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EuroSafe Alert

European Association for
Injury Prevention and Safety Promotion

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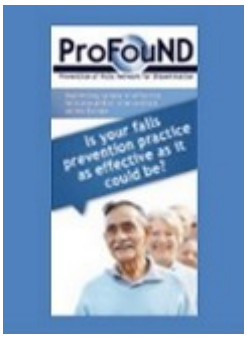
*"Working together to make Europe a safer Place"*

**Contents**


| | |
|---|---|
| EuroSafe news | 1 |
| EU news | 2 |
| WHO news | 5 |
| Injury data | 6 |
| IDB-country update | 8 |
| Consumer safety | 11 |
| Safety for seniors | 12 |
| Sport safety | 14 |
| Violence prevention | 15 |
| Agenda | 16 |


## ► EuroSafe news

### UN International Day of Older Persons: keeping older people fit is the best protecting against fall-injuries




At the occasion of the United Nations International Day of Older Persons, 1st October 2013, EuroSafe called for enhanced actions on preventing falls among senior citizens in Europe.

Falls, and the injuries they cause, are not an inevitable part of ageing. There are many things that we can do, along with older people, to prevent falls. EuroSafe is a partner in a network called ProFouND (the Prevention of Falls Network for Dissemination) funded by the EC, which is making training material available across EU.

Falls are a leading cause of fatal injuries among older people, but experts from across Europe argue they shouldn't just be written off as a unavoidable consequence of ageing. Many people wrongly think that falls are just a part of ageing and something to be expected as you get older, but that is not true.

Research shows that there are plenty of things people can do to prevent falls escalating with age. For example, strength and balance exercises can protect against falls, but these should be done with professional guidance to ensure they are suitable and to maximise their effectiveness.
People should reduce the amount of time spent sitting and being sedentary for extended periods – in fact older adults should aim to be active daily and do 150 minutes of moderate intensity activity in bouts of 10 minutes or more a week.

Falls risk can also be increased if an older person takes four or more medications or have a fear of falling, problems with continence, poor vision or strength and balance problems. Therefore, people with a history of falls should talk to a health professional about local falls services that might help them and ask to have the doctor or pharmacist review their medications.

With partners in almost all EU-countries, EuroSafe will work in coming three years to raise awareness among older people, their relatives and organisations working with older people, that falls can be predicted and prevented using some simple methods.

The Prevention of Falls Network for Dissemination (*ProFouND-website* http://profound.eu.com/ is an EC funded initiative dedicated to bring about the dissemination and implementation of best practice in falls prevention across Europe. It is working with the European Innovation Partnership. ProFouND aims to influence policy to increase awareness of falls and innovative prevention programmes amongst health and social care authorities, the commercial sector, NGOs and the general public so as to facilitate communities of interest and disseminate the work of the network to target groups across EU.

More information: http://www.eurosafe.eu.com/

## EuroSafe's conference: 'The use of injury data'

EuroSafe is organising jointly with the European Public Health Association a one day conference on the use of injury data for driving accident prevention policies and actions in countries and at EU-level in Brussels 13 November 2013.

The aim of the conference is to demonstrate the value of ED-based injury information both for health initiated policies and actions and for consumer product safety policies and implementation practices. The conference will showcase local and national level initiatives that are geared by data from accident and Emergency Departments at hospitals.

***Major themes***

The first session of the conference will introduce participants into the European perspective of injury prevention and data as a major foundation for policies and actions. Then a number of examples will be presented as to how injury data can drive targeted actions on safety. This will be followed by a round table discussion and an invitation to participants to bring in other show cases to share with the audience.

The afternoon session will focus on the use of injury data in shaping injury prevention policies and programmes, for instance in setting local and national health agenda's and for programming EU-enforcement joint actions. Again this will followed by round table discussions resulting in conclusions and recommendations for enhanced injury data use in order to increase the impact of injury prevention actions

More information: http://www.eurosafe.eu.com/

# ► EU news

## Report on Health inequalities


The wide variation in life expectancy and infant mortality between EU countries is narrowing, according to a report published by the European Commission. The gap between the longest and shortest life expectancy found in EU-27 decreased by 17% for men between 2007 and 2011 and 4% for women between 2006 and 2011. The gap in infant mortality between the EU countries with the highest and the lowest rates went down from 15.2 to 7.3/ per1000 live births between 2001 and 2011. Average infant mortality in the EU also fell during this period - from 5.7 to 3.9 per 1000 live births. The report points to some positive developments in implementing the EU strategy on health inequalities, 'Solidarity in Health', while concluding that more action is needed at local, national and EU levels.

The report examines various factors causing health inequalities and finds that social inequalities in health are due to a disparity in the conditions of daily life and drivers such as income, unemployment levels and levels of education. The review found many examples of associations between risk factors for health, including tobacco use and obesity, and socioeconomic circumstances.

***Addressing health inequalities in the EU***

In 2009, the Commission adopted a strategy on health inequalities entitled "Solidarity

in Health: Reducing Health Inequalities in the EU". The progress report looks at how far the EU has come on the five main challenges laid out in the strategy:

- an equitable distribution of health as part of overall social and economic development;
- improving the data and knowledge base;
- building commitment across society;
- meeting the needs of vulnerable groups; and
- developing the contribution of EU policies.

Overall, the Commission's action aims both to support policy development in EU countries and improve the contribution of EU policies to address health inequalities. An on-going Joint Action, *http://ec.europa.eu/eahc/projects/database.html?prjno=20102203*, running from 2011 to 2014, is a major vehicle to achieve this.

