Author's response to reviews

Title: The opportunities for and obstacles against prevention: the example of Germany in the area of tobacco and alcohol

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Author's response to reviews: see over
How we responded to the comments

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We thank the reviewers for the careful and very constructive comments. Some of the comments clearly suggested a very significant overhaul and restructuring of the paper, which is what we have done. Please see below in red how we responded to each of the points raised. We have also had a native speaker copy-edit our article now.

Comments Gavin Yamey

Background:

*It would be helpful to say more about the controversy surrounding whether prevention saves money. See, for example, van Baal PHM, Polder JJ, de Wit GA, Hoogenveen RT, Feenstra TL, et al. (2008) Lifetime Medical Costs of Obesity: Prevention No Cure for Increasing Health Expenditure. PLoS Med 5(2): e29. doi:10.1371/journal.pmed.0050029. These authors found that "Although effective obesity prevention leads to a decrease in costs of obesity-related diseases, this decrease is offset by cost increases due to diseases unrelated to obesity in life-years gained."

We have inserted an extra sentence in the first paragraph of the background section to reflect the very mixed evidence and indeed controversy about this hypothesis, as well as two references, the first of which contains a much more extensive discussion of the issue (Suhrcke et al 2008) and the second being the one kindly suggested by the reviewer. While this issue clearly might deserve more treatment here, we felt that with given word limits we could not spend much more space on this major issue in the present article.

*One recurring weakness of this paper, which would be straightforward to fix, is that many of the statements lack specificity and aren't fully grounded in evidence. So, for example, the authors say, "there is no doubt that prevention can be a cost-effective investment." The term "prevention" encompasses hundreds, or perhaps thousands, of interventions and strategies. Some are cost-effective, others are not. So this sort of blanket statement ("no doubt") is not helpful.

We focus on primary prevention and health promotion. This includes structural prevention as well as behaviour oriented prevention. We also take the point about having been somewhat too un-scientific and/or sweeping in some of our statements. We have now revised this throughout the article by being more specific and by adding more references throughout the text.

*The authors say that Germany is a "particularly interesting example," but I am not convinced, from the paper, that this is the case. In their major revision, I'd urge the authors to make a stronger case for its uniqueness.

Upon reflection, we take this point and refrain from calling the German example a very notable or special one. While the historical legacy clearly would argue for a "special case", many of the other features are indeed common in many countries in
Europe and worldwide. In this sense the main appeal of the case study Germany is in that it illustrates points that have wide applicability in many other countries, too.

The scope for prevention:

*Here's another example of imprecise, non-specific language (which, again, can be fixed)--the authors say that 'evidence-based preventive interventions are in principle known.' What does this mean? Why 'in principle'? Are there interventions supported by multiple systematic reviews of RCTs, or are there none? If there are, which interventions are the authors talking about? Changed to "in principle acknowledged" and added as reference two policy strategies published by the WHO to tackle alcohol consumption and smoking, respectively. Both strategies have been ratified by the Member Countries and the policies they contain are described as being “evidence-based”.

*The authors make the assumption that if Germany has a high risk factor burden, it must automatically mean that prevention efforts are under-used. I am not certain that this assumption is valid (can the authors show it to be valid?). For example, it is possible for a country to implement an intervention at large scale and yet the intervention does not reduce the risk factor prevalence, e.g. because the highest risk groups aren't reached, or people's motivation to change hasn't been addressed, etc.

We do acknowledge in the text that “Assessing the scope for health gains from more and/or “better” prevention in any given country is a challenging task” (p.5). Moreover on p. 5 we explicitly speak of “(inevitably imperfect) proxy indicators”. Our proxy indicators do include the risk factor attributable burden but we also look at the efforts undertaken, compared to Germany’s neighbours (e.g. tobacco control scale). Taken together this is still an imperfect proxy, but as long as we acknowledge this, we believe this is a defendable approach.

Prevention policies:

*For a general reader, could you add a box/sidebar explaining the Tobacco Control Scale.

We have now included a box in the annex, briefly describing the Tobacco Control Scale.

*I am very unclear indeed why the authors picked just a few policies, and not others. This seems a little random. One of the paper's weaknesses (again, this can be fixed) is that the choice of policies discussed, and the choice of underlying supportive evidence that is cited, seem haphazard rather than systematic. I obviously am not suggesting that the authors need to do a systematic review, but it would be terrific for this paper to have a more ‘systematic approach’ to laying out policies, strategies, and evidence.

Can it be prevented at good value:

We introduced a framework for the policy analysis based on the theory of policy change by Kingdon. In this context we describe, why we think smoking and alcohol consumption are good examples for the analysis of obstacles to policy change in
Germany. In light of the vast possible array of prevention, we did see a need to limit the scope of the article to a few salient areas, instead of attempting to cover every relevant issue.

