
THE DRAFT NATIONAL INJURY PREVENTION PLAN

2004 Onwards

August 2004





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August 2004



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With the kind permission of the New Zealand Accident Compensation Corporation (ACC), this document draws heavily from the New Zealand Injury Prevention Strategy (October 2002) ISBN 0-478-27904-3, www.nzips.govt.nz

Some concept ideas have been adapted from the Canadian Injury Prevention Strategy: Canadian Collaborating Centers for Injury Prevention and Control *Developing an integrated Canadian Injury Prevention Strategy*. www.injurypreventionstrategy.ca accessed May 26, 2004

Figure 1: Elements of the Australian Injury Prevention Plan

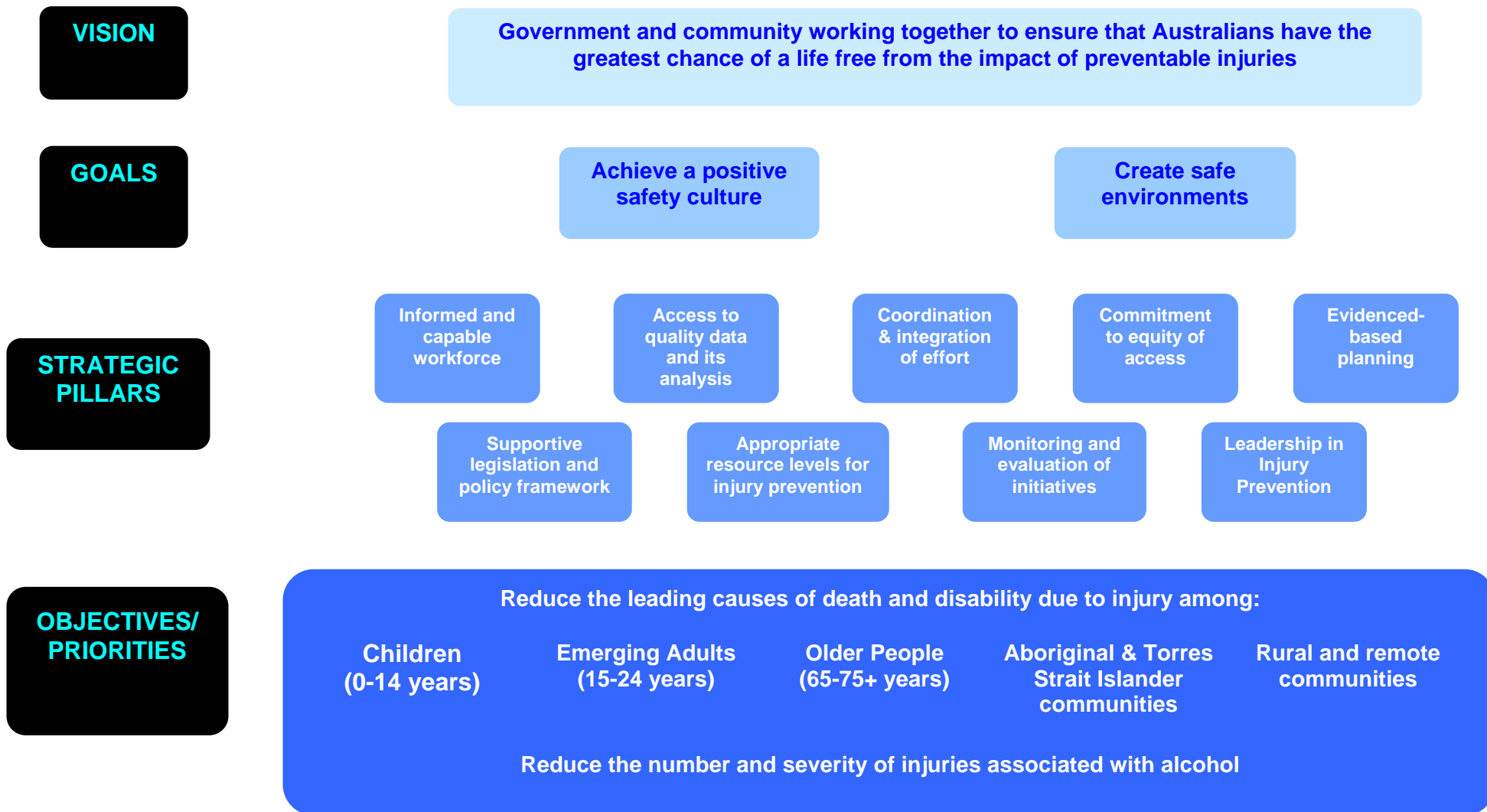


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OVERVIEW

Purpose of the Plan

The purpose of the National Injury Prevention Plan is to establish a framework for the injury prevention activities of government agencies, local government, non-government organisations, communities and individuals.

The Plan will assist Australia to better focus its injury prevention efforts and resources by providing clear priority areas as a focus of investment.

How the Plan was developed

The Plan provides a framework for the policy development and service delivery activities of government agencies and non-government organisations with an involvement in injury prevention. It is envisaged that the Australian Government Department of Health and Ageing through the Strategic Injury Prevention Partnership (SIPP) will apply the Plan across government portfolio areas. However, government agencies are not the only organisations that might contribute to the Plan's implementation. As the actions within the Plan illustrate, local government, non-government organisations, businesses, communities, families and individuals all have an important role to play in injury prevention. It is anticipated that the Plan could be used as a resource for all of these groups.

The development of the National Injury Prevention Plan was led by the Strategic Injury Prevention Partnership sub-committee in consultation with many individuals and organisations throughout Australia. The Strategic Injury Prevention Partnership comprises of representatives from each of the state and territories. Appendix A presents a list of all the SIPP members (including the sub-committee overseeing the development of this document).

An Aboriginal and Torres Strait Islander Safety Promotion and Injury Prevention Plan is also being developed by the Aboriginal and Torres Strait Islander Injury Prevention Action Committee (ATSIIAPC) to complement this Plan. The Aboriginal and Torres Strait Islander Safety Promotion and Injury Prevention Plan covers all aspects of safety promotion. It seeks to reduce harm, increase community capacity to promote well being, and provide opportunities for Aboriginal and Torres Strait Islander people to take greater control of initiatives aimed at enhancing community safety.

Who the Plan is for

The Plan provides a framework for the Health sector to drive policy development and service delivery activities of government agencies and non-government organisations to address the Six Priority Areas.

It is envisaged that the Objectives and their underlying Actions, incorporating the strategic pillars and key injury issues within each priority area, will be used by such organisations to better focus their injury prevention efforts and resources by providing clear direction.

Links to other injury prevention and related strategies

An Aboriginal and Torres Strait Islander Safety Promotion and Injury Prevention Plan is being developed by the Aboriginal and Torres Strait Islander Injury Prevention Action Committee (ATSIIAPC) to complement this Plan and to address the specific needs of Aboriginal and Torres Strait Islander people.

The National Injury Prevention Plan embraces a number of other national strategies dealing with specific injury areas that sit within the Plan's overall framework. Examples of current relevant national strategies are described briefly in Appendix B.

The Plan's Vision

The Plan has a vision of the government and community working together to ensure that Australians have the greatest chance of a life free from the impact of preventable injuries while continuing to lead active and challenging lives.

Delivering the Plan - what happens next?

To advance us toward this vision the Health sector needs to embrace the role of co-ordinating the development of an Implementation Plan for the National Injury Prevention Plan in collaboration with key government agencies, and other relevant organisations and community groups.

SIPP will continue to play an advisory role in informing the development of an Implementation Strategy for the Plan.

It is expected that the first Implementation Strategy for the Plan will take effect from 1 July 2005.

The Plan is intended as a living document and injury prevention work under it will be ongoing.

More details about delivering the Plan can be found on page 21.

INTRODUCTION

Why a National Injury Prevention Plan?

Injury and poisoning (hereafter 'injury') are common, costly, and often preventable. While injury occurs at all ages, it is a particularly prominent health problem for children and young adults.

55% of deaths at ages 1 to 40 years of age registered in Australia in 2002 were due to injury (NISU unpublished). Other causes are common at older ages, and injury accounts for about 6% of deaths at all ages.

