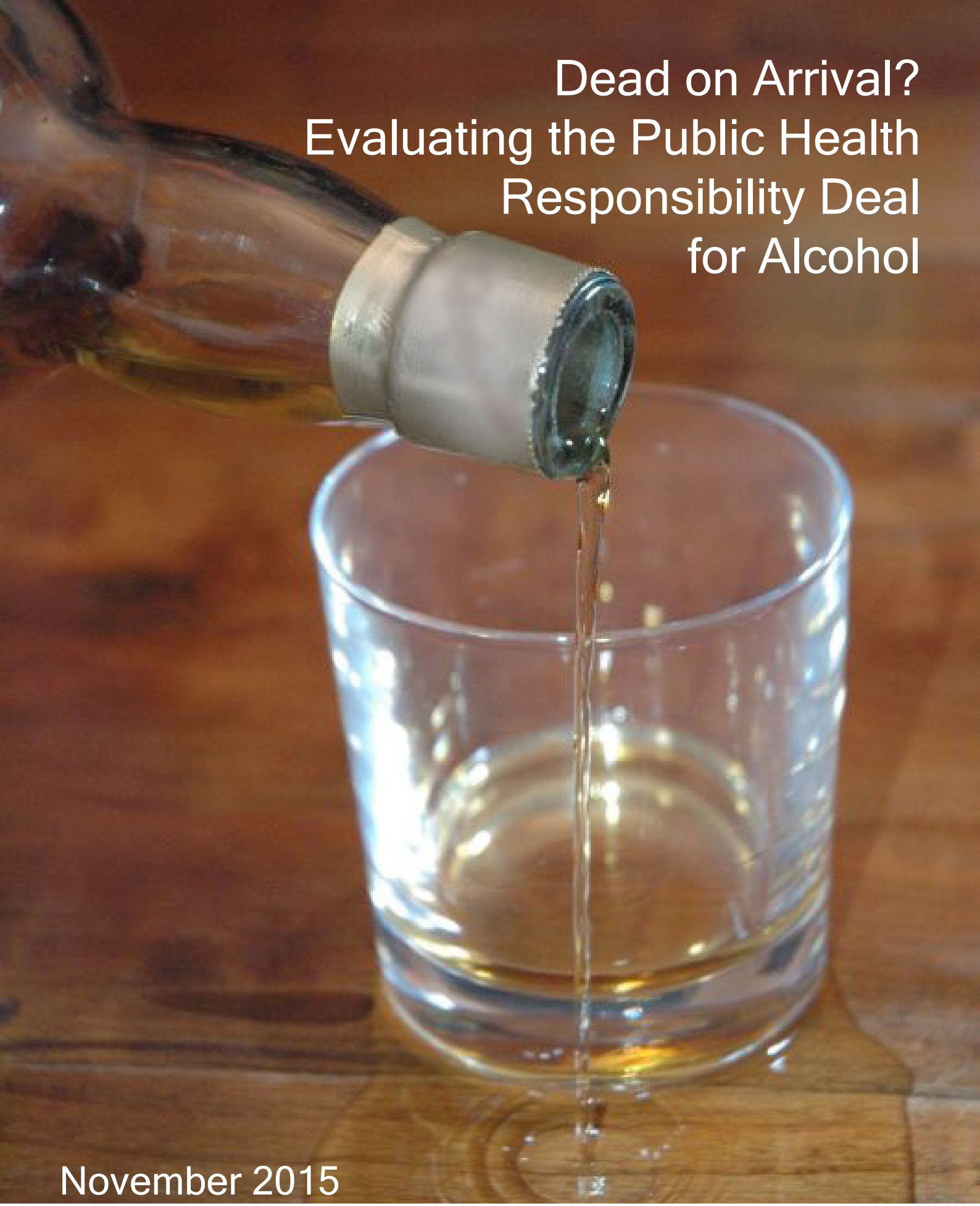

Dead on Arrival? Evaluating the Public Health Responsibility Deal for Alcohol

November 2015

Institute of Alcohol Studies

www.ias.org.uk | @InstAlcStud

Dead on Arrival? Evaluating the Public Health Responsibility Deal for Alcohol

Key points

- **The Responsibility Deal is not endorsed by academics or the public health community**
- **It has pursued initiatives known to have limited efficacy in reducing alcohol-related harm**
- **The evidence on the effectiveness of the Responsibility Deal is limited and unreliable, due to ambiguous goals and poor reporting practices**
- **Where evaluation has been possible, implementation has often failed to live up to the letter and/or spirit of the pledges**
- **The Responsibility Deal appears to have obstructed more meaningful initiatives with a stronger evidence base behind them**

What is the Responsibility Deal?

