Introduction

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When *JEMS* published its first special issue on the industrial organization of health care in 1994, the vigorous and contentious debate on health care reform applied to all payers in the United States except Medicare. Currently, the situation is reversed. National policy reform focuses on Medicare, while private health insurance, Medicaid, and the problem of the uninsured are left to the states or private markets. Perhaps as a consequence of the rapid pace of decentralized change, innovations in the health industry continue at a phenomenal rate.

Interest in the economics of health care continued to generate research. This third special issue on the industrial organization of health care contains a number of articles that analyze important issues. Competition in the delivery of health care has led to an increased number of mergers, and economists are naturally interested in their antitrust implications. Risk adjustment and its incentive effects are not completely understood; yet capitation as a form of contracting between payers and health plans is becoming common. More recently, payers have also begun addressing the fundamental issue of outcome verifiability, and incentives contracts based on actual health outcomes have been used. These innovations coexist with conventional cost-based and prospective payment mechanisms, which continue to be studied by economists as they are refined.

Esther Gal-Or studies vertical contractual arrangements in the health market (''Mergers and Exclusionary Practices in Health Care Markets''). While payers offering preferential treatment to providers often raises anticompetitive concerns, the fundamental incentives affecting why such mergers may happen remain incompletely understood. Gal-Or characterizes conditions on the competitiveness of the industry for vertical mergers to be profitable. Her focus on bargaining strength between contracting parties yields very important comparative static results. This study blends theories of insurance, product differentiation, bargaining, and vertical mergers in the industrial organization literature. Her application in the health care market

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shows how various forces can work together in a theoretical model, and serves as a benchmark that other researchers will find useful.

One of the most serious concerns with any payment mechanism in health care is the possibility of providers dumping unprofitable patients. Policy makers are worried that a risk adjustment method will entail perverse incentives of dumping, and considerable effort has been made to prevent that from happening. Tracy Lewis and David Sappington, in ''Using Subjective Risk Adjusting to Prevent Patient Dumping in the Health Care Industry,'' use a formal model to address these issues. Instead of taking the conventional view that dumping is to be avoided at all costs, Lewis and Sappington investigate the costs and benefits of allowing dumping. Surprisingly, they find that if it is not too costly for providers to acquire superior information, allowing dumping may be optimal. Their analysis confirms that cost-sharing arrangements are valuable for preventing dumping, but prospective payments, while allowing dumping, may still be optimal in a variety of circumstances. Their attempt to use the model to illustrate existing industry policies is very insightful and will be useful for policy analysis.

Mingshan Lu (''Separating the 'True Effect' from 'Gaming' in Incentive-Based Contracts in Health Care'') investigates whether reported improvements in health outcomes are actually due to providers misrepresenting the true outcome information, or due to genuine improvements. Theoretically, if health outcomes are contractible, a source of asymmetric information will be eliminated, and efficiency can be expected to increase. Nevertheless, health outcomes are probably better thought of as ''reports'' by providers, and it remains an open question if any reported improvement in health outcomes can actually be substantiated. Lu develops a general method to separate the change in providers' reporting practice from the providers' change of effort in delivering health services. Clearly, this approach allows the true evaluation of performance-based and incentive contracting, and is very valuable for policy analysis. More importantly, Lu's contribution allows other researchers to extend her analysis to other cases in which outcome measures have been used in health-care delivery contracts. From a methodological point of view, this analysis sheds light on the degree of empirical significance of incentive contracting.

In an earlier era, the federal government and Medicare were innovators in health policy (not the laggard Medicare is today). Many regard Medicare's Prospective Payment System (PPS), based on Diagnosis-Related Groups (DRGs) and begun in 1983, as the first significant policy to affect medical utilization by directly manipulating

incentives to providers. Prior to that time, direct incentives were only regarded as proper if they were given to patients, in the form of demand-side cost sharing. Many payers have since followed Medicare's lead and started paying hospitals according to some form of prospective payment. Continuing earlier research that has demonstrated the positive correlation between a hospital's revenues and costs, Boyd Gilman (''Measuring Hospital Cost-Sharing Incentives under Refined Prospective Payment'') asks whether it may be more appropriate to think of the prospective payment systems as ''mixed'' systems: a combination of cost-based and prospective payment systems. For incentive purposes, it is essential then to understand the nature of the mix. Gilman, building on the earlier work, proposes a method for doing so with a payment system for AIDS-related hospital cases from the state of New York.

The evolution of managed care, health maintenance organizations, and new ways of contracting between payers and providers have given economists new motivation for theoretical and empirical analysis of the health market. Many papers in previous and current special issues have been presented in the Biennial Industrial Organization of Health Care Conference, jointly sponsored by the Management Science Group of the Veterans' Administration and the Industry Studies Program at Boston University. Dr. Ted Stefos, the director of the Management Science Group, has continued his support of these conferences, as the fourth in the series is planned for the fall of 1999. We hope that research in the industrial organization of health care will continue to provide methodological advances.