Loyola University Chicago Law Journal

Volume 18
Issue 3 *Spring 1987 Health Care Law Symposium*

Article 3

1987

Foreword II

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This country's health care industry has experienced a steady evolution from 1930 through 1983. The advent of the Medicare and Medicaid Programs in the mid-sixties was not revolutionary: no institutions were overturned, no major changes in delivery or stewardship took place. The dual governmental programs, however, did infuse great sums of money into an existing system and have provided, over the past twenty years, the financial underpinnings for the industry. The magnitude of Medicare and Medicaid payments to hospitals, however, finally spawned a revolution. The Administration and Congress believed that action had to be taken to curb the voracious appetites of health care consumers and providers. Thus, in 1983 Congress passed the Medicare Prospective Payment System Act.

The impact of this legislation, together with the parallel growth of managed care programs (health maintenance organizations, preferred provider arrangements, and other forms of alternative delivery financing), is far-reaching, affecting virtually every aspect of health care in this country. These changes have spawned allegations relating to quality of care, accessibility of care, reduction of services, and premature patient discharges. Such allegations are apparently due to the belief that the economic incentives for providers encourage the rendition of fewer services in shorter periods of time. Unlike the period from 1930 to 1983, hospitals are simply no longer paid for each day, each test, and each service. Now, hospitals are paid by an ever increasing number of third party payors on either a fixed cost based upon the patient's diagnosis or on a flat capitation payment per subscriber, without regard to the resources consumed by a patient or the number of days of care rendered. The introduction of mandatory third party review compounded the impact of these dramatic changes. Third party review, in the form of peer review organizations, has the power to deny payment, to sanction providers, and to establish extended criteria for quality and cost-effective medicine.

These changes are an indication of the dynamic times that the industry is facing and the new frontiers that "health law" is experiencing and will continue to experience. New areas of liability and corporate law will be chartered, and new parameters of exposure to criminal fraud and civil abuse will drive medical decisions. The

health law of the eighties and nineties will involve a full panoply of corporate, tort, and criminal activity to challenge all who dare to participate in these revolutionary times and in this dynamic and diversified legal speciality.

I congratulate Loyola University of Chicago School of Law on its recognition of the importance and the diversification of the legal areas involved in this industry and for taking a leadership role in educating law students and practicing lawyers through the publications of the papers presented in this *Journal*.

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