Achieving the goals of Europe 2020 for inclusive growth is fundamental to addressing health inequalities. In February 2013, the Commission adopted a paper on Investing in Health, *http://ec.europa.eu/health/strategy/docs/swd_investing_in_health.pdf*, as part of the Social Investment package. The paper strengthens the link between EU health policies and national health system reforms and presents the case for: smart investments for sustainable health systems; investing in people's health; and investing in reducing inequalities in health.

The EU Health Program, the Cohesion and Structural Funds, as well as the Research and Innovation Funds (Horizon 2020) are expected to support investment in health all across the European Union.

More information: *http://ec.europa.eu/health/social_determinants/policy/index_en.htm*

## Continued investments in health needed

On 4 and 5 September 2013, the Lithuanian Presidency of the Council of the European Union and the European Public Health Alliance (EPHA) organised a two-day conference entitled "Brave New World: Inclusive Growth and Well-Being or Vested Interests and Lost Generations?" which brought together more than more than 200 high level health policy makers across the EU. The Conference addressed the current challenges to ensure that ordinary people, their health and well-being are sufficiently protected and promoted.

The event's speakers, which included Health Commissioner Tonio Borg who opened the Conference with a video message and Zsuzsanna Jakab director of the WHO office for the European Region, agreed that social inequalities are still too high across Europe, and while public health systems deal with the outcomes of these disparities both in terms of the unnecessary disease burden and the associated costs, our leaders must address the root causes that bring about these inequalities through political commitment, good governance and inclusive growth. This includes injury prevention, an area in which health inequities are particularly conspicuous.

The protection of people's well-being and their right to healthcare cannot be swept aside in any circumstances, let alone in times of crisis. As Vytenis Povilas Andriukaitis, Lithuania Minister of Health, said during his speech, "healthy people are more creative and productive. Their well-being sets the foundations that move societies forwards. Health in all policies should be at the driving seat of our efforts to cut inequalities as it lays the groundwork for social justice and economic sustainability".

"Health is at the centre of the lives and concerns of almost everybody. To rebuild the trust of European populations, European leaders must take steps to ensure they do no more harm and have the courage to take action that will improve the lives and well-being of those they are responsible for and in whose name they act," said Monika Kosińska, Secretary General of EPHA.

On the one hand, shrinking public health budgets have accentuated the need to address the flaws of Europe's health care systems. As Paola Testori Coggi, European

Commission's Director-General for Health and Consumers pointed out in her speech, in its Annual Growth Survey and the Country Specific Recommendations, the European Commission encourages EU-Member States to make sure that their health systems are more cost effective and sustainable, while ensuring the access to quality health care. To go beyond mere efficient gains like lower pharmaceutical prices and lower wages and initiate genuine structural reforms for patient centred health systems, they have a broad range of tools at their disposal, like health technology assessments, e-health, and innovation. This is part of an 'Investing in Health' approach, as established by the Commission in a paper of February this year, which furthermore includes investing in effective health promotion and prevention, and fighting inequalities in health as they are a waste human potential and an economic loss at the same time."

On the other hand, the current squeeze in public finances has brought to a renewed light neglected public health principles. "Health promotion and disease prevention not only produce results in the long run - they also do so in the short term. There is a solid body of evidence about the ample economic advantages of preventive policies and that social welfare spending is associated to mortality reduction more than GDP increase," said in her intervention Zsuzsanna Jakab, World Health Organisation Regional Director for Europe. It is time to recognise the economic weight of the health sector as an engine for wealth, job creation, investment and growth.

As good health and high quality accessible healthcare are essential for economic and social development, the current economic situation should be an opportunity for action, not inaction. Improving health requires bold leadership and addressing structural issues within European political governance.

More information: *http://www.epha.org/a/5809*

## EU Public Health Policy

In its latest publication titled Improving health for all citizens, the Commission presents a snapshot of its public health actions over the past seven years and
an outlook as to the next financing period.

EU health policy complements national policies to ensure that everyone living in the EU has access to quality healthcare. While the organisation and delivery of healthcare is the responsibility of individual countries, the EU is expected to bring added value in helping countries achieve common objectives.

To achieve a high level of human health and quality of healthcare across the EU, countries are facing common challenges such as demographic changes which place pressure on society and the economy, as well as healthcare systems. Also chronic diseases represent great suffering to citizens and come at a huge cost to society. Many cases of chronic diseases are preventable and linked to four common risk factors - tobacco, harmful use of alcohol, nutrition and lack of physical activity.

The EU's current health programme runs from 2008 to 2013 (a third multiannual EU health programme will begin in 2014 and run to 2020). Its objectives are: to improve citizens' health security, to promote health and to generate and disseminate health information and knowledge. The total budget of the 2008–13 programme is €321.5 million, which so far has been used to fund more than 120 different actions. Since 2003, the EU health programme has provided funding for a total of 673 individual projects and operating grants, supporting a range of initiatives.
Other sources of EU financial support, e.g. Structural Funds and the research framework programmes, also contribute to health priorities.

At the end of 2011, the European Commission proposed a public health programme for 2014–20. It emphasises the role of good health in promoting productivity at work, economic competitiveness and living a better quality of life for longer. The Commission wants to continue to support national efforts in

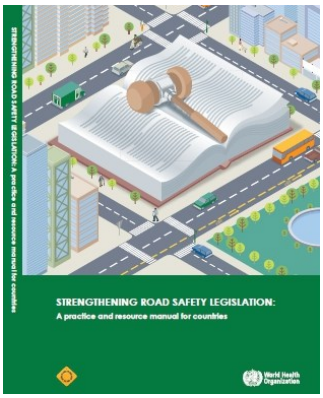
four key areas such as health promotion, the protecting citizens from cross-border health threats and the prevention of major diseases such as cancer.

