

## A Social Contract for Health Information

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### 1. Knowledge and Privacy

As US health care slowly moves toward an integrated system of electronic health records, questions of justice with respect to the use of health information become more pressing (Safran et al., 2006). Better information should mean more knowledgeable providers and patients. But it also will mean more knowledgeable insurers, which in the US gives health insurers greater selectivity about whose coverage to deny or whose premiums to increase. This paper argues that from a social contract view of health information, such risk selection by insurers is unjust. The argument is based on the definitive work of John Rawls (1971; 1996; 2001). The injustice of risk selection can easily be remedied by regulation.

It is misleading to view moral issues about health information as entirely about "privacy." A morally significant idea of privacy depends on the situation in which information is used (Havani, 2007). In health care and in insurance, sharing information on health risks is a necessary and normal part of the management of health care in any society. The 1996 Health Insurance Portability and Accountability Act, for instance, reflects this by giving the entities covered by this law permission to disclose protected health information if this disclosure is part of "treatment, payment, or health care operations" (45 CFR 164.502(a)(1)(ii)). This reasonable exception for health care operations, however, is quite broad and includes insurers.

Suppose that a patient checks into a hospital and gives consent for relevant information to be shared among care providers, but then the patient is found to have another condition requiring treatment by other providers. Suppose, for example, the patient has an infection but is found to have HIV. No one would want to impose a barrier to the provision of care, even if the patient is incapacitated and unable to give consent.

But payment for care is also part of health care operations. As is explained below, in nearly every case this must be done by some form of health insurance, whether public or private. It is inevitable and necessary to share information with health insurers. The important moral question is what insurers do with this information. This paper argues that there are clear moral limits on this.

## 2. Health Insurance

Injustice with respect to access to health insurance is especially pressing because, in nearly all cases, health care must be distributed by means of insurance, either public or private. It is worth noting, however, why this point may not have always seemed important, and has not figured in the literature on health care justice. Moral problems about health insurance are superficial in comparison with the morally deeper problem of prioritizing care. Access to health insurance coverage does not determine what is covered and in what order of priority. So this paper will leave untouched the deeper problem of health care justice.

But for a social contract theory of health justice it is helpful to distinguish the issue of health insurance access from the deeper issues. Moral questions about health insurance resemble the questions about equity with respect to class and wealth that motivate social

contract theories. It is helpful to see that this part of the problem of health care justice can be treated in this familiar way. The leading social contract theorist of health care justice, Norman Daniels (1985) overlooks the possibility of this partial solution to the problem of health care justice, perhaps in part because the deeper problem of prioritization is not addressed this way.

This paper, however, does not deal with the issue of income distribution because equity in wealth and income is already a central issue in any social contract theory. This paper moves beyond this issue by assuming that if any of the parties does not have enough money to make insurance payments, wealth or income is redistributed to make these payments on that party's behalf. This paper then argues that the problem of health insurance access can be reduced to the familiar problem of equity with respect to wealth.

Health care must be purchased in the form of health insurance because it is generally too expensive for those who need care to bear the costs themselves. 69% of US health care costs are spent on 10% of the population and 5% account for the majority of costs, an imbalance that has remained constant over the past four decades, through a rapid growth in overall expenditures and many other social and medical changes (Berk & Monheit, 2001). As a result, health care must be purchased and distributed to a group who share the costs for the needy few, if anyone is to have health care.

A "public good" in economics is something that must be consumed by a group if any individual is to have it. This is usually understood to mean that it is prohibitively difficult to exclude people from a public good, and that providing it to some does not deny it to others. But neither condition is clear-cut. People can be (and often are) excluded from such paradigmatic public goods as clean air or public

safety by selective enforcement of laws or regulations, or by permitting inequities to persist. For the paradigmatic public good of immunization service, in a shortage of vaccine providing it to some may deny it to others. But except where there is an irremediable shortage in, for example, transplantable organs of some kind, health services can in principle be expanded to meet demand by building more facilities, training more providers, etc. It is likely that soon transplantable organs will be manufactured.

So in the weaker sense of being consumed by a group rather than an individual, health care generally, not just public health measures such as immunization or clean air, is a public good simply because it must be purchased in the form of insurance. Nevertheless, some inexpensive care, such as eyeglasses, might not be a public good, as long as it is not an undue burden for individuals to pay for these without insurance. But this paper defers the question of what should be covered by health insurance.

