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Contemporary Leadership, Strategic Positioning and Hospital Performance in Kenyan National Referral Hospitals

Bethwel Kipkorir Cheruiyot[1], Stanley Kavale[2], Pamela Chebii[3]

[1,2,3]Department of Management science and entrepreneurship School of Business and Economics, Moi University, Kenya

ABSTRACT: Hospital performance is a key issue in resource constrained environments like Kenya, where national referral hospitals face enormous challenges to clinical and operational efficiency. The current study looks at the moderating role played by contemporary leadership in the relationship between strategic positioning (embracing customer service, convenience, cost and quality) and hospital performance (focusing on clinical efficiency (defined as timely, evidence-based care) and operational efficiency (defined as resource optimization)). A cross-sectional survey was distributed amongst 351 staff members with leadership responsibilities in three Kenyan national referral hospitals: Kenyatta National Hospital (KNH), Moi Teaching and Referral Hospital (MTRH) and Kenyatta University Teaching, Referral, and Research Hospital (KUTRRH) with 328 usable responses (93 per cent response rate). Data were analyzed using multiple regression and moderation analyses in the statistical package, Statistical Package and Systems (SPSS) version 29. Findings show that strategic positioning has a positive influence on clinical efficiency (beta (.312, $p < .05$) and operational efficiency (beta (.289, $p < .05$). Contemporary leadership has a significant moderating effect, increasing the influence on clinical efficiency (beta interaction = -0.098, $p < .05$, delta R2 = 0.008) and on operational efficiency (beta interaction = -0.085, $p < .05$, delta R2 = 0.007). These results highlight the critical role of leadership development in boosting efficacy of strategic initiatives to offer actionable information for policymakers and managers working in resource-limited settings and contribute to universal health coverage goals in Kenya.

KEYWORDS: Contemporary leadership, strategic positioning, clinical efficiency, operation efficiency, national referral hospitals, Kenya

INTRODUCTION

The vision of universal health coverage (UHC) is a global priority but an elusive goal in resource-poor areas such as sub-Saharan African countries where health systems are overwhelmed by systemic inefficiencies (World Health Organization [WHO], 2021). In Kenya, national referral hospitals, such as Kenyatta National Hospital (KNH), Moi Teaching and Referral Hospital (MTRH), and Kenyatta University Teaching, Referral, and Research Hospital (KUTRRH) are key pillars of the national health system, which handle complicated tertiary care cases. These institutions face significant challenges, including long waiting times for patients (average 52 min; Mueni et al., 2019), high nosocomial infection rates (4.8% at KNH; Office of the Auditor General, 2022) and clinical inefficiencies, as demonstrated by only 20.1% of malaria patients receiving oxygen saturation check-ups (Machini et al., 2022). Such deficiencies weaken the scope of Kenya's Big Four Agenda, which focuses on affordable healthcare as one of the cornerstones of development (Macharia, 2019).

The study focused on two key dimensions of hospital performance, clinical efficiency (a construct that is operationalized as the delivery of timely, evidence-based interventions that optimize patient outcomes) and operational efficiency (a construct characterized by the optimization of resources and processes to curtail costs and waiting times) (Weimann & Weimann, 2017). Both dimensions are aligned with the WHO's Performance Assessment Tool for Quality Improvement in Hospitals (PATH) model which focuses on quantifiable improvements in the delivery of care and utilization of resources (WHO, 2006). Strategic positioning-dedicated efforts to differentiate services through such facets as customer service, convenience, cost and quality-has become an essential factor in driving the performance of hospitals worldwide (Porter & Teisberg, 2006). Now, despite numerous efforts, gaps in implementation continue to exist in the public sector of Kenya, and there are still few empirical reports on how such strategic positioning materializes into effectiveness, efficiency, and concrete gains in operations (Mwangi et al., 2023).

