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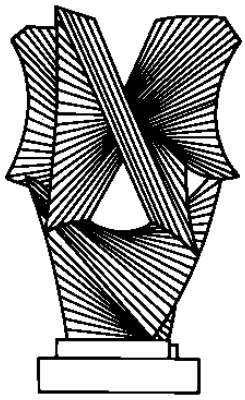

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The single most conspicuous growth industry in Washington D.C. is regulation and the administrative structure it spawns. The number of programs in Washington that start big is relatively small. The dominant strategy in all cases is to identify some failure in the private sector and then to propose some well-tailored government program to combat it. At the stage of inception, everyone is sensitive to the risks of overreaching through regulation. But the mood shifts on implementation of the program.

The key question is what attitude is brought to the two kinds of error that must be confronted by any system of social control: too much or too little. Within this new context, the risks of under inclusion are always high on the agenda. The risks of over inclusion tend to be neglected.

To give but one example, the 1964 Civil Rights Act was sold as a statute that was intended to remove a particular form of irrationality in the market place by refusing to allow employers to make invidious distinctions on grounds of race, sex, and national origin. At the time everyone disclaimed any effort to impose prohibitions when employers did not resort to conscious differences in treatment. No one thought that employers could be held responsible for the background conditions in society at large that contributed to differential levels of preparation of, for example, black and white

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applicants.[1] But we all know the story as to how the initial program grew rapidly by a combination of administrative regulation and judicial decisions. The same story could be told over and over again, for example, with the growth in Social Security and Medicare.

The Health Insurance Portability and Accountability Act is obviously of more recent vintage, but it shows the same precocious capacity for growth so evidently present in earlier forms of federal regulation (Scott 2000: 70-73). The language of the statute suggests that its primary concern was with "portability," namely the ability of individuals with preexisting conditions to keep their insurance coverage when they went from one job to another. But the real sleeper in HIPAA is found in its provisions on privacy, where the regulations, adopted in the face of a Congressional impasse, have just taken off. In order to see how the process works, I propose to examine HIPAA in two ways. The first part is narrower in its orientation, and looks at what I believe to be the important conflict between the concern for privacy on the one hand, and the ability of medical scientists, physicians, and institutions to continue on with their traditional research activities. The second part will be more global, and will examine the larger intellectual framework on privacy that, in my view, fuels this latest misguided round of regulatory expansion. The third part of this paper then concludes with a discussion of the public choice explanation that drives these changes.

HIPAA and Medical Research

In order to understand the impact of HIPAA on medical research, it is important to establish a baseline for comparison, which allows us to assess the differences between

[1]See Michael Sovern, Legal Restraints on Racial Discrimination in Employment (1966), noting the inability to bring disparate impact cases based on employment tests, before Griggs v. Duke Power Co., 401 U.S. 424 (1971).

the pre- and the post-HIPAA world. The former world should not be treated as though it were the state of nature, in which no one knew about privacy or cared about the consequences that might flow from the inopportune release of information. Quite the opposite, the tradeoffs between the control of information and the need for its dissemination into different arenas did not first surface in 1995 or 1996. Rather, it has long been at the center of the discussion for research protocols used by physicians, hospitals, and research centers. The protection of medical records was always a big deal, one that was subject to regulation as well as contract (Moses 2000: 519, 520), including the Freedom of Information Act and Medicare rules.[2]

The questions that were raised in response to this challenge were in my view the right questions: how much do we value privacy, how much will it cost to protect it, and what tradeoffs do we have to make with respect to other institutions?

In the abstract these questions are always hard to answer. Each person standing in isolation is a devoted champion of both privacy and full disclosure. He wants information about him to be kept private so as to increase his ability to project a favorable image and to shape his dealings with other individuals. He also wants to collect all information about others so that he can deal with them from a position of knowledge and strength. Clearly one person is able to attain both these objectives only so long as other individuals fail on both counts.

