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CHAPTER

Service Area Competitor Analysis

"The competition will bite you if you keep running; if you stand still, they will swallow you."

William Knudsen, Jr.

Introductory Incident

Competition Revs Up in the Indianapolis Service Area

A heart-care building boom is occurring in many cities, although the volume for open heart surgery seems to be declining. Critics believe that overbuilding may split up heart surgery volume enough that many facilities will not meet Leapfrog-recommended volume standards just at a time when consumers are becoming much more aware of them (see Perspective 6-1 on the Leapfrog Group). For example, in Milwaukee, 13 cardiology programs serve a population of 1.6 million, whereas Cleveland has five open-heart centers for a metropolitan statistical area (MSA) of 2.7 million and Rochester has two programs for a population of 1.1 million.

In the Indianapolis service area, cardiac capacity increased 15–20 percent in the past three years. The reason? MedCath, the for-profit corporation

that built and was operating 13 free-standing heart hospitals, began having discussions with local cardiologists. MedCath partnered with cardiologists, cardiovascular surgeons, and other physicians to deliver patient-focused health care to those with cardiovascular disease. MedCath enabled physicians to be involved in the design and planning of the facility as well as managing its operations. Often physicians were involved in ownership, enabling them to enhance stagnant incomes. MedCath targeted states, such as Indiana, that did not have certificate of need (CON) laws.

As a defensive ploy, and to avoid the potential loss of physicians (and through them, their patients), Indianapolis service area hospitals forged partnerships with physicians to consolidate or expand

heart surgery programs. Each of the four hospital systems – Clarian Health Partners, Community Hospitals of Indianapolis, St. Vincent Hospitals, and Wishard Health Services – built free-standing heart hospitals and two of them – Clarian and St. Vincent – were built as joint ventures with physicians.

Population for Marion County (which includes Indianapolis) is 1.62 million. The Indianapolis MSA includes nine counties with a population of more than 1.8 million. The MSA has more than 3,600 physicians (1.9 per 1,000 population) and 15,800 registered nurses. Although the MSA has 2.5 staffed hospital beds per 1,000 population, the city of Indianapolis has 3.0 staffed beds per 1,000 population.

HMO penetration is low in the city (21 percent and declining); most of the 22 major employers (including Eli Lilly, Anthem, Inc., and Consecro, Inc. on the Fortune 500 list) offer PPOs. About 12 percent of the population is without health insurance (13 percent in the county). In both the city and the county 11 percent of the population is over 65 years of age (compared with an average of 15 percent for the United States).

Indianapolis had been a city where health care was described as “genteel competition” but that is no longer the case. Competition among the hospitals has intensified as several of the systems have built new hospitals or significantly renovated older facilities in what has traditionally been others’ geographic market areas. Some of the construction is designed to move services of flagship hospitals to

more lucrative, faster growing areas (outside the city limits of Indianapolis). In addition, St. Vincent’s Hospital opened a children’s hospital to compete with Clarian’s Riley Children’s Hospital (affiliated with Indiana University and historically the only children’s hospital in the region). Orthopedics groups were announcing plans to open orthopedic hospitals and oncologists were in discussions with a for-profit national company, spurring hospitals to build additional outpatient cancer facilities.

In addition, there has been friction among the physicians at Indiana University and Methodist Hospital (merged in 1997 to become Clarian Health Partners) such that many physicians affiliated with Methodist have left to go to competing hospitals, undermining Clarian’s dominant market position.

Health and medical care in the Indianapolis service area is very competitive. With population growth, will demand for cardiac services increase 20 percent over the next few years to utilize the new facilities? Will each of the heart centers perform sufficient numbers of surgeries to remain competitive? Which of the systems will be survivors in such a competitive market?

Source: Aaron Katz, Robert E. Hurley, Kelly Devers, Leslie Jackson Conwell, Bradley C. Strunk, Andrea Staiti, J. Lee Hargraves, and Robert A. Bereson, “Competition Revs Up the Indianapolis Health Care Market,” *Community Report No. 1: Indianapolis* (Washington, DC: Center for Studying Health System Change, Winter 2003) and Michelle Rogers, “Cardiovascular Services: Heart Race,” *HealthLeaders* (January 28, 2004) at <http://www.healthleaders.com/magazine/cover>.

Learning Objectives

After completing this chapter the student should be able to:

1. Understand the importance of service area competitor analysis as well as its purpose.
2. Understand the relationship between general and health care environmental issue identification and analysis and service area competitor analysis.
3. Define and analyze the service area for a health care organization or specific health service.
4. Conduct a service area structure analysis for a health care organization.
5. Understand strategic groups and be able to map competitors' strategies along important service and market dimensions.
6. Understand the elements of service area competitor analysis and assess likely competitor strategies.
7. Aggregate general environmental and health care industry issues with service area and competitor issues and synthesize specific strategy implications.
8. Suggest several questions to initiate strategic thinking concerning the service area and competitors as a part of managing the strategic momentum.

Further Focus in External Environmental Analysis

Environmental analysis involves strategic thinking and strategic planning, focusing on increasingly more specific issues. Chapter 2, "Understanding and Analyzing the General Environment and the Health Care Environment," provided the fundamental approach and strategic thinking frameworks for scanning, monitoring, forecasting, and assessing trends and issues in the environment. However, once the general and industry trends and issues in the external environment have been identified and assessed, a more specific analysis is required. As shown in Exhibit 2-1, service area competitor analysis is the third part of a comprehensive environmental analysis. *Service area competitor analysis* attempts to further define and understand an organization's environment through identifying specific service area/service category issues, identifying its competitors, determining the strengths and weaknesses of these rivals, and anticipating their strategic moves. It involves collecting data concerning the service area and rivals to analyze and interpret the data for strategic decision making.¹

The Service Area

The *service area* is considered to be the geographic area surrounding the health care provider from which it pulls the majority of its customers/patients. It is usually

limited by fairly well-defined geographic borders. Beyond these borders, services may be difficult to render because of distance, cost, time, and so on. Therefore, a health care organization must not only define its service area but must also analyze in detail all relevant and important aspects of the service area, including economic, demographic, psychographic (lifestyle), and disease pattern characteristics.²

The service area is defined by customers' preferences and the health care providers that are available. Certainly, the consumer has become empowered by the amount of information available concerning disease conditions and providers (see Perspective 3-1). Exhibit 3-1 shows the determinants of a service area

Perspective 3-1

The Empowered Patient – Challenge and Opportunity

The empowered patient has become a significant presence in the health care environment and a challenge for health care organizations. With confidence gained from Internet access and media exposure, the patient often has an opinion and may not appreciate the paternalistic style of health care delivery, no matter how well-intentioned. "Informed" consumers expect to be participating partners in their own health care and when their families need care.

There is an upside to this challenge. Fully informed patients who participate in the decision process are more likely to be satisfied with their care and to adhere to the treatment advice.¹ Treatments will reflect patient preferences and values. Patient expectations will be knowledge-based. The challenge is to make sure that the patient's information is based on good evidence.

To become a fully informed and participating partner, a patient must experience the following process: (1) The patient must obtain an accurate understanding of the risks or seriousness of the condition. (2) The patient must understand the risks, benefits, and uncertainties of the treatment under consideration and the alternatives. (3) The patient must have weighed his or her values as they relate to the potential harm and benefit of the treatment. (4) The patient must have had the opportunity to participate in the decisionmaking process at whatever level he or she desires.²

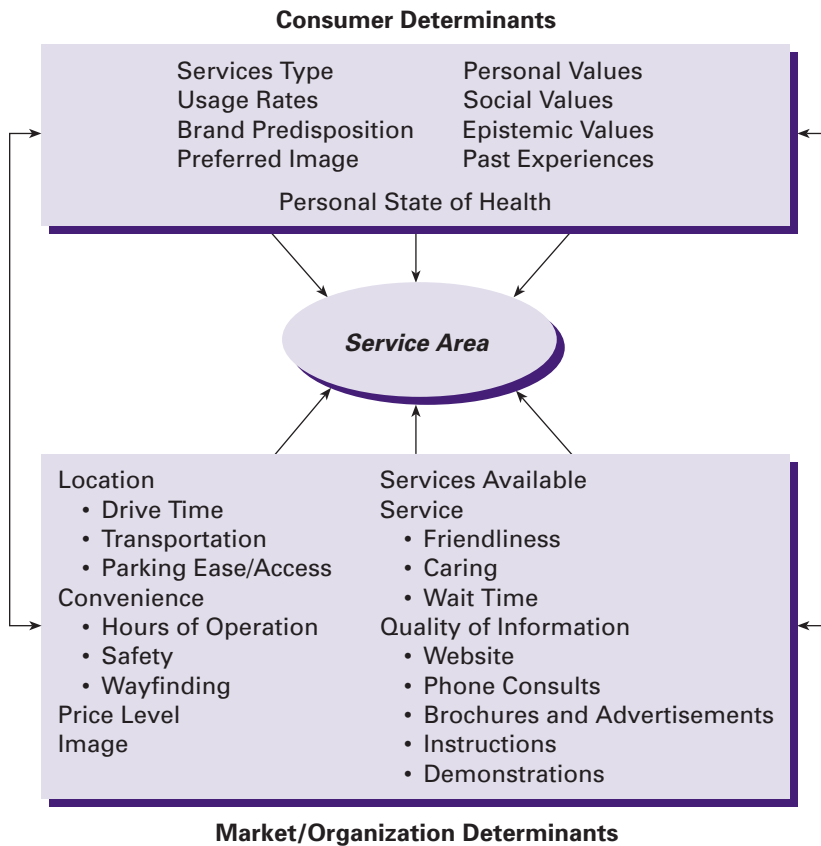
Health care providers may see this task as unreasonable in the face of reduced reimbursements and the pressure to streamline care. However, failure to ensure that the patient is fully informed will leave a void to be filled by other suppliers of information. Such information may be poorly researched or subtly biased to serve ulterior motives. Providers who succeed in this educational endeavor will gain their patient's trust and loyalty. The power of this approach can be seen on the web page of Cancer Treatment Centers of America. Their message presents their model of "Patient Empowered Medicine" as an argument for choosing their centers over the more traditional medical center.

As patients are asked to face higher deductibles and cost sharing of premiums, this empowerment phenomenon seems even more appropriate. Providers need patients to be active partners in the redesign of a delivery system that is more efficient and is available to everyone. The empowered patient should fit well into the health care system of tomorrow.

Notes

1. R. Grol, "Improving the Quality of Medical Care: Building Bridges Among Professional Pride, Payer Profit, and Patient Satisfaction," *JAMA* 286, no. 20 (2001), pp. 2578-2586.
2. S. Sheridan, R. Harris, and S. Woolf, "Shared Decision Making About Screening and Chemoprevention," *American Journal of Preventive Medicine* 26, no. 1 (2004), pp. 56-66.

Source: Edmond F. Tipton, MD, MBA, and PhD student, University of Alabama at Birmingham.

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Exhibit 3–1: Service Area Determinants


including the consumer variables and the market (provider) variables. For the consumer, the services need could include health care that is preventive, diagnostic, alternative, routine, episodic, acute, or chronic. Usage rate would be related to a variety of economic, demographic, psychographic, and disease pattern variables. Brand predisposition indicates the consumer has a preference for some health care providers over others. For example, if there is only one hospital in town, and the consumer does not like its “looks,” location, or perceived quality of care, he or she may prefer to drive to the nearest larger city. For routine medical care, some consumers prefer to go to specialists; others prefer a primary care doctor; still others prefer clinics that have primary care physicians and specialists; and, finally, some consumers prefer physician assistants or nurse practitioners. These different consumer preferences will be determinants in defining the service area.

Another group of consumer determinants will be related to personal factors such as personal and social values, epistemic (knowledge) values, past experiences, and the individual’s personal state of health. In concert, these variables develop the

individual's preferences for health care providers. However, if providers are not available in that there are limited or no options in the immediate area, the consumer will travel greater distances to gain the desired care.

Options or choices are controlled by the health care structure. The market and organizations within it determine what will be offered or made available to the consumer. The "market" contains health care providers in a variety of locations that bear on convenience and image. Location includes drive time from home (or, increasingly, work), availability of transportation, as well as access and parking ease. Convenience may be hours of operation, safety, availability of food, signs to assist in finding the way, and so on. Image for the market entails positioning among the various providers. The health care provider might have the image of being more caring, friendlier, or more high-tech; or it may be perceived as attracting desirable or undesirable demographic, socioeconomic, or ethnic groups. The organization itself has an image of the services (health care provided) as well as the service and the quality of information provided. Location, convenience, and image are all in relationship to the other providers in the area, including those within driving distance and those that are remote but perceived as providing better quality, further services, or other desirable characteristics. Health care providers make these decisions, in part, based on their understanding of consumers' needs and wants.

Managed care interrupts the normal decision making by consumers. An employed individual today usually has some choice in health care insurance. The employer may offer one or more different health plans. However, once the consumer has selected a managed care plan, the ability to choose providers – both hospitals and physicians – becomes more restrictive. And, in fact, the more the HMO attempts to control health care costs by further structuring health care delivery, the more restricted the choice becomes for consumers. Restricted choice is not favored by most Americans and they have been quite vocal about it with their employers. The result is that many employers are only willing to commit to a health plan that offers choice (and thereby removes the quantity discounts previously offered) and, hence, organizations have seen health care cost increases in double digits again.

Competitor Analysis

In addition to the trends and issues associated with the service area, health care organizations must focus specifically on service area competitors. Business organizations have long engaged in competitor analysis, viewing it as an essential part of environmental analysis. These companies have learned that focusing on competitor analysis aids in the identification of new business opportunities, the clarification of emerging ideas, improved ability to anticipate surprises, and the development of market penetration and market share growth strategies.³ As a matter of fact, one well-documented reason Japanese automobile firms were able to penetrate the US market successfully, especially during the 1970s, was that they were much better at doing competitor analysis than US firms.⁴ For business organizations the task of understanding the industry and specific competitors is

a challenge; it is far more difficult for health care organizations because consumers will travel great distances for some kinds of care. For example, people from around the world travel to the Mayo Clinic in Rochester, Minnesota for care.

In the past, general environmental and industry analysis were sufficient for most health care organizations. General and health care industry technological, social, political, regulatory, economic, and competitive issues provided enough information to make most strategic decisions. Service area competitor moves and countermoves were not that important. However, during the past decade, because of fundamental changes within the industry brought about by the influences of managed care, efforts to reduce costs and increase efficiency, and the increased presence of for-profit health care organizations, every segment of the industry has become highly competitive. Certainly, as suggested in the Introductory Incident, aggressive competition has entered the health care market in Indianapolis.

CHALLENGES FOR THE HEALTH CARE MARKET

Analyzing this new competitive environment is difficult for health care organizations for a variety of reasons. Perhaps most obvious is that in the recent past very few health care organizations were concerned with competition. In fact, those in the “helping professions” believed there was no need to compete. Hospitals, long-term care facilities, and physicians were more concerned with trying to meet the demand for their services. This history of noncompetition changed when legislation led to an increased number of hospital beds and an increased number of physicians (particularly within certain specialties). Eventually, the oversupply led to a more competitive environment. As discussed in Perspective 3–2, in health care, competition has occurred between health plans, health care networks, and hospital systems when perhaps health care organizations should instead compete on specific disease treatment and outcomes.

