



Consumer Federation of America

May 2, 2015

Richard D. Olson, M.D., M.P.H.
Designated Federal Officer, 2015 Dietary
Guidelines Advisory Committee
Office of Disease Prevention and Health
Promotion
Office of the Assistant Secretary for Health
U.S. Department of Health and Human Services
1101 Wootton Parkway, Suite LL100
Tower Building
Rockville, MD 20852

Colette I. Rihane, M.S., R.D.
Lead USDA Co-Executive
Secretary, 2015 Dietary Guidelines Advisory
Committee
Director, Office of Nutrition Guidance and
Analysis
Center for Nutrition Policy and Promotion
U.S. Department of Agriculture
3101 Park Center Drive, Room 1034
Alexandria, VA 22302

Kellie Casavale, Ph.D., R.D.
Deputy Designated Federal Officer, 2015
Dietary Guidelines Advisory Committee
Nutrition Advisor; Office of Disease Prevention
and Health Promotion
Office of the Assistant Secretary for Health
U.S. Department of Health and Human Services
1101 Wootton Parkway, Suite LL100
Tower Building
Rockville, MD 20852

Shanthy A. Bowman, Ph.D.
USDA Co-Executive Secretary
Nutritionist, Food Surveys Research Group
Beltsville Human Nutrition Research Center
Agricultural Research Service
U.S. Department of Agriculture
10300 Baltimore Avenue
BARC-West Bldg 005, Room 125
Beltsville, MD 20705-2350

Re: The Dietary Guidelines for Americans, 2015

Dear Dr. Olson, Dr. Casavale, Ms. Rihane, and Dr. Bowman:

The Consumer Federation of America (CFA) appreciates the opportunity to comment on the report prepared for the eighth edition of the *Dietary Guidelines for Americans* (DGA) by the Dietary Guidelines for Americans Committee (DGAC). Overall, we strongly support the conclusions and policy recommendations in the report.

CFA is an association of nearly 280 non-profit consumer organizations that was established in 1968 to advance the consumer interest through research, advocacy and education. Member organizations include local, state, and national consumer advocacy groups, senior citizen associations, consumer cooperatives, trade unions and food safety organizations. CFA's Food Policy Institute was created in 1999 and engages in research, education and advocacy on food safety, food and agricultural policy, agricultural biotechnology, and nutrition.

Introduction

As the DGAC's expert report recognizes, achieving a healthy overall diet is more important than any specific food or nutrient. A variety of dietary patterns are linked to reduced risk of chronic diseases, including cancer and heart disease, and those diets share many of the same characteristics, including higher intakes of fruits, vegetables, low- and non-fat dairy foods, fish, poultry, legumes, whole grains, healthy oils, and lower intakes of added sugars, saturated fat, sodium, and red and processed meat. While the basic nutrition advice in the Guidelines has remained largely consistent over the years, obesity is still an important public health problem with insufficient consumption of fruits, vegetables, and whole grains and other healthy foods.

Reversing current obesity trends and changing dietary patterns on a broad scale requires a comprehensive approach that engages all levels of the socio-ecological model, and includes policy changes, education and promotion campaigns, and environmental changes to address both diet and physical activity. CFA supports the DGAC's use of the socio-ecological model and recognition that individual diet, physical activity, and weight management behaviors are influenced by individual biological, household, community, societal, and cultural factors, as well as public and private policies, systems, and environments.

CFA supports calls for the DGA to prominently feature the DGAC's recommendations for policies and environments that support and promote healthy diets and lifestyles. The DGA should emphasize the important role that the food environment and public policies play in the ability of Americans to follow the DGA's recommendations. The DGA should include a call to action for a wide range of stakeholders—including policy-makers at all levels of government, public health experts, the food and beverage industry, restaurants and food retailers, media companies, schools, businesses, community-based organizations, and others—to make healthy lifestyles and disease prevention top priorities.

Overall Dietary Patterns

The DGAC found that the overall body of evidence identifies a healthy dietary pattern as one that is higher in fruits, vegetables, whole grains, low or non-fat dairy, seafood, legumes, and nuts; moderate in alcohol, among those who choose to drink; lower in red and processed meats; and low in sugar-sweetened foods and drinks and refined grains.

