

Sovereign Immunity And Health Care: Can Government Be Trusted?

As its health care role expands, does government's legal immunity undermine its accountability?

by John L. Akula

PROLOGUE: Americans rely heavily on legal redress to pressure the health care system to meet their high expectations. They take a dim view of limits on such redress—consider the outcry against the interpretation of the Employee Retirement Income Security Act (ERISA) that shields some managed care organizations from liability. The often-drawn analogy between ERISA-based immunity and diplomatic immunity is a stretch—diplomatic immunity extends even to crimes. John Akula suggests in this paper that a better analogy would be to sovereign immunity, the protection against liability enjoyed by government.

The fact that Americans have little trust in government, especially when it comes to health care, is often noted but little understood. The distinctive legal standards that apply to government's accountability provide insight into this mistrust. Akula suggests that these legal standards may also prove a serious obstacle to government's successfully carrying the responsibilities of a broader role in the health care system.

Akula is well qualified to address this issue, having practiced law for fifteen years. He was a partner and head of the health care group at Goodwin, Procter, and Hoar, one of Boston's largest firms, and chair of the Massachusetts Bar Association's Health Law Section. He now divides his time between Harvard University, where he is an adjunct lecturer at the John F. Kennedy School of Government, and the Massachusetts Institute of Technology, where he is a visiting lecturer at the Sloan School of Management. Akula earned a law degree and a doctorate in sociology from Harvard.

ABSTRACT: When government provides or arranges for health care, it is held to lower legal standards than private parties are, especially when liability is barred by “sovereign immunity.” This paper examines sovereign immunity and its implications for health care quality by comparing private-sector and government accountability in several legal contexts. It then considers whether the law should be changed; the possible relationship between limited government accountability and public mistrust of a larger government role in health care; and the potential role of disparate legal standards if a lower tier of care evolves in government programs.

IN 1983 A NATIONAL GUARDSMAN who would later be known in the lawbooks as DBS required surgery during training and was transfused at an army hospital. One of his donors would later test positive for human immunodeficiency virus (HIV). In 1986 the army surgeon developed policies for notifying and counseling persons at high risk for acquired immunodeficiency syndrome (AIDS). These policies identified persons transfused in 1983 as high risk. But the army never notified DBS. Later, still in the National Guard, DBS fathered a child. He, his wife, and child tested HIV positive. The family sued the government, alleging that the army was negligent in failing to notify DBS. Since these events took place during peacetime training, the army was subject to the same legal standards as any federal agency. However, the government argued “sovereign immunity”—what cynics call the “good enough for government work” doctrine—which often shields the government from liability for conduct for which a private party would be liable. The court agreed that sovereign immunity applied and dismissed the case without determining whether the government had been negligent, since negligence would have been of no legal consequence.¹

This ruling is not exceptional; it typifies the distinctive and lower standards of legal accountability applicable to government. A broad literature and lively public debate exist on legal accountability in the U.S. health care system, focused for the moment on managed care and the Employee Retirement Income Security Act (ERISA). However, little attention has been paid to the special rules on legal accountability that apply to government.

This paper addresses that gap. It is written for a policy audience, not for lawyers.² Some legal complexities are glossed over, and it focuses on the federal government (not states).³ However, the law is not distorted—its broad contours are accurately described, and the cases discussed represent the legal mainstream.⁴

Mistrust of government is a central feature of the U.S. health care landscape. However, it is difficult to assess whether that mistrust is well founded. In what respects is government likely to prove trustworthy or not? What consequences are likely to flow from different

allocations of responsibility between the public and private sectors? The law provides insight into these issues.

Negligence, Due Care, And Government Discretion

The most important legal rubric for accountability in health care is negligence law. Negligence law imposes a duty on individuals and organizations to exercise due care. If failure to do so harms another, the responsible parties can be sued and will be found liable by a court. They must pay damages and suffer the stigma of having been found at fault. For professionals, the standard of care is good professional practice; medical malpractice is a form of negligence. Outside the arena of professional judgments, a more diffuse “reasonableness” standard applies.

Negligence principles have some relevance to almost any activity. However, they are especially central to health services, in which the sick and vulnerable seek care from those whose primary responsibility is to provide it.

