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COMMUNICATION FROM THE COMMISSION

concerning a Community action programme on injury prevention
in the context of the framework for action in the field of public health

Proposal for a
EUROPEAN PARLIAMENT AND COUNCIL DECISION

adopting a programme of Community action from 1999 to 2003
on injury prevention in the context of the framework for action
in the field of public health

(presented by the Commission)

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I. INTRODUCTION

1. By virtue of Articles 3(o) and 129 of the Treaty establishing the European Community, the Community has for the first time been given an explicit legal basis for undertaking action in the field of public health. The role of the Community is to contribute towards ensuring a high level of human health protection, directing actions towards the prevention of diseases, in particular by encouraging cooperation between Member States and, if necessary, lending support to their action, and by promoting coordination of their policies and programmes. In its communication of 24 November 1993 on the framework for Community action in the field of public health[1], the Commission defined the role of the Community as underpinning the efforts of the Member States in the public health field, assisting in the formulation and implementation of objectives and strategies, and contributing to the provision of a high level of health protection across the Community, setting as a target the best results already obtained in a given area anywhere in the Community.

2. In keeping with Article 129's focus on the "major health scourges", one of the Commission's stated priority areas is the prevention of intentional and unintentional injuries and accidents. Injury accounted for 190 000 deaths in the 12 EC Member States in 1991 (more than any other category except cardiovascular and respiratory diseases and cancer). In the EC, injury remains the leading cause of death at all ages between 1 and 34. This concentration of mortality in the youngest age groups makes injury a disproportionate cause of potential life years lost. In older people, although injury is eclipsed by other causes of death, the death rate from injury is still higher in the over-75s than in any other age group. Disability and morbidity is also very substantial: in England it is estimated that every year one child in ten needs health care following an accidental injury, along with 500 000 people over the age of 65 for home and leisure accidents alone. Every year in the EC an estimated 700 000 people are admitted to hospital following attempted suicide. In France it is estimated that 2.9% of the population (more than 1.5 million people) are living with a disability caused by an accident.

3. The economic impact of injury is also very substantial. In Denmark it has been estimated that 11% of all days in hospital are the result of accidents; the medical costs of home and leisure accidents in the Netherlands are thought to be over ECU 450 million per year. Costs to the injured person and his or her family are much wider than the direct medical expenses. Damages payments by insurance companies can give some indications: in France the average payment following each road accident to a child are over ECU 15 000.

4. More encouraging, however, is the evidence that prevention measures can be highly cost-effective. There is well-supported evidence that the initial investment can be recovered in as little as three years, notably from participants in the WHO Safe Communities programme in a number of countries including Sweden, who report reductions of 25% or more in accident rates during this period. The strength of this evidence for cost-effectiveness is rare among health promotion activities.

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1 COM(93) 559 final, 24 November 1993.

5. For these reasons, and those discussed below, the Commission is proposing a programme of Community action on injury prevention in the context of the framework for action in the field of public health.

II. PREVENTING ACCIDENTS AND INJURIES

6. In surveying the field of injury and its prevention, it is appropriate to start by considering all external causes of injury and poisoning, for example as defined in the WHO's International Classification of Diseases (ICD). This definition covers accidents, intentional self-harm, assault, "legal intervention", war, the complications of health care and the sequelae of all these. Within this vast field a selection of the areas for Community actions will be discussed in sections V and VI.

7. The key aim of any prevention programme must be to counter the fatalistic view that "accidents will happen" and by implication cannot therefore be prevented. This attitude must be replaced by the realization that accidents and injuries need not happen and thus strenuous efforts must be made to identify the hazards and causes so that they can be avoided, prevented or at least guarded against by the best possible protective measures.

8. Accidents and injuries can conveniently be considered for prevention purposes from three main aspects: where they happen, to whom they happen, and how they happen. The "where" and the "when" aspect gives rise to the classic distinctions between accidents at work, commuting accidents, those resulting from traffic (mainly on the roads) and those that take place at home or in sporting or recreational places. These distinctions separate most current Community actions on the subject.

9. The groups of people who are the victims of accidents or injuries - and those who cause them - are important as they are the target populations for preventive actions. High among most people's priorities are infants and children who are the most vulnerable and who have most to lose in terms of years of life or quality of life. Accidents and injuries are the greatest threat to them.

10. Elderly people are however another vulnerable group, and the numbers of the very old are increasing. More limited target groups can also be distinguished such as young people deliberately seeking out dangerous pursuits, sportsmen and sportswomen, women and children (often in poor socio-economic circumstances) subject to domestic violence, and special groups particularly subject to suicide such as farmers, police and doctors.

11. The nature or immediate cause of the accident or injury is clearly very important for prevention purposes as it may point to faults or hazards in products, equipment, substances, services or environments which can be put right, reduced or be the subject of warnings

12. An important distinction is often drawn in accident prevention between "active prevention"- altering the behaviour of those at risk, and "passive prevention"- modifying the environment so as to separate people from sources of danger and/or to eliminate the source of risk. There is increasing evidence that passive prevention is usually more effective and cost-effective. Children and traffic illustrate both cases. In a world dominated so much by motor vehicles, road safety skills are obviously essential (active prevention). However there is research evidence that while children under about eight or nine years old may understand safety messages well, they are unable to remember that these must be applied all the time. Children's safety can only be assured by keeping them away from moving vehicles (passive prevention).

Potential areas for injury prevention

Population groups

13. The identification of particular population groups to whom preventive actions should be directed is not only a matter of those most vulnerable to accidents or injuries but also suggests the most appropriate form of the action and the way in which it should be delivered. The settings in which particular groups can be reached are very important for effective action.

14. Children are at higher risk because of their relative inability to judge risks, and greater vulnerability. Accident risk is strongly associated with social deprivation, for example via cramped and inadequate living accommodation, cheap, badly designed products, lack of supervision and even deliberate injuries inflicted by stressed parents.

15. Frustration, boredom or just the sheer energy of young adolescents lead to deliberate risk-taking which can have tragic consequences. The balance between prevention, familiarization with risks, proper preparation and training for dangerous pursuits and over protection is a difficult one to strike and dependent on the establishment and maintenance of relations with the young people concerned.

16. Elderly people are most at risk of accidents when their mobility or faculties become impaired, or they are deprived of the partners or environment on which they have come to rely. Prevention related to coping skills and the sensible use of appropriate tools or appliances can avoid injuries and improve their quality of life considerably. The encouragement of self confidence and esteem by using equipment safely, participating in social activities and moving without danger indoors and outdoors can be extremely important.

17. The need for accident and injury prevention measures for professional sportsmen and women is probably best left to their professional organizations. Amateur sportsmen, especially those practising on their own without involvement in sporting organizations and access to all necessary information and advice, are at greater risk as they may expose themselves to dangerous situations without adequate protection and training. Those taking part in travel to unfrequented parts of the world on their own may similarly get into trouble. The provision of information and advice for such people is particularly difficult. Similarly the lone do-it-yourself practitioner using

unfamiliar tools and materials, or the gardener using power tools and materials may be at risk and will be difficult to reach.

18. Other special population groups requiring preventive action include mentally ill, physically disabled and sociably deprived people, drug and alcohol abusers and in some cases ethnic minorities unused to the precautions that have to be taken in dealing with modern urban life in Western society, from the use of utilities such as gas or electric devices to the dangers of poisoning from foodstuffs stored at the wrong temperature or caustic substances used for domestic purposes.

Behaviour-related accidents and injuries

19. These will include both intentional and unintentional accidents and injuries but it is not necessary to be too concerned about exact distinctions between the two. This is one of the main advantages of a programme which is concerned with both categories. Deliberate carelessness or exposure to serious risks may be very difficult to distinguish from suicides, para-suicide or, in the case of harm to other persons, from homicide or assault. While preventive measures can be clearly distinguished in type and approach where an act is clearly intentional or unintentional, the approach in the grey area of overlap is harder to devise. The provision of skills, information, expertise and self-confidence may be relatively straightforward for those who are in full possession of their physical and mental faculties, but it requires special training for advisors and counsellors in other cases.

20. The prevention of suicide and para-suicide poses particular problems and requires special services ready at the time they are required. The availability of communication channels, particularly telephone counselling services, has proved very effective in this context. Social isolation is often a causative factor in suicide and telephone counselling provides one acceptable way for the socially isolated to obtain help without the threat of a face to face encounter. Other forms of counselling and support may however be necessary in the medium term, once the immediate threat has been removed.

