DECISIONS ABOUT ACCESS TO HEALTH CARE AND ACCOUNTABILITY FOR REASONABLENESS

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ABSTRACT Insurers make decisions that directly limit access to care (e.g., when deciding about coverage for new technologies or formulary design) and that indirectly limit access (e.g., by adopting incentives to induce physicians to provide fewer or different services). These decisions raise questions about legitimacy and fairness. By holding health plans accountable for the reasonableness of their decisions, it is possible to address these questions. Accountability for reasonableness involves providing publicly accessible rationales for decisions and limiting rationales to those that all "fair-minded" persons can agree are relevant to meeting patient needs fairly under resource constraints. This form of accountability is illustrated by examining its implications for the three examples of direct and indirect limit setting noted here.

In our system, private, generally for-profit employers and health plans make decisions about access to medical care that have the potential to affect our health and welfare in fundamental ways. Some of these decisions are "direct" ways of limiting access to services, such as coverage decisions for new technologies and decisions about the contents and design of a formulary. Other decisions "indirectly" limit access by implementing novel forms of risk-sharing incentives with physician groups; the incentives induce physicians to limit access to care. Ideally, setting limits in the appropriate ways can improve the quality of outcomes of a covered population by eliminating unnecessary care, implementing outcomes-based clinical guidelines, ensuring improved continuity and integration of care, and setting fair priorities under resource constraints. In practice, however,

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limit setting is greeted with suspicion and distrust, for many fear that it is only the costs to powerful stakeholders that drive decisions, not a commitment to meeting health needs fairly in a covered population. As a result, an increasing number of Americans fear that a treatment they need will not be covered by their insurer.[1]

In what follows, I argue that we cannot ensure the fairness or legitimacy of direct or indirect limit setting unless we implement forms of public accountability not now in place.[2] Specifically, we must go beyond demanding *market accountability*, the simple demand for clear information about options and performance, and must instead implement measures that establish *accountability for reasonableness*.[3] Accountability for reasonableness demands public access to rationales for limit-setting decisions. It also requires that these rationales be ones that "fair-minded" people can agree are relevant to meeting population health needs fairly under resource constraints. In effect, this is a call for the transformation of the corporate culture in which these decisions are made. I try to be quite practical in suggesting how this accountability can be established in key areas of direct and indirect limit setting.

Before developing the argument for this strong form of accountability and illustrating what it would mean in practice, I want to emphasize that decisions that limit care for those with insurance are hardly the only decisions that affect access to care. Decisions that affect access to insurance, and thus access to care, are made at various levels. One societal decision, made at the national level, is that we shall not institute universal insurance coverage, except for the elderly and except for certain treatments for kidney disease. Consequently, 44 million Americans lack any insurance coverage, and millions more are underinsured. At the state level, we have failed similarly to institute universal coverage, and we set levels for state eligibility for Medicaid that leave many uninsured who, with more generous state funding, could be eligible. At the state level, we also establish more or less adequate levels of funding for public clinics and hospitals. Important as these political decisions about access are,[4,5] I do not discuss them here.

As a result of these political decisions, we empower employers, who derive a tax benefit from providing medical insurance, to make fundamental decisions about access to care. They decide whether to offer a benefit at all, whether to include dependents, and, when they self-insure, just what services they will cover free of interference from state insurance regulations. Health plans and other insurers also make economic decisions that affect access to insurance through

their risk-selection and marketing strategies.[6] I do not talk about any of these business decisions here.

I return instead to limit-setting decisions that affect the content of insurance that most Americans have.

LEGITIMACY AND ACCOUNTABILITY FOR REASONABLENESS

Elsewhere, I have argued (with James Sabin) that the direct and indirect limit-setting decisions made by health plans and other insurers pose a "legitimacy problem."[2,7] Specifically, why should moral authority for such important and morally controversial decisions be lodged with these institutions? More constructively, under what conditions should we come to view the exercise of such authority as legitimate and fair?

