

# What's on the Menu?

Making Key Nutrition Information  
Readily Available in Restaurants

Technical Report  
April 2013

	<i>Calories</i>	<i>Sodium (mg)</i>	<i>Price</i>
<i>Sandwiches</i>			
<i>Deluxe Hamburger</i>	<i>860</i>	<i>740</i>	<i>\$5.99</i>
<i>Crispy Chicken Sandwich</i>	<i>680</i>	<i>1430</i>	<i>\$5.99</i>
<i>Turkey Burger</i>	<i>560</i>	<i>620</i>	<i>\$6.99</i>
<i>Veggie Burger</i>	<i>570</i>	<i>1180</i>	<i>\$4.99</i>
<i>Pulled Pork Sandwich</i>	<i>1060</i>	<i>3300</i>	<i>\$6.99</i>
<i>Chicken Wrap</i>	<i>660</i>	<i>1660</i>	<i>\$5.99</i>

**Reference:**

Toronto Public Health. What's on the Menu: Making Key Nutrition Information Readily Available in Restaurants. Toronto, Ontario. April 2013.

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**Distribution:**

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**About this Report:**

On June 1, 2010, the Toronto Board of Health endorsed the Toronto Food Strategy recommendations in [Cultivating Food Connections: Toward a Healthy and Sustainable Food System for Toronto](#), which identified menu labelling as one strategy for empowering Toronto residents with food skills and information.

Since 2010, Toronto Public Health (TPH) has reviewed the experiences of other jurisdictions and the scientific studies of the impact and effectiveness of menu labelling. Toronto Public Health also conducted survey research and consultations with key stakeholders in collaboration with the Food Policy Research Initiative at the Centre for Addiction and Mental Health and University of Toronto, to assess readiness for menu labelling in Toronto. This technical report summarizes the findings of that research. In addition, there is a TPH staff report titled, *Menu Labelling – A "Right to Know" Approach to Healthy Eating*, that summarises this technical report and identifies actions TPH is taking along with recommendations for the Board of Health to promote leadership on menu labelling in Toronto restaurants. The staff report and this technical report were presented to the Toronto Board of Health on April 29, 2013.

Copies of both reports can be found at:

<http://www.toronto.ca/health/>

# Executive Summary

The purpose of this technical report is to synthesize Toronto Public Health (TPH) research on menu labelling and the policy environment for disclosing nutrition information in Toronto restaurants. Menu labelling is a type of nutrition labelling where information about the nutrient content of foods is provided on restaurant menus/menu boards at or before the point of sale. This report provides a critical review of key evidence to inform policy, with a focus on real-world experiences with menu labelling in related jurisdictions. It also identifies municipal levers for menu labelling within the City of Toronto. It is intended as a tool to assist in coordinated action by many stakeholders in order to make optimal progress towards healthy food environments for all Toronto residents.

Food is part of our daily personal choices and, at the same time, part of the social and physical environments in which we live, work, and play. An increasing array of evidence suggests that what we choose to eat is strongly influenced by the food environments we find ourselves in, even beyond individual factors such as attitudes and knowledge. Given that people are eating out more than ever before, food environments away-from-home are an important setting in which to consider interventions to improve population health. Some of the well-documented barriers to healthy eating out include large portion sizes, excessive levels of calories and sodium, misleading health claims, wide variations in the nutrient content of foods, and nutrition information that is hard to access.

Menu labelling is an intervention that can help to address some of these barriers. Many high-level public health policy reports and research reviews, as well as professional associations and civil society organizations, have recommended menu labelling as a policy that can improve the quality of the eating out environment. Specifically, menu labelling meets Health Canada's goals for nutrition labelling in general which include helping consumers make informed dietary choices, and helping consumers easily compare foods based on consistent information. Both of these conditions support what is sometimes referred to as the 'community right-to-know'.

Currently in Canada, some nutrition information is made available by individual restaurants or chains on a voluntary basis, but the vast majority of this information is neither standardized nor readily visible at the point of purchase. Many restaurants and industry associations continue to emphasize that their principal purpose for taking steps to address health and nutrition issues is to respond to consumer demand.

Different jurisdictions have adopted varying forms of menu labelling. Legal analyses in Canada have suggested that all levels of government likely hold authority to develop mandatory menu labelling policies. However, the most prominent set of approaches in Canada to date are voluntary initiatives. For instance, the British Columbia provincial government runs Informed Dining, which has been endorsed as the preferred nationwide approach by the Canadian Restaurant and Foodservices Association. The Heart and Stroke Foundation also runs a menu labelling initiative as part of its Health Check program. In the US, mandatory menu labelling has

become the norm for large restaurant chains. New York City was the first US jurisdiction to adopt a Health Code amendment, and since then, the US federal government has enacted menu labelling legislation as part of the Patient Protection and Affordable Care Act, 2010.

While policies and programs vary, most menu labelling initiatives require, at minimum, disclosure of calorie content of food for all standard menu items. Where programs differ most is in the display of the information (on menus versus standardized brochures, for example), which is a contentious parameter. Furthermore, most menu labelling, especially when enshrined in law, is designed for larger foodservice chains rather than independently owned restaurants.

Evidence on the effects of menu labelling policies and programs continues to increase. The most detailed evidence from real-world settings comes from the New York City example. When menu labelling legislation was put in place, nutrient information became visible to a majority of restaurant patrons and increased awareness of calorie content of meals. A smaller proportion of patrons used the information to inform or change their purchasing decisions. Overall, most research has found a modest reduction or no change in average calories ordered by customers after menu labelling was put in place. When broken down by subgroups of customers who actually used the information, however, menu labelling appears to have a more substantial effect.

The other key environmental change that has been considered in existing research and evaluations of menu labelling initiatives is the phenomenon of menu reformulation, where disclosure of information leads to companies reworking their offerings for improved nutrient profiles. This change has been frequently mentioned but is not yet well evaluated in the literature.

For independent restaurants, the literature and TPH consultation findings point to some perceived operational challenges of menu labelling, such as lack of time and capacity to standardize menu items and conduct nutritional analyses. Such restaurants often benefit from dedicated public health supports.

Menu labelling is strongly supported by the public, with over 85% approval in New York City, for instance. Toronto Public Health's own background work on menu labelling reveals strong support for nutrition information disclosure. In a recent TPH survey of about 1700 residents, 78% of respondents said that they would use nutrition information 'at least sometimes' if it were to become readily available. A smaller research study done through the University of Toronto showed that 83% of Toronto consumers would like to see nutrition information when eating out.

In summary, many objective and subjective factors ultimately interact to shape personal food choices and our eating out environments. Nutrition information provided through menu labelling is one factor that does inform some individuals' food decision making. Governments have a role to play in supporting consumers' right to transparent information. Menu labelling is therefore a policy initiative that could be considered an environmental intervention to support public health and the public good.

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# 1. Introduction

Menu labelling refers to a type of food labelling where information about the nutrient content of foods is disclosed on restaurant menus at or before the point of sale. This report synthesizes Toronto Public Health (TPH) research and a review of studies on menu labelling as an intervention that can help to establish healthier and more supportive food environments for Toronto. Toronto Public Health also conducted a public survey and consultations with key stakeholders, including restaurant associations with a local presence, independent and chain restaurant operators, and other jurisdictions.

Past research by TPH on the state of Toronto's food outlines how policy and program interventions at many levels and scales are needed to improve food environments for all Toronto residents.<sup>1</sup> The Toronto Food Strategy has identified how TPH and the City have valuable levers at their disposal to enact positive change relating to food environments.<sup>2</sup> This discussion paper reviews menu labelling as an intervention that changes the food environment to support healthier eating.

Food is part of our daily personal choices and, at the same time, part of the social and physical environments in which we live, work, and play. An increasing array of evidence suggests that what we choose to eat is strongly influenced by the food environments we find ourselves in, so much so that food environments<sup>a</sup> affect our health over and above individual factors such as food-related knowledge, skills, and motivation.<sup>3</sup> Such environmental factors include food access, availability, cost/affordability, marketing/promotions, social and cultural norms and values, and other environmental cues.<sup>4</sup> These environmental conditions interact with our individual biology to shape our food attitudes and behaviours.

Food environments are therefore a major determinant of both individual and population health. Food is essential to our wellbeing, but unhealthy diets are a key contributor to ill health and preventable early death.<sup>5,6</sup> Rates of chronic diseases including heart disease, diabetes, chronic respiratory diseases, and cancer, as well as obesity, have soared alongside changes in our modern food environments and diets.<sup>7,8,9</sup> Ensuring healthy and supportive food environments has been identified as an important way to promote and protect health and prevent disease. Public policies that enable individuals to eat well also promote human rights and health equity.<sup>10</sup>

As the majority of the world's population now lives in cities,<sup>11,12</sup> city governments and local public health agencies have an important role to play in leading the establishment of healthy urban food environments on behalf of the public good, including enacting health-promoting local policies.<sup>13,14,15,16</sup>

Subsequent sections 2-8 of the report describe the following: 2) eating out behaviour in Canada; 3) prevalence of obesity and hypertension; 4) environmental barriers to healthy eating out; 5) menu labelling as a type of nutrition labelling; 6) the effects and effectiveness of menu labelling as a health intervention; 7) menu labelling policy experiences in other jurisdictions; 8) the

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<sup>a</sup> For a description of food environments please refer to Section 2.

rationale for putting calories and sodium on the menu; 9) readiness for menu labelling in Toronto; and 10) municipal levers for menu labelling.



