In their cross-sectional study, Barry and colleagues estimate the expense of emergency and inpatient medical care and the relative mortality associated with assault-related injuries in US hospitals. A primary objective is to specifically quantify the burden of interpersonal firearm assaults. The authors commendably combine several nationally representative data sources on emergency and inpatient care, health care outcomes, and health care charges and costs. As is possible, they use these data within the context of their limitations. The findings of this study support previous research that reports the costliness of assault injuries for US health care systems. Compared with more prevalent mechanisms of assault injuries, such as blunt force, firearm assault injuries are upheld as the costliest per injury. The high cost of firearm injuries results from the harm that bullet wounds catalyze in the body, the requirement for high-acuity clinical care, and the substantial physical, psychological, and social ramifications experienced by survivors.

As recently as 2 decades ago, evidence of disparities in cost and mortality outcomes associated with assault-related traumatic injuries was scarce. This state of affairs has changed substantially and place-based, racialized, and economic disparities in assault injury risks and recovery outcomes are now well supported. There remains a crucial need for research to identify the underlying causes of these disparities and the ideal implementation of structural interventions, such as policies with broad public impact. Future studies on the economic and relative costs of assault-related hospitalizations will ideally progress from cross-sectional research to that which uncovers changes in disparities over time and the association of change with policy shifts or major clinical advancements.

Cross-sectional hospital cost and cost-recovery estimates have certain value as a lever to advocate for health system investment in preventive public health. Evidence that supports public health investment is important but can be limited in impact if not tied to specific policy and practice change recommendations. In discussing their findings, Barry and colleagues reinforce previous research that has shown the significant association between assault injuries and either a lack of insurance or use of Medicaid or Medicare. They propose that the costs of assault injuries and firearm violence are inordinately “borne by the public.” Another way to interpret this finding is that when the public does not invest in and codify solutions for social inequality, a consequence is that the public will subsidize results that lie at the intersection of poverty, employment-contingent health care access, and violence. The authors rightly affirm that health care expenditures are only a small fraction of the total costs of violence, including years of potential life lost and the totality of consequences for affected individuals, families, and communities, and still conclude that solutions lie in affecting health care burden through “policies aiming to reduce the costs of firearm violence” that “consider violence more broadly” and establish the “extent to which costs can be avoided.”

The policy solutions that the authors endorse to achieve cost avoidance include revocation of stand-your-ground and right-to-carry laws and wider implementation of child access prevention laws. A range of other structural solutions can be added to their list. Extreme risk protective orders, for example, are policies codified in a limited number of states that regulate firearm access in persons who have articulated or demonstrated a threat of violence. A limited number of states have also authorized the use of Medicaid funding for hospital-based violence prevention services as a promising tertiary prevention strategy for individuals hospitalized following assaults. There are also policies, such as federal, state, and local budget allocations and service mandates, that can change...
the socioecological context in which violence thrives. Examples include enhancements and increased access to green space, remediation of poor housing conditions, and improvements to the built environment. An additional example is the Cardiff Model for Violence Prevention, which builds multisector partnerships to identify and better understand hot spots of violent assaults by combining emergency department and law enforcement data. Whether these hot spots are public spaces, businesses, or social institutions (eg, schools), the purpose of the multisector partnership is to determine and then test the outcomes of tailored interventions and measure any ensuing change in violence incidence and severity over time. In addition, when unprevented violence necessitates medical intervention, it would be remiss not to at least contemplate the ways in which a national single-payer health care system might reduce the burden on the public and the costs and consequences incurred by individual health care systems.

Through their study, Barry and colleagues have successfully corroborated previous research and added data to further establish the immense costs of assault injuries and firearm violence in the US. At this juncture, researchers, policy makers, advocates, and health system leadership should be well informed. This is the time to shift attention to the ideal implementation and the relative effectiveness of population health interventions that support the ways in which violence, in all its forms, can be prevented.

ARTICLE INFORMATION
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