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GUEST EDITORIAL

The roadmaps to managed competition: theory and practice

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1. Context and relevance

Equal access to health care is a continuous concern for governments in developed countries. As systems are progressively confronted with the rise in healthcare costs, policymakers face growing financial pressures, which trigger regulatory responses.

In this context, the managed competition model emerged, with its theoretical foundations established in Alain Enthoven's seminal (1978) work. This model gained traction during the 1990s, in what Cutler terms the third wave of 'medical care' reforms, responding to the perceived problems in healthcare systems (ie. increasing costs, inefficiencies, quality concerns), as well as dominant economic theory and the political climate (Cutler, 2002). These reforms focused on incentives, particularly competition, to promote efficiency and responsiveness to consumers. Nevertheless, there are substantive reasons for caution. Competitive markets tend towards risk rating, which can result in unaffordable costs for individuals with expensive medical conditions. Moreover, health care is often viewed as a 'right' or moral imperative (Handel and Ho, 2021), whereby market-based incentives might conflict with equity goals. As a result, competitive reforms have remained tentative.

Influential country reforms included the Netherlands' Dekker Plan, which led to full implementation by 2006 (Schut and Van de Ven, 2011); the Clinton reform (Diamond, 1992); and reforms in Switzerland (Schneider, 1996). Notably, similar principles were implemented under different labels, with 'internal market' reforms in the UK NHS (Le Grand, 2009) and later in Sweden, New Zealand, and parts of Spain.

In the last 30 years, the model of managed competition and its application have evolved. Both policymakers and health economists have strived to provide a theoretical framework in which the classical economic trade-off of equity and efficiency is balanced in the contemporaneous setting. Notable contributions include the work of Van de Ven *et al.* (2013), in which the authors developed a list of 10 preconditions to achieve the goals of equity and efficiency and evaluated their achievement in selected countries (Belgium, Germany, Israel, the Netherlands, and Switzerland); work by McGuire and Van Kleef (2018), which laid out categories of specific regulatory tools that are available to achieve the model and provide a comprehensive review of health plan payment in countries ranging from Australia, the USA, to China; and lastly, Van de Ven *et al.* 2024 follow-up study, which evaluated the progress of the five original countries over the 2012–2022 decade.

This work reveals a series of theoretical and practical challenges this model faces currently. While it provides a solid economic foundation paired with regulatory tools to integrate aspects of

financing, insurance, and provision of care to achieve universal healthcare coverage, and policy goals of equity and efficiency, it has been noted to be a time-consuming endeavour. This is due to the complexity of some preconditions, the conflicting nature of others, and the challenge of fulfilling them simultaneously, which requires careful prioritisation. Furthermore, not only is empirical performance relevant but also societal preferences. Currently, the managed competition model is applied not only across Europe but also in parts of Latin America, Asia, and Russia, and as healthcare systems shift from integrated models towards more hybrid features (Berardi, Schut, and Paolucci, 2024), the growing tensions between equity and efficiency require careful policy design to balance access, affordability, and system sustainability, in a wider range of settings.

2. Aim and outline of the volume

This volume presents a set of conceptual and empirical contributions that critically examine how managed competition principles have been adapted, challenged, or partially implemented in countries with diverse institutional settings, many of which fall outside the traditional social health insurance (SHI) archetype.

To organise these diverse contributions, we use the preconditions framework originally developed by Van de Ven *et al.* (2013), which outlines the regulatory features considered necessary for managed competition to function effectively. This framework facilitates cross-country comparison and critical reflection. Indeed, one of the goals of this issue is to assess the utility and limitations of this framework when applied beyond the European context for which it was originally developed. In the first conceptual paper, 'The roads to managed competition for mixed public–private health systems: a conceptual framework', Henriquez *et al.* revise and extend the preconditions for managed competition and typologise the roadmaps to achieve the model, particularly to fulfil the precondition of 'free consumer choice of insurer'. In the essay 'Balancing between competition and regulation in healthcare markets', Trottmann *et al.* (2023). discuss criteria and tools that regulators can use to fine-tune the balance between competition and regulation in managed competition-based healthcare systems. These two conceptual papers create a whole picture of managed competition models.