We agree with the DGAC report that the DGA should continue to emphasize the importance of consuming an overall healthy dietary pattern and recommend that nutrient needs be met primarily by consuming nutrient-dense, whole foods. This approach allows individuals to consume a wide range of foods and meet nutrient needs in a variety of ways, as appropriate to their individual needs and cultural preferences. Providing several example dietary patterns may help consumers better understand how to better incorporate healthy foods into their diets.

CFA has specific comments regarding individual components identified in the DGAC report. These are discussed below.

Added Sugars

Excessive sugar intake can increase the risk of obesity, diabetes, and cardiovascular disease. With regard to high consumption of added sugars, the DGAC concluded that there was "strong evidence" for an increased risk of excess body weight, obesity, and type-2 diabetes and "moderate evidence" for an increased risk of hypertension, stroke, coronary heart disease, high blood pressure, serum triglycerides, and dental caries. After reviewing the evidence, the Committee found that "strong evidence supports

reducing added sugars intake to reduce health risks” and that a limit on “added sugars to a maximum of 10 percent of total daily caloric intake” was supported by the food pattern modeling analysis and the scientific evidence review on added sugar and chronic disease risk.¹

According to data from the National Health and Nutrition Examination Survey (NHANES), children and adolescents obtain approximately 16 percent of their total caloric intake from added sugars (2005-2008)² and approximately 13 percent of adults' total caloric intake came from added sugars (2005-2010).³ The NHANES researchers point out that those numbers are averages and that percent of total caloric intake changes depending on gender, age, income, and ethnicity. Consuming foods high in added sugars makes it more difficult to meet nutrient needs and stay within calorie limits. Added sugars contribute nothing to the overall nutrient adequacy of the diet and thus have implications for weight management. In contrast, foods high in natural sugars, such as fruits and dairy products, are often high in other nutrients.

We support the DGAC’s recommendation for consuming no more than 10 percent of calories from added sugars, and believe that that could form an adequate basis for FDA to include a percent DV for added sugars on the labels of packaged foods. CFA notes that other organizations have made similar recommendations. In 2009, the American Heart Association (AHA) recommended that women and men consume no more than 100 calories (25 grams) or 150 calories (37.5 grams) per day from added sugars, respectively.⁴ In 2015, the World Health Organization (WHO), following a comprehensive review of the science, recommended that consumers should reduce added sugars to less than 10 percent of total energy intake.⁵ The WHO also suggested that additional benefits could be gained by reducing sugar intake to below 5 percent.

We agree that the DGA should endorse policies such as revising the Nutrition Facts Panel to have a line for added sugars, with amounts expressed in both grams and teaspoons, along with a percent DV. Currently, the Nutrition Facts Panel does not provide information regarding added sugars, so consumers have little way of knowing how much added sugar they are consuming. Consumers likely find it difficult to follow the DGA recommendation to reduce consumption of added sugar if they are not provided this information on food labels. Listing added sugars on the Nutrition Facts Panel would provide essential information on the amount of added sugars in a food and help consumers eat less added sugars. In order to facilitate better understanding of the amount of added sugars in various foods, added sugars should be expressed in teaspoons, as well as grams. Consumers readily understand teaspoons since that is how ingredients are measured in most recipes.

¹ Science Based Chapter, Cross-cutting Topics of Public Health Importance, 2015 DGAC slides. *See also* Scientific Report of the Dietary Guidelines Advisory Committee, 2015, Part D. Chapter 6, at 20.

² Ervin RB, Kit BK, Carroll MD, Ogden CL, “Consumption of Added Sugar Among U.S. Children and Adolescents, 2005–2008.” NCHS Data Brief: Number 87, February 2012, via: <http://www.cdc.gov/nchs/data/databriefs/db87.htm>

³ Ervin RB and Ogden CL, “Consumption of Added Sugars Among U.S. Adults, 2005–2010.” NCHS Data Brief: Number 122, May 2013, via: <http://www.cdc.gov/nchs/data/databriefs/db122.htm>

⁴ Johnson, R. K., Appel, L. J., Brands, M., Howard, B. V., Lefevre, M., Lustig, R. H., ... & Wylie-Rosett, J. (2009). Dietary sugars intake and cardiovascular health a scientific statement from the American Heart Association. *Circulation*, 120 (11), 1011-1020.

