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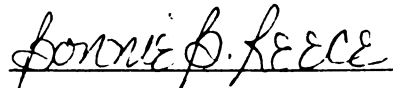
Health Maintenance Organizations
and Media Agenda-Setting

presented by

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**HEALTH MAINTENANCE ORGANIZATIONS AND
MEDIA AGENDA-SETTING**

By

Maxine Kollasch

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ABSTRACT

HEALTH MAINTENANCE ORGANIZATIONS AND MEDIA AGENDA-SETTING

By

Maxine Kollasch

In 1996, the Group Health Association of America (now American Association of Health Plans, AAHP) released findings of a survey that asked Americans about health maintenance organizations (HMOs). AAHP reported that respondents, several of whom had little if any HMO experience, felt “less positive” about HMOs than they used to. AAHP surmised that public opinion was not being shaped by first-hand knowledge while others named a villain--media--and decried media coverage as unbalanced and negative.

Theory on agenda-setting suggests “that the public agenda--or what kinds of things people discuss, think and worry about (and sometimes press for legislation about) --is powerfully directed and shaped by what the news media choose to publicize” (Larson, 1986). This paper investigated the claims of media agenda-setting and bias against HMOs, drawing on agenda-setting research and attitude theory and using content analysis of 94 magazine articles. The findings indicated that media agenda-setting was possible and that media coverage was biased in the unfavorable direction. This paper also addressed the question, “Who else could be influencing public opinion?” and offered a framework in which to consider responses.

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Introduction

Time (22 January 1996) magazine's cover shot of a physician gagged by a surgical mask sparked outrage among managed care¹ proponents. The cover's caption read, "What your doctor can't tell you: an in-depth look at managed care--and one woman's fight to survive."

The article, "The soul of an HMO," recounted the story of a young woman dying of breast cancer who was denied a bone-marrow transplant because her health maintenance organization (HMO) considered the treatment experimental and would not pay for it. Physicians were portrayed as being at the mercy of the HMO. They had little control over the treatment denial and were chastised for even discussing the treatment with the dying woman. The HMO was depicted as a lucrative business run by greedy executives: the HMO executives made millions by controlling physicians and shortchanging patients, regardless of deadly consequences.

In a February 12, 1996, article in *Modern Healthcare* (p. 112), managed care proponents cried foul, calling media coverage of HMOs "unbalanced" and accusing the media of "HMO-bashing." Some managed care proponents fear that a bad public reputation will lead to unwarranted citizen alarm, consumer advocacy and, ultimately, government regulation.

Amidst the claims that media are giving HMOs negative coverage, Group Health

¹HMOs are the most common form of managed care (Miller and Luft, 1994). In this paper, the term "HMO" will be used synonymously with "managed care" unless otherwise noted.

Association of America (GHAA)² released results of a national research study it had commissioned. The research was conducted during 1995 and the results were reported in December 1995. The results showed that “a plurality of Americans say the things they have heard recently about HMOs and similar managed care plans have made them feel less positive toward these plans.” A major phase of the study was a national telephone survey of 1,003 adults, including 222 people enrolled in HMOs; 207 in other forms of managed care; and 404 in traditional fee-for-service arrangements. Six focus groups were also held: two were for HMO members, two for fee-for-service subscribers, and two for health benefit administrators in small- and medium-sized companies.

The report noted that of those who felt less positive toward HMOs, only a few were actually enrolled in HMOs, implying that public opinion is being shaped by factors other than first-hand experience. The report also identified a number of HMO-related themes the public identified as important.

Background on HMOs

“In life,” the old saying goes, “two things are inevitable--death and taxes.” But fear of mortality isn’t the only thing making health care a major concern of Americans today.

For many individuals, cost and accessibility have raised fears. Edwards, Blendon and Leitman (1992, p. 62) report that “61% of Americans worry that health insurance will

²In 1995, the merger of GHAA the American Managed Care and Review Association was announced. The merged organization was named the American Association of Health Plans (AAHP). Subsequent references in this document to GHAA will appear as AAHP, reflecting the organization’s current name.

become so expensive they will be unable to afford it, and they may be right.” About half of all Americans said that high cost is the most important problem in the U.S., and about one-third said that health care coverage/ access is the main problem (Edwards, Blendon and Leitman, 1992). The situation is exacerbated by a gap between wages and insurance costs. In 1992, real wages rose about 3% compared with an increase of about 20% in the average cost of insurance.

For the 160 million Americans who buy their own policies or share the cost of insurance with their employers, the situation could result in reduced access to health services, such as limits on the types and amounts of medical treatments they may receive. For some, an inability to continue paying premiums could mean dropping insurance coverage altogether, and these people would join the more than 40 million Americans who are currently uninsured (American Hospital Association, 1997).

The role of employers in health care is significant, given that employer sponsored health insurance covers 64% of the American population. The average annual contribution an employer makes for insurance coverage for one employee is \$3,605, or roughly 6.5% of an employee's total compensation. The increase in health care costs to employers has risen every decade. For example, in 1950 health care was .5% of total employee compensation. By 1970 it was 2.3% (Taylor, Leitman and Blendon, 1992).

On a national level, concerns about health care and the economy go hand in hand. Today, health care is 14% of the gross national product (Bishof and Nash, 1996). Over the last decade, say Blendon and Hyams (1992, p. 72), “for all types of care, prices have risen at about twice the rate of growth in the general economy (9.2% average annual

growth in health care versus 4.9% average annual growth in the economy).”

Evolution of HMOs

To more fully understand the scope and significance of HMOs, it is helpful to look at factors influencing their emergence, growth and structure. HMOs are widely acknowledged to be the first form of what is now generally called “managed care.” Managed care has been defined as “an attempt to influence the access, delivery or financing of health care. Others simply consider it to be the application of business principles to health care” (Bishof and Nash, 1996, p.226).

The HMO concept had its origins in the nineteenth century. Large industries, such as mining and lumber, needed medical services for injured workers in the field. These industries made arrangements with local providers to treat workers for a fixed, prepaid fee. For example, around 1880 in Big Rapids, Michigan, a lumber company paid a set amount of money per worker per year to the Sisters of Mercy and physicians at Mercy Hospital to provide medical care for lumberjacks (*Mercy Health Services Annual Report*, 1991).

By the early 1900s, business had begun to view health care benefits as a practical, economical way to increase workers’ overall compensation without directly increasing their wages, and by 1940, employers were the main source of insurance for all Americans.

The HMO concept was further advanced in 1929, when two physicians established the Ross-Loos Health Plan. The plan offered prepaid care to more than a single business. Like its predecessors, the plan brought medical care to the geographic

area where it was needed (Cafferky, 1995, pp. 5-6). Even while in its infancy, the HMO concept met with opposition from organized medicine, namely the American Medical Association (AMA). While the AMA did not oppose prepayment for services, it was concerned that prepaid plans might limit the scope and quality of medical services provided, and that further developments in medicine might be hindered (McLeod, 1995).

From the early 1900s and well into the latter 1900s, medical services typically were billed to patients on a fee-for-service (FFS) basis. That meant that for each doctor visit or hospital stay, there was a bill. The more treatments that health care providers gave, the more money they made. Thus, providers had little incentive to exercise restraint when it came to patient treatment.

Prepaid systems, however, virtually reversed that formula. Health care providers had to render care for patients within the costs that had been paid in advance. If they went beyond the prepaid amounts, the money came out of their pockets. They could not make more money or compensate for losses by simply doing more treatments.

From the 1930s through the 1960s, prepaid medical groups emerged across the country. These groups demonstrated that not only could they provide medical services of good quality, but they could also manage patient care and costs. Employers continued to express interest in these arrangements, while the American Medical Association continued to oppose them.

In 1965, the government introduced Medicare and Medicaid, sparking what seemed like a feeding frenzy among health care providers who were reimbursed under FFS, which was still the predominant form of payment. The costs of health care moved

ever upward and soon began to outpace the rate of inflation.

This situation drew the attention of the Nixon administration and in 1973 the Health Maintenance Organization Act was passed. McLeod (1995) observes that “bipartisan support for managed care was based on the concept that HMOs can decrease costs and encourage free-market competition in the medical care arena with only limited government intervention” (p. 3).

The HMO Act encouraged and supported organizations that would address the problems of health care. The number of people enrolled in HMOs grew slowly in the first few years after the act was signed, but then expanded quickly. Enrollment in HMOs more than doubled within a decade. According to the AAHP, there were 27.5 million people enrolled in HMOs in 1986 and, by the end of 1996, there were about 70 million enrollees. As HMO growth exploded, FFS plans declined. In 1988, traditional FFS insurance was 73% of the private health insurance market, and by 1993, it had slipped to only 33% of that market (Bishof and Nash, 1996).

Are HMOs today living up to the expectations of cost control, quality care and access? The answer depends on whom you ask.

According to a *Wall Street Journal* report, people do not have the information they need to make judgements about the performance of HMOs. Many Americans -- even those with experience in HMOs -- lack knowledge of HMOs in large part because “many plans refuse to release ‘report card’ data that might help consumers judge the quality of their services. Others require doctors to sign gag orders forbidding them to reveal the financial arrangements of the HMO, which often include financial incentives to

limit treatment” (Langreth, 1996).

Yet there are several national and regional studies by companies not affiliated directly with HMOs that suggest HMOs are performing well and that enrollees are satisfied with their care.

A 1995 KPMG Peat Marwick study reported that HMO premiums increase at a slower rate than fee-for-service premiums. The average cost of care per employee is 9% lower in HMOs than in fee-for-service arrangements (A. Foster Higgins, 1994). HMOs have considerably fewer hospital admissions and shorter hospital stays than fee-for-service providers (Miller and Luft, 1994).

The lower cost of HMOs has not resulted in inferior care, according to research. In a literature analysis of 54 studies on the performance of managed care plans, primarily HMOs, Miller and Luft (1994) observed that HMO and indemnity plan enrollees had roughly comparable clinical outcomes. While HMO enrollees were satisfied with the quality of their care and the patient-physician interaction, their level of satisfaction was somewhat less than their fee-for-service counterparts. Miller and Luft observed, “Although generally satisfied with their care, some HMO enrollees accepted the tradeoff of less satisfaction with their care in return for lower out-of-pocket premium and service costs” (p. 1581).