But once the question becomes a social question, one in which we recognize the like rights of other persons, then all of us have to recognize that none of us shall prevail entirely on either of these legitimate desires. Like it or not, we have, as it were, to make

[2]§ 5 U.S.C. § 552(b)(6); 42 CFR § 482.24(b)(3).

our judgments from behind the Rawlsian veil of ignorance to decide when to opt for disclosure and when to opt for privacy. At this point, we all face a serious tradeoff which requires for its solution the local knowledge that Hayek pointed out was indispensable for the day-to-day operation of any complex set of social institutions. The solutions that evolved over time were decentralized and spontaneous. They were certainly a bit mushy about the edges, and they tended to evolve with changes in technology, which have generally increased the ability to reproduce and transmit information at rapid rates to large numbers of individuals.

In the pre-HIPAA arena, various tradeoffs were made on the borderline between privacy and medical research. The constellation of practices was to a great degree a matter of shared expectations and conventions. Most people, when they went in for medical treatment, knew that they did not suffer from a rare disease or have some dangerous condition. For them, the connection between their own well-being and medical research was not the dominant issue.

By the same token, most people do not matter in the arcane world of medical research. The profile of casual indifference that captures most routine physician/patient interactions most decidedly does *not* apply to people with chronic conditions or to people faced with life-threatening illnesses or major disabilities. At this point, the quest for knowledge becomes intensive. Many a person has kept himself alive by learning enough about his basic condition to aid and facilitate his treatment, or done the same for his loved ones, as well as others with similar conditions.

The proof here is in the pudding. Much of the money raised for medical research comes from individuals who have suffered from major conditions or who have family

members so afflicted. Two recent examples that come to mind are Michael Milken and Andy Grove, both of whom devoted major resources to research into new treatment of prostate cancer. These cases have been replicated countless times on a smaller scale. People who know the ravages of certain illnesses first hand are often willing to do a great deal, and to pay a great deal, to eradicate them.

Expenditures for medical research do not come cheap. But what of ordinary individuals who cannot afford to fund it? To see how they might participate, ask yourself this question: If someone were to ask you to participate in a study that might help cure or alleviate the effects of a particular disease from which you suffered, would you participate in the program, stand aloof from it, or oppose its operation on the ground (of course) that it invades your right of privacy. My sense is that most people would opt for the first alternative out of the usual set of mixed motives. Participation in these studies often secures access to better physicians. It may allow patients to network with others who have similar conditions and, in some cases, may reduce the cost of service. It may also increase the prospects for treatment and cure. It is very unlikely that people would oppose the creation of knowledge when it works both for their own interest and the interests of others. The more serious the condition, the more likely the participation.

It takes, I believe, little empirical imagination to conclude that this scenario has been undertaken thousands of times. Each time, moreover, it carries with it some definable risk to privacy. But these are risks that are worth bearing for the gains that they promise.

The question then arises as to what incremental steps ought to be taken to minimize the risks. Once again there are strong guidelines but no safe harbors. One

possibility is that all clinical data must be used and recorded anonymously. After all, what the research program needs is not autobiographical information, but workable patient populations sorted by age, sex, disease condition, occupation, and the like. It is also clear that when these data are reported publicly, numerical identifiers replace individual names. All readers know is that number 356 in table one is the same person as number 356 in table two. The names are suppressed

However, there are difficulties with extending this approach to the collection and storage of data. One question is how much information should be stored in connection with any given case. Here it is difficult to identify in advance any test of relevance that determines what information should be stored and what disregarded. In dealing with diseases and chronic conditions, it is important to know where people were born, when they were born, how many siblings they had, who their parents were, what was their race and religion, and so on down the line. One or another of these attributes could contain important information about the nature of the condition or its probable severity and the like. All of this material is obviously relevant for the study and classification of genetic diseases. Rich files are therefore the order of the day to keep in archival form material that may have some day be retrieved for research.

There is also a question of how long the data has to be stored. In some cases it might be possible to store the information in stripped-down form, as when there is a one-shot transaction that requires no follow-up work or evaluation. But cases like that are decidedly not the rule. In most cases, it is necessary to follow patients through multiple treatments. Follow-up studies in cancer cases often run for five or ten years. Other kinds of developmental and longitudinal studies require the collection and retention of data for

the better part of a lifetime. The only way that these studies can operate is to keep the names of the individuals in the files in order that each piece of data can be correctly associated with all others. The only feasible solution to the privacy problem is to restrict access to the data to people who have reason to know who is involved.