A standard reply to this question is that when consumers exercise informed choices about their insurance options, then their choice of plan counts as "informed consent" to the limits it imposes. According to this view, consumers do not need to know why plans set the limits they do any more than they need to know why car or computer manufacturers make the design decisions they make. It is sufficient that the limits are clear so that clear choices can be made. Questions about legitimacy are dissolved by the consent involved in the purchase of a plan—or car or computer—at a given price.

The facts that legitimacy requires consent and consent comes through actual informed choice show the key limits of this view. First, nearly half of American workers have no choice of plans: their employers choose for them. In addition, many of us become aware of what limits mean for us only in the context of treatment, when it is too late to make another choice of health plan. Second, the enormous uncertainty that surrounds health care is different from that involved in the purchase of other goods.[8] We have better information about our computer or automobile "needs" and how to match them to appropriate computers or cars than we do about our health needs and how to match them to appropriate plans, clinicians, or treatments. (This information problem makes our ongoing, interactive relationship with clinicians we can trust crucial to health care delivery, but not car buying.) In addition, if we buy a car or computer that no longer meets our needs, we can sell it and buy one that does, perhaps with some inconvenience and cost, but without serious impact on our well-being. When a plan turns out not to meet our newly discovered health care needs, we may not be welcome in another one, or we may be too urgently ill to shop around.

Perhaps most important, if the computer market fails to provide us with

machines that meet all our information-managing needs, that is too bad, but no injustice is done. But, if health plans fail to meet our needs fairly under necessary resource constraints, we violate a societal obligation to provide appropriate care for those needs,[4] albeit a societal obligation that we have not acknowledged adequately in the political decisions I noted above. That means an injustice is done. There is simply no way to hold plans accountable for their role in meeting that societal obligation if we do not insist on accountability for making reasonable decisions. There is simply no way to guarantee that even an ideal market will provide people with reasonable coverage and treatment options without holding players in that market explicitly accountable for reasonableness.

To implement accountability for reasonableness, four conditions must be met (they are necessary, but probably not sufficient, conditions).[2]

1. *Publicity*: Decisions regarding coverage for new technologies (and other limit-setting decisions) and their rationales must be accessible publicly.
2. *Reasonableness*: The rationales for coverage decisions should aim to provide a reasonable construal of how the organization should provide "value for money" in meeting the varied health needs of a defined population under reasonable resource constraints. Specifically, a construal will be reasonable if it appeals to reasons and principles that are accepted as relevant by people who are disposed to finding terms of cooperation that are justifiable mutually.
3. *Appeals*: There is a mechanism for challenge and dispute resolution regarding limit-setting decisions, including the opportunity for revising decisions in light of further evidence or arguments.
4. *Enforcement*: There is either voluntary or public regulation of the process to ensure that conditions 1–3 are met.

Condition 1 requires openness or publicity, that is, transparency with regard to reasons for decisions. If it is implemented, for example, in decisions about coverage for new technologies or in decisions about the design of a formulary, then a kind of "case law" is established. Plans reveal their commitment to appropriate reasons for limiting care through the demand that these constitute a coherent, defensible body of decisions over time.

Condition 2 requires the most explanation since it involves some constraints on the kinds of reasons that can play a role in the rationale. At its core, it recognizes the fundamental interest all parties in a cooperative scheme for delivering health care have in finding a justification all can accept as reasonable. We can think of

Condition 2 as requiring that we limit ourselves to reasons that fair-minded people can agree are relevant to pursuing appropriate patient care under necessary resource constraints.

Fair-minded people are those who seek terms of cooperation that are mutually justifiable. In sports, we consider people fair minded if they play by accepted rules of the game. Indeed, fair-minded people want the rules of the game to promote its essential skills and the excitement their use produces. For example, they want rules that permit blocking in football, but not clipping or grabbing face masks, because they want to encourage teamwork and skill and not the mere advantage that comes from imposing injuries. Of course, having rules of a game that fair-minded people accept does not eliminate all controversy about their application, but it does narrow the scope of controversy and methods for adjudicating them.

