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▶ The Public Health Responsibility deal: has a public-private partnership brought about action on alcohol reduction?

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At the heart of the UK government's alcohol strategy are 'Responsibility Deal' pledges made by alcohol companies, but rather than being prompted by the deal, this report says actions committed to were usually already done or underway. Other sources suggest the process helped forestall a more effective measure – a minimum per unit price for alcohol.

SUMMARY The Public Health Responsibility Deal in England was launched in 2011 by the Department of Health as a public–private partnership. Together with government, industry and other partners developed a set of commitments or 'pledges' including associated targets and actions which business, health, community and public organisations can commit to in order to improve health. The health topics addressed were food, alcohol, physical activity and health at work. The featured article from a university unit funded by the Department of Health to evaluate the Responsibility Deal presents an analysis of the pledges in the alcohol domain.

Although at the time of the featured study there were eight alcohol pledges, it focused on four key pledges: A1 – alcohol labelling (92 signatories); A4 – tackling underage alcohol sales (63 signatories); A6 – advertising and marketing alcohol (92 signatories); and A8 – alcohol unit reduction (32 signatories) ▶ panel below. These were selected because they cover much of what is proposed in the remaining pledges.

On committing to a pledge, signatories are asked for a delivery plan setting out their ideas and goals for fulfilling the pledge, and each Spring to report progress. The featured analysis assessed whether the actions pledged and undertaken would have happened anyway, or were likely to have been generated by the Responsibility Deal process, based on pledges, plans and progress reports from 2013 and 2014. The delivery plans themselves were used to assess what the companies would have done in the absence of the Responsibility Deal process, meaning those assessments probably erred on the side of crediting the process with generating new actions.

Key points

From summary and commentary

The Public Health Responsibility Deal for alcohol in England offers a set of pledges which alcohol industry and other bodies can choose to commit to with a view to improving health.

Rather than being prompted by the deal, the actions committed to were usually already done or underway. Even if implemented, a companion paper has judged the pledges unlikely to significantly improve health.

The pledge on lower strength alcohol products could be effective in certain circumstances, but government calculations that it helped remove 1.3 billion units of alcohol from the UK market have been disputed.

Whatever its effects on consumption, the Responsibility Deal seems to have helped forestall a more effective measure – a minimum per unit price for alcohol.

Main findings

The pledge documents proposed 15 different actions organisations could take in order to fulfil the four key pledges. Most commonly listed among their undertakings (by 58 of 92 signatories to pledge A1) was including the Chief Medical Officer's lower-risk consumption guidelines on the labels of alcohol products. Other frequently listed interventions (planned by 53% to 59% of signatories) were the inclusion of unit alcohol content and a pregnancy warning on alcohol product labels, adhering to Drinkaware brand guidelines, and committing to improving the availability, marketing and promotion of lower-alcohol products.

Four key pledges

As of 3 July 2015

A1. We will ensure that over 80% of products on shelf (by December 2013) will have labels with clear unit content, NHS guidelines and a warning about drinking when pregnant.

A4. We commit to ensuring effective action is taken in all premises to reduce and prevent under-age sales of alcohol (primarily through rigorous application of Challenge 21 and Challenge 25).

A6. We commit to further action on advertising and marketing, namely the development of a new sponsorship code requiring the promotion of responsible drinking, not putting alcohol adverts on outdoor poster sites within 100m of schools and adhering to the Drinkaware brand guidelines to ensure clear and consistent usage.

A8. (a) As part of action to reduce the number of people drinking above the guidelines, we have

Of the 432 planned actions, just over 1 in 10 seemed generated by the Responsibility Deal process and another quarter might have been. Nearly two-thirds appeared already to have happened or been under way when the process was launched. Only in respect of the A8 pledges about developing and promoting less strong beverages were most of the actions probably or possibly generated by the deal. For example, of the 14 commitments to reduce the alcoholic content of drinks, 36% were judged to have been brought about by the deal and another 43% might been. Most other interventions generally appear to have happened regardless of the process.

