Local policies related to restaurant menu labeling: Barriers, facilitating factors, and the role of local health departments

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and have found that it is complete and satisfactory in all respects,
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Abstract

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Background: Policy development is a public health essential function, but local health departments may have limited policy development capacity. Policy models such as the Advocacy Coalition Framework can be used to understand the policy process and to identify effective points of intervention. Three local health departments in Washington State took different approaches to improve the restaurant food environment. In King County menu labeling was required, in Pierce County a voluntary menu labeling program was conducted in locally owned restaurants, and in Thurston County menus for children's meals were improved in collaboration with a local franchise. This study took advantage of these different policy approaches to build understanding of nutrition policy development processes. **Objectives:** to determine the roles, relationships and barriers related to menu labeling and to identify strategies that health departments can use to facilitate nutrition policy development. **Design:** Thirty-one interviews were conducted with public health employees, board of health members, restaurant owners and the Washington Restaurant Association. **Results:** Policy beliefs are key determinants of policy development decisions; there were differences in beliefs about the appropriate role of public health departments in the marketplace and the relationships between health departments and industry. External

events such as precedent legislation and support from national organizations were important, but played out differently in each county. The structure of the county Board of Health was also a key determinant. Policy learning, or the ability of opposing actors to learn how to find common ground and work together over time, was demonstrated in King County. **Conclusions:** Application of policy development models can build capacity for policy development. Practitioners can use model constructs to structure planning for policy efforts, take a long-term view of the policy development process and be ready to advance policy when the context shifts in their favor.

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I would like to thank the Nutritional Sciences faculty and staff for providing me with an excellent education. I am most grateful for Donna Johnson's guidance, support and many engaging conversations. Special thanks to the BOH members, public health employees, Washington Restaurant Association representatives, restaurant owners, steering committee members and Molly McNees for making this project possible and to Barbara Bruemmer for serving on my thesis committee.

Introduction

Obesity politics, fast food and health disparities

As the prevalence of obesity and associated chronic diseases such as type-2 diabetes continue to increase, obesity politics have largely coalesced around two main frames; personal responsibility versus environmental factors.[1-3] After nearly two decades of targeted individual level interventions have failed to make a dent in obesity rates, public health practitioners have been increasingly looking to environmental and policy level solutions.[4-10] Environmental and policy-level changes have the advantage of being able to benefit all people exposed to the environment and these changes are often more permanent than many public health programs focused on individual-level behavioral change.[5] Many policy advocates have called for an approach to obesity that mirrors successful anti-tobacco work, focusing on environmental factors that protect the population from unhealthy nutrition and make it easier to make healthy choices.[4, 6, 11] Nutrition policies based on anti-tobacco work seek to change social norms to make unhealthy food less accessible, less desirable and less acceptable.[4]

The restaurant environment has been the focus of many of the new proposed environmental and policy-level changes.[4, 12-14] Eating in restaurants and in particular, eating in fast food restaurants, has been identified as a contributor to increasing obesity rates.[10, 15-17] The rise in obesity rates have mirrored increases in eating out, with food eaten away from home now comprising up to a third of total calories consumed.[18, 19] In recent years, sales at fast food restaurants have increased at three times the rate of sales in full service restaurants and nearly three-quarters of total restaurant visits are at fast-food and other chain restaurants.[20, 21] Forty-two percent of the most frequent consumers of fast food are eating at

these chains more than 12 times per month. [22] Most menu items at fast-food restaurants are generally high-calorie foods, served in large portions.[23, 24] Consumption of fast food is associated with higher intake of calories, and saturated fat, higher BMI, insulin resistance, and an increased risk of obesity and type 2 diabetes.[16, 17, 25, 26]

Fast food is disproportionately consumed by people with lower socio-economic status (SES) who also more likely to be overweight.[27] Multiple studies have shown that residents of low-income, minority, and rural neighborhoods are most often affected by poor access to supermarkets and healthful food, while at the same time the density of fast-food restaurants is greater in lower-SES and minority neighborhoods.[28-36] The environment in restaurants may differ by neighborhood racial characteristics; in Los Angeles, neighborhoods with fewer African-American residents were found to be significantly more likely to label healthy food items and provide nutritional information, than restaurants located in neighborhoods with a higher proportion of African American residents.[33] A 2009 review of the impact of neighborhood differences on food access found that residents with limited access to fast-food restaurants have healthier diets and lower levels of obesity.[34]

A variety of public health strategies have been proposed to reduce the effects of exposure to fast food. These include: 1) providing customers with nutrition information at the time of purchase (menu labeling); 2) increasing knowledge and awareness about healthy food choices; 3) encouraging restaurants to offer healthy menu items; and 4) using zoning ordinances to limit the density of fast food outlets.

Menu labeling

In March 2010, the passage of the Patient Protection and Affordable Health Care Act, made restaurant menu labeling federal law.[37, 38] Section 4205 of H.R. 3590 mandates that restaurants with more than 20 locations nationwide post calorie information and make other nutrient information available to consumers.[37] Prior to the passage of the federal menu labeling law, local menu labeling legislation had been implemented in New York City and King County Washington, several states including California, Massachusetts, and Oregon, and menu labeling legislation was under consideration in many other jurisdictions across the country.[37] New York City's first attempt at menu labeling legislation was passed in 2006 and since then use of menu labeling as an obesity prevention strategy has gained widespread attention from public health practitioners.[37, 39] In Washington State, three counties approached the issue of menu labeling in restaurants with different strategies. In King County, a mandatory menu labeling policy was developed, adopted and implemented. In Pierce County, a voluntary menu labeling program was used to gather data as part of the health department's policy development process and in Thurston County, the health department is studying the impact of healthy food labeling on kids menu's in collaboration with a local restaurant franchise owner.

Policy advocates see menu labeling policy as an area where local public health practitioners can have a larger political impact, by bringing obesity policies to the foreground and setting precedent for officials in other jurisdictions.[1] Local policies can start to change the social norms around unhealthy food with menu labeling hopefully making high calorie food less desirable. If those items are bought less frequently they may also become less accessible as restaurants update their menus to reflect consumer demand.[4] However, these

ideas about changing food environments to improve health need to be evaluated for effectiveness, unintended consequences and actual impact (if any) on health and body weight.[10] Evaluation of the policies that have been enacted are ongoing. Regardless of their effectiveness, the policy development process provides an opportunity to study the interactions between public health departments and the food industry. Beyond the issue of menu labeling, nutrition policy work will continue to involve public health policy advocates, and the food industry and public health practitioners will benefit from taking a deeper look at these interactions.

Study Purpose and Aims

The three counties in Washington State that used different strategies to address the food environment in restaurants provide an opportunity to examine policy development and decision-making within different contexts. The goal of this project is to determine the roles, relationships and barriers related to working with restaurants to improve nutritional aspects of food eaten away from home and to identify strategies that health departments can use to facilitate development, adoption and implementation of policies that address nutritional aspects of food in restaurants.

Specific Aims

1. Examine the interactions among restaurant owners, the Washington Restaurant Association, and local health departments to determine political and contextual factors that are barriers or enablers to the provision of nutrition information in restaurants.
2. Describe the role of local health departments in developing and implementing restaurant nutrition information policies.

In its systematic application of the Advocacy Coalition Framework to study the process of policy development, this research will contribute to the understanding of the barriers and factors that enhance the development of policy related to the provision of nutrition information in restaurants. By investigating the different approaches taken by three health departments, this study will contribute to knowledge about the role of community beliefs and structures and external events in the policy process.

Background

Efforts to promote healthier food choices in restaurants are not new. A variety of voluntary restaurant labeling programs have been promoted over the years, many focusing on labeling heart-healthy menu items and putting other health messages on menus.[40, 41] However, highlighting healthy foods and health messaging on menus has not been shown to be enough to change consumer purchasing behavior.[11, 40] While providing healthy menu items is certainly desirable, some consumers may avoid menu items marked 'healthy' because they believe healthy food is not as flavorful or satisfying.[11, 42] In addition, the use of healthy submenus may lead to a so called 'health halo' in which consumers assume food is healthier than it is and underestimate calories.[43]

In an effort to improve the nutritional quality of food eaten away from home, health experts have called on restaurants on to reduce portion sizes, prominently display calorie information and offer more healthful menu options. Despite over a decade of calls to reduce portion sizes, including the 2001 Surgeon General's *Call to Action*, restaurants have not responded and some chains have even increased portions.[21, 24] About half of the major chain restaurants have voluntarily provided some nutrition information to consumers but that information has generally only been available online or in pamphlets and calorie information has not been prominently posted.[21, 44] Since industry has not responded to voluntary requests to improve the health of food being offered many public health experts believe regulations such as menu labeling may be the most effective way to improve the food environment in restaurants.[3, 24, 45, 46]

Menu labeling

Most people, including health professionals, are unable to accurately estimate the calorie content of restaurant meals.[42, 47, 48] The inability of consumers to identify menu items with the lowest calories, fat or salt is equally poor regardless of education or income level.[49] Regular underestimation of calories consumed, even at just one restaurant meal per week could cause significant weight gain over time.[47] Portion sizes in restaurants have increased and most consumers tend to eat what they are served, assuming they are being given one serving.[21, 22] This confusion about serving size and pricing incentives, whereby consumers are offered larger sizes for relatively smaller increments in cost contribute to the difficulty of calorie estimation.[21]

