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How will the single European market affect health care?

Good question

Because no one agency within the European Community oversees health no systematic evaluation of the likely effects of the new single markets in goods, services, labour, and capital has been made. The best we have is a list drawn up by an advisory committee to the directorate responsible for science and research.

The financing of health care tops the bill. With greater economic integration will come more movement among countries: more people will receive health care from member states different from the one in which they are insured or covered by a national health service. Current regulations provide cover for immediate care—for example, during tourist visits or short stays related to work. Reimbursement is first made by a financial intermediary, according to the rules of the country providing the care, which then claims the money back from the patient's home country.

Such claims refer to services in connection with health insurance, accidents at work, and work related diseases. Family members or pensioners living in states other than those in which they paid insurance premiums or taxes are also eligible for reimbursement. Some countries have agreements to waive claims. Many gaps exist in our knowledge of the extent of "care trading" within the community, although by the end of 1988 outstanding claims between member states were known to total 314m European currency units (ecus) (£203·7m).[1] Rules for trading in health care and more transparency in pricing and payments will be needed in the future.

With longer term changes of residence people will switch social security systems, which will affect the insurance portfolios in the countries both that they are leaving and that they are joining. Already one in 40 members of compulsory sickness funds in Germany are citizens of other countries belonging to the European Community, and numbers are increasing.[2] Also relevant to any consideration of health care financing is private health insurance: at least 50 million people within the community bought premiums worth 15bn ecus (£9·8bn) from 775 insurance companies in 1988 (data are not available for Greece, Luxemburg, and Portugal).[3] Private health insurance is used differently in member states; large changes may be expected when regulations for the insurance industry are harmonised.

The advisory committee next singled out health care professionals as likely to be affected by the new single market, although the evidence here is more equivocal. Despite mutual recognition of medical, dental, and nursing qualifications among member states since the 1970s no substantial medical migration has occurred, largely because of problems with language, ignorance of relevant national laws, and other professional and cultural factors.[4] These may well change with time, and trends in and determinants of future migration deserve monitoring.

The single market will also bring standardised liability regulations for medical services. A directive has been proposed to make doctors liable for defective services without requiring patients to prove any causal relation, as long as damage occurs within a year of the defective service. Current discussions focus on extensions beyond direct, causal liability. National medical organisations are becoming increasingly aware of the need to monitor new legislation having an impact on health, and the European Community's Standing Committee of Doctors is trying to increase its influence on decision making within the community.[5,6]

Large effects are expected on the pharmaceutical industry. By 1992 legislation will cover all industrially produced medicines within the community, with harmonisation of the criteria for judging their quality, safety, and efficacy (F Sauer, conference on health care in Europe after 1992, Rotterdam, 1989). Drug approval in the single market may be initiated at either community or national level. National agencies may object to decisions of other member states—these objections are then dealt with at a community level. Will drug prices, which currently vary widely among countries,[7,8] become more similar? Reasons for current variations in prices include national differences in control measures such as taxation on drugs, regulation of pharmacists' profits, systems of reimbursement, cost sharing regulations (which should have been made public since the European Community's "transparency directive"), and pricing policies within the pharmaceutical industry.

Supply and demand

Many of these differences will continue in a single market and, as drugs may still be approved nationally, regional submarkets will also continue. How this will affect supply and demand and how member states will respond remain to be seen. Postmarketing surveillance is also set for harmonisation: at present countries have different laws, place different obligations on their doctors, and differ in how they respond to the information collected.

When it comes to hospitals and other health care providers the single market may promote competition, especially among specialist hospitals within the community. Demand for medical procedures available in some member states but not others—for example, transplantation and abortion—may grow. A more integrated market could make it more difficult for single countries to enforce attempts to control the quality of medical care and the use of medical technologies. Other community policies might indirectly affect health. For example, harmonising taxes on cigarettes and alcohol could change consumption. The common agricultural policy and environmental policies may have effects on health.

Because politicians have not given the topic much priority, consideration of the impact of a single European market on health and health care has not gone much beyond the generation of interesting hypotheses. This must change, beginning with the collection of reliable data on health and systems of health care within the community. Only then can some of the interesting and important questions thrown up by the single European market be answered. With the European Community likely to be given formal "competence"—and hence power to legislate for public health—the need to fill the gaps in our knowledge becomes even more urgent.

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Rugby injuries

The need for case registers

Nearly 20 years have elapsed since Sir Roger Bannister, as chairman of the Sports Council, called for a better system of preventing sports injuries.[1] This requires knowing the frequency and distribution of injuries, but capturing this information has proved difficult. With the increasing interest in injuries incurred during Rugby Union football comes the opportunity to correct this deficiency—at least in one contact sport.

Though media attention has concentrated on the few tragic events in which injury has resulted in death or permanent disability, a wide range of injuries occurs. Problems with both the numerator and the denominator, however, make calculating rates of injury difficult. Consistency is a problem when defining injury. Perception, experience, motivation, and accuracy will influence the interpretation of the nature, extent, and severity of the injuries that are recorded. No universally accepted way exists to express the denominator—rugby players at risk of injury. No standard way to describe the nature or site of rugby injuries or the circumstances in which they occur has been adopted. This is particularly relevant in a contact sport in which bumps, bruises, strains, and sprains are inevitable consequences of "a good hard game." Moreover, injuries recorded in official games and practices may represent only a small fraction of all injuries: those resulting from unsupervised "street games" go unrecorded.

Despite these limitations broad conclusions about rugby injuries may be drawn. At the senior club level most footballers will be injured at least once a season and, once injured, four out of 10 players will miss at least three consecutive weekly matches because of injury.[2,3] This does not include the need for dental care.[4]

A study conducted on behalf of the Scottish Rugby Union found that 1·45 injuries occurred per 100 player appearances. Half of those injured did not rejoin the game, about one in six were temporarily absent from the field, and one in three remained on the field despite injury. In a survey carried out in New Zealand 18% of injuries were recurrences.[3] These and other studies have established that the likelihood of rugby injuries increases with age, forwards are most at risk, and injuries are evenly distributed about the body. Most damage occurs during tackles, and soft or muddy rather than hard grounds favour injuries. Competitive play produces more injuries than social games; practice matches are relatively benign.[5-11]

Whether rugby injuries are increasing over time is unknown. When the results of a study conducted in Christchurch, New Zealand, in 1980 were compared with those of a French study in 1968-9 the rate of injury seemed to have increased from one per 256 player exposures to one per 191 player exposures, although the criteria for injury were probably different.[3] Interpreting these data is made more difficult by the change in the laws of the game in 1969 that disallowed a direct kick into touch outside the 22 metre line—thereby increasing the playing time during which players are exposed to injuries.

Several studies have reported an increase in spinal cord injuries in both adults and schoolboys playing rugby,[12-14] but these findings are difficult to interpret because they are based on few cases, the number of participants may have been increasing over the duration of the studies, and reporting may have improved. Further reports have suggested that recent changes in the laws of the game may have contributed to fewer injuries to the cervical spine.[15,16]

More needs to be known about the circumstances leading to injury. One way forward is for rugby football unions to establish case registers of injuries, on either a national or a regional basis. Such a register was set up in the United States in response to concerns about injuries to the cervical spine in American football players; it helped establish the importance