Injury is also a common reason for admission to hospital. 436,513 episodes in hospital due to injury concluded during 2001-02, 6.8% of all episodes (Australia's Health 2004). Injury was the reason for 16% of episodes in hospital at ages 5 to 24 years (NISU unpublished).

Less severe injuries are much more numerous than severe injuries. About 12% of Australians reported sustaining an injury in the previous month which resulted in medical consultation or treatment, or reduction of usual activities (NHS 2001 ABS cat 4384.0). While the average impact of less severe injuries is relatively low, they are so numerous that the aggregate burden due to them is considerable (eg. in terms of costs of providing treatment and time lost from work).

Many severe injuries and some injuries which do not initially appear to be severe have lasting effects on health and quality of life. Results of the 2001 National Health Survey indicate that 12% of Australians have a long term condition resulting from an injury, mostly diseases of the musculoskeletal system and connective tissue.

In 2000-2001, injuries represented 8.3% (\$4.06 billion) of the total allocated health expenditure and accounted for the fourth highest health expenditure behind cardiovascular disease, nervous system disorders and musculoskeletal diseases.

What causes injury?

A broad range of interacting factors affect how many injuries occur. The factors that contribute to an injury event can be described as being related to:

- ***Lifestyle or behaviour*** - shaped by:
 - attitudes,
 - knowledge,
 - access to safer choices
 - health status including issues relating to fitness and mobility, physical health and mental health
- ***Environment*** – including:
 - the physical environment around us such as roads, buildings, leisure and work settings, products
 - the socio-economic environment such as education, income, employment status, housing
 - the socio-cultural environment – which can influence choices associated with group identity such as gender, age, cultural background.

Furthermore, factors that influence the outcome of an injury event in terms of its severity include:

- ***Presence of safety features*** that reduce the exchange of energy in the event of an injury, such as seatbelts, helmets, harnesses and guard rails.
- ***Access to quality medical treatment*** – including speed of retrieval and delivery to trauma care and the quality of care.

- **Adequacy of rehabilitation services** – including quality of services, appropriateness of return to work programs etc.

The benefits of injury prevention

Investments in injury prevention can result in significant economic and social benefits. It can reduce the number of new cases of injury, as well as reduce the severity of those injuries that do occur. The benefits of injury prevention include continued quality of life for individuals and families, and less disruption and increased productivity for businesses and service organisations. The wider community also gains from having a safer, positive, and more productive population, and from less demand being placed on the health care system due to injury.

Achievements in reducing injuries in Australia

Australia has achieved some significant gains in the prevention of a number of different types of injuries over recent years where concerted efforts have been made. For example, with the support of an integrated government strategy, a significant reduction in road injuries and fatalities has occurred over the past decade. This was a result of a concerted and targeted commitment in the early 1990s. Road transport related death rates have reduced from 11/100,000 in 1992 to 9/100,000 in 2000. For young males aged 15-24 years, the road transport related death rates have dropped from 30 per 100,000 in 1992 to 27 per 100,000 in 2000.¹

Gains have also been made in the area of suicide prevention and poisoning in children because of a collaborative and targeted approach. In the year 2000, the all-ages male death rate from suicide was 19.4 (per 100,000) compared with the all-ages male death rate from suicide in 1997 of 23.4 per 100,000². Hospital separation rates for poisoning in children aged 0-4 years have dropped from 302 in 1991-1992 to 267 in 1999-2000³. Refer to Appendix C for selected Australian Injury statistics.

Although injury rates in Australia have declined over the past decade, further reductions are possible and desirable. We need to develop a culture that positively supports and values the prevention of injury. We have to shift people's thinking about injuries so they are seen to be preventable rather than an inevitable and unavoidable part of life – whether it is falls among older people or traffic crashes among young males. We need to raise the level of motivation and skill among individuals and organisations to create safer environments and support protective behaviours. We must also identify and address the conditions in our society that lead people to take unacceptable risks and/or cause harm to themselves or others. Achieving a positive safety culture and creating safer environments is challenging and will only be achieved if injury prevention activity is well informed and well organised.

Current gaps that need to be addressed

There are a number of deficiencies in our current injury prevention efforts. These include:

- **Fragmentation of effort.** Given the wide range of agencies and organisations involved in injury prevention, it is necessary to ensure that messages are consistent and not unnecessarily duplicated. Injury prevention activity needs to be integrated through co-ordination and collaboration between government agencies and other organisations.
- **Gaps in injury prevention activity.** Some important injury issues have attracted limited attention relative to their impact, e.g., fall prevention and drowning prevention. Coverage in some areas is patchy.

¹ Australian Institute of Health and Welfare 2002. Australia's Health 2002. Canberra: AIHW.

² *ibid.*

³ *ibid.*

- **Workforce capability issues.** The injury prevention workforce is diverse, often isolated and has limited access to training opportunities. The capability of the injury prevention workforce needs to be enlarged and strengthened.
- **Quality of, access to, and dissemination of injury information.** There is a need for better, more accessible, and improved dissemination of injury data and information to support injury prevention activity. Basic information about the risk levels of key groups within the community such as Aboriginal and Torres Strait Islander or culturally and linguistically diverse communities.
- **Limited understanding of effective injury prevention activities.** We have benefited from strong research in some areas of injury prevention such as road safety, but need desperately to expand such knowledge to many other injury areas through quality research and evaluation.
- **Insufficient resourcing of injury prevention.** Investing in prevention is generally ranked a very low priority against treatment needs.

The National Injury Prevention Plan seeks to address these gaps through the Health sector accepting that it is well positioned to advocate, negotiate and provide the necessary data and its analysis for a coordinated National approach to addressing the major injury prevention priorities.

The focus of the Plan is improving the infrastructure that supports injury prevention activity in Australia, as well as the development of national strategies to address specific national injury prevention priority areas.

Priority areas for action

In developing the Plan, six national injury prevention priority areas were identified based on the population groups at greatest risk of injury as well as the recognition of the cross-cutting risk factor of alcohol. This approach recognises the value of seeing injury prevention as part of a comprehensive approach to enhance health and quality of life.

The priority areas for investing in injury prevention are:

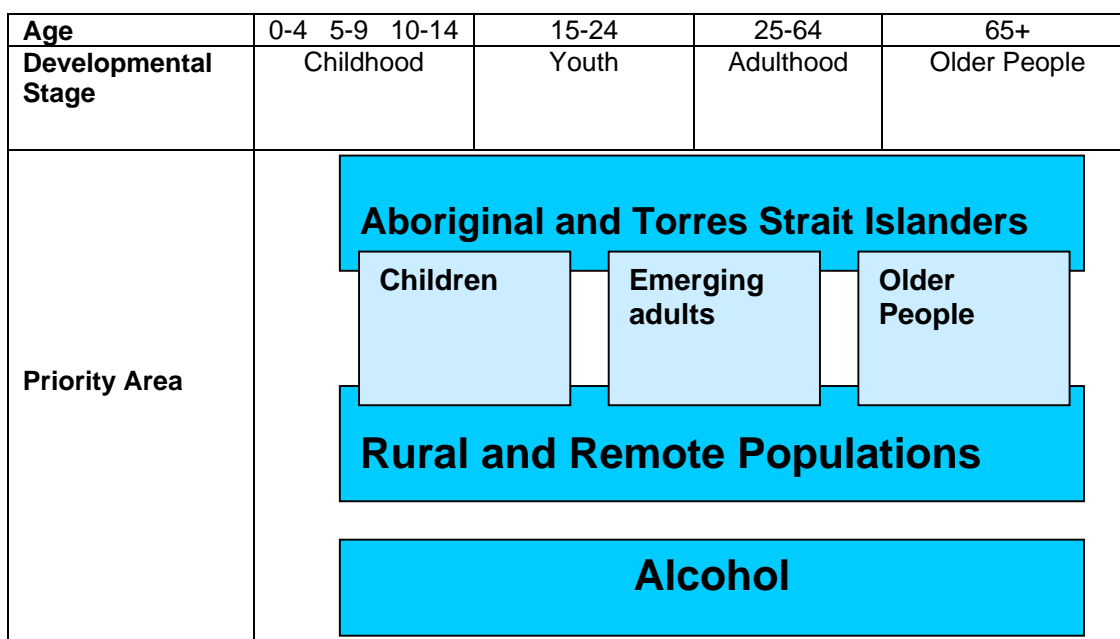
- Children (0-14 years)
- Emerging and young adults (15-24 years)
- Older people (65 years and over)
- Rural and remote population
- Indigenous communities
- Alcohol – as a major risk factor for injury.