It is also more efficient for members of society to have health insurance than not. The money that would otherwise rationally be set aside for illnesses is more efficiently allocated by insurance than by individual saving. This paper returns to this when addressing an objection that it may be more efficient to deny access to insurance for some people.

### 3. Rawls and Risk Selection

In this paper, "risk selection" refers to the use of information about health risks as a basis for changing a decision to purchase or not to purchase health insurance, or to change its cost. This includes decisions by purchasers to buy health insurance because of high risks, which is described in the health insurance industry as "adverse" risk

selection. But this also includes decision by sellers of health insurance to raise its costs or to refuse to sell it to someone who carries higher than average risks, or to members of a group that includes people with higher than average risks. (Freudenheim, 2007)

This paper argues that risk selection in health insurance is morally impermissible. This conclusion is justified by social contract reasoning for health risks that do not result from the patient's actions. Moral judgment is perhaps less clear for health risks, such as lung cancer or automobile accident injuries, that are affected by the patient's actions. When such actions are insured they give rise to "moral hazard." So discussion these more difficult cases is postponed to follow the main argument against risk selection.

The usual regulatory remedy for the impermissible use of health information in risk selection is a combination of "community rating," requiring insurers to sell insurance at the same price to people with different risks, and "guaranteed issue," requiring insurers to sell insurance to those who will pay for it. Six US states (Maine, Massachusetts, New Hampshire, New Jersey, New York, and Vermont) have such regulations (Pauly and Herring, 2007).

Rawls's social contract theory of justice (1971; 1996; 2001) models a fair negotiation over social rules by considering a hypothetical "original position" in which none of the negotiators knows his or her own status with respect to sex, ethnicity, sexual orientation, social position, religion, or other beliefs about which goals in life are worth pursuing. The parties to the original contract are said to be behind the "veil of ignorance." They then negotiate over the "primary goods," which are the things they would need "as free and equal citizens living a complete life" (Rawls 2001, 58). These primary goods first include basic rights and liberties, but also health

care. (Rawls 2001, 171-175) Since the parties do not know who will be favored by any inequality, Rawls argues they would agree to the Difference Principle: Inequality is permissible but any inequality is to benefit the least advantaged member of society (Rawls 2001, pp. 42-43). Rawls's argument for these principles, in broadest outline, is to compare these with utilitarianism, which Rawls regards as the most plausible alternative.

It may initially seem clear that Rawls's social contract theory forbids risk selection. If none of the contracting parties knows whether he or she has any condition resulting in higher than average health risks, it seems that they would not agree to rules governing insurance that permitted insurance to be denied to those with higher than average risks. In this respect, the least advantaged person would be the one with the highest risks. But behind the veil of ignorance, none of the parties would know whether he or she was that person, and none would agree to allow such risk selection.

Thus Philip Kitcher argues that in the midst of the current rapid growth in our knowledge of human genetics, people today are actually behind a veil of ignorance with respect to future knowledge of health risks, and not merely hypothetically behind a veil. (Kitcher, 1997, pp. 136-139) It is possible, however, that more is learned about human genetics, this knowledge will be so complicated by compound probabilities that in some sense people in the future will remain behind the veil of ignorance. But Kitcher is optimistic about the possibility of enlightened use of genetic knowledge.

From our genetic ignorance, Kitcher argues for universal tax-funded health insurance. Apart from genetic ignorance, however, it is widely recognized that each of us is ignorant about his or her future health risks, or those of elderly family members. So even in the US,

despite powerful political opposition, health insurance for the elderly is partially tax funded.

#### 4. The Difference Principle

This argument, however, is not decisive because the parties in the Rawlsian original position are not entirely ignorant. Any theory of justice needs to make some assumptions about the human beings for whom our theory is intended. Rawls seeks to maximize the generality of his theory by minimizing these assumptions. Rawls (1996; 2001) sets out a minimal commitment to human "moral powers" or capabilities to have a moral life, which he argues is sufficient as a basis for the contract he proposes. But Rawls supposes that the parties in the original position have access to as much general knowledge about human life as they want.