The restaurant industry has historically been opposed to any attempts to regulate the provision of nutrition information.[45, 50] Industry objections are generally focused on what they argue is an unreasonable cost burden including the cost of changing menu boards, conducting nutrient analysis and lost revenue if posting the information results in decreased purchasing.[22, 45, 51] The restaurant industry is motivated by profit and by law (Dodge v. Ford) businesses can only pursue interests other than profit when required by regulation.[45] Industry also argues that nutritional information is already available in-store or online, that consumers don't want or won't use nutrition labels, and that requiring calorie information to be posted is a violation of individual freedoms.[42, 52] Industry benefits from the use of personal responsibility rhetoric in framing issues of food choice and obesity because they can continue to claim they are providing people 'choice' and that consumers are free to choose.[45]

Public health advocates have argued that most chains have already done a nutrient analysis on their menu items and frequently update their menu boards so providing nutrient

information at point of purchase should not be an unreasonable burden.[44] In addition, the nutrition information currently made available in-store or on a website may not be helpful to consumers. The in-store information can be hard to find and an observational study found that fewer than 0.1% of consumers access that information, suggesting it is neither accessible nor useful.[53] It's unrealistic to assume that most people will look up nutrition information online before going to a restaurant, particularly fast food restaurants where speed and convenience is part of the draw.[18, 42] Industry claims that consumers don't want this information don't hold up; nationwide and statewide public polls indicate broad public support for menu labeling.[49, 54-61] In a 2009 study conducted among a random sample of community members and high school students in Minneapolis, MN more than three-quarters of participants said they would use posted calorie information when ordering.[54]Among a low-income, minority population in LA County 93 % thought that calorie information was 'important' and 86% thought that restaurants should be required to post calorie information on their menu boards.[62]

Potential Impact of Menu Labeling

The restaurant industry has also objected to menu labeling regulations with the claim that there is no evidence that menu labeling will have an impact on either consumer purchasing behavior or, in the long run, on health and body weight.[22, 51] The scientific evidence on the effect of menu labeling on consumer purchasing behavior has been mixed. A 2008 review of eight experimental studies found that menu labeling showed some efficacy in six of the studies, and no effect in two of the studies reviewed.[63] Other studies have found that calorie and fat content information on menus may not modify the food-ordering behavior

of adolescents and may even lead to the purchase of higher calorie meals, particularly among males.[64, 65] However, many of these studies have major methodological flaws including use of a non-naturalistic setting, lack of randomization, or use of proxy measures of food intake.[63] More recent studies have attempted to address some of the methodological flaws of past studies. For example, a 2010 randomized control trial found there was a significant reduction in caloric intake when calories were labeled on the menu, an effect that was increased when calorie labeling was combined with information about daily caloric needs, resulting in an average decreased intake of 250 calories per day.[66] A 2008 Los Angeles County health impact assessment found that even if menu labeling resulted in only 10% of consumers ordering 100 fewer calories per meal, nearly 40% of the total annual average population weight gain could be avoided.[67] This suggests that mandated menu labeling could reduce population weight gain even if only a small number of consumers made modest changes in response to the provision of nutrition information.

Many of the methodological flaws of past studies can be addressed using real world situations in which to assess the impact of menu labeling on consumers. For example, in a real world setting, prior to the implementation of menu labeling in New York City, nutrition information provided by the Subway chain voluntarily was associated with the purchase of lower calorie meals.[68] Since implementation of the menu labeling regulation on July 2008, evaluation in New York City has been ongoing and to date, two studies have been published.[69, 70] One study was conducted in restaurants in low-income, minority communities in New York City, comparing purchasing behaviors before and after menu labeling with a control population in New Jersey where restaurants were not subject to menu labeling legislation. The study found that almost half of the respondents in New York noticed the

calorie information and of those nearly a third said it influenced their food choices. However, there was no reduction in calories purchased after menu labeling by any group.[70] While it is possible that other groups will respond differently to the provision of nutrition information, this study suggests that restaurant labeling regulation may do little to address the disparities in fast food consumption seen in lower income, minority communities. The second study in New York found that the number of people who reported seeing the calorie information increased substantially post-enforcement of the menu labeling regulation and that almost a third of those people say they used that information to make calorie-based purchase decisions.[69]

A final potential impact of menu labeling is the hope that it will spawn a virtuous cycle whereby consumers choose healthier menu items and restaurants respond by making more of those options available, increasing the availability of healthy food and making it easier for consumers to choose healthier items.[4, 6, 42] Although there have been no studies to date on the effect of menu labeling legislation on restaurant menus, menu labeling advocates look to what happened with packaged food labels. In 1989, the federal Nutrition Labeling and Education Act (NLEA) mandated the provision of nutritional information on packaged foods. Following the implementation of NLEA, food manufacturers improved the nutritional quality of existing products and introduced new low sodium and low fat products.[71]

Lessons from New York City's menu labeling and trans fat ban legislation

As the first jurisdiction to implement menu labeling and a trans fat ban in restaurants, the experience of New York City's Board of Health and Sanitation provides a starting point for looking at the effective policy development. Building public support and consensus are

often cited as key to successful policy process, particularly with contentious issues likely to involve industry pushback.[4, 5] In New York City, the Board of Health has been criticized for not including the restaurant association (NYSRA) or other stakeholders before making its menu-labeling rule. However, the Board of Health did use several tactics in an attempt to build public support for the regulation. For example, they responded to public comments and made some modifications to the regulation in response to comments and they conducted public polling about the acceptance of menu labeling. The Board of Health did face legal challenges from the NYSRA who were successful in their first case which was ruled against the Board of Health largely based on the fact that the regulation only applied to chains that had already done a nutrient analysis of their menu items. After revision of the rule, extending the regulation to all chains with 15 or more locations, the second lawsuit was decided in favor of the Board of Health.[72]

Three menu labeling cases in Washington State

In King County, the Board of Health passed a menu labeling regulation (now called nutrition labeling) that requires chain food restaurants with 15 or more establishments nationwide to provide calorie, saturated fat, carbohydrate and sodium information to customers at the point of purchase. King County was the second jurisdiction to pass menu labeling after New York City and pushback from the industry was intense with both the national and state Restaurant Associations involved in trying to block the regulation. After a protracted struggle with industry, including an attempted statewide preemption, negotiations between the Health Department and the Washington Restaurant Association resulted in a revised regulation that was weaker than initially proposed. The final menu labeling went into

effect January 1, 2009. The regulation was recently re-written to comply with the new anticipated federal rules. Evaluation in King County is ongoing. In the one study published to date, an assessment of consumer purchasing in one restaurant chain pre and post menu labeling failed to find any significant decrease in caloric content of the meals.[73] However, it is difficult to ascribe the results of this study to all restaurants affected by menu labeling in King County and as evaluation continues, a more complete picture of the impact of menu labeling may emerge.

In Pierce County, the Tacoma-Pierce County Health Department (TPCHD) developed a voluntary menu labeling project for local, independently owned restaurants. The *SmartMenu* Program was designed to gather data about the feasibility and effectiveness of implementing menu labeling in local restaurants as part of the health department's menu labeling policy development process. The health department partnered with the MultiCare Center for Healthy Living to provide participating restaurants with free nutrient analysis of all of their menu items. Health department staff worked closely with restaurant owners to get standardized recipe information and to then post the nutrient information (calories, fat, sodium, and carbohydrates) on their menus. Evaluation of program found only a minimal improvement in customer purchasing patterns while a process evaluation revealed that it would be unfeasible to continue either as on ongoing voluntary measure or as a recommendation for policy due to the resource intensiveness of the program.[74, 75]

In Thurston County, the Thurston County Public Health and Social Services Department (TCPH) conducted a nutrition environment assessment (NEA) in 2008 to gather local data to inform the development of healthy eating and chronic disease prevention programs. Eating out among families with children was determined to be the area of highest

priority, which resulted in a decision to focus on children's menus at local restaurants. In 2009 TCPH was awarded a Robert Wood Johnson Foundation (RWJF) Healthy Eating Research grant to implement two phases of research in partnership with a local restaurant franchise. The first phase adds availability of healthier items to the children's menu and the second phase tests the marketing of these healthier items. The intent is to help restaurants increase point-of-sale prompts and use labeling of healthier items as a means of creating environments that support healthier consumer selection.

Policy change models

There are a lack of studies on policy interventions in the public health literature, in part because they can be difficult to evaluate.[76, 77] In addition, the public health literature on policy development often lacks theoretical framing, making it difficult to apply lessons learned to future policy processes.[76] Models of policy change provide useful framing for evaluating and understanding policy development across a variety of applications. There are many models of policy change that have been developed in different disciplines. Some of the most well known and useful models include, Punctuated Equilibrium Theory, Advocacy Coalition Framework, Agenda Setting, Messaging and Frameworks, Power Elites and Community Organizing.[78] Applying theories of policy change to real-life policy situations provides a model for understanding why some policy approaches gain traction and move forward while others flounder. This research will make use of the Advocacy Coalition Framework to examine the menu labeling policy development processes in the three cases in Washington State; results can be applied to future policy process involving health departments and industry.

Theoretical Framework

Paul Sabatier and Hank Jenkins-Smith developed the Advocacy Coalition Framework (ACF) to describe the process of public policy development and change over time.[79] The ACF begins with three main principles; 1) a sufficient length of time (at least a decade) is needed to fully evaluate the impact of the enlightenment function of research and policy oriented learning on policy change, 2) policy subsystems, rather than government institutions, are the basic unit of analysis, and 3) these policy subsystems are comprised of intergovernmental and nongovernmental actors that form advocacy coalitions. The ACF understands policy change to occur as a product of two processes: policy-oriented learning (discussed below) and the effect of external perturbations on the constraints and resources of subsystem actors.[79] The ACF was chosen for this analysis because of its inclusion of the impact of external influences, the importance of policy beliefs, and its non-linear perspectives on policy learning. In the past 30 years, the ACF has been applied to over 60 policy situations and has proven useful in understanding many different levels of public policy change.[79, 76,] The ACF has most frequently been used to understand the policy change process in tobacco policy subsystems and has been recommended to public health practitioners as a useful model for understanding public health policy.[76]

According to the ACF, there are four components that can be used to describe and understand a given policy process (Figure 1).

