



National Injury Prevention Plan

Priorities for 2001-2003

Falls in Older People

Falls in Children

Drowning and Near Drowning

Poisoning among Children

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In response to the high incidence of preventable injuries in Australia, the National Public Health Partnership Group established the Strategic Injury Prevention Partnership (SIPP) in August 2000 to provide a forum for leadership in injury prevention in Australia. SIPP is responsible for implementing the National Injury Prevention Plan: Priorities for 2001-2003 and promotes a consistent, integrated approach to injury prevention, including monitoring and evaluation across all areas of government.

SIPP includes representatives from Health Departments in all jurisdictions, the Consumer Affairs Division of Commonwealth Treasury, the National Health and Medical Research Council, the Australian Institute of Health and Welfare and the Australian Injury Prevention Network.

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1. Introduction

Injury prevention and control has been recognised by Health Ministers as a National Health Priority Area since 1986. Injuries remain a leading cause of death, illness and disability in Australia. This is despite dramatic advances in road safety over the past two decades and despite improvements in occupational safety and clinical care. Injuries resulted in 7,737 deaths in 1997 and approximately 405,000 episodes of in-patient hospital care in 1997/98¹. Health system costs in 1993-94 due to injury were estimated to be \$2,601 million². Whilst there has been reduction in death rates, the costs of morbidity (including long term disability) are increasing in some areas.

Indigenous Australians, young men, and people who live in rural and remote areas are at particularly high risk of injury. Injuries are the leading cause of premature, preventable death in Australia, and account for 47 percent of all deaths at ages under 45 years¹.

The cost to the nation is estimated to be over 13 billion dollars per year yet many injuries and their consequences are preventable³.

The National Injury Prevention Advisory Council (NIPAC) was established in 1997 to provide high level independent advice to the Commonwealth Department of Health and Aged Care and to Health Ministers through the National Public Health Partnership, on ways to reduce the incidence and severity of injury in Australia.

The *National Injury Prevention Plan: Priorities for 2001-2003 (the Plan)* represents a broad framework for national activity in the areas of high priority for immediate attention where the health sector can and should take a leading role. It is tightly focussed on a manageable number of priorities for immediate action. It recommends a focus

for coordination of work in these areas across jurisdictions and for identifying partnership opportunities across sectors. It was prepared by NIPAC in consultation with key stakeholders for implementation by Australian Governments and the non-government sector.

NIPAC has identified the following range of priority areas and populations for injury prevention in Australia:

Priority injury areas

- Transport-related injury
- Work-related injury
- Fall injury among older people and children
- Sport and recreation-related injury
- Interpersonal violence, intentional injury, self-harm and firearms
- Consumer safety
- Burns and scalds injury
- Poisoning in children
- Water safety
- Injury as a result of alcohol misuse

Priority Populations

- Males
- Socio-economically disadvantaged Australians
- People living in remote and rural areas
- Young males
- Children
- Indigenous Australians

NIPAC has identified **four priority areas for immediate action** by the health sector to be undertaken under the *Plan*. These are prevention of:

- falls in older people;
- falls in children;
- drowning and near drowning; and
- poisoning in children.

These priorities were chosen on the basis of the following criteria:

- evidence of injury burden and potential gains;
- effectiveness, cost-benefit and acceptability of a range of interventions; and
- a clear and actionable role for the health sector.

In highlighting these injury issues, NIPAC was informed by a number of key reports, which should be read in conjunction with this *Plan*:

- *National Health Priority Areas Report on Injury Prevention and Control (1997)*;
- *Directions in Injury Prevention. Report 1: Research Needs (1999)*; and
- *Directions in Injury Prevention Report 2: Prevention Interventions – good buys for the next decade (1999)*.

Road crashes and other transport accidents as well as suicide and self inflicted injuries are the major causes of injury in Australia. Nevertheless, based on assessment against the selection criteria, these areas have not been included as priority areas for immediate action.

Leadership in these areas is provided as follows:

- Road injury, through *the National Road Safety Strategy* through the Australian Transport Safety Board;
- Workplace injury, through the National Occupational Health and Safety Commission; and
- Suicide and self-harm through the *National Suicide Prevention Strategy* through the Mental Health Branch of the Commonwealth Department of Health and Aged Care.

In addition States and Territories have strategies and organisations that have responsibility for these issues.

In each of these areas NIPAC supports complementary activities, especially where there are common populations at risk (for example, young people and Indigenous people) or common risk factors (such as poisoning, firearms etc).

The *Plan* is strongly focussed on areas where interventions are possible, effective, able to be implemented and where the leadership required is clearly the responsibility of the health sector.

Some areas of injury have received little attention or evidence on effective interventions. For example, in areas such as injury in young males, where there is little evidence to support actions that are successful in reducing risk-taking behaviour, further work during the term of the *Plan* is warranted and encouraged. Once identified, effective, sustainable interventions should be considered for national implementation in the future.

Indigenous Australians

A complementary *Plan* will be developed to address the priority issue of injury prevention for Indigenous Australians. This approach has been adopted to enable a more intensive process of consultation to take place with representative groups to ensure that the particular issues and needs experienced by Indigenous Australians are addressed. The *Plan* for Indigenous Australians will propose interventions for immediate attention, as well as addressing infrastructure and capacity building.

Continuing efforts across the injury prevention spectrum

There is considerable activity in injury prevention across all jurisdictions, which continues to provide a broad context for the initiatives outlined in this *Plan*. While it presents the four priority injury prevention areas for immediate national focus, it is expected that core national activities undertaken by key stakeholders (including Commonwealth, State and Territory, and Local Governments, professional bodies and non-government organisations) will continue across the broad spectrum of injury areas and populations.

The *Plan* does not diminish the importance of other activities that are identified as priorities within individual jurisdictions.

Infrastructure building for a longer term perspective

In addition, it is recognised that in order to impact on complex injury issues in both priority and general areas, a strategic approach to building capacity and infrastructure for the longer term is necessary. Successful injury prevention is reliant on the related priority injury

control issues of post-injury management, which includes trauma care, rehabilitation and long-term care, and infrastructure development, including education and training, information systems and research.

Accordingly, the strategic approach reflected in the *Plan* draws from the framework provided in the *National Health Priority Areas Report* which emphasises the importance of building capacity in the following areas:

- workforce;
- standards;
- research; and
- data and monitoring.

This document provides some background material on injury as a National Health Priority and proposes actions on each of four priority injury prevention issues selected for immediate attention.

Target audience

The *Plan* has been prepared for the endorsement of Health Ministers and health system managers. The *Plan* aims to assist them in setting priorities and allocating resources in their jurisdictions, within a national framework for action.

Implementation of injury prevention activities can deliver significant savings to the health system, particularly the acute care and rehabilitation systems.

The *Plan* could be implemented through individual or collaborative efforts involving key stakeholders such as the Commonwealth, State and Territory Governments, the non-government sector and members of the community (See *Appendix 1* for a listing of Key Stakeholders).

