African Journal of Emerging Issues
Peer reviewed | Double blind | Interdisciplinary

African Journal of Emerging Issues (AJOEI)
Online ISSN: 2663 - 9335
Available at: https://ajoeijournals.org

STRATEGIC MANAGEMENT

MODERATING ROLE OF STAKEHOLDERS COLLABORATION ON THE RELATIONSHIP BETWEEN STRATEGIC LEADERSHIP AND PERFORMANCE OF HOSPITALS IN KENYA

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Publication Date: April 2024

ABSTRACT

Purpose of the study: This study sought to find out the relationship between strategic leadership and performance of hospitals in Kenya with stakeholder's collaboration moderating this relationship.

Problem Statement: The desire to link strategic leadership with performance of health care is crucial for hospitals seeking above average performance. However, dearth of evidence in literature exists on the relationship between strategic leadership and performance of health care sector. Thus, the relationship remains blurred. In addition, limited literature on the effect of stakeholder's collaboration on the relationship between strategic leadership and performance of hospitals exist. Moreover, scholarly work in this thematic area has been majorly done in Developed Nations creating a contextual gap in the body of knowledge. It is against this background that this study was conducted.

Study Methodology: The study employed hierarchical moderated multiple regression (MMR) analyses and structural equation modeling (SEM) to test hypotheses and fit the theoretical models. The study sample comprised of 228 Hospitals.

Results of the study: The study revealed that stakeholder's collaboration significantly moderated the relationship between strategic leadership and performance of Hospitals in Kenya.

Conclusion and Policy Recommendation: The study concludes that stakeholder's collaboration moderates the relationship between strategic leadership and performance of Hospitals in Kenya is very vital for decision makers. Therefore, hospitals can contract other stakeholders for the services they do not offer. This study recommends the leadership in our hospitals should develop a policy mechanism that could enhance collaboration for enhanced performance.

Keywords: *strategic leadership practices, performance, stakeholders' collaboration, Hospitals*

INTRODUCTION

Health care has been globally recognized as the cornerstone of human development due to its impact on human resource productivity (Kaseje, 2015). By improving health care UNDP (2016) averred that a Country's economic progress and stability would be realized due to longer life expectancy, increased savings, increased investments and reduced health care expenditure. To optimize gains from health care, stakeholders in both developed and developing countries must undertake strategic leadership practices in order to address the changing needs of patients occasioned by lifestyle and technological changes (Speziale, 2015).

Banzato and Sierra (2016) argued that strategic leadership is the ability of leaders to predict and coordinate the activities of an organization to successfully achieve its pre-determined goals and objectives. On the other hand, Hitt, Ireland and Hoskisson (2014) pointed out that strategic leaders are able to influence successful strategic actions, shape strategic missions and intent which have a direct effect on the overall performance of an organization. The ability to recognize and guide the actions of an organization toward successful attainment of initiatives reflects strong strategic leadership (Carter & Greer, 2013). Carmeli, Schaubroeck and Tishler (2011) cautions that some organizations may fail to attain projected profitability due lack of strategic leadership.

Mungania and Karanja (2015) pointed out that leadership is a major factor affecting the implementation of an organization's strategic plans. Understanding the effects of leadership on performance requires examining various stakeholders that may affect an organization both internally and externally. The demands from shareholders and stakeholders have increased throughout the years. These demands requires senior executives to have an in-depth knowledge of strategic leadership (Carter & Greer, 2013). To achieve this goal, training on how to envision an organization's purpose, how to maintain core competencies, how to develop human capital, sustaining an effective organizational culture, emphasizing ethical practices and establishing balanced organizational controls should be carried out.

This is affirmed by Hitt, Ireland and Hoskisson (2014) who opined that for strategic leadership to be achieved, leaders must see in advance where their organizations are supposed to be in the future and then align people and resources in order to get there. From their perspective; Obiwuru, Okwu, Akpa and Nwankewere (2011) further affirmed that strategic leaders should rally their followers behind organizational goals and objectives for the purpose of contributing towards their accomplishment because without effective strategic leadership, the capability of an organization to achieve or sustain a competitive advantage would be greatly constrained (Elenkov, 2008).

For an organization to perform well, stakeholder collaboration is crucial because it increases engagement and transparency regarding company's purpose, value addition through exchange of ideas, and bringing stakeholders on board in trying to come up with ways of addressing challenges (Gamm & Dansky, 2012). Stakeholders group can be organizational, societal and economic (Werther & Chandler, 2011). In healthcare industry there are four groups of stakeholders these are grouped through virtue of their control of patients (maj, 2015). These stakeholders are: physician who contribute to the referral of patients through consultation, patients, insurance companies or managed care that are contracted for healthcare services delivery, and government officials or entities who determine the conditions for providing services including the social scheme (Ahmad, 2017). This study will explore the moderating role played by stakeholders' collaboration on the relationship between strategic leadership and performance of hospitals in Kenya.