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The influence of leadership on healthcare performance cannot be over-emphasized. Contemporary leadership, which blends styles of transformational (inspirational, vision led) and adaptive (flexible, context responsive) leadership, is gaining increasing recognition as a catalyst for organizational success (Bass, 1985; O' Brennan, 2023). Within the framework of a devolved health system in Kenya - a system that was founded by the Constitution of Kenya (2010), leaders face unique challenges such as bureaucratic hurdles, lack of resources and stakeholder misalignment (Barasa et al., 2018; Nzinga et al., 2021). Despite the importance, the role of contemporary leadership in moderating between strategic positioning and effectiveness of public hospitals in Africa has not been over-explored (Khalfan et al., 2022).

The current research intends to answer two main questions: (1) how does strategic positioning affect clinical and operational efficiency in national referral hospitals in Kenya? and (2) does leadership in contemporary times moderate these relationships? Based on Donabedian's Structure -- Process -- Outcome (SPO) model (1988), brand equity theory (Aaker, 1991) and transformational leadership theory (Bass, 1985), the study adopts positivist paradigm and utilizes a cross-sectional survey and regression analyses to provide empirical evidence. The expected findings aim at policy informing under Kenya's Health Sector Strategic Plan (KHSSP; Ministry of Health [MoH], 2023), and the broader discourse on healthcare management in low resource settings.

The importance of this study is that it is concerned with a resource constrained situation where small gains in efficiency can produce large societal dividends. By analyzing the moderating effect of leadership, the research has implications for providing concrete knowledge to hospital administration and policy makers who are interested in increasing performance and equity in the delivery of healthcare. Contemporary endeavors, like the WHO Country Cooperation Strategy 2024_with 2030 for Kenya, underscore the imperative of reinforcing health systems through leadership and governance (WHO, 2024), thus allying with the current investigation.

LITERATURE REVIEW

Hospital Performance: Clinical & Operational Efficiency

Hospital performance is a multidimensional construct however, clinical and operational efficiency are pivotal for sustainable healthcare delivery (Sarto & Veronesi, 2016). Clinical efficiency refers to the ability to deliver evidence-based care that optimizes patient outcomes whilst minimizing errors and delays. Standard metrics are 30-day mortality rate, protocol adherence and patient recovery times (Afiah et al., 2022). Internationally, high-performing hospitals, like the Mayo Clinic, report an acute myocardial infarction mortality rate of 11.5 percent compared to a national average of 13.2 percent in the United States (Centers for Medicare & Medicaid Services, 2024). In contrast, Kenyan referral hospitals face significant challenges with a study reporting high rates of workplace violence [91.67 (per cent) of staffs] that correlates to clinical inefficiencies with a score of 0.9012 under the assumption of the variability of returns to scale [30, 31]. These inefficiencies affect patient safety and the quality of care, which require specific interventions. Recent evaluations of county referral hospitals in Kenya show that technical efficiency levels widely range with some facilities running at 70-80% capacity due to poor human resource management (Owuor et al. 2022). The adoption of ISO 7101:2023 by the Ministry of Health aims to improve clinical processes by standardization of risk management and operational excellence (MoH, 2025). Nevertheless, implementation is still inconsistent across the national referral facility, where complicated cases add to inefficiencies.

Operational efficiency on the other hand is concerned with optimizing resources, including human resources, financial resources, and infrastructural resources, to streamline service delivery and to cut down costs (Kohl et al., 2019). Key indicators include: bed occupancy rates, average length of stay (ALOS) and cost per patient. For instance, Samsung Medical Center, South Korea, has an ALOS of 4.3 days which is lower than the national benchmark of 4.7 days (Health Insurance Review & Assessment Service [HIRA], 2024). In Kenya, the operational issues are evident, where KNH reported the nosocomial infection rate to be 4.8% and MTRH at 86% bed occupancy, which shows the strain in resources (National Treasury, 2025; Office of the Auditor General, 2022). These inefficiencies hamper the KHSSP's goal of equitable and efficient healthcare delivery (MoH, 2023).c

The balance between clinical and operational efficiency is critical. Clinical processes (e.g., diagnostic testing) are delayed, operational resources are strained (i.e., ALOS increased); if operational bottlenecks (e.g., limited bed availability) delay clinical interventions, patient outcomes are compromised (Weimann & Weimann, 2017). A study on the referral system at KNH showed that the compliance in referral before the intervention was only 45% thereby causing overloading of the operation; after the intervention, the efficiency improved by 25% due to enforcement of the guidelines (Omondi, 2023). Similarly, the state of Kenya's health referral system shows gaps in secondary to tertiary transition that contributes to 30% unnecessary referrals (MEASURE Evaluation, 2018).