The absence of any reference to the injury issue in the Commission's publications on the new health policy is striking. This in spite of the growing evidence of the burden of injuries to society and the preventability of a large portion of these injuries. The Council Recommendation on Injury prevention (C164/ 2007) and the current health programme acknowledged the importance of the issue and the need for enhanced efforts to combat injuries. Since 2011 the Commission is working on an evaluation of the actions that resulted from these initiatives and a report is awaited to be published by the end of 2013. In spite of the success of a number of actions in this area, the Commission has apparently drawn its own conclusions and dropped it from the list of priority issues in its new health program.

EC publication can be found at:
*http://ec.europa.eu/health/health_policies/docs/improving_health_for_all_eu_citizens_en.pdf*

## ▶ WHO news

### WHO launches manual aimed at strengthening road safety legislation in support of the Decade of Action for Road Safety 2011-2020




Comprehensive road safety legislation - which incorporates evidence-based measures and strict and appropriate penalties, backed by consistent, sustained enforcement and public education - has been proven to reduce road traffic injuries and fatalities.

For that purpose, WHO released a new publication, titled Strengthening road safety legislation: a practice resource manual for countries, which describes methods and provides resources that practitioners and decision-makers can use for enacting new laws or amending existing ones as part of a comprehensive road safety strategy.

The Global status report on road safety 2013 revealed that legislation on five known key risk factors for road traffic injuries (speeding, drink-driving, and the non-use of motorcycle helmets, seat-belts and child restraints) is incomplete in the majority of countries and that current laws are often inadequately enforced, particularly in low- and middle-income countries. The report revealed that only 28 countries (covering just 7% of the world's population) have comprehensive laws on these five risk factors.
More work needs to be done to improve road safety legislation globally, and meet the target of the Decade of Action for Road Safety 2011-2020 which aims to raise from 15% to 50% the number of countries worldwide that have comprehensive legislation on five key risk factors. The manual recommends a stepwise approach to assessing and improving legislation relating to these risk factors, as well as post-crash care.

The manual, which was funded by Bloomberg Philanthropies as part of the Global Road Safety Programme, can be used to:

- develop an understanding of the framework of legislation and relevant processes that are applicable in a country;
- review current national legislation and regulations and identify barriers to the implementation and enforcement of effective road safety measures;
- identify available resources, such as international agreements, and evidence-based guidance and recommendations on effective measures, to improve legislation;
- prepare action plans to strengthen national legislation and regulations for the five main risk factors and for post-crash care, including advocating for improvement.

More information:
*http://www.who.int/violence_injury_prevention/media/news/2013/06_08/en/index.html*

## ► Injury Data


### Drowning Statistics from Denmark

The National Public Health Institute at the University of South of Denmark published a report on unintentional drowning in Denmark. The study is based on diverse data sources such as the National Cause of Death Register, the National Patient Register, Reports on rescue operations, police reports and newspaper articles.

In the period between 2001-2011, 713 people died by unintentional drowning in Denmark. The 45-64-year-olds had the highest incidence of drowning, while children aged 0-14 years the lowest. Drowning deaths among the 15-34 -year-olds decreased, while it remained almost unchanged among the 45-64-year-olds. Throughout the period 2001-2011, among children below 15 years, the yearly number of fatal unintentional drowning deaths was consistently low.

***Place of occurrence***
The majority (68%) of the cases of fatal unintentional drowning occurred in open sea, harbour or at beach/coast. For men, most of the drowning accidents occurred at sea or in harbours, whereas for women most occurred at beach/coast and in open sea. The majority of unintentional drowning accidents at sea or in harbours occurred among 45-64-year-olds.

Most people who drowned at beaches/coasts were over 45 years, while drowning in private swimming pools and public swimming baths occurred mostly for children and adolescents.

***Activity***
As expected, about 1/5 of drowning deaths occurred during leisure boating/sailing (22%), a little less during bathing or swimming (18%) and whereabouts in the harbour (17%). Together, these activities account for 70% of those for which the preceding activity was known. Of the 32 traffic-related drowning deaths most occurred in cars (27), usually by driving into the harbour, in a river or lake. Four accidents occurred while riding bikes and one while riding a moped.

Alcohol was a major factor in unintentional drowning; in 177 cases (25%) the drowned had been drinking alcohol before the event. In 16 of the 125 fatal bathing accidents (13%), the victim was intoxicated at the time of the accident. In half of the traffic-related drowning deaths, it appears that the deceased was under the influence of alcohol.

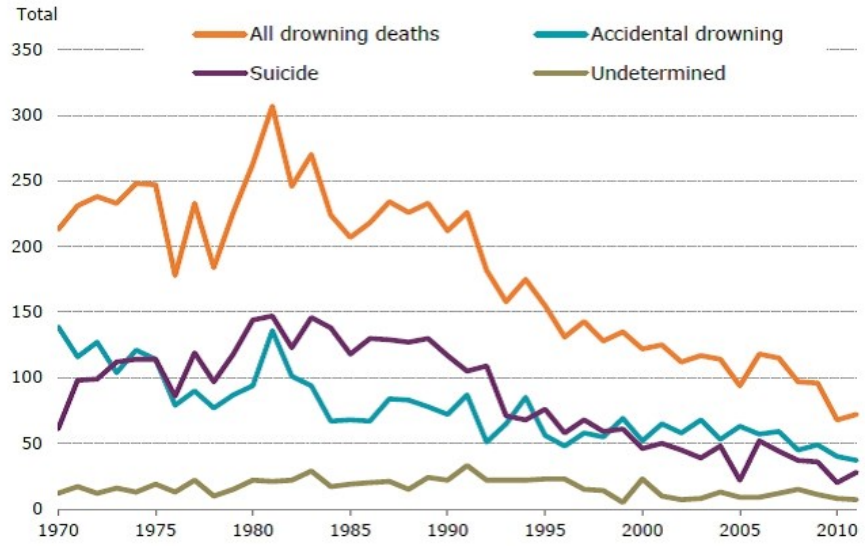
The category "other activities" covers many different activities, including walking by a river, or a lake, boarding a boat (outside a harbour), various activities on ice, driving a tractor or other vehicles. Of the 125 who drowned when bathing or swimming, 20 (16%) were children between 5 and 14 years, and 79 (63%) were elder than 45 years (Table F).