This supposition does not specify what this knowledge includes. In particular it does not specify what the parties know about medicine or human genetics, where our knowledge is advancing rapidly now. But then for the sake of argument it can be assumed that the contracting parties do know the general distributions of risks for whatever health conditions are to be insured for, genetic or otherwise. Also for the sake of argument it can be assumed that the risk distributions are known both for having the condition and for the various degrees of severity of the illnesses, which would then require care of different levels and expenses. Then it is possible that a utilitarian calculation would show that denying care to the most severely affected and expensive patients would give a higher overall benefit to society. Does the social contract theory still forbid risk selection, even when the distribution of risks is known? It does. The argument here is based on the difference principle.

If it is supposed that the veil of ignorance does not conceal the contracting parties' knowledge of some or all of their health risks, they would find it rational to exclude from the contracting group those with higher risks of some kinds. These remaining strong parties could agree to discriminate against the weak parties with higher risks.

But some differences in health risks would exist even among these remaining strong parties. As they negotiate for a difference principle applying among themselves, they would not permit risk selection on the basis of the risk differences remaining among themselves. But if they agree to a form of the difference principle that forbids risk selection on the basis of risk differences among the strong parties in the group, but allows risk selection on the basis of other risk differences, this would violate one of the formal constraints on moral principles. This difference principle would not be formulated in general terms. (Rawls, 1971, pp. 130-136) Instead it would single out the weak group as those for whom there were greater than average risks of certain kinds. Rawls's social contract theory view then forbids risk selection altogether. In some cases cooperation among the strong benefits the weak.

A fine point in this argument is that health is a natural primary good, (Rawls, 1971, p. 62) but a system of cooperation as Rawls understands it (the "basic structure") distributes only the social primary goods, including health insurance. The least advantaged person in the argument above is identified by a lack of natural primary goods. Rawls's discussion of how to identify the least advantaged person (Rawls, 1971, pp. 97-98) does not exclude this, but the discussion of "The Tendency to Equality" and the "natural lottery" (pp. 100-108) invites this. Natural primary goods are not directly under the control

of social agreement, but the only redress is in the form of social primary goods.

#### 5. Patients' Choices

Moral hazard is usually understood only as the increase in risk to insurers that results from the insured parties' knowledge that they are covered. This occurs when insurance covers risks that are affected by insured parties' choices and actions. It is worth noting that "moral hazard" can also be viewed impartially as affecting insurers as well as insured. (Heimer, 2002) Thus "moral hazard" might also describe the risk to insured parties that insurers will find loopholes allowing them to avoid fulfilling the contract.

Nonetheless, it is helpful to consider whether health risks resulting from patients' choices and actions justify risk selection in such cases. In part this is an empirical issue. It seems unlikely that insurance coverage for lung cancer would raise smoking rates. But insurance for automobile accident injuries may do so.

The moral question, however, seems clearer than the empirical question. Should health care or coverage be denied to someone because he or she smokes? Should health care or coverage be denied to someone because he or she caused an automobile accident injury? Probably not. This may not need an argument for cases of severe injury or illness. But perhaps it may be justified to deny care for a minor injury or illness, if the patient is at fault. But even this would probably seem to most people to be unnecessary punishment, since the patient is already suffering.

#### 5. Efficiency

The difference principle is understandably controversial. Rawls does not try to give a decisive argument in its favor. Instead, he argues that the difference principle does better than utilitarianism when judged by various criteria that would be reasonable to apply to decisions made in the original position. These criteria include publicity, reciprocity, or formal constraints on moral rules, which are appealed to in the argument above. It should also be noted that the difference principle is just by Rawls's standards only in situations that already satisfy the principle of equal liberty.

The difference principle allows for inequality but regulates it. It is useful to ask whether this is efficient for the satisfaction of the desires of members of society. In particular it is useful to ask whether health insurance without risk selection is efficient. This paper argues that it is not efficient to reallocate insurance on the basis of risk selection. Starting from an initially equal allocation of goods, risk selection does not move toward greater efficiency. (Efficiency does not determine what health insurance arrangement is just. Many distributions of goods are efficient despite being extremely inequitable (Rawls, 1971, pp. 69-71).)