The ability of HMOs to deliver on expectations about cost, quality and access relates to the way they are structured and how they function. Not all HMOs are alike, nor are the descriptions of HMOs alike, although they touch on some common characteristics of HMOs.

The Massachusetts Association of Health Maintenance Organizations defines HMOs simply as “health plans that are responsible for delivering and paying for their members’ medical care” (MAHMO, 1997).

One journalistic account of HMOs is that they “manage health care much like discounters manage to sell merchandise at reduced prices. An HMO purchases medical care at bulk prices--contracting with a doctor to cover a large number of patients under the HMO’s plan. And then, the HMO delegates to a ‘primary care provider’ responsibility for holding down medical costs by allowing the patient to see a more expensive specialist only when needed” (Gaddy, 1996).

This definition gets to the notion of the primary care physician as “gatekeeper.” In the traditional view of HMOs, when members enroll in an HMO, they must select a primary care physician from the panel of physicians approved by the HMO. This physician, functioning as a gatekeeper, coordinates the enrollee’s care and controls patient access to specialists and other types of care. Unless there is a referral or similar authorization for care beyond the basic level, the HMO may not pay for the service, particularly if it is from a provider outside the HMO’s network.

Another definition of HMOs is offered by the Health Insurance Association of America (1992):

“HMOs provide:

- an organized system for providing health care in a certain geographic area, as well as responsibility for providing or otherwise assuring delivery of that care

- an agreed-upon set of basic and supplemental health maintenance and treatment services
- a voluntarily enrolled group of people.

In exchange for a set premium or dues, HMOs provide all the agreed-upon health services to their enrollees. There are generally no deductibles and no or minimal copayments....” (p. 1).

This definition touches on several important characteristics of HMOs, one of which is that providers in HMOs have their performance monitored and measured regularly, through the utilization review process. The process is used to determine how well the care process was managed and whether the services rendered were provided as effectively and efficiently as possible. One issue related to efficiency has to do with ethics: “There is an inherent conflict,” according to Wagner (1995), “between prepayment and underutilization, just as there is between fee-for-service and overutilization.”

Wagner (1995) defines HMOs in terms of models, noting that there are four prevailing models in operation today (p. 30):

- the staff model, in which physicians and other providers are employees of the HMO
- the group model, where a group of physicians (usually three or more) contract with the HMO
- the independent practice association (IPA), in which the HMO contracts with physicians in independent practice

- the network model, in which the HMO contracts with a number of independent group practices.

Physicians and other care providers share financial risks and rewards of medical treatments in all the models, although the way they do this varies from model to model. For example, an employed physician may have a different incentive (e.g., year-end bonus) regarding treatments and cost than a physician under contract has (e.g., receives a portion of the health care dollars that were prepaid but not spent for treatments). The “financial incentives” aspect of HMOs is one part of the controversy regarding “gag clauses,” which already have been outlawed in a number of states.

The definitions that have been offered allude to some of the key characteristics, or principles, of HMOs and managed care in general. As summarized by Cafferky (1995), the principles are:

- Strong emphasis on primary care physicians
- Utilization management tools such as medical supervision, authorization systems, utilization review, case management, medical practice guidelines and continuing care planning
- Quality monitoring and improvement
- Decreased emphasis on hospital care
- Interest in disease prevention and health promotion
- Collaboration with [family members]
- Selective contracting with physicians and hospitals
- Emphasis on appropriate self care

The principles are helpful in understanding HMOs in contemporary times, when defining HMOs is increasingly problematic. One aspect of the difficulty, says Wagner (1995), is that since about 1988 the once-distinguishing features of HMOs, other forms of managed care, and traditional indemnity insurance have been blurring: "Today, an observer may be hard pressed to uncover the differences between products that bill themselves as HMOs, PPOs, or managed care overlays to health insurance. For example, many HMOs, which traditionally limited their members to a designated set of participating providers, now allow their members to use nonparticipating providers at a reduced coverage level" (p. 24).

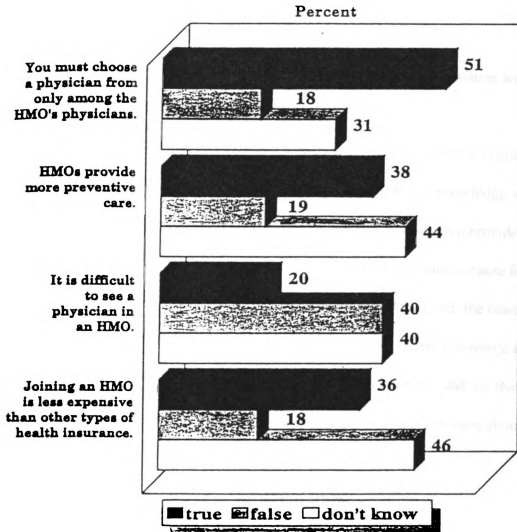
A survey of Americans in 1990 gives some insight into what the public believes about HMOs and how the public might define HMOs (EBRI Poll, 1990). Edwards, Blendon and Leitman (1992) summarized the findings on Table 1, concluding that "consumers don't know about the relative cost of HMOs, whether or not they get a choice of doctor, and whether they would get more preventive care in an HMO....This evidence is contradictory to the commonly held perception that people are rejecting HMOs; it is more likely that they simply do not understand their choices" (p. 71).

Purpose

The purpose of this study is to explore whether or not the claims of media agenda-setting and bias against HMOs are justified. The study also explores the possible effects of media coverage about HMOs on the public's attitudes toward HMOs and considers the impact of the coverage on public opinion and on the HMO industry.

In this study, magazine coverage of HMOs from January 1, 1995, to July 31, 1996,

Table 1

Public's Beliefs About HMOs.

Source: EBRI Poll. Public Attitudes on HMOs and PPOs. Employee Benefits Research Institute. April 1990. In R.J. Blendon and T.S. Hyams (Eds.) *Reforming the system: containing health care costs in an era of universal coverage* (1992): p. 71.

was content analyzed. Specifically, the following questions were addressed:

- Did the media coverage bring certain issues about HMOs into public prominence, as demonstrated by a match between themes in the coverage and themes in the AAHP survey?
- Is the media coverage of HMOs biased or balanced?
- Is media coverage going in the “unfavorable” direction, consistent with the direction of public opinion observed by AAHP?

The research improves on previous research in three ways. First, it explores an issue (HMOs) about which Americans lack first-hand experience or knowledge, using a widely accepted research method: content analysis. Second, the research provides useful information to the HMO industry about whether or not media coverage is cause for concern and what the possible repercussions of coverage may be. Third, the research offers HMO purchasers³ and consumers⁴ a chance to understand media coverage about HMOs in a broader context--through theory and a conceptual model-- and use that information to draw their own conclusions and make more-informed choices about HMOs.

Literature Review

The theoretical framework for investigating the research questions is based on the

³“Purchasers” are employers, the government or other organizations who buy group health coverage.

⁴“Consumers” are the ultimate end-user of health care coverage (e.g., patients, the covered individual and his or her family, etc.)

areas of media agenda-setting and attitude formation.

Many of the earliest studies on media agenda-setting were conducted in relation to news media and political issues. The notion that news media set the public agenda stemmed from the contention that people learn from the news media what the important issues are. The research does not suggest, however, that media can “make” people feel a certain way or hold particular attitudes about the issues. Indeed, the research on media agenda-setting does not presume to establish a causal link between news coverage and public opinion, but strong correlations have been offered.

Agenda-setting is a function not only of the news media, however, and later research in media agenda-setting involved entertainment sources, such as television and movies, and information sources, such as advertising. Research on attitude formation indicates that mass media -- whether conveying news or other types of information--can be highly successful in shaping and even changing the public’s attitude, especially under certain conditions.

Media Agenda-Setting

Theory on agenda-setting holds that "the public agenda--or what kinds of things people discuss, think and worry about (and sometimes ultimately press for legislation about) -- is powerfully shaped and directed by what the news media choose to publicize" (Larson, 1986).

From the past 25 years of research on agenda-setting comes strong evidence that media can bring issues into public consciousness and influence, to an extent, the importance that the public attaches to the issues. The evidence applies not

only to news media, but also to media that provide other types of information.

One of the landmark studies in media agenda-setting was done by McCombs and Shaw (1972). The study took place during the 1968 presidential campaign. McCombs and Shaw selected 100 voters in Chapel Hill, NC, and asked them to identify the most important issues of the day. They then analyzed the content of major news sources in Chapel Hill (such as television, *Time* magazine, the *New York Times*, etc.). They found that the issues with the most coverage in the media were the issues that the public considered to be the most important. They reported this as evidence of media agenda-setting. The research, however, was not without methodological difficulties. For example, the study compared aggregates: the opinions of voters as a group were compared to the composite of “important issues” derived from media coverage. An individual voter’s opinion was not matched directly with the media to which the voter had been exposed. In other words, it could not be said unquestionably that a voter’s opinion was actually shaped by the media that set forth the opinion. While this methodology was problematic, nonetheless in the aggregate of public opinion and of media coverage, there were correlations that were considered to be evidence of media agenda-setting.

From their study, McCombs and Shaw concluded that the more media coverage an issue received, the more important the issue became to the public. Later researchers generally agreed that when issues receive major media coverage, those issues become the topics of conversation and concern in the public.

Mazur (1981) examined media coverage on the issues of water fluoridation and

nuclear power. He compared local and national public opinion polls and magazine coverage on these issues over a period of 25 years. He concluded that fluctuations in public opinion reflected the media's influence. Furthermore, he believed that when the amount of coverage on these scientific issues went up, so did negative public opinion. His methodology, like that of McCombs and Shaw (1972), was to match aggregate public opinion with aggregate media coverage.

Similarly, Smith (1987) found a correlation between the amount of media coverage and public opinion. In a study of newspaper coverage in Louisville, Kentucky, for a period of seven years, Smith correlated increases in coverage on local community issues with increased public concern and with negative evaluations of local government services.