***Drowning in open water***
In the period 2001-2011, between 6 and 16 persons drowned annually while bathing or swimming. In total, 125 people drowned at the beach, in pools, in lakes or other places of open water. One fifth of the victims were below 18 years of age, while adults over 45 years accounted for the majority (79, corresponding to 63%). Men constituted 78% of the drowned and women 22%. Drowning most often occurred at the beach (70%), and mainly in July and August.
A minor part occurred in swimming pools (indoor or outdoor) (12%) and lakes (8%). Foreigners (tourists) accounted for 30% of all unintentional drowning deaths when bathing (mainly at the beach).

***Trend 1970-2011***
Over a longer period, the annual number of fatal drowning incidents (ALL causes) in Denmark dropped significantly in the period 1970-2011 from 213 in 1970 to only 68 in 2010 (see Figure).

The number of fatal unintentional drowning fell from 139 in 1970 to 37 in 2011, and most among children, adolescents and adults less than 44 years of age, while the number among 45-64-year-olds and in the oldest group over 65 years remained about unchanged.

**Figure: Danish residents who drowned 1970-2011**




*The table includes both Danes and foreigners. "Danes" means residents in Denmark, while foreigners include tourists, sailors and fishermen visiting Danish waters.*

***Changed coding practice***

By 2007, the Danish National Board of Health changed the registration practice of death certificates and causes of death to a system of direct electronic reporting by the medical doctor, who had issued the death certificate. This meant that the coding of ICD10 Codes for the underlying and contributory causes of death to the Cause of Death Register was performed by the medical doctor at the post mortem examination, and not as previously by skilled coding staff in the National Board of Health that received all death certificates with doctors' notifications. Compared to former practice, a relatively large share of the electronic death certificates lacks information on the circumstances of the death. Furthermore, the coding of causes of death is obviously incorrect in a number of cases, while in some cases the cause of death is not stated at all. However in 2010 and 2011, the quality of coding has improved compared to 2007-2009.

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**Conference on the Use of Injury data**
**Brussels, 13 November 2013**

EUROPEAN PUBLIC HEALTH CONFERENCE

In collaboration with the Injury Section of the European Public Health Association (EUPHA), EuroSafe is organising a conference on the use of injury data for driving accident and injury prevention policies and actions at local, national and EU-level.

The aim of the conference is demonstrate the value of ED-based injury information both for health initiated policies and actions and for consumer product safety policies and implementation practices. The pre-conference will showcase local and national level initiatives that are geared by data from accident and emergency departments at hospitals.

The conference will be organised as satellite to the EUPHA-main conference.
Further: http://www.eupha.org/site/upcoming_conference.php?conference_page=372

## ► Country update on Injury Surveillance

In the framework of the Joint Action on Injury Monitoring in Europe (JAMIE) we are regularly informing the Alert-readers on current activities of our JAMIE-partners in injury surveillance.

The objective of JAMIE, co-funded by the EU and its Executive Agency for Health and Consumers (EAHC) is to work towards one common hospital-based surveillance system for injury prevention in operation in all Member States (MSs) by 2015, that is integrated within the Community Statistics on Public Health (see also http://www.eurosafe.eu.com/csi/eurosafe2006.nsf/wwwVwContent/l2injurydata.htm).

In this issue of the Alert our colleagues from Latvia and Spain share with us their latest experiences in injury surveillance and reporting.

### Injury data collection in Latvia

In Latvia, like in other European countries, injuries are a significant and wide preventable public health problem.
The main areas of responsibility of the Centre for Disease Prevention and Control of Latvia (CDPC) are the prevention of communicable and non communicable diseases. Also, as an authority, our Centre collects, summarises and analyses public health data and statistical information of health care, provides public health monitoring, carries out studies on the health habits of the general population. The competence of our Centre includes the maintenance and development of the Web-based Injury register.
Injury data are being registered in compliance with Regulation Nr.746 of Cabinet of Ministers adopted on 15 of September, 2008.

***The injury register***

Data collection started in 2005 with the implementation of European Commission pilot project for injury surveillance. Information is being collected by hospital staff using a standardised data register form. The data is entered into the Injury register online software. Compared with the previous data collection trails that used paper-pencil formats, the online system provides a number of benefits: data entry has become much faster; and the processing data takes less time and resources.

The register contains information about injury cases (accordingly ICD-10 codes S00.0 - T78.9). Currently 21 in-patient hospitals are regular data suppliers. Only two of the hospitals provide information on ambulatory treated injuries voluntary. All hospitals collect information in Full data set level.

To ensure quality and completeness of the data we have quality control protocol in place, where data coding consistency with the injury case narrative are checked and case selection and coding processes in the hospitals are audited regularly. The hospital staff and data entry system users are regularly informed about their most frequent mistakes.

From December 31, 2011 extra information about poisonings was included in register form. As information on injuries and poisonings has already started to be collected in the Injury register, but as a response to Directive 2009/128/EC of the European Parliament and the Council it was decided to add some extra questions about poisoning with pesticides. Following consultations with doctors from The Clinic of Toxicology and Sepsis it was decided to add some extra information in the Injury register form. That allows us to collect and analyse deeper the data about poisoning in Latvia. These changes have positively affected the injury collection.