Another major reason for the lack of competitor analysis within health care is that the separation of consumers of health services (patients) from payors (insurance companies and employers) provided few checks on the system. When all the health care providers in a service area were well paid by insured patients, increasingly higher costs for more and more services provided to insured as well as uninsured patients were passed on to the insured patients. This “cost shifting” became a major concern in the tight economy of the early 1990s, and again in the first years of the twenty-first century, because employers paid for most insurance coverage for their employees. When US companies felt they could no longer be competitive in world markets because of high health care costs, they began searching for ways to decrease the burden. They brought pressure on health care providers to reduce costs and began focusing on price competition. Employers began requiring employees to pay a higher portion of the health care costs (higher premiums, co-pays, and then higher co-pays) and businesses became increasingly interested in “managing health care.”

The philosophy of managed care was that by controlling consumer choice to a limited number of providers, greater buying power was achieved through economies of scale. When patients’ choices of hospitals or physicians were

Perspective 3–2

Redefining Competition in Health Care

According to Michael Porter and Elizabeth Teisberg, in healthy competition: ongoing improvements in processes and methods drive down costs; product/service quality improves; innovation leads to improvements which are quickly adopted; uncompetitive producers go out of business; value-adjusted prices fall; and the market expands. However, in health care: costs are high and rising, despite efforts to reduce them; rising costs are not the direct result of improvements in quality; medical services are restricted (rationed to those who can pay); patients receive care that is not the current accepted practice; and high rates of medical error continue. In addition, considerable variation in cost and quality occurs among providers and across geographic areas. Diffusion of best practices takes, on average, 17 years to become standard practice.

Clearly the health care system is broken but the authors do not advocate that government takes over and “solves” the problem. Rather, they suggest that business could cause changes to occur if employers were to insist on competition occurring at the right level. For Porter and Teisberg, problems in health care occur because the competition is at the level of health plans, networks, and hospital systems whereas the “right level” is competition to care for the various health conditions or diseases. If providers competed directly across a broad geographic area for cardiac patients, for example, businesses would pay a premium for best results. The provider with the best results would attract patients and would be imitated quickly or the other providers (who did not achieve good results) would end up with no patients. Currently, hospitals and physicians are paid to provide care for the citizens in a service area regardless of the quality of outcomes.

According to the authors, wrong forms of competition include:

- Annual competition among health plans to sign subscribers (effectively blocking competition at the disease level);
- Deep discounting to payors/employers with large patient populations (it does not cost less to treat a patient employed by a large business versus a small one);
- Provider concentration that does not create patient value but boosts bargaining power;
- Cost shifting that creates no patient value;
- Local competition insulating mediocre providers and inhibiting the use of best practices;
- Suppressing information that would enable patients to choose the best provider (many providers do not even make available how many patients they have treated for a specific disease/condition);
- Incentives for payors to enroll healthy people and deny coverage to sick people (and complicate the billing process); and
- Not referring to other providers with more experience.

Porter and Teisberg believe positive competition occurs when:

- Providers develop distinctivenesses (create unique value);
- No restrictions are placed on patients’ selection of providers;
- Pricing is transparent;
- Billing is simplified;
- Information is easily accessible and comparable;
- Non-discriminatory insurance underwriting is available (large risk pools for small businesses);
- Fewer lawsuits reduce defensive medicine; and
- Minimum levels of coverage are offered.

Companies have purchased health care on the basis of cost not quality. If employers were to refocus their goals to have healthy employees, they would buy health care differently. Competition would be efficient – the best providers would thrive and those delivering inferior service would go out of business.

Source: Michael E. Porter and Elizabeth O. Teisberg, “Redefining Competition in Health Care,” *Harvard Business Review* 82, no. 6 (June 2004), pp. 65–76.

limited, strong competition emerged among health care providers for the managed care organization's insured group. Physicians, notably primary care physicians, became "gatekeepers" into the system and attempted to direct patients to only one hospital to obtain the best possible rates. Hospitals "competed" for these desirable contracts.

In the first decade of the twenty-first century, managed care has produced considerable backlash from physicians, who do not want managed care "bureaucrats" telling them how they should practice medicine, and from consumers, who want choices. Some state legislatures have enacted laws dictating to HMOs the minimum length of stay for various diseases and conditions. The federal government and several state legislatures are investigating a patient's bill of rights. Exclusive contracts have been replaced by greater choice for employees by employers – multiple health plans to choose from – and greater choice within a specific plan – the option to go outside the plan to seek care from a specific physician who might not be a member of that particular plan. The result, according to the *Interstudy Competitive Edge Report 4.0*, is that HMO enrollment has declined from around 80 million in 1999 to less than 72 million in 2003.⁵

STRATEGIC SIGNIFICANCE OF COMPETITOR ANALYSIS

Within the health care community there is a growing understanding that health care organizations must be positioned effectively vis-à-vis their competitors. Competitor information is essential for selecting viable strategies that position the organization strongly within the market. Many health care managers agree that an organized competitor intelligence system is necessary for survival. The system acts like an interlinked radar grid constantly monitoring competitor activity, filtering the raw information picked up by external and internal sources, processing it for strategic significance, and efficiently communicating actionable intelligence to those who need it.⁶

The pharmaceutical industry makes extensive use of competitive intelligence gathering – estimates are that more than \$20 billion per year is used on government filings, trade news, and market research. A number of services, such as DRUGLAUNCH, DRUGNL, and DRUGUPDATES provide information on R&D activities, new product launches, and patent analysis for the US market as well as around the globe.⁷ Others, such as PHAR (Pharmaprojects) and PHIN (Pharmaceutical and Healthcare Industry News), provide information on new product development in major markets worldwide through publications and prepublication news. A relatively new competitive intelligence company, Skila (named after Dustin Hoffman's secret agent brother in *Marathon Man*), goes beyond data gathering to information analysis (see Perspective 3–3).

The Focus of Competitor Analysis

An organization engages in *competitor analysis* to gain a general understanding of the competitors in the service area, identify any vulnerabilities of the competitors,

Perspective 3–3

Skila Is a Secret Weapon

Skila is an information services company that operates as a virtual intelligence officer by improving decision making in the pharmaceutical, medical device, and biotechnology industries. Its Internet-based information system combines all the pieces of data, sifts and sorts them, and then selects just the information that clients need to make decisions about their products and markets. Leveraging its proprietary Intelligration® technology, services, and methodology, Skila integrates all relevant information and people into a *Single Touch Point* (Skila's term for a sophisticated database accessible by all members of a team, department, group, or organization) to deliver the right information, to the right people, at the right time, for commercialization processes. By providing fast and easy access to up-to-date, dynamic, and relevant knowledge to brand management (improving the coordination across subteams), alliance management (enabling alliance partners to function as a single fast, agile, and effective team), medical teams (helping build and maintain the support of opinion-leading physicians with local, regional, national, and global influence), and managed markets (creating access and coordinating pull-through), Skila offers technology that rapidly brings together a variety of information and people relevant to the achievement of the organization's objectives.

Skila's strategic advantage is well-packaged information and a delivery system full of "bells and whistles" to create its Intelligration® platform. The system seeks and automatically integrates information from Skila's proprietary research, a client's own databases and computer banks, and third-party sources such as Lexis/Nexis, Edgar, and Medline. Intelligration® summarizes huge amounts of data and then consolidates, categorizes, and organizes all relevant information based on the client's requirements. The client's team is able to find the precise information needed to make effective business decisions by aligning objectives and increasing the speed of access to relevant knowledge. The system sends the data through various tags, filters, and matching programs to develop what lands on the client's desk – a comprehensive but tightly focused report on, for example, treating psoriasis, that is delivered electronically in the morning and added to or updated daily until the decision maker feels that he or she can develop closure.

Skila's service offers three benefits:

1. One-stop shopping for information;
2. Content determined by the client's business needs; and
3. Information delivered directly to decision makers.

Skila's service offers time and money savings as well as better intelligence to provide "knowledge for the business of health care."

Source: Company sources.

assess the impact of its own strategic actions against specific competitors, and identify potential moves that a competitor might make that would endanger the organization's position in the market. Analyzing competitors assists organizations in identifying a clear *competitive advantage* – some basis on which they are willing to compete with anyone. Competitive advantage is the means by which the organization seeks to develop cost advantage or to differentiate itself from other organizations. Organizations constantly take offensive and defensive actions in their quests for competitive advantage vis-à-vis competitors.⁸ Competitive advantage might be centered on image, high-quality services, an excellent and widely recognized staff, or efficiency and low cost, among others.

It is useful to classify competitor information as general, offensive, and defensive. This classification system will aid in strategy development.

General competitor information is important for an organization to:

- avoid surprises in the marketplace;
- provide a forum for leaders to discuss and evaluate their assumptions about the organization's capabilities, market position, and competition;
- make everyone aware of significant and formidable competitors to whom the organization must respond;
- help the organization learn from rivals through benchmarking (specific measures comparing the organization with its competitors on a set of key variables);
- build consensus among executives on the organization's goals and capabilities, thus increasing their commitment to the chosen strategy; and
- foster strategic thinking throughout the organization.

Offensive competitor information is helpful to:

- identify market niches and discontinuities,
- select a viable strategy, and
- contribute to the successful implementation of the strategy.

Defensive competitor information will aid in:

- anticipating competitors' moves, and
- shortening the time required to respond (countermoves) to a competitor's moves.

Depending on the intent of the competitor analysis, an organization might use all of these categories or just one or two. For example, in the early stages of competitor analysis, the organization may seek only general information. As an organization plans to enter new markets, offensive information may be the primary focus of the competitor analysis. In the face of strategic moves by a powerful competitor, defensive information may take precedence. In large, complex markets, all of these information categories are appropriate and essential for positioning the organization.

Impediments to Effective Competitor Analysis

Monitoring the actions and understanding the intentions of competitors is often difficult. Health care executives agree that it is necessary and growing in importance, yet they are still not doing effective competitor analysis. Six common impediments or "blind spots" have been identified that slow an organization's response to its competitors' moves or even cause the selection of the wrong competitive approach. Flawed competitor analysis, resulting from these blind spots, weakens an organization's capacity to seize opportunities or interact effectively with its rivals, ultimately leading to an erosion in the organization's market position and profitability.⁹ The six impediments to effective competitor analysis include:

- misjudging industry and service area boundaries,
- poor identification of the competition,
- overemphasis on competitors' visible competence,
- overemphasis on where, rather than how, to compete,
- faulty assumptions about the competition, and
- paralysis by analysis.¹⁰

CLEARLY DEFINED SERVICE AREA

A major contribution of competitor analysis is the development of a clear definition of the industry, industry segment, or service area. To avoid a focus that is too narrow, the industry, industry segment, and service area must be defined in the broadest terms that are useful. In today's health care environment, competition may come from very nontraditional competitors (outside the health care industry). For instance, based on their experience in the hotel business, the Marriott Corporation entered the long-term care and retirement center markets. Utilizing its expertise in accommodations management, Marriott created Senior Living Services in 1984. In 2000, the corporation had 144 senior living communities in 29 states with others under development. Marriott's mission statement for its Senior Living Centers is summed up in two words: "We Care." Accommodations for independent and assisted living, Alzheimer's and other memory loss disorders, and nursing care were provided.¹¹ However, by mid-2003, Marriott had concluded that even independent senior living centers were not part of its core competency and sold Senior Living Services to Sunrise Senior Living and a number of its properties to CNL Retirement Properties, Inc. The total sale amounted to almost \$350 million. In the past, multihospital systems and nursing home chains dominated this industry segment. As competition increases from nontraditional competitors, social activities, décor, meals, and housekeeping may become more important competitive factors.

Typically, health care managers have focused their analysis on locally served markets. Patients were treated by the local doctor, in a local hospital (or the closest one available). There was little travel for medical or health care. Thus, doctors and hospitals were insulated from other health care organizations outside their geographic service area; however, that is no longer the case. Market entry by competitors from outside the metropolitan area, the region, or the state is now quite common. For example, expansion by multihospital for-profit systems such as HCA—The Healthcare Company (formerly Columbia/HCA) and Tenet represent serious new competitive challenges in many markets. MedCath has built specialty hospitals in a number of markets for cardiac care. Nationally recognized clinics, such as the Mayo Clinic and the Cleveland Clinic, have expanded to locations in Florida and Arizona. A health care organization that maintains a local or regional focus may be delayed in recognizing changes in the service area boundaries.

COMPETITOR IDENTIFICATION

Often, only cursory attention is given to other segments of the health care industry. Hospitals traditionally focused on acute care. They were not concerned with intermediate care or home care as a competing segment. Yet, because of length-of-stay issues, patients have been sent to an intermediate care or home

care situation outside the hospital's purview, which increased revenues to those organizations and decreased the hospital's revenues. For hospitals to survive, integrated delivery systems, seamless care, and continuum of care emerged. As a result there are fewer but more direct competitors in many market areas today. Clearly, misjudging how the industry, industry segments, or service area is defined will lead to poor competitor analysis.

Another possible flaw of competitor analysis is the improper or poor identification of precisely which organizations are the competitors. In many cases, health care executives focus on a single established major competitor and ignore emerging or lesser-known potential competitors. This is especially true when the perceived strengths of competitor organizations do not fit traditional measures or there is an inflexible commitment to historical critical success factors (traditional inpatient services instead of outpatient approaches). Academic medical centers, with their focus on research, have traditionally viewed only other academic medical centers as competitors. However, with the impact of managed care and lowered reimbursements, some of them are in real danger of having to close.

INFORMATION ABOUT COMPETITORS

Another problem in performing competitor analysis is the tendency to be concerned only with the visible activities of competitors. Less visible attributes and capabilities such as organizational structure, culture, human resources, service features, intellectual capital, management acumen, and strategy may cause misinterpretation of a competitor's strengths or strategic intent. Certainly the Mayo Clinic's strong culture of excellence has played an important role in shaping its strategic decisions. Similarly, in an environment of rapid change, intellectual capital represents a primary value creation asset of the organization.¹² In addition, effective competitor analysis requires predicting how competitors plan to position themselves. Although often difficult, determining competitors' strategic intent is at the heart of competitor analysis. An effective competitor analysis should focus on what rivals can do with their resources, capabilities, and competencies – an extension of what competitors are currently doing – and include possible radical departures from existing strategies.¹³

Accurate and timely information concerning competitors is extremely important in competitor analysis. Misjudging or underestimating competitors' resources, capabilities, or competencies is a serious misstep. Faulty assumptions can suggest inappropriate strategies for an organization. Poor environmental scanning perpetuates faulty assumptions.

