AN EMPIRICAL STUDY ON THE USE OF PROMOTION IN HOSPITALS

DISSERTATION

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By

Pradeep Gopalakrishna, B.S, M.B.A

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The role of marketing and marketing communication in hospitals has grown in the last decade. The need for hospitals to make careful decisions about their marketing communication efforts is mandated, given the changes taking place in the hospital industry.

The purpose of this dissertation was to conduct empirical research to determine whether for-profit and non-profit hospitals perceive and utilize promotion as a marketing strategy element. The two steps taken included: identifying important factors considered by hospital administrators and marketing staff in the development of communication messages designed for patients, hospital staff and medical staff; and testing the factors developed and studying the attitudes of hospital personnel toward promotion using a national sample of hospitals.

In phase 1, focus group interviews were conducted in a surrogate for-profit hospital and a surrogate non-profit hospital. In phase 2, an original mail questionnaire was used to collect data from a sample of 80 hospitals. A total of 38 hospitals participated, providing 114 usable responses.
Test statistics included content analysis, Chi-Square, Pearson correlation coefficient and Analysis of Variance.

The results of the focus group study indicated the practice of marketing in hospitals is in its early growth stages and marketing is viewed as nothing more than advertising and public relations. The results of the mail survey indicated that respondents in small for-profit hospitals with 20 to 30 years of experience as professionals, with key decision making authority, are favorably disposed to marketing and marketing communication. It was also found that respondents in large non-profit hospitals are very positive towards marketing. In contrast, respondents in medium and large for-profit hospitals, who are not directly involved in decision making, tend to be less positive towards marketing.

The study serves as a basis for future research which may involve, (1) a larger sample frame, (2) hospitals in inner-city and rural areas, (3) investigation of the association between hospital ownership and hospital efficiency, and (4) development of a profile of respondents by title held, in hospitals.
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CHAPTER 1

INTRODUCTION

Medical care is the nation's most important and controversial service industry today, in terms of the contrast between the money spent on health care as a percentage of the GNP and the millions of disadvantaged persons who are denied basic medical treatment because of a poor delivery system. Medical care accounts for seven percent of gross national product (GNP), and it is the third largest industry in terms of the number of persons employed in the United States. Health care expenditures have grown over 3500 percent over the last 30 years, with more than half due to inflation (from $12.7 billion in 1950 to $500 billion in 1987) (Reisler 1985 1985; New York Times 1988). Many developments have occurred that are changing the environment of the $500 billion health care industry in the U.S (New York Times 1988). The term 'Marketing' which has been embraced by business organizations extends to nonbusiness organizations as well (Kotler and Clarke 1987). Nonbusiness organizations include accounting firms, legal firms and health care institutions.

As exemplified in American industry, marketing is the process of planning and executing the conception, pricing,
promotion and distribution of ideas, goods and services to
create exchanges that satisfy individual and organizational
objectives (AMA Board 1985). Thus marketing is the process
of relating the needs and desires of the market (customers)
with the products or services offered to effect a transfer
of ownership (Fryzel 1978). Both profit seeking and
nonprofit institutions perceive marketing as a necessary
management practice. However, traditionally, health care
institutions have exhibited reluctance to identify the
marketing activities practiced as "marketing." In the past
few years, the reluctance on the part of health care
institutions to recognize marketing as an integral function
of its management orientation has resulted in operating
inefficiency and marketing ineptitude.

Problems In Health Care - An Overview

The past few years have seen hospitals in a state of
turmoil, a result of significant changes and developments
in the health care industry. Some of the marketing problems
and developments include:

1. Since the 1970s the utilization rate of the beds in
the nation's 7000 hospitals has declined from 80 percent to
only 60 percent.

2. Several new types of health care delivery systems
have emerged to respond to changing consumer
attitudes/needs and changing regulatory forces. Health
maintenance organizations (HMOs) and Preferred Provider organizations (PPOs) have grown rapidly since the 1970s. The overall impact has been aggressive competition which older health care institutions have not been ready for.

3. Third party payers such as Medicare and other insurance programs have enacted a prospective payment system (PPS) in 1983 for the providers of health care services. PPS rewards providers of health care services who are cost efficient and penalizes those that are not cost efficient. The majority of the nation's hospitals are non-profit institutions (80% of all U.S hospitals). These hospitals were for the last 20 years used to "cost-plus" reimbursement from Medicare, that is, they were automatically paid for whatever amount they spent. Some non-profit hospitals have failed to control their costs and continue to struggle under the new Medicare reimbursement regulations (Fisher 1985).

4. For-profit hospital chains are buying up non-profit hospitals at bargain prices. The investor owned hospital chains are surviving the current turmoil in the industry by focusing on minimizing costs and diversification to take advantage of the changing needs of the marketplace. For instance, Humana Corp. that owns 78 hospitals, runs all of its far-flung hospitals out of one large business office headquartered in Louisville, Kentucky (Fisher 1985).

5. A significant oversupply of physicians will exist by
the end of the decade as a result of the increased numbers of physicians and decreased demand. In 1987, there were 553,000 licensed physicians, 22 doctors for every 10,000 people in the U.S (Easterbrook 1987).

6. The image of hospitals has been eroding in the public eye. Patients' consciousness, the side effects of physicians' loss of esteem, consumerism, and changing societal expectations are some factors contributing to the declining image (Hisrich and Peters 1982).

These changes have resulted in hospitals throughout the nation intensifying their efforts to survive. It is estimated at least 500 hospitals will be forced to close by 1990 (Health Care Financial Management 1986). To survive, it is imperative for hospitals to adopt innovative marketing techniques and practice marketing in a systematic and scientific way, rather than on an ad hoc basis (Malhotra 1986).

The issue of marketing in hospitals has been debated in several articles. Some hospitals have been found to employ marketing techniques for defensive/survival reasons (Malhotra 1986). To quote John Alexander McMahon, President of the AHA:

The mention of hospital marketing brings a reaction from almost everyone. Some positive, saying it's the wave of the future; some negative saying it will undermine the voluntary system. And both views are often supported equally well (American Hospital Association, First Quarterly Report, 1977).
The longstanding emotional debate over the utilization of marketing as a management tool for hospitals has been captured in the above statement.

The Role of Marketing in Hospitals

Marketing activities play an important role in the success of modern organizations. The need to know one's markets, attract sufficient resources, convert the resources into goods, services and ideas, and make them accessible to the consumers is the key to survival. This is true for both commercial, profit-oriented businesses and health care institutions as well.

Marketing has its defenders as well its critics. Supporters of marketing believe that marketing is more than advertising, selling and public relations. It is inclusive of activities required to plan, facilitate, and conduct voluntary exchanges to mutual benefit. Some advocates note that marketing is value free. It is comprised of a set of concepts and techniques which can be used for good or for evil. Further, it is believed that marketing techniques reduce health care costs by helping both providers and receivers of the service to make more rational and efficient decisions.

Critics of hospital marketing on the other hand, note that marketing is the same thing as advertising, selling and public relations. Marketing is equated with
'hucksterism' and manipulation. Another reason for the limited acceptance of marketing by hospitals is the concern to label health care as a 'product,' and the fear that competition could lead to hospitals focusing on filling beds rather than on providing needed services. Also related to the stigma of marketing as advertising and/or selling is the association of marketing with profit making (Robinson and Cooper 1980-81). Marketing wastes money. That this is particularly true for nonprofit health care institutions is the contention of critics. Traditionally, nonprofit hospitals have had to deal with three parties: physicians, donors and consumers. The majority of marketing activities in the past have been focused on the donors. However, this is changing with the shift to the prospective payment system by Medicare and other third-party insurance organizations. One reason being that funds from donors have not kept up with the financial needs of nonprofit hospitals since the shift.