***Preliminary results***

After these changes in the process of injury collection the number of poisoning record has increased. In 2012 poisoning is the fifth most common injury by the type of injury, after fracture, contusion and bruise, open wound and concussion. In 2011, there were registered only 67 cases of poisoning, but after changes in the registration form in 2012

there were registered 1220 cases of poisoning.

In 2012 about 81% of all cases were recorded as unintentional. The remaining cases were assaults (10.4%), intentional self-harm (3.5%) and in 5.4% of the cases the intent were not indicated.

45% of all recorded injuries occurred at home, the majority of cases being children under nine years. Females most commonly suffer from injuries at the age of 15 and injuries significantly increase after the age of 70. For the men, the number of injuries is highest in the age group 10 – 44 years.

***Data use***
The statistics from the Injury register are used by a wide range of authorities, organizations, mass media, educational institutions and national authorities for example The Consumer Rights Protection Centre. Annual statistics are published in CDPC webpage and Statistical Yearbook of Health Care in Latvia.

Main stakeholders for injury monitoring in Latvia are the Ministry of Health, Ministry of Welfare, Consumer Rights Protection Centre of Latvia, The Welfare Department of the Riga City, State Labour Inspectorate, Central Statistical Bureau.

More information:
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http://www.spkc.gov.lv

## Injury surveillance in the Navarra Region, Spain

In spite of WHO-European Region Resolution of 2005 and the European Council Recommendation of 2007, urging member states to enhance Injury Surveillance Systems, injury data is still scarcely available in Spain.
In the last four years, an increasing number of countries have gathered data about injuries and contributed to the EU Injury Data Base, but Spain has not contributed with any data yet, therefore we don't know the real situation of this problem in our society.

Fortunately, the Ministry of Health in Madrid accepted in 2009 the invitation to join the JAMIE project and invited the Navarra Public Health Service (Servicio Navarro de Salud-Osasunbidea) to take on board a pilot programme for the routinely collection of injury data in hospitals within the region.

***Reasons for choosing the Navarra region***
There are a number of strengths which were identified in the process of assessing the suitability of the region of Navarra to take part in the project:

- The relative small size of the region which makes the pilot more manageable to implement the system;
- Capability and willingness of the Navarra Accident and Emergency Services to participate;
- Track record of Navarra Public Health Service in providing good quality health care services.
- Positive on-going collaboration among A&E departments in hospitals taking part in the project.
- Support from the Navarra Regional Government which recognises the relevance and need of having an information system in place to collect this type of data. As declared in an press conference on http://www.saladeprensa.navarra.es/Search.asp?verb=ListRecords&set=Intervenciones%3Asesion%2F%7bD0C32F76-BBBA-45C5-88E2-C2570DD36778%7d&ps=5&mf=oai_dc&from=13%2F03%2F2013&until=14%2F03%2F2013&Kw, on 14th March 2013 by Navarra Health Department.

These were the main considerations for the Ministry of Health in Madrid to charge the Navarra Public Health Service with the tasks to pilot test the implementation of an Injury Surveillance System and to gather data in hospitals, to design and develop an efficient and sustainable methodology in order to provide data and to become a National Reference for future implementation in other re-

gions and share best practice as a result of our experience.

***Navarra Region***

Navarra covers an area of 10.421 Km² and counts almost 637.000 inhabitants. There are three hospitals that provide accident and emergency services, i.e. in the following cities: Pamplona, Estella and Tudela.
The three public hospitals share one and the same patient recording software. About 80% of A&E patients are codified according to ICD-9. The original information system in place was designed for clinical rather than epidemiological purposes and therefore, some changes need to be incorporated in order to provide data as requested.

***Data collection efforts in 2013***

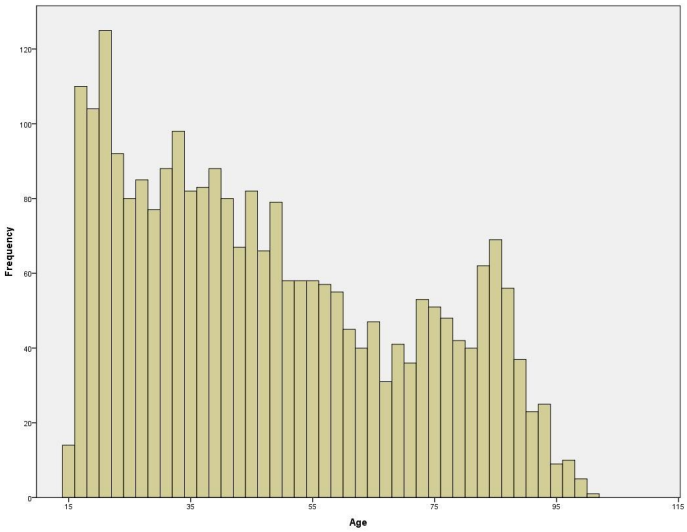
The main work this year consisted of collecting data according to the Minimum Data Set in 2013 on the expected 30.000 cases that will be treated in the three hospitals over a twelve months period. In addition, in one hospital data will be collected in compliance with the Full Data Set requirements. These data will be collected by reviewing 'clinical health records' retrospectively during 2013.

Existing data will be converted into variables as required by JAMIE. The completed sets will be then analysed in collaboration with the Barcelona Public Health Agency.

In collaboration with Ministry of Health the results obtained will be evaluated and possible ways for improving Spain´s representativeness of data for the entire nation will be explored. The accumulated experience since we joined JAMIE and the need to adapt our data to European requirements let us envisage the possibility of speeding up extraordinarily this arduous task by automating the data collection/process whenever it is possible and by developing a specific tool. An information system will be developed which will allow the automatic conversion of data from existing clinical health records entered by physicians in A&E services.