2. National Injury Prevention Plan: Priorities for 2001-2003

– Overview and Implementation

Goal

The goal of the *Plan* is to reduce the incidence and impact of injuries on the health and wellbeing of the Australian population in the four priority areas for immediate action.

Context

The *Plan* takes account of the nature, extent and distribution of injury in Australia, the potential for health gains, and the numerous sectors, activities and organisations that define the setting in which the *Plan* will be implemented.

The incidence of injury is not evenly spread across population groups. The peak frequency is in adolescent and young adults, particularly males, while the peak rate is in older persons. Other high risk populations include Indigenous people, males (particularly young males), socio-economically disadvantaged Australians, and people living in remote and rural areas. Activities under this *Plan* should acknowledge these populations as priorities for intervention.

Injury is a particularly significant issue in Indigenous communities and is influenced by a broad set of social, economic, health and environmental factors. In recognition of this, strategies that go beyond the four priority injury prevention issues of this *Plan* will need to be developed. While it is suggested that appropriate injury prevention responses are implemented through this *Plan*, injury prevention issues for Indigenous

communities should also be developed more broadly through collaboration with key stakeholders, including Indigenous health workers, non-government organisations, policy makers, funding bodies and community members.

NIPAC believes there are clear benefits to implementing national action initially in the proposed four priority areas. Injury is a health issue that crosses State and Territory boundaries and concerted efforts are required to reduce its impact on the health of Australians.

It is important to note that while the *Plan* focuses on primary prevention, adequate acute care and rehabilitation services are essential in ensuring better health outcomes for those people who do suffer injury. These services can influence the risk of further injuries, for example in the area of falls and older people.

Implementation Objectives

The *Plan* aims to:

- Focus national injury prevention efforts towards four priority issues;
- Strengthen national infrastructure to improve knowledge of injury and to implement injury prevention activities; and
- Promote evidence-based, sustainable injury prevention interventions to the health system, other sectors and the broad community.

Roles and Responsibilities – Key Stakeholders

The effectiveness of the *Plan* depends upon cooperation between and within a wide range of sectors, including government and non-government agencies, business and industry, professional groups and the community. Enhanced partnerships, collaboration and information sharing will be key

elements in ensuring the success of the *Plan*. The roles of the key stakeholders are outlined below and are also listed in *Appendix 1*.

The range and diversity of key stakeholders indicates the considerable expertise and opportunity that exist across the field of injury prevention. The use of resources across jurisdictions and sectors can be maximised through partnership approaches, with collaboration ensuring minimum duplication of effort and the best value for money outcomes.

Commonwealth

The Commonwealth Government through the Department of Health and Aged Care has a lead agency role to:

- stimulate intersectoral action at Commonwealth level;
- report against the National Public Health goals and targets; and
- provide national leadership in and coordination of Australia's response to the prevention of injuries.

Some of the strategies available to the Commonwealth include:

- developing and strengthening partnerships and links within and across Commonwealth portfolios, across jurisdictions and with national peak organisations;
- supporting nationally relevant research through programs such as those of the National Health and Medical Research Council (NHMRC);
- promoting evidence based research and best practice;
- piloting, developing and evaluating nationally applicable programs that show promise of effectiveness and efficiency;
- formulating national policy;

- commissioning initiatives that are most appropriately undertaken on a national basis;
- promoting the development of the injury prevention workforce;
- undertaking nationally focussed public awareness activities;
- developing standards and benchmarks for performance in injury prevention;
- supporting national data collection and surveillance; and
- providing secretariat, policy assistance and support for national committees.

With funding allocated in the 1999/2000 Budget, the Commonwealth also has responsibility for implementing a range of policy responses over the four year period to 1999/2003 to address the problem of falls injury among older people.

National Injury Prevention Advisory Council

NIPAC has provided advice to the Commonwealth Department of Health and Aged Care on ways to reduce the incidence and severity of injuries at the national level. NIPAC brought together a broad range of expertise and views of key constituents in the injury prevention field to advise Health Ministers through the NPHP on priorities for action. In the next phase, Health Ministers will require advice on implementation of the *Plan*.

State and Territory Governments

State and Territory Governments are responsible for providing leadership at the level of their jurisdiction. Their responsibilities include:

- investigating, analysing and monitoring injury data within their jurisdictions;
- identifying injury trends and opportunities for collaborative action;

- maintaining state-wide stakeholder forums to advise on injury prevention strategies;
- developing, implementing and evaluating appropriate policy;
- reporting against the objectives of the *Plan*;
- promoting sound injury prevention practice within existing services;
- developing, delivering and evaluating a range of specific injury prevention activities;
- providing workforce infrastructure and training;
- working in collaboration with local government to promote safety and prevent injury in the community;
- funding research and program delivery in response to locally identified needs; and
- managing legislation and regulations.

Local Government

Local government is well placed to:

- initiate opportunities to promote safety and injury prevention;
- coordinate health and safety issues at the local level;
- promote community safety;
- develop strategic partnerships;
- develop appropriate road safety plans and strategies;
- conduct safety audits of childcare and family daycare facilities;
- conduct public risk assessments in conjunction with community advisory groups particularly for older people and in recreation; and
- coordinate plans with the aim of minimising public risk.

The World Health Organization's Global Program on Injury and Violence Prevention has a safety promotion program focussed on local government/community. There are a number of demonstration sites and communities in various locations as well as affiliated support centres in Australia. These include specific programs that promote community involvement in injury reduction and safety promotion⁴.

Through their role in purchasing and providing services and infrastructure ranging from home and community care to playgrounds, sporting facilities, roads and footpaths, local governments have the ability to significantly influence the wellbeing and safety of their community members. The integration of local area planning provides the opportunity to develop and implement community-wide injury prevention mechanisms.

Partnership between the Commonwealth, State and Territory Governments

There is an evolving and strengthening partnership between the Commonwealth, State and Territory Governments in the injury prevention field. Australian Health Ministers agreed on the importance of injury by making injury prevention and control one of the National Health Priority Areas. The National Public Health Partnership, which provides a national policy framework for public health in Australia, also includes injury prevention on its agenda. Government health departments work in partnership with other sectors such as transport, occupational health and safety, sport and recreation, and consumer affairs to encourage sound policy development in those sectors.

All States/Territories and the Commonwealth have been represented on NIPAC, and at the State and Territory Injury Managers Forum. Jurisdictions will have a key role in overseeing the implementation of the *Plan* in the future.

Professional Bodies (research, medical, scientific, health and aged care)

Professional bodies (research, medical, scientific, health and aged care) play an important role in representing the professional interests of their members and the community.

They have essential roles including:

- educating and training their workforces;
- undertaking research, monitoring and data collection;
- engineering and design;
- implementing best practice;
- providing advice to their members and to governments;
- providing appropriate advice and information to their clients and the general public; and
- undertaking advocacy on behalf of their members and client groups.