⁵ Guideline: Sugars intake for adults and children. Geneva: World Health Organization; 2015.

- **Sugar-Sweetened Beverages**

Sugar-sweetened beverages, including soda, fruit drinks, energy drinks, sports drinks, and sweet teas, are the largest source of calories in Americans' diets.⁶ Soft drinks are the only beverage/food that has been directly linked to obesity, in large part due to the large volumes consumed, the large amounts of added sugars, and the liquid form. Randomized controlled trials have provided convincing evidence that drinking sugar-sweetened beverages can lead to weight gain.⁷ Evidence from intervention studies shows that calories consumed in liquid form are less satiating than the same number of calories consumed from food.⁸ That can lead people to overeat and eventually gain weight.

Sugar-sweetened beverages provide calories with few nutrients, which makes it difficult for consumers to meet nutritional needs and stay within calorie requirements. Given that sugar-sweetened beverages make a unique direct contribution to obesity, the DGA should emphasize strongly that Americans should consume these beverages only rarely, comparing the amount in typical servings to the recommended maximum daily intake and that public policies should be developed that encourage consumption of healthier beverages, including water.

Sodium

We applaud the DGAC for emphasizing sodium reduction in its report. Sodium continues to be a major public health problem, with Americans consuming an average of roughly 3,500 mg per day—far more than the recommended amount. Excess sodium consumption is linked to the development and worsening of high blood pressure and an increased risk of heart disease, stroke, kidney failure, gastric cancer, and osteoporosis.^{9 10}

To help Americans achieve a healthier sodium intake, the Committee has recommended that the general population limit sodium to less than 2,300 mg or the age-appropriate Dietary Reference Intake (DRI) amount.¹¹ Although an even lower target could have additional benefits, 2,300 mg or less can be

⁶ U.S. Department of Agriculture and U.S. Department of Health and Human Services. (December, 2010). Table 2-2. Top 25 sources of calories among Americans ages 2 years and older, NHANES 2005–2006. *Dietary Guidelines for Americans, 2010*. 7th Edition, Washington, DC: U.S. Government Printing Office. Page 12.

⁷ Te Morenga, L., Mallard, S., & Mann, J. (2013). Dietary sugars and body weight: systematic review and meta-analyses of randomised controlled trials and cohort studies. *BMJ*, 346, e7492; de Ruyter, J. C., Olthof, M. R., Seidell, J. C., & Katan, M. B. (2012). A trial of sugar-free or sugar-sweetened beverages and body weight in children. *New England Journal of Medicine*, 367 (15), 1397-1406.

⁸ DiMaggio, D. P., & Mattes, R. D. (2000). Liquid versus solid carbohydrate: effects on food intake and body weight. *International journal of obesity*, 24 (6), 794-800; Mourao, D. M., Bressan, J., Campbell, W. W., & Mattes, R. D. (2007). Effects of food form on appetite and energy intake in lean and obese young adults. *International Journal of Obesity*, 31 (11), 1688-1695.

⁹ Appel LJ, Frohlich ED, Hall JE, *et al.* "The importance of population-wide sodium reduction as a means to prevent cardiovascular disease and stroke: a call to action from the American Heart Association," *Circulation* 2011, vol. 123, pp. 1138-1143.

¹⁰ Whelton PK, Appel LJ, Sacco RL, *et al.* "Sodium, blood pressure, and cardiovascular disease: Further evidence supporting the American Heart Association sodium reduction recommendations," *Circulation* 2012, vol. 126, pp. 2880-9.

¹¹ We recommend that the final policy document specify the amount of sodium that corresponds to the DRI amount for each age group so that policies can be set accordingly. Per the 2006 IOM DRIs for sodium, the Upper Levels (mg/day) are: Age 1-3: 1,500; Age 4-8: 1,900; Age 9-13: 2,200; Age 14-18: 2,300. Hellwig, J. P., Otten, J. J., &

viewed as an interim recommendation based on current consumption levels and the amount of sodium in the food supply.

