

Frequently Asked Questions on Accident and Injury Data

background document to the

Joint Call for a pan-European accident and injury data system

- *What is the burden of accidents and injuries in the EU?*

The report, "Injuries in the European Union - Statistics Summary 2008-2010", reveals that around 6 million people are admitted to hospital annually, with 34 million more treated as outpatients, as a result of an injury. These injuries result in personal suffering and significant financial costs to individuals and families, as well as to employers and the state, in terms of lost earnings, lost production and health care costs. By far the majority of these injuries (73%) are due to home and leisure accidents, affecting in particular vulnerable groups such as children, older people and people with disabilities.

Extensive research in the Netherlands and the UK reveals that the direct medical cost of injuries treated in emergency departments can be estimated at 150 euros per citizen. This implies that no fewer than *78 billion euros* are spent annually across the EU only on treatment and rehabilitation.

- *Why do we need to invest more in home and leisure safety?*

The past century has seen increases in levels of safety and consequent reductions in the exposure of the population to the risk of accidental injuries, especially those arising from accidents in the workplace and from transport-related accidents (road traffic accidents as well as journeys by air, rail and sea). The number of deaths and serious injuries arising from these categories of accident has dropped dramatically over the past decades. This improvement is due to increased knowledge of the risks involved and the introduction of preventive measures (e.g. safety awareness training; regulations governing safety in the workplace and in transportation).

However, there has been no similar decline in the number of *home or leisure accidents (HLAs)* that cause of 73% of injuries each year in the EU. The annual total of HLAs has remained unchanged for a decade and is even increasing in respect of older people.

It is particularly difficult to develop policies aimed at preventing injuries from HLAs as such accidents occur in a very broad range of settings and circumstances. Moreover, the responsibilities for ensuring proper safety measures here are often far less clearly defined than in the case of safety in the workplace.

This challenge can be overcome by presenting a better picture of the characteristics of HLAs, and through the identification of stakeholders and actions across a range of sectors at the local, national and European levels.

- *Does HLA prevention work?*

Experience in countries such as the UK, Sweden, the Netherlands and Austria shows that well-designed HLA prevention programmes can reduce accidents by 20 to 30 per cent for a given target population or area. The return on investment typically ranges between 3 and 10 times the investment made.

- *Why do we need better data?*

Injury data are essential for making informed decisions about a country's priorities and in developing effective policies and actions. They are also critical in harnessing political will, public support and the funding needed to undertake actions. Data are also required to evaluate the success and the cost-effectiveness of actions.

Information is available on accidents in the workplace and transport accidents. Each of these fields has a specialised reporting system on accidents and disasters, operated by the appropriate authorities (i.e. inspectorates of health and safety for accidents in the workplace; the police for road traffic accidents).

However, none of these dedicated reporting systems collects information on HLAs. Yet many of the injuries arising from HLAs – particularly the most serious - will be seen in the Emergency Departments (EDs) of hospitals for emergency care and treatment. Hence selected EDs could provide a valuable source of data that could be extrapolated to assist the development of preventive policies and actions, and the assessment of such policies and actions. This information would also be beneficial in improving road safety and safety in the workplace as it is known there is underreporting of both types of accident.

- *What kind of information is needed?*

In addition to what is already in the patient file, some further elements are needed such as the 'place of accident' (e.g. a school or sports field), 'the activity undertaken at the time of the accident' (e.g. a sport), and 'product involved in the accident' (e.g. a bicycle or trampoline). The last element records whether a product or an environmental feature has been involved in the accident, but does not say anything about the possible cause of the accident. Hence, the information collected at EDs should be enhanced by a narrative describing how the accident took place, including information on the circumstances of the accident and the role played by the victim and possible bystanders.

- *Who uses the data?*

Reliable and up-to-date accident and injury data are of great importance to very many stakeholders and stakeholder representatives at national, regional and European level. Examples are governments, designers, manufacturers, retailers, service providers, standards developers, enforcement authorities, prevention agencies and civil society organisations.

For these groups, injury data are essential in raising awareness of the magnitude and complexity of injuries due to HLAs; for integrating proper injury prevention measures in the daily business of administration; and in the production and consumption of goods and services in the home, schools and in leisure time activities.