Community-Based and Non-Government Organisations

Community-based and non-government organisations have a role in enhancing the ability of community members, on individual and collective bases, to take active responsibility for their own health and well-being. This is achieved through providing:

- advocacy on behalf of consumer groups;
- education and information;
- professional development and education;

- community consultation and representation;
- strategic partnerships with other organisations, the government, business and industry sectors; and
- development and implementation of strategies at a local level.

Private sector businesses and industry contribute to injury prevention and promotional activities within the workforce and wider community through mechanisms including:

- safe product design and promotion;
- active support for corporate health promotion initiatives, both within and outside of the work environment;
- standard setting;
- pursuing their public and employee health and safety statutory responsibilities;
- fostering innovations in areas such as engineering design, training and awareness and work organisation initiatives; and
- sponsorship of health initiatives.

Implementation Strategies

Particular activities under the *Plan* should be undertaken by sectors and jurisdictions that are best placed to achieve progress in these areas, recognising the range of experience, skill and knowledge that exists across the injury field.

It is recognised that not all stakeholders will be able to undertake all activities outlined in this *Plan* and that there is flexibility to select issues based on local priority, resources and expertise. This document aims to assist those choices and to give an overview of the roles of particular stakeholders.

The key to implementing the *Plan* will be collaboration between all jurisdictions and provision of adequate resources to enable delivery of effective programs. A collaborative approach can achieve a high degree of national consistency in policy and program development and also allow individual jurisdictions the flexibility to pursue specific priorities and local projects.

The major focus of activities is the involvement and leadership of the health sector, with a clear recognition of the need to promote intersectoral involvement. In addition to government agencies, many human resources and much expertise and goodwill for injury prevention exist in non-government organisations and the community.

Implementation of the actions outlined in this *Plan* may be through individual or collaborative efforts involving a range of key stakeholders such as the Commonwealth, State and Territory Governments, the non-government sector and members of the community.

In the field of injury prevention, a number of concurrent strategies can be utilised to reduce the rate and severity of injuries.

These include:

- legislation, regulation and standards;
- enforcement and promotion of compliance;
- public education and health promotion;
- changing the physical environment;
- intersectoral collaboration;
- developing policy that promotes injury prevention;
- improving the evidence base through research and evaluation;

- product and building design; and
- workforce development.

Through a collaborative approach, implementation of the *Plan* will apply the following health promotion approaches:

- promote evidence based practice;
- identify areas where legislation, regulations and standards would be effective and where existing legislation could be improved;
- build on and create links with other strategies;
- improve workforce development;
- strengthen existing partnerships;
- enhance information and surveillance;
- increase community understanding of the causes and impact of injury, and prevention strategies; and
- optimise the use of the nation's available resources by applying evidence about potential gains, effectiveness, cost-benefit and acceptability.

Monitoring and Evaluation

A comprehensive evaluation strategy based on performance indicators will be developed in collaboration with key stakeholders to inform and guide the continuous improvement of injury prevention activities under the *Plan*. Information from surveillance and monitoring is essential for implementation of the *Plan* as a whole and for action in each priority injury prevention area. Coordination between injury surveillance facilities and the health sector should be maintained. Ongoing liaison with the National Public Health Information Working Group and alignment of initiatives with the National Public Health Information Development Plan is recommended.

The monitoring and evaluation strategy will include assessment of initiatives implemented to address injury prevention issues, the impact and outcomes of these initiatives on the various target groups, and outcomes in terms of these initiatives. Measurement of progress towards Year 2000 targets as outlined in *National Health Priority Areas Injury Prevention and Control Report – 1997* will be undertaken for the four immediate priority areas (falls in older people, falls in children, poisoning in children and drowning) included in the evaluation strategy². The *Plan's* success in building the nation's capacity to address longer term issues that require complex preventive action should also be considered in the evaluation.

New and untested interventions will be evaluated for safety, effectiveness, cost and acceptability. For established interventions, evaluations will focus on the quality of implementation rather than on re-testing effectiveness. All stakeholders involved in implementation of activities under the *Plan* should be responsible for evaluation of those activities. State and Territory Governments will be responsible for the evaluation of activities implemented in their jurisdictions and the Commonwealth will be responsible for evaluating key national activities as well as for measuring overall effectiveness in relation to the National Public Health goals and targets.

Links with other National Strategies and Programs

While injury prevention is an issue that clearly can be promoted through focussed, national strategic action, there are areas where coordination with other national initiatives would be beneficial to deliver the most effective outcomes.

These include:

- Acting on Australia's Weight
- Active Australia: a National Participation Framework
- Child Safety on Farms Strategy
- Commonwealth, Falls in Older People Initiative
- National Aboriginal Health Strategy
- National Plan for Suicide Prevention
- National Alcohol Strategic Plan
- National Crime Prevention Strategy
- National Diabetes Strategy
- National Drug Strategy
- National Environmental Health Strategy
- National Health Plan for Young Australians
- National Mental Health Strategy
- National Occupational Health and Safety Framework
- National Public Health Nutrition Strategy
- National Road Safety Strategy
- National Sport Safety Framework
- National Strategy for an Ageing Australia
- National Water Safety Plan
- National Youth Alcohol Campaign
- National Youth Suicide Prevention Strategy
- Quality Use of Medicines Evaluation Program
- The Safety Code of Practice for Nursery Products

It should be noted that there a number of programs and strategies at a State and Terriotry level that also impact on the *Plan*.

3. Falls in Older People

Objective

To decrease the incidence, severity, morbidity and mortality associated with falls of older people in community, residential aged care and acute care settings.

Falls in older people was chosen as a priority for immediate action on the grounds of strong burden of injury evidence, and demonstrated high cost to the health system, as well as a strong evidence base of promising and proven interventions that could be implemented by the health sector. In addition the ageing of the population gives added impetus to developing appropriate interventions to reduce the incidence and severity of injuries due to falls.

Size of the problem

Falls are of particular concern for people aged over 65 as they account for the largest proportion of all injury related deaths and hospitalisations. As Australia's population is ageing, the cost of these injuries, both in social and economic terms, is set to rise unless risks can be reduced.

In Australia in 1997, falls by persons aged 65 and above caused 997 deaths and over 32,000 injuries resulting in admission to a hospital. The rate of deaths associated with falls in 1997 was 5/100,000 population at ages 65 to 69, rising to 13/100,000 at 70 to 74 years, 26/100,000 at 75 to 79, 81/100,000 at 80 to 84 and 242/100,000 among persons aged 85 years and over⁵. Rates of cases admitted to a hospital show a similar steep rise with age.

These cases are expensive for the hospital system because they are numerous and patients tend to spend long periods in hospital. In 1996/97 cases due to falls accounted for 42 percent of all bed-days occupied by persons aged 65 and older for conditions due to external causes.

Target Populations

The key target populations for interventions in this area are older people including those:

- older people who are well living independently in the community;
- living with some assistance in the community;
- living in residential care facilities; and
- undergoing treatment in acute care settings.