■ **Sovereign immunity.** Broad bars to legal liability are often called “immunities.” Most immunities have fared poorly in recent decades in the U.S. plaintiff-friendly courts, especially when health care is at issue. For example, “charitable immunity,” which long shielded not-for-profit hospitals, has been cut back sharply.

However, sovereign immunity remains strong. Government—the sovereign—cannot be sued for negligence without its consent. The doctrine has roots in the reluctance of English courts to challenge the king. The modern rationale focuses on the inappropriateness of holding government to standards applicable to private parties, given its special responsibilities, and on the need to limit judicial second-guessing of the executive and legislative branches. The current scope of federal sovereign immunity is set out primarily in the Federal Tort Claims Act (FTCA).

■ **Protecting government discretion.** The federal government enjoys sovereign immunity whenever it exercises a “discretionary function.” This rule shields the making and implementing of policy, but its reach is broader than the rationale suggests at first. Immunity applies whenever there is discretion “susceptible to policy analysis.”⁵ Discretion is present unless the law mandates a specific course of action, leaving no room for judgment. Discretion is susceptible to policy analysis if any economic, political, or social factors might be relevant to its exercise. A court will not ask whether government actors entertained policy considerations, but only whether policy concerns might be relevant given the applicable statutes, regulations, and rules. The presence of discretion creates a “strong presumption” of policy concerns.⁶ Government need not undertake a

policy analysis or claim to have done so; not developing a policy is itself a policy. In the DBS case the government did not need to defend its procedures. The army's notification protocols, while detailed, did not mandate a specific course of action. The court found the army's actions susceptible to policy analysis; thus, immunity applied.

When the Food and Drug Administration (FDA) and the National Institutes of Health (NIH) have been challenged for their roles in the licensing and release of vaccines, the courts have outlined the appropriate analysis: It must be determined whether an agency goes through each step specified in the applicable rules, because as to required steps there is no discretion and no immunity. However, whether these rules are sound is beyond legal challenge, and so is the soundness of any judgment calls permitted by the rules or absence of rules (so long as these judgment calls are susceptible to policy analysis).⁷ The negative stereotype of the "bureaucrat," proceeding down a rigid checklist and otherwise indifferent to the soundness of his or her actions, is a good fit with this legal standard, although this approach in the private sector would invite liability.

Courts recognize that immunity can shield laziness, incompetence, and otherwise indefensible determinations, but the FTCA explicitly protects discretion "whether or not the discretion involved be abused."⁸ For years the U.S. Postal Service sold the general public thousands of surplus vehicles that its own studies indicated had a propensity to overturn at highway speeds. It provided no warnings, even after concerns arose, but was immune from suit.⁹

While government discretion that is susceptible to policy analysis is protected by sovereign immunity, discretion that is not susceptible to policy analysis can give rise to liability. When the driver of a government car turns into oncoming traffic, the government is typically liable—the driver has discretion, but there is usually no possible policy reason for turning into traffic. One careless driver creates liability, but the decision to sell thousands of unsafe vehicles, which is susceptible to policy analysis, does not. As one Supreme Court justice commented, the FTCA amends the old doctrine that "the King can do no wrong" to "the King can do only little wrongs."¹⁰

■ **Medical judgment.** When a government doctor commits the simplest kinds of "hands-on" malpractice—such as missing a diagnosis—the government is often liable. Such medical judgments are like the driver's wrong turn; the discretion lacks policy relevance.

However, there are clear boundaries to this exception to sovereign immunity. Health care has a complex administrative overlay. In the private sector, decisions made at an administrative, managerial, or fiscal level—by health maintenance organizations (HMOs), hospitals, and insurance companies—can lead to liability if the

decisions affect quality of care. (Some courts read ERISA as creating de facto immunity for certain managed care entities, but my guess is that the law will settle at a point that preserves substantial liability.) In the public sector, sovereign immunity typically applies as soon as we move to judgment at a higher organizational level than the individual doctor treating a patient, because almost all discretion at higher levels is susceptible to policy analysis.