STATEMENT OF THE PROBLEM

During the first quarter of 2023, the health sector in Kenya grew by a paltry 5.4 percent representing a dip in growth rate in comparison to the corresponding quarter in 2022. This meant that the value added to the Country's Gross Domestic Product (GDP) by health sector dropped from 5.7 percent that was previously recorded in the corresponding quarter (Cowling, 2023). The health care sector has the capability to contribute more immensely to the Kenyan GDP than is currently the case. But in order to survive in a vibrant and dynamic business environment, adopting strategic leadership skills practices is necessary. Therefore, it is expected that by developing leaders with strategic management skills, the performance of healthcare in Kenya may be enhanced.

The desire to link strategic leadership with performance of health care is crucial for hospitals seeking above average performance. However, dearth of evidence in literature exists on the relationship between strategic leadership and performance of health care sector. Thus, the relationship remains blurred. In addition, limited literature on the effect of stakeholder's collaboration on the relationship between strategic leadership and performance of hospitals exist. Moreover, scholarly work in this thematic area has been majorly done in Developed Nations creating a contextual gap in the body of knowledge. It is against this background that this study was conducted.

RESEARCH OBJECTIVES

The general objective of this study was to establish the moderating role of stakeholder collaboration on the relationship between strategic leadership and performance of hospitals in Kenya. Specifically, the study sought to establish the influence of strategic leadership on the performance of hospitals in Kenya. It also sought to find out the moderating role of stakeholder's collaboration on the relationship between strategic leadership and performance of hospitals in Kenya. In order to address the above objectives, the following null hypotheses were tested

RESEARCH HYPOTHESES

H_{01}: There is no significant relationship between strategic leadership and performance of hospitals in Kenya.

H_{02}: Stakeholder's collaboration does not moderate the relationship between strategic leadership and performance of hospitals in Kenya.

THEORETICAL FRAMEWORK

The study was founded on the theoretical underpinnings of upper Echelons, Resource based view and stakeholder theories.

Upper Echelon Theory

Upper Echelon Theory was developed by Hambrick and Mason (1984). According to the theory, demographic characteristics of senior executives such as age, education and experience affects the type and amount of information they use. Therefore, it affects the strategic decisions and financial performance. Baik (2004) mentioned that company's strategic leadership plays a critical role in developing a company's capabilities for expanding its competitive advantage and performance. Singh et al. (2023) argued that strategic leadership gained significant attention in the literature after the upper echelon theory into the management literature by Hambrick and Mason (1984)

Upper echelons theory by Hambrick and Mason (1984) focuses on the top decision-makers in organizations and brings the team level of analysis into the scope of strategic management

research. However, while the role of the external environment has been recognized from the inception of upper echelons theory, existing reviews (Carpenter, Geletkanycz & Sanders, 2004; Finkelstein, Hambrick& Cannella 2009) have paid scarce attention to the external context in which top management teams are embedded. Hambrick and Mason (1984) noted that executive characteristics and effects are likely to vary with different industry contexts.

The mid1980s indicated a shift from the study of supervisory leadership (House & Aditya, 1997) towards the study of strategic leadership. This change in emphasis was accompanied by a newfound sense of interest, initially centering on the upper echelon's theory (Hambrick & Mason 1984) and the study of TMTs, as well as what has been labeled the new leadership theories (Hunt, 1999). The attention of early leadership researchers focused predominantly on what lower-level managers did or should do in their attempts to provide guidance, support and feedback to subordinates (Yukl, 1998).

According to Finkelstein and Hambrick (1996) they had a profound impact on understanding of organizational processes and outcomes. Most of the studies have been conducted in countries with developed economies. As such, the way in which strategic leadership behaviors vary throughout the world is unknown and relatively unexplored (Elenkov et al., 2005). The upper echelons research has also recognized that sometimes top managers matter significantly to organizational outcomes, and sometimes not at all. They are often somewhere in between, depending on how much discretion or latitude of action they are afforded. Discretion exists when there is an absence of constraints in decision making and when there are many plausible alternative courses of strategic action. With more discretion, top managers are more likely to realize their original intentions and vice versa.

This theory offers a model within which the role of strategic leaders in influencing organizational outcomes can be interpreted, the key postulation being that organizational outcomes and strategic decisions are partially predicted by strategic leaders (Carpenter et al., 2016). The theory showed how strategic leadership plays a critical role in developing a company's capabilities for expanding its competitive advantage and performance (Baik, 2004).

Stakeholder Theory

Stakeholder theory suggests the need for organizations to satisfy all stakeholders of the organization and recognize the interest of these stakeholders and address them through appropriate strategies (Christopher, 2010). Stakeholder theory is in line with the evolution of corporate governance whereby the concept was broadened to include not just shareholders but also all stakeholders of the organization. This theory operates on the premise that managers will treat the interests of all stakeholders as if they have intrinsic value to the firm. It is argued that this theory is particularly important for developing and implementing adequate governance mechanisms and processes relative to the broader environmental influences and interdependencies of organizations with various internal and external stakeholders (Christopher, 2010).