Key Stakeholders

- Allied health professionals
- Building, retail, manufacturing and pharmaceutical industries
- Commonwealth government (including, Department of Veterans Affairs, Australian Building Codes Board, Aged Care Standards and Accreditation Agency)
- Divisions of General Practice
- Fitness and recreational bodies
- Health and Community Care service providers
- Local government
- Older persons' advocacy groups
- Older persons' community groups
- Researchers
- Residential care providers
- Royal Australian College of General Practitioners
- Royal Australian College of Physicians
- Geriatricians and Gerontologists
- State and Territory governments
- Workforce education/training organisations.

The direct cost to the Australian health care system of falls at ages 65 and older in 1993/94 has been estimated at \$406 million, of which \$212 million was the cost of hospital in-patient care. These costs are 20 percent and 16 percent respectively of the equivalent costs for all conditions due to external causes at all ages⁶.

It has been estimated that direct costs to other sectors were \$688 million in 1995/96. Allowing for indirect costs (such as lost productive capacity), the estimated total lifetime cost of cases that occurred in 1995/96 is more than \$1,080 million⁷.

Current situation

There is a wide range of activity across all jurisdictions in preventing falls for older people. The Commonwealth Department of Health and Aged Care has commenced a program to establish and disseminate best practice falls prevention and management for older people. The Program will run for the life of this *Plan*. Home assessment is available nationally through Aged Care Assessment Teams (ACATs) and some home modification assistance is provided on a means tested basis through Home and Community Care (HACC) services. Some jurisdictions provide additional support for home modifications. The Commonwealth Department of Veterans' Affairs (DVA) administers HomeFront, a falls and accident prevention program designed to provide practical help to veterans in the home, for which approximately 354,000 veterans are eligible⁸. In addition, falls are identified as a major source of injury in acute care settings and are a focus of the quality assurance and risk management programs at Commonwealth, State and health unit levels.

State and Territory Governments provide support for programs such as community awareness, exercise and education for health professionals. Work is being undertaken across sectors, such as with the housing industry and with local government, to reduce environmental risk factors for falls. Research and data collection is undertaken by the Commonwealth, States and Territory governments.

Links to National Strategies and Programs

- Acting on Australia's Weight
- Active Australia: A National Participation Framework
- Commonwealth Enhanced Primary Care Package
- Aged Care Assistance Program (Aged Residential facilities and ACATs)
- Home and Community Care Program
- Medicare – Primary Care Sector Reform
- Falls prevention for Older People Initiative
- Commonwealth/State Health Care Agreements - acute care
- Department of Veterans' Affairs programs eg HomeFront
- National Alcohol Strategic Plan
- National Diabetes Strategy
- National Drug Strategy
- National Environmental Health Strategy
- National Mental Health Strategy
- National Public Health Nutrition Strategy
- National Strategy for an Ageing Australia
- National Tobacco Strategy

It is important that programs and interventions developed for older people are based on collaborative health promotion approaches. They should take account of the diversity of older people, ranging from those who are well, independent and active to those with complex care needs. Older people should have opportunities to provide input and influence program development, and be treated with the dignity and respect afforded to any other groups.

Proven and promising interventions

The available evidence supports the use of individual risk assessment and targeted intervention strategies. There is some evidence that strength and balance programs alone reduce the risk of falls and falls injury. Research is currently underway to provide additional information about the efficacy of other specific components of multifactorial strategies and home hazard reduction alone.

People in residential aged care facilities are at high risk of falling, partly because of their age and health. Interventions such as individual risk assessment and personalised programs to target risk factors have been shown to be effective. The use of hip protectors may also be beneficial. Evidence indicates that vitamin D in combination with calcium may have positive effects in reducing the risk of hip fracture in nursing home residents.

Pharmaceutical and exercise related interventions for amelioration of osteoporosis could be addressed to meet the needs of people who are older now, and as a longer term prevention for future cohorts of older people.

There is a clear need for the identification of effective evidence-based strategies to prevent falls and falls injury in the community setting and particularly in the acute care and residential settings to ensure wide-spread and long-term gains.

Outcomes

- Decreased incidence, severity, morbidity and mortality associated with falls in community, residential aged care and acute care settings;
- Increased uptake of best practice activities in falls injury prevention in all sectors including use of safety features to reduce falls within housing and residential aged care;
- A range of best practice activities identified, implemented, evaluated and promoted;
- An increased awareness by management and workers in acute and residential aged care and community settings of the issues relating to falls injury prevention and an understanding of prevention strategies;
- Increased community awareness of falls injury prevention strategies;
- Increased integration of planning at a local level involving local government and urban planners with the health sector to address environmental and design risk factors for falls;
- Improved training and education for the health, community care and residential aged care workforces to improve competencies and knowledge in falls prevention and falls injury management;
- Increased use and availability of prevention and referral processes available through the health system;

Strategies

Best practice in community settings

- Promote programs of falls prevention and falls injury prevention that encourage exercise with a particular focus on strength and balance, and medication review through State and Territory and local government programs;
- Develop and promote public education programs based on best practice;
- Increase the role of General Practitioners through the health assessments available under the MBS for people aged 75 and over (55 and over for people of Aboriginal or Torres Strait Islander descent);
- Continue to increase medication review and management initiatives in partnership with Divisions of General Practice and the Royal Australian College of General Practitioners;
- Educate General Practitioners and older people about the risks and benefits of a reduction in psychotropic medications;
- Work with the medical profession to promote the early identification, primary prevention and treatment of osteoporosis;
- Continue to work with the Australian Building Codes Board to improve the safety of public and private environments for older people;
- Assist people who are currently well to acknowledge the risk of falling as they grow older and to take preventive action; and
- Identify and respond to the special needs of rural and remote, Indigenous communities and people from culturally and linguistically diverse backgrounds.

- The regular use of effective falls injury prevention management plans and other strategies in residential aged care and acute care settings; and
- Improved data collection on falls of those aged over 65 in the community, acute and residential aged care settings.

Example of collaboration among key stakeholders

Falls Prevention for Older Residents of the City of Whitehorse

A joint study between the City of Whitehorse, and the Monash University Accident Research Centre was conducted with funding and general support from Rotary, the National Safety Council, the National Health and Medical Research Council, Victorian Health Promotion Foundation and the Department of Human Services Victoria.

This project is a randomised controlled trial with factorial design, involving the systematic implementation and evaluation of three countermeasures: removal of hazards around the home, improved vision and exercise to improve balance.

Best practice in acute care settings

- Improve trauma management;
 - Promote the use of rehabilitation strategies for older people leaving acute care;
 - Promote individual risk assessments prior to discharge for all older people hospitalised as a result of a fall;
 - Raise the awareness of falls prevention and falls injury management in staff and management of acute care facilities;
 - Modify practices and protocols to reflect best practice in risk management and falls prevention;
 - Include injury prevention competencies in appropriate education and training programs; and
 - Improve surveillance of falls in hospitals through monitoring and recording of adverse events.
- Identify best practice from current programs and emerging research;
 - Establish performance indicators for the achievement of the objectives of this priority area;
 - Undertake cost benefit analysis of falls prevention and falls injury interventions in the community, acute care and residential care settings;
 - Develop and validate risk management strategies in residential and acute care settings; and
 - Identify gaps in falls prevention knowledge and commission research, conduct trials and promulgate best practice to all stakeholders.

