

09-11

STATEMENT OF POLICY

Menu Labeling, Trans Fats, and Salt

Policy

NACCHO supports local health department (LHD) leadership in bringing about new food policies and organizational practices that improve the nutrition content of prepared and processed foods. These policies include the following:

- Local and state regulations, ordinances, and statutes that would prohibit the use of artificial trans fats and similar artificial, unhealthy oils in prepared foods offered at chain restaurants.
- The steady reduction in the amount of salt in prepared and processed foods through health department-led surveillance and targeted food industry and restaurant salt reductions, such as the New York City-sponsored National Sodium Reduction Initiative. NACCHO recommends that LHDs become partners in this initiative.
- Regulations, ordinances, and statutes requiring comprehensive menu labeling at the point of decision-making in chain restaurants. Menu labeling is comprehensive when it includes nutrition information, such as calories, fats (including trans fats), carbohydrates, and sodium, most critical to people with chronic diseases. Such nutrition information should be displayed or made available in a clear, non-confusing, uniform way across restaurants. Menu labels, menu boards, and menu tags should at least display calorie content with additional language referencing a standard 2,000 calorie diet. The information should be available in Spanish and other languages prevalent in the chain restaurant's community.

NACCHO supports local, state, and federal funding for LHDs to provide (1) public education about trans fats, salt, menu labeling, and fresh foods; (2) technical assistance to food establishments to support reformulation; and (3) adequate compliance and surveillance.

Justification

Trends in dining out. According to the National Restaurant Association, Americans now spend nearly half of their food dollars on foods prepared outside the home—twice as much as they did in the 1970s.² An analysis conducted by an expert panel for the Food and Drug Administration³ shows that families consume an average of four meals prepared outside the home each week, with American adults and children consuming about one-third of their calories from restaurants and other food-service establishments.

A growing body of scientific evidence links eating outside of the home with higher caloric intake and conditions that include increases in body mass index, weight gain, insulin resistance, and obesity both in adults and children. Restaurant food consumption has been associated with an increase in body fat among men and women ages 19 to 80 years.⁴ Compared to home-prepared foods, restaurant foods are generally higher in salt, calories, and saturated fats and lower in nutrients and fiber. There is an increased risk of exceeding one's caloric



requirement when Americans average four meals out per week—not just on the day the person eats out but also for the entire week.

The increase in eating out is having a particular impact on children. Pediatricians across the country are witnessing overweight children as young as 12 years old with type 2 diabetes, hyperlipidemia, and abnormal blood pressure – conditions that can be brought on by poor diet and, in part, treated through improved nutrition.⁵ A study reported in *Hypertension* shows a statistically significant association between salt intake and total fluid intake that more often than not includes sugar-sweetened soft drinks.⁶ Essentially, the high sodium content of fast food causes children to crave high content corn syrup drinks, which often are super sizes, further contributing to weight gain among children. The research suggests that one public health strategy to help reduce childhood obesity would be to reduce the salt content in fast foods.

Health equity. Many Americans live in “food deserts,” where fresh, affordable healthy produce are unavailable. Food deserts arise partly from zoning and other regulatory decisions that create barriers to opening and operating grocery stores that offer the full range of healthy food products. In rural areas, lack of transportation infrastructure can be a significant access barrier.⁷ Many low income communities often have a high concentration of fast food restaurants and advertisements for unhealthy foods, cigarettes, and alcohol. In addition, produce at small corner stores in low income communities is more expensive and of poorer quality than that found in larger, but more distant grocery stores. The greater availability and affordability of unhealthy processed and fast foods, combined with the lack of access to affordable, high quality fruits, vegetables, and other produce means that families in these communities face significant barriers to eating a healthy diet composed of nutritious, low density foods needed to maintain a healthy weight.⁸

Policies to address inadequate access to healthy foods can potentially reduce health inequities. Menu labeling, trans fats bans, and voluntary sodium reduction policies may beneficially impact people living in these communities on account of the greater concentration of processed and fast food restaurants in those neighborhoods. However, policies and practices that support the greater availability of affordable, high quality produce could have a much greater impact in the long run. These impacts would involve organizational practice changes, public policies, and other strategies to support a more localized food system that works for everyone.

