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Strategic differences among private hospitals in Bangkok and vicinity : Implications for policy planning

Jiruth Sriratanaban*

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Background : *Although the public sector has traditionally been the major health care provider in this country, the recent growth of private hospitals significantly increases the role of the private sector in providing care for the Thai population. However, no study has explored whether and how private hospitals are strategically different so as to help policy makers understand them better.*

Objectives : *To examine generic strategies of private hospitals in Bangkok and in nearby provinces, and their relationships with hospital ownership and the medical facilities available at the hospitals.*

Design : *Cross-sectional survey*

Sample : *Ninety four private hospitals in Bangkok and five vicinity provinces which met the study inclusion criteria.*

Data collection : *In-person interviews with hospital executives and written hospital survey forms*

Results : *The response rate was 88.3 percent. Some 38 percent of the hospitals belonged to hospital systems. The most common position*

and pace strategies pursued by private hospitals were focus (34.9 percent) and defenders strategies (25.6 percent). Hospital strategies--power, position and pace--were significantly related to ownership status and associated with the availability of medical facilities.

Conclusion : *Private hospitals are strategically different from one another. To understand and control hospital behaviors from the policy perspective, hospital strategy needs to be taken into consideration.*

Key words : *Private hospital, Strategy, Health policy.*

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จิรุตม์ ศรีรัตนบัลล์. ความแตกต่างเชิงกลยุทธ์ระหว่างโรงพยาบาลเอกชนในเขตกรุงเทพและ
ปริมณฑล : นัยเพื่อการวางแผนนโยบาย. จุฬาลงกรณ์เวชสาร 2541 มี.ค;42(3) : 157-72

- ที่มา** : ถึงแม้ภาครัฐจะเป็นผู้ให้บริการทางสาธารณสุขของประเทศไทยมาตลอด
บทบาทของภาคเอกชนได้ทวีความสำคัญขึ้นเรื่อยๆ ในการให้การดูแล
สุขภาพแก่คนไทยอย่างไรก็ตามยังไม่มีการศึกษาว่าโรงพยาบาลเอกชน
มีความแตกต่างกันเชิงกลยุทธ์หรือไม่ อย่างไรก็ตามนี้เพื่อช่วยให้ผู้วางแผนนโยบาย
ได้มีความเข้าใจต่อโรงพยาบาลเอกชนได้ดีขึ้น
- วัตถุประสงค์** : เพื่อศึกษากลยุทธ์ทั่วไปที่โรงพยาบาลเอกชนในเขตกรุงเทพมหานครและ
ปริมณฑลใช้อยู่ และความสัมพันธ์ของกลยุทธ์ที่มีกับสถานะความเป็น
เจ้าของของโรงพยาบาลและ อุปกรณ์เครื่องมือทางการแพทย์ต่างๆ ที่
โรงพยาบาลมี
- รูปแบบการศึกษา** : การสำรวจแบบตัดขวาง
- กลุ่มตัวอย่าง** : โรงพยาบาลเอกชนในเขตกรุงเทพมหานครและจังหวัดปริมณฑล 5 จังหวัด
ที่ตรงตามเกณฑ์คัดเลือก รวม 94 แห่ง
- การเก็บข้อมูล** : การสัมภาษณ์เป็นรายบุคคล และแบบสำรวจโรงพยาบาล
- ผลการศึกษา** : อัตราการตอบกลับเท่ากับร้อยละ 88.3 โรงพยาบาลเอกชนร้อยละ 38 เป็น
สมาชิกของระบบโรงพยาบาล กลยุทธ์ด้านตำแหน่งและจังหวัดที่ใช้มากที่สุด
คือกลยุทธ์เป้าหมายเฉพาะกลุ่ม (ร้อยละ 34.9) และกลยุทธ์ defenders
(ร้อยละ 25.6) กลยุทธ์ด้านอำนาจ ตำแหน่งและจังหวัดที่โรงพยาบาลใช้
มีความสัมพันธ์อย่างมีนัยสำคัญกับสถานะความเป็นเจ้าของ และอุปกรณ์
เครื่องมือทางการแพทย์ต่างๆที่โรงพยาบาลมี
- สรุป** : โรงพยาบาลเอกชนมีความแตกต่างกันเชิงกลยุทธ์ ดังนั้นเพื่อความเข้าใจ
และการควบคุมพฤติกรรมโรงพยาบาลในเชิงนโยบาย จะต้องคำนึงถึง
กลยุทธ์ของโรงพยาบาลด้วย