Amount of coverage was not the only condition associated with media's ability to set the public agenda. Gladys and Kurt Lang (1981) felt that the type of issue being covered and the nature of the coverage it received were major factors as well. In their study on Watergate coverage, they argued that "high threshold" issues -- those with which people lack direct contact -- need more coverage than low-threshold issues, whose relevance is more readily apparent to the public. They reasoned that because the public has little direct contact with wrongdoing at the highest levels of government, as in Watergate, the media had significant power over what people knew and how they felt. This power was not due to the amount of coverage but to the content and nature of the coverage. To create an issue from the high-threshold Watergate event, said the Langs, "media had to do more than just give the problem publicity. They had to stir up enough

controversy to make it politically relevant, not only on the elite level but also to give the bystander public a reason for taking sides” (p. 464).

McCombs and Shaw (1991) later elaborated on the Langs’ research. They observed that the news media’s power to put issues on the public agenda was greatest for “unobtrusive” issues -- those with which people have little direct personal experience or knowledge.

Englis and Solomon (1995), who conducted research on attitude formation, demonstrated that on issues where people lack first-hand experience, knowledge and interest, especially where media is their main source of information, media are powerful shapers of opinion. (Further discussion of attitude theory appears in the next section.) They compared PRIZM lifestyle categories (generated by marketing researchers to define groups of consumers) to respondents' perceptions of those categories. Respondents identified products and brands most associated with (1) their own reference group, (2) a group to which they aspired and (3) an avoidance group.

Respondents knew the least about avoidance groups and relied on media depictions for their information. They had many commonly-shared stereotypes about the avoidance group but few for the groups about which they had more knowledge (their own and the aspired-to groups). Englis and Solomon observed that the "'truth' about a lifestyle category may be less important than its 'mass mediated' image (i.e., its reality as conveyed by mass media depictions)...." (p. 14). This suggests that the less we know about a subject, the more potential media have to influence our opinions.

This is a particularly important observation considering that, where people lack

personal experience, media by default can be a main information source.

Without media, most Americans would lack access to and awareness of issues such as Watergate. In that situation, the media, notably the *Washington Post*, was both the source and the conveyor of information. This is not always the case. Media, as Mazur (1981), and Englis and Solomon (1995) suggest, also play the role of "mediator," wherein media process and present information originating from other sources.

Such is the case with the U.S. economy. Holbrook and Garand (1993) indicate that "individual citizens know very little about real economic conditions" (p. 315). Furthermore, according to MacKuen et al (1992), "individuals rely on economic forecasts available in the mass media" (p. 315). Goidel and Langley (1994), who content-analyzed the *New York Times'* front-page coverage of the economy from 1981-92, found that when there was negative media coverage, there were also negative public evaluations of the economy, even when economists felt that real economic conditions did not warrant such pessimism. This also suggests that media reports have credibility in the eyes of the public even if the content is inaccurate or incomplete.

Further support for media's credibility comes from the area of clinical research, which, like economic news, is usually mediated information. Again, lack of direct personal experience and reliance on media as a main information source are critical factors in the media's power to shape public opinion and influence actions. Angell and Kassirer (1994), editors of the *New England Journal of Medicine*, point out that most Americans lack direct knowledge of clinical research: "No one would expect people to go to medical journals and evaluate the evidence [from research] themselves" (p. 190).

The media, they believe, are largely responsible for the information -- or more specifically, the misinformation -- that exists in the public about research findings.

Angell and Kassirer observe: "Often the media reports are exaggerated or oversimplified... Health conscious Americans increasingly find themselves beset by contradictory advice. No sooner do they learn the results of one research study than they learn of one with the opposite message. They substitute margarine for butter, only to learn that margarine may be worse for their arteries....In our view, the problem is not in the research, but in the way it is interpreted for the public...." (p. 189).

Angell and Kasirrer note that clinical researchers are concerned about inaccurate and contradictory coverage on clinical findings because people act on the information, changing diets, lifestyles, etc. They also charge that such coverage has led to a deepening public distrust not of the media, but of clinical research.

Media content on health-related issues can override personal experience as a main shaper of opinion and behavior. Safer and Krager (1992) found empirical evidence linking negative media coverage to behavior. They examined local news coverage of a local lawsuit involving the pharmaceutical drug methylphenidate, commonly used to treat attention deficit disorder (ADD). In response to the negative coverage, use of the drug by elementary school children declined by half and sales at local pharmacies decreased 60%, despite the fact that the drug has been prescribed for over 30 years to successfully treat ADD in children.

All these studies involved a time element, which is typical of agenda-setting research. One question regarding time relates to media coverage: given that some issues

move to the public agenda quicker than others, what is the appropriate duration of media coverage to be analyzed? A similar question involves measuring the public's opinions: at what point and over what duration of time should opinion be sought? A question related to both media coverage and public opinion has to do with lag time: given that media coverage needs to come before the emergence of an issue on the public agenda, how much time should elapse between the media coverage and the measurement of public opinion?

There are no absolute answers to any of these questions. The answers depend largely on the purpose and nature of the research inquiry, the types of issues involved, and a host of other factors. The overarching concern about the time element is that there should be a logical, defensible reason why certain time periods are used in the analysis.

Attitude Theory

Attitude theory is a useful complement to media agenda-setting theory in that it may yield clues as to the expected nature of media coverage. For example, if people's attitudes were negative, and if attitudes were influenced by media coverage, then media coverage would be expected to be negative.

Theory on media agenda-setting has noted a number of observations as to the conditions that influence media's ability to set the public agenda and influence public opinion, such as the amount of coverage, type of issue, nature of the coverage and people's prior knowledge and experience of the issue. But why is it that people respond in different ways to the same coverage or same issue?

The variation in responses is underscored by social psychologists Boninger,

Krosnick and Berent (1995), who note, “Convictions on political issues such as abortion, the right to die and racial equality can sometimes become so strong as to take over people’s lives for many years. Yet at the same time, numerous other people seem completely unmoved by these same issues” (p. 61).

Over a decade ago, the Langs (1981) had talked about the role of relevance in shaping opinions. As noted earlier, the Langs felt that for media to have an impact on people, media had to do more than publicize an issue; they had to make known the issue’s relevance to people. How people interpreted the “why” depends on internal factors related to attitude.

An attitude can be defined as “an enduring organization of motivational, emotional, perceptual and cognitive processes with respect to some aspect of our environment” (Hawkins, Best, and Coney , 1995, p. 355).

Aaker, Kumar and Day (1997) offer another definition of attitudes: “Attitudes are mental states used by individuals to structure the way they perceive their environment and guide the way they respond to it” (p. 254).

Attitudes are thought to originate from three main factors: (1) a person’s own material self-interests -- the tangible rights, privileges and lifestyle a person desires; (2) a person’s reference groups -- the social groups with which a person strongly identifies, and (3) value reference -- an abstract ideal a person has about how people should act, what they should think and how they should feel (Boninger, Krosnick, and Berent, 1995; Hawkins, Best and Coney, 1995).

It is from these three main sources that attitudes are learned. Many social

scientists as well as marketers have long believed that attitudes predispose people to think, feel and act in certain ways that are fairly consistent over time. Beliefs, feelings and actions (or cognitions, affect, and behavior) are the three dimensions of attitude (Figure 1). While they are not entirely consistent with one another (e.g., a person may know that a diet high in fat can cause heart attacks, but they love fried potatoes and eat them at every meal), the dimensions are interrelated, such that a change in one is likely to bring about related changes in one or both of the others (e.g., knowing that a high-fat diet can be deadly but still loving french fries, a person limits fat intake by eating french fries only once a day).

The extent to which the attitude may be amenable to change depends in great part on "attitude strength." In general, a strong attitude is harder to change than a weak attitude. "A large body of evidence indicates that attitudes people consider personally important are firmly crystallized and exert especially strong influence on social perception and behavior," note Boninger et. al. (1995, p. 61). In other words, the stronger an attitude is: (1) the more resistant to change it is, (2) the less likely it is to change over time, (3) the more it will have an impact on cognitions and (4) the more it will have an impact on affect (Boninger, Kosnick, and Berent, 1995; Zuwerink and Devine, 1996).

Cognitive Approaches to Attitude. Attitude change could be approached by stimulating new cognitive responses. A general description of cognitive response theory can be derived from Rossiter and Percy (1997, p. 269).

As the theory goes, a person who is exposed to a message will seek to relate it to information he or she already has. In processing information, the person has

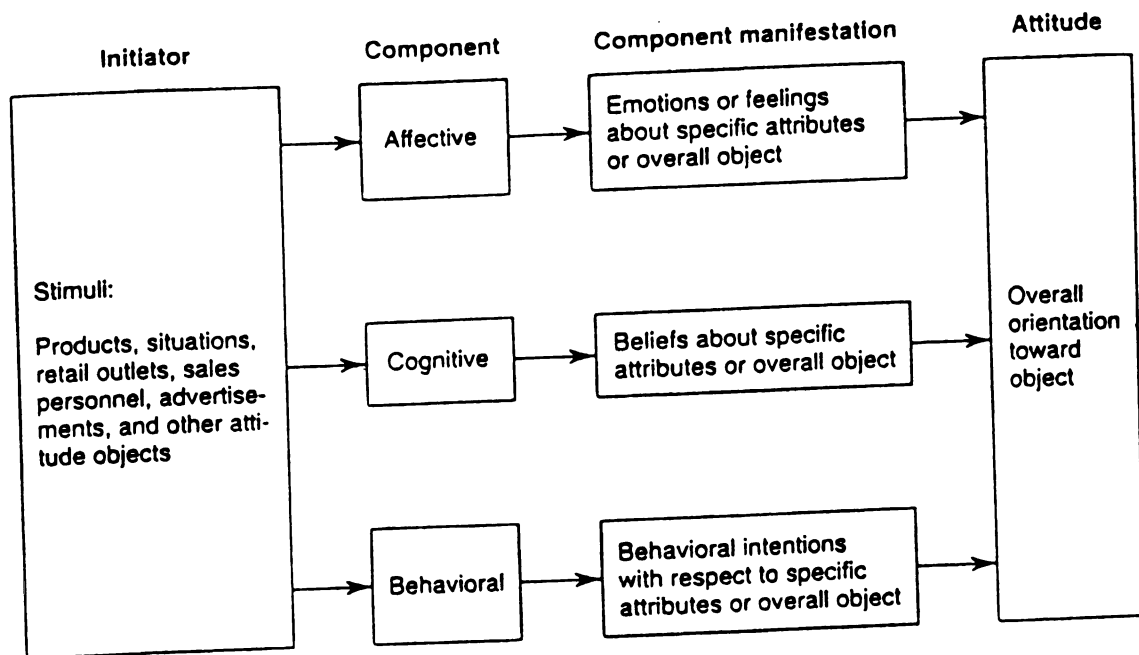


Figure 1

Attitude Components and Manifestations.