We also agree with the Committee's conclusion that adults who would benefit from blood pressure lowering should reduce their sodium intake ideally to 1,500 mg per day. The current *Dietary Guidelines* warns that 2,300 mg is too high for many individuals who are 51 and older, children, African-American, or have hypertension, diabetes, or chronic kidney disease. This represents a significant portion of the U.S. population.¹²

We agree with the Committee's recommendation that "primary emphasis be placed on policies and population-based strategies for sodium reduction while at the same time paying attention to consumer education." Despite decades of dietary guidance advising Americans to reduce their sodium consumption, high intakes have persisted. It is clear that relying on individual behavior change alone is not enough. With nearly 80 percent of the sodium we eat coming from packaged and restaurant foods, Americans will continue to have difficulty reducing their sodium intake unless there are changes to the food supply. As the Committee advised, HHS and USDA should work with the food and restaurant industry to lower the amount of sodium in the food supply.

Protein

The DGAC proposed altering the current Dietary Guidelines language regarding meat intake from "choose lean meat and poultry" to "limit red and processed meats." The DGAC also recommended that consumption of other protein sources—including plant protein sources—be increased. The DGA should recommend other types of protein sources that should be consumed as part of a healthy diet, including seafood, nuts, legumes, and lean poultry, so that consumers can be aware of the many opportunities to include protein in their diets. Many health organizations already support these recommendations for protein foods. For example, the American Cancer Society supports consuming a healthy diet with an emphasis on plant foods.¹³ The American Heart Association recommends that the general population eat a variety of (preferably fatty) fish at least twice a week and include oils and foods rich in alpha-linolenic acid (flaxseed, canola, and soybean oils; flaxseed and walnuts). The DGA should contain clear, consistent, and actionable guidance for consumers regarding the types of protein foods that should be a regular part of their diet.

Fruits and Vegetables

We agree with the DGAC report that additional measures are needed to encourage consumption of fruits and vegetables as part of a healthy diet. Americans currently eat a diet that is low in vegetables and fruits, and this dietary pattern contributes to increased risk of chronic disease and poor health. Among the U.S. population, 90 percent do not eat the daily recommended amount of vegetables, and 80 percent do not eat the daily recommended amount of fruit. Americans eat few vegetables, and

Meyers, L. D. (Eds.). (2006). *Dietary Reference Intakes: The Essential Guide to Nutrient Requirements*. National Academies Press.

¹² U.S. Department of Agriculture and U.S. Department of Health and Human Services. *Dietary Guidelines for Americans, 2010*. 7th Edition, December 2010.

¹³ Kushi et al., 2012.

consumption has even declined by about 10 percent since 2003.¹⁴ Fruit intake has declined by about 16 percent since the late 1990s, and consumption of fresh fruit has remained low, but stable.

Fresh, frozen, and canned fruits and vegetables contribute many important nutrients of public health concern, including fiber, potassium, iron, folate, and vitamin A. A diet rich in fruits and vegetables is associated with a decreased risk of cardiovascular disease.¹⁵ High intakes of vegetables and fruits were the only dietary characteristics consistently associated with many positive health outcomes. Therefore, the DGAC recommends that the U.S. population be encouraged to eat a diet rich in fruits and vegetables.

We agree that it will take strong action to achieve healthy dietary patterns in the U.S. and that environmental and policy changes are important in achieving this goal. The DGAC notes the importance of implementing comprehensive nutrition standards to increase fruits and vegetables in school meals. School-based environmental changes that also include nutrition education and parent involvement are especially effective in increasing children's fruit and vegetable consumption. The DGA also should recommend that the Supplemental Nutrition Assistance Program (SNAP) give further consideration to financial incentives for people to buy more fruits and vegetables, because studies have shown that discounting the cost at stores or farmers markets leads to greater purchases and, presumably, consumption.¹⁶

Water Promotion

Water is an essential nutrient.¹⁷ Adequate hydration is crucial for the proper function and regulation of the kidneys and heart; good hydration also supports mental concentration, mood, skin health, helps prevent headaches, and lubricates joints.