1. Relatively Stable Parameters: factors external to the policy subsystem that are stable over long periods of time. This includes the larger context in which the policy subsystem is operating such as the fundamental legal, governmental and economic structures as well as the basic attributes of the policy issue at hand. In the case of

menu labeling policy, these attributes include the need for restaurants to remain profitable, the frequency with which American's eat away from home and the relationship between dietary behaviors, obesity and chronic disease outcomes. Although the relatively stable parameters impact the constraints and resources of a given policy subsystem, because they are stable factors that are resistant to change they are unlikely to be the subject of advocacy coalition efforts.

2. External Events: dynamic external factors that are often the focus of advocacy coalition efforts to affect policy change. These events can include changes in socioeconomic conditions and technology, changes in public opinion and political power (i.e. critical elections), and the impact of other policy decisions and subsystems. External events can represent opportunities for prepared advocacy coalitions to act when conditions swing in the direction of their core beliefs or they can frustrate the efforts of advocacy coalitions that are not as well prepared to react to the changes.
3. Constraints and Resources: The combination of relatively stable parameters and external events create the constraints and resources that act on the policy subsystem.
4. Policy Subsystems: The policy subsystem is the basic unit of analysis in the ACF and is comprised of the set of actors involved with a particular policy problem. Unlike traditional theories that describe policy change as occurring within a single level of government (i.e. 'iron triangles'), the ACF expands the notion of policy actors to include multiple levels of government as well as nongovernmental actors such as researchers, activists and journalists who form advocacy coalitions within the policy subsystem based on shared values or beliefs. According to the ACF, understanding

any policy change process necessitates investigating the belief system that the policy is based on.

> Beliefs: The ACF identifies beliefs as the overarching driver for policy actors. These are categorized as: (1) Deep core beliefs - essentially unchangeable deeply held personal beliefs such as beliefs about freedom, the role of distributive justice and human nature. (2) Policy core beliefs – fundamental policy positions concerning the articulated policy goals of an advocacy coalition. Policy beliefs include beliefs about the proper scope of government vs. marketplace activity, basic choices about policy instruments, and the identification of social groups whose welfare is of greatest importance. The policy beliefs of an advocacy coalition are resistant to change although in the case of a substantive challenge they can change over time. (3) Secondary beliefs generally concern issues related to the administration and implementation of policy and are the most susceptible to change.

Policy-oriented learning

A fifth concept of the policy process as described by the ACF is policy-oriented learning. Policy-oriented learning occurs primarily either as a result of direct challenge to an advocacy coalition (via opponent challenge or changes in external events) or as a result of accumulated experience, the so-called enlightenment function of policy process that can take up to a decade or more.[79] In general, advocacy coalitions resist challenges to core and policy beliefs and although substantive accumulation of evidence over time can effect changes in a coalitions more deeply held beliefs, changes are usually limited to secondary beliefs.

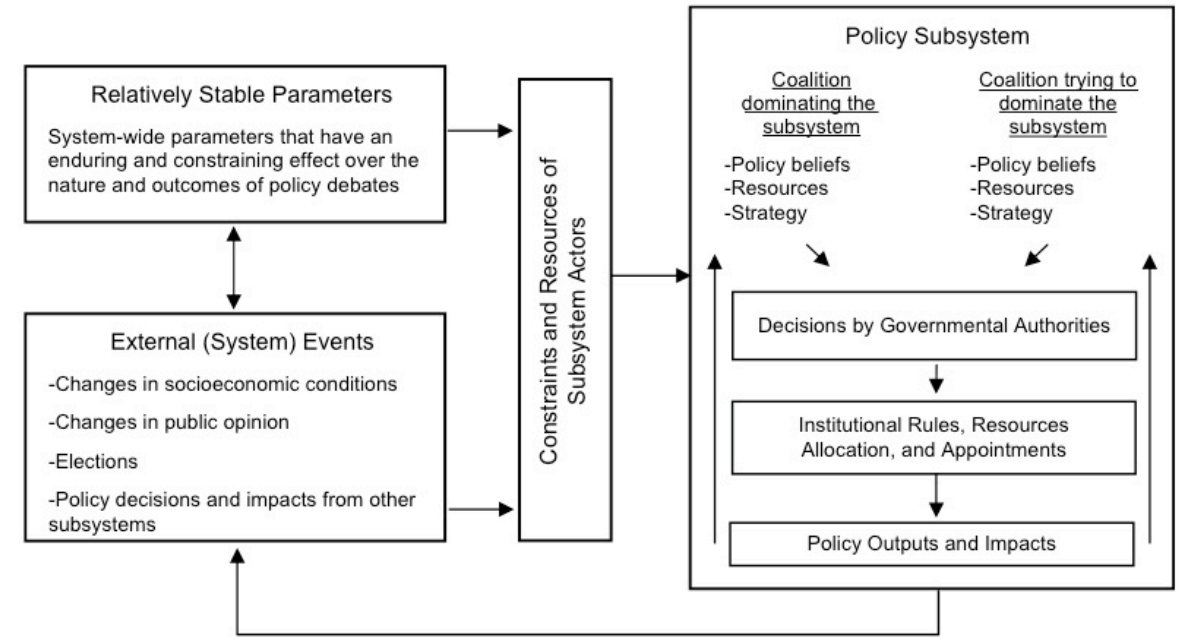

Figure 1: The Advocacy Coalition Framework[79]

Methodology

Study Design

This study will use a multiple-case, replication study design. Sallis and Glanz recommend the use of case studies to best understand the effect that environmental and policy innovations have on communities.[10] The multi-case design takes advantage of the opportunity to study three counties in Washington that took different approaches to providing nutrition information in restaurants, allowing for analysis both within each county and across counties. Public health officials in Seattle-King County, Tacoma-Pierce County and staff from the Thurston County Public Health and Social Services Department pursued three different approaches to addressing the nutritional quality of food served in restaurants, and those three approaches define the three cases to be studied.

Data Collection

A steering committee comprised of one key informant from each county health department was formed. Data collected for this project includes written documentation of the process undertaken in each county and key informant interviews. Documentation was provided by each of the three health departments. Key informant interviews were conducted using a semi-structured, open-ended interview format. Interview guides were created using the responsive interviewing approach described by Rubin and Rubin and the recommendations to interview guide development outlined by Miles and Huberman (Appendix A).[80, 81] Interview questions were designed to explore themes related policy process and change as described by the advocacy coalition framework.

Written Documentation

Steering committee members provided written documents for review related to the menu labeling policy process, project or research study undertaken in that county. Documentation reviewed includes:

- Meeting minutes and agendas (BOH)
- Menu labeling regulation
- Annual division planning reports
- Project summaries and timelines
- Planning documents and project proposals
- Project evaluations, process templates and data collected
- Media reports and press releases
- Marketing and outreach materials

Key Informant Interviews

Steering committee members from each of the three health departments provided a list of potential key informants including public health officials, board of health members, restaurant owners and members of the Washington Restaurant Association. Based on the recruitment process described by Dillman, an email (or letter) introducing the project was sent to 40 potential key informants by steering committee members from each county.[82] An email requesting an interview was sent three days later. Anyone who did not respond to the initial request for an interview was sent a second request three days after the initial request. Some key informant restaurant owners in Pierce County did not have access to email and those individuals were sent written letters of introduction, followed by a phone call five days later. In King County, an internal health department process evaluation was underway and

the principle investigator shared eight interview transcripts. In addition to the transcripts shared, four people were recruited in King County for re-interview, and three of those recruited were interviewed. In Pierce County, 31 people were recruited, and 15 were interviewed; seven did not respond to either the initial or follow-up requests to participate, and nine could not be reached. In Thurston County five people were recruited, and all were interviewed. The Thurston County steering committee member did not include Board of Health members in the key informant contacts, so no BOH members were interviewed in Thurston County. Interviews were conducted by phone, and oral consent was obtained using procedures approved by the University of Washington Institutional Review Board in January 2010. The interviews ranged from 20 to 100 minutes in length and were recorded to ensure complete data collection. The interview sample by county is presented in Table 1.

Table 1. Interview Sample (n)

	Public Health Employees	Board of Health Members	Restaurant Owners
King Co*	**3****	**4**	**4**
Pierce Co	**5**	**5**	**5**
Thurston Co	**3**	**0**	**1**

Plus one additional interview with a Washington Restaurant Association representative
*Transcripts from interviews conducted as part of the health department's process evaluation
**3 public health employees were re-interviewed after being interviewed for the health department's process evaluation resulting in a total of 6 interview transcripts

Data Analysis

Interview results were analyzed using the two-stage analysis process based on the methodology of Rubin and Rubin.[80] In the first stage of analysis the interviews were professionally transcribed and reviewed for key concepts and themes. In the second stage, a coding structure was developed, based on the constructs of the ACF. The initial coding structure was reviewed by another investigator, documents were coded by more than one analyst, and the rational behind the coding was discussed between investigators. Atlas.ti qualitative data analysis software was used to manage coded data.[83] Coded data was explored both within and across cases, looking for patterns and linkages. Data from each case was used to assess the fit to the advocacy coalition framework for policy change, which can strengthen the case study's internal validity. Interview data was triangulated with written materials to increase validity.

Results

The specific political and contextual factors that impacted the provision of nutrition information in restaurants will be reported first, including factors that were barriers or enablers of the policy process in each county. The policy subsystem in each county including the nature of the relationships between restaurant owners, the Washington Restaurant Association and local health departments will be examined and respondent's beliefs about the role of local health departments will be summarized.