We invited authors to contribute country-specific case studies to this volume. Our prompt to them consisted in, by utilising the economic and regulatory prerequisites for managed competition to satisfy the equity and efficiency principles, to examine the existing gaps (and propose strategies to address them), ultimately aiming to align their country health systems more closely with an integrated framework in comparison with the current status. The authors were given the freedom to use their local expertise to determine the methodology that would best reflect the challenges and the future of their health system.

The volume draws on the case studies of Australia (Berardi et al., 2024), Chile, Colombia, Ireland, Aotearoa New Zealand (focusing on Primary Health Organizations – PHOs that act as health plans contracting with primary care providers), South Africa (focusing on medical schemes), and the USA (focusing on the subsystems of Medicare Advantage, Market-places, Medicaid Managed Care Organizations – MCO). We selected these countries *first*, because they vary in terms of economic development and geographic location. *Second*, since the degree to which managed competition has already been established differs. Some countries (eg. Colombia) already implemented a managed competition-based system but remain outside the set of countries where this model is typically studied. In other countries, a strong public sector covers either 100 per cent of the population (eg. Australia, Ireland, Aotearoa New Zealand) or a significant portion (eg. South Africa, Chile, USA), and the private market either offers primary coverage (eg. Chile, USA) or duplicative/supplementary coverage (eg. South Africa, Australia, Ireland and Aotearoa New Zealand) to a relevant percentage of the population. *Last*, these countries also share the fact that managed competition has been explored as a reform option: in the USA, the concept was crucial in the introduction of the 'Affordable Care Act' in 2010; in Australia, the National Health

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and Hospital Reform Commission in 2009 discussed the idea in the 'Medicare Select' proposal; in Ireland, the Fine Gael and Labor Programme for Government suggested establishing Universal Health Insurance through competition the 'Dutch way' in 2011; in Chile, the idea has come up in the Programme for Government of the former president Sebastian Piñera in 2018, and served as the basis in two legislative projects (2011 and 2019); in South Africa reforms from 1994 proposed a move to a National Health Insurance system; and in Aotearoa New Zealand, these ideas influenced reforms stemming back to the late 1990s but were later abandoned.

3. Findings and perspective

The country contributions discuss the challenges inherent in the managed competition model and gauge their varying significance in each specific context. A central aspect of the papers pertained to the assessment of a set of 13 preconditions or prerequisites that needed to be fulfilled to achieve managed competition (10 of which correspond to those outlined by Van de Ven *et al.* (2013) and 3 of which are introduced by Henriquez *et al.* 2024). The results from the assessment of the original preconditions outlined by Van de Ven *et al.* (2013) are presented in Table 1.

Consumer choice motivates market competition. The assessments reveal that, apart from Chile, 'free consumer choice of insurer' prevails in the private insurance sector through open enrolment and no refusal based on pre-existing conditions. However, in Aotearoa New Zealand, access to primary care services can be limited due to the 'book' closure of general practices. Moreover, in countries like Australia and Ireland, where a mandatory contribution to the public insurer is enforced, the existence of choice is precluded. In the case of the USA, choice is often tied to the household's employment.

Competition based solely on price risks quality skimping if there is no market transparency and information on the quality of insurers, plans, and medical products and services. Regulations must be in place to ensure 'consumer information and market transparency'. The absence of a standardised basic benefit package is the primary factor contributing to lack of market transparency in the insurance market, characterised by numerous products (as seen in Australia, Chile, Ireland (Armstrong, 2025), South Africa, and the USA), and the lack of clarity around entitlements in Aotearoa New Zealand's PHO's, hindering the achievement of this precondition. This is not the case for Colombia, where a standardised basic benefit package was implemented. Overall, if there is information on medical products and services, it was approached from the perspective of 'effective quality supervision' precondition, revealing that this type of quality was barely monitored, and therefore, public information on this is not widely available.

Insurers and providers should bear financial responsibility to ensure efficiency. In terms of 'risk bearing buyers and sellers', financial responsibility is diminished by several factors. For instance, risk sharing can be a contributing factor, as seen in Australia and Ireland (while not deemed considerable in the latter). Risk adjustment reduces but does not eliminate risk-bearing capacity in the USA. Additionally, financial responsibility is reduced when hospitals' fixed budgets are supplemented (Australia, Chile) or there are other ways to avoid cost consequences (South Africa) (van den Heever, 2024). Moreover, the overall possibility of shifting financial responsibility to consumers (through either price setting of medical services or premium increases) is also observed in Australia, Chile, and Aotearoa New Zealand. In the case of strict capitation with no outside options for financing (eg. Colombia), risk-bearing capacity increases.