Taking a population approach

The National Injury Prevention Plan utilises an approach which recognises that risk factors are often shared by population sub-groups (defined by age, geographic or cultural affiliation) and these risk factors are likely to cut across different types of injuries. The resultant approach will enable different regions to target the issues that best meet the needs of the priority groups in their region. Taking a population approach to injury prevention also allows us to build on efforts stemming from the injury issues targeted in the 2001-2003 Injury Prevention Plan, for example falls, poisoning and drowning and near drowning in children.

Three of the priority populations cover three of the four life stages while the remaining priority populations (Aboriginal and Torres Strait Islander and rural and remote populations) and alcohol issues are cross-cutting issues (see Figure 2, below).

Figure 2: Injury Priority Area across the Developmental Stages⁴



Key issues for Priority Areas

The Priority Areas for the National Injury Prevention Plan have been adopted from the Discussion Paper: National Injury Prevention Plan Priorities for 2004 and Beyond (Pointer et al., 2003). The following key issues for each Priority Area have been identified in this Discussion Paper.

(Refer also to Appendix C for more data for each of the Priority Areas.)

Children 0-14 years

- Children are dependent and susceptible to injury.
- Children progress through a number of developmental stages between the ages of 0-14. Successful progression to adulthood is dependent on successful navigation of these stages and injury prevention and intervention can greatly assist in a successful transition.
- Children aged 0-14 years represent 16.5% of all injury related hospitalisations and just over 4% of all injury related deaths.
- Key concerns focus on transport related injuries (including on and off road and driveway runovers), falls, other unintentional injury (this includes such events as choking and suffocation), poisoning (primarily pharmaceuticals), drowning and near drowning, and burns and scalds.
- To date, little consideration has been given to access to prevention and intervention programs for children from culturally and linguistically diverse families.

⁴ Pointer S, Harrison J, Bradley C. 2003. National Injury Prevention Plan Priorities for 2004 and Beyond: Discussion Paper. Injury Research and Statistics Series Number 18. Adelaide: AIHW (AIHW cat no. INJCAT 55).

Emerging Adults 15-24 years

- Emerging adults represent about 1 in 6 of all injury deaths and about 1 in 7 of all injury hospitalisations.
- Emerging adults are over-represented in injuries associated with transport, violence, pharmaceutical poisoning and self-harm.
- Emerging adults represent 15.7% of all injury hospitalisations and 14.3% of all injury related deaths.
- Young males outnumber young females in deaths due to injury for all injury categories.
- Particular pressures and opportunities such as access to motor cars and alcohol present new risks for emerging adults.
- Research suggests that suicide rates reached by a cohort during their emerging adults years may persist over other developmental stages.
- For males aged 20-24 years, alcohol-related injury death accounted for 18% of injury deaths (compared with 15% of male injuries across all ages).
- The type of activity emerging adults are engaged in at the time of their injury differs for age sub-groups. Injury sustained while engaged in a sports activity is highest in 15-16 year olds and decreases at age 17-18 when it tends to plateau from 18-24 years; and injury sustained during work activity increases sharply from 17-24 years as young people join the workforce.

Older People 65+ years

- The burden of injury for this age group is likely to rise with the ageing population.
- For injury related hospitalisations the most common causes of injury are: falls (accounting for 66.5% of hospital separations for injury) followed by complications from medical and surgical care, other unintentional injury, transportation and intentional self-harm and pharmaceutical poisoning.
- The most common causes of injury related deaths are: falls (accounting for 62.2% of injury related deaths) followed by other unintentional injury, transportation, intentional self harm and complications from medical and surgical care.
- Both the hospitalisation rates and death rates increase sharply from age 75+ (refer to Table 1 in Appendix C for age specific rates).

Aboriginal and Torres Strait Islander People

- Both injury death rates and hospitalisation rates due to injury are higher in Aboriginal and Torres Strait Islander people than for non-Indigenous people.
- There is a lack of targeted interventions and programs for this group.
- Key issues to address include injury involving violence and self-harm; transportation and alcohol-related injury.
- There are limitations in existing data sources that need to be addressed.
- A separate Aboriginal and Torres Strait Islander Safety Promotion and Injury Prevention Strategy has been developed by the Aboriginal and Torres Strait Islander Injury Prevention Action Committee (ATSIIAPC). Its aims are to reduce the burden of injury among Aboriginal and Torres Strait Islander people, and to focus agencies and organisations from all sectors on the role they can play in promoting safety and preventing injury in Aboriginal and Torres Strait Islander people.

Rural and Remote Populations

- Rates of suicide and self-harm and traffic accidents (both on and off road) are high among rural emerging adults, particularly young males.
- Farm machinery injuries, poisonings on farms and other work related injuries are also risk for rural and remote populations.
- Falls (particularly in older females) are a key reason for hospitalisation and injury mortality in rural and remote populations.

- Complications from surgical and medical care are the fourth highest cause for hospitalisation in this population.
- The consequences of small populations and vast distances impacts injury outcomes due to reduced availability of emergency and specialist care. These issues should also be considered in planning and resourcing injury prevention efforts in these areas.

Alcohol related injury

- Database development of indicators of alcohol involvement in injury is required.
- Alcohol use is known to contribute importantly to motor vehicle crashes, falls, interpersonal violence and water-related injury. The extent of its involvement in other types of case is less well known.
- Alcohol is involved with a larger proportion of injuries in young males and Aboriginal and Torres Strait Islander people than with the overall Australian population.
- Pharmaceutical poisoning is the third most common alcohol associated death (following intentional self-harm and transportation).
- For males aged 20-24 years, alcohol-related injury death accounted for 18% of injury deaths (compared with 15% of male injuries across all ages).

Improving our injury prevention efforts

The National Injury Prevention Plan sets out a vision and strategic direction for injury prevention. It establishes a framework that will enhance and support the injury prevention activities of government agencies in particular and other organisations and groups in the wider community. It will require regional and local government, non-government organisations, businesses and community groups, who have such an important role to play in injury prevention, to use the Plan to inform and guide their activities.

The Plan focuses on the prevention of injury (both unintentional and intentional), which involves using preventive measures to reduce the number of new cases of injury, and reduce the severity of those injuries that do occur. Injury prevention requires appropriate action to be taken on an everyday basis by all members of society in their various roles such as parents, caregivers, managers, workers, landlords, and road users. Knowing what is appropriate action is not always common sense, however, and will need to be fostered through education, training and research. Current evidence suggests that injury prevention will work best when it:

- is based on a strong understanding of the problem and its contributory factors
- addresses the multiple factors that contribute to injury
- is based on evidence of effective interventions
- encourages environmental and behavioural change
- engages the people who are most at risk
- involves action across sectors (e.g. health, police, education)
- is sustained and reinforced over time (e.g. through policies, laws, engineering and influencing the influencers in a community).

PRINCIPLES / STRATEGIC PILLARS

The National Injury Prevention Plan is based on nine underlying principles or “strategic pillars” that the Government sees as fundamental to building national capacity to effectively prevent injuries affecting high risk groups within our population. These are a broad set of statements, which should serve to guide and inform injury prevention policies and activity across the public sector into the future. These principles are also intended to guide the injury prevention activities of regional and local government, community groups, businesses, families and individuals.