Let us suppose that we decided to work through this process by stripping out names from files. The cost to the researchers could be substantial. Yet at the same time, it is not clear that this program gives you any protection of anonymity. Modern search engines are so powerful than it is quite easy for skilled operators of Google or Yahoo to work back from the raw data to identify the person contained in the file. It therefore follows that we have only two real choices: Eliminate effective access to the data, or take the risk that some unauthorized person will turn it to an improper end.

I have no question that the second risk is well worth running in these cases. My evidence is that there are few if any major instances of breaches of the promises of confidentiality under which this data was collected in the first place. Wholly apart from any legal sanction, the system seems to work tolerably well in practice.

At this point the appropriate response is to stay one's hand by refraining from making fundamental changes in these practices. It is not, I will stress again, that these practices are uniform. Quite the contrary, we should expect some level of variation dependent on the nature of the information stored, so that psychiatric records receive greater protection than simple data on height and weight. Indeed many people do not want to have their psychiatric information recorded at all, so they privately pay for it to keep the records out of the insurance system (Scott 2000: 493, California Press Release). In good Hayekian fashion, the level of response to this problem is likely to vary as a

function of the nature of the institution, the nature of the subject population, the nature of the disease, and the nature of the resources. Anyone can list multiple factors and determine which way they cut. But it is extremely difficult in the abstract to find one general rule that would allow you from the center to replicate the variety of practices that are common in medical institutions.

These observations are not peculiar to medical records. Industrial firms constantly have to worry about the protection of trade secrets, and they typically calibrate their precautions to the sensitivity of the information so that highly classified information, for example, may be inspected but not copied or removed, while authorized individuals may copy less sensitive information for specific purposes. This is no small enterprise. The internal procedures for trade secrets can run on for pages.

With the advent of HIPAA and its massive regulations, all this changes. Under our new mandate, the basic presumption is that everyone needs to obtain consent for the disclosure or use of any particular medical record for any kind of purpose. HIPAA starts to distinguish among purposes, as it must, with an eye to the individual situation. The rules of consent are relatively easy on matters of any one individual's treatment or payment.

But when the regulations turn to medical research, these direct patient benefits aren't there, so the regulations impose tougher requirements on disclosure. Most obviously, researchers now have to strip identifiers out of the case. Of course, if you just take out the name and put in a number, then someone could track it back to the name again.

It is here that the regulatory pyramid starts to exert its influence. What is necessary is to take that next step by removing all the reasonable bases for identification from the record. It is here that the search engines are capable of undermining the program and create the prospect that long-term studies will become impossible because the information cannot be kept in usable form. In addition, the future collection of this information, which may have only limited relationship to future treatment, becomes harder to accomplish. Routine practices must be preceded by obtaining consent, which requires a level of cooperation that many people will find objectionable. Participation rates can start to decline, and with them the effectiveness of the studies in question, for spotty participation rates can raise the level of bias and adverse selection[3] and generally reduce the effectiveness of these studies (Melton 1997).

In order to escape this real dilemma under HIPAA, the regulators decided to punt, as they often do. Their position is to avoid this problem in the abstract by depending on guidance from IRBs, those ubiquitous internal review boards that are put together to review and to examine protocols for medical research. Clearly some institutional safeguards are needed to deal with experimental treatments that contain high risks but often promise only limited rewards. These review bodies are the buffers designed to run interference for individual patients who are asked to enroll in such programs. In and of themselves, the IRB certifications can help get people to participate in clinical studies by assuring them that some independent body has taken a hard look at the overall situation.

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[3]Thomas J. Liesegang, Potential Effect of Authorization Bias on Medical Record Research, 128 Am. J. Ophthalmology 129 (1999) (describing the impact of a stringent Minnesota disclosure law on the research activities of the Mayo Clinic).