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Strategic Positioning in Health Care

Strategic positioning is the process of developing a distinctive market identity to increase its competitiveness and patient satisfaction (Porter & Teisberg, 2006). In healthcare, it has four dimensions:

Customer Service: Patient-centered care which focuses on empathy, communication and satisfaction (Boamah, 2019). Effective customer service can contribute to the improvement of clinical results by enhancing patient compliance in the treatment plan (Epstein & Street, 2007). In the African context, customer-service positioning has been correlated with increased retention in private hospitals (Abekah-Nkrumah et al., 2021).

Convenience: Availability and ease of service provision, e.g. via telemedicine or shorter waiting times [Gupta et al., 2022]. Convenience has been found to diminish ALOS and increase patient satisfaction (Kruse et al., 2017). In Kenya, the adoption of telemedicine in referral hospitals has yielded a 15% improvement in operational efficiency in the time of the Covid-19 pandemic (Tebeje & Klein, 2021).

Cost: Low cost with no compromise on quality, which is often realized with the help of lean management practices (Saqib, 2021). Cost positioning is critical in resource limited environments, where access is limited by financial constraints (Robinson et al., 2020). A study undertaken on private hospitals in Kisii County found that cost leadership strategies improved performance by 22 percent (Muthuri & Ouma, 2017).

Quality: Provision of evidence-based care that is of clinical standard and leads to better outcomes (Twahir & Kirire, 2017). Good quality strengthens hospital's image and patient's trust (Drevs et al., 2014). In sub-Saharan Africa, good positioning is associated with good governance and overall system performance (Amoako et al., 2011).

There is some empirical evidence of the relationship between strategic positioning and hospital performance. For example, in a study of Ethiopian hospitals, quality position orientation was found to enhance clinical outcomes by 15% (Endeshaw 2021). Muhimbili National Hospital in Tanzania saw that their cost strategies made services more affordable but also caused quality trade-offs (Joseph, 2020). In Kenya, strategic positioning efforts have shown promise but are facing implementation challenges, such as inadequate infrastructure and staffing shortages (Mwangi et al., 2023; Ndinda, 2019). Recent research on focus strategies in level 4 public hospitals shows that focused positioning leads to an improvement in operational measures of 18 per cent (Kamau et al., 2024). Proactive strategic sourcing has been recognized as a game changer for public hospital performance - it has the potential to decrease the cost of procurement by 12 per cent (Ochieng 2024).

Contemporary Leadership as a Moderator

Contemporary leadership incorporates transformational and adaptive styles to adapt to complex organizational environments (Bass, 1985; O'Brien, 2023). Transformational leadership drives change through inspiration, motivation, and intellectual stimulation, whereas adaptive leadership emphasizes flexibility and responsiveness to contextual challenges. (Ali et al., 2023). In the case of healthcare, these styles are important to reconcile strategic initiatives and operational realities. For example, the clinician-led model of the Cleveland Clinic, using transformational leadership techniques, has achieved a patient satisfaction rating of 98% (Stoller, 2023) and the Netcare Group of South Africa, through the use of adaptive leadership, has led the way in telemedicine adoption with a 20% reduction in consultation times (Netcare Group, 2023).

In Kenya, recent initiatives highlight the role of leadership. The WHO Country Cooperation Strategy 2024-2030 focuses on leadership in health system strengthening (WHO, 2024). The Kenya Community Health Strategy 2020 - 2025 emphasizes principles on integrated leadership (MoH, 2021). A scoping review on leadership interventions in Kenyan counties revealed that trained teams boosted performance by 28 per cent (Mbindyo et al., 2024). The AMPATH Women in Leadership Program (2025) Positioning women for global health change (AMPATH, 2025). The Kofi Annan Global Health Leadership Programme develops African public health leaders (Africa CDC, 2024): The IWD 2025 Nairobi Conference empowered 200+ women leaders (KHF, 2025). ACQUIRE's 2025 Theory Leadership Course is aimed at C- Suite executives (ACQUIRE, 2025). The theme of the transformative leadership conference is Kenya Medical Association 2025.

