

Scientific Advisory Committee on Nutrition

SUMMARY OF RESPONSES RECEIVED TO REQUEST FOR COMMENTS ON SALT & HEALTH DRAFT REPORT

Procedure

The Salt Subgroup agreed at the meeting of 11 September (SACN saltsub02/min04) to alert interested parties to the draft report on *Salt and Health* when it had been placed on the website. The Secretariat wrote to interested parties on 4 November requesting any comments on the draft report to be submitted by 3 January 2003.

Response

- 28 responses were received and are available, in full, in the attached file (Annex 1).

- Responses were received from the following organisations & individuals:
 1. British Dietetic Association (BDA)
 2. British Frozen Food Federation (BFFF)
 3. British Nutrition Foundation (BNF)
 4. British Retail Consortium (BRC)
 5. Cochrane Heart Group (CHG)
 6. Consensus Action on Salt and Health (CASH)
 7. Co-operative Group (Co-op)
 8. Food Commission (FC)
 9. Food & Drink Federation (FDF)
 10. Hooper L, Bartlett C, Davey Smith G, Ebrahim S
 11. Inside Story
 12. Institute of Food Science & Technology (UK) (IFST)
 13. Intercollegiate Group on Nutrition (IGN)
 14. LoSalt
 15. Macnair A
 16. McGee E
 17. Meat & Livestock Commission (MLC)
 18. Medical Research Council, Human Nutrition Research (MRC HNR)
 19. National Heart Forum (NHF)
 20. National Osteoporosis Society (NOS)
 21. Nutrition Society (NS)
 22. Sainsbury's
 23. Salt Institute (SI)
 24. Salt Manufacturers' Association (SMA)
 25. Scottish Consumer Council (SCC)
 26. Socialist Health Association (SHA)
 27. Snacks, Nuts & Crisps Manufacturers Association (SNACMA)
 28. Stroke Association (SA)

- An overview of the responses received is provided in Table 1.
 - 15 respondents were in general agreement with the conclusions of the report
 - 2 respondents agreed with parts of the draft report
 - 4 respondents raised specific points but did not comment on whether they agreed with overall conclusions
 - 7 respondents did not agree with conclusions

- The concerns raised by respondents are summarised, for discussion, in Table 2.

Table 1: Overview of responses received to Salt and Health draft report

General response	Comments	Organisation
<i>Organisations in general agreement with report</i>	<p>Welcome draft report, especially: recommendations for target salt intakes for children; recognition that the key to achieving salt reduction in the diet is to limit addition of salt during processing and preparation of foods; the emphasis on the need for clarity & consistency in information provided to consumers about salt & sodium.</p>	FC Inside Story
	<p>The review has identified a number of important new studies since 1994 COMA report. Results of intervention trials such as DASH Sodium & TOHMS provide substantial new evidence that a population wide benefit likely to accrue from significant reductions in salt intake, which are likely to translate into reductions in hypertension & possibly cardiovascular disease.</p>	MRC HNR
	<p>The conclusions are warmly welcomed. Review of the evidence long overdue & provides much needed support for a government programme to raise consumer & food industry awareness of the risks of a high salt intake. Report makes a sound assessment of the role that salt plays in development of coronary heart disease.</p>	NHF
	<p>Welcome new assessment of the impact of dietary salt on health which is generally rigorous, comprehensive. In agreement with general thrust of report.</p>	NS
	<p>Consider the report to be thorough and comprehensive and broadly endorse the conclusions reached. There are still areas of lack of knowledge & differences over interpretation of existing knowledge, in particular whether it is appropriate to encourage reduced salt intake for whole population. Recent evidence may have shifted balance in favour of doing so.</p>	IFST
	<p>The review is a well researched & carefully prepared document which will be of substantial value to doctors in helping to clarify the evidence for a change in salt intake.</p>	IGN
	<p>Welcome the scope and breadth of the review. Pleased to note that question of salt intake for children has been looked at in depth and suitable conclusions reached.</p>	LoSalt
	<p>Welcome re-evaluation of this subject since 1994 COMA report and the clear conclusions it expresses. Hope this will persuade those who challenge current recommendations to support a reduction in the amount of salt in processed foods and drinks. This should include reducing salt levels in standard product formulations as well as providing low and reduced salt alternatives and replacements.</p>	Co-op
	<p>Welcome the conclusions in relation to the health benefits that a reduction in salt intake would achieve. Strongly support the recommendations for reducing salt intake in adults and children.</p>	SA
	<p>Strongly welcome the draft report but concerned about difficulties of implementing it.</p>	SHA
	<p>Support all the recommendations made.</p>	SCC

