



## Understanding health care markets

A PCT guide to market analysis and market management

8 April 2009

# Understanding health care markets: a PCT guide to market analysis and market management for

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# 1. Introduction

The new NHS Constitution has at its centre the right of patients to choose. This choice is underpinned by competition between health care providers; competition that is intended to be a driving force for improved quality and efficiency.

The creation, analysis and shaping of healthcare markets are therefore essential skills that commissioners must master if they are to achieve their goal of world class competence.

The Principles and Rules of Cooperation and Competition (PRCC)<sup>1</sup> set out the framework within which the healthcare system should be managed. These rules make clear that PCTs must seek to obtain services from those providers that are best placed to meet the needs of their populations. Procurement must be through a transparent process and must not discriminate against particular providers. The recently created Cooperation and Competition Panel will enforce the PRCC<sup>2</sup>.

Our understanding of health care markets in the context of the English NHS is still evolving. And, of course, not all health care markets are the same. In elective hospital care, for example, the government's policy that the market should be open to all registered providers (an 'any willing provider' regime) is more mature. Here patients' choice of provider should be unrestricted.

Other health care markets have different characteristics. For example, the entry to the market for general practice services is controlled by local PCTs who have the discretion whether or not to award contracts. In contrast, markets for community health services and accident and emergency care are largely dominated by local monopoly providers.

It is clear that PCTs are now required under the PRCC to develop commissioning strategies that will introduce more competition over time (in particular for community health services<sup>3</sup>). Competition is one tool among many available to help drive improvements in quality. Commissioners need to understand when and how to use competition effectively.

## What is in this guide?

This guide is intended as a short introduction for Primary Care Trusts to market analysis and market management.

**Section 1** sets out a framework for defining healthcare markets and considering the state of competition in these markets.

**Section 2** sets out a framework for analysing markets and understanding their current and future 'dynamism'.

**Section 3** describes a systematic process by which PCTs can prioritise and undertake their market analysis.

**Section 4** sets out the market management levers available to PCTs to shape markets.

A worked example of how the processes set out in the guide could be applied in practice is given at **appendix 1**.

<sup>1</sup> Department of Health, *The NHS in England: The operating framework for 2008/9 Annex D – Principles and rules for co-operation and competition* (December 2007)

<sup>2</sup> Cooperation and Competition Panel for NHS funded services ([www.ccp-panel.org.uk](http://www.ccp-panel.org.uk))

<sup>3</sup> Department of Health, *Transforming community services: enabling new patterns of provision* (January 2009)

## 2. A framework for understanding competition in healthcare

### Defining healthcare markets

#### Segmentation

The judicious use of competition is intended to increase quality of care for patients and efficiency within the health market as a whole. This is because providers are subject to 'competitive tension'. This tension, in theory, suggests that providers will fear the consequences of letting quality fall (such as a loss of revenue, prestige etc. as patients or PCTs take their business elsewhere) and will have an incentive to increase quality (gains in revenue, prestige, etc.).

We define markets as groups of healthcare activities across which competition creates this incentive to increase quality. Some important conditions must be met for this theory to be effective in practice:

- ▶ **Demand side conditions:** patients an/or PCTs must be able to switch between substitutes (such as physiotherapy, osteopathy or pain relief for back pain).
- ▶ **Supply side conditions:** providers of care must be able to switch resources such as staff and equipment into new areas of care, or expand existing areas, in response to opportunities.

Therefore we can define different 'market segments' by looking at a cluster of services designed to meet a patient need (see box 1 below).

#### Box 1 – an example of a market segment

The market for back pain relief would incorporate all providers of osteopathy, chiropractic, general practice and physiotherapy within, for example, a 15 minute drive time distance of a population centre. Providers of other services (such as pharmacists, health clubs, etc.) would also be considered as part of this market if they had resources that they could switch to take advantage of an opportunity to provide back pain relief.

**Non-community product markets**

<b>Maternity</b>	<b>Other surgery</b>
Birth	ENT
Other maternity (ante/post natal)	Ophthalmology
Pregnancy – termination	Urology
<b>Paediatrics</b>	Oral and Maxillo facial surgery
Paediatric surgery	Other surgery
Paediatric neurology	Optometry
Other paediatric	<b>Infectious diseases</b>
<b>General medicine</b>	<b>Pharmacology</b>
Gastroenterology	<b>Haematology</b>
Cardiology	<b>Anaesthetics</b>
Respiratory medicine (thoracic medicine)	Pain management
Other general medicine	Other anaesthetics
<b>Other medicine</b>	<b>Immunology and allergy</b>
Dermatology	<b>Plastic surgery</b>
Endocrinology	<b>Mental health – non-community based</b>
Neurology (adult, incl. stroke)	Adult – all except substance misuse
Other medicine	Older people – all except substance misuse
<b>Oncology</b>	CAMHS – all except substance misuse
Hospital-based chemotherapy	Substance misuse
Hospital-based radiotherapy	<b>A&amp;E</b>
<b>Rheumatology</b>	<b>Obstetrics and gynaecology</b>
<b>General surgery</b>	Minor procedures
<b>T&amp;O</b>	Other OBGYN
Trauma	
Orthopaedics	

**Geography**

For any particular market segment, it is also necessary to define the relevant geography. The geography is important as it is a key constraint on the ability of patients or PCTs to choose from among competing providers.