Barriers and enablers (constraints/resources) to menu labeling policy development

The Advocacy Coalition Framework (ACF) describes constraints and resources of a given policy subsystem that come from two sources; relatively stable parameters that are basically unchangeable by subsystem actors, and external events that are more dynamic factors that influence the policy subsystem. The relatively stable parameters and external events were similar in all three counties but they had different effects on the policy subsystem in each county. For example, changes in the economy had a constraining effect on the policy subsystem in Pierce County but had less of an impact in King and Thurston counties. Key factors that impacted the policy subsystem in each county are summarized in table 2.

Table 2. Barriers and enablers: key factors by Advocacy Coalition Framework construct in each county

	Relatively Stable Parameters	External Events
King	• Obesity rates • Increased meals away from home • Restaurants need to be profitable	• Political climate/Board of Health • Precedent policy in New York City • Support from national organization
Pierce	• Obesity rates • Increased meals away from home • Restaurants need to be profitable	• Economic recession • Political climate/Board of Health • Industry push-back: New York City, King Co • Federal legislation
Thurston	• Obesity rates • Increased meals away from home • Restaurants need to be profitable	• Funding • Political climate/Board of Health • Industry push-back: New York City, King Co

Relatively stable parameters

The factors that are external to the policy subsystem and have been relatively stable over time include increasing obesity rates, increases in meals eaten away from home and the need for restaurants to be profitable.[84] Respondents indicated that these parameters did play a role in the decisions made in the local health jurisdictions. A few respondents mentioned the relationship between cheap food of low nutritional quality and disparities in health, and some respondents talked about the societal cost of obesity and chronic disease. Board of health members, public health employees and restaurant owners in each county agreed that obesity rates indicate that something must be done. Many respondents said that increases in meals eaten away from home made looking at the restaurant environment an obvious choice and

that they believe that access to nutrition information, particularly calories would likely be helpful to restaurant customers.

While many respondents acknowledged that restaurants are a business and thus need to be profitable, this attribute was discussed differently among certain respondents. In King County, the need for restaurants to make a profit was seen as evidence of the need for regulation because restaurants will not voluntarily do anything that they think might hurt their bottom line. There was an expressed understanding of coming from different perspectives, "…industry is just a different model. Their bottom line is about what are they going to do to make the most profit. Anything that could hurt that, you know, I totally understand why you would want to resist it." (PHSKC2). The choice to target chain restaurants in Seattle-King County was related to the need for restaurants to be profitable since "research tells us that about half of the chains already had the nutritional analysis completed on their menus." (KC002KPH) and these chains would be better able to bear the costs.

In Tacoma-Pierce County there was a similar understanding among respondents that public health objectives and restaurants interests are often at odds, "I mean, a restaurant has one set of objectives which is to make money. I know that at least some of the time that is orthogonal, you know to the goal of providing food of high nutritional quality so that is certainly a dilemma." (TPCHD4). Public health and BOH respondents thought that the main draw of the *SmartMenu* program for restaurants was certainly that restaurants received nutrient analysis and advertising for free and that there would likely be little support for an (unfunded) regulation. Responses from restaurant owners supported this assumption, as one restaurant owner said, "Its probably very slim to none [that we would continue to offer menu

labeling] unless it becomes a requirement. Like I said, its just another hoop that you have to jump through in order to operate. Certainly we are appreciative of the health department and what they have done so far, you know, but with restaurants operating on such a slim profit margin as it is, I doubt that there's little incentive to sustain that." (TPCRO3)

In Thurston County observations about restaurants being businesses tended to be employed as an explanation for using a collaborative approach rather than regulating restaurants. One public health employee commented, "I mean, it's just kind of like business is done, our internal public health business is done a little bit differently and that we might stand a better chance at like developing policy and developing change if we look at them as a partner and recognize that they are a business and they are for profit. They are not a public service." (ThHD2)

Recognition that increased intake of food eaten away from home is likely to be a factor in rising obesity rates was an enabler of work to improve the restaurant food environment in each county. These factors were recognized across all respondent categories, which helped to frame the issue of menu labeling and created a baseline agreement about the issues being addressed. However the need for restaurants to be profitable is an attribute of the policy issue that enabled the development of menu labeling policy in King County and acted as a barrier to policy action in Thurston County. In Pierce County the need for restaurants to be profitable spurred restaurant participation in the voluntary *SmartMenu* program but was seen as a barrier to the development of policy that would require non-chain restaurants to incur the costs of menu labeling.

External Events

External events are dynamic factors outside the policy subsystem. Subsystem actors can often influence these factors and to advance a policy agenda, subsystem actors may try to capitalize on certain changes in external events. External events that impacted policy subsystems in some counties include the rise in menu labeling legislation across the country, pushback from Restaurant Associations including lawsuits in other jurisdictions, support and advocacy from a national organization, the impact of the economic recession, the role of leadership priorities and actions and the political climate in each county. In King County, strong leadership from the BOH and the Public Health director as well as the influence of menu labeling legislation and advocacy nationally enabled the successful passage of the menu labeling regulation. In Pierce and Thurston Counties the external events of changes in the economy, the political climate and lack of leadership support were barriers to the passage of menu labeling policy.

Economic factors

The economic situation in each county influenced health department decision making around menu labeling. At the time that menu labeling policy was being considered in each of the counties, the economy was in recession. In Pierce and Thurston Counties respondents noted that requiring restaurants to take on the additional costs associated with menu labeling would not play well politically. The recession had an impact on the health department in Pierce County, resulting in budget cuts and loss of personnel. The funding structure in Thurston County provided protection from the recession but may also limit programmatic

options. In King County, having a large, well-funded health department may have protected menu labeling work from being impacted by the recession.

In Tacoma-Pierce County the economic downturn resulted in a massive restructuring at the health department involving the loss of many public health employees including a manager who was credited with being the champion of menu labeling. The loss of their champion, coupled with large-scale cut backs, re-prioritization of tasks and the time required for new leadership to get up to speed on the work meant that by the time public health employees were ready to move forward with a menu labeling policy, they were concerned about preemption by the passage of federal menu labeling legislation. The combination of the impact of economic factors and the timing of the federal legislation effectively stalled the policy development process.

In addition, the *SmartMenu* program was incredibly resource intensive and as the data gathered showed only modest changes in consumer behavior it became untenable for the Health Department to continue the project.[75, 74] Restaurant owners who participated in the *SmartMenu* program said it would be a financial barrier to offer menu labeling without support from the health department. Most restaurant owner respondents had either stopped updating their menus with nutrient information or said that they would probably do so sometime in the future as they made changes to recipes or menus.

In Thurston County the chronic disease prevention team was already operating on a 100% grant funded budget, so county budget shortfalls did not result in any loss of resources or personnel on that team. However this funding structure did influence their involvement in menu labeling work. County staff applied for a Robert Wood Johnson Foundation (RWJF) grant to work on healthy kids menus. The grant application was strengthened by pilot data

collected with funding from the CDC Steps to a Healthier US program. This Thurston County Nutrition Environment Assessment (NEA) showed the need for work on children's menus. The RWJF grant funded the healthy kids menu research project which aligns with the results of the NEA but reliance on grant funding means that the work is largely shaped by the terms of the grant; in the case of menu labeling it means conducting a research project rather than using other tools.

In King County public health employee respondents acknowledged that being a larger health department with the staff and resources for chronic disease prevention work probably made a difference in being able to move forward with the menu labeling policy. They also discussed the importance of the BOH using their political clout to defend the regulation, particularly using political connections at the state level to defend the regulation against statewide preemption.

The Board of Health and the political climate

Differences in Board of Health (BOH) structure and philosophy as well as the political climate in each county appear to have made a difference in whether or not menu labeling policy was enacted. King and Pierce Counties both have home rule charter, which means the board of health is established by the county council that appoints members to the board and sets the terms of office, compensation and membership criteria. Thurston County does not have home rule charter, so the board of health is comprised of the three county commissioners who are elected to four-year terms in a general election. Seattle-King and Tacoma-Pierce also have the only combined city-county health departments in the state. Board of Health membership is similar in these two counties, comprised of appointed county

council members, city (Seattle or Tacoma) council members, representatives from other cites and towns in the county and health professionals. Seattle-King has eleven BOH members total, three of whom are health professionals, including the one nonvoting member on the board. Tacoma-Pierce has ten BOH members, including one alternate and an appointed at-large member who is a medical doctor nominated by the Piece County medical society. Thurston County's BOH membership is limited to the 3 county commissioners who may or may not have any background or expertise in health.

In King County, the BOH played a central role in the development of menu labeling policy. Respondents said that the very progressive BOH had been a leader on obesity prevention for years, from sponsoring the community forums on obesity to passing an initiative to do obesity prevention work in 2006. The BOH didn't just pass the menu labeling regulation they really championed it, stood up for the policy and really owned it. Respondents credited the passage of the menu labeling regulation to a combination of having a BOH with a strong political will to do obesity prevention work, the leadership to see it through and the commitment from the new Public Health director, Dr. David Flemming. The BOH voted unanimously in favor of the menu labeling regulation and as one BOH member said, "[T]he BOH was united. We knew that there were objections coming forward from the restaurant industry. But we had very strong support from the community, and from the BOH and from the medical community." (KC011K-BOH) When the regulation was challenged by the WRA in an attempt to get a statewide preemption via a bill sponsored at the state legislature, respondents noted that the BOH was willing to take the risk and really "put in their political chits with state legislature" to keep the state from preempting the regulation.