## 2. Eating Out in Canada

Available national statistics suggest that Canadians are eating out more than ever before.<sup>17,18,19</sup> Overall, about 60% of Canadians are eating out one or more times per week.<sup>20</sup> Nearly 40% of Canadians eat out at least a few times per week, and about 7% eat out on a daily basis.<sup>20</sup> Restaurant foods currently make up at least one-fifth of the average Canadian's daily diet.<sup>20</sup> In 2010, households reported spending an average of \$7,443 on food, and it has been estimated that between twenty-five and thirty cents of every food dollar spent is on food eaten away from home.<sup>21,22</sup>

People of all income levels and across all age groups eat out. People in higher income groups, however, eat out more often and spend more.<sup>21</sup> Younger people also spend more on eating out.<sup>22</sup> In 2010, the National Survey of Household Spending indicated that households headed by a person under 30 years of age spent the highest share of household spending of any age group on restaurants and the lowest share on food from stores (5.4% of total household spending on restaurants; 8.6% on food from stores). In contrast, households headed by seniors spent the lowest share of any age group on restaurants, and the highest share on food from stores (3.4% of total household spending on restaurants; 12% on food from stores).<sup>22</sup>

There are many reasons why people eat away from home. Eating out can be for 'practical' reasons (e.g., availability; necessity; convenience), but also 'symbolic' ones (e.g., expressions of social relationships, cultural norms, and economic power; or for pleasure).<sup>23</sup>

The food environment when Canadians eat 'away from home' encompasses a variety of contexts.<sup>21</sup> Even eating 'at home' can include pre-cooked, ready-to-eat meals purchased 'away' at stores. People eat away from home when they travel, but also when they stay in their immediate living environments. When people eat out, it might be for breakfast, lunch, dinner, or snacks. When people eat at restaurants, this can include table-service (also referred to as 'sit-down'), quick-service (also known as 'fast food' or take-out), cafeterias, mobile food sellers, and other venues. Statistics Canada (2001) indicates that the majority of restaurant spending occurs in table-service restaurants; in 2001, nearly 60% of restaurant spending occurred in table-service establishments versus 26% on fast food. The higher cost of food in sit-down restaurants may contribute to this finding.

### 2.1. Consumers Underestimate Calorie and Nutrient Levels in Restaurant Meals

Consumers have little understanding of the nutrient content of their restaurant meals when eating out, and this is especially true for less healthy meals and/or larger meals.<sup>24,25,26,44, 73,74, 108</sup> In one study, participants underestimated calorie levels in typical quick service foods by about 30%, which translated into unknowingly consuming 900 extra calories in a week from restaurant meals,<sup>74</sup> the equivalent of 6 kg (13lbs) of body weight over the course of a year. In a survey by the Canadian Obesity Network, 67% of people underestimated the calories in a salad containing 1150 calories. Half of the participants identified this salad as a 'low-calorie' option and 31%

thought that they would be 'sure to lose weight' by eating this salad daily.<sup>24</sup> Another study tested consumers' estimates of calories, fat, saturated fat, and sodium in "more healthy" or "less healthy" restaurant menu items. A high majority of participants underestimated calories and sodium for both sets of menu items, and fat and saturated fat for "less healthy" items. About one third of participants underestimated fat and saturated fat for "more healthy" items. Overall, sodium levels were underestimated the most. Calories of "more healthy" items were underestimated by 9% and "less healthy" items by 93%. Sodium levels in "more healthy" items were underestimated by 254% and "less healthy" items by 341%. Fat levels in "more healthy" items were underestimated by 35% and "less healthy items" by 137%. The findings were quite similar for saturated fats.<sup>73</sup>

## 3. Burden of Illness from Obesity and Hypertension

Two health conditions that coincide with poor diet, and especially with food eaten in the restaurant environment, are obesity and hypertension.

### 3.1. Obesity

The rising prevalence of obesity is a significant national and local health concern. In Toronto, 46% of adults,<sup>27</sup> and about 21% of adolescents (aged 12-17 years),<sup>28</sup> are either overweight or obese, compared to 56% of adults in the rest of Ontario<sup>27</sup> and 62% in Canada.<sup>29</sup> Carrying excess weight is a risk factor for type II diabetes, cardiovascular disease, high blood pressure, osteoarthritis, some cancers, gall bladder disease as well as mental health issues, functional limitations, and disabilities.<sup>27</sup> Childhood obesity is of particular concern as it has immediate and long term health consequences. Estimates of the economic burden of obesity in Canada range from \$4.6 billion to \$7.1 billion annually.<sup>29</sup> This includes direct costs to the health care system and indirect costs from premature mortality or disability.

The rise in obesity levels is largely attributed to increases in calorie intakes.<sup>30,31</sup> Eating out frequently is associated with higher calorie intakes, overweight, and obesity.<sup>32,33,34</sup> In one study, 11- to 18-year-olds who regularly ate fast food consumed an extra 800 calories per week for boys and 660 for girls. These extra calories translate into a possible weight gain of about 4.5 kilograms (10 pounds or more) per year.<sup>35</sup> The House of Commons Standing Committee on Health concluded in their *Healthy Weights, Healthy Kids* report (2007) that if rising childhood obesity rates go unchecked, this generation of children will be the first to live shorter, sicker lives than their parents.<sup>50</sup> Reducing population level caloric intakes, which includes a focus on the restaurant environment, is an important component of addressing high obesity rates.<sup>30</sup>

### 3.2. Hypertension

High blood pressure, or hypertension, is among the leading preventable risk factors for death in Canada.<sup>38</sup> In 2006/07, the prevalence rate of (diagnosed) hypertension among adults aged 20 years and older in Canada was 22.7% and 22.6% in Ontario.<sup>36</sup> In 2007, 23.4% of Toronto residents 20 years of age and older (4.4% of 20-44 year olds and 27.7% of 45-64 year olds) had high blood pressure.<sup>37</sup> High sodium intake increases the risk of hypertension, which can lead to heart disease, stroke, and kidney disease.<sup>38</sup> Canadians consume, on average, 3400 mg of sodium per day.<sup>38</sup> This is more than twice the recommended adequate intake for adults (1500 mg per day). Reducing sodium consumption by 1800 mg per day would avert up to 23,500 fatal and non-fatal cardiovascular disease events per year. This would result in direct and indirect health care savings of \$18.47 billion per year (in 1998 dollars).<sup>38</sup> As food consumed in restaurants and foodservice establishments accounts for 18% of the average total sodium consumed per day,<sup>38</sup> action to reduce sodium intake in the restaurant environment would contribute to the goal of reducing Canadian's daily sodium intake.<sup>38,53</sup>

## 4. Environmental Barriers to Healthy Eating Out

An increasing array of evidence suggests that people's food environments can interfere with their ability to eat healthily when away from home. This also has a corresponding effect on the nutritional quality of their diets. In the United States (US), for example, eating away from home is associated with excessive intakes of calories, sodium, and fat.<sup>39,40,41</sup> As discussed above, overconsumption of calories and these nutrients increases the risk of obesity/overweight and hypertension.

### 4.1. Large Portion Sizes

Beyond what is eaten, restaurant environments affect *how much* is eaten. Researchers Pierre Chandon and Brian Wansink, experts on consumer behaviour and marketing, have documented in numerous experiments over the last decade how social and environmental cues prompt people to eat more than they need, and more than they would if they were choosing normally.<sup>42,43,44,45,46,47</sup> There is also strong evidence that portion sizes for many foods have increased substantially over time, especially in restaurants.<sup>48</sup>

Large portion sizes affect eating behaviours in multiple ways. First, large meals prompt people to eat more than usual because it appears appropriate and reasonable to consume the amount of food set before them. Second, large meals alter people's ability to make a reasoned guess about what is in their food. As indicated in Section 2.1, people routinely underestimate nutrient content in meals consumed away from home. This tendency to underestimate calories is not linked to individuals' *ability* to estimate, but rather, their environments.<sup>42,43</sup> Even professional dietitians were found to be unable to estimate calorie content accurately when presented with a larger sized meal.<sup>43</sup> The larger the meal, the more people underestimated the calories in front of them. When the same people were presented with the meals divided into smaller parts, they were able to estimate calories more accurately.

### 4.2. Misleading Health Claims

Marketing in restaurant settings can also shape individuals' behaviour. This has been noted in previous TPH work on food and beverage marketing to children.<sup>49</sup> Chandon and Wansink<sup>43</sup> have described how marketing can create a 'health halo' or bias in calorie estimation in restaurant environments. When popular foodservice establishments claim that their restaurants are 'healthy,' people tend to underestimate how many calories they are actually eating. Such 'healthy' claims have an effect on how people perceive the restaurant as a whole, as well as individual menu items and meals. For example, in a series of experiments on this 'health halo' effect, Chandon and Wansink found that people underestimate calorie content of foods based on perceptions that McDonald's is generally 'unhealthy' and Subway is 'healthy'. The researchers then demonstrated that when a specific main dish was labelled as 'healthy,' people unknowingly added beverages, side dishes, and desserts of up to 131% more calories to their meal as compared to when they thought the main dish was 'unhealthy' – even though, the main course labelled 'healthy' actually contained 50% more calories than the one labelled 'unhealthy'.

### **4.3. Wide Variation in Nutrient Content of Foods**

These environmental influences are particularly concerning given what is known about the wide range of nutrient content of foods in restaurants. Recent analyses of major chain and franchise restaurants in Canada reveal that there is a great range of calorie and sodium levels in restaurant foods as well as a vast range of variation in calorie and sodium content of food for items even in the same food category.<sup>32,50</sup>

University of Toronto researchers found that the average restaurant meal (with entrée and side dishes) contains 56% of an adult's daily calorie requirement and 98% of an adult's daily limit for sodium.<sup>51</sup> Within a single food category, the calorie content of entrees in sit-down restaurants can differ as much as 7.5-fold across restaurants. For example, rib entrées varied from 330 calories to nearly 2500 calories.<sup>32</sup> This wide variation makes it virtually impossible to guess the calorie content of restaurant menu items based on healthy eating recommendations alone. For example, over half of salads contained more calories compared to lower-calorie hamburgers in Canadian restaurant chains.<sup>32</sup>

The sodium content in Canadian restaurant foods was even more concerning. The highest average sodium content for single entrées (not meals) was in the stir-fry category. The sodium content for a single entrée in the sandwiches/wraps category, however, was found to be as high as 6523mg.<sup>53</sup> This vastly exceeds both the daily recommended Adequate Intake (AI) level (1500 mg) as well as the maximum Tolerable Upper Intake Level (UL) (2300 mg) for Canadians, as originally set out by the U.S. Institute of Medicine.<sup>38,52</sup> The range of sodium can also vary from a two-fold difference among stir fry entrées to a 78-fold difference among sandwiches/wraps.<sup>53</sup> For Caesar salad, sodium levels varied five-fold across restaurants, from 300 mg to about 1500 mg.<sup>50</sup>

### **4.4. Nutrition Information in Restaurants is Not Visible**

Even when nutrition information is available for restaurant foods, it is difficult for people to access. Although current voluntary programs in restaurants often note that nutrition information will be 'made available upon request', researchers have revealed that such information, in reality, is hard to find or absent.