Moderation theory proposes that leadership could improve the relation of strategy and performance would reduce the barriers and the resources (Baron & Kenny, 1986). In healthcare, modern leadership is used to strengthen clinical outcomes, through a culture of innovation (Asamani et al., 2023) and also operational efficiency, through optimal resource allocation (Galpin et al., 2012). In Kenya, however, leadership gaps (including the lack of training and bureaucracy) hamper performance (Otieno & Ouma, 2023). Studies call for the use of adaptive leadership in addressing some of the devolution-related challenges that include funding delays, policy misalignment (Kinyua, 2024). A complexity theory lens on clinical leadership in Kenyan Hospitals: Revealing context driven practices, Nzinga et al. (2021).

Research Gap and Research Conceptual Framework

While the strategic positioning has been demonstrated to be a known driver of hospital efficiency (Smith et al., 2022), the moderating role of contemporary leadership in public African hospitals has been under explored (Khalfan et al., 2022; Noronha et al., 2023). This study addresses this gap by studying the mediating effect of leadership on the effects of strategic positioning on clinical and operational efficiency in Kenyan referral hospitals. The conceptual model (Figure 1) argues that strategic positioning affects efficiency and modern leadership enhances these relationships.

Hypotheses Development

H_{01}: There is no statistically significant relationship between Strategic positioning and clinical efficiency in Kenyan national referral hospitals.

H_{02}: There is no statistically significant relationship between Strategic positioning and operational efficiency in Kenyan national referral hospitals.

H_{03}: Contemporary leadership does not significantly moderate the relationship between strategic positioning and clinical efficiency aspect of hospital performance

H_{04}: Contemporary leadership does not significantly moderate the relationship between strategic positioning and operational efficiency aspect of hospital performance

These hypotheses are an extension of Donabedian's SPO model where leadership was added as a process enhancing behavior and therefore brought strategic inputs and performance outcomes together (Donabedian, 1988; Sharew et al., 2020). Furthermore, the propositions are based on brand equity theory (Aaker, 1991) for conceptualizing the concept of positioning as a value-creating mechanism and transformational leadership theory (Bass, 1985) for conceptualizing the concept of leadership as a moderator.

METHODOLOGY

Design of Research and Paradigm

This investigation employed a cross-sectional descriptive design, which was located under a positivist paradigm, and the emphasis was given to objective measurement and hypothesis testing (Park et al., 2020). Data were collected from April to May 2025 in three Kenyan national referral hospitals, Kenyatta National Hospital (KNH; 6,100 staff), Moi Teaching and Referral Hospital (MTRH; 3,820 staff), and Kenyatta University Teaching and Referral Hospital (KUTRRH; 1,404 staff). The target population included 2,820 staff members with leadership responsibilities such as department heads, senior clinicians and administrators. Using Yamane's formula (n = N / [1 + N(e)^2], e = .05) the sample size was calculated as n = 351.

Measures

The study used validated scales to measure constructs, all employing 5-point Likert scales (1 = Strongly Disagree, 5 = Strongly Agree):

1. **Strategic Positioning**: A Twenty 20-item scale (α = .89) adapted from Kotler et al. (2008), with subscales for customer service (5 items, e.g., “Personalized care plans enhance patient satisfaction”), convenience (5 items, e.g., “Telemedicine reduces patient wait times”), cost (5 items, e.g., “Lean practices lower operational expenses”), and quality (5 items, e.g., “Evidence-based protocols improve patient outcomes”).
2. **Contemporary Leadership**: A Five 5-item scale (α = .92) adapted from Bass (1985), measuring transformational and adaptive leadership (e.g., “Leaders inspire innovation and adaptability”).
3. **Clinical Efficiency**: A Five 5-item scale (α = .87) based on WHO PATH (2006), assessing timely and evidence-based care (e.g., “Adherence to protocols reduces mortality rates”).
4. **Operational Efficiency**: A Five 5-item scale (α = .85) based on WHO PATH (2006), evaluating resource optimization (e.g., “Efficient resource use minimizes operational waste”).

