Education and debate

Road safety advocacy

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Health professionals have an important role in implementing measures to reduce deaths and injuries on the roads

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As many as 50 million people each year may be injured in road traffic crashes globally—a total representing the combined populations of Beijing, Delhi, London, Paris, and New York.¹ Without increased safety effort to match the growing number of motor vehicles in low to middle income countries, road traffic injury is predicted to be the third leading contributor to the global burden of disease and injury by 2020.² Heeding such a forecast, the World Health Organization this week placed road safety advocacy high on the agenda for public health professionals, alongside other key activities.¹ According to WHO, “hidden epidemics” such as road traffic deaths and injuries receive relatively little national or international attention.³ Without solid action now, the forecast looks bleak over the next decades for low income countries.⁴ Even in countries that have more active road safety programmes, too few evidence based measures are being implemented and too few are being promoted by too few organisations.⁵ Road crashes continue to be the leading cause of death and hospital admission for people under 50 years old in the European Union.⁶ So what can health professionals do to help?

What is advocacy?

WHO defines advocacy as “a combination of individual and social actions designed to gain political commitment, social acceptance, and system support for a particular goal or programme.”⁷ Surprisingly,

little analysis of public health advocacy has been published, and most “good practice” is transmitted orally.⁸ Nevertheless, concerted health sector advocacy has been a key element in delivering successful measures that have saved many lives. This contribution is needed just as much today.

Policy makers need objective evidence on effectiveness, public acceptability, and cost effectiveness to inform decision making. Advocacy seeks to narrow the gap between what is known to be effective, acceptable, and efficient in preventing road injuries and what is practised. Advocacy addresses the major barriers that interfere with the implementation of proved policies and measures.

Barriers to improved road safety

The lengthy campaigns for many injury prevention measures show that political decisions are not made merely on the basis of good evidence. Important road safety measures rarely come about in the normal order of things or as a result of consensus of all stakeholders. Time after time, opposition from powerful sources has been an important barrier to introducing evidence based measures, even when these are demonstrably cost effective and acceptable to the public. This opposition can take several different forms.

Firstly, opposition can come from proponents of political philosophies that undermine health at the expense of economic considerations.⁸ For example, legislating in a high level of protection into products or operations may be seen as red tape or a barrier to trade, irrespective of the socioeconomic benefit.

Secondly, vociferous minorities perceiving state interference with civil liberties have played a large part in delaying, preventing, or even overturning major injury prevention policies. It took 10 years, for example, for a successful parliamentary initiative to make seat belts compulsory in the United Kingdom; this delay had a high price, given that seat belts have saved around 2500 lives and prevent around 25 000 serious injuries annually. Despite numerous surveys showing widespread support for speed cameras in the United Kingdom and the support of the select committee on transport,⁹ the acceptability of cameras is still being questioned in the media by a vociferous, highly active, minority.

**Emergency scene;
image removed at
request of agency**

Thirdly, vested commercial interests have a strong influence. Industry provides the products and services and thus, ultimately, shares responsibility for aspects of road safety. However, it can often be as much a part of the problem as a potential partner in delivering solutions. Examples include lobbying by the alcohol industry against random breath testing or reductions in legal blood alcohol limits for driving^{10 11} and the activity of the car industry in delaying or even preventing effective vehicle safety legislation.^{12–15}

What health professionals have achieved

Health professionals and organisations have been able to cut through the influence of powerful opposition. The Royal Australasian College of Surgeons was a powerful, non-party political advocate campaigning for Australian occupant restraint legislation in the early 1970s.¹⁶ The legislation was the first of its kind and provided the evidence needed to back up similar campaigns elsewhere.

In Britain, many attempts were made to introduce legislation to make use of front seat belts compulsory after the first try in 1973. Opposition came mainly from a leading motoring organisation and a small group of parliamentarians from all parties who argued against the “nanny state.” The British Medical Association, the Casualty Surgeons Association, the Royal College of Surgeons, the British Paediatric Association, and the Child Accident Prevention Committee (now trust) all had a key role in the coalition that eventually helped to get this measure into the Transport Act 1981.¹⁷ The measure was passed despite opposition from the prime minister and leader of the opposition at the time and the final free vote being scheduled on the eve of the wedding of the heir to the throne.