Stakeholder theory evolved since Freeman's (1984) exploration of strategic management from a stakeholder's perspective based on the stakeholder concept (Friedman & Miles, 2002; Rowley, 1997). The theory has been used in different fields including cost management. Stakeholder theory is associated with stakeholder analysis, a process through which stakeholders' role and influence are explored (Brugha & Varvasovky, 2000). According to Blair and Fotler (1990), stakeholder theory can be seen as a strategic analytical tool for stakeholder management that entails the following six stages or processes: Stakeholder identification, stakeholder assessment, stakeholder diagnosis and classification, stakeholder

strategy formulation, strategy implementation and evaluation of stakeholder management effectiveness.

Stakeholder management affects a firm's triple bottom line performance as organizational. Stakeholder groups influence managerial activities internal and external to the firm. It provides a more complex perspective and new ways of measuring the notion of value and the corporate sustainability (Harrison &Wicks, 2013; Perrini & Tencati, 2006) that have been overly narrowed to focus on economic returns (Jensen, 2002) and emerges as important weapon for strategic management in managing complex stakeholder interests (Lim, Ahn & Lee, 2005).

Resource based view

The focus of resource-based view is on the relationship between firm resources and firm performance (Penrose, 1959). Firm should select strategy which makes the most effective use of its core resources and capabilities to achieve above normal rates of return. Porter (2001) argues that strategy must not regard competitiveness of a firm to be limited to specific and known forces of the market. According to Penrose, the resource-based view of the firm proposes that firms consist of bundles of productive resources and that different firms possess different bundles of these resources in competitive environments.

Different types of resources including tangible assets, intangible assets and skills have been identified as underlying the distinctive or core competences of a firm (Prahalad & Hamel, 1990). These core competences can only achieve sustainable competitive advantage when underlying resources are valuable, rare, cannot be imitated, and have no substitutes (Barney, 1995; Grant, 1991; Peteraf, 1993; Wernerfelt, 1989). RBV has an inside-out perspective. The main focus is on efficiency in relation to use the organization's internal resources to gain competitive advantage (Teece, Pisano& Shuen, 1997) and value creation, which Peteraf and Barney saw as a key concept in developing the RBV concept (Peteraf & Barney, 2003).

A more dynamic version of RBV focuses on the impact of the rapid and unpredictable external and internal changes many organizations now experience (Teece, Pisano & Shuen 1997; Eisenhardt & Martin, 2000), leading to the need to develop dynamic capabilities. These dynamic capabilities often consist of simple and experimental processes which use knowledge and knowhow in new ways to solve complex issues through adapting the firm to the volatile environment (Eisenhardt & Martin, 2000) some examples are strategic decision-making processes and product development routines. The focus is not on static resources but instead on integrating, building and reconfiguring resources and competences to deal with major and rapid changes in the environment (Eisenhardt & Martin, 2000).

More attention has been given to RBV in public organizations than to Porter's strategic positioning model. Some empirical investigations, for instance, Carmeli and Tishler (2004) show a positive relation between resources (like managerial capabilities and human capital) and the performance of public organizations. RBV addresses ways to gain profit, achieve a competitive advantage and create strategies that cannot be imitated by others, all seen as problematic in traditional public organizations. However, RBV focuses on value creation, how to use and develop resources to create value.

Pradabwong, Braziotis, Tannock, and Pawar (2017) asserted that there is a positive relationship between organizational performance and competitive advantage. According to Barney (2001), the success of the RBV theory relies on the optimal gathering and the effective and efficient application of particular internal resources to enhance organizational performance.

Ramish and Aslam (2017) asserted that profitability is among the key performance indicators in organizations. Some of the key drivers of organizational profitability include vision, strategic

leadership, internal quality, competitive advantage, value creation, employee engagement, and satisfaction (Tuominen, Hirvonen, Reijonen, & Laukkanen, 2016).

EMPIRICAL LITERATURE REVIEW

This paper discusses previous empirical literature on the relationship between strategic leadership and performance of hospitals. The paper also reviews empirical work on the relationship between stakeholder collaboration and performance of hospitals in Kenya.

Strategic leadership and Performance of Hospitals

Various studies have linked strategic leadership practices to improved organizational performance (Serfontein & Hough, 2011; Alhyasat & Sharif, 2018). Najmi et al., (2018) studied the linkage of strategic leadership practices and public health sector performance. The findings revealed significant relationship between the two variables. Thus, the role of top leaders in determining performance of organizations through their strategic choices and behavior is most critical (Quigley & Hambrick, 2015).

Najmi et al., (2018) conducted a study to assess the effect of strategic leadership on organizational performance. The study targeted four hospitals in Makassar city government, Indonesia where 100 respondents were selected. Structural Equation Modeling (SEM) was used to analyze data. Strategic leadership was measured using both financial and non-financial approaches through a balanced score card. The study concluded that strategic leadership had a significant effect on hospital performance, only if mediated dynamic capability were also higher.