Perhaps accountability in government will “push up” to administrative decisions, if these can be analogized to professional judgments. However, I see no signs of this in health care or other government programs. It appears more likely that sovereign immunity will “push down” to professional medical judgments, since these are sometimes susceptible to policy analysis. DBS argued that professional medical judgment required that he be notified. The court responded that “labels do not control our analysis” and that whether or not notification was a matter of professional medical judgment, it also raised various policy issues including “the competing concerns of safety and cost.”¹¹

Likewise, when a Veterans Affairs (VA) hospital discharged a patient with mental problems who then killed a person, the estate of the deceased sued, alleging that the discharge had been a negligent medical judgment and thus not protected by sovereign immunity. The government asked for a pretrial dismissal, arguing that sovereign immunity should apply because discharge is only in part a medical judgment and in part involves policy considerations such as public safety, an ironic contention under these facts. The court took a middle position. It did not dismiss the case, holding that discharge should be considered a medical judgment unless shown otherwise. However, it left open to government the opportunity to show at trial that policy considerations were relevant, in which case sovereign immunity would apply even if the discharge was irresponsible in light of the policies being raised.¹² We have yet to see the case where, say, a hospital run by the federal government admits to poor care but attributes it to cost constraints and argues that sovereign immunity therefore should apply.¹³

■ **Increasing government accountability by narrowing discretion?** Government’s accountability could be broadened by statutes and regulations that reduce discretion. However, Congress can revisit a statute only occasionally and with limited expertise, and broad delegations to regulatory agencies are unavoidable. Agencies write their own regulations and formal policies and understand the legal risks of being specific. Regulations are often a mix of specific obligations imposed on private parties and vague agency undertakings. Agencies can and do repeal regulations when they find that a

provision threatens to give rise to government liability.

Moreover, the public would often be poorly served by agencies that tied their own hands with detailed regulations that limited discretion. Revising regulations is cumbersome, and health care evolves rapidly. The Department of Biological Services licensed a polio vaccine that did not meet detailed and mandatory scientific criteria in its regulations. The vaccine caused some illness, as vaccines usually do, and the government was sued for the negligent disregard of its own regulations. The court acknowledged that the approved vaccine was in fact “state of the art” and that the agency had acted in what it believed to be the public interest in releasing the vaccine without first amending its regulations to reflect the latest refinements in scientific understanding. Nevertheless, the court was obliged to hold the agency liable for failing to conform to the out-of-date but nondiscretionary standards set out in its regulations.¹⁴

■ **Liability and scrutiny.** Liability is not just about damages. It is also a morality play, in which a public trial, probing factual inquiry, reasoned moral analysis, and sanctions all combine to educate the defendant and others as to proper conduct. Scrutiny is perhaps as important as liability. When government argues sovereign immunity, that argument is heard first and if successful ends the case. Thus, sovereign immunity typically bars scrutiny as well as liability. In my experience, the spotlight of litigation on drug companies, HMOs, and other parties has a major impact on how individual defendants and the groups from which they are drawn view their responsibilities, especially in curtailing complacency and dismissiveness toward criticism. To the extent that government complacency is a problem, immunity will aggravate it.

■ **Individual and professional accountability.** In the private sector, individuals are almost always legally liable for their lapses even if some larger corporate entity is liable as well. As a practical matter, corporate liability often reduces the likelihood that individual liability will be pursued. However, individual liability remains a frequent threat for two groups: top corporate policymakers, especially corporate directors, and professionals such as doctors.

In government, all employees typically enjoy individual immunity (called “official immunity”) for any action taken in the course of their employment. Thus, even when a government doctor commits hands-on malpractice for which the government is liable, the doctor is not. Is individual immunity important? Government alone is a deep pocket. However, government as sole defendant can more easily stonewall. To the extent that individual liability buttresses diligence, government employees, including health care professionals, may demonstrate less of it.

High Technology, Drugs, And Strict Liability

Private-sector actors are sometimes liable for harm even when they have exercised due care. This “strict liability” applies to certain hazardous activities and to consumer products (which are subject to product liability law, a form of strict liability). In health care, strict liability is the dominant legal standard for the accountability of those who manufacture and distribute drugs and medical devices. Thus, a nonnegligent manufacturer of a drug will be liable for harm caused by “defects.” Standards on acceptable risks and adequate warnings are especially complex for products, like drugs, that are very useful, very dangerous, and at the cutting edge of new technology.

