

**Sodium Issue Brief Template**

**Introduction to the Template:**

In 2010, Los Angeles County Department of Public Health published an issue brief related to sodium (<http://publichealth.lacounty.gov/docs/SodiumConsumptionBrief2010.pdf>). They have shared this brief with their community stakeholders, policy makers (e.g., County of Los Angeles Board of Supervisors, State of CA), County of LA Departments (that buy, sell, or procure food), and other local health departments. It has helped bring attention to the issue of sodium and cardiovascular health in LA County, and subsequently was one of the documents to help support the passage of a Board Motion requiring all County of LA Departments that buy, sell, or procure food to consult with the Department of Public Health before releasing any Request for Proposal for a new food vendor.

The Cardiovascular Health (CVH) Council Sodium Practice Group contacted LA County Public Health Department to ask permission to use their issue brief as a template that other states and local regions could use.

Data tables have been created in an Excel spreadsheet. Figures 1 and 2 rely solely on national-level data. Figures 3 and 4, as well as Table 1 rely on state or local-level data. Los Angeles County had been able to use regional NHANES data that will not be readily available to most others interested in developing their own sodium issue brief. Upon consultation with CDC DHDSP Epidemiology and Surveillance Branch, as well as the CVH Council Epidemiology and Evaluation Committee, we decided to rely on BRFSS data.

We would like to acknowledge everyone who helped in the development of the sodium issue brief template. The idea began within our Sodium Practice Group, and was carried out by members of the CVH Council Capacity Building and Epidemiology/Evaluation Committees. We would also like to thank Rob Merritt, Cathleen Gillespie, and Guijing Wang for their assistance with the template.

And, finally, we would like to thank Los Angeles County Public Health Department for their initial development of the sodium issue brief. They have been very helpful in working with the CVH Council to ensure that the sodium issue brief template can meet the needs of those who wish to replicate the work of LA County. If you choose to use either the Word document or the data files, please add the following reference: "**This publication, including the cost and health impact estimation procedures, was adapted by the National Association of Chronic Disease Directors from work performed by the Division of Chronic Disease and Injury Prevention in the Los Angeles County Department of Public Health.**"

*You may customize the Brief in any way you prefer; please make sure references are attributed correctly if you edit the document. Areas highlighted in yellow are for you to add your state or local data. We have included an Excel file that will help you create the figures and table referenced in the text.*

Reducing Sodium Consumption in (State)

**Most Americans Consume Too Much Sodium**

Most people in the United States consume much higher amounts of sodium than they should. Average daily sodium consumption during 2007–2008 was 3,266 mg among persons 2 years and older, well above the current *Dietary Guidelines for Americans* recommenda­tions of less than 2,300 mg a day. Some high risk individuals should consume only 1,500 mg a day; about half of the population are part of this group, which includes individuals who are 51 years and older and those of any age, including children, who are African American or have high blood pressure, diabetes, or chronic kidney disease.[[1]](#endnote-1)

The words salt and sodium are not exactly the same, yet these words are often used in place of each other. For example, the Nutrition Facts food label uses “sodium,” whereas the front of the package may say “low salt.”[[2]](#endnote-2) Ninety percent of the sodium we consume is in the form of salt.[[3]](#endnote-3) Excess dietary sodium (salt) can increase blood pressure and lead to heart disease, stroke, and kidney complicatons.[[4]](#endnote-4)

Over the past 30 years, sodium consumption in the population has increased dramatically. Americans consume approximately 55% more sodium today than they did a generation ago (Figure 1).[[5]](#endnote-5) Presently, most of the sodium that Americans consume comes from processed and restaurant foods (Figure 2).[[6]](#endnote-6) Over the past 25 years, Americans have increased the number of meals they eat away from home, making restaurant foods an important source of dietary sodium.[[7]](#endnote-7) Frequently, consumers are not provided with information about sodium content for menu items in restaurants, and will typically underestimate the amount of sodium that is contained in a variety of restaurant foods.[[8]](#endnote-8) Even when sodium information is provided, it may be difficult for consumers to make sense of the information. In addition, lower calorie meals or food options can sometimes be misleading as low calorie foods, processed or at restaurants, are frequently high in sodium. Although public health messages regarding fat intake and high-energy diets are more widespread, the harmful effects of excess sodium consumption have received considerably less attention.[[9]](#endnote-9)

**Health and Economic Consequences of Excess Sodium Consumption**

In the U.S., the burden of hypertension is considerable. The residual lifetime risks of developing hypertension for middle-aged adults (ages 55 to 65 years) is nearly 85%.[[10]](#endnote-10) Additionally, the lifetime likelihood of receiving anti-hypertension medications for individuals ages 55 years and older is approximately 60%.10 Compared with whites, African Americans experience higher rates of hypertension. In this group, the condition often begins at an earlier age and is usually more severe.[[11]](#endnote-11) Elevated blood pressure is increasingly becoming a problem among children. From 1993 to 2003, the average systolic blood pressure (the top number of a blood pressure reading) among children ages 8 to 17 years has increased by 1.4 mm Hg, with greater increases seen among Hispanic and African American children.[[12]](#endnote-12)