'Contestable markets' relates to whether the regulation is set to allow for new insurers, hospitals, or independent providers to enter/exit the market. No explicit or hard restrictions are identified by the countries (eg. prohibitions to set up a new insurer). Depending on country-specific characteristics, the establishment of public hospitals is constrained by sectoral public investments. Indeed, in Aotearoa New Zealand, District Health Boards (DHBs) determine PHOs' geographical locations. Contestability can be reduced by market outcomes such as the consolidation of insurers (and providers) in Australia, Ireland, Chile, the USA, and South

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Table 1. A summary and cross-country comparison of the assessment of the 10 preconditions as outlined by Van de Ven *et al.*, 2013. In Australia, Chile, Colombia, Ireland, Aotearoa New Zealand, South Africa, and the USA

Preconditions	Australia	Chile	Colombia	Ireland	Aotearoa New Zealand (PHOs)	South Africa (Medical Schemes)	US (Medicare Advantage, Market-places, Medicaid MCO)
Free consumer choice of insurer	Lack of insurer choice due to compulsory public insurer (Medicare) and duplicative voluntary PHI for hospital care. Open enrolment and no pre-existing condition restriction in PHI with waiting periods. No minimum contract period or terms of notice.	There is choice of insurer in theory. Open enrolment and no pre-existing conditions apply to the public insurer, but not for private insurance (fully substitutive). Guaranteed renewability (in private insurance).	Open enrolment and no restrictions based on pre-existing conditions. Significant inertia in switching. Limited Choice in small geographic markets.	Public insurance and PHI for private facilities. Open enrolment with waiting periods in PHI. Significant switching amongst low-risk groups.	Choice of general practices and PHOs, but general practices can close their books. Limited choice in small geographic markets.	Consumers are largely able to choose their insurer (some exceptions remain).	Segmented markets mean consumers have varying degrees of choice; in many cases, choice is tied to individual or household employment.
Consumer information and market transparency	Product tiers (basic bronze, silver, gold) in the absence of a basic benefit package. Large number of products. In Medicare, transparency concerns at provision level, particularly due to unknown out-of-pocket fees in GP and non-GP care.	Large number of products in private insurance, and no plan choice in the public insurer.	Single benefit package (same coverage of benefits and out of pockets). Process and outcome indicators at the provider and insurer level related to the high-cost account.	Large number of products, no standardisation of product information, other complicated differences.	No benefit package that all PHOs and general practices have to deliver. Information on quality of care (eg. performance) not available for practices.	Lack of standard benefit package, complexity of the benefits, multiplicity of products, and conflicting advice offered by brokers.	Lack of standard benefits and complexity of benefits, as well as fragmentation across insurance type and state, leave markets for insurance opaque to most consumers.
Risk-bearing buyers and sellers	Insurers risk-bearing capacity reduced by risk equalisation and	Risk bearing is arguably mostly reduced in private insurance	Insurers bear risk as they receive a per-capita payment from the	Insurers risk-bearing capacity reduced but not nullified by risk sharing	PHOs and general practices bear financial risk through	Both medical schemes and private healthcare providers can avoid	Risk adjustment reduces risk bearing by insurers, but

(*Continued*)

Table 1. (*Continued*)