***Preliminary results first two months***

The preliminary results of two-month collecting data (pediatric patients excluded) are presented according to age and numbers




| Causes | Frequency | Ratio | Valid ratio |
|---|---|---|---|
| Traffic accident | 268 | 10,5 | 10,6 |
| Fall | 1.067 | 41,7 | 42,4 |
| Injury | 302 | 11,8 | 12,0 |
| Poisoning | 50 | 2,0 | 2,0 |
| Burn | 28 | 1,1 | 1,1 |
| Others | 803 | 31,4 | 31,9 |
| Sub-total | 2.518 | 98,5 | 100,0 |
| Missing | 39 | 1,5 | |
| Grand-total | 2.557 | 100,00 | |

The data collected provide indications as to specific population groups and risk areas that deserve increased attention in the framework of our policies for health and consumer protection. These include home accidents, in particular accidental poisonings and burns and scalds in children and older people, falls among older people and domestic violence (child abuse, elder abuse).
The knowledge of these circumstances will enable us to develop policies and procedures and implement adequate public health measures (as it was previously done in the field of traffic accidents) which will enable us to reduce morbidity and mortality due to these causes and improve health and quality of life in the region.

More information: Tomás Belzunegui Otano tbelzuno@navarra.es, Principal Investigator. Hospital Complex of Navarre and Marisol Fragoso Roanes, mfragosr@navarra.es, Project Manager. R&D Project Management Unit. Navarrabiomed – Miguel Servet Foundation www.navarrabiomed.es

## ► Consumer safety

### ANEC Strategy

ANEC has published its Strategy for the years 2014 to 2020, following the adoption of the Strategy by the ANEC General Assembly in June. The new Strategy features ten Strategic Objectives. It was adopted after a consultation of partners through a public comment phase.

In order to ensure ANEC continues to play a key role in the protection of consumers, through influencing European legislation and the development of European standards, the strategy aims to address the challenges facing effective consumer participation, which range from constraints on financial support to the increasing complexity of standards work.

ANEC wants to continue to ensure its response to new and emerging consumer priorities as well as concerns related to more mature sectors of interest. Beyond general product safety, the use of standards as a tool for consumer protection is to be found in legislation on the safety of specific products (such as toys); in policy on sustainability & environmental protection, and on the accessibility of products. Europe also has the ambition to improve the safety and quality of services. All of this within a market that is becoming increasingly global, and where European approaches to safety - such as the precautionary principle – may not be universally shared.

More information: *http://www.anec.eu/attachments/ANEC-GA-2013-G-010final.pdf*

### EC-Marking


The European Parliament's IMCO Committee issued its draft report on the Commission proposal for a Regulation on Consumer Product Safety (CPSR) and draft report on the Commission proposal for a Regulation on Market Surveillance (MSR). ANEC and BEUC welcome the reports as they reflect many points raised by them. One issue remains of serious concern: the suggestion to introduce a mandatory third party certified safety mark – "CE+ marking".

In September, ANEC published a position paper on the proposal in the draft IMCO report on the CPSR to introduce CE+ marking. ANEC, and other consumer associations at national and European level, do not support the fixing of CE marking on consumer products as it is often misunderstood by consumers. Our particular concern is the allusion to CE marking as a mark of safety for consumers.

Hence, the proposed CE+ marking could deepen the confusion for consumers as its name is a play on CE marking and, as proposed in the draft IMCO report, it would be affixed on products not allowed to bear the usual CE marking. Moreover, is not clear whether CE+ marking would be exclusively affixed by a third-party or also by the manufacturer. If the latter, there would be no essential difference between CE marking and CE+ marking.

Although ANEC and BEUC welcome the intention to increase consumer safety, the draft CPSR should provide the possibility to choose an appropriate conformity assessment level depending on the risks a product may pose and/or the categories of consumers at risk. They therefore believe it is better to focus on the aspects of conformity assessment than marks themselves

*More information:*
*http://www.anec.eu/attachments/ANEC-SC-2013-G-037final%20%28short%20version%29.pdf*

## ► Safety for seniors

### A Good Life in Old Age?

According to a new OECD report titled 'A Good Life in Old Age? – Monitoring and Improving Quality in Long-term care', the fastest-growing age group are people over 80 whose number will almost triple by 2060, rising from 4.6% of the population to 12% in 2050 in the European Union. It is estimated that up to half of them will need help to cope with their daily activities. Yet even today, families and public authorities are struggling to deliver and pay for high-quality care to elderly people with reduced physical and mental abilities.

The OECD-study report seeks to invert the negativity inherent to the well-articulated challenges of long-term care for older people by focusing on progression and improvement for policy and practice. Building on ample research in 13 European countries, evidence is provided for how the construction of long-term care systems can be taken forward by practitioners, policy-makers and stakeholder organizations. By focusing on prevention and rehabilitation, the support of informal care, the enhancement of quality development as well as by decent governance and financing mechanisms for long-term care, stakeholders may learn from European experiences and solutions on the local, regional and national levels.

***Policy priority***

With the ageing populations and growing costs, ensuring and improving the quality of long-term care (LTC) services has become an important policy priority across OECD countries. The goal of good quality care is to maintain or, when feasible, to improve the functional and health outcomes of frail elderly, the chronically ill and the physically disabled, whether they receive care in nursing homes, assisted living facilities, community-based or home care settings.

LTC quality measurement lags behind developments in health care. Only a few OECD countries have well-established information systems for care quality. Four-fifths of countries have indicators of inputs, such as staffing and care environment, but work on quality measurement has come to encompass both clinical quality (care effectiveness and safety), user-experience (user centred-ness and care co-ordination), and quality of life.

