

## National Nutrition Monitoring Policy: The Continuing Need for Legislative Intervention<sup>1</sup>

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Calls for a coordinated, comprehensive system of nutrition surveillance that could provide timely and accurate data on the nutritional status of Americans have been made repeatedly since the 1969 White House Conference on Food, Nutrition, and Health (1). The twenty-year history of federal failure to respond to these calls (2) is a well-documented national scandal; its key events are summarized in the Table. Despite recent summaries of the content (3) and findings (4, 5) of federal monitoring activities, critics charge that these efforts remain inadequate and are likely to remain so unless Congress intervenes (6, 7).

During every succeeding Congress since 1984, legislative proposals have been introduced in the U.S. House of Representatives and Senate that would compel the two federal agencies most responsible for nutrition monitoring — the Department of Health and Human Services (DHHS) and the Department of Agriculture (USDA) — to improve the scope and coordination of their national surveys. Most bills have called for a ten-year plan to monitor the nutritional status of the overall population and of high-risk groups and for a scientific advisory council to oversee implementation of this plan (2). To date, none of these legislative proposals has been enacted into law. Such legislation has been opposed strongly by USDA (8) and weakly by DHHS (9), principally on the grounds that variations in survey methods have been resolved by the Departments and that the proposed external advisory council would be unnecessary and burdensome. In 1988 legislation finally passed both houses of Congress but was vetoed by the President (10). In 1989, in what one

legislator described as “a kind of cult ritual . . . the Congressional equivalent of a fraternity hazing” (11), nutrition monitoring bills again were introduced in both houses (12).

Often forgotten in this history is the critical need for dietary data on which to base the development of rational nutrition policies, programs, and resource allocations. My experience as Managing Editor of the 1988 *Surgeon General's Report on Nutrition and Health*, and in my current position, provide substantial evidence that the present barriers to timely and effective data collection are unlikely to be overcome without legislative intervention. This Viewpoint presents four examples of areas of current nutrition policy development that could benefit greatly from such intervention.

### TRENDS IN DIETARY INTAKE

In July 1988, the *Surgeon General's Report on Nutrition and Health* identified overconsumption of fat as a national priority for dietary change (13). The report, however, provided no information on trends in fat consumption that could be used to confirm the need for dietary change or as a basis for the evaluation of intervention strategies. This omission was no mere oversight. During the four years it took to prepare the report, at least seven doctoral-level nutrition professionals wrote lengthy drafts of a chapter on Dietary Patterns and Practices that was intended to describe DHHS and USDA data on food availability and dietary intake. In reviewing these successive drafts, members of the editorial working committee were unable to reach a consensus on the significance of the available data; existing survey methods did not provide sufficient information from which to draw scientifically valid conclusions about trends over time. The chapter was deleted from the final report.

As published, the *Surgeon General's Report on Nutrition and Health* describes the major monitoring surveys but draws no inferences for either long- or short-

<sup>1</sup> A preliminary version of this Viewpoint was presented as testimony before the Joint Hearing on National Nutrition Monitoring Legislation of the Committee on Science, Space, and Technology (Subcommittee on Science, Research, and Technology) and Committee on Agriculture (Subcommittee Department Operations, Research, and Foreign Agriculture and Subcommittee on Domestic Marketing, Consumer Relations, and Nutrition), U.S. House of Representatives, September 21, 1989.

**Table.** Selected events in the history of attempts to develop a coordinated, comprehensive National Nutrition Monitoring System (NNMS).<sup>1</sup>

