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Delegations will find attached Commission document COM(2006) 328 final.

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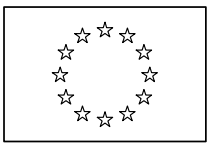

COMMISSION OF THE EUROPEAN COMMUNITIES

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COMMUNICATION FROM THE COMMISSION TO THE EUROPEAN PARLIAMENT AND THE COUNCIL

on Actions for a Safer Europe

COMMUNICATION FROM THE COMMISSION TO THE EUROPEAN PARLIAMENT AND THE COUNCIL

on Actions for a Safer Europe

(Text with EEA relevance)

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1. PURPOSE

This communication focuses on the prevention of accidents and injuries in Europe by public health actions. It is intended to provide a strategic framework which is needed to help all Member States prioritise their actions to reduce accidents and injuries. These actions should be undertaken in the framework of the Community Public Health Programme (2003-2008)[1], the Consumer Policy Strategy (2003-2006)[2] and follow-up initiatives.

An injury is a bodily lesion resulting from acute exposure to energy (mechanical, thermal, electrical, chemical or radiant) or from an insufficiency of a vital element (drowning, strangulation or freezing). The time between exposure and the appearance of the injury needs to be short. Injuries are often classified as unintentional (due to accidents) and intentional (due to self harm or interpersonal violence).

Injuries are a leading cause of death among the European population. The risk of death and severe injury is particularly high in such diverse areas as the home, leisure activities and sports, road transportation, the workplace, and in connection with consumer products and services. Unintentional and intentional injuries are estimated to be the main cause of chronic disability in the young, leading to an enormous loss of life years in good health. Among people over 65 years old, too, accidents and injuries are a major cause of death and disability and are often the trigger for a fatal deterioration in their health. Considering the huge impact of the injury epidemic on productivity, health and well-being in the Community, a Community response to the issue would have added value. Progress could be achieved through a co-ordinated approach with sustained leadership by the Commission, the Member States and related partner organisations.

A number of initiatives have been taken in the past to reduce the frequency of injuries due to accidents and violence and have been particularly successful in reducing road fatalities, workplace accidents, chemical accidents and consumer product-related injuries. There is also ample evidence that improvements in trauma care have led to a significant reduction in mortality from trauma.

However, there is still scope for more effective action to reduce the huge social toll of accidents and injuries, in particular by addressing risk settings and risk groups that have until now received less attention. The significant differences in accident and injury rates between Member States and within their populations indicate that there is still great potential for reducing the burden of injuries in the Community and in neighbouring countries. The current injury mortality rate in the European Union ranges from 27 death per 100 000 residents in the United Kingdom and in the Netherlands to more than 120 death per 100 000 in the Baltic countries (129 in Latvia and Estonia and 143 in Lithuania).

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1 Decision N° 1786/2002 EC of the European Parliament and the Council of 23 September 2002 adopting a programme of Community action in the field of public health (2003-2008)

2 Commission's Community Consumer Policy Strategy (2002-2006), doc 8907/02

This communication highlights the role of the health sector in injury prevention by quantifying the problems, reporting risk factors, advocating primary prevention, disseminating evidence-based strategies increasing the professional capacities for advising people at risk, leading cross-cutting action plans, and informing the public about hazards and safety precautions.

2. BURDEN OF INJURIES

Accidents and injuries place a huge burden on societies and individuals in the Community. This is due not only to the enormous human costs in terms of premature death and years of life lived with disability, but also to high health care costs and the costs to society from lost productivity.

Injury is, after cardiovascular disease, cancer and respiratory disease, the fourth most common cause of death in the Member States. Every year, about 235 000 citizens of the Member States die as a result of an accident or violence. Annually, over 50 million citizens seek medical treatment for an injury and 6.8 million of these are admitted to hospital.

More specifically, injury is:

– **The number one killer among young people.** Accidents and injuries are *the* leading cause of death in children, adolescents and young adults. The burden of premature deaths is particularly high in such seemingly diverse areas as traffic accidents, drowning and suicides.

