No 192
April 2015

Salt Skip News

Published in the public interest on the web at www.saltmatters.org

*The **business address** of the Salt Skip Program is Queensland Hypertension Association PO Box 193, Holland Park, QLD 4121, Fax (07) 3394 7815.*
Use the **editorial address** when writing about the newsletter—see the panel on page 4.

Are Current Dietary Guidelines for Sodium and Potassium reasonable?

A recent study looked at how well people in France, Mexico, the United Kingdom and the United States are meeting World Health Organisation dietary goals for limiting sodium and increasing potassium intake. The data confirmed that people in all those countries eat too much sodium and not enough potassium. But they also suggested that the daily targets proposed by WHO and other health agencies may be out of reach.

The WHO recommends we consume at least 3510 mg of potassium daily, again to lower our odds of heart disease and stroke.

To reduce the risk of heart disease and stroke, the World Health Organisation recommends we consume no more than 2000mg of sodium a day – less than a teaspoon of salt.

That's a lot of potassium. Potatoes, for example, are considered to be a relatively potassium-rich food. Yet to get to 3510 mg a day you would have to eat about six potatoes day. Or drink 9 cups of milk. Or eat 2 1/2 cups of beet greens -- a day.

So how are these overseas countries doing at hitting the WHO targets?

Dr Adam Drewnowski, Professor of epidemiology who directs the Centre for Public Health Nutrition at the School of Public Health at the University of Washington, wanted to find out. He and five international colleagues looked at dietary national surveys conducted by the governments of France, Mexico, the United Kingdom and the United States.

They found that at best, only 0.3% of Americans, or about three in a thousand achieve the WHO dietary goals. The French do a little bit better, with 0.5% hitting the targets. The Mexicans do a bit worse, with just 0.15% making the mark. The British did the worst with just 0.1%, or one in a thousand, meeting the recommended dietary targets.

"The data confirms that we eat too much sodium and not enough potassium," said Drewnowski. "But they also suggest that the numbers being proposed by WHO and other health agencies are completely unfeasible. The chances that a majority of a population would achieve these goals is near zero."

Are current dietary guidelines for sodium and potassium reasonable? (cont.)

"The problem is that sodium and potassium are found in many of the same foods," Drewnowski explains. "Milk has sodium in it, so if you want to reduce your sodium intake you can drink less milk. But milk also has potassium, so if you want to increase your potassium intake, you have to drink more milk. So you cannot have a recommendation that tells you to reduce the amount of sodium you eat by two thirds and to double the amount of potassium you take in."

You can boost your potassium intake by eating potassium-rich foods, such as greens, citrus and fish, but these foods tend to be more expensive. Including these foods in everyday diet would improve diet quality, but would also add to diet cost. Supplementation is not the answer because potassium has a metallic, bitter taste that would make most foods unpalatable.

Drewnowski said there are several lessons to take away from the new study. First, it will be hard to achieve significant reduction in dietary sodium by consumer education alone. Most of the sodium in the American diet comes from processed foods, including breads, pizza, processed meats and cheese. Reformulating foods to lower their sodium content would be one strategy to reduce sodium intake. But global guidelines need to take global food patterns into account.

"Pizza is a major source of sodium in the U.S. I doubt that this is also the case in Asia," Drewnowski said. "We get too much data from Boston and not enough from Bangladesh.

The bottom line, said Drewnowski, is that dietary guidelines, especially global health guidelines, need to set targets that are reasonable and are backed by backed by more data from low and middle-income countries.

Reference: A. Drewnowski, C. D. Rehm, M. Maillot, A. Mendoza, P. Monsivais. **The feasibility of meeting the WHO guidelines for sodium and potassium: a cross-national comparison study**. *BMJ Open*, 2015; 5 (3): e006625 DOI: 10.1136/bmjopen-2014-006625

Comment: *"The Australian Dietary Guidelines" and the "Australian Guide to Healthy Eating" provide up-to-date advice about the amounts and kinds of foods that we need to eat for health and wellbeing. The recommendations are based on scientific evidence, developed after looking at good quality research.* **Visit www.nhmrc.gov.au**

Making Hard Tack

Have you ever thought how the Australians at Gallipoli could be supplied with food: many thousands of men, at short notice, with no refrigeration?

While they were fighting on Gallipoli the Australian soldiers were supplied with food from as far away as Egypt and Greece, and this, combined with the lack of refrigeration, meant that they could get very little fruit, vegetables, meat or dairy products.

So what did they eat? Bully beef (tinned corned beef), rice, jam, cocoa, tea, some bread and above all *hard tack* fed the Australian soldiers at Gallipoli.

Hard tack, also known as "ANZAC Wafer", or "ANZAC Tile", has a very long shelf life, unlike bread. Hard tack biscuits continued to be eaten during the Second World War and are now known as ANZAC biscuits.

The combination of bully beef, bread and hard tack would have, unfortunately, led to our diggers having a diet high in sodium.