A 1994 survey of 68 of the largest foodservice corporations in the US found that only one-third of respondents were providing nutrition information to their customers.<sup>54</sup> Nearly a decade later, Wootan and Osborn<sup>55</sup> surveyed 287 of the largest chain restaurants in the US and found that 54% had made some nutrition information available, but 86% provided it only on the company website. Wootan's research team also visited 29 (88%) of the McDonald's outlets in Washington, DC, to investigate on-site availability of nutrition information. They found that 72% of outlets provided some in-store information, but in 62% of restaurants, the researchers had to consult with two or more employees in order to obtain a copy of the information.<sup>56</sup>

In January 2008, the Centre for Science in the Public Interest (CSPI) in Canada released the results of its 2007 survey of 136 outlets of 27 large chain restaurants across Canada that had committed to making nutrition information available through the Canadian Restaurant and

Foodservices Association (CRFA) Nutrition Information Program (described in section 7 - Jurisdictional Policy Experiences). The CSPI survey found that 18 (66%) of the chains provided some nutrition information at some of their outlets, including brochures and wall posters. Only one chain, McDonald's, had information available at all outlets surveyed, but the information was available on the tray liner which is provided after the purchase is made.<sup>57</sup>

In 2007, prior to their calorie labelling legislation coming into effect, the New York City Health Department assessed the visibility of calorie information to patrons in 167 locations of chain restaurants across all five boroughs, representing 11 major fast-food chains, (see also section 7.3.2 on New York City evaluations). Apart from Subway, where 32% of patrons reported seeing calorie information, only 4% of patrons at other restaurants reported seeing the calorie information that was available.<sup>58</sup>

It is clear that there is an overall lack of transparency of the nutrient content of restaurant meals and a variety of environmental cues are present that can promote unhealthy eating in restaurant settings.

## 5. Menu Labelling as a Type of Nutrition Labelling

Menu labelling is a type of nutrition labelling where information is disclosed to the public about the nutrient content of foods (including beverages) on restaurant menus or menu boards before or at the point of sale. Successive government agency reports and syntheses have recommended menu labelling as a policy option that can improve the quality of the eating out environment,<sup>14,35,38,59,60</sup> and therefore can be a tool for addressing rising rates of obesity and hypertension. Various professional associations and civil society organizations in Canada have also expressed their support for menu labelling.<sup>61</sup>

A decade ago, the World Health Organization (WHO) advised that adopting food labelling interventions could be an important part of broader strategies to prevent the growing burden of non-communicable, or chronic, diseases.<sup>5</sup> The WHO noted that such labelling should be “accurate, standardized, and comprehensible.” Food labelling would not only enable people to make informed choices but would also support a right and the means to access food rich in nutrients (as compared to foods that are high in calories but poor in nutrients) through ensuring appropriate and accurate industry use of health and nutrition claims.<sup>5,6</sup>

In Canada, prepackaged food products are required to carry a variety of information about the nutrition content of their products under federal legislation in place since 2003, but food served in restaurants is not. Following amendments to the *Food and Drugs Act* and *Regulations* which came into effect in 2005, nutritional labelling has been required on most prepackaged food labels. Nutrition labels are one of the primary means by which consumers differentiate between individual foods and brands to make informed purchasing choices.<sup>62</sup> There is a consistent link between the use of nutrition labels and healthier diets.<sup>63</sup>

Before nutrition labelling on pre-packaged foods became mandatory, food manufacturers did not provide any or adequate information to consumers. Other problems of the voluntary approach included unreliable and inconsistent information. Also, the format of the nutrition facts table was not standardized and consumers often had trouble understanding the information.<sup>64,65</sup> Mandatory nutrition labelling laws addressed most of these issues by forcing manufacturers to provide information in a standardized format.<sup>64,65</sup>

## 6. Menu Labelling as a Health Intervention

Menu labelling is an environmental intervention that is proposed to influence individual behaviour when it comes to food purchasing and eating, which, in the long run, could have a substantial impact on population health outcomes including obesity<sup>66</sup> or hypertension.<sup>38</sup> What we currently know about the effects of menu labelling as a health intervention is based on academic research (including various types of intervention studies and experiments) and analyses of real-world experiences (including evaluations of existing policies and programs). This section will review some of the academic research on menu labelling to illustrate how it is intended to work as a health intervention. It also focuses on research in restaurant environments, although, particularly in Canada, our knowledge base on consumer understanding and use of nutrition information comes from work on prepackaged foods.<sup>67</sup> Section 7 of the report reviews what has been learned from different jurisdictions that have adopted menu labelling initiatives across North America.

Overall, there is a growing range of evidence that menu labelling can be a useful intervention in moving towards healthier food environments.

### 6.1. Making Nutrient Information More Visible

Menu labelling makes nutrition information more available and visible, addressing one of the key barriers to healthy eating out, and thereby increases the likelihood that it will be used to make a menu choice. Experimental research has shown that when nutrition information is available at the point of purchase, at least 50% -70% of customers notice it.<sup>68,80</sup> Evidence of the improved availability and visibility of nutrition information following the adoption of menu labelling is presented in Section 7.

To increase visibility of nutrition information on the menu, it is recommended that font size, format, colour, and location of the label be given careful consideration.<sup>69,84</sup> Also, studies have shown that displaying a contextual statement explaining an adult's daily intake requirements for the nutrient in question increases understanding and use of the nutrition information.<sup>69,76,84,70</sup> Finally, education campaigns can be used to increase consumer awareness and understanding about menu labelling information.<sup>50</sup> Many jurisdictions in the US, such as New York City and Tacoma-Pierce County in Washington, incorporated these elements into their menu labelling strategies.

### 6.2. Helping People to Factor in Nutrient Content in Food Choices

As noted above, most consumers find it difficult to estimate the nutrition content of restaurant foods on a commonsense basis, and menu labelling helps many people to factor in objective nutrient content when making their food decisions. Even if the effects on food choices are sometimes small<sup>71</sup> or absent,<sup>72</sup> it is valuable to consider that menu labelling has been shown to have an effect and inform decisions in multiple contexts, including survey-based experiments,<sup>73,74</sup> clinic-based or psychology lab-style experiments,<sup>75,76,77</sup> as well as in quasi-experiments in real-world institutional settings such as university cafeterias.<sup>78,79,80</sup>



It is important to acknowledge that while menu labelling can help inform people's eating decisions, it does not have a major effect on everyone who sees it. In a set of statewide surveys carried out in Arkansas before menu labelling was implemented anywhere in the US, for example, researchers discovered that consumers underestimated fat and calorie content of restaurant menu items by as much as half. Then the researchers tested whether nutrition information would alter consumer attitudes, purchase intentions, and food choices (that is, ordering higher or lower calorie meals). They found that when nutrition information revealed that food items were much 'worse' than participants had expected (for example, higher in calories), people were more likely to change their purchase intentions as well as their food choices as compared to when their expectations more closely matched the actual nutrient content of the food items.<sup>73</sup> Burton and colleagues later carried out experiments that suggested that the most important factor determining the effect of menu labelling on purchase intentions and food choices was the extent to which disclosed objective nutrient information confirmed initial expectations or surprised individuals.<sup>74</sup>

In Canada, researchers at the University of Waterloo carried out an experiment to test the effects of different ways of displaying nutrition information on menus.<sup>80</sup> In this recent study, 635 adult participants, who did not know that they were part of a menu labelling study, were divided into four groups and asked to order real menu items from a Subway restaurant menu. Each group was presented with one of four types of mock menus: Group 1, no nutrition information; Group 2, calorie content listed; Group 3, calorie content alongside a 'traffic light' (green = low, yellow = medium, and red = high) signal; and Group 4, calories, fat, sodium, and sugar content with traffic lights for each. The researchers found that menu labelling clearly made nutrition information more visible. Seventy-two per cent (72%) of participants in Group 2 (calorie content) and 71% in Group 3 (calorie content + traffic light) reported seeing calories on the menu, compared to 3% in Group 1 (no information). Only 49% of people in Group 4 (four nutrients + traffic lights) reported seeing calorie information, suggesting that too much information may interfere with people's ability to process it. When asked if the nutrition information influenced their order, a statistically significant proportion of people in Groups 2 (42%), 3 (37%), and 4 (38%) said that it had. The researchers then tested the food that had actually been ordered and eaten, and while there was no significant difference between groups in the amount of calories people had ordered, people in each of the groups who had been presented with nutrition information had eaten less of their food.

A recent experimental study conducted by University of Toronto researchers also tested the effect of menu labelling on food purchase intentions.<sup>81</sup> A panel of 3,081 Canadians participated in the survey that was administered in April 2012. They found that providing calorie and sodium values on menus can change purchase intentions. About one quarter (26%) of participants chose to change their orders after seeing calories and sodium values on the menu. As well, compared to nutrients ordered before seeing menus with nutrition labelling, there was a significant overall decrease of 99 calories, 225 milligrams of sodium and 6 grams of dietary fat ordered after seeing menu labelling. Among the subset of people who changed their orders after seeing menu labelling, they chose meals with 209 fewer calories, 523 milligrams less sodium and 11 fewer grams of dietary fat.<sup>81</sup>

Toronto Public Health commissioned an analysis of the Toronto results of this study. The Toronto findings are based on a small subset of the national panel (n=199) and not necessarily representative of Toronto residents, but nonetheless provided some valuable insights into how people might use nutrition information in restaurants. The results were consistent with the findings from the larger nationally representative sample. After seeing menu labelling, 30% of respondents chose to change their order, resulting in a significant overall decrease of 188 calories, 277 milligrams of sodium and 6 grams of dietary fat. Those who changed their orders chose meals with 399 fewer calories, 939 milligrams less sodium and 21 fewer grams of dietary fat. The effects on food choices were more prominent among consumers who reported they were trying to lose weight, as well as those who had initially selected meals with significantly more calories, sodium, and dietary fat.<sup>81</sup>

### **6.3. Unintended Effects of Menu Labelling**

In addition to enabling consumers to choose a healthier menu option, there are two other potential effects of menu labelling that may have a positive impact on population health. Menu labelling enables people to balance their eating and physical activity throughout the day or week. So although knowing that a menu option contains a high amount of calories and sodium may not change one's choice to consume it, having that information may lead an individual to compensate in other ways, such as eating less at the next meal or doing more physical activity that day. There is preliminary evidence that this is more likely to happen when menu labelling includes a statement about nutrient daily intake requirements.<sup>76</sup> This area requires focused study.

