

pneumococcal vaccination gives better protection against severe illness and death than relying on antibiotic treatment once the disease has developed.

Methods towards solutions

For effective antiviral drugs use in a pandemic, supplies need to be available in advance, because rapidly increased production could not be relied upon. Stockpiling will avoid international competition for limited supplies as well. European protocols for identifying priority population groups and criteria for release for clinical use should be used in establishing the scale of stockpiling and for its logistic management. Similar factors apply to the deployment of pneumococcal vaccine also in the context of the already existing policy for

offering annual vaccination to mostly elderly persons in some European countries.

Conclusions

In preparation on influenza pandemic a common European policy of stockpiling and deploying antiviral drugs and of vaccinating risk groups with pneumococcal vaccine should be considered.

Plenary discussion: Is there a need and urgency for a common public health practice policy in Europe in preparation on the next large scale outbreak?

Lead by the two chairpersons

Local Injury Registration as a Base for Prevention: Workshop

Organisers: University of Oslo (UiO) and Directorate for Health and Social Affairs (DHSA), Norway

Chairpersons: Lund J¹, Olsen BO²

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Injuries place heavy burden on European societies in terms of human suffering, health expenses and compensation costs. A prerequisite for planning, implementation and evaluation of injury prevention strategies is an understanding of the occurrence of injuries in terms of time, place, person, and factors contributing to injuries in the population.

In this workshop experiences from registration and prevention in communities in Norway and the Check Republic will be presented. Minimum Data Sets on Injuries developed in an European project will be demonstrated. Such MDSs are instruments for settings that have limited resources (time, money and or/information). A project that tested geographical mapping of accident sites on digital aerial photos will be presented.

This workshop intends to raise awareness about injury registration and prevention for European public health practitioners. An aim might be to establish a section on injury prevention in the European Public Health Association.

- Helge Lund: Injury registration and prevention in a small community in Norway
- Saakje Mulder: Minimum Data Sets on Injuries in the European Union
- Veronika Benesova, J. Cihalova, P. Nencka: Accident data collection at local level in the Czech Republic
- Gunnar Tellnes, Johan Lund, Leiv Sandvik, Børge Ytterstad: Long-term effects of community-based injury prevention
- Hans Magne Gravseth: Geographical mapping of accident site in an emergency department.

Injury registration and prevention in a small community in Norway

Lund H

Norway

Problem

Os municipality has 2200 inhabitants. Ten percent of the population in Os municipality require medical attention as the direct effect of an accident. Injuries from accidents are real health problems.

Description

The registration of accidents in Os municipality is continuous and are done in the GP' electronic journals. All accidents that require medical attention are registered. The collected data serves as an indicator for future preventative initiatives. The electronic journals recognise certain diagnosis and will automatically request registration of the incident if it is likely that the injury suffered in an accident. Different variables are recorded. There is also an option for notes where further details can be written. The data are then transported automatically to Microsoft Excel. The electronic system is less time consuming than the equivalent paper based system. The registration procedure for each patient takes up on average 30 seconds, while extracting the data and creating statistics can be done in an hour.

Lessons learned

Scene of accidents 1999 (N=182 accidents): At home 28%, Traffic 13%, School / kindergarten 9%, Agriculture accidents 12%, At work 9%, Sport and leisure 22%, Unknown 7%. Accidents among children and the elderly occurs in their homes, sport and leisure accidents among the youngsters. There were few serious accidents.

The number of accidents in 1996 were 199 and in 2003 the numbers had fallen to 96!

Conclusions

It is necessary to produce local data in order to prevent accidents. The recording system should be electronic rather than paper questionnaires.

Minimum Data Sets on Injuries in the European Union

Mulder S

Problem

Member States of the European Union are interested in injury information in different health care settings. Settings with limited resources (time, money and/or information) and/or who start recording might use Minimum Data Sets on injuries (MDS-Is). In a European project, MDS-Is were developed, taking into account the variety in objectives and settings and the availability of resources, and the need to have compatibility to the most relevant existing classification systems. The focus of the MDS-Is Europe is limited to the all types of medically treated injuries.

Description

After an inventory of current use and experiences with MDS-Is in Member States, applicant countries and other countries worldwide, the wishes and demands concerning MDS-Is in the injury field were formulated. Based on these two activities and consulted by a team of European experts several draft MDS-Is for different settings and objectives were developed. They are based on the International Classification of External Causes of Injuries (ICECI), the International Classification of Diseases and Related Health Problems (ICD), and the classification of the European Home and Leisure Accident Surveillance System (EHLASS). The draft MDS-Is were reviewed in 10 EU countries and field-tested in 7 EU countries. The testing results formed the input for the development of the final MDS-Is.

Lessons learned

The group of experts agreed upon four levels of objectives and four different health care settings. This led theoretically to sixteen MDS-Is. The wish for as few MDS-Is as possible led to the decision to develop only five MDS-Is.

Conclusion

The MDS-Is are available for use. However, active promotion should be carried out to stimulate the use of the MDS-Is in settings with less resources. They are also suitable as a reporting format for comparing injury data from well-resourced EU Member States and/or settings.

Accident data collection at local level in the Czech Republic

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Czech Republic

Problem

Centre for Injury Prevention initiated the collection of injury data in the city of Kromeriz, with a population of 29.739 inhabitants, as a base for WHO Safe Community program development.

Description

Registration form was constructed and used by local medical practitioners in all health care units, hospitals, out patient wards and GPs. The data were analysed focusing on place, time of occurrence, mechanism, age group and consequences of injuries. The percentage of treated injuries was 10,6% of the population in Kromeriz.