The geography of a market is defined by understanding how far a patient is willing or able to travel to receive care – this will of course vary by the patient need in question, for example, for many primary care services patients may only be willing to travel 15 minutes or so by foot. For some very specialist forms of cancer treatment or brain surgery patients may be willing to travel hours by car or even plane.

The combination of defining a market segment and a geography provides the full definition of the market. Once they have been defined, it is possible to begin to understand how competition works, or fails to work.

**Competition ‘in-the-market’ and ‘for-the-market’**

Because different health care markets have different economic characteristics, different types of competition should be used to drive up quality and efficiency. Three different types of competition can be identified – competition ‘in the market’, competition ‘for the market’ and a hybrid of the two (see box 3).

### Box 3 – different forms of competition

**Competition ‘in-the-market’:** where licensed providers compete for patients on a day-to-day basis with no guaranteed activity volumes or revenues.

**Competition ‘for-the-market’:** where PCTs contest the right to provide services for a given population. The winning provider earns the right to offer the service for a given period of time, over the course of this period it has some guaranteed payments to provide capacity.

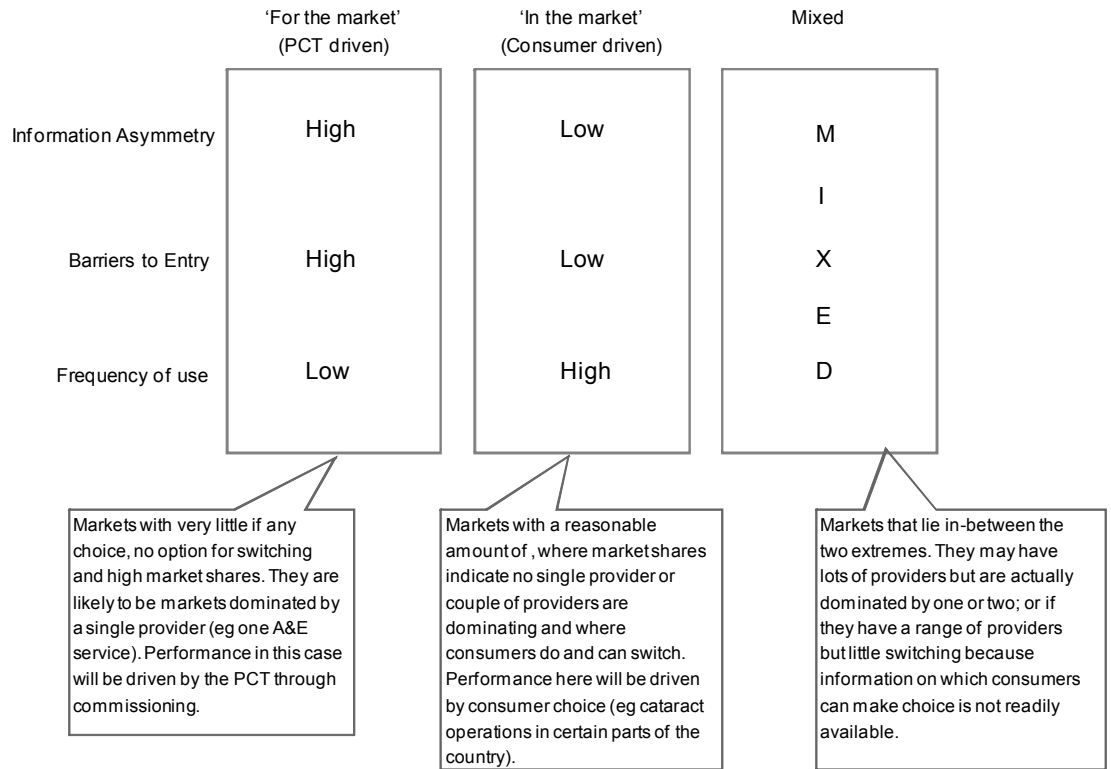
**Mixed market:** a combination of ‘for’ and ‘in’ the market, where a PCT selects a restricted number of providers and lets them compete for patients.

These types of competition are broadly associated with different ‘market archetypes’ (see Figure 1). These archetypes define the prevailing economic characteristics of different markets. The main characteristics that we are interested in are:

- ▶ **Barriers to entry** – the ability for providers to enter a market place will vary significantly according to the healthcare being provided. Barriers will be significant for highly capital intensive services (such as complex hospital care). In contrast, barriers may be minimal for those services delivered with little expensive equipment (such as physiotherapy or community nursing), there may also be regulatory or legal barriers that limit entry
- ▶ **Information asymmetry** – patients will be more able to make informed judgements about the quality of some services compared to others. For example, patients are likely to have a relatively good sense of quality for services, such as general practice, that are used frequently
- ▶ **Economies of scale** – some services may be better organised on a large population basis for economic or clinical economies of scale. For example, highly specialist services, such as hyper acute stroke services, are likely to be delivered with higher quality outcomes if concentrated on fewer sites.

These characteristics mean that PCT competition strategies will need to vary. In particular, PCTs will need to determine what type of competition is appropriate (competition ‘**in-the-market**’ or competition ‘**for-the-market**’ or a hybrid of the two) and how effective the chosen type of competition is likely to be in driving quality improvements.