Yet it is dangerous practice to take an institution designed for one purpose and to press it into service for another. The danger here lies in the interactive effects between multiple programs. In this particular case, we can see quite vividly how these effects work out. In July 2000, Johns Hopkins University was entirely suspended for a couple of days from conducting medical research because one of its asthma studies was found flawed after it resulted in the death of a previously healthy human subject (Pelton 2001: A1). That conspicuous case of failure prompted a strong administrative reaction, which demanded that IRBs take harder looks at new research protocols. It was only when everyone realized that the suspension of all ongoing clinical research programs could expose innocent patients to serious risks from loss of medical treatment that HHS retreated and allowed these programs to go forward, albeit on a short leash.

But the resources of IRBs are finite. If they are now asked to do more in their traditional sphere, why do we have any confidence that they will be able to navigate through the thorny question of what new consents are needed to secure cooperation of current patients in long-term studies? The problem is new, the fear of failure hangs over the situation, and the great risk is that this problem will receive insufficient attention, which will result in the use of tough restrictions that offer little protection to program participants but impose heavy costs on strapped research programs and budgets. Whatever assumptions Congress or the regulators might have had when this solution was first devised cannot be updated quickly enough to take into account the profound shift in the external environment. No one can be sure what will happen.

The General Privacy Framework

The research piece is only one small portion of the overall scope of HIPAA. When we ask the larger question of how HIPAA works, it quickly becomes clear that it reverses what was once the ordinary presumption, which held that when you went to a doctor, you generally knew that the medical records could be used for any purpose which was reasonably related to your treatment or care, or to the overall assessment of the system. No consent was necessarily required as a matter of law, although some consent might have been required for internal purposes by the system. The default position thus favored the free flow of information within customary channels. The question of breach was handled less by a system of ex ante regulation and more by a variety of sanctions imposed after the fact. Actions for breach of fiduciary duty, invasion of privacy, intentional infliction of emotional distress, medical malpractice, and defamation could be brought, along with various actions for breach of civil and criminal statutes (Moses 2000: 526-33). The small incidence of their use is a telltale sign that this massive system was working about as well as could be expected.

What led us to abandon this traditional framework? Where have we gone wrong philosophically? At a higher level of generalization, what flawed premises fueled this remarkable expansion of government power?

Let us start with a stripped-down libertarian position, which views the world as follows. First, it believes that the purpose of government is by and large to restrain those activities with adverse consequences upon their fellow individual, and that *systematically* the only activities that satisfy this condition involve the use of force and fraud. So our social objective is to create a remedial structure that picks out those things for

government sanctions and accordingly lets all sorts of other voluntary cooperative activities go on more or less as people organize them. Slightly oversimplified, to be sure, for this approach does not take into account taxes, or monopoly regulation. But for these purposes this model lets us understand where the errors in HIPAA lie.

Well, it is one thing to declare an allegiance to a theory of rights while speaking in the Hayek Auditorium and writing in the *Cato Journal*. It's another thing to figure out how to enforce these rights within a working legal system. We have two kinds of remedies that we can impose, and two kinds of risks with which we have to deal. One remedy, broadly speaking, is remedies *ex post*, so that once the violation of the right has taken place, someone is going to be chastised, fined, fired, or sued, and perhaps even put into jail. The threat of that discipline reduces the likelihood of the initial breach. The second class of remedies operates *ex ante*, before matters go astray. It seeks to impose some kind of injunctive relief to stop it from happening at all. Usually it is difficult for private individuals to bring actions to enjoin certain types of behavior that may hurt someone, without knowing whom. Thus in order to overcome a serious coordination problem, we use driver's licenses and not private injunctions to keep bad drivers off the highways. The hope here is to stop harm before it begins, so that remedies after the fact will not be needed. The risk of the injunctive relief is that its stops many lawful activities as well.

Tradeoffs of this sort are endemic to the legal system. (Epstein 2002). How do we decide which way to exercise this critical one? Generally speaking there is only one way to approach that kind of problem, and that is to ask ourselves how we deal with risk under conditions of uncertainty. Libertarians are much more comfortable in delineating about

rights and wrongs than they are in confronting uncertainties and the errors that necessarily arise in responding to that uncertainty. We should like to eliminate error, but we cannot. So long as there are two kinds of error—from moving too fast *and* from moving too slow—the best we can hope for socially is to minimize the sum of their risks, coupled with the cost of their enforcement. An ex post remedy of damages will not work against a party that is insolvent, but it should work against a major health care provider. But even if it does, it will not restore life or limb or make information private that has been improperly made public. Yet to stop all disclosures is to make it hard to do any useful work at all with medical records.