	<p>Welcome the draft which provides a much needed comprehensive review of the subject. Confirmation of current recommendations remaining valid since previous work undertaken by COMA will enable consistency of approach. Support the daily target of average salt intake for infants and children from public health viewpoint.</p> <p>Welcome re-endorsement of the COMA recommendation of 6g/d for adults and the target set for children for the first time. This is particularly important in view of the fact that children are now consuming the same amount of salt as adults.</p> <p>Pleased to see draft report on salt and health issued.</p>	<p>BDA</p> <p>CASH</p> <p>Hooper et al</p>
<i>Organisations supportive of parts of draft report</i>	<p>Welcome consideration of salt sensitivity and support the conclusion that a population approach would appear most beneficial for reducing salt intakes. Welcome clear statement with regard to insufficient data to reach conclusions about salt and bone health. Support point made regarding the need for clarity and consistency in the information provided to consumers and the need for food labels to be reviewed with industry and government.</p>	<p>Sainsbury's BRC</p>
<i>Organisations that made specific comments but made no general comments about draft report</i>	<p>See Table 2</p> <p>See Table 2</p> <p>See Table 2</p> <p>Comments relating to schools asking children to buy Walkers crisps to collect tokens for books.</p>	<p>NOS</p> <p>CHG</p> <p>BNF</p> <p>McGee</p>
<i>Organisations not supportive of draft report</i>	<p>See Table 2</p>	<p>FDF</p> <p>BFFF</p> <p>MLC</p> <p>SNACMA</p> <p>SMA</p> <p>SI</p> <p>Macnair</p>

Table 2: Issues for discussion arising from responses received to report

Subject	Comments	Organisation
<i>General</i>	The evidence base drawn up is principally concerned with short-term experiments of raising or lowering BP in response to varying dietary consumption. Focus on acute effects may underestimate the population impact of an overall lower salt diet over a lifetime.	NS
	Lack of scientific consensus on the benefits of restricting salt intake for normotensive population.	MLC
	The data since 1994 does not provide stronger evidence of an association between sodium & hypertension but indicate potentially more fruitful approaches than salt reduction to reducing hypertension.	FDF
	Lack of any clear indication of potential health gains in terms of life years saved or costs involved. Reference made to uncited evidence from food industry on feasibility of lowering salt content of processed food; helpful to know how much reduction was achieved and cost.	CHG
	<i>Health outcomes</i> are the legitimate public health concern and not intermediate variables such as blood pressure. Mistaken focus on blood pressure to the exclusion of hard end points of cardiovascular disease & all-cause mortality has confused scientists, distracted public health leaders & stalled effective attack on public health nutrition interventions to reduce cardiovascular disease. Blood pressure does not matter if there are no discernible improvements in morbidity & mortality.	SI
	The entire report should be rewritten as it does not address the <i>key issues</i> and represents a highly biased, inappropriately focused and arbitrarily interpreted commentary resulting in misdirected dietary recommendations.	SI
	SMA rejects draft conclusions of the report which is unbalanced, superficial, and lacking in evidential support. Without compelling evidence of what constitutes a <i>healthy</i> range of salt intake, public health policy should not dictate population intake levels. There is no consistent evidence that current UK salt intake causes high blood pressure or disease in the general population.	SMA
	Potential health dangers of sodium restriction have been ignored and report dismisses the possibility that low sodium intake may be linked to increased mortality & effectively ignores all other dangers.	SMA
	Relationships between intakes of sodium & potassium and blood pressure not most appropriate subjects of study for a committee advising on nutrition but should rather have been reviewed by cardiovascular & renal physiologists.	Macnair
	Seems likely that number of deaths in heat waves will increase if recommendations for salt intake are followed. This effect may be exaggerated by current trends in climate change.	Macnair
Disappointed that no reference made to use of salt replacers or their suitability for children.	Sainsbury's BRC	
As only about half the hypertension in the community is generally diagnosed, the report tends to underestimate the potential impact of typical salt consumption levels on population health.	NS	