When a drug causes harm, its maker may claim ignorance. Ignorance can be negligent (when there has been no reasonable investigation) or intentional (when troubling facts have been avoided) but often reflects the current level of scientific understanding. However, proponents of strict liability contend, the current level of scientific understanding of drug risks is largely driven by drug companies. If we hold them accountable whatever their knowledge, we eliminate legal rewards for ignorance and push them to learn more.

The federal government has immunity against all strict liability. Given that government’s liability for negligence is so narrow, accountability under the more demanding standards of strict liability would make little sense. Pressing government to expand the boundaries of scientific understanding would distract it from its own concerns. However, government’s role in drugs and medical devices will evolve in the context of an especially sharp disparity between public- and private-sector accountability.

In other contexts this disparity has been jarring. Litigation on workers’ asbestos exposure helped to shape modern strict liability law. Questions remain about precisely when the risks of asbestos were understood, but asbestos manufacturers were found liable under strict liability standards, making it unnecessary to answer those questions. The government had a major role in asbestos use, especially in World War II shipyards, but efforts to hold government accountable have been blocked. Strict liability is barred, and allegations of negligence have been defeated by the discretionary-function doctrine.¹⁵

Patients’ Rights

There is a growing body of law on “patients’ rights,” to provide protection and remedies for abuses particular to health care other than simple malpractice. Here, too, sovereign immunity is a powerful shield, and patients’ rights statutes that on their face appear to

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reach government typically do not or are toothless when they do.

For example, the Emergency Medical Treatment and Active Labor Act (EMTALA) of 1986 is the primary federal protection against “patient dumping.” It appears to require all hospitals participating in Medicare (virtually every acute care hospital) to provide screening and certain treatment of emergency medical conditions, including childbirth, to all who request it. The act provides for damages against any hospital that fails to meet this obligation. On its face, EMTALA does not differentiate between private and government hospitals. A federal hospital run by the Indian Health Service failed to diagnose a patient’s acute infection, even though the patient came to the emergency room repeatedly and his family physician informed the hospital of the suspected infection. The patient died, and his family sued under EMTALA. The government argued sovereign immunity. The court agreed and dismissed the claim. It cited the rule of statutory interpretation that only an “unequivocally expressed” waiver of sovereign immunity is effective and that the grant of a general remedy in language that does not distinguish between government and private parties does not meet this standard.¹⁶

Consumer Protection

General consumer-protection law has an increasingly important role in health care, especially when individual patients deal with large organizations and have concerns that relate to both clinical judgments and the commercial context in which those judgments are made, as is especially likely in managed care settings.

■ **Misrepresentation.** Consumer protection has its roots in some long-standing forms of civil liability, especially for “misrepresentation.” In commercial dealings, a private party who makes misstatements upon which others rely to their detriment is liable for resulting economic loss and sometimes other kinds of harm.

Under the FTCA the federal government is immune from liability for misrepresentation of fact or law, whether negligent or intentional. This protection applied to a federal employee’s claim that he had incurred health care costs because government neglected to provide a carrier accurate information about his coverage.¹⁷ It also applied when a patient’s family claimed to have lost the right to sue a drug manufacturer because they were not given timely and correct information about the role of a drug in the patient’s death.¹⁸

Immunity may not apply if the misrepresentation is a means of breaching a broader duty. If a government driver causes an accident by failing to signal a turn, that is negligent driving, not misrepresentation. By the same reasoning, if a government doctor misinforms a patient about the risks of surgery, that is malpractice.

Thus, government is most clearly immune when its role is primarily informational, as under reform proposals for government tracking of medical errors, or for government “report cards” on providers or carriers. The agencies involved would not be legally accountable for the timeliness, accuracy, or honesty of such efforts.