Note. Figure from Hawkins, D.I., Best, R.J., and Coney, K.A. (1995). *Consumer behavior: implications for marketing strategy* (6th ed.). Chicago: Richard Irwin, Inc.

new thoughts and images about the message -- these new thoughts and images are a cognitive response. A major assumption of this theory is that people who are exposed to the message will actually process it. Cognitive response theory and its approaches are most applicable to situations that are highly relevant to a person and in which the person is highly involved.

There are a number of approaches that focus on cognitions as a way to change attitudes. Hawkins, Best and Coney (1995) offer four:

1. Change consumers' beliefs. To change beliefs, "facts" may be presented and repeated often. An example of this from health care would be the message cited earlier in this paper that "HMOs save money."

2. Shift the importance to consumers of some attribute of the message or product. To create a shift in the importance of attributes, reasons may be given as to why some attributes are more important than others. This is the type of shift alluded to by Miller and Luft (1994) in their observation that some HMO enrollees accepted the tradeoff of lower satisfaction with their care in return for lower out-of-pocket costs.

3. Add new beliefs to what consumers already believe. An example of this could be informing business audiences (the majority of whom already believe that HMOs save money) that lower costs can go hand in hand with higher quality, as the auto industry has demonstrated since the 1960s.

4. Change consumers' perceptions as to what constitutes the "ideal." One illustration of is HMOs' emphasis on preventive care: the "ideal" health care provider keeps patients healthy instead of waiting to treat patients who have become sick.

Behavioral Approaches to Attitude. Behaviors are observable actions, such as the use of a product or service. Behavioral approaches are based on principles related to operant condition, a process popularized by B.F. Skinner and based on rote learning and reinforcement. This approach attempts to stimulate a behavior regardless of what a person believes or feels about the object or message to be acted upon In marketing, coupons are often used as a stimulus to induce trial or repeated use of a product (purchase and usage behaviors).

In the context of HMOs, behavioral approaches could take many forms. For example, if you are a worker whose employer offers only one health plan, you would likely sign up for it, versus going without insurance or paying a high premium for a personal policy. You may not have positive feelings about HMOs and believe they are skimping on care, yet these things have not affected behavior negatively. “Low cost” or “no cost” for HMO services serves as a strong inducement, followed by no deductibles and small co-pays later on.

Another example would involve physician choice in a traditional model of HMO. If you are an HMO member, you cannot choose a specialist as your primary care provider. If you seek primary care from the specialist, you pay the bill, not the HMO (the bill serves as a negative reinforcer of this behavior).

Affective Approaches to Attitude. Affective approaches are aimed at stimulating emotional responses. These approaches are sometimes based on classical conditioning, in which a message or other stimulus is paired with something that subjects like. Recall the classic example of this conditioning in the experiments of Pavlov, who demonstrated this

notion of “transference” in associating the sound of a bell with food to stimulate a favorable response from animals.

Another affective approach relates to repetition. Boehm (1994), as other researchers before him, studied the effects of repetition on perceived validity and concluded that repetition enhances perceived validity. Thus, an audience that is repeatedly exposed to a message (particularly in high-involvement situations) will increasingly view the message as valid, whether or not the message is grounded in facts. One of the fears that HMOs have is that “bad” messages from the media about HMOs, such as medical neglect due to treatment limits, will stir negative emotions in people, even if the messages are not supported by “the facts.”

Source Credibility

Researchers widely agree that attitudes are more readily influenced when the source of the message is seen as credible. Credibility has two components: expertise and trustworthiness. These components are not dependent; that is, a source can be considered an expert and yet not be considered trustworthy because it is not viewed as being objective enough.

The source may be the originator of the message or simply the communicator of a message originated by another. An example of this was cited by Angell and Kassirer (1994), who described how clinical research in the *New England Journal of Medicine* (author and journal are sources) was reported by news media (secondary “sources,” which mediate information). They testified to the influence of expertise, noting that many people rely on physicians for medical advice, and to the influence of trustworthiness

regarding a secondary source, noting that even when the media didn't report the facts correctly, the public had no reason to not believe the media.

Magazines may be especially influential because they are widely regarded as credible, or at least as more credible than other media (Kotler, 1991). In this respect, magazines are "celebrity presenters." Celebrity presenters, because of their credibility, have demonstrated an ability to enhance attitudes. Adding to the credibility dimension, magazine subscribers are a self-selected audience and thus are more likely to be motivated to process the information they encounter in the magazine.

Hypotheses

Based on research, media agenda-setting regarding HMOs is a distinct possibility for many reasons. One reason would be that until fairly recently, most people lacked experience with HMOs. As noted earlier, there is also a belief that people still lack knowledge about HMOs because performance data on HMOs are not credible, widely available or accessible to the public. Even with experience and knowledge, the public is inclined to defer to media reports about issues.

Thus, it can be argued that "HMOs" are unobtrusive, even though "health care" per se is obtrusive, in that most Americans have had direct contact with a health care provider at some point in life, for example, doctor visits, hospitalizations, or immunizations.

Media agenda-setting is demonstrated in research typically by comparing media coverage with public opinion surveys or polls. For agenda-setting to occur, there must be a relationship between the issues important to the media and those important to the

public. As noted earlier, aggregate measures are typically used, wherein a body of media coverage is compared with a body of survey results. In terms of this study, for agenda-setting on HMOs to have occurred, the themes in AAHP's survey should be the same as those in media coverage of HMOs. Thus:

H1 The majority of coverage will contain a reference to at least one of these themes: cost, physician selection or treatment options.

The themes identified by AAHP can be broadly defined as follows:

1. Cost: the cost of HMO coverage for those who purchase the coverage, such as businesses, and for those who use it, such as employees, whose additional costs may include co-pays or other fees.

Businesses and the government are the major purchasers of health plans. These purchasers may offer more than one plan to their employees and, in fact, most of the 2,500 largest business in the U.S. do so. Of the 80% of large businesses who offer more than one health plan to employees, over half offer an HMO or other managed care product, while only one-fifth of the companies offer traditional fee-for-service plans (Blendon, et. al., 1992, pp. 84, 94).

A consumer's costs relate to the type of health plan he or she joins. Health plans, as noted earlier, vary in many respects. For instance, HMOs typically have lower (or no) co-pays than fee-for-service plans have. Fee-for-service plans, however, may cost more and may cover a wider range of treatments than HMOs cover, and HMO enrollees who need or want such health services usually must pay for them out of pocket. This factor may make an HMO less affordable to consumers.

Thus, the cost theme may surface in a variety of ways. It may be reflected in expressions such “affordability,” “expensive / inexpensive,” or “cheap,” among others. The cost theme may also be reflected in the notions of cost efficiency and effectiveness--the idea of “value for the dollar.”

What does not fall within this definition of cost are the opinions that purchasers and consumers may have about why health care providers charge certain prices or don’t offer certain treatments. For example, a business may feel good about its health care costs even if it criticizes what it considers to be excessive management costs.

2. Provider selection: the HMO enrollees’ capacity to have a say in the choice of their health care provider. The theme of provider selection involves the degree of personal control an HMO enrollee may have in regard to physicians, other care providers or settings of care (e.g., hospitals, emergency rooms, doctors office, etc.). For example, can an HMO enrollee change physicians, choosing a different primary care physician from within the same health plan? If an enrollee’s primary care physician determines that specialty care is needed, can the enrollee have a say in who that specialist should be?

3. Treatment options: this category goes beyond the selection of a provider. It refers to the specific medical treatments covered and paid for by the HMO, as well as the information that is available to enrollees about a wide variety of treatment options, including those not specifically covered by the health plan.

This theme encompasses such things as the permitted duration of maternity stays; treatments that are considered to be experimental; patient access to information from HMO physicians and other professionals in the HMO about non-covered treatments;

among others.

The treatment options theme is not to be confused with the provider selection theme, which centers on a type of provider versus a type of treatment that a provider gives. One might argue that a lack of choice regarding providers, particularly specialists, is the same as having restricted treatment options, in that if you can't choose a specialist, you don't have the option of specialty treatment. This theme is, in a sense, a reversal of that position: if the specialty treatment is not covered or if it is deemed to be unnecessary by the primary care physician, then choice of specialist is a moot point.

4. Other: this category includes HMO-related themes other than those noted above. For example, there may be references to executive compensation in HMOs or to HMO profitability. "Other" themes are regarded as those having no or very indirect relationship to the themes above.

AAHP reports that "while business purchasers and consumers are clearly concerned about the affordability of health plans, the most salient points of departure for consumers in thinking about health plans today are considerations of choice and personal control" (p. 1). Thus, cost is a concern to both purchasers and consumers, but purchasers and consumers do not see eye-to-eye regarding physician selection and treatment options.

At first glance, it may seem incongruous that purchasers would not have the same level of concern as consumers about physician selection and treatment options. After all, many people who purchase health coverage are consumers of that same coverage. This apparent contradiction is addressed by Pearce (1979), who observes that conflicts exist between "public needs and private wants" (p. 8).

He notes, “Marketers have increasingly had to recognize and deal with the fragmented personality of their customers. The same individual is consumer-citizen-parent-employee...The multi-personality of an individual results in inconsistent behavior baffling to marketers. As citizens, people tell marketers they do not want polluting detergents, nonreturnable bottles, sweetened breakfast cereals, tobacco products, fluorocarbon propellants and so on. As consumers, however, these same people apparently buy what they say the public does not want” (p. 8).