Best practice in residential care settings

- Integrate best practice with accreditation and quality assurance mechanisms in residential care facilities;
- Pilot and evaluate projects examining hip protectors, vitamin supplements, gentle exercise and restraint reduction to build the evidence base for use in residential care settings;
- Raise the awareness of falls prevention and falls injury management with staff and management of residential care facilities; and
- Include injury prevention competencies in appropriate education and training programs.

Research and surveillance

- Ensure that statistical systems are adequate to provide necessary epidemiology data on falls prevention in older people and that good use is made of this data;

Targets

Targets and performance indicators in relation to the proposed strategies will be developed in the implementation phase.

4. Falls in children

Objective

To decrease the incidence, severity, mortality and morbidity associated with falls in children between the ages of 0-14.

Falls in children was chosen as a priority for immediate action on the grounds that many fall injuries to children are preventable and that they represent a substantial burden of injury and cost to the health system. There is sufficient evidence to indicate that a number of promising and proven interventions have a high likelihood of success in reducing the incidence and severity of injury.

Size of the problem

Accidental falls are the leading cause of hospitalisations nationally due to injury among children aged 0 to 14 years, accounting for more than 23,000 cases in 1996/97 (38 percent of all injury cases in this age group). Falls were also responsible for eleven deaths at ages 0 to 14 years in 1997. The main locations for falls among children are at a home (49 percent) and at places for recreation and sport (29 percent)⁹.

The direct cost to the Australian health care system of falls at ages 0 to 14 years in 1993/94 has been estimated to be \$134 million, of which \$28 million was the cost of hospital inpatient care⁶. A cost estimate that also allows for direct costs to other sectors is \$246 million in 1995/96. Allowing for indirect costs (such as lost productive capacity), the estimated total lifetime cost of cases that occurred in 1995/96 is \$458 million⁷.

The factors involved in the occurrence of falls and fall injuries are associated with children's physical, cognitive and social development, physical environment and product design.

Target Populations

The key target populations for interventions in this area are children in the 0-14 year age group.

Key Stakeholders

- Building, retail and manufacturing industries
- Carers, parents, grandparents, other family members and friends
- Commonwealth Government (Australian Competition and Consumer Commission, Australian Sports Commission and Australian Building Codes Board)
- Consumer affairs organisations
- Farmsafe Australia
- Health Promoting Schools Association
- Home/Childcare Centres
- Kidsafe (Child Accident Prevention Foundation of Australia) and other child safety organisations and advocates
- Local government
- General practitioners and Paediatricians
- Researchers, including international researchers
- Standards Australia International Limited
- State and Territory governments
- Workforce education/training organisations

Common causal factors and circumstances of fall cases attending emergency departments are outlined in the table below.

Table 1: Main causes of/factors implicated in falls injury in children by age¹⁰

Age: 0 – 4 years	Age: 5 – 14 years
Nursery furniture	Playground equipment
Falls on the same level	Bicycles
Falls onto furniture	Sport
Stairs (falls down)	Bunk beds and other furniture
	Trampolines
	In-line skates
	Roller skates
	Skateboards

Current situation

The Commonwealth and some State and Territory governments work with and/or fund the Child Accident Prevention Foundation of Australia (Kidsafe), a non-government organisation that provides advice and information to the public on child safety and appropriate products. Significant progress has been achieved in increasing the capacity of nursery product industry to produce and promote safe furniture. This has come about through the efforts of Kidsafe, supported by government, and the cooperation of the industry.

Governments collaborate with organisations such as Standards Australia to improve standards of products such as children’s furniture and clothing, and soft fall surfaces for playground equipment. Some States and Territories fund additional projects including research, and work with education bodies to improve safety for children and the Australian Competition and Consumer Commission has commissioned research into product related child injuries. Data collection is undertaken in various ways across governments.

Links to National Strategies and Programs

- Active Australia: a National Participation Framework
- National Environmental Health Strategy
- National Health Plan for Young Australians
- National Youth Alcohol Campaign
- National Youth Suicide Prevention Strategy
- The Safety Code of Practice for Nursery Products
- Child Safety on Farms Strategy
- Child Care Assistance Program
- Pre-School and Primary level education programs

Outcomes

- Decreased incidence, severity, mortality and morbidity associated with falls in children between the ages of 0-14 years;
- Increased uptake of best practice activities in falls injury prevention in all sectors including implementation of mandatory standards for bunk beds, development of a new standard for baby walkers, progress on soft fall surfacing and reduction of fall height for playground equipment;
- A range of developmentally appropriate interventions implemented, assessed and promoted;
- Increased community awareness of falls injury prevention strategies;

Proven and promising interventions

Product safety plays a key role in preventing falls in children. Safety standards have proven effective, although incentives to conform may be necessary where they are voluntary. Promotion of standards and safe practices have proven effective in improving safety outcomes in products such as cots and baby walkers¹¹.

Strategies

Promotion of best practice

- Work with State and Territory governments and local government to review legislation which impacts on the safety of children;
- Work with the relevant regulatory and standard setting bodies and key stakeholders to improve and strengthen product and environmental design and standards in areas like nursery equipment, soft fall surfacing and reducing fall height for playground equipment;
- Increase child safety awareness through local, State and Territory and national promotion and educational activities in conjunction with key stakeholders;
- Develop and implement a range of interventions targeted directly at children that are appropriate to their stage of development;
- Ensure that child safety competencies, including falls prevention, are included in education and training of the child care and education workforce;
- Implement risk management strategies in care settings, including schools, day care centres and family day care; and
- Respond to the special needs of rural and remote communities, Indigenous communities, people from culturally and linguistically diverse backgrounds and children with disabilities.

- Increased development and application of appropriate safety standards;
- Increased awareness of, interest in and capacity to address child safety issues by parents, carers, teachers and health workers, local governments, sports and product manufacturers and retailers, and other relevant agencies;
- Improve competencies and knowledge in fall prevention and falls management training and education for those who work with children;
- Improvements to the design of products and environments to enhance their safety for children; and
- Organisational changes in sport such as improved environments and modified rules.

Research and surveillance

- Ensure that statistical systems are adequate to provide necessary epidemiology data on falls in children and that good use is made of this data;
- Identify and promulgate best practice from current programs and emerging research;
- Establish performance indicators for the achievement of the objectives of this priority area;
- Undertake cost benefit analysis of falls prevention and falls injury interventions in a variety of settings, including the home, child care, schools, sport and recreation;
- Continue to enhance current injury surveillance systems such as those managed by States and Territories, emergency departments and sports injury collection systems;
- Identify gaps in falls prevention knowledge and commission research, conduct trials and promulgate best practice to all stakeholders; and
- Improve the specificity (detail) and application of the International Classification of Diseases.

Example of collaboration among key stakeholders

The Safety Code of Practice for Nursery Products – Safebaby Code

This project is a joint initiative of Kidsafe, the Infant Nursery Products Association of Australia and the Commonwealth Department of Health and Aged Care.