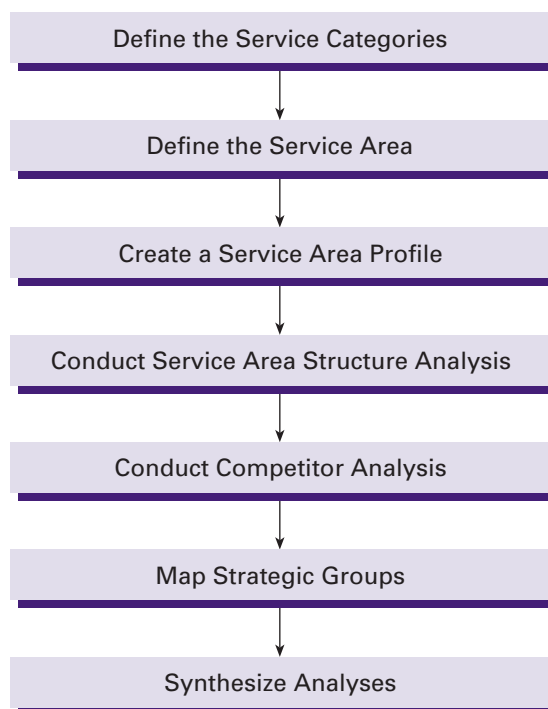
Because of the sheer volume of data that can be collected concerning the external environment and competition, paralysis by analysis can occur. In environments undergoing profound change, huge quantities of data are generated and access to it becomes easier. Under such conditions, information overload is possible and separating the essential from the nonessential is often difficult. As a result, it should be emphasized that the intent of competitor analysis is to support strategic decision making; overanalysis or "endless" analysis should be avoided. Competitor information must be focused and contribute to strategy formulation.

A Process for Service Area Competitor Analysis

Service area competitor analysis is a process of understanding the market and identifying and evaluating competitors. Together with the general and health care trends and issues, service area competitor analysis must be synthesized into the strategic issues facing the organization. The synthesis will be an explicit input into the formulation of the organization's strategy.

As illustrated in the strategic thinking map in Exhibit 3–2, service area competitor analysis begins with an understanding and specification of services or service categories the organization provides to its customers. Next, the service area must be specified for the various services or service categories. Then the service area structure or competitive dynamics should be assessed. Competitors providing services in the same category in and around the service area must be analyzed. Each of the organizations can be positioned against the important dimensions of the market and assessed as to their likely strategic moves. Finally, the results of the analysis must be synthesized and implications drawn. These conclusions will provide important information for strategy formulation.

Exhibit 3–2: Service Area Competitor Analysis



Defining the Service Categories

The first step in service area competitor analysis is to specify the *service category* to be analyzed. Many health care organizations have several service categories or products, and each may have different geographic and demographic service areas. For a multihospital chain deciding to enter a new market, the service category may be defined as acute hospital care, but for a rehabilitation hospital, the service category might be defined as physical therapy or occupational therapy or orthopedic surgery. In addition, because many health care services can be broken down into more specific subservices, the level of service category specificity should be agreed on before analysis begins. For example, pediatric care may be broken down into well-baby care, infectious diseases, developmental pediatrics, pediatric hematology-oncology, and so on. Certainly pediatric hematology-oncology as a service category would have a far larger service area than well-baby care. A parent with a child who has cancer would travel farther for care from a specialist than a parent who sought well-baby care available from nurse practitioners.

Another example of a service that requires a clear definition is the subacute care segment. Subacute care, sometimes termed the middle ground of health care, provides services for those patients who no longer require inpatient acute care, but need a higher level of care than can be provided in a skilled-nursing facility or through home care. There are multiple ways to segment this market that includes diverse post-acute care and rehabilitation services. An organization could select one or a combination of services to offer within subacute care. For example, Vencor, Inc., founded in 1985, provides long-term care and rehabilitation services through 295 nursing centers in 31 states. It grew rapidly by purchasing Hillhaven Corporation, a traditional supplier of long-term care; TheraTx, a provider of rehabilitation and respiratory therapy program management services to nursing centers; and Transitional Hospitals, providers of care for ventilator-dependent patients. By combining these service categories the company focused on treatment programs for patients with complex medical conditions. However, its strategy was not very successful: Vencor filed voluntary reorganization under Chapter 11 in September 1999. In third quarter 2000, Vencor reported a loss of \$27 million or \$0.38 per share compared with a loss of \$42 million or \$0.61 per share in third quarter 1999.¹⁴ Vencor emerged from the reorganization in April 2001 and changed its name to Kindred Healthcare. The 52-week high for its stock in 2002 was \$49.78 but in 2003 the price fell below \$20 per share. By mid-2004 the stock had rebounded to a little over \$25 per share. Many long-term care facilities are in bankruptcy because of the impact of the Balanced Budget Act of 1997 that significantly reduced reimbursements for long-term care.

In addition, several competitor nursing home chains, such as the largest in the industry, Beverly Enterprises, with 550 facilities in 30 states and 62,878 licensed beds, and the second largest, Mariner Post-Acute Network, with over 430 facilities in 40 states and 50,686 licensed beds, have added subacute care for the chronically ill to their services offering, thereby further increasing competition for

Vencor. On the other hand, the number of seniors requiring care is projected to rise drastically in the near future. Thus, to have a clear idea of what is to be accomplished by the service area competitor analysis, it is important to first understand and define the service category, starting narrowly with direct competitors, but then expanding the category to include more indirect competitors.

Plastic surgery is a medical specialty that can be defined as a service category. However, there are additional service categories that need to be explored to determine direct and indirect competitors. For instance, reconstructive plastic surgeons often specialize on the face, dealing with congenital deformities and injuries due to trauma. Eye, ear, nose, and throat physicians as well as oral surgeons are performing some of the same procedures. Cosmetic plastic surgeons may offer a full range of services including reconstructive surgery, or they may specialize on the face, breast, or other body parts. Furthermore, they may specialize on the basis of procedures they use, such as laser or liposuction. Thus, to understand how customers perceive the organization's service category is an important determination for a beneficial service area competitor analysis.

Determining Service Area Boundaries

Understanding the geographic boundaries is important in defining the service area, but is often difficult because of the variety of services offered. In an acute care hospital, the service area for cardiac services may be the entire state or region, whereas the service area for the emergency room might be only a few blocks. Thus, for a health care organization that offers several service categories, it may be necessary to conduct several service area analyses. For example, the Des Moines, Iowa, market has two geographic components: the metropolitan area of the city as well as the suburbs of Polk County (population approximately 350,000) and the 43 primarily rural counties of central Iowa that surround the capital (population about 1 million). The opportunities and threats for each of these multiple service areas may be quite different; therefore, considerable effort is directed toward understanding and analyzing the nature of the health care organization's various service areas. At the same time, for some organizations, defining only one service category may suffice (such as in the case of a long-term care facility).

Service areas will be different for different organizations. A national for-profit hospital chain may define its service area quite generally, but even then there may be different strategies in place. For example, HCA—The Healthcare Company's strategy is to become a major health care presence in highly concentrated markets, whereas Health Management Associates' strategy is to only enter nonurban markets. An individual hospital, home health care organization, or HMO may define its service area much more specifically. In general, health services are provided and received within a well-defined service area, where the competition is clearly identified and critical forces for the survival of the organization originate. For instance, hospitals in rural areas have well-defined service areas for their particular services. These hospitals must be familiar with the needs of the population and with other organizations providing competing services. Some of the competitive

Perspective 3–4

Small Community Hospitals Can Compete

Small community hospitals face a number of challenges. They cannot offer the depth and breadth of physician subspecialties and clinical professionals as academic medical centers and integrated health care systems. They face considerable patient out-migration to larger competitors in nearby or distant markets, especially when consumers with the desire and means to shop around perceive that the local provider offers low quality. In addition, small community hospitals often are weaker financially because

they have limited access to capital, they have a larger proportion of underinsured and uninsured to treat, and they encounter diseconomies of scale because of lower patient volumes. Yet small community hospitals do have their own strengths and can compete effectively with academic health centers and larger health care networks for services that are appropriately delivered in the community hospital setting. Bigger is not always better.

Today, there is considerable evidence that the customer is beginning to drive health care. Customers are exercising considerable influence over the selection, purchase, and use of health care products and services. Forces contributing to consumer-directed health care include the number of baby boomers aging into retirement, higher education levels and greater access to medical and health care information through the Internet, advances in technology and science (accompanied by consumer expectation to access the latest innovations in pharmaceuticals and treatments), public pressure to scrutinize provider quality and patient safety, and the shifting of more of the risk and burden for health care to consumers through higher co-pays, defined contribution plans, and other financial incentive plans. In addition, pay-for-performance initiatives are developing among government, employers, and insurers. Measures of quality performance are required for many of these initiatives and provider “scorecards” are increasingly available.

All hospitals are facing increased expectations to deliver quality care. Quality is definitely an issue given:

- According to the Institute of Medicine reports, between 44,000 and 98,000 Americans die annually from medical error;¹
- Only 55 percent of patients sampled from 12 metropolitan areas received recommended care, whether for acute episodes, chronic conditions, or prevention;²
- The lag between the discovery of more effective treatment and incorporation into routine patient care is 17 years;³
- The Institute of Medicine reports that 18,000 Americans die each year from heart attacks because they did not receive preventative medications for which they were eligible;⁴
- The Institute of Health reports that more than 50 percent of patients with diabetes, hypertension, tobacco addiction, hyperlipidemia, congestive heart failure, asthma, depression, and chronic fibrillation are currently managed inadequately.⁵

According to consultants with The Strategy Group (TSG), “Academic medical centers and large clinically advanced hospital systems often draw headlines and build brand reputations with miraculous medical breakthroughs that most health care consumers are fortunate enough to never need. This is not the arena in which community and rural hospitals should, or can, compete.” They point out that the health care needs and illnesses of many consumers can be treated and managed in the small community hospital. For example, diabetes, pneumonia, heart attack, and heart failure can be treated locally through the adoption and application of evidence-based standards of medicine. A smaller facility that adheres to standards and objective measures of performance can stand up against a larger competitor.

For the most part, the standards of care reporting requirements are not focused on rare or complex surgeries and procedures; nor do they require extensive investment in staff and technology. For instance, evidence-based protocols for acute myocardial infarction include aspirin on arrival, aspirin prescribed at

discharge, beta-blocker on arrival, beta-blocker prescribed at discharge, and ACE inhibitor for left ventricular systolic dys-function. Over time, a small community or rural hospital can adhere to the standards and objective measures and perform better than many larger competitors. In this situation, a smaller hospital is not necessarily at a disadvantage because a larger hospital with “failing grades” will struggle more to turn it around than a small hospital that is quick to grasp the opportunity to do what it does very well.

The authors conclude, “Embracing targeted clinical excellence is likely to be the most important initiative of the decade for community hospitals. Success will be defined by the speed and scope of clinical improvement, physician participation/commitment to the strategy, and then the organization’s ability to create customer preference for superior care.” A community hospital will need to achieve clinical excellence and then market it to an ever more educated health care consumer. Consumers want quality care and prefer to stay in their community if they can receive it there.

Notes

1. Linda Kohn, Janet M. Corrigan, and Molla S. Donaldson (eds) *To Err is Human: Building a Safer Health System* (Washington, DC: Committee on Quality of Health Care in America, Institute of Medicine, 2000).
2. Elizabeth McGlynn, Steven M. Asch, John Adams, Joan Keesey, Jennifer Hicks, Alison DeCristofaro, and Eve A. Kerr, “The Quality of Health Care Delivered to Adults in the United States,” *New England Journal of Medicine* 348, no. 26 (June 26, 2003), pp. 2635–2646.
3. E. Andrew Balas, “Information Systems Can Prevent Errors and Improve Quality,” *Journal of the American Informatics Association* 8, no. 4 (July–August 2001), pp. 398–399.
4. Karen Adams and Janet M. Corrigan (eds) *Priority Areas for National Action: Transforming Health Care Quality* (Washington, DC: Committee on Identifying Priority Areas for Quality Improvement, Institute of Medicine, 2003).
5. Institute of Health 2003 and *Sixth Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure* (Washington, DC: National Institutes of Health, November 1997).

Source: Karen V. Corrigan and Robert H. Ryan, MD, “Community Hospitals Can Leverage Unique Strengths to ‘Raise the Quality Bar’ in their Market,” *COR Healthcare Market Strategist* 5, no. 8 (August 2004), pp. 1, 21–24.

challenges of small community hospitals are discussed in Perspective 3–4. Similarly, the service areas for public health departments vary within a state, depending on whether they are metropolitan or rural, and may suggest quite different opportunities and threats.¹⁵

Determining the geographic boundaries of the service area may be highly subjective and is usually based on patient histories, the reputation of the organization, available technology, physician recognition, and so on. In addition, geographic impediments such as a river, mountains, and limited access highways can influence how the service area is defined. The definition of communities (see Perspective 3–5) is often helpful in determining a service area.

SERVICE AREA PROFILE

Once the geographic boundaries of the service area have been defined, a general service area profile should be developed. Capturing the dimensions of a service area requires tapping and synthesizing information from various sources:

- both quantitative and qualitative data for framing and understanding a service area;

- population-based health status data (specifics of the various health dimensions of an entire population and its subgroups); and
- health services utilization data (specifics on the patterns and frequency of health service use for various health conditions by different groups of individuals in the population).¹⁶

Perspective 3–5

What Is a Community?

Community is a very important concept in public health as well as health care policy, planning, and management. In general parlance, a community refers to a group of people living together in a defined place; the place could be a neighborhood, a rural village, an urban area or an entire country. In addition, community implies a collective group of individuals who share some feature in common, be it a profession (the scientific community), a religion (the Jewish community), or some other characteristic (the gay community; the Hispanic community).

The public health community (a group of professionals who share a common purpose) spends considerable effort monitoring the health of communities (groups of people living together in geographic communities within states and nations) because of its interest in promoting and preserving the health of entire populations. Within the health care community, issues relating to the larger community within which health care organizations do business must be critically examined and either accommodated or exploited to promote successful health care outcomes.

In this context, the community represents the competitive environment within which health care organizations function, while also representing a set of community factors – values, needs, resources, and constraints – that may suggest modifications to a typical health care structure or a usual set of services arranged and delivered. The *competitive environment* as community would include such factors as availability of and access to care, available financing strategies, the ways in which resources are allocated, and systems of accountability.

Examples of *community factors* that can affect health care organizations include:

1. The level (federal, state, local) and scope of governmental entities that regulate the health system and the extent of regulation directed at health care organizations;
2. The nature and scope of professional organizations that set standards, accredit or otherwise engage in accountability functions for health care organizations;
3. The nature and scope of health care financing agencies, including purchasers and private and public insurers, that participate in the health care marketplace in the community;
4. The availability of health care providers, facilities, supplies, and ancillary services across the community; and
5. The characteristics of the populations ultimately paying for and receiving health care services. These characteristics could include socioeconomic status (education, occupation and income), race and ethnicity, family structure, health status, health risk, and health seeking behaviors.

A community, then, in this context, can refer to the health care community, the community of individuals served by a health care system, the physical community within which the individuals reside and the health system functions, and the competitive environment within which any given health care organization operates. Identifying and considering the community of interest (service area) facilitates strategic planning and strategic management of health care organizations.

Source: Donna J. Petersen, MHS, ScD, Dean, College of Public Health, University of South Florida.