Competition in the market is likely to be powerful in driving improved quality where there are relatively few barriers to entry (or a large existing base of providers), where patients have good information with which to judge quality and economies of scale do not mean that it is inefficient or a risk to quality to provide a range of competing providers within easy reach of the population. Where these conditions do not hold, competition ‘for-the-market’ may be preferred or some mix of the two.



**Figure 1: Market archetypes**

### 3. Assessing market dynamism

Having defined the market in terms of market segmentation, geography and competition type (as set out in section 1 above) one is able to then analyse the intensity of that competition.

There is no single indicator with which to measure competition. Instead, it is necessary to build up a picture of the degree of competition (or 'market dynamism') by examining a range of evidence. This is the approach adopted by competition authorities when assessing competition in other markets.

There are many different ways of measuring competition. In healthcare, it is helpful to consider four specific measures:

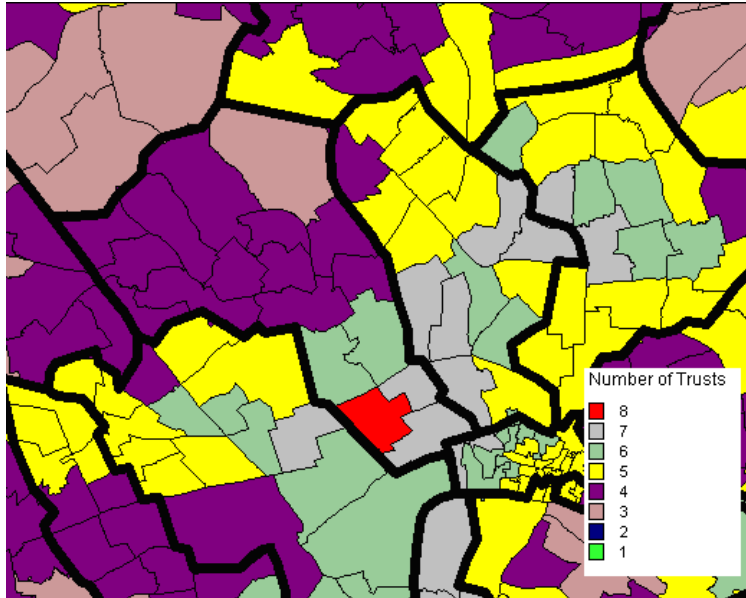
- ▶ **Choice:** the number of potential providers within a defined area.
- ▶ **Concentration:** market structure – the market share of providers serving a defined areas (i.e. where patients *actually choose* to receive treatment, as opposed to where they *could* receive treatment)
- ▶ **Switching:** changes in patient flows from year to year, potentially proxied by changes in market share
- ▶ **Rivalry:** the degree of actual or potential entry into and exit from a market

More detail on each of these indicators is set out below.

#### Choice

Choice is defined as the number of providers of services within the geographical market (as defined by a particular travel time). To simplify this analysis, travel time can be measured as the time it takes to go by car (or, in a major city, potentially by public transport) from the centre of a relevant population centre (e.g. an electoral ward) to the healthcare provider (mapping programmes can automate this calculation (see Figure 2)). It is clearly important that the travel time is appropriate to the market segment under analysis. For example, the time someone is prepared to travel to reach their GP is likely to be much less than that to reach a provider of an inpatient operation.

This measure simply represents a theoretical level of choice – it does not capture whether or not these choices are taken up by many or even any patients. In general, if a provider is the only choice for most of its patients, it may not face strong market incentives to provide high quality care (it does not face 'competitive tension'). Of course, this is not to say that other incentives to provide high quality do not exist, such as professional pride and a sense of duty among local clinicians and managers.



**Figure 2. 'Heat map' showing theoretical choice of provider within 30 minute travel time for different populations, based on electoral wards**

### Concentration

Market structure is defined by the market shares of the providers serving the population. A common summary measure of the market shares for all providers serving a population is the Herfindahl Hirschman Index (HHI). This allows a view of how concentrated a market is, i.e., the extent to which activity is focused on a small number of providers. The HHI ranges from 10,000 for a monopoly market (with one provider having 100% market share) to 100 for a market with a large number of very small providers (see appendix 1 for more information on the HHI). Healthcare markets are currently relatively highly concentrated when compared to markets in other sectors (the UK Competition Authorities define a market with an HHI in excess of 1800 as highly concentrated; our analysis of many markets across London suggests that the average HHI for London PCTs is more than 4000 and higher in other regions).

### Switching

Switching is the 'churn' in a market: the number of people (or PCTs) moving from one provider to another in a given time period (e.g. over the course of a year). In some healthcare markets this can be observed directly. In others it is necessary to approximate it by looking at the change in market share of the providers. Changes in market share (e.g., from a provider undertaking 30% of procedures in a particular area to undertaking 25% from one year to the next) is the result of patients (or PCTs) choosing to switch from one provider to another. (capacity constraints could be another explanation which should also be investigated in a detailed analysis of switching behaviour). Switching provides the stimulus for providers to improve or maintain the quality of their service. Where the quality of services provided is uneven (i.e., some providers offer poorer services than others) a dynamic market would be characterised by switching from poor providers to better ones. However, patients (and their general practitioners) need reliable information upon which to base any switching decision, for example about the relative differences in quality between alternative providers. Market concentration and switching are related; concentration is the product of patterns of switching (and capacity constraints) at any given time.