Gusmão et al., (2018) conducted a study to assess the effect of strategic leadership on organizational performance in Timor-Leste. In the methodology, non-probability sampling technique was used to select 40 directors who responded to the questionnaires while data analysis was conducted using Structure Equation Partial Least Square model. The study concluded that strategic leadership had a positive and significant effect on organizational performance. Since non-probability sampling procedures have higher chances of bias, this study carried out a census survey for youth based health facilities for increased accuracy.

A study by Collette (2019) on the role of strategic leadership in healthcare profitability manifested the importance of strategic leadership and its significance in increasing organizational growth and profitability. All 114 participants indeed agreed that strategic leadership is crucial for an organization growth, competitive advantage, employee output, and customer satisfaction. This strongly corresponded with previous research by Akeke, 2016). The findings from this research study also aligned to a rather great extent with those of Gupta (2018). He emphasized that strategic leaders apply a mixture of leadership styles, including ethics and value-oriented decision making, planning for long term goals, executing plans to achieve those goals, providing a positive and supportive environment for employees, having hands-on knowledge of finance and the organization itself, and providing linear and nonlinear thinking.

Stakeholders collaboration and performance of Hospitals

A stakeholder is often referred to as the industry in which the organization operates and includes those elements or groups that directly affect and are affected by an organization's major operation. According to Hitt et al. (1999), the industrial organization model challenges organizations to locate the most attractive industry sector in which to compete. Collaboration has become an essential component to implementing health promotion and disease prevention/management (Odum & Whaley, 2012). Due to the high rates of medical errors over the past several decades, inter professional collaboration has emerged as a pragmatic

intervention step that can reduce errors and improve care (Inter professional Education Collaborative (IPEC), 2016). More generally, through participation, stakeholders may empower their voice in governance by interacting with hospital decision-making processes and performance, which influence (or are influenced by) them. On the other hand hospital can develop their stakeholder relationships and better manage them in order to create joint processes of sustainable value (Freudenreich, Freund & Schaltegger, 2019).

Hobbs (2007) argued that hospital collaborations are critical to achieve good health outcomes. Collaboration can aid hospitals' huge challenges to retain and recruit the largest amounts of resources at the lowest possible cost (Loxley, 2008). As institutions, hospitals have a social mission to fulfill their goals by providing quality services to the needy when required. How well their institutional and organizational mission (King, 2015) is accomplished determines their legitimacy in the eyes of the community. In this context, multiple stakeholders and variables in the relationship between hospitals and their environments have a significant impact on the success of the strategies they develop (Meyer, Pascuci, & Mamédio, 2016)

O'Malley, Woods-Jaeger and Dowd (2017) explored how collaborative efforts in a children's hospital and an early childhood education and social center fostered and leveraged the strengths of the different staff and managers in the hospital and the early childhood center towards improvement of services for the children in the two facilities. The study found that collaboration between the staff and managers in the hospital and the early childhood education and social center led to improvements in the provision and quality of services for the children including shelter, safety, food, education and health care. Collaborative also led to the expansion of the services provided to the children. The study also found that the collaboration also improved the level of trust and partnership among the staff in the hospital and early childhood education and care center

A study by Akwanalo and Njuguna (2019) studied Strategies for effective stakeholder engagement in Strengthening Referral Networks for Management of Hypertension across Health Systems in Kenya. The study sought to identify and engage key stakeholders involved in referral of patients in the Ministry of Health, western Kenya. Key stakeholders identified were the Ministry of Health, the Academic Model Providing Access to Healthcare, health professionals, communities and their leadership, and patients. Engaging them resulted in permission to contact research in their areas of jurisdiction and enabled collaboration in updating care protocols with emphasis on timely and appropriate referrals. The study concluded that stakeholder identification and engagement using the International Association of Public Participation model eased explanation of research objectives, building consensus, and shaping the interventions to improve the referral process.

RESEARCH METHODOLOGY

This study used mixed method research design where qualitative and quantitative data analysis was carried out. Mixed method was used due to its ability to blend elements of both qualitative and quantitative research approaches (Johnson, Onwuegbuzie & Turner, 2007). The target population in this study comprised County Government Hospitals, National Hospitals, faith-based hospitals and private hospitals registered in the ministry of health. The respondents were the medical superintendents or hospital administrators as the chief administrators of the hospitals. The target population in this study was 529 hospitals (Kenya Health Sector Strategic plan, 2013-2017). To obtain the desired sample size for the study with the population of 529, Yamane (1967) provides a simplified formula to calculate sample sizes. The study employed stratified random sampling technique in coming up with a sample size of 228 respondents from a target population of 529. The goal of stratified random sampling was to achieve the desired representation from various sub-groups in the population. The study concentrated on the

