The Ethics Of
Accountability In
Managed Care Reform

Recent efforts at reforming managed care practices have one thing in common: a call for accountability to consumers.

by Norman Daniels and James Sabin

PROLOGUE: No country in the world can afford all of the medical care that providers can render to populations. Thus, in every nation governments and private-sector organizations design mechanisms that ration resources in ways that seem compatible with the values of a particular society. For the most part, governments establish these mechanisms, and most of the resources flow through public budgets or at least publicly fashioned funding channels. But in the United States the purchasers of medical care have increasingly favored the allocation of resources through marketlike mechanisms rather than by government regulation. Consumers and providers have found many of these strictures objectionable and have argued that private health plans must be called to greater accountability for their allocation decisions.

In this paper Norman Daniels, a philosopher, and James Sabin, a physician, argue that the basis for assuring accountability in a democratic society is through the use of processes that accentuate fairness and openness. In the current political climate, neither party seems prepared to leave the development of these processes to the private marketplace, but whether Congress can achieve consensus on these contentious issues before the end of the 105th session is debatable.

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ABSTRACT: Two notions of accountability embodied in proposals to reform managed care have different ethical implications. Market accountability requires plans to inform purchasers and consumers about performance and options, in theory legitimizing limits to care through consumer choice. Recognizing the limits of consumer choice, accountability for reasonableness requires that the rationales for limits to services be public and be based on reasons or rules that "fair-minded" people can agree are relevant to pursuing appropriate patient care under necessary resource constraints. Accountability for reasonableness educates clinicians and patients about the need for limits and empowers a more focused public deliberation in which ultimate authority for limiting care rests with democratic processes.

Public accountability is the apple pie and motherhood of health care reform. All reform efforts—President Clinton's Consumer Bill of Rights and Responsibilities, the Principles for Consumer Protection proposed by a coalition of health plans and consumers, the many legislative proposals introduced at the federal and state levels, and the accreditation and performance standards by the National Committee for Quality Assurance (NCQA)—call for robust disclosure of relevant information about health plan benefits and performance, and "due process" in the form of a grievance or appeals procedure.¹

Accountability has obvious appeal. Disclosure informs our consent, not just to treatments but to our choice of providers and plans. Informed choice expresses our autonomy and is the lever that pushes markets to work responsibly and efficiently.

There are, however, two distinct notions of public accountability: market accountability and accountability for reasonableness. It is important to distinguish between them because they are central to quite different views about what constitutes a fair and just health care system. In our mixed public/private system, both are necessary.

Market accountability is the idea that information about performance and options must be made available to purchasers and enrollees in managed care plans so that they can effectively make choices among plans, clinicians, and treatments. Only with such information can consumers and purchasers leverage providers to improve quality of care and be responsive to patients' needs and desires. Accountability for reasonableness is the idea that the rationales for important managed care plan decisions should not only be publicly available, but should also be those that "fair-minded" people can agree are relevant to pursuing appropriate patient care under necessary resource constraints.

By fair-minded we do not simply mean like-minded friends who just happen to agree with us. We mean people who in principle seek to cooperate with others on terms that are mutually justifiable.
Indeed, fair-minded people accept rules of the game—or sometimes seek rule changes—that promote the game’s essential skills and the excitement that their use produces. Such rules aim at “the common good.” Of course, having rules of a game that fair-minded people accept does not eliminate all controversy about the application of those rules. Nor does it eliminate all rule violations. It does, however, narrow the scope of controversy and the methods for adjudicating them.

In the “game” of delivering health care, whether through public or private insurance schemes, fair-minded people will seek reasons they can accept as relevant to meeting consumers’ needs fairly under resource constraints. As in football or fishing, the rules shape a conception of the common good that is the goal of cooperation within plans, even when plans compete. In health care delivery, as in football, some will seek “mere advantage” by ignoring the rules or by imposing rules that benefit only them, and there will still be disagreement about how to apply the rules. Still, the fair-minded search for mutually acceptable rules narrows the scope of disagreement and the grounds on which disputes can be adjudicated.

Accountability for reasonableness obviously goes beyond what is required by market accountability alone. Market accountability requires only that we be informed about the options insurers give us and about their record of performance. Accountability for reasonableness requires that we also have access to the reasons for the insurer’s policies and decisions and, crucially, that these policies and decisions be based on the kinds of reasons fair-minded people consider relevant to the challenge of providing high-quality care to all within limited resources. Market accountability leaves it to the consumer to infer whether a managed care plan is committed to patient-centered care. Accountability for reasonableness requires the plan to be explicit about its commitments.

