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10-11-1999

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Light, Donald W.. Managed Competition: Lessons from Britain. LDI Issue Briefs. 1999; 5 (2). <http://ldi.upenn.edu/policy/issue-briefs/1999/10/11/managed-competition-lessons-from-britain>

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# Managed Competition: Lessons from Britain

## **Abstract**

As phrases like “managed care backlash” become part of the lexicon in American health care policy circles, it is instructive to examine a managed competition experiment in a vastly different context. Britain’s Conservative government instituted reforms in 1991 to transform the National Health Service (NHS) from a centrally administered service to managed competition between purchasers and providers. Five years later, it replaced those reforms to promote cooperation rather than competition. This Issue Brief summarizes what the NHS can learn from decades of American experience with purchasing care, and what the American health system can learn from the British experiment with an internal market in the 1990s.

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# LDI *Issue Brief*

Volume 5, Number 2  
October 1999

Leonard Davis Institute of Health Economics

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## ***Managed Competition: Lessons from Britain***

Editor's Note: As phrases like "managed care backlash" become part of the lexicon in American health care policy circles, it is instructive to examine a managed competition experiment in a vastly different context. Britain's Conservative government instituted reforms in 1991 to transform the National Health Service (NHS) from a centrally administered service to managed competition between purchasers and providers. Five years later, it replaced those reforms to promote cooperation rather than competition. This Issue Brief summarizes what the NHS can learn from decades of American experience with purchasing care, and what the American health system can learn from the British experiment with an internal market in the 1990s.

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### ***How the NHS is structured***

The British National Health Service is a government-financed system serving all 50 million residents through more than 100 district health authorities. It provides universal coverage within set budget limits.

- The NHS contracts with primary care physicians on a low-risk, part-capitation contract. It owns its own hospitals, and employs its specialists and other staff on a salary basis. It operates on a primary care gatekeeper model, meaning that patients get access to specialists through their general practitioner (GP).
- About 12% of the population purchases private health insurance that supplements their NHS benefits. Private insurance offers choice of specialists, avoidance of queues for elective surgery, and higher standards of comfort and privacy than the NHS. Private insurance accounts for about 4% of health expenditures.
- Before 1991, the NHS was publicly administered and centrally governed. The main budget for hospital and community health care was allocated to district health authorities, and GPs were paid through a separate, national contract. This single bureaucracy was replaced in 1991 with the introduction of competition within the system.
- Over the previous 40 years, careful planning had created a taut system with equitable distribution and access, and very little surplus. Costs were kept at 20% less than the average for Northern Europe.

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### ***Managed competition,*** ***British style***

The 1991 Thatcher reforms introduced an "internal market" that was meant to promote competition between purchasers and providers. Within set budget limits, the reforms created markets of competitive contracts among doctors and hospitals.

- Purchasers and providers were separated. District health authorities became
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purchasers of community, secondary and tertiary services, with risk-adjusted budgets based on the district's population.

- Hospitals and other providers became sellers or “trusts” with quasi-independent powers (though still part of the NHS). These providers, in theory, would compete for contracts, but budget surpluses and losses were tightly controlled to avoid destabilizing the system.
- Larger GP practices (4-8 physicians) were given the option of becoming “fundholders,” with the power to purchase a defined set of secondary services for their patients. Fundholders were given part of the health authorities’ budget to manage, and were allowed to keep any surpluses (to be spent on upgrading services or facilities for patients). Non-fundholding GPs continued on their national GP contract and bore no risk for secondary services they ordered.

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### ***Do primary care doctors make good purchasing agents for their patients?***

One of the most promising aspects of the 1991 reforms was the potential to have GPs purchase community and secondary services for their patients. In theory, it would allow doctors to be purchasing agents for their patients, and reduce waste in specialty and hospital medicine. But in practice:

- About half of GPs did not want to become fundholders, because of ethical or practical issues; they lacked the time and training for this complex task. Of fundholding GPs, half indicated that they want to get out of fundholding.
- A national review of fundholders found that only a small minority of practices realized the potential of fundholding to increase value and quality, while the rest did little with the power of the purse. They did not have the technical skills and infrastructure to challenge ineffective practices. GP fundholders could implement simple changes such as shifting to generic drugs and bargain hunting, but usually did not tackle the larger savings that lie in reducing visits or procedures of questionable effectiveness.
- Fundholding seriously compromised the ability of the health authorities to purchase equitably for the entire district population and to develop public health programs. The fundholding practices received part of the health authorities’ budget to purchase the lower-risk, elective 20% of hospital, specialty and community health services. The health authorities remained responsible for many high-cost and community care benefits for the fundholders’ patients.