management cadre which is in charge of making crucial financial and strategic decisions in Hosspitals (Hutzschenreuter, Kleindienst, & Greger, 2012). A total of 190 questionnaires were returned from sample size of 228. A total of 38 hospitals declined to participate in the survey, out of which 10 claimed that the hospital policy does not allow them to participate in the survey, while the rest just could not participate at the time. This resulted in a response rate of 83.33%. Babbie (1990) stated that a response rate of 50% is adequate while Bailey (1987) set an adequate response rate at 75%. Mugenda (2008) avers that a response rate of 50% is adequate, 60% and above good, and above 70% very good. Therefore, a response rate of 83.33%, cognizant of the sensitive nature of the study the response was adequate. IBM Statistical Package for the Social Sciences (SPSS) version 21.0 for Windows 7 was used for data entry, data cleaning, running the initial Exploratory Factor Analysis (EFA). Analysis of Moment Structures (AMOS) software version 21, which is essentially analysis of mean and co-variance structures, was used for Confirmatory Factor Analysis (CFA), Path Analysis, Structural Equation Modeling (SEM) and computation of Goodness-of-Fit Indices.

RESEARCH FINDINGS AND DISCUSSIONS

To ensure that there was no violation of statistical assumptions, this study tested for linearity, homoscedasticity, multicollinearity, non-response bias and common method variance. The results of the tests conformed to the respective thresholds for each test. The data was analyzed using a two-phase process that comprised of confirmatory measurement model and confirmatory structural model as suggested by Anderson and Gerbing (1988). The initial step involved confirmatory factor analysis (CFA) that evaluates the measurement model on multiple criteria such as internal reliability, convergent, and discriminant validity. Before CFA was carried out, the exploratory factor analysis (EFA) was done whose key steps included the computation of factor loading matrix, communalities and principal components analysis (PCA). According to Tabachnick and Fidell (2013) EFA has the ability to narrow down a large data set into smaller one. In other words it assists the researcher in identifying the belongings of the variables (Emory & Cooper, 1991). Prior to performing EFA, two statistical tests which determine the suitability of data for structure detection were done, that is, Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy and Bartlett's Test of Sphericity. Table 1 indicates the results of the test for suitability of structure detection.

Table 1: Results of the Test for Suitability of Structure Detection

KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.798
Bartlett's Test of Sphericity	Approx. Chi-Square	6304.360
	Df	990
	Sig.	.000

Based on the results in Table 1, it is evident that KMO value is 0.798 which is close to 1. This meant that factor analysis was suitable. With $p < 0.05$ in the Bartlett's Test of Sphericity, this was an indication of suitability of data for structure detection. This study applied principal component analysis (PCA) in order to validate the construct validity of the items. Three variables, namely, Strategic Leadership (SL), Stakeholder Collaboration (SC) and Performance of hospitals were put into consideration. In addition, the factor loadings for all items ranged from 0.560 to 0.941, which satisfied the minimum criteria of 0.30 (Hair *et al.*, 2014). CFA was

employed to test whether there exists a relationship between the observed variables and their underlying latent constructs (Hair *et al*, 2014). The items for the study variables were examined using CFA on the basis of EFA results to examine the dimensionality of each variable and to test the model fit of the factors of the study variables (Anderson & Gerbing, 1988). Each observed variable was assigned to one and only one latent variable.

CFA was also done to measure the construct validity in the measurement model on multiple criteria such as convergent, internal reliability and discriminant validity. Bahl and Wali (2014) argued that convergent and discriminant validity is both subcategories of construct validity. Evidence that constructs validity exist is demonstrated by presence of both discriminant and convergent validity. None alone is sufficient for measuring construct validity.

For convergent validity, the factor loadings should be 0.5 or higher (Hair *et al.*, 2014). In this study, the average loadings are more than 0.7, implying that they are high enough to be convergent, as shown in Table 2. Composite reliability (CR) suggests a value of 0.6 for acceptability, which indicates internal consistency of the measurement model (Kline, 2005; Hair *et al*., 2014). As depicted in Table 2 the CR value of all items ranged from 0.728 to 0.986 suggesting that high internal reliability of the data exist. Therefore, internal reliability threshold was met.

Table 2: Convergent Validity

Code	Constructs	Composite reliability >0.7	AVE (Average Variance Extracted) >0.5
PERF	Performance	0.817	0.598
SL	Strategic Leadership	0.765	0.584
SC	Stakeholders Collaboration	0.809	0.617

To establish discriminant validity, one needs to show that measures that should not be related are, in reality, not related (Hair *et al.,* 2010). In table 4.38, none of the loadings is greater than 0.927 demonstrating discriminant validity.

The second step involved answering the study's objectives where AMOS software version 23 was used for confirmatory factor analysis, measurement model and structural equation modeling. Structural equation modeling (SEM) is a very general, chiefly linear, chiefly cross-sectional statistical modeling technique (Schumacker & Lomax, 2004). Jackson, Gillaspy and Purc-Stephenson (2009) argued that SEM is largely a confirmatory technique rather than exploratory and the AMOS software can be used to perform CFA. In the same vein they noted that path analysis, factor analysis and regression are all special cases of SEM. In this study, SEM was used to test hypotheses and to fit the theoretical model.