Why insist on such a demanding standard in health care but not in other industries?

**Legitimacy And Reform**

To be successful, the reforms proposed in such measures as the president’s Consumer Bill of Rights and Responsibilities must address a basic ethical question about moral authority that we call the legitimacy problem: Why, or under what conditions, should we (the public, patients, and clinicians) entrust moral authority to private organizations, such as managed care plans, to make controversial limit-setting decisions that fundamentally affect our welfare? Under what conditions is legitimate authority not only established (whether through implicit social contract or explicit public policy),
but maintained and justified?

The preamble to President Clinton’s Consumer Bill of Rights and Responsibilities asserts that “costs matter” in the distribution of health care. Indeed, all health care systems, here and abroad, face this unsolved problem of distributive justice—namely, how to meet competing claims on limited health care resources fairly in a population of insured patients. How much priority should be given to the sickest patients? When do modest benefits for larger numbers outweigh significant benefits for a few? Should we seek “best outcomes” or allow more people to have fair chances at some benefits? The legitimacy problem asks who has the moral authority to solve these controversial moral problems on our behalf. Under what conditions should we cede that authority to private corporations?

**Ethical Limits Of Market Accountability**

Market accountability reflects one approach to the problem of legitimacy: Consumers retain “moral authority” by making choices. When consumers make informed choices among plans, they give “informed consent” to the limits the plan imposes. Consumers need not 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. If the limits set by plans are clear enough, there is no doubt about what consumers have authorized.

The strong demand in current reforms for full disclosure of information to consumers reflects this conception of market accountability and legitimacy. Disclosure is demanded of the health plan’s structure and provider network, down to names and credentials of its physicians; the coverage provided and excluded; the capitation schemes and other reimbursement methods used; members’ cost-sharing requirements; procedures for utilization management and for the coverage of investigational treatments; formulary restrictions and rules; disenrollment data; procedures for obtaining emergency and out-of-network care; information about regulatory agencies; reporting on measures of performance; and loss ratios.

In theory, all of this information can help consumers to choose plans that better meet their needs. For example, people who know their family medical histories may anticipate that they will be better served by one provider network than another, or by one set of rules rather than another for using out-of-network treatments. Whether people assimilate and act on this information is, however, an empirical question.

These principles requiring disclosure of information are justifiable on relatively uncontroversial grounds rooted in market theory. No one should have to buy a pig in a poke. The required information
“If health plans fail to meet our needs fairly under necessary resource constraints, an injustice is done.”

would—if all could act on it—lead to a more efficient market.

The fact that legitimacy requires consent and consent comes through actual informed choice shows the key limits of this view. First, there is a problem of system design: Nearly half of American workers have no choice of plans, because their employers choose for them. If there is no choice, then by the theory’s own lights, there is no legitimacy, since consumers retain no moral authority. (Accordingly, one of the Principles of Consumer Protection rather lamely insists that all individuals should be given a choice of plans; that requirement was to have been a feature of the 1993 Clinton health plan.)

Second, the enormous uncertainty that surrounds health care is different from that involved in the purchase of other goods. We have better information about what our computer or automobile “needs” are 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 to car buying. System design and uncertainty combine: When a plan turns out not to meet our newly discovered health care needs, our “preexisting condition” may make us unwelcome in another one, or we may be too urgently ill to shop around, whereas if we buy a car or computer that no longer meets our needs, we can sell it and buy another without serious impact on our well-being.

Perhaps most important of all, if the computer market fails to provide us with machines that meet all of 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, an injustice is done. It violates a societal obligation to provide appropriate care for those needs. There is simply no way to hold plans accountable for their role in meeting that societal obligation and to ensure that the insurance market offers reasonable coverage and treatment choices, unless we insist on accountability for making reasonable decisions.

In short, those for whom choice is not possible at all, or for whom the market provides no appropriate, reasonable choices, can complain that market accountability does not assure the legitimacy of the limits they face.
Accountability For Reasonableness In Practice

Before saying more about its bearing on legitimacy, we emphasize that accountability for reasonableness is not merely a utopian idea. Elements of such accountability are already a practical, if not systematic and explicit, goal of some current reforms.