Between 2005 and 2010, more than a quarter (28 percent) of children aged 4–13 years old in the United States did not have a drink of plain water on two consecutive days.¹⁸ Plain water accounted for less than one-third of total daily dietary water intake from beverages and foods for children aged 4-13 years old.¹⁹

¹⁴ U.S. Department of Agriculture, Economic Research Service. (2014). Food Availability (Per Capita) Data System: Loss-Adjusted Food Availability Documentation. Available at [http://www.ers.usda.gov/data-products/food-availability-\(per-capita\)-data-system/loss-adjusted-food-availability-documentation.aspx](http://www.ers.usda.gov/data-products/food-availability-(per-capita)-data-system/loss-adjusted-food-availability-documentation.aspx). Accessed March 20, 2015.

¹⁵ Wang, X., Ouyang, Y., Liu, J., Zhu, M., Zhao, G., Bao, W., & Hu, F. B. (2014). Fruit and vegetable consumption and mortality from all causes, cardiovascular disease, and cancer: systematic review and dose-response meta-analysis of prospective cohort studies. *BMJ*, 349, g4490; WCRF/AICR, 2007; Thomson, 2014.

¹⁶ U.S. Department of Agriculture, Food and Nutrition Service. (September, 2014). Evaluation of the Healthy Incentives Pilot (HIP) Final Report: Summary. Available at <http://www.fns.usda.gov/sites/default/files/HIP-Final-Summary.pdf>. Accessed March 20, 2015; Dimitri, C., Oberholtzer, L., Zive, M., & Sandolo, C. (2014). Enhancing food security of low-income consumers: An investigation of financial incentives for use at farmers markets. *Food Policy*.

¹⁷ National Research Council. (2005). *Dietary Reference Intakes for Water, Potassium, Sodium, Chloride and Sulfate*. Washington DC; The National Academies Press.

¹⁸ Drewnowski, A., Rehm, C. D., & Constant, F. (2013). Water and beverage consumption among children age 4–13y in the United States: analyses of 2005–2010 NHANES data. *Nutr J*, 12 (1), 85.

¹⁹ Ibid.

While it is possible to meet all hydration needs with other sources, plain water is ideal because it does not contain calories and has virtually no adverse effects.²⁰

Recent research shows that substituting drinking water for sugar drinks (sodas, juice drinks, pre-sweetened tea and coffee drinks, sports drinks, and energy drinks) can help reduce intake of calories from added sugars among both children and adults²¹ and reduce the risk of dental caries.²²

HHS and USDA should promote water as the primary beverage of choice. Among packaged beverages, water should be promoted over other, less-healthy beverages. This would build on recommendations in the 2010 DGAs as well as strengthened recommendations for drinking water made in the 2015 DGAC report. :

- “Strategies are needed to encourage the U.S. population to drink water when they are thirsty. Water provides a healthy, low-cost, zero-calorie beverage option,”²³ and
- “Approaches might include: Making water a preferred beverage choice. Encourage water as a preferred beverage when thirsty.”²⁴

In addition to including strong language on drinking water in the 2015 DGA, we recommend education and promotion to encourage water as a preferred beverage. In 2014, leaders in nutrition policy urged DGAC to encourage a symbol for water on MyPlate.²⁵ The addition of a water symbol would enable MyPlate to promote water consumption along with its other messages. Such a message would be consistent with the Partnership for a Healthier America’s Drink Up campaign to raise public awareness

²⁰ Popkin, B. M., Armstrong, L. E., Bray, G. M., Caballero, B., Frei, B., & Willett, W. C. (2006). A new proposed guidance system for beverage consumption in the United States. *The American Journal of Clinical Nutrition*, 83 (3), 529-542.

²¹ Pan, A., Malik, V. S., Schulze, M. B., Manson, J. E., Willett, W. C., & Hu, F. B. (2012). Plain-water intake and risk of type 2 diabetes in young and middle-aged women. *The American Journal of Clinical Nutrition*, 95 (6), 1454-1460; Pan, A., Malik, V. S., Hao, T., Willett, W. C., Mozaffarian, D., & Hu, F. B. (2013). Changes in water and beverage intake and long-term weight changes: results from three prospective cohort studies. *International Journal of Obesity*, 37 (10), 1378-1385; Tate, D. F., Turner-McGrievy, G., Lyons, E., Stevens, J., Erickson, K., Polzien, K., ... & Popkin, B. (2012). Replacing caloric beverages with water or diet beverages for weight loss in adults: main results of the Choose Healthy Options Consciously Everyday (CHOICE) randomized clinical trial. *The American Journal of Clinical Nutrition*, 95 (3), 555-563; Wang, Y. C., Ludwig, D. S., Sonnevile, K., & Gortmaker, S. L. (2009). Impact of change in sweetened caloric beverage consumption on energy intake among children and adolescents. *Archives of Pediatrics & Adolescent Medicine*, 163 (4), 336-343; Zheng, M., Rangan, A., Olsen, N. J., Andersen, L. B., Wedderkopp, N., Kristensen, P., ... & Heitmann, B. L. (2015). Substituting sugar-sweetened beverages with water or milk is inversely associated with body fatness development from childhood to adolescence. *Nutrition*, 31 (1), 38-44.