Pearce goes on to explain that consumer expectations play a role in the public-private conundrum. Consumers expect marketers to be socially responsible--to do more than simply make a profit.

When applied to health care, Pearce’s ideas give shape to some interesting scenarios. One such scenario is drawn by Bishof and Nash (1996), who noted that the U.S. spends about 14% of its gross domestic product on health care. They describe one form of what could be considered social irresponsibility: “People are concerned...that if the current growth rate of health care expenditures continues, there will not be enough resources for other essential needs” (p. 225).

However, this fear of resource shortages in the future does not produce a decline in demand for health care in the present. Bishof and Nash observe, “The demand for health care will likely continue to outstrip the national willingness to pay for it, making cost effectiveness and cost containment enduring challenges” (p. 226).

Purchasers and consumers agree that there is a problem with health care costs, but not necessarily with two of the means by which cost is controlled (treatment options and

provider selection). Thus, it seems logical that:

H2a Media targeting a consumer audience will have the same amount of coverage on “cost” as media targeting a business audience.

H2b Media targeting a consumer audience will have significantly more coverage on “provider selection” and “treatment options” than will media targeting a business audience.

As noted earlier in this paper, AAHP believes media coverage is negative, despite reports that in general HMO enrollees say they are satisfied with their HMO care. To test AAHP’s claim, one could hypothesize that:

H3 More of the coverage of HMOs is unfavorable than favorable.

Because business gets the cost advantage of HMOs without having to necessarily “trade off” satisfaction with care, the business community would be expected to be less negative toward HMOs than individual enrollees/consumers would be. Thus,

H4 Less “unfavorable” coverage of HMOs will appear in media targeting a business audience than in media targeting a consumer audience.

Research Methods

Content analysis of magazine articles was used to investigate the research questions. Stempl (1989) cites Bernard Berelson’s 1952 description of content analysis as the classic definition: “a research technique for the objective, systematic and quantitative description of the manifest content of communication” (p. 125). A more

accessible definition is offered by Aaker, Kumar, and Day (1995), who define content analysis as a “technique used to study written material by breaking it into meaningful units, using carefully applied rules” (p. 770).

The procedure for content analysis involves four main steps:

- Selecting the unit of analysis, such as paragraphs, headlines or entire articles.
- Creating categories that reflect the main inquiries of the study. The themes in this study are one example of types of categories.
- Identifying the population. This involves a sampling of content when the population is so large that only a representative sample is manageable. A sample is not drawn, of course, when an entire population is used.
- Consistency of classifications for coding purposes. Consistency has to do with reliability and refers to the level of agreement that coders have when assigning content (such as themes) to categories.

Content analysis is widely used in research in a variety of fields, including political science, health care, medicine, etc. The method has been used to establish agenda-setting by the media, typically by comparing some element of coverage with public opinion polls, surveys, or evaluations. For example, McCombs and Shaw (1972) and Mazur (1981) used “amount of coverage” as a measure and compared it with public opinion polls. Safer and Krager (1992) content-analyzed news coverage to determine if the coverage was favorable, unfavorable or neutral and linked it to a change in purchase behavior.

Magazine Article Selection

Magazines were selected as the medium for study for reasons of perceived higher credibility and for practicality. To know with any degree of certainty that media have influenced opinions, one must be reasonably sure that audiences were motivated enough to actually process the messages presented in the media. As noted earlier, magazines are a high-involvement medium with selective audiences. Magazine content is shaped to appeal to audience characteristics (e.g., demographics or psychographics); thus, audiences presumably have a greater interest in and motivation for reading and processing magazine content.

Magazine articles for content analysis were identified using citations from a database which indexes the contents of 700 periodicals. The search terms used to identify articles included *Health Maintenance Organization (HMO)*; *HMO and health care*; *HMO and managed care*; *HMO and medicine*. The selection criteria for articles were:

- The article was published between January 1, 1995, and July 31, 1996. This time frame was chosen because it overlaps with the dates of AAHP's study (conducted in 1995, report released in December 1995) and the comments in *Modern Healthcare*.
- The central topic of the article is health maintenance organizations.
- The article does not appear in a health care trade magazine or a health care journal.

Of the 108 articles indexed on the database, 94 were usable for analysis (the ones that were not used were omitted because they were not about HMOs, but other topics,

such as insurance companies, hospitals or physicians).

Forty-eight of the articles were in magazines classified by Standard Rate and Data Service as “business,” and 46 were in the “consumer” category. The variety of magazines used in the analysis is shown in Table 2. There were 38 different magazines used in this study. As is apparent in the table, HMO articles ran in more than one issue in some magazines.

Measurement and Analysis

The magazine article was the unit of analysis. Headlines, call-outs, captions, boxed inserts and other material outside the main text were excluded from analysis. Each paragraph in an article was (1) analyzed to determine which theme it contained (cost, physician selection, treatment options, other) and (2) rated for how it covered the theme (favorable, unfavorable or neutral). If the paragraph did not refer to HMOs in any way, the “not applicable” (NA) code was used.

The theme categories and coding instructions were piloted by four coders working independently. The coders, each of whom is college-educated and one of whom has an MBA, have worked in the communications, public relations and advertising fields for 10 or more years. All four coders have, at one point in their career, worked for a health care organization and have broad-based knowledge of health care delivery and financing. None of them have ever provided hands-on clinical care (e.g., as physicians, social workers, etc.), nor have they held top responsibilities for managing a hospital, nursing home, or other provider organization or health insurance plan.

Table 2

Magazine Titles.

Business Magazines	# of Issues	Consumer Magazines	# of Issues
Barron's	7	American Demographics	1
Black Enterprise	1	Columbia Journalism Review	1
Business Week	7	Consumer's Research Magazine	4
Economist, The	1	Esquire	1
Entrepreneur	2	Exceptional Parent	1
Financial World	1	Glamour	1
Forbes	13	Good Housekeeping	1
Fortune	1	Info World	1
Harvard Law Review	1	Kiplinger's	7
HR Focus	7	Money	2
Managing Office Technology	1	Monthly Labor Review	1
National Journal	3	Mother Jones	1
Personnel Journal	2	Newsweek	2
Trial	1	PC Week	1
		Progressive, The	1
		Reader's Digest	1
		Redbook	1
		Scientific American	1
		Social Justice	1
		Time	5
		U.S. News and World Report	8
		Variety	1
		Vogue	1
		Woman's Day	1
Business Total	48	Consumer Total	46

The first test for intercoder agreement (reliability) involved each individual coding five articles. The results showed an unacceptable level of agreement among the coders. After a discussion about sources of the disagreement, the category descriptions and coding instructions were revised. Then a second test for reliability was conducted.

In the second test, the four coders used the revised categories and instructions to code five more articles (not the same five as before). This time, intercoder reliability reached 84% for HMO themes, and 94% for ratings of the coverage (favorable, unfavorable, neutral). To be considered valid, says Tan (1985), procedures and categories must reach 80% or more agreement.

The coefficient of agreement was calculated using the formula $\frac{\# \text{ of agreements}}{\# \text{ of agreements} + \# \text{ of disagreements}}$. This formula is consistent with Tan's (1985) definition of coefficient of agreement as "the degree to which coders agree on assignment of items to categories, or on their ratings of categories."

The coding of the articles themselves was done by two individuals, one of whom had participated in the reliability tests. The other individual is a communications consultant with a Master's degree in communications and considerable experience in health care communications.

The coders marked only one theme per paragraph. If the paragraph alluded to more than one theme, the coders used the paragraph before and after as context for identifying the dominant theme. If a dominant theme could not be isolated, the coder marked the paragraph and discussed it with the other coder to make the determination.

The coders also rated the coverage of the themes as favorable, unfavorable or neutral.

The neutral category applied in two ways: (1) when the coverage was simply a statement neither favorable nor unfavorable and (2) when the coverage included favorable and unfavorable statements to a degree judged to be equal by the coder. Paragraphs marked 'not applicable' were not considered to be neutral.

Intercoder reliability was checked upon completion of coding for the first 30 articles and on completion of the second 30 articles. For the purpose of the check, the coders read four of the same articles, and the results were calculated. At both check points, reliability levels were well within the acceptable range. When the coding was completed, data for all variables (Table 3) were entered into a table, and frequencies and means were calculated.

Simple averages were used in calculations involving the number of articles. For example, one way to measure the amount of coverage given to provider selection is to look at the number of articles that contain at least one reference to that theme. If an article has one reference, it has the same value (one article) as if it had 50 references to the theme. The number of references adds no additional weight to any article.

Percentages were used in demonstrating how much of an individual article was devoted to a particular theme or type of coverage (favorable, unfavorable, neutral). For example, an 80-paragraph article with 20 favorable paragraphs is 25% favorable; a 40-paragraph article with 20 favorable paragraphs is 50% favorable. These individual percentages were summed and then divided by the total number of items in the classification (e.g., 25% + 50% + etc./48 business articles). This produced a group mean.

Table 3

Variables Used in Coding.

V1	Article name / identification number	V8	Number of favorable Provider Selection paragraphs	V15	Total number of Other paragraphs
V2	Class (business or consumer, per <i>Standard Rate and Data Service</i>)	V9	Number of unfavorable Provider Selection paragraphs	V16	Number of favorable Other paragraphs
V3	Total number of Cost paragraphs	V10	Number of neutral Provider Selection paragraphs	V17	Number of unfavorable Other paragraphs
V4	Number of favorable Cost paragraphs	V11	Total number of Treatment Option paragraphs	V18	Number of neutral Other paragraphs
V5	Number of unfavorable Cost paragraphs	V12	Number of favorable Treatment Option paragraphs	V19	Number of Not Applicable paragraphs
V6	Number of neutral Cost paragraphs	V13	Number of unfavorable Treatment Option paragraphs	V20	Total paragraphs
V7	Total number of Provider Selection paragraphs	V14	Number of neutral Treatment Option paragraphs		

The method that was rejected because it would produce inaccurate results was to sum the number of paragraphs and divide by the total number of items (e.g., 20 + 20 + etc./48).

