Prevention of Chronic Disease Through Menu Labeling, Trans Fat Bans, and Sodium Reduction

Chronic diseases are now the leading causes of morbidity and mortality in the U.S. They are also the primary drivers of healthcare expenditures. Food intake choices are a major contributor to chronic diseases, such as diabetes, cancer, hypertension and heart disease. The environments we live in can contribute to healthy living. If there is lack of healthy food and a lack of access to physical activity, making the healthy choice is not easy. The purpose of implementing menu labeling, trans fat bans and sodium reduction policies is to provide critical information to consumers so that they can make decisions about the foods they eat along with taking out unnecessary and harmful fat and sodium.

Menu-Labeling

About two-thirds of U.S. adults are now obese or overweight. What has occurred that can account for this change? Clearly human physiology could not have been fundamentally altered in such a short time frame. What has changed in a myriad of ways, however, are the environments in which we make choices about what to eat and how active to be. Because many changes have occurred in our environments there is no single "fix" to this problem. However, these changes can be addressed if we have the political will to do so.

In 1970, Americans spent just 26 percent of their food dollars on restaurant meals and other meals prepared outside their homes. Today, Americans spend almost half (46 percent) of their food dollars at restaurants[1] and eat about a third of their calories away from home. Although people with higher incomes eat out more often than those with lower incomes, people with annual household incomes below $15,000 eat out more than three meals per week.[2] Lower income neighborhoods often have limited healthy foods choices and instead tend to have fast-food restaurants and other unhealthy, inexpensive food choices.

Portion sizes have increased substantially and foods from fast-food and other food-service establishments are generally higher in fat and calories, as compared to home-prepared foods. Consumers cannot make informed choices about what to order in a restaurant unless they have adequate information about what they are choosing. Also, they must have that information when they place their order, known as 'point-of-decision-making.' The current voluntary system of nutritional labeling at restaurants is inadequate and ineffective. Approximately half of chain restaurants do not provide any nutrition information about their foods to their customers.[3] Those chains that do provide information often do so through the Internet or by means other than the point-of-decision-making. This greatly limits the influence that this information can have on the choices consumers make.

A recent study about the purchasing behavior of customers at Subway®, which provides nutrition information at the point-of-sale, found that customers who reported seeing the nutrition information consumed 52 fewer calories than those who did not report seeing the nutrition information. In addition, among those who reported seeing the information, only 17 percent purchased meals with more than 1000 calories, compared with 23 percent of those who reported not seeing the nutrition information.[4] Another report from Los Angeles calculated the potential impact on the population as a whole when individual purchasing behavior changes, such as those found in the study cited above are made. A 50 calorie reduction per meal among 30 percent of large chain restaurant customers would avert 58 percent of the average annual weight gain in Los Angeles County.[5]

Most Americans support menu-labeling. According to a 2008 national poll, 78 percent agreed that fast-food and other chain restaurants should list nutritional information such as calories, fat, sugar or salt content, on menus and menu boards.[6]

Ultimately, menu labeling may lead to product reformulation. In their competition for health-conscious consumers, food manufacturers respond to policies targeted directly at consumers, such as nutrition information and education programs.[7] For example, since the U.S. Food and Drug Administration issued its proposal for mandatory disclosure of trans fat content on food labels in 1999 and its final regulation in 2003, several large manufacturers, have reformulated many of their products to eliminate trans fat.[8]

Although ASTHO recognizes the need for national uniformity, states historically do not support federal pre-emption of state law. However, ASTHO supports the following aspects of menu-labeling:

- Requiring fast-food and other chain restaurants to provide calorie information at a minimum, at the point of decision-making, and other information about saturated and trans fat (combined), and sodium content of standard menu items in an easily readable format. Restaurants that use menu boards, where space is limited, should be required to provide calorie information with the same font size as the food title and price on their menu boards at the point of decision-making.
- Applying menu labeling policies to establishments with 20 or more locations doing business under the same name or that are affiliated and offering for sale substantially the same menu items.
- Providing federal funding to states if they have responsibility to enforce menu labeling policies.
- Promoting menu-labeling beyond chain restaurants.
- Teaching people how to use nutritional information to make healthier choices.
- Supporting restaurant efforts to improve nutritional quality and make smaller portion options available.
- Partnering with the restaurant industry to address the obesity epidemic. Menu labeling can be a tool to encourage menu reformulation throughout the country.