■ **Modern consumer-protection statutes.** Consumer protection has been expanded by modern statutes. The most important are “little FTC laws” enacted by most states, which mirror the Federal Trade Commission (FTC) statute but are tailored to the individual consumer. These laws typically apply to any “unfair or deceptive acts or practices” and provide successful plaintiffs with multiple damages and attorneys’ fees unless a defendant makes a good-faith settlement offer before a lawsuit is filed. Similar statutes address insurance in particular. A consumer with a complaint against an HMO other than simple malpractice—for example, one who alleges having been misled as to benefits, provider qualifications, or provider financial incentives—typically would use such a statute rather than a traditional action for misrepresentation. However, consumer-protection statutes are interpreted in light of sovereign immunity and generally do not provide remedies against government for the same practices that would give rise to liability in a private party.¹⁹

Challenging Administrative Agencies

Workaday government operates through administrative agencies. Most proposals to expand government’s health care role (such as those for monitoring health care quality or medical errors) would create new agencies or expand the powers of existing ones. All such agencies are governed by a set of principles generally referred to as “administrative law,” one purpose of which is to provide remedies to those who believe that they have been treated improperly.

Generally, any person aggrieved by an agency policy or decision can challenge it. However, he or she must first make full use of any review provided by the agency, and agencies can wear down complainants with multiple levels of internal appeal. The complainant, if still dissatisfied, can then take the agency to court. However, the only relief available is usually limited to the agency’s doing what it should have done in the first place. Any injury not rectified by this goes uncompensated. For example, although the wrongful denial of health benefits often has grave and irremediable health conse-

quences, compensation is generally unavailable for that harm when government denies coverage. When even a meritorious claim cannot yield damages, an aggrieved individual must often do without legal counsel, who are typically paid out of damages. Without counsel, complainants are unlikely to be successful.

Moreover, courts are required to defer to agency expertise and correct only egregious errors—one common standard is that agency action will be overturned only if it lacks any “rational basis.” If a statute gives an administrative agency broad interpretive powers, it is very difficult to challenge its interpretation or even predict what a statute will be deemed to require. For example, the Clinton health reform plan appeared to provide for generous health care coverage, but an administrative agency had broad discretion over how the statutory mandates would be interpreted.²⁰

Flagrant Wrongs And Punitive Damages

Negligence typically involves no more than a lapse in judgment or attention. Sometimes conduct is more egregious, involving extreme irresponsibility, recklessness, or even purposefully inflicted harm. In the private sector such conduct is often what the law calls an “intentional tort,” and a body of harsher principles governs such cases. Perhaps most importantly, such conduct typically gives rise to “punitive” damages. The “compensatory” damages generally available for simple negligence are designed to make up for the harm suffered. Punitive damages, which can be much larger, are designed to punish the offender and deter others. Intentional torts and punitive damages are the heavy artillery of private-sector liability.

In general, the federal government enjoys immunity from the special kinds of liability that attach in the private sector to the reckless or intentional infliction of harm (except when constitutional or civil rights are compromised). The rationale is that the government must function as society’s policeman and would be too timid if it operated under the shadow of liability for bruising methods. Although this rationale has limited relevance to the provision of health care, the immunity nevertheless applies. Likewise, the federal government can never be subject to punitive damages.

As a result, even egregious conduct is typically treated as simple negligence. A VA hospital failed to diagnose a patient’s throat cancer or its recurrence even though the patient had by then been hospitalized. The attending physician repeatedly failed to conduct examinations or tests and was out of contact with the patient. The condition was curable if treated in time, but the patient died a slow and painful death, receiving end-of-life care that the court characterized as “a dismal picture of neglect,” including failure to provide pre-

scribed pain medicine. The court found “incredible” certain key trial testimony offered by the VA and noted that experts retained to testify for the VA retreated from their opinions during trial upon being confronted by facts that the VA had apparently not provided them. The court expressed concerns about the credibility of an earlier VA administrative proceeding at which this claim had been rejected. In the private sector such facts probably would have evoked an array of legal claims and massive punitive damages. Yet this matter was litigated as simple negligence, and the court could award only modest compensatory damages.²¹

Punitive damages have been criticized as erratic and excessive, and there is doubt about the effectiveness of any damages to shape government conduct, since government is less sensitive to financial sanctions than are profit-driven organizations. However, the threat of punitive damages pushes organizations to respond constructively to any initial lapse and is the main deterrent to cover-ups and bad-faith defenses, which otherwise are often a rational strategy.

Some Broader Implications

Let us consider in a more speculative spirit some of the possible broader implications of this legal pattern.