The *service area profile* includes key competitively relevant economic, demographic, psychographic (lifestyle), and community health status indicators. Relevant economic information may include income distribution, major industries and employers, types of businesses and institutions, economic growth rate, seasonality of businesses, unemployment statistics, and so on. Demographic variables most commonly used in describing the service area include age, gender, race, marital status, education level, mobility, religious affiliation, and occupation.

Psychographic variables are often better predictors of consumer behavior than demographic variables and include values, attitudes, lifestyle, social class, or personality. For example, consumers in the service area might be classified as medically conservative or medically innovative. Medical conservatives are only interested in traditional health care – drugs, therapies, and diagnostics they are familiar with – whereas medically innovative individuals are willing (often eager) to try new alternative drugs, therapies, or diagnostics. Although medically independent individuals are high in self-esteem and assertiveness, often questioning one physician's diagnosis and seeking a second opinion, medically dependent individuals follow what the doctor prescribes exactly and would never think of questioning "doctor's orders."

Health status of the service area is also important in considering its viability, as disease may be related to age, occupation, environment, or economics. Health status includes all types of data normally considered to represent the physical and mental well-being of a population. Demographic, psychographic, and health status information should be included in the analysis only if it is competitively relevant. Possible variables in developing a service area profile are summarized in Exhibit 3–3.¹⁷ These variables produce issues that must be integrated and considered in conjunction with the general and health care environmental issues.

Service Area Structural Analysis

Harvard's Michael E. Porter developed a five forces framework for analyzing the external environment through an examination of the competitive nature of the industry. *Service area structural analysis* provides considerable insight into the attractiveness of an industry and provides a framework for understanding the competitive dynamics (the future viability of an industry). Porter's five forces framework has been applied to industry analysis for many industries – however, because of the nature of competition in health care, it is more appropriate to apply the framework to the service category/service area. Use of Porter's five forces in health care can be referred to as service area structural analysis.

Porter suggested that the level of competitive intensity within the industry is the most critical factor in an organization's environment. In Porter's model, intensity is a function of the threat of new entrants to the market, the level of rivalry among existing organizations, the threat of substitute products and services, the bargaining power of buyers (customers), and the bargaining power of suppliers.¹⁸ The strength and impact of these five forces must be carefully monitored and assessed to determine the viability of the service category today

Exhibit 3–3: Service Area Profile Variables

Economic

- Income Distribution
- Foundation of the Economy
- Major Employers
- Types of Businesses
- Growth Rate
- Seasonality
- Unemployment

Demographic

- Age Profile
- Gender Distribution
- Average Income
- Race Distribution
- Marital Status
- Education Level
- Religious Affiliation
- Population Mobility
- Stage in Family Life Cycle
- Occupational Mix
- Residence Locations

Psychographic

- Medical Conservatives
- Medical Innovators
- Medical Dependents
- Personal Health Controllors
- Youthfulness
- Sociability

Health Status Indicators

- Mortality
- Deaths from all causes per 100,000 population

- Motor vehicle crash deaths per 100,000 population
- Suicides per 100,000 population
- Female breast cancer deaths per 100,000 population
- Stroke deaths per 100,000 population
- Cardiovascular deaths per 100,000 population
- Work-related injury/deaths per 100,000 population
- Lung cancer deaths per 100,000 population
- Heart disease deaths per 100,000 population
- Homicides per 100,000 population
- Infant deaths per 1,000 live births

Notifiable Disease Incidence

- AIDS incidence per 100,000 population
- Tuberculosis incidence per 100,000 population
- Measles incidence per 100,000 population
- STD incidence per 100,000 population

Risk Indicators

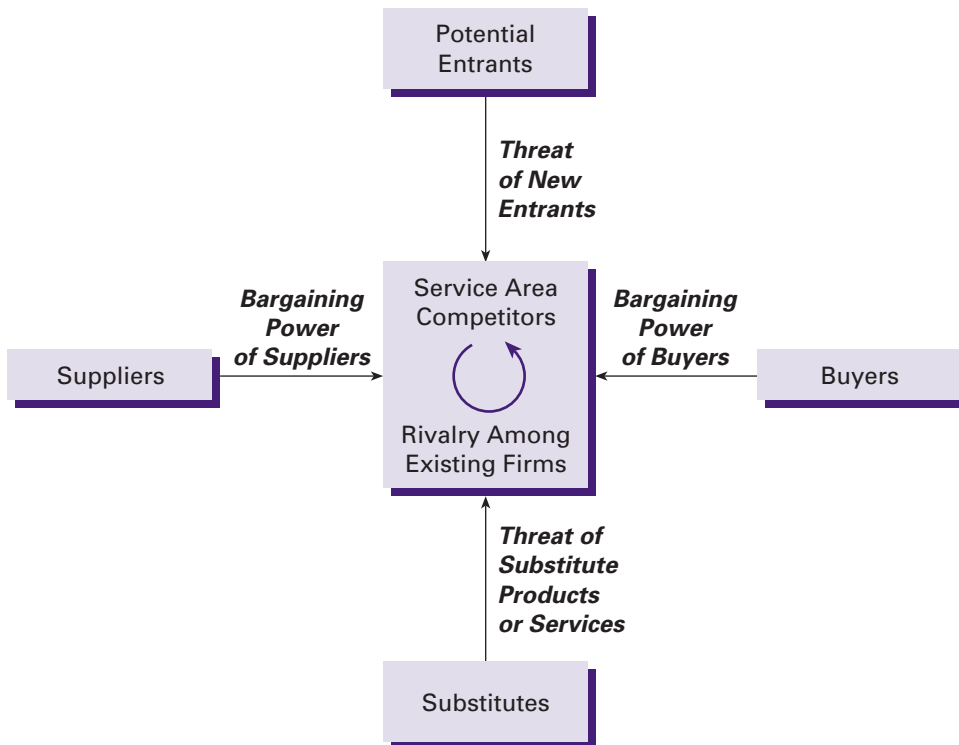
- Percentage of live-born infants weighing under 2,500 g at birth
- Births to adolescents as a percentage of live births
- Percentage of mothers delivering infants who received no prenatal care in first trimester of pregnancy
- Percentage of children under 15 years of age living in families at or below the poverty level
- Percentage of children under 15 years of age without all childhood inoculations
- Percentage of women over 50 without a mammogram
- Percentage of population more than 50 pounds overweight
- Percentage of persons living in areas exceeding the US EPA air quality standards
- Percentage of persons who do not wear seatbelts

and may be used to assess the changes likely to occur in the future. As illustrated in Exhibit 3–4, Porter’s industry structural analysis may be adapted to service areas to understand the competitive forces for health care organizations.

THREAT OF NEW ENTRANTS

New entrants into a market are typically a threat to existing organizations because they increase the intensity of competition. New entrants may have substantial resources and often attempt to rapidly gain market share. Such actions may force prices and profits down. The threat of a new competitor entering into

Exhibit 3–4: Service Area Structural Analysis: Forces Driving Service Area Competition



Source: Michael E. Porter, *Competitive Strategy: Techniques for Analyzing Industries and Competitors*. Copyright © 1980 by the Free Press. All rights Reserved. Adapted with the permission of The Free Press, a division of Simon & Schuster Adult Publishing Group.

a market depends on the industry or service area barriers. If the barriers are substantial, the threat of entry is low. Porter identified several barriers to entry that may protect organizations already serving a market:

- Existing organizations' economies of scale;
- Existing product or service differentiation;
- Capital requirements needed to compete;
- Switching costs – the one-time costs for buyers to switch from one provider to another;
- Access to distribution channels;
- Cost advantages (independent of scale) of established competitors; and
- Government and legal constraints.

These barriers may be assessed to determine the current or expected level of competition within an industry or service area. In health care markets, the barriers to entry for new “players” may be substantial. Consolidation (creation of large

health care systems) and system integration (control of physicians and insurers) may make entry into a particular service area difficult because of economies and cost advantages. In an effort to create cost efficiencies, managed care has had the effect of limiting the ease of entry into markets. Where managed care penetration is high, market entry by new competitors will be more difficult because switching costs for some populations are high. However, the difficulty of adding new service categories for existing organizations in a managed care market may be lessened. Service categories may be added to better serve a captured (managed care) market.

Certificate of need, or CON, laws and regulations can present significant barriers to entry in those states that have them. CON is the reason that MedCath, based in the southeast, started building heart hospitals in states in the southwestern US and Midwest, where there are no CON barriers.

INTENSITY OF RIVALRY AMONG EXISTING ORGANIZATIONS

Organizations within an industry are mutually dependent because the strategy of one organization affects the others. Rivalry occurs because competitors attempt to improve their position. Typically, actions by one competitor foster reactions by others. Intense rivalry is the result of the following factors:

- Numerous or equally balanced competitors;
- Slow industry (service area) growth;
- High fixed or storage costs;
- A lack of differentiation or switching costs;
- Capacity augmented in large increments;
- Diverse competitors – diverse objectives, personalities, strategies, and so on;
- High strategic stakes – competitors place great importance on achieving success within the industry; and
- High exit barriers.

Often consolidation has created several balanced large health care systems in a service area. For example, in the Cleveland market, consolidation has resulted in two large integrated systems with high fixed costs and extremely high strategic stakes. For some markets, consolidation has resulted in competition between large for-profit and not-for-profit systems. Additionally, because of managed care, switching costs for consumers are high. Because many markets have supported too many providers in the past, the strategic stakes are extremely high. Most experts agree that further consolidations are likely, rivalry will intensify, and still more providers will not survive.

THREAT OF SUBSTITUTE PRODUCTS AND SERVICES

For many products and services there are various substitutes that perform the same function as the established products. Substitute products limit returns to an industry because at some price point consumers will switch to alternative

products and services. Usually, the more diverse the industry, the more likely there will be substitute products and services. A major substitution taking place in health care has been the switch from inpatient care to outpatient alternatives. In addition, alternative therapies such as chiropractic, massage therapy, acupuncture, biofeedback, and so on, are increasingly substituted for traditional health care (see Perspective 3–6).

BARGAINING POWER OF CUSTOMERS

Buyers of products and services attempt to obtain the lowest price possible while demanding high quality and better service. If buyers are powerful, then the competitive rivalry will be high. A buyer group is powerful if it:

- purchases large volumes;
- concentrates purchases in an industry (service area);
- purchases products that are standard or undifferentiated;
- has low switching costs;
- earns low profits (low profits force lower purchasing costs);
- poses a threat of backward integration;
- has low quality requirements (the quality of the products purchased by the buyer is unimportant to the final product's quality); and
- has enough information to gain bargaining leverage.

Perspective 3–6

Complementary and Alternative Medicine: Moved to Integrative Medicine?

Americans are frustrated with the inability of traditional medicine to meet their expectations and needs. In addition, US society has a growing interest in generally better health and wellness. Further, individuals have access to more health care information than ever before through the Internet. Discontent and the search for “more” have led many Americans to explore complementary and alternative medicine (CAM).

The five domains of CAM used in the United States include alternative medical systems built on complete systems of theory and practice separate from conventional medical approaches, including homeopathy and naturopathy; biologically based therapies that use substances found in nature, such as herbs, special diets, or vitamins (in doses outside those used in conventional medicine); energy therapies that involve the use of energy fields, such as magnetic fields or biofields (energy fields that some believe surround and penetrate the human body); manipulative and body-based methods including massage therapy, chiropractic, and osteopathy; and mind–body medicine that uses a variety of techniques designed to enhance the mind’s ability to affect bodily function and symptoms (yoga, spirituality, and relaxation therapy).

According to the CDC Advance Data Report more than 36 percent of adults are using some form of CAM. (When megavitamin therapy and prayer specifically for health reasons are included in the definition of CAM, that number rises to 62 percent.) CAM use spans people of all backgrounds, although, according to the survey, some people are more likely than others to use CAM. Overall, CAM use is greater by women than men; people with higher educational levels; people who have been hospitalized in the past year; and former smokers, compared with current smokers or those who have never smoked. ►

According to a 2004 American Hospital Association Health Forum survey, about 16.6 percent of US hospitals provided CAM services (up from 7.9 percent in 1998). The most frequently provided services by those hospitals that offer CAM include massage therapy (78 percent), pastoral counseling (62 percent), stress management (61 percent), and yoga (58 percent).

Consumers are somewhat wary of untested CAM therapies. A possible threat to CAM potential is that some complementary therapies interfere with effective conventional treatments and cause unintended but harmful side effects. Although the threat exists, the majority of patients integrate both conventional care and CAM interventions into their health care and wellness programs instead of viewing the two entities as substitutes.

In 1998, cognizant of society's changing perspectives on health care and well-being, Congress expanded the Office of Alternative Medicine (started in 1993) by creating the National Center for Complementary and Alternative Medicine (NCCAM). NCCAM is one of the 27 institutes and centers that make up the National Institutes of Health (NIH). The NIH is one of eight agencies under the Public Health Service (PHS) in the Department of Health and Human Services (DHHS). According to the "NCCAM Strategic Plan: 2005–2009," it has four primary areas of focus:

1. *Research.* We support clinical and basic science research projects in CAM by awarding grants across the country and around the world; we also design, study, and analyze clinical and laboratory-based studies on the NIH campus in Bethesda, Maryland.
2. *Research training and career development.* We award grants that provide training and career development opportunities for predoctoral, postdoctoral, and career researchers.
3. *Outreach.* We sponsor conferences, educational programs, and exhibits; operate an information clearinghouse to answer inquiries and requests for information; provide a website and printed publications; and hold town meetings at selected locations in the United States.
4. *Integration.* To integrate scientifically proven CAM practices into conventional medicine, we announce published research results; study ways to integrate evidence-based CAM practices into conventional medical practice; and support programs to develop models for incorporating CAM into the curriculum of medical, dental, and nursing schools.

With a budget of \$117.8 million in 2004, its mission states: "NCCAM is dedicated to exploring complementary and alternative healing practices in the context of rigorous science, training complementary and alternative medicine researchers, and disseminating authoritative information to the public and professionals." Its vision includes: "NCCAM will advance research to yield insights and tools derived from complementary and alternative medicine to benefit the health and well-being of the public, while enabling an informed public to reject ineffective or unsafe practices."

As stated by Dr. Stephen E. Straus, the first and current Director of NCCAM, "As CAM interventions are incorporated into conventional medical education and practice, the exclusionary terms 'complementary and alternative medicine,' will be superseded by the more inclusive, 'integrative medicine.' Integrative medicine will be seen as providing novel insights and tools for human health, practiced by health care providers skilled and knowledgeable in the multiple traditions and disciplines that contribute to the healing arts."

Source: Originally written by Meredith Willard Luber, UNC Charlotte MBA, from the National Center for Complementary and Alternative Medicine website (<http://nccam.nih.gov/>) and its strategic plan, *Expanding Horizons of Healthcare 2001 to 2005*; updated from the website and P. Barnes, E. Powell-Griner, K. McFann, and R. Nahin, "Complementary and Alternative Medicine Use Among Adults: United States, 2002," *CDC Advance Data Report #343* (Washington, DC: May 27, 2004); and "Hospital Trends," *Marketing Healthcare Services* 24, no. 2 (Summer 2004), p. 9.

