CONFERENCE REPORT

Action on Injury—a stepping off point for the UK

Michael Hayes, Elizabeth Towner

How to measure the success or failure of a conference is always problematic. One crude but perhaps encouraging aspect of the Action on Injury Conference held in London in November 1998 was that a large proportion of the people who attended were not the regulars you see at most injury prevention gatherings in the UK! If this could be used as a measure of progress, we have taken at least one step in the right direction.

A brief history

What is the Action on Injury initiative? What were we trying to achieve? When Professor Stephen Jarvis, Professor of Community Child Health at the University of Newcastle upon Tyne, invited a group of people together to consider how to put injury prevention for children and young people more securely on the strategic map in March 1997, we quickly generated several ideas of how to move matters forward but we rapidly realised that we could not pursue all simultaneously.

The make-up of the group is in itself interesting. Stephen Jarvis managed to bring together senior representatives of the Faculty of Public Health Medicine, the Royal Colleges of Paediatrics and Child Health and of General Practitioners, key academic departments with a longstanding interest in childhood injury prevention research, the BMJ Publishing Group, and the Child Accident Prevention Trust. What was novel about this group was that the Royal Colleges and the Faculty have not been regarded as leaders in this subject, but are influential players within UK medical circles. Later, we were joined by officials from the health departments for the four countries of the UK.

Another key moment arrived in May 1997 and it was not of our doing—there was a general election that swept a new government into power. As a result, draft strategies started appearing on the table and civil servants were hunting around for ideas to fulfil the insatiable appetite of their new ministers. For the first time, a Minister of State for Public Health was created in the Department of Health, and a while later a draft public health strategy identifying injury—or as it was then called accident—prevention as a priority area emerged.¹

The Action on Injury initiative

The tide was now flowing in the right direction. Two linked courses of action were agreed

upon—preparation of a publication to highlight the subject and the organisation of a conference as the first part of its widespread distribution. The model for this publication was *Injury in America*, which in many quarters was credited with putting injury on the public health agenda in the US.²

The UK publication, *Action on Injury: Setting the Agenda for Children & Young People in the UK*,³ was produced thanks to financial support from the Department of Health. It comprises contributions from the members of the ad hoc group covering the scale of the injury problem, including the costs, reviews what is known about effective prevention, discusses the problems of implementing prevention nationally and locally, highlights opportunities that exist through the UK's membership of the European Union, and considers the role of post-trauma care in injury prevention. As Jarvis and Towner say in their introductory chapter: "This document is intended to provoke a national commitment to injury prevention and control as the single highest health priority for our young people in the UK in 1998".⁴

To achieve this commitment, we sought to bring together senior managers in the health sector—especially from public health—and local government, commissioners of health research, representatives of the major medical research funding bodies, academics, and government departments, and organisations with an interest or responsibility for specific areas of injury prevention—transport, product safety, occupational safety, etc. The rejection rate for the initial round of invitations was disturbing, but perhaps should not have been surprising—people with little interest in injury prevention do not go to conferences on injury prevention. Eventually this reluctance was overcome and the turnout provided the basis for healthy, interdisciplinary discussion.

In addition to discussions centring on the specific chapters, the delegates to the conference were invited to consider four issues raised by Jarvis and Sibert in their concluding chapter of the supplement:

- The need for a dedicated agency to implement national programmes of injury prevention and control.
- The need for improved, coordinated national surveillance of injury.
- A rapid expansion of our academic research capacity in this subject area.

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- The value of having a national standing committee dedicated to the subject.

A dedicated agency

Opinions were divided on this issue, in part because of the use of the word agency, but the overall feeling was that injury prevention would benefit from having a focal point. Whether this should be real—a specific institution with its own staff, etc—or virtual—perhaps a number of existing bodies having a linked remit, similar to World Health Organisation collaborating centres—was not considered in depth but were alternatives mooted. Also, whether such a body should be within or outside government was left unresolved, and in the time available, little thought was given to its precise remit.

The proposal aired referred to the implementation of programmes. But programme implementation implies responsibilities for our environment, products, traffic systems, education curriculum, etc. These all lie within existing departmental bounds. Given that several government departments already carry out injury prevention, the relationship between any new body and the work and responsibilities of the present players needs to be considered carefully. There are unquestionably tasks and issues that confront all departments: the research agenda, multiagency working, evaluation methods, data processing, and perhaps most importantly, linking the databases held within departments. How would the body relate to the Office for National Statistics and its counterparts in Scotland, Wales, and Northern Ireland? None of these questions need present insurmountable problems but will require time and probably goodwill to resolve. Perhaps the first step is to examine how such overarching bodies work in other legislatures and whether there are any precedents within the UK.

Under whose wing would such a body exist? Should it be part of the Department of Health, or would an extradepartmental existence be possible, making it answerable directly to parliament?

Better injury surveillance

There are few people who would argue against the need for improvements in relevant surveillance systems. However, surveillance *per se* does not prevent injuries, it is merely a tool in the prevention system, albeit an important one. There can be a tendency to hide behind the inadequacies of surveillance systems and argue that nothing can be done until the right system is in place. This presupposes that when—or if ever—we have a system meeting the gold standard, all other imponderables will have been resolved: we will know how to prevent the injury causing events, put the secondary safety devices in place reliably, and treat the injuries when they do occur. We have to attack on all fronts simultaneously.