Menu labelling can also alter social norms and increase consumer demand for healthier products, just as nutrition labelling on packaged foods created a demand for healthier options.<sup>50,84,117</sup> Food reformulation improves diet for everyone, even for those who do not make use of nutrition information. There is some preliminary evidence that restaurant menu reformulation has occurred, but this beneficial effect of menu labelling still needs greater study.<sup>82</sup>

An analysis of 245 U.S. chain restaurant menus found that restaurants that made nutrition information accessible on websites had significantly lower calorie, fat and sodium levels across menu items than those providing information only upon request.<sup>83</sup> Requiring nutrition information to be made more visible by putting it on the menu/menu board could increase this effect. A study in King County, Washington, assessed menu entrees after menu labelling was legislated. They found that the average amount of calories in entrées had been reduced by 73 calories in sit down restaurants 18 months after the legislation was put into place, and sodium and saturated fat levels also decreased significantly.<sup>82</sup>

In summary, menu labelling is believed to work along the following 'logic', or expected pattern of effects and outcomes.<sup>84</sup> First, people see nutrition information, then read it, develop an understanding of it, then can use it as a factor in food purchasing and consumption decisions. Of course, in planning public health policy, these steps represent 'intermediate' effects of menu labelling, because they are only part of the pathway to overall health outcomes. Whether better health is ultimately achieved (such as a reduction in population obesity levels), is also mediated by additional factors such as social context, competing factors such as taste, price, and

convenience of foods, unintended effects, and differential effects among population subgroups; moreover, it depends on whether policies are successfully implemented.<sup>84</sup>

## **6.4. Strong Public Support for Menu Labelling**

Menu labelling has been generally well supported by the public in terms of their interest in having nutrition information made available.<sup>17,24,25,34,81,85,86</sup> This has been the case when surveys have been completed as part of consultations related to specific policy initiatives (see section 7) as well as in surveys carried out for research purposes in Canada and the US. Two recent Canadian surveys found that over 90% of Canadians and Ontarians support menu labelling in fast food restaurants,<sup>85</sup> and that 86% of Canadians want nutrition information, including calories, readily available and clearly visible at the point of purchase at all restaurants.<sup>24</sup> Another recent Canadian survey using a nationally representative consumer panel found that 73% of respondents felt it was important to require restaurants to display the amount of sodium in the foods they serve.<sup>87</sup> Canadians most strongly support disclosure of calories and sodium values. Of a panel of about 3000 Canadians, 75% would like to see calories on the menu, 71% sodium, 49% fat, 47% sugar, 43% saturated fat.<sup>81</sup>

In the US, where menu labelling has largely focused on posting calories, a 2009 telephone survey on menu labelling was carried out by researchers from the Johns Hopkins Bloomberg School of Public Health with a nationally representative sample of adults aged 18 and older. They found that 68% of respondents favoured having government require chain restaurants to post calorie information on menus; 76% indicated that having calorie content of foods at the point of purchase in a chain restaurant would be ‘very or somewhat useful’; and 60% reported that calorie posting would encourage them to select a food of lower calorie content. Women, Black and Hispanic respondents, adults older than 45 years, and adults with more than a high school education were significantly more likely to report that they would use calorie posting to choose a lower calorie food.<sup>88</sup> Another American study using national-level health survey data on self-reported health status and eating behaviours found that there are two population ‘clusters’ or subgroups that are more interested than average in menu labelling: 1) generally active, healthy females with an average age of 41 years, who already watch what they eat; and 2) less-educated, less active, middle-income females with an average age of 48 years, who have poor diets and eat out more frequently.<sup>89</sup>

Toronto Public Health's survey of Toronto residents, discussed in Section 9, confirms high support for menu labelling as does the University of Toronto research on menu labelling which included a small sample of Toronto residents.<sup>81</sup>

# 7. Jurisdictional Policy Experiences

This section provides examples of menu labelling initiatives from across North America to outline real-world experiences of how menu labelling can be adopted, implemented, and used. Different types of menu labelling interventions have been adopted in various jurisdictions, and, where available, findings from evaluations of these initiatives are described as well. A summary table of common parameters and practices for existing menu labelling initiatives in Canada and the US is included in the Appendix (Section 12).

## 7.1. Legislation – Canada

A legal analysis prepared for the Public Health Agency of Canada (PHAC) has suggested that all three levels of government in Canada would likely have jurisdiction to enact mandatory menu labelling legislation.<sup>90,91</sup> Some localities in Canada have advocated for provincial or federal legislation on menu labelling, for example in Ontario, Ottawa,<sup>92</sup> Peel,<sup>93</sup> Simcoe-Muskoka District,<sup>94</sup> and Durham Region,<sup>95</sup> but none have enacted local legislation.

At the provincial level in Ontario, New Democratic Party (NDP) Member of Provincial Parliament (MPP) France Gélinas has introduced a proposal for menu labelling legislation on three occasions. The most recent version of the bill<sup>96</sup> proposed an amendment to the *Health Protection and Promotion Act* to require chain restaurants with five or more locations and gross annual revenue over \$5 million to display the calorie content of all menu items, via a menu, menu board, or food item tag where there are no menus, as well as a warning for high sodium content. The bill did not proceed to second reading due to the prorogation of Parliament in October 2012.

In March 2013, the Ontario Government released their Healthy Kids Panel report with recommendations to address childhood obesity. The three-part Healthy Kids Strategy recommends building healthier environments for children at the pre- and post-prenatal period, in the community, and in the food environment. Recommendations focused on changing the food environment include requiring menu labelling in all restaurants, including fast food outlets, and in retail grocery stores.<sup>97</sup> On April 4, 2013, the Province released *Make No Little Plans: Ontario's Public Health Sector Strategic Plan* which includes achieving the goals of the Healthy Kids Panel report among its strategic goals and collective areas of focus.<sup>98</sup>

At the federal level, Liberal Member of Parliament Tom Wappel introduced a series of private member's bills nearly a decade ago<sup>99</sup> to amend the *Food and Drugs Act* to require a number of food labelling provisions for 'foods sold for immediate consumption' by operators with over \$10 million in gross annual revenues, including display of calorie, sodium, and fat content. This bill was ultimately defeated at second reading in 2006.

NDP Member of Parliament Libby Davies has also introduced a private member's bill that may have menu labelling implications (Bill C-460, introduced November 5, 2012). While the text of the bill does not specifically mention menu labelling, apart from 'high sodium' warnings on standardized items at large chain restaurants, it sets in place parameters to implement the Sodium

Reduction Strategy for Canada.<sup>100</sup> Recommendation 1-8 in the Sodium Reduction Strategy advises that provincial menu labelling legislation be enacted for standardized menu items “prepared and assembled on site at restaurants and food services establishments ... in establishments with a high degree of standardization.”<sup>38</sup>

In 2011, a Federal-Provincial-Territorial Task Group on Provision of Nutrition Information in Restaurants and Foodservices was struck to develop a national framework for nutrition information disclosure in restaurants for Health Canada. Membership includes representatives from Health Canada, PHAC, and Ministries of Health for Ontario, British Columbia, Alberta, and Newfoundland. Both voluntary and mandatory options are being considered. There are no details on the format this will take, but there are plans underway to develop an approach to focus test next year. The timeline for delivery of a Health Canada framework has been projected at mid-2015 at the earliest.<sup>101</sup>

## **7.2. Voluntary Initiatives – Canada**

Menu labelling initiatives are often viewed as encompassing two approaches: voluntary guidance (led by various governmental and nongovernmental agencies, including industry) and requirements embedded in law (‘mandatory’ menu labelling legislation). A review of the examples below suggests that voluntary programs can vary substantially, and can be administered and funded through different public and private sources. This section outlines three examples of voluntary menu labelling initiatives: Health Check, administered by the Heart and Stroke Foundation of Canada, a nongovernmental organization; Informed Dining, run by the British Columbia provincial government; and industry-led action by the Canadian Restaurant and Foodservices Association (CRFA).

### **7.2.1. Health Check (Heart and Stroke Foundation of Canada)**

The Heart and Stroke Foundation of Canada (HSF) and its provincial offices run the Health Check labelling program. Health Check was launched for prepackaged food items in 1999 and for restaurant menu items in 2006.

The Health Check restaurant program currently works with 14 chain restaurant 'licensees' in Ontario. Individual food products or menu items are submitted by licensees who bear the costs of laboratory nutrition analysis (subsidized by the Ontario Ministry of Health and Long Term Care) and then request evaluation by HSF for compliance with program-defined nutrition standards and to receive a Health Check designation for that menu item. In many cases, restaurants develop new menu items to adhere to Health Check requirements. A licensing fee is charged for each Health Check menu item. This allows the program to operate on a cost recovery basis. Successfully evaluated items are labelled with a Health Check logo on the menu, the same logo that is used on the front-of-pack for Health Check prepackaged foods. In restaurants, in addition to the logo, Health Check menu items are required to have an explanatory message and nutrition facts brochure available prior to the point of sale.

In February 2012, a menu labelling component was added to the Health Check restaurant program. Nutrition information for Health Check menu items including calories, sodium, fat, and

other ‘Health Check nutrients’ must be displayed on menus and menu boards or in some other format available prior to the point of sale. By definition, the focus is only on "healthy" items and not all menu options.

The Heart and Stroke Foundation has highlighted key lessons from the Health Check restaurant experience, three of which are especially relevant here: a) some operators find the licensing and nutrition analysis costs prohibitive (and only chains are currently engaged); b) implementation time for restaurants to meet standards was from months to years; and c) random annual audits done by HSF have indicated ‘strong’ compliance.

#### Sources

- Health Check website (<http://www.healthcheck.org/>)
- Toronto Public Health menu labelling workgroup consultations in 2011, 2012 and 2013 with the Business Development Manager of Foodservice and the Program Manager of the Health Check Ontario Dining Program
- Presentation by Terry Dean, Director, Health Check at Ontario Sodium Summit, Toronto, February 16, 2012<sup>102</sup>

### **7.2.2. Informed Dining (British Columbia Ministry of Health)**

The British Columbia (BC) Ministry of Health identified nutrition information disclosure in restaurants as a priority initiative in April 2010. Following early consultations, a political endorsement for a voluntary “provincial restaurant recognition program” was gained in November 2010. The program evolved from then and had its official launch as “Informed Dining” in August 2011. A Restaurant Working Group was convened in December 2010 to discuss program development and design, which included representatives of the Ministry of Health, the CRFA, the BC Restaurant and Foodservices Association, and key industry leaders. Additional consultations were held with public health and industry stakeholders in early 2011. The Heart and Stroke Foundation BC joined Informed Dining as a formal partner in March 2011 for program implementation and evaluation support. The tagline for Informed Dining is “Stop Guessing. Start Asking”.