²² Guido, J. A., Martinez Mier, E. A., Soto, A., Eggertsson, H., Sanders, B. J., Jones, J. E., ... & LUIS, J. (2011). Caries prevalence and its association with brushing habits, water availability, and the intake of sugared beverages. *International Journal of Paediatric Dentistry*, 21 (6), 432-440.

²³ 2015 Dietary Guidelines Advisory Committee Report. Available at <http://www.health.gov/dietaryguidelines/2015-scientific-report/06-chapter-1/d1-3.asp>. Accessed March 8, 2015.

²⁴ U.S. Department of Agriculture and Department of Health and Human Services. (2015). Scientific Report of the 2015 Dietary Guidelines Advisory Committee. Available at: <http://health.gov/dietaryguidelines/2015-scientific-report/04-integration.asp>. Accessed March 8, 2015.

²⁵ Ritchie L, et al. (2014). Letter to Chairwoman Millen and Members of the Dietary Guidelines Advisory Committee, September 10, 2014. Available at www.npi.ucanr.edu/files/207504.pdf. Accessed March 8, 2015.

about the benefits of drinking water,²⁶ as well as with key strategies of the Centers for Disease Control and Prevention designed to decrease consumption of SSBs.²⁷

Alcohol

CFA agrees that alcohol is a unique part of the diet that should continue to have a separate guideline devoted to its responsible consumption. We support retaining the current recommendation of moderate consumption (*i.e.*, that those who choose to drink should do so in moderation) and the current definition of an alcoholic beverage, *i.e.*, a “standard drink.”

Approximately 50 percent of adults are regular drinkers and 14 percent are infrequent drinkers.²⁸ While moderate alcohol consumption has been shown to have beneficial effects, such as lower risk of cardiovascular disease, excessive drinking is linked to significant health problems.

Excessive drinking increases the risk of cirrhosis of the liver, hypertension, stroke, type 2 diabetes, cancer of the upper gastrointestinal tract and colon, injury, and violence.²⁹ Excessive drinking over time is associated with increased body weight and can impair short- and long-term cognitive function. Of those who drink, about 29 percent of U.S. adult drinkers report binge drinking within the past month, usually on multiple occasions. This results in about 1.5 billion episodes of binge drinking in the United States each year. Excessive alcohol consumption is responsible for an average of 79,000 deaths in the United States each year, more than half of which are due to binge drinking.

Providing consumers with specific guidance about moderate drinking can help them make more informed decisions when drinking. Further, providing consumers with a reference point such as a “standard drink” can help clarify guidance on drinking alcohol.

We strongly urge HHS and USDA to include in the body of the DGAs the moderate drinking definition, which is up to 1 drink per day for women and up to 2 drinks per day for men. To assist consumers in following this definition, it is critical that the Guidelines continue to include information on what constitutes a drink as reflected in the 2010 *Dietary Guidelines*:

How is alcohol defined? One drink is defined as 12 fluid ounces of regular beer (5% alcohol), 5 fluid ounces of wine (12% alcohol), or 1.5 fluid ounces of 80 proof (40% alcohol) distilled spirits. One drink contains 0.6 fluid ounces of alcohol.

While it is true that consumers do not always consume alcohol in these precise amounts, the concept of a standard drink provides consumers with an important reference point similar to serving size information on packaged food labels. The definition of a drink also provides context for the *Dietary Guideline’s* current recommendations that consumers should limit their consumption of alcoholic

²⁶ Partnership for a Healthier America: Drink Up Campaign. Available at <http://ahealthieramerica.org/our-work/you-are-what-you-drink/>. Accessed September 3, 2014.