The food system is the set of processes involved in feeding a community. Many decisions about these processes (i.e., growing, harvesting, processing, packaging, transporting, marketing, preparing, and eating) are outside of the hands of local communities—with the concomitant health consequences discussed above. Reformulation policies regulate the processing and preparing stages of food production without modifying the underlying food system. Reformulation policies can directly change a product by mandating the removal, reduction, and/or replacement of harmful ingredients or indirectly by introducing market incentives to change ingredients. Because the reformulation of food benefits everyone, not just the nutritious conscious individual, it is a powerful means of improving nutrition at the population level.

Trans fats. Trans fatty acids, typically referred to as trans fats, are formed when liquid vegetable and plant oils undergo a chemical process, called partial hydrogenation, during which hydrogen is added to make the oils more solid. Artificial trans fats are known to be harmful to human health, by increasing our levels of low-density lipoproteins (LDLs), while decreasing our levels of high-density lipoproteins (HDLs). Eliminating artificial trans fats from prepared foods is a necessary public health intervention to address cardiovascular disease, the number one cause of death in Americans.

Trans fats are an artificial chemical that should be eliminated from the food supply. Banning trans fats from all prepared foods is a proportionate response to the public health danger posed by trans fats. While LHDs can support ordinances or regulations to ban trans fats in prepared foods, sufficient resources will be needed for adequate enforcement, public education, and technical assistance. Additional staff time and training will be needed to do the following:

- Ensure compliance with a trans fat ban;
- Implement a public education campaign about the dangers of trans fats;
- Provide technical assistance to support food establishments' efforts of compliance and reformulation using trans fat-free ingredients; and
- Continually monitor the oils used in prepared foods, as new artificially produced, yet trans fat-free, products could potentially have the same harmful effects of trans fats.

New York, Philadelphia, Boston, and California have already implemented bans on trans fat, and industry has responded with new products. There are a number of trans fat-free products on the market for producing baked goods. Many of these products are comparable in price and quality to products containing artificial trans fats. There also are many trans fat-free lower saturated fat alternatives on the market such as palm and canola blends.

Sodium. Sodium reduction is necessary to reduce chronic disease. Hypertension is a risk factor for heart disease and stroke, the first and third leading causes of death in the United States.⁹ High sodium consumption, mainly through salt in food, increases the risk for hypertension. Americans consume an average of 3,436 mg/day of sodium, which is nearly one and a half times the daily amount (2,300 mg/day) recommended by the Department of Agriculture (USDA). Moreover, the *Dietary Guidelines for Americans, 2005* recommends that persons with hypertension, African Americans, and all middle-aged and older adults should consume no more than 1,500 mg/day of sodium.¹⁰

The American Medical Association estimates as many as 150,000 early deaths might be saved annually if consumers reduced their salt intake by half. According to research by the Centers for Science in the Public Interest, as much as 75 percent of dietary salt comes from processed and restaurant foods.¹¹ Thus, reformulation policies to reduce sodium in processed and restaurant foods are a key public health strategy to address hypertension.

New York City has launched the National Salt Reduction Initiative that aims to reduce salt intake nationally by 50 percent over a decade. Over 41 local, state, and national health organization partners are co-sponsoring the initiative, and NACCHO recommends that LHDs sign on as partners. The initiative includes working with the food and restaurant industries to identify foods most frequently eaten and food with the highest salt content in order to target foods for voluntary, gradual salt reductions.