It is a sad commentary on public policy that the weighing of these error costs is often done by careless extrapolation from conspicuous failures. In some instances, computer glitches could result in the widespread if mistaken disclosure of confidential information. In other cases, hospital workers could leak information about the health conditions of celebrity patients (Scott 2000: 487). These cases dominate the public discourse, and the quieter successes of most activities is thereby overlooked. The upshot is a climate of public opinion that overstates the need for direct forms of regulation to avoid the political heat.

Perhaps because they are aware of this bias, libertarians actually do have a fairly strong belief about the relevant tradeoffs. The general presumption against state action means that the legal system should rely generally on ex post sanctions, unless and until it can be clearly established that there is some imminent peril that calls for an anticipatory response. So if the law has to deal with the nuisance next door, it will enjoin future emissions once fumes start to percolate across the boundary line. But by the same token,

it will not allow a landowner to enjoin the nearby construction of a factory or a home before there are any signs of nuisance: the neighbor has to wait until the conflict emerges, knowing that his damage remedy remains in the background if intervention comes a bit too late.

There are no perfect solutions, but this bias for the *ex post* seems to have worked well over time. Public action is needed to overcome coordination problems when it is known that someone will be harmed, but uncertain as to who that person will be. But the right approach would require the public body to meet the *same* standards of imminent peril for anticipatory relief that are routinely imposed on private parties who, in the absence of any coordination difficulties, are able to act on their own account. The shift from private to public enforcement changes *who* the plaintiff is. It should not change what that plaintiff must prove.

At this point, a second bias enters into the equation, one that is closely associated with the work of William Niskanen of the Cato Institute. Public remedies require public bureaucracies for their enforcement. Bureaucrats wish to expand the scope of their influence and are not happy when confined by a standard that requires them to show imminent peril before allowing for public action. Whether we deal with environmental regulation, securities regulation, or privacy regulation, the tale is the same. Once the government becomes the real party in interest, its public virtue gives it greater clout and ex ante review becomes the order of the day. One encounters a much more intrusive system of permits and permissions, whereby the burden of proof of reversed. Individuals may be free to act only if they persuade the government bureaucracy that their conduct is safe (Epstein 1995: 19). Now the house or factory (or pier or railroad) can be built only

after multiple permits are acquired. A change in standards of government action introduces a small legal revolution.

The matter becomes more serious because the process of delegation results in an implicit shift in the center of gravity. At the congressional level, both sides in the privacy/disclosure debate may have a relatively even voice. But once the issue becomes a question of delegated authority, what is critical is *to whom* that delegation is made. In principle, we should have close constitutional checks on the use of delegated power, but the rise of the administrative state makes virtually all delegations, even those as broad as found under HIPAA, immune from constitutional challenge (Schoenbrod 1993).

The lax level of judicial supervision is not without consequences. Freed from external constraint, delegation takes a predictable course, which in this case leads to a grant of power to privacy experts--people who will tend to weight privacy quite heavily. What made matters worse was that it was virtually certain that Congress would not revisit this issue when it approved HIPAA language giving the Department of Health and Human Services (HHS) the power to issue regulations if Congress itself could not resolve this matter within a six-month period. This second bias of delegated authority thus reinforces the inertial tendency toward bureaucratic expansion. Both tendencies are shielded from judicial review by a deferential attitude toward agency regulation in, of course, the name of the public interest.

The upshot from this confluence of forces is an implicit change in the evaluative weights. Institutionally, we now assume that the error of going ahead when something untoward might happen will be great, whereas the error of being blocked from useful activities will be small. To make that judgment in connection with global systems, the

minimum condition is a succession of widespread failures. But with HIPAA we have seen no such explosion of improper disclosures of sensitive information, and no systematic unwillingness to deal with the problems that do arise by private organization or even by more limited and focused regulatory responses. It is hard to see a less fertile ground for comprehensive government regulation; yet that is exactly what has happened in the privacy regulations promulgated by HHS under HIPAA.