1. **Leadership in injury prevention:** The health sector has a lead role in supporting injury prevention through appropriate action in terms of advocacy, the provision of quality analysis of injury data, coordination, skill development and exemplary policies and standards.
2. **Coordination and integration of effort:** Collective action on injury prevention planning and activity is essential to addressing gaps and minimising duplication of effort. This requires the active participation of local government, community groups, businesses, families and individuals working in partnership with state and federal government.
3. **Informed and capable workforce:** Strategic planning at federal, state and local levels will ensure that individuals whose work context encompasses injury prevention are sufficiently informed and skilled to undertake best practice in the prevention of injuries.
4. **Access to quality data and its analysis:** The health sector has a major role to play in providing quality data and its analysis for use in injury prevention planning, monitoring and evaluation by its partners. Through the provision of quality data and its analysis, injury prevention activity can appropriately anticipate and respond to changes in injury patterns, exposure to risks and population trends.
5. **Commitment to equity of access:** planning and delivery of injury prevention activity will aim to reduce inequalities in injury outcomes within and between groups, by attending to creating equity of access to information, services and products to those groups at greatest risk of injury.
6. **Evidence-based planning:** Injury prevention activity will be based on evidence of effective interventions and, where possible, good information about the political and social context in which interventions will be introduced.
7. **Supportive legislative and policy framework:** Sustainable changes in behaviour and the environment to reduce the risk of injury can be facilitated by supportive laws, policies and regulations operating at federal, state, local and community levels.
8. **Appropriate resource levels for injury prevention:** Investment in injury prevention needs to adequately reflect that injury is a leading cause of death and disability in each of the identified priority population groups (children, emerging adults, older people, ATSI communities and rural and remote communities).
9. **Monitoring and evaluation of initiatives:** Identifying and implementing interventions that make the best use of resources (both human and financial) will be assisted by systems that ensure the ongoing monitoring and evaluation of interventions. Such systems should be designed to identify what works, what doesn't and the contextual factors that influence outcomes, and emerging knowledge about proven or promising interventions.

THE NATIONAL INJURY PREVENTION PLAN

Vision

The vision for the National Injury Prevention Plan is:

Government and community working together to ensure that Australians have the greatest chance of a life free from the impact of preventable injuries

This vision is practical and achievable yet challenging. It will act as a motivating force in both stimulating and guiding injury prevention efforts in Australia.

As we move toward this vision we will see:

- ***Collaborative action by governments and communities*** to maximise the reach and efficiency of investments in injury prevention and reduce unnecessary duplication of services
- ***The focus of our efforts will be on those injuries with the greatest impact*** on individuals, families and communities – i.e. injuries that result in death, and severe or lasting impact on quality of life including physical disability and loss of confidence or independence.
- ***Injuries being universally accepted as preventable*** – by individuals, communities, health care workers, policy makers, and across all settings (e.g. workplaces, schools, public places, residential settings, roads, and sport and recreational environments).

Goals

To realise the vision we need to work strategically and collaboratively towards the goals of:

- achieving a positive safety culture; and
- creating safe environments.

A positive safety culture is a shared set of beliefs, attitudes, values and ways of behaving that support the prevention of injury. The goal of achieving a positive safety culture means that individuals, families, cultures, organisations, and governments all share the belief that injuries are preventable and investing in injury prevention is worthwhile. This goal would see, for example:

- young people believing as passengers in a motor vehicle that they should speak out if they are uncomfortable with the way the driver is driving
- general practitioners accepting that falls in older people are not inevitable
- culturally appropriate injury prevention resources are developed for Aboriginal and Torres Strait Islander communities,
- workplace safety being embraced as a priority in all business planning.

Once a safety culture is achieved, policies, planning and action or behaviour will follow.

Safe environments are social and physical surroundings or conditions that support the prevention of injury. Creating safe environments means creating safer products, workplaces, roads, homes, and public spaces including recreational facilities. It also means providing opportunities for greater equity of access to these safer environments, for example:

- safety standards for baby products are mandatory so it is not only the expensive products that comply with safety recommendations
- transportation alternatives are provided in rural areas to allow young people to get home safely from weekend social activities.

The following set of objectives has been developed to assist in reaching these goals above, through focusing on the six priority areas for the National Injury Prevention Plan.

Objective 1 Reduce the leading causes of death and disability due to injury among children 0-14 years

Actions

1. Raise awareness that transportation injuries, drowning and near-drowning, falls, poisoning and burns are the leading causes of injury related death and disability among children.
2. Create cultural acceptance that injuries to children are largely preventable and that investing in prevention is worthwhile.
3. Ensure the prevention of falls in children is given an appropriate level of consideration in decision-making relative to current standards for products and environments.
4. Raise the capacity of the injury prevention workforce to enable greater advocacy for safety on standard setting committees regarding products and environments to which children are exposed.
5. Provide culturally appropriate information to reach high-risk communities about drowning prevention and transport safety among children.
6. Work collaboratively with communities, all levels of government and the private sector to advocate, implement and promote effective strategies to prevent injuries to children.
7. Provide equity of access to health care and safer products and environments for children.
8. Provide data to communities, organisations and individuals that clearly identify the risk groups for injury among children, the size and nature of the problem, the key risk factors and long term impact of injury.

NSW Scalds Prevention Campaign targeting young children⁵

Hospital separations data was used to identify scald injury as a leading cause of hospital bed days due to injury among young children (0-4 years). Hot tap water was identified as a highly preventable component of this problem and responsible for the most severe burns among this age group. A campaign run by NSW Health in the 1990's combined:

- Community awareness raising about the problem, its prevention and first-aid treatment in the event of a scald
- Developing the capacity and commitment of plumbers, builders and designers to reduce the temperature of hot tap water in homes
- Working with manufacturers and national policy setting bodies to raise the safety standards of products associated with the delivery of hot tap water.

The Australian Standard for home hot water temperature delivery was amended. Telephone surveys and household temperature testing with random samples of families with young children indicated an increased knowledge of the problem and a reduction in average hot water temperature.

Importantly, data analysed for the two years following the campaign indicated that the number of hospital bed days due to scalds in children 0-4 years fell by 22%, with the greatest change among the most severe injuries with a 26% reduction in the number of scald cases of children hospitalized for 5-9 days, and a 30% reduction in the number hospitalized for 10 or more days.

⁵ Adapted from Elkington J: *Injury Prevention*. In Moodie R & Hulme A (Ed.s) *Hands-on Health Promotion*. IP Communication, Melbourne, 2004.

Objective 2 Reduce the leading causes of death and disability due to injury among emerging adults (15-24 years)

Actions

1. Increase collaboration and co-ordination between the injury prevention sector and sectors responsible for policies and planning for services and facilities for emerging adults to integrate prevention activities and avoid unnecessary duplication of effort.
2. Provide quality data and its analysis on injuries among emerging adults to government sectors responsible for the safety and welfare of young people, such as police, education, community services and occupational health and safety.
3. Invest in more longitudinal, in-depth multi-disciplinary research that examines the interplay of risk factors that place young people, particularly young males at elevated risk of serious injury.
4. Ensure that resources devoted to preventing injuries among emerging adults reflect the relative size of the problem in terms of the quality of life years (QALYs) lost due to injuries among this age group.
5. Promote among young people awareness and development of personal skills in injury prevention through the education sector, workplaces, public campaigns and community-based programs.
6. Invest in the monitoring and evaluation of promising but currently unproven strategies to reduce injuries in young people.
7. Increase the access by disadvantaged and high-risk emerging adults to safer products and environments particularly regarding recreational facilities and transportation.

“Leavers’ Live” - School leavers’ safer celebrations on Rottnest Island, WA⁶

One of the most popular destinations for Western Australian school leavers celebrating the end of school is Rottnest Island, 20km off the coast of Perth. Drawing on the Sunshine Coast, Queensland, “Schoolies” intersectoral strategy, the School Drug Education Project (SDEP) has been systematically developing a locally appropriate, acceptable and effective strategy to minimising the harm of these celebrations to the school leavers.

Commencing with a review of the literature, working in partnership with the Rottnest Island Authority (RIA) and then conducting formative evaluations of initial efforts, the ‘Leavers Live’ program has evolved. Collaborative planning was undertaken by the SDEP, the RIA, Police, youth advisory councils, local media and licensed venues.

Strategies included increasing availability of food, providing a Chill Out Tent, establishing under-age dancing areas at the local Hotel with coloured wrist bands for over 18s, providing additional entertainment, and development of policies regarding venue hire.

Surveys after the 1999 and 2000 events indicated a reduction in emphasis on alcohol by school leavers as a focus of their activities, elimination of any reports of being bored, and reduced reported experience of violence or sexual harassment. Unexpectedly, there was a reported increase in illicit drug use which was recommended for greater emphasis in future years.