Preconditions	Australia	Chile	Colombia	Ireland	Aotearoa New Zealand (PHOs)	South Africa (Medical Schemes)	US (Medicare Advantage, Marketplaces, Medicaid MCO)
	risk sharing. Hospital spending above financing growth cap paid by states and territories.	and provision due to the legal ability to shift cost increases to premiums paired with fee-for service model. Public hospitals are subsidised and their budget is supplemented by the central government. Capitation in primary care leads to over-referrals.	risk equalisation fund and prospective budget for services outside the benefit package.	(high-cost claims pool). Individual consumers are increasingly purchasing excess/co-payment products.	capitation, but they have the ability to set their own levels of user charges.	the consequences of cost and quality failures.	does not eliminate it.
Contestable markets	Hindered by consolidation. Private provision has increased over time.	Hindered by consolidation and provider integration. Subsidised and public providers not allowed to fail.	Capital requirements hard to enforce, and government delays in paying providers exist.	Highly concentrated market explained by past regulatory uncertainty, switching difficulties, vertical integration, and small market volume.	DHBs determine PHO establishment in a geographical area.	Hindered by consolidation for both medical schemes and hospitals.	Hindered by consolidation, as well as high degrees of market fragmentation within and across states.
Freedom to contract and integrate	Requirements differ between public and private insurance. Commonwealth funds services, state finance public hospitals, causing gaps. Fee-	Private insurers can organise networks and integrate to some extent. Contracting for the public insurer is constrained by legal barriers	Contributory scheme (CS) largely selectively contracts. Subsidised scheme (SS) has contracting restrictions (eg.	Freedom to contract for private providers but particularly allowing for insurers to freely contract for public hospitals and creating one	PHOs can contract with providers of care, but national agreements set funding; limited practice choice.	Regulation permits medical schemes to make any arrangement to comply with covering the costs of benefits	Limited public opposition to integration and network formation

(*Continued*)

Table 1. (*Continued*)

Preconditions	Australia	Chile	Colombia	Ireland	Aotearoa New Zealand (PHOs)	South Africa (Medical Schemes)	US (Medicare Advantage, Market-places, Medicaid MCO)
	for-service hinders innovation and integration. PHI's freedom to contract and integrate is restricted and contingent on the service type and regulatory complexity	(who to contract and how to contract).	with public hospitals)	integrated marketplace of public and private providers of care.			
Effective competition regulation	Competition is regulated by law and enforced by a special office.	General guidance by the competition authority, but not specific to health care.	Generic framework and authority enforces across all sectors, but not specific to health care.	The Competition and Consumer Protection Commission enforces competition rules in health care, excluding public hospitals exempt from competition oversight.	Commerce Commission protecting against anticompetitive practices, while unclear in proactiveness.	Competition Act, major market inquiry findings and recommendations now feed into merger investigations and examinations of market conduct.	Competition regulation is enforced for large mergers with national markets, but little is done to regulate smaller, local markets.
Cross subsidies without incentives for risk selection	The public scheme has no incentives to select risks. In PHI, this is not the case. Community rating paired with crude risk equalisation (based on risk sharing using pre-defined weights and high-cost pool). Product differentiation through premium differentiation.	Income and risk selected subsidies in public insurer. Small community rated premium in private insurer, otherwise no subsidies. Crude risk equalisation formula based on age and sex.	SS fully subsidies, and contributions to CS are based on salary. Risk adjustment by age, gender, and geography and high-cost account for five high-cost medical conditions.	No income-related cross subsidies in private insurance, and unsophisticated compared to many others with the use of age, gender and type of cover.	Weighted capitation funding formula based on age and sex.	Does not have a risk adjustment mechanism to remove risk selection incentives.	Risk adjustment removes risk selection incentives with varying degrees of success across insurance markets.

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Table 1. (*Continued*)

Preconditions	Australia	Chile	Colombia	Ireland	Aotearoa New Zealand (PHOs)	South Africa (Medical Schemes)	US (Medicare Advantage, Marketplaces, Medicaid MCO)
Cross subsidies without opportunities for free riding	Individuals cannot free-ride the mandatory tax-financed public scheme. Private insurance is incentivised by subsidies and penalties.	Mandate to contribute a percentage of taxable income.	Compulsory enrolment in either the CS or the SS. Strong incentives to minimise contributions for CS or remain in SS despite not being eligible.	Voluntary system and mandatory health insurance rules do not exist.	Individuals cannot free-ride the mandatory tax-financed tax-funded system.	Voluntary. Waiting periods and late joiner penalties exist.	No requirement to enrol in health insurance or contribute to insurance schemes.
Effective quality supervision	Provider accreditation uniformly for public and private providers.	Ex-ante evaluations (eg. provider accreditations) but not ex post monitoring (eg. readmissions or plan ratings).	Quality supervision has focused on structure and process indicators, which are not necessarily good proxies of desirable health outcomes	Health Information and Quality Authority (HIQA) are largely fit for purpose to ensure consumers are protected	Accreditation for general practices, and Health Quality and Safety Commission, and the work of PHOs.	No regulatory supervision of quality in the private.	Quality supervision does little to ensure effective quality although some individual states monitor Medicaid and the Marketplace
Guaranteed access to basic care	Waiting times increase for the public and differences between the public and private. Disparities in access remain for rural and remote Australians, as well as Aboriginal and Torres Strait Islanders.	Major problem in the public insurance. No targets for Non-GES conditions	Access is guaranteed while some barriers to care exist.	Significant concern in public health system (problem of resources), while less of a concern within the voluntary health insurance system.	No obligation for PHOs and general practices to take on all potential patients, no minimum benefit package with access criteria or monitoring of quality service delivery.	Access to care is not guaranteed.	Access to non-emergency care is not guaranteed.