– **A major cause of disability**. Many survivors of severe injuries suffer lifelong impairment. Although not accurately quantified, accidents and injuries are assumed to be the main cause of chronic disability among younger people, leading to an enormous loss of life years in good health.

– **A major cause of morbidity and health care costs**. On average, in all age groups, injuries account for about 11% of all hospital admissions. In addition to the huge financial burden on health and welfare systems, injuries often affect the whole family, emotionally, organisationally and financially.

– **Detrimental to Community productivity**. There is little data available on the causes of sick leave and disability due to injuries. Both are important factors in reduced productivity. National data indicate that up to 8% of retirement on the grounds of disability and 20% of sick leave days are the result of injuries.

– **Unequal in its impact on social groups.** The risk of dying from an injury is five times greater in the Member State with the highest injury rate than in that with the lowest rate. There are also inequalities in exposure to injury risks according to sex, age and social status.

3. PREVENTABILITY OF INJURIES

Major advances have been made in a number of areas of safety concern, but there is still room for more effective action to reduce the huge toll of accidents and injuries in society for the following reasons:

– In contrast to many other causes of ill health or premature death, injuries can be prevented by making our living environment and the products and services that we use safer. This does not always necessitate active involvement through changes in the behaviour of the risk group involved;

– There is ample evidence of proven effectiveness in accident prevention measures that are still not widely applied throughout the Community;

– Most of these measures have also been proven to be cost-effective, because the benefits of preventing injuries often outweigh the costs of intervention by a factor of ten;

– Even in countries with a good safety record and in risk areas where significant injury reductions have been achieved, there are still opportunities for further improvements and health gains. A multi-sectoral approach is required in order to deal with common risk factors such as alcohol abuse, which is a major contributing factor in both accidents and intentional injuries.

– It is still possible, therefore, to make a major difference by bringing together stakeholders from all the sectors and by fostering co-operation and concerted action within the Community and in neighbouring countries.

4. COMMUNITY ACTION PLAN

The following Action Plan is designed to give the Community the evidence-based information that is needed to help all Member States reduce the burden of injuries. The ultimate goal is to reduce injury mortality and morbidity and to ensure that the Community becomes a safer place to live in. The fulfilment of this vision requires that Member States acknowledge the challenges of injury prevention and place injury prevention and safety promotion higher on their list of public health priorities.

4.1. Basic infrastructures for injury prevention

Community action in the field of public health will create added value by:

– Quantifying the problems, identifying risk factors and measuring the effectiveness of interventions;

– Identifying, adapting and proposing evidence-based and cost-efficient interventions and sharing experiences;

– Supporting the building of capacity for tackling the issue;

– Facilitating the development of multi-sectoral policies and programmes, guided by the health sector;

– Initiating campaigns for injury prevention.

4.1.1. Community-wide injury surveillance

The aim of a common information system on accidents and injuries is to provide all stakeholders with the best available information about the magnitude of the problem including high-risk population groups as well as major risk determinants and risks linked to certain consumer products and services. This information is a prerequisite for policy making, gearing of actions, and evaluation of outcome.

The Community injury information system will be built on experiences from national systems of some Member States and will:

– Provide a comprehensive picture of all injury risks in Member States as well as in the Community;

– Combine injury data from health statistics collected within the European Statistical System (causes of death, hospital statistics, health interview and other household surveys such as the labour force survey and crime victimisation survey) and specific registers such as the hospital based Injury Data Base (IDB), the Community Road Accident Data Base (CARE), and the European Statistics on Accidents at Work (ESAW);

– Assess the health burden with respect to different consequences (fatality, hospital treatment), enabling the assessment of the impairment and financial burden;

– Compare injury risks and risk determinants between countries as a key element of motivation for national efforts;

– Identify risk factors in order to be in a position to assess the need for policy initiatives;

– Measure progress and determine whether the targets of prevention plans are being met.

The statistical element of the system will be developed in collaboration with Member States using, where necessary, the Community Statistical Programme[3] to promote synergy and avoid duplication.

4.1.2. Community support for exchange of good practice

The aim is to collate and widely disseminate information on prevention measures that have been proven to be successful by Community or national projects. The effective exchange of experiences will avoid duplication of work, facilitate maximum utilisation of available knowledge and secure greater benefits from limited resources.