Participating restaurants in Informed Dining are not required to provide nutrition information directly on menus or menu boards. Rather, they are expected to offer nutrition information in any of several standardized formats such as via menu insert, brochure, or poster. Restaurants are asked to share nutrition information for all standard menu items, including calories and 13 core nutrients, with calories and sodium highlighted, and information on daily calorie and sodium intake requirements. They must make this information available, upon request by patrons, at or before the point of ordering, but as noted, not necessarily on the menu itself. Restaurants must display the program logo and a statement on the menu/menu board advising patrons that nutrition information is available.

At the launch of the program, the province offered free nutrition analysis aided by provincial dietetic staff as an incentive to early adopters and to promote participation among smaller/independent operators. This was popular but resource intensive for the province. A new Small Business Support Program has since been developed including nutrient analysis, recipe

reformulation, graphic design, and printing supports for operators with fewer than five locations and fewer than 50 employees per location. All other operators are responsible for obtaining their own nutrient analysis, which can be obtained independently through laboratory or computer software methods. Provincial public health inspectors are responsible for monitoring and quality assurance, not including nutrient accuracy.

To date, Informed Dining has recruited 18 restaurants (including two national chains) to voluntarily participate. Additional restaurants have signed on and are at various stages of program implementation. Informed Dining has been mandated for foodservice operators in publicly-funded provincial healthcare institutions, but it has not yet come into effect. The cost of Informed Dining to the BC provincial government has been estimated at more than \$2 million, with approximately \$1 million for a promotional campaign. An internal evaluation of Informed Dining is underway, with results anticipated in spring 2013.

#### Sources

- Informed Dining website (<http://www.healthyfamiliesbc.ca/home/informed-dining>)
- Toronto Public Health menu labelling workgroup consultations from 2011-2013 with the Provincial Nutritionist and the Senior Manager/Acting Provincial Nutritionist of BC Ministry of Health, and shared internal documents

### **7.2.3. Canadian Restaurant and Foodservices Association Nutrition Information Program**

In 2005, the Canadian Restaurant and Foodservices Association (CRFA) launched a voluntary nutrition information program with guidelines to support their members to provide nutrition information to their customers. Participating restaurants are asked to provide information on calories and the 13 nutrients found on the Nutrition Facts Table required for pre-packaged foods, and on allergens, for all core/standard menu items. They are asked to provide this information through in-store pamphlets, brochures, or posters, and on their websites.<sup>103</sup> Over 30 large chains are participating in this program, although compliance with program recommendations has been found to be inconsistent.<sup>50</sup>

The CRFA has continually emphasized that it supports the development of a nationally consistent framework for menu labelling for all restaurants. The CRFA has participated in consultations held by the Federal-Provincial-Territorial Task Group noted above. The CRFA publicly announced in December 2012 that it is endorsing a transition from the CRFA voluntary guidance program to the Informed Dining program and will support BC restaurants that also have outlets across Canada to participate.<sup>104</sup> The CRFA is also seeking partnerships with provincial governments to support the implementation of Informed Dining in non-BC chains.

#### Sources

- CRFA website (<http://www.crfa.ca/>)
- Toronto Public Health menu labelling workgroup consultations in 2012 with the Vice President of Ontario & Sustainability and the Executive Vice President of Government Affairs of CRFA; and the Chair of CRFA Board of Directors

## 7.3. Legislation – United States

A number of jurisdictions in the US, at the municipal, county, and state levels, have introduced or enacted menu labelling legislation that focuses on posting calories.<sup>105</sup> These policy initiatives will largely be superseded in 2013 by a federal menu labelling provision embedded in the *Patient Protection and Affordable Care Act (ACA)* (PL111-148), Provision 4205. Only three US jurisdictions (California, Seattle/King County, and Philadelphia) have mandated menu labelling that requires posting calories plus additional nutrient values (sodium, fats, carbohydrates) on the menu or, in some other format, at the point of purchase. In all three jurisdictions, only calories are required on menu boards. All state and local menu labelling legislation will be pre-empted by the federal legislation once it comes into force. Philadelphia, however, has applied for an exemption based on the grounds that the city has a very high prevalence of adult obesity, cardiovascular disease and hypertension, and diabetes. As California's menu labelling law has not been evaluated,<sup>106</sup> and the results of Philadelphia's evaluation are not yet available, these jurisdictions are not included in this section.

### 7.3.1. US Federal Menu Labelling

The ACA became law in March 2010 and was upheld in a Supreme Court ruling in 2012. It establishes calorie labelling requirements for large chain restaurants and related retail foodservice operators with 20 outlets or more nationwide. The legislation requires calorie content of standard menu items to be posted prominently on menus, menu boards, or drive-through menus, with contextual information on daily requirements. Calorie posting is also required on vending machines near the selection button where consumers cannot inspect the prepackaged Nutrition Facts Panel prior to purchase. This legislation is expected to come into force in April 2013.

#### Sources

- Legislation cited
- US Federal Register Volume 75, Number 129 (Wednesday, July 7, 2010), Docket No. FDA-2010-N-0298, <http://www.gpo.gov/fdsys/pkg/FR-2010-07-07/html/2010-16303.htm>; Volume 75, Number 164 (Wednesday, August 25, 2010), Docket No. FDA-2010-D-0370 and FDA-2010-D-354 <http://edocket.access.gpo.gov/2010/pdf/2010-21067.pdf>

### 7.3.2. New York City

New York City was the first jurisdiction in the US to adopt menu labelling legislation, and provides important information on implementation and effectiveness. In December 2006, the New York City Board of Health agreed to adopt a municipal Health Code amendment, Article 81.50, requiring foodservice establishments who already make calorie information publicly available to post this information on menu boards. After legal challenges by the New York State Restaurant Association, the New York City Health Department went on to repeal, rewrite, and reenact the amendment to require posting of calorie information for all foodservice establishments of a particular size in the city, and the Board of Health adopted this in January 2008.



New York City's menu labelling requirement took effect in April 2008 with enforcement beginning in July 2008. It requires foodservice establishments with 15 or more locations nationwide to post calorie information for all menu items on menus, menu boards, drive through menus, and food item tags, with provisions for elements such as format/font size, flavours/varieties, and food item combinations.

New York City is one of a few jurisdictions that has undertaken a formal evaluation of their menu labelling program. An analysis of the New York City experience by City officials emphasized three lessons for other jurisdictions considering menu labelling legislation: 1) voluntary initiatives were highly unlikely to succeed; 2) a combination of public health disciplines and city staff was needed to ensure success; and 3) local authorities have a high degree of expertise and capacity in terms of public health authority over food distribution and retail, particularly restaurants.<sup>107</sup>

Evaluative evidence from New York City offers modest but compelling empirical evidence that mandatory menu labelling has several important effects. Two are undisputed: menu labelling changes the food information environment in restaurants by rendering calorie content of foods visible; and this information is readily noticed after implementation by a majority of patrons.<sup>108,109,110</sup>

Three key pieces of research break down the effects of the legislation further. The Health Department team and collaborators carried out baseline, and 3 month pre- and post-enforcement exit surveys across 11 chains (not including coffee chains), collecting information from over seven thousand customers each time (baseline n=7,318; pre n=7,309; post n=8,489). They found high baseline calorie intakes, with over one-third of customers ordering over 1,000 calories for a lunchtime meal prior to the legislation.<sup>58,111</sup> The pre-post evaluation found that after the legislation, 72% of respondents reported seeing the calorie information; 15% reported using it; and overall, there was no significant difference in overall calories purchased.<sup>112</sup> Yet significant reductions were observed for particular chains (McDonald's, Au Bon Pain, and KFC), and among those who reported using the information, there was an average reduction of 106 calories purchased per transaction.

This study's baseline findings from the Subway chain are also worthy of note. Subway had posted calorie values on the menu board before the legislation went into effect. At baseline, Subway patrons who reported having seen the calorie information purchased 52 fewer calories and fewer higher-calorie meals than Subway patrons who did not see it. Of Subway patrons who reported seeing calorie information, 37% reported that this information had an effect on their purchases. Those who reported seeing and using calorie information purchased 99 fewer calories compared to those who reported seeing the information, but stated that it had no effect.<sup>58</sup>

A smaller study consisting of lunchtime surveys of 1156 customers leaving a restaurant at selected low-income neighbourhood locations of four large fast food chains (McDonald's, Burger King, Wendy's, KFC) in New York City and Newark, New Jersey, found that there was no significant difference in overall calories purchased two weeks pre and four weeks post enforcement, and no difference in calories purchased between the two cities.<sup>110</sup>

Finally, an intensive study by Bollinger et al. (2010), with access to every sales transaction (n=over 100 million) at Starbucks locations in New York City, Boston, and Philadelphia from January 2008 through February 2009, including individual-level data from store cardholders, found that calorie posting did have significant effects on calories purchased. Overall, there was a 6% average reduction in calories ordered per transaction; a 14% reduction for food items, excluding beverages; and among individuals who ordered more than 250 calories per transaction prior to the labelling rule, a 26% reduction. The reduction effect was also seen for commuters (i.e., individual cardholders who purchased at Starbucks inside and outside New York City), leading the authors to suggest that there was a learning effect of display of information. They also discovered that there was no change in revenue for Starbucks, with a 3% increase in revenue for Starbucks located close to Dunkin Donuts establishments. An untested hypothesis that was put forward by the researchers was that the availability of calorie information at Starbucks may have attracted some Dunkin Donuts patrons.

