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EDITORIAL

The mixed legacy of managed competition: between policy and practice

Iris Wallenburg[1] and Rocco Friebel[2]

[1]Erasmus School of Health Policy Management, Erasmus Universiteit Rotterdam, Rotterdam, Netherlands and [2]Department of Health Policy, London School of Economics and Political Science, London, UK
Corresponding author: Rocco Friebel; Email: r.friebel@lse.ac.uk

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About 25 years ago, managed competition – also termed 'the internal market' and 'regulated competition', depending on the institutional characteristics and regulatory mechanisms that were highlighted – was introduced as a response to growing waiting lists and political concerns about the sustainability of health systems. Moving forward on the waves of new public management, and stretching from Australia to Columbia, and from the United Kingdom to South Africa, many health systems introduced some form of managed competition. Among other aspects, this would hold together the conflicting aims of efficiency and equity, combining 'public' security with 'private' market innovation and cost reduction.

In this special issue of *Health Economics, Policy and Law*, edited by Josefa Henriquez, Shuli Brammli-Greenberg, Francesco Paolucci, and Maria Trottmann, we aim to provide insights into the impact of managed competition as a policy instrument. To what extent have countries been successful in realising its full potential? And what might that potential look like in evolving health systems, where new challenges are emerging ever since? The special issue starts with an editorial by the editorial team, comparing the countries featured (*i.e.* Columbia, New Zealand, Ireland, Australia, the United States, Chile, South Africa, and the United Kingdom), highlighting and discussing their institutional characteristics that impact the (im)possibilities and challenges to achieving a managed competition model.

The editorial is followed by two theory-informed papers in which Trottmann et al. (2023) and Henriquez et al. (2024) present a theoretical framework and analytical model that explains the central features of the regulated competition model, emphasising the conditions that should be met to enable managed competition and to identify possible competition failures. In the subsequent papers, countries are held up to these standards.

The paper of Van den Heever (2024) shows that in South Africa, the managed competition model has only been partially introduced. It assesses the existing regulatory framework and the resulting market outcomes against the preconditions for a complete system of regulated competition as argued by theory. Also, the other papers describe the challenges to bring theory in practice, besides initial or only partial successes. Berardi et al. (2024), for example, discuss how in Australia structural deficiencies exist in public–private partnerships, which makes it difficult to deliver high-quality and accessible care for all. Ellis et al. (2024) points out the complex nature of the US health system and the programmes in which it has been introduced as a governing principle (*i.e.* the Affordable Care Act, Medicaid managed care organisations, and Medicare Advantage plans). They argue that the differences between these systems as well as their lack of

transparency hamper a shift towards 'real' managed competition. Castano et al. (2024) argue that also in Colombia, not all preconditions have been fulfilled to move further in the direction of managed competition, despite its success in obtaining better access to care. In fact, the current left-wing government has announced to move away from the private sector to the public sector, aiming for a system of integrated care. Armstrong (2025) examines how to adapt the current health insurance system in Ireland to support Sláintecare reform objectives of equitable healthcare access based on need, using the Enthoven managed competition model framework to assess preconditions for equity and efficiency. Finally, Cumming (2024) studies whether New Zealand could introduce a system of managed competition. The answer is however mainly negative – mainly because the promises of managed competition have lost political support after some early attempts in the late 1990s and preconditions of transparency and comparability have not been met.

Collectively, the papers in this special issue highlight that the spirit of managed competition is still very much present among policymakers and researchers, driven by the experiences from implementing certain elements and conditions in a range of countries. Importantly, though, evidence also shows that these attempts, which require several accompanying regulations and technical instruments, have been overtaken by emerging problems for which quick solutions were found that do not align with the conditions of a system of managed competition.

The effects of managed competition are not negligible. It has paved the way for more market thinking in health care and the introduction of for-profit and financial players. This shift focuses more on creating a profitable market rather than emphasising visibility and transparency, which are central to managed competition. Recently, the issue of the private and for-profit sector in health care was discussed in depth during a workshop in New York City, organised by the editors of *Health Economics, Policy and Law*, researchers from Columbia University, and the Commonwealth Fund. These discussions – and, consequently, the role of the (financial) market – will contribute to an upcoming special issue expected in early 2026.

We end with a critical note. This special issue is the result of committed scholars, able to conduct in-depth empirical and theoretical research that can be critical of (their) national governments. Free speech and critical research are key to science, to democracy, and to our journal. Increasingly, these fundamental features are under threat around the world. It is for that reason that the editorial board strongly endorses a statement signed by leading *Health Economics* journals (https://www.cambridge.org/core/services/aop-file-manager/file/685044542ced6b00769a86bd/Statement-of-Principles-from-the-Editorial-Boards-of-Leading-Health-Economics-Journals-05-21-25.pdf), expressing our commitment to the principles of rigorous, open, and inclusive scientific inquiry.

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