⁶ Young N, Farrington F, Midford R: School leavers’ celebrations on Rottnest Island (Leavers Live); Evaluation Report. Report prepared by the National Drug Research Institute, WA July 2001 (www.sdep.wa.edu.au/leavers/ndri)

Objective 3 Reduce the leading causes of death and disability due to injury among older people (65-75 years+)

Actions

1. Collect, analyse and disseminate data that can be used at local, regional and state level to assist in the development of policies and programs to prevent injuries due to falls, transportation, complications of surgical and medical care and pharmaceutical poisoning to older people in supported care, acute care and those living independently.
2. Develop the capacity of health professionals and other service providers to older people to address falls prevention commencing with raising their awareness of the preventability of fall injuries and the resources and services available to promote falls prevention.
3. Support the development of policies that serve to prevent injuries due to falls among older people through acute care facilities, and among those older people living in residential care facilities and those living independently within the community.
4. Improve equity of access by older people to opportunities for increasing their participation in regular exercise.
5. Work collaboratively with a range of sectors within the community to develop systematic approaches to managing environmental risks in residences and public spaces and facilities.
6. Control exposure to slipping and tripping hazards through the improved design and maintenance of environments, systems and products used by older people.
7. Encourage older people to consider injury prevention when making purchasing decisions.
8. Invest in sound evaluation of community-based falls prevention programs in order to expand our understanding of best practice and most cost-effective practice in this area.

Preventing falls through a mix of strategies - Stay on Your Feet Program⁷

The Stay on Your Feet (SOYF) falls prevention program targeted 80,000 residents aged 60 years and over on the North Coast of NSW. The program identified footwear, vision, physical activity, balance and gait, medication use, chronic conditions, and home and environmental hazards as key risk factors for falls. To address these risk factors the program included policy development, awareness raising and skill development among health professionals, older people, and those responsible for products and housing for older people. The program achieved a 20% reduction in hospital falls admissions, and an estimated saving of \$1 million a year.

An adapted version of the SOYF program has been run in every state in Australia and in New Zealand. Toronto University conducted an international review of injury prevention strategies before selecting the Northern Rivers model as the best falls prevention model in 2003. Based on thorough evaluation to identify the most effective components of the program, five years after SOYF was completed, it was concluded that older people were more responsive to a 'healthy ageing' message than a direct 'falls prevention' message. This finding has led to the development of the new program, Stay Active Stay Independent (SASI).

⁷ Northern Rivers Area Health Service (website) "Falls and Injury Prevention – Stay Active Stay Independent <http://www.nrahs.nsw.gov.au/population/promotion/falls/>

Objective 4 Reduce the leading causes of death and disability due to injury people living in rural and remote areas

Actions

1. Together with relevant industry partners focus attention on rural and remote issues in the development of injury data collection systems that will capture detailed data on injury types and severity and the identification of high-risk groups.
2. Provide greater access to information and data that will aid the planning of injury prevention for rural and remote communities.
3. Address equity of access to safety in program funding – to enhance the access by rural and remote communities to safety information, skilled workforce, and safe transport options, workplaces, recreational and residential facilities.
4. Raise awareness among health care and other service providers, policy makers and the community of the impact of road trauma, self-harm, violence, falls and alcohol related injury on rural and remote communities in Australia.
5. Collaborate with key agencies and government bodies responsible for services and planning in rural and remote areas to ensure that the prevention of injuries is integral to planning and policy development.
6. Encourage individuals and organisations in positions of influence within rural and remote communities to demonstrate leadership in injury prevention.
7. Ensure that government agencies with injury prevention responsibilities include injuries within rural and remote communities in their accountability documents and performance measures.
8. Assist rural and remote communities to implement and evaluate promising injury prevention strategies tailored to their needs and opportunities particularly in Aboriginal and Torres Strait Islander communities.

Capacity building in rural and remote areas of NSW⁸

In some rural and remote areas of New South Wales (NSW), Australia, alcohol-related violence and crime rate have been reported to be 3-4 times higher than other areas of the state. Previously, due to non-systematic processes, NSW Police were unable to collect comprehensive data on alcohol-related incidents. As a consequence, they were limited in their capacity to assess the need for alcohol-harm reduction initiatives and effectively target resources.

In order for NSW Police to better respond to alcohol-related crime, a collaborative initiative between the Hunter Centre for Health Advancement and NSW Police was undertaken in the rural and remote policing regions of NSW. As an outcome of this capacity building process, NSW Police have more comprehensive and complete data on alcohol-related crime including the type of offence by alcohol involvement, and the place where offenders consumed alcohol.

These improvements in data recording have revealed a high prevalence of alcohol-related crime and harm in the community and demonstrate a need for increased priority to be given to alcohol-harm reduction initiatives, especially those targeting consumption at licensed premises and private residences.

⁸ Radvan D, Wigger J et al: *Alcohol-harm reduction: The process and outcome of capacity building within NSW Police* – from 18th World Health Promotion Conference, April, 2004 (Melbourne)
http://www.health2004.com.au/program2/tuesday/al_op_01.asp

Objective 5 Reduce the leading causes of death and disability due to injury among Aboriginal and Torres Strait Islander (ATSI) communities

Actions⁹

1. Improve ATSI injury surveillance systems to ensure their reliability and validity and supplement them with detailed qualitative data.
2. Increase knowledge of, commitment to, and skills in injury prevention in both ATSI communities and in non-Indigenous workforce.
3. Encourage the setting of safety promotion and injury prevention priorities by Aboriginal community leaders.
4. Provide sufficient resources to build workforce capacity and build an evidence base of effective strategies in preventing injuries among Aboriginal and Torres Strait Islander communities.
5. Build collaborative relationships for injury prevention within and between federal, state and local government and community groups in full partnership with ATSI people to collectively address serious injury among ATSI groups
6. Support strategies that address a mix of environmental and behavioural risk factors and which provide a good example of dealing with the underlying alienation and disadvantage of ATSI people.
7. Develop mechanisms to co-ordinate injury prevention research and evaluation activities.

Crime and violence prevention in remote Aboriginal and Torres Strait communities¹⁰

The concept of Night Patrols (NPs) arose from within aboriginal communities when groups of senior traditional people were concerned about the escalating levels of violence and misuse of alcohol in their community. These volunteer NP workers walked around the new settlements at night to keep an eye on things and negotiate with and between trouble making groups. Over the past decade every major settlement in central Australia has had a Night patrol at some stage.

NPs act as a nexus to connect people and services such as clinics, courts, Police, community government councils, and family. They mediate disputes, remove people from danger, keep the peace at events such as sports carnivals, are consulted by agencies such as courts for input into sentencing, and play a crucial role in the development of community justice groups.

As examples in the Northern Territory, the Ali Curung Night Patrol and Safe House for women are reported to have reduced levels of drunkenness and domestic violence to almost zero, and the Laramba Night Patrol has improved the health of their families by stopping alcohol and fighting, and card games for money.

The problems faced by remote Aboriginal communities and towns are complex and inter-related and Night Patrols provide a culturally acceptable, multi-pronged and long-term approach to a community problem.

⁹ Adapted from: Moller J, Thomson N, Brooks J (for the Commonwealth Department of Health and Ageing) Injury Prevention Activity among Aboriginal and Torres Strait Islander Peoples Volume 1: Current Status and Future directions /www.crcah.org.au/resource/Injury (August 2003)

¹⁰ Jenny Walker, Sharon Forrester: Tangentyere Remote Area Night Patrol. Conference paper – National Crime Prevention Conference, Sydney Sept, 2002 (www.aic.gov.au/conferences/crimpre/walker.pdf)

Objective 6 Reduce the number and severity of injuries associated with alcohol

Actions

1. Develop and maintain a database of indicators of alcohol involvement in serious injuries
2. Ensure that injury prevention research efforts consider the importance of a focus on the role of alcohol in injury risk, the demographic (e.g. age and gender), geographic, and socioeconomic characteristics of groups most at risk of alcohol related injury, and the impact of alcohol harm minimisation strategies on injury outcomes.
3. Build collaborative partnerships in research, policy and planning with agencies responsible for drug and alcohol issues, mental health, community services, policing and criminology, and youth affairs to better understand and address injuries associated with alcohol.
4. Encourage individuals and organisations in positions of influence within communities to demonstrate leadership in reducing the harm associated with alcohol and provide adequate resources for these communities to develop their own specific and culturally appropriate strategies to reduce alcohol related injuries.
5. Build the capacity of communities to develop behavioural and environmental approaches to minimising the risk of alcohol related injuries through the provision of training, data and partnership opportunities with local government, retailers, sports clubs, service clubs, educational facilities and workplaces.
6. Focus on opportunities to implement best practice in alcohol harm minimisation on the high-risk groups of young males, Aboriginal and Torres Strait Islander communities and those at risk of self-harm.
7. Expand our understanding of best practice in this area through adequate resourcing of monitoring and evaluation of promising but unproven strategies that seek to reduce injuries associated with alcohol.