What individual health professionals can achieve

It is widely acknowledged that the road traffic system needs to reflect better the human limitations of its users if road deaths and serious injuries are to be cut further.¹ A supplementary report prepared by WHO Europe for World Health Day calls on the health sector to become a leading champion for road safety by advocating safe road transport systems that reject preventable deaths and serious injuries, supporting the implementation of effective measures, and supporting the efforts of the transport sector to keep speeds within safe levels. This would be an important way for the health sector to fulfil its mission of protecting the fundamental human right to health.¹⁸

Professionals working in trauma care and rehabilitation witness the human tragedy behind road traffic injury and can be powerful advocates of prevention. For example, in New Zealand in 1987, a group of four intensive care specialists decided to tackle the growing epidemic of road traffic injuries. At that time, victims of road traffic crashes accounted for 30% of intensive care admissions and 40% of inpatient days in their Auckland based intensive care unit. Their prevention campaign had five objectives: to promote the use of the term crash rather than accident; to install motorway median barriers (which they identified as having

Risk of pedestrian death according to speed of impact of car.
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potential to reduce injuries locally); to ensure appropriate child restraints in vehicles; to analyse blood alcohol content of those injured in road crashes; and to advocate for a Ministry of Trauma Prevention.

The campaign for median barriers on motorways was supported by the suburban newspapers, which organised a 16 000 signature petition that was later presented to parliament. They put out their message on radio, television, and in the newspapers and gained widespread popular support. In 1998, as a result of pressure on the minister for transport, the prime minister announced that all new motorways in New Zealand would be built with median barriers and that existing motorways would have them fitted.¹⁹

Future advocacy challenges

Although substantial progress has been made in reducing road deaths and injuries, considerable challenges remain. Pedestrians have a 90% chance of surviving crashes at 20 mph (32 km/h) or less but less than a 50% chance of surviving a crash at speeds around 30 mph (48 km/h) (figure). The wider introduction of 20 mph speed limits in residential areas in which there is currently a dangerous mix of fast moving traffic, cyclists, and pedestrians, many of whom are children or elderly people, is a key area for ongoing advocacy.

Even more challenging is the long awaited European Union legislation on safer car fronts for pedestrians that would ensure vehicles passed well established, well researched performance tests that have been used in consumer information for years. A directive is being implemented, but it fails to guarantee the adoption of the necessary vehicle safety tests despite, as WHO notes, their potential to save up to 2000 lives annually in the European Union alone.¹ Health practitioners with expertise in epidemiology and risk assessment can have a key role in advocacy for lower blood alcohol limits. The current UK limit of 0.8 g/l is twice that identified as the point at which excess risk becomes significant.²⁰ Similarly, the public health impact of random breath testing, which has been shown to reduce alcohol related crashes by 20%, has yet to be realised in the UK, even though the BMA has campaigned for its implementation since the late 1980s.^{1 21} In low and middle income countries, the challenges are even more acute but there is huge potential for health gain.

Summary points

Road crashes account for a high proportion of morbidity and mortality globally

Attempts to introduce proved road safety measures are often opposed by groups with minority interests

Health professionals can act as a powerful lobby for change

The health sector bears a large part of the socioeconomic burden of road injury. It would benefit from better road injury prevention in terms of fewer hospital admissions, reduced severity of injuries and, in the event of safer conditions for pedestrians and cyclists, health benefits from more walking and cycling. Anything worth doing in road injury prevention in future, as in the past, requires strong and persistent advocacy from those with the public health most in mind.

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Does your heart go on vacation?

Carlos, a quiet 7 year old with light brown tousled hair and big brown eyes, arrived with his mother for his yearly check up. He sat on the examination table, swinging his legs back and forth.

As I walked in, Carlos told me he had a question. "What is your question?" I asked.

"Can you check my mom to see if she can have another baby?" he asked with sincerity and thoughtfulness.

"Would you like another baby at your house?" I asked, watching his 2 year old sister climb on to his mother's lap. Carlos talked about his cousin, who had a new baby, and how he liked babies. We decided that the decision about whether his mother had another baby would be up to his parents. His mother smiled.

Satisfied, Carlos had another deep question. "Does your heart go on vacation?" he asked, becoming fidgety.

"Tell me more about that," I replied.

Carlos asked whether hearts stop beating and then start again, and what happens to your heart when you die. "Does it go on vacation then?" he asked.

Carlos's mother explained that Carlos was concerned about death, what happens at that time, and that he had been asking questions about death. I learnt that no one in his family or anyone he knew had died, and there were no recent losses. "It's a natural curiosity," I explained to his mother. "Children are curious about death at all ages. Younger children see death as transient, yet around Carlos's age they begin to understand, as they did not earlier, that death is permanent."

We continued to talk about answering children's questions about death, and then Carlos asked another question. "When do people die?" he asked, his small body now swaying from side to side on the examination table. I explained that people usually do not die until they are very old with white hair and wrinkles. Carlos talked about how he could make his hair white and paint wrinkles on his face. "Would I die then?" he asked me.

"No, you wouldn't die then," I replied. "Even if you made your hair white and drew wrinkles on your face, you would still be 7 years old." Carlos's shoulders relaxed, and he leaned back with quiet relief.

When we listen with acceptance and respect, we can hear our patients' concerns in their metaphors and stories. This holds true for patients of all ages.

Elizabeth Rider *codirector, Communication Skills Teaching Program, Harvard Medical School, Boston MA, USA*

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