Similarly, if the "game" is delivering health care, whether in public or private insurance schemes, then fair-minded people will seek reasons all can accept as relevant to meeting people's needs fairly under resource constraints. As in sporting games, the rules shape a conception of the common good that is the goal of cooperation (or competition). In both games, people who seek "mere advantage" by ignoring the rules, or by seeking rules that give advantage only to them, are not fair minded. There still will be disagreement about how to apply the rules, but seeking mutually acceptable rules, as fair-minded people do, narrows the scope of disagreement and the grounds on which disputes can be adjudicated.

Conditions 3 and 4 provide mechanisms for connecting deliberation and decisions within managed-care organizations (MCOs) to a broader deliberative process, that is, for making them accountable to the results of a wider deliberation about fairness requirements in health care. The kind of appeals process required by Condition 3, for example, establishes a form of due process and helps open discussion about contested decisions to broader scrutiny. At the same time, if properly designed, these appeals should diminish adversarial confrontation in the courts.[9] Condition 4 recognizes that public regulation may be necessary if self-regulation proves inadequate, but the combined intention behind the four conditions is to focus regulation on process rather than on "organ-by-organ" mandates in health plans. Current reform efforts contain elements of accountability for reasonableness, but they have not focused clearly on that as a central goal.[3]

The guiding idea behind these conditions is to convert private MCO solutions to problems of limit setting into part of a larger public deliberation about a major, unsolved public policy problem. If we had a publicly financed health care system,

as in Canada, Great Britain, and many European countries, we might think that the way to address this problem is to do what the Netherlands and Sweden have done, namely, form public commissions to frame general principles to be followed in setting priorities among health needs and services. There is good reason to believe, however, that general principles of distributive justice and general characterizations of the goals of medicine[10] really cannot address the problems of setting priorities in ways that satisfy our moral concerns in particular cases. Rather, we must seek agreement on how to make the practical decisions about limits that arise at various levels within both purely public and mixed public and private delivery systems.

In designing its rationing scheme for Medicaid, Oregon had to face this problem of reconciling general approaches with the difficulties involved in particular decisions. Oregon developed a public process, but it had to revise its methodology several times, shifting, for example, away from cost-effectiveness rankings, to rankings by categories of benefits, to much more subtle adjustments and deliberations about their appropriateness. It is quite unclear whether any general principles really characterize the process or outcomes that resulted in the Oregon procedure. In many cases, the process ended up with commissioners making fairly specific choices in response to arguments and evidence about the rankings of particular services.

Since the US health care system is a mixed public and private one, key decisions will be made by private institutions that reimburse and organize the delivery of services for specific groups of patients. The four conditions we describe convert those otherwise private and localized decisions into part of a larger public deliberation about acceptable solutions to these problems of setting limits. There are reasons to believe that keeping the focus of problem solving within delivery systems may yield more coherent and defensible practices in the end than proclamations by public commissions—provided that these delivery systems are properly connected to a broader public deliberation and provided that the results of that broader public deliberation can modify or constrain the decisions made within particular elements of the delivery system. If met, these conditions help these private institutions to enable or empower a more focused public deliberation that involves broader democratic institutions. They indeed may be a model for how solutions should be approached even in public systems as well. The broader public deliberation we envision here is not necessarily an organized democratic procedure, though it could include the deliberation underlying public regulation of the health care system. Rather, it may take place in various forms in an array of institutions, spilling over into legislative politics only under some circumstances.

For private health care institutions to acquire legitimacy for their limit-setting decisions, they must see themselves, and be seen by others, as contributors to a broader deliberative process that they embrace constructively. The four conditions that establish accountability for reasonableness contribute to a solution to the legitimacy and fairness problems by placing MCOs visibly in that role. Embracing these conditions and the way in which they connect internal decisions to broader, public deliberation clearly carries many of these organizations beyond the dominant perceptions they have of their organizational and (in many cases) "corporate" culture for it makes them accountable to more than their own boards of directors and in more ways than they are accountable to stockholders (if they have them). In an intensely competitive environment, embracing these conditions may be easier for associations of organizations than for individual MCOs, though it also may be possible to show there is some market value to having a visible record of commitment to patient-oriented decision making. If they are not embraced voluntarily and through self-regulation, then public regulation should require them.