Perhaps the greatest change in the nature of the health care industry in the past decade has been the growing power of the buyers. Managed care organizations purchase services in large volume and control provider choices. The increasing power of the buyers has fueled system integration as well as blurring of providers and insurers. Large employers as buyers have power over managed care organizations, because they determine whether the MCO will be on the list that employees have to choose from for their health care. The poor economy, resulting in lowered profits during the period between 2000 and 2004 has pushed employers to find ways to lower their health care costs.

BARGAINING POWER OF SUPPLIERS

Much like the power of buyers, suppliers can affect the intensity of competition through their ability to control prices and the quality of materials they supply. Through these mechanisms, suppliers can exert considerable pressure on an industry. Factors that make suppliers powerful tend to mirror those making buyers powerful. Suppliers tend to be powerful if:

- there are few suppliers;
- there are few substitutes;
- the suppliers' products are differentiated;
- the product or service supplied is important to the buyer's business;
- the buyer's industry is not considered an important customer; and
- the suppliers pose a threat of forward integration (entering the industry).

Traditionally, physicians and other health care professionals have been important and powerful "suppliers" to the industry because of their importance to health care institutions. Because of the nature of managed care, the physician remains the "gatekeeper" to the system and plays a crucial role in controlling consumer choice. This supplier power has added pressure to include physicians in system integration through the purchase of primary care individual and group practices by hospital systems. Other suppliers, such as those who supply general medical needs such as bandages, suture materials, thermometers, and so on, have tended not to exercise a great deal of control over the industry.

Concluding Structural Analysis

Porter's approach is a powerful tool for assessing the level of competitive intensity within the health care service area. Porter's framework for analyzing the external environment is applied to a nursing home in Exhibit 3-5. Competitive intensity and ultimately the profitability of the service category in the service area is determined by the number of favorable factors. In Exhibit 3-5, the threat of entry is low which is favorable to the existing skilled-nursing facilities. Similarly the intensity of rivalry among existing organizations is low, the threat of substitutes is relatively low, and suppliers (labor) have not been powerful players. All these factors are favorable. However, the bargaining power of the buyer is high

Exhibit 3–5: Using Porter’s Industry Structure Analysis

The Hanover House Nursing Home, a skilled-nursing facility, used differentiation as its major competitive advantage. In its early years, in a less regulated environment, the home was very profitable. As the facility began to age, and with increasingly stricter regulations for long-term care, profit margins began to deteriorate. The administrators of Hanover House used Porter’s Industry Structure Analysis to better understand the forces in their external environment. The following is a summary of their analysis.

Threat of New Entrants

The supply of nursing homes and other long-term care facilities is currently limited because there is a moratorium on additional beds within the geographic area. Competition is based on process or quality. If the moratorium is lifted, it will remain costly to enter the market because it is highly regulated. The greatest threat as a new entrant (when the moratorium is lifted) will be hospitals attempting to compensate for decreasing occupancy rates. Switching costs are low for hospitals (the same bed can be used for acute care or long-term care). Access to the distribution channel is high as hospitals have many of the required resources, including access to nurses, familiarity with the regulations, and capability to enter quickly (by converting acute care beds to long-term care).

Intensity of Rivalry Among Existing Organizations

Although there is competition, the long-term care industry is not fiercely competitive. Hanover House has six competitors – Mary Lewis Convalescence Center, Hillhaven, Altamont Retirement Community, St. Martins in the Pines, Lake Villa, and Kirkwood – that have relatively stable market shares. Because the service has both quality and dollar value, there is the opportunity to differentiate, and switching costs are high for the consumer. It is a highly regulated area and, therefore, not a great deal of diversity among competitors is apparent. The long-term care industry is maturing but remains a rapid-growth industry driven by demographic and social trends (the graying of America and the deterioration of the extended family). The most significant factor creating rivalry is the high fixed assets, which make exit difficult and success important.

Threat of Substitute Products and Services

There are few substitute products for nursing home care. Home care is a substitute but an increasingly less available alternative because of the mobility and dissolution of the family unit. Other alternatives include nonskilled homes, retirement housing, and domiciliaries. Increased costs and DRGs have virtually eliminated hospitals as an alternative. On balance, substitutes do not appear to be a strong force in the nursing home industry.

Bargaining Power of Customers

The power of the customer in the industry is generally high. The major consumer, the government, purchases over 45 percent of nursing home care and regulates reimbursement procedures as well as the industry. Therefore, significant levels of information are available. In addition, for private-pay customers, the purchase represents a significant investment and comparison shopping is prevalent. Product differentiation tends to reduce buying power but relatively low switching costs and government involvement make nursing home care a buyers’ market.

Bargaining Power of Suppliers

Because the product is simultaneously produced and consumed in service industries, labor is the major supplier in the nursing home industry. Although Hanover House is unionized, it has maintained good labor relations, and the union is not particularly powerful. Most who work in long-term care have selected the field to satisfy their need to care for others or make a contribution rather than to earn large salaries. Suppliers are not a dominant force in the nursing home industry.

Source: Elaine Asper, “Hanover House Nursing Home,” an unpublished case study.

and thus unfavorable to the service category. As a result, four factors are favorable and one is unfavorable. Competitive intensity for this service category in this service area is relatively low, leading to favorable returns. Four or five unfavorable factors make competition intense and will lower profitability.

Conducting Competitor Analysis and Mapping Strategic Groups

The next step in service area competitor analysis (refer back to Exhibit 3–2) is to evaluate the strengths and weakness of competitors, characterize their strategies, group competitors by the types of strategies they have exhibited, and predict competitive future moves or likely responses to strategic issues and initiatives by other organizations.

COMPETITOR STRENGTHS, WEAKNESSES, AND STRATEGY

In assessing the rivalry of the service area, the competitors are identified. Next, the strengths and weaknesses of each competitor should be specified and evaluated. Organizations have a unique resource endowment and a comparison with a given competitor will help to illuminate the relationship between them and to predict how they compete with (or respond to) each other in the market.¹⁹ Evaluation of competitors' strengths and weaknesses provides clues as to their future strategies and to areas where competitive advantage might be achieved.

Both quantitative and qualitative information may be used to identify strengths and weaknesses. Competitor information is not always easy to obtain, and it is often necessary to draw conclusions from sketchy information. A list of possible competitor strengths and weaknesses is presented in Exhibit 3–6

Exhibit 3–6: Potential Competitor Strengths and Weaknesses

Potential Strengths

- Distinctive competence
- Financial resources
- Good competitive skills
- Positive image
- Acknowledged market leader
- Well-conceived functional area strategies
- Achievement of economies of scale
- Insulated from strong competitive pressures
- Proprietary technology
- Cost advantages
- Competitive advantages
- Product/service innovation abilities
- Proven management
- Ahead on experience curve

Potential Weaknesses

- Lack of clear strategic direction
- Deteriorating competitive position
- Obsolete facilities
- Subpar profitability
- Lack of managerial depth and talent
- Missing key skills or competencies
- Poor track record in implementing strategies
- Plagued with internal operating problems
- Vulnerable to competitive pressures
- Falling behind in R&D
- Too narrow a product/service line
- Weak market image
- Below-average marketing skills
- Unable to finance needed changes in strategy
- Higher overall costs relative to key competitors

Such information may be obtained through local newspapers, trade journals, websites, focus groups with customers and stakeholders, consultants who specialize in the industry, securities analysts, outside health care professionals, and so on. Identification of competitor strengths and weaknesses will aid in speculating on competitor strategic moves. The range of possible competitive actions available to organizations varies from tactical moves, such as price cuts, promotions, and service improvements that require few resources, to strategic moves, such as service category/area changes, facilities expansions, strategic alliances, and new product or service introductions that require more substantial commitments of resources and are more difficult to reverse. Such competitive actions represent clear, offensive challenges that invite competitor responses.²⁰

SERVICE CATEGORY CRITICAL SUCCESS FACTOR ANALYSIS

Critical success factor analysis involves the identification of a limited number of activities for a service category within a service area for which the organization must achieve a high level of performance if it is to be successful. The rationale behind critical success factor analysis is that there are five or six areas in which the organization must perform well and that it is possible to identify them through careful analysis of the environment. In addition, critical success factor analysis may be used to examine new market opportunities by matching an organization's strengths with critical success factors.

Typically, once the service category critical success factors have been identified, several goals may be developed for each success factor. At that point, a strategy may be developed around the goals. Important in critical success factor analysis is the establishment of linkages among the environment, the critical success factors, the goals, and the strategy. In addition, it is important to evaluate competitors on these critical success factors. Indeed, excellence in any (or several) of these factors may be the basis of competitive advantage. Further, these factors form the fundamental dimensions of strategy.

Organizational strategies may differ in a wide variety of ways. Michael Porter identified several strategic dimensions that capture the possible differences among an organization's strategic options in a given service area:

- *Specialization*: the degree to which the organization focuses its efforts in terms of the number of product categories, the target market, and size of its service area.
- *Reputation*: the degree to which it seeks name recognition rather than competition based on other variables.
- *Service/product quality*: the level of emphasis on the quality of its offering to the marketplace.
- *Technological leadership*: the degree to which it seeks superiority in diagnostic and therapeutic equipment and procedures.
- *Vertical integration*: the extent of value added as reflected in the level of forward and backward integration.
- *Cost position*: the extent to which it seeks the low-cost position through efficiency programs and cost-minimizing facilities and equipment.

- *Service*: the degree to which it provides ancillary services in addition to its main services.
- *Price policy*: its relative price position in the market (although price positioning will usually be related to other variables such as cost position and product quality, price is a distinct strategic variable that must be treated separately).
- *Relationship with the parent company*: requirements concerning the behavior of the unit based on the relationship between a unit and its parent company. (The nature of the relationship with the parent will influence the objectives by which the organization is managed, the resources available to it, and perhaps determine some operations or functions that it shares with other units.)²¹

The organization can determine the strategic dimension or dimensions that it will use to compete – however, these decisions cannot be made in a vacuum. Consideration must be given to which of the dimensions competitors have selected and how well they are meeting the needs of customers.

STRATEGIC GROUPS

Service area analysis concentrates on the characteristics of the specific geographic market whereas strategic group analysis concentrates on the characteristics of the strategies of the organizations competing within a given service area. Strategic groups have been studied in many different industries and there are often several strategic groups within a service area. A *strategic group* is a number of organizations within the same service category making similar strategic decisions. Members of a strategic group have similar “recipes” for success or core strategies.²² Therefore, members of a strategic group primarily compete with each other and do not compete with organizations outside their strategic group – even though there are other competitors outside the group that may offer similar products or services.

External stakeholders have an image of the strategic group and develop an idea of the group’s reputation. The reputation of each strategic group differs because the identity and strategy of each group differ.²³ Organizations within a strategic group use similar resources to serve similar markets. However, leadership in an individual organization must find ways (sometimes subtle) to have its organization stand out from the group (differentiation) to develop competitive advantage over other group members.²⁴

Reputation has been defined as an organization’s true character and the emotions toward the organization held by its stakeholders. Strategic group reputation may be a mobility barrier leading to increased performance. If reputation does lead to increased performance, individual organizations within the strategic group may need to consider the impact of their actions on the collective reputation of the group.²⁵ Thus, if several managed care organizations in a service area are in the same strategic group, the actions of one influence the reputation of them all. The grouping of organizations according to strategic similarities and differences among competitors can aid in understanding the nature of competition and facilitate strategic decision making. There are four major implications for the strategic group concept:

1. Organizations pursue different strategies within service categories and service areas. Creating competitive advantage is often a matter of selecting an appropriate basis on which to compete.
2. Organizations within a strategic group are each other's primary or direct competitors. As Bruce Henderson, founder of Boston Consulting Group, has noted, "Organizations most like yours are the most dangerous."
3. Strategic group analysis can indicate other formulas for success for a service category. Such insight may broaden a manager's view of important market needs.
4. Strategic group analysis may indicate important market dimensions or niches that are not being capitalized on by the existing competitors. Lack of attention to critical success factors by other competitive organizations offering the same or a similar service may provide an opportunity for management to differentiate its services.

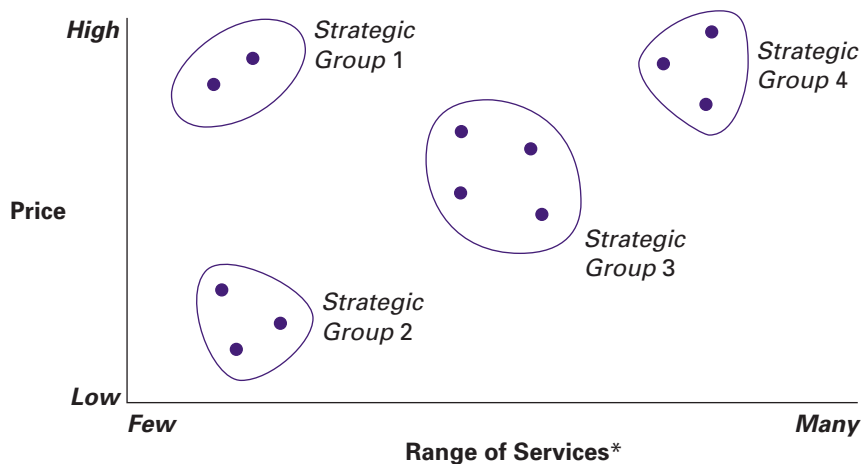
Organizations within a group follow the same or similar strategy along the strategic dimensions. Group membership defines the essential characteristics of an organization's strategy. Within a service category or service area there may be only one strategic group (if all the organizations follow the same strategy) or there may be many different groups. Usually, however, there are a small number of strategic groups that capture the essential strategic differences among organizations in the service area.²⁶

The analysis of competitors along key strategic dimensions can provide considerable insight into the nature of competition within the service area. Such an analysis complements Porter's structural analysis but provides some additional insights. As a means of gaining a broad picture of the types of organizations within a service area and the kinds of strategies that have proven viable, strategic group analysis can contribute to understanding the structure, competitive dynamics, and evolution of a service area as well as the issues of strategic management within it.²⁷ More specifically, the usefulness of strategic group analysis is that it:

- can be used to preserve information characterizing individual competitors that may be lost in studies using averaged and aggregated data;
- allows for the investigation of multiple competitors concurrently;
- allows assessment of the effectiveness of competitors' strategies over a wider range of variation than a single organization's experience affords; and
- captures the intuitive notion that "within-group" rivalry and "between-group" rivalry differ.²⁸

When analyzing strategic groups, care must be taken to ensure that they are engaging in market-based competition. Many organizations may not be direct or primary competitors because of a different market focus. Organizations will have little motivation to engage each other competitively if they have limited markets in common. It is not unusual for organizations that serve completely different markets yet have similar strategic postures to be grouped together and assumed by analysts to be direct competitors when in fact they are not.²⁹ For example, a pediatric group practice affiliated with a children's hospital and a community health clinic emphasizing preventive and well care may serve the same population but not be direct competitors because of a different market focus.