Thus with donors providing fewer funds and resources, and users generating more funds through third-party payors, traditional non-profit hospitals are increasing their marketing efforts to attract users. An additional reason why health care organizations are interested in marketing is the impact of the regulatory process. Marketing in health care institutions is acceptable and necessary to combat the combined effect of political, economic and
social forces. The shift from a cost based reimbursement system to a prospective payment system (PPS) by Medicare and third party insurance carriers established strong economic incentives for hospitals to keep their costs down. According to the PPS, Medicare will pay capital costs and physician fees on a prospective basis (Health Care Financial Management 1986). The regulated pricing system rewards hospitals that control their costs below the predetermined rate and penalizes hospitals that exceed the rate. The cost-based reimbursement system compensates hospitals for the length of the patient's stay and the amount of treatment. By 1987, the Medicare program that accounts for 36 percent of hospital operating revenues will pay hospitals average pre-fixed rates for each of 467 categories of illness, called "diagnosis related groups" (DRGs) (Kotler and Clarke 1987). The average length of stay of hospitals has dropped from 9.5 to 7.5 days, after the regulation has taken effect (Tomasson 1984). An informal survey of 100 physicians nationwide, conducted by Omega Research Consultants, Inc. Chicago, and Hospitals magazine, revealed that 65 percent of the physicians agree that providers should treat patients without considering their ability (Powills 1987). According to Kotler and Clarke (1987) an increasing number of marketers are incorporating consumer needs, consumer wants and society's interests in their decision making. This is called a societal marketing
orientation (Kotler and Clarke 1987). Jack Owen, director of American Hospital Association, speculates that with competition in the hospital industry intensifying, the fear that hospitals may lose sight of their mission, which is to provide care for all people (including the poor and needy) within the community (Interview 1985). Health care spending since 1950 has been increasing steadily. In recent years more than 50 percent of hospital cost increases are attributable to price rise. Health care providers are also competing to combat the excessive supply of services.

Thus, there is a need for hospital marketers to realize that marketing is a management tool which can provide more efficient distribution of the health care dollars. Overall, the interest in health care marketing is a result of the increase in competition. The health care industry has slowly but steadily embraced the 'marketing concept.' The marketing concept is a management philosophy with a three-pronged emphasis: (1) a market or customer orientation; (2) a subordination of departmental aspirations to company-wide goals; and (3) a unification of company operations (Fryzel 1978).

Because of the recent fundamental changes in the health care industry, it is imperative that both 'profit' and 'non-profit' hospitals compete for health care dollars, as though their lives depended on it. Hence, to stay competitive in the changing environments, hospitals must
make careful decisions about product, pricing, promotion and distribution. Promotion is a form of communication used to inform, persuade, or remind people about an organization's goods, services and ideas (Evans and Berman 1987). Promotion is a critical element of marketing that is useful and is of appreciable value to a health care institution. In the last ten years, since 1977, the use of systematic communication strategies designed to gain the attention and interest of the public has greatly increased. Specifically, the increase in competition, emergence of alternate forms of delivery, eroding image of hospitals and, changing consumer preferences have made it important for a hospital to differentiate its market position and present a distinctive image. Cavusgil (1986) points out that the "communications" component is an integral part of the marketing plan for hospitals. The strengths of a hospital should be identified and communicated to target markets via the communication component. For example, a few appropriate themes that can be communicated via the promotional efforts include:

1. The human care element (friendly, courteous people);
2. Diversity of services offered;
3. Location; and
4. Ancillary services offered (educational and community-oriented programs).
The changes in health care marketing in general mandate that hospitals (in particular) need to enhance and strengthen their efforts in developing innovative marketing practices. Specifically, as the public becomes more educated and cost conscious, hospital administrators will need to manage their facilities more efficiently. The need to adopt a marketing orientation can be a viable management tool, in the effort to effectively communicate with the public and stay in touch with the increasingly competitive environment (Cavusgil 1986).

Given that the hospital industry is in a state of flux and changes continue to take place, the hospitals that will eventually survive and be seen as "winners" include those that learn to manage their marketing communication efforts (MacStravic 1985; Malhotra 1986). A hospital's communication responsibilities go far beyond communicating to target consumers only. Effective communication with publics in the external environment, such as the press, government agencies, and the financial community, is required. Hospitals must also communicate effectively with the groups within the hospital: (1) board members, auxiliaries, trustees; (2) hospital employees (nurses, technicians, housekeeping, support personnel) and; (3) Hospital medical staff (Kotler 1982). Efforts directed toward the external publics and the internal publics must complement each other and serve a unified purpose of
enhancing quality, productivity and efficiency. In a hospital, with several categories of people, communication among them can be as difficult as with external people.

Purpose of Research

The purpose of this dissertation was to conduct an empirical research study involving both for-profit hospitals and non-profit hospitals. Both types of hospitals are seen as encountering pressures from competitive, regulatory and patient environments.

The dissertation research consisted of two major phases:

Phase I: To identify the important factors, which influence and are considered by various hospital personnel (administrator and marketing staff members) in the development of communication messages, designed for: (a) patients (external groups) and; (b) hospital employees and medical staff members such as physicians.

Phase II: To identify and study the attitudes of hospital personnel (senior administrative members and medical staff members) in a national sample of for-profit and non-profit hospitals, toward (a) Important factors considered in the development of communication messages, derived in Phase I.
(b) Perception and utilization of 'promotion' as a marketing strategy element.

Specifically, in Phase I, focus groups were conducted in a surrogate for-profit hospital and a surrogate non-profit hospital. Subsequently, in Phase II, based on findings using focus groups in Phase I, hypotheses were developed and tested utilizing mail surveys. The questionnaires were structured and based on the hypotheses to be tested. Questionnaires were mailed to 40 for-profit and 40 non-profit hospitals throughout the nation. A multi-step interactive interpersonal influence communications model by Robertson, Zielinski, and Ward (1984) served as the theoretical basis for the dissertation research. A flow-chart of the current study, indicating the two phases, is shown in Exhibit I which appears later.

Statement Of The Problem

The problem underlying the current study is the way promotion is perceived and utilized as a marketing strategy element in hospitals. Full service general medical care hospitals represent the part of the health care industry in the current environment with the greatest need for effective use of marketing strategies, including promotion. It is perceived that there is lack of empirical research in the way promotion as a marketing strategy element is perceived and used in hospitals. In addition, there is no
theoretical model advanced in the communications literature that has been applied in health care institutions.

The Statement Of Major Study Propositions

The following research propositions were examined in Phase I of the current study. Details on research propositions appear later in Chapter III. The propositions will be stated as follows:

P1: For profit hospitals have a greater propensity to consider audience factors or 'targets of communication' in the development of communication messages, in contrast to nonprofit hospitals, given differences in perceptions on the competitive, regulatory and patient environments.

P2: For profit hospitals have a greater propensity to consider communication factors in the development of communication messages, in contrast to nonprofit hospitals, given differences in perceptions of the competitive, regulatory and patient environments.

P3: For profit hospitals have a greater propensity to utilize advertising, personal selling, publicity and sales promotion as tools in contrast to nonprofit hospitals, given differences in perceptions of the patient, regulatory and competitive environments.
P4 : For profit hospitals have a greater propensity to wield greater personal influence between the hospital and its employees, in contrast to non-profit hospitals -- vis-a-vis the multi-flow interpersonal influence model chosen for the study. Given, there are differences in perceptions of the competitive, regulatory and patient environments.

P5 : Administrative personnel (administrator, marketing staff) have a greater propensity to be favorably predisposed toward 'promotion,' in contrast to other hospital personnel (medical staff, departmental staff).

P6 : Administrative personnel (administrators and marketing staff) in for-profit hospitals have a greater propensity to be favorably predisposed toward promotion, in contrast to administrative personnel in non-profit hospitals.

Major Questions Addressed

Major questions to be addressed in the dissertation include the following:

1. Do profit hospitals have a greater propensity to consider audience factors or 'targets of communication' designing communication messages in contrast to nonprofit hospitals, given differences in perceptions on the competitive, regulatory and patient environments?
2. Do profit hospitals have a greater propensity to consider communication factors in contrast to nonprofit hospitals, designing communication messages, given differences in perceptions of the competitive, regulatory and patient environments?

3. Do profit hospitals have a greater propensity to utilize advertising, personal selling, publicity and sales promotion as tools in contrast to nonprofit hospitals, given differences in perceptions of the patient, regulatory and competitive environments?

4. Do profit hospitals have a greater propensity to wield greater personal influence, between the hospital and its employees, in contrast to non-profit hospitals -- vis-a-vis the multi-flow interpersonal influence model chosen for the study, given differences in perceptions of the competitive, regulatory and patient environments.