²⁷ Centers for Disease Control and Prevention. (2010). The CDC Guide to Strategies for Reducing the Consumption of Sugar-Sweetened Beverages. Available at http://www.cdph.ca.gov/SiteCollectionDocuments/StratstoReduce_Sugar_Sweetened_Bevs.pdf. Accessed September 3, 2014.

²⁸ U.S. Department of Agriculture and U.S. Department of Health and Human Services. *Dietary Guidelines for Americans, 2010*. 7th Edition, December 2010.

²⁹ U.S. Department of Agriculture and U.S. Department of Health and Human Services. *Dietary Guidelines for Americans, 2010*. 7th Edition, December 2010.

beverages to one to two drinks a day. Without defining a standard drink, that important advice becomes meaningless. Moreover, virtually all federal and state government recommendations and warnings about alcohol consumption are worded in terms of number of standard drinks.³⁰ All such advice is of little value if consumers have no idea what a drink is.

Graphic depictions showing the equivalent of a standard drink for different types of alcoholic beverages would be helpful as well. The National Institute on Alcohol Abuse and Alcoholism's 2005 edition of *Helping Patients Who Drink Too Much: A Physician's Guide* has an excellent example of a graphic chart illustrating U.S. standard drink equivalents.³¹ A similar depiction should be included in the DGAs as it would provide consumers with a visual understanding of a standard drink and further enhance the usefulness of the *Dietary Guidelines* recommendations regarding alcohol consumption.

In 2003, CFA, National Consumers League, and many other organizations petitioned the Alcohol and Tobacco Tax and Trade Bureau (TTB) to require Alcohol Facts labeling on alcoholic beverage containers. As indicated in the petition, the relevant alcohol facts would include information about alcohol per serving, servings per container, calories, carbohydrates, percent alcohol by volume, and the definition of a standard drink. This information could be displayed in a standardized format, similar to the Nutrition Facts label on packaged food. In 2013, TTB issued a ruling permitting alcohol producers to voluntarily put Alcohol Facts labels on their products, pending completion of a final rule.³² USDA and HHS now have the opportunity to establish that information about alcohol content should be required on all alcoholic beverage containers. This would help consumers moderate their drinking as well as provide essential information about calorie content.

Caffeine

CFA supports the DGAC's focus on caffeine, in particular the concerns about the effects of caffeine intake on children and adolescents. The DGAC notes that the main sources of caffeine among both adults and children are coffee, tea, carbonated soft drinks. The DGAC cites the FDA in stating that the upper level of moderate caffeine intake in healthy adults is 400 mg/day. The DGAs should define moderate consumption as no more than 400 mg of caffeine a day from any caffeinated beverage.

The DGAC raises concern about high-caffeine drinks, and particularly highlights energy drinks as being implicated in adverse events in recent years. The DGAC does not however provide specific detail on what amount of caffeine would be considered "high-caffeine" and whether this term refers to a single consumption or daily overall consumption. If the DGAs use the term "high-caffeine" it should be adequately defined and should apply to any caffeine beverage that is above the defined level. The DGAs should also consider that beyond a quantitative reference point, concentrations of caffeine are important factors in the definition.

³⁰ For example: FDA warning on labels of over-the-counter painkillers ("Alcohol Warning: If you consume 3 or more alcoholic drinks every day, ask your health professional whether you should take acetaminophen or other pain relievers/fever reducers. Acetaminophen may cause liver damage."); advice about drinking and driving in most state drivers license manuals; National Institute on Alcohol Abuse and Alcoholism, *Helping Patients Who Drink Too Much: A Physician's Guide* (2005).

³¹ National Institute on Alcohol Abuse and Alcoholism, *Helping Patients Who Drink Too Much: A Physician's Guide* (2005), page 24.

³² Alcohol and Tobacco Tax and Trade Bureau Ruling 2013-2, "Voluntary Nutrient Content Statements in the Labeling and Advertising of Wines, Distilled Spirits, and Malt Beverages," May 28, 2103 via <http://www.ttb.gov/rulings/2013-2.pdf>.