First it can be seen that it is more efficient for a group to insure its members mutually than for each member to self-insure by individual saving. The insurable risks are for costly losses, rather than inexpensive losses. Also, it is pointless to insure against a loss with a very high risk. (For example, it is pointless to insure against old age.) So individually it is rational each year to set aside only a fraction of the cost of the loss. But then if any member of the group has the bad luck to suffer a loss in the first years of saving, that member will be unable to cover it.<sup>1</sup>

Since only the very wealthy are able to set aside enough to cover possible costs, for health insurance everyone else always remains in the situation of the mutual insurance group members in the first years of their agreement when they are unable to fully cover any losses. It is more efficient, then, to have health insurance than not.

Now suppose that some members of the group are found to have higher risks than others. If the insurance scheme charged the high risk members more than the low risk members, this would shift costs from the low risk members to the high risk members. This shift as such is not Pareto efficient. Some members would lose at the expense of the others.

The efficiency of an arrangement depends on the starting point. If the starting point is insurance that excludes high risk people from coverage, it will require a non-efficient redistribution to extend coverage to them. Lower risk people would be charged more. Then this might be considered as "harming" the lower risk people (Pauly & Herring, 2007, 777). But not so if the starting point is the arrangement in which everyone rationally self-insures and then consider how society as a whole can better handle risks.

Is it possible that selection against high risk members of the group could free up funds that might be used to compensate them for their loss of insurance? If so, then risk selection would be Kaldor-Hicks efficient, even if not Pareto efficient. But recall that health care must be distributed by insurance if anyone is to have care. It seems unlikely that there could be any compensation that would satisfy those suffering a loss of health insurance.

It also needs to be considered whether forbidding risk selection would harm insurers. People with higher risks tend to buy more insurance. If insurers do not practice risk selection, they must raise

their prices in order to cover higher risk patients. Then insurance may cease to be worthwhile for lower risk patients. This raises the average risk of the remaining group of insured patients and pushes insurers to raise prices further. The insurance market might collapse in an "adverse selection death spiral." But Buchmueller and DiNardo (2002) find that this does not happen for health insurance. Apparently the strength of demand for health insurance overpowers the tendency toward a "death spiral."

#### 6. Criticism of Actuarial Fairness

Equal insurance costs are efficient for different risks if the starting point is an equal allocation of costs. But this allocation of costs violates actuarial fairness, which would require that costs should be proportionate with risks, and actuarial fairness may seem to be common sense.

It is the nature of insurance that individual contributions to insurance funds do not match individual benefits, and instead spread costs. Insurance by its nature does not provide fairness to individuals in the sense of giving them what they pay for. Actuarial fairness instead gives groups with equal risks what they pay for. But it is arbitrary to pick smaller or larger groups. The above example begins with a larger group, which insures itself fairly according to its average risk.

Subdividing the large group into smaller groups, and then allocating costs by the different risks of the smaller groups may be justified in some cases. If the risk is due to individual choices that there is a reason to discourage, then insurance costs may provide a disincentive to these choices. Risk selection may be permissible in such cases. But it is morally significant for health care that many

health risks are not due to individual choices that there is a good reason to discourage.

Health care is among the primary goods that members of society need if they are to lead any kind of life and if they are to seek any other kind of goods. This is, of course, a moral understanding of health care. But from this view of health care, it follows that it is among the goods distributed by the social contract. With respect to health care, in a society in which health care is done on an industrial scale too costly for individuals to purchase, so that health insurance is needed to distribute the costs, "we are all in it together." Exclusion from health insurance by risk selection is, then, a form of exile.

Actuarial fairness may seem to be common sense because it may be thought that each person in some sense owns his or her own risks. The risks may seem to "belong to" each individual. From this view, a person with high risks is like someone with a large debt. But this view of risks as property is as misleading as viewing the taxes each person pays as somehow belonging to them. Taxes are part of the rules for cooperation in a society and part of the rules establishing private property rights. In a hypothetical measurement what each of us gets for his or her tax payments, each would get more than he or she pays for. (Murphy & Nagel, 2002) Health care similarly is worthwhile to each of us, despite insurance costs not being commensurate with each individual's benefits.

## 7. Conclusion

The idea that each of us owns his or her health information may also seem to be common sense. Consider a patient who checks into the hospital with an infection but is found to have HIV. It may be

medically necessary to share this information for health care purposes, even if the patient is incapacitated and cannot give consent. It would not be permissible, however, to use this information to exclude the patient from insurance coverage. If it is wrong to share this information with an insurance company, this is only because it can be expected the company to use the information in this way, not because of who may be thought to own the information. This use of the patient's health information would be wrong because having health insurance is part of membership in society, and social exclusion is wrong in this case.