Note: Medicare = Australia's public scheme; PHI = Private Health Insurance; PHOs = Primary Health Organizations; DHBs = District Health Boards; SS = subsidised scheme; non-GES = services not guaranteed in terms of access.

Africa, while private providers (at different levels of care) have increased contestability in Chile and Australia. Fragmentation of the market within and across states in the USA also decreases market contestability. In Colombia, low barriers exist, which, on the contrary, might leave consumers unprotected due to capital requirements appearing hard to enforce, and money flows being delayed by the government, reducing interest in market entry. In the case of private provision, several countries observe evidence of new independent providers effectively emerging, revealing contestable markets in this area.

Insurers and providers should have the freedom to contract and integrate within certain regulations. Segmented (between public and private schemes) contracting rules exist in Australia, Chile, and Colombia; therefore, the 'freedom to contract and integrate' precondition differs between public and private schemes. Usually, the private insurers have more freedom to (selectively) contract, albeit within certain limits. The public insurer or subsidised scheme (SS) (as in Colombia) is subject to contracting restrictions. Contracting seems to be more flexible in South Africa and Aotearoa New Zealand, where PHOs can contract with providers of care, but national agreements set funding. In the USA, selective contracting, integration, and network formation are more accepted and prevalent.

Regulation is needed to prevent anticompetitive practices. 'Effective competition regulation' in the mixed public–private systems necessitates an analysis of the status of this regulation for public and private schemes, as well as insurers, hospitals, and independent providers. Regulation against anticompetitive practices is well-established in most countries. However, some challenges remain, such as giving more emphasis to health markets (eg. Chile and Colombia) or the lack of oversight on the competition of certain actors (eg. public hospitals in Ireland or smaller markets in the USA).

Affordability of health insurance requires establishing cross subsidies, typically in the form of premium rate restrictions, subsidies, and risk equalisation schemes. 'Cross subsidies without incentives for risk selection' is addressed through risk equalisation schemes across countries. These formulas are usually simple in nature and are characterised by risk factors such as age (Australia), gender (Chile, Colombia, Ireland, Aotearoa New Zealand), and geographical location (Colombia), except for the USA, and in three cases, a high-cost pool (Ireland, Australia, Colombia). Risk equalisation is a key feature of managed competition, absent in South Africa, effectively driving selection and impeding competition based on cost and quality.

The regulatory tools to achieve 'cross subsidies without opportunities for free riding' vary considerably between countries. A universal legal mandate to enrol exists only in Colombia, primarily responding to the universality of the managed competition system in that country. Still, contributions, either through taxation (in the public Medicare – Australia, and Aotearoa New Zealand) or income-related contributions, as in Chile, are other forms of minimising free riding/mandating health insurance cover. Australia, Ireland, and South Africa share 'softer' mandates for enrolment in voluntary private insurance through incentives and penalties. Those are more extensive in Australia and less in Ireland and South Africa – with only penalties for late joiners. In the USA, there is no mandate (or similar) to enrol.

Consumers should be protected against poor service quality. 'Effective quality supervision' is mostly attained through provider accreditation across public and private providers (Australia, Chile, Colombia, Ireland, Aotearoa New Zealand) except for South Africa, where there is no regulatory supervision. A common feature is the absence of health outcomes or ex post monitoring (as highlighted by Chile and Colombia). In the USA, state variation exists in terms of Medicaid and Marketplace quality monitoring, with an overall lack of effective quality supervision.