5. Do administrative personnel (administrators and marketing staff) have a greater propensity to be favorably predisposed toward 'promotion' in contrast to other hospital staff (physician staff, departmental staff)?

6. Do administrative personnel (administrators and marketing staff) in for-profit hospitals have a greater propensity to be favorably predisposed toward 'promotion,' in contrast to administrative personnel in non-profit hospitals?
Importance of Research

Since the introduction and acceptance of a more prominent role for marketing in the health care industry, promotion has evolved to mean more than public relations. The present research effort is important for both practitioners and academicians. From a practitioner point of view, the research is important for both public and private hospitals because it considers the factors and process involved in considering competitive alternatives available to various types of institutions, and selecting among them. In addition, the research attempted to categorize the attitudes of various individuals involved in the decision process. Also, the research endeavor is important for public and private hospitals, concerned with reimbursement for health care advertising. Although most of the hospitals that engage in institutional advertising have not been reimbursed, some have fallen under acceptable reimbursement guidelines (Kotler and Clarke 1987). However, today under the DRG or the prospective payment system, acceptable reimbursement guidelines may not be relevant for third party payors (such as Medicare). Thus if the advertising is not to be reimbursed, it must be perceived as an investment with a probable payback. Advertising is expected to grow in the future in the hospital market, given the legal loosening of restrictions, the increasingly competitive health care environment, and the greater
acceptance of marketing techniques (Kotler and Clarke 1987). Given, that promotion of health services has come under severe attack recently in regard to peer pressure and violation of professional norms, this dissertation is timely.

From an academic standpoint the research contributed to the existing limited knowledge base on the development and use of communication in health care institutions. Very little empirical research has been done in this area. Since the phenomenal surge of interest in the application of marketing to health care situations in the 1970s, over 200 articles and many books have been published on the healthcare field and marketing, but few on the use of promotion in the healthcare field. Researchers have examined the extent to which changes are occurring rapidly in the hospital industry. Marketing techniques and health care advertising have been found to be partial solutions to the problem of shorter patient stays and empty beds (Cooper 1985; Kotler and Clarke 1987; MacStravic 1986; Zaltman and Vertinsky 1971). Other areas of research that exist pertain to the value of marketing in health care (Clarke 1978) and the adoption of product line management techniques by hospitals, to better meet the needs of consumers, increase efficiency, and speed the decision making process (Lutz 1987; Malhotra 1986). MacStravic (1984) has studied the stringent rules that apply to the kinds of things hospitals
can say about themselves and their services, over and above the ethical concerns that apply to advertising. While some hospitals have attributed their success to effective advertising, many have reported dismal failures (MacStravic 1984). Overall, significant contributions have been made in the literature linking the utilization of marketing as a management tool in the alternative health care delivery systems, and in full service hospitals - but not in the use of communications and promotion.

There is a lack of empirical research in regard to the factors considered by hospitals in the development of communication messages. The present research is an attempt to develop a list of factors that are considered in the development of communication messages, and to test those factors using a national sample of general full service medical care hospitals.

Limitations of the Study

The dissertation is limited to a sample of full service general medical care hospitals which served as representative of tax-supported (public) and non-tax supported (private) hospitals. Generalization of the results beyond full service general medical care hospitals is limited. Further, the study is not designed to measure the effects of communication efforts, in terms of desired behavior changes in the receiver. Instead, the focus is to
determine if various members within the hospital differ in their perceptions toward marketing and marketing communication.

The Sample

As indicated earlier, in implementing the study two phases were involved. In Phase I, mini focus groups were conducted in two hospitals. In phase II, a national sample of 38 hospitals including 19 for-profit and 19 non-profit institutions were utilized. The sample included hospitals which varied in terms of number of beds, number of medical specialties offered, number of physicians, and number of medical staff on board. Since the purpose of the dissertation is not to examine the sequence of stages consumers progress through after being exposed to messages, no attempt will be made to query targets of the communication. Management personnel in all hospitals may not necessarily have the same job titles. Since all of the hospitals have basic differences in terms of financial stability and number of employees, role expectations may vary across the hospitals.

The two hospitals surveyed in Phase I differed in ownership. One is owned and operated by a non-profit corporation and the other is a for-profit hospital owned by American Medical International (AMI) Inc., the fourth largest hospital chain in the U.S. Ownership patterns
impacted the degree of control the marketing personnel had in the designing and implementation of communication messages. It was believed that the members in the two medical settings had different perceptions about the shift in the supply-demand relationship in the health care industry. Differences arose by virtue of their degree of stability in the industry. The national sample of hospitals varied in terms of all of the above factors.
CHAPTER II

A REVIEW OF THE LITERATURE

Introduction

An overview of the major issues in consumer behavior pertinent to the current study are presented in the literature review. In addition, theoretical base for the present study is established from the literature. The review is divided into four parts. Part one contains descriptions of the major consumer behavior models. Part two focuses on the communication literature and the major models advanced to date. A summary indicating the model to be chosen for this study as a theoretical base concludes part two. In Part three the emerging health care marketing literature is reviewed. Part four highlights the literature on the use of marketing by hospitals, particularly planning.

Overview of the Major Consumer Behavior Models

It was not until the middle 1960s that consumer behavior began to emerge as an interdisciplinary science, investigating decision making activities of individuals/families in their consumption roles. Some of the early writings in the discipline were built upon models
(Schiffman and Kanuk 1987). A model replicates the phenomenon it is intended to designate, that is, it specifies variables and identifies the nature of relationship among them (Engel and Blackwell 1982). To date several consumer behavior models have been developed. The most widely cited consumer behavior models are typically similar in a philosophical sense and do not differ significantly on an explicit basis.

In a philosophical sense, the models are conceived to capture the dynamics of consumer decision making and to provide a framework for researchers to test various dimensions of the models. In addition, some of the more complex consumer behavior models were designed to tie together the contents of a specific consumer behavior book.

On an explicit basis, the models provide insights for the design of future research to increase understanding of consumer behavior (Schiffman and Kanuk 1987). The models that have been developed over the past two decades have served several functions. Some of the models provide a bases for unifying research findings into a meaningful whole, such as the Engel-Kollatt Blackwell model. Other models have enabled research analysts to differentiate relevant concepts/relationships from certain behavioral variables thus eliminating some confusion and frustration. Still other models have served as guides to understanding the concept of these models, including the one advanced by
Hawkins, Best and Coney. In the next section a brief overview of some of the comprehensive models of consumer behavior is provided. Each model represents a particular point of view. In a general sense, the most widely accepted models of consumer behavior are: the Howard-Sheth model, the Engel-Kollatt-Blackwell model, the Nicosia model and the conceptual model advanced by Hawkins, Best and Coney.

The Howard-Sheth Model

The Howard-Sheth model of buyer behavior represents one of the earliest systematic efforts to develop a comprehensive theory of consumer behavior. There are four major constructs in the model: stimuli or information inputs, perceptual constructs, learning constructs and outputs. The information inputs represent stimuli from the environment. The input variables include stimuli from the product itself -- price factors, quality and service, or from symbolic representations -- verbal and visual product characteristics. These two inputs are called significative and symbolic stimuli. Family, social groups and social class could be another input variable that represent stimuli from the social environment. This refers to information such as word of mouth communication provided by the buyers' social environment regarding a purchase decision.

Perceptual constructs in the model include internal search for information, stimulus ambiguity, attention and
perceptual bias. Each perceptual construct procures and processes information relevant to a buying decision. Attention, one of the perceptual constructs for example functions as a gatekeeper to information entering the consumers' mental set. The consumer either devotes attention to information or ignores it. Stimulus ambiguity is a construct that affects 'attention' and 'overt search.' Consumers may at first pay attention to a message due to its novelty and then ignore it as being too trivial. Also, a message may receive attention due to its ambiguity up to a certain tolerance level. Thus, stimulus ambiguity refers to the perceived uncertainty and lack of meaningfulness of information received from the environment. Perceptual bias refers to the information distorted by consumers to achieve congruence with a given frame of reference, to parallel information already stored in the mind. Active information search (overt search) is engaged upon by the consumer when he/she is in a state of doubt about the choice between brands. This encompasses both extended and limited problem solving situations. Learning constructs include confidence, motives, intention, attitude, choice criteria, brand comprehension and satisfaction. These variables lead to concept formation. Both of these internal state variables are hypothetical constructs because they are not observable but must exist for outputs to occur. This model is one of the pioneering research efforts that represents the first
systematic effort to develop a comprehensive theory of buyer behavior. The model helps identify the variables that underlie the buying process (Howard and Sheth 1969).