While the collection of LTC quality data poses a number of challenges, there is a potential for harmonising data collection on LTC quality at the international level such as the OECD health quality indicators such as avoidable hospitalisations for older people. Another system widely used in LTC, the inter-RAI system for assessment of care needs, aggregates person-level data, recorded for the purpose of care planning and provision of care, to compare quality of care and efficiency of services.

***Regulatory controls***

The most common policy approach to safeguard and control quality in OECD and EU countries focuses on controlling inputs (labour, infrastructure) by setting minimum acceptable standards and then enforcing compliance. In two-thirds of the OECD countries reviewed, certification or accreditation of facilities is either compulsory or a condition for reimbursement.

Despite regulation, compliance and enforcement may not be strong enough. There are still questions regarding the effectiveness of fines, warnings and threat of closure. Too much of it can stifle innovation or discourage providers from going beyond minimum requirements.

***Setting standards for 'doing the right things''***

Standardisation of practice is one way to find more effective solutions for driving care processes towards a desired level of care quality.
Conversely, standards of practice are not widely adopted yet due to the relatively low qualification levels of LTC workers, fewer peer-learning opportunities, lack of guidelines to respond to complex conditions of the frail elderly, and the difficulty of turning clinical guidelines often developed around specific diseases to cover the multiple, complex conditions of frail elderly.

***Market-based care approaches***

Two-thirds of OECD countries have implemented cash-for-care, voucher or consumer-

directed benefits delivering high satisfaction among LTC users. Consumer-centred approaches and quality-rating systems assume frail disabled people can make informed choices, therefore the quality and simplicity of the information for comparing options is a key factor affecting their ability to choose. Offering providers financial rewards for delivering good outcomes in long-term care show potential but are limited to a handful of countries and evidence on improvement in quality is not robust enough as yet.

The more complex conditions of the elderly require a higher degree of integration (multidisciplinary teams, organisational collaboration, joint care planning). Good case management, primary-care co-ordinators, integrated information systems linking data through portable records, multidisciplinary assessments teams and single-entry points have all been identified as potentially quality-enhancing. While heavy regulation of LTC services, particularly institutional care services, has presented high administrative burdens for providers, the transition of quality assurance to outcomes-based measures should be supported by robust data infrastructure and clear guidance.

The report concludes that there is potential for using market-based approaches to improve LTC quality, but incentives to spur desired behaviours must be trade off against possible unintended consequences.

OECD/European Commission (2013), *A Good Life in Old Age? Monitoring and Improving Quality in Long-term Care,* OECD Health Policy Studies, OECD Publishing. http://dx.doi.org/10.1787/9789264194564-en

## Dublin Declaration

The *EU Summit on Active and Healthy Ageing* was held 13-14 June in association with the Irish Presidency, jointly organised by the Ageing Well Network and the Global Coalition on Aging. It was held in collaboration with the European Innovation Partnership, with active support from the WHO's Age Friendly Cities and Healthy Cities programmes. As a strategy to drive economic and social development across the EU, the summit assembled EU and global leaders to set priorities and strengthen commitments to advancing age-friendly practices with a special focus on cities and communities.

At the closing ceremony 40 new cities and communities have signed the Dublin Declaration 2013, while 33 had signed a previous version in 2011. The aim of the new 'Dublin Declaration on Age-Friendly Cities and Communities in Europe 2013' is to solicit support for a range of sustained actions that can contribute to building an age-friendly Europe by 2020. Building on the 2011 declaration, the 'Dublin Declaration 2013' sets out underpinning values and principles of action, recognising challenges and opportunities that must be accommodated within the European context, including the work of the European Innovation Partnership on Active and Healthy Ageing (EIP-AHA), and the specific action promoting innovations in age-friendly buildings, cities and environments. The core commitments to promote, to collaborate, and to communicate, are supported by a set of pledges that can be immediately incorporated into key planning instruments to support sustainability.

The full text of the Dublin Declaration 2013 can be found here: http://www.ahaconference2013.ie/dublin_declaration/dublin_declaration_text

## ► Sport safety

### Accident Research in Sports

In its recently published Safety dossier «Accident Research in Sports», the bfu – Swiss Council for Accident Prevention – presents a safety analysis of sports in Switzerland. The purpose of the report is to make sure that decision-makers in the sports sector have a basis for accident prevention planning.

The method used follows the three stages in accident research:

- accident analysis, the section wherein the extent of sport related accidents will be documented and focal points detected;
- the risk analysis section discusses and weights the factors relating to the focal points that are of relevance for accidents in Switzerland; and
- the intervention analysis section presents a wide range of prevention possibilities and evaluates them in terms of their effectiveness, efficiency and the degree to which they can be implemented to meet Swiss conditions.

This resulted in a conclusive list of prevention recommendations for enhancing sport safety.

Every year, around 300.000 Swiss residents are injured in sports accidents inside and outside Switzerland which are severely enough to require medical treatment. An average of 180 people suffer fatal sports accidents in Switzerland. Snow sports, off-road biking, mountain sports, water sports (drowning) and football are among the sports that are the most involved in injuries.

The risk factors identified are largely specific to each type of sport. They relate to the individual person (particularly risk competence, physical and physiological factors), risk settings and the activity involved (including sports infrastructure, equipment, natural surroundings, official rules).

Potential interventions for reducing the risk of sport related accidents and injuries are also specific in relation to the type of sport. For example, improving swimming pool infrastructures might prevent drowning accidents in particular, while in mountain sports it is not the infrastructure that must be the focus of prevention efforts but the active participants. Evidence-based recommendations for measures are not always possible given lack of research evidence.
The report concludes that research work needs to be increased and expanded over the coming years, as for the time being one has too often to rely on expert opinions and common sense as to what might work in prevention. It is also important to explore with the potential prevention partner organisations as well as with representatives of the target groups (focus interviews) the feasibility of implementation and expected levels of compliance among managers, trainers/ coaches and sportsmen and -women.