The Australian Drug Foundation's Good Sports Alcohol Accreditation Program¹¹

This program is the outcome of six years of careful developmental work among community-based sports clubs in Victoria. Excessive drinking linked with the sale of alcohol on club premises to raise revenue for clubs was seen to be contributing to unsafe and unpleasant environments and a loss of club supporters.

The Good Sports program helps clubs develop a policy for greater responsibility of serving of alcohol through typical measures such as:

- Training bar staff/servers in responsible serving practices
- Providing low-alcohol or non-alcoholic drinks
- Serving meals when alcohol is sold
- Not using alcohol as a reward for sporting performance
- Arranging safe forms of transport for patrons.

Participating clubs have found no loss in revenue linked with greater patronage, and increased support from community agencies and sponsors.

¹¹ Adapted from Stronach B, Munro G: *Minimising harm from alcohol*. In Moodie R & Hulme A. (Ed.s) Hands-on Health Promotion. IP Communication, Melbourne, 2004.

DELIVERING THE PLAN

Leadership

This Plan recognises the leadership role that the health sector must play in:

1. Providing quality data and its analysis to all sectors with a role in injury prevention to facilitate their planning processes.
2. Encouraging individuals and organisations in positions of influence within communities to give priority in their planning to the prevention of injuries.
3. Working collaboratively with other disciplines and sectors to expand the reach of injury prevention opportunities, and avoid gaps and duplication of effort.
4. Providing resources for and assistance in the evaluation of promising injury prevention activities.
5. Reducing health inequalities faced by rural and remote communities and Aboriginal and Torres Strait Islander communities.
6. Developing the skills and access to information on effective injury prevention practices throughout the health sector and its partners.

The Australian Government Department of Health and Ageing in conjunction with the health departments of the States and Territories and the Strategic Injury Prevention Partnership (SIPP) will take the leadership on this Plan, its implementation and evaluation.

Implementation

Recognising the importance of ongoing stakeholder involvement in the implementation process, the Australian Government Department of Health and Ageing will co-ordinate comments from a wide cross-section of government departments, non-government agencies and community groups on the draft plan and the development of an Implementation Strategy in collaboration with the Strategic Injury Prevention Partnership (SIPP).

It is envisaged the first Implementation Strategy will take effect from 1 July 2005. The Australian Government Department of Health and Ageing will work with government agencies to apply the Plan across government portfolio areas. A progress reporting process will be instigated to ensure that the Plan is being implemented as intended and to identify any areas of duplication or gaps. The Australian Government Department of Health and Ageing will also collect information, where appropriate, from other organisations and groups which will assist in monitoring progress towards the achievement of the Plan's objectives and actions.

In addition to reporting on implementation of the Plan, a report on Australia's injury prevention performance will be published at approximately two year intervals. This report will provide information on measures of safety culture and safe environments, and key injury statistics and trends.

APPENDICES

Appendix A

Members of Strategic Injury Prevention Partnership (SIPP)

Jurisdiction	Name	Position	Organisation
Co-Chair	Dr Rod McClure	Director, Injury Research Group; School of Population Health	University of Queensland
Co-Chair	Ms Jackie Steele	A/g State Manager, Public Health Services	Queensland Health
C'WEALTH	Ms Rae Scott	Director, Injury Prevention	Department of Health and Ageing
TAS	Mr Stan Bordeaux	Injury Prevention Policy Officer, Population and Health Priorities	Department of Health and Human Services
ACT	Ms Leah McKinnon	Project Officer, Health Promotion Unit	ACT Health
AIHW	Associate Professor James Harrison	Director	AIHW National Injury Surveillance Unit
NSW	Ms Pam Albany	Manager, Injury Prevention Policy Unit	NSW Health
SA	Dr Ron Somers	Injury Surveillance and Control Unit, Epidemiology Branch	SA Department of Human Services
QLD	Mr Michael Tilse	Manager, State Health Promotion Unit, Public Health Service	Queensland Health
VIC	Ms Nicola Rabot	Manager, Injury Prevention, Public Health Branch	Department of Human Services
NT	Mr Steven Skove	Community Physician, Centre for Disease Control	NT Department of Health and Community Services
WA	Ms Nicole Bennett	Injury Prevention Unit, Population Health Division	Department of Health
New Zealand	Ms Sandy Brinsdon	Portfolio Manager, Public Health Directorate	Ministry of Health, NZ
Consumer Policy Division, Treasury	Mr John Wunsch	Unit Manager, Consumer Safety Unit, Consumer Policy Division	Treasury
AIPN	Mr Richard Franklin	National Manager, Research and Health Promotion	Royal Life Saving Society Australia
SIPP Secretariat	Ms Annamaree Reisch	Injury Prevention Team	Department of Health and Ageing
SIPP Secretariat	Ms Samantha Diplock	Injury Prevention Team	Department of Health and Ageing

Appendix B

Links to other injury prevention and related strategies

The current Plan will need to be worked alongside several other National Strategies or Plans. Links to and an overview of these Plans is provided below.

National Falls Prevention for Older People Initiative

<http://www.health.gov.au/pubhlth/strateg/injury/falls/index.htm>

In the 1999/2000 Federal Budget, the Australian Government committed \$6.6 million over four years towards the National Falls Prevention for Older People Initiative. This was extended for one year by an allocation of \$2.2 million for 2003-04, giving a total budgeted amount of \$8.8 for the five years. The Initiative also received an allocation of \$9.5 million over four years in the 2004/05 Budget.

The Initiative aims to reduce the incidence, morbidity and mortality associated with falls in people aged 65 years and over in community, acute care and residential care settings.

National Drug Strategic Framework

Ministerial Council on Drug Strategy (November 1998) The National Drug Strategic Framework 1998-1999 to 2002-2003 Building Partnerships: A strategy to reduce the harm caused by drugs in our community.

<http://www.health.gov.au/pubhlth/publicat/document/ndsf.pdf>

The National Drug Strategic Framework provides a vision and direction for governments and non-government organisations in developing strategies and allocating resources for the prevention and reduction of the harmful effects of substance use on Australian society.

The principle of harm minimisation has formed the basis of the National Drug Strategy since 1985. Australia implements a comprehensive and balanced approach between the reduction of supply, demand and harm associated with the use of drugs across sectors and jurisdictions.

In November 1998, after extensive community, industry, government and non-government sector consultation, the National Drug Strategic Framework (NDSF) 1998-99 to 2003-2004 was endorsed. A new Framework for the period 2004-2009 is currently under development.

National Alcohol Strategy

Endorsed by the Ministerial Council on Drug Strategy (July, 2001) National Alcohol Strategy: A plan for action 2001 to 2003-2004. Commonwealth Department of Health and Aged Care.

http://www.nationaldrugstrategy.gov.au/pdf/alcohol_strategy.pdf

The [National Alcohol Strategy A Plan for Action 2001-03/04](#) was endorsed by Ministerial Council on Drug Strategy in July 2001 to provide a national framework for action to reduce alcohol related harm in Australia. The National Alcohol Strategy is an initiative of [National Drug Strategy](#) and was developed by the [National Expert Advisory committee on Alcohol](#).

National OHS Strategy

<http://www.nohsc.gov.au/nationalstrategy/Strategy2sep.pdf>

Endorsed by the Workplace Relations Ministers' Council (May, 2001). The National Occupational Health and Safety Strategy 2002–2012.

The National Occupational Health and Safety Strategy 2002-2012 is a landmark development signifying the commitment of all Australian governments, as well as the Australian Chamber of Commerce and Industry and the Australian Council of Trade Unions, to work cooperatively on national priorities for improving OHS and to achieve minimum national targets for reducing the incidence of workplace deaths and injuries. The Strategy was developed by the members of the National Occupational Health and Safety Commission (NOHSC) and reflects their agreement to share responsibility for continuously improving Australia's performance in work-related health and safety.