CFA supports the labeling of caffeine content per serving for all food and beverage products containing caffeine. This would help consumers follow the DGA's advice if they were able to identify the amount of caffeine in products they consume. While some food and beverage companies already provide information on their labels about caffeine content (and some also provide warning statements regarding caffeine consumption by pregnant women and children), others do not. Consumers should have access to information about caffeine content on all products that contain caffeine.

Sustainability

The DGAC discussion around sustainability has raised significant attention. CFA agrees that in order to maintain healthy diets over the long term, we need to consider whether the food production methods that support healthy diets are sustainable. This would include whether we have sufficient sources of fish and seafood to meet global demand, whether we can grow enough fruits and vegetables to meet dietary recommendations and whether current production methods allow us to continue food production into the future. Our ability to meet future food needs depends substantially on our environment, particularly in the context of a changing climate, with more extremes in weather such as drought and flooding, resource shortages, changes in global dietary patterns, and population growth.³³

The DGAC's review of the links between individual and population-level dietary patterns on sustainability is both timely and in the interest of public health. As noted by the DGAC, "the availability and acceptability of healthy and sustainable food choices will be necessary to attain food security for the U.S. population over time." Better alignment of nutrition policy with other food and agriculture policies could help enhance coordination across sectors and possibly reduce unintended consequences.

Food Safety

Foodborne illness is a considerable public health problem. Each year in the United States, 48 million people are sickened by a foodborne disease, 128,000 are hospitalized and 3,000 die.³⁴ Those most at risk include children, pregnant women, the elderly and persons with compromised immune systems. The economic toll on society is large as well. A 2012 study estimated the total economic impact of foodborne illness across the nation to be a combined \$77 billion annually³⁵.

Foodborne illness is primarily a preventable problem. In order to obtain the most benefits from a healthy diet, the food consumes eat also must be safe. The DGs should continue to warn consumers about the hazards associated with eating certain raw foods such as raw milk and cheeses, raw sprouts, raw juices, and raw or undercooked animal foods like seafood, meat, poultry and eggs.

The DGs should continue to provide consumers with actionable steps they can take to prevent foodborne illness. But the DGs should avoid language which makes claims about the location where the majority of foodborne illness occurs in the absence of adequate data. The 2010 DGAs make assumptions

³³ Nellesmann, C. (Ed.). (2009). *The environmental food crisis: the environment's role in averting future food crises: a UNEP rapid response assessment*. UNEP/Earthprint.

³⁴ Centers for Disease Control and Prevention, "CDC Estimates of Foodborne Illness in the United States 2011" via <http://www.cdc.gov/foodborneburden/2011-foodborne-estimates.html>.

³⁵ Scharff RL. Economic burden from health losses due to foodborne illness in the United States. *J Food Protect* 2012;75(1):123-31.

that a substantial amount of foodborne illness occurs in the home. Yet data from the CDC found that restaurants were most commonly reported as the location of food preparation for outbreaks in 2012.³⁶

The DGs should also place the appropriate emphasis on the role of the food industry and government in preventing contamination from occurring. The food industry, including retail and foodservice, has the primary responsibility for producing safe food and preventing foodborne illness. The government also has a critical role to play in setting strict food safety standards and holding companies accountable for meeting those standards, including conducting regular inspections of food plants and restaurants.

Regarding the “Recommended safe minimum internal temperature chart,” USDA has recently included directions in its cooking temperature communications regarding stand or rest time for beef, pork, veal and lamb steaks, roasts and chops. This is to allow for additional cooking of the product after it is removed from the heat source. In addition, USDA is likely to soon require labeling of mechanically tenderized meat and accompanying cooking instructions. The DGs should adopt this same language in order to be consistent with USDA guidance.

CFA appreciates the opportunity to provide comments on these important topics.

Sincerely,

A handwritten signature in black ink that reads "Chris Waldrop". The signature is written in a cursive, flowing style.

Chris Waldrop
Director, Food Policy Institute
Consumer Federation of America

³⁶ Centers for Disease Control and Prevention, “Surveillance for Foodborne Disease Outbreaks United States 2012: Annual Report,” via <http://www.cdc.gov/foodsafety/pdfs/foodborne-disease-outbreaks-annual-report-2012-508c.pdf>.