**Limitations**

The model is more applicable to individual buyer behavior than to decision making within the family. In actual use, the model is more pertinent to explain choices between brands of the same product type than choices between alternative actions (for example taking a trip to the Bahamas versus buying a new stereo). The model does not take into account nonsystematic behavior. For example, consumers may engage in the purchase of products simply for variety or because of boredom with a certain brand.

Another limitation of the model is that it cannot be applied in situations in which there is no awareness of individual products within a product class that can be construed in the minds of the buyer as "brands." Some researchers argue that the model has numerous problems with regard to operationalization and predictive ability. The model has been considered to be needlessly confusing and in effect the applications of the model is complicated (Berkman and Gilson 1986).

Glenn Walters in his book Consumer Behavior: Theory and Practice comments:

The very complexity of the (Howard-Sheth) model causes problems with quantification. In the model as presented, there is no allowance for product
rejection or product postponement, and there is no real connection between purchase and the inputs that started the entire process. The interaction of the inputs, stimulus ambiguity and perceptual bias are inadequately explained (Walters 1978).

Furthermore, such variables as needs, communications, and decision processes are not emphasized in the model. Overall, the model has very little practical value for marketing practitioners (Walters 1978).

Advantages

One major advantage of the model is that it has been partially tested empirically which provides some credibility for the model. Also, the model is dynamic, incorporating learning that occurs due to the change in exogenous variables over time. The model is the first of its kind that incorporates the concept of evoked set (partial list of products in a class) as a novel idea. The model serves as an efficient teaching tool and as a heuristic model (McNeal and McDaniel 1982).

The Howard-Sheth model was revised, culminating in Howard's own model published in 1977. Howard's model has a high-involvement orientation and, like many of the other consumer behavior models, explains a large proportion of behavior with an explicit consumer decision process. Both the Howard-Sheth model and the Howard model are a viable means of organizing and interrelating research findings. See Figure 4 for a flow chart of the model discussed above.
The Engel-Kollatt-Blackwell Model

The Engel-Kollatt-Blackwell (E-K-B) model was developed to serve as a comprehensive framework for understanding consumer behavior. It serves as a reasonable predictive model of consumer behavior. The E-K-B model is constructed around the three major components: the central control unit, information processing and the decision process. The central control unit consists of both conscious and unconscious processes. It serves two functions: (1) reacting to external stimuli and (2) initiating and overseeing the decision process. Thus the central control unit which is vaguely synonymous with the central nervous system contains variables that interact to filter incoming stimuli, retaining some and discarding some. Information processing serves as a means by which external stimuli are filtered by a portion of the central control unit before they are admitted to consciousness. The four stages in information processing are: (1) exposure, (2) attention (conscious awareness) (3) comprehension and (4) retention (Berkman and Gilson 1986; Runyon 1980). The model places explicit emphasis on information processing. There are five stages or constructs around the decision process: (1) problem recognition, (2) information search, (3) alternative evaluation (4) choice and (5) outcome.

Problem recognition is activated by incoming stimuli via active memory. The stimuli emanate from sources such as
marketer dominated sources, mass media and personal sources of information. Motives may serve as a stimulus too. Problem recognition is defined as a difference of sufficient magnitude between the ideal and the actual state(s) to arouse the decision making process. Stage 2 characterized as information search involves sources of information used to make a decision among competing alternatives, and the relative influence of each. Prior beliefs and attitudes help serve as information sources in the initial internal search within memory stage. Often one brand will be preferred over another based on past experience and a decision will be made on the spot to make a purchase as soon as possible. This is an example of a low-involvement purchase decision. Often because of the length of time between purchases and the cost and effort associated with a purchase -- as in the case of the purchase of an automobile it is necessary to resort to external search. The extent of search is determined by the balance between the cost outlays to be expended and the expected gains. After search has been completed every consumer must evaluate the different alternatives and arrive at a purchase intention. In the alternative evaluation stage (3), the interaction between several different types of variables is involved. Evaluative criteria which are standards utilized by consumers to judge products are compared with the information gained through
the search process. The outcome is formation of beliefs. Once beliefs are either formed or changed, attitudes will also change, all things being equal. If an attitude is favorable it then is followed by the formation of a purchase intention, all things being equal. Postponement of a purchase may even result from unanticipated circumstances such as loss of a job or a demotion in a job and other pressing needs that need to be satisfied. Choice and outcome (Stages 4 and 5) are the final two stages in the decision process. Selection of a product among alternative products and selection of a retail store characterize these stages. If the outcome is positive, the result is satisfaction. Cognitive dissonance is a possible outcome after the product/service is purchased. Dissonance is a state of ambiguity that results concerning whether or not the right choice of alternatives was made. Typically, consumers engage in search for additional information to reduce dissonance to support the decision that the correct product was purchased. The Engel-Blackwell model serves as a direct guide for developing marketing strategy.

Limitations

One of the weaknesses of the E-K-B model is that the search and evaluation stages are overemphasized. Hunt (1983) states that a researcher who wishes to include 'environmental influences' in a test of the E-K-B model, will have very little guidance as to specifically which
environmental influences to include and how each should be related to other key constructs (Hunt 1983). Some researchers agree that the chief limitation of the model lies in its simplicity. For example, the control unit's structure and function are unclear and, the stages in the consumer decision process appear mechanical disregarding the complexities of human behavior. Several key psychological variables such as needs, motivation, learning, are merely implied in the model, not explicitly specified. The link between the environmental influences, the central control unit and to information processing are exceedingly vague.

Advantages

The primary advantage of the E-K-B model is its emphasis on decision making and conscious behavior, characteristics that extend themselves to analysis and experimentation. The model is both comprehensible and comprehensive -- focussing on the decision process more effectively than some other models. The model has been applied across situations as diverse as the purchase of automobiles and laundry detergents with significant results of marketing decision making. Overall, the E-K-B model both clarifies and extends the understanding of consumer behavior (Berkman and Gilson 1986; McNeal and McDaniel 1982; Runyon 1980). A flow chart of the model is shown in Figure 3.
The Nicosia Model

The Nicosia model describes a 'modus operandi' of a type of decision process without reference to any specific product and brand. The model comprises of four major fields or building blocks, with certain variables and functional relations placed in different fields based on the theoretical perspective of the author. The overall comprehensive scheme is basically a computer program that describes the invariant structure of consumer behavior showing the interrelationships between a company's decision process, the feedback of the consumer's process and, the feedback of the consumer's response to the company. The presentation of the model begins with the assumption that neither the firm nor the consumer has any history directly relevant to the content of a firm's message. The firm is introducing a new brand and the flows detail the resulting consumer sequence. Field One comprises two subfields. In particular, subfield one represents the firm's attributes; the firm's attributes interact to produce a message directed toward the consumer. If the consumer is exposed to the message the promotional message then becomes the input to subfield two, the consumer's space. Subfield two contains the consumers' psychological attributes, relevant to the internalization of the message. The resulting output of subfield two may or may not be the formulation of an attitude to the product/brand advertised. Field two
consists of a search for relevant information and evaluation of the product/brand in relation to other alternative products. The output from field two may or may not be the formation of a motivation toward the advertised brand. The motivation from field two is the input into field three. Field three entails the consumer to be motivated to act, resulting in the purchase of the product. Field four is the feedback loop consisting of operations such as storage and actual consumption that lead to experience the brand. The resulting experience becomes the input into field one, thus closing the consumer's loop. This comprehensive scheme portrays a funneling type of decision process, thus attempting to give an integrated view of many marketing and advertising problems (Nicosia 1966).