Exhibit 3–7: Service Area Assisted-Living Competitors



For this service area, assisted living organizations are pursuing four basic strategies:

high price with highly specialized services (*Strategic Group 1*), low price with few ancillary services (*Strategic Group 2*), medium price with some (selected) services (*Strategic Group 3*), and high price with many services (*Strategic Group 4*). The primary (direct) competitors for these organizations are other organizations within their own strategic group. Customers who seek the attributes of one strategic group, such as highly specialized rehabilitation services, are unlikely to be attracted to another strategic group. These assisted-living organizations should change strategy cautiously as a decision to add services may move an organization to a new strategic group and therefore a new set of competitors. Note that in this example there may be an opportunity to enter or move toward a medium-cost, many services niche and become a strategic group of one.

*Range of services includes skilled nursing, organized social activities, outings, physical therapy, education, rehabilitation, speech therapy, Alzheimer's care, nutritional services, infusion, pharmacy, homemaker services, live-ins, companions, and so on.

MAPPING COMPETITORS

Mapping competitors for any service category (broadly or narrowly defined) within a service area may be based on the critical success factors or important strategy dimensions. Exhibit 3–7 shows strategic groups of assisted-living organizations within a service area. Several strategic maps may be constructed demonstrating different strategic views of the service area. In addition, a single dimension may be so important as a critical factor for success that it may appear on several strategic maps.

Likely Competitor Actions or Responses

Strategy formulation is future oriented, requiring that management anticipate the next strategic moves of competitors. These moves may be projected through an evaluation of competitor strengths and weaknesses, membership in strategic

groups, and the characterization of past strategies. In many cases competitor strategic goals are not difficult to project, given past behaviors of the organization. Strategic thinking is a matter of anticipating what is next in a stream of consistent decisions. Strategic behavior is the result of consistency in decision making, and decision consistency is central to strategy. Therefore, in determining competitors' future strategies, strategic managers must look for the behavioral patterns that emerge from a stream of consistent decisions concerning the positioning of the organization in the past. A thorough analysis of the key strategic decisions of competitors may reveal their strategic intent. A strategic decision timeline can be helpful in showing the stream of decisions. *Strategic response* includes the likely strategic objectives and next strategic moves of competitors. These may be anticipated because of their perceived strengths and weaknesses, past strategies, or strategic group membership. If an organization is planning an offensive move within a service area, an evaluation of competitor strengths and weaknesses, past strategies, strategic group membership, and assumed strategic objectives can anticipate the likely strategic response. For example, HCA—The Healthcare Company's analysis of the strategic response of competitors for a new market they are considering is an important variable in their expansion strategy.

Synthesizing the Analyses

To be useful for strategy formulation, general and health care external environmental analysis (see Chapter 2) and service area competitor analysis (as covered in this chapter) must be synthesized and then conclusions drawn. It is easy for strategic decision makers to be overwhelmed by information. To avoid paralysis by analysis, external environmental analysis should be summarized into key issues and trends, including their likely impact, and then service area competitor analysis summarized.

Example of a Service Area Competitor Analysis

Service area competitor analysis is increasingly important for health care organizations. For-profit as well as not-for-profit health care organizations will have to understand the competitive dynamics of service categories and service areas. For example, ophthalmologists are in a medical specialty that is quite competitive, not only because there are typically a number of them in a given service area but also because there are licensed optometrists that deliver some of the same services and at a lower price to the consumer. If an ophthalmologist were to consider entering the refractive surgery market in Charlotte, North Carolina, the service area competitor analysis is a systematic method to evaluate whether the area represents a potentially profitable opportunity. Refractive surgery is a surgical procedure aimed at improving the focusing power of the eye. Perspective 3–7 provides an overview of the nature of eye care and serves as background for a service area competitor analysis.

Perspective 3–7

Eye Care

Three different types of health care professionals provide care of the eye: ophthalmologists, optometrists, and opticians. Ophthalmologists are medical doctors (MDs) who specialize in the medical and surgical care of the eyes and visual system and in the prevention of eye disease. They are trained to diagnose, treat, and manage all eye and visual systems and

licensed by a state to practice medicine and surgery. In addition, they can deliver total eye care including vision services, contact lenses, and eye exams.

Optometrists have attended a four-year course in optometry but not medical school. They are state licensed to examine the eyes and to determine the presence of vision problems. They prescribe spectacles, contact lenses, and eye exercises. In some states they are permitted to prescribe pharmaceuticals for some eye conditions.

Opticians are technicians who make, verify, and deliver lenses, frames, and other specialty fabricated optical devices or contact lenses. They provide the product prescribed by the ophthalmologist or the optometrist.

Service categories for care of the eye include the following:

- *General services* – eye chart exams, pupil exams, optometric eye exams, vision therapy, low-vision aids, prescription contact lenses, prescription eyeglass lenses, prescription eye drop solutions and ointments, custom contact and eyeglass fittings, eye dilation.
- *Specialized services* – glaucoma, cataracts, legally defined blindness protocols, pediatric ophthalmology, geriatric ophthalmology, eye disease, and eye injury.
- *Surgery* – radial keratotomy (RK); corrective laser surgery: photorefractive keratectomy (PRK), laser in-situ keratomileusis (LASIK), laser thermokeratoplasty (LTK); NearVision CK (for presbyopia); corneal rings, implantable contact lenses (ICLs), and transplants; reconstructive and plastic surgery; and cataract removal (removal of cataracts).
- *Retail services* – glasses and sunglasses, nonprescription eye drop solutions, carrying cases, frames, eye-glass straps, designer frames, and so on.

In the example marketplace discussed in the text – Charlotte, North Carolina – all eye care services are offered. Analysis and a strategic group map in Exhibits 3–8 to 3–11 illustrate the major competitive groups.

Corrective refractive surgery is an elective surgery performed on the eye to improve focus and lessen dependence on glasses and contact lenses. Treated primarily as cosmetic surgery by insurance companies, consumers are paying out of pocket for this surgery because it offers freedom from dependency on glasses or contact lenses. Many consumers are tired of the inconvenience of contacts, the discomfort of glasses, the limitations of glasses or contacts while playing sports (comfort and safety), and the insecurity of knowing that they are helpless without their corrective lenses (such as felt by mothers of young children). Some consumers will choose surgery for occupational enhancement (fire fighters, airline pilots, police officers, professional athletes, and so on), and frequent travelers want to be less dependent on corrective eye wear for safety and convenience. Others choose surgery simply to improve their looks or self-image. It is an expensive choice – the average was \$1,700 per eye in 2004, up from the lower average of \$1,590 in 2002. The increase was primarily because of new technology that allows for greater accuracy in vision correction. The total value of the surgery includes: direct out-of-pocket cost, long- and short-term effects of the surgery (no need to buy glasses or contact lenses times the number of years), experience of the surgeon, risk versus benefits, and recovery time from the surgery (time away from work). In addition, consumers have to understand what the price of the surgery does and does not include and that prices charged can vary tremendously. Many ads tout \$299 per eye for LASIK, but that “price” is available only to those who need minimal vision correction and have no astigmatism (uneven cornea). Factors affecting price include:

1. Severity of vision correction required and presence or absence of astigmatism;
2. Expertise of the physician performing the surgery;
3. Pre-operative and post-operative visits (included in the price or extra?);
4. Surgeon performing the surgery (customer choice or assigned the day of surgery?);
5. Post-operative care (surgeon or optometrist?);
6. Complications (if they occur, who will provide care and cover the cost?);
7. Enhancements (provided as part of the initial procedure price, or, if extra, how much – full price or reduced price?) and for how long after the initial procedure (specified time period or lifetime?).

Research on the excimer laser began in the 1970s. Its use in ophthalmology was introduced in the 1980s. In 1995 the FDA granted approval to use excimer lasers for photorefractive keratectomy (PRK) in the United States. Analysts predicted that there would be as many as 1.4 million surgeries to correct myopia by 1998. There were actually about 250 thousand, translating into an \$840 million business. The excimer laser brought more accuracy to refractive surgery, less discomfort, and faster healing. The newest technology, wavefront guided laser surgery, was approved by the FDA in 2003.

During 2003, global demand for refractive surgery was 3.02 million procedures, up from 2.87 million procedures in 2002. The increase resulted primarily from rapid growth in China, India, and other developing countries. In the United States, the number of procedures was flat (attributable to the generally poor economy during 2000 through 2003, uncertainty in the economy between 2004 and 2005, and unemployment figures that persistently remained higher than desired over the same period). Consumers who are uncertain about their future job prospects are hesitant to spend on discretionary items such as LASIK. During 2001, 1.31 million refractive procedures were performed in the United States, but the number declined to 1.15 million in 2002. For 2003 the number performed was 1.3 million and estimates were that the number of surgeries in 2004 would be improved, assuming the economy strengthened and unemployment declined.

Over 4,500 US ophthalmologists are trained to perform laser vision correction. Vision may need to be corrected for myopia (nearsightedness), hyperopia (farsightedness), astigmatism (uneven corneas, resulting in impaired sight), or presbyopia (aging eye syndrome). Over 162 million people in the United States need corrected vision; 150 million use corrective eyewear; over 70 million are nearsighted. Americans spend approximately \$18 billion each year on corrective eyewear.

LASIK surgery provides the greatest range of correction, is the least painful, has the quickest recovery time, and incurs the fewest infections of any of the current vision correcting surgeries. According to the American Society for Cataract and Refractive Surgery, 56 percent of consumers who undergo LASIK surgery achieve vision of 20/20 or better and 90 percent achieve 20/40 or better (the minimum requirement for driving without corrective lenses). Between 8 and 17 percent of patients require enhancements (undergoing further surgery in the attempt to improve vision or correct for errors). Some enhancements are deliberate, as when the patient has severe myopia and the surgeon proceeds cautiously, allowing several months to pass to see how much further correction is necessary. With LASIK procedures, vision can continue to improve up to six months for some patients (three months is typical). Recently approved by the FDA, wavefront “custom” LASIK uses sophisticated measuring technology with a guided laser to improve correction and eliminate some of the problems such as nightblindness, halving, and so on with traditional LASIK.

Service Category and Service Area

The analysis would begin by identifying the service category – refractive eye surgery – and investigating the service area – Charlotte, North Carolina – as in Exhibit 3–8. All analyses of the service area should be related to the identified service category. The “comments” column is used to indicate the applicability.

Service Area Structural Analysis

To assess the viability of the market, Michael Porter’s five forces analysis is used to evaluate the service area. As described in Exhibit 3–9, the five forces suggest that it would be challenging to enter this market, but opportunities do exist. Barriers to entry for new competitors are somewhat high and the other forces suggest that this is a difficult market in which to compete – rivalry is high, consumers (buyers) wield a great deal of power, there are substitutes (which continue to increase), and suppliers of laser equipment (required to do refractive surgery) have increased to five in number and they have had to become somewhat more competitive: however, not all lasers are the same and the best technology is still tightly controlled. One of the manufacturers (Bausch & Lomb) is rumored to be thinking of withdrawing from the market in the near future. Thus, the power of suppliers has decreased somewhat but remains powerful for those physicians who want to use the very best equipment. In the future, the five forces for this service category, in this service area, are not likely to change dramatically. Barriers to entry for new competitors may decrease somewhat, rivalry will remain high, the consumer will be able to shop on price and defer purchase, and substitutes will likely increase. The number of suppliers of the technology may decrease from the current five major suppliers.

Strengths and Weaknesses

Next, the strengths and weaknesses (see Exhibit 3–10) should be assessed for providers of refractive surgery. Assessing strengths and weaknesses of competitors is often difficult for outsiders. However, careful observation and data gathering through websites and media can make this somewhat speculative process fairly accurate. In addition, over time the understanding of competitors’ strengths and weaknesses can be refined and improved.

Critical Success Factors

From the preceding analysis the critical success factors for this service category in this service area may be surmised. The critical success factors for refractive eye surgery in Charlotte include the following:

Exhibit 3–8: Analysis of the Charlotte, North Carolina, Eye Care Market

Service Category **Eye Care Services, Refractive Surgery**

Service Area **Charlotte, Mecklenburg County, North Carolina**

I. Service Area – General

Competitively Relevant Issues

- The largest city in either of the Carolinas, located on the border. The nearest city, Winston-Salem, is more than 90 miles away
- Many people come to Charlotte for their health care. People travel to Duke University for extraordinary care (no medical school in Charlotte)
- Insurance covers injury to the eye, diseases of the eye, and malfunctions of the eye, but does not typically cover correcting vision (although it may be covered and some employers offer flexible spending accounts that can be used to cover the cost of refractive surgery so that it is at least pretax dollars that are spent)
- Nearly 60 percent of all Americans need corrective lenses, 30 percent have myopia
- Cataracts and glaucoma are eye diseases that occur with aging

Comments

- Not much need to travel outside of Charlotte for health care, especially routine care
- Physicians who have pursued corneal fellowships after ophthalmology residency practice in Charlotte
- There are few employers that offer eye care insurance for routine care in the Charlotte area. Flexible spending accounts are common among the major employers, but uncommon among small businesses
- 60 percent in a growing market represents an opportunity
- Laser surgery has been used for cataracts

II. Service Area – Economic

Competitively Relevant Issues

- Median household income in Charlotte is \$48,975 (compared with \$38,204 in NC and \$43,057 in US)
- Percentage below poverty at 10.6% is less than the state and nation (NC: 12.3%; US: 12.4%)
- Retail sales per capita \$13,867 (NC: \$9,740; US: \$9,190)
- Economy improving and number of jobs increasing – however, unemployment is still considerably higher than pre-9/11/01, at 5.6% for Charlotte (NC: 6.3%; US: 6.0%)
- Identified as one of the top cities for entrepreneurs
- Nearly 80 percent of residents work in businesses of less than 100 employees

Comments

- Charlotte has a population that can afford the procedure
- People with a higher standard of living are interested in LASIK
- People in Charlotte spend 39.5% of the money they earn at retail (27.5% in NC; 24.8% in the US)
- Unemployed postpone the purchase because it is an out-of-pocket expense (not covered by insurance)
- Entrepreneurs are often innovators and early adopters
- Big business tends to require the corporate “look”

Exhibit 3–8: (cont'd)

III. Service Area – Demographic

Competitively Relevant Issues

- More than 620,000 people live within Charlotte’s city limits; 800,000 in Mecklenburg County; 1.5 million in the Charlotte MSA; Mecklenburg County is expected to grow by 3.6% in 2005
- Population over 65 at 7.6% is lower than the state and nation (11.6% in NC; 11.9% in US); median age in Charlotte is 32.7 years (NC: 35.3 years; US: 35.3)
- Population over 25 with college degree in Charlotte: 36.4% (NC: 22.5%; US: 24.4%)
- Ethnic mix is 58.3% white (NC: 72.1%; US: 75.1%), black 32.7% (NC: 21.6%; US: 12.3%), Native American 0.3% (NC: 1.2%; US 0.9%), Asian 3.4% (NC: 1.4%; US: 3.6%), Hispanic 7.4% (NC: 4.7%; US: 12.5%)

Comments

- A growing population may mean there is more room for a new provider using LASIK surgery
- A younger population is more likely to adopt the new surgery
- Better educated consumers are more likely to pay for the surgery
- The black population has been slower to adopt the new surgery, but as more experience occurs, it presents an expanding market