Next the analysts narrowed in on progress against the planned actions which at least might have been generated by the deal process. In 2013, 92% of signatories reported on their progress against

their plans, falling to 75% the following year. In

people drinking above the guidelines, we have already signed up to a core commitment to "foster a culture of responsible drinking which will help people drink within guidelines". To support this we will remove 1bn units of alcohol sold annually from the market by Dec 2015 principally through improving consumer choice of lower alcohol products. (b) To support our pledge to remove a billion units of alcohol sold annually from the market, we will carry out a review of the alcohol content and container sizes of all alcohol products in our portfolio. By December 2014 we will not produce or sell any carbonated product with more than (4) units of alcohol in a single-serve can.

their plans, falling to 75% the following year. In both 2013 and 2104 most (52% and 61%) progress reports described rather than quantified progress, though 15 of 22 signatories did quantify progress on alcohol content reduction. A substantial minority of 2014 progress reports (eg, a quarter in respect of pledges A4 and A6) merely repeated what had been said the year before. Across all the pledged actions possibly or probably due to the deal process, 63% of reports in 2013 indicated that the initial delivery plan had been implemented, and most of the rest reported movement towards this objective.

A closer look was taken at progress on A8 plans to promote consumer choice of lower alcohol products. In 2013 ten signatories said they had developed new lower-alcohol products, 12 that they had promoted lower-alcohol products. Five reported decreasing the alcohol content of existing products. A grand total of units of alcohol potentially removed from the market could not be calculated, but the reported unit reductions ranged from 1.6 million to 111 million, although it was unclear whether these were entirely during the period of and due to the Responsibility Deal. Of the signatories whose reports quantified further progress in 2014, most reported the launch (56%) and promotion (67%) of new lower-alcohol products, 17% reducing the production or promotion of alcohol products, and 8% actions to remove alcohol units from existing products.

The authors' conclusions

The Responsibility Deal is likely to have added little to efforts to reduce alcohol consumption. Most signatories appear to have committed to actions that they would have taken anyway, regardless of the deal process. This study also demonstrates the importance of requiring rigorous monitoring using standard quantitative measures.

In respect of labelling, in 2007 the alcohol industry had already entered into, and by the start of the Responsibility Deal, largely implemented, a voluntary agreement with government to place similar information on alcohol containers. Similarly, Challenge 21 and 25 schemes to prevent underage alcohol sales were well-established before the inception of the Responsibility Deal, accounting for why few signatories selected them for implementation. Drinkaware was in operation five years before the deal, which may explain the low proportion of signatories pledging to add its web address to their labels or to adhere to its brand marketing guidelines.

Just 11% of the planned interventions were likely to have been brought about by the Responsibility Deal, a proportion at its maximum in respect of pledge A8 on alcohol unit reduction. Even though the number of signatories to this pledge was small, among them were major alcohol producers, distributors and retailers with a considerable share of the market. However, as noted in a companion article, it will be important to account for any countervailing reactions; for example, consumers might add new or more heavily promoted low-alcohol products to their drinking repertoires but not cut back on higher-alcohol variants left at their existing strengths. Possibly significant is the fact that compared to 2013, in 2014 fewer A8 signatories said they were going to remove alcohol units from existing products, and more planned to launch and promote new lower-alcohol variants.

About half the progress reports reported only descriptive information and there has been a shift away from quantitative measures since the Responsibility Deal was originally implemented. Over-reliance on descriptive monitoring adds to the difficulty of evaluating whether or not the deals's objectives have been met.

FINDINGS **COMMENTARY** A companion article from the same research team concluded that even if the pledges were fully implemented, they would be unlikely to affect consumption or have any significant positive impact on population health. The reason was that the pledges generally do not entail actions which would make alcohol less available (1 2) or more expensive, the main ways to curb consumption. Indeed, the deal has been presented as an alternative to the mandatory regulation needed to enforce such measures across the market. Counteracting any possible benefits seems to be (▸ below) the major public health negative of helping to forestall a minimum unit price for alcohol in England. If the deal has helped substitute relatively ineffective pledges for more effective regulations, it cannot be considered a good deal in terms of population health in England.