The Public Health Responsibility Deal (RD) was launched in 2011 as a voluntary partnership between the government, commercial organisations, public bodies, academics and NGOs to promote public health goals. Through a set of non-binding pledges, these actors – and in particular industry – are expected to take steps to reduce health harms.

The RD is organised into four networks addressing particular challenges, each with distinct sets of pledges: food, alcohol, physical activity and health at work. This paper evaluates the success of the Responsibility Deal Alcohol Network (RDAN).

At present (November 2015), there are 11 different pledges made in relation to alcohol under the RD, each attracting different sets of signatories. These are laid out below.[1]

Responsibility Deal Pledges

A1. Alcohol Labelling: "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". (101 signatories)

A2. Awareness of Alcohol Units in the On-trade: "We will provide simple and consistent information in the on-trade (e.g. pubs and clubs), to raise awareness of the unit content of alcoholic drinks, and we will also explore together with health bodies how messages around drinking guidelines and the associated health harms might be communicated." (46 signatories)

[1] https://responsibilitydeal.dh.gov.uk/pledges/

Responsibility Deal Pledges (continued)

A3. Awareness of Alcohol Units, Calories & other information in the Off-trade: "We will provide simple and consistent information as appropriate in the off-trade (supermarkets and off-licences) as well as other marketing channels (e.g. in-store magazines), to raise awareness of the units, calorie content of alcoholic drinks, NHS lower-risk drinking guidelines, and the health harms associated with exceeding the guidelines." (49 signatories)

A4. Tackling Under-Age Alcohol Sales: "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)." (68 signatories)

A5. Support for Drinkaware: "We commit to maintaining the levels of financial support and in-kind funding for Drinkaware and the 'Why let the Good times go bad?' campaign as set out in the Memoranda of Understanding between Industry, Government and Drinkaware." (80 signatories)

A6. Advertising & Marketing Alcohol: "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." (97 signatories)

A7 (a). Community Actions to Tackle Alcohol Harms: "In local communities we will provide support for schemes appropriate for local areas that wish to use them to address issues around social and health harms, and will act together to improve joined up working between such schemes operating in local areas as:

- Best Bar None and Pubwatch, which set standards for on-trade premises
- Purple Flag which make awards to safe, consumer friendly areas
- Community Alcohol Partnerships, which currently support local partnership working to address issues such as under-age sales and alcohol related crime, are to be extended to work with health and education partners in local Government
- Business Improvement Districts, which can improve the local commercial environment" (60 signatories)

A7 (b). Targeted Local Action: "To support our pledge to provide schemes appropriate for local areas that wish to use them to address issues around social and health harms, we will fund and/or support industry action in Local Alcohol Action Areas, by ensuring that suitable existing partnership schemes are in the process of being rolled out in Local Alcohol Action Areas by March 2015." (10 signatories)

A8 (a). Alcohol Reduction: "we will remove 1bn units of alcohol sold annually from the market by December 2015 principally through improving consumer choice of lower alcohol products" (34 signatories)

A8 (b). Responsible can packaging: "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." (8 signatories)

A9. Lifeskills education and alcohol education in schools: "We will financially support the Lifeskills Education and Alcohol Foundation (LEAF) with a minimum of 250,000 thousand pounds as a start-up fund. Subject to favourable reporting and evaluation of delivery, we will seek to increase programme scope through funding from the alcohol industry and others." (7 signatories)

The Responsibility Deal is not endorsed by academics or the public health community

Despite being designed as a 'partnership', the RD for alcohol has been comprehensively rejected by most public health organisations. Six of the most prominent bodies working in the field – Alcohol Concern, British Association for the Study of the Liver, British Liver Trust, British Medical Association, Institute of Alcohol Studies, and the Royal College of Physicians – refused to sign up to the agreement in 2011. In boycotting the initiative, they cited not only the content of the deal (echoing many of the points detailed below), but also the perception that the process of formulating the pledges privileged the alcohol industry at the expense of the health community. According to IAS' Katherine Brown, the pledges "were largely written by Government and industry officials before the health community was invited to join the proceedings". [2]

