tegration, however, is the resulting impact on confidentiality restrictions, a topic covered in the book. The linkage of MEPS to the NHIS has resulted in greater confidentiality restrictions than would be necessary for an independent survey and made the release of a public-use NHIS/MEPS data set more challenging. This issue will continue to be critical for health services research more generally, as illustrated by recently proposed changes in confidentiality regulations.

In summary, *Informing American Health Care Policy* is a useful, even entertaining, book for anyone who uses health data or who wants to understand the history and evolution of expenditure surveys. It will give the reader a greater appreciation of the challenges faced by the survey sponsors, as they strive to carefully balance the often competing demands for surveys that meet the needs of both researchers and policymakers.

# The Politics Of Explicit Rationing

BY DANIEL M. FOX

***Pricing Life: Why It's Time for Health Care Rationing***
by Peter A. Ubel
(Cambridge: MIT Press, January 2000), 208 pp., $25.00

Peter Ubel, a physician who has considerable expertise in ethics and economics, assesses recent controversies about rationing health care in this lucid book. He recommends that physicians use the results of cost-effectiveness analysis (CEA) to guide their judgments about treating individual patients. However, Ubel has only a limited appreciation of the historical, institutional, and political factors that inform health policy making.

*Pricing Life* is a useful introduction to the recent convergence of the principles and methods of the disciplines of ethics and economics. In just under 200 pages of text Ubel summarizes the range of opinion about health care rationing among ethicists during the past several decades and the growing relevance of economists to the subject as their methodologies have evolved to more complicated measures of the value of medical interventions for different populations.

Ubel makes strong assertions about both analysis and policy and then qualifies the most important of them. For example, he endorses incorporating into CEA the preferences that consumers express to researchers in answers to hypothetical questions. But he acknowledges that "people's ideas of fairness and efficiency are…a mess" (p. 131), that "many people do not want to allocate scarce resources in ways that maximize health benefits" (p. 83), and that "public preferences can be unjust" (p. 182).

Similarly, Ubel advocates "bedside rationing," but he also acknowledges that the physicians he has studied ration implicitly but "probably do not feel they are trading social cost for patient welfare" (p. 131). As a result of this tension between what he advocates and what he knows, Ubel suggests stringent criteria for "bedside rationing" and insists that "clinicians must be very cautious making judgments about whether a particular patient's quality of life is good enough to deserve resources" (p. 180).

Nevertheless, the last page of the book undercuts all that preceded it. Ubel says that he agrees with the oldest justification for opposition to rationing: "Life is priceless." Nevertheless, he insists that rationing is necessary because "health care is expensive" (p. 183).

Ubel is also disarmingly innocent about how policy is made. He wants policy for rationing by private and public purchasers, insurers, provider organizations, and individual physicians to incorporate the preferences of potential patients. He also insists that policy

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can incorporate these preferences because they can be analyzed with the mathematical models that yield quality-adjusted life years (QALYs), a sophisticated form of CEA. Yet he admits that he does not "know enough about politics…to pretend to say how health systems will ration" (p. 181).

Perhaps it is this lack of knowledge about politics that accounts for the contradiction between Ubel's enthusiasm for new policy and his awareness of the fundamental political problem that makes rationing a controversial issue of policy: "[P]eople do not want to make difficult choices" (p. 74). Most policymakers would agree. Those who run for office or meet payrolls also know that there is strong public opposition to explicit rationing of health care in general as well as in particular situations. The main source of this opposition is that people dislike making difficult choices until they want a particular option for themselves or someone close to them.



Rationing of health care is not the "relatively new phenomenon" that Ubel says it is (p. *xvi*). Rationing has been implicit in the social contracts that have been the basis of mutual trust between the medical profession and the public in each country. Moreover, most governments, other payers, and managers of provider organizations in the past tacitly endorsed these social contracts. For centuries physicans and their allies in paying for and providing care have rationed it by class, gender, race, and geography. Patients and families, moreover, historically accepted physicians' advice about choices among available treatments.

The social contract between medicine and the public has been under active renegotiation since the 1970s, in the United States and elsewhere. Patients everywhere have become consumers. They are better informed about treatment alternatives and increasingly aware that their relationship with physicians has business as well as fiduciary aspects. Everywhere, too, public and private purchasers of care have applied techniques adapted from business to contain increasing health care costs.

The United States, more than any other country, has built its health policy on the assumption that progress in medical science and technology would improve everyone's health. This was the fundamental reason that we created the most expensive health care system in the world. From this assumption flowed decades of cost-based reimbursement and of utilization that was driven almost entirely by the decisions of physicians.

The belief of many Americans that they are entitled to any health care that might help them is fundamental to understanding current debates about rationing, cost containment, and managed care. Whoever proposes explicit rationing or, as in the case of some managed care organizations, seems to be doing it becomes a target of hostility. Elected officials, employers, and leaders of provider organizations are eager to avoid the public opprobrium that results from appearing to want to deny any potentially beneficial treatment to any person or group.

Nevertheless, as Ubel insists, rationing is logical and, in a world of scarce resources, unavoidable. It is difficult to disagree with Ubel that a rational basis for rationing, such as CEA offers, despite its present limitations, could be more just and fair than the informal rationing of which there is so much evidence in the past and at present.

However, I do not share Ubel's optimism about encouraging physicians to ration at the bedside. Such rationing seems likely to encourage even wider, and more dangerous, variation in health care than now exists, to the detriment of patients.

The politics of explicit rationing of health care will always be difficult, and hence most policymakers will always be eager to avoid the subject. Indeed, throughout American political history a successful politics of explicit rationing, of any goods or services, has only been possible in time of war or perceived national emergency.