Environment-related accidents and injuries

21. Environments can be very influential in the causation of accidents and injuries whether they consist of the inside of the home, the garden, the street, the school or the wider world. It is never possible to remove or even guard against all the hazards they present but it is possible to identify environmental causes which are most frequently involved and to produce safe homes, schools, or communities. Fire and security inspections are becoming fairly familiar but more general safety surveys would be possible and carefully considered plans for prevention could prove more effective than ad hoc panic reactions to horror stories.

22. Traffic accidents are the single greatest cause of injuries in Europe; road traffic accidents alone give rise to some 48 000 deaths per year in the EC. They have been tackled with a wide range of prevention measures, some of which are mentioned in sections 3 and 4. It should be recalled that transport safety is a specific Community competence under Article 75, and that improving transport safety is a prime objective of the Common Transport Policy.

23. Accidents and injuries at work are another field which has already seen much prevention activity. This has produced impressive reductions in accidents rates in some areas in recent decades. Prevention activities at a European level are part of the Community's social policy.

Product-related accidents and injuries

24. In this area most of the data will be gathered through the existing Community rapid reporting scheme for dangerous products or the Community System of information on home and leisure accidents (EHLASS) established under the Community's consumer protection policy[2]. Modifications to products, labelling, warning signs, information provisions and standard-setting are among the concerns of Community policies on the movement of goods and services. These have achieved an important result on general product safety.

III. OVERVIEW OF MEASURES TAKEN IN MEMBER STATES AND BY INTERNATIONAL ORGANIZATIONS

Member State governmental action

25. The deaths, injuries, suffering and costs caused by accidents and injuries have prompted all Member States to launch programmes to attempt to reduce them. Some are directed by Government Departments or groups of Government Departments working with non-governmental organizations. Others are run by Governmental agencies. Frequently, it is Consumer Affairs Ministries and organizations rather than health ones, which run programmes for home and leisure accident prevention. Traffic accidents and accidents at work have their own ranges of organizations working with Transport and Employment Ministries. Much of the most important accident prevention is undertaken at regional and local government level.

Voluntary and non-governmental organizations

26. Voluntary and non-governmental organizations play a very important part in accident and injury prevention reaching out as they often do through local branches to the general public and involving in their programmes professional and academic experts from national and local organizations. The contribution of the health professions to injury prevention, for example through advice to patients and the general public, is frequently one of the most significant. In the area of suicide prevention voluntary organizations have played a vital role in pioneering ways of reaching those at risk and are now beginning to collaborate internationally. In many cases poisons and burns centres make a particular contribution to the task of informing the public about risks.

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2 OJ No L 319, 21.12.1993, extended by OJ No L 331, 21.12.1994.

International organizations

27. International organizations also play an important part in accident and injury prevention and actions in the European Community can be most effective if they cooperate with the activities of such organizations in Europe to avoid duplication and reinforce each other's efforts. The World Health Organization's accident prevention programme is directed from its headquarters in Geneva and was responsible for the actions associated with World Health Day (7 April) in 1993 on the theme "prevent accidents and negligence". Several WHO projects stem from this programme: the "helmet initiative" (cyclists), the "safe communities project", injury surveillance and data systems and evaluation of the health impact of injuries. WHO organizes World Conferences on Safety Promotion and Injury Control. It also has a network of collaborating centres concerned with the subject.

28. Non-governmental international organizations are active in Europe in such fields as product safety standards, child safety, fire prevention, sports injury prevention, accident research and consumer safety regulation and enforcement. They are also concerned with rapid responses to accident and injuries before the victims reach the hospital. Such actions can prevent the effects of the injuries from being as serious and permanently damaging as otherwise they would have been. The contribution of professional organizations at the European level is also an important one.

IV. OVERVIEW OF CURRENT ACTIVITIES OF THE EUROPEAN COMMUNITY

Health and safety at work

29. In July 1995 the Commission adopted a Communication on a Community programme for safety, hygiene and health at work (1996-2000)[3]. Its main provisions include greater support for improvements to safety in small and medium-sized enterprises and non-legislative measures such as guidance notes, information and training. The ESAW (European Statistics on Accidents at the Workplace) project, which provides statistics on accidents at work for high risk industries, continues work on the inclusion of more variables to provide better insight onto the causes of accidents at work. In addition, a pilot project has been launched on comparable data on occupational diseases in Europe (EODS: European Occupational Disease Statistics). Commission work to extend the development of harmonized Occupational Exposure Limits also continues[4] and in September 1995 a proposal was published to amend Directive 90/394/EEC on carcinogens by setting limit values and extending its original scope[5].

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3 COM(95) 282 final of 12 July 1995.

4 Including the adoption of a Community Decision establishing a Scientifc Committee for Occupational Exposure Limits to Chemical Agents: OJ No L 188, 9.8.1995.

5 OJ No C 317, 28.11.1995.

Transport

30. In the road traffic field, current activities cover roadworthiness tests, speed limitation devices in lorries and buses, introduction of new standards for driving licence theoretical, practical and medical tests, and development of new equipment for the enforcement of driving time for professional drivers. Non-legislative measures proposed include information campaigns on drink-driving, young drivers.... Under the CARE programme adopted in 1993[6] a data bank on road accidents has been established allowing the analysis of detailed information on accident causes throughout the Community. Other recent transport safety actions include a Regulation on safety management in roll-on roll-off ferries[7] and Directives on the transport of dangerous goods[8].

Home and leisure accident surveillance

31. Council Decision 86/138/EEC[9] approved a demonstration project with a view to the introduction of a Community system of information on accidents involving consumer products (EHLASS). The initial objective was to identify areas in which preventive measures were necessary. The project collected data from the casualty departments of selected hospitals or by household survey. The system has made it possible to identify products involved in accidents, the resulting need for hospitalization, average stay in hospital, type of injury sustained and age of person injured. This information has informed prevention (information and awareness) campaigns, negotiations with industry to modify products and the introduction of standards or regulations. The EHLASS project has now been extended to the end of 1997[10].

Product safety

32. The Council adopted Directive 92/59/EEC on general product safety on 29 June 1992[11]. This is a broad legislative provision requiring only safe products to be placed on the market, the provision of information about possible risks and the establishment of mechanisms for reporting risk products and for their withdrawal from the market where necessary. The safety of a product is determined by Community provisions, Member State provisions or voluntary codes of good practice depending on what exists for the product in question. Member States are responsible for introducing legislation concerning checks on product safety, sampling, temporary prohibitions, etc. and must notify the Commission of restrictions on marketing which they have imposed (RAPEX), particularly where emergency restrictions have proved necessary because of serious risks. The Commission may then require all Member States to take temporary measures, stating the reasons for this. An Advisory Committee on Product Safety Emergencies is established to assist the Commission.

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6 Council Decision 93/704/EC, OJ No L 329, 30.12.1993.
7 OJ No L 320, 30.12.1995.
8 OJ No L 145, 19.6.1996, OJ No L 235, 17.9.1996.
9 OJ No L 109, 26.4.1986.
10 OJ No L 331, 21.12.1994.
11 OJ No L 228, 11.8.1992.

Construction products: fire

33. Community action relating to the prevention of fires mainly derives from provisions for the fire resistance of materials or components used in construction. A Directive of 21 December 1988[12] sets Community standards in this field.

Product standards

34. The work of the European Standards organizations CEN, CENELEC, and ETSI has been assisted since 1983 by SECO, the European Secretariat for coordinating consumer representation in standardization. Since the new approach to the reduction of technical barriers to trade in the Community was introduced in 1985, the legislation contains only general safety requirements. Manufacturers are presumed to conform to essential safety requirements if their products are produced to acknowledged European Standards established by the Standards Organizations. A new joint structure has been agreed in 1994 for coordinating consumer representation in the standardization process from 17 EC and EFTA Member States. It is known as ANEC.

Food safety and agriculture

35. A high level of Community activity is always devoted to protecting the consumer against food poisoning, in the fields for example of hygiene in its production and distribution, restricting unsafe imports and regulating maximum permitted pesticide residues. In 1995 actions included three Directives harmonizing maximum residue levels for nine pesticide active substances and amending the existing levels for twenty others[13]; a Directive amending Directive 64/433/EEC on the production and marketing of fresh meat[14]; and a proposal for a Directive on protection against certain zoonoses including rabies[15].