Each model variable was tested for normality and outliers on variables aspects. This was an exploratory data analysis (EDA) for understanding the structure of the variable before further data analyses was undertaken. This assisted in employing the appropriate analytical data analyses techniques to avoid crucial violations of key assumptions in consequent modeling processes. This was followed by model fit testing. In structural equation modeling, the fit indices establish whether, overall, the model is acceptable, and if acceptable, researchers then establish whether specific paths are significant (Moss, 2009).

The study considered two types of fit indices that are commonly used, that is, absolute fit indices and incremental fit indices (Hair *et al.*, 2010). For absolute fit indices, this study used on Goodness-of-Fit Index (GFI), Adjusted Goodness-of-Fit Index (AGFI) and Root- Mean-

Square Error of Approximation (RMSEA). For incremental fit indices Comparative Fit Index (CFI) and Normed-Fit Index (NFI) were used.

For the measurement model, Table 2 shows results of the alternative goodness of fit test statistics for the CFA model. RMSEA for the study was .027. A rule of thumb is that RMSEA < .05 indicates close approximate fit; values between .05 and .08 suggest reasonable error of approximation and RMSEA > 0.10 suggests poor fit (Browne & Cudeck, 1993). The study's RMSEA was considered a moderate fit.

Influence of strategic leadership on performance of hospitals in Kenya

The study sought to establish the influence of strategic leadership on performance of hospitals in Kenya. Normality test on the factors produced Skewness and Kurtosis values of between -1 and +1. The outliers were tested for each of the observations, with observations farthest from the centroid, Mahalanobis distance, being taken into consideration. There were no outliers detected. The values obtained in testing the model fit indices were within the thresholds as shown in Table 3.

Table 3: Model- Fit Indices for the influence of strategic leadership on performance of hospitals in Kenya

Model fits for the relationship between strategic leadership on performance

Model	CFI	GFI	AGFI	NFI	RMSEA
Default model	.917	0.930	0.977	0.871	0.037
Saturated model	1	1		1	
Independent model	0.000	0.117	0.031	0.000	0.052

Table 4: Regression analysis for the relationship between strategic leadership on performance

Path			B	Beta	S.E.	C.R.	P
Strategic leadership	<---	Performance	0.902	0.458	0.090	10.177	0.000

The hypothesis to test for this specific objective was:

H_{01}: There is no relationship between strategic leadership and performance of hospitals in Kenya.

Figure 1 shows there was a positive (regression weight = 0.46) and statistically significant relationship between strategic leadership and performance of hospitals in Kenya. In this regard, H_{01} was rejected. This model was significant at 95% significance level (α-level 5% for a 2-tailed test). Popular α-levels are 10% (0.1), 5% (0.05), 1% (0.01), 0.5% (0.005), and 0.1% (0.001) (Fisher, 1926). The findings implies that strategic leadership has a significant effect on hospital performance. An increase in strategic leadership variables will be followed by an increase in hospital performance and a decrease in the strategic leadership variable will be followed by a decrease in hospital performance. The results of this study are in line with the

research results of Sasono et al., (2021) who stated that strategic leadership has a significant effect on hospital performance.

Aseka et.al, (2021) in their study on the effect of strategic leadership practices on performance of health facility-based youth centers in Kenya demonstrated a concrete reason to give more attention on strategic leadership practices in order to be able to achieve better performance outcomes. The study found out that there was a positive and significant relationship between strategic leadership practices and performance of health facility-based youth centers in Kenya. Similar study by Gatwiri and Sije (2021) on strategic management practice and universal healthcare service delivery in Nairobi County, revealed that strategic leadership positively and significantly affects universal health care service delivery in Nairobi. This affirms that management of the health institutions should enhance and practice strategic leadership in the management of the health institutions since the practice positively affects the extent of delivery of universal health care service in the county.

The findings of this study illustrated that management competency and ethical practices are strategic leadership aspects that influence employees to make voluntarily decisions that increase the long-term viability of organization while maintaining financial viability of the hospital (Samimi et al. (2020). Therefore, healthcare institution must have strategic leadership directed towards managing change effectively and become "masters of renewal" in this dynamic healthcare environment (Afonina, 2015) to achieve superior performance.

A strategic leader's role is to make decisions that aid the organization grow, sustain, strengthen, leverage and exploit core values. Generally, the most relevant core values are derived from intangible resources, as they are difficult for competitors to imitate and relate to employees' knowledge, skills, and attributes (Daniel, 2020). Likewise, hospitals seeking to achieve competitive advantage the strategic leaders should play critical role in developing and implementing hospitals capabilities and resources for expanding competitive advantage and performance.