Hypertension has significant health and economic consequences. This chronic condition greatly increases the risk of medical complications and death from cardiovascular and kidney diseases, such as heart attack, stroke, heart failure, and end-stage kidney failure.[[13]](#endnote-13) Cardiovascular diseases are costly to society; direct and indirect costs of cardiovascular diseases in the U.S. are estimated to be approximately $312 billion per year.[[14]](#endnote-14)

*In [insert your state/county/region here], the prevalence of hypertension mirrors the general US population.\_\_\_% of adults age \_\_\_ and \_\_\_% age \_\_\_ have hypertension. (Figure 3) Hypertension-related health conditions account for (Hospitalization data) a year in (state.) Despite advances in medical technology and treatment, heart disease and stroke remain the (1st?) and (2nd?) leading causes of death in (state.) (You may want to add mortality data or Years of potential life lost.) (Figure 4)*

Even a modest, long-term reduction in sodium consumption can have a beneficial impact on blood pressure control and can lead to the reduction in preventable cardiovascular events.[[15]](#endnote-15) Reducing sodium consumption in the population to 2,300 mg per day as recommended by the *Dietary Guidelines for Americans*, could reduce the number of hypertension cases in the U.S. by 11 million and save $18 billion in health care costs.[[16]](#endnote-16)

*(Insert Table 1 from Excel data file. Be sure to use the most recent data available.)*

**Reduce Population Sodium Consumption**

Reduction in sodium consumption can be accomplished with minimal impact on taste. Research suggests that most people would adapt to or not detect a decrease in sodium content in food when done gradually over time. Reducing sodium consumption at the population level is possible. Many countries, including the United Kingdom and Finland, have ongoing national programs that address this public health problem and have effectively reduced the sodium content in their food supply. The United Kingdom has used a complementary, multi-strategy approach to:

* Increase the percentage of people who are aware of the recommended daily sodium limit.
* Increase the percentage of people trying to lower their daily sodium intake.
* Reduce the amount of sodium in most processed foods by 20% to 30%.15

In 2008, a coalition of health organizations and public health agencies led by the New York City Department of Health and Mental Hygiene, established the National Salt Reduction Initiative (NSRI) and began exploring strategies for reducing population sodium consumption in the U.S. This has launched discussions with food industry leaders to develop a voluntary framework for substantive, gradual reductions in sodium content across a range of foods.[[17]](#endnote-17) Concurrently, several public health departments, [*including your health department?],* have expressed support for local interventions (e.g., food purchasing policies) to augment the national effort.

**National, State, and Local Strategies**

Activities at the national, state, and local levels can play an important role in reducing the population’s sodium consumption. For example, food retailers, governments, businesses, institutions, and other large-scale organizations that purchase or distribute food can establish food policies that specify sodium limits for the foods they purchase and/or the food service operations they oversee.4

Policymakers can work nationally to reduce the amount of sodium in the food supply. More specifically, policymakers can work to reduce the amount of sodium found in processed and restaurant foods, since over 75% of the sodium consumed by Americans is found in these sources. Policymakers should:

* Support the national collaborative effort, the NSRI, to engage food manufacturers and restaurants in voluntarily reducing the amount of sodium in their products.17
* Support the removal of sodium and other sodium-containing compounds from the Generally Regarded As Safe (GRAS) list or restriction of sodium’s GRAS status in a step-wise manner. This will allow for the Food and Drug Administration (FDA) to set limits on the amount of sodium food manufacturers can add to the food supply.4

Several strategies can be implemented at the state and local levels to complement national sodium reduction efforts.17,[[18]](#endnote-18),[[19]](#endnote-19) Local action can help increase consumer demand for low sodium products from food manufacturers by:

* Increasing awareness through public education about the recommended daily sodium limit and the health benefits of lowering sodium consumption.
* Implementing venue-based or venue-specific food policies that set nutrition standards, including sodium limits, on all food purchased, served, or sold by an institution or employer. These policies could help drive product reformulation, given the purchasing power of many states, counties, cities, and large businesses.[[20]](#endnote-20)
* Taking advantage of funding to support sodium reduction efforts. For example, [*insert example for your region here].*

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16. Palar, K and Sturm, R. (2009). Potential societal savings from reduced sodium consumption in the US adult population. *American Journal of Health Promotion,* 24(1), 49-57. [↑](#endnote-ref-16)
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