The dangers are evident when we look at the way in which HHS proceeded to act. It did not take an incremental view of the entire problem and decide to regulate where the dangers were greatest. Far from acting incrementally, it opted from the start for the most comprehensive system of regulation to solve a wide number of problems without any evidence of systematic and sustained abuse. It also acted before it understood the interactive effects between its regulations and thousands of other regulations that are elsewhere on the books, or which could be added in short order with the expansion of other programs. To make matters worse, the regulations introduce unintended glitches, which in turn need to be corrected. They also raise countless borderline questions of classification, which increase the costs of monitoring and updating the system. Yet the overall costs are just taken as part of doing business, not as an impediment on how business is done. Ironically, when these failures and omissions become known, they may only be a spur for new, more, and better regulation -- when what may well be needed is a relaxation and reduction of the entire effort that no bureaucracy can accept.

One sign of this progression is the way in which the HHS regulations seek to expand HIPAA's sphere of influence. The original mandate under HIPAA covered some but not all provider operations. What the regulators have managed to do is to stipulate

that any covered entity that provides medical records to a person or firm (known as "business partners") who does not fall under the HIPAA umbrella must require by contract that provider to observe all the HIPAA requirements.[4] So mandatory contracts become the weapon of choice to expand government power, when in fact there has been no clear delegation of authority. The point here is not that it is clear that these parties should not be part and parcel of the overall system. But if they are so covered, we should hope for two things: clearer authorization and a strong sense that these business partners have failed in their operations in ways that justify what is done. But here again we see the consequences of a system that sets a presumption in favor of legislation and not in favor of limited government.

These institutional arrangements might not matter if the substantive program of HIPAA were sound. But even on this point, I think that its overweighing of privacy tends to lead its regulators to downgrade the interests on the other side. The substantive risks of HIPAA are best encapsulated in its basic suspicion shown toward disclosure. The operative regulatory phrase is that covered entities are required to make "all reasonable efforts" not to use or disclose more than the minimum amount of protected health information necessary to accomplish the intended purpose of the use or disclosure[5] (Moses 2000: 545). The logic of this section is in a sense inexorable. The basic statute has decided that the disclosure is a presumptive wrong, and not a routine incident of business within the health care system. It therefore follows that disclosure has to be justified. That in turn means that we want as little of it as is necessary rather than as much

[4]45 CFR § 164.504.
[5]45 CFR § 164.506(b)(1); 64 Fed. Reg. at 60054.

as might otherwise be generated in ordinary business. We cannot of course demand of anyone that they make no errors, so the law requires of them that they make "all reasonable efforts" to minimize the disclosure, even though it is common knowledge that this kind of language invites endless disagreements by making questions of degree the centerpiece of the basic statute. We therefore impose a tough standard designed to influence the choices made under conditions of uncertainty.

How does this all work? I do not know what that answer is, so I shall speculate by taking a very simple case. Say somebody who has medical records on file at a hospital in Illinois is involved in an automobile accident in Ohio. Which medical records does the Illinois hospital send to Ohio? If that someone is me, I have no doubt about the correct operating procedure: send the whole file fast. I don't want anything to be left out, because I don't know what the physicians in Ohio will regard as relevant. But once HIPAA is in place, there is a serious question of whether that simple judgment could survive in the new environment. Suppose, just suppose someone in Illinois thought, "Well, this Epstein fellow only broke his arm, so we'll send only the arm-related information." That sorting could take an hour to figure out, which increases the risk of death or serious injury. The mere fact of making a decision is so prejudicial that it is better that the whole enterprise be abandoned than conducted, even if the latter is done eventually under the *right* standard of relevance, calibrated to the case of medical emergency. Nor would I, or anyone else, who was injured by the delay take comfort because the mistake was made in furtherance of a law that was intended to protect my interest, and by a government or private official who acted in accord with the highest professional standards. The old tort

maxim was that good motives do not excuse bad consequences. That same maxim should apply in the regulatory arena.

The risks here, however, are not confined to delay. They also extend to any conscientious effort to make sense of the minimum disclosure standard. To revert to my simple example, suppose that I am taking a leg medicine, which means that if you give me a certain arm medicine, you're going to harm or kill me. Do not fight the hypothetical on its facts. It is simply designed to point out the importance of drug and other forms of interactions, all of which can arise in protean and improbable ways.