In July 2013, protesting the Government's u-turn on its commitment to introduce minimum unit pricing in England, Prof Nick Sheron, co-chair of the network, withdrew along with most of the remaining public health bodies in the RDAN, including Cancer Research UK, Alcohol Research UK, the Faculty of Public Health and the UK Health Forum.[3] These organisations saw the move as evidence that the RD was being used as a substitute for legislation and so undermining a more comprehensive public health policy.[4]

Consequently, the core remaining group of the RDAN is dominated by the alcohol industry, which provides 12 of the 15 representatives.[5] Moreover, of the three nominally independent NGOs involved, two (Addaction and Mentor UK) receive significant funding from the alcohol industry.[6]

As a result, regardless of the substance of the RD, it has lacked legitimacy from its very inception. The alienation of independent NGOs and academics (see below) from its formulation and development continues to count against it.

---

[2] Royal College of Physicians (2011), Key health organisations do not sign responsibility deal. [Press release]. Available: https://www.rcplondon.ac.uk/press-releases/key-health-organisations-do-not-sign-responsibility-deal [Accessed 21 October 2015].

[3] Ross, T. (2013), Health advisers quit over scrapping of minimum alcohol price, *The Telegraph*, 17 July. Available: http://www.telegraph.co.uk/news/politics/10186587/Health-advisers-quit-over-scrapping-of-minimum-alcohol-price.html [Accessed 26 October 2015].

[4] Cancer Research UK, Faculty of Public Health, UK Health Forum & Sheron N (2013), Joint statement by Cancer Research UK, Faculty of Public Health, UK Health Forum and Nick Sheron, Responsibility Deal Alcohol Network Co-Chair, Head of Clinical Hepatology, University of Southampton [Press release]. Available: http://nhfshare.heartforum.org.uk/RMAssets/NHFMediaReleases/2013/NGOs%20pull%20out%20of%20Responsibility%20Deal%20Alcohol%20Network.pdf [Accessed 2 November 2015].

[5] https://responsibilitydeal.dh.gov.uk/alcohol-network-core-group/

[6] Lyness S.M. & McCambridge, J. (2014) The alcohol industry, charities and policy influence in the UK. *European Journal of Public Health* 24, pp. 1-5.

The Responsibility Deal has pursued initiatives known to have limited efficacy in reducing alcohol-related harm

Moreover, there is reason to be sceptical about the effectiveness of the RD on substantive grounds. The academic literature provides little evidence that its measures can reduce alcohol consumption and associated harms. A recent independent evidence review, funded by the Department of Health, found that most of the RD pledges "fall into the category of 'probably ineffective' or 'no/poor/inconclusive evidence'".[7]

Research into the effects of providing drinking guidelines, warning labels and unit alcohol content on alcohol packaging (pledge A1) has found that whilst such information can help to raise awareness amongst consumers of the risks associated with alcohol consumption, existing labelling schemes have had no substantial impact on how much people drink. Reviews of the effectiveness of responsible drinking messages (pledge A6) have given little support to the claim that they reduce consumption. While better enforcement of minimum age restrictions is associated with lower alcohol consumption, voluntary training of servers (pledge A7a) to encourage responsible retailing of alcohol has generally been found to be poorly applied in practice. Rather, the most effective age verification programmes involve community mobilisation and stricter use of licensing laws.[8]

Perhaps the most promising measure, in terms of support from the research evidence, is the commitment to refrain from advertising within 100m of schools (pledge A6). A number of studies have shown that greater exposure of young people to alcohol advertising increases both the probability that they will take up drinking and the quantity that they drink if they do start.[9] Moreover, one study in the US found that exposure to alcohol within 1,500 feet of their school is associated with greater likelihood of young people expressing the intention to drink.[10] However, it is worth stressing that even in this case, the evidence is indicative at best.