Environmental exposure to risks of poisoning and other injuries

36. In a similar way, one of the principal emphases of Community environment policy is to protect human health, as required by Article 130r of the Treaty establishing the European Community. Most of the possible threats to health come within the heading of external causes of injury and poisoning with which section II of this Communication began. For example, 1995 saw the consideration of Commission proposals on the quality of ambient air[16]; the control of air pollution arising from vehicle motors and other machines[17]; integrated pollution prevention and control[18]; modifications of the draft Directive on biocide products[19]; revision of the Directive

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12 Council Directive 89/106/EEC of 21 December 1988, OJ No L 40, 11.2.1989.

13 Council Directives 95/38/EC, OJ No L 197, 22.8.1995; 95/39/EC, OJ No L 197, 22.8.1995, and 95/61/EC, OJ No L 292, 7.12.1995.

14 OJ No L 243, 11.10.1995.

15 COM(95) 491 final of 23 October 1995.

16 COM(94) 109 final of 4 July 1994.

17 COM(94) 558 final of 16 December 1994; COM(94) 559 final of 16 December 1994 and COM(95) 350 final of 6 September 1995.

18 COM(95) 88 final of 15 May 1995.

19 COM(95) 387 final of 20 July 1995.

on the protection of persons undergoing medical examination or treatment involving ionising radiation[20]. 1996 saw the revision of the Basic Safety Standards Directive for the protection of workers and the public against the dangers arising from ionising radiation[21] and the adaptation to technical progress and modification of the classification and labelling of the dangerous substances directive[22].

COUNCIL

37. In Resolutions of 1986[23] and 1990[24] the Council and the representatives of the Member States, meeting within the Council, called on the Commission to implement specific measures contributing to better toxicology and prevention and treatment of acute poisoning, which have since been pursued in collaboration with poison control centres in Member States. The Council recognized in its 1991 Resolution on fundamental health-policy choices[25] the need for closer cooperation and collaboration between Member States and singled out among topics warranting joint consideration the drawing up of comparative data, the development of strategies to facilitate priority-setting and the stimulation of scientific and public debate. In May 1993 the Council reaffirmed the need for close cooperation and laid down a number of important guidelines for Community action such as adding life to years and years to life, multi-annual planning and the selection of areas for action with regard to their amenability to preventive action[26]. These themes were developed in its resolution of June 1994[27] responding to the Commission's Communication on the framework for action in the field of public health.

EUROPEAN PARLIAMENT

38. The European Parliament has for some time been keen to see a greater Community contribution to actions against accidents and injuries as illustrated by a number of Resolutions[28]. Most significantly, its Resolution on public health policy after Maastricht of October 1993[29] called on the Commission to develop and execute activities on accident prevention in the context of public health.

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20 84/466/Euratom, OJ No L 265, 5.10.1984. The proposal for revision is to be found in COM(95) 560.

21 80/836/ Euratom, 89/618/ Euratom, 96/29/ Euratom, OJ No L 159, 29.5.1996.

22 Directive 96/56/EC, OJ No L 236, 18.9.1996 and Directive 96/54/EC, OJ No L 248, 30.9.1996.

23 OJ No C 174, 23.7.1986.

24 OJ No C 329, 31.12.1990.

25 OJ No C 304, 23.11.1991.

26 Resolution of 27 May 1993, OJ No C 174, 25.6.1993.

27 OJ No C 165, 17.6.1994.

28 such as its Resolution on dangerous substances (more than 12 since 1982); health and safety at work (more than 30 since 1981); accidents and catastrophes (more than 8 since 1984); toxicology (1985); pollution (more than 14 since 1980) and the accidents and dangers related to consumer goods (3 since 1980).

29 OJ No C 329, 6.12.1993.

ECONOMIC AND SOCIAL COMMITTEE

39. Opinions have been delivered in recent years on matters such as acute human poisoning[30] and the Community system of information on accidents involving consumer products[31]. The Committee's wide-ranging Opinion of 6 July 1994[32] on the Commission's Communication on the Framework for action in the field of public health urged a wide interpretation of the field for health activities.

V. THE NEED FOR ADDITIONAL PUBLIC HEALTH ACTIONS AT COMMUNITY LEVEL

40. A study of the scope of the activity just described points to gaps which demonstrate the need for new public health actions on accidents and injuries in addition to existing Community activities. This section describes first the general principles which apply to public health actions at Community level, and then the process of reasoning which leads to a selection of a small number of key areas in which new actions are now needed. Section VI then gives details of the actions now proposed.

General approach to Community public health activities

41. In accordance with the principles established in Article 129 and in the Commission's Communication on the framework for action in the field of public health, Community action will, in particular, focus on encouraging cooperation between Member States, lending support to their action and promoting, in close contact with them, useful coordination of their policies and programmes, and fostering cooperation with third countries and international organizations.

42. Community action must also respect the principle of subsidiarity defined in Article 3b of the Treaty establishing the European Community. In matters not under its exclusive competence, the Community therefore intervenes only when the action proposed, by reason of its scale or effect, may better be carried out at Community level. Whether a matter comes under its exclusive competence or not, action by the Community must be proportional to the objectives to be achieved. Activities should be selected on the basis of prior appraisal and should yield a Community added value while achieving maximum cost efficiency.

43. The criteria mentioned in the Commission's Communication on the framework for action in the field of public health can be applied as follows in the selection of topics for intervention, and the means to be chosen, by the Community in this programme:

(a) the topic should be a substantial cause of mortality or morbidity, or a cause of mortality or morbidity whose rate of increase causes concern;

(b) the proposed measures should not duplicate other work already under way, and where existing work is relevant they should be coordinated with it;

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30 OJ No C 124, 21.5.1990.
31 OJ No C 62, 12.3.1990.
32 OJ No C 388, 31.12.1994.

(c) there should be grounds to believe the proposed means will be cost-effective; and

(d) the proposed measures should yield a Community added value by fulfilling one of the following definitions:

- activities on a scale which Member States themselves could not, or could only with difficulty, implement;

- activities, the joint implementation of which would offer obvious benefits even after taking account of the extra costs involved;

- activity which, because of the complementary nature of work being done at national level, enables significant results to be obtained in the Community as a whole;

- activity which leads, where the need is recognized, to the establishment of best practice norms and standards;

- activities which contribute to the strengthening of solidarity and social cohesion in the Community, and promote its overall harmonious development.

Selection of topics for action

44. In view of the limited resources at the Community's disposal, large potentially promising areas must be excluded. The above criteria are a rational basis for doing so. On the first criterion, epidemiology, it is justified to narrow the focus to children, young adults and the elderly, since injury is most prevalent in these groups. It is also appropriate to exclude injury caused by crime, since the numbers are relatively small in relation to accidental injury and suicide. The same applies to medical accidents, natural disasters, pollution incidents and international conflict. On the second criterion, avoiding duplication, actions to be undertaken under a public health programme should in present circumstances avoid the following already occupied fields: accidents to vehicle passengers; work-related accidents, accidents caused by defective products, and those forms of chronic and acute accidental poisoning which are covered by the existing range of actions on toxicology, food safety, the environment, etc.

45. Duplication with the Community programme on health promotion, education and training[33] will be avoided. Whereas that programme addresses horizontal questions including health promotion strategies, means of targeting disadvantaged groups, nutrition, health education and vocational training in health promotion, the injury prevention programme will be tightly focused on activities intended to prevent injury directly. Similar close coordination will avoid duplication between actions in this programme targeted at schools and those which already exist within the Community's health and safety at work programme[34].

46. The third criterion, cost-effectiveness of the means used, militates against the Community directly mounting public information and education campaigns. These would probably not be the most cost-effective ways to use a very limited budget available for actions at Community level. This criterion is also to be borne constantly in mind in the selection of activities.

47. The criterion of community added value has a particularly strong sifting effect on injury prevention: it is very easy to compose long lists of prevention activities that are known or likely to be effective, but on examination nearly all of them are most suitable for national or sub-national implementation.

48. Two areas of activity lend themselves to Community action. The first is the sharing and shared development of expertise, particularly in the selection of interventions and the epidemiology of injury. An enormous amount of experience and ability exists in injury prevention in the Member States, but it is spread unevenly and practitioners are at times largely unaware of the experience of others. Measures to share the best practices with a much wider field would certainly fulfil the criterion in paragraph 43 (d) of enabling significant results to flow from the complementary nature of work being done at national level. In some cases the result might principally be a flow of information from Member States with longer experience of highly industrialised societies and their problems to those now experiencing the ill effects of their rapid economic development in the 1970s and 1980s. For example suicide rates in some southern Member States now appear to be rising steadily and public health authorities there may wish to learn from the experiences of Member States with established suicide prevention activities.