Limitations

The model has been criticized for its long listings of variables and its inability to explain repetitive decisions. Also, the model reflects an inadequate understanding of the influences and interrelationships among the consumers' psychological attributes represented in subfield two. The assumption that consumers have no prior knowledge or experience with the product is unrealistic. The model has been criticized for its lack of specificity. For example, there are statements such as "and so forth" referring to certain sub-attributes, which
indicates that the variables have not been clearly identified. Finally, under each element is listed a multitude of attributes that appear to indicate a lack of commonality among them. This impedes a researcher's ability to arrive at an overall description of each element. Further, the model has not been empirically tested. The model may never be empirically tested with the existing inexact linkages between certain elements and brevity offered. The operation of the model is ambiguous for repetitive actions that make up a major part of consumer purchases.

Advantages

This model is the only one of the three models discussed that includes the perspective of the selling firm. It is a good example of computer simulation techniques, contributing a new dimension to theory building. The dyadic nature of the model should have far reaching implications for marketers and promotional managers. The model offers complete closure, that is, the structure is not affected by the choice of a starting point. For example, it is possible to trace the specific attitude toward a product; we could trace the feedbacks of this attitude as well as the forward flow resulting from the attitude (Berkman and Gilson 1986; McNeal and McDaniel 1982; Runyon 1980). The model's advantage lies in its recognition that several steps are involved between
attitude formation and the purchase or no purchase of a product. Also the model includes the firm in its representation of the consumer decision process. Nicosia and Wilton (1984) modified the original model capturing post-purchase phases of the consumer process (actions and psychological events) that may lead to brand loyalty (Berkman and Gilson 1986). See Figure 2 for a flow chart of the model.

The Hawkins, Best and Coney Model

The conceptual model developed by Hawkins, Best and Coney presents a general framework for understanding consumer behavior indicating the major concepts that influence the consumer behavior process. In the model consumer lifestyle process is a summarizing construct that receives the greatest emphasis with both external and internal influences (factors) impinging on lifestyle. External influences consist of culture, values, demographics, social status, reference groups and household. Some of the internal influences that impinge on consumer lifestyle include factors such as perception, learning, motives and personality. The model places explicit emphasis upon the premise that consumers engage in consumption activities to either maintain and/or enhance individual or household lifestyles. An assumption of the model is that information processing is a never-ceasing activity. Consumer lifestyle, attitudes and situational
influences are said to activate the consumer decision process. As presented in the model, consumer decision process stages involve the following steps for a high-involvement purchase situation: problem recognition, information search, alternative evaluation, store choice, actual purchase and post-purchase processes. The authors note that marketing stimuli affect problem recognition by affecting our desired lifestyle.

**Limitations**

In this model explicit emphasis is not placed on the information processing construct that is the central focal point in the E-K-B model. The model is too general to be regarded as a guide for marketing strategy decisions. It is not a model that could be regarded as a viable means of organizing and interrelating research findings. It is not a predictive model, which is attributable to the researchers, who designed the model as a "top of the mind" guide to think about consumer behavior.

**Advantages**

The model mentions all the situational variables that have been credited to earlier models. The external influences on consumer behavior include several variables such as households, social class and demographics that do not receive explicit attention in the earlier models. Finally, being less complex in nature, the model presents a highly simplified summary of the authors' philosophy.
concerning consumer behavior (Hawkins, Best and Coney 1986). See Figure 5 for a flow chart of the model.

Summary

Models do have a place in marketing literature. They encompass relevant variables, specify relationships and attempt to explain a process. All of the consumer behavior models reviewed serve as effective teaching tools and heuristic models. The models that have been outlined in this chapter have a number of similarities. All the models: (1) revolve around the flow process and (2) portray the consumer as the central component and problem solver with inputs and outputs, and (3) treat the environmental variables as influences. Overall, the models have made significant contributions to the understanding of consumer behavior. Overall the model serves the purpose of representing a useful way of thinking about consumer behavior. It suggests the key variables that a manager should consider.

Communications Literature

Overview

There has been extensive interest in the study of communications from classical Greek and Roman days to the present. Historically, all human efforts to study communications have attempted to discover the nature, essence, and dynamics of communication (Bormann 1980).
During the early part of the nineteenth century, the study of rhetoric (art of using words effectively) for oral communications was focussed upon. During the latter part of the nineteenth century and in the early decades of the twentieth century, the study of rhetoric started waning. The early 1920s marked the beginning of interest in the study of communication. The 1930s saw the beginning of the study of learning and behavioral principles. This focus continued until the 1950s. During the post World-War II period, communication scholars and social psychologists made rapid advancements in the area of communication called 'attitude change studies.'

Researchers next moved to develop conceptual theories of human communication, namely, the mathematical theory of communication and the balance explanations of attitude change. Research scholars during the 1960s and the 1970s critically evaluated the philosophical assumptions underlying communications research and theory. During the 1970s, and beyond, "communication theory" began to be studied from a social scientific standpoint. Communications has been found by many to be a bridge or a link between consumers and the socio-cultural environment that surrounds us (Schiffman and Kanuk 1987).

The effects of communication on consumer behavior has been demonstrated throughout this century via the use of models. Models help develop general frameworks for
understanding a phenomenon (Rothschild 1987). Communication theories have been incorporated in models ranging from the simplistic to the complex. The simplistic models have portrayed the media as exerting a power influence on human behavior, while the more complex models recognize how consumers mediate the impact of mass communication through such factors as perception, cognitive defenses, prior experience, and selective processes. The contemporary view, shared by the developers of complex models, is that the impact of mass-media on the beliefs, attitudes and behaviors of audience members is no longer direct and powerful as contended in the past.

The following is a brief overview of the communication terms, concepts and major theories/models to be used in the proposed study. These are derived from contemporary theory in mass communication.

What is Communications?

In simple terms, communication is the transmission of a message from a sender (source) to a receiver via a channel, by means of a signal. The communication act includes the following elements or actors, that is, source, message, channel, audience, response and other extraneous influences. According to Hiebert, Ungruait and Bohn (1985) communications is a tool, a means, a process; it is neither good nor bad. Communication is a process, by which people share meaning and establish a commonness of thought (Shimp
and Delozier 1986). Communication is a link that glues our society and cultures together. It is defined functionally as the "sharing of experiences," or the "transfer of meaning." As noted above, communications has been viewed differently by researchers over the years, with the idea that a common thread (thought) needs to be established between the sender and the receiver for communication to occur effectively.

The semantics of the word 'communication' is derived from the Latin word communis which means "common" (Severin and Tankard 1979). Hovland, Janis and Kelley (1953) have defined communications as being persuasive in nature, and as the process by which an individual (communicator) transmits stimuli (usually verbal) to modify the behavior of other individuals (the audience). Schramm defined communications as the sharing of an orientation toward a set of informational signs. Both, Hovland et al. and Schramm have indicated in their definitions that communication is dynamic, proactive, interactive and above all contextual (Mortenson 1972). For the purpose of this study the term communication will include both interpersonal and mass levels. Another term that will be used interchangeably with communication is promotion.

Having briefly looked at several definitions of communication, it is imperative to also examine marketing communications. The term refers to the two-way exchange of
information and persuasion that enables the marketing process to function more efficiently and effectively.

The Communication Process

In its simplest form the communication process encompasses three variables or elements: a sender, a message and a receiver. The sender also referred to as the source is an individual or a group of individuals who have a thought to share with another person or a group of persons. The message is the symbolic expression of the sender's thoughts. The message is usually printed copy or spoken words. The third element, the receiver is the person with whom the sender shares his thoughts. For example, in marketing, the objective of the sender (organization) may be to change the knowledge, attitudes and beliefs of the receiver (present or prospective customers). Figure 6 contains a schematic of the communication process.

Mass Communication Versus Interpersonal Communication

The communication process described above is basic and pertinent to both mass communication and interpersonal communication. Both the forms of communication share similar elements: a sender, message and a receiver. However, there are also distinctions. The term 'mass communication' differs from the term 'interpersonal communication' in terms of the following characteristics:

1. Mass communication is indirect, that is, it uses
some vehicle to convey the message, such as a TV or a radio.

2. It is impersonal, because the source of the message sends the message to a large audience of people, instead of a specific person.