In terms of lessons for policy development and implementation, three points should be made. First, the New York City experience indicates that public support for menu labelling is very high. Ninety-nine percent (99%) of respondents to the City's public consultation supported the legislation prior to adoption and 86% of respondents to an August 2008 survey after implementation noted it was a 'positive move'.<sup>113</sup> Second, evidence demonstrates that nutrition labelling works in the way it is intended: through improved information transparency, people are influenced to make healthier food choices.<sup>114</sup> Third, the legal analyses have concluded that local governments have the clearest authority over labelling when it is about information transparency, in contrast to regulation of health/nutrition claims, which are largely seen to be the responsibilities of the federal government and private companies.<sup>114</sup>

#### Sources

- Toronto Public Health menu labelling workgroup consultations with the Director of Built Environment and Active Design, New York City Department of Health and Mental Hygiene
- Peer-reviewed literature cited

### **7.3.3. King County, Washington**

King County is a large county in Washington State encompassing the City of Seattle, with a population of over 1.9 million people. Seattle & King County Public Health is the metropolitan health department and administers both local (Board of Health) and state policies and programs. On July 19, 2007, the King County Board of Health adopted Rule and Regulation (R&R) 07-01, which requires chain restaurants with fifteen or more locations nationwide, with at least \$1 million USD in gross annual sales, to label calories, saturated fat, carbohydrates, and sodium content for all standard menu items on menus, menu boards, and as of 2009, drive-through menus. This requirement came into effect August 1, 2008 and was enforced as of January 1, 2009. In light of the pending US federal menu labelling legislation, King County initiated a process to revise its regulation and align it with the national statute, which was approved at a public hearing at the Board of Health on May 20, 2010, effective June 19, 2010.

Finkelstein et al. carried out an assessment of the effects of the original King County regulation using data from Taco Time Northwest, a chain restaurant that provided transaction data for all menu items sold one year before and after the legislation was enforced.<sup>115</sup> Based on transaction analysis, the researchers did not find any substantial difference in calories per transaction before and after the legislation came into effect. A year and a half after the regulation, however, health department staff found that consumers were less likely to be making ‘high calorie’ meal purchases (defined as over 667 calories per meal), with an approximately 4% reduction in customers buying ‘high calorie’ items.<sup>116</sup>

Other researchers carrying out an audit of King County restaurants affected by the legislation, including sit-down and quick-service chains with four or more locations in King County, found some evidence that menu reformulation also took place. They found a modest decrease in calories, fat, and sodium in entrées and combination meals after the legislation, with the exception of pizza chains.<sup>117</sup>

Another group of researchers compared King County to San Diego County (where there was no regulation). While they found no significant difference between the two counties in terms of calories ordered, they did note that in King County, the proportion of people who reported seeing nutrition information increased significantly post-regulation, from 44% to 87%, whereas there was no change in San Diego County.<sup>118</sup>

#### Sources

- King County government website (<http://www.kingcounty.gov/healthservices/health/nutrition/healthyeating.aspx>)
- Peer-reviewed literature cited

## 7.4. Voluntary Initiatives – United States

### 7.4.1. SmartMenu (Tacoma-Pierce County Health Department, Washington)

Tacoma Pierce County is a mid-sized public health jurisdiction in Washington State, home to 800,000 people, including ~200,000 people in the City of Tacoma, and 3,200 food establishments of which 600 are independently locally owned and operated. The SmartMenu pilot recruited 24 independent establishments from mid-June 2007 to Sept 2008. The program did not do any further recruitment. These establishments were seen as “early adopters.” The program included software nutrition analysis supported through the Health Department and contracted Registered Dietitians; restaurant recognition and promotions; and menu labelling for calories, fat, carbohydrate, and sodium content in a standardized but optional format for all regular menu items. The total cost of the program was estimated at over \$350,000 USD.

Evaluations of the program process<sup>119</sup> and effects on consumer behaviour<sup>120</sup> have provided evidence to assist other local health authorities in thinking through their own initiatives. Consumer behaviour findings echoed those of other initiatives. They found that 34% of customers reported using the nutrition information to make a healthier choice (for example, 20% chose an entrée lower in calories and 8% chose an entrée lower in sodium). Those who used the

information to make a lower calorie choice were estimated to have ordered about 75 fewer calories.<sup>120</sup> Britt et al. detail how this pilot-scale, voluntary program was time and resource intensive; Health Department staff supported menu item standardization and carried out the software nutrition analysis.<sup>119</sup>

From a broader perspective, the experience from the SmartMenu pilot cannot really be seen as a ‘lead up’ to legislation or even reasonably compared with a potential health agency burden following implementation of legislation for major chain restaurants; rather, it should serve as a source of implementation lessons for a voluntary independent restaurant program model.

#### Sources

- Tacoma-Pierce County Health Department website (<http://www.tpchd.org/index.php>)
- Peer-reviewed literature cited
- Toronto Public Health menu labelling workgroup consultations in 2012 with an Evaluator and a Prevention Specialist of the Tacoma-Pierce County Health Department

### **7.4.2. Healthy Hometown Restaurant Program (Louisville, Kentucky)**

Using part of a major federal grant for obesity prevention in 2010, Louisville, Kentucky initiated a program of support for smaller restaurants to implement US federal requirements for menu labelling (local restaurants with fewer than 20 locations nationwide; budget allotted was approximately \$600,000 USD for development and implementation of the program). Initial public consultations indicated that there was strong public support for menu labelling. The health department offered the following supports to participants: software nutrition analysis by dietitians; access to contracted local chefs who helped with recipe standardization and menu reformulation; free healthy cooking workshops; free printing of menus; and restaurant promotion.

Forty restaurants out of 1300 eligible were participating as of May 2012. An outcome evaluation of the menu labelling initiative was undertaken but the findings have not as yet been released. Project staff noted anecdotally that very few restaurants changed their menu upon seeing the nutrition analysis; those who did change their menu item adjusted the portion size rather than adjusting the recipe. Although there was interest in an implementation evaluation, the funding timelines did not allow for this undertaking. One of the objectives of this initiative was to improve access to healthy food in lower income areas. It was noted that restaurants in lower income areas were reluctant to participate because they thought that changing their menu to make it healthier could negatively affect their sales.

#### Sources

- City of Louisville government website (<http://www.louisvilleky.gov/Health/PuttingPreventiontoWork/RestMenuLabel.htm>)
- Toronto Public Health Menu Labelling Work Group consultation with the Coordinator of the Louisville's Healthy Hometown Restaurant Program, May 30, 2012
- Toronto Public Health Menu Labelling Work Group consultation with Lead Evaluator, Healthy Hometown Restaurant Program, January 22, 2013.

## 7.5. Key Learning from Jurisdictional Policy Experiences

In summary, the review of jurisdictional policy experiences has highlighted several key points.

- Public support for menu labelling is high. Menu labelling clearly makes nutrition information more visible in eating out environments and it can influence ordering behaviour, including calorie reductions, for a subset of customers.
- There is a growing range of evidence on menu labelling process and outcomes, including specific ‘lessons learned’ from jurisdictions on how to do menu labelling initiatives well. Program design depends on the policy context in each jurisdiction. It is necessary to engage industry in the development phase.
- Specific adoption and implementation barriers exist for both voluntary and mandatory menu labelling initiatives. These barriers are not insubstantial, particularly for smaller/independent restaurants. The New York City example suggests that beyond acceptability of the legislation in the first place, fewer implementation challenges may exist for mandatory menu labelling among large chains. Menu labelling is unlikely to be widely supported or adopted by the restaurant and foodservice industry on a voluntary basis.
- For voluntary menu labelling initiatives:
  - multiple recruitment strategies have to be used and attrition should be expected;
  - dedicated health staff and financial resources have to be allocated to ensure sustainability; and
  - one of the most challenging components is nutrient analysis because, although using computerized nutrient analysis can be lower in absolute cost, it can be resource intensive in terms of public health staff resources required to support restaurants to complete the process.

## 8. Rationale for Calories and Sodium on the Menu

In order to prioritize which nutrients to include on the menu, the following criteria were considered: a) nutrition information that is associated with critical population health concerns because of the high levels found in restaurant foods and the overconsumption of these nutrients; b) nutrients that consumers have difficulty estimating in their restaurant meals; c) nutrients that consumers most want to know about; and d) the amount of the nutrition information which consumers have the capacity to easily see, understand and use at the point of purchase.

Calories and sodium values are recommended as the key nutrients to include on chain restaurant menus/menu boards since they meet all of the above criteria. The evidence linking excess calorie consumption to weight gain and excess sodium intake to high blood pressure is strong, with implications for population level obesity reduction and chronic disease prevention efforts. Previous sections of this report showed that restaurant meals are generally very high in calories and sodium, and that consumers highly underestimate calorie and sodium levels.

A small number of US jurisdictions have included fat (either total fat or saturated fat) and carbohydrates (either total carbohydrates or sugars) in menu labelling initiatives. Although both low-fat and low-carbohydrate diets can lead to weight loss, the most important determinant of maintaining weight loss is the ability to sustain a lower-calorie diet regardless the source of the calories.<sup>121,122</sup>

The evidence linking dietary fat and carbohydrate intakes to chronic diseases is not straightforward.<sup>123</sup> While there is strong evidence linking diets high in saturated and trans fat with cardiovascular diseases, other types of fatty acids (i.e. unsaturated) are considered an important part of a healthy diet. Similarly, there are "good" carbohydrates derived from whole grains, vegetables, fruit and legumes which are health promoting, in contrast to carbohydrates derived from added sugars that are associated with poor health effects such as dental caries and obesity. Therefore, a total fat or total carbohydrate value is not a useful indicator of the healthfulness of a menu item beyond being a proxy for calorie content. Furthermore, adding information on a larger number of nutrients can make it challenging for people to process. As in other jurisdictions, large chain restaurants (both sit-down and quick-service) should also be required to provide customers with comprehensive nutrition information, upon request, so that individuals with particular health or dietary concerns can access the information they need to make an informed choice.

Finally, according to a survey of about 3000 Canadians, the strongest public support is for calorie and sodium values on the menu (75% wanted calories, 71% sodium, 49% fat, 47% sugar, and 43% saturated fat).<sup>81</sup>

# 9. Readiness for Menu Labelling in Toronto

## 9.1. Issue History in Toronto

Toronto Public Health has studied the issue of menu labelling since 2008. The Toronto Food Strategy's May 2010 Board of Health report, *Cultivating Food Connections: Toward a Healthy and Sustainable Food System for Toronto*,<sup>2</sup> identified menu labelling as a direction that TPH would explore to help achieve one of the priority areas on 'empowering people with food skills and information.'