- 1969 White House Conference on Food, Nutrition, and Health calls on DHEW to plan and implement an effective nutrition surveillance system linked with appropriate programs of other federal, state, and community agencies.
- 1975 Senate Select Committee on Nutrition and Human Needs identifies need for coordinated, comprehensive NNMS as essential component of national nutritional policy.
- 1977 House Committee on Science and Technology holds oversight hearings on nutrition-related research and monitoring, which prompted inclusion in the Food and Agriculture Act of 1977 (P.L. 95-113) of a provision that directs USDA and DHEW to submit a proposal for a coordinated, comprehensive NNMS within ninety days.
- 1978 Preliminary proposal submitted. At request of the House Committee on Science and Technology, the General Accounting Office reviews this proposal and recommends development of a more comprehensive implementation plan. Congress rejects the preliminary proposal and directs agencies to provide more specific details on implementation.
- 1980 *Promoting Health/Preventing Disease* calls for establishment by 1990 of an NNMS capable of detecting nutritional problems in special population groups as well as obtaining baseline data for decisions on national nutrition policies.
- 1981 Joint DHHS-USDA Implementation Plan (requested in 1978) submitted to Congress; commits DHHS and USDA to improve coordination of surveys and to develop reports to Congress. Joint Nutrition Monitoring Evaluation Committee (JNMEC) appointed; first meeting delayed until 1983.
- 1984 President's Task Force on Food Assistance calls on federal government to improve information on nutritional status of Americans. National Nutrition Monitoring and Related Research Act submitted to House as H.R. 4684 (defeated) and Senate as S. 3022 (no action). National Research Council recommends improved linkage of USDA and DHHS survey methods.
- 1985 Legislation introduced in House as H.R. 2436 (passed, 1986, and forwarded to Senate) and in Senate as S. 1569 (no action on either bill).
- 1986 JNMEC report submitted to Congress; recommends improvements in NNMS.
- 1987 Operational Plan for the NNMS submitted as revision of 1981 plan; describes progress, summarizes goals for implementation. Legislation again introduced into House (H.R. 2151) and Senate (S. 1081).
- 1988 S. 1081, as amended, passes House and Senate, but is vetoed by President as too cumbersome and costly. *Surgeon General's Report on Nutrition and Health* recommends establishment of a nutrition surveillance system to enhance monitoring of trends in diet-related risk factors and conditions. Interagency Committee on Nutrition Monitoring (ICNM) established to promote goals of 1987 Operational Plan.
- 1989 Legislation reintroduced into House (H.R. 677 and H.R. 1608) and Senate (S. 253); hearings focus on accom-

plishments, delays in implementation. The Senate bill, as amended, passes and is forwarded to House (no action to date). The ICNM issues *Directory of Federal Nutrition Monitoring Activities*. DHHS and USDA sponsor publication of *Nutrition Monitoring in the United States — An Update Report*.

<sup>1</sup> Adapted from reference 2 and testimony from 1989 House and Senate hearings.

term dietary trends. This conspicuous gap is addressed by the report's recommendation to establish "... a nutrition surveillance system that will enhance the monitoring of population-specific and state-specific trends in the occurrence of nutrition-related risk factors and conditions." Other recent reports also note this problem (14) and recommend actions to address it (5, 15).

How is it possible that the major nutrition monitoring surveys fail to provide information on dietary trends? Food availability data from the USDA and dietary intake data from both USDA and DHHS are collected in surveys that use different methods to collect different kinds of information from different groups of people (16). Like apples and oranges, their results cannot be compared.

USDA compiles information on food availability from annual estimates of the quantities of food commodities produced and marketed in the U.S., and has been doing so since 1909. The agency publishes these data as a historical series to the mid-1960s (17), with regular updates for the most recent twenty years (18). These data report the amounts of food that are available at the wholesale and retail level, without correction for waste, losses, inedible components, or amounts fed to pets. They are also uncorrected for variations in use by population subgroups. Thus, availability data provide only an indirect indication of dietary intake and are limited in the ways they can be interpreted.

Dietary intake is assessed by USDA through its Nationwide Food Consumption Survey (NFCS) and Continuing Survey of Food Intakes by Individuals (CSFII). Data from the NFCS, which collects information from households, were last published for 1977-78; data from the 1987-88 collection are not yet available (19). The CSFII was initiated in 1985 and repeated in 1986. Its data have been limited to three sub-groups: children 1 through 5 years, and adult men and women 19 through 50 years of age (20, 21). Because the NFCS and CSFII differ in sample populations, food composition data bases, and methods of data collection, their results cannot be used to draw reliable conclusions about dietary changes between 1977 and 1986. Although subsequent data collections are designed to correct these problems, they will not yield information on time trends until the mid-1990s.

Dietary intake data are also collected by the DHHS Centers for Disease Control/National Center for Health Statistics as part of the National Health and Nutrition Examination Survey (NHANES) (22). NHANES I was

conducted in 1971-74, NHANES II in 1976-80, and the Hispanic HANES in 1982-84. Because NHANES III has only just begun collecting current information, its data also will not yield time trends in the immediate future.

Efforts to resolve methodologic differences between the various USDA and DHHS surveys have preoccupied Congress since the mid-1970s (23) and representatives of the sponsoring agencies throughout the last decade (2). Progress has occurred, but slowly (11). The pressing need for reliable information on trends in dietary intake — and the agencies' present liability to produce it — demand significant changes in the present system.