### Rivalry

Rivalry is the degree of actual or potential entry into and exit from a market. Rivalry is a useful measure of competition because competitive markets are characterised by real entry and exit as well as the threat of entry and exit. The degree of rivalry is influenced by factors

such as the extent of any barriers of entry (such as fixed costs or the ability to access patients, obtain a contract etc.). In practice, in healthcare, rivalry is generally measured qualitatively through interviews with existing and potential providers.

Combining the results of analysis in each of these four areas provides a good overview of the state of competition in or competition for a market. It helps to understand whether competition is likely to be able to help drive improvements in quality, or what a PCT should do to allow competition to help to drive quality improvements.

However, it is important to recognise that competition is a means rather than an end in itself. Competition is used to drive up quality and it is therefore essential that a clear view of current service quality is a core part of any strategy to analyse and manage markets. We discuss this further in the following section.

### Quality

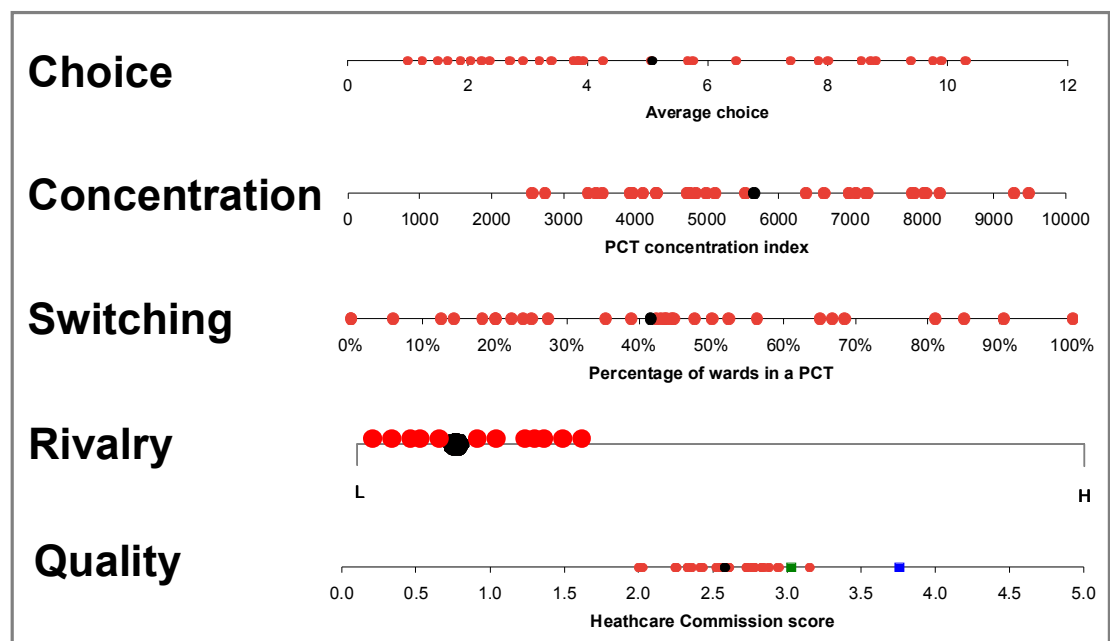
Competition is only a means to achieving improvements in quality (and only one of many system management tools that can be used to drive up quality). Therefore, any analysis of competition must be carried out in the context of an analysis of current service quality within that market.

High service quality is not necessarily an indication that no intervention is needed. Even a poorly functioning market may have high quality for a period of time, but it is unlikely to be maintained for long. Moreover, patients' rights to choose their provider may mean that intervention is needed in uncompetitive markets even if quality is high.

However, given the large number of healthcare segments overseen by PCTs it may make sense to prioritise markets where quality is currently a concern for investigation, while keeping an eye on others.

### Summarising market dynamism

The different characteristics described above can be summarised through a 'market dynamism dashboard' (see Figure 2).



**Figure 2. A Market Dynamism Dashboard with illustrative PCT benchmarks**

The dashboard is useful in displaying market characteristics in a systematic way and in allowing PCTs to compare their markets with those in other areas. However, it would be


wrong to think of market management as a precise science that can be applied in the same way in every area.

There is, as yet at least, no consensus over a set of benchmarks that can be used to determine the 'right' market characteristics. For example, commissioners cannot refer to a degree of market concentration that they should be aiming for that will hold good in all circumstances.

Therefore, PCTs will need to develop their own sense of what the 'right' dashboard should look like in their local context. The market archetypes that were described earlier can be used to by commissioners to identify different market characteristics that they might aim for, although should not be slavishly followed. In Figure 3, we have used experience in health care markets to date to identify a set of benchmarks for different types of market. These are illustrative only and the Cooperation and Competition Panel for NHS funded services will likely develop its own benchmarks in each of these areas. Over time the Cooperation and Competition Panel will begin to establish a form of case law that will guide PCTs as to the desired characteristics of healthcare markets.

