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Wither the Next Phase of Health Law

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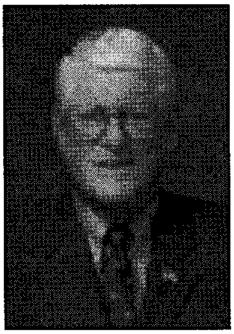

The question on the table is, with a new decade here and national health reform looming in Washington, where is U.S. health law headed? Rephrased in a law school context, the question morphs into what health law skills will be needed in the future for which the appropriate legal education will lead to fully-employed health lawyers? Threshold inquiries include: (1) what forces cause material change in U.S. healthcare generally; and (2) what has tended to motivate health lawyers in the past and the present to become health lawyers? Juxtaposing the answers to these two questions illustrates the somewhat schizophrenic nature of both health care and health law in the U.S.

Economic forces have driven change in U.S. health care since approximately 1965, the birth date of Medicare and the advent of tort liability for health care providers other than physicians, including private institutions. This statement has become more true with each additional percentage point of the U.S. GDP becoming devoted to health care expenditures since 1965 (now pushing 18%). Moreover, as the total dollars available to pay for health care have risen, the genius of American enterprise (usually investor-owned) has added untold, sophisticated goods and services to the shopping carts of health care consumers. Meanwhile, most individual providers, nonprofit or governmental health care institutions and first generation health lawyers undertook their careers and missions with healing, public health and empathic motivations driving their decision-making. The reconciliation of these altruistic roots with the "big business" of health care has not always been a comfortable co-existence. The future, it is suggested, will be even less comfortable.

Several significant forces are pushing toward the ascendancy of proprietary health care in the U.S. These include: (1) high-growth life

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sciences/bio-health businesses; (2) waning religious sponsorship of institutional health care; (3) mergers and acquisitions of non-profit institutions into or by for-profits; (4) victory of "buy" over "make" within the growing health systems; (5) theoretical disappearance of charity care under pending healthcare reform, (6) growth of large group physician practices; and (7) potential increased loss of tax-exempt status from factors (1) through (6). These trends, in turn, will demand the availability of more business-oriented health lawyers who can handle whatever deals come along.

There will be fewer private practice generalists and certainly fewer who will want to combine profitable corporate deals with medical records, medical staff bylaws, clinical credentialing and similar topics which all good health lawyers in the past have mastered. Instead, health lawyers will specialize earlier to enhance their marketability, whether in law firms or in-house, complete with all the well-known professional dangers of premature specialization. With more specialized health lawyers on the market, there will be fewer conversions of non-health lawyers to institutional general counsel positions (except in highly-political circumstances where clout trumps substance). This poses the risk that the health law bar will become increasingly more fractionalized and in-bred.

As is true today, however, the most valuable health lawyer of the future will have three unmistakable characteristics. He/she will: (1) be a "good lawyer" without regard to health law; (2) have to be highly adaptable with regard to service lines mastered from time to time; and (3) have to be willing to work very hard over the long haul. Law schools which are practice-oriented must balance current specialty courses with fundamental skills and knowledge courses and must matriculate leaders to their student ranks.