In June 2010, TPH first expressed its official support for menu labelling legislation at the provincial level as one of the signatories to a letter coordinated by the Centre for Science in the Public Interest (Canada), in support of Ontario MPP Gélinas' private member's bill on menu labelling.

Since late 2010, TPH has carried out in-depth background research to assess the policy environment and stakeholder readiness for menu labelling, including:

- Consultations with representatives of local, provincial, and national groups and organizations in Canada and the US involved in menu labelling initiatives (outlined above);
- Consultations with restaurant associations and operators;
- A telephone survey of Toronto residents;
- An online survey of independent restaurant operators; and
- In-depth key informant interviews with executives and decision makers at chain and franchise restaurants.

The following sections report on TPH research on readiness for menu labelling with Toronto residents and independently owned/operated and chain/franchise restaurants in Toronto.

## 9.2. Eating Out in Toronto and Resident Attitudes

A consumer eating out module was incorporated into the 2011 Toronto Health Survey, a population health surveillance telephone survey of Toronto residents (n=1,699) commissioned by TPH and carried out by a market research firm between October 2011 and March 2012.<sup>124</sup> The survey found that eating out is very common among Toronto residents. Over 7 in 10 (71%) Torontonians reported having eaten out at a restaurant or fast food outlet (or both) at least once in the past week. Over half (54%) reported having eaten at a restaurant and nearly half (47%) reported having eaten fast food. Eating out is more common among men and younger age groups, for both restaurants and fast food. Torontonians who have postsecondary education or a higher household income are significantly more likely to have eaten out at a restaurant than those with less education or lower income.

Most respondents also noted that they believed getting "nutritious food" was important, with over half (54%) agreeing that it was "very important" and another third (36%) "somewhat important" to them. When asked about their current and intended use of nutrition information

(self defined), people responded positively. Nearly 70% of respondents indicated that they already consider nutrition information when eating out ‘at least sometimes’ and 78% suggested that they would use nutrition information ‘at least sometimes’ if it were readily available. Females, those in younger age groups, and those with higher levels of education were significantly more likely to report that they would use nutrition information if it were readily available.

A smaller study mentioned above, requested by TPH and carried out through the University of Toronto, revealed that 83% of Toronto consumers would like to see nutrition information when eating out.<sup>81</sup> The nutrients of greatest interest to consumers are calories and sodium, with 79% and 74% of consumers, respectively, saying they want to see these nutrients. Fifty-eight percent (58%) of consumers said they want to see information about dietary fat. About half of consumers are interested in seeing values for trans fat, saturated fat and sugar. Only one in six consumers were interested in seeing vitamin content and one in eight want to see mineral content.

### **9.3. Views on Menu Labelling Among Independent Restaurants**

Toronto Public Health contracted a market research firm to administer an online survey of independent restaurant operators across Toronto from December 2011 to January 2012 (n=256 completed surveys). The survey suggested that the majority of these independent restaurants at present are not interested (72%) in providing nutrition information to their customers. Underpinning this view appears to be an idea that people already have a good idea of what is healthy or not (91%) and that restaurants’ ability to provide nutrition information would not affect consumers’ decisions to eat at their establishment (62%).

There are worries about what menu labelling would mean in practical implementation terms. Three quarters (76%) of independent operators agreed that adjusting menus to provide nutrition information would be an expensive undertaking. 64% felt that they were too busy to “figure out” how to provide nutrition information and 62% of respondents said that they would not provide it unless they absolutely had to.

Yet over half (57%) of respondents to the survey reported feeling some responsibility to provide nutrition information. Half of respondents thought that nutrition information could be good for business in terms of attracting customers. As well, 80 restaurants (42%) expressed interest in working with TPH on a pilot project focused on providing nutrition information to their customers.

In the summer of 2012, follow-up consultations were conducted with a sample of this group of restaurant operators to further explore their interest in a proposed TPH menu labelling pilot project. The stated purpose of the pilot was to test the feasibility of menu labelling among independently owned/operated and small chain restaurants in Toronto. The proposed parameters of the pilot were that operators would analyze all standard items on their menu (using computerized software or laboratory analysis) and post calories, sodium, and fat values on the menu/menu board. Similar to models in other jurisdictions described in Section 7, TPH would provide some support in conducting the nutrition analysis and recognition to participating restaurants in a number of ways.



Of the 13 independent restaurant operators that were consulted, 11 confirmed their interest in participating in a pilot. Two others would consider it further once the parameters of the pilot project were finalized. Overall, these operators indicated that they want to be leaders and see menu labelling as an opportunity to take advantage of a current trend and create a competitive advantage against chains. They hoped that they could boost their business by providing this service to their customers, promoting their menu, and receiving recognition for participating in the pilot. Restaurant operators indicated needing some support from TPH, primarily with the cost and time requirements of nutritional analysis.

#### **9.4. Views on Menu Labelling Among Chains and Franchises**

Toronto Public Health commissioned in-depth interviews with executives of 9 chains/franchises operating in Toronto, conducted in February 2012. Consultations were also conducted in 2011-2012 with the CRFA, the Ontario Restaurant, Hotel & Motel Association, and the Ontario Chinese Restaurant Association. Similar to the independent restaurant operators, the executives of chains and franchises interviewed by TPH noted that restaurants are responsive to consumer demand, including health concerns, which are seen to be a topical industry issue. (This is consistent with industry perspectives elsewhere in Canada and the US.)<sup>125,126</sup>

‘Health’ is also broadly defined in the restaurant sector. The range of health concerns discussed by chain/franchise executives went well beyond calorie or even nutrient-specific information. With little prompting, interviewees raised topics such as general health and health conditions (e.g., diabetes), health concerns among particular population groups (e.g., aging population), foods or preparations that are perceived to be “healthy” (e.g., fish or grilled items), allergies, diets (e.g., gluten free), quality of products or standards of production (e.g., agricultural origin), and broader environmental issues (e.g., biodegradable packaging), in addition to traditional nutrient categories (e.g., calories, portion sizes, sodium).

The largest chains already see themselves as industry leaders in providing nutrition information, but smaller chains interviewed also reported taking active steps to provide this service. Nearly all interviewees noted that they had taken health concerns into account to reformulate their menu offerings in some way, including sodium reduction or clearer food handling policies to minimize risk of allergies. One small chain recounted how carrying out nutritional analysis had prompted them to reduce sodium, lower fat, and even switch to brown rice in their menu items. The same small chain suggested that smaller companies, in contrast to large ones, could more readily and feasibly adapt menus since they were less embedded in complex food supply chains.

Overall large chain restaurants, and some smaller chains, both indicated that they were already providing some type of nutrition or health information to consumers. Several interviewees questioned the evidence on effectiveness of menu labelling interventions to shape consumer behaviour.

There was not strong support for menu labelling amongst chain restaurants in Canada. Rather, there is a preference for the current model of voluntary nutrition information disclosure as set out

by the CRFA. The views presented by the consulted restaurant associations were consistent with these findings.

An additional six local chains were consulted by TPH staff in the fall of 2012 about the proposed TPH menu labelling pilot project which yielded consistent findings. Most chain representatives indicated that they already provide comprehensive nutrition information on their website and make it available in their restaurants, upon request. One chain was providing calorie and fat values for some menu items and another US-based chain had begun posting calories on the menu/menu board in their Canadian locations. Overall, there was recognition that menu labelling is on the horizon, but most were hesitant to undertake it voluntarily. Unlike the view of independent operators, they did not see any benefit for their chain, only for their customers. They feared it could negatively affect their revenue from lower sales of 'less-healthy' items. Another challenge was the issue of cluttering the menu board; three operators said it would be easier to do menu labelling with LED screens. There were mixed views about menu labelling with calories, sodium, and fat values, and reluctance to participate in the pilot project.

The cost of putting nutrition information on the menu has been identified as a concern by the restaurant industry, as well as those consulted by TPH. The U.S. Federal Department of Agriculture conducted a cost-benefit analysis of their federal menu labelling legislation.<sup>127</sup> They estimate the cost per large restaurant chain for nutritional analysis, replacing menus/menu boards and staff training to be on average USD \$45,720 per year. This may not be a substantial cost for larger chains, and the potential health benefits of menu labelling have to be considered.<sup>127,128</sup> Menu labelling may also offer opportunities to recover some of these costs through increased sales, as more health conscious consumers indicate that they will eat out more often if easily accessible nutrient and calorie information is available.<sup>74</sup>

# 10. Municipal Policy Levers for Menu Labelling

Although there is agreement among diverse stakeholders that a provincial and/or federal menu labelling legislation is preferable, every level of government has a role to play in creating environments that protect and promote health.

Toronto Public Health's mandate comes from two principal sources. It fulfills the requirements of the provincial Ontario Health Protection and Promotion Act (HPPA) and associated regulations, including the Ontario Public Health Standards (2008). R.R.O. 1990, Regulation 562 deals specifically with Food Premises. Toronto Public Health also holds a role within the City of Toronto municipal government, reporting to the municipal Board of Health, defined by the City of Toronto Act (COTA).

Part III of the HPPA, Community Health Protection, permits the medical officer of health to investigate and take action to eliminate potential health hazards, including food premises. The Act makes it incumbent upon food premise operators to provide the medical officer of health with information regarding the food at or distributed from the food premise. Section 96(3) (b) through (e) and (h) through (j) provide the province with powers to enact regulations regarding food premises including food vending machines. A “food premise” includes those premises “where food or milk is manufactured, processed, prepared, stored, handled, displayed, distributed, transported, sold or offered for sale, but does not include a private residence.”

The Ontario Public Health Standards include several sections that refer to healthy eating and food premises. Beyond the detailed descriptions of food premise requirements for safe food and food handling, the section on chronic disease prevention notes that local boards of health “shall collaborate with local food premises to provide information and support environmental changes through policy development related to healthy eating”. Menu labelling could be one such policy initiative.