Surveillance systems do not come free of charge. Initially, we have to ensure that the systems in place are meeting the needs of their

“stakeholders” and then, when this cannot be achieved, think about replacing them or adding new systems. Improvements in data linkage may help in this fraught area.

In many injury areas, the UK’s record for childhood injury mortality is comparable with the best in Europe—but it is not clear why. What are we doing that results in this? In contrast, deaths from house fires and to pedestrians are poor by European standards. Data systems are needed that not only cover death and injury but also allow exposure to risk to be explored.

Economic data were regarded as a potentially powerful tool in the fight to justify action. While widely used in the transport safety field, cost information is not readily available for other injury-generating areas.

Expanding academic research

Injury prevention and control have been the poor relations of health research in the UK for too long. Given the scale of the problem and the cost to society from injuries, the level of research spending is disproportionately—and disappointingly—low, particularly outside the transport safety field.

There was general recognition for the need for capacity building in the field in the UK, both for researchers and practitioners.

Treatment and rehabilitation

Mixing injury prevention specialists with those involved in treatment and rehabilitation was unusual for UK meetings, but it was seen as a productive step. Much of the reduction in injury mortality rates can be attributed to improvement in treatment regimens, leaving the reduction of morbidity as the challenge. Injury morbidity extends beyond physical harm, with evidence of psychological damage to children also arising. Those involved in treating children and young people can contribute to primary and secondary prevention—preventing the event and reducing the severity of the injury—through counselling and advocacy.

Children and young people or all age groups?

Investment in new agencies, systems, training, etc is more easily justified if the costs are benefiting as wide a target population as possible. This is one argument against focusing specifically on children and young people when taking the outcomes of this initiative forward. On balance, delegates favoured the all ages approach but this may have been an artefact of the composition of the audience. This question remains high on the agenda for the group charged with progressing this initiative.

Next steps

It would have been easy to end this commentary with a section entitled “Conclusions” but that would have implied a finality that would be out of place given the enthusiasm and interest apparent at the conference. The challenge now

is to extend this enthusiasm to the people who were not able to attend; to build on the opportunities offered by the government's strategies—not just the public health strategy but also those relating to the health service generally, the development of local government, improved integration of public transport, etc; to identify and seek the earmarking of funding; and to facilitate collaboration and cooperation between the current and future players in this field. We have the impressive

results of the experience of *Injury in America* to guide us.

- 1 Secretary of State for Health. *Our healthier nation. A contract for health*. London: The Stationery Office, 1998.
- 2 Committee on Trauma Research, Commission of Life Sciences, National Research Council and Institute of Medicine. *Injury in America: a continuing public health problem*. Washington DC: National Academic Press, 1985.
- 3 Pless B, Townner E. Action on injury: setting the agenda for children & young people in the UK. *Inj Prev* 1998;4(suppl).
- 4 Jarvis S, Townner E. Introduction. In: Pless B, Townner E, eds. *Action on injury: setting the agenda for children & young people in the UK*. *Inj Prev* 1998;4(suppl):S7–S9.

Editorial Board Member: brief biography

DAVID A SLEET, PhD

Dr David A Sleet is the Associate Director for Science in the Division of Unintentional Injury Prevention at the Centers for Disease Control and Prevention (CDC), National Center for Injury Prevention and Control. He received his bachelor's degree in psychology, his master's (with honors) in exercise science, and doctorate in health education and behavioral sciences from the University of Toledo (Ohio). He joined the faculty at San Diego State University in 1974 and conducted early research on Olympic athletes as a member of the USA Research Team for the Montreal Olympic Games in 1976. He helped establish the Graduate School of Public Health at San Diego State University, where he taught for many years as a faculty member in the division of health promotion.

He joined the National Highway Traffic Safety Administration (NHTSA) as a research psychologist in 1981 and helped develop a focus on public health within NHTSA. He was a visiting fellow and

acting director of the Road Accident Prevention Research Unit in Perth, Australia (1989–91) and authored a statewide injury control plan for the Health Department of Western Australia. He subsequently developed the first distance learning course on injury control for Curtin University. His published research synthesis on the relationship between blood alcohol concentration (BAC) and driving performance helped create a national BAC legal limit of 0.05 g/dl in Australia.

As a visiting scientist in Helsinki, he conducted the first study in Finland on the potential benefits of airbags on reducing injuries and fatalities on Finnish roads. He was a research fellow in Brussels, Belgium assisting the design of sports injury surveillance research and establishing links to injury data with the Commission on Public Health of the European Union.

He served on advisory committees to the CDC's Behavioral Risk Factor Surveillance System, the Youth Risk Behavior Surveillance System, the School Health Programs and Policy Study, working groups for 1990 Objectives for the Nation, and subsequent Year 2000 and 2010 US Objectives for injury control. He co-chaired the evaluation panel for the National Committee for Injury Prevention and Control and contributed to the US National Plan for Injury Control.

He joined CDC in 1992 and was named Acting Director of the Division of Unintentional Injury Prevention in 1994. He is on the faculty of the Rollins School of Public Health at Emory University in Atlanta, where he teaches courses in social and behavioral science in public health. His interests are in applying principles of social and behavioral sciences to injury prevention.