[3] Decision 2367/2002/EC of European Parliament and the Council of 16 December 2002 on Community Statistical Programme 2003-2007, O J L 358, 31.12.2002, p.1.

Effective measures are set in different political sectors like public health, transport, workplace, consumer protection, education, welfare, as well as on different political levels. Effective exchange of experiences across the borders of these sectors is needed and should be provided by the public health sector. Community programmes such as the Public Health Programme[4], the general Framework for Financing Community Actions in Support of Consumer Policy[5] and the Research Programme[6] should be used to support Community-wide exchange of information and evidence-based practices, which will also foster the sharing of resources for research, development and implementation and a greater consistency in measures and messages.

4.1.3. Community network of stakeholders

In order to be successful in injury prevention, it is essential to establish a network which enables the consolidation of expertise, efforts and outputs to deal with the immediate needs for preventing accidents and injuries effectively in the Community. The Commission will work with the authorities of the Member States, in particular the ministries of health and consumer protection, to enhance public health actions in favour of injury prevention and to ensure synergy with other relevant policy domains.

4.1.4. Capacity-building in the Community

Health professionals such as medical doctors, rescue and emergency staff, nurses and other health care providers could advise patients and clients, decision makers and media about hazards and safety measures more effectively than they do now. Due to their knowledge these groups are effective in health promotion regarding many health aspects like smoking, nutrition, and exercise, but lack appropriate vocational training in risk assessment and safety promotion. Within future work plans of the Community Public Health Programme[7] the inclusion of this public health aspect in the vocational training of health care professionals will be considered as a priority.

Also other sectors in society and the professional community bear a responsibility for injury prevention, like welfare professionals, teachers, architects, sales staff and service providers. Basic information on hazards and safety measures should be included in the vocational training of these groups, in order to ensure the provision of good information to costumers. Health policy should promote the inclusion of safety knowledge in basic training and further education. The health sector should work closely with those policy sectors responsible for designing and regulating the relevant curricula demanding for respective changes in training regulations.

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4 OJ L 271, 9.10.2002, p.1.

5 Decision N°20/2004/EC of the European Parliament and of the Council of 8 December 2003 establishing a general framework for financing Community actions in support of consumer policy for the years 2004 to 2007, OJ L 5, 9.1.2004, p.1.

6 Decision No 1513/2002/EC of the European Parliament and of the Council of 27 June 2002 concerning the sixth framework programme of the European Community for research, technological development and demonstration activities, contributing to the creation of the European Research Area and to innovation (2002 to 2006), OJ L 232, 28.8.2002, p.1.

7 OJ L 271, 9.10.2002, p.1.

4.1.5. Supporting national action plans

It is suggested that all Member States create policies for injury prevention, i.e. a framework of actions that engages the relevant partners and stakeholders and defines institutional responsibilities. Since such policies need the coordination of different political sectors and aim at improving health, the health sector should take a coordinating role.

Key characteristics of the national policies are that they will be in line with the Community vision and basic priorities identified in section 4.2, addressing the specific needs and demands of the respective country, they will contain specific goals that are also to be defined in terms of attainable injury reductions, and will rely on a solid commitment by governmental and non-governmental organisations in the country.

The Commission will encourage the Member States in developing national plans by:

– Facilitating situational analyses based on Community-wide injury surveillance information including comparative data for benchmarking;

– Providing information on promising solutions for safety issues by supporting Community-wide exchange of good practice;

– Supporting projects which explore existing opportunities for implementing prevention strategies and developing guidelines;

– Assisting in the identification of key partners and stakeholders who can foster sustainable implementation of solutions;

4.1.6. Risk communication

Effective risk communication puts people in a position to make safer choices. Risk communication takes into account that many benefits of activities, settings or products cannot be obtained without accepting at least a minimum risk. Well designed campaigns make people aware of certain hazards, inform them about the benefits of safety measures and facilitate the change to safer behaviour. Examples of successful campaigns in many Member States are: car safety belts, child resistant cigarette lighters, safety boots of construction sites, barrier free public buildings, legislation against intimate partner violence. These have all been successful in reducing preventable injuries.