49. Other forms of expertise are likely to be less predictably distributed: the point is the value to be gained by establishing where it is and making it available. Experience also suggests that the centres of expertise which are offering information in a particular case also gain through the process of reflecting on their practice and what its best or most transferable features might be.

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33 Decision No 645/96/EC, OJ No L 95, 16.4.1996.

34 The key text for health and safety at work activities is at present Directive 89/391/EEC of 12 June 1989 on the introduction of measures to encourage improvements in the safety and health of workers at work, often referred to in this field as the "Framework Directive": OJ No L 183, 29.6.1989.

50. The other area suitable for Community action is improving the quality of data. Data are vital to accident prevention as they allow epidemiological investigation of what situations, products, behaviours, chain of events and even places are dangerous. This allows scarce prevention resources to be targeted at the right road junction, toy, sporting activity, etc. At a European level, comparability of national recording systems and the harmonization of methodologies, where this can be agreed, would make data a much more powerful tool. The Commission has already proposed a programme of Community action on health monitoring[35] which envisages actions of this type. Work on data in the injury prevention programme will be carefully coordinated with that programme's activities.

VI. PROPOSED ACTIONS FOR A FIVE-YEAR PROGRAMME

Topics and objectives

51. The Commission believes that the field of activity indicated by this process of selection is a valuable one, in which the distinctive contribution of public health can play an important part in injury prevention. The overall goal of such a programme should be to make a contribution to public health activities which reduce the incidence of injury. The programme should focus on five topics selected by the foregoing process of elimination:

(a) home, leisure and school accidents to children;
(b) home and leisure accidents to young adults;
(c) home and leisure accidents to elderly people;
(d) suicide;
(e) injury prevention capacity.

The category of leisure would include giving due emphasis to sports injuries.

52. In each of the first four fields the objective of Community action should be to contribute to the more effective dissemination and application of injury prevention techniques whose worth is widely accepted by experts. The detailed subjects which might be covered in each area are suggested in paragraphs 70-75 below.

53. In addition to activity in these fields, a modest investment at Community level in the public health sector's more general capacity for injury prevention is justified (e). Achievements in the specific areas can be enhanced by sharing public health expertise in the generic organization and delivery of injury prevention activities. This would help public health authorities improve their capacity to collect, interpret and use data, identify the best areas for work, enlist support, build alliances, select the best interventions, monitor health effects, evaluate programmes and make necessary changes. The detailed subjects which might be covered are described in paragraph 75 below. The objective would be to contribute to the strengthening of public health bodies' capacity to mount effective injury prevention activities.

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35 COM(95) 449 final of 16 October 1995 and COM(96)581 final of 11 November 1996.

Means

54. The means which will be appropriate for this sharing of expertise at a Community level will be very similar for all five areas. Suitable means are: creating networks, disseminating information on campaigns, supporting surveys and technical investigations, improving the quality of data and helping Member States to coordinate policies and programmes. These are discussed below.

Creating networks

55. The interchange of information between government and non-governmental organizations is one of the forms of European cooperation most frequently sought by these groups, and interest is already being expressed in networks of groups working in suicide prevention and child accident prevention. There may also be opportunities for fostering links with associated third countries which have interests in particular aspects of the subject. Part of this activity may be concerned with the development of new approaches or innovative methods of tackling common problems. Exchanges of materials, guidelines and handbooks can save a great deal of time and effort in the development of preventive actions for local populations. Interested organizations might be assisted in using telematic means such as the Internet to share information across national boundaries.

56. The training of groups of staff, frequently of a multi-disciplinary kind, by professional organizations would be particularly helpful in spreading messages and methods for the prevention of carefully identified aspects of accidents and injuries. Thus the training of staff for help-lines and the development of counselling groups and organizations able to work in the local community might be a useful contribution to combatting suicide. Training for staff in contact with children and families on identifying risks and proposing measures to avoid them is another example. Professional sports medicine organizations or other professional groups can be encouraged to provide training for leaders and coaches from sports clubs and recreational centres.

57. Community action will take the form of encouraging and assisting European organizations or combinations of Member State institutions to undertake networking actions of various types.

Disseminating information about campaigns

58. While the Community will not organize campaigns itself within the programme, it will seek to assist those doing so by promoting cooperation and exchanges of expertise, staff and materials between Member State organizations arranging these activities. To facilitate this process, the Community will seek to develop a bank of information on the campaigns that have been carried out with, if possible, assessments of their value, effects and generalizability. It might be possible to organize a competition to find the best prevention campaigns.

59. On some subjects it may be appropriate for the Community to promote the organization of parallel campaigns in a number of Member States and to assist the development of basic materials and publicity which could be used with modifications by all participating.

60. The programme will also seek to list a number of "model" accident prevention campaigns, illustrating the processes of fact finding, pre-testing of the methodology and materials and appropriate monitoring and evaluation mechanisms.

Improving data about accidents

61. Data on home and leisure accidents have been collected since 1986 under the EHLASS system. Because the size of the system, data collection is not sufficient to be used as a statistical evidence. Improving data about accidents would help considerably in planning cost-effective interventions. The pursuit of agreed approaches to coding, the better recording of place of occurrence as well as on behavioural aspects and on chain of events, the precision of cause of death certification, severity scales and minimum data sets would pay dividends. Harmonization of data definitions and minimum data sets should be pursued to allow inter-country comparisons, as well as examination of coverage of existing data collection systems and where necessary development of measures to improve such coverage and, in conjunction with EHLASS, the potential value to the EC of the work being done in the International Collaborative Effort on Injury Statistics should be maximized.

62. The conduct of special enquiries and analyses is a frequently used tool in planning better prevention activities. Under its proposed Health Monitoring programme, the Community could add questions or modules to existing Community-wide surveys. In close coordination with the Health Monitoring programme, the injury prevention programme could do the same in its own particular field. The knowledge and contacts gained in the injury prevention programme will make it possible to assist in identifying the need for such work, and a database of known surveys could be created to help those planning an activity to identify what had already been done. This could avoid much wasted effort in, for example, methodologies being reinvented in several places.

Technical investigations

63. Policy makers and those responsible for prevention measures require technical services to inform their actions and decisions and to look into the likelihood of accidents, the probable costs arising from them, the causes and the technical improvements that can be made. The Community will seek to promote collaboration between institutions with specialized knowledge and facilities able to undertake such activities, and could develop an inventory of institutions and their projects so that each Member State does not need to duplicate analytical or testing programmes but instead can draw on information or facilities already available. The Community will also promote conferences and exchanges between such institutions and programmes.

64. Technical institutions of this kind are in some cases also in a good position to carry out evaluations of prevention projects and campaigns from an impartial and informed standpoint and the Community will support such developments.

Consultation and cooperation

65. Article 129 of the Treaty establishing the European Community provides that the Community shall encourage cooperation between Member States and the coordination of their policies and programmes to ensure a high level of human health protection and the prevention of major health scourges. The Commission is empowered to take any useful initiative to promote this process.

66. Consultations may need to be about almost any aspect of the subject but the main areas will be the development of public policies and strategies at different levels of government (international, national, regional and local) and the comparison of measures used to implement those policies, whether legislative, administrative or by the negotiation of voluntary standards and codes.

67. Areas in which such policy cooperation will be particularly important are those concerning the selection of priorities for action, surveys of public attitudes towards accidents, risk-taking and suicide, preventive actions directed towards particular population groups e.g. young children, and measures to reduce environment-related risks.

68. Action organized, sponsored or assisted by the Commission may take the form of formal and informal meetings at different levels of government, conferences and seminars, working groups and advisory groups. Consultations could include independent experts and representatives of non-governmental organizations. Groups will have precise, time-limited mandates. The Committee for the programme outlined in paragraph 76 will be the forum for general oversight of these activities.

Adding public health value to other Community programmes

69. The fifth specific field of action, strengthening the public health input to injury prevention, would also benefit from activities to increase the use which public health bodies can make of other Community policies for injury prevention. Several umbrella groups already assist their members by raising awareness of Community programmes and the conditions for participation in them, helping to set up consortia across national boundaries and helping groups with a particular interest to discover the most useful interlocutors in Community institutions. The programme could support similar activities focused in more detail on injury prevention and disseminated to an injury-related audience.