**Current reforms.** The reform documents mentioned earlier and legislative proposals based on them both supplement market accountability with accountability for reasonableness when they call for a “prudent layperson” standard for emergency care. This standard stipulates that plans should provide coverage for services whenever the member goes to an emergency room “with symptoms (including severe pain) that a prudent layperson would reasonably believe to be an emergency medical condition.”

Market accountability alone does not justify this requirement about the nature of limitations on emergency coverage. Market accountability would simply require plans to disclose their emergency coverage policies. Then it would let consumer preferences do the work of weeding out unpopular restrictions. Accountability for reasonableness, in contrast, justifies the “prudent layperson” standard. Obviously, insurers must take steps that result in more appropriate, cost-effective uses of emergency department resources. It is unreasonable, however, whatever some plan managers may have thought, to place the full risk-taking burden on prudent patients who believe in good faith that they are in an emergency situation. Of course, especially with hindsight, experts can weed out instances of decisions to go to emergency departments that do not reflect true emergencies. But plan managers seeking rules that they can justify to consumers must realize that fair-minded consumers, who accept the need for reasonable limits, would never agree that such stringent cost-effectiveness standards should outweigh their good-faith concerns about serious risks to life or health. (Consumers might be forced, through limited options, to “choose” a plan that does not meet the prudent layperson standard, but such a forced choice is not the kind of consent that preserves moral authority.)

Other features of the Principles for Consumer Protection also reflect an implicit appeal to accountability for reasonableness. Consider, for example, the requirements that providers, including specialists, be reasonably accessible to patients, that continuity of care be adequately planned for, and that formulary exceptions be made when medical necessity requires it. All of these principles, vague as they are, implicitly reject as unreasonable more restrictive decisions about how to limit care because such restrictions would ignore considerations that fair-minded patients and clinicians think are
relevant to meeting patients' needs under necessary resource constraints. If fair-minded patients and clinicians cannot agree to these limits, then fair-minded managers cannot either, since each party must seek limits justifiable to others with whom they cooperate in the health care game. Excluding these limits on care cannot be explained by an appeal to market accountability alone, since market accountability would simply let informed consumers choose the level and quality of care they prefer.

The principle governing coverage exclusions for experimental technologies also takes an important step beyond market accountability toward accountability for reasonableness. It not only requires organizations to establish a technology assessment procedure (already required by NCQA standards) but also requires them to institute an external, independent review process in cases of disputed denials of coverage where the condition has a high probability of causing death within two years. The independent review is one important way to assure patients (at least after the fact) that the reasoning employed by a plan in making a decision is not unduly vulnerable to distortion through conflict of interest. Market accountability, in contrast, requires only that a description of the decision-making process, not an independent review, be available to consumers.

NCQA standards. NCQA standards and performance measures, which are primarily intended to provide for market accountability by assuring large-scale purchasers that "accredited" organizations meet rigorous quality standards, also show an implicit recognition of accountability for reasonableness. For example, in providing an explanation (on its Web site) of its utilization management (UM) standards, the 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 (UM1) that requires clearly defined utilization management structures, procedures, and responsibilities, the 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, the NCQA recognizes that fairness and consistency must be demonstrable to members. In its rationale for the standard (UM2) that requires publicly available utilization review decision criteria based on sound clinical evidence, the 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 where they have been introduced, and they must be available and understandable to clinicians. At the same time, such guidelines cannot be viewed as “absolute” criteria and must allow for variation among patients (UM5). Fair-minded people would agree to the limits imposed by clinical guidelines only if allowance were made for the specific features of individual cases.

The rationale for the NCQA standard that concerns appeals procedures (UM6) explains that “accountability” for its decisions means that a managed care plan 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” (emphasis added). In sum, members and practitioners affected by a denial of coverage are directly owed accountability for a full explanation of the rationale for the decision.

Accountability For Reasonableness And Legitimacy For Managed Care Plans

The consumer-driven reforms we have noted take important steps beyond market accountability toward accountability for reasonableness. We propose four conditions that provide coherence and direction to further reforms aimed at accountability for reasonableness. If met, they should, over time, lead enrollees, patients, and the public to respect managed care plans’ decision making for its fairness and legitimacy. (1) Publicity condition: Decisions regarding coverage for new technologies (and other limit-setting decisions) and their rationales must be publicly accessible. (2) Relevance condition: These rationales must rest on evidence, reasons, and principles that all fair-minded parties (managers, clinicians, patients, and consumers in general) can agree are relevant to deciding how to meet the diverse needs of a covered population under necessary resource constraints. (3) Appeals condition: 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 condition: There is either voluntary or public regulation of the process to ensure that the first three conditions are met.
"Although the plans we studied engaged in a careful process, they failed to make the rationales for their decisions accessible."