Pierce County respondents also spoke about having a generally supportive and progressive Board of Health. However, unlike in King County, the BOH in Pierce County did not play a central role in the menu labeling policy process. In Pierce County the drive to do menu labeling work as part of obesity prevention came from within the Health Department. Respondents all discussed the crucial leadership role played by Rick Porso, the public health manager who's position was eliminated in a health department restructure as well as Federico Cruz, the former Public Health Director who stepped down in 2007. One board of health member described a BOH that is divided politically with some pretty conservative "the less government the better" types, but all of the board members were in support of the voluntary *SmartMenu* pilot project. Although supportive of the voluntary approach, BOH members were less enthusiastic about the idea of passing menu labeling regulation. BOH members described how the pushback from industry and the public, 'you shouldn't be forcing this on us', in King County and New York City helped shape their approach. One respondent said, "Number one we didn't want to lose the support of industry. We also wanted to make sure that we weren't seen as pushing something on the restaurants that the public would see as invasive." (TPCBOH2). Another BOH member said that concern about pushback and objections from industry, "that's why it was kind of like we weren't going to mandate anybody doing this" (TPCBOH3). BOH members also mentioned their history with the Pierce County smoking ban initiative and the resulting pushback from restaurants as shaping their approach in working with restaurants this time around.

In Thurston County, although no BOH members were interviewed, public health employees said that advancing a menu labeling policy was never even on the agenda, "[N]o way would our county commissioners or BOH basically support something like that [menu

labeling regulation] either. It wouldn't even be an option here to do something like that. That's not how they look at it" (ThHD2). Respondents described the BOH and leadership at the Health Department as very committed to using a collaborative approach with industry. One public health employee said, "I think that comes from a gradual change that our leadership is really setting the tone, and they've heard from the board over time, too, I think is that we don't want to have a battle every time that there's a public health issue that needs to be addressed." (ThHD1). Because they are a very small and visible BOH that faces elections every 4 years, the county commissioners are likely to be more sensitive to public opinion about BOH decisions than in King and Pierce Counties. Thurston is the smallest of the three counties with a population just over 250,000. One public health employee said, "[E]ven though we're a pretty Democratic county, we have a mix- a very republican mix, lots of military families lots of different things like that. You have to really be careful in terms of thinking through how people look at individualism and individual choices." (ThHD2) As articulated by another public health employee, "I think they (BOH) would have shut it (menu labeling regulation) down immediately. That's not the style of this community. We started doing public health in a community collaborative approach back in the early 90s. The whole philosophy of the department is that we can't do public health without community partners. We cannot do it solely as a government function." (ThHD3)

The influence of other menu labeling legislation and advocacy nationally

Respondents in all three counties discussed the impact of menu labeling legislation being passed in other jurisdictions, along with the resulting media attention as a key factor in bringing menu labeling to the policy agenda. In Seattle-King County, the introduction of

menu labeling legislation in other jurisdictions across the country provided a template for policy action. However, in Tacoma-Pierce and Thurston Counties, the buzz being created in Seattle-King County (and to a lesser degree, NYC) around menu labeling and the pushback from the restaurant industry was cause for concern, decreasing the advocacy potential of menu labeling supporters.

In Seattle-King County, the legislative effort in New York City, including the lawsuit brought by the New York Restaurant Association was particularly helpful. The ruling in the NYC lawsuit was used as a check for the regulation being crafted in Seattle-King County and public health officials in NYC were consulted frequently throughout the process. Another factor that was key to moving the policy process in Seattle-King County was the support of the Center for Science in the Public Interest (CSPI) a national consumer advocacy organization whose mission includes conducting advocacy for health and nutrition. Respondents recalled that the BOH was ready to move on obesity prevention and working on the regulation to ban trans-fat when Margo Wootan, Nutrition Policy Director at CSPI presented on menu labeling at a BOH meeting. "So she gave that presentation and everything kind of changed. The BOH was quite taken with the information and presentation, so was David [Flemming, Public Health Director] and from there we started having meetings…"(KC002K-PH). CSPI had developed model policy language and done a lot of the background work, which made it much easier to move quickly on menu labeling. Public health respondents said that CSPI spent a lot of time working with them and the BOH helping them advocate for and move the policy along.

In Tacoma-Pierce and Thurston counties the lawsuit in NYC as well as the pushback from industry in Seattle-King were viewed as an example of what not to do. Although public

health employees in Tacoma-Pierce County were clear that the *SmartMenu* program was part of their policy development process, as previously discussed some of the BOH members were more supportive of the voluntary approach than moving forward with regulation in part because of concerns about industry pushback. Public health respondents were concerned that what happened in NYC and Seattle-King County might happen if they did move forward with a policy. They knew that though they had enjoyed the support of the Washington Restaurant Association (WRA) during the *SmartMenu* program, that friendly relationship would disappear once a regulation was on the table. In Thurston County, public health employees were watching what was happening in Seattle-King County closely and what they saw made them cautious about how to approach restaurants to participate in their study. They didn't want to look like they were trying to put anyone out of business and restaurants were suspicious of their motives, so felt they had to be careful. On the other hand, some Thurston respondents thought that all of the media attention on the issue changed industry receptivity, "when you call and say I want to talk about this healthy dining thing- they get right back to you! Which makes it easier to partner, have the conversation. What was going on in other places got their attention and they were more attentive to our discussions." (ThHD3)

The policy subsystem

The policy subsystem is the set of actors involved in a particular policy issue over time. The Advocacy Coalition Framework (ACF) further aggregates these subsystem actors into advocacy coalitions that form on either side of a policy issue; however the policy subsystem in King County was the only of the three counties to form true advocacy coalitions as described by the ACF. The policy subsystem actors involved in menu labeling

include health department leaders and staff, industry representatives from the Washington State Restaurant Association (WRA), community members and national organizations. Subsystem actors involved varied in each county and are summarized in table 3.

Table 3. Policy subsystem actors

King	**Leaders:** Board of Health, Public Health Director **Staff:** HEAL*, environmental health **Industry:** restaurant owners (local and national chains), Washington Restaurant Association **Community:** health organizations & advocates **Center for Science in the Public Interest**
Pierce	**Leaders:** Board of Health, former health department manager, former Public Health Director **Staff:** HEAL*, environmental health **Industry:** owners (local, non-chain), Washington Restaurant Association
Thurston	**Leaders:** Board of Health, senior health department leadership **Staff:** HEAL*, environmental health **Industry:** local franchise owner, Washington Restaurant Association

* Healthy Eating Active Living staff of the local health department

In King County, the largest policy subsystem of the three is comprised of a number of diverse actors, which is consistent with the description of policy subsystems as described by the ACF.[79] Within the health department the BOH and the public health director were leaders that championed the menu labeling policy, and health department staff included Healthy Eating Active Living (HEAL) staff and the restaurant inspectors in the environmental health division. Industry included restaurant owners of both the national chain restaurants that would be impacted by the menu labeling regulation as well as locally owned chains and representatives of the Washington State Restaurant Association (WRA). Community members and health advocates came to BOH meetings and testified in favor of the menu

labeling regulation and health organizations such as the American Heart Association, American Diabetes Association and local health advocates signed a letter in support of the menu labeling regulation. In addition, the Center for Science in the Public Interest (CSPI) were advocates for the King County menu labeling regulation, and their collaboration places them within the policy subsystem in King County.

In Pierce County the policy subsystem is comprised of leadership that includes the former Health Department manager, Rick Porso who was credited with championing the menu labeling policy development process as well as the former Public Health director, Federico Cruz, who was supportive of the menu labeling work and the BOH. The staff involved were HEAL and environmental health staff and the industry actors included the local, non-chain restaurant owners who participated in the *SmartMenu* program and a representative of the WRA who was supportive of the voluntary program.

Thurston County had the smallest policy subsystem of the three counties with leadership from the BOH and senior leadership within the health department. Health department staff such as HEAL and environmental health employees were involved in recruiting and working with the local franchise owner. The WRA was also involved in an earlier phase of the project as consultants for the project.

In addition, each policy subsystem has various resources and strategies that are influenced by the constraints and resources working on the subsystem as well as by the actors themselves. The subsystem actors however are most relevant in the formation of advocacy coalitions, the relationships that form within and between coalitions and the belief systems that shape and support the formation of advocacy coalitions.

Relationships

The relationships between members of the policy subsystem were different in each of the three counties. In Seattle-King County, the only one of the three counties to have true advocacy coalitions form around the menu labeling issue, the relationships between and within the coalitions shifted over time, moving from collaborative to contentious and back again. Although the absence of regulation in Tacoma-Pierce County and Thurston County precluded opposing advocacy coalitions from forming, the relationships both within the health department and between the health department and industry were key to moving forward with voluntary programs.

