Cost and effect

Pricing life: Why it's time for health care rationing
Peter A. Ubel
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Peter Ubel, a general internist who has published extensively on ethics, equity and medical decision-making, has written a book on health care rationing that deserves to be widely read and discussed among health care decision-makers at all levels and by health care providers in particular. Well-argued and written in an accessible style, *Pricing Life* is peppered with concrete clinical examples. Ubel's discussion integrates a wide-ranging literature in economics, ethics and medicine, and directly confronts an issue central to the future of health care. Ubel also strives to be explicit with respect to both his argument and its implications, forgoing the temptation to hide behind euphemisms, hidden assumptions and rhetorical tricks to make his conclusions more palatable.

Although Ubel recognizes (and gives due weight to) the numerous caveats, qualifications and subtleties that inevitably surround discussions of rationing, the essence of his argument is straightforward. First, the increasing cost of health care makes rationing necessary; second, bedside rationing by clinicians is an essential element of any effective approach to health care rationing; and, third, cost-effectiveness information should be an integral part of rationing decisions.

The book begins with a discussion of alternative notions of what constitutes health care rationing. Because a great many ambiguities are inherent in concepts central to most definitions of rationing (e.g., appropriateness, scarcity), Ubel settles on a broad definition: "health care rationing includes any implicit or explicit mechanisms that allow people to go without beneficial services."

He then argues that the following conditions are necessary for a clinical decision to represent bedside rationing. The clinician must (1) withhold, withdraw, or fail to recommend a service that, in the clinician's best judgement, is in the patient's best medical interest; (2) act primarily to promote the financial interest of someone other than the patient, including an organization, society at large, or the clinician himself or herself; (3) have control over the use of the medically beneficial service.

This conception of bedside rationing — in which a clinician consciously withholds, due to a financial consideration, an intervention that can reasonably be expected to provide positive (even if small) medical benefit to the patient — is crucial to Ubel's larger purpose, which is to explicitly challenge the ethic that the physician has an absolute obligation to do only what is best for the individual patient. He argues, instead, that not only is it acceptable to allow considerations of others to influence the pursuit of a patient's best interest (as physicians commonly do, for instance, when considering issues of community resistance in choosing antibiotics for a patient), it is acceptable to do so out of consideration of costs borne by others. Specifically, it is acceptable for clinicians to withhold a service when the benefits to the patient do not justify the costs. How do we know when such instances arise? Cost-effectiveness information, he argues, should play an important (but not exclusive) role in guiding such decisions.


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Why is bedside rationing (as opposed to rationing solely through higher-level managerial and allocation policies) essential? It is because of the nature of health care services and the distribution of information in the health care system. Very few services are either totally ineffective or effective in all instances, and so rationing through all-or-nothing coverage rules is too blunt an instrument. An effective system of rationing on the basis of health care need requires that each service be provided when it is effective (and in some sense cost-effective) and not provided when it is not effective. The information required to make such a judgement, however, emerges only during the clinical encounter. Hence, such rationing decisions must ultimately be made "at the bedside."

Ubel's argument poses a broader challenge to the traditional medical imperative that physicians have an absolute obligation solely to their patients. Unlike the period during which the traditional ethic was developed (in which clinicians had only a small number of low-cost interventions to offer), modern health care is expensive and the required systems of finance create complex interdependencies among members of society (even those that rely primarily on private finance). Physicians can therefore no longer focus solely on their role as the patient's agent. Rather, they are unavoidably in a position of dual agency: agents for their patients and agents on behalf of society in allocating health care resources.

I concur with Ubel on this fundamental point and with many particular elements of his analysis. There are two areas, however, where I differ on the strength of his conclusions (our differ-

ences are more of emphasis than opposition). The first relates to the role of higher-level guidelines and policies that set the context for the practice of individual clinicians. Ubel is right that they do not avoid the need for clinicians to practise bedside rationing, but — for three reasons — I give them more value than Ubel does. First, assuming that physicians participate in their development, creating such guidelines (at any level — a practice, a medical unit, a hospital) provides an opportunity for physicians to exercise their social-agency obligation outside the patient encounter, allowing physicians to discharge their sometimes conflicting dual-agency roles in distinct settings. Second, by setting a context for individual practice, guidelines and related protocols can make tough bedside decisions easier by providing the physician an external reference standard for the decision. Lastly, the process of developing such higher-level guidelines can foster a greater awareness of the central issues we confront.

The second point relates to the role of cost-effectiveness analysis. Ubel presents an excellent, balanced discussion of cost-effectiveness analysis, its strengths and its weaknesses. Yet, in the end, he has more faith in its usefulness than I do. Even if we develop better ways to measure health benefits and to incorporate equity concerns and other community values, the nature of the information generated by cost-effectiveness analysis is such that at best it can serve as a rough guide. Useful, yes — but more limited, in my view, than Ubel believes.

Regardless of whether you agree with Ubel's argument and conclusions, this book will challenge and teach you much.

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