The guiding idea behind these four conditions is to convert private managed care plans' solutions to problems of limit setting—where, we have seen, highly controversial moral issues are at stake—into part of a larger public deliberation about a major, unsolved public policy problem: namely, how to use limited resources fairly to promote the health of a population with varied needs. In the market view, moral authority remains in the hands of individual consumers who confer legitimacy on plan limits with their contractual choices. In our view, because of the limits of the market view and the moral importance of distributing health care fairly, ultimate moral authority rests with the public. Just as market accountability is a precondition for the exercise of individual market choice, so too accountability for reasonableness is a precondition for the proper exercise of democratic authority and a precondition for responsibly seeking the flexibility, creativity, and efficiency that may result from conferring legitimacy on health plans to set limits.

Meeting the four conditions converts accountability into a process of interactive education among all parties. A culture of openness and reasonableness about rationales would facilitate learning on the parts of clinicians and enrollees about the need for limits. It is often said that we are a culture in which the litigious public will accept no limits. To change that culture requires a concerted effort at education, and education requires openness about the rationales for managed care plans' decisions.

These conditions help private institutions to enable or empower a more focused public deliberation that would involve regulation, legislation, courts, and electoral process. These conditions put us on a learning curve that will permit cultural change both inside and outside the institutions that must make and implement decisions about limits.

Rationale for the publicity and relevance conditions. The publicity condition addresses a problem we discovered in our study of how managed care organizations make decisions about coverage for new technologies. Although the plans we studied generally engaged in a careful and thoughtful process that any observer would agree was based on appropriate types of reasons, they failed to make the rationales for their decisions publicly accessible. Specifically, coverage decisions often are not "yes" or "no" but "mini-guidelines" that involve patient selection criteria and deliberation about how to
ensure quality and cost worthiness when the treatment is administered. Patients who do not meet these coverage criteria should know why their exclusion is reasonable.

The publicity condition thus provides a public record of the commitments to which the plan adheres in making these kinds of decisions. A case-law record such as this improves fairness in decision making because it provides a basis for judging the coherence and consistency of decisions made over time. It gives those affected by decisions—often when they have no real choice to seek alternatives—a way of knowing why they face the restrictions they do. The publicity condition thus satisfies what many believe is a basic requirement of justice: The grounds for decisions that fundamentally affect our well being must be made publicly available to us.

The relevance condition imposes important constraints on the kinds of reasons that should play a role in rationales for coverage decisions, thereby narrowing the range of disagreement. The basic idea is that fair-minded parties in a managed care plan pursue a common goal or common good: In their health care game they agree to pursue their diverse needs on terms they can justify to each other. Since hard choices will have to be made about how to meet those needs fairly, the grounds for those decisions must be ones that fair-minded people can agree are relevant to that kind of decision.

Even if it narrows the range of disagreement, the relevance condition obviously does not mean that all parties will agree with the specific decisions made. Parties may agree that reasons are relevant but still give different weight or importance to them. As long as fair-minded parties who make the decision and those who are affected by it can accept that the grounds for it are relevant, however, then even those who say that the specific outcome is wrong must admit that it is a case of reasonable disagreement. Achieving this basis for cooperation is an important gain over the current situation, where patients or clinicians readily—and often correctly—insist that decisions are made on grounds other than meeting their needs fairly under resource constraints.

Fair-minded people should accept many kinds of evidence and reasons as relevant to coverage decisions. These include scientific evidence about effectiveness and safety. In some cases, evidence about cost-effectiveness also will be uncontroversial, as when there is a less costly way to deliver an equal or superior benefit. Controversy about cost-effectiveness enters when we must trade away some achievable benefits for a group of patients to achieve greater cost-effectiveness. In these cases, reasons and principles that are used to justify the judgment that a more cost-effective therapy should be used must be carefully explicated. The situation is even
more controversial when the cost-effectiveness comparison involves treatments for different groups of patients with different conditions. We found no evidence in our study, however, that new technologies were evaluated as competitors within an overall budget. All evaluations were made primarily on the basis of safety and efficacy, and costs entered the discussion only in thinking about how to manage the delivery of the new treatment. If budget-driven, comparative judgments do become part of the coverage process—as eventually they must—then even more attention will have to be paid to the reasoning about distributive fairness in these cases.

