

09-11

STATEMENT OF POLICY

Menu Labeling, Trans Fats, and Salt

Policy

NACCHO supports local health department leadership in educating the public and bringing about new food policies and organizational practices that improve menu labeling and the reduction of trans fats and salt.

- NACCHO urges the Food and Drug Administration (FDA) to make a final determination that partially hydrogenated oils are not generally recognized as safe, as proposed in November 2013.
- NACCHO urges the FDA to release final menu labeling rules in accordance with the Affordable Care Act passed in March 2010 without delay.
- NACCHO supports 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.
- NACCHO urges local health departments to support regulations, ordinances, and statutes requiring comprehensive menu labeling at the point of decision-making in chain restaurants.
- NACCHO supports reducing the amount of salt in the food supply through health department-led initiatives that partner with the food and restaurant industry and institutional food service sectors to set targets that progressively lower sodium levels in prepared and processed foods.
- NACCHO supports educational campaigns and programs that increase public and health provider awareness about sources of sodium intake and the health consequences associated with excess salt consumption. Programs should also increase health literacy by teaching consumers to properly read nutrition labels for the purpose of identifying low-sodium food choices and provide hypertension screening and control services.
- NACCHO urges local health departments to join the National Sodium Reduction Initiative.
- 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 U.S. Department of Agriculture, food consumption in the United States has increased by 16 percent since 1970, corresponding to an increased calorie intake of 2,234 calories per person per day in 1970 to 2,757 calories in 2003.¹ In addition, a study from 2003 found significant changes in portion sizes from 1977-1998, with portion sizes ranging from an increase of 49 to 133 calories per item among commonly consumed foods such as salty snacks, soft drinks, hamburgers, French fries, and Mexican food.²

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.³ Compared to home-prepared foods, restaurant foods are generally higher in salt, calories, and saturated fats and lower in nutrients and fiber.

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.⁴ 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.⁵ This study reported that the high-sodium content of fast food causes children to crave high-content corn syrup drinks, which often are super sizes, further contributing excessive caloric intake and ultimately 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.

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 levels of low-density lipoproteins (LDLs) while decreasing levels of high-density lipoproteins (HDLs). Long-term consumption of trans fats is also associated with increased risk for developing gallstones.⁶ Eliminating artificial trans fats from prepared foods is necessary public health intervention to address cardiovascular disease, the number one cause of death in Americans.

Trans fatty acids are artificial chemicals that should be eliminated from the food supply. While local health departments 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' compliance efforts and reformulation using trans fat-free ingredients.
- 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. Due to these local initiatives, consumption of trans fatty acids has declined from about 4.6 grams per day in 2003 to 1.3 grams per day in 2012.⁷ This impressive reduction has led the FDA to propose a ban on all artificial trans fats because many partially hydrogenated oils (PHOs)—the main source of many trans fats—are still prevalent in our food system. Banning trans fats and PHOs could prevent between 10,000–20,000 heart attacks and 3,000–7,000 coronary heart disease deaths each year in the U.S according to the CDC.⁷

Sodium

Sodium reduction is necessary to reduce chronic disease. Approximately 90 percent of Americans consume too much sodium and nearly 80 percent of the sodium consumed comes from packaged or restaurant food that may or may not even be salty. Excess sodium consumption is a leading cause of hypertension, which in turn is a risk factor for heart disease and stroke, the first and third leading causes of death in the United States.⁸ 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, 2010* 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.⁹

The American Medical Association estimates as many as 150,000 annual early deaths could be avoided if consumers reduced salt intake by 50 percent. A recent survey also called for the combined reduction of salt intake and increased potassium intake for even more positive effects on hypertension in adults.¹⁰ Research demonstrates that 75 percent of dietary salt intake is attributable to processed and restaurant food sources.¹¹ Thus, reformulation policies to reduce sodium in processed and restaurant foods is a key public health strategy to address hypertension.