[7] Knai C., Petticrew M., Durand M. et al (2015). Are the Public Health Responsibility Deal alcohol pledges likely to improve public health? An evidence synthesis. *Addiction* 110, p. 1,236.
[8] Knai C., Petticrew M., Durand M. et al, op. cit.
[9] Anderson, P., de Bruijn, A., Angus, K. et al (2009), Impact of Alcohol Advertising and Media Exposure on Adolescent Alcohol Use: A Systematic Review of Longitudinal Studies. *Alcohol & Alcoholism* 44:3, pp. 229-43.
[10] Pasch, K., Komro, K., Perry, C. (2007), Outdoor Alcohol Advertising Near Schools: What Does It Advertise and How Is It Related to Intentions and Use of Alcohol Among Young Adolescents? , *Journal of Studies on Alcohol and Drugs* 68:4, pp. 587-96.

The evidence on the effectiveness of the Responsibility Deal is limited and unreliable, due to ambiguous goals and poor reporting practices

While the international evidence suggests voluntary industry measures will have little impact on levels of drinking, it is possible – if unlikely – that such initiatives in this country might produce a different result due to different implementation methods or context. However, the way the RD has been carried out ensures it is extremely tricky to determine if industry activities are having any effect because of the limitations of data and evaluation.

To begin with, many of the pledges are formulated in an ambiguous way that makes it difficult to determine whether they have been met. For example, pledges A2 and A3 promise "simple and consistent" information on unit and calorific content, without specifying what constitutes meeting this standard.[11] Pledge A4 commits to "ensuring effective action" is taken to reduce sales to underage drinkers, but does not set any clear targets or objectives which would demonstrate that this is being achieved.

As a case in point, the industry's much-vaunted claim that it has removed over a billion units of alcohol from the UK market[12] (pledge A8a) has been challenged on the grounds that it is impossible to know how much of the decline in alcohol consumption is the result of deliberate industry action, rather than underlying consumer trends.[13] This number has been found to rest on unreliable data, an over-simplified model of consumer choice, and does not account sufficiently for confounding factors. Indeed, researchers have called upon the Department of Health to withdraw the evaluation report of the billion unit pledge due to the flaws in the methodology used, and to cease making references to the results until they can stand up to scrutiny.[14]

Moreover, the evidence provided to demonstrate progress on RD pledges is often too imprecise. An independent Department of Health-funded study found that reporting has worsened over time, with quantitative evidence provided against just 39% of RD pledges in 2014, down from 52% a year earlier. Incredibly, 14% of progress reports submitted in 2014 were identical to ones from 2013, demonstrating limited care and effort invested in the process.[15]

Most concerningly, objections have been raised about industry's conduct in evaluating the Responsibility Deal. The industry-funded Portman Group has sought to discredit critical independent researchers publishing in peer-

[11] These may well be the same standards as A1, but in that case it is not clear how these are substantively different from that first pledge.
[12] Health Improvement Analytical Team (2014), Responsibility Deal: Monitoring the number of units of alcohol sold – second interim report, 2013 data. London: Department of Health.
[13] Holmes J., Angus C. & Meier, P. (2015) UK alcohol industry's "billion units pledge": interim evaluation flawed. *BMJ* 350.
[14] Holmes J., Angus C. & Meier, P., op cit.
[15] Knai C., Petticrew M., Durand M. et al (2015). The Public Health Responsibility deal: has a public-private partnership brought about action on alcohol reduction?. *Addiction* 110.

reviewed academic journals.[16] Further, there is evidence that they have obstructed the RDAN's official monitoring process. Professor Mark Bellis, the public health Chair of the RDAN Monitoring and Evaluation (M&E) Group, resigned his position, claiming that "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".[17]

Where evaluation has been possible, implementation has often failed to live up to the letter and/or spirit of the pledges

The considerations above demonstrate the difficulty of proving or disproving the effectiveness of industry efforts to reduce harm at a population level. However, it seems clear that industry initiatives, whether or not they are effective, are not being implemented as well as they might be.