The health care sector of Thailand has been changing rapidly and significantly for a decade or so. Although the public sector has traditionally been the major health care provider in this country, the recent growth of private hospitals significantly increases the role of the private sector in providing care for the Thai population. The proportion of private beds increased from 7.4 percent in 1973 to 23.1 percent in 1994.⁽¹⁾ Having been described as a 'sun-rising industry' since 1988, the growth in the numbers of private hospitals and private hospital beds during the past 20 years may be one of the most striking phenomena in the health system of Thailand.⁽²⁾ During 1986-1990, the annual health care expenditures in the private sector increased by 24 percent each year.⁽³⁾ The annual income growth rates of private hospitals in Bangkok, which had been 16 percent during the 1983-1987 years, were 21, 16, 25 and 30 percent during 1988-1991 respectively.^(1, 4) From 1976 to 1984, the growth rate of private beds was, on average, 26 percent per year, while the average rate during 1984-1992 was 17 percent per year.⁽⁵⁾

The recent growth in private hospitals has taken place almost entirely in the for-profit sector and, thus, the hospitals concentrated in urban areas particularly in Bangkok and its vicinity provinces.⁽⁶⁾ The population to bed ratio in Bangkok decreased from 259 in 1991 to approximately 200 in 1994.^(3, 7, 8) The majority of the private hospitals are for-profit. Not-for-

profit private facilities play a relatively limited role. Moreover, they tend to behave on a relatively commercial basis as they ensure that user fees cover virtually all their costs.⁽⁶⁾

Tangcharoensathien, Khongswatt et al⁽⁵⁾ conducted a hospital census in 1992 and arbitrarily group private hospitals into 4 categories: 1) private hospitals owned by private corporations; 2) private hospitals owned by foundations (not-for-profit); 3) private hospitals owned by public corporations listed in the Stock Exchange of Thailand; and 4) small private hospitals like clinics and polyclinics with beds. The study showed that they were different in terms of size, numbers of qualified health personnel per bed, and room charges. Nevertheless, this study achieved an overall response rate of 69 percent. The rate was only 50 percent in Bangkok.

Due to the growth and market concentration within the private sector, competition among private hospitals has been dramatically increasing.^(9, 10) Several authors in the field of public health in Thailand characterize how private hospitals primarily compete with one another as non-price competition, including procurement of high-cost medical technologies,^(4, 6, 11) emphasis on strong public image, availability of such high-tech instruments, medical specialty centers, convenient locations, hotel-like services and accommodations.⁽¹²⁻¹⁵⁾ Some hospitals increase the access of potential customers to their services by opening new branches while others

focus on market niches.^(9, 10) Price competition among private hospitals also exists although it is not as explicit as non-price competition. Several articles on private hospital business emphasize how the hospitals set their target customers, price their services accordingly, and then offer discounts.^(10, 12-14)

Despite the increasing role and importance of this sector, few studies have been conducted on private hospitals in Thailand. None has explored whether and how private hospitals are strategically different. This study, therefore, aims to examine generic strategies of which private hospitals in Bangkok and its vicinity provinces are using and whether they are related to hospital ownership status, as well as some medical facilities available at the hospitals. The answer to the question may give insights to help policy makers understand the private hospital sector, leading to effective and productive policy initiation in the future.