Lastly, access to basic care should be ensured by insurers, and adequate solutions should be provided to meet demand. In terms of 'guaranteed access to basic care', to varying degrees, public and private patients face differential waiting times for care (eg. Australia, South Africa, Ireland, Chile). In the USA, only emergency care is guaranteed. Also, no targets (Aotearoa New Zealand PHOs and general practices and Chile conditions excluded from the basic package) hinder the

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attainment of this precondition. Colombia has managed to improve access to care, while some barriers still exist.

Three additional preconditions, 'basic benefit package', 'affordable out of pocket payments', and 'no conflict of interest by the regulator', are added in this volume, and the cross-country assessments are summarised in Table 2.

To ensure a minimum standard of care, a benefit package should be established. The definition of a standardised 'basic benefit package' varies amongst the countries. To an extreme, no set basic benefit package exists in South Africa and Aotearoa New Zealand and is less clear in Ireland (both public and private), and while arguably with greater comprehensiveness in Colombia and Chile, in the latter, benefits are largely disintegrated. The latter is also the case for the USA, where different packages exist across insurance types and markets.

Excessive out-of-pocket payments will be detrimental to the poor and sick. 'Affordability of out-of-pocket payments' varies amongst the countries, but there are shared features. In Australia, Aotearoa New Zealand, and South Africa, cost-sharing structures that allow providers to set their own fees and high safety nets affect high-risk users. This is also the case in Chile, where service exclusion is also noted as an important driver. In Ireland, it is highlighted how affordability differs between the public and private settings. In the USA, the main gap remains in terms of catastrophic expenditure protection.

The final precondition added to meet equity and efficiency under the managed competition model is no conflict of interest by the regulator. This will require governance/stewardship to be separated from the other healthcare functions and institutions to have clear and non-conflicting goals. The country case studies revealed that healthcare regulators often struggle to maintain independence from government influence, particularly regarding public insurance schemes (both insurance and provision). For example, in the case of Chile and South Africa, political discretion in terms of appointments creates conflicts of interest. There is also increasing interconnection with safety-net hospitals (eg. Colombia). In all studied cases, there was a clear distinction between government and privately owned insurers/providers, which helps prevent conflict of interest. In the USA, it is highlighted how political polarisation hinders long-term priority setting and effective regulatory frameworks.

While some preconditions of the managed competition model remain unfulfilled and challenging in the country-specific case studies, it is insightful to compare the situation with the European countries subject to Van de Ven *et al.*'s original paper. In its review 10 years later (Van de Ven *et al.*, 2024), the authors highlight how the varied success across different countries can be attributed to three key factors: technical complexity, such as challenges in developing effective risk equalisation; resistance from interest groups, including healthcare providers opposing selective contracting and transparency; and diminishing political support paired with growing scepticism about market-based approaches in public sectors. These are elements that should be addressed if managed competition were to be implemented. 'Free consumer choice of insurer' is the only precondition more strongly met. This is not surprising and is expected, as these are countries with universal mandatory insurance coverage, while those considered in this volume are mixed systems. Hence, a reform to integrate the two systems would help to fulfil this precondition, as is currently being implemented in Colombia.

The framework outlined three transition pathways for mixed public–private systems to managed competition and achieve 'free consumer choice of insurer': 1) convergence of the public and private scheme, 2) abolishing the private scheme and establishing the principles of managed competition within the public scheme, and 3) privatising the public scheme and establishing the principles of managed competition within the private system. The roadmaps highlight how the way to health reform is interconnected with the political agenda.

Colombia showcases an implemented model of the convergence of the public and private scheme, demonstrating the feasibility of this pathway and showcasing the achievement of near-universal coverage, equitable guaranteed access to health care, and close to no financial hardship.