The regulatory remedy is well known. It is a combination of "community rating," which requires insurers to charge the same for health insurance for people at all risk levels, and "guaranteed issue," which requires insurers to sell to those who ask for insurance. But these regulations do not address the problem of health care costs. This problem requires some form of prioritization of care, which is the deeper moral problem of health care justice.

The argument against the use of health information for insurance risk selection cannot easily be extended to other moral issues about information. The argument here depends on the use of this information in connection with provision of a primary good. In other cases, it is not so clear whether one or another piece of information would, if given to the wrong person or agency, suffice to deny someone a primary good. (Information necessary for obtaining a primary good might include whatever is needed to show citizenship or residency rights.) There is some analogy, however, with the use of criminal records to deny voting rights, or other rights, such as rights of free movement, or the use of sexual offender registries to deny choice of living place.

## Note

1. Suppose four able-bodied, entirely self-interested people agree to mutual insurance against a 1/4 chance of a \$100 loss each year. It is rational for each of them to set aside \$25 each year against this loss. But if there is a loss in the first year, without insurance none of the four could cover the loss individually. Among the four, however, there is a 108/256 chance of a single loss by one of the four in the first year, and an 81/256 chance of a no loss by any of the four in the first year. (The probability of  $k$  events occurring in  $n$  trials,  $P_n(k)$ , is  $[n!/(k!(n-k)!)]p^k(1-p)^{n-k}$ , where  $p$  is the probability of an event. (Gnedenko & Khinchin, 1962)) So if the four agree to make \$25 payments to each other to cover losses, there is a 189/256 chance they can fully cover any losses in the first year. This is Pareto efficient as long as the \$25 is already set aside, and thus not lost by the member of group who has to give it up.

## References

- Berk, M. & Alan Monheit, A. (2001). The Concentration of Health Care Expenditures, Revisited. *Health Affairs* 20(2): 9-18.
- Buchmueller, T. & DiNardo, J. (2002). Did Community Rating Induce an Adverse Selection Death Spiral? Evidence from New York, Pennsylvania, and Connecticut. *The American Economic Review* 92(1): 280-294.
- Daniels, N. (1985). *Just Health Care*. Cambridge: Cambridge University Press.
- Freudenheim, M. (2007, May 5). When Even One Illness Can Push Insurance Costs Up. *New York Times*.

- Gnedenko R. V. & Khinchin, A. Ya. (1962). *An Elementary Introduction to the Theory of Probability*. (Trans. Leo Boron). New York: Dover.
- Havani, H. (2007). Philosophical Theories of Privacy: Implications for an Adequate Online Privacy Policy. *Metaphilosophy* 38(1).
- Heimer, C. (2002). Insuring More, Ensuring Less: The Costs and Benefits of Private Regulation Through Insurance. In Baker, T. & Simon J. (Eds.), *Embracing Risk: The Changing Culture of Insurance and Responsibility*. Chicago: University of Chicago Press.
- Kitcher, P. (1997). *The Lives to Come: The Genetics Revolution and Human Possibilities*. New York: Touchstone.
- Murphy L. & Nagel, T. (2002). *The Myth of Ownership: Taxes and Justice*. New York: Oxford University Press.
- Pauly M. & Herring, B. (2007). Risk Pooling and Regulation: Policy and Reality in Today's Individual Health Insurance Market. *Health Affairs* 26(1): 770-779.
- Rawls, J. (1971). *A Theory of Justice*. Cambridge, Mass.: Harvard University Press.
- Rawls, J. (1996). *Political Liberalism*. New York: Columbia University Press.
- Rawls, J. (2001). *Justice as Fairness: A Restatement*. Cambridge, Mass.: Harvard University Press.
- Safran, C., Bloomrose, M., Hammond, W. E., Labkoff, S., Markel-Fox, S., Tang, P., & Detmer, D. (2006). *Toward a National Framework for the Secondary Use of Health Data*. Bethesda, MD: American Medical Informatics Association. Retrieved August 3, 2007 from <http://www.amia.org/inside/initiatives/healthdata/2006/index.asp>