As choice and competition in and for the market establishes itself, it is likely that these benchmarks will change.

Patient choice led				Highly specialised non elective				Specialised elective with clinical dependencies			
	Low	Medium	High		Low	Medium	High		Low	Medium	High
<b>Choice</b>	0-2	3-5	5+	<b>Choice</b>	0-2	3-5	5+	<b>Choice</b>	0-2	3-5	5+
<b>Concentration</b>	0-2000	2001-4000	4000+	<b>Concentration</b>	0-2000	2001-4000	4000+	<b>Concentration</b>	0-2000	2001-4000	4000+
<b>Switching</b>	0-25%	26-60%	61-100%	<b>Switching</b>	0-25%	26-60%	61-100%	<b>Switching</b>	0-25%	26-60%	61-100%
<b>Rivalry</b>	Low	Medium	High	<b>Rivalry</b>	Low	Medium	High	<b>Rivalry</b>	Low	Medium	High

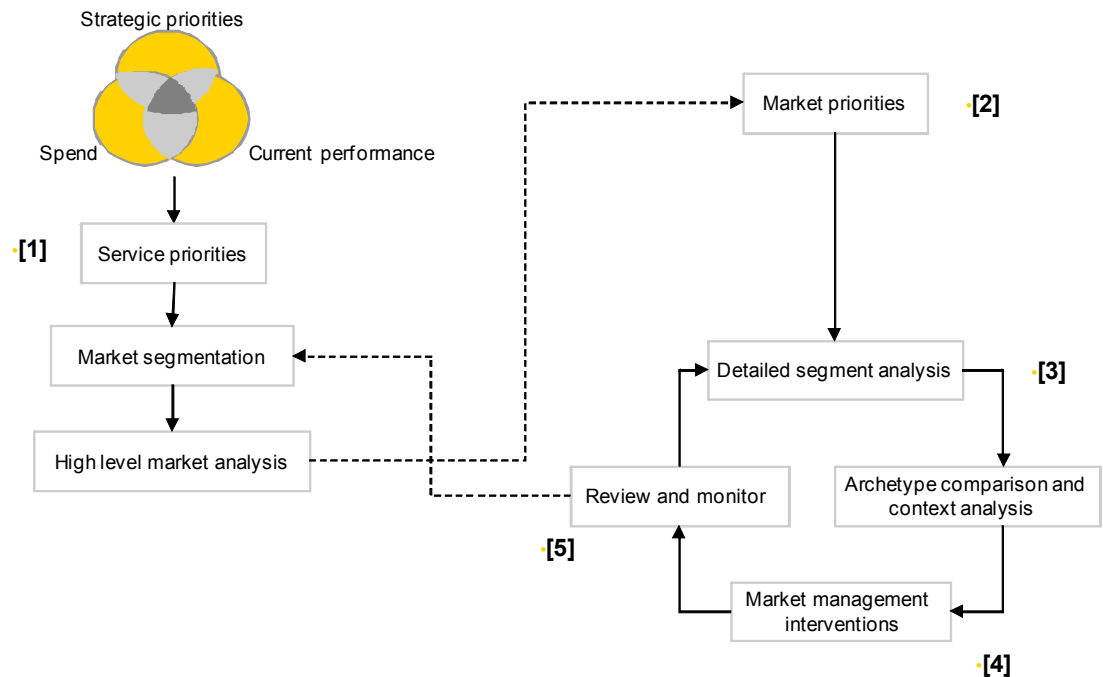
 Optimal level

**Figure 3. Benchmarks for different types of market archetypes**

What is achievable and desirable in terms of choice, concentration, switching and rivalry will vary in different PCTs according to local circumstances. There is value in comparative benchmarking across PCTs that share similar characteristics. Indeed, PCTs will need to collaborate on market management with their neighbours in any case – patient-focused markets are no respecters of PCT organisational boundaries.

## 4. Market analysis and review

Even using a conservative estimate, the overall healthcare system is comprised of dozens of healthcare market segments. This means that PCTs must adopt a strategic approach to market analysis and management. In Figure 4 below, we set out a conceptual approach to market analysis.



**Figure 4. Strategic market analysis and market management**

### Service prioritisation

It is important to focus limited PCT resources and efforts clearly on areas of high local significance. This can be done by a review of the PCT commissioning portfolio assessing:

- ▶ **Strategic priority:** for example, what has been agreed as local health need priorities together with the Local Authority; how do national requirements impact on PCT priorities (such as the requirement on PCTs to increase choice and competition in community health services)?
- ▶ **Current performance:** for example, areas where 'vital signs' are showing poor performance, feedback from patients and the public about areas where improvements are required.
- ▶ **Spend:** analysis of commissioning spend to focus attention on the areas where most resources are spent.

No one dimension used for prioritisation is likely to be sufficient, instead a synthesis of all three (and other dimensions agreed locally) can be used to provide an initial filter that identifies areas where market management strategies may be useful to address local issues. This process generates '**service priorities**'.

## High level market analysis

A high level market analysis across the market as a whole will provide a snapshot of current dynamics. This analysis is itself a further form of prioritisation – identifying areas where market characteristics do not align with those that would be desirable for that particular market. This will generate **'market priorities'**.