ACCOUNTABILITY FOR REASONABLENESS IN THREE CONTEXTS

New Technologies

Despite pressures to reduce costs, new technologies enter our health care system at a high rate and are viewed by many economists as the primary force driving the rate of health care cost increases.[11] A 3-year study of selected MCOs suggests that, despite intense competition and pressures to reduce costs, the evaluation of new technologies is done on a case-by-case basis without the imposition of a "budget" for new services that would force comparative judgments about their relative importance in meeting population health needs.[2,7] There was little explicit discussion of costs or demand for, or use of, cost-effectiveness analysis in evaluating new technologies (outside formularies). Contrary to public suspicions, however, there is generally a very high level of deliberation about the evidence regarding safety and efficacy, and considerable attention is paid to designing "miniguidelines" to manage introduction of these technologies and ensure reasonable quality.

What is missing, despite this high level of deliberation (in the select MCOs studied), is public accessibility to the rationales for decisions. Often, for example, a coverage decision for a new technology is announced in a medical director's newsletter, and it specifies the terms and limits of coverage, including patient selection criteria, but it does not elaborate on the reasons and rationale for the

limits to coverage. For example, when one MCO decided to cover growth hormone treatment for children who had a growth hormone deficiency or who suffered from Turner's syndrome, it announced its coverage limitation without providing a rationale for these limits. Adequate, reasonable rationales were discussed in the meetings of the coverage committee. These focused not only on the limited evidence of safety and efficacy for an expanded population of very short patients, but also on the idea that use of services for "enhancement" of otherwise normal traits was not the mission of a health plan, whereas treating disease or disability was.

One problem with not being explicit about the grounds for the limits introduced is that an opportunity is missed to undertake both internal and external education about appropriate reasons for coverage.[12] If silence about rationales ends up implying that the coverage limit was based on limited evidence about safety and efficacy, then new evidence might reopen the coverage decision. If the plan had been explicit about invoking a resource allocation principle that gave priority to treatments over enhancements, then even if this principle proves controversial in some cases, it can be evaluated to see if fair-minded people consider it a reasonable basis for limiting care.

Health plans studied were fearful about transparency, but were responsive to discussions about its importance. When the same MCO discussed above recently approved coverage for pallidotomy, a neurosurgical procedure for relieving certain symptoms of advanced Parkinson's disease, it adopted the patient selection criteria used in the existing published studies. When it was pointed out that it was unclear whether these criteria arbitrarily limited access of patients who might benefit, the plan revised its announcement of its coverage policy to make it explicit about the grounds for the selection criteria. This MCO had been persuaded that internal clarity about rationales not only would improve its own decision making, making it more likely it would arrive at defensible, coherent decisions across cases, but also that patients and clinicians in time would come to see that the pattern of reasoning underlying these cases was driven by reasonable concerns about patient welfare.

We have proposed generalizing these small steps to ensure accountability for reasonableness by embodying them in National Committee for Quality Assurance (NCQA) standards regulating technology coverage decisions in accredited health plans. For example, here is what a revision of the 1997 NCQA utilization management (UM) standard for technology assessment would look like if it incorporated accountability for reasonableness (proposed revisions are in italics):

UM 7. The managed care organization evaluates the inclusion of new medical technologies and the new application of existing technologies in the benefit package. This includes medical procedures, drugs, and devices.

UM 7.1. The managed care organization has a *publicly available* written description of the process used to determine whether medical technologies and new uses of existing technologies will be included in the benefit package.

UM 7.1.1. The written description includes the decision variables that the managed care organization uses to decide whether new medical technologies and the new application of existing technologies will be included in the benefit package.