Relationships between opposing advocacy coalition members in King County

In Seattle-King County there were several phases of the policy process during which the nature of the relationships seem to have shifted. In the first phase of the process, as the BOH was developing the menu labeling regulation, respondents described the nature of the relationship between the BOH and the WRA quite differently. The BOH and public health employees generally describe the relationship with industry in the beginning as inclusive and open, saying that the BOH really wanted to bring industry to the table early on in the process, wanted to get their input and hoped to have a collaborative process. The WRA representative and restaurant owners on the other hand described a relationship in which industry was ostensibly at the table but no one was listening to their input. Some restaurant owners were upset that although the WRA was invited to participate in the BOH meetings local restaurant owners were not called to the table until after the regulation had passed. The WRA representative said, “There was no real open dialogue. It wasn't ‘what do you guys think?’ It

was this is what we want to do and we hope that you'll get onboard. Well, how do we have the ownership, or how do we feel like this is the best way to go if we can't even comment?" BOH members said that the WRA was very involved from the beginning, they came to meetings, talked to board members, their voice was heard but it was the minority opinion, "people didn't agree with their point of view but that's not the same thing as being shut out". However, BOH and public health employees realized that though the WRA was included in the process the BOH had fairly made up its mind at that point. One BOH member said, "I think the WRA felt like, 'why did you ask us to the table, you already know what you are going to do?' I think you'll hear that. To a degree they're right. We had already made up our minds that the board was going to go this direction. We wanted them to help us figure our how to do it. They really felt like they were brought in after the horse left the barn." (KC015-BOH)

In addition, there was dissent between the WRA and some of its members. Public health employees spoke about hearing a rumor that some of the big chain restaurant owners were angry with the WRA, thought they weren't doing enough to stop the regulation and wanted the WRA to sue the BOH after the regulation was passed. On the other hand, one local restaurant owner was unhappy that the WRA didn't try harder for a compromise with the BOH and he didn't feel that the interests of local restaurant owners were represented by the WRA. "I don't agree with their position, they are very conservative and out of touch with the Seattle mentality, I don't agree with what they are doing. I think they should have tried to find a middle ground, should have talked to us local restaurant owners about what we want and what would work for us." (KCRO13)

There was also some dissent within the Health Department after the regulation was passed from the restaurant inspectors in the environmental health division who would be the ones to enforce the regulation. Public health respondents said that some of the inspectors didn't see the health impact of menu labeling compared to preventing food borne illness, which is their main responsibility and that there was resistance to performing additional inspection with no additional time or resources. Public health respondents described how important it was to get the inspectors on board with the regulation since they are the health department employees who have the most direct contact with restaurant owners and they historically have good, long-standing relationships with the industry. Efforts to bring the inspectors on board included trainings on the regulation and working with the inspectors to make enforcement of the policy as streamlined as possible.

Changing the nature of relationships between opposing advocacy coalitions in King County

Most of the respondents agree that after the regulation was passed, the stakeholder process, the WRA's attempt to get statewide preemption and the subsequent negotiations between the Health Department and the WRA really changed the nature of the relationship between industry and the Health Department. The health department convened a series of stakeholder meetings after the regulation passed with the intention of collaborating with industry on the implementation of the regulation. Public health employees described the first couple of meetings as very contentious, restaurant owners were furious about the regulation, felt that they had been shut out of the process, not given a voice and now they were being asked for their cooperation. Public health employees talked about how they had to come into the stakeholder process and re-establish trust, rebuild relationships, and that it took a lot of

work. Both restaurant owners and public health employee respondents describe a very congenial, productive relationship between the health department and restaurant owners in the end, "[B]y the time of last stakeholder process, went from a really adversarial, angry first meeting to people who were hugging goodbye, saying how good they felt about the process." (PHSKC2) Although some of the restaurant owners were initially upset about the regulation, all four of the restaurant owner respondents thought that the stakeholder process was very well done. They felt that the public health employees really listened to them, were very responsive and available throughout the process. Public health employee respondents also spoke to the time and effort they put into the stakeholder process, saying it was very important to them to make implementation as smooth as possible and that they learned a lot from the restaurant owners in the process. The health department offered a sort of pre-approval process to restaurant owners where they could send in their menus and get feedback and technical assistance on meeting the regulation, which restaurant owners appreciated. In fact, after implementation, the National Restaurant Association wrote and said that Seattle-King County is being held up as a national model for how government and industry should work together which the public health respondents credit to the stakeholder process and being able to turn around those contentious relationships.

Also crucial to shifting the nature of the relationship between the health department and industry was the attempt by the WRA to get a statewide preemption of the King County regulation and the subsequent negotiations that led to a compromise regulation that replaced the initial regulation. The WRA representative describes the process, "We ran a statewide labeling bill that would have created a consistent statewide standard. King County fought us the whole way through that, and so unfortunately that was very combative there. Through

that though we got them to come to the table and sit down with us and talk through our concerns…Anyway, out of that fortunately we turned into a relationship that became sort of positive. We continued working with them and we found an ordinance that our folks could agree upon."

The role of leadership in shifting relationships

The negotiations between the WRA and the Seattle-King County health department resulted in a compromise regulation that didn't necessarily make everyone happy, but did shift the nature of the relationships between industry and the health department and resulted in the implementation of menu labeling regulation. Public health respondents credit the successful negotiation to the leadership role and negotiation skills of the Public Health Director, Dr David Flemming. Respondents also note that the BOH took an active role in saving the regulation the statewide preemption, calling on King County representatives and using their political clout to block the passage of the statewide bill.

Beliefs

The Advocacy Coalition Framework (ACF) describes advocacy coalitions that form around policy core beliefs. These policy core beliefs are developed based on the deeply held personal beliefs (deep core beliefs) that members of advocacy coalitions have in common although they are not usually articulated. Deep core beliefs are essentially unchangeable. Policy core beliefs are resistant to change and advocacy coalition members will try very hard to preserve the aims of their policy core beliefs. Secondary beliefs are those that are related to the administration or implementation of policy and of the three tiers of beliefs they are the

most susceptible to change. Policy core beliefs related to the role of the health department and the use of regulation as a tool are summarized in table 4.

Table 4. Policy core beliefs by county

	Policy core beliefs: Appropriate role of government, priority of regulation
King	Board of Health and public health employees unanimously endorsed the belief that it is an appropriate role of public health to use regulation when necessary to protect the health of the community
Pierce	Board of Health and public health employees less united on the question of using regulation, role of public health is to educate vs. role is to safeguard public health and regulation is appropriate
Thurston	Public health employees say role of public health is to ensure choice, regulation is only used as last resort

Beliefs about the role of public health departments

In the ACF, beliefs about the appropriate distribution of authority between government and industry are part of the policy core beliefs, the tier of beliefs in between the deep core beliefs and the secondary beliefs. BOH and public health respondents in King County unanimously endorsed the belief that it is an appropriate role of public health to use regulation when necessary to protect the health of the community. One public health respondent said, " We are committed to the fact that the people who live, work and play here deserve to have that information, we hope it will help them make healthier decisions, that's our goal." Many said that while they value a collaborative approach and believe that trying

voluntary measures can be a good place to start, a voluntary approach doesn't always work. Several respondents spoke about the history of public health using regulation to fight communicable diseases and that using regulation is also an appropriate response to chronic diseases like obesity, heart disease and diabetes. Most of the King County respondents also discussed the importance of changing the restaurant environment to support healthy behavior change. Respondents said that policy is the most effective way to change the environment and to reach a lot of people whereas voluntary approaches only change the environment in the restaurants that volunteer. One BOH member said, "They (WRA) wanted it to be voluntary. That's what they kept coming back to. And we had that. That was already in place. Any restaurant at any time, from the beginning of time, has the right and the ability to voluntarily provide that information. A couple were." (KC011K-BOH) These commonly held policy core values suggest that in King County there were shared deep core beliefs among BOH members and public health employees. For example, one of the values held by King County respondents seems to be that the protection of public health is a priority. There may be a belief that humans are resistant to change, necessitating large-scale environmental changes and regulatory force to effect behavior change. There also seems to be a belief in the value of distributive justice, that citizens of King County are entitled to the nutrition information.

In Tacoma-Pierce County there was less of a united position on the appropriateness of using regulation to advance public health priorities. BOH members in Tacoma-Pierce County tended to endorse using a voluntary approach rather than regulation whereas the public health employees were more likely to say that regulation is an appropriate approach for public health to take. Public health employees also spoke about the importance of safeguarding the

health of the community and that obesity is clearly the result of an environment that does not support healthy choices. One public health employee said, "[T]he fact that the population as a whole is becoming unhealthy has terrible side effects for the rest of the community, It's not isolated to just the side effects of an individual. There are economic consequences to society, and there are other consequences as well. If it was a behavioral choice that somebody makes that the consequences were limited to the individual, that's one thing but when society and communities and the environment are shaping people and encouraging people to be unhealthy, then it's our role to step in- especially if there are societal consequences." (TPCHD1) Respondents from Tacoma-Pierce County had a mix of beliefs about the appropriateness of 'policing' restaurants with some of the public health employees and at least one BOH member against any kind of regulation while other public health employees said that regulating restaurants was appropriate. One BOH member from Tacoma-Pierce County said, "this is still a free country even after yesterday (referring to the passage of the Patient Protection and Affordable Health Care Act), you know? We still have choices to make! The less mandated the better." (TPCBOH5) Although this board member's comments were at the extreme end of the anti-regulation sentiments expressed by some of the BOH and public health employees in Tacoma-Pierce County, the overall picture is that there seems to be a lack of a unified belief system in Tacoma-Pierce County. Many of the public health employees seem to share some deep core beliefs with respondents in Seattle-King County such as, the belief that protection of public health is a priority, a belief that humans are resistant to change, necessitating large-scale environmental changes and regulatory force to effect behavior change and a belief in the value of distributive justice, that citizens of are entitled to nutrition information. Other public health employees and BOH members seem to

have different deep core values such as prioritizing freedom (from regulation), and a belief that humans are fairly susceptible to change, and as long as information is available people and industry will make the "right" choice.

In Thurston County public health respondents spoke about their belief that the role of public health is to ensure that people have choices, "[W]e don't resort to the regulatory hammer unless we have to, unless it becomes a pressing public health emergency type of situation." (ThHD1) Respondents spoke about the department philosophy of collaborating with industry and making sure to align public health interests with business models in order to ensure successful projects. For example, the hope with the current menu labeling research is that they will be able to demonstrate that food labeled 'healthy' on the menu will sell, hopefully even outsell other items. From there the plan is to use that information to persuade other restaurants to feature healthy alternatives on their menus. Respondents said that if they can't demonstrate that healthy food sells, healthy menu labeling won't work because restaurants aren't going to add menu items that won't sell. Respondents also spoke about a long history of using a community based collaborative public health approach, beginning in the 1990's with workplace interventions that earned the health department a good reputation with the local Chamber of Commerce. "We are not out here to protect public health at the expense of other interests or other objectives in the community. So if we can achieve public health outcomes without fights- without a protracted court battle and without shutting down a business- that's preferred. We would love business to continue to thrive and public health objectives being that. I think that there is a lot of common ground in that, and that's I think the basis for our department's sort of collaborative approach." (ThHD1) It seems likely that decision makers are influenced by different sets of deep core beliefs in Thurston County

compared to Seattle-King and Tacoma-Pierce counties. Deep core beliefs held by public health employees in Thurston County may include a belief in the priority value of freedom (from regulation), and a belief that human nature is susceptible to change and as long as information is available people and industry will make the "right" choice. In terms of distributive justice, Thurston County respondents seem to believe that the provision of nutrition information in restaurants is useful but not necessarily of paramount importance.