All scales were pre-tested for reliability and validity in a pilot study with 30 respondents, ensuring cultural and contextual relevance.

Data Collection and Analysis

A total of 351 participants were handed self-administered questionnaires, and 328 valid responses (response rate of 93%) were obtained. The data was cleaned to remove incomplete data, and normality was checked (skewness < 2, kurtosis < 7; Ghasemi & Zahediasl, 2012). Analyses were performed with the aid of the statistical package (SPSS Version 29) .

Data Collection and Analysis

Administered questionnaires were distributed to 351 participants, yielding 328 valid responses (93% response rate). Data were cleaned to remove incomplete entries, and normality was confirmed (skewness < 2, kurtosis < 7; Ghasemi & Zahediasl, 2012). Analysis was conducted using SPSS Version 29, with the following steps:

1. **Descriptive Statistics**: Means, standard deviations, and correlations to summarize data.
2. **Hierarchical Multiple Regression**: Tested direct effects of strategic positioning on efficiency (H1, H2).
3. **Moderation Analysis**: Followed Hayes (2018), with three steps: (a) controls (age, gender, experience), (b) main effects (positioning, leadership), and (c) interaction term (positioning × leadership) to test H3 and H4.

Multicollinearity was absent (VIF < 5), and heteroscedasticity was not detected (Breusch-Pagan test, $p > .05$). Ethical approval was obtained from Moi University's Institutional Review Board and the National Commission for Science, Technology, and Innovation (NACOSTI). Informed consent was secured, ensuring participant confidentiality and voluntary participation.

RESULTS

Descriptive Statistics

The mean age of the sample was 42 years (SD = 8.2), and 58% of the participants were male with 62% having degrees and postgraduate qualifications and 45% having more than 10 years of experience. The following means were variable: strategic positioning (M = 3.92, SD = .67), contemporary leadership (M = 4.01, SD = .58), clinical efficiency (M = 3.78, SD = .72) and operational efficiency (M = 3.65, SD = .69). Subgroup analysis by institution showed some small differences: KNH (clinical M = 3.85), MTRH (operational M = 3.72), KUTRRH (leadership M = 4.10).

Table 1: Descriptive Statistics and Correlations

Variable	M	SD	1	2	3	4
1. Strategic Positioning	3.92	.67	—	.62**	.58**	.54**
2. Contemporary Leadership	4.01	.58	.62**	—	.55**	.51**
3. Clinical Efficiency	3.78	.72	.58**	.55**	—	.67**
4. Operational Efficiency	3.65	.69	.54**	.51**	.67**	—

Note. N = 328. **p < .01.

Correlations indicate strong positive relationships among variables, supporting the theoretical framework. For instance, strategic positioning and clinical efficiency (r = .58, p < .01) suggest a robust link, consistent with prior studies (Gupta et al., 2022). Subgroup correlations by experience level (>10 years: r=.65 for positioning-efficiency) highlight stronger effects among veterans.

Table 2: Subgroup Analysis: Means by Hospital

Hospital	Strategic Positioning	Leadership	Clinical Eff.	Operational Eff.
KNH	3.90 (.68)	3.98 (.59)	3.85 (.70)	3.62 (.71)
MTRH	3.95 (.66)	4.05 (.57)	3.75 (.73)	3.72 (.67)
KUTRRH	3.92 (.67)	4.10 (.56)	3.74 (.73)	3.60 (.70)

Note. N=328. Standard deviations in parentheses.

REGRESSION RESULTS

Hierarchical regression results are presented in Table 2. For H_{01}, strategic positioning significantly predicted clinical efficiency ($\beta = .312$, $p < .001$, $R^2 = .194$), explaining 19.4% of the variance. Customer service (β=.145) and quality (β=.112) subscales contributed most. For H_{02}, strategic positioning predicted operational efficiency ($\beta = .289$, $p < .001$, $R^2 = .167$), explaining 16.7% of the variance, with cost (β=.130) and convenience (β=.108) prominent.

