Correspondence

For health lawyers, things never looked so good

To the Editor:

The ever-expanding governmental concern over health care costs, and the parallel development of laws and regulations addressed to this issue, will guarantee long-term prosperity for attorneys who specialize in health law, if for no one else.

During the past several months, I've been speaking around the country about the inescapable realities of change confronting our health care delivery system. The major point I've been making is that these realities won't go away, and it is in the interest of the "medical care establishment" to accept them and to respond constructively, or we will be outflanked and change will pass us by without our contribution to the resulting structures.

I've made this point to hospital trustees, administrators, and other professional groups within hospitals. Sometimes the applause hasn't been loud, because the message calls for changing behavior, which isn't much fun. I discover, however, that my message is pleasing to lawyers, because each of the points I make seems to guarantee them more legal work.

My major premise subdivides into 10 separate points, each of which I'll describe briefly, suggesting what I think to be the implications of each for attorneys who specialize in health law.

1. *Money for health services, now and forever after, will be limited.* This point has at least two important implications for health lawyers. For one thing, we are going to have more state cost-control commissions, like the Massachusetts Rate Setting Commission. Such commissions will use any convenient pretext to reduce hospital income (and government expense). The inevitable result will be more appeals by hospitals to the commissions, and, when that administrative remedy is exhausted, more recourse to the courts. Second, the limit on available health care funds guarantees increasingly ferocious competition between providers for a larger slice of the melon—nursing homes against hospitals, neighborhood health centers against private practitioners, dentists against physicians, home health agencies against nursing homes—all of them fighting for "fair treatment" from government. The number of class actions brought by health attorneys on behalf of individual categories of providers is sure to increase dramatically.

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2. *Provider risk sharing, on the HMO model, will develop at an accelerating rate.* HMOs, by their very nature, are intricate organizations, primarily because they seek to combine the interests of physicians and broader public interests. Legal expertise is required for the preparation of by-laws and articles of incorporation, of contracts with governments and other purchasers, and of arrangements for funding—front-end and rear-end. In addition, each HMO must traverse a thick regulatory jungle, which an institution cannot even enter, let alone cross, without the major involvement of skilled health lawyers.

3. *Along with the HMO movement, and partly as a result of the national push for more HMOs, we will see the development of many more multi-specialty group practices.* Traditional medical resistance to this mode of practice is eroding quickly. Besides, when the chips are down, physicians tend to go where the money is. Medical instincts of self-protection, among other motives, will result in a brisk business for health lawyers for many years to come in helping physicians to organize their own groups. We probably also will see medical groups separating from hospitals (politically, and in many instances geographically), to protect their physician members' legal, economic, and other "rights" vis-à-vis the hospital.

4. *Because of the cost issue, "systems consolidation" of hospitals and related institutions will increase.* Mergers, consolidations, holding companies, and core management services all are becoming popular, because they allegedly reduce "unnecessary duplication" of clinical services and produce significant economies of scale. When there isn't enough money to support competition with a hospital's neighbors, its governing board generally begins to think positively about becoming part of a larger organization, which, in turn, generates more need for health law services, involving, for example, corporate reorganization, affiliation and merger agreements, and management contracts.

5. *Partly as a result of the "systems consolidation" push, concentration of specialized and superspecialized services into fewer patient care settings will increase.* New HEW health planning guidelines aim at optimum, and hopefully efficient, critical mass for certain specialized services, including neonatology, dialysis, open heart surgery, and cardiac catheterization, as well as OB and pediatrics. This seems to be only the beginning of a strong trend. Under this approach, hospitals will be told to treat a certain number of patients or to perform a set number of procedures, or else to stop providing the service. The problem of what to do about medical specialists who are dislocated by this process, however, is not yet being seriously addressed. The private sector, particularly individual physicians, therefore, often is threatened by health planning and its consequences. As a result, much more litigation by health law practitioners in defense of providers' "rights" can be anticipated.

6. *The delivery of primary care, and how it should be organized and sponsored,*

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will be an important issue for the indefinite future. Critics of our "medical care establishment" have long been attacking both the fee-for-service system and the imbalance of specialists among practicing physicians. It is now clear that individual, private entrepreneurship in medicine will not, and cannot, be the instrument for meeting the primary care needs of the masses of poor people in our inner cities. Similarly, the hospital outpatient department and/or emergency room is an inadequate substitute for having one's own doctor. Instead, we are likely to have more neighborhood health centers—prototypes for a more personal kind of service—with local community sponsorship. Such an institution usually consists of a salaried medical practice, with or without HMO ties. The development of neighborhood health centers poses complex health law problems—similar to those of HMOs—whose solution requires a balancing of community and professional interests. In addition, these organizations cannot survive without some connection to a hospital, which also involves health-related legal problems.