Methods

A cross-sectional observational survey was conducted from August 1996 to May 1997. The study population consisted of all of the private hospitals in Bangkok and its vicinity provinces including Nakorn Pathom, Nonthaburi, Pathum Thani, Samut Prakarn, and Samut Sakorn that met the following criteria: 1) being legally registered with the Medical Registration Division of the Ministry of Public Health, and named as a hospital for general or specialized acute care; 2)

having more than 25 registered beds in 1994; 3) being owned by companies or foundations; 4) having been in operation for at least the two full years of 1994 and 1995, and remaining open during the survey; 5) providing modern medical services with multi-specialties. Based on the database of the Medical Registration Division, the total number of the hospitals in the sampling frame was 99.⁽¹⁶⁾

However, it was found that five small hospitals in four hospital systems are satellite hospitals of bigger ones, being owned by the same companies, located in the same market areas, sharing resources and having the same management teams. As they were not independent units, these five satellite hospitals were combined with their headquarter hospitals into the same units for further analysis to avoid bias towards over-representation of a particular type of hospital management. As a result, the population was reduced to 94, all of which were included in the study.

The survey included in-person interviews conducted by the principal investigator and self-administered hospital survey questionnaires. The questionnaires were pre-tested with a few hospital executives for corrections of any confusing terms or questions. One of the following hospital executives, or an equivalent, was interviewed in each hospital: Chief Executive Officer, Hospital Director, Hospital Administrator, or Deputy Hospital Administrator, or a person designated

by those individuals as the equivalent in their organizations. In addition, relevant secondary data, especially for environmental-market characteristics, were collected from governmental agencies, such as the National Statistical Office, the Bangkok Metropolitan Administration, and the Revenue Department.

Assessment of hospital strategies

Hospital strategies were assessed in three dimensions: power, position and pace.⁽¹⁷⁾ Power strategies realize the advantage through the accumulation and effective combination of mass. For example, hospitals may expand their size or form hospital systems, or groups sharing some forms of common management structure, or using umbrella-branding. By doing so, they may gain some market power over suppliers, as well as customers.

By contrast, position strategies gain the advantage by achieving distinctive value in the minds of consumers. Porter^(18, 19) suggests that there are three generic position strategies: 1) **cost leadership**--relatively low cost position, producing a product or providing a service at a lower cost than competitors' offerings and maintaining an acceptable level of quality; 2) **differentiation**--creating uniqueness in the mind of customers by making a product or a service different (product differentiation) or appearing so (marketing differentiation) from competitors' products and services; 3) **focus**--better serving a narrow market niche by selecting distinctive

segments in the market and orienting one's appeal uniquely to them, such as focusing on specialized products or services, or narrow customer groups by geographic locations.⁽¹⁸⁻²⁰⁾

Finally, pace strategies attain the competitive advantage through managing the timing and intensity of actions. Miles and Snow⁽²¹⁾ classify four patterns of the strategies: 1) **defender**--maintaining stability, control and efficiency and engaging in little search for additional opportunities for growth; 2) **reactor**--having inconsistent and unstable pattern in adjusting to its environment and making changes primarily in response to environmental pressures; 3) **analyzer**--combining control and flexibility and pursuing new opportunities after thorough analysis; 4) **prospector**--seeking to be flexible, actively pursuing new product and market opportunities, becoming a pioneer, creating change and uncertainty in the environment that demand competitors' responses.

Two techniques for measuring strategies--**self-typing and external assessment**--have been applied. The self-typing method allows the top executive of a hospital to characterize his/her organization's strategy.^(22, 23) Given descriptions of the Porter's position strategies, each executive was asked to identify which strategies the hospital used as a leading strategy. In addition, the executives were given a brief description of each Miles and Snow's strategy types, and asked to classify how their hospitals had strategically

behaved for the past five years, or since their establishments were founded, in case the hospitals had been operating for less than five years. They were also required to provide brief justifications for their responses.