Although our market-driven health care system depends on competition as a central mechanism, the situation is especially controversial when the continued competitiveness or profitability of a health plan is the issue regarding cost. We do not rule out the relevance of this kind of reason, at least in principle. Fair-minded patients and clinicians would accept competition and profitability as relevant kinds of reasons only if they could be persuaded that a system of competing, private health plans actually makes no people worse off than they need be and improves the outcomes for others. If, however, the system simply produces advantages for some (say, stockholders in a for-profit managed care plan) and imposes disadvantages on others (patients), then fair-minded people would not accept the appeal to profitability.

Although “cost” considerations that are ultimately claims about competitiveness or profitability may in principle be relevant reasons for limits, in practice they will probably prove to be highly controversial and contested. For good business reasons, managed care plans might not want to reveal the information necessary to prove their relevance. In general, supporting these reasons requires information that is often not available, that is difficult to understand when it is available, and that ultimately depends on fundamental moral and political judgments about the feasibility of quite different alternative systems of delivering care. Thus, these reasons are likely to fuel rather than resolve disagreement. Unless managed care plans build up credit over time by adhering to the conditions we outline and establishing a record of demonstrated commitment to “the common good,” their appeal to rationales involving market position will only deepen the suspicion of patients, clinicians, and the public.

What about consumer participation? One response to the failure of market accountability is to propose that consumers be involved in decision making about coverage and other limit-setting decisions. We agree that some forms of consumer participation might improve deliberation about some issues. We also think that at least some organizations might be willing to experiment with forms
of consumer participation. Although we support the concept of consumer participation, we believe that it is neither a necessary nor a sufficient condition for ensuring accountability for reasonableness or for establishing the legitimacy of managed care plans’ decisions.

Consumer participation is not necessary because the conditions we advocate would by themselves establish when decisions are reasonable in the relevant sense. Consumer participation might improve deliberation about some matters, but it is unlikely that we could ever enlist active enough consumer participation to deliberate about limit setting in the many contexts where managed care plans must make such decisions. Simply being accountable to a “board” containing consumer representatives would not ensure that the right sort of deliberation took place at appropriate levels in the plan. In addition, there is no realistic mechanism for making consumers who participate truly representative of the consumer population as a whole, especially when we are concerned with private organizations, including for-profit systems.

Managed care plan deliberation that meets the four conditions does not substitute for any public democratic process, such as legislative or executive branch deliberation. Rather, it facilitates that process. The four conditions compel plans to contribute their deliberative capacities to whatever broader public deliberation is conducted through democratic institutions, formally or informally. The four conditions provide connective tissue to, not a replacement for, a broader democratic process. Ultimately, these broader processes have moral authority and responsibility for guaranteeing the fairness of limit-setting decisions.

Implementing Accountability For Reasonableness

Do health plans have any incentive to implement accountability for reasonableness? Greater clarity about rationales can make decision making more coherent and efficient. In addition, some plans might be able to “market” their accountability for reasonableness to competitive advantage. However, the main incentive for this change is that the current system is broken, and a distrustful public has already been driven to try to fix it with legislated regulations. Our proposal is a way for plans to seize the initiative on regaining trust.

Are we simply calling for bureaucratic triviality? No doubt, the idea could be turned into a meaningless bureaucratic requirement, but the cultural change we seek is not an appeal for make-work paper pushing.

Is it cost escalating? We believe that conflict reduction (the ultimate aim of our approach) will ultimately reduce costs. The Henry J. Kaiser Family Foundation commissioned a Coopers and Lybrand
study of the Clinton bill of consumer rights that showed the cost of implementation for four of its key rights was only $31 per family, contrary to managed care plans' claims of high cost. 9

Is it real change or only a patina of fairness? The accountability we call for would be a real change. Its effects on resource allocation will emerge when we understand better the reasons for current decisions.

Will it affect the decisions of the "real" players—the large purchasers? Purchasers complain that they want to act on good information about performance but lack a way to do so. Accountability for reasonableness adds to the tools for assessing performance and will produce greater public understanding of how all players make decisions.

Here are some specific suggestions about implementation.