Detailed subject content of the topics selected

70. The selection of five topics for action was described in paragraphs 51-53, and paragraphs 54-69 showed the means by which Community objectives in those fields could be pursued. It remains to illustrate the content in a little more detail.

Home, leisure and school accidents to children

71. Best practices being disseminated in this area could include those in areas such as home safety check schemes for toddlers, parent support and education, provision of safety glass or safety film for glass, provisions of package equipped with child resistant closures, smoke alarms and other safety aids in the home, coaching for sports and leisure pursuits, learning to swim, daily living skills in, for example, the kitchen, safety of playgrounds, specialist work of school health services, safety education in the curriculum, training of childcare workers and development of self-help and voluntary groups.

Home and leisure accidents to young adults

72. Areas particularly suitable for work under this heading include coaching for sports and leisure pursuits, the inclusion of more general safety information in the packaging of sports products, awareness of the effects of alcohol and drugs on risk-taking behaviour, awareness in high risk sports such as the danger of spinal injury from diving into unknown water, first aid and resuscitation, identifying key collaborators such as cycle shops, record shops and youth groups, raising awareness of hazards in the kitchen and do-it-yourself, development of self-help and voluntary groups. Expertise gained by sports bodies with professional sports people may be valuable in preventing accidents to amateurs too.

Home and leisure accidents to elderly people

73. In this field best practices should be disseminated in fields such as home safety check schemes, appropriate mobility and flexibility exercises, giving advice in suitable contexts such as contacts with health services, maintenance of safe and even pavements, safety policies in nursing homes, checking on heating arrangements, review of medication (especially sedatives, tranquillizers and hypotensive agents) to avoid unnecessary use, adequate lighting including street lights and the development of self-help and voluntary groups. A particular focus is the prevention of falls which can be very disabling and permanent in their effects in the oldest groups.

Suicide

74. Those involved in suicide prevention could use the programme to share information in areas such as effective help for those have attempted suicide (the group at the highest risk of a further attempt), organization of the quality of provision for suicide attempters to minimize the risk of repeat attempts, wider understanding of depression and support for people with severe somatic illness, evaluation of different help line and counselling approaches, and development of self-help and voluntary groups (including those for alcohol abusers and people with mental illness).

Strengthening the capacity of the public health sector

75. In addition to the actions adding value to other Community activities described in paragraph 69, information can be shared on topics including epidemiology of injury, community mobilization (for example building on the WHO Safe Communities programme in coordination with its organizers), building alliances of agencies, effectiveness and cost-effectiveness of injury prevention actions and evaluation tools.

VII. CONSULTATION ASSESSMENT AND REPORTS

Consultation

76. In seeking to establish a five-year programme in this field, the Commission will rely on close collaboration with the Member States, above all in the field of coordination of policies and programmes but also in every other part of the programme. In implementing the programme, the Commission intends to have recourse to an Advisory Committee of representatives of the Member States. Appropriate links will be maintained with the WHO, other international organizations and third countries as the programme requires, subject to other pertinent Community provisions.

Evaluation reports

77. Assessment of the programme will be provided in two reports:

- an evaluation report during the third year of this programme to the Council, The European Parliament, the Economic and Social Comittee, and the Committee of the regions. The purpose of this report is to ensure that the Community institutions and, through them, all the parties concerned, are kept fully informed on the progress of the actions undertaken in the context of this action plan;

- a final report on the implementation of the programme, which will include an evaluation of the actions undertaken, will be submitted to the abovementioned institutions by the Commission after the completion of the programme.

General information activities

78. In addition to the information activities contained in the programme, the Commission will ensure that the general public and all parties concerned have access to reports on the actions, studies, and assessments undertaken.

Proposal for a

EUROPEAN PARLIAMENT AND COUNCIL DECISION

adopting a programme of Community action from 1999 to 2003 on injury prevention in the context of the framework for action in the field of public health

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EXPLANATORY MEMORANDUM

1. In its Communication COM(93) 559 of 24 November 1993 on the framework for action in the field of public health, the Commission outlined the principles and strategy to be followed in undertaking Community activities directed towards the attainment of the objectives on health protection laid down in Articles 3(o) and 129 of the Treaty establishing the European Community. The role of the Community is identified as underpinning the efforts of the Member States in the public health field, assisting in the formulation and implementation of objectives and strategies, and contributing to the provision of health protection across the Community, setting as the target the best results already obtained in a given area anywhere in the Community.

2. In accordance with Article 129, the Commission presents proposals for the adoption by the European Parliament and the Council of incentive measures intended to contribute towards ensuring a high-level of human health protection. The aforementioned Commission Communication sets out criteria on which to determine priority areas for Community action programmes. In accordance with these criteria, injury prevention was identified as such a priority area. The present Commission proposal, based on Article 129 and already announced in the Commission's annual programme of work, comes under the principle of shared competence between the Community and the Member States, and seeks to promote public health by contributing to actions which reduce the incidence of injury.

3. Injury is a broad concept which in principle covers, according to internationally accepted definitions, all kinds of ill-health resulting from external causes (as opposed to disease processes), for example impacts, burns, poisoning, bites and stings and crushing, and without distinction as to the cause of the external event: deliberate self-harm, deliberate harm by another person, lawful or not, or accidental. The present Commission proposal targets a small number of key areas within this broad field, selected on the basis that they are an important cause of avoidable injury and death, are not already addressed by action at Community level, present opportunities for cost-effective intervention, and would deliver Community added value by bringing together and complementing work done at national and sub-national level.

4. The target areas selected are home and leisure accidents to children, young adults and elderly people, and accidents to children while at school, and also the topic of suicide and lesser forms of deliberate self-harm (sometimes called parasuicide). This selection of fields is amply justified by the criteria just mentioned and tackles all the classes of injury which are the most substantial sources of death, disability and ill-health, apart from occupational injury and road traffic accidents, which are already addressed by other Community activities. For example, data collected by Ireland's Hospital In-Patient Enquiry System show that the categories selected here cover three-quarters of all injuries which led to in-patient admission in that country in 1993.

5. The incentive measures proposed are of two kinds. The first is support for the sharing - and shared development - of expertise, particularly in the selection of interventions and the epidemiology of injury. An enormous amount of experience and ability exists in injury prevention in the Member States, but it is spread unevenly and practitioners are at times largely unaware of the experience of others. Measures to share existing best practices will help to spread more widely the best results already obtained anywhere in the Community. When a Member State's incidence of injuries is higher than the lowest national rate of any Member State of the Community, the excess injuries could reasonably be called avoidable and this proposal would help to transfer necessary expertise to assist in reducing such avoidable injury.

6. The second kind of incentive measure proposed is encouraging improvement in the quality of data. Data are vital to injury prevention as they allow epidemiological investigation of what situations, products, behaviours, and places are dangerous. Whereas the epidemiology of many diseases is increasing better established in the Community, the data needed to support a proper epidemiology of injury are gravely lacking, and as a result it is correspondingly hard to target scarce resources to the most productive prevention activities. At a Community level, better data would be a powerful tool in the hands of those planning prevention who could use them to identify, for instance, whether or not their national or regional burden of sports or cycling injuries was significantly worse than neighbouring countries, and if so in what ways, thereby suggesting areas for attention.

7. Community action under this proposal would take the form of encouraging and supporting the creation of networks, dissemination of information about prevention campaigns, work on improving data including surveys and technical investigations. Suitable opportunities could also arise for helping Member States to coordinate their policies and programmes in the way envisaged in Article 129 of the Treaty establishing the European Community.

8. Evidence is mounting that injury prevention measures can be both effective and cost-effective, particularly those so-called "passive" prevention measures which create a safer environment as opposed to training people to live more safely in environments which remain potentially dangerous. However, not all interventions work equally well and the value of the Commission's proposal is that it would help publicize those which have been found to work best and communicate their underlying principles to those in other Member States who wish to adopt similar measures.

9. The European Parliament has long shown an interest in actions at community level to prevent injury, and the present proposal responds specifically to its Resolution on public health policy after Maastricht which contained a specific call for activities on accident prevention. Actions on injury prevention also respond to the priorities expressed by the Council in the field of public health such as the need to select areas for action with regard to their amenability to preventive action.

10. This programme can only be undertaken on the basis of a European Parliament and Council decision pursuant to Article 129. It does not come under the exclusive competence of the Community and does not seek or require the harmonization of national provisions in the field covered.