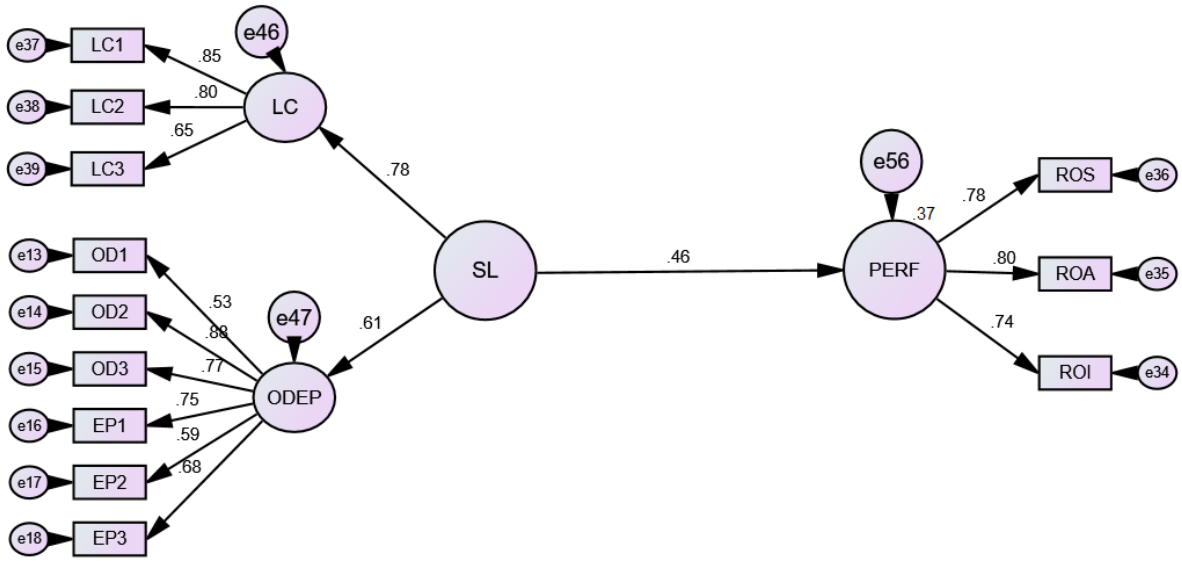

Figure 1: Significance Test for Strategic Leadership

Moderating Effect of stakeholder's collaboration on the Relationship between strategic leadership and Performance of hospitals Kenya

Using product indicator approach analysis in this study, the moderating effect of the variable (interaction term) was analyzed by interpreting the R^2 change in the models obtained from the

model summaries, and by interpreting the regression coefficients for the interaction term obtained from the coefficient's tables. It involves multiplying each indicator of the exogenous construct with each indicator of the moderator (Chin et al., 1996). Hence, the product indicators become the indicators of the interaction term. Specifically, the notion of product indicator approach is the product term (X * Z) which is used to examine the influence that the moderator z would have on the relationship between predictor X and the dependent variable of interest Y.

The R^2 was used to show the proportion of variation in dependent variable explained by the structural equation modeling (SEM) model. Aiken and West (1996) posited that moderation occur when variable M alters the relationship between the variables X and Y, by enhancing, strengthening / weakening or changing direction of the relationship. In order to determine the function of the moderator, difference in R^2 is employed as recommended by Carte and Russell (2003).

Table 6 shows the moderating effect of stakeholder's collaboration on the relationship between strategic leadership and performance of hospitals in Kenya. Figure 2 shows that R^2=0.451, and from figure 1 the R^2= 0.37. The value of R^2 with a change of 0.081 indicates that 8.1% of the variance in performance of hospitals can be accounted by strategic leadership and stakeholder's collaboration. This implies that the goodness of fit improves with the introduction of stakeholder's collaboration hence a conclusion that stakeholder's collaboration has a positive moderating effect on the relationship between strategic leadership and performance of hospitals.

Model 1 indicates that strategic leadership was statistically significant (p=0.000, β = 1.216). This implies that for a 1- point increase in strategic leadership, performance of hospitals is predicted to have a difference by 1.216; given that stakeholders' collaboration is held constant. The regression coefficient associated with stakeholder's collaboration means that the difference in performance of hospitals with stakeholders' collaboration is 0.447, given that strategic leadership is held constant. As shown in table 4.47. On substituting of the coefficients in equation 1,

PRE = 1.216SL + 0.447SC + ... + **E**

Model 2 shows the results after the interaction term (strategic leadership *Stakeholders collaboration) was introduced in the model. The compounding effect of SL * SC was also found to be significant (p = 0.000< 0.05, β = 1.099) as shown in table 4.47. On substituting of the coefficients in equation 2, we obtained

PRE = 1.216SL + 0.447SC + 1.099SL*SC ..... + **E**

These findings confirms that within any organization, the role of leader is strategic in an effort to increase organizational capability in implementing and executing strategy into various program and integral actions. Implementation of good knowledge management would very much determine hospital dynamic capability in handling stakeholder demand that become more critical and the changing hospital environment. The success of strategy implementation is very much depending on the role of strategic leadership in driving and spearhead the entire potential resources amidst uncertainty and complexity in organizational operating environment (Sudirman, 2013). In similar Owek (2021) on his study found a significant moderating effect of stakeholder engagement on the relationship between strategic leadership practices and performance of health facility-based youth centers in Kenya this indicate that stakeholder engagement enhances performance when strategic leadership practices are carried out. This is in line with argument by (Drath, Palus, O'Connor & McGuire, 2008) that collaborative

leadership is the collective activity of setting direction, seeking alignment, and building commitment.