Statistical Tests

Z-tests were used to determine whether the differences in group means were significant. Z-tests were used instead of t-tests because there were more than 30 units

involved in the study. One-tailed tests were used vs. two tailed tests because the study sought to show a specific kind of difference (a comparative difference) instead of showing that there was some kind of difference, without specifying the nature of the difference. To achieve .05 level of significance, the z-score for a one-tailed test would have to be at least 1.645.

For hypotheses 1, 2 and 4, the means of consumer articles and the means of business articles were used in the test. Hypothesis 3, which posited that more of the coverage is unfavorable than favorable, the means of unfavorable and favorable coverage were compared. The balance of coverage was also considered.

Results

Some general observations of the results are as follows. There were a total of 1,547 paragraphs involved in the analysis (the 240 “not applicable” paragraphs are not included in this count). The average number of paragraphs per article is 16.4. The average is remarkably stable across business and consumer magazines, with the 48 business magazines having an average 16.4 paragraphs, and the 46 consumer magazines, 16.5 paragraphs. One difference, however, is that consumer magazines had twice the number of “not applicable” paragraphs than business magazines had (162 and 79 “not applicable” paragraphs, respectively).

Hypothesis 1

Hypothesis 1 predicted that the majority of coverage would contain a reference to at least one of the three themes -- cost, provider selection or treatment options.

Table 4

Coverage by Category: Three Themes, Other Themes.

Theme	Number of Articles Containing the Themes			Theme Coverage, as % of All Articles		
	B (n = 48)	C (n = 46)	Mean (n = 94)	B	C	Mean
Three Themes	45 (93.8%)	41 (89.1%)	86 (91.5%)	41.4%	51.2%	46.3%
Other	44 (91.7%)	38 (82.6%)	82 (87.2%)	41.3%	41.9%	41.9%

Note. Z-score listed only where $z \geq 1.645$.

The hypothesis was strongly supported in terms of the number of articles with at least one theme reference. Nearly all of the 94 articles (91.5%) had a theme reference (Table 4), and there were almost as many business articles (93.8%) as consumer articles (89.1%) with a theme reference.

The hypothesis was somewhat supported in terms of the amount of coverage that articles devoted to the themes. The three themes combined accounted for a plurality of the coverage in the articles (46.3%) compared to “other” themes (41.9%).

Business articles had a similar amount of coverage on the three themes as on “other” themes, at 41.4% and 41.3%, respectively. Consumer articles also covered the three themes and “other” themes about the same, at 51.2% and 41.9%, respectively.

Hypothesis 2a

Hypothesis 2a asserted that media targeting a consumer audience would have the

Table 5

Amount of Theme Coverage in Business vs. Consumer Articles.

Theme	Number of Articles Containing the Theme			Theme Coverage as % of Article		
	B (n = 48)	C (n = 46)	Mean	B	C	Mean
Cost	39 (81.3%)	32 (69.9%)	71 (75.5%)	30.8%	19.6%	25.2%
Provider Selection	11 (25%)	20 (45.3%)	31 (33%)	4.8%	10.0%	7.4%
	$z = 2.11$					
Treatment Options	15 (31.3%)	31 (67.4%)	46 (48.9%)	7.7%	19.6%	13.7%
	$z = 3.5$			$z = 1.7$		
Other	44 (91.6%)	38 (82.6%)	82 (87.2%)	41.3%	41.9%	41.6%

Note. Z-scores listed only where $z \geq 1.645$.

same amount of cost coverage as media for a business audience. The findings (Table 5) supported this hypothesis. In terms of the number of articles, there was not a statistically significant difference between business magazines and consumer magazines. The cost theme appeared in 81.3% of business articles and 69.9% of consumer articles ($z = 1.22$).

In terms of the amount of coverage devoted to cost (as a percent of the entire article), business and consumer magazines again were similar. Cost made up 30.8% of the coverage in all business articles and 19.6% in consumer articles, although this

difference was not significant ($z=1.24$). (In this context, “all” includes every article, whether or not it contained the cost theme.)

Hypothesis 2b

This hypothesis stated that media for a consumer audience would have more coverage on provider selection and treatment options than would media for a business audience. The findings (Table 5) supported this hypothesis, revealing some significant differences in coverage by business magazines versus consumer magazines.

Provider selection. One of the significant differences had to do with the number of articles with the provider selection theme. Almost twice as many consumer as business articles (45.3% compared with 25%) cited provider selection ($z=2.11$). However, there was not a significant difference between consumer and business articles in the amount of coverage on provider selection. Business articles devoted only 4.8% of their coverage to the theme, versus 10% for consumer articles.

Treatment options. A significant difference found for this theme was that over twice as many consumer articles as business articles carried the theme. The theme appeared in 67.4% of all the articles in consumer magazines, but only 31.3% of articles in business magazines ($z=3.5$) (Table 5). There was also a significant difference in the amount of coverage given to the theme in consumer articles versus business articles. Consumer articles devoted 19.6% of their coverage to treatment options, compared with 7.7% for business articles ($z=1.7$).

Hypothesis 3

Hypothesis 3 stated that more of the coverage would be unfavorable than

Table 6

Number of Articles and Paragraphs of Favorable, Unfavorable, and Neutral Coverage

Nature of Coverage	Number of Articles Containing the Theme			Number of Paragraphs		
	B (n = 48)	C (n = 46)	Mean	B	C	Total
Favorable	35 (72.9%)	27 (58.7%)	62 (65.8%)	180	98	278
Unfavorable	33 (68.6%)	35 (76.1%)	68 (72.3%)	251	403	654
Neutral	46 (95.8%)	40 (87.0%)	86 (91.5%)	346	269	615

Note. Z-scores listed only where $z \geq 1.645$.

favorable. In terms of significant results, there is support for hypothesis 3, as illustrated in Table 6.

The support is not apparent when the number of magazine articles with favorable coverage is compared to the number with unfavorable coverage. Table 6 shows that favorable coverage appeared in nearly as many of the 94 articles (65.8%) as did unfavorable coverage (72.3%). The raw numbers of paragraphs also fail to support hypothesis 3. There were 278 paragraphs of favorable coverage compared to 654 paragraphs of unfavorable coverage. It is important to note that these numbers provide only a general sense of the coverage and cannot be viewed as significant.

Table 7

Amount of Favorable, Unfavorable, Neutral Coverage, by Group Means

	Favorable	Unfavorable	Neutral
B	26.3%	27.3%	46.0%
C	17.2%	41.1%	42.3%
Total	21.8	34.2	44.2%

$z=1.9$

$z=1.41$

$z = 3.27$

There is support for AAHP's claims of negative coverage when the total means for favorable and unfavorable coverage are compared and when balance of coverage is considered (elsewhere in this paper, only the relationship between favorable and unfavorable coverage has been explored, exclusive of the effect of neutral coverage).

Table 7 shows the means for favorable and unfavorable coverage in all articles and indicates that the total amount of favorable coverage (mean 21.8%) was indeed lower than that of unfavorable coverage (mean 34.2), at $z=1.9$. This affects overall balance of coverage, which takes into consideration the role of neutral coverage.

Balance of coverage is achieved when the percentages literally balance each other out. As Table 7 shows, the combined mean for favorable and unfavorable

coverage ($21.8\% + 34.2\% = 56.0\%$) is greater than the mean for neutral coverage (44.2%). This indicates that the coverage is biased. The bias goes in the negative direction, as indicated by the greater mean amount of unfavorable versus favorable coverage.

Hypothesis 4

Hypothesis 4 proposed that less “unfavorable” coverage would appear in media for a business audience than in media for a consumer audience. The findings show support for hypothesis 4.

In terms of number of articles, Table 6 had indicated that fewer of the articles in business magazines (68.6%) than in consumer magazines (76.1%) ran unfavorable coverage, although this difference was not significant ($z=1.453$). Likewise, as shown in Table 8, the amount of unfavorable coverage as a proportion of the entire article was lower in business articles (27.3%) than in consumer articles (41.1%), and this difference was significant ($z = 1.68$).

Summary and Conclusions

The impetus for this study was the implication by AAHP that the media are giving negative coverage about HMOs, which is contributing to the public feeling “less positive” than it used to toward HMOs. Thus, the questions addressed in this study related to (1) whether or not the media set the public agenda on HMOs, (2) if the media coverage was biased against HMOs and (3) whether or not the direction of media coverage matched the direction of public opinion about HMOs.

Table 8

Nature of Coverage (Favorable, Unfavorable, Neutral) in Business versus Consumer Articles

Nature of Coverage	Theme Coverage as % of Article		
	B (n = 48)	C (n = 46)	Mean
Favorable	26.3%	17.2%	21.7%
Unfavorable	25.0%	41.3%	33.2%
	$z \approx 1.68$		
Neutral	48.7%	41.5%	45.1%

Note. Z-scores listed only where $z \geq 1.645$.

Media Agenda-setting, Attitude Theory and HMOs

Research on media agenda-setting and attitude theory along with the findings of this study suggest that media could have done these things. However, there are several important qualifications about that observation.

Researchers agree that, in general, media have the capacity to set the public agenda. The extent to which media can set the public agenda and influence opinions varies widely and is contingent on a host of conditions. Notably, on issues with which people lack direct personal experience, as many do with HMOs, the media have a

greater capacity to set the public agenda. Media has demonstrated a capacity to bring such issues into public awareness and to shape public opinion, to the extent that media are a main information source and are perceived as a credible.

In scientific or other highly technical fields, such as medicine, people are often willing to discount their own personal experience and beliefs and trust the “experts” instead. These experts could be people or they could be media vehicles, such as magazines (e.g., *Bicycling Magazine* could be perceived as an expert in riding techniques).

For media agenda-setting to have occurred, it must be demonstrated that the issues in the media are the issues the public considers important, as measured by public surveys, polls, and the like. The themes of concern to AAHP did appear in the magazine articles and collectively represented the majority of coverage in the articles. Some discussion of the themes is as follows.