<p><i>Dietary Exposure</i></p>	<p>Figure of 15-20% quoted for levels of discretionary salt likely to be on high side & suggest 10-15% more realistic.</p> <p>The figure of 9g/d quoted as current intakes is based on 1987 data & doesn't take into account the significant reductions of salt content of manufactured foods since 1987, e.g. in bread.</p> <p>Important to obtain accurate figures for current salt intake so magnitude of task facing industry can be properly assessed. SACN report & recommendations should not be published until the new NDNS data is available for inclusion.</p> <p>Important to recognise that many food additives are sodium based. In some categories (e.g. cured meat & processed cheeses) sodium contribution from sources other than sodium chloride can be up to 40%.</p> <p>IGD have concluded that impossible to generalise about role of salt in products or levels required. Each formulation is unique and consumers' reactions to change in salt content will vary from one product to another.</p> <p>Misleading to present the figures for meat & meat products together (20.8%). In terms of sodium contribution this amounts to 0.54g compared to 0.98g from cereals suggesting a greater potential for influencing overall salt intake by modifying baked goods particularly as they are lower risk foods than meat & meat products.</p> <p>Report should indicate steps being taken to assess current salt intakes of children.</p> <p>Limiting dairy foods on grounds of their sodium content needs to be considered against child's needs for calcium.</p> <p>Major steps must be taken to work with food manufacturers to achieve reductions at point of food processing, particularly those foods frequently eaten by children.</p>	<p>LoSalt</p> <p>IFST</p> <p>BFFF</p> <p>FDF</p> <p>MLC</p> <p>MLC</p> <p>BFFF</p> <p>FDF</p> <p>SCC</p>
<p><i>Labelling</i></p> <p>(most issues in this section concern FSA)</p>	<p>Clarity of nutrition panel & food labels with regard to salt should be reviewed with industry & government.</p> <p>Strongly support mandatory labelling of sodium content, with this information translated into the salt equivalent.</p> <p>Improvements should be made to labelling of sodium & salt on food products, in particular the translation of sodium content into salt equivalent to provide clearer information for the consumer.</p> <p>Emphasis for labelling has been placed on fat content of products & salt/sodium largely ignored. Information through product labelling will assist consumers in making informed decisions about their diet.</p> <p>Helpful for foods to be marked high, medium or low salt for clarity.</p> <p>Clarification needed regarding the conversion factor for sodium to salt that should be used for labelling purposes.</p> <p>Useful for food labels to carry declaration of target salt intakes in interest of consumer education & choice.</p>	<p>MLC</p> <p>FC</p> <p>SA</p> <p>SCC</p> <p>SHA/LoSalt FC</p> <p>Sainsbury's Co-op/BRC</p> <p>FC</p>

	<p>Recommend alterations to labelling laws so that salt levels in products are shown as percentage of the adult intake target of 6g.</p> <p>Brand owners face difficulties in labelling. Sodium is legally required nutrient in labelling & technically it is illegal to include salt within the nutrition panel. Including both exacerbates consumer confusion.</p> <p>Salt is not the only source of sodium in the diet. Information provided on label should be on sodium rather than salt content as this is accurate, scientifically based, and is the dietary element on which medical debate is based.</p>	<p>LoSalt</p> <p>Co-op</p> <p>FDF</p>
<p><i>Evidence for relationship between salt intakes and blood pressure</i></p>	<p><u>General</u> Too much attention given to individual trials when systematic reviews provide more robust estimates of effect size. Surprised that SACN thinks chimpanzee trial & DASH Sodium provide strongest evidence given very large number of long-term trials among humans. Partial use of evidence by SACN runs risk of discrediting its conclusions & runs counter to established methods of evidence appraisal.</p> <p>Disproportionate amount of report considers data from extreme dietary distortions such as primitive populations & restricted animal studies.</p> <p><u>Animal data</u> Use of animal studies for this health issue not appropriate or necessary.</p> <p>With chimpanzees the association is neither simple nor relevant.</p> <p>Inordinate amount of space devoted to small questionable study where majority of chimpanzees, fed 15 times their normal salt intake, became hypertensive. Fails to point out adequately the difference in human physiology.</p> <p>Rat data irrelevant to humans consuming normal diet.</p> <p>Only reliable studies with any true relevance are randomised intervention studies in man.</p> <p><u>Intervention studies</u> A recommendation should be included in summary & conclusions of this section & in main conclusions around TONE study where older hypertensives had been able to remain off medication by successful combination of weight loss & salt reduction intervention. SACN should also recommend that DH disseminate such findings with Royal Colleges etc. to encourage GPs to help their patients make lifestyle changes.</p> <p><u>DASH/DASH Sodium Trial</u> Most relevant conclusion is that diet high in fruit & veg with reduced total & saturated fat has highly significant impact on BP in hypertensives & normotensives whereas reduction in sodium has little impact.</p> <p>Greatest reductions in BP observed when DASH diet combined with low salt diet. Additive effect supports view that healthy whole diet most effective as population-based approach to lowering BPs.</p> <p><u>Meta-analyses</u> Conclusions of the different analyses conflict with each other.</p> <p>This section should include systematic review by Hooper et al.</p>	<p>CHG</p> <p>SMA</p> <p>SNACMA</p> <p>SNACMA/FDF</p> <p>SMA</p> <p>SNACMA</p> <p>Macnair</p> <p>NHF</p> <p>SNACMA/FDF</p> <p>MLC</p> <p>SNACMA/FDF</p> <p>Hooper et al BDA</p>