The National Road Safety Strategy

<http://www.atcouncil.gov.au/strategy.pdf>

The National Road Safety Strategy 2001-2010 was formally released by the Federal Minister for Transport, John Anderson in November 2000, and came into effect from January 2001. The target of the Strategy is to reduce Australia's road fatality rate per 100,000 population from 9.3 in 1999 to no more than 5.6 in 2010 – a 40% reduction.

National Mental Health Strategy

<http://www.mentalhealth.gov.au/mhinfo/nmhs/index.htm>

The National Mental Health Strategy is an agreement between the Commonwealth and all State and Territory governments that aims to improve the lives of people with a mental illness. The Quality and Effectiveness Section of the Mental Health Branch is responsible for implementing a range of Strategy initiatives associated with information development, depression and suicide.

National Suicide Prevention Strategy

<http://www.mentalhealth.gov.au/sp/nsps/index.htm>

In the 1999-2000 Federal Budget, the Government committed \$39.2 million over four years from July 1999 for a National Suicide Prevention Strategy (NSPS) to build on the former [National Youth Suicide Prevention Strategy](#) (NYSPPS).

The importance of local level suicide prevention activities, support of community organisations and the development of community models of suicide prevention is a priority under the NSPS. The Key Outcomes of the NSPS are:

- support of national suicide prevention activities across the life span; and
- development and implementation of a [strategic framework](#) for a whole of government and whole of community approach to suicide prevention across all levels of government, the community and business.

National Youth Suicide Prevention Strategy

<http://www.mentalhealth.gov.au/sp/nysps/about.htm>

A total of \$31 million was allocated over 1995-99 for the National Youth Suicide Prevention Strategy (NYSPS). Underpinning the NYSPS was the premise that suicide is a complex problem that must be addressed using a range of approaches. The four goals of the NYSPS included:

- Prevent premature death from suicide among young people
- Reduce rates of injury and self harm
- Reduce the incidence and prevalence of suicidal ideation and behaviour
- Enhance resilience, resourcefulness, respect and interconnectedness for young people, their families and communities.

National Framework Life

<http://www.mentalhealth.gov.au/resources/life/framework.htm>

The *LIFE* Framework aims to foster strategic partnerships and to position suicide prevention effort across all sectors. It was developed by the National Advisory Council on Youth Suicide Prevention, guided by consultation with key groups and evidence that suicide prevention requires a multi-faceted approach involving collaboration between all levels of government and the community.

The *LIFE* Framework consists of three companion documents: *LIFE: Areas for action*, *LIFE: Learnings about suicide* and *LIFE: Building partnerships*.

Regional Health Strategy

Commonwealth Department of Health and Ageing. (2000) Regional Health Strategy: More doctors better services.

<http://www.health.gov.au/budget2000/rural.pdf>

Components of the Regional Health Strategy are mutually reinforcing. They will work together to increase the availability and viability of rural health services for the long term. Fifteen points are presented addressing provision of health services to rural Australia.

Rural Health Strategy

<http://www.ruralhealth.gov.au/>

Building on the achievements of the Regional Health Strategy announced in the 2000-2001 Budget, the Rural Health Strategy will continue to fund a range of initiatives including rural health services, programs to support the recruitment and retention of GPs and long-term measures to increase the rural workforce. The Rural Health Strategy will also focus on new preventive health measures to address the gap in health outcomes between rural and urban Australians. The 2004 Rural Health Strategy provides \$830.2 million over four years, for a flexible package of health and aged care services and workforce measures.

National Strategy for an Ageing Australia

<http://www.health.gov.au/budget2000/fact/acfact1.htm>

There are now 2.3 million Australians aged 65 years and over which is 12 per cent of the population. By 2016, this will increase to 3.6 million or 16 per cent of the population.

The International Year of Older Persons and the Government provided \$6 million over two years in the 1998-1999 Federal Budget and a further \$5 million in the 1999-2000 Budget to support a positive change in attitudes towards ageing and to enhance community recognition of the value of older Australians.

A whole-of-government approach to the issues will be facilitated. Positive attitudes towards older Australians will be encouraged and the benefits flowing from healthy lifestyles for older people will be highlighted. A further key element of the National Strategy for an Ageing Australia will be activities aimed at raising the profile of mature aged workers and their contribution to national economic growth.

National Strategic Framework for Aboriginal and Torres Strait Islander Health

National Strategic Framework for Aboriginal and Torres Strait Islander Health: Framework for action by Governments, NATSIHC, Canberra.

<http://www.health.gov.au/oatsih/pubs/healthstrategy.htm>

The stated goal of this framework is "To ensure that Aboriginal and Torres Strait Islander peoples enjoy a healthy life equal to that of the general population that is enriched by a strong living culture, dignity and justice." Aims and priorities are presented and "key result areas" fall under three categories: 'towards a more effective and responsive health system', 'influencing the health impacts of the non-health sector' and 'providing the infrastructure to improve health status'.

National Physical Activity Guidelines for Australians

<http://www.health.gov.au/pubhlth/publicat/document/physguide.pdf>

The *National Physical Activity Guidelines* for Australians are a blueprint to promote physical activity by building individual awareness of the benefits of small amounts of moderate-intensity physical exercise and encouraging people to be healthier by being more active.

The intent of the Guidelines is to offer guidance and options for moderate-intensity physical activity, which are both achievable and sustainable across gender, socio-economic and occupational groups. They refer to the minimum levels of physical activity required for good health. They are not intended for high-level fitness or sports training.

Reports

Alcohol and Water Safety

Driscoll, T., Steenkamp, M. & Harrison, J. (2003) Alcohol and Water Safety: National Alcohol Strategy 2001 to 2003-4: Occasional Paper. January 2003: Commonwealth Department of Health and Ageing.

<http://www.health.gov.au/pubhlth/publicat/document/alcwater.pdf>

This report was prepared in response to an invitation to examine the role of alcohol in drowning and other types of injury associated with recreational aquatic activities. The purpose of this report is to collate available information, including new sources, to support priority setting and policy formulation. The report specifically aimed to provide:

- A statistical description of the burden of alcohol-related drowning and near-drowning in Australia based on an attributable fractions method and published estimated fractions
- Analysis of National Coroners Information System (NCIS) data on the involvement of alcohol in drowning deaths and deaths associated with recreational boating (whether by drowning or not).
- An assessment of the potential value and feasibility of collecting data on alcohol-relatedness as part of emergency department surveillance of drowning and near-drowning cases.
- A review of literature concerning alcohol as a risk factor for drowning, near-drowning and other serious injury sustained during swimming and other water-related activities, particularly including recreational aquatic activity; and interventions against these risks.

The Costs of Illness Attributable to Physical Inactivity in Australia

Stephenson, J., Bauman, A., Armstrong, T., Smith, B. and Bellow, B. (2000) The costs of illness attributable to physical inactivity in Australia: A preliminary study. Report prepared for the Commonwealth Department of Health and Aged Care and the Australian Sports Commission.

http://www.health.gov.au/pubhlth/publicat/document/phys_costofillness.pdf

“A preliminary analysis of the costs of illness attributable to physical inactivity, with particular emphasis on coronary heart disease (CHD), non-insulin dependant diabetes (NIDDM) and colon cancer. Other costs of illness attributable to physical inactivity are described, although in less detail.”

Appendix C

General injury data

Injury deaths

- Injury is the most common cause of death in both males and females aged 0-24 years.
- Injury accounted for 8,098 deaths in 2000.
- Injury accounted for 51.3% of all deaths for people aged 0-44 years in 1999¹².
- The most common causes for death (2000) in the three age related Priority Populations combined were falls, transportation and self harm.

Injury hospitalisations

- Injury accounted for 413, 652 hospital separations in 1999-2000.
- The most common causes for injury related hospital separations (1999-2000) in the three age related Priority Populations combined were: falls, other unintentional injury and complications from medical and surgical procedures.

Injury costs

- Injuries represented 8.3% of total allocated health expenditure¹³.
- Injuries accounted for 11% and 5% of Disability Adjusted Life Years (DALYs) for males and females respectively¹⁴ in 1996.

Priority populations

The data presented in the AIHW document *National injury prevention plan priorities for 2004 and beyond: discussion paper* (Pointer et al., 2003) have been summarised for each of the Priority Areas below.