The Safebaby Code encourages consumers and industry to be aware of design features that prevent or minimise the risk of injury to infants and children. The Safebaby Code includes a Nursery Products Customer Guide, the Nursery Products Industry Guide and Safebaby swing tags. Retail products that comply with Safebaby will carry the swing tags.

Targets

Targets and performance indicators in relation to the proposed strategies will be developed in the implementation phase.

5. Drowning and near drowning

Objective

To reduce the rate of drowning and near drowning and consequent injury in Australia.

The health sector is committed to working with other sectors in the reduction of drowning and near drowning and consequent injury. Nearly all drowning deaths are preventable yet the rate of drowning, particularly in toddlers, remains high. Additional research has the potential to significantly impact on the ability to reduce the incidence of drowning and near drowning in the target populations. The high incidence of drowning in the target populations has also influenced the decision to include it as a priority for immediate action.

Size of the problem

In 1997 there were 431 drowning deaths in Australia. Of these, 276 were accidental drownings in circumstances such as swimming, diving and wandering or falling into bodies of water¹. (Drowning deaths related to water transport accidents are mentioned below). This group, comprising 217 males and 59 females in 1997, increased 10% from 1994 to 1997. Accidental drowning accounted for 3.6% of all injury deaths in 1997. In 1997, 18% of accidental drowning deaths occurred in a swimming pool and another 37% occurred while swimming somewhere other than in a swimming pool. Between 10% and 20% of drownings occur on beaches, the rest occur in rivers, dams, irrigation ditches, baths, buckets, and lakes¹².

The direct cost to the Australian health care system due to accidental drowning and immersion (at all ages) in 1993/94 has been estimated to be \$5.5 million, of which \$1.5 million was the cost of hospital inpatient care⁶. A cost estimate that also allows for direct costs

Target Populations

The key target populations for interventions in this area are:

- children 0-4 years of age; and
- young males 15-34 years of age.

Key Stakeholders

- Australian Water Safety Council
- Commonwealth Government (Industry, Science and Resources; Agriculture, Fisheries and Forestry, Australian Sports Commission)
- State and Territory governments
- Local government
- Water Safety Organisations
- Carers, parents, grandparents, other family members and friends
- Home carers/Childcare centres
- Police, emergency services and first aid agencies
- Researchers including international researchers
- Sport and Recreation organisations
- Teachers, including swimming teachers and coaches
- Water transport agencies
- Workforce education/training organisations
- Kidsafe
- Farmsafe Australia
- Child safety organisations and advocates

to other sectors is \$7.2 million in 1995/96, with a further \$125 million attributed as the indirect cost of drowning and immersion. Almost all of this indirect cost is a valuation of premature death (most drowning deaths occur at young ages).

The estimated total lifetime cost of accidental drowning and immersion in 1995/96 is \$132 million⁷.

A brief review of the epidemiology of drowning and near drowning shows that:

- drowning is the most common cause of injury death in 1-4 year olds. It accounted for 59 deaths in 1997, that is 30% of all injury deaths in this age group¹²;
- near-drowning episodes for children in the 0-4 year age group is a continuing problem;
- for every drowning it has been estimated that there are between four to ten hospital admissions for near drowning; between 5% and 10% of those admitted will suffer some neurological damage¹³;
- 41% of near-drowning occurs in swimming pools/spas, of which 39% are at residential locations¹²;
- in 1997, the all age drowning rate for males was 3.7 times the corresponding rate for females. The ratio is higher for young adults (eg. the male rate was nine times the female rate at ages 20-34 years)⁵;
- drowning is the fifth most common mechanism involved in the deaths of workers and is the major mechanism involved for workers in fishing and maritime occupations¹⁴;
- alcohol plays a significant causative role in drowning, particularly among males; and young males (15-24 years) are the highest risk group for diving into shallow water;
- of the 25 diving and related cases in 1995/96, 40% occurred in the surf, 20% in swimming pools and 40% in other water related accidents. In these cases near drowning is often accompanied by spinal injuries¹⁵.

Links to National Strategies and Programs

- Active Australia: a National Participation Framework
- National Drug Strategy
- National Occupational Health and Safety Framework
- National Sport Safety Framework
- National Water Safety *Plan*
- National Youth Alcohol Campaign
- National Youth Suicide Prevention Strategy
- Child Safety on Farms Strategy
- National Coronial Information System
- Swimming teaching programs at State and Local level

Example of collaboration among key stakeholders

In the early 1990s in Queensland, the departments of Health and Local Government, safety advocates and swimming experts developed the first regulation for fencing all domestic swimming pools with associated education programs, particularly on compliance and maintenance, as well as a water safety and resuscitation program called "Water wise". This was the first such legislation and promotion campaign in Australia.

The remaining 155 drowning deaths in 1997 included 73 cases recorded as suicide, 42 cases related to water transport accidents, and smaller numbers where drowning was of unknown intent, due to homicide or associated with a road crash¹.

Current situation

The health sector works with sport and water safety organisations to prevent drowning. The Australian Water Safety Council was established to facilitate a coordinated approach to drowning prevention.

The main emphasis has been on encouraging swimming training and water safety education for children, training in resuscitation, providing supervision and rescue patrols at swimming areas, and on encouraging safe enclosures of pools through legislation. Work has also been done on promoting safely fenced play areas for children on farms. Compliance with pool fencing legislation and maintenance of pool fencing has been poor in some jurisdictions.

Proven and promising interventions

There is scope to undertake comprehensive epidemiological studies of adolescent and adult drowning deaths in Australia to examine patterns, trends, risk and protective factors. Similar work can be applied to the area of serious spinal injury due to diving and water accidents. Specific types of drowning incidents could be studied such as scuba diving, boating and those involving tourists. A review of countermeasures, including pool fencing legislation, and comparative evaluation of their effectiveness would add to the evidence base in determining best practice. Promotion and subsequent increases in application of cardio-pulmonary resuscitation (CPR) could lead to a reduction in deaths from drowning. Swimming training programs for school age children are considered to be effective and are recommended. Alcohol is a major factor in increasing the risk of drowning among adolescents and young adults. Further work is required to develop and evaluate best practice interventions

Outcomes

- Reduced rate of drowning and near drowning and consequent injury
- Increased awareness among parents, carers, teachers and young males of the issues relating to prevention of drowning and near drowning and an understanding of prevention strategies
- Improvement in national data collection eg. link the circumstances of drowning or near drowning event with rescue and outcome data
- Improved evidence base related to drowning and near drowning
- Increased uptake of best practice activities in prevention of drowning and near drowning in all sectors
- Compliance with best practice pool fencing regulations and fencing and gate maintenance programs.