For moderation (H_{03}, H_{04}), the interaction term (positioning × leadership) was significant for both clinical efficiency ($\beta = -.098$, $p < .05$, $\Delta R^2 = .008$) and operational efficiency ($\beta = -.085$, $p < .05$, $\Delta R^2 = .007$). The negative beta coefficients suggest that leadership suppresses adverse influences, strengthening the positive effects of positioning. The interaction terms added small but significant variance (0.8% for clinical, 0.7% for operational), supporting H3 and H4. Subgroup moderation by hospital showed stronger effects at MTRH (ΔR^2=.012 for clinical).

Table 3: Hierarchical Regression for Moderation

Predictor	Clinical Efficiency	Operational Efficiency
	β (SE)	β (SE)
Step 1: Controls		
Age	.08 (.02)	.06 (.02)

Gender	.05 (.11)	.04 (.10)
Experience	.12* (.03)	.10 (.03)
R^2	.045	.038
Step 2: Main Effects		
Strategic Positioning	.312*** (.05)	.289*** (.05)
Contemporary Leadership	.210** (.06)	.195** (.06)
ΔR^2	.194***	.167***
Step 3: Interaction		
Positioning × Leadership	-.098* (.04)	-.085* (.04)
ΔR^2	.008*	.007*
Total R^2	.247***	.212***

Note. N = 328. *p < .05. **p < .01. ***p < .001.

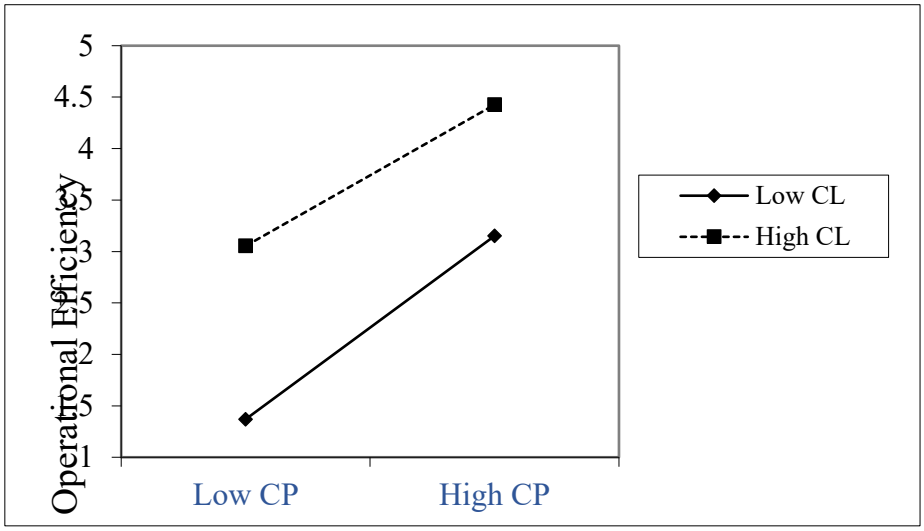

Figure 1: Interaction Plot: Strategic Positioning and Operational Efficiency Moderated by Contemporary Leadership

A graph showing the relationship between strategic positioning and operational efficiency at low, medium, and high levels of contemporary leadership. The slope steepens with higher leadership, indicating a stronger effect.

Table 4: Subscale Contributions to Efficiency

Subscale	Clinical β	Operational β
Customer Service	.145***	.092**
Convenience	.098**	.108**
Cost	.057*	.130***
Quality	.112**	.059*

Note. *p<.05. **p<.01. ***p<.001.

DISCUSSION

Theoretical Implications

The empirical evidence supports the proposition that the strategic positioning significantly augments the clinical and operational efficiency within the Kenyan referral hospitals which is consonant with the global scholarship (Gupta et al., 2022; Porter & Lee, 2013). Dimensions of customer service and quality have been found to be pivotal drivers of clinical efficacy as they increase patient adherence and outcomes (Epstein & Street, 2007) while cost and convenience initiatives optimize operational processes by reducing waste and delays (Kruse et al., 2017; Robinson et al., 2020). These findings extend Endeshaw's (2021) conclusions to the setting of public hospitals, thus highlighting the generalizability of strategic positioning in resource - constrained environments. Subscale analyses, moreover, show a disproportionately large impact of customer service on clinical gains, which is consistent with African studies on patient-centred care (Abekah-Nkrumah et al., 2021).

