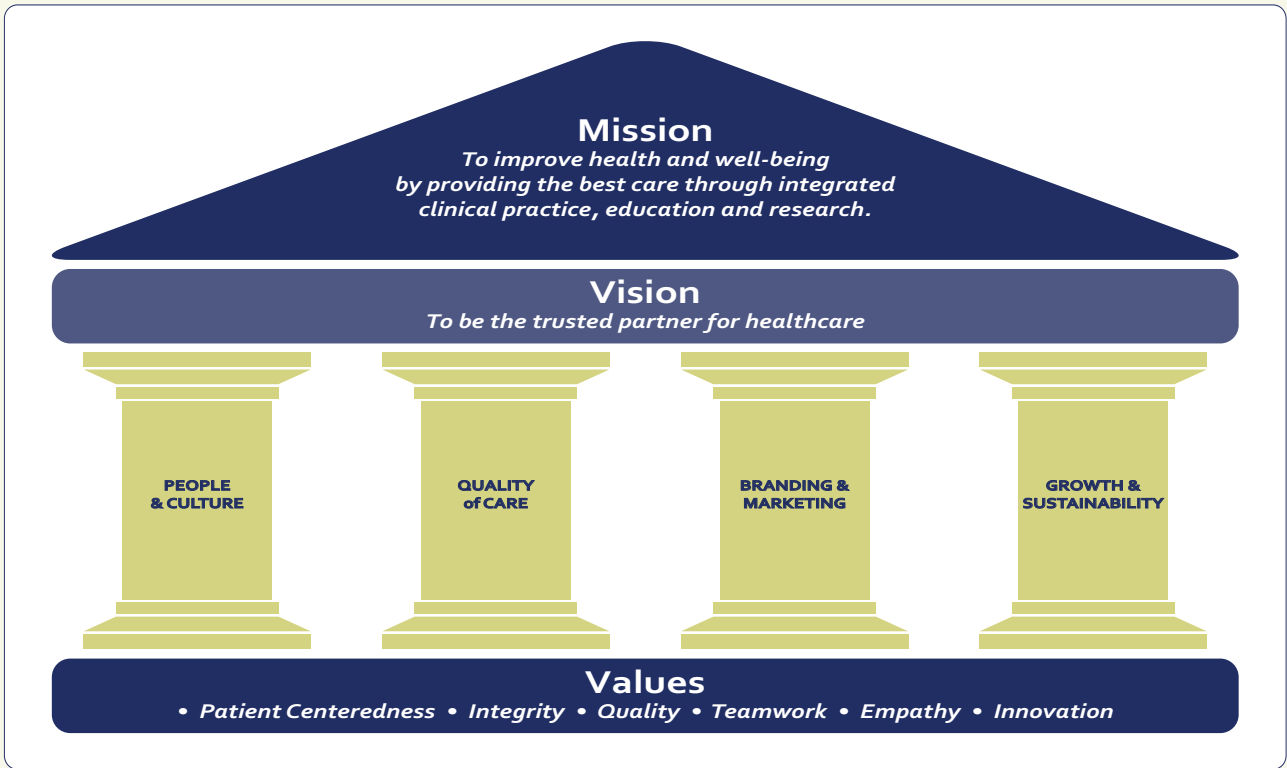


Vision
To be the trusted partner for healthcare.



Mission
To improve health and well-being by providing the best care through integrated clinical practice, education and research.

Figure 4: Strategic Direction



Core Values

- 1. Patient Centredness:** The needs of the patient come first.
- 2. Integrity:** We abide by the highest moral principles and professional standards by a commitment to honesty, confidentiality, trust, respect, and transparency.
- 3. Quality:** We ensure the highest standards and excellent outcomes through effective interactions, decision-making, and actions.
- 4. Teamwork:** We work together, in an environment where all are valued and respected, to ensure the best possible care, safety, and well-being of our patients and fellow caregivers.
- 5. Empathy:** We imagine what another person is going through, work to alleviate suffering, and create joy whenever possible.
- 6. Innovation:** We drive changes to transform and improve healthcare for the best possible patient outcomes.

