

99-08

STATEMENT OF POLICY

Food Safety

Policy

The National Association of County and City Health Officials (NACCHO) supports the development of a science-based food safety system that assures local public health department participation in all areas of food safety as a means to reduce foodborne illness with particular attention to challenges such as imported food supply, new and re-emerging foodborne pathogens, changing demographics, and intentional contamination.

Food Safety Policy

- NACCHO supports the ongoing interaction of local health departments (LHDs) with state and federal agencies to enhance the food safety system.
- NACCHO supports local public health workforce training to identify risks associated with purveying of food to the public through active inspection and surveillance programs.
- NACCHO supports policies that enhance laboratory capacity for testing to identify foodborne illness outbreaks and respond quickly.
- NACCHO supports legislation that includes education for consumers, food handlers, retail food establishments, and other sectors of the food industry at the local level to enhance foodborne-illness prevention and reporting to public health officials.
- NACCHO supports legislation that enhances the ability of LHDs to identify and address the overarching and interrelated economic and health equity issues that influence the burden of foodborne illness.
- NACCHO supports the development of methods for compensation or reimbursement from the federal government to LHDs for special requests and assistance during food safety recalls or foodborne-illness outbreaks.

Food Safety Funding

- NACCHO supports policies that provide increased federal and state funding for foodborne-illness research, student education subsidy, and training for the current local public health workforce as effective means to protect people from disease and enhance prevention and control of foodborne illnesses at the local level and throughout the larger food safety system.
- NACCHO supports enhanced federal and state funding for LHDs' food safety capacity and infrastructure for routine public health activities including food safety education, food retail and manufacturing inspection, and foodborne-illness surveillance, investigation, and control.
- NACCHO supports additional federal, state, and local funding to build and improve communications, coordination, and partnerships throughout the food safety system, including federal agencies, state and local health departments, emergency preparedness programs, food industry, consumers, and public health professional organizations.



Justification

Foodborne illness in the United States is estimated to cause 76 million cases of illness, over 325,000 hospitalizations, and 5,000 deaths each year.¹ Hospitalizations due to foodborne illnesses are estimated to cost over \$3 billion each year. The cost of lost productivity is estimated at between \$20 billion and \$40 billion each year.² Preventing foodborne illness remains one of our greatest public health challenges.

Foodborne illness is defined as “any disease or infection caused by or thought to be caused by consumption of food or water.”³ While single cases of foodborne illness are common, the true number of foodborne outbreaks is not known because of underreporting. The United States Department of Agriculture (USDA), the Food and Drug Administration (FDA), and the Centers for Disease Control and Prevention (CDC) have ongoing consumer education programs. Despite these programs, CDC estimates that only one in 37 cases of foodborne illness is reported.⁴ The proportion of cases of foodborne illness reported to public health authorities can depend on the severity of the case, reporting of the illness to health officials, and surveillance capacity at the state and local levels.⁵ Consumer education and LHD capacity will continue to be critical to prevention and informing the food safety system.

Each reported case of foodborne illness must be identified, investigated, and controlled primarily at the local and state levels. According to the National Association of State Departments of Agriculture, more than 80 percent of food establishment inspections are conducted by local and state governments. These same governments also investigate the majority of foodborne illnesses and are responsible for the sampling of food products for contamination.⁶ These first steps taken by local and state health departments are critical to improving prevention and response to foodborne illness in the United States.

According to a 2005 survey of LHDs conducted by NACCHO, 76 percent of LHDs conduct food service inspection and licensing, 75 percent of LHDs conduct environmental health surveillance, and 75 percent of LHDs provide food safety education.⁷ Expanding resources at the local level may prevent potential foodborne outbreaks and control further illness. This NACCHO survey also showed that federal funds account for approximately 20 percent of LHDs’ revenues. Federal funds allocated to LHDs for food safety have been modest. Increased financial support is necessary to help LHDs to continue and further enhance their efforts in food safety.