To spur a population-level reduction in sodium consumption, the National Forum for Heart Disease and Stroke recommends increasing the adoption of sodium limits in food procurement guidelines; increasing the availability of nutrition information of packaged foods; and creating policies to make lower-sodium food options available.¹² The American Heart Association supports the reduction of sodium in the food supply in an effort to gradually condition the population's preference to lower sodium foods.¹³ The Institute of Medicine (IOM) recommends addressing the food supply and, through regulation, instituting a well-researched and monitored gradual reduction of salt as an ingredient in prepared and processed foods.¹⁴ This approach must apply to all restaurants and food manufacturers in order to “level the playing field” to ensure that companies are not put at a disadvantage, in regard to sales, when lowering salt content in their foods.¹⁴ The IOM also recommends a holistic approach to reducing salt in the food supply, with collaborations between the government, community groups, and consumers.¹⁴

The FDA recognizes that population sodium consumption has reached an unhealthy level. In

2014, the FDA addressed this issue by working to create sodium guidelines for the food industry, and pressuring food companies and restaurants to use less salt in their foods. These guidelines are voluntary and are a start to industry-wide salt reduction in foods.

In recent years, local communities have addressed sodium reduction in their chronic disease programs. The Centers for Disease Control and Prevention awarded funds to support communities in decreasing sodium consumption in the population through the 2013–2016 Sodium Reduction in Communities Program (SRCP). SRCP aims to increase access to and the accessibility of lower sodium food options, to reduce sodium intake, and to continue to build practice-based evidence around effective population-based strategies to reduce sodium consumption at the community level.¹⁵

New York City began this process when it launched the National Salt Reduction Initiative (NSRI).¹⁶ The initiative aims to reduce salt intake nationally by 50 percent over a decade by working with food and restaurant industries to identify foods most frequently eaten and foods with the highest salt content in order to target foods for voluntary, gradual salt reductions.¹⁶ Companies that participate in the initiative pledge that overall sales of products in a food category, such as cheeseburgers, will meet NSRI's sodium content targets.¹⁶ These targets gradually decrease each year so that sodium content in foods is progressively reduced. For restaurant foods, for example, the baseline sodium content for soup in 2009 was 395 mg/100g. The 2012 and 2014 sodium content targets are 340 mg/100g and 280 mg/100g, respectively.¹⁷ The same framework is applied to reducing sodium in packaged foods as well.¹⁸ Over 41 local, state, and national health organization partners are co-sponsoring the initiative.

Menu Labeling

Menu labeling regulations and ordinances will have 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 but that the format of the label information may play a role in ordering and consumption behaviors. 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. (Note: The difference between a Quarter Pounder with cheese (549 calories) and a Quarter Pounder without cheese (460) is 89 calories.) 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.¹⁹

Other research suggests that the strongest impact of menu labeling policies is likely through incentives to reformulate. For example, researchers at the U.S. Department of Agriculture'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.²⁰

A necessary condition for menu labeling to incentivize healthier 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. Recent studies have also touted the possible benefits of using more symbolic labeling including “fitness labeling,” which involves using symbolic representations of how much exercise would be required to burn the amount of calories consumed. It is possible that these and other types of symbolic labeling may have a greater impact on ordering habits than traditional, complex caloric labels.²¹ Several municipalities have taken this strategy and include key nutrition items besides calories.

The Los Angeles County Department of Public Health launched the Choose Health LA campaign to improve nutrition education and the food environment in several communities in Los Angeles County. The department promoted changes in food procurement, purchasing, and preparation in schools and food-service operations run by public agencies. Strategies included adopting and implementing nutrition standards and gradual sodium reduction.

The campaign was partially supported by the Los Angeles County Sodium Reduction Initiative (LACSRI), a CDC-funded project under the Sodium Reduction in Communities Program. LACSRI’s goal was to encourage community activities that reduce sodium intake at the individual and organizational levels. The initiative’s plan objectives included the following:

- Implementing strategies and practices to improve food-service venues (e.g., menu labeling, smaller portion sizes, product placement, pricing strategies, and gradual sodium reduction).
- Increasing healthy options on school cafeteria menus.
- Using social media and other communication channels to raise public awareness about sodium.