UM 7.1.1.1. Allowable decision variables are restricted to those that appeal to evidence, reasons, and principles considered relevant to the meeting of patient needs under reasonable resource constraints.

UM 7.1.2. The process includes a review of information from appropriate government regulatory bodies, as well as published scientific evidence.

UM 7.1.3. Appropriate professionals participate in the process to decide whether to include new medical technologies and new uses of existing technologies in the benefit package.

UM 7.2. The managed care organization implements this process to assess new technologies and new applications of existing technologies.

UM 7.2.1. The implementation includes making each decision and the underlying rationale for it (including, for example, the rationale for patient selection criteria) publicly available in writing, thereby accumulating a "case law" record of the reasoning employed by the organization.

UM 7.2.2. The implementation allows for new arguments and input from appeals so that decisions can be revisited in light of relevant information.

There is room for this revision because NCQA already embodies concerns about accountability for reasonableness in some of its standards. For example, in providing an explanation (on its Web site, www.ncqa.org) of its utilization management (UM) standards, NCQA captures their overall spirit with these questions: "Does the Plan use a reasonable and consistent process when deciding what health services are appropriate for individual's needs? When the Plan denies payment for services, does it respond to member and physician appeals?" In its rationale for the standard (UM 1) that requires clearly defined UM structures, procedures, and responsibilities, NCQA says:

A well-functioning UM program manages the use of limited resources to maximize the effectiveness of the care provided to the member. By defining how utilization decisions are made, a well-structured UM program promotes fair and consistent UM decision making.

Quite correctly, NCQA recognizes that fairness and consistency not only must be present, but also must be demonstrable to members. In its rationale for the standard (UM 2) that requires publicly available utilization review decision criteria based on sound clinical evidence, NCQA says:

The managed care organization must be able to demonstrate to members and practitioners that UM decisions are made in a fair, impartial, and consistent manner that serves the best interests of the members. Therefore, the managed care organization has objective, measurable UM decision-making criteria that are based on reasonable medical evidence.

Specifically, decisions must be consistent with clinical practice guidelines if they have been introduced, and they must be available to and understandable by clinicians. At the same time, such guidelines cannot be viewed as "absolute" criteria and must allow for variation among patients (UM 5). Here, too, fair-minded persons would agree to the limits imposed by clinical guidelines only if allowance was made for the specific features of individual cases.

The rationale for the NCQA standard that concerns appeals procedures (UM 6) explains that "accountability" for its decisions means an MCO that denies coverage must:

Clearly explain the reasons for the denial to the member if the member was involved in the UM process, as well as to the practitioner, as appropriate. *The inclusion of the reason for a denial allows the member and/or practitioner to understand the reasoning behind the managed care organization's decision* [italics added].

In sum, the member (and practitioner) affected by a denial of coverage is owed direct accountability for a full explanation of the rationale for the decision.

The most controversial technology coverage decisions health plans make are those that involve "last-chance" therapies for fatal or severely debilitating illnesses. In these cases, there is considerable room for disagreement about how to weigh the values of stewardship of scarce resources and the generation of knowledge about effective treatments, which would incline plans not to cover unproven therapies, against the value of meeting urgent needs, which might lead to more liberal coverage of last-chance therapies. This moral controversy makes this a highly contentious area, and it is not surprising that a mechanism for external review of appeals has emerged as one model for providing due process in these cases. Accountability for reasonableness can be embodied in various strategies for addressing the disagreements these types of decisions involve, but I refrain from further comment on some of these "best practices" here.[9]

Formulary Management

A small number of pharmacy benefit management (PBM) "carve-out" companies now design and manage the formularies for half of all people with insurance. The two largest companies each manage benefits for over 50 million lives. The attraction of these companies is that they have been able to use their purchasing leverage to arrange discounts from drugstore chains and rebates from manufacturers, slowing the rate of cost increase in formularies. In recent years, however, discounting has not been able to slow the rapid increase in formulary costs, which have risen far more rapidly than health care costs generally. Since a flood of new pharmaceuticals is in the pipeline of research and development, cost pressures only will increase. Indeed, Viagra brought to public consciousness the degree to which costs, if not cost-effectiveness, will play an explicit role in coverage decisions and plan design.