■ **Accountability at the organizational level.** Some commentators on quality of care in the United States suggest that we have focused too narrowly on specific hands-on lapses and should pay more attention to higher-level organizational systems and the ways in which care is managed and structured.²² Private-sector liability has already expanded in that direction and will continue to do so if professional and managerial good practice shifts that way, since the law closely mirrors such standards of good practice. However, the barriers to government’s legal accountability—especially the discretionary-function doctrine—are strongest in that direction. Thus, the disparity between private- and public-sector legal accountability may become sharper.

■ **Is weak legal accountability a serious problem?** Weak legal accountability is not necessarily a serious problem. Many factors other than legal liability determine whether people and organizations do good jobs. In fact, lack of legal accountability may reflect confidence in other social devices. Any systematic consideration of these other factors is beyond the scope of this paper, but many agree on certain strengths and weaknesses of government.

Some of these strengths are especially important to health care, especially when government is compared with market-driven institutions. Most importantly, government has a strong commitment to inclusiveness and equity. Government programs often offer more

stability, at least in the short run. Government restricts opportunities for profiteering. It operates in a relatively open manner. Political accountability is high and provides many avenues for redress, including new legislation, congressional oversight of agency policies, and constituent services. However, government is widely viewed as having certain weaknesses. Agencies are bound by inflexible rules on staffing, budgeting, and procedures. The absence of market pressures fosters inefficiency. Government attracts some talented individuals willing to do the people's business for modest salaries, but productivity, motivation, and skill among employees is uneven: At higher levels, pay is relatively low and appointments often political, while other employees are protected by civil service and unions.

In my view, when we look beyond law to accountability more broadly, the problem of government laxity at what we have called the organizational level remains.

■ **Should the law be stricter?** Cutting back on sovereign immunity could strengthen accountability. Strong public expectations about health care quality might provide the political impetus. Nevertheless, I doubt that this is a likely or promising path.

The rationale for sovereign immunity is perhaps especially strong in health care, where private-sector standards are so demanding that their application to government would be especially problematic. As safety-net provider, government cannot suspend operations when exacting standards cannot be met, as private parties do. Expanded liability can be unmanageable when responsibilities are defined broadly. For example, should the FDA, which must approve all new drugs, slow down the approval process to the degree that would be appropriate if it were subject to private-sector liability standards? Application of the principles of civil liability would substitute the judgment of judges and juries for those of the legislature and executive with respect to many political and policy choices. For example, could the Health Care Financing Administration (HCFA) deploy its oversight resources to focus on, say, managed care, if it were liable for any resulting relaxation of oversight in other areas?

Even if a stricter standard were desirable, it would be difficult to formulate one that did not go too far. Some courts have tried, but the effort has been frustrating. A leading recent case involved a swimming area maintained by a federal agency and marked with buoys tied to concrete anchors. Some anchors drifted into the swimming area, and although the agency was aware of the problem, it did not remove the anchors or warn swimmers. A swimmer sued after suffering paralysis from smashing head first into an anchor in the muddy water. Government claimed immunity for its discretion. The court reasoned that Congress could not have intended to shield such

irresponsibility and suggested that while the decision to use anchored buoys was protected as discretionary, the decision could not then be implemented negligently.²³ A line of cases emerged in which liability was imposed for such “operational” (as opposed to “policy”) decisions. However, the Supreme Court rejected this distinction, reasoning that liability for the specific acts by which any policy is implemented would open virtually all policies to liability.²⁴ I think that this analysis is sound. In our legal system small loopholes in immunity entail big exposure, and government can be free of the “vexation” of liability suits only if sovereign immunity is broad and firm.

Were there pressure to impose stricter legal standards on government, government officials and employees might resist. Although sovereign immunity may be sound policy, insulation from the workplace pressures engendered by liability is also a “perk.” So is the chance to award jobs and contracts free of fears of liability relating to the competence of those who are selected or the judgment of those who select them.

In any event, sovereign immunity at the federal level is solid and becoming more so. Recent Supreme Court decisions have toughened it. Congressional tinkering with the FTCA has generally strengthened immunity (apart from some provisions relating to civil rights violations), and the last major amendment, in 1988, strengthened the official immunity of all government personnel.