Menu labeling. Menu labeling regulations and ordinances will have their maximum impact when they are designed to (1) facilitate healthy decisions among those with an intention to select healthy foods and (2) create incentives for reformulation. With the passage of menu labeling laws across the country, evidence is mounting that the policy does enable people to make healthy choices. For example, a study conducted at a fast food chain restaurant found that 32 percent of customers who saw calorie information purchased meals averaging 52 fewer calories than those who did not see the calorie information. Customers who claim that they proactively use calorie information purchased meals averaging 99 fewer calories than those who did not see the calorie information.¹² This research supports the view that menu labeling at the point of decision-making can lead to

more healthy choices, particularly among health conscious consumers, including those with chronic disease on special diets or those attempting to maintain a healthy weight.¹³

Other research suggests that the strongest impact of menu labeling policies is likely through incentives to reformulate. For example, researchers at the USDA's Economic Research Service identify two types of incentives to reformulate in response to menu labeling: (1) manufacturers may opt to reformulate as part of a strategy to build brand reputation, including well-advertised investments in new "healthy" ingredients and processes and (2) manufacturers may reformulate and adopt expensive process changes to raise de facto industry quality standards, thus creating effective barriers to entry when other firms find it difficult to meet rising health and quality expectations.¹⁴

A necessary condition for menu labeling to induce an incentive for more healthy reformulation is having nutrition information that is targeted to health conscious people, such as those with chronic disease or on special diets, thereby supporting market segmentation. This would require nutrition information that is standard and readable across competing restaurants and available at the point of decision-making. Moreover, the nutrition information must be presented in ways that are not obscured by other extraneous facts. One strategy is to ensure that several key nutrition items such as calories, fats (including trans fats), sodium, and carbohydrates are highly visible because this is information that people with chronic disease should be concerned about. Several municipalities have taken this strategy and gone beyond calories to include other key nutrition items.

Record of Action

*Approved by NACCHO Board of Directors
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References

¹ Processed foods have been altered from their natural state for safety reasons and for convenience. The methods used for processing foods include canning, freezing, refrigeration, dehydration and aseptic processing. Processed foods can be sold at supermarkets and other retailers or wholesalers and combined at home or in restaurants. We define "prepared foods" are those foods mixed and combined from other food ingredients *by a chain restaurant* and sold in a heated state or heated (or chilled or frozen, in some cases) *by the chain restaurant*.

² National Restaurant Association (2005). *Industry at a Glance*.

³ Food and Drug Administration(2006). *The Keystone Forum on Away-From-Home Foods: Opportunities for Preventing Weight Gain and Obesity. Final Report*.

⁴ M. A. McCrory, P. J. Fuss, E. Saltzman, and S. B. Roberts (2000). Dietary Determinants of Energy Intake and Weight Regulation in Healthy Adults. *J. Nutr.* **130**, 276.

⁵ Steinberger J, Daniels SR. (2003). *Obesity, insulin resistance, diabetes and cardiovascular risk in children. An American Heart Association scientific statement from the atherosclerosis, hypertension, and obesity in the young committee*, 1448-1453.

⁶ He FJ, Marrero NM, MacGregor GA. (2008). Salt Intake Is related to soft drink consumption in children and adolescents: a link to obesity? *Hypertension*, 51(3): 629-34

⁷ United States Department of Agriculture (2009). Access to affordable and nutritious food—Measuring and understanding food deserts and their consequences: Report to Congress. USDA: <http://www.ers.usda.gov/Publications/AP/AP036/>

⁸ Ibid.

⁹ Ayala C, et al. (2009). Application of lower sodium intake recommendations to adults -- United States, 1999-2006. *Mortality and Morbidity Weekly Report*, 58: 281-83.

¹⁰ United States Department of Agriculture. (2005) *Dietary Guidelines for Americans 2005*. Washington (DC): Government Printing Office.

¹¹ *Industry Not Lowering Sodium in Processed Foods, Despite Public Health Concerns*. Retrieved August 21, 2009, from CSPI web site: <http://www.cspinet.org/new/200812041.html>

¹² Note: The difference between a Quarter Pounder with cheese (549 calories) and a Quarter Pounder without cheese (460) is 89 calories.

¹³ Basset MT, Dumanovsky T, Huang C, Silver LD, Young C, Nonas C, Matte TD, Chideya S, Frieden TR. (2008). Purchasing behavior and calorie information at fast-food chains in New York City, 2007. *Am J Public Health*, 98:1457-1459.

¹⁴ Laurian Unnevehr and Elise Golan (eds.) (2008). Special section on food product composition, consumer health, and public policy. *Food Policy*, Vol. 33, Issue 6.