Formulary design involves decisions at several levels. First, there are "categorical" decisions concerning the general types of pharmaceuticals covered. Then, a further "drug selection" decision often is made to cover only some drugs within the covered categories (usually on the basis of cost or cost-effectiveness considerations). A third level of decision concerns indications for conditions for which the drug is to be used. Finally, there may be "drug use" decisions, including limits on the amount that might be prescribed for an episode.

Different types of reasons tend to be prominent at the four levels of decision. At the categorical and indication levels, for example, reasons range quite broadly over the goals of the plan (e.g., offering treatments but not "medically unnecessary" enhancements), safety and efficacy, risk-benefit evaluations, and costs and cost-effectiveness. At the drug selection and drug use levels, decisions are more influenced by cost and cost-effectiveness than by other considerations.

These formulary design decisions all provide a context in which decision makers should be held accountable for the reasonableness of their decisions. They provide a perfect context in which a PBM company, in conjunction with the purchasers who contract for its services, can articulate a coherent framework of reasons and rationales that all fair-minded stakeholders can judge for acceptability. These reasons and rationales, incorporated in the formulary design, then constitute a publicly accessible body of case law. The case law then helps the plan to remain consistent and coherent in its decision making and provides an educational device that can be used to help clinicians and patients in their deliberations about care.

Without an approach such as this, formulary design will be viewed as another

"bottom line" exercise, regardless of how much patient-oriented thought goes into deliberation about its features. Since pharmaceutical manufacturers increasingly advertise directly to consumers and since patients increasingly have access to information on the Internet, a PBM must be able to address the demand in a manner that reveals reasons and rationales for commitments that fair-minded participants in schemes, including clinicians, can see are relevant to meeting a population's health needs.

All stakeholders in our system, including large purchasers such as employers, would benefit from insisting on accountability for reasonableness. If employers do not demonstrate a concern for the quality of the care they purchase and if they are seen increasingly only to be concerned about reducing costs, then the stability of the system will be undermined, and the demand for intrusive—and perhaps cost-ineffective—regulation will increase.

Physician Incentives

Accountability for reasonableness must be demanded and provided not only for direct limit setting, but also for indirect limit setting. More and more physicians have agreed to work under financial incentives aimed at limiting care and its cost.[13] Most commonly, the health plan "withholds" some percentage of the income of an otherwise fee-for-service provider, restoring the withholding if organizational cost targets are achieved. With increasing frequency, physician groups, often those with the least familiarity with the cost-conscious culture of traditional, staff-model health maintenance organizations, accept the insurance risk of providing some range of patient services within a negotiated payment per patient per month. This capitation also can be coupled with bonuses and other incentives to reduce costs or achieve certain quality goals.

Do these novel incentives impose an undue risk on patients that physicians will violate the "primacy principle," which calls on them to put patient welfare above their own financial interests? We do know, after all, that physicians respond to incentives.[14,15] They modify their utilization of services in response to withholdings and capitation schemes, and they do so not only in primary care settings, but in various specialty groups as well. If they do so respond, how can we be assured that these schemes do not impose unacceptable risks on patients? Accountability for reasonableness requires assurance to patients—evidence and arguments—that the incentive schemes negotiated between physicians and plans constitute a reasonable limit-setting device.

This test of reasonableness is illustrated by considering an important reason

why simple disclosure of physician incentives, a measure called for in various codes of ethics for managed care and by proponents of "market accountability," addresses inadequately the problem of "conflict of interest" and the normative question about trust. If the only problem we face is identifying a hidden conflict of interest, then simple disclosure has some plausibility. But, the real problem is more complex.