The featured analysis concluded that even the relatively weak levers of the Responsibility Deal have generally not been activated by the deal, but had already been or were in the process of being activated regardless. However, it seems possible that even if they do not generate new actions, the public commitments entailed in the deal might sustain changes already done or in process. A gap in the analysis is that it relies on a head count of commitments rather than weighting the significance of each depending on the importance of the signatory; as the authors acknowledge, a commitment entered in to (for example) by a small local brewer means much less than the same commitment from a major national distributor. Moreover, the actions undertaken to fulfil the flagship pledge to remove a billion units of alcohol from the market are the ones which the featured analysis judged most likely to have been generated by the deal, and which the companion article saw as having the potential to improve health by reducing consumption. A Department of Health analysis has calculated that the target was exceeded, but the validity of their figure has been disputed, and even if valid, how far the deal was responsible is unclear ▸ below.

Has the deal has worked – to forestall regulation?

One of the most worrying findings of the featured analysis was the apparent impossibility of estimating the impact on consumption and health of actions taken to fulfil the pledges. When the deal was promised as part of the 2010–2015 Conservative-led government's public health plans for England, it was presented as a light-touch voluntary arrangement which if it failed to improve health, might be bolstered by regulation forcing companies to comply. But it seems that given current data sources, it could not convincingly be demonstrated that the deal has or has not worked, meaning that the conditions for triggering an escalation to mandatory regulations cannot be met.

Forestalling regulation unwelcome to influential sectors of the alcohol industry has been seen as the

Forestalling regulation unwelcome to influential sectors of the alcohol industry has been seen as the prime function of the Responsibility Deal, one which would have a detrimental impact on public health because regulatory measures which increase price and decrease availability are the most powerful public health levers. At least in England, in this respect the deal seems to have been a success.

The Responsibility Deal for alcohol came about after the government had committed itself to a minimum per unit price policy for England. The move had been strongly resisted by sections of the alcohol industry, but made it into law in Scotland when the Scottish National Party – not one of the UK-wide parties the industry had been courting – took power. Famously, the commitment for England was reversed, seemingly a tribute at least partly to the industry's successful long-term cultivation of relationships with UK political parties in order to position themselves as "key stakeholders in the policy process, who must be consulted on policy developments as a matter of course".

In its formal announcements of the U-turn in July 2013 (1 2), government appealed to the Responsibility Deal as providing an alternative to minimum pricing, and the rejection of minimum pricing as offering the industry "an opportunity to demonstrate what more it can do to reduce harms associated with problem drinking ... building on what has already been achieved through the Public Health Responsibility Deal."

For the British Medical Journal, industry influence meant the consultation which preceded the policy reversal had been a "sham". The journal had discovered that in February 2013 public health minister Anna Soubry had met seven industry representatives who voiced their "deep concern" that minimum pricing would damage Responsibility Deal agreements with the industry and hit Treasury revenues. Soubry was told they would prefer a ban on below-cost sales, an ineffectual measure which was in fact implemented instead of minimum pricing, though it was not asked about in the consultation document.

Assuming the veracity of this report, their concerns can be read as a warning that the deal would be undermined if the administration went ahead with minimum pricing. That warning was also apparent to the chair of the Responsibility Deal monitoring and evaluation group. In his July 2013 resignation letter he recalled that, "At the last meeting an industry representative even made it clear that their continued contributions to the deal were dependent on a minimum unit price not being implemented." To Professor Bellis this was not the only example of the deal being "turned by industry into a tool to avoid actions that would improve people's health". Though the fact that alcohol industry figures used the deal to press for withdrawal of the minimum pricing policy seems clear, whether this influenced the reversal of that policy is not, but having to admit that a central and repeatedly trumpeted plank of their alcohol strategy had fallen through would have been a bitter pill for government to swallow. For public health academics and lobbyists, it was enough that the industry seemed to be bargaining a key public health initiative in the form of the Responsibility Deal against another, rather than supporting the deal process regardless as their contribution to reducing harm from their products.