■ **Mistrust of government and privatization.** The United States, compared with other economically advanced nations, has been especially mistrustful of and resistant to an expansive government role in health care. Our high-strung system of legal liability in health care is also an outlier, as are, I suspect, the public expectations that this liability buttresses and reflects.

Are concerns about government’s accountability a significant factor in the mistrust of a broader government role? Perhaps not. The legal issues discussed here have received virtually no attention in the health policy arena. However, concerns about government’s competence and responsiveness is common; the phrase “good enough for government work” is often used, only half-jokingly, inside and outside government. In the business world, at least, there is widespread belief, well grounded in experience, that government holds itself to especially lax standards. As we have seen, such concerns in health care are well founded insofar as law provides a benchmark.

Nevertheless, there appears to be little public pressure to subject government’s health care role to stricter legal accountability. The broad reading of ERISA by some courts, which provided de facto immunity to certain managed care activities in the private sector, generated a major backlash. Similar immunity for government-run

programs and institutions has raised no outcry. Perhaps this reflects lack of concern, but I would guess that it is more a reflection of resignation about what can be expected of government and of greater confidence in a strategy of limiting government's role than of holding it to higher standards. The trend in America and in most economically advanced nations toward privatization is driven in part by concerns about government's accountability. Health care in many nations is an exception to this trend, perhaps because equity appears to require a major government role. However, health care, with high requirements of expertise, adaptability, and diligence, may be a task to which government is otherwise ill suited.

The Clinton plan was defeated largely because of mistrust of government. As to the narrow concerns of this paper, this mistrust had grounds: The plan would have preserved sovereign immunity for government's greatly expanded role.²⁵

■ **Finding the right public/private mix.** How is legal accountability best structured in the U.S. system, with its complex mix of public and private roles? The current mix may serve well. When drug companies are held to high standards, the FDA can take a selective approach to public protection. When government is regulator and a major payer but the delivery system is primarily private, accountability at the point of delivery remains high. The "tone" of the relatively small public delivery system is perhaps best maintained by the spillover of standards and expectations shaped by the private system.

However, one group for whom the current mix is problematic is private parties who work closely with government in providing care but remain outside the cloak of sovereign immunity (which can extend to private parties when they are assisting in the performance of governmental functions). If all parties with an impact on care are accountable, the law presses all to exercise care and spreads damages among all responsible for any lapses. When government has immunity, it is less likely to act responsibly—it may, for example, provide erratic financing or put together inadequate networks, as when Medicaid precipitously transferred beneficiaries to only partly organized managed care systems. Private parties, especially those closest to hands-on delivery, are likely to be implicated in any lapses in care that result. Even if their role in these lapses is secondary, plaintiffs will stretch to find them liable if government is shielded. Any private parties found liable will often pay all of the damages, since government bears none, even though they may have limited power to address the underlying problem.

■ **Single-payer prospects.** One public/private division of responsibility is "single payer": Government would assure universal

coverage and finance care, but through a private delivery system. This might combine government's commitment to equity with private-sector accountability, but I am not optimistic. Our private-sector experience suggests the importance of holding payers accountable for the impact of financial incentives on care. Accountability in the private sector relies in large part on nuanced financial rewards, and a delivery system paid in government's rigid fashion might begin to function more like a government bureaucracy.

Canada's experience with a single-payer system offers mixed indications. For the first few decades, public satisfaction was high. But the past ten years have seen a sharp drop, which may be the result of temporary budget constraints but which some critics of a single-payer approach are inclined to view as the main tendency. In this view, when government acquires a dominant financing role, it can correct some deficiencies of a private system and still draw for decades on institutional and professional strengths that the more accountable private system accrued. Those strengths are increasingly corroded, in part because the more finely tuned mechanisms of accountability that dominate in a private system are increasingly eclipsed by the blunter and lurching policy shifts, often budget-driven, typical in government-financed entitlement programs. Equity may be realized, but it provides declining comfort if government does an increasingly poor job for all.

■ **The poor—a lower tier of care?** Government-sponsored programs for the poor, such as Medicaid, are under especially sharp pressures to provide a lower tier of care. However, a double standard is contrary to the ethics of health care providers and the sensibilities of many other Americans. The twitchy U.S. liability system is intolerant of care that falls behind the cutting edge.