For example, the industry has fallen short of its target to have clear unit content, NHS drinking guidelines and warnings about drinking during pregnancy (pledge A1) on 80% of products. An industry-commissioned audit found 79% of products in the off-trade complied with this pledge, but this fell to 70% of products when weighted by market share.[18] It concluded that "the best estimate is that 80% content compliance had not been achieved".[19] An independent academic study corroborated these findings, reporting 78% compliance in an unweighted sample.[20]

What this suggests is that the industry has missed its labelling pledge, though it would be unfair not to recognise that progress has nevertheless been made. Though direct comparisons are not possible, the proportion of the market carrying pregnancy information has risen from 18% to 93%; the proportion carrying drinking guidelines has risen from 6% to 83% and the proportion carrying unit content has risen from 56% to 87%.[21]

It is interesting to note that the pledge has not been met largely because of failures of 'minor brands' (those with lower market share). While the compliance rate is 89% among major brands, it is only 57% among minor brands. What this suggests is that fragmentation of the industry is a significant obstacle to enforcing industry commitments – the large producers appear unable to keep their smaller competitors in line. This, in turn, demonstrates the benefits of statutory regulation: it overcomes the industry's inability to coordinate a collective response.

---

[16] Hawkes, N. (2015), Industry's pledges to limit harms of alcohol are unlikely to work, research finds. *BMJ* 350:h1671.
[17] Institute of Alcohol Studies Freedom of Information Request. Available from http://www.ias.org.uk/uploads/AttachmentB.pdf
[18] Volume market share of total pure alcohol sold. Campden BRI (2014) Audit of compliance of alcohol beverage labels available form the off-trade with the Public Health Responsibility Deal Labelling Pledge, p23.
[19] Campden BRI (2014), op. cit, p. 4.
[20] Petticrew, M., Douglas, N., Knai, C. et al (2015) Health information on alcoholic beverage containers: has the alcohol industry's pledge in England to improve labeling been met? *Addiction* 110. DOI: 10.1111/add.13094
[21] Campden BRI (2014), op. cit, p. 5.

Yet even if we believe that drinks companies have adhered to the letter of their voluntary pledges (which is only plausible under the weakest readings of the pledge – for example pledge A1 calls for 'clear' labelling, a standard that appears often to be missed), they regularly flout the spirit of these regulations. Only 47% of labels have been found to reflect what is considered 'best practice' by industry-agreed standards.[22] The average font size for health information on labels is 8.17, well below the 10-11 point size that is optimal for legibility. 60% of labels display health information in smaller font than then the main body of information on the label, contrary to official industry guidance. Pregnancy warning logos are significantly smaller on drinks targeted at women than those aimed at men. Moreover, they are frequently grey in colour, with only 10% in more eye-catching red.[23]

Voluntary industry activities to tackle underage drinking (pledge A4) have also often suffered from poor implementation, and there is suggestive evidence that similar issues affect the UK's 'Challenge 25' policy, which requires customers under the age of 25 to prove their age when buying alcohol. A project in Shropshire discovered that a third of licensed premises failed to check for ID when selling to under 25s.[24]

It has further been suggested that Drinkaware, the industry-funded charity (supported under pledge A5), might in fact indirectly encourage alcohol consumption – for example, by creating positive perceptions of the alcohol industry, or normalising drinking and drunkenness. For instance, the current Drinkaware campaign designed to prevent alcohol related sexual assault, '*You wouldn't sober, you shouldn't drunk'*, can be seen as promoting a tacit acceptance of drunkenness.[25] One experimental study has found that people tend to drink more alcohol in the presence of a Drinkaware poster than without it.[26]

The Responsibility Deal appears to have obstructed more meaningful initiatives with a stronger evidence base behind them

None of the arguments above are sufficient to show that the RD is positively harmful. Indeed, a couple of the pledges, such as restricting marketing near schools and improving labelling, may have done some good – albeit in a limited way that is difficult to demonstrate. Thus we might be tempted to say that there is no harm in the RD, and not let the best be the enemy of the good. The problem with this argument is that in this case the proponents of the best and the proponents of the good *are* enemies: the RD does appear to have had the negative consequence of obstructing more effective policies addressing alcohol harm.

---

[22] Campden BRI (2014), op. cit., p. 23.
[23] Petticrew, M., Douglas, N., Knai, C. et al (2015) op. cit.
[24] Shropshire Council (2011) Tackling Underage Drinking, 2011. Available from: <http://www.webcitation.org/6WEfxujkq>
[25] Drinkaware website. Available from: <https://www.drinkaware.co.uk/wouldnt-shouldnt>
[26] Moss A., Albery I., Dyer K. et al. (2012) The effects of responsible drinking messages on attentional allocation and drinking behavior. *Addictive Behaviors* 44.