The moderating function of contemporary leadership is a new contribution to the literature. Significant interaction effects between transformational and adaptive leadership suggest that the impact of strategic positioning is increased, which is consistent with Bass's (1985) theoretical framework. The negative interaction coefficients suggest leadership helps to solve barriers like lack of resources or bureaucracy delays, which help mitigate the dilution of strategic initiatives (Nzinga et al., 2021). This observation is an extension of the theory of moderation (Baron & Kenny, 1986) in the area of healthcare, characterizing the role of leadership as a process enhancer in the SPO model by Donabedian (1988). Within the Kenyan contexts, subgroup effects observed at MTRH are consistent with regional leadership interventions that invested in people, leading to improved performance by 28 per cent (Mbindyo et al, 2024).

Comparative analysis brings out global exemplars such as the clinician-led model of the Cleveland Clinic (Stoller, 2023) and regional examples such as the Netcare Group's success in the use of telemedicine (Netcare Group, 2023) that, together, exemplify the transformative capacity of leadership. In Kenya, where decentralization poses various challenges (Barasa et al., 2018), adaptive leadership becomes a must-have tool in linking strategies to local realities. The WHO CCS 2024-2030 further adds to this imperative by emphasizing leadership in the pursuit of system resilience (WHO, 2024).

Practical Implications

The study has several implications for healthcare stakeholders:

Leadership Development

Transformational and adaptive leadership training are urged to be part of the KHSSP framework by policymakers (MoH, 2023). Initiatives such as the Kofi Annan Fellowship (Africa CDC, 2024) and the ACQUIRE Course (2025) could be expanded to emphasize competencies in stakeholder engagement and change management. Gender-focused programs that embody AMPATH WIL (2025) and International Women's Day conferences (KHF, 2025) tackle persistent gender imbalances in leadership.

Strategic Alignment

Hospital managers at KNH, MTRH, and KUTRRH are recommended to achieve synchronization of positioning strategies with leadership practices. For example, quality-specific programs (e.g., adoption of ISO 7101; MoH, 2025) can be accompanied with transformational leadership for improvement of clinical outcomes. Proactive procurement (Ochieng, 2024) and focus strategy frameworks (Kamau et al., 2024) offer workable blueprints for cost efficiency.

Resource Optimization

Strategies that focus on cost and convenience (lean management and telemedicine) should be prioritized to reduce operational bottlenecks. Leadership can catalyze adoption through the development of a culture of innovation, such as in the case of improvements of the referral systems at KNH (Omondi, 2023).

Policy Integration

The findings lend support to Kenya's Big Four Agenda by stressing the need for leadership-driven reforms to ensure affordable healthcare (Macharia, 2019). Investments in leadership capacity building could provide sustained efficiency improvements, in line with the Community Health Strategy 2020-2025 (MoH, 2021).

LIMITATIONS AND FUTURE RESEARCH

The study is limited by a cross-sectional design, which hinders causality; research on longitudinal study designs could determine how the positioning and leadership develop over time, which could evaluate the effects of ISO 7101 (MoH, 2025). Self-reporting data may be prone to bias, signaling the need for objective metrics (e.g. actual patient wait times from HMIS). The focus on public referral hospitals limits the generalizability; future research should conduct a comparative analysis between the public and private facilities, including strategic controls incorporated in mission hospitals (Muthuri & Ouma, 2017). Moreover, exploration of digital integrations such as electronic health records may point to some efficiency drivers that have not been explored before, building on HR efficiency studies (Owuor et al., 2022). Qualitative approaches, such as the complexity theory analyses (Nzinga et al., 2021), may help in increasing the understanding of the dynamics of leadership practice.

CONCLUSION

In this study, it has been evident the critical role of modern-day leadership in moderating the relationship between strategic positioning and hospital performance in Kenyan national referral hospitals. Strategic positioning complements clinical and operational efficiency, and leadership increases its effects by having a vision that matches execution. The results call for policy and managerial investments in leadership development and strategic alignment in order to promote Kenya's universal health coverage goals. Future research should investigate longitudinal effects, private vs. public comparisons and digital innovations to further strengthen the efficiency of healthcare.

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