Used in combination with self-typing, the external assessment asks individuals external to the focal organization (e.g., competitors) to evaluate its strategies.^(22, 23) Applying the same questions utilized in the self assessment, the hospital executives were asked to rate their major competitors' strategies. The externally assessed results of a particular hospital were then compared with those of the self-typing approach for validation and reliability evaluation.

In brief, self-typing and externally assessed strategies achieved fair to good agreement with kappa statistics of 0.533 and 0.405 for position and pace strategies, respectively. Descriptions of what hospitals have done given by hospital executives appear justifying validity of self-typing results. Details of these analyses were presented elsewhere.⁽²⁴⁾

Measurement of hospital-related characteristics

Geographic locations of private hospitals include inner Bangkok area, border Bangkok area (districts adjacent to vicinity provinces), and vicinity areas. In addition, hospitals were basically grouped by their ownership status into 1) not-for-profit hospitals which were owned by

foundations or religious organizations; 2) for-profit hospitals which were not listed in the Stock Exchange of Thailand (For-profit, non-SET); and 3) for-profit hospitals which were listed in the Stock Exchange of Thailand (For-profit, SET listed).

Certain specialized medical facilities, including ultrasonography, rehabilitation service, an intensive care unit, neurosurgery, dental service, CT scanners, psychiatric service, laser surgery, heart surgery, a hemodialytic unit, an infertility unit, an occupational health unit, a coronary care unit, an ultrasonic lithotripter and an MR scanner, were also surveyed whether they were offered by hospitals.

Results

Out of the 94 hospitals, the response rate was 88.3 percent (83 hospitals). Non-respondents were not different from respondents in terms of geographic location (Fisher's exact test: $p=1.000$), ownership status (Fisher's exact test: $p=0.592$) and system membership (Fisher's exact test: $p=0.126$). However, small hospitals (26-99 beds) were significantly less likely to participate in the study than mid-size (100-199 beds) and large (200 beds up) hospitals (75% vs. 89% and 100% respectively; Fisher's exact test: $p=0.009$). Despite the difference, the response rate among small hospitals was still satisfactorily high.

Because certain hospitals shared same management teams, those with the same teams

were interviewed only once. There were eight hospitals from four different hospital systems in this situation. Thus the total number of interviews conducted was 79. These 83 hospitals were treated as individual units in subsequent analysis; the data concerning hospital management were duplicated for those that share management teams. Certain data of all hospitals are available regardless of their participation in the study while other data is missing for non-respondents.

Table 1 shows general characteristics of all 94 private hospitals in the study. The majority were in the Bangkok area (71.3 percent), and were for-profit hospitals (90.4 percent) as ten of them belonged to companies listed in the SET. Only nine hospitals were not-for-profit. In addition, the mid-size hospitals, those having 100-199 beds, were the largest group (38.3 percent). The median size of the hospitals in 1995 was 106 beds, on average six beds larger than in 1994.

Table 1. General characteristics of private hospitals in the study.

Characteristics	Number (%)
Geographic location:	
= Inner Bangkok	50 (53.2%)
= Border Bangkok	17 (18.1%)
= Vicinity areas	
- Nakornprathom	2 (2.1%)
- Nonthaburi	4 (4.3%)
- Pathumthani	5 (5.3%)
- Samutprakarn	13 (13.8%)
- Samutsakorn	3 (3.2%)
	27 (28.7%)
Ownership status:	
= Not-for-profit	9 (9.6%)
= For-profit, not listed in SET	75 (79.8%)
= For-profit, listed in SET	10 (10.6%)
Registered number of beds:	
= less than 100 beds	28 (29.8%)
= 100 - 199 beds	36 (38.3%)
= 200 beds or more	30 (31.9%)
Main contractors under the social security scheme	40 (42.6%)
Total number of hospitals	94 (100%)

Some 58 out of 94 hospitals (61.7 percent) were independent while the other 36 hospitals belonged to hospital systems. Table 2 indicates that hospital ownership statuses were significantly related to system membership ($p=0.001$). The for-profit, SET-listed hospitals were more likely

to be parts of hospital systems than other hospitals. Although they also tended to be bigger than for-profit, non-SET hospitals and not-for-profit hospitals in terms of registered numbers of beds, the differences were not statistically significant ($p=0.140$).