*Again, in the smoking section, it is a bit puzzling as to why the authors chose references 16 and 17. It seems a little random. The paper needs a better approach to searching for, appraising, and synthesizing the key evidence. The reason the former references 16 and 17 (now 21 and 22) were used is that they focus on the cost-effectiveness of tobacco taxation, as opposed to just their effectiveness, of which there would have been many more studies, including systematic reviews of course. In this sub-section we were particularly interested in evidence on cost-effectiveness.

**"Some claim that...." Who is 'some'? Ref 19 is just a single person--it would be better to name her/him. Changed to “Abelson claims...”

*In the alcohol section, the authors dive into a discussion of health insurance funds. At this point in the paper, non-German readers will be a little lost unless the authors can give just a brief overview of the German health system (e.g. in a sidebar). A Box on a “Brief outline of the German Statutory health insurance funds” included in the Annex

Why is not more being done:

*The section on individualism is hard to grasp. The authors first state that individualism could explain the limited public policy response. But then they say it does not explain it. This is puzzling. We further elaborated this section to help clarify the seeming contradiction. The point we intend to make is that while some policymakers or other participants in the public debate state that the German population follows particularly individualistic values (and hence major intrusive prevention policies would be against their preference), actual opinion surveys fail to confirm that the German population is particularly individualistic by international standards. Hence, the individualism hypothesis is not really a valid explanation of the lack of prevention in Germany.

*The section on history is fascinating, and I wanted to know more. This is one of the few sections in the paper where there is some 'uniqueness.'

Thanks

*Again, the section on the federal system is very strong, and begins to get at why the German situation may have features not seen elsewhere.

Thanks
Comments Steve Allsop

1. The title and the content do not align. Most of the discussion focusses on alcohol and tobacco, but the title implies broad based prevention foci. To that end, I suggest that the authors either indicate the focus on alcohol and tobacco in their title or include greater focus on other prevention domains
   Point taken. We changed the title and made this focus explicit in the abstract, too.

2. The paper will benefit from a more critical analysis and connection to the body of work on the links between research and policy. There is an extensive literature on this and it is largely neglected in the paper. For example, if the authors were to include the work of Kingdon, and the models he has described, this would provide a framework for their hypotheses about the limited preventive effort in Germany. As it stands, the hypotheses seem more like a speculative list rather than having emerged from critical appraisal of the research-policy process - why are these areas selected and not others. (e.g.see KINGDON, J. (1995) Agendas, alternatives and public policies Boston, Little, Brown & Co.; SABATIER, P. A. (1999) Theories of the Policy Process (Boulder, Westview); BERRY, F. S. & BERRY, W. D. (1999) Innovation and diffusion models in policy research Theories of the Policy Process, pp. 169-200 (Boulder, Westview). Such an approach will move the paper from being merely descriptive to a more important critical analysis and consideration of the key issues. This relates to the next point.
   Thanks for pointing us to this useful way of organising our line of arguments. We now applied Kingdon’s “three-streams” framework to our paper in order to give a systematic approach to analysing the obstacles for health policy change. This has obviously led to a very significant (and beneficial) re-structuring of the paper.

3. Also, is there any evidence supporting the hypotheses - that is, how did the authors arrive at these? I am surprised that there is little about the long-term impact of preventive policy being at odds with the short time frame for political investment (ie the relatively short term focus of most governments)
   Thank you for pointing out this aspect. We have now included it in the summary part.

4. Page 8 surely some consideration should be given to the combined effect of interventions? After all, smoking interventions have rarely been provided in isolation?
   We agree there is reason and evidence to believe that the effect of a combination of interventions may in some instances exceed the sum of the effect of the single interventions. We had already pointed to the possible complementary effect by saying on p.9 „However, anti-smoking campaigns may affect consumption indirectly by making tax increases and smoking ban policies more acceptable.” Why we would shy away from adding more on such complementary effects is a) that there is rather little evidence on the exact size of such effects and b) for the sake of our argument it is already enough to show that there is significant evidence on the cost-effectiveness of the single interventions.
More minor issues

page 2 use of shortened "especially" is this acceptable in the abstract?
*Changed*

page 4 smoking rate of 31% for women is even the highest (suggest delete word "even")
*Word deleted*

page 6 minor change to language - suggest that line 9 should read "adolescents stated they had bought..." rather than current "stated to have bought" - same changees on line 10
*Changed*

Page 6 line 13 insert comma - "to some, if volunatary, regulation"
*Changed*