These collective efforts, for example, achieved passage of a County of Los Angeles Board of Supervisors Motion that allows the health department to comment on and recommend healthy food standards for new and renewing food services and vending contracts in county departments that serve or procure food.

Procurement

Food procurement policies can be designed to make healthier food more readily available, affordable, and appealing. These policies can work to change individual factors (e.g., knowledge of how to choose healthy options), social factors (e.g., social norms), and environmental factors (e.g., access to healthy options). Food procurement policies use existing food dollars to create a more nutritious food environment and drive demand toward increased availability and demand for more healthful products. Food procurement policies can target many nutrients and set

standards for calories, fat, trans fat, and sugar to increase the overall healthfulness of food options and provide a more healthful food environment. Procurement policies change the role of state and local government from a passive consumer to an active driver of the market, in the process providing greater demand for and access to healthful foods.²²

National Education Programs

The FDA educates consumers about the high sodium levels in processed foods added by manufacturers on their website. FDA provides instructions for reading nutrition labels to identify salt content, recommendations for reducing sodium intake, and information about the connection between sodium and disease.²³ The New York City Health Department also provides similar information in concert with their National Salt Reduction Initiative.²⁴ NACCHO urges LHDs to follow this example and provide consumers with information about reading nutrition labels and recommendations for making low sodium food choices.

The addition of menu labeling on restaurant boards and menus complements efforts to increase health literacy and health education. The Affordable Care Act in 2010 made it a requirement for chain retail food establishments with 20 or more locations to post calorie information and provide nutritional information, which includes sodium, for customers if requested.²⁵

Many local health departments created menu labeling policies in their jurisdictions before this federal designation. Local health departments in King County (Seattle), WA, Multnomah County, OR, Philadelphia, PA, and San Mateo County, CA have joined this effort in ensuring chain retail food establishments have information about sodium content available to consumers.²⁶

References

1. Hodan Farah, H., & Buzby, J. (2005). U.S. food consumption up 16 percent since 1970. *Amber Waves*, 3:5.
2. Nielson, S., & Popkin, B. (2003). Patterns and trends in food portion sizes, 1977–1998. *Journal of the American Medical Association*, 289(4):450–453. doi:10.1001/jama.289.4.450
3. McCrory, M. A., Fuss, P. J., Saltzman, E., & Roberts, S. B. (2000). Dietary determinants of energy intake and weight regulation in healthy adults. *Journal of Nutrition*, 130: 276.
4. Steinberger, J., & Daniels, S. R. (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.
5. He, F. J., Marrero, N. M., & MacGregor, G. A. (2008). Salt intake is related to soft drink consumption in children and adolescents: A link to obesity? *Hypertension*, 51(3): 629-34.
6. Giovannucci, E., Willett, W., Tsai, C., & Leitzmann, M. (2005). Long-term intake of trans-fatty acids and risk of gallstone disease in men. *Archives of Internal Medicine*, 165(9):1011-1015.
7. Centers for Disease Control and Prevention. (2012). Trans Fats: The Facts webpage. Retrieved September 8, 2014, from http://www.cdc.gov/nutrition/downloads/transfat_508_final.pdf
8. Ayala, C., Kuklina, E. V., Peralez, J., Keenan, N. L., & Labarthe, D. R. (2009). Application of lower sodium intake recommendations to adults -- United States, 1999-2006. *Mortality and Morbidity Weekly Report*, 58: 281-83.
9. U.S. Department of Agriculture and U.S. Department of Health and Human Services. (2010). *Dietary Guidelines for Americans, 2010 (7th ed.)* Washington, DC: U.S. Government Printing Office.
10. Aaron, K. J. (2013). Role of dietary salt and potassium intake in cardiovascular health and disease: A review of the evidence. *Mayo Clinic Proceedings*;88(9), 987. doi:10.1016/j.mayocp.2013.06.005
11. Center for Science in the Public Interest. (December 4, 2008). Industry Not Lowering Sodium in Processed Foods, Despite Public Health Concerns [webpage]. Retrieved August 21, 2009, from <http://www.cspinet.org/new/200812041.html>
12. National Forum for Heart Disease and Stroke Prevention. (2012). National Forum Sodium Reduction Action Plan.