	<p>Too much prominence given to McGregor & He's meta-analysis. Their estimate of effects larger than those obtained by other systematic reviews which raises questions of methodology, as same evidence has been included in these reviews.</p> <p>Every respected meta-analysis of research since the 1994 COMA report has concluded evidence does not support any recommendation to reduce salt intake for the general population. The latest such review by Hooper et al (2002) also reached similar conclusion which has been ignored.</p> <p>Several meta-analyses & reviews since 1994 (Midgley et al 1996, Cutler et al 1997, Graudal et al 1998) consistently show that effect of salt restriction on blood pressure in normal healthy subjects is clinically irrelevant and do not form basis for recommendation to restrict salt intake on population wide basis.</p>	<p>CHG</p> <p>SMA</p> <p>Macnair</p>
<i>Salt sensitivity</i>	<p>Potassium also has role in determining salt sensitive status so those with inadequate potassium intake will respond to excess sodium.</p> <p>Support population approach for reducing salt intakes however targeted advice may be required for some ethnic groups who have higher intakes.</p> <p>Increase in blood pressure with age appears to occur irrespective of salt sensitivity & salt sensitivity in normotensive population rather high which alone implies need for public health measures. Final sentence of para 4.32 should be separate para to emphasise that greatest benefits are likely to be achieved by taking population approach to reducing salt intakes.</p> <p>People with high BP do not consume more salt than normotensives. Vital that the phenomenon of salt sensitivity is characterised in order to identify & develop predictive markers for such individuals. Advice & possible medical intervention needs to be targeted at those most at risk.</p> <p>The conclusion that since <i>some individuals</i> will display an inability to cope with excess salt at lower levels of intake than others, <i>everybody</i> should be persuaded to restrict their salt intake, is little short of bizarre. There can be no case for recommending salt restriction in any individual in whom it has not been shown to be effective, since it may be harmful.</p>	<p>SNACMA/FDF</p> <p>Sainsbury's BRC</p> <p>NHF</p> <p>MLC</p> <p>Macnair</p>
<i>Role of other factors in hypertension</i>	<p>Other factors only considered briefly, creating the impression that salt intake is the major factor controlling BP.</p> <p>Whole area of minerals & hypertension should have been reviewed, particularly the interdependent role of sodium & potassium.</p> <p>General area of potassium nutrition and its consequences in relation to hypertension should be further investigated.</p> <p>SACN should take a closer look at importance of other nutrients in lowering BP including role of potassium, folate, calcium, magnesium, and fish oils should be considered further.</p> <p>Nutrition issues need to be considered in context of healthy lifestyles.</p> <p>Lack of physical activity has much greater impact on BP both directly & indirectly through reducing body weight.</p>	<p>SNACMA</p> <p>SNACMA/FDF</p> <p>FDF</p> <p>FDF</p> <p>SNACMA/FDF</p> <p>SNACMA</p>