7. *Health service for the American people, and what's wrong with it, is now a totally politicized issue, and will remain so.* For many years, hospital leaders tried their best to keep clear of political arguments relating to health care on the theory that somehow this would insulate the field from "political interference." But staying aloof didn't help when costs became so great that government believed it had to step in. Now that 40 percent of the hospital tab is picked up by state and federal governments, health care is a political issue every time a government budget comes up for consideration. Hospital associations, shedding their earlier "detachment," have increased their lobbying activities tremendously, both in legislative and regulatory bodies. Lobbying, however, is much more than organizing constituencies to affect government decision making. A great amount of specialized legal work also is involved—*e.g.*, analyzing existing or proposed legislative or regulatory language; drafting necessary amendments; and studying transcripts of hearings to identify legislative intent. Lobbying also involves heavy interaction with lawyers in government, and the interest groups in medicine learned long ago that they need their own health lawyers to deal effectively with government lawyers.

8. *Competition will intensify in the health care field, but the nature of the competition gradually will change and become more pluralistic.* We are moving out of an era when the modality of competition was hospital against hospital and physician against physician. Multi-institutional systems are evolving, along with HMOs and large multi-specialty groups. We are entering an era when the "bigs" will dominate the medical care scene just as the "bigs" dominate the production economy in our country. One result is that a whole new world is opening up for health lawyers and their antitrust colleagues. The national health planning act, in one perspective, may be a vast conspiracy in restraint of trade. The pressure now coming

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from the federal government to create more competition in medicine—as in the push to permit advertising of medical fees—doesn't necessarily fit with government's own interest in controlling, and standardizing, fee schedules. The apparently inexorable drive toward large health care delivery organizations will create many conflicts, which will generate more demand for health law services.

9. *All trends indicate that despite the push for more preventive medicine, the demand for health services will increase across the care spectrum, rather than decrease.* In the health care area, the country seems to be moving simultaneously in two opposite directions. One is a move toward guaranteed "comprehensive" health services as a right of citizenship, regardless of social and economic status. The other is toward a de facto rationing system of health services under which providers will have to limit use of their services on the basis of a limited number of dollars made available to them. At this time, the forces for broader entitlements seem to be stronger, and more entitlements undoubtedly will bring more use of services. The collision between this political force and the "real world" fact of finite and eroding resources and limited government dollars will be fraught with political, economic, and legal problems. Patient's rights advocates already have won important court decisions, defining the obligations of states to provide a course of active treatment to patients in state prisons and mental hospitals. As the squeeze on resources gets tighter, there undoubtedly will be many cases involving patients who have been denied their entitlements because a hospital, a hospital "resource allocation" committee, or a regulatory agency decided that the treatment was not really "needed" or "cost effective." This problem is particularly likely to arise in relation to life-prolonging procedures and is certain to spawn more and more need for health lawyer services due to increased litigation.

10. *In spite of the current ineffectiveness of regulation, we are likely to have more of it before we have less.* Regulation generates significant incremental costs to the hospital, as has been documented by studies in highly regulated states like New York and Massachusetts. A generous chunk of these expenditures represent the cost of legal services. Both New York and Massachusetts, for example, pioneered certificate-of-need legislation, with the result that general law firms in both states hired certificate-of-need specialists. Certificate of need now has gone "national," with the same result virtually guaranteed in the remaining states. The same point can be made concerning "appropriateness" reviews under the federal health planning act. Because the cost crunch will not disappear, more laws and regulations in such areas are inevitable, as well as more demand for the specialized services of health lawyers.

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Legal expenses are, in fact, beginning to put a heavy strain on the budgets of health professional organizations and institutional provider

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organizations such as the Massachusetts Hospital Association, and because of the cost controls now imposed throughout the delivery system, memberships are becoming increasingly resistant to dues increases. So we are caught in a bind very similar to that of government. We are skeptical, however, about our capacity to "control" increases in our expenditures for health law services, because—at least in the Massachusetts environment—it seems that the only way to get the attention of our government adversaries is through the courts, or through a demonstration of our ability, readiness, and willingness to take this route.

DAVID M. KINZER
President, Massachusetts Hospital Association

Editor's Response*

Dear Mr. Kinzer:

I generally share your views on the absence of adequate shelter from the strong winds of change presently buffeting our health care delivery system. These winds aren't likely to cease or diminish, certainly not in the short term. The medical care establishment must acknowledge their presence and respond constructively, lest it be damaged or passed by without the opportunity to influence future events. I also generally share your views on the role that health lawyers are likely to play in helping health care providers to shape the future, to adapt themselves to that future as best they can, and to win some of the many skirmishes that lie ahead.

Furthermore, I take no significant exception to the 10 separate points into which you have subdivided your major premise. I particularly share your belief that despite the nearly total ineffectiveness of current federal, state, and local government attempts at regulation of the health care industry, both statutory and regulatory, we are likely to have more government regulation before we have less. In addition, as a practicing Boston health lawyer, I share your frustration at the degree to which that industry already is overregulated. Our best efforts notwithstanding, the continued irrational use of large quantities of ineffectual, cost-ineffective, or counterproductive government regulation to "reshape" health care provider conduct—allegedly to improve (but apparently often to impede) the quality (in terms of efficacy, uniformity, and comprehensiveness of care), the quantity (in terms of availability of care), the distribution (in terms of access to

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