### NATIONAL NUTRITION OBJECTIVES

Since the late 1970s, the Department of Health and Human Services (DHHS) has been engaged in a nationwide campaign to establish a national public health agenda (24) through the development of specific, measureable objectives for improvements in key areas of health behavior. The first set of 226 objectives was developed in 1980 and targeted for achievement by 1990 (25). Among these objectives, the seventeen devoted to nutrition were designed to improve maternal and child health; to reduce dietary risk factors for chronic disease; to promote the education of consumers, foodservice personnel, school children, health professionals and their patients; and to create a national system to monitor these and other indicators of nutritional status in the population (26).

In 1985, mid-way through the decade, the Public Health Service reviewed the progress toward achievement of these objectives and concluded that only six of them (35%) could be expected to be accomplished by 1990 (27). This conclusion, however, did not necessarily mean that the country was failing to meet 65% of its nutrition priorities. Because tracking data were either inappropriate or unavailable, progress toward attainment of six of the objectives could not be measured. As a result, it will not be possible to evaluate the overall progress of the nutrition component of the 1990 objectives. For the nutrition community, the principal benefit of this exercise has been experience on which to base the development of objectives for the year 2000 (15) and recognition of the need to improve the ability to define progress toward these objectives.

### HUNGER PREVALENCE

Increasing demands for emergency food assistance, coupled with the realization that the new poor include families, women, children, and recently employed adults, have stimulated efforts to define the extent of hunger (28) or of deficiencies in access to food (29) in the U.S. Within the past ten years, church, community, advocacy, and governmental groups have administered more than

200 hunger surveys to selected target populations (30). Despite the efforts of these groups, the national prevalence of food insufficiency remains undefined. As a result, the extent of need for intervention is uncertain and demands for large-scale federal programs to improve food security are unnecessarily controversial (31).

Most local hunger surveys were designed to document the need for increased resources or to focus attention on the food needs of poverty groups; few of them have included the systematic documentation, precise definitions, consistent study methods, and appropriate sampling techniques necessary for the application of their results to larger populations (32, 33). The national DHHS and USDA surveys do not sample homeless people, migrant families, and certain other groups that might be expected to have limited access to food (22).

Development of standards and means of measurement that more accurately portray hunger and poverty was a principal recommendation of the 1984 President's Task Force on Food Assistance. The Task Force "... was consistently troubled by the lack of appropriate information on the extent of hunger and poverty in the U.S.," and it emphasized that "the absence of reliable data makes the evaluation of and solution to such problems considerably more difficult" (28). Yet USDA opposition to the inclusion of food sufficiency questions on NHANES III, reportedly, was overcome only through intercession by the Office of Management and Budget (34). Mediation by an outside agency was effective in this case and is likely to be necessary in others.

### DIETARY PATTERNS OF MINORITY GROUPS

A disproportionate burden of diet-related chronic disease is borne by minority sub-groups in the population (35). Black Americans, for example, display higher rates of blood pressure, stroke, and diabetes and other diseases associated with obesity than do the general public (36), and diet-related chronic diseases are the major causes of death among American Indians and Alaska Natives (37). Although these observations suggest the potential benefits of dietary change, too little is known about the dietary patterns of these groups to design appropriate strategies. Both USDA and DHHS have addressed the need to obtain dietary data from high-risk groups, but their large surveys collect information on too few minority individuals to distinguish results by gender, age, socioeconomic status, or location (38). The CSFII reports results in just three race categories — black, white, and other (20, 21, 39). Eventually, Hispanic HANES will yield information on Mexican-, Cuban-, and Puerto Rican-Americans; NHANES III plans to oversample Mexican-Americans and blacks (22). If USDA and DHHS surveys were better coordinated, population samples might become large enough to provide adequate information on groups at greatest risk.

## CONCLUSIONS

From these examples, it is evident that the present national nutrition monitoring system needs significant improvement and that such improvement is unlikely to occur without legislated intervention. Independent examination of the goals, objectives and methods of the national nutrition monitoring system would help make it more responsive to the needs of researchers and policymakers. It is time to insist that the system deliver on its long-standing promises. It is time for a new era of cooperation in monitoring the nutritional health of Americans. Legislation is one step in that desirable and necessary direction. □

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