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LETTER TO THE EDITOR

Response to Segal and Dalziel

We thank Segal and Dalziel for their interest in our work. They are correct in their assessment that the ACE approach to priority setting endeavours to utilise the ‘best available evidence’ and to inform policy development in public health. We are pleased to share our reasoning for our optimistic assumption about the maintenance of benefit through time, which includes both policy and technical elements.

At the policy level, our rationale has been to provide the best possible estimates for the potential contribution of the selected interventions to controlling the obesity epidemic. Yet, even with the most optimistic assumption about maintenance of effect through time, the conclusion is that these interventions alone are unlikely to be sufficient to control, let alone reverse, the obesity epidemic. We have tried to keep this optimistic assumption in perspective by clearly noting it is a critical assumption almost linearly related to size of health outcomes. For example, if attenuation of the impact over time is 50%, health gain is approximately halved.

At a more technical level, there are two related issues: (i) whether the assumption has the potential to distort the health benefit and cost-effectiveness results reported for the specific interventions; and (ii) if so, whether there was better data to use. In relation to the first point, we agree this is a potential danger, which we noted in the paper. The extent of potential bias, however, is an empirical issue that goes to the second point about the lack of available data on which to base quantitative modelling. Unfortunately, the studies quoted by Segal and Dalziel have little direct application to the ACE-Obesity project. For example, the meta-analysis cited was of diet-only treatment programs that specifically targeted overweight or obese middle-aged adults. In contrast, the ACE-Obesity project predominantly included population-based preventative interventions in children and adolescents. The only targeted interventions were of surgery or included diet, behaviour modification and exercise components. Moreover, most of the studies included in the cited meta-analysis were non-randomised observational designs without a control group, leaving open the possibility that adults who did not receive the intervention may also have increased their weight.

What we have done though is to be transparent about our maintenance of benefit assumption. When reporting the cost-effectiveness results for interventions we will also be reporting (in future ACE-Obesity papers) on how much the 100% maintenance of benefit assumption could be reduced before the intervention would cease to be cost-effective.

As with tobacco prevention some 20 years ago, we have clearly just embarked upon the obesity prevention road and there are still significant gaps in the evidence base, including the need for better long-term evidence of effectiveness of both current and new interventions. But estimates of likely health benefit and cost-effectiveness of potential interventions are needed to guide action and cannot wait until that evidence becomes available.

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