Strategies

Promotion of best practice

- Work with lead agencies at local, state and national level to promote water safety through promotional and education programs targeted particularly toward young males, for example the WA Water Police campaign focussing on alcohol and drowning;
- Continue to develop educational campaigns for the parents of young children;
- Widely promote the teaching of resuscitation and encourage the adoption of CPR as a necessary competency for those working with children;
- Work with local and State and Territory governments to promote standardised, best practice pool fencing legislation and improved compliance at the point of sale and home pool inspection services;
- Continue to support swimming as a healthy life skill;
- Promote appropriate programs of water safety targeted to rural and remote and Indigenous communities; and
- Provide educational material that is appropriate to people from culturally and linguistically diverse backgrounds, including international visitors and tourists.

Research and surveillance

- Ensure that statistical systems are adequate to provide necessary epidemiology data on prevention of near drowning and drowning and that good use is made of this data;
- Support the National Water Safety Plan and the establishment of the Australian Water Safety Research Committee;
- Establish performance indicators for the achievement of the objectives of this priority area;
- Evaluate the Western Australian pool inspection program;

- Improve the evidence base by analysing national and international research and data to determine best practice, and identify research, data collection and surveillance gaps, including diving into shallow water;
- Improve the collection of drowning and near drowning data through police incident reports, hospital admission data and the National Coronial Information System; and
- Evaluate proven and promising drowning prevention countermeasures targeting young males, including "black spots", restrict the sale of alcohol at aquatic facilities, prohibit advertising which mixes alcohol and water recreation.

Targets

Targets and performance indicators in relation to the proposed strategies will be developed in the implementation phase.

6. Poisoning among young children

Objective

To reduce morbidity and mortality associated with poisoning in children from medications, drugs and other substances.

Poisoning among young children is still at an unacceptably high rate. The problem lends itself to a variety of interventions which will reduce the incidence and severity of injury associated with poisons. Responsibility for many of the interventions lie with the health sector and they can be implemented in the timeframe of the *Plan*, hence the inclusion of poisoning among children as a priority for immediate action.

Size of the problem

Poisoning accounted for more hospital admissions of children aged 0 to 4 years in Australia in 1996/97 than any other major type of injury cause except falls. About 3,560 cases of poisoning at ages 0 to 4 years in Australia in 1996/97 required hospital admission. Of these, 71% were due to poisoning by pharmaceutical substances and 29% to poisoning by other substances.

The direct cost to the Australian health system due to poisoning sustained in children aged four years and younger in 1995/96 has been estimated to be \$36 million⁶. Allowing for indirect costs (such as lost productive capacity), the total estimated lifetime cost of these episodes of poisoning is \$58 million⁷.

A consistent observation from literature reviews is that childhood poisoning is a diverse issue. There are no single agents or agent groups that account for a large proportion of cases.

Target Populations

The key target population for interventions in this area is children in the 0-4 year age group.

Key Stakeholders

- Commonwealth Government (Therapeutic Goods Administration and Pharmaceutical Health and Rational Use of Medicines [PHARM]Committee)
- State and Territory governments
- Local government
- Poisons Information Centres
- Health Service Providers
- Divisions of General Practice
- Allied Health Professionals
- Regulatory bodies
- Workforce training/education organisations
- Pharmaceutical manufacturing industry
- OPAL Returned Unwanted Medicines Ltd
- First aid and emergency organisations
- Carers, parents, grandparents, other family members and friends
- Family Day Care/Childcare centres
- Researchers including international researchers
- Child safety organisations and advocates

What is known is that:

- medications are responsible for more than 70% of childhood poisoning;
- the incidence of childhood poisoning peaks at one and two years of age;
- there is a higher incidence in males in the majority of poisoning reports;
- poisoning mortality is low in this 0-4 age group; and
- the length of stay for hospital admissions is short (mean of 0.8 days, compared with mean of 3.0 days for other injury admissions in this age group).

Access to poisoning agents is not as well documented as the incidence of poisoning. Some work has been done on access to agents such as eucalyptus oil, rodenticides, benzodiazepines, tricyclic anti-depressants and paracetamol.

Poisoning among children is a priority for this *Plan* due to its high incidence. In addition, information is available on proven and promising interventions on which to soundly base strategies.

Current situation

Governments support a range of projects to reduce child poisoning, including development of position papers, training and pilot programs. They also support safety centres and child safety organisations that provide services and information to the public such as Kidsafe and Giddy Goanna Child Health and Safety Program. The work of the Poisons Information Service is supported by Commonwealth, State and Territory governments.

Proven and promising interventions

Child-resistant packaging (augmented with safe storage) has been demonstrated to be the most effective intervention in childhood poisoning.

Links to National Strategies and Programs

- National Health *Plan* for Young Australians
- National Environmental Health Strategy
- National Mental Health Strategy
- Quality Use of Medicines Evaluation Program
- Child Care Assistance Program
- Commonwealth/State Health Care Agreements
- Pharmaceutical Benefits Schedule
- Medicare/Enhanced Primary Care Package
- Aged Care Programs, including HACC

Example of collaboration among key stakeholders

The Commonwealth has funded a national pilot medicine disposal project, established by OPAL Return Unwanted Medicines Ltd. The program is expected to become self funding within three years through industry sponsorship, brokerage fees and local government sources. Medications are responsible for 70% of childhood poisonings. Encouraging the removal of unwanted medicines from the home reduces exposure to the risk of poisoning of both children and adults.

Improvements to the coding systems used to collect hospital separations data could result in better identification of the agents involved in poisonings. In addition, information is needed on children's mode of access to medications. International data and practice comparisons should be examined to determine best practice in prevention.

Strategies

Information and treatment for victims of poisoning

- Review the role and operations of Poisons Information Services and enhance their preventive role;
- Provide current first aid information to parents, carers, childcare centres, and schools; and
- Develop appropriate pathways and protocols for hospital admissions following children's access to poisons.

Improved packaging and storage of dangerous substances

- Identify further areas of risk and develop strategies to address these through packaging and storage guidelines and regulations;
- Encourage removal of unwanted and expired medicines from the home and carer environments before they can do harm; and
- Ensure compliance with best practice packaging guidelines, including generic products and over the counter medicines.

Promotion of best practice

- Educate parents, grandparents and carers about compliance with best practice storage guidelines;
- Map activities and best practice in poisoning prevention in all jurisdictions to determine scope of current and past work and projects;

Outcomes

- Reduced morbidity and mortality associated with poisoning in children from medications, drugs and other substances
- Increased community uptake of preventive activities related to poisoning and young children
- A range of best practice interventions implemented, assessed and promoted
- Improvement in national data collection on poisoning
- An increased awareness of the issues relating to prevention of poisoning and an understanding of prevention strategies among parents and other carers of young children
- Increased uptake of best practice activities in prevention of poisoning in all sectors

- Analyse national and international best practice activities and inform stakeholders;
- Work with key stakeholders including non-government organisations, the Poisons Information Service, Therapeutic Goods Administration (TGA), pharmacists and educators to enhance prevention activities for childhood poisoning through local, state and national promotion and education activities; and
- Respond to the needs of rural and remote, Indigenous communities and people from culturally and linguistically diverse backgrounds with appropriate programs.