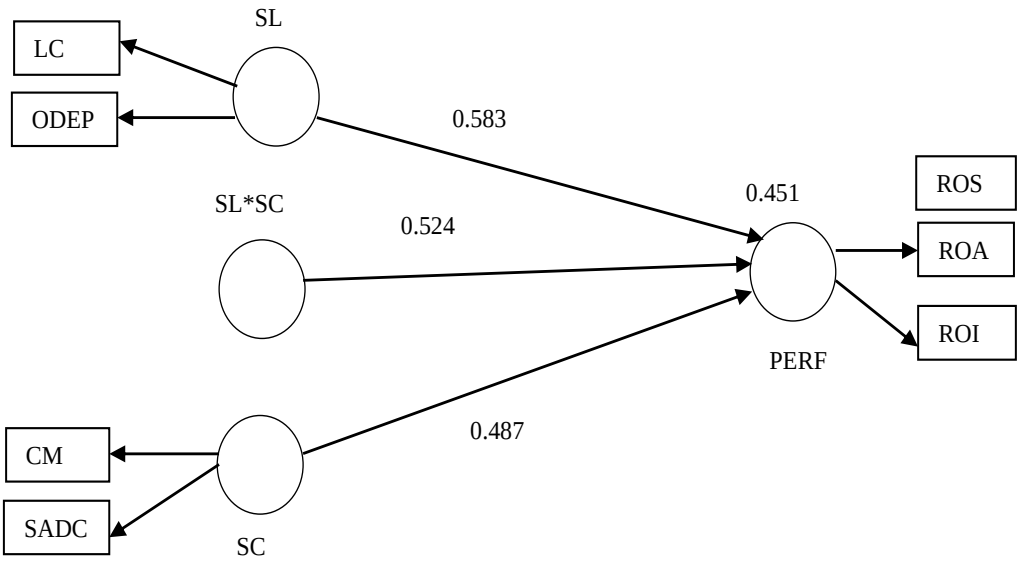

Figure 2: Moderating effect of strategic leadership on performance of Hospitals

Table 5: Model fits for the Moderated Regression analysis for the relationship between strategic leadership and performance

Model	CFI	GFI	AGFI	NFI	RMSEA
Default model	.923	0.935	0.979	0.901	0.032
Saturated model	1	1		1	
Independent model	0.000	0.110	0.033	0.000	0.048

Table 6: Moderated Multiple Regression Model Summary for Strategic Leadership

Path			B	Beta	S.E.	C.R.	P
Strategic leadership	<---	Performance	1.216	0.582	0.202	6.021	0.000
Stakeholder's collaboration	<---	Performance	0.447	0.487	0.09	4.969	0.000
SL*SC	<---	Performance	1.099	0.524	0.094	11.699	0.000

CONCLUSION

Strategic leadership had a positive and statistically significant relationship with performance of hospitals in Kenya. Goffee and Jones (2016) provide evidence that when leaders practice strategic leadership there is improved organizational performance. In affirmation to this argument, Kirimi and Minja (2017) observed that strategic leadership is no doubt important to all organizations. The findings support the upper Echelon's theory which states that strategic leadership plays a critical role in developing a company's capabilities for expanding its competitive advantage and performance.

Stakeholders' collaboration had a moderating effect on the relationship between strategic leadershi and performance of hospitals in Kenya. This is consistent with stakeholder's theory that postulates the need to provide ways to organizations, institutions, or professions to achieve more on the operations and to share costs, spread risk, and reduce supply chain uncertainty while forming strategic economic alliances for innovation and learning. The moderating role was in line with the study by Nyamu (2016) on the role of organization collaboration where the findings revealed that Kenyan hospitals collaborate with other organizations mainly to lessen budget restrained suffered during technological innovation process. Bolouki1 & Lewa (2018) argued that due to growth of the economy, the middle class has a higher demand for healthcare services and particularly expansion of NHIF coverage, privatization of hospitals through mergers and acquisitions (M&A) and collaboration of hospitals probably would make economic sense in Kenya.

RECOMMENDATION

Based on the findings of this research study, various recommendations were made. Hospital leaders to develop policy and mechanism that could drive knowledge management initiative in order so that these in the future could lead to organizational capability and have a competitive edge in the market. Initiative of knowledge management that they could establish is in the form of knowledge acquisition, storing, sharing and application. Implementation of good knowledge management would very much determine hospital dynamic capability in handling stakeholder demand that become more critical in situation analysis of hospital environment.

The success of strategy implementation depends on the role of strategic leadership in driving and spearhead the entire potential resources amidst uncertainty and complexity in organizational operating environment. Therefore, it is worthy to continue advocating to hospital leaders that organization knowledge that being processed through knowledge management cycle could become the source for their capability.

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