11. The actions to be implemented under the proposed programme will yield added value in a number of different ways:

(1) they will allow activities already undertaken in relative isolation at national level to be brought together and complement one another with significant results for the Community as a whole, such as the widespread dissemination of good practice previously confined to one region, the more rational and effective division of labour in technical fields and the preparation of Community-wide comparable data;

(2) they will contribute to the strengthening of solidarity and cohesion in the Community and contribute to its overall harmonious development by helping regions where injury is most prevalent to benefit from the experience of regions where more attention has already been given to injury prevention; and

(3) they will lead, where the need is recognized, to the establishment of best-practice norms and standards.

12. An evaluation of the actions implemented under the programme will be provided in two reports:

- during the third year of the programme, an evaluation report;

- a final report on the implementation of the programme.

These reports will incorporate information on Community financing in the various fields of action as well as the results of evaluations. They will be transmitted to the Council and the European Parliament, as well as to the Economic and Social Committee and the Committee of the Regions.

Proposal for a

EUROPEAN PARLIAMENT AND COUNCIL DECISION

adopting a programme of Community action from 1999 to 2003 on injury prevention in the context of the framework for action in the field of public health

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THE EUROPEAN PARLIAMENT AND THE COUNCIL OF THE EUROPEAN UNION,

Having regard to the Treaty establishing the European Community, and in particular the first indent of Article 129(4) thereof,

Having regard to the proposal from the Commission[36],

Having regard to the opinion of the Economic and Social Committee[37],

Having regard to the opinion of the Committee of the Regions[38],

Acting in accordance with the procedure referred to in Article 189b of the Treaty[39],

1. Whereas injuries should be considered one of the major health scourges referred to in Article 129 throughout the Community and are a cause of substantial public concern;

2. Whereas, in accordance with point (o) of Article 3 of the Treaty, Community action shall include a contribution to the attainment of a high level of health protection;

3. Whereas Article 129 expressly provides for Community competence in this field, by encouraging cooperation between the Member States and, if necessary, lending support to their action; promoting coordination of their policies and programmes, and fostering cooperation with third countries and international organizations competent in the sphere of public health; whereas Community action should be directed towards the prevention of diseases, and the promotion of health education and information;

4. Whereas the Resolution of the Council and the Ministers for Health, meeting within the Council of 27 May 1993 on future action in the field of public health[40], affirmed the need for Community action aiming at adding life to years and years to life and selection of areas for such action with regard to their amenability to preventive action;

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36 OJ No

37 OJ No

38 OJ No

39 OJ No

40 OJ No C 174, 25.6.1993, p. 1.

5. Whereas the European Parliament, in its Resolution on public health policy after Maastricht of 19 November 1993[41] called on the Commission to develop and execute activities on accident prevention;

6. Whereas the Commission, in its Communication of 24 November 1993 on the Framework for Action in the Field of Public Health[42], identified intentional and unintentional injuries and accidents as a priority area for action in the public health field;

7. Whereas the European Parliament and the Council, in their Decision 3092/94/EC[43], introduced a Community system of information in home and leisure accidents with which this Decision should be closely coordinated;

8. Whereas, in accordance with the principles of subsidiarity and proportionality laid down in Article 3b of the Treaty, action on injury prevention should be undertaken by the Community only if and in so far as, by reason of its scale or effects, it may be better achieved at Community level; whereas this programme will yield a Community-added value by bringing together activities already undertaken in relative isolation at national level and by complementing one another with significant results for the Community as a whole, by contributing to the strengthening of solidarity and cohesion in the Community and by leading, where the need is recognized, to the establishment of best-practice norms and standards.

9. Whereas cooperation with the international organizations competent in the field of public health and with third countries should be fostered;

10. Whereas, by providing support for acquiring better knowledge and understanding of, and wider dissemination of information about, injury prevention, ensuring improved comparability of information in this field and by developing actions complementary to existing Community programmes and actions, while avoiding unnecessary duplication, the programme will contribute to the achievement of the Community objectives set out in Article 129;

11. Whereas, in order to increase the value and impact of the programme, a continuous assessment of the actions undertaken should be carried out, with particular regard to their effectiveness and the achievement of the objectives set and with a view, where appropriate, to making the necessary adjustments;

12. Whereas this Decision lays down a financial framework constituting the principal point of reference, within the meaning of point 1 of the Declaration of the European Parliament, the Council and Commission of 6 March 1995[44], for the budgetary authority during the annual budgetary procedure;

13. Whereas the Community's financial perspective is valid up to 1999 and will have to be revised for the period beyond that date;

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41 OJ No C 329, 6.12.1993, p. 375.
42 COM(93) 559 final of 24 November 1993.
43 OJ No L 331, 21.12.1994, p. 1.
44 OJ No C 102, 4.4.1996, p. 4.

14. Whereas this programme should be of five-year duration in order to allow sufficient time for actions to be implemented to achieve the objectives set,

HAVE DECIDED AS FOLLOWS:

Article 1
Establishment of the programme

1. A programme of Community action on injury prevention, hereinafter referred to as "the Programme", is hereby adopted for the period 1 January 1999 to 31 December 2003 in the context of the framework for action in the field of public health.

2. The aim of the Programme is to contribute to public health activities which seek to reduce the incidence of injury, by promoting the more effective dissemination and application of prevention techniques whose worth is widely accepted by experts, and by helping to strengthen the general capacity of public health bodies to mount effective injury prevention activities.

3. The actions to be implemented under the Programme and their specific objectives are set out in the Annex.

Article 2
Implementation

1. The Commission shall ensure implementation, in close cooperation with the Member States, of the actions set out in the Annex.

2. The Commission shall cooperate with institutions and organizations active in the field of injury prevention.

Article 3
Budget

1. The financial framework for the implementation of the Programme for the year 1999 shall be ECU 1.3 million, in keeping with current financial perspectives.The financial framework for the final four years of the programme (2000-2003) shall be determinated in detail after the establishment of the future financial perspectives.

2. The annual appropriations shall be established by the Budgetary Authority in accordance with the current financial perspectives.

Article 4
Consistency and complementarity

The Commission shall ensure that there is consistency and complementarity between the Community actions to be implemented under the Programme and those implemented under other relevant Community programmes and actions.

Article 5
Committee

1. The Commission shall be assisted by an advisory committee, hereinafter referred to as "the Committee", consisting of representatives of the Member States, and chaired by the Commission representative.

   The representative of the Commission shall submit to the Committee a draft of the measures to be taken.

   The Committee shall deliver its opinion on the draft, within a time limit which the chairperson may lay down according to the urgency of the matter, if necessary by taking a vote.

   The opinion shall be recorded in the minutes; in addition, each Member State shall have the right to ask to have its position recorded in the minutes.

   The Commission shall take the utmost account of the opinion delivered by the Committee. It shall inform the Committee on the manner in which its opinion has been taken into account.

2. The Committee shall be consulted, in particular on:

   (a) the criteria and procedures for selecting and financing projects under this programme;

   (b) the evaluation procedure.

3. The representative of the Commission shall keep the Committee regularly informed about Commission proposals or Community initiatives and the implementation of programmes in other policy areas which are relevant to the achievement of the objectives of this programme.

Article 6
International cooperation

1. In the course of implementing the Programme, cooperation with third countries and with international organizations competent in the field of public health shall be fostered.

2. The Programme shall be open to participation by the associated countries of Central and Eastern Europe, in accordance with the conditions laid down in the Association Agreements or Additional Protocols related thereto concerning participation in Community programmes. The Programme shall be open to participation by Cyprus and Malta on the basis of additional appropriations in accordance with the same rules as those applied to the EFTA countries, in accordance with procedures to be agreed with those countries.

Article 7
Monitoring and evaluation

1. In the implementation of this Decision, the Commission shall take the necessary measures to ensure the monitoring and continuous evaluation of the Programme, taking account of the general and specific objectives referred to in Article 1 and in the Annex.

2. During the third year of the Programme, the Commission shall present an evaluation report to the European Parliament and the Council.

3. The Commission shall submit to the European Parliament and the Council a final report on completion of the Programme.

4. The Commission shall incorporate into those two reports information on Community financing in the various fields of action and on complementarity with the other actions referred to in Article 4, as well as the results of the evaluations. It shall also send them to the Economic and Social Committee and the Committee of the Regions.