Table 2. Relationship between ownership status and numbers of operating beds in 1995 and the system membership status of the hospitals.

	Number (%) of hospitals by ownership			p value
	Not-for-profit	For-profit, non-SET	For-profit, SET listed	
System membership				0.001 ⁽¹⁾
= Independent hospitals	6 (66.7%)	51 (68.0%)	1 (10.0%)	
= System hospitals	3 (33.3%)	24 (32.0%)	9 (90.0%)	
Hospital size by registered beds				0.140 ⁽¹⁾
= less than 100 beds	3 (33.3%)	25 (33.3%)	0 (0.0%)	
= 100 - 199 beds	3 (33.3%)	29 (38.7%)	4 (40.0%)	
= 200 beds or more	3 (33.3%)	21 (28.0%)	6 (60.0%)	
Total	9 (100.0%)	75 (100.0%)	10 (100.0%)	

Note (1) Fisher's exact test

Table 3 reveals numbers of hospitals using different position strategies and pace strategies. Among the 83 responding hospitals, there were 29 hospitals using focus strategies as their leading strategies (34.9 percent), 23 hospitals using differentiation strategies (27.7 percent), 24 using cost leadership strategies (28.9 percent), and 7 hospitals having no leading strategies (8.4 percent). The most common pace

strategies were defenders (24 hospitals, or 25.6 percent) and prospectors (23 hospitals, or 24.5 percent). According to executives interviewed, differentiation strategies may include opening specialized diagnostic and treatment centers; offering amenities, appearance, cleanliness, and other tangibles; emphasizing interpersonal aspects of care, improved general services; changing name, building image; emphasize marketing

activities; and adding new high-tech equipment and service innovations. The examples of cost leadership strategies were to increase operational efficiency and transfer low costs to consumers; to emphasize cost control measures, such as standardized medical and drug supplies, tightened inventory control, job rotation of personnel; to limit number of personnel; to cut unnecessary expenses; to cut amenities, limit capital investment to reduce interest burden; to look

for economies of scales, especially in purchasing; and never use interest-bearing debts. At the same time, the focus hospitals tended to be community hospitals, emphasizing primary care; focusing on particular groups such as the elderly, families, contracts or to target workers, social security beneficiaries, or to focus on specific medical specialties while still offering general care.

Table 3. Position and pace strategies pursued by private hospitals.

	Number	(%)
Position strategies		
= Focus	29	(34.9)
= Differentiation	23	(27.7)
= Cost leadership	24	(28.9)
= No leading strategy	7	(8.4)
Pace strategies		
= Defender	24	(25.6)
= Reactor	18	(21.7)
= Analyzer	18	(21.7)
= Prospector	23	(24.5)
Total	83	(100.0)

As shown in Table 4, hospitals' pursuit of these position strategies were strongly related to their ownership statuses ($p=0.006$). While for-profit, SET listed hospitals predominantly used differentiation strategies (70 percent), there were rather equal numbers of for-profit, non SET hospitals which employed focus strategies or cost

leadership strategies (37.5 and 34.4 percent). Not-for-profit hospitals might or might not have any leading strategies. Moreover, Table 4 demonstrates that hospitals with different ownership statuses tended to have differing pace strategies ($p=0.005$). For-profit, SET listed hospitals were likely to be proactive, being

prospectors (70 percent). In contrast, for-profit, non-SET hospitals had no preferential pace strategies. Non-for-profit hospitals were rather conservative; only four out of nine hospitals were defenders.

Table 4. Relationships between ownership status and the leading competitive strategies (n=83 hospitals).

