Panjwani, C. & Caraher, M. (2014). Response to Petticrew and colleagues. Health Policy, 119(1), pp. 98-99. doi: 10.1016/j.healthpol.2014.08.008

Dear Editor

We thank Pettigrew and colleagues for their letter in response to our article [1]. They are the team of academic researchers that has been funded to undertake an evaluation of the Responsibility Deal (RD). Their points of clarification re the funding of their research and its current focus are welcome. However, we would have been interested to learn whether the findings in our paper will influence their research as we feel this might impact on the direction of their research evaluation.

The focus of our research was the calorie reduction pledge of the RD, and particularly its working practices. We were only examining this one aspect of the initiative and we recognise that the research brief of Pettigrew et al is much wider. However, our findings exposed serious flaws in both the process and the lack of outcome measures. To reiterate the key points in our paper:

- Stakeholder representation was seriously compromised with no public health representatives on the steering group but a full complement of industry representatives.
- This stakeholder imbalance enabled the industry lobby to rewrite the rules to include processes and 'old gains' as indicators of success, and to preclude any meaningful monitoring or evaluation of industry actions.
- Processes became the outcomes on which business were to be measured.
- There is no agreed outcome measure with respect to population level outcomes. In fact, this commitment seems to have been written out of the agreement. Industry data on packaged food categories could be used to measure a company's commitment to a reduction in calories.

Pettigrew et al point out that the current phase of their research will, like our research, evaluate the RD through its working practices. They

also say they will measure the 'impact of the RD on a range of health and nonhealth outcomes', but our point was that the population health and nonhealth outcomes had not been agreed at the steering group level. We agree, as we said in the original article, that '*it is possible to evaluate the potential of 'the Responsibility Deal approach' as a public health policy tool, by looking in detail at the initiative's working practices*'. However in the light of our conclusions this comes with serious caveats.

We agree that working practices are an important organisation-level component of any evaluation, but this must be combined with the evaluation of population-level outcomes. You may evaluate a process but if you cannot demonstrate that it is achieving the required, or indeed any, contribution to its targets then why continue that evaluation? Clearly there is an academic interest in determining what processes contribute to the achievement of an outcome. Although we lack the insights of Pettigrew and colleagues we feel a question that must be posed and addressed is whether there is an evaluative balance between process and outcomes.

Our research reinforced the findings of others who have illustrated the corporate capture of public health and government's eagerness to implement sanction-free voluntary agreements with business over legislative alternatives, to the detriment of public health [2] [3]. Similar criticisms have been levied at other components of the RD, such as the alcohol pledge.[4] In their paper [5] on how to evaluate a complex initiate such as the RD, Pettigrew et al conclude that there is evidence that Public Private Partnerships (PPP) can contribute to public health outcomes but that business must deliver what it has pledged. Our research suggests that business has reneged on its pledge. It has derailed the original objective of the initiative which was not just about having lower calorie options but was about shifting the whole offering in a healthier direction; a goal championed by the then Secretary of State for Health.

Our findings contend that the delivery of public health outcomes has been compromised. In many respects we feel that industry's actions are to be expected. They are not there to argue public health at any cost. What is disturbing is the lack of a public health voice and the lack of accountability by ministers and civil servants to argue for the greater good or to set limits on what is negotiable. The corporate capture of public health is epitomised by the RD and government's eagerness to enter into voluntary agreements at the expense of evidence-based alternatives that prioritise public health[6]

The question in our title '*brokering a deal for public health, but on whose terms?*' still remains valid and has yet to be addressed.

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[1] Panjwani, C. & Caraher, M. (2014). The Public Health Responsibility Deal: brokering a deal for public health, but on whose terms?. *Health Policy*, 114(2), pp. 163-173. doi: 10.1016/j.healthpol.2013.11.002

[2] Gornall J. Is the billion unit pledge just window dressing? BMJ 2014; 348:g3190 doi: 10.1136/bmj.g3190

[3] Moodie R, Stuckler D, Monteiro C, et al. Profits and pandemics: prevention of harmful effects of tobacco, alcohol, and ultra-processed food and drink industries. *Lancet* 2013; 381: 670–79.

[4] Scottish Health Action on Alcohol Problems (SHAAP) (2013) *The '(Ir)responsibility Deal'?: Public Health and Big Business*. SHAAP, Edinburgh

[5] Petticrew M, Eastmure E, Mays N, Knai C, Durand MA, Nolte E. The Public Health Responsibility Deal: how should such a complex public health policy be assessed? *J Public Health* (Oxf). 2013; Jul 23. http://jpubhealth.oxfordjournals.org/content/early/2013/07/23/pubmed.fdt064.abstract

[6] Mindell JS, Reynolds L, Cohen DL, McKee M. All in this together: the corporate capture of public health. *BMJ* 2012; 345: e8082.