Clearly there is a need to balance entrepreneurial freedom with the use of public policy and regulation that aims to protect the public. In each of the counties that form the three cases in this study, the tension between the priorities of industry and beliefs about the role of public health departments were evident in the confluence of factors that influenced the work to improve the food environment in restaurants. In King County where advocacy coalitions formed, these tensions were the most obvious, but respondents in Pierce and Thurston counties also spoke about the different priorities of industry and public health. In all three counties BOH members and public health employees spoke about the need to change the restaurant food environment, to promote and support healthier food environments and choices for consumers. Restaurant owners and the WRA representative also spoke about providing healthy choices for consumers but highlighted the need for restaurants to be profitable, and to be free from the constraints of regulation. As described by the ACF, policy core beliefs about the appropriate role of public health and the use of regulation defined key differences in the policy subsystems in each county and help to explain the process that occurred in each subsystem. A summary of the key results in each county by ACF construct is presented in table 5.

Table 5. Summary of key results in each county

King County
Relatively stable parameters framed the menu labeling policy issue: • Obesity rates • Meals away from home • Restaurants need to be profitable
External events enabled the policy process: • Political climate supportive of regulation • New York City precedent policy • Support from Center for Science in the Public Interest (CSPI)
The policy subsystem, operating under the constraints and resources generated by the relatively stable parameters and external events: • Advocacy coalitions formed around shared policy beliefs • Board of Health champions menu labeling • Menu labeling policy is developed, adopted and implemented • Evidence of policy oriented learning
Pierce County
Relatively stable parameters framed the menu labeling policy issue: • Obesity rates • Meals away from home • Restaurants need to be profitable
External events were barriers the policy process: • Economic recession • Political climate not supportive of regulation • Push-back from industry in New York City, King Co • Federal menu labeling legislation passed
The policy subsystem, operating under the constraints and resources generated by the relatively stable parameters and external events: • Health dept restructure, loss of menu labeling policy champion, new leadership • Board of Health, public health employees different beliefs about the role of public health, use of regulation • Board of Health more supportive of voluntary program • Policy development process stalled by threat of federal preemption, new priorities at the health department
Thurston County
Relatively stable parameters framed the menu labeling policy issue: • Obesity rates • Meals away from home • Restaurants need to be profitable
External events were barriers the policy process: • Availability of grant funding • Political climate not supportive of regulation • Push-back from industry in New York City, King Co

Table 5 continued

The policy subsystem, operating under the constraints and resources generated by the relatively stable parameters and external events: • Grant driven funding limits strategies • Board of Health, health dept leadership favors collaboration with industry • Belief that role of public health is to provide choice, support industry • Menu labeling policy development was never an option

Discussion

The overarching goal of this study was to identify strategies that health departments can use to facilitate development, adoption and implementation of policies to improve restaurant food and food environments. This research sought to determine the roles, relationships and barriers related to working with industry to improve the nutritional quality of food in restaurants. Three counties in Washington State that took different approaches to addressing the food environment in restaurants provided the opportunity to investigate three cases with different policy outcomes. Examination of the process that occurred in each county revealed information that will be useful for public health practitioners working with industry in the future.

An aim of this project was to determine the political and contextual factors that are barriers or enablers to the development of policy related to the provision of nutrition information in restaurants. The Advocacy Coalition Framework (ACF) provided an understanding of barriers and enablers that are the product of relatively stable parameters and the more dynamic external events that constrain and provide resource to the policy subsystem. The results of this research suggest that key factors influencing the policy process include the need for industry (restaurants) to be profitable, the impact of economic conditions both on industry and health departments, the presence of precedent or role-model policy, support from national groups, the political climate and leadership support for the policy.

Many of these factors are beyond the reach of subsystem actors while others may represent opportunities for prepared advocacy coalitions to act on. The need for industry to be profitable is unlikely to change, but the differing policy core beliefs in each county led to different strategies for how to approach this factor. Factors such as the impact of economic

conditions, the presence of precedent policy, support from national groups and the political climate are opportunities that prepared advocacy coalitions could exploit in their favor. For example, in King County the menu labeling policy that passed in New York City and the available technical support from the Center for Science in the Public Interest (CSPI) was capitalized on by advocates within the BOH and health department to move menu labeling policy forward.

Another aim of this project was to examine the role of local health departments in the policy development process. Beliefs about the appropriate role of government are closely tied to the process that occurred in each county. In King County, BOH members and public health employees all espoused beliefs about the appropriateness of using regulation to achieve public health aims, which is consistent with the policy process outcome that resulted in the development, adoption and implementation of menu labeling regulation. In Pierce County there was less unity in beliefs, with some public health employees expressing the belief that less regulation the better and other public health employees strongly supporting the use of regulation to support public health aims, a mix of beliefs that is consistent with the more cautious approach to menu labeling policy development that occurred in that county. Thurston County respondents discussed the belief that regulation is not an appropriate option unless proof exists that similar outcomes cannot be achieved through collaboration, and this belief is consistent with the collaborative approach taken in Thurston County and the lack of a policy development process regarding menu labeling.

Other authors have examined the policy process in public health initiatives and similarly found the political climate, economic context and leadership to be important factors. [5, 7, 51] The Advocacy Coalition Framework has been used to examine and describe

anti-tobacco policy processes.[76] With a growing interest in using the successes of tobacco policy to develop anti-obesity policy, using the ACF to understand what happened in each of these three counties is especially relevant. True advocacy coalitions, as described by the ACF, were only formed in King County. The pro-menu labeling coalition, comprised of BOH members, health department employees, community supporters and national organizations was perceived to be dominating the policy subsystem by the coalition opposing menu labeling, comprised of restaurant owners and the Restaurant Association (national and Washington). In challenging the regulation at the state legislature, the anti-menu labeling coalition forced an analytic debate and negotiations with the pro-menu labeling coalition. Challenge by the coalition attempting to dominate the subsystem and the resulting analytic debate is described by the ACF as a classic mechanism through which policy-oriented learning can occur. As predicted by the ACF, the result of the analytic debate was a change to the secondary belief system of the pro-menu labeling coalition, as the negotiations resulted in a compromise re-write of the original regulation. The changes to the regulation were confined to implementation of the policy, or secondary beliefs, while the deep core and policy beliefs of the pro-menu labeling coalition were preserved. As one public health respondent remarked, "We had to compromise, but we got the menu-labeling regulation so it was worth it!"(PHSKC3)

While the ACF proved to be a useful framework for the analysis of policy process in the current study, it may be helpful to combine the ACF with other theories of policy change in order to develop a model that can be applied to a wide variety of public health nutrition policy issues.[76,79] One difficulty of using the ACF as a model is the decade or more required to see the full scope policy change within a given policy subsystem. Applying other

frameworks in combination with the ACF may help broaden the application of theory.[76] For example, in Kingdon's theory of agenda setting, the influence of the ACF's relatively stable parameters and external events can be understood as components of agenda setting, but the time frame is more immediate making it easily applicable to current policy situations.[78] The ACF, which allows for a broader understanding of policy actors, their beliefs and aggregation into coalitions adds depth to other theories of policy change that traditionally describe policy change as occurring solely through the work of policy elites. Combining the ACF with theories of policy strategy such as Messaging and Frameworks or Community Organizing would complement the formation of advocacy coalitions in the ACF while adding useful policy practice strategies.[78]

Implications for Practice

The development, adoption and implementation of policy is an important tool in the promotion of healthier food environments, and public health practitioners can benefit from understanding the factors at play in the policy process. The Advocacy Coalition Framework offers a structure for understanding policy change over time and can help orient policy advocates to barriers and enablers that will need to be addressed for successful policy outcomes.

Building an advocacy coalition is important for the successful passage of policy, and as seen in King County, having leadership support, policy-mentors and the support of other (national) organizations are key. Without a coalition of advocates for a given policy position, policy development is unlikely to get off the ground. In Pierce and Thurston counties, lack of cohesive coalitions advocating for menu labeling policy precluded the development of

policy. Advocacy coalitions are also useful for weathering the inevitable pushback against regulation. In King County the strength of the pro-menu labeling coalition lay in access to political capitol with the BOH and in the alignment of deep core and policy beliefs among coalition members.

Understanding the external events such as the political and economic context can provide information about when it might be strategic to move forward with a policy initiative. Prepared policy advocates will look for favorable conditions and be ready to move on policy when the context shifts in their favor. Policy advocates in King County moved when the national momentum on menu labeling was reaching a high, capitalizing on the resources available from NYC and the Center for Science in the Public Interest (CSPI) to advance their policy core beliefs. Policy advocates in Pierce County were not convinced that the case for menu labeling was strong enough and while they were collecting more evidence, external events shifted and they missed the opportunity to act on menu labeling policy.