As noted in the “Results” section, the cost theme was particularly prominent, appearing in three-fourths of all articles and constituting 25% of the coverage in the articles. Treatment options also emerged as a major topic, appearing in nearly half of all articles and constituting about 14% of the coverage in the articles. But, weakening AAHP’s claim of agenda-setting is that the provider selection theme appeared in only one-third of the articles and constituted a mere 7.4% of the coverage. While provider selection emerged from AAHP’s survey as a major public concern, it did not emerge as such in this content analysis.

Further, this study also showed that 87.2% of the articles contained themes

other than cost, treatment options and provider selection, and that these “other” themes constituted 41.6% of the coverage in the articles. This suggests the presence of additional themes--some of which may be major themes-- not accounted for in AAHP’s survey and in this study. What might those themes be? Some possibilities may derive from a study commissioned by several large HMOs and reported in *Modern Healthcare* (Kertesz, 4 November 1996).

The study, purportedly one of the first of its kind to be published, was a media survey done by the public relations firm Powell,Tate. The survey examined coverage of HMOs in several major newspapers, business magazines, and television news programs. Powell, Tate said in *Modern Healthcare* that “four highly charged issues generated most of the negative themes: denial of care, executive compensation, drive-through deliveries and gag-clause controversies. The three main sources of favorable coverage were stories that focused strictly on cost to consumers, customer satisfaction and quality surveys” (p. 10).

Powell, Tate’s results thus bear some similarities to the findings in this study and suggest at least three additional themes. One similarity has to do with the “negative themes,” in particular denial of care, drive-through deliveries and gag-clause controversies. To the extent that these themes are related to treatment options, then the Powell, Tate study and this study are consistent in finding that thematic coverage was unbalanced in the negative direction. “Executive compensation,” a theme not noted in AAHP’s survey, is worthy of being singled out for further analysis. (In this study, executive compensation was combined into the “other themes” category.)

Another similarity between the Powell, Tate study and this study relates to the cost theme. “Cost to consumers” was a major source of favorable coverage in the Powell, Tate study, which examined only business publications. In this study, which included consumer as well as business publications, “cost” was also a major source of favorable coverage and the only one of the three themes with more favorable than unfavorable coverage. It is not surprising to note that, as shown in this study, business articles contributed a disproportionate amount of favorable coverage to cost, and that the difference in favorable cost coverage between business and consumer articles was significant (Table 7, $z = 2.77$). Like the executive compensation theme, the themes of customer satisfaction and quality surveys were not identified by AAHP as major areas of public concern. In this study, these themes would have been combined into the “other themes” category. They may, however, warrant research in the future as individual themes.

In considering comparisons between this study and the Powell, Tate study, it is important to keep in mind that the latter considered three types of media and the former, a single type. It cannot be assumed that television and newspapers cover HMOs in the same way that business magazines, or magazines in general, do. The aggregate findings for three media may not be in proportion to the findings for an individual medium. Thus, when comparing aggregate and individual findings, a skewed comparison may result.

All in all, however, to the extent that the themes in this study match the themes from AAHP’s survey, and to the extent that researchers consider such matches to be

evidence of media agenda-setting, then it can be said that media may have played a role in bringing certain HMO issues to the public agenda.

Media Bias

In the aggregate, results of this study substantiate the belief that the media coverage is negative. Within that aggregate, however, it must be noted that selective bias exists. Most notable was that, compared with business articles, consumer articles had significantly more unfavorable coverage. Conversely, business articles had more favorable coverage. Thus, if there are increasingly more unfavorable attitudes toward HMOs because of the media, those attitudes are more likely coming from consumers and not purchasers of HMOs.

Recommendations for Further Research

In the preceding section, some additional themes were suggested as a possibility for further research. Another avenue for research involves placing themes from content analysis in a context--in this case, a conceptual model--to identify and possibly predict the groups whose issues may be headed for government regulation.

The context provided by the model sheds light on why AAHP might be concerned about media coverage; why AAHP counteracted in the form of an outcry against the media; and who, in addition to media, might be (or already are) targets for AAHP counteraction. As noted earlier in this paper, managed care proponents alluded to their concern that negative press would lead to a poor public image, citizen alarm, consumer advocacy and ultimately government regulation (Kertesz, 12 February 1996).

HMOs have enjoyed tremendous profits for the past few years, although there is evidence that profitability in the past fiscal year is not as strong as it once was. Government intervention at a time of profitability could pose a threat to future HMO growth, if regulations are passed that restrict the HMOs' profitable activities. In fact, government intervention is already occurring. In the area of treatment options, for example, many states have banned the so-called physician gag rules, which prohibit doctors from revealing certain types of information to their patients. Another example is that some states have curtailed "drive through deliveries," wherein a mother and her newborn are discharged from the hospital sometimes fewer than 24 hours after delivery.

The concerns of HMO proponents are reflected in the model in Figure 2, "The Public Arena of Marketing" (Pearce, 1979). The model shows the many public influences on organizations such as HMOs that market goods or services. Pearce notes that in an "imperfect market," where competition does not give buyers a power equal to or greater than that of sellers, "consumers usually get the short end of the stick" (p. 3). Some marketplace imperfections, according to Pearce (p. 4), are:

- inadequate or misleading warranties and service contracts
- misleading and deceptive practices
- inadequate information and excessive persuasion
- servicing rip-offs

Media, including the *Wall Street Journal* (Langreth, 1996), have openly assigned such imperfections to HMOs. Pearce contends that when there is widespread

dissatisfaction with the imperfect market, consumers are likely to act. Such an expression of dissatisfaction, says Pearce, may be termed “consumerism” (shown graphically as the arrow between the customer and company in Figure 2) and is the “backlash” to marketing.

Consumerism, despite its name, does not necessarily originate with consumers. It may be driven by a number of groups who act to bring about change in the market. These groups, whom Pearce calls “advocates,” include activists, media writers and pressure groups. Each group may have different motives and different abilities to influence the marketplace and government, says Pearce. In health care, there are several advocates in addition to media and the HMOs themselves, such as:

- traditional indemnity insurers, whose enrollments have dropped precipitously in the past few years
- hospitals, who have more costly, licensed beds than they can fill in part because of managed care’s emphasis on providing care in other, less expensive settings and the shorter length of stays under managed care
- health care professionals of all types who believe it is unethical and immoral for business to have any say in the treatments that patients get
- have access to specialty physicians, whose access to patients is controlled by the terms of the HMO arrangement
- businesses and individuals who welcome the cost efficiencies of HMOs, have been satisfied with their experiences with HMOs, and believe that health care reform has been long overdue

- nursing homes, which offer skilled nonacute care at a lower cost than hospitals

These groups, in addition to consumers themselves, can exert tremendous pressure on government, which, in contemporary times, has shown increasing willingness to intervene in the marketplace (Kotler, 1991; Pearce, 1979).

As well as politicizing issues, these groups can also promote issues in the general public, perhaps to spur consumer alarm (whether such alarm is warranted or not) and trigger a backlash to business and perhaps an entire industry. Pearce comments, “There are many ways to measure the extent of consumerism. Some analysts monitor complaints to various organizations, while others use media as a proxy measure” (p. 6). Based on AAHP’s reaction to media coverage, one might well assume that AAHP is the latter type of analyst.

Nonetheless, AAHP is wise to monitor the environment and take note of the issues surfacing in the media. If AAHP views its survey results and media coverage as the early warning signs of consumerism, then it seems to have chosen one of the four basic responses to consumerism that Pearce describes, which is “to regard [consumerism] as a threat to be vigorously opposed” (p. 7). Pearce’s counsel, which is consonant with that of Kotler, would apply to HMOs: “In general, we have found that those firms who have regarded expressed consumer discontent as a marketing opportunity have fared far better than those marketers who have responded negatively or not at all” (p. 7).

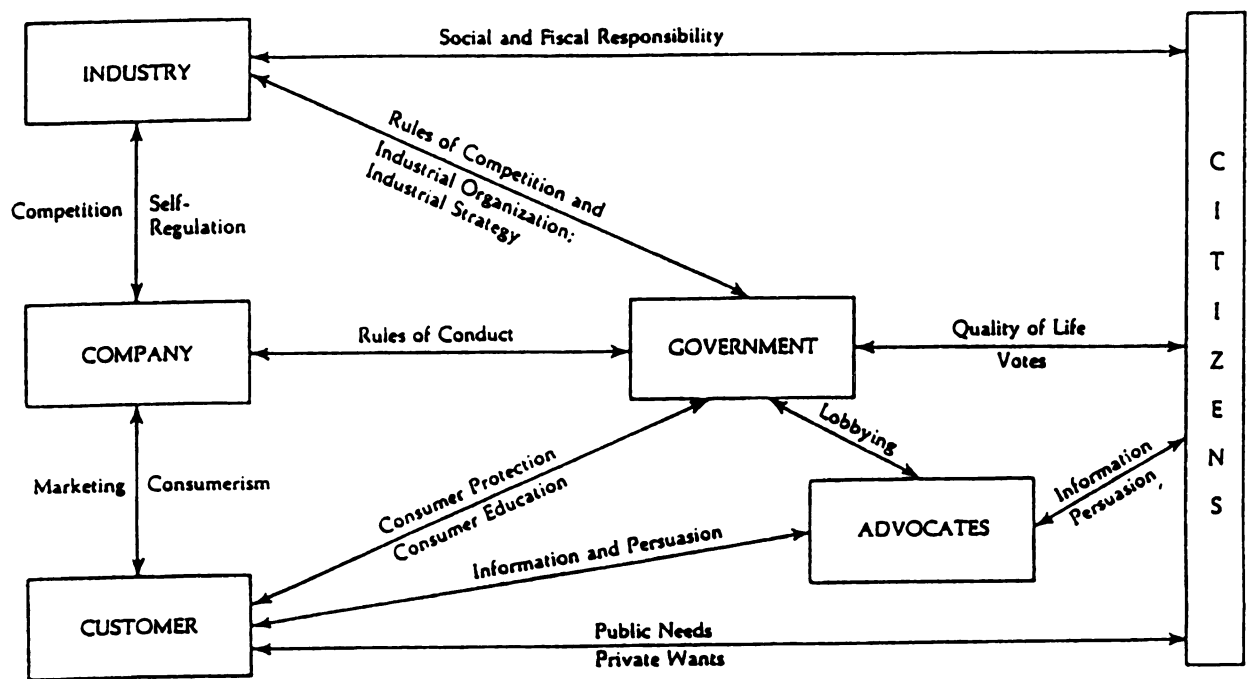


Figure 2

The Public Arena of Marketing.