Children (0-14 years)

- In 1999-2000 there were 68,134 hospital separations in children due to injury and poisoning from external causes, accounting for 16.5% of the total number of injury hospitalisations in the general population.
- In 2000, there were 332 deaths due to injury, accounting for 4.1% of all injury deaths.
- Boys are almost twice as likely as girls to be either hospitalised or to die from injury or poisoning:
 - The age adjusted rate (in 1999-2000) of injury hospitalisations for boys was 2,117.2 and 1,339.7 for girls (per 100,000 population).
 - In 2000, the age adjusted injury death rate was 10.8 and 6.2 for boys and girls respectively (per 100,000 population).
- In 2000, the three highest causes of death due to injury for children were: transportation (129 deaths), drowning and near-drowning (68 deaths) and other unintentional injury (60 deaths).
- In 1999-2000, the three highest causes of injury-related hospitalisations for children were: falls (28,431 hospital separations), other unintentional injuries (18,154 hospital separations) and transportation (9,667 hospital separations).

¹² Australian Institute of Health and Welfare 2002. Australia's health 2002. Canberra: AIHW.

¹³ Australian Institute of Health and Welfare (AIHW 2004). Health system expenditure on disease and injury in Australia, 2000-01. AIHW cat. no. HWE 26 Canberra: AIHW (Health and Welfare Expenditure Series no. 19).

¹⁴ AIHW: Mathers C, Vos T & Stevenson C 1999. The burden of disease and injury in Australia. AIHW Cat. No. PHE 17. Canberra: AIHW.

Emerging Adults (15-24 years)

- Different patterns of injury occur according to age and gender –
- In 1999-2000 there were 65,073 hospital separations in emerging adults due to injury and poisoning from external causes, accounting for 15.7% of all hospitalisations for injury.
- In 2000, there were 1,158 deaths from injury, accounting for 14.3% of all injury deaths.
- In 2000, the three highest causes of death due to injury for emerging adults were: transportation (522 deaths), intentional, self-harm (339 deaths) and poisoning, pharmaceuticals (137 deaths).
- In 1999-2000, the three highest causes of injury-related hospitalisations for emerging adults were: other unintentional causes (19,578 hospital separations), transportation (13,855 hospital separations) and falls (11,452 hospital separations).
- Young males outnumber young females in deaths due to injury for all injury categories.
- Young males outnumber young females in all hospitalisations due to injury for all injury categories EXCEPT pharmaceutical poisoning and self-inflicted injuries.
- In males aged 20-24 years alcohol-related injury deaths accounted for 18% of injury deaths (compared with 15% of male injuries across all ages).

Older people (65+ years)

- People aged 75 and over generally have higher injury related death rates and hospitalisation rates than people aged 65 – 74 years (refer to Table 1 below).
- People aged 75 years and over have the highest age adjusted injury related death rate and hospital separation rates per 100,000 than of any of the five priority populations.
- In 1999-2000 there were 100,851 injury related hospital separations in older people accounting for 24.4% of all hospitalisations for injury.
- In 2000 there were 2,290 injury related deaths, accounting for 28.3% of all injury related deaths.
- In 2000, the three highest causes of death due to injury for older people were: falls (1,173 deaths), transportation (314 deaths) and intentional, self-harm (305 deaths).
- In 1999-2000, the highest causes of injury-related hospitalisations for older people were: falls (57,701 hospital separations), complications of surgical or medical care (27,087 hospital separations), other unintentional injury (8886 hospitalisations) and transportation (4,489 hospital separations).
- Falls accounted for 62.2% of all injury deaths and 66.5% of all injury related hospitalisations in older people.
- Although women accounted for more than twice the number and almost three times the percentage of injury related hospitalisations, the gender difference is reduced when the figures are adjusted for the gender proportions in this age group.

Indigenous and Torres Strait Islander Population

- Higher rates of injury deaths and hospitalisations than for the whole Australian population.
- The Aboriginal and Torres Strait Islander population has the second highest age adjusted injury death rate and hospitalisation rate per 100,000 for all five priority groups.
- There is a lack of targeted injury intervention and prevention programs.
- In 1999-2000 there were 12,363 injury related hospital separations in Aboriginal and Torres Strait Islander people accounting for 7.2% of all hospitalisations for injury.
- In 2000 there were 247 injury related deaths, accounting for 7.3% of all injury related deaths.
- In 2000, the three highest causes of death due to injury for Aboriginal and Torres Strait Islander males were: intentional, self-harm (56 deaths), transportation (43 deaths) and intentional, inflicted by another (21 deaths).
- In 2000, the three highest causes of death due to injury for Aboriginal and Torres Strait Islander females were: transportation (18 deaths), intentional, inflicted by another (17 deaths) and intentional, self-harm (10 deaths).

- In 1999-2000, the three highest causes of injury-related hospitalisations for Aboriginal and Torres Strait Islander males were: intentional, inflicted by another (1,805 hospital separations), other unintentional injuries (1,691 hospital separations) and falls (1,165 hospital separations).
- In 1999-2000, the three highest causes of injury-related hospitalisations for Aboriginal and Torres Strait Islander females were: intentional, inflicted by another (2,121 hospital separations), other unintentional injuries (970 hospital separations) and falls (827 hospital separations).
- Complications of medical and surgical care (683 hospital separations) accounted for 9.7% of injury related hospitalisations for this population group.
- Alcohol related cases accounted for 22.7% of all Aboriginal and Torres Strait Islander injury deaths, compared with 5.1% of the Non-Aboriginal and Torres Strait Islander injury deaths.

Rural / remote population

- In 1999-2000 there were 145,158 hospital separations in rural and remote areas due to injury and poisoning from external causes, accounting for 35.1% of all hospitalisations for injury.
- In 2000, there were 2,777 deaths from injury, accounting for 34.3% of all injury deaths.
- In 2000, the three highest causes of death due to injury for males in rural and remote areas were: intentional, self-harm (633 deaths), transportation (610 deaths) and other unintentional injuries (190 deaths).
- In 2000, the three highest causes of death due to injury for females in rural and remote areas were: falls (261 deaths), transportation (233 deaths) and intentional, self-harm (136 deaths).
- In 1999-2000, the three highest causes of injury-related hospitalisations for males in rural and remote areas were: other unintentional causes (27,964 hospital separations), falls (20,970 hospital separations) and transportation (13,866 hospital separations).
- In 1999-2000, the three highest causes of injury-related hospitalisations for females in rural and remote areas were: falls (21,818 hospital separations), complications of surgical and medical care (10,481 hospital separations) and other unintentional injury (10,288 hospital separations).
- Overall, transportation accidents were the leading cause of injury related deaths and the fourth highest reason for hospitalisation in the rural and remote areas.

Alcohol and injury¹⁵

- Alcohol use has high correlations with motor vehicle crashes, falls, interpersonal violence and water-related injury.
- Pharmaceutical poisoning is the third most common alcohol associated death behind intentional self-harm and transportation.
- For males aged 20-24 years, alcohol-related injury deaths (2000) accounted for 18% of injury deaths (compared with 15% of male injuries across all ages).
- Alcohol related cases accounted for 22.7% of all Aboriginal and Torres Strait Islander injury deaths (2000), compared with 5.1% of the Non-Aboriginal and Torres Strait Islander injury deaths.

¹⁵ Note: Alcohol related injury deaths and hospital separations are possibly underestimations given the current that the 'drugs flag' in the ABS mortality data has not been validated (refer to discussion re Surveillance Indicators – Alcohol in Pointer et al., 2003).

Table 1: Age adjusted injury rates per 100,000

	Children 0-14	Emerging adults 15-24	Older people 65+	Aboriginal & Torres Strait Islander	Rural / remote
Hospital separations (1999-2000)	1,738.2	2,415.34	4040.2	5,260.8	2,683.0
Deaths (2000)	8.6	42.77	86.6	109.7	50.6

Table 2: Age adjusted rates per 100,000 for Older People by age group

	65-69	70-74	75-79	80-84	85+	Total (65+)
Hospital separations						
Males	2405.3	2935.9	4023.4	5398.2	8502.0	3697.9
Females	2209.1	3131.2	4706.8	7186.8	11125.8	4234.4
Total	2305.1	3039.5	4412.5	6496.7	10317.5	4040.2
Deaths						
Males	48.6	72.3	102.5	161.8	442.2	109.9
Females	26.9	37.2	52.7	114.2	339.2	69.7
Total	37.5	53.7	74.2	132.7	371.0	86.6