Limitations & Recommendations for Further Research

The constraints placed on the respondent recruitment were a limitation of this study. In King County, access to key informants was limited by request of the health department to not re-interview board of health members and restaurant owners who had already been interviewed for the internal process evaluation. Although the health department shared interview transcripts, those respondents participated in a different interview process with slightly different questions being asked. This difference in interview process could reduce the comparability of responses between counties, however examination of the interview data did not reveal any substantive gaps in content covered during the interviews. In Thurston

County, access to board of health members was not granted, and in Pierce County several former health department employees, including the former health department manager widely credited with being the champion for menu labeling policy, did not respond to requests for interviews. Lack of access to such key players in the process that occurred in each county may have led to an incomplete picture of the story in these two counties. It is also possible that the restaurant owners who agreed to be interviewed were those who were the most pleased or upset with the process, and thus those restaurant owners who were more neutral may have not been represented. It is worth noting that most of the interview participants in all three counties appeared to be candid about their take on the process, the relationships and conflicts.

Another limitation of this study is the time frame being examined. According to the ACF, at least a decade or longer is required for analysis of policy change within a given policy process. This study, given the limitations of time, is looking at the menu labeling process in Washington within a much shorter time frame. However, the results of this study may prove interesting in the context of a longer-range look at policy processes involving the health department and the food industry. Future research can use the results of this study to frame the beginning of health department development of advocacy coalitions for work with industry. For example, while the story of menu labeling policy may be over in King County, other policy initiatives for improving the food environment in restaurants, such as sodium or sugar-sweetened beverages, are in their infancy and will likely involve many of the same factors and policy subsystem actors.

Conclusion

Environmental and policy approaches have become an important part of the public health response to reduce obesity and related chronic diseases. Food environments that make healthy food more accessible, acceptable and desirable make it easier for individuals to make healthy choices. Public health practitioners working to improve the food environment in restaurants must balance the need of industry to be profitable with public health priorities and an awareness of the larger policy context. The menu labeling policy process in King County demonstrates that local health departments can advance public health aims through the formation of advocacy coalitions, making the most of the constraints and resources of the policy subsystem and building on leadership support for public health policy.

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Thank you for talking with me today. The purpose of our interviews is to gather information about approaches that can be taken to address the nutritional quality of foods in restaurants. We will be talking to restaurant owners, representatives of the restaurant industry and public health practitioners to put together case studies about what has happened in King, Pierce and Thurston Counties.

No names will be used when we report out our findings for the case studies. I will be happy to send you a copy of the cases for your feedback and review.

In order to make sure that I capture everything that you say, I'd like to record our conversation today. Is that OK with you?

Thanks. Let's get started.

I. Questions for Public Health Informants

Why was your health department originally drawn to the topic of working to improve restaurant foods?

Probes:
- Obesity prevention
- Improving nutrition environments

What factors outside of your health department (such as public opinion, politics, laws, or other events) influenced your decisions about the policy/pilot project/healthy food labeling project?

Probes:
- NYC legislation?
- CSPI, other national org support?
- Proposed Federal legislation (Harkin, etc.)

What external factors, or concerns about the influence of external factors, constrained the decisions that were taken about working to improve restaurant foods?

Probes:
- Food industry concerns & pressures
- Potential law suits
- National restaurant association concerns/pressures

In what ways did the governance (BOH interviewees) or director (PH employees) shape the work?

Probes:
- In what ways did the leadership support the work?
- In what ways did leadership constrain the work?
- Other directives/priorities from leadership?

What resources were used to support this work?

Probes:
- What funding sources were used to support the time of public health staff who worked on restaurant issues?
- Were there other costs associated with this work?

How did you participate in the development of the menu labeling policy (in Seattle-King Co) [or pilot project in Tacoma Co, healthy food labeling project in Thurston Co]?

Probe:
- What was your role in the development of the menu labeling policy (in Seattle-King Co) [or pilot project in Tacoma-Pierce Co, healthy food labeling project in Thurston Co]?
- Who else participated in the process? What were their roles in the process? What were their positions on the issues?

Please describe the relationships between the individuals and groups that were involved in this initiative, both inside and outside the health department.

Probes:
- Who was supportive of improving restaurant foods?
- Who was not supportive?
- How did these relationships play out as decisions were made?

Appendix A
Interview Guide

How important do you think the quality of restaurant food is to the health of the population?

To what extent do you think that the nutritional quality of restaurant food can realistically be improved

How important was it to tailor your approach to populations at high risk for obesity?

Probes:
- How were health disparities taken into account?
- Can you describe decisions that were made to address the impact on high-risk populations?

How do you think that public health should be involved in efforts to address the nutritional quality of food in restaurants?

Probe:
- What is the role of the health department?
- Why do you think this is the appropriate role?

Can you describe roles for any other groups, agencies and organizations in this work?

What information did the health department use to build the case for the policy/pilot project/healthy food labeling project?

Probe:
- What resources were utilized, for example:
- Scientific literature?
- Public support/opinion polls?
- Expert and consumer testimony
- Precedent (i.e. NYC)?

What arguments were made to support the work of public health in improving the quality of food in restaurants?

Probe:
- Importance of health disparities
- Burden of disease/disease management for diabetes
- Ease of implementation

What types of strategies were chosen to implement the policy/pilot project/healthy food labeling project?

Probe:
- Which strategies were useful? Successful? Why?
- Which strategies were less useful? Why?

Appendix A
Interview Guide

How would you define success in the work to address the nutritional quality of restaurant food?

Probe:
- To what extent do you think this has been achieved?

What lessons have you learned in this process?

Probes:
- What would you do differently?
- What was successful?

Now that this policy (pilot/program) is in place, what is next?

Probes:
- What other policies are being considered to address the nutritional quality of foods in restaurants?
- What role does public opinion play?
- What role does evaluation play?

II. Interviews with Washington Restaurant Association Representatives

What factors do you think have lead health departments to focus on the topic of working to improve restaurant foods?

Probes:
- Obesity prevention
- Improving nutrition environments

What factors do you think make the topic of improving the nutritional quality of restaurant foods important to the restaurant industry?

Are there any events that have been especially important to the restaurant industry in this area?

What factors (such as public opinion, politics, laws, or other events) do you think influenced the decisions of public health to pursue the policy/pilot project/healthy food labeling project?

Probes:
- What factors moved the issue of improving the nutritional quality of restaurant food onto the policy agenda?
- NYC legislation?
- CSPI, other national org support?
- Proposed Federal legislation (Harkin, etc.)

How did your board and members participate in this work?

Does your organization, or similar organizations at the national level, have a strategic plan or internal directives that address issues associated with nutritional quality of foods in restaurants?

Probe:
- What can you tell me about this?

How were the association's resources used for this work?

Probes:
- Staff time
- Lobbyists
- Members' time

How did you participate in the development of the menu labeling policy (in Seattle-King Co) [or pilot project in Tacoma Co, healthy food labeling project in Thurston Co]?

Probe:
- What was your role in the development of the menu labeling policy (in Seattle-King Co) [or pilot project in Tacoma-Pierce Co, healthy food labeling project in Thurston Co]?
- Who else participated? What were their roles in the process?

Why was it important for the restaurant association to be involved?

How do you think you influenced the decision making in _____ county?

How important do you think the quality of restaurant food is to the health of the population?

To what extent do you think that the nutritional quality of restaurant food can realistically be improved?

How do you think that the government should be involved in efforts to address the nutritional quality of food in restaurants?

Probe:
- What is the role of the health department?
- Why do you think this is the appropriate role?

Can you describe roles for any other groups, agencies and organizations in this work?

What strategies did the WRA use to influence the work to improve the nutritional quality of restaurant food?

What influence strategies were the most successful? Why do you think they were successful?

How would you define success in the work to address the nutritional quality of restaurant food?
Probe:
- To what extent do you think this has been achieved?

What lessons have you learned in this process?
Probes:
- What would you do differently?
- What was successful?

Now that this policy (pilot/program) is in place, what is next for the restaurant association?
Probes:
- What other nutrition initiatives are being considered?
- What role does public opinion play?

III. Interviews with Restaurant Owners

What are some reasons you are you interested in improving the nutritional quality of foods in your restaurant?

What factors do you think have lead health departments to focus on the topic of working to improve restaurant foods?

Probes:
- Obesity prevention
- Improving nutrition environments

What factors do you think make the topic of improving the nutritional quality of restaurant foods important to the restaurant industry?

Was there input from others that directed how you were able to participate in this work?

Probe:
- National franchise organizations
- Owners/managers/chef

What kind of resources did it take to make the changes at your restaurant?

Probes:
- Staff time – working with RDs, learning how to apply the new regs, training on new food prep methods, etc.
- Working with vendors
- Printing and changing menus, reader boards
- Marketing
- Others?

How did you participate in the development of the menu labeling policy (in Seattle-King Co) [or pilot project in Tacoma Co, healthy food labeling project in Thurston Co]?

Probe:
- Why did you decide to be involved?
- Who else participated? What were their roles in the process?

Did you feel that you were part of the decision making for this project?

Appendix A
Interview Guide

How important do you think the quality of restaurant food is to the health of the population?

Probe:
- Do you think that there are benefits to providing nutrition information in restaurants?
- Do you think that there are benefits to changing the way restaurant foods are prepared to make them more nutritious?

To what extent do you think that the nutritional quality of restaurant food can realistically be improved?

Probe:
- Do you think that this is economically feasible for you?

How do you think that the government should be involved in efforts to address the nutritional quality of food in restaurants?

Probe:
- What is the role of the health department?
- Why do you think this is the appropriate role?

Can you describe roles for any other groups, agencies and organizations in this work?

What changes have been made in your restaurant as a result of this work?

Do you think that these changes will last?

What kind of impact do you think this has this had on your customers? Your business and profits?

Are there other approaches to improving the nutritional quality of food in your restaurant that you think would have provided more benefit?

Do you have any plans for additional changes?

What lessons have you learned in this process?
Probes:
- What would you do differently?
- What was successful?