Strategic Themes

- 1. People and Culture**
 - 2. Branding and Marketing**
- 3. Quality of Care**
 - 4. Growth and Sustainability**

Strategic Initiatives

THEME 1: PEOPLE AND CULTURE	
Strategic Objective 1: By FY 2025/26, Premier will seek to achieve at least 70% in employee engagement and build high performing teams with at least 85% achieving their targets (at a rating of 3)	
Strategy 1. Strengthen institutional governance to support strategy delivery	
Activity 1.1. Align governance to the new strategy for clarity of roles, and authority matrix. Activity 1.2. Facilitate Board to institutionalize good corporate governance in line with the new strategy Activity 1.3. Develop and implement a clear HR Manual that covers entire employee life cycle (recruitment to separation) Activity 1.4. Conduct a business skills for health training for HODs on running a healthcare business	KPIs 1. Level of staff engagement 2. % of Employees meeting targets 3. Critical staff retention of 80%
Strategy 2. Enterprise Performance Management	
Activity 2.1. Schedule and hold town halls to sensitize staff on Premier’s strategic direction (Vision, Mission, Strategic Priorities, Core Values) Activity 2.2. Sensitize all employees on Performance Management Activity 2.3. Train middle level management on Performance Management Activity 2.4. Develop performance score cards and cascade to employees. Activity 2.5. Introduce a reporting tool that consolidates, aggregates, and arranges performance measurements and metrics Activity 2.6. Link reward to performance and introduce total rewards concept for teams and individuals	
Strategy 3. Build a Strong Employee Value Proposition	
Activity 3.1. Develop Premier’s Employee Value Proposition (EVP) Activity 3.2. Implement effective internal communication channels Activity 3.3. Continuously assess employee engagement and satisfaction with the implemented EV	

THEME 2: QUALITY OF CARE	
Strategic Objective 2: By FY 2025/26, dominate the Primary to Tertiary Healthcare market with the relevant accreditations and requisite infrastructure with 80% customer satisfaction index.	
Strategy 1: Build and Sustain a Patient Centred Culture	
Activity 1.1. Implement a robust Continuous Quality Improvement system Activity 1.2. Obtain Safecare Certification for the hospital and new clinics Activity 1.3. Align performance of third-party providers to the PH Strategy	KPIs 1. Customer Satisfaction Index 2. Physician Engagement Index & referrals 3. Certifications
Strategy 2: Provide patient centric care	
Activity 2.1. Articulate the patient journey and improve lowly rated touch points Activity 2.2. Leverage data analytics to drive personalized patient experience Activity 2.3. Engage and support patients after discharge and outpatient visits Activity 2.4. Introduce regular customer satisfaction feedback process and create meaningful management information	
Strategy 3: Strengthen internal customer engagement	
Activity 3.1. Refine and implement internal customers (consultants) value proposition Activity 3.2. Align performance of Consultants to the PH Strategy	