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Table 2. A summary and cross-country comparison of the assessment of the extended preconditions as outlined by Henriquez *et al.*, 2024. In Australia, Chile, Colombia, Ireland, Aotearoa New Zealand, South Africa, and the USA

Preconditions	Australia	Chile	Colombia	Ireland	Aotearoa New Zealand (PHOs)	South Africa (Medical Schemes)	US (Medicare Advantage, Market-places, Medicaid MCO)
Basic benefit package	Includes the Medicare Benefit Schedule and Pharmaceutical Benefit Schedule, plus free hospital entitlements. No set package in private insurance.	Includes, 87 healthcare conditions, ISAPRE's mandatory benefits and supplementary and complementary benefits, FONASA services in public and private providers, and 'Ricarte Soto' Law (high-cost conditions). Excludes, for the most part, outpatient pharmaceuticals.	One single benefit package (negative list) with same coverage of benefits and out-of-pocket expenses in both CS and SS.	Public health system as to what constitutes an appropriate benefit package from a societal equity perspective in Ireland and with this in mind entitlement within the medical card have been left ambiguous.	No basic package in primary care. While there are some minimum standards set.	No system of price supervision that can address the prices charged for PMBs and out-of-pocket expenses	Basic packages differ across insurance types and markets.
Affordable out-of-pocket payments	Arguably low but rising. Cost-sharing structures affect GP and primary care OOP.	High out-of-pocket payments due to service exclusions, FONASA service rationing, ISAPREs complex cost sharing.	Arguably low.	Gradually been reduced in the public sector and increased in the private.	Government support for those that cannot afford user charges, safety nets are set for very high users.	No provider supervision charged for PMBs and out-of-pocket expenses	Arguably, no protections exist against catastrophic payments for even emergency care.
No conflict of interest by the regulator	Complex federal-state division hampers efficient governance and purchasing	Presidential discretion to remove high positions across the board in the public scheme (insurer, Health services and providers).	Purchaser provider split, while government not at arm's length with safety-net hospitals.	The Health Service Executive has the role of provision while the Department of Health is responsible for governance/regulation. Other bodies take on other regulatory elements.	Oversight by different government agencies, and primary care providers all being privately owned.	Key positions are all political appointments.	Political polarisation hampers effective regulation, and the rise of private equity ownership of physician practices further generates conflicts of interest.

However, it highlights challenges in achieving integration of provision for value-based care, mainly driven by existing regulatory barriers (eg. restrictions to vertical integration, and prospective payments), as well as other aspects of implementation to maximise the efficiency gains of the model such as dealing with informal employment (Castano et al., 2024).

Australia, Chile, and Ireland prefer the convergence of the public and private schemes as a pathway for reform to address existing challenges in the health systems. These cases also mention the contentions existing on the role of private insurance and preferences towards consolidating the single-payer system. Nevertheless, they highlight that the lack of policy coherence over time has affected equity and efficiency. Incremental changes in both the public sector (which suffers from typical single-payer problems) and the private scheme (which lacks equity) can be informed by this volume, and existing evidence that the foundational structures for this model exist due to the fact that several preconditions for managed competition are already almost fulfilled.

In Aotearoa New Zealand (Cumming, 2024), regulations that (in theory) would deliver effective, efficient, and equitable PHOs in a managed competition model are missing. This has had serious consequences for the performance of primary care in recent years. South Africa explores improving the role of medical schemes while complementing the public system to achieve universal health coverage through proper regulation. In its experience, it shows the consequences of an incomplete reform in the absence of risk equalisation, which has created unproductive forms of competition (eg. risk selection) between both insurers and providers. Finally, in the USA (Ellis et al., 2024), the authors state that expanding managed competition remains an 'uphill struggle' and that if current silos, which segment the markets are not harmonised by introducing a portable system of coverage, it is unclear how a workable roadmap to manage competition would be established.

Reflecting on this volume, important insights are offered to policymakers. These include new preconditions needed to achieve managed competition, such as the importance and necessity of a basic benefit package and considering the conflicts of interest by the regulator introduced by the hybrid nature of the case studies. Additionally, considerations over the pathways to transition towards free consumer choice of insurer are made. This volume also raises important questions, such as, can a politically and technically supported transition to managed competition be agreed upon? If this is questioned, should policymakers rather focus on selectively targeting improvements to the preconditions within their health systems instead of a complete overhaul?

Finally, in terms of the broader literature, we acknowledge the need for future research to expand the countries considered for a more accurate reflection of challenges and solutions in implementing managed competition. Additionally, while this volume didn't specifically address countries with predominant NHS systems, it remains an intriguing avenue for future research to determine the preconditions for establishing a single-payer system to meet equity and efficiency.

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