■ NCQA standards. Earlier, we noted that accountability for reasonableness was already an element in the NCQA rationales for some of its standards for utilization management and appeals. To make accountability for reasonableness a more explicit requirement, we have proposed to the NCQA that it modify the standards for technology assessment to require organizations to (1) make rationales for their coverage decisions publicly available and (2) demonstrate that these decisions are based on evidence, reasons, and principles that address meeting patients' needs under reasonable resource constraints. Other standards could be similarly strengthened to support accountability for reasonableness. The result would be to use accreditation as a way to promote a culture of openness in managed care plans about the rationales for limit-setting decisions of all kinds.

■ Consumer Bill of Rights and Responsibilities. If the preamble to Clinton's Consumer Bill of Rights and Responsibilities called more explicitly for accountability for reasonableness, it would strengthen some of the proposed rights. For example, the "right to participate in treatment decisions" requires access to the rationales that justify limits on available options, including coverage for unproven but promising technologies. The culture of openness and reasonableness that would result from meeting our four conditions supports the widely held goal of collaborative decision making among patients and clinicians.

In the statement of consumer responsibilities, we are told that a consumer is responsible to "be aware of a health care provider's obligation to be reasonably efficient and equitable in providing care to other patients and the community." There is no way to exercise that responsibility, however, unless the managed care plan is publicly accountable for the reasonableness of its limit-setting deci-
sions. Consumers cannot tell if the plan is being "reasonably efficient and equitable" if they do not have access to the rationales for decisions that are made about limits.

**Legislative initiatives at the state level.** Forty-four states made proposals for managed care regulation in 1996. Many regulations call for very specific coverage mandates—what has been called "organ-by-organ health care reform." The net effect of these sorts of mandates is to reinforce the idea that managed care plans are not to be trusted and cannot be legitimate authorities for making responsible limit-setting decisions. In contrast, our proposal is that the legislative reform should concentrate on process-focused regulation that aims for both market accountability and accountability for reasonableness. Such process-oriented reforms create the conditions under which plans can establish a visible track record of reasonable decision making. For example, the Friedman-Knowles legislation in California provides a model for defusing fears of conflict of interest in the case of "last-chance" experimental treatments and is far superior to mandating coverage for specific unproven therapies, as happened with bone marrow transplants for breast cancer.¹⁰

**Legitimacy: Not Simply A Market Problem**

The legitimacy and fairness problems that face our private health delivery organizations, such as managed care plans, have their analogies in public (universal coverage) systems such as the National Health Service in Great Britain and the Canadian single-payer system. At one level, the legitimacy problem in those systems has a clearer answer. The public agencies that set limits are publicly accountable in the sense that they are ultimately under democratic recall. Nevertheless, much of what we have said here about explicit reason giving and accountability, as well as about mechanisms for appeal and dispute resolution, carries over to these public systems as well."¹² In these systems accountability is often hidden in the black box of "budget" decisions.

In addition to its relevance from the broader international perspective, accountability for reasonableness is also important at the level of the individual patient/physician relationship. It creates a climate that empowers patients and physicians in collaborative decision making. Patients and clinicians advocating for the use of promising but unproven technology need to know why the technology is not covered. Without access to the rationale for decisions, including the evidence, analysis of risks and benefits, and reasons for any patient selection criteria, collaborative treatment planning is undermined.

The conditions we describe for addressing the legitimacy and fairness problems apply to public as well as private delivery institu-
tions (whether or not they include universal coverage). All such institutions have an opportunity to enhance or diminish their credentials for fair decision making about such fundamental matters every time they make such decisions. Whether in public or mixed systems, establishing the accountability of decisionmakers to those affected by their decisions is the only way to show, over time, that arguably fair decisions are being made and that those making them have established a procedure we should view as legitimate. Even if direct public participation is not an essential ingredient of the process in either public or mixed systems, accountability to the public for reasonableness is necessary to facilitate the broader democratic processes that regulate the system.

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NOTES

1. The coalition included Kaiser Permanente, Group Health Cooperative of Puget Sound, HIP Health Insurance, the American Association of Retired Persons, and Families USA.
3. We discuss the relationship between legitimacy and the concept of democratic deliberation in Daniels and Sabin, "Limits to Health Care," 336–340.
5. One of us has written extensively about this social obligation; see N. Daniels, Just Health Care (New York: Cambridge University Press, 1985); and N. Daniels, D. Light, and R. Caplan, Benchmarks of Fairness for Health Care Reform (New York: Oxford University Press, 1996).
6. These conditions are discussed in detail in Daniels and Sabin, "Limits to Health Care," 322–343.
10. Daniels and Sabin, "Last-Chance Therapies and Managed Care."