The Community Public Health Programme should support campaigns on the priority areas of this document. Key characteristics should be the focus on intermediaries, the aim of sustainable results, the support for Member States, the reliance on evidence of what works in prevention and safety promotion, and the quality of the evaluation and documentation. Public-private partnerships will help to create wider exposure and better distribution channels so that the safety messages are acted upon.

4.2. Key priority areas for actions

In defining key priorities for actions on injuries, the following criteria have been used:

– The social impact of injuries in terms of the number, severity and consequences of the various categories of injury, such as loss of productive years, disability and human suffering.

– The evidence regarding the effectiveness of interventions and the cost-effectiveness of alternative interventions in relation to the various priority options.

– The feasibility of successful implementation of interventions in the European context and given the great diversity of infrastructures within Member States.

– The time frame and measurability of intermediate outcomes of actions and impacts in terms of injury reduction.

This has led to the identification of the following seven priority areas:

– **Safety of children and adolescents;**

– **Safety of elderly citizens;**

– **Safety of vulnerable road users;**

– **Prevention of sports injuries;**

– **Prevention of injuries caused by products and services;**

– **Prevention of self-harm;**

– **Prevention of interpersonal violence.**

All Community public health campaigns will inform the public about the quantity of the problems, demand for better primary prevention, disseminate good practices, support networks, provide health administrations of Member States with policy tools for national action.

4.2.1. Safety of children and adolescents

Children and adolescents have been chosen as a priority because injuries and their disabling consequences have a tremendous impact on health in this age group in particular.

Under a project of the Community Public Health Programme, the European Child Safety Alliance currently facilitates the establishment of national action plans for child safety in the majority of Member States. The main priority is to integrate the remaining Member States and candidate countries into the process and to prepare the implementation of the national child safety action plans. The implementation of these plans must be evaluated and further enhanced. At present, Community-wide campaigns are being conducted on priority issues such as drowning and child safety products. The issue of injuries to babies is considered to require particular attention.

In particular, campaigns on child safety should tackle severe injury hazards for preschool children at home (falls, scalds, suffocation, poisoning, drowning), playground safety and safety of child products, the usage of car restrain systems and bicycle helmets amongst older children.

4.2.2. Safety of elderly citizens

The highest mortality rates due to injury are reported among people aged 65 and over, with falls being the major cause of these deaths. Injuries, and in particular fall injuries, also account for a higher than average hospitalisation rate and an excess share in the direct medical costs due to injuries in this age group.

Future projects under the Community Public Health Programme will address this priority area in a concerted manner. Existing good practice and innovative approaches in relation to the respective risk groups will be disseminated among related professional groups, management of care facilities and associations of the elderly or pensioners. In particular, campaigns on safety elderly citizens should tackle hazards for fall at home (floor covering, illumination, furniture, layout of bathrooms), in and around buildings (stairs, handrails, design of footpaths).

4.2.3. Safety of vulnerable road users

Children, the elderly, the handicapped, cyclists, skaters, and pedestrians on public roads are not only at risk due to vehicles. Health statistics show high numbers of severe injuries due to falls without counterpart or when using public transport. These risks deserve much more attention, for example: Better design of foot paths, side walks, pedestrian crossings, bicycle paths, public transport facilities as well as the wearing of bicycle helmets can further contribute to saving lives according to road accident statistics. Public Health action in this field will be supplementary to ongoing Community actions for vulnerable road users in the area of transport[8].

A collaborative study will soon identify national and local good practices in this field which may serve as examples to others. In particular, campaigns should tackle hazards due to poor road design as mentioned above, and should promote the wearing of protective gear.

4.2.4. Prevention of sports injuries

Exercise and sporting activities clearly make an important contribution to health and a healthy lifestyle, as well as to physical, emotional and social well-being. Promoting exercise is an essential health promotion strategy for tackling the epidemic of obesity. However, according to studies carried out in some Member States a significant proportion of these health gains are lost due to sports injuries.