Was the '1 billion fewer units' target exceeded?

Among the most promising of the pledges is the reduction in the strength of alcohol products. If effective, government estimated that the resultant removal of around 2% of alcohol from the market would in a decade "result in many hundreds fewer alcohol-related deaths; many thousands fewer hospital admissions and alcohol-related crimes, as well as substantial savings to health services and crime costs each year." However, even this will not work in health improvement terms unless there are strong availability and price incentives to switch from higher strength products. Without this, lower strength products can simply add to net drinking. That can be counteracted by reducing the strength of the high-content products, but the featured report says actions taken to fulfil this pledge mainly appeared to involve launching and promoting new low-alcohol products rather than removing units from existing products, leaving consumers the option of continuing with undiluted higher-strength drinks, or adding lower-strength drinks to their repertoires rather than switching to them.

Reassurance that this had not happened came in 2014 when Department of Health analysts calculated that in 2012 and 2013, 1.9 billion fewer units of alcohol were distributed in the UK than would have been the case if sales of 52.1 billion units in 2011 had been repeated. Reductions in the average strength of alcoholic products (especially beer) accounted for 1.3 billion of the 1.9 billion drop, exceeding the Responsibility Deal target. These calculations imply that lower-strength products did not simply add to the total volume of alcohol consumed, but helped reduce it.

However, researchers from the Sheffield University unit entrusted by UK governments to model the effects of minimum pricing (1 2 3) say increasing underestimates of units sold as wine and cider between 2011 and 2013 could have accounted for the entire 1.3 billion units. They also highlight other possible influences on the calculations and trends in drinking patterns which make it unclear whether 1.3 billion units were removed from the market, and whether any changes in units distributed were due to the Responsibility Deal. Given available data, they concluded, "It is not clear whether a robust quantitative evaluation of the billion unit pledge is possible" – again, an indication that failure of the deal is not provable, meaning (if this is the criterion) that the case for replacing it with regulation will also remain unproven.

One clear example of an influence independent of the Responsibility Deal is that in October 2011, around the time the deal was launched, government raised duty on strong beers by 25% and halved duty on weak beers, creating a substantial extra price differential if these changes fed through to retail prices. Even before these changes, the structure of the duty tax meant reducing strength was one way to reduce costs per can of beer. For example, when brewing giant AB InBev announced in 2012 that it was cutting the alcohol content of some of the UK's biggest selling lager brands from 5% to 4.8%, a report from an alcohol trade magazine did not mention the Responsibility Deal as the instigator. AB InBev's line was that it was following "evolving UK category trends", but the report highlighted the potential savings of many millions of pounds in duty costs, helping the company off-set rising costs and retain market share by keeping prices stable. Such influences might have generated strength reductions, even without the Responsibility Deal.

In March 2015 what they felt was inappropriate alcohol industry involvement in assessing whether the 1 billion unit pledge had been fulfilled was highlighted by the Institute for Alcohol Studies, which had contributed comments to a draft of Sheffield University's critique of the Department of Health's calculations. The institute had used the Freedom of Information Act to extract email correspondence from the department which showed that the alcohol producers' health promotion organisation the Portman Group had asked for critical data "to be refined without informing the Chair and other public health members of the [Responsibility Deal monitoring and evaluation group], [and] that the Chair was not apparently included in crucial emails between the Department of Health and the Portman Group." At

not apparently included in crucial emails between the Department of Health and the Portman Group. "At the very least, said the institute, "the process was not transparent". So concerned had been the group's chair from the Centre for Public Health at Liverpool John Moores University that in July 2013 he resigned from the group, saying "transparency and trust in the process has been eroded by data being delivered inappropriately to the industry's Portman Group who not only failed to inform me that they had the data but also unilaterally asked for it to be revisited at least twice."

Thanks for their comments on this entry in draft to research author Cécile Knai of the London School of Hygiene & Tropical Medicine in England. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

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