Done at Brussels,

For the European Parliament

The President

For the Council

The President

ANNEX

SPECIFIC OBJECTIVES AND ACTIONS

I. ACCIDENTS TO CHILDREN, YOUNG ADULTS AND ELDERLY PEOPLE[45]

Objective: **to contribute to public health activities which aim at reducing the incidence of injury from home, leisure and school accidents, by promoting the more effective dissemination and application of prevention techniques whose worth is widely accepted by experts**

II. SUICIDE

Objective: **to contribute to public health activities which aim at reducing the incidence of injury from deliberate self-harm, by promoting the more effective dissemination and application of prevention techniques whose worth is widely accepted by experts**

III. INJURY PREVENTION CAPACITY

Objective: **to contribute to the strengthening of public health bodies' capacity to mount effective injury prevention activities.**

Actions to be undertaken in support of each of these objectives:

(Actions may relate to more than one objective: for example a project on safety in sport might affect childre, young adults and older people.)

1. Networks: encouraging and assisting the creation of networks, dedicated in particular to: development of new approaches or innovative methods of tackling common problems, exchanges of materials, guidelines and handbooks, organization of training activities.

2. Campaigns: supporting the dissemination of information about campaigns; including the development of a bank of information on the campaigns that have been carried out, with, if possible assessments of their value, effects and transferability, and organization of competitions to identify the best injury prevention campaigns; promoting where appropriate the organization of parallel campaigns in a number of Member States; assisting the development of basic materials and publicity.

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[45] The Community action in the field of civil protection is excluded from this programme (cf. in particular the proposal for a Council Decision establishing a Community action programme in the field of civil protection COM(95) 155 final).

3. Data about injuries: in conjunction with EHLASS promoting agreed approaches to coding, data definitions, better recording of place of occurrence, as well as on behavioural aspects and on chain of events, more precision in cause of death certification, the use of relevant severity scales and minimum data sets; supporting the application of relevant results of the International Collaborative Effort on Injury Statistics; examination of the coverage of existing data collection system and where necessary development of measures to improve such coverage inclusion of additional questions or modules in existing Community-wide surveys; assistance in identifying the need for surveys; promoting the creation of a database of known surveys.

4. Technical investigations of injury risk factors: promoting collaboration between institutions with specialized knowledge and facilities able to undertake such activities; supporting the development of an inventory of institutions and their projects, and evaluations of prevention projects and campaigns.

5. Consultation and cooperation: support for formal and informal meetings at different levels of government, conferences and seminars, working groups and advisory groups.

in addition, the following actions will support objective III:

6. Activities to increase the use which public health bodies can make of other Community policies for injury prevention: raising awareness of Community programmes and the conditions for participation in them, helping to set up consortia across national boundaries and helping groups with a particular interest to discover the most useful interlocutors in Community institutions.

FINANCIAL STATEMENT

1. TITLE OF OPERATION

Proposal for a European Parliament and Council Decision adopting a programme of Community action from 1999 to 2003 on injury prevention in the context of the framework for action in the field of public health

2. BUDGET HEADING INVOLVED

B3-.....

3. LEGAL BASIS

Article 3(o) and Article 129 of the Treaty establishing the European Community.

4. DESCRIPTION OF OPERATION

4.1 General objective

To contribute to achieving the objectives laid down by the Treaty:

- under Article 3 (o), the Community is required to make a contribution to the attainment of a high level of health protection;

- Article 129 requires the Community to contribute towards ensuring a high level of human health protection, in particular by encouraging cooperation between the Member States, and if necessary lending support to their action, promoting coordination of their policies and programmes, and fostering cooperation with third countries and the competent international organizations in the sphere of public health. Community action is directed towards the prevention of diseases, in particular major health scourges, by promoting research into their causes and their transmission, as well as health information and education.

The general objective of the action programme is to contribute to public health activities which aim at reducing the incidence of injury from home, leisure and school accidents and from deliberate self-harm, by promoting the more effective dissemination and application of prevention techniques whose worth is widely accepted by experts, and by contributing to the strengthening of public health bodies' general capacity to mount effective injury prevention activities.

The method for achieving this objective consists of undertaking actions which:

- encourage and assist the creation of networks of those active in injury prevention;
- disseminate information about injury prevention campaigns;
- improve the available data about accidents by means of surveys and otherwise;
- promote better technical investigations of injury risk factors through greater collaboration between expert centres;
- foster consultation and cooperation where appropriate between Member States; and
- help public health bodies to make better use of other Community policies to assist with injury prevention.

4.2 Period covered and arrangements for renewal or extension

- five years: 1 January 1999 to 31 December 2003
- Report on implementation to be transmitted to the Council and European Parliament during the third year of the programme
- Report to the Council and European Parliament after completion of the programme together with the results of evaluations.

5. CLASSIFICATION OF EXPENDITURE OR REVENUE

- Non-compulsory expenditure
- Differentiated appropriations

6. TYPE OF EXPENDITURE OR REVENUE

Subsidy for joint financing with other sources in the public and/or private sector (not exceeding a certain percentage of the total cost of the proposed projects).

The level of funding granted depends on the scope of the measure to be financed and on the extent to which the action programme is reflected in the various activities planned. Such funding will not exceed 70% of the total budget earmarked for the proposed projects except in the case of networks and work ordered and of direct use to the Commission, where the subsidy may amount to 100%.

7. FINANCIAL IMPACT

7.1 Method of calculating the total cost of operation (definition of unit cost)

The method of calculation is the result of experience acquired in previous activities related to public health activities. This encompasses the various types of Community action listed in Table 4 of Commission Communication COM(93) 559 final of 24 November 1993, and represents ten years of know-how in financing cooperative efforts with the Member States and NGOs of collection, analysis and dissemination of information, setting up of networks, survey of the quality of campaigns such as European weeks, establishment of mechanisms and procedures of consultation and cooperation for setting common objectives and for policy coordination and for the formulation and development of strategies at the Community level. The specific cost estimates are based on the assumption that half of the activities to be undertaken under this programme will require 100% funding while the other half will require 50% funding and that the activities to be undertaken will involve most or all of the Member States. An amount of ECU 1.3 million is deemed necessary for the implementation of these activities for the year 1999. The new budget framework for the final four years will be established in the year 2000 taking into account the future Community's financial perspectives. The annual allocations will be decided in accordance with the normal budgetary procedures.

7.1.1 Reduction in accidents

- Networks

In 1999 the running of three networks per year has been scheduled at an average cost of ECU 200 000 per year.

- Dissemination of information

Being a new action estimated cost has been calculated from the experience of other already existing programmes in public health (cancer, Aids and communicable diseases, drugs, health promotion) and its cost (ECU 100 000 per year).

7.1.2 Suicide

- Networks

In 1999, the running of one network per year has been scheduled at an average cost of ECU 200 000 per year.

- Dissemination of network

  Being a new action estimated cost has been calculated from the experience of other already existing programmes in public health (cancer, Aids and communicable diseases, drugs, health promotion) and its cost (ECU 100 000 per year).

  Improving data about suicide

  Being a new action, the estimated cost of ECU 200 000 has been calculated from the experiences of EUROSTAT and, the EHLASS system on home and leisure accident.

7.1.3 Prevention Capacity

Support to at least two country events per year at ECU 50 000 (with special relevance in 1999) when lauching the programme.

7.2 Itemized breakdown of cost (in ECU million)

OBJECTIVE	ACTION AREA	YEARS					
		1999	2000	2001	2002	2003	Total
Contribute to reduction in accidents to children, young adults and elderly people	encouraging and assisting the creation of networks; disseminating information about campaigns; improving data about accidents; technical investigations of injury risk factors; consultation and cooperation;	Indicative programming					
		0.7	-	-	-	-	0.7
Contribute to reduction in the incidence of suicide	encouraging and assisting the creation of networks; disseminating information about campaigns; improving data about accidents; technical investigations of injury risk factors; consultation and cooperation;	0.4	-	-	-	-	0.4
Contribute to strengthening injury prevention capacity	encouraging and assisting the creation of networks; disseminating information about campaigns; improving data about accidents; technical investigations of injury risk factors; consultation and cooperation;	0.1	-	-	-	-	0.1
	activities to increase the use which public health bodies make of other Community policies to assist with injury prevention	0.1	-	-	-	-	0.1
	Total	1.3	**pm**	**pm**	**pm**	**pm**	**1.3**

7.3 Indicative schedule of appropriations (in ECU million)

	1999	2000	2001	2002	2003	TOTAL
Commitment appropriations	1.3	-	-	-	-	1.3
Payment appropriations						
1999	0.78	-	-	-	-	0.78
2000	0.52	-	-	-	-	0.52
2001	-	-	-			-
2002	-	-	-	-	-	-
2003	-	-	-	-	-	-
Subsequent years	-	-	-	-	-	-
TOTAL	**1.3**	**pm**	**pm**	**pm**	**pm**	**1.3**

8. FRAUD PREVENTION MEASURES; RESULTS OF MEASURES TAKEN

The grant application forms will require information on the identity and nature of potential beneficiaries so that their reliability can be assessed in advance.