However, government immunity partially clears a legal path to a lower tier. It is possible to drift down this path even in the face of legal standards that appear to ensure otherwise. As we saw with EMTALA, standards that are universal of their face often do not reach government. Administrative discretion provides similar opportunities. For example, if a government program provides a statutory list of benefits but gives an administrative agency discretion over interpreting the list, the benefits can be more limited than would be assured by the same language in private contracts.

The impact of limited government accountability can be minimized by "mainstreaming." For example, Medicaid beneficiaries could be served through networks and contractual arrangements mirroring the private sector. However, the private sector may be unwilling to enter such arrangements if payment is too low to enable it to meet the high standards of accountability to which it is held.

The limits of sovereign immunity in health care have not yet been tested. Political support for Medicare is too strong. The federal government's retreat from accountability in Medicaid thus far has relied on shifting responsibility to the states. We have not yet seen the aggressive use of devices such as cost-justified compromises on quality or the extension of government immunity to private parties. This may be sovereign immunity's new frontier.

NOTES

1. *C.R.S. by D.B.S. v U.S.*, 11 F.3d 791 (8th Cir. 1993).
2. The references to cases in these notes omit some detail that lawyers usually include.
3. Similar legal rules on accountability apply to state and local governments, but the standards are more varied and murky and are complicated by federalism.
4. For a full treatment of federal sovereign immunity, see L. Jayson and R. Longstreth, *Handling Federal Tort Claims* (New York: Matthew Bender, 1963 and supplements).
5. *U.S. v Gaubert*, 499 U.S. 315 (1991), 325.
6. *Ibid.*, 324.
7. See, for example, the Supreme Court's decision in *Berkovitz v U.S.*, 486 U.S. 531 (1988).
8. 28 U.S. Code Annotated 2680(a).
9. *Myslakowski v U.S.*, 806 F.2d 94 (6th Cir. 1986) and cases cited.
10. See the dissent of Justice Jackson in *Dalhite v U.S.*, 346 U.S. 15 (1953), 60.
11. *C.R.S. by D.B.S. v U.S.*, 801.
12. *Mayer v U.S.*, 774 F.Supp. 1114 (D.N.D.Ill. 1991).
13. Immunity statutes in a few states appear to recognize this argument. See *Civil Actions against State and Local Government*, 2d ed. (Colorado Springs: Shepard's/McGraw-Hill, 1992), sec. 3.18 ("Operation of Hospitals").
14. *In re: Sabin Oral Polio Vaccine*, 984 F.2d 124 (4th Cir. 1993).
15. See, for example, *Lively v U.S.*, 870 F.2d 296 (5th Cir. 1989).
16. *Cheremiah v U.S.*, 55 F.Supp.2d 1295, 1301 (D.N.M. 1999).
17. *Roper Hospital v U.S.*, 869 F.Supp. 362 (D.S.C. 1994).
18. *Sheriden v U.S.*, 542 F.Supp. 1243 (D.E.D.N.Y. 1982).
19. See, for example, the discussion of the application of Massachusetts's "little FTC statute" to government agencies in M. Gilleran, *The Law of Chapter 93A* (Rochester, N.Y.: Lawyers Co-Operative Publishing, 1989 and 1999 supp.), secs. 6.3-6.6.
20. See *Health Security Act*, secs. 1128 (investigational treatments), 1151 (comprehensive benefit package), and 1154 (medical necessity).
21. *Gaddis v U.S.*, 7 F.Supp.2d 709 (D.S.C. 1997).
22. See, for example, Institute of Medicine, *To Err Is Human: Building a Safer Health System*, ed. L. Kohn, J. Corrigan, and M. Donaldson (Washington: National Academy Press, 2000).
23. *Denham v U.S.*, 834 F.2d 518 (5th Cir. 1987).
24. See *U.S. v Gaubert*, esp. 321 and 331.
25. The Health Security Act was generally silent on sovereign immunity, which would preserve immunity. It explicitly preserved sovereign immunity in connection with its malpractice reform provisions. See *Health Security Act*, sec. 5301(a)(3).

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