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Debate on the paper by Costa e Silva et al.

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[1] *Paula Johns*

[1] *Aliança de Controle do Tabagismo, Rio de Janeiro, Brasil.*
paula.johns@actbr.org.br

The theme proposed by the article is highly relevant for expanding and contributing to the debate on governance in public health at the national and international levels. The answer to the question on the risk of public-private partnerships (PPP) in public health is not so much whether it can but whether it should be classified, analyzed, and monitored independently. The proposed analytical categories to minimize the risks of potential conflicts of interest in PPPs, divided into impossible, possible with caveats, and possible partnerships are extremely valid, but we should add other important analytical elements, for example the risks of associating brand names and companies with the authority and credibility of national governments, academia, and intergovernmental mechanisms for formulation of policies and guidelines.

Tobacco is an emblematic case: beyond the aspects already addressed and analyzed in the article, it sheds light on the history of companies that might have entered into an agreement of mutual interest with the public sector (as for example in joint work between the tobacco industry and government to fight the illegal tobacco trade), but where such an agreement is not justifiably acceptable in the eyes of the global public health community and has become the object of explicit restriction/exclusion in Article 5.3 of the World Health Organization Framework Convention on Tobacco Control (WHO-FCTC).

What were the historical reasons that led to this total ban on any agreement or partnership with an industry that produces a product that is incontestably harmful, but not illegal? One important reason for tobacco reaching the degree of restriction imposed by the WHO-FCTC was in part unveiled by the disclosure of secret tobacco industry documents through court action in the United States, revealing that the tobacco industry's practices and policies aimed primarily at undermining the objectives of reducing the consumption of tobacco products, which would have affected its profits. This was an essential historical fact for reaching a consensus that any kind of partnership with the tobacco industry is diametrically opposed to public health interests. In addition, the tobacco industry's unethical behavior has been extensively documented and studied.

In addition to the analysis divided into possible, possible with caveats, and impossible partnerships, I would add the analysis of three Ps (product, practices, and policies) [1] to identify behavior patterns in the ultra-processed foods industries; a more careful and critical analysis will show that its practices and policies differ little from those of the tobacco industry. Naturally it is desirable and necessary to work from the perspective of reducing harmful levels of sugar, salt, sodium, trans fats, and/or other harmful additives in ultra-processed foods. However, it is not necessary to address this issue through a PPP, since regulation produces more effective results.

In the current context, governments and thus their representative global bodies such as the WHO are increasingly vulnerable to the influence of large corporations and economic conglomerates whose capital exceeds the GDP of many of the member countries. While the negotiation of the WHO-FCTC served as a model and inspiration for the global public health community when dealing with the challenges of other risk factors for chronic non-communicable diseases (inadequate diet, excessive

alcohol intake, and physical inactivity), it also helped these industries, especially alcohol and ultra-processed foods, to take steps to prevent a ban from affecting their business.

The comparison of tobacco products and ultra-processed food products suggests an interesting parallel between Article 9 of the WHO-FCTC (regulation of the content of tobacco products) and voluntary agreements with the fast foods industry to reduce harmful ingredients (sodium, salt, sugar, trans fat, etc.). In the final analysis, ultra-processed food products are superfluous and co-factors in the interference in traditional food systems and the resulting transition from the dietary pattern of consuming natural and/or minimally processed foods and home-cooked meals to a growing share of ultra-processed foods in the diet in various countries. The consequence is the increase in obesity, as documented in Moodie et al. [2] as cited in the article.

Importantly, although Finland (North Karelia) is a successful case of partnership, this was a specific social context in a different historical moment, and in the case of diet there are other variables that make it more complex to export solutions from countries in the Northern Hemisphere to countries where eating habits still prevail that are not dependent on ultra-processed foods and which still do not apply satisfactory regulation of advertising targeted to children. This situation might be comparable to the currently debated issue on electronic cigarettes, presented as a good solution in the United Kingdom but not necessarily applicable to countries in the Southern Hemisphere.

Evidence suggests that voluntary agreements and/or partnerships are less effective than mandatory measures. In addition, the proposal to include the ultra-processed foods industry in the category of possible partnerships with caveats has an embedded risk of association of the company's image and purchase of political goodwill, which cannot be underestimated. Partnership means something different from negotiation with companies over deadlines and targets for the enforcement of a policy set by actors whose ultimate objective is to protect the population's health.

According to a study in Australia, salt reduction in food products is 20 times more effective when it is mandatory (http://www.ncbi.nlm.nih.gov/m/pubmed/21041840/). In Brazil, an independent analysis shows that the salt targets negotiated by government and industry are actually far higher than the mean sodium levels in food products already on the market (http://www.idec.org.br/o-idec/sala-de-imprensa/release/pesquisa-do-idec-aponta-que-acordo-para-reduco-do-sodio-no-muda-a-quantidade-de-sal-nos-alimentos), and other studies have shown that voluntary agreements in advertising are ineffective (http://www.unscn.org/files/Publications/SCN_News/SCNNEWS39_10.01_low_def.pdf). We thus lack sufficient evidence to believe that we should opt for partnerships with the ultra-processed foods industry to reverse the current trend in the obesity epidemic.

Another problem is the more subjective and subtle question of the development of interpersonal relations in the arena of negotiation and definition of public policies. When the Ministry of Health makes teams available to organize partnerships with industries that are the cause of the problem at issue, it creates a privileged communications channel between partners in the initiative which often does not exist even for civil society organizations that have a statutory objective to defend the public interest, far closer to the government's objectives than the companies' objectives.

Returning to the example of tobacco and the WHO-FCTC, most of the efforts have been made in measures to reduce the demand for cigarette consumption through regulation of the environment (smoke-free spaces), promotion, advertising and sponsorship, labeling (health warnings), and tax increases. Reformulation of the product (ban on additives), although studied by the WHO working group, was not chosen as a priority measure, since the objective is to reduce demand. Thus, if the obesity problem is caused by the transition from food patterns and culture that are being replaced by a growing percentage of consumption of ultra-processed foods, the priority measures to achieve this objective should be similar to those used for tobacco.

Congratulations to the authors for promoting this crucial debate, especially at present with the adoption of the Framework of Engagement with Non-State Actors (FENSA) at the 69th World Health Assembly, which will require careful and detailed analysis for its implementation.

1. Gomes FS. Conflitos de interesse em alimentação e nutrição. Cad Saúde Pública 2015; 31:2039-46.
2. Moodie R, Stuckler D, Monteiro C, Sheron N, Neal B, Thamarangsi T, et al. Profits and pandemics: prevention of harmful effects of tobacco, alcohol, and ultra-processed food and drink industries. Lancet 2013; 381:670-9.