3. Mass communication lacks a means of immediate feedback, and the sending of information is one-way.

4. The source of the message is an institution or organization (Severin and Tankard 1979; Shimp and DeLozier 1986).

Communication Theories

Communication theories provide a set of organizing concepts to understand better, how audiences respond to communications. Also, theories in communication help researchers determine what kinds of information benefit decision makers. There are a host of theories or models in communication. Most of the models that have been developed to date, work fairly well in specific situations, but none is clearly superior. A brief discussion of the most relevant models for this study follows.

The Individual Differences Theory

During the post World-War I period, psychological theorists were exploring new directions. Several concepts gave more direction and added emphasis to the study of individual (human) differences. The concepts conditioning, motivation and learning, have become the central focus in
the study of human differences. According to the theory, some fundamental postulates have emerged which have become widely held. For example, all individuals vary greatly in their personal psychological organization, due in part to biological differences and differences in learning. Humans raised in different environments are exposed to differential viewpoints. The learning environment transmits a set of attitudes, values and beliefs that make up their personality and set them apart from each other. Thus, one important outcome of learning is the way individuals acquire stable habits and perceive events around them.

The theory also resulted in two new concepts — selective attention and selective perception. Individuals vary in their perception of the world around them, by virtue of their personal make-up. Consumers subconsciously exercise a great deal of selectivity regarding which stimuli they perceive. Each day consumers are exposed to literally thousands of messages, yet they do not lose their sanity, and personal orientation to the world around them. This is because consumers exercise selectivity in perception. Two major factors impact the selection of stimuli by consumers. The consumer's prior experiences as it affects his or her expectations and their motives at the time, (needs, desires in addition to the nature of the stimulus, serve to increase or decrease the probability that the stimulus is perceived (Hawkins, Best and Coney
Perception can thus be thought of as a result of stimulus factors and personal factors (Robertson 1971). Contrast is a key stimulus attribute often used by marketers. Another important attribute is selective exposure. Consumers selectively expose themselves to messages that reassure them of the wisdom of their purchase decisions. Consumers tend, through the concept of selective distortion to be attentive to messages that meet their needs and disregard those which don't fit their own self-interest.

Individual differences theory is an important basic theory for understanding mass communication effect. Selective attention and selective perception are based on the personal makeup of an individual, causing members of an audience to respond in different ways to messages. Also, the theory is of extreme importance because it can be used to predict that individuals' homogeneous in terms of their personal make-up respond uniformly to messages, given all individuals uniformly exercise selective attention and selective perception. A logical structure of the theory is shown below:

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CAUSE -> INTERVENCING PROCESS -> EFFECT
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The Psychodynamic Model of the Persuasion Process

An effective persuasive message is purported to be one which possesses properties capable of altering the mental state of an individual in a way desired by the source of the message. One of the effects of mass communications is 'persuasion.' As DeFluer contends:

The key to persuasion lies in modifying the internal psychological structure of the individual so that the psychodynamic relationship between latent internal processes and manifest overt behavior will lead to acts intended by the persuader (DeFluer 1966).

For example, an advertising campaign aimed at reducing child abuse acts in reality, by trying to reduce child abuse shown on television is illustrative of the concept. A persuasive message would qualify as being "effective" if it coerces an individual to engage in overt behavior intended by the source. Typically, persuasive messages are directed at attitudes assuming a close relationship between a person's attitudinal structure and overt behavior. The model has a large foundation of theoretical backing. Yet, it is important to keep in mind that the validity of the model is still not fully verified. Conflicting findings have been produced under different situations. These findings have led some researchers to conclude that conditions under which exposure to a particular variable will lead to a particular type of action are unknown. Further evidence is needed to support the psychodynamic
model of persuasion. This theory incorporates several salient groups of factors and variables including the theories of motivation, perception, learning and psychoanalysis. These factors are critical to the understanding of the communication process. Please see Figure 7 for a graphic outline of the model.

The Social Categories Theory

According to this theory, human behavior can be categorized into broad groups. For example, variables, such as age, sex, income level, serve as useful characteristics by which individuals can be grouped into aggregates. The basic assumption of the social categories theory is that human beings in society, although heterogeneous in nature, do possess certain similar characteristics which result in similar modes of orientation to the mass media. This theory takes into account the more general sociological theories of the nature of mass society. Lasswell (1948) used individual differences theory and social categories theory, in combination with related situational variables, to describe communications. He utilized the combination to answer the following questions:

"Who, Says What, In Which Channel, To whom, With What Effect?"

The Individual differences theory and the Social Categories theory mark the beginning of a new chapter in
contemporary mass communication theory. Both the theories support the belief that variations in stimulus factors, in media, in content, as well as in audience, can have far-reaching impact on the effect achieved by mass communications.

The Sociocultural Model of the Persuasion Process

According to this theory, the media effects are influenced by the social interactions an individual has with his fellow group members. Although social and cultural variables play a key role in the diffusion of innovations in a society, there has been little attention paid to the effect of these variables on the persuasion process. Over the years, the theories of persuasion have viewed group interaction as a possible source of impediment to the persuasion process and, not as a tool that can be used to achieve its desired effects. A possible reason is the preoccupation of social scientists with the psychodynamic model. Several studies (Lohman and Reitzes 1954, Minard 1952) have stated that whenever the influence of social norms, values, expectations and beliefs on behavior patterns is studied, reference must be made to the individual predispositions being independent of the behavioral actions. It is thus true, in a general sense, that most of the time sociocultural variables modify the way in which psychological processes are related to overt action. Most of the evidence indicates that groups provide
shared orientations, for members. By means of these shared orientations, individuals interpret realities, to which they, as individuals, have only limited direct access at best. In effect, when a message is communicated via mass media, the effect of a consensus (with regard to the goal of persuasion) is felt. Through messages, it can be demonstrated that social rewards accompany adoption of the goals of the communicator. Negative social sanctions are imposed on individuals who fail to conform. The persuasion for adoption of a product/behavior patterns in a socially acceptable context illustrates the effect of mass communications.

One Way Flow Model

The traditional one-way flow model or the "hypodermic needle model" of mass communication effects reflects the communication flows from the source to a receiver, via a media channel. The source or the perceived originator of the message may be a government official or a multinational company sponsoring an advertising message. The message may be newsstory or an ad. Channels include both marketer controlled sources and non-marketer dominated channels. For example, advertising, personal selling and sales promotion fall under the rubric of marketer-controlled channels, while publicity and personal selling are considered non-marketer dominated channels. The audience in the model is the group of people to whom the message is directed.
Response refers to product purchase and thus serves as a source of feedback to the source about the effect of the communication program (Robertson 1971). Please see Figure 8 for a graphic view of the model. The model is postulated on the premise that all consumers are passive recipients of the persuasive mass-media content. Stated another way, the one-way flow model is an accurate representation of the communication process because consumers do not respond in a stimulus-response fashion as the model portrays.

**Criticisms Of the Model.** The one-way model has been criticized as a naive, inaccurate conceptualization of the interpersonal communication process (Katz and Lazarsfeld 1955). Since influence is filtered and mediated through a web of interpersonal networks, the model has been considered to be an incorrect representation of the communication process. According to Robertson (1971) there are two basic faults:

1. The model suggests that most messages get through to consumers.
2. It further suggests that if a message does get through, the consumer will act in accordance with the communicator's goal; that is, he/she will make a purchase response (Robertson 1971).

The One-way model exemplifies a 'stimulus-response' type model. Subsequent studies showed that audience members are active, information processors and should not be
perceived as passive recipients of persuasive mass media content (Robertson, Zielinski and Ward 1984).

Raymond Bauer (1963) noted that it was time to view the communication process as a two-way or transactional model in which both the source and the receiver (audience) are actively involved and take important initiative (Robertson, Zielinski and Ward 1984).