In what ways could HMOs and consumers apply findings from studies of media coverage, in light of Pearce's model? HMOs could use the findings and the model to monitor issues in the future; to determine if consumerism is arising from unhappy consumers or another force seeking change in the market; to identify the group(s) who stand to gain from market changes; and to take corrective action so that today's issue does not become tomorrow's crisis.

Consumers who view media coverage in the context of Pearce's model may draw different conclusions about HMOs than they otherwise would, especially if they have no direct personal experience to inform their judgements. For example, as consumers, we may recognize that groups (including media) who are advocates for change regarding HMOs may have their own interests at heart, not the interests of consumers. We may also begin to see the dichotomy of health care in our own lives, wherein our individual desire for the fullest possible range of treatments is in contrast to our societal desire for limits on the cost of health care.

APPENDIX

APPENDIX

Coding Instructions

1. This project requires that you put aside any personal or professional opinions you may have about health care providers of any kind, such as health maintenance organizations, hospitals, doctors, nurses, etc. Your objectivity is required.
2. Read each paragraph of the articles and code each paragraph in the manner described below. Please be sure to put the marks clearly by each paragraph (when the type is small and paragraphs are close together, it could otherwise be hard to tell which marks go with which paragraph). DO NOT MARK headlines, captions, boxed inserts, call-outs or any other copy that is not part of the body copy.
3. Code each paragraph as follows:
 - ▶ **Mark only one theme per paragraph, using C, P, T or O**
 - C** = Cost: the overall cost of HMO coverage paid by purchasers of group health coverage and by insured individuals
 - P** = Provider Selection: the insured individuals' capacity to select the family doctor or specialist of their choice
 - T** = Treatment Options: the types of medical treatments covered and paid for by the HMO, as well as the information that is available to patients in HMOs about a range of treatment options.
 - O** = Other: any theme other than the three noted above
 - ▶ **If the paragraph is not at all about HMOs, mark it as "not applicable"**
 - NA** = Not Applicable
 - ▶ **Mark the coverage of the three themes, using F, U or N (do not mark coverage of the NA paragraphs)**
 - F** = Favorable to HMOs
 - U** = Unfavorable to HMOs
 - N** = Neutral to HMOs, which includes:
 - when the coverage is neither favorable nor unfavorable
 - when the coverage has both favorable and unfavorable statements to an equal degree

LIST OF REFERENCES

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- A. Foster Higgins. (1994). *National survey of employer-sponsored health plans*. New York: Author.
- Aaker, D.A., Kumar, V., and Day, G.S. (1995). *Marketing Research* (5th ed.). New York: John Wiley and Sons.
- American Hospital Association (1997). *Campaign for Coverage*. Washington, D.C.: Author.
- Angell, M., and Kassirer, J.P. (1994). Clinical research -- what should the public believe? *New England Journal of Medicine* 331: 189-90.
- Bishof, R.D. and Nash, D.B. (1996). Managed care: past, present and future. *Medical Clinics of North America* 80 (2): 225ff.
- Boehm, L.E. (1994). The validity effect: a search for mediating variables. *Personality and Social Psychology Bulletin* 20(3): 285-93.
- Boninger, D.S., Krosnick, J.A., and Berent, M.K. (1995). Origins of attitude importance: self interest, social identification and value relevance. *Journal of Personality and Social Psychology* 14 (1):61-80.
- Cafferky, M.E. (1995). *Managed care and you: a consumers' guide to managing your health care*. New York: McGraw Hill.
- Edwards, J.N., Blendon, R.J., and Leitman, R. (1992). The worried middle class. In R.J. Blendon and T.S. Hyams (Eds.), *Reforming the system: containing health care costs in an era of universal coverage* (pp. 61-81). New York: Faulkner and Gray.
- Englis, B., and Solomon, M.R. (1995, Spring). To be and not to be: lifestyle imagery, reference groups and the clustering of America. *Journal of Advertising* 24 (1), 13-28.
- Frey, L.R., Botan, C.H., Friedman, P.G., and Kreps, G.L. (1991). *Investigating communication: an introduction to research methods* (pp. 212-15). Englewood Cliffs, NJ: Prentice Hall.

- Frey, L.R., O'Hair, D., and Kreps, G.L. (1990). Applied communication methodology. In D. O'Hair and G. Kreps (Eds.), *Applied communication theory and research*. Hillsdale, NJ: Lawrence Erlbaum Associates.
- Gaddy, A. (1996, February). What's an HMO? *Missouri Digital News*. State Government Reporting Program, University of Missouri School of Journalism.
- Goidel, R.K., and Langley, R.E. 1995. Media coverage of the economy and aggregate economic evaluations: uncovering evidence of indirect media effects. *Political Research Quarterly* 48 (2): 313-28.
- Group Health Association of America. (1995). *Industry positioning research*. Washington D.C.: Peter D. Hart Research Associates.
- Hauss, D. (1993, February). Measuring the impact of public relations: new electronic research methods improve campaign evaluation. *Public Relations Journal*, 14-21.
- Hawkins, D.I. Best, R.J., and Coney, K.A. (1995). *Consumer behavior: implications for marketing strategy* (6th ed.). Chicago: Richard D. Irwin.
- Holbrook, T., and Garand, J.C. 1993. What do citizens know and how do they know it? Explaining accuracy in economic perception during the 1992 presidential election. Paper presented at the 1993 annual meeting of the American Political Science Association, Washington, D.C. Sept. 1-5.
- Kertesz, L. (1996, February 12). Payers start to worry about impact of HMO's bad press. *Modern Healthcare*.
- Kertesz, L. (1996, November 4). Survey confirms HMOs' bad press. *Modern Healthcare*.
- Kotler, P. (1991). *Marketing management: analysis, planning, implementation and control* (7th ed.) Englewood Cliffs, NJ: Prentice Hall.
- KPMG Peat Marwick. (1994). *Trends in health insurance*. New York: Author.
- Lang, G.E., and Lang, K. (1982). Watergate: An exploration of the agenda-building process. In G.C. Wilhoit and H. DeBock (Eds.), *Mass communication review yearbook* (Vol. 2, pp. 447-68). Newbury Park, CA: Sage.
- Langreth, R. (1996, October 24). Picking a plan. *Wall Street Journal*, p. R24.

- Larson, C.U. (1986). *Persuasion* (4th ed.). Belmont, CA: Wadsworth.
- Larson, E. (1996, January 22). The soul of an HMO. *Time*. 147 (4): 44-52.
- Massachusetts Association of HMOs. (1997). What are HMOs? *Background and history of HMOs*. Author.
- MacKuen, M.B., Erickson R.S., and Stimson, J.A. 1992. Peasants or bankers? The American electorate and the U.S. economy. *American Political Science Review* 86: 597-611.
- Mazur, A. (1981). Media coverage and public opinion on scientific controversies. *Journal of Communication* 31 (2) (Spring): 106-15.
- McCombs, M., Einsiedel, E., and Weaver D. (1991). *Contemporary public opinion: issues and the news*. Hillsdale, NJ: Lawrence Erlbaum Associates, Publishers.
- McCombs, M., and Shaw, D.L. (1972). The agenda-setting function of the mass media. *Public Opinion Quarterly* 36 (Summer): 176-87.
- McLeod, G.K. (1995). An overview of managed care. In P.R. Kongstvedt (Ed.), *Essentials of managed care* (pp. 1-8). Gaithersburg, MD: Aspen Publishers.
- Mercy Health Services (1991). *Annual Report*. Farmington Hills, MI: Author.
- Miller, R.H., and Luft, H.S. (1994). *Journal of the American Medical Association* 271 (19): 1512-19.
- Pearce, M.R. (1979). The public arena of marketing. In C.J. Frey, T.C. Kinnear and B.B. Reece (Eds.), *Public policy issues in marketing* (pp. 1-16). Ann Arbor, MI: The University of Michigan.
- Peter, J.P., and Donnelly, J.H., Jr. (1995). *Marketing management knowledge and skills* (4th ed.). Chicago: Richard D. Irwin.
- Rossiter, J.R., and Percy, L. (1997). *Advertising communication and promotion management*. New York: McGraw Hill.
- Safer D.J., and Krager, J.M. (1992). Effects of a media blitz and a threatened lawsuit on stimulant treatment. *Journal of the American Medical Association* 268: 999-1003.

- Scissors J.Z., and Bumba, L. (1993). *Advertising media planning*. Chicago: NTL Business Books.
- Smith, K. (1987). Effects of newspaper coverage on community issue concerns and local government evaluations. *Communication Research* 14 (4): 379-95.
- Stempl, Guido. (1989). Content analysis. In G. Stempl (Ed.), *Research methods in mass communication* (pp. 125-36). Englewood Cliffs, NJ: Prentice Hall.
- Tan, A. (1985). Research methods in mass communication. *Mass communication theories and research*. New York: John Wiley & Sons.
- Taylor, H., Leitman, R., and Blendon, R.J. (1992). Large employers and managed care. In R.J. Blendon and T.S. Hyams (Eds.), *Reforming the system: containing health care costs in an era of universal coverage* (pp. 83-101). New York: Faulkner and Gray.
- Wagner, E. (1995). Types of managed care arrangements. In P.R. Kongstvedt (Ed.), *Essentials of managed care* (pp. 24-33). Gaithersburg, MD: Aspen Publishers.
- Zuwerink, J.R., and Devine, P.G. (1996). Attitude importance and resistance to persuasion: it's not just the thought that counts. *Journal of Personality and Social Psychology* 70 (5): 931-44.