	Number (%) of hospitals by ownership			p value
	Not-for-profit	For-profit, non-SET	For-profit, SET listed	
Position strategies				0.006 ⁽¹⁾
= Focus strategy	2 (22.2%)	24 (37.5%)	3 (30.0%)	
= Differentiation strategy	2 (22.2%)	14 (21.9%)	7 (70.0%)	
= Cost leadership strategy	2 (22.2%)	22 (34.4%)	0 (0.0%)	
= No leading strategy	3 (33.3%)	4 (6.3%)	0 (0.0%)	
Pace strategies				0.005 ⁽²⁾
= Defenders	4 (44.4%)	20 (31.3%)	0 (0.0%)	
= Reactors	3 (33.3%)	14 (21.9%)	1 (10.0%)	
= Analyzers	1 (11.1%)	15 (23.4%)	2 (20.0%)	
= Prospectors	1 (11.1%)	15 (23.4%)	7 (70.0%)	
Total	9 (100.0%)	64 (100.0%)	10 (100.0%)	

Note (1) Fisher's exact test

(2) Kruskal-Wallis test

Table 5 exhibits numbers of 15 surveyed medical facilities available in the 83 responding hospitals. Ultrasonography was the most prevalent, whereas MR scanners was the least. About half of the hospitals (47 percent) had seven facilities or fewer. None had all. The availability of medical facilities was strongly associated with hospitals' position and pace

strategies, as indicated by analysis of variance (ANOVA) models shown in Tables 6 and 7. Adjusting for size, hospitals with differentiation or focus strategies had significantly more facilities than those with no leading strategies ($p < 0.001$). Prospector hospitals also had significantly more facilities than other hospitals ($p < 0.001$).

Table 5. Numbers of medical facilities in the private hospitals.

No.Fac- ility	No. Hosp	Cum. Percent	Number of hospitals having particular facilities or services														
			us	reh	icu	neu	den	cat	psy	hem	inf	occ	las	ccu	hrt	lit	mri
0	4	4.8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1	4	9.6	1	0	0	0	0	0	0	0	1	1	1	0	0	0	0
2	6	16.9	5	2	0	0	4	0	1	0	0	0	0	0	0	0	0
3	4	21.7	2	3	2	1	2	0	1	0	0	1	0	0	0	0	0
4	2	24.1	2	2	2	1	0	0	1	0	0	0	0	0	0	0	0
5	4	28.9	4	4	4	4	2	1	0	0	0	1	0	0	0	0	0
6	3	32.5	3	2	3	3	1	3	3	0	0	0	0	0	0	0	0
7	12	47.0	11	12	12	12	12	9	9	3	1	3	0	0	0	0	0
8	7	55.4	7	7	7	7	7	6	3	3	1	4	0	1	2	0	1
9	10	67.5	10	10	10	10	10	8	8	7	6	3	3	2	1	2	0
10	8	77.1	8	8	8	8	7	7	7	8	4	5	5	3	1	1	0
11	5	83.1	5	5	5	5	5	5	5	5	2	2	3	4	1	1	2
12	8	92.8	8	8	8	8	8	8	8	8	6	3	7	7	5	3	1
13	5	98.8	5	5	5	5	5	5	5	5	5	3	4	5	4	3	1
14	1	100.0	1	1	1	1	1	1	1	1	1	0	1	1	1	1	1
Total	83	-	72	69	67	65	64	53	52	40	27	26	24	23	15	11	6

Note us=ultrasound, reh=a rehabilitation service, icu=an intensive care unit, neu=neurosurgery, den=a dental service, cat=a CT scanner, psy=a psychiatric service, hem=a hemodialysis facility, inf=an infertility unit, occ=an occupational medicine unit, las=laser surgery, ccu=a coronary care unit, hrt=heart surgery, lit=an ultrasonic lithotripter, mri=a magnetic resonance scanner

Table 6. ANOVA model of relationships between numbers of medical facilities and position strategies adjusted for hospital size.