Two-Way Flow Model

It was during the 1930s and the 1940s that the stimulus response principle characterized much of psychological research. The impact of the mass media was analogous to that of a hypodermic needle or bullet. During the 1940s, President Roosevelt was running for office for a third time - a move unprecedented in American history. A group of social scientists from the Columbia Bureau of Social Research investigated the effects of the mass media on political behavior. The researchers selected four groups of registered voters from Erie County, Ohio to study the effectiveness of the mass media in influencing voting decisions. It was found that personal contacts appeared to be more effective and frequent than the mass media in influencing voting decisions. The experiments suggested that information seemed to move through two stages. First, individuals more in contact with the media (called opinion leaders), received the information. Second, the information moved from those persons through more interpersonal
channels to individuals who were in less direct exposure to the mass media. This kind of communication process was termed the two-step flow model of communication (DeFluer 1966). Personal influence is viewed as an important intervening mechanism operating between the mass communication message and the outcome of the message (response behavior). Katz and Feldman (1962) described the two-step flow of communications as one in which:

"....individual decisions are influenced less often by the mass media, than by the opinions of other people (who) are more likely to be exposed to relevant mass media than are the people whom they influence."

Subsequent to the 1940 voting study, a number of studies were done to verify and refine the concept. The results of these studies suggested that individuals who were more in contact with mass media and more influenced by mass media were found to influence voting behavior more than those who were less influential.

The two-way model's portrayal of "Advertiser-Message-Source" is deemed an accurate reflection of what consumers actually perceive when they view advertising. For example, Cliff Robertson who promotes AT&T services is a highly recognized source, delivering the message on behalf of the company. Factors, such as "noise," and "other influences" include the possible effects of price, product quality and competitor's advertising that affect segments of the
audience. In the model it is implicitly recognized that consumers first become aware of the advertised object, gain knowledge, and possibly change attitudes - and, finally, some buy the product. This sequential process underlies the 'hierarchy of effects' notion propagated by Lavidge and Steiner (1961) and named by Palda (1966).

The hierarchy-of-effects scheme consists of six basic steps and serves as a framework for measuring advertising effectiveness (Robertson 1971). Lavidge and Steiner's six basic steps are:

1. Awareness - The individual is aware of the product's existence.

2. Knowledge - The individual knows "what the product has to offer."

3. Liking - The individual has favorable attitudes toward the product.

4. Preference - The individual's favorable attitudes have developed to the point of preference over all other possibilities.

5. Conviction - Preference is coupled with a desire to buy and confidence that the purchase would be a wise one.

6. Purchase - The consumer actually moves into action (actual buying behavior).

The six basic steps here are related to three basic psychological states: cognitive, affective and conative. The cognitive component refers to the dimension of
thoughts; the affective component is the dimension of emotions (feelings); and the conative (behavioral) component is the dimension of motives (Robertson 1971).

Advantages Of the Model. The two-way model represents an improvement over the one-way model by more explicitly identifying the elements in the structure of mass communications and suggesting how mass communications actually works. The model also assumes that individuals do not live alone in society, instead, they are bound to other people by distinctive social interaction patterns which affect consumption behavior. One important benefit of the model is that it challenged the notion that ideas and influences trickle down the status levels of society. Since people within the same social class tend to interact with each other more often, the amount of influence exerted horizontally among members of similar status levels is well understood (King 1963). For example, it was assumed that fashions were perpetuated at the upper class levels and moved vertically down to the lower classes.

Limitations. The two-step flow has been criticized on a number of grounds (Dommermuth 1984; Engel, Warshaw and Kinnear 1979); Robertson 1971; Robertson, Zielinski and Ward 1984). Rogers (1969) cites several limitations of the two-step model. That opinion leadership is viewed as a dichotomous trait is cited as a limitation by Robertson (1971) and Rogers and Shoemaker (1971). Related to the
observation is the issue that the definition of opinion leader versus non-opinion leader dichotomy is unclear (Lin 1971). Other limitations cited include:

1. Many studies indicate that major news stories are spread directly by the mass media to a far greater extent than by personal sources (Westley 1971).

2. The model implies that opinion leaders rely on mass media channels only. It has been found that in many developing nations, without extensive networks of mass media, personal trips and conversations with change agents assume the information role that mass media may play (Severin and Tankard 1979).

3. The indication that individuals who receive the information later exhibit different behaviors than the individuals who are exposed to the information earlier isn't necessarily supported. It has been contended that early knowers of information rely on mass media sources while the late knowers rely upon interpersonal sources (Rogers and Shoemaker 1971).

4. The definition of mass media in the model has taken several empirical twists. For example, the term 'mass-media' has been understood to include specialized media (special bulletins) in some instances only (Severin and Tankard 1979).

5. Several statements made in the two-way flow model need to be replaced by appropriate mathematical functions
and statements of probability. Reference is being made to "ideas often flow from the media to opinion leaders and from them to less active populations." Terms such as 'often' and 'less' are vague and need to be replaced.

Thus, it may be surmised that, as with any model, the original model was found to be less than accurate. Subsequent research has expanded and refined the model resulting in a more widely supported theory of interpersonal influence called the multi-step interactive flow model, as advocated by Robertson, Zielinski and Ward (1984). Please see Figure 9 for a schematic of the Two-way model.

**Multi-step flow Interpersonal Theory**

Robertson (1971) writes that, personal influence is the change in attitude or behavior, resulting from interpersonal communication. Personal influence is a multi-dimensional phenomena and can occur in several ways. The multi-flow theory of personal influence is an extension of the two-flow theory, derived in research during the 1940 presidential election campaign. In this theory personal influence occurs in multiple patterns. One such pattern is influence among peers. Individuals who are similar to each other in terms of socio-economic variables, such as age, sex, social status, and education exert considerable influence upon one another. Since, most people tend to interact with people who are similar to themselves, the
nature of influence is based on 'strong' ties. Such influence is called 'homophilous influence.' Personal influence can also be transmitted among people who are dissimilar to each other in terms of socio-economic variables. Such influence occurs rarely and is based on 'weak ties.' Personal influence of this nature is called 'heterophilous influence.' According to the multi-flow theory, personal influence may be 'source-initiated' and 'receiver-initiated,' that is, the source of the message, and the receiver of the message, may both effect personal influence. Individuals who engage in new product purchases tend to communicate information to other persons, regarding the acquisition, and at times seek information to rationalize their purchase behavior (Robertson 1971). The multi-step flow theory purports that personal influence can be either one-way or two-way. The receiver of information can influence and be influenced. Returning to the new product purchase example, used earlier, the possible occurrence of two-way influence can be noted under conditions of cognitive dissonance. Consumers tend to seek confirming evidence that a correct decision was made, in order to reduce tension. This condition may lead to the consumer, influencing others while being influenced himself or herself. Personal influence can be initiated through verbal cues as well as visual cues. Consumers use cues to identify and give meaning to products and brands (Tom,
Barnett, Lew and Selmants Spring 1987). Certain goods that are socially visible, achieve social acceptability through visual communication. For example, a puzzled face or the failure of friends to mention a new dress, can cause a person to seriously wonder about his or her acceptability within a group. Personal influence is not wielded equally by all consumers. Consumers vary in their interest and knowledge about a product or product category. Consumers to whom individuals turn most for advice and information are called 'Opinion leaders.' Opinion leaders wield the most personal influence, since they supply consumption related information to others (Hawkins, Best and Coney 1986). Opinion leaders tend to be an effective influence on behavior, even if they do not say anything. Consumers who look to opinion leaders for leadership are influenced by the tremendous pressure to follow suit. This phenomenon is called 'keeping up with the Joneses' (Nickels 1980). Opinion leaders exist at all status levels and in every informal group. For instance, in a study Coleman, Katz and Menzel (1966) assessed the flow of influence among physicians in the adoption of a new drug. The opinion leadership exerted was found to vary with the personality and social participation of the physicians. Doctors who were gregarious and socially integrated (scored high on opinion leadership and opinion seeking), exerted the most personal influence. To summarize, opinion leaders in
general:

1. Have more product knowledge than followers.

2. Have greater exposure to mass media, than followers, that is a fitness oriented opinion leader is more exposed to fitness magazines than a follower.

3. Tend to have greater social participation than followers.

4. Are more innovative than followers that is, they adopt new products earlier than followers.

5. Have a more gregarious personality than followers.

6. Tend to be limited to related product categories, with regard to expertise (Robertson, Zielinski and Ward 1984; Hawkins, Best and Coney 1986; Schiffman and Kanuk 1987). See Figure 10 for a schematic of the multi-step flow model.