13. American Heart Association. (October 31, 2013). Reducing Sodium in a Salty World webpage. Retrieved September 8, 2014, from http://www.heart.org/HEARTORG/GettingHealthy/NutritionCenter/HealthyEating/Reducing-Sodium-in-a-Salty-World_UCM_457519_Article.jsp
14. Institute of Medicine. (2010). *Strategies to Reduce Sodium Intake in the United States: Report Brief*. Washington, DC: Institute of Medicine.
15. Centers for Disease Control and Prevention. (April 2014). *Sodium Reduction in Communities Program (2013- 2016)*. Retrieved September 8, 2014 from http://www.cdc.gov/dhbsp/docs/Sodium_Reduction_Communities_Overview.pdf
16. New York City Department of Health and Mental Hygiene. National Salt Reduction Initiative webpage. Retrieved [[September 8, 2014], from <http://www.nyc.gov/html/doh/html/diseases/salt.shtml>
17. New York City Department of Health and Mental Hygiene. (n.d.). *National Salt Reduction Initiative Restaurant Food Categories and Targets*. Retrieved September 8, 2014, from <http://www.nyc.gov/html/doh/downloads/pdf/cardio/cardio-salt-nsri-restaurant.pdf>
18. New York City Department of Health and Mental Hygiene. (n.d.). National Salt Reduction Initiative: Packaged Food webpage. Retrieved September 8, 2014 from <http://www.nyc.gov/html/doh/html/diseases/salt-initiative-packagedfood.shtml>
19. Basset, M. T., Dumanovsky, T., Huang, C., Silver, L. D., Young, C., Nonas, C., et al. (2008). Purchasing behavior and calorie information at fast-food chains in New York City, 2007. *American Journal of Public Health, 98*:1457-1459.
20. Unnevehr, L., & Golan, E. (Eds.). (2008). Special section on food product composition, consumer health, and public policy. *Food Policy, 33*(6): 465–469
21. Swartz, J. (2013). Simplifying healthful choices: A qualitative study of a physical activity based nutrition label format. *Nutrition Journal, 12*(1); 72-81. doi:10.1186/1475-2891-12-72
22. Centers for Disease Control and Prevention. (February 2011). *Improving the Food Environment Through Nutrition Standards: A Guide for Government Procurement*. Atlanta, GA: Centers for Disease Control and Prevention.
23. Food and Drug Administration. (June 20, 2014). *Sodium in Your Diet: Using the Nutrition Facts Label to Reduce Your Intake*. Retrieved September 8, 2014 from <http://www.fda.gov/Food/ResourcesForYou/Consumers/ucm315393.htm>
24. New York City Department of Health and Mental Hygiene. Choose Less Sodium webpage. Retrieved September 8, 2014 from <http://www.nyc.gov/html/doh/html/living/cardio-sodium.shtml>
25. U.S. Food and Drug Administration. (2014, July 9). *Guidance for Industry: Questions and Answers Regarding the Effect of Section 4205 of the Patient Protection and Affordable Care Act of 2010 on State and Local Menu and Vending Machine Labeling Laws*. Retrieved September 8, 2014 from <http://www.fda.gov/Food/GuidanceRegulation/GuidanceDocumentsRegulatoryInformation/LabelingNutrition/ucm223408.htm>
26. Center for Science in the Public Interest. (2009). *Nutrition Labeling in Chain Restaurants: State and Local Bills/Regulations – 2007-2008*. Retrieved September 8, 2014 from <https://www.cspinet.org/nutritionpolicy/MenuLabelingBills2007-2008.pdf>

Record of Action

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