	<p>Need to consider how effective different strategies are & if reducing salt intake is the most beneficial approach. Would be valuable to acknowledge that physical activity is essential. Lack of reference to physical activity is of greater significance in section 6 on infants & children.</p> <p>SACN review has elevated salt disproportionately, when balance of evidence suggests that obesity, inactivity, and excessive alcohol are the primary risk factors for high blood pressure.</p> <p>Role of stress on blood pressure should not be ignored.</p>	<p>FDF</p> <p>SMA</p> <p>FDF</p>
<i>Salt and other health outcomes</i>	<p><u>Renal disease</u> The role of sodium/salt in the treatment of renal stones, nephrotic syndrome & renal failure should be considered.</p> <p><u>Osteoporosis</u> Helpful to provide quantification regarding the “high salt intakes” associated with increased urinary calcium loss.</p> <p>Use of Ginty reference to support statement about short-term high intakes of salt causing calciuria in men & women of all ages is misleading as study only focused on young women.</p> <p>Sodium chloride supplementation study (Evans et al, 1997) should be included. A marker of bone resorption was found to be higher in post menopausal women on high sodium diet compared to low sodium diet. Also, the most recent sodium chloride supplementation paper (Sellmeyer et al, 2002) is not included. This study found a significant increase in urinary calcium excretion & bone resorption in postmenopausal women on 4wk high salt diet.</p> <p>Several observational studies examining relationship should also be included (Greendale et al 1994, Devine et al 1995, Matkovic et al 1995, Dawson-Hughes et al 1996). Results are conflicting but are important to overall picture.</p> <p>Findings of DASH & DASH Sodium trials should also be commented on regarding their findings for calcium & bone metabolism.</p>	<p>BDA</p> <p>NOS</p> <p>NOS</p> <p>NOS</p> <p>NOS</p> <p>NOS</p>
<i>Targets recommended for salt intake</i>	<p>Adults defined as 15 years upwards. Suggest wording amended to read “people” aged 15y upwards.</p> <p>Clarification required regarding why no differentiation between men and women & whether there are plans for differentiated targets. No scientific evidence to support changing from current on-pack GDAs to single figure of 6g/d.</p> <p>Difference between <i>daily target intakes</i> and RNIs/DRVs need to be clearly explained.</p> <p>To achieve a reduction from 9 to 6g for adults and the lower amounts for children can have considerable ‘personal & social costs’ (Swales 2001).</p> <p>Important to be clear that 6g/d target intake is 50% above RNI. In DASH Sodium, the group with the lowest sodium intake & greatest decrease in hypertension consumed less than current recommendations (4g/d). Whilst reduction to 6g/d worthwhile goal SACN should emphasise that, on scientific grounds, the target is 4g/d so that it can be incorporated into strategy to reduce intake in stepwise manner towards RNI.</p>	<p>Sainsbury’s BRC</p> <p>Sainsbury’s Co-op BRC</p> <p>Sainsbury’s BRC</p> <p>MLC</p> <p>MRC HNR</p>

	<p>Anxious that target of 6g/d does not lead to unrealistic & unattainable expectations for the public & for food manufacturing industry. Processed foods are not the only source of sodium in the diet & future recommendations should take discretionary salt & naturally occurring salt into account.</p> <p>Degree of urgency in implementing targets for salt reduction in terms of lives saved by reduction in coronary deaths and stroke.</p> <p>SACN to note that WHO has set a worldwide adult target for salt intake of 5g/d.</p>	<p>FDf</p> <p>CASH</p> <p>CASH</p>
<i>Implementation of recommended targets</i>	<p>Report should acknowledge that a relatively long period of time is needed to bring about cultural shift necessary for recommended changes in salt intakes.</p> <p>Question whether the strategy of food industry lowering salt levels in processed foods in isolation of other efforts could be expected to result in a gradual lowering of population salt intakes over time. Reasons for this include consumer acceptability & their expectations of product shelf life.</p> <p>Essential that consumer safety not compromised by any reductions in salt content.</p> <p>In the short to medium term it is important to be realistic about what can be achieved with regard to salt reduction in products. Bread is a relatively low risk product from microbiological safety point of view, however risks substantially higher for other products, e.g. meat products. Whilst food industry aware of need for action, some sectors face greater problems than others.</p> <p>The very high levels of salt added to foods aimed at children by manufacturers means it is vital for Government to give particular attention to the improvement and control of children's food and SACN should make this explicit in its final report.</p> <p>The main source of salt in children's diets is cereals & cereal products. As both these food groups are promoted as healthy staples for children & are eaten in large quantities, it is especially important for salt levels to be reduced/removed from these foods.</p>	<p>Sainsbury's BRC</p> <p>MLC</p> <p>MLC/FDF</p> <p>MLC</p> <p>NHF</p> <p>FC</p>
<i>Children</i>	<p><u>General</u> Useful to add a paragraph with a summary of the evidence on dietary salt intake in infancy & early childhood to follow approach adopted in reviewing the evidence for adults. This would help in assessing feasibility of targets and lay basis for formulating guidance on food preparation for young children.</p> <p>Extremely concerned about provision of recommendations for children when there is such a paucity of data and no evidence on the need to reduce intakes or the efficacy of doing so.</p> <p>Concerned about potential risks of hyponatraemia as children can be particularly active & lose significant amounts of sodium through sweat.</p> <p><u>Recommendations for target salt intakes</u> Some representation of how proposed salt-restricted diet might look for different age groups when a reduction in salt is incorporated alongside targets for energy and other nutrients.</p>	<p>NS</p> <p>SNACMA FDF/SMA</p> <p>SNACMA FDF</p> <p>BNF</p>