The Toronto Food Strategy identified how the City of Toronto already has many roles, responsibilities, and levers to help make food systems more health promoting.<sup>2, 129</sup> Moreover, one major dimension of a supportive food environment that was identified by Torontonians as important to them is food system transparency. Residents want to know more about their food, in a way that is accessible and easy to understand, and they want City government to champion that kind of food system transparency.<sup>129</sup>

## 10.1. Lessons from TPH DineSafe

Promoting food system transparency is not a new role for the City. Toronto has already demonstrated that it is a leader in food system transparency through the Toronto Food Premises Inspection and Disclosure (DineSafe) program. Federal, provincial, and local authorities all hold responsibilities for overseeing food safety in Canada. Based on its provincial and local (Board of Health) authority over environmental public health hazards, TPH initiated DineSafe in 2001. DineSafe combines food safety inspection and public disclosure for foodservice businesses, food handler training and certification, a quality assurance component, and data management. It was

the first program of its kind in Canada and has become a model for similar programs in localities worldwide.<sup>130</sup> DineSafe makes information about the safety of food establishments freely and readily available to the public, through Inspection Notice postings at restaurants and in detail on the web. The program has also benefited local businesses by providing their customers with a third-party guarantee of the safety standards to which they adhere. A multidimensional evaluation of DineSafe in 2003 and a series of legal rulings since the adoption of DineSafe have demonstrated continued improvements in food safety practices and compliance by operators, fair inspection practices, improved public confidence, and a legally valid role for the City in public disclosure of inspection notices.<sup>130</sup>

## **10.2. Lessons from TPH ChemTRAC**

The City of Toronto has also been a leader in establishing legislation that enables community access to information about other types of environmental risks through Toronto's Environmental Reporting and Disclosure Bylaw (Municipal Code Chapter 423) and the Environmental Reporting Disclosure and Innovation (ChemTRAC) program, developed in 2005 and adopted in 2008.<sup>131,132</sup> This program collects information to support healthy environments while promoting the city's green economy through: requiring businesses and other facilities to report annually on their manufacture, use, and release of 25 toxic chemicals into the air, surface water, or land that are of priority as public health risks; increasing public awareness about toxic substances; and offering support to facilities on how to prevent pollution, especially smaller enterprises.

In the case of both DineSafe and ChemTRAC, public health programming to inform and support Toronto residents as well as operators/facilities is accompanied by legislation requiring information disclosure. In addition, both programs offer dedicated public health supports to businesses in terms of improving the healthfulness of their practices.

# 11. Conclusion

The overarching objective of and rationale for a menu labelling policy for Toronto would be to help make Toronto a more transparent and supportive environment for residents to eat healthily when dining out.

Through provision of readily available nutrition information at the point of sale, menu labelling can help to fill gaps in the availability of facts and inputs that people use towards optimal purchasing and consumption decisions. This is a key part of food literacy and the government's role in championing food system transparency, both of which Toronto Public Health has previously identified as being essential to building a healthy, sustainable, and equitable food system.<sup>2,129</sup>

While it is clear that many objective and subjective factors interact to ultimately shape personal food choices, it does not take away from the clear and increasing evidence that nutrition information is a logical and valid variable that increases awareness and enters into people's food decision making. There is certainly no compelling reason why nutrition information should be hidden or obscured from consumers who wish to use it to inform what food items they order. Accordingly, policy for a more supportive food environment should include interventions to make nutrition information more readily available to support purchasing and consumption decisions.

Menu labelling can serve to link public health and local foodservice businesses to engage with consumer demand in ways that are more health promoting. Certainly, business owners, and especially small entrepreneurs, need government to promote economic growth and to enable them to comply with rules and regulations. They want a fair and consistent approach that will help them to serve their customers well and enable successful operation.

Voluntary guidance for food businesses (i.e., informal standards) and mandatory measures (i.e., formal regulation) are often viewed as mutually exclusive policy options along a continuum of intervention; i.e., voluntary nutrition information disclosure is sometimes offered as an option that should be tried first, and if unsuccessful, could be a reason for moving on to mandatory menu labelling. This reasoning is ostensibly based on the principle of least restrictive intervention that is common in public health.<sup>133</sup> Yet as a public health intervention, the restriction in this case would be to place requirements for information disclosure on private sector food businesses, which, as a policy instrument, is less intrusive than requiring changes to food content.<sup>91</sup> There is no evidence that menu labelling restricts choices of individuals and populations.

In essence, menu labelling can be interpreted as an intervention that represents the role of the state in ensuring that markets operate in a way that promotes the public good. Thus, menu labelling is supportive of Health Canada's two aims for nutrition labelling: to help consumers to make informed dietary choices and to help consumers easily compare foods based on consistent information.

In the US, where menu labelling for major chain restaurants has already been adopted through federal legislation, it has been highlighted that “consumers’ right to truthful information” is the basis for regulations governing the disclosure of nutritional information, both on pre-packaged food and in restaurant settings.<sup>134</sup>

In summary, nutrition information provided through menu labelling is one factor that does inform some individuals’ food decision making when eating away from home. Menu labelling is therefore a policy initiative that should be considered as an environmental intervention that could be used to support public health and the public good. In doing so, it will be important to build in a rigorous and substantive evaluation process to monitor intended and unintended outcomes that can be used to facilitate effective future adaptations of policy interventions in a complex and ever-changing food environment. No single food-related policy will be able to create the complex changes that are needed to improve the overall quality of the eating out environment. Beyond menu labelling, therefore, it will continue to be important to study, test, and evaluate a wide range of environmental interventions to improve public health in the long term.<sup>135</sup>

## 12. Legislation Cited

City of Toronto Act (S.O. 2006, c. 11, Sched. A)

Consumer Packaging and Labelling Act (R.S.C., 1985, c. C-38)

Consumer Packaging and Labelling Regulations (C.R.C., c. 417)

Food and Drugs Act (R.S.C., 1985, c. F-27)

Food and Drug Regulations (C.R.C., c. 870)

Health Protection and Promotion Act (HPPA) (R.S.O. 1990, c. 17)

Ontario Public Health Standards (2008)

United States, Patient Protection and Affordable Care Act (Public Law 111-148, 111th Congress, 2010)

## 13. Appendix: Jurisdictional Policy Experiences with Menu Labelling- Parameters and Practices

Policy/Program	Type	Jurisdiction	Nutrients	Menu items	Information Location	Type of Foodservices	Impact/Evaluation
MPP Gelinas– most recent (Bill 126 omnibus)	Legislation (private members’ bill)	Provincial	Calories; High and very high sodium warnings	All items “sold or served for immediate consumption”	Menus, menu boards, or item label	Chain foodservice premises with 5 or more locations provincially and > \$5 million gross annual revenue	Unknown; draft legislation did not proceed as parliament prorogued Oct.2012
Sodium Reduction Strategy for Canada (see p. 27)	Strategy (working group, now disbanded) recommended a mandatory (or structured voluntary) approach	Federal strategy, but advises provincial legislation	“Nutrition information” (presumably including sodium values)	Standardized menu items, prepared and assembled on-site, “where feasible”	On-site	Establishments “with a high degree of standardization”	Unknown; draft legislation to implement strategy introduced in Nov. 2012 as a federal private member’s bill
Health Check (Heart and Stroke Foundation (HSF))	Voluntary, NGO-led logo-based food product program	National program but provincial implementation	Calories, sodium, fat, and ‘positive’ ‘Health Check nutrients’	Only Health Check menu items	Can be included on menus or other format (e.g., brochure)	Chain restaurant operators	Some consumer awareness data available; no outcome evaluation yet – planned research with University of Waterloo in 2013
BC Informed Dining	Voluntary, provincial government-led; endorsed by HSF and CRFA (Canadian Restaurant and	Provincial; ‘national’ component for chain restaurants involved in BC program	13 core nutrients; calories and sodium highlighted	All standard menu items	Logo on menu; nutrition information via standardized brochure,	Any foodservice operator; Small Business Support Program for operators with <5 locations and <50 employees per	Evaluation currently underway



Policy/Program	Type	Jurisdiction	Nutrients	Menu items	Information Location	Type of Foodservices	Impact/Evaluation
	Foodservices Association)	supported by CRFA			poster, or menu insert	location; mandatory component for provincial publicly funded healthcare institutions to be implemented	
US Federal legislation in Patient Protection and Affordable Care Act	Legislation	National	Calories and contextual information on daily recs Additional nutrients to be disclosed in a brochure	All standard menu items	Menus, menu boards, drive-throughs, vending machines	Chains and related foodservice with 20 or more outlets nationwide	Survived Supreme Court challenge (the Act as a whole); implementation pending
NYC Health Code amendment	Legislation	Municipal	Calories Additional nutrients to be disclosed in a brochure	All standardized menu items; standard refers to all menu items that are served in 'standard' portion sizes and content	Menus, menu boards, drive through menus, food item tags	Foodservice establishments with 15 or more locations nationwide	Overall, no change in calories ordered (large scale evaluation + two independent studies), <b>but after:</b> information was visible to 60-70% of customers; 15-20% of customers report using info and of those, up to ~100kcal (NYC study) / 6% cal (Bollinger study) reduction per order
King County, WA, Health Code provision	Legislation	County	Calories, saturated fat, carbohydrates, sodium	All standard menu items	Menus, menu boards, drive through menus	Chain restaurants with 15 or more locations nationwide	Overall, no change in calories ordered, although later evaluation suggested a reduction in 'high-

Policy/Program	Type	Jurisdiction	Nutrients	Menu items	Information Location	Type of Foodservices	Impact/Evaluation
							calorie' meal orders and some indication of reformulation; subsequently updated to align with US federal legislation
SmartMenu, Tacoma-Pierce County, WA	Voluntary pilot program led by public health department	County	Calories, fat, carbohydrates, sodium	All regular menu items	On menu, in a standardized but optional format	Independently owned and operated foodservice establishments	Nutrition information became more visible to most patrons but was only used by a subset who were estimated to have ordered 75 fewer calories; operational challenges/issues documented in process evaluation
Louisville, KY	Voluntary program led by public health department for smaller restaurants to adhere to US federal menu labelling standards	Municipal (funded via federal grant)	Consistent with US federal requirements	Consistent with US federal requirements	Consistent with US federal requirements	Local restaurants with fewer than 20 locations nationwide	Not yet evaluated

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derived from validated, disease registries maintained by the Institute for Clinical Evaluative Sciences (ICES). Community Health Centre (CHC) visits and non-OHIP claims are not available. Rate ratios for both sexes were created by dividing the local area rate by the City of Toronto aggregate rate. Rates for City of Toronto are not age-adjusted. For information about definitions, data quality & limitations, and selection and preparation of variables, please go to: <http://www.torontohealthprofiles.ca/aboutTheData.php>.

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