Measuring the social burden of foodborne illness on a community is difficult, but a greater understanding is needed to develop and implement effective policies and strategies to make a positive impact. A report from the United Kingdom indicates a relationship between socioeconomic status and foodborne illness that may apply to the United States. It found that hospital admissions for gastrointestinal infections increased with increasing socioeconomic deprivation.⁸

In addition, an economic burden is associated with foodborne illness. The Virginia Cooperative Extension estimates that, in 1993, the cost of each case of foodborne illness was \$942.⁹ CDC estimates that foodborne illnesses cost the nation more than \$8 billion annually in medical expenses and lost productivity.¹⁰

As stated in the Food Safety Healthy People 2010 Progress Review, improvements are still needed in a variety of areas to combat new and re-emerging issues, such as inadequate laboratory pathogen detection methods and technology and an increase in fresh produce as a source of foodborne illness. Improvements in reporting and surveillance are needed to identify and track parasite and virus contributions to the burden of foodborne illness.

Protection of the food supply should be integrated into food safety programs. Additional resources should be directed to protect special populations at greater risk for foodborne illnesses. Finally, the Progress Review suggested that innovation is needed to improve food safety throughout the food industry.¹¹ Despite significant progress in public health food safety efforts, foodborne illness remains a serious concern.

Record of Action

Approved by the NACCHO Board of Directors

November 7, 1999

Updated March 6, 2008

¹ Mead, P.S.; Slutsker, L.; Dietz, V.; et al. (1999). Food-related illness and death in the United States. *Emerging Infectious Diseases*. 5(5):607-625.

² Food and Drug Administration (FDA), Department of Agriculture (USDA), & Environmental Protection Agency (EPA). (1997). *Food safety from farm to table: a national food safety initiative. Report to the President, May 1997*. Washington, DC: FDA, USDA, EPA.

³ Adams, M. & Motarjemi, Y. (1999). *Basic food safety for health workers*. Geneva: World Health Organization.

⁴ Centers for Disease Control and Prevention/DBMD, Foodborne Disease General Information. *How are foodborne disease diagnosed?*. Retrieved January 11, 2008 from http://www.cdc.gov/ncidod/dbmd/diseaseinfo/foodborneinfections_g.htm

⁵ Lynch, M., Painter, J., Woodruff, R., & Braden, C. (2006). Surveillance for foodborne-disease outbreaks — United States, 1998–2002. *Morbidity and Mortality Weekly Report*, 55, SS-10. Retrieved from <http://www.cdc.gov/mmwr/PDF/ss/ss5510.pdf>

⁶ Myers, Lee M. (July 19, 2007). *Myers Testimony before House Committee on Homeland Security: National Association of State Departments of Agriculture*.

⁷ National Association of County Health Officials. (2006). *2005 National profile of local health departments*. Washington, DC: National Association of County and City Health Officials.

⁸ Olowokure, B., Hawker, J., Weinberg, J., Gill, N., & Sufi, F. (1999). Deprivation and hospital admission for infectious intestinal diseases. *Lancet*; 353, 807.

⁹ Lambur, M., Rajopal, R., Lewis, E., & Cox, R. (2003). *Applying cost benefit analysis to nutrition education programs: focus on the Virginia expanded food and nutrition education program*. Virginia Cooperative Extension.

¹⁰ Food and Drug Administration. *Testimony before United States Senate Committee on Appropriations, May 10, 2001*. Subcommittee on Agriculture, Rural Development, and Related Agencies. Retrieved on January 11, 2008, from <http://www.fda.gov/oc/oms/ofm/budget/2002/senatefinalwritten.htm>

¹¹ Department of Health and Human Services (HHS). (2004). *Healthy People 2010 progress review, food safety*. Washington, DC: HHS, Public Health Service (PHS), Office of Disease Prevention and Health Promotion (ODPHP). Retrieved from <http://www.healthypeople.gov/data/2010prog/focus10/FoodSafetyPR.pdf>.