The process should start with a preliminary definition of the market (what market segment and geography is being analysed). The analysis of the segment that has been defined should then incorporate the measures of market dynamism discussed above (choice, market structure, switching, rivalry), together with local intelligence. In order to be clear where current market conditions need to be changed, it is necessary to have a clear sense of what improved market conditions might look like. This is done by creating a small number of 'market archetypes' to which different market segments can be matched. These archetypes will capture the preferred characteristics of different markets in terms of likely choice and market structure. These should not be seen as an absolute target; **local conditions mean that there is unlikely to be any such thing as ideal market conditions that should apply across the board**. Rather the archetypes provide a direction of travel. We have set out in Appendix 2 a practical example of how this approach could be applied.

By combining the service and market priorities, segments can be identified that are both important in terms of local needs and where market conditions are clearly sub-optimal. These segments provide the focus for deeper analysis.

## In depth analysis

In depth analysis of a targeted group of segments is designed to understand prevailing market conditions in more detail, including relevant local context (for example, local demographic or geographic conditions that impact on the distribution and use of services). A more detailed definition of the market can be undertaken (e.g. collecting evidence on willingness to travel). It also allows the findings of the high level analysis to be tested. For example, is switching between providers correlated with any relevant quality difference in the service offerings? If it is not, what steps should be taken to prepare the ground for the use of market mechanisms? For example, making quality information more accessible. This leads into the next step.

This level of analysis also allows a qualitative view of the market to be taken, for example, interviews of potential suppliers to understand rivalry, which would be prohibitively expensive if carried out across all segments.

## Market management interventions

Market analysis is not an end in itself; it exists to guide PCT action. While the analysis identifies areas where action should be taken together with a desired direction of travel, it is market management interventions themselves that deliver the required changes. Market management interventions are discussed in detail in the following section.

## Review

Market conditions need to be kept under constant review so that PCTs can monitor the impact of their interventions and to see whether new priorities are emerging. This process of market analysis and management is continuous and iterative. In particular, as markets evolve segmentation may need to be revisited. For example, new segments may be created through the process of market management either because current pathways are disaggregated (e.g., ante and post natal care) or aggregated (e.g., integrated care for long term conditions). A monitoring system could be set up for markets of particular concern. This may, among other things, result in the PCT updating the quality indicators and the market dynamism dashboard on an annual basis to understand how the market is evolving.

## Market management interventions

### Market management levers

There are a range of levers available to commissioners to help shape their local markets. These can be split into three groups: demand side, supply side and regulatory levers. Identifying the right blend of levers will depend on a full analysis of prevailing market conditions and, in particular, in understanding which market archetype applies.

The main levers at the disposal of commissioners are summarised in Fig 5 below.

Lever type	Lever sub category	Lever
Demand side	Demand shaping and education Provision of information Consumer engagement	Activities by PBC/PCT to influence care seeking behaviours by patients Making available comparative data on providers to inform patient choices Formal dialogue with patients to inform development of new market options (such as new care pathways) Use of patient 'voice' within providers (eg members of FT)
Supply side	Market creation (with/without incentives) Market development (with/without incentives) Market exit Provider management	Stimulating competition where monopoly exists Introducing a greater range of providers in existing markets Concentrating markets where there is fragmented supply Decommissioning existing providers (and potentially re-commissioning) replacements Altering key performance indicators and other quality drivers in contracts
Regulation	Licensing De-licensing Regulatory influence	PCT requiring additional licensing requirements as community services markets are established Removal of licenses granted by PCTs Provision of information to formal licensing authorities