• *What would we gain by having more data?*

Comprehensive and accurate accident and injury data will help decision-makers in the private and public sectors to:

- perform proper assessment of the health burden of injury with respect to different consequences (mortality, morbidity and disability), and the assessment of the economic burden of injuries in terms of lost productivity;
- establish a comprehensive picture of injury risks collectively at EU-level, as well as in individual Member States or regions, in order to allow comparison between and among Member States and the application of benchmarking. Comparison of injury risks and risk determinants among Member States are key motivational factors in initiating and sustaining national actions; in introducing educational campaigns; and in convincing market players of the need to develop new or revised safety standards for products or services;
- determine the hazards related to specific settings (e.g. in the home, recreational settings, transportation, workplaces or schools), specific activities (e.g. playing, sporting activities, the driving of vehicles, housekeeping or maintenance work), and specific products or services;
- facilitate the development of measures in defining minimum safety requirements for settings, activities or product or service categories; guiding the development of safety information and educational efforts in raising awareness of risk groups and empowering them to take appropriate preventive actions; or enabling sound decision-making on measures to address new or emerging risks.;
- measure progress over time in order to determine whether the aims of prevention policies and actions are being met.

• *Why collect data from hospitals in particular?*

The focus should be on the prevention of the *most severe* accidents and injuries. It is a fact that almost all severe injuries, except those causing immediate or almost immediate death, will be seen and recorded by medical specialists in the EDs of hospitals. Most of these departments have developed state-of-the-art systems for recording data related to diagnosis, treatment and rehabilitation, so information on the type and severity of injury is readily available. In order to make an accurate diagnosis and decision on treatment, it is also essential to know the causes and the circumstances of the accident and resultant injury, and for such information to be recorded easily, systematically and routinely by EDs in all hospitals. Hence EDs already have much of the data needed. In the prevention of certain categories of injury, more detailed information may be required but this could be collected easily from a representative sample of the reported cases.

• *Which countries in the EU are participating in ED-based injury data exchange?*

In the EU and EFTA today, only twelve countries routinely collect injury data from EDs and feed these into an EU database: Austria, Cyprus, Denmark, Germany, Italy, Latvia, Malta, the Netherlands, Norway, Portugal, Slovenia and Sweden. France collects data from EDs but does not participate in EU-level exchange.

The collection of these data has proved to be feasible and affordable in these countries. However, even in many of these countries, improvements need to be made to broaden

the scope of injuries covered (some do not include outpatients while others only collect injuries in the home or accidents related to children) and the sample of hospitals involved in the data collection (which needs to include large as well as medium-sized hospitals, urban as well as rural areas).

Twenty more countries need to start from scratch in developing a routine injury data collection system in EDs, although this is being facilitated through the **Joint Action on Injury Monitoring in Europe** (known as JAMIE).

The objectives of JAMIE are to define EU-level quality criteria for data collection efforts, such as representativeness and comparability, and to increase the number of countries reporting injury data in accordance with these criteria in the years 2012-2014.

This is a daunting task, as the participating countries have consented only to implement JAMIE for a limited time. As the effects of the economic crisis are restricting the ambitions of decision-makers in the public sector, it is a difficult time to encourage the adoption of new policies, even those requiring only modest investments with the promise of significant returns within a short timeframe. Most Member State governments and the European Institutions have still not given commitment to the continued exchange of ED-based injury data after 2014.

Hence a firm commitment from the Institutions and the Member State governments is desperately needed, including a binding arrangement whereby all countries must provide ED-based injury data, in order to ensure the exchange of data beyond 2014.

• *What does data collection cost?*

The cost of collecting a comprehensive set of data about causes and circumstances from a representative sample of injury patients treated in EDs would be insignificant compared with the costs of treating these injuries: less than 5 eurocents per citizen compared with the 150 euros per citizen spent annually on making the medical facilities available.

The mere availability of data will lead to injury-reduction initiatives and benefits exceeding the additional cost of data collection by a multiple.

• *Why are private companies concerned about the lack of injury data?*

Companies want to offer safe products to customers and want unsafe products banned.

At the same time, the mutually-acceptable level of product safety is part of a discussion between public and private stakeholders. In this dialogue, stakeholders and stakeholder representatives need access to accurate data on accidents and injuries, especially as to causes of injuries. These data can help define proper (EU harmonised) risk assessments. For many products, the data are missing. That is of concern to companies.