THEME 3: BRANDING AND MARKETING	
Strategic Objective 3: A commitment to building a strong brand that will generate superior value in the long-haul and maintain a NPS of over +75 by FY 2025/26	
Strategy 1. Build a strong Premier Hospital Brand	
Activity 1.1. Develop Premier’s Branding and Marketing Strategy Activity 1.2. Build & maintain effective communities of internal and external brand ambassadors Activity 1.3. Establish and Operationalize the Premier Hospital Foundation Activity 1.4. Implement CSR activities through the Foundation	KPIs 1. Net Promoter Score 2. A Branding & Marketing Strategy 3. Premier Hospital Foundation
Strategy 2. Develop and Implement value propositions for each target customer segment.	
Activity 2.1. Analyse customer needs for each customer segments Activity 2.2. Develop compelling value propositions for each of the segments Activity 2.3. Communicate the value proposition through marketing activities Activity 2.4. Enhance analytical capability to enable improved market segmentation, create more specific sales activity for groups of customers and provide tailored customer experience Activity 2.5. Continuously evaluate and reshape our product and service portfolio in-line with changing customer expectations	
THEME 4: GROWTH AND STABILITY	
Strategic Objective 4: By FY 2025/26, grow sales turnover to KES 2.25 billion, achieve gross margin of 60% and maintain EBITDA at 20%.	
Strategy 1: Grow sales turnover to KES 2.25 billion by FY 2025/26	
Activity 1.1. Increase facilities by expanding the Nyali Hospital and adding 4 new clinics Activity 1.2. Diversify revenue streams by introducing new disciplines & procedures, oncology, and additional specialized care services Activity 1.3. Develop a funding strategy that includes full consideration of working capital Activity 1.4. Launch specific packages that are popular with payors (out-of-pocket and insurers/corporates) Activity 1.5. Optimize services for cost control and efficiency	KPIs 1. Sales Turnover & EBITDA 2. Number of clinics 3. Number of beds & occupancy 4. Number of patient consultations
Strategy 2: Build and Maintain strategic partnerships for growth	
Activity 2.1. Develop strategy & due diligence procedures for the identification, assessment and management of partnerships and alliances Activity 2.2. Determine core competencies and seek alliances that deliver scale and/ or improved revenue and profitability Activity 2.3. Continuously track and ensuring statutory and regulatory compliance	
Strategy 3: Reengineer Premier Hospital’s internal business processes	
Activity 3.1. Finalize the procurement of a new HMIS Activity 3.2. Re-engineer and document Premier’s key processes and mini-processes Activity 3.3. Train process owners on the re-engineered processes Activity 3.4. Develop and implement risk, resilience, and sustainability strategy across the entire organization	
Strategy 4: Build Premier Hospital’s capacity in Medical Education and Research	
Activity 4.1. Pursue accreditation as a KMPDC approved internship centre Activity 4.2. Establish and grow a modern medical library within Premier Hospital Activity 4.3. Pursue accreditation as a <u>College of Surgeons of East, Central and Southern Africa (COSECSA)</u> Surgical training centre Activity 4.4. Generate and disseminate evidence in healthcare delivery and clinical practice	