Concerted health policies can make a difference by promoting safe sports, advocating safety as well as participation in sports. Appropriate information on sports, use of personal protective equipment, adequate qualification of coaches, quality assurance and maintenance of equipment are the main strategies to be applied. Community actions will facilitate these developments by the dissemination of advocacy documents, good practice and policy tools. In particular, campaigns should focus on popular sporting activities with a high injury risk like soccer and other ball sports, drowning and water sports, skiing and mountain sports.

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[8] Communication from the Commission on a European Road Safety Action Plan (2003 – 2010), COM(2003) 311 (not published in the Official Journal).

4.2.5. Prevention of injuries caused by products and services

Ensuring high standards of consumer safety is one of the main objectives of the Community. The safety of non-food consumer products is ensured by a wide range of sectoral legislation and complemented by Directive 2001/95/EC of the European Parliament and of the Council of 3 December 2001 on general product safety[9]. Nevertheless, accidents involving non-food products and/or consumer services (i.e. tourism services, sports and leisure services) are numerous. Such accidents need to be prevented by making sure that safety requirements are appropriate and adequately enforced. To facilitate this it is also essential to have an effective injury monitoring and reporting system which identifies the nature of the injury, the nature of the product and/or service and the circumstances of the injury. This information can then be used by regulators and product developers to ensure there are continuous improvements in safety and injuries are reduced Community wide.

4.2.6. Prevention of self-harm

Acts of self-harm and suicide are another important cause of premature death and hospitalisation. The issue of self-harm and suicide is closely related to mental health and in particular the prevention of depression.

In October 2005 the Commission published a Green Paper on Mental Health[10] which emphasised suicide prevention. In the follow-up to this Green Paper, actions to improve mental health and prevent mental ill-health will be developed and promoted in all Member States. In this context, actions to prevent suicides will be encouraged at local, regional, national and Community level. Actions in the field of injury prevention should therefore link up with existing projects in the mental health domain, with the Green Paper on Mental Health and with future action plans in this area.

4.2.7. Prevention of interpersonal violence

Interpersonal violence is an issue of growing public concern and includes domestic violence, child abuse, abuse of the elderly and youth violence. Interpersonal violence takes many forms (physical, mental and sexual) and occurs in different environments (in the family, between intimate partners, in the community, in institutions and at work). It undermines the social and economic conditions in society.

The recording of violence by the police is not sufficiently accurate or detailed. In addition, the issue is heavily under-reported, due to the reluctance of victims to report it. In the framework of the Public Health Programme, improved reporting techniques will be developed in order to get better estimates of the size of the problem. To supplement the limited data available from police records, efforts will be made to integrate information on 'hidden' forms of violence available from crime victimisation surveys. This might involve the development of a harmonised survey or module by the European Statistical System.

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9 OJ L 11, 15.1.2002, p. 4.

10 Green paper improving the mental health of the population: towards a strategy on mental health for the European Union COM(2005) 484

There is a need for more systematic documentation and dissemination of violence prevention practices, in particular involving the health sector in collaboration with the polices, justice and welfare system. Stakeholders need to be empowered by the provision of tools for planning, implementing and evaluating violence prevention projects.

Actions in this domain will be initiated in close collaboration with other Community programmes such as the DAPHNE Programme[11].

5. IMPLEMENTATION

There is a clear need for focus as regards the organisation of resources and the development of a sustainable approach for injury prevention for the future. The Commission intends to support this initiative through the Public Health Programme.

This communication outlined the main priority areas around which activities should be organised and ultimately lead to a better understanding of injuries and fatalities and their prevention.

Understanding and tackling the injury issue requires sustained co-operation between the national, regional and local authorities of the Member States, their public health and research communities, businesses and interest groups such as consumer organisations.

Stakeholder groups, such as academia, business and civil society, play a key role in making knowledge and expertise available for exchange at national and Community level. They should be engaged in the research process, as well as in the implementation of models of good practice.

[11] Decision No 293/2000/EC of the European Parliament and of the Council of 24 January 2000 established a Programme of Community action on preventive measures to fight violence against children, young persons and women and to protect the victims and groups at risk. OJ L 34, 9.2.2000, p. 1.