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### ***Managed competition did not work as planned***

By most accounts, managed competition did not succeed in reducing inefficiency and improving quality in the NHS. When applied to a health care system with safeguards against cream skimming, cost shifting, and reduced quality, competition did not work as well as it appears to in the United States.

- Competition created new inefficiencies, costs and dislocations. The number of managers in the NHS tripled. Health care institutions that “lost” in competitive markets did not shut down quickly; instead, they remained and added to everyone’s costs.
  - Competition is only as effective as the purchasers and the information they have collected. Due to limited information on costs and quality, health authorities purchased services in block contracts with hospitals, and little competition for contracts occurred.
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- Ironically, the introduction of a competitive market led to more government controls and regulation than the publicly administered system. The government dictated the extent of competition to protect the public from the potential economic and political consequences of institutional closures; government bailouts assured that few providers failed or left the system.

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### ***Britain's new reforms replace competition with cooperative purchasing***

By spring of 1996, the Conservative government shifted its policies and rhetoric to “partnership” and “cooperation.” They also integrated separate budgets for primary, secondary, and community services. The Labor government has developed these themes further.

- The new reforms propose to universalize fundholding by requiring GPs to form “primary care groups” (PCGs), responsible for purchasing all health care for defined geographic populations of 80,000-100,000 people. In stages, the entire risk-adjusted budget will be transferred to PCGs.
- Health authorities will no longer purchase services for a defined population, but will remain accountable to the central government for how the PCGs perform. The health authorities will also manage the transition process.
- A national performance framework has been developed. The reforms shift the focus from measuring activity and its efficiency, to a focus on effectiveness, quality and health gain. Two new national entities will be created: the National Institute for Clinical Effectiveness, to set standards, and the Council for Health Improvement, to enforce them.

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### ***Lessons from the U.S. for effective purchasing of services***

In Britain, there is a sense that most of the benefits of the 1991 reforms stemmed from the act of purchasing, and almost all of the disruptions and inequities came from competitive contracting. But will the new PCGs be effective, knowledgeable purchasers? Based on the experience of the best American purchasing groups in the 1980s, Light identifies these prerequisites for effective purchasing:

- Purchasing organizations need to be large and strong, with marketplace clout and a large population base. Larger groups can better manage and bear risk, especially for rare, costly cases. They also can support a skilled team of clinical and financial managers, and can spread the resulting administrative and transaction costs over a larger client base. They need data systems that provide good measures of benefits and quality, as well as costs.
- Purchasers and providers must have some incentives and bear some risk for the decisions they make. This risk should be enough to motivate people, but not so much that they can make (or lose) large sums.
- Primary care itself needs to be purchased effectively. The capacities, clinical decisions, and inequities of primary care providers determine how equitable and cost effective the rest of the system is.

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### ***POLICY IMPLICATIONS***

Despite radically different health care systems, the United States and Britain have much to learn from each other. The experience of large purchasers and managed care organizations in the U.S. suggests that the National Health Service should:

- Get community-based primary care groups (PCGs) functioning well first, before they are made responsible for purchasing all secondary services.

*Continued on back.*

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## **POLICY IMPLICATIONS**

*Continued*

- Reap the benefits of primary care purchasing by making the PCGs advisory to health authorities, which may be the best structure for effective purchasing of services. The GPs (as leaders of the PCGs) could provide local knowledge, clinical savvy, and professional legitimacy; the health authorities would offer technical advantages and the clout of a larger purchaser.

The British experiment with managed competition may have implications for U.S. policymakers as they address the “managed care backlash” and struggle to find the optimal role for competition within the health care system.

- The British experience raises questions about how much is being saved by competition per se, and how much only appears saved through cost shifting, short-term price discounts, and risk selection.
- The British experience highlights the difficulty of implementing real competition while maintaining safeguards against undertreatment, access barriers and cost shifting. U.S. policymakers should consider this as they face the converse problem of implementing many types of patient protections while maintaining real competition within the managed care marketplace.

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*This Issue Brief is based on the following articles by Dr. Light: Here we go again: repeating implementation errors. British Medical Journal, Sept. 4, 1999, vol. 319, pp.616-618; Managed care in a new key: Britain's strategies for the 1990s. Intl. Journal of Health Services, 1998, vol. 28, no. 3, pp. 427-444; Is NHS purchasing serious? An American perspective. British Medical Journal, Jan. 17, 1998, vol. 316, pp. 217-220; From managed competition to managed cooperation: theory and lessons from the British experience. The Milbank Quarterly, Sept. 1997, vol. 75, pp. 297-341.*

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*Published by the Leonard Davis Institute of Health Economics, University of Pennsylvania, 3641 Locust Walk, Philadelphia, PA 19104-6218, 215-898-5611.*

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*Published by the  
Leonard Davis Institute  
of Health Economics  
University of Pennsylvania*

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