In this case, how do we know *in advance* what interactions are relevant, and hence what information is relevant to the treating physicians? No one can give a satisfactory answer to that question. On that score, I have no hesitations about rejecting the relevancy test altogether. I would rather trust the physician on the spot to look at the entire medical record and figure out what potential interactions to guard against than to have somebody, no matter how able, try to decide at the point of possible release to limit the sending of information on grounds of relevance. I would hate to go into the operating room only to learn that the information thus far supplied was only relevant to the condition that was initially suspected, but not that which was ultimately diagnosed, so that an urgent update was necessary -- subject, perhaps, to the same mischievous ex ante relevancy constraints. Again, time does not only translate into money. It also influences the odds of survival.

In light of what has been said, anyone who runs the error calculations will quickly lurch to the optimal solution: The emergency room doctor gets whatever information is available, but he may use it only for restricted uses related to my well-being. He cannot

turn around and sell my records to a soap vendor or drug company the next day. That's exactly how business was done before HIPAA. Nobody in business sought to impose a "minimum necessary disclosure" requirement then, precisely because full information is likely to minimize errors in decisions made under conditions of uncertainty. It makes no sense to invest in rules that spend time and effort to shrink the flow of information. Nor are these calculations wrong for routine health care. Perhaps some information will not be requested, but I can see no reason for using external standards grounded on privacy issues to prevent the transfer of any information that the treating physician requests, absent some very strong reason for doing so.

The Role of Consent

We can draw some sobering lessons about the processes of government. In the largest sense, these regulations are about the role of consent in the organization of economic and social affairs. At first blush, it looks as though HIPAA is a vindication of the importance of consent. But on a closer look, the entire system seems more Orwellian than libertarian. In this case, the constant mantra of consent functions as a tool to disguise public coercion. The key strategy: all individuals are required to give consent, not comprehensively, but for each separate transaction. What the regulations do is create a system in which each of us is required to exercise, repeatedly and against our own will, this "right" to permit others to use information about us. The loss of freedom in this context comes from our inability to waive the protections of the Act with a single Internet message that says, "Doc, use whatever records you want in the way that you think best, in accordance with the common practice of your institution."

The point gains additional force because it shows the importance of default provisions in organizing the legal system. Most commonly when lawyers speak about default provisions in the law of contract, they mean that set of terms that will fill the gaps in the event that the parties have not spoken to the issue at hand. One theory of the default rule is that “penalty defaults” are appropriate in order to force the more powerful party to a transaction to obtain the explicit consent of his trading party in order to secure the terms of his choice (Ayres and Gertner 1989). This penalty default approach works in opposition to the view that sets default terms in line with common practice, so as to minimize the need and the costs of contracting out.

As a general matter, I think that we should distrust the penalty default theory. Its basic assumption is that individuals who seek to contract out of firm disclaimers of liability reveal information that allows a (price discriminating) monopolist to charger higher rates to those people who reveal a greater need for the firm's goods and services. But there is little if any evidence that large firms ever rely on these default provisions. If only to secure uniformity across different states, they take exquisite care in drafting, in bold type no less, limitations on consequential damages to protect themselves against unwanted liability. The penalty default approach therefore requires parties in a huge number of cases to contract out of a default rule that nobody wants in the first place.

All the work on default provisions under the Gramm-Leach-Bliley Financial Services Modernization Act of 1999 shows a high level of consumer indifference to privacy protections when they are asked to contract *into* privacy protection. As Fred Cate reports, most people "click through" privacy warnings or throw away written advisories (Cate 2002). But those types of statutes lack the punch of HIPAA, which requires

affirmative action to waive the protections that are so afforded, which turns out to be an enormous undertaking for no purpose when medical records are often used constantly, such that individual medical records could be used about 400 times (I cannot verify this number, obviously) in the course of a single hospital stay. The clear implications is that the entire system could easily strangle under the efforts to right itself under a default provision that seems calculated to disrupt routine practices and in consequence to undermine the basic principle of freedom of contract.

