US health maintenance organisations: better care from non-profit plans

Scott Gottlieb *New York*

The quality of care provided by profit making health maintenance organisations in the United States is lower for several outcome measures than the quality of care provided by their non-profit making counterparts, reports a study published last week.

Researchers from the Center for National Health Program Studies at Boston's Cambridge Hospital compared the two types of health maintenance organisation on 14 quality measures, including immunisation rates, β blocker treatment for patients who had had a heart attack, mammography, and antenatal care (*JAMA* 1999;282:159-63). They found that the profit making organisations achieved poorer outcomes in every measure analysed. The findings were based on quality of care data for 329 health maintenance organisations, of which 248 were investor owned and 81 were non-profit making. Between them these organisations covered more than half of all US citizens enrolled in a health maintenance organisation at the time of the study.

One of the study's authors, Dr Steffie Woolhandler, associ-

ate professor of medicine at Harvard Medical School, suggested that profit making plans delivered a lower quality of care than non-profit plans because of higher overhead costs and bigger pay packages to the organisations' executives. "For those who do have a choice, they should know that, on average, not-for-profit health maintenance organisations will offer better quality of care," she said.

Officials in the managed care industry criticised the study, calling it an ideologically influenced attack on the industry. They pointed out that both types of organisation tended to do much better than traditional "fee for service" plans, where doctors are reimbursed separately for each medical service they provide. The study's four authors, including Sidney Wolfe, director of the Public Citizen Health Research Group, are all advocates of a nationalised health insurance system for the United States.

Analysing 1997 data from the health plan employer data and information set, the study found that 71% of heart attack patients in non-profit plans received rec-

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US immunisation rates are higher in non-profit plans

ommended β blocker treatment, compared with 59% of patients in profit making plans. The immunisation programme completion rate for children aged 7 was 72% in non-profit plans, compared with 64% in profit making plans. For mammography, the proportion of women aged 52 to 69 who had undergone a screening within the previous two years averaged 75% in non-profit plans and 69% in profit making plans.

Total monthly costs for members were virtually the same for both non-profit and profit making plans, but the "medical loss ratio" (the percentage of revenue spent on patient care) was 87% for non-profit health plans compared with 81% for profit making organisations. □

Power of attorney change in England and Wales

Clare Dyer *legal correspondent, BMJ*

People in England and Wales will be able to appoint friends or family members to take healthcare decisions if they lose the ability to make their own decisions, under reforms to be unveiled in October.

A new "continuing power of attorney," drawn up when the giver has full mental capacity, will come into effect if capacity is lost. This will allow the proxy decision maker to take healthcare decisions, including consent to the withdrawal of life prolonging treatment, as well as welfare and financial decisions. The present enduring power of attorney is limited to financial matters.

The changes will plug a long recognised gap in the law under which no one, not even the court, has the power to take decisions for an incapacitated adult. Under the doctrine of "necessity," doctors may take such decisions in the best interests of the patient, with no legal right for the family to have a say. The court's role is simply to declare that doctors would not be acting unlawfully in providing or withdrawing treatment in the patient's best interests.

New legislation will also include a "general authority to act reasonably," giving carers a legal framework for taking day to day decisions.

The reforms follow a green paper, *Who Decides*, published in December 1997, which drew 4000 responses. The paper was based on proposals put forward by the Law Commission in 1995. A key plank is a new Court of Protection, with power to appoint a manager—probably a family member or social worker—to handle an incapacitated person's financial affairs, personal welfare, or health care. The power would be used where ongoing decisions were necessary. The court itself would take one-off decisions, such as whether a patient should have an operation. □

Laparoscopic hernia surgery linked to increased complications

Hilary Bower *London*

New UK research has prompted calls for hernia surgery to return to the domain of general surgeons and the use of open repair rather than laparoscopic procedures.

The findings come from a 26 centre, randomised trial by the Medical Research Council Laparoscopic Hernia Group, which compared laparoscopic surgery for hernia with open procedures in more than 900 patients. In line with previous studies, the group found that laparoscopic techniques caused patients less pain and allowed them to return to normal life

more quickly. But it also found that all instances of serious complications and hernia recurrences in the trial—three and seven events respectively—took place in the laparoscopy group (*Lancet* 1999;354:183-8).

No association was found between the level of a surgeon's experience and the complication rate, but the trial's leader, Professor Patrick O'Dwyer from the Western Infirmary, Glasgow, said that the results supported a move to make laparoscopic hernia surgery the domain of specialist surgeons only. "Although laparoscopic hernia repair has

advantages for patients, safety concerns indicate open repair is the more appropriate option for the general surgeon."

In contrast, Professor Andrew Kingsnorth, director of the NHS-run Hernia Centre at Plymouth's Derriford Hospital and one of the authors of the Royal College of Surgeons' guidelines on hernia procedures, argued that, far from encouraging the development of laparoscopic hernia specialists, the findings should bury the idea as a waste of resources. "Hernia is a simple operation—100 000 are done a year—and you don't need to be a specialist to get good results in open surgery. We would be much better using our money in highly specialist areas such as cardiology and oncology where laparoscopy can make a difference." □