	<p>Approach used to set the target limits not clear. The explanation for approach (RNI X 1.5) does not match figures given, e.g. should be 2.4g for 1-6y.</p> <p>Recommended targets for children have been presented as whole numbers rather than to one decimal place, e.g. 2g instead of 2.4 for 1-6yr olds. This discrepancy of 20% could mean the difference between a nutritious food being included or excluded, e.g. thin slice of bread provides 0.38g salt.</p> <p>Further consideration should be given to restricting daily target intake to 3g for 7-10y age group (or at the most 4g) to match LRNI & RNI figures given by COMA.</p> <p>Target levels set for children very low and may not be realistically achievable on a healthy diet with sufficient energy & other nutrients. Target levels may deter consumption of foods of nutritional importance for children (e.g. cheese, milk).</p> <p><u>Age Groups</u> Clarification needed regarding age of “children”.</p> <p>Basis of choice of age ranges not clear. Age groups not consistent with DRVs and have no scientific basis. Clarification required of approach used to set target levels and age groups used. Without strong scientific data to support alternative age groupings, age groups set out in DRV report should be used.</p> <p>Age groups cover too wide an age band. For example, the diet, lifestyle, and total food intake of 7y girl would be substantially different from that of 14y boy. This age band covers small children through to age of puberty. Similarly diets of 1y old would be substantially different from 6y old.</p> <p><u>LVH</u> Occurrence of LVH in children related to BP measurements not sodium intake. The condition may be genetically determined.</p>	<p>Sainsbury's BRC</p> <p>BNF</p> <p>FC</p> <p>Sainsbury's BRC</p> <p>SNACMA BRC</p> <p>Sainsbury's BRC</p> <p>FDF</p> <p>SNACMA</p>
<p><i>Conclusions</i></p>	<p>Despite reasonable interpretation of research data within body of text, the overall conclusions do not match this information. Data since 1994 demonstrate limited impact despite reductions in sodium intake.</p> <p>Evidence has not been provided to support the unchanged recommendations. In particular, there is no evidence that average British salt intake is other than a physiological norm.</p> <p>The point made regarding clarity & consistency in information provided to consumers (para 5.12) should be included in the conclusions.</p> <p>Conclusion 7.7 should be extended to cover foods prepared and/or served outside the home & to use of salt in home cooking & at the table.</p> <p>Helpful if there could be a summary section indicating the strength of the evidence for the various conclusions & the research necessary to bring evidence up to levels regarded as necessary for clinical guidelines. The future need to tailor advice for individuals depending on genetic polymorphisms & for more specific advice in relation to disease states other than hypertension would make such a summary of proposed future research even more relevant.</p>	<p>SNACMA FDF</p> <p>Macnair</p> <p>Sainsbury's BRC</p> <p>IFST</p> <p>IGN</p>

	Disappointed that no mention made of communication in conclusions section or the need for Government to make commitment to providing education about the role of salt in food.	Sainsbury's BRC
<i>Research recommendations</i>	<p>Report identifies a number of key areas for future research. It would be useful if these recommendations were brought together to bring them to the attention of researchers & funders to stimulate progress.</p> <p>Research needed to assess whether "home prepared" meals are lower in salt than prepared ready meals. Further research also required on the contribution of foods eaten outside the home to overall salt intakes in UK.</p> <p>Further research should be carried out to assess feasibility of the target levels & their potential impact on the overall diets of children.</p> <p>Research to identify multiple genetic polymorphisms that contribute to variability of BP responses to salt needed as matter of urgency.</p>	<p>MRC HNR NS</p> <p>Sainsbury's</p> <p>Sainsbury's</p> <p>MLC</p>