IV. Service Area – Psychographic

Competitively Relevant Issues

- Younger, upwardly mobile population; youthful orientation
- Business-oriented community: second largest banking center, sixth largest in wholesaling, sixth in number of Fortune 500 company headquarters
- Bible belt – 73% church or synagogue members
- Outdoor activities at the beach or mountains; both in easy driving distance

Comments

- LASIK is generally surgery for lifestyle and cosmetic reasons
- Population wants to “look” successful and not be hindered by glasses or wearing contacts
- Religious question: is surgery for cosmetic reasons the right thing to do?
- Outdoor activities are easier without having to keep up with glasses or search for a lost contact

V. Service Area – Health Status

Competitively Relevant Issues

- Generally healthy population
- NC is in the middle range of numbers of the population that requires vision correction
- Diabetes occurs more frequently in the South and contributes to problems with the eyes often leading to blindness

Comments

- Healthy candidates required for this elective procedure
- Sufficient market size
- Refractive surgery is *not* recommended for anyone with diabetes or the possibility of developing diabetes, although the new technologies are enabling many diabetics to have LASIK if they choose to

Exhibit 3–9: Service Area Structural Analysis

Five Forces	Forces Driving Service Area Competition	Conclusion
Threat of New Entrants	<ul style="list-style-type: none"> • Existing providers have already climbed the learning curve – experience level is important in successful surgeries (need more than 500 performed to be “experienced”) and establishment of economies of scale • Capital requirements are high – the laser equipment costs \$200,000 to \$800,000 to buy, requires frequent and costly upgrades as well as maintenance, and a \$150/eye to \$500/eye royalty fee • Barriers to entry – only ophthalmologists (MD degree) who have been trained on the laser equipment and have access to it can perform the procedure • Existing service differentiation – perceived differentiation (high image) for Christenbury Eye Center as the first provider of LASIK and Dr. Christenbury performs the most procedures each month 	<p><i>Medium</i></p> <p>Threat of new entrants into market is presently medium, primarily because of the increase in the number of providers (new graduates with the ophthalmology specialty have learned to use the equipment)</p> <p>Economies of scale and the high equipment costs are still barriers but more options exist and equipment costs have declined somewhat, although new technology (wavefront custom) has raised the cost of equipment</p>
Intensity of Rivalry	<ul style="list-style-type: none"> • Thirteen practices have physicians who perform laser eye surgery • Capacity is augmented in large increments – a laser costs between \$200,000 and \$800,000 • Diverse competitors – competitors employ distinctly different strategies (also diverse personalities) • High strategic stakes – focusing primarily on refractive surgery increases risks (narrow product line) • High exit barriers – once the equipment commitment is made, it is difficult to alter strategy or move in new direction 	<p><i>High</i></p> <p>Rivalry is likely to remain intense in this market as the competitors are well balanced, strategic stakes are high, and it is difficult to exit the market</p>
Threat of Substitutes	<ul style="list-style-type: none"> • Do not bother to correct vision that is worse than 20/20 • Nonsurgical vision correction – contacts and glasses • Orthokeratology – use of specially designed rigid contact lenses that progressively reshape the curvature of the cornea over time (nonsurgical) • Older methods: RK – the oldest surgical procedure; PRK – older laser surgery; LASIK (without wavefront custom) • Implantable corneal rings and contact lenses • Cornea replacements 	<p><i>High</i></p> <p>Currently there are a number of low-cost, nonsurgical substitutes</p> <p>Older surgical methods are less expensive</p>
Bargaining Power of Customers	<ul style="list-style-type: none"> • Elective surgery – rarely covered by insurance and consumer can easily defer procedure to later time • Can obtain enough information to gain bargaining leverage – some customers are traveling to Canada where the procedure is as much as \$1,200 per eye less expensive 	<p><i>High</i></p> <p>Consumers have high bargaining power because of elective nature of the procedure and its out-of-pocket cost</p>

EXAMPLE OF A SERVICE AREA COMPETITOR ANALYSIS **135**

Exhibit 3–9: (cont'd)

Five Forces	Forces Driving Service Area Competition	Conclusion
	<ul style="list-style-type: none"> • Consumers can “shop” for price and service (low switching costs before procedure) • Word-of-mouth is powerful 	Consumers can opt for a much less expensive substitute, shop price, or wait for prices to decline
Bargaining Power of Suppliers	<ul style="list-style-type: none"> • Few suppliers of equipment: <ul style="list-style-type: none"> – Alcon, Inc. manufactures the LADARVision System – Bausch & Lomb manufactures the Technolas 217Z – INTRALASE manufactures the INTRALASE FS – NIDEK manufactures the NIDEK EC-5000 – VISX manufactures the VISX Star S3 • Equipment substitutes are not expected in the near future • Equipment is essential to the business 	<p><i>Medium</i></p> <p>Currently there are five suppliers, all have FDA approval as of 2005</p>

1. Expertise in number of procedures performed. Number of procedures has to be more than 80 procedures per month to break even because of high fixed costs: \$200,000 to \$800,000 to buy a laser with all the various components to perform LASIK or custom LASIK surgery and \$150 to \$500/eye royalty depending on volume, surgeons' fees, and referral fees.
 - Experience and reputation of the surgeon.
 - Price.
 - Service – pre-op, post-op, and billing.
2. By 2004, low rate of complications: < 3 percent generally, < 1 percent for experienced surgeons. (Many consumers believe that even 1 percent of complications is high for elective surgery.)
 - Success with achieving 20/20 vision.
 - Number of enhancements (additional surgeries required to fine tune and improve vision).
 - Lifetime guarantee.
3. Positive word-of-mouth (estimates are that a satisfied patient refers on average five others); 55 to 75 percent of new patients are referrals.
 - Satisfaction of the clients.
 - Latest technology.
4. Offer complementary consultations (all current practices offer free consultations although what is included in the consultation may vary considerably from a simple eye check and discussion with an aide to a full work-up and discussion with the surgeon).

Exhibit 3–10: Competitor Strengths and Weaknesses

Competitor	Strengths	Weaknesses
Carolinas Eye Center	<ul style="list-style-type: none"> • Owned by local ophthalmologist and does only refractive surgery • Performed more than 25,000 surgeries; 200/month • Less than 4% enhancements required • \$299/eye to \$1,500/eye • Uses Bausch&Lomb Technolas 217Z wavefront custom laser • Extensive payment plans offered 	<ul style="list-style-type: none"> • Dr. Clement is the sole provider of the procedure • No lifetime program; however, enhancement discount offered • Pre-op and post-op handled by another physician
Charlotte Eye, Ear, Nose, and Throat	<ul style="list-style-type: none"> • A large, comprehensive practice with 20 physicians who specialize in treatment of the eye • Ophthalmologist has done more than 5,000 procedures • Handles all care, pre-op and post-op, unless the patient prefers to use their own optometrist • Payment plan is handled through TLC, although Charlotte EENT offers a discount with some insurance companies • Cost/eye is \$2,450 to \$2,750 	<ul style="list-style-type: none"> • Although six MDs were doing LASIK surgery, there is now one physician in the practice that performs laser surgery • Performs 50 surgeries per month (two Fridays/month) • No laser on site; uses TLC Laser Center
Christenbury Eye Center	<ul style="list-style-type: none"> • Personality and energy of Dr. Christenbury • First to do LASIK surgery and first to perform Wavefront Custom IntraLASIK in Charlotte; completed more than 50,000 procedures • General manager who's responsible for strategic planning • Extensive marketing by a marketing manager and Dr. Christenbury • Business development director makes sales calls on companies to speak to corporate discounts and flexible spending accounts • Systematic marketing research • Skilled staff of 45 • Number of procedures done per month: 600 to 800, all by Dr. Christenbury • Offers five machines: IntraLASIK FS, LADARVision 4000, LaserSight LSX, Nidek EC-5000, or Bausch & Lomb Technolas 217Z 	<ul style="list-style-type: none"> • Dr. Christenbury is the sole provider of the procedure • Clients feel "herded" to "keep the doctor on schedule" • So much advertising that it diminishes the image • Very fast-paced, sometimes stressful work environment • Minimal discounts (special promotional discount for teachers in the month of August)

Exhibit 3–10: (cont'd)

Competitor	Strengths	Weaknesses
Horizon Eye Care	<ul style="list-style-type: none"> • Cost based on severity of impairment from \$595/eye to \$2,195/eye; financing available • Ad agency that creates and places ads in TV, radio, direct mail, newspaper, magazines, Yellow Pages, and Internet • Good information systems, budgeting, and billing procedures • Locally owned 	<ul style="list-style-type: none"> • Variability in physician experience: Ugland & Galentine more than 3,000 procedures each; others “several hundred” to “less than a hundred;” the group performs about 10,000 in a year • They “do not keep numbers” of individual doctors’ procedures • No numbers on frequency of “enhancements;” enhancements are “done for those who have higher prescriptions to fine tune” • Between 5 and 10% are not candidates for LASIK (these numbers have fallen as the use of wavefront custom lasers allows for greater correction)
LASIKPlus Center	<ul style="list-style-type: none"> • National organization, headquartered in Cincinnati, Ohio; 39 centers in major markets in the US, plus four centers in Canada and Finland • Four employees operate the Center along with one ophthalmologist (Selkin) who has had a corneal fellowship after residency, is certified on four different lasers, and has performed more than 40,000 procedures • All employees are cross-trained and can substitute for each other • Number of procedures is 200/month 	<ul style="list-style-type: none"> • Less “local” orientation • Dr. Selkin rotates between centers in North Carolina, Tennessee, and Texas. He spends about six to eight days (occasionally up to ten days) a month in Charlotte • Pre-op and post-op is done by the patient’s own ophthalmologist • Ophthalmologists generally have older patients

Exhibit 3–10: (cont'd)

Competitor	Strengths	Weaknesses
TLC Laser Center	<ul style="list-style-type: none"> • Area ophthalmologists are invited to use the facilities • Cost \$299/eye to \$2,200/eye, one seminar attendee will be given a free procedure (drawn from a hat) • Three different payment plan options available; assistance with flexible spending accounts • Lifetime Continuous Care Program (no additional charges) • Good information systems, budgeting, and billing procedures • Surgery is done on one Saturday per month with day-after follow-up done at 8:00 A.M. on Sunday morning • National organization, headquartered in Canada; 50 centers in the US, seven in Canada, two in Mexico, and one in London • Six employees plus two local ophthalmologists on staff (Jaben has performed over 4,900 surgeries and Tate has performed over 15,000 surgeries) • Performs 176 procedures per month • Advertises in radio, magazines, Yellow Pages, and Internet with personal calls on local optometrists • Customer satisfaction: 93% satisfied or very satisfied; 99% would recommend TLC to family/friends; enhancements at no charge for up to two years • Tiger Woods is a well-known and credible spokesperson • Lifetime Commitment Program (for additional fee and required annual visits with a TLC-affiliate doctor; no charge for additional myopic procedures forever) • Developed a network of 45 physicians and optometrists who use or refer to the Center (of 92 ophthalmologists and 180 optometrists in the Charlotte area) 	<ul style="list-style-type: none"> • LCA does little marketing for the Center; rather it expects physicians to market themselves and use the Center • General manager often has to make appointments and handle phones • Scheduling of independent physicians to perform the procedure on their clients • Employees are consistently asked to work overtime • Only a moderately helpful website • Less “local” orientation • Marketing handled by corporate, with local coordinator • Near capacity at current location • Referrals usually from optometrists who will be responsible for follow-up and are owed \$400/eye for referral • Tate performs surgeries every other Thursday and Jaben performs surgeries three Tuesdays and two Fridays per month • Website only moderately helpful. Refers to telephone numbers often

EXAMPLE OF A SERVICE AREA COMPETITOR ANALYSIS 139

Exhibit 3–10: (cont'd)

Competitor	Strengths	Weaknesses
	<ul style="list-style-type: none"> • Payment plan financing available, negotiated contracts with some insurance plans for reduced rates, assists with flexible spending accounts; \$250/eye discount if procedure can be watched by others, \$100/eye discount if attended a seminar prior to surgery • VISX Star3 laser used • Good information systems, budgeting, and billing procedures 	
Mecklenburg Eye Associates	<ul style="list-style-type: none"> • One ophthalmologist has performed several hundred procedures • Uses custom LASIK and IntraLase lasers • Full service eye care (three physicians) • Cost \$1,000/eye to \$2,000/eye 	<ul style="list-style-type: none"> • Dr. Blotnick is the sole provider of the procedure • Uses TLC Center for surgeries • Difficult to get through on the phone • Website only moderately helpful
Providence Eye & Laser Specialists	<ul style="list-style-type: none"> • One ophthalmologist who has performed more than 10,000 procedures; corneal fellowship after residency • Doctor works with the patient from pre-op through post-operative care • Three different lasers • Cost is \$1,200/eye to \$1,800/eye • Excellent website • Extensive newspaper advertising 	<ul style="list-style-type: none"> • Dr. Mozayeni is the sole provider of the procedure

Competitor Analysis – Strategic Groups

There are many opticians located in the offices of ophthalmologists as well as offices of optometrists. Many opticians work in nationally owned vision center chains where customers seek retail purchase of eye wear. They may receive referral fees for recommending a particular practice, but they do not otherwise participate in refractive surgery.

There are 92 optometrists in the Charlotte/Mecklenburg area, with estimates of another 200 in the service area. Younger, healthier clients who simply need periodic eye exams for glasses or contacts typically go to optometrists because the average price for an eye exam by an optometrist is between \$80 and \$90 in the Charlotte area. (Contact lens exams/fittings are nearly twice that amount.)

Older patients are advised to see an ophthalmologist because of their increased risk of eye diseases such as cataracts and glaucoma. The average price for an eye exam performed by an ophthalmologist in the Charlotte area is between \$160 and \$180. (Some physicians charge as high as \$250.)

Prior to 1998, most of the ophthalmologists in Charlotte were in solo practices although there were several practices of three or four. As managed care became more of a market force in North Carolina, a number of mergers occurred. In 2004, 57 ophthalmologists practiced in the Charlotte market area and more than half work in two large practices: Horizon Eye Care has 13 eye care physicians (seven perform refractive surgery) and Charlotte Eye, Ear, Nose, and Throat has 20 physicians who specialize in eye care (six performed refractive surgery but did not perform enough to include it in their practice long-term; now just one physician performs the procedure routinely and the others in the practice refer to him).