According to the aforementioned review of evidence underpinning the RD, "the most effective evidence-based strategies to reduce alcohol-related harm are not reflected consistently in the RD alcohol pledges. The evidence is clear that an alcohol control strategy should support effective interventions to make alcohol less available and more expensive".[27] Not only have these sorts of measures been ignored by alcohol producers and sellers, but they have been actively resisted through lobbying and legal challenges – as seen in the Scottish and Westminster governments' efforts to introduce a Minimum Unit Price for alcohol.

This is not necessarily linked to the RD: its launch document explicitly states that "Pledges developed under the auspices of the Responsibility Deal are not intended to replace Government action – they complement it".[28] Nevertheless, even within the same paper, then Health Secretary Andrew Lansley acknowledged a potential trade-off between the two: "By working in partnership, public health, commercial, and voluntary organisations can agree practical actions to secure more progress, more quickly, with less cost than legislation".[29]

It is of course difficult to demonstrate a clear connection between the RD and the government's relative inactivity in terms of statutory regulation. However, there is evidence that it has been used as a bargaining chip against government action. The former independent chair of the Responsibility Deal's monitoring and evaluation group has claimed that "an industry representative even made it clear that their continued contributions to the deal were dependent on a minimum unit price not being implemented". More generally, he claims "I have seen the Deal turned by industry into a tool to avoid actions that would improve people's health".[30]

Such incidents provide compelling support for the allegations made by former RDAN co-chair Nick Sheron and public health bodies such as Cancer Research UK that "the Government is choosing instead to give the drinks industry the opportunity to 'show what it can do' on a voluntary basis", rather than enforcing more effective statutory measures.[31]

---

[27] Knai C., Petticrew M., Durand M. et al. op. cit., p. 1,232.
[28] Department of Health (2011) *Public Health Responsibility Deal.* London: Department of Health, p. 3.
[29] Department of Health (2011), op. cit., p. 2.
[30] Institute of Alcohol Studies Freedom of Information Request. Available from http://www.ias.org.uk/uploads/AttachmentB.pdf
[31] Cancer Research UK, Faculty of Public Health, UK Health Forum & Sheron N (2013), Joint statement by Cancer Research UK, Faculty of Public Health, UK Health Forum and Nick Sheron, Responsibility Deal Alcohol Network Co-Chair, Head of Clinical Hepatology, University of Southampton [Press release]. Available: http://nhfshare.heartforum.org.uk/RMAssets/NHFMediaReleases/2013/NGOs%20pull%20out%20of%20Responsibility%20Deal%20Alcohol%20Network.pdf [Accessed 2 November 2015].

Conclusion

The Responsibility Deal has never been a genuine partnership, having been boycotted by almost every independent public health group. Many of their objections have been vindicated in the four years since. The RD has systematically focused on relatively ineffective interventions that are unlikely to reduce alcohol consumption. It has set up its pledges in ambiguous terms that resist assessment. The alcohol industry has obstructed rigorous evaluation of the RD, through the unreliability of its progress reports, and more damningly through its misconduct in the official evaluation process. Where independent evaluation has occurred, as with the billion unit pledge or the labelling pledge, the industry has generally failed to show it has met its targets. And even when the industry has lived up to the letter of its pledges, it has sought to circumvent the spirit of the endeavour. All of this would be forgivable if the RD were a harmless sideshow. Yet it appears to have been the main element of the UK's alcohol strategy in recent years (though the current status of the RD is uncertain), and has been used by the industry to resist more effective policies. If this is the case, the RD has worsened the health of the nation, and so must be considered a failure.

Institute of Alcohol Studies

2015

'*Dead on Arrival? Evaluating the Public Health Responsibility Deal for Alcohol*' is written and produced by the Institute of Alcohol Studies.

About the Institute of Alcohol Studies

The core aim of the Institute is to serve the public interest on public policy issues linked to alcohol, by advocating for the use of scientific evidence in policy-making to reduce alcohol-related harm.

For more information visit www.ias.org.uk.

A company limited by guarantee, Registered Charity No 1112671.