More information:
http://www.bfu.ch/PDFLib/1818_22473.pdf

### Knee injuries in snow sport: The role of proper equipment

Although the total incidence of alpine skiing injuries has shown a steady downward trend over the
last four decades, it is noticeable that knee injuries did not benefit from this decline
to the same extent. In Switzerland a minor increase in the proportion of knee injuries is recorded. Also in the USA a clear increase of severe knee injuries has been recorded up until the early 1990s. Overall, the proportion of knee injuries remains very high compared to the total incidence
of injuries and continues to be the central topic for prevention in alpine skiing.

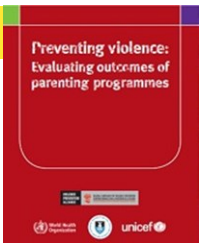
To examine critically the current situation regarding knee injuries in relation to ski equipment, a complex analysis of the literature was carried out by bfu, the Swiss Council for Accident prevention. The study includes a review of published scientific papers and “grey literature”, and also looked into patents as well as international standards as a possible source of information on safety requirements. The overall objective of the subject literature research was to indicate the current status of research and technology in the field of ski equipment.

On this basis, technological opportunities for

the prevention of knee injuries, in other words design changes to the functional unit of a ski-binding boot are presented in the study report. As such, it provides a basis for discussion both for researchers and product developers, and can act as a strategy paper for people in the public health sector as well as product managers.

More information:
http://www.bfu.ch/PDFLib/1877_105.pdf

## ► Violence prevention




### Parenting programme

This new publication, published by the WHO-programme for Violence and Injury Prevention, seeks to increase understanding of the need for conducting outcome evaluations of parenting programmes in low- and middle-income countries and the process of such evaluations. The guidance is aimed at policy-makers; programme planners and developers; high-level practitioners in government ministries; representatives of nongovernmental and community-based organizations; and donors working in the area of violence prevention.

The publication focuses on parenting programmes to prevent child maltreatment and other forms of violence later in life such as youth and intimate partner violence. It is made up of three main sections:

- Section 1 defines outcome evaluations, explains why they are important and counters some of the oft-encountered justifications for not doing them.
- Section 2 reviews the evidence for the effectiveness of parenting programmes to prevent violence, discusses adapting parenting programmes to other cultures, and identifies some of the main features of effective programmes.
- Section 3 describes the activities that need to be completed before an evaluation can be carried out and the six steps of the evaluation process.

Supplementing this publication is a web-appendix which includes links to useful evaluation websites, evaluation guides, key scientific papers on evaluation, and a list of evaluators working in the area of parenting programmes to prevent violence.

More information: http://www.who.int/violence_injury_prevention/publications/violence/parenting_evaluations/en/index.html

### Child Abuse


At the sixty-third session of the WHO Regional Committee for Europe in Çeşme Izmir, the WHO Regional Office for Europe launched the European report on preventing child maltreatment. This report outlines the high burden of child maltreatment, its causes and consequences and the cost−effectiveness of prevention programmes. It makes compelling arguments for increased investment in prevention and, by offering policy-makers a preventive approach based on strong evidence and shared experience, it will help them respond to increased demands from the public to tackle child maltreatment.

More than 18 million children aged under 18 years suffer from maltreatment in the WHO European Region. Published in a new report from these figures are a concern for any policy-maker implementing Health 2020, the new European health policy framework.
“It is time to recognize child maltreatment as a public health concern, and not solely a criminal justice and social issue. Child abuse is preventable through a mainstreamed public health approach, an opportunity that we cannot afford to miss. In the coming months, we will prepare a set of measures that countries can take to address this, and we are ready to assist with the implementation,” said Zsuzsanna Jakab, WHO Regional Director for Europe.

***Who is most at risk?***
Young, single and poor parents with low education levels living in deprived communities may be more likely to maltreat their children. The social and cultural acceptability of physical punishment of children, inequality, economic stress

and legislation all affect rates of child maltreatment. A strong association also exists between child maltreatment and alcohol and drug abuse in the family, parenting stress and domestic violence. Poor children are hit the most: rates of fatal maltreatment are more than twice as high in low- and middle-income countries and, within countries, the fatality of children of less-well-off parents is several times higher that of children from wealthier parts of society.

***What can be done?***
Prevention is more cost-effective than dealing with the consequences of maltreatment. A public health approach is required with the sustained implementation of evidence-based measures such as the following:

- Targeting at-risk families with programmes that intervene in the first few years, such as home visiting to provide parenting support, parenting programmes and pre-school education, reduces maltreatment.
- Programmes to prevent abusive head trauma (shaken baby syndrome), reducing the availability of alcohol, and intensive social and medical support to high-risk families are effective.
- Interventions such as mass media campaigns, social norms programmes and measures to alleviate poverty are promising, but more research is needed in Europe.

More information:
*http://www.euro.who.int/en/publications/sections/latest-books/european-report-on-preventing-child-maltreatment*

## ► AGENDA

### 2013

**14-16 November in Brussels**
6th European Public Health Conference
*http://www.eupha.org/site/upcoming_conference.php*

**20-21 November in Helmond, Netherlands**
International Cycling Safety Conference
*http://www.swov.nl/UK/Actueel/Nieuws/ICSC2013-CfP.html*

### 2014

**10-12 April in Monaco**
IOC World Conference on Prevention of Injury & Illness in Sport
*http://www.ioc-preventionconference.org/*

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