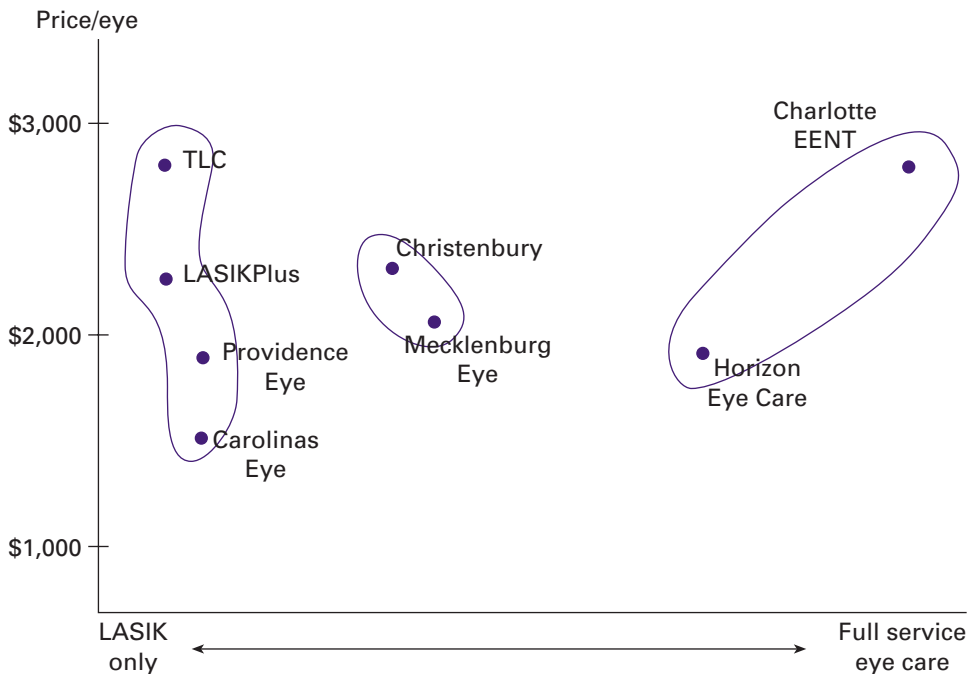
There are three practices that have three physicians. In each of these smaller practices, there is one physician who performs refractive surgery (Childers/Cook/Woody, Christenbury/Gross/Santander, and Adair/Bedrick/Blotnick). There are three partnerships. In one partnership, both partners perform refractive surgery (Mundorf/Renaldo); in the other two partnerships, none of the partners performs refractive surgery (Greenman/Greenman and Tillett/Tillett). The nine remaining ophthalmologists are solo practitioners. Seven of the nine solo practitioners perform refractive surgery in their own practice (Grayson, Mozoyeni, Reeves, and Titone) or as employees of one of the surgery centers (Clement, Selkin, and Tate). A total of 18 physicians from 13 different practices in the Charlotte area have training and expertise in laser surgery. However, only eight locations have the laser equipment necessary to perform the procedures; consequently, those without equipment on site use LASIKPlus or TLC Laser Centers.

In Charlotte's eye care market, four providers – Carolinas Eye Center, LASIKPlus, and TLC Laser Eye Center, and Providence Eye & Laser Specialists – are surgery centers that offer only or primarily LASIK surgery. Several local ophthalmologists focus on LASIK surgery but their practices offer other aspects of eye care in addition to the LASIK – Charlotte Ophthalmology Clinic, Christenbury Eye Center, Eye Care Clinic Vision & Laser Center, Genesis Eye Center, Mecklenburg Eye Associates, Mundorf & Renaldo, and Reeves Eye Clinic. Charlotte EENT (Eye, Ear, Nose, and Throat) and Horizon Eye Care are large practices that provide comprehensive, full-service eye care from routine eye exams to treatment of complex disease and surgery on the eye. Therefore, at the beginning of 2005, three strategic groups existed for the service category, each one having emerged using a different strategy.

Competitor Analysis – Mapping Competitors

Exhibit 3-11 shows a map of the strategic groups for refractive surgery in the Charlotte eye care market. In 2000, there was just one strategic group for refractive surgery. By the beginning of 2005, three distinct groups had emerged – the laser centers that only provide refractive surgery, the large group practices that

Exhibit 3–11: Competitor Analysis – Mapping Competitors



provide comprehensive care plus refractive surgery, and the very small group practice/solo practitioners who provide eye care and refractive surgery. The competitors will likely attempt to maintain the positioning that they have already established – or attempt to differentiate. The providers are somewhat different in their prices, equipment, the number of refractive procedures they perform in a month, and the comprehensiveness of the practice.

Competitor Analysis – Likely Response

A new competitor or any of the existing competitors have to realize the following:

- Any price decrease will likely be matched.
- Dr. Christenbury was the first to perform refractive eye surgery in the city. He owns more equipment than the other practitioners and continues to perform a high number of surgeries. More than likely he will continue to be at the forefront of any new technology.
- Competition is intense and the entrance of a new provider will be met with considerable resistance.

- Preemptive strategies – more advertising, reduced prices, and so on – by current competitors are highly likely if they have any indication that a new competitor may enter the market, thereby increasing the difficulty of entering the market.

Synthesis

Surgery to correct vision problems moved into maturity between 2002 and 2005 in the Charlotte market; the number of providers, the price competition, and the amount of advertising have all increased substantially. Consumer demand is increasing as the surgery is being performed with less pain and more accurate results. Providers who perform the surgery must gain enough experience to avoid complications and gain positive word of mouth. Until costs begin to decline as the laser technology moves through the product life cycle, providers need to perform more than 80 surgeries per month to surpass break even.

The four laser centers are in a strategic group; they are mutually dependent because the strategy of one affects the others. Intense rivalry exists as they attempt to improve their position in the market. Carolinas Eye Center is owned by a local ophthalmologist who has performed more than 25,000 procedures (200 procedures per month). Providence Eye & Laser Specialists is also owned by a local ophthalmologist who had a corneal fellowship after residency and has performed more than 10,000 procedures. Both of these locally owned centers focus exclusively on corrective vision surgery.

LASIKPlus Center's strategy is to develop relationships with ophthalmologists in the area and offer the Center for them to use to perform the LASIK surgery. LASIKPlus benefits from having many ophthalmologists in the area learn the LASIK surgery techniques and use its facilities to perform the surgery on their patients. Preemptive discounting to local ophthalmologists could wrap up its referral base.

TLC's strategy is to develop relationships with the many optometrists in the area to gain referrals. Again, preemptive discounting could wrap up the optometrists' referral base for TLC. Because younger consumers tend to use optometrists more, and optometrists cannot perform surgery, TLC provides staff surgeons. The younger population (but over eighteen with no change in eye prescription in the past two years) offers better candidates for LASIK as they do not have the problem of presbyopia (aging eye).

All four in this strategic group have to be aware of and ready for any of the new technologies that may receive FDA approval at any time. The introduction of a new technology would be the best chance to enter the market as a new provider.

Among the local ophthalmologists, Dr. Christenbury has positioned his practice as the best value, himself as the most experienced in performing the surgery (50,000 at the beginning of 2005), and he owns six laser machines. He has the legitimate claim of being the first to do LASIK surgery in Charlotte and his continued referrals and full waiting room attest to the investment he has made in developing the first-mover advantage. The other partnerships and smaller group practices offer refractive surgery as part of comprehensive care.

In conclusion, a new provider entering the market would have significant challenges and would need deep pockets. Certainly the provider would have to be experienced in the procedure, willing to invest heavily in advertising to develop a position in the market, use the latest technology, and be willing (and able) to have low volume for some time. Given the risks, high barriers to entry, competitive rivalry, and so on, it appears that Charlotte would not be a new ophthalmologist's first choice location for setting up a practice to start refractive surgery. An established ophthalmologist in the Charlotte area would have a better opportunity to seek additional training and certifications on equipment and begin offering refractive surgery to his or her own patients rather than referring them to other physicians. On the other hand, for either the new-to-the-Charlotte-market or the new-to-refractive-surgery physician, the Charlotte market is growing, its population is younger than average, and it possesses higher discretionary spending ability.

This analysis reveals that a provider who is new to the service area or the service category would have to develop some competitive advantage not currently offered to be successful. Given deep pockets and excellent surgical results (no complications to achieve effective word of mouth), it is possible.

Strategic Momentum – Validating the Strategic Assumptions

As with the general and health care environments, the initial analysis of the service area provides the basic beliefs or assumptions underlying the strategy. Once the strategic plan has been developed, managers will attempt to carry it out. However, as implementation proceeds, new insights will emerge and new understanding of the competitive services will become apparent. Changes in the service area or new competitor strategies will directly affect performance of the organization and therefore must be monitored and understood. Competitive awareness and analysis are ongoing activities. The strategic thinking map presented in Exhibit 3-12 provides a series of questions designed to surface signals of new perspectives regarding the service area assumptions.

The Use of General Environmental and Competitor Analysis

In health care organizations today there is a real understanding that not every organization will survive; that no one health care organization can be "everything to everybody." Understanding the external environment – including the general, health care, and service area/competitor environments – is fundamental to strategic management and survival. A comprehensive general and health care environmental analysis and service area competitor analysis combined with an assessment of competitive advantages and disadvantages (Chapter 4) and establishment of the directional strategies (Chapter 5) provide the basis for strategy formulation.

Exhibit 3–12: Strategic Thinking Questions Validating the Strategic Assumptions

1. Is the strategy consonant with the competitive environment?
2. Do we have an honest and accurate appraisal of the competition?
3. Have we underestimated the competition?
4. Has the rivalry in the service category/service area changed?
5. Have the barriers to entering the service category/service area changed?
6. Does the strategy leave us vulnerable to the power of a few major customers?
7. Has there been any change in the number or attractiveness of substitute products or services?
8. Is the strategy vulnerable to a successful strategic counterattack by competitors?
9. Does the strategy follow that of a strong competitor?
10. Does the strategy pit us against a powerful competitor?
11. Is our market share sufficient to be competitive and generate an acceptable profit?

Summary and Conclusions

Service area competitor analysis is the third element of environmental analysis and increases the focus. Service area competitor analysis is an increasingly important aspect of environmental analysis because of the changes that have taken place in the health care industry throughout the past decade. Specifically, service area competitor analysis is the process of assessing service category/service area issues, identifying competitors, determining the strengths and weaknesses of rivals, and anticipating their moves. It provides a foundation for determining competitive advantage and subsequent strategy formulation.

Health care organizations engage in service area competitor analysis to obtain competitor information and for offensive and defensive reasons. However, analysts must be careful not to misjudge the service area boundaries, do a poor job of competitor identification, overemphasize visible competence, overemphasize where rather than how to compete, create faulty assumptions, or be paralyzed by analysis.

The process of service area competitor analysis includes an identification of the service category for analysis, assessment of the service area conditions, service area structure analysis, competitor analysis, and a synthesis of the information collected and analyzed. Identification of the service category provides the basis for the analysis. Service categories may be defined very broadly or quite specifically and will vary with the intent of the analysis. An identification of the service area will include establishing geographic boundaries and developing a service area profile that might include economic, demographic, psychographic, and disease pattern information.

Service area structural analysis may be accomplished through a Porter five forces analysis: evaluating the threat of new entrants into the market, the service area rivalry, the power of the buyers, the power of the suppliers, and the threat of substitute products or services. Next, competitor analysis should be undertaken. Comprehensive competitor analysis would include an identification and

QUESTIONS FOR CLASS DISCUSSION 145

evaluation of competitor strengths and weaknesses, competitor strategy, strategic groups, critical success factors, and likely competitor actions and responses. Finally, service area and competitor information should be synthesized and strategic conclusions drawn to allow recommendations to be made.

Chapter 4 will explore how an organization examines its own strengths and weaknesses to understand competitive advantages and disadvantages as a basis for strategy formulation.

Key Terms and Concepts in Strategic Management

Competitive Advantage	Service Area	Service Area Structural Analysis
Competitor Analysis	Service Area Competitor	Service Category
Critical Success Factor Analysis	Analysis	Strategic Group
Mapping Competitors	Service Area Profile	Strategic Response

QUESTIONS FOR CLASS DISCUSSION

1. What is entailed in service area competitor analysis? Why should health care organizations engage in competitor analysis? Should not-for-profit organizations perform competitor analysis?
2. What is the relationship between general and health care environmental analysis and service area competitor analysis?
3. What competitor information categories are useful in competitor analysis? Are these categories appropriate for health care organizations? How can these information categories provide a focus for information gathering and strategic decision making?
4. What are some impediments to effective competitor analysis? How may these impediments be overcome?
5. Explain the steps or logic of service area competitor analysis.
6. Why must the service categories be defined first in service area competitor analysis for health care organizations?
7. Why is it important to clearly define the service area? How does managed care penetration affect service area definition?
8. How does the use of Porter's five forces framework help identify the major competitive forces in the service area?
9. Why is an identification and evaluation of competitor strengths and weaknesses and the determination of strategy essential in service area competitor analysis?
10. What are the benefits of strategic group analysis and strategic mapping?
11. Why should a health care organization attempt to determine competitors' strategies and likely strategic responses?
12. What is the purpose of the synthesis stage of service area competitor analysis?
13. Conduct a service area competitor analysis for a health care service with which you are familiar.

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ADDITIONAL READINGS

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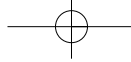
Institute for the Future, *Health and Health Care 2010*, 2nd edn (Indianapolis, IN: Jossey-Bass Publishing, 2003). This is the second edition of a comprehensive review of the technological and diagnostic advances of today’s health care system. The book provides an overview of a number of areas critical to an understanding of the US health care system. Some of the important topics include demographic trends, managed care, health care customers and competitors, public health services, and a variety of other important topics.

Morley, David and Scott Miller, *The Underdog Advantage: Using the Power of Insurgent Strategy to Put Your Business on Top* (New York: McGraw-Hill, 2004). The underdog advantage is a set of principles that have been proven successful over time. The advantage of the incumbent has diminished over time and may have disappeared completely. According to these authors, today is the day of the underdog. Since today’s customers are empowered with instant information they often feel overloaded and many traditional approaches to marketing are no longer effective. This book provides a strategy for the insurgent that is designed to overcome established competitors.

Porter, Michael E., *Competitive Strategy: Techniques for Analyzing Industries and Competitors* (Boston: The Free Press, 1998). In this classic work, Porter reviews competitive structure and the generic strategies in the first chapter – vintage Porter. The third chapter provides a detailed approach and framework for competitive analysis. He goes on to address competition in various types of industries. The discussion of industries that are fragmented, those in transition, and those with vertical integration are particularly pertinent for health care leaders.

Salaman, Graeme and David Asch, *Strategy and Capability: Sustaining Organizational Change* (Malden, MA: Blackwell Publishing, 2003). Virtually every writer has a formula for changing complex organizations in a way that will improve their effectiveness. This book also looks at how to effect organizational change in a fast-paced world. The major approaches to organizational improvement are identified, analyzed, assessed, and evaluated. The sometimes subtle relationships between strategy and capabilities are highlighted.

Tsoukas, Haridimos and Jill Shepherd (eds) *Managing the Future: Strategic Foresight in the Knowledge Economy* (Malden, MA: Blackwell Publishing, 2004). A set of ten papers by leading authorities on strategy and organizational learning. The papers address questions such as how organizational foresight can be conceptualized, how organizations make sense of their environments, how foresight can be developed, and similar issues. The book is a valuable source of information on strategic management in the knowledge-based society of today.



Zook, Chris, *Beyond the Core: Expand Your Market Without Abandoning Your Roots* (Boston, MA: Harvard Business School Press, 2004). Growth is an imperative. Growth, however, involves risks. Only about one fourth of growth initiatives succeed. Most of the business disasters of the past five years were growth initiatives gone bad. Most enduring performers succeeded by focusing on one or two well-defined dominant cores. Many organizations fail because they prematurely abandon their core to chase after a hot topic or fad.