GOVERNANCE

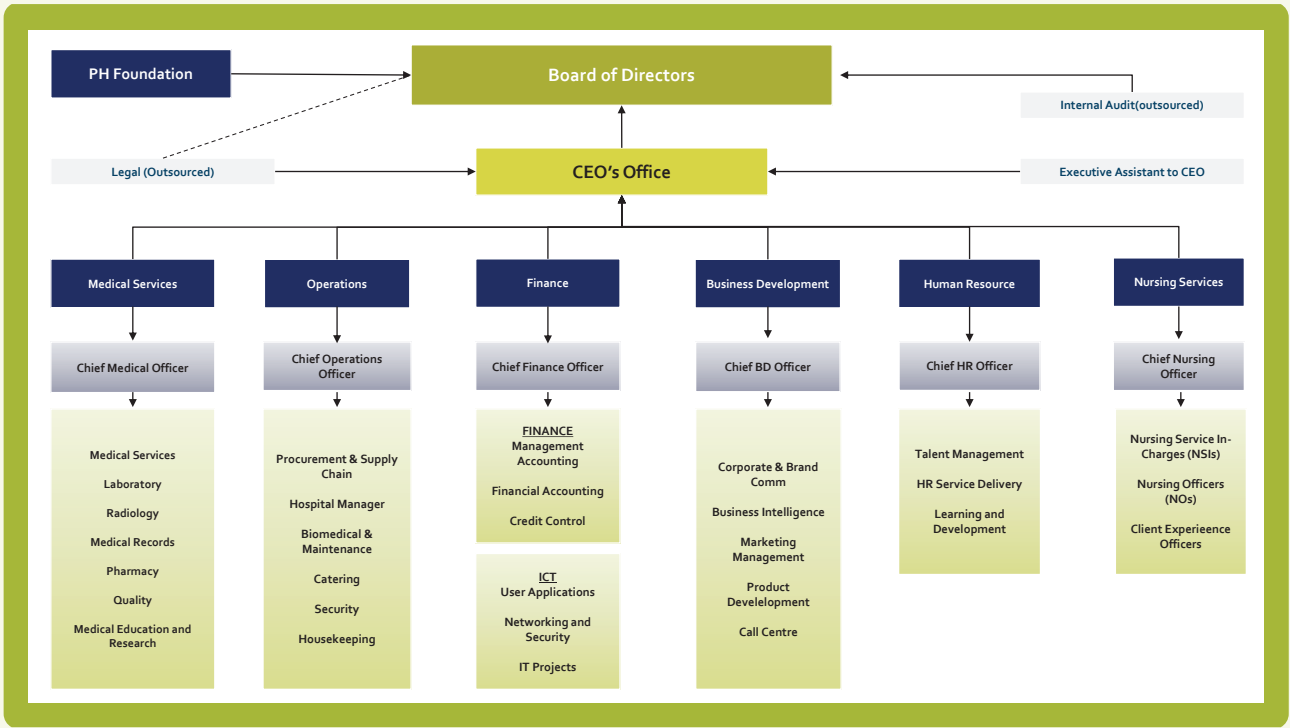
A. Current Governance Structure

The current structure has multiple (11) direct reports to the CEO. This bears the risk of making the CEO operational rather than visionary and strategic. Reducing the direct reports may thus strengthen the CEO’s strategic stance within Premier Hospital.