**Figure 5. Market management levers**

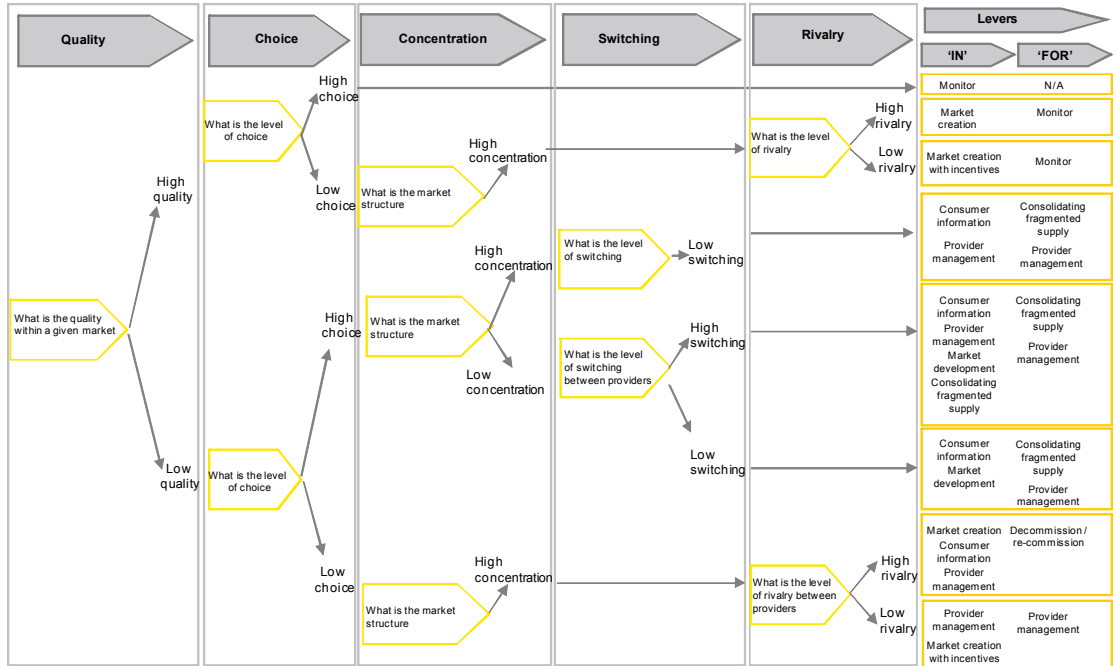
### Identifying which levers to pull

While there is an array of market shaping levers available to commissioners, the trick is identifying the right combination for a particular market. The choice of lever is determined by the precise nature of current market conditions, together with the economic characteristics of the market segment in question.

For segments that conform mostly to competition 'for-the-market', action is most likely to focus on supply side and regulatory levers (although some demand side levers such as the encouragement of patient and public 'voice' are also relevant).

For segments that conform mostly to competition 'in-the-market', the combination of levers may be more diverse. Here, a systematic approach to the analysis of market conditions is required.

Figure 6 below sets out a simple 'decision tree' which commissioners can use to identify the right combination of levers under different market conditions. The process first considers the quality of existing services, then looks at the four key indicators of competition (choice, concentration, switching, rivalry) and finally indicates appropriate commissioning levers to be considered. This decision tree is not exhaustive but captures many of the most likely combinations of market indicators (there are very many more possible combinations).



**Figure 6. Decision tree: identifying the right market management levers**

The levers are pulled in order to create market conditions that are more likely to increase service quality for patients (or maintain it if it is already high). By using the relevant market archetype together with relevant benchmarks (what 'good' might look like as described in section 2 above) a direction of travel can be determined, together with short and medium term desirable destinations. The market dynamism dashboard can be constructed and updated to monitor progress towards the desired end state.

## 5. Conclusion

Market analysis and management is unfamiliar territory for most PCTs and they will need to build their competence in these areas quickly. The establishment of the Cooperation and Competition Panel makes this task even more urgent as PCTs may be called in front of this body to justify their decisions.

The understanding of healthcare markets in an NHS context is still immature and a robust sense of what 'good' looks like is elusive. However, with the NHS Constitution's focus on patients' rights to choose, competition is likely to be a feature that commissioners will need to deal with for some time to come.

In this guide we have set out a systematic approach to market analysis but, importantly, have linked it practical actions that PCTs can take to improve services for the people they serve. After all, market analysis is not an end in itself but a step that empowers commissioners to shape the markets to deliver the outcomes that they want.

## Appendix A Worked example of market analysis

### PCT X's dermatology market

PCT X has gone through a process of prioritisation and has identified dermatology as one of the market segments they want to analyse.

The PCT establishes that the geography for this market is a 30 minute drive time around the main centre of population. We can now draw border around the population in question which delineates the limits of how far people can travel in 30 minutes. Every provider of dermatology services within that border is within our market.

**Choice:** There are five main providers and a number of very small providers.

**Concentration:** The PCT analyses the number of dermatological procedures carried out by each provider in the previous year, which results in the market shares set out in Table 1 below. The largest provider undertook over 60% of the treatments in the year in question, the second largest about a third with a fringe of very small providers<sup>4</sup>.

The HHI for this market is about 4,800.

**Table 1: Market shares**

Provider	Market share
1	61.7%
2	31.5%
3	1.7%
4	1.3%
5	1.3%
Range of very small providers	< 1% each

**Switching:** In common with many healthcare markets, the PCT does not have data showing exactly how many people moved providers for dermatology in the year in question. However, we can look at the change in market shares of the providers from one year to the next. This is a proxy for switching which is likely to under-estimate its full effect because it measures the net effect of all switching over the course of a year. The geographical area we are examining (i.e. within the 30 minute travel time) contains 30 electoral wards and the PCT finds that in 60% of them, market shares changed by more than 5%.

**Rivalry:** Finally, an investigation of the nature of rivalry in the market reveals sufficiently high barriers to entry that it is not clear there will be any significant new entry in the near future. A view of the rivalry within a market will often be obtained from interviews with current market incumbents and potential new market entrants. However, this can be supplemented by other available sources of evidence that support the decision made (e.g., the number of bids received following a recent tender exercise) and the exercise of local judgement.

We now have a snapshot of the nature of the market. It is summarised in Table 2 below.

<sup>4</sup> The HHI is calculated by adding together the squares of the percentage market share of each provider in the market place, e.g., if there are two providers in a market, one with 90% market share and the other with 10% market share, the HHI is 8200 (8100+100).

**Table 2: Summary market overview**

Indicator	Measure
Choice	Over 5 providers, 2 with significant market shares
Market Structure	HHI = 4,800 (approx.)
Switching	60% of wards saw 5% year-on-year change in market share
Rivalry	Low due to relatively high barriers to entry

**Quality:** suppose the reason that the PCT is investigating this market in detail is that quality of provision is currently relatively poor (for example measured through a high first to follow up ratio).