• *Why would stakeholders benefit from these data?*

Ensuring that products and services are safe is a basic objective of consumer policy. But there are differences among Member States in enforcing product safety legislation. These hamper creation of a level playing field for business and the fair treatment of consumers. Furthermore, globalisation of the production chain continues (for example, an increasing proportion of consumer products - including 85% of toys bought in the EU - are now made in China). This makes the detection of unsafe products extremely difficult.

Data from EDs would significantly increase the ability of governments, businesses, consumer organisations and standards developers to respond to emerging hazards and to monitor trends in lifestyle-related risk behaviour. The economic crisis means consumers and businesses focus predominantly on price, with the risk that safety considerations lose importance and the market penetration of substandard products increases. Surveillance authorities face new demands in policing the market, as do customs authorities and other enforcement agencies. Their tasks would be aided by reliable accident and injury data.

• *Who will benefit from such data?*

The ultimate beneficiaries of the enhanced availability and use of accident and injury data would be EU citizens, as they would benefit from an increased awareness of injury risks through information from public authorities and private sector, and from implementation of safety measures aimed at creating a safer environment in which to live.

Intermediaries in the public and private sectors will be the primary beneficiaries of injury data for the purpose of developing their safety policies; informing and educating citizens on safe behaviour, and designing and delivering products and services to citizens.

Through reducing the number and severity of injuries, society will benefit from:

- Lower health care costs
- Lower social expenditures due to disabilities caused by injury
- Increased productivity due to fewer medium and long-term absences from work
- Lower compensation costs

• *Who is responsible for ED-based data collection?*

The list of potential beneficiaries is long and diverse. However, as society will benefit, not least from decreases in public expenditure and an improvement in the functioning of the market, it must be the responsibility of governments – both at the level of the Member States and EU - to ensure the legal frameworks needed for the implementation and the monitoring of injury prevention programmes.

• *Who has to take a lead in ED-based injury data collection?*

Governments should make a mandatory provision in order to ensure:

- *Minimum data* are provided routinely by all hospitals on *all injury patients* treated in their EDs
- A *Full Data Set (FDS)*, including data on causes and circumstances, is collected in a representative sample of hospitals, e.g. in a *5-10% sample of all hospitals with an ED*.

For the FDS, governments should make sustainable arrangements to ensure financing of the extra workload of collecting and processing data related to the additional elements in participating hospitals. An estimate is 5 euros per case on average. Regarding national data processing and analysis, governments should appoint a competent body and ensure its adequate and sustainable resourcing.

- *Why should injury prevention be the concern of EU?*

The main responsibility for health and consumer policy is vested in the individual Member States. However, there are areas where Member States cannot act alone effectively and where cooperative action at Community level is invaluable. These include safety issues with a cross-border impact, such as safety in holiday resorts, as well as those relating to free movement of goods, services and people. Work on health and consumer protection at Community level adds value to the actions of Member States by promoting the well-being of individuals and society as prerequisites for economic productivity and prosperity.

Protection of the health and safety of EU citizens is an obligation under Article 152 of the TEC. It states that a "high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities". Community-level work includes scientific risk assessment, strategies to tackle risks from conditions, actions on accidents and injuries and actions on consumer protection.

Moreover, Regulation EU 765/2008, which sets requirements on the market surveillance of products, requires Member States to undertake a continuous survey of product-related injuries in a way that facilitates the assessment of those injuries and the circumstances in which they occur.

A European Home & Leisure Accident Surveillance System (EHLASS) used to operate in the EU before. It was developed to collect data on home and leisure accidents where the injury was treated in one of a sample of emergency departments in the Member States. The aim was to monitor home and leisure accidents; in a harmonised way, to identify the causes, circumstances, nature and consequences of accidents. It was discontinued in the late 1990s. Since then, only a few countries have continued to collect the injury data that is now being uploaded on to the EU Injury Data Base, in the framework of short-term projects such as JAMIE.

END.

More 'Injury Data'-information on web:

<http://www.eurosafe.eu.com/csi/eurosafe2006.nsf/wwwVwContent/I2injurydata.htm>

More information by Email:

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