Conclusion

Putting all the pieces together, what is going on here? The single largest and most ambitious power grab in the history of American health care was the proposed Clinton Health Security Act, which failed in 1994. Essentially, that bill was an effort to create a massive regulatory apparatus to control, either directly or indirectly, the provision of all private forms of health care. After it failed, HIPAA continued the search for government control by the salami tactic: take control over the industry one slice at a time. In this context, one move to disarm the opposition is to announce that government insists on various sorts of restrictions to protect against pervasive market failures in the private sector. Once those regulations are imposed, of course, the private health system will not be able to respond to the challenges it faces without incurring additional costs for few if any benefits. The upshot is that the health system will creak even further than it does today. That further decline will in turn be invoked as a reason justify further forms of regulation, so that by the time we are done, this hodge-podge system of market-cum-regulation will be deemed unworkable. At that time, the failure of private markets will

lead sober commentators to conclude that the only sensible solution is in fact single-payer nationalized medicine.

In an odd sense this issue relates back to the larger topic of takings on which I have written far too much already (Epstein 1985). But the usual understanding of property rights is that ownership gives you the rights to the exclusive possession, use, and disposition of property. The modern version of regulation treats it as consistent with the private ownership of property, which it is to the extent that it protects the like rights of others, as through a law of nuisance. But there can be no general position that the "regulation" of property falls into one category while the "taking" of property falls into another. The upshot is, rightly understood, that any limitation on ownership that goes beyond what is required under the nuisance law counts as a partial taking of property, which in this case cannot be justified by any legitimate public purpose.

It is therefore important in political terms to understand that the salami image is quite exact: all the rights of ownership are of equal dignity, and the government will disrupt the system if and when it takes any fraction of them. In political terms this means that regulation is partial confiscation that then paves the way for the ultimate takeover through nationalization of the system. The threat here is real, and only by being alert to the danger will people be in a position to resist further encroachments on individual liberty through misguided and excessive forms of privacy regulation.

Unfortunately, the current legal situation takes a rather different view of the subject. Even though the provision of medical care is something that could easily be organized by contract (operating under an intelligent set of default rules), the categorization of government regulation under the current set of constitutional norms is

quite different. The usual definition of the police power is that power inherent in the sovereign that is exercised to protect the "safety, health, and morals" of the public at large. No one doubts that any organized society must recognize such a right. State power is needed to curb common criminals and to prevent ordinary nuisances. But it hardly follows from the simple fact that certain contracts are about health issues that the government then can disrupt their operation when they pose no threat to the interests of third parties. Yet the current system of judicial deference is so strong that all attempts to review health care legislation with a view toward protecting property and contract rights have failed. Hence my sense is that any challenge to the current set of bloated HIPAA regulations will fail. At this stage in our constitutional history, political and intellectual actions are the only source of effective resistance to further government encroachments on individual liberties in the health care arena.

Yet how does this political situation shake out? I think that it is hard to say what will happen. At one level there will be some sympathy for the drafters at HHS. The problem is known to be difficult and no one can accuse them of acting with malice, no matter how excessive their entanglements. So the hard question is whether the manifest inconveniences of the regulation will lead to some kind of public backlash. That can surely happen. Thus one account of the situation in Maine indicated just how quick the public response could be (Scott 2000: 494-495). Apparently, the Maine statute made it impossible for family and friends to receive information about a patient's health status over the telephone. Florists could not deliver flowers without special authorization. Priests were denied access to dying patients. Newspapers could not report on accident

victims. Within two weeks, that statute was repealed and one less severe (but not necessarily ideal) was put in its place.

The point has near-Marxist overtones. Marx emphasized that strong socialists did not want capitalism to fail by half measures. Rather they hoped for its complete collapse and therefore took the position that they should do nothing to improve the short-term condition of the workers. That, indeed, is one of the ironies that opponents of government regulation face in their own way with respect to this statute. If HIPAA turns out to be a true and genuine catastrophe so that every right-minded citizen from left or right across the political spectrum says, "We can't live with this," it will get repealed. But if it proceeds to stumble along in more modest steps, then it could become a permanent impediment on the operation of the health care system and yet another wedge towards its ultimate nationalization. The stakes are high, and the road uncertain, which is business as usual in political affairs.

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