**Direction of travel?** We would then want to look at the four competition indicators relative to a range of benchmarks, to determine the direction of travel – for example, should we look to increase or decrease concentration? Benchmarks represent how we would expect this market to look if it was functioning well, with sufficient dynamism that the institutions would have clear incentives to improve the quality of their provision.

Local benchmarks may be developed over time by looking at how these measures of market dynamism vary across different segments, or what they look like for the same segment in other PCTs. However in the absence of local benchmarks, we have developed an initial set of benchmarks for three market archetypes (see section 4 of the main paper).

Dermatology is a patient choice-led market. The relevant archetype benchmark is set out in the table below:

**Table 3: Benchmark for patient-choice-led markets. (suggested optimal levels in yellow)**

	Low	Medium	High
Choice	0-2	3-5	5+
Concentration	0-2000	2001-4000	4000+
Switching	0-25%	26-60%	61-100%
Rivalry	Low	Medium	High

**Table 4: Current state of PCT X's dermatology market (current levels in grey)**

	Low	Medium	High
Choice	0-2	3-5	5+
Concentration	0-2000	2001-4000	4000+
Switching	0-25%	26-60%	61-100%
Rivalry	Low	Medium	High

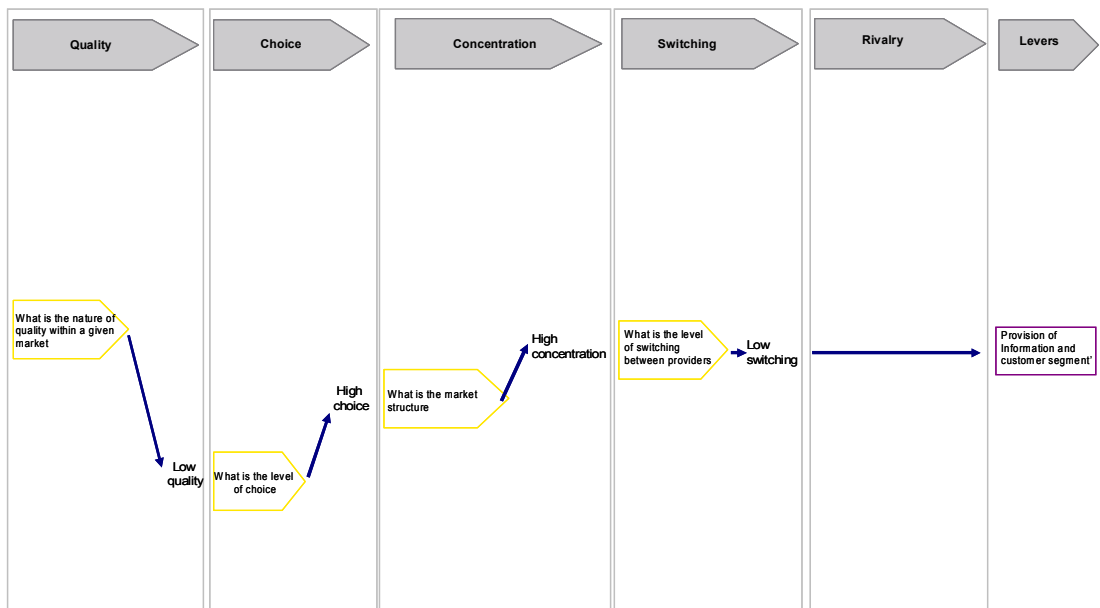
In this example, using the relevant benchmark suggests that we should **decrease the concentration** in this market, in part by **increasing switching**, in order to try to drive improvements in quality.

**What might a future market look like?** In terms of concentration, Table 5 below provides an indication of how things might have to change to develop a more dynamic form of competition: competition where one single provider does not have such a large market share. There are many other options as well as these three, but these serve to illustrate how the shape of the providers might have to change. The table illustrates that in order to drive down the HHI index to levels more in-line with those of a well-functioning market, it is likely that the 60% share of the current market leader would have to fall significantly (alternatives 1 or 2) or that those of currently fringe providers would have to rise a lot (alternative 3).

**Table 5: Alternative market structures**

Provider	Market shares		
	Alternative 1	Alternative 2	Alternative 3
1	20%	25%	50%
2	20%	25%	20%
3	20%	25%	10%
4	20%	25%	10%
5	20%	0%	10%
New HHI	2,000	2,500	3,200

**Which levers should PCT X pull to move towards this state?** In this example, the PCT is very unlikely to wish or to be able to simply impose the desired market shares. Indeed, to do so may be counterproductive. Instead, it needs to pull the relevant commissioning levers available in order to create incentives that result in market shares more in line with a well functioning market. A decision tree is shown below:



The relevant lever here is provision of information. To encourage switching, the PCT may provide the public, for example, with better information about the quality of service provision by different providers. It may encourage GPs to discuss in greater depth the range of alternative providers prior to referral, or encourage existing providers to advertise within the guidelines that have been set out. Importantly, having done the above analysis, the PCT is in a good position to see if its actions are having the desired effect and, if not, to change them.

**Review** PCT X should continue to monitor the market indicators, to see whether its interventions do in fact increase switching, and lessen the market share of the lead provider. Alongside this, they must continue to monitor quality, to see whether this improves as the market structure changes.