Salt and Vinegar - on your weeds?

Add a cup of common salt to a litre of vinegar. After it's dissolved, brush it directly onto weeds. Remember, it's not a selective weed killer. It'll kill anything it touches so be very careful how you use it.

QHA BP Monitor article (cont.) courtesy of Salt Skip News: "Taking the Specialist to Rural and Remote Communities: Telehealth

How to bridge the geographical gap?

1. Transport patients to the health professional
2. Travel subsidies for patients
3. Transport health professional to the patient
4. Incentives for Doctors to work rurally
5. Royal Flying Doctor Service
6. Medical Specialist Outreach Assistance Program
7. Patients meet health professional virtually
8. Telehealth

Medical Specialist Outreach Assistance Program

Funded by MSOAP, there are advantages and disadvantages of Telehealth:

- **For the Patient:**
  - Able to stay in own environment
  - No disruption to work and family
  - Cheaper for patient
  - No travel and accommodation
- **For the Doctor**
  - Can appreciate environment
  - Links with local health care providers
  - Less time away from work commitments and family
  - Less cost
  - No travel and accommodation

Is a Solution Telehealth?

Is it safe? Cost effective? Do patients like it?

- Videoconferencing
  - Direct patient consultation
  - Case conference to assist in education of primary care
  - Patient education
  - Staff education

Opportunities for Telehealth are increasing

- Telehealth technology is becoming more accessible
  - Network performance is improving
  - Equipment and transmission prices are falling
  - Governments are investing
  - Telehealth infrastructure (NBN, Private Networks)
  - MBS Item numbers

Clinical Essentials for Telehealth

- Easy access to equipment
  - Suitable consulting environment
  - Case preparation
  - Data access
  - Shared records
  - Clinical coordination
  - Scheduling
  - Requires AO support, DNE and consultant
  - Imposition on the receiver end too

Building blocks of Telehealth

- **Funding**
  - Clinicians
  - Clinical support
  - (Technical) operational costs
- **Organisational readiness**
  - Training
  - Change management
  - Work flow realignment
  - Scheduling and records systems
- **Technology**
  - Equipment
  - Connectivity
  - Support

Conclusion - Telehealth

- Specialist consultations for diabetes management via Telehealth are an efficacious and efficient way of managing diabetes in rural and remote Queensland
- Financial incentives to establish Telehealth services with support to both the receiver and provider
- Needs to be some cultural shifts for health professionals to accept Telehealth
- Patients are satisfied and thankful to receive specialist services in a timely manner in their own community.

A big thank you to Associate Professor Anthony Russell for his most informative QHA talk on diabetes care and the role of Telehealth in rural and remote Queensland. *Thank you!*

SALT SKIP NEWS
No 192

April 2015

Page 4 of 4

Salt Skip Program
editorial address:
Malcolm Riley
5 Malcolm St, Flinders
Park SA 5025

Email:
Malcolm.Riley@csiro.au

Salt Skip News will continue to be distributed in hard copy in The BP Monitor (QHA Newsletter)

BP Monitor with Salt Skip News is published every 2 months, from February to December (6 issues a year) and printed by Snap Printing, Felix Street, Brisbane.

Golden Carrot Onion Dressing

Ingredients

- **1 medium carrot, roughly chopped**
- **1/2 cup grapeseed or olive oil**
- **1 tablespoon apple cider vinegar**
- **2 tablespoon orange juice**
- **1/4 white onion, roughly chopped**

Directions

Fill a small pot with 2 inches of water and then place a steamer basket on top, above the water. Place the carrot pieces in the steamer basket and with the lid on, steam over medium heat until the carrots are tender, 12 to 15 minutes.

Then transfer the carrots to a small food processor or blender. Add the remaining ingredients and blend until smooth. Slather, dip, and dress immediately or refrigerate until use. Will keep in the fridge for a week. Makes 3/4 cup.

Note: If you want to increase the flavour and natural sodium, add 1 small yellow beet, peeled and steamed, to the blender with the carrot and other ingredients.

At Salt Skip News, we are always interested to hear from readers. Please send us your Salt Skip news, tips and salt-free or low sodium recipes…

BP Monitor with Salt Skip News is published every 2 months, from February to December (6 issues a year).
Salt Skip Editorial Committee: Prof Michael Stowasser (Director, Hypertension Unit, University of Qld School of Medicine, Princess Alexandra Hospital, Brisbane), RN Cynthia Kogovsek (Hypertension Nurse, Hypertension Unit, Greenslopes Private Hospital, Brisbane), Prof Caryl Nowson (Nutrition & Ageing, Deakin University, Melbourne), Jane Brown (Home Economist, Salt Skip Program, Hobart), and Dr Jennifer Keogh (Dietitian, Australian Institute of Weight Control, Adelaide). Text drafted (edited where other authors are named) by Dr Malcolm Riley, Nutrition Epidemiologist, CSIRO. Printed by Snap Printing, Felix Street, Brisbane.