The real problem involves finding incentives that align and balance properly the several interests that are at stake in cooperative schemes to deliver health care. For example, because we are concerned in such schemes about population health and not simply the health of individual patients, we also must consider the interests of all parties in the covered population. Doctors cannot ignore the issue of population health since they ration their own time and often must make implicit comparisons among their own patients. In addition, the private organizations, including those for profit, that organize and deliver care in our system acquire their own interests. These interests also may conflict with the interests of the covered populations, as well as with the interests of the physicians that contract with them.

A reimbursement method such as capitation must achieve an appropriate, reasonable balance among these competing interests. This balance must seem reasonable to all fair-minded parties cooperating in these schemes in light of their common goal of meeting the health care needs of a covered population fairly under reasonable resource constraints. One implication is that fair-minded parties should recognize a collective interest in pursuing the cost-effective delivery of services. They should admit that reasonable resource constraints preclude providing every beneficial service regardless of cost.

If cost-effectiveness is relevant to pursuing population goals in health care, then incentives that push physicians to think about cost-effectiveness by giving them some direct interest in pursuing it may involve a conflict of interest with *individual* patients. At the same time, these incentives represent an alignment of interests between a *population* of patients and the physicians that treat them. When multiple interests are at stake, the perception of conflict depends on perspective.

Of course, the economic incentives to physicians to undertreat could be too strong. This situation would come about if physicians and health plans form an alliance to share the benefits of reducing costs without careful consideration of the interests of the covered population. Physician interests then would conflict with both those of their individual patients and those of the population of patients as a whole.

A reasonable reimbursement method, then, must solve a complex problem in which interests may conflict in several directions. A reasonable solution, however, should not be simply the result of bargaining that reflects the relative power of the different interests—and the absence of patients at the table. It must be based on a consideration of how to achieve the common goal shared by fair-minded parties in the health care "game."

Existing guidelines for incentive schemes are theory based, not evidence based. Several authors[16,17] have urged that incentive schemes not put too much of a physician's income at risk, and that risks be spread over appropriately large groups of patients and physicians. But, these recommendations—reasonable as they seem—should be backed by evidence that particular incentive arrangements do not put patients at undo risk. The main empirical study that focuses on this issue directly is a survey of plan-manager beliefs about when they feel uncomfortable with the effects of incentives on clinicians.[18] There is also no outcomes evidence to validate these beliefs.

It simply is not reasonable to put trust in the doctor-patient relationship at such risk without being able to show, through actual evidence, that incentive schemes are compatible with delivering appropriate care. Plans must provide institutional support for professional ethical values by providing not only disclosure, but also actual evidence that their schemes are reasonable.

LEARNING ABOUT LIMITS IN THE LONG RUN

I have argued that accountability for reasonableness provides a way to address the problem of legitimacy that faces insurers in our system, and I have illustrated that this is a feasible concept to apply in three contexts of limit setting. I want to conclude with a brief remark about the way in which accountability for reasonableness enables an educative, as well as deliberative, process.

It often is remarked that Americans are particularly demanding, even individualistic, and that culturally they cannot accept the kinds of limits that might be imposed in systems less driven by the market. People who make this remark use it to explain, in part, why we assign such a large role to the market in our system. I think the point can be turned around. Exposure to a market, rather than to a politically based system, can encourage irresponsible demand that ignores reasonable resource limits. In reality, however, resource limits are set, if only by employers and other large purchasers. Consequently, there is even more need for our society to embark on a learning process about health care limits.

There is no short-term solution to the problem of getting Americans (or others) to accept resource limits in health care. These limits always will seem arbitrary

and unacceptable if the public thinks they are imposed by stakeholders with narrow economic interests. But, if the public over time comes to see—through the educative and deliberative process that is provided by accountability for reasonableness—that key institutions make responsible, reasonable decisions, then the public will internalize conceptions of fair play that will moderate demand. Of course, people faced with life-and-death issues that affect their children or parents will try to do the most they can to help them. Whether they see restrictions as reasonable and fair, however, has a lot to do with their willingness to comply with them, even when their individual interests are threatened. There is no reason in the world to think Americans are less amenable to fair play than the rest of the developed world.

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