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Injury prevention leads to better health

EDITORIAL

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Injury epidemiology research and prevention of injuries depend on good-quality data on where, when and how injuries occur.

Accidents are the main cause of death for people under 45 years (1). In addition, accidents cause a large number of personal injuries that are not fatal, but may have serious consequences for those concerned and for society. An estimate from 2011 indicates that a fatal accident costs approximately NOK 30 million, and that the treatment of a severely and slightly injured person costs NOK 11 million and a little over NOK 600 000 respectively (2). There is a large potential for prevention of both fatal and non-fatal accidents, and a reduction in the number of accidents would account for a solid gain in terms of public health (1).

While prevention of cancer and cardiovascular disease requires decades for an evaluation to be robust, the effect of good injury prevention can be documented after only a few years. The *Harstad Injury Prevention Study* documented reductions in the rates of injury over ten years: rates of burn injuries in children, fractures caused by falls in older people, and traffic accidents (3). Local data from the national injury database, maintained by the Norwegian Institute of Public Health, enabled high-quality analyses, targeted interventions and robust evaluations. Harstad was the first municipality in Norway and the eleventh in the world to be certified by the World Health Organization as a safe local community (4). Unfortunately, one position for quality assurance of injury registrations in Harstad was discontinued in 2016 with the impenetrable justification that restructuring was called for. The consequence of this decision

is a discontinuation of future injury epidemiology research at the University Hospital of Northern Norway, Harstad, which has registered data over the period 1985–2015 (5).

The national registry was closed down in 1992. Nine years later it was replaced by a mandatory, downscaled national trauma registry, a so-called Shared Minimum Data Set (SMDS). Unfortunately, key variables were excluded. For example, neither snowmobiles nor water scooters are listed under means of transport. In the Harstad registry, the prevalence of personal injuries associated with the use of snowmobiles can be found with a few keystrokes. The registry from 2001 has considerable weaknesses and is not well suited for analyses of the national injury panorama or for prevention of injuries in Norway outside Oslo. Oslo University Hospital has contributed more than half of all registrations, despite the fact that the population of Oslo accounts for no more than 12 % of Norway's total population. Registrations from the other hospitals around the country are incomplete, despite their mandatory responsibility in this regard (6).

In a study of fatalities and personal injuries associated with the use of snowmobiles and ATVs (All-Terrain Vehicles) in Northern Norway, published in the Journal of the Norwegian Medical Association, the authors call for official statistics on injuries occurring during the use of such vehicles (7). In the absence of such data, they had to search through police archives, hospital records, trauma databases and the internet. An admirable and time-consuming effort was made. The results showed that in 2013–14, seven persons were killed while driving a snowmobile and none while driving an ATV. The number of personal injuries associated with driving snowmobiles and ATVs was 74 and 13 respectively. The study is published at an auspicious time and may serve as a reference study for later studies. In May 2015, Norwegian local councils were granted authority to regulate snowmobile traffic, and this may change their use and thus also the injury panorama.

'We spend too much money from the health budget on treatment and too little on prevention,' Kjersti Toppe, member of the Storting, stated in 2013 (8). Unfortunately, this situation still persists. Giving higher priority to nationwide registration of injuries would have been a step in the right direction. At the local level, hospitals should be permitted to use injury data that they themselves register. Each hospital needs to be provided with funding for personnel that can take overall responsibility for quality assurance of injury registration. The number of registered variables in the trauma registries ought to be increased. The Directorate of Health and the hospitals have a job to do.

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