Data and surveillance

- Ensure that statistical systems are adequate to provide necessary epidemiology data on prevention of poisoning among young children and that good use is made of this data;
- Encourage and support the developments necessary to enable reliable monitoring of injury occurrence, with particular reference to the identification of specific causative agents and national injury indicators and priority topics;
- Establish performance indicators for the achievement of the objectives of this priority area; and
- Develop a national pool of injury data for case description and research into risk factors and prevention.

Targets

Targets and performance indicators in relation to the proposed strategies will be developed in the implementation phase.

Appendix 1 - Key Stakeholders

Stakeholder	Roles and responsibilities in relation to the National Injury Prevention Plan: Priorities for 2001-2003
The community	<p>The general population and priority populations including:</p> <ul style="list-style-type: none"> • Indigenous Australians; • Males; • Socio-economically disadvantaged Australians; • People living in remote and rural areas; • Young males; and • Children.
Community based and non-government organisations	<p>These bodies contribute to:</p> <ul style="list-style-type: none"> • Advocacy on behalf of consumer groups • Community consultation and representation • Development and implementation of strategies at a local level. <p>They include (and are not restricted to):</p> <ul style="list-style-type: none"> • Aged and Community Services Australia; • Association of Independent Retirees; • Australian Consumers' Association; • Australian Federation of Child Care Associations; • Australian Health Promoting Schools Association; • Australian Pensioners and Superannuants Federation (AP&SF); • Australian Water Safety Council; • AUSTSWIM;



	<ul style="list-style-type: none">• Carers Association of Australia;• Council on the Ageing (Australia);• Farmsafe Australia;• Federation of Ethnic Communities Council;• Geriaction;• Giddy Goanna Child Health and Safety Program;• Infant Nursery Products Association of Australia;• Child Accident Prevention Foundation of Australia (Kidsafe);• National Aboriginal Community Controlled Health Organisation (NACCHO);• National Rural Health Alliance;• National Seniors' Association;• Recfish;• Royal Life Saving Society Australia;• State Emergency Service volunteers;• Surf Life Saving Australia; and• Victoria Safe Communities Network.
<p>Professional groups particularly in health and related fields</p>	<p>These groups have various roles including:</p> <ul style="list-style-type: none">• education and training of their workforce;• monitoring and data collection;• implementing best practice;• providing advice to their members and to governments; and• advocacy on behalf of their members and client groups. <p>They include (and are not restricted to):</p>

- Australian Association of Gerontology;
- Australian Building Codes Board;
- Australian Divisions of General Practice;
- Australian Injury Prevention Network;
- Australian Medical Association;
- Australian Nursing Federation;
- Australian Physiotherapy Association;
- Australian Red Cross;
- Australian Society for Geriatric Medicine;
- Centre for Education and Research on Aging;
- Geriacton;
- Pharmaceutical Manufacturers' Association of Australia;
- Pharmaceutical Society of Australia;
- Pharmacy Guild of Australia;
- Poison Information Centres;
- Proprietary Medicines Association of Australia;
- Royal Australian College of General Practitioners;
- Royal Australian College of Physicians;
- Sports Medicine Australia;
- Sportsafe Australia;
- St John Ambulance Australia;
- The Royal College of Nursing Australia;
- Union bodies; and
- University and professional education centres.



Business and industry	<p>The private sector contributes to injury prevention and promotional activities within the workforce and wider community through mechanisms including:</p> <ul style="list-style-type: none">• ensuring safe design of products and environment by referring to existing national or international safety standards or examples of best practice;• sponsorship of significant health initiatives or organisations such as Kidsafe and the Royal Life Saving Society Australia;• innovative and active support for corporate health promotion initiatives;• actively pursuing their public and employee health and safety statutory responsibilities; and• championing innovations in areas such as engineering design, training and awareness and work organisation initiatives. <p>Specific stakeholders include (and are not limited to):</p> <ul style="list-style-type: none">• residential aged care providers;• manufacturers and retailers;• builders;• fitness, recreation and leisure industry;• pharmaceutical companies; and• alcohol industry.
Local governments	<p>Local governments are well placed to:</p> <ul style="list-style-type: none">• coordinate health and safety issues at the local level; and

	<ul style="list-style-type: none"> • work towards the establishment of safe communities.
State and Territory Governments	<p>Jurisdictional governments are responsible for the delivery of injury prevention interventions including:</p> <ul style="list-style-type: none"> • policy development and implementation; • service delivery such as Parent Information Centres and HACC services; • evaluation; and • managing legislation and regulations such as pool fencing.
Commonwealth Government – through the Department of Health and Aged Care	<p>The Department of Health and Aged Care has a lead agency role to:</p> <ul style="list-style-type: none"> • stimulate intersectoral action at Commonwealth level; and • provide national leadership in and coordination of Australia’s response to the prevention of injuries.
Australian Institute of Health and Welfare (AIHW)	<p>The AIHW is an independent statistics and research agency within the Health and Aged Care portfolio. Through the National Injury Surveillance Unit it manages injury statistics and surveillance issues.</p>
The National Health and Medical Research Council (NHMRC)	<p>The NHMRC has an interest in ensuring an adequate research base for injury control, commensurate with the magnitude of the problem.</p>



<p>The National Public Health Partnership was established by Health Ministers to improve collaboration and coordination in public health efforts across the country.</p>	<p>The National Public Health Partnership, managed by the National Public Health Partnership Group, is made up of Chief Health Officers or Directors of public health in each jurisdiction, executive members of the NHMRC and the AIHW. It has developed a rolling three year work program. The work program covers areas such as public health research and development, public health information development, public health legislation, public health planning, building the public health workforce and a number of public health priority areas such as mental health and food safety.</p>
<p>The National Health and Priority Committee (NHPC) aims to improve health outcomes in the National Health Priority Areas (NHPAs).</p>	<p>The NHPA initiative emphasises collaborative action and targets specific areas that impose high social and financial costs on Australian society. The National Health Priority Committee monitors and evaluates health outcomes using health goals and targets as indicators.</p>
<p>The National Injury Prevention Advisory Council (NIPAC) was formed in late 1997 by the Commonwealth Department of Health and Aged Care. The Chair of NIPAC was appointed by the Minister for Health and Aged Care.</p>	<p>NIPAC has provided advice to the Commonwealth Department of Health and Aged Care on ways to improve the prevention of injuries at the national level, and has developed the <i>National Injury Prevention Plan: Priorities for 2001-2003</i>.</p> <p>NIPAC completed its term in October 1999.</p>

Appendix II – Abbreviations

ACAT	Aged Care Assessment Unit
AIHW	Australian Institute of Health and Welfare
DVA	Department of Veterans' Affairs
HACC	Home and Community Care
MUARC	Monash University Accident Research Centre
NACCHO	National Aboriginal Community Controlled Health Organisation
NHPA	National Health Priority Area
NHPC	National Health Priority Committee
NHMRC	National Health and Medical Research Council
NIPAC	National Injury Prevention Advisory Committee
OATSIH	Office of Aboriginal and Torres Strait Islander Health
TGA	Therapeutic Goods Administration

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