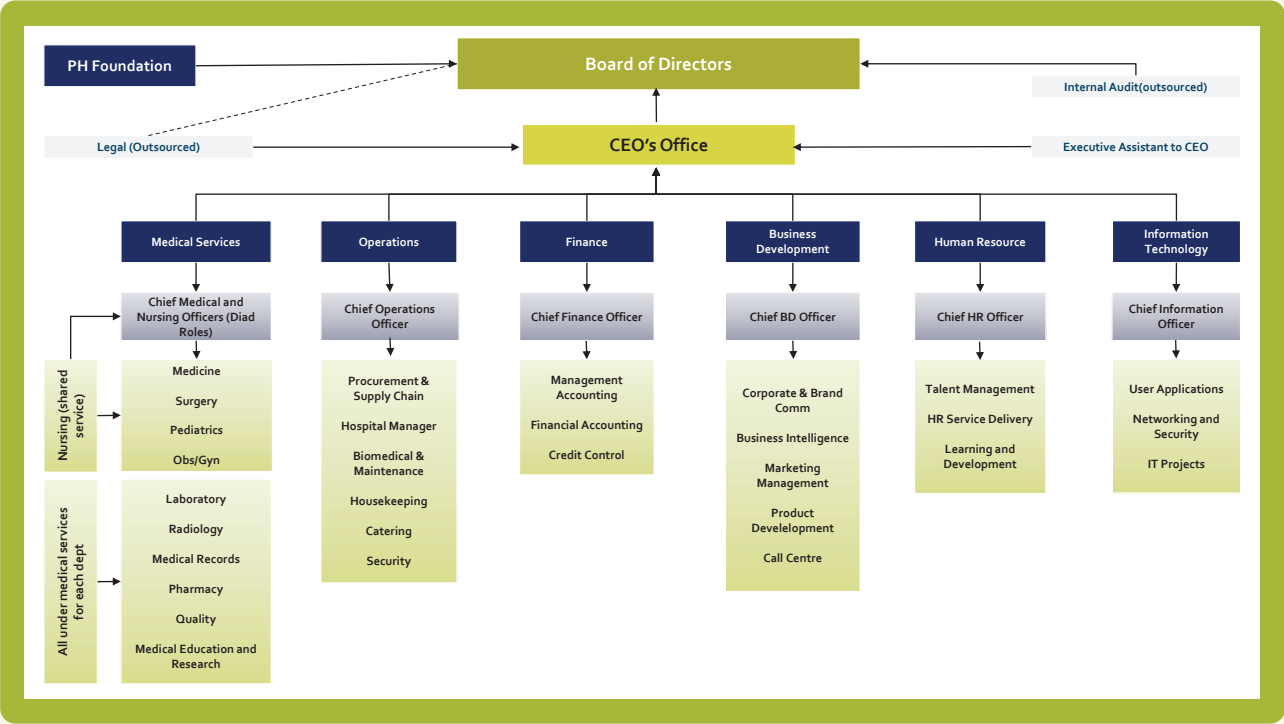
Implication

- Have a functional organizational structure rather than a divisional structure
- Group people who do similar tasks based on specialty
- Each tier can share information and offer direction horizontally
- Have several layers of accountability: Board of Directors, Executives, Heads of Department and Service Providers.

B. Proposed Functional Structure (Year 2021-2024)



C. Proposed Functional Structure (Year 2024-2026)



D. Unpacking the Proposed Structure

Medical Services, Education & Research	Operations	Nursing Services	Finance	Business Development	Human Resource	Information Technology
Chief Medical Officer: Oversight & Coordination of Medical Services, Education & Research	Chief Operations Officer: Oversight & Coordination of operational functions.	Chief Nursing Officer: Oversight & Coordination of nursing services.	Chief Finance Officer: Oversight & Coordination of Financial services.	Chief BD Officer: Oversight & Coordination of Business Development & Marketing.	Chief HR Officer: Oversight & Coordination of Human Capital.	Chief Information Officer: Oversight & Coordination of Information Technology Services.
Medical Services Manager: Coordination of Specialist services, Medical, Dental & Clinical Officers, Physiotherapy services	Hospital Administrator/ Manager: Coordination administrative functions	Nursing Services Incharges: Coordination nursing in respective service units.	Financial Accounting: Recording, summarizing, and reporting streams of transactions.	Corporate & Brand Communication: External brand communication	Talent Management: Identification, Recruitment, Retention, Performance Management of Human Capital	User Applications: Design and support for functional information systems for users.
Laboratory Services Manager: Coordination of laboratory services	Procurement & Supply Chain Manager: Coordination of procurement and supply chain management	Nursing Officers: Provision of nursing care in respective service units.	Management Accounting: Analysis, interpretation, and communication of financial information to guide management.	Marketing Management: Management of existing client accounts	HR Service Delivery: Contracting, absence management.	Network & Security: Management of service network systems and security
Radiology Services Manager: Coordination of diagnostic imaging services	Biomedical & Maintenance Manager: Coordination of biomedical engineering and maintenance services	Client Experience Officers: Surveillance of client experience for responsive service delivery.	Credit Control: Management of creditors and debtors.	Business Intelligence & Product Development: Market intelligence and responsive service design	Learning & Development: Strategic Capacity Development of staff	IT Projects: Technical support to scale up/ designated IT investments
Pharmacy Services Manager: Coordination of pharmacy services	Catering Services Manager: Coordination of diagnostic imaging services			Customer Call Center: Managing customer inquiries on service offerings		
Health Records Manager: Coordination and management of health records	Housekeeping Services Manager: Coordination of housekeeping services					
Head-Medical Education: Coordination of Medical Education & Research	Security Manager: Coordination of Security services					
Head-Quality Assurance: Coordination of QA, Standards, Compliance						

Note:
1. The respective positions reflect functional roles hence must not exist separately but can be embedded in existing offices.
2. Titles can be changed to reflect PH preferences.





Patient Centeredness • Integrity • Quality • Teamwork • Empathy • Innovation

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