Trans Fat Bans

Artificial trans fat is the most harmful fat in the food supply and is linked to about 50,000 fatal heart attacks annually.[9] Trans fat raises LDL cholesterol and decreases HDL, the “good” cholesterol. Researchers at the Harvard School of Public Health estimate that trans fat causes 72,000 to 228,000 heart attacks per year.[10] Trans fat may also increase the risk for diabetes. By eliminating trans fat from the food supply, an estimated 50,000 lives per year can potentially be saved. [11] The total amount of trans fat put in our food has declined by 50 percent since about 2005.[12]

Currently, a number of cities and one state (California) have passed laws largely eliminating artificial trans fat from restaurants. Some of the largest restaurant chains have also done so voluntarily. However, there are still many restaurants that use trans fat in their food. In order to increase the number of restaurants with policies to ban trans fat, ASTHO recommends:

- Enacting laws to eliminate trans fat in restaurants or, at a minimum, to label all menu items containing trans fat.
- Supporting educational campaigns to reduce trans fat use at restaurants.
- Tracking consumption patterns over time to ensure that other unhealthy oils and shortenings are not substituted for trans fats.
- Providing education and guidance to restaurants.

Sodium Reduction

Heart disease and stroke are the first and third leading causes of death in the United States., respectively. High blood pressure leads to more than half of all heart attacks and strokes. Nine out of ten Americans will develop high blood pressure over their lifetime. At present, 72 million American adults have high blood pressure and another 59 million have "pre-hypertension." The prevalence of high blood pressure is 60 percent greater among African Americans than among the rest of the population.[13]

Higher consumption of salt, along with age, obesity, and family history, leads to higher blood pressure. *The Dietary Guidelines for Americans*, 2005, states that approximately 75 percent of total salt intake is derived from processed food. The natural salt content of food accounts for about 10 percent of total intake, while discretionary salt use (salt added at the table or while cooking) provides another 5-10 percent. *The Guidelines* recommend that the general population consume no more than 2,300 mg/day of sodium and that persons with hypertension, African Americans, and middle-aged and older adults consume no more than 1,500 mg/day. However, the average daily intake of sodium is 3,375 mg—well above the recommended amount.[14] Sodium consumption in the United States has increased over the past few decades. Reducing sodium levels in packaged foods and restaurant foods by half would likely result in a 20 percent reduction in the prevalence of hypertension and 150,000 fewer deaths.[15]

Given that the major source of excess dietary sodium is the consumption of processed foods, ASTHO supports the following actions:

- Urge the FDA to revisit its current regulation of sodium.
- Limit sodium in foods served in schools, government cafeterias, prisons, hospitals, and government- sponsored meetings.
- Support warning labels on high-sodium foods or on supermarket shelves or on placards.
- Urge companies to lower sodium content of processed, manufactured, and restaurant foods by 50 percent over the next decade and increase the selection of low-sodium foods.
- Support and promote opportunities to educate the public about the sodium content of foods and the effects of excessive salt consumption.

Together, these policies can help Americans to make healthier food choices. They will also help to reduce obesity, improving health and quality of life of our citizens, and save costs. Such policies are very important to ASTHO in its role as the founding partner in the national Alliance to Make US Healthiest.

Approval History

ASTHO Position Statements relate to specific issues that are time sensitive, narrowly defined, or are a further development or interpretation of ASTHO policy. Statements are developed and reviewed by appropriate Policy Committees and approved by the ASTHO Executive Committee. Position Statements are not voted on by the full ASTHO membership.

Prevention Policy Committee Review and Approval on July 28, 2009

Executive Committee Review and Approval on August 20, 2009

Policy expires on August 20, 2012

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