Lessons learned

The data collection using the registration forms represents certain burden for health care practitioners. However, well presented instruction help the performance and adherence to the program. The

surprising result of the data collection was the high number of injuries in the age group 0–1 year and the injuries of seniors which are underreported by medical practitioners. Self reported injury occurrence is as high as 50% of this age group.

Conclusions

The data collection is possible even without economically demanding computerized technology. The role of the local authorities for the whole community is essential, not only from the health sector. The lead should be taken by the public health representatives.

Long-term effects of community-based injury prevention (will be presented as a poster)

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Norway

Problem

An injury prevention programme started in 1981 and ran until 2000 in a small island community (Værøy) in Northern Norway with a population of about 1,000. The design of the programme facilitated a study on the long term effects of injury prevention over a period of 20 years.

Description

Injuries resulting in a consultation with the physician on the island were recorded in the years 1970, 1980, 1982–83, 1985–87, and 2000. An injury was defined as severe if the patient had either: injury with Abbreviated Injury Scale (AIS) of value 2 (moderate) and higher, was hospitalised and/or was granted sick-leave. concerted community based intervention programme was carried out more or less with same intensity until the end of the 1980's. It was then reduced to a 20–30% level of intensity, a level which lasted throughout the 1990's, and is still maintained today.

Lessons learned

For all injuries, the incidence rate for the island's population was reduced from 17.7% in 1980 (N=188) to 9.7% in 1987 (N=97), a reduction of 45%. The same rate of 9.7% was observed in 2000 (N=91). No reduction was observed in children (0–14 years) while the age groups 15–24 and 45 and over showed the most distinct reductions. Both occupational injuries, home injuries and traffic injuries showed a marked reduction throughout the eighties. Similar reductions were observed also for severe injuries.

Conclusions

The results of this study indicate that a community based intervention with defined aims can lead to a considerable and long-lasting reduction in injuries. The factors associated with the

reductions might be the small size of the community, enhancing synergetic effects in the community, and preventive measures tailor-made to the relevant risks.

Geographical mapping of accident site in an emergency department

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Norway

Problem

Mapping of traffic accidents is important for prevention. Police reported accidents are mapped accurately, but underreporting is considerable. Most traffic victims will be visiting major emergency departments, which could be possible arenas for the use of mapping tools. However, this might be time consuming, and it might be difficult for patients to make a precise identification of the accident spot.

Description

Oslo Emergency Ward tested a system for geographical mapping of accidents during one week of March 2004. We had a computer with digitalised aerial photographs of the city. It was possible to zoom in and detect objects like cars, zebra crossings etc. One doctor served the computer, usually sitting next to the patient. The accuracy with which the accidents were mapped was given on a scale from 1 to 3, and the time spent was registered. 57 accidents were mapped. Median age of patients was 31 years, range 4–87 years. 35 of the accidents were traffic and pavement accidents, with single pedestrian accidents (mostly fall on ice) as the largest group. The rest of the accidents were related to sport activities, schools, playgrounds or work.

Lessons learned

49 of the accidents (86%) were mapped with high accuracy, i.e. maximum 20 metres measurement inaccuracy, usually considerably less. 6 accidents were mapped with medium accuracy, whereas only 2 accidents had poor accuracy, i.e. more than 2–300 metres measurement inaccuracy. Suboptimal accuracy was noted only for accidents involving the oldest or the youngest, or accidents that had been taking place in rural areas, like forest. Time spent for the registration varied from 41 seconds to more than 6 minutes, median 91 seconds. Time consumed was less than one minute in a quarter of the cases.

Conclusions

In an emergency department, it is possible to map most relevant accidents with high accuracy and with little time spent.

Primary Health Care and General Practitioners

Patterns of utilization of primary health services in a Danish

cohort: the results of Markov Chain modelling
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Aim

The study was undertaken to identify determinants of patterns of general practitioner (GP) and emergency room (ER) utilization in Denmark including characteristics of the health services, characteristics of the community, and health and socio-demographic characteristics of the population.

Methods

A follow-up design involving a time dimension of 12 months. A cohort of 3,000 50-year old men and women was randomly selected from an urban county near Copenhagen and a rural county in Western Jutland, 65% agreed to participate. Data were collected 1991–92 through questionnaires mailed to the participants every three months, a questionnaire mailed to all general practitioners in the counties, and the Health Insurance Register. Using Markov Chain models we looked for possible associations between characteristics and events measured repeatedly during four time periods.

Results

Utilization of ER was found to be systematically and strongly associated only with county and health conditions whereas visits to the GP were determined by gender and income as well as health. Use of ER was associated with use of GP in the same quarter whereas use of GP was found to be associated with use of ER in the same as well

as in previous quarters. Heavy tracking involving repeated contacts with the same kind of service was found both regarding GP and ER.

Conclusions

By maximising the use of the time dimension in the analytic model the study has demonstrated a rather complex interaction between the use of different services over time as well as inclinations to utilize the same services repeatedly. Further studies should identify the actual mechanisms behind these patterns of utilization as well as the effects before decisions on changes in access to primary care services are made.

Delivery of Primary Health Care in Slovenia in View of Transition

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Issue

Transition of early nineties brought substantial changes to Slovenia's health system as it followed political changes started at the end of the 1980s. Social health insurance was introduced and based on the Bismarck's model with a single national insurance fund which acts also as the main purchaser in health care. The concept of primary health care remained almost unchanged with GPs, paediatricians and school medicine specialists and gynaecologists keeping their gate-keeping roles and thus free access to their services. Transition affected primary health care through change in reimbursement strategies and privatisation. These were a constant drive for conflicts between the Ministry of Health and local communities and between local communities, primary health care centres and private practitioners. We should note a lack of a clear-cut strategy for the development of primary health care delivery.