Fraud prevention measures (checks, intermediate reports, final report) are included in the agreements or contracts between the Commission and beneficiaries. The Commission will check reports and ensure that work has been properly carried out before intermediate and final payments are made.

In addition, spot checks are carried out by the Commission to verify how funds have been used. Checks have already been carried out in other public health budget lines in relation to the financial years 1991 to 1995 and have shown their effectiveness.

9. ELEMENTS OF COST-EFFECTIVENESS ANALYSIS

9.1 Specific and quantifiable objectives;

The general objective of the action programme is to contribute towards ensuring a high level of health protection against injury by promoting the more effective dissemination and application of prevention techniques whose worth is widely accepted by experts, and by helping to strengthen public health bodies' general capacity to mount effective injury prevention activities.

The indicators showing whether or not targets are achieved in this field will include measures of the following kinds. These will be refined further in collaboration with the new programme on health monitoring, whose tasks include the development of indicators for Community public health policies. The method for achieving this objective consists of undertaking actions which:

- encourage and assist the creation of networks of those active in injury prevention;

- measure how active the networks are (membership, production of e.g. information bulletins, conferences, WWW discussion groups...);

- disseminate information about injury prevention campaigns (e.g. surveys of number and quality of publications assisted by the programme);

- improve the available data about accidents by means of surveys and otherwise (e.g. what new measures are brought into use and in what countries);

- promote better technical investigations of injury risk factors through greater collaboration between expert centres (number and quality of such reports assisted by the programme);

- foster consultation and cooperation where appropriate between Member States, (description of cases of such consultation etc.); and

- help public health bodies to make better use of other Community policies to assist with injury prevention (numbers and description).

Target Population

1. Competent public authorities of the Member States, at national, regional and local level and competent international organizations in the spheres of public health and injury prevention;

2. Health professionals, health epidemiological services, health and medical associations, specialists in the prevention of different kinds of injury, academic institutions, etc;

3. NGO's and other bodies interested in health matters and injury prevention, and the public in general.

9.2 Grounds for the operation

In initiating action under Article 129, the Community has to address itself to preventing diseases and protecting health. The Commission's communication on the framework for action in the field of public health (COM(93) 559 final of 24 November 1993) sets out criteria on which to determine priority areas for Community programmes. In accordance with these criteria, the 1993 "framework" Communication evaluated the different options for addressing diseases, in particular major scourges and their underlying causes, by various types of community actions and retained on the basis of criteria listed in that communication, eight priority areas of which injury prevention was one.

The present proposal targets a small number of key areas within this broad field, selected on the basis of *ex ante* evaluation that they are an important cause of avoidable injury and death, are not already addressed by action at Community level, present opportunities for cost-effective intervention, and would deliver Community added value by bringing together and complementing work done at national and sub-national level. This would be substantially more effective than leaving such questions to inter-governmental cooperation without a Community contribution: in this field the input envisaged for the Community and the Commission by Article 129 provides a clear common framework of rules, avoiding open-ended and time-consuming negotiation, allowing more rapid progress on a firmer footing.

The target areas selected are home and leisure accidents to children, young adults and elderly people, and accidents to children while at school, and also the topic of suicide and lesser forms of deliberate self-harm (sometimes called parasuicide). This selection of fields has been amply justified by ex ante evaluation using the criteria just mentioned and tackles all the classes of injury which are the most substantial sources of death, disability and ill-health, apart from occupational injury and road traffic accidents, which are already addressed by other Community activities.

As regards the intervention methods and the allocation of funds, the following will apply:

- specific application of the principle of subsidiarity when identifying measures to be undertaken and co-financed;

- identification and selection of projects for co-financing in the fields of injury prevention;

- the concept of added Community value, which will continue to be realised in particular through the coordination of national measures, the dissemination of information and experiences, the establishment of priorities, the development of networking as appropriate, selection of European projects and the motivation and mobilisation of all involved.

Two methods will be employed to implement the programme. One is to support projects carried out in Member States and at the Community level. The selection of priority projects is based largely on general and intermediate objectives, and implementation of the measures themselves depends on the quality and effectiveness of projects submitted to the competent department during the course of the year. The other is to undertake specific activities necessary to achieve the objectives of the programme, which will be fully financed by the programme.

The selection criteria for projects are as follows:

- Compatibility with the objectives and conformity with at least one of the established objectives;
- Examination of the "added Community value" of the projects (transnational participation, development of a model applicable in other Member States, information usable in other Member States, etc.);
- Presumed effectiveness and value;
- Clarity and justification of requirements;
- Relevance of selected methodology;
- Organizational competence and experience;
- Suitability of budget for objectives;
- Support for projects from national partners;
- Objective assessment;
- Opinion of the advisory committee involved.

The budget proposed of ECU 1.3 million for the first year of this programme, matches that proposed at the same time for the programmes on rare diseases and on pollution-related diseases. This reflects the equal priority attached to each field in the Commission's 1993 Communication, an evaluation which remains valid today. The amount proposed represents the bare minimum required to start the programme.

9.3 Monitoring and evaluation of the operation

9.3.1 Monitoring of the operation

Monitoring at the Community level is to be carried out by the Commission, which will submit a report half-way through the implementation of the programme, and a final report after its completion to the Council, the European Parliament, the Economic and Social Committee, and the Committee of the Regions, drawing from national reports as well as evaluations of the actions under the programme and of individuals projects.

9.3.2 Evaluation

Evaluation will be by means of:

- An evaluation of the main measures and of subsidised projects involving, where necessary, the participation of independent experts;
- An evaluation report during the third year;
- An overall report on the quality and effectiveness of projects implemented under the action plan, to be submitted by the Commission to the other Community institutions after completion of the programme.

Performance indicators selected for this evaluation:

- Evaluation of projects by Commission officials and/or those cooperating with them;
- Analysis of intermediate reports on measures scheduled and financed, allowing a shifting of emphasis where possible;
- Impact studies by external bodies;
- Relevance of the methodology used by organizers;
- Suitability of the budget for the objectives;
- Skills and experience of bodies;
- Dissemination of results.

Evaluation procedures and intervals:

- Drawing up of intermediate and final reports on the various measures undertaken in the field;
- Development of a "standard" evaluation form for the measure, to be forwarded by the beneficiaries with their final reports, and checking of these documents by officials either at the Commission or in the field.

10. ADMINISTRATIVE EXPENDITURE (PART A OF THE BUDGET)

Actual mobilization of the necessary administrative resources will be conditioned by the Commission's annual decision on the allocation of resources, having regard in particular to additional staff and funds provided by the budgetary authority.

10.1 Impact on the number of employees

Types of employees		staff carrying out action		source of employee		duration
		permanent employees	temporary employees	from within DG or service	supplementary staff	
Officials or temporary agents	A	1	0	1	0	
	B	1	0	1	0	
	C	1	0	1	0	
Other resources						
Total		3	0	3	0	

10.2 Financial impact of supplementary staff

No supplementary staff are envisaged.

10.3 Increase in other running costs arising from the action

Budget line	Amounts	Method of calculation
Meetings A2510	ECU 104 250	2 meetings of advisory committee/year, 1 representative/Member State = 2 meetings/year x 15 reprs x ECU 695/repr x 5 years = ECU 104 250

The resources necessary to cover the expenditure below for the five-year period will be obtained by re-deployment of existing financial resources and the use of supplementary resources will not be required.

(a) Personnel Expenses (Title A1, A2 and A5)

3 x ECU 100 000 x 5 years = ECU 1 500 000

(b) Operational Expenses

Expenses for meetings (A-250)
2 meetings/year x 15 experts x ECU 825/expert x 5 years = ECU 123 750
Expenses for travel (A-130)
24 missions/year Brussels-Luxembourg x 200 ecus/mission x 5 years = ECU 24 000
60 missions/year to Member States x ECU 1 000/mission x 5 years = ECU 300 000

(c) Total: ECU 1 947 750

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