Source	SS	df	MS	Number of obs	=	83
Model	695.689061	5	139.137812	F (5, 77)	=	21.00
Residual	510.190457	77	6.62585009	Prob > F	=	0.0000
				R-squared	=	0.5769
				Adj R-squared	=	0.5494
Total	1205.87952	82	14.7058478	Root MSE	=	2.5741

	Coef.	Std. Err.	t	P> t	[95% Conf. Interval]
100-199beds	4.406	0.760	5.795	0.000	2.892 5.920
200+ beds	5.937	0.776	7.652	0.000	4.392 7.482
Focus	2.333	1.127	2.070	0.042	0.089 4.577
Differentiation	4.204	1.183	3.555	0.001	1.849 6.559
Cost leadership	2.151	1.161	1.852	0.068	-0.161 4.463
_constant	0.951	0.993	0.958	0.341	-1.026 2.928

Table 7. ANOVA model of relationships between numbers of medical facilities and pace strategies adjusted for hospital size.

Source	SS	df	MS	Number of obs	=	83
Model	709.035416	5	141.807083	F(5, 77)	=	21.98
Residual	496.844103	77	6.45252081	Prob > F	=	0.0000
				R-squared	=	0.5880
				Adj R-squared	=	0.5612
Total	1205.87952	82	14.7058478	Root MSE	=	2.5402

	Coef.	Std. Err.	t	P> t	[95% Conf. Interval]
100-199beds	4.770	0.740	6.444	0.000	3.296 6.244
200 + beds	6.537	0.728	8.974	0.000	5.086 7.988
Reactors	-1.557	0.799	-1.949	0.055	-3.148 0.034
Analyzers	-1.142	0.780	-1.428	0.157	-2.734 0.451
Prospectors	1.534	0.755	2.030	0.046	0.030 3.038
_constant	3.356	0.678	4.951	0.000	2.006 4.706

Discussion

The results of this study suggest: 1) private hospitals in Bangkok and the vicinity were strategically different; 2) their strategic differences can be predicted by hospital ownership status; 3) the strategies were related to availability of medical facilities at the private hospitals.

Private hospitals were predominantly located in the highly populated and urban areas. Additional evidence suggests that they behaved differently. For-profit hospitals, especially those that were listed in the SET, were more aggressive in pursuing certain strategies to achieve competitive advantage and market power over their competitors. They were more likely to use power strategies by forming hospital systems, employ differentiation strategies, and be strategically proactive and keep looking for new product-market opportunities. This study contributes to the literature on the overall picture of private hospitals organizational strategies and tactics being used.

The findings also confirm the validity of the classification scheme of private hospitals previously used by Tangcharoensathien, Khongswatt et al⁽⁶⁾ that is based primarily on ownership status. It is demonstrated that hospitals with differing ownership statuses did behave differently in terms of business strategies, in addition to other characteristics such as numbers of beds, room rates and occupancy rates. However, understanding strategy provides new insights to

hospital behaviors since it can predict how many medical facilities hospitals may acquire. The acquisition of medical technology is known to be related to increasing medical expenditure.⁽⁶⁾

Finally, more research questions arise. Do different strategies produce similar organizational outcomes, in terms of quality, productivity and profitability? Will private hospitals with different strategies respond to particular health policies similarly? Is public-private cooperation possible? Will it offer strategic value to private hospitals? Which ones? Further investigations into these issues are needed.

Conclusions and policy implications

Private hospitals are strategically different. Ownership can predict how private hospitals behave to certain extent. However, some exceptions exist. The empirical evidence suggests that policy makers should not treat all hospitals similarly, or expect similar responses to any new policy innovation from every hospital. Any policies--investment promotion, financing and insurance schemes, etc.--may differently affect private hospitals. They may adversely affect one group of hospitals while it favors others. To counter some particular undesirable behaviors of hospitals, selectivity of new policy interventions should be evaluated. To understand and control hospital behaviors, hospital strategy needs to be taken into consideration. Appropriate implementation approaches, including proper education and alternatives, should be planned in order to

avoid unnecessary damage to the private sector, and to achieve sustained desirable development of the health services of the country.

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