**Marketing Implications.** Research evidence suggests, based on the multi-step flow of communication theory, it is important to reach opinion leaders as well as opinion receivers. The key to this strategy lies in whether it is actually possible to identify opinion leaders. Advertising has been used by marketers to increase product related discussions.

Personal influence has been found to be dysfunctional, especially for radically new products or complicated products. Untrue rumors tend to spread through a population and tarnish the image of the product in question. Negative
rumors need to be controlled, before they get out of hand. Ads can be used to combat rumors and to demonstrate that they are untrue. According to Robertson, Zielinski and Ward (1984): The importance of personal influence to the marketing of a product or service stems from its pervasiveness and impact.

Summary

Marketing communication models that have been examined in this chapter conceptualize the role of mass-media advertising and the transmission of personal influence over time, in the transmission of information about products and services. The models that have been outlined in this chapter, serve the purpose of helping readers understand the pattern of development of contemporary theories in the study of mass media. Also, the models presented, provide a useful foundation for the effective use of marketing communications in all disciplines of interest, particularly health care. The present chapter describes how models of mass communication effects, combined with audience and communication factors can be used to design effective communication messages.

The multi-step interactive interpersonal influence model will serve as the theoretical basis for this study. Personal influence is a key issue in the transmission of information about hospital services. It has been well documented that health care decisions, recommendations from
friends and physicians, tend to have significant impact. In general, people are part of a reference network comprising of friends, coworkers, family members, and acquaintances who can be valuable sources of information. Hence, it is appropriate to assume that people inquire from friends about a service or provider during a casual conversation. Central to the theory of personal influence is the belief it is bound by multiple patterns. It is imperative for hospitals to encourage their employees to engage in positive word of mouth, in order to enhance their reputation and image within a community. The personal influence wielded by the members of the hospital varies with the position held, within the institution. Physicians can be seen as being as more credible and authoritative sources. They can be designated as 'Opinion leaders.' Medical staff employees and volunteers may be asked to seek their peers who may be in need of some service and supply them with appropriate information. Thus employees within a hospital, who are in the lower rungs of the institutional ladder, would be generally seen as less credible and authoritative than higher placed hospital employees.

The purpose of the dissertation is to identify and test the important factors considered by for-profit and non-profit hospitals in the development of communication messages. Entailing interaction among specific management people both within the hospital and with the community
outside of the hospital. This is analogous to two-way influence in the model to be used. Personal influence is the primary source of information for consumers who wish to know more about hospital services (high involvement service) given, and the high level of perceived risk associated with the choice of a given provider.

In summary, the dissertation will also examine the communication tools utilized by both for-profit and non-profit hospitals to inform members within the institution, of day to day events, the choice of the multi-step interpersonal influence model is justified given the nature of the interpersonal interaction.

Emergence of Healthcare Marketing

Overview

The rapid growth and interest in the field of healthcare marketing as a disciplined emerged in the 1970s. However, examples of marketing tools and techniques have appeared in the literature since the middle 1960s (Anderson and Near 1983; Cooper 1986; Keith 1981; O'Conner 1982). Since the creation of Medicare and Medicaid in 1965, hospitals have come a long way. Hospitals have assumed a "customer" orientation, and they use marketing techniques to offer services to the different groups they serve (Cooper 1986; Tucker 1977). The interest is not surprising, since there are 130,000 excess hospital beds (based on Federal government reports) costing $2 billion a year
because of overbuilding, shorter hospital stays, more outpatient clinics and, changing demographics of the U.S population (Keith 1981; Kotler and Clarke 1987). Although many hospital providers are realizing the need to apply marketing techniques in hospitals, some hospital providers still misconstrue the importance of marketing. No more than 10 percent of the nation's 7000 hospitals have established formal marketing programs or have hired marketing directors (Lublin 1979). Hospitals, in order to thrive in the highly competitive, resource constrained environment need to adopt marketing approaches in a scientific and systematic way, rather than an ad hoc basis (Malhotra 1986). The changing hospital environment in the U.S has crated strategic concerns on all fronts, resulting in the in the adoption of strategic market planning by hospitals. In this section the 'Emergence of Health Care Marketing' is discussed followed by review of the literature on Strategic Market Planning applied in hospitals.

The Rise of Consumerism

Background

During the decade of the 1960s 'community hospital' was a term ingrained in the American way of life as "apple pie" and "motherhood." Community hospitals described as acute care, short-term institutions, came under severe attack from community members during the 1960s (Rosenstein 1986). Alienation between members of the community and the
hospitals grew even more, as the hospitals grew bigger. The main reason was that hospitals were not responsive to the community. Hospitals preoccupied themselves with new technological procedures and cascading scientific advances at the expense of the patient's wellbeing. Patients were concerned that they could not afford the services they received in hospitals. Since 1950, consumerism grew to become a significant influential force in the health care environment. In 1950, individuals paid a significant proportion (65 percent) of the health care costs and, as recently as in 1985 individuals accounted for less than 30 percent of medical costs (Easterbrook 1987).

Since the creation of Medicare and Medicaid, hospitals traditionally passed along their costs to government. Patients stayed in hospitals for extended durations without any concern for costs. During the early 1980s, the Medicare system was in financial chaos. In 1983, government through Medicare fixed an average predetermined rate for 467 categories of illness called DRGs. This was the impetus for hospitals to keep their costs down. This has led to empty beds and lost revenues for hospitals in the 1980s.

Overview Of Relevant Literature

Emergence of Health Care

Rosenstein (1986) states that consumers in the 1980s are becoming educated shoppers in the hospital marketplace.
He notes that hospital patients are looking for convenient, fast and price-competitive medical services because consumers lead active lifestyles and are aware of preventive health programs. Ken Dychtwald, President of a health care consulting firm in a keynote address states:

"I think it extraordinary that we've got a health care system that can help us when we're sick, but the American public has got to wake up to the fact that we must do the best we can to stay well. I think the health care system can help us in that regard" (Academy of Health 1987).

Preventive Care

Glick (1979) writes that the outgrowth of the consumerism movement is a shift from a "curative" approach to a "preventive" approach to health care. Further, the author states that with increasing government interference, the future will see integration of health institutions into comprehensive health care systems, with a reduction in the number of separate institutions. Hospital mergers will become commonplace with most of the providers geographically dispersed and focusing on specialized care.

Horizontal Care or Ambulatory Care

Cooper (1986) writes that the health care delivery system is moving away from horizontal care (hospital-based) to vertical care (ambulatory facilities). Resurgence of interest in health maintenance organizations (HMOs) and, the rise of alternative delivery systems -- walk-in-medical
centers, Preferred Provider Organizations (PPOs) and Independent Practice Associations (IPAs), as well as Prepaid Group Practices (PGPs), are indicative of the shift to vertical care (Hamilton and Pitzer 1987; Cooper 1986; Fisher 1985; Easterbrook 1987; Rosenstein 1986).

Soaring Hospital Costs

One of the earliest to write about the Prospective Payment System (PPS) or Prospective Rating System was Richards (1983). The new system, as the author points out is an economic impetus for hospitals to keep their costs below pre-fixed rates for different categories of illnesses called Diagnosis Related Groups (DRGs) (Richards, March 1983). According to O'Gara (1983), the new system (PPS) reflects that the government pressure to curb hospital costs will cause hospitals to change their ways of doing business. One approach, hospitals' around the country have resorted to, is the use of nontraditional solutions such as marketing techniques (Cooper 1986).

Emergence of Marketing In Hospitals

Zaltman and Vertinsky's (1971) article is considered a cornerstone in health care marketing literature. The authors discuss social marketing in a health context and develop a psychosocial model, with reference to key psychosocial variables and behavioral variables. The model is applied in less developed countries. The model's main
contribution to health care marketers in different cultures was that, marketing activities can make significant contributions in the health care industry (Zaltman and Vertinsky 1971). Since this article appeared, the value of marketing in hospitals, from the standpoint of increasing patient volume, providing a broad mix of services and promoting the services offered has been discussed by MacStravic (1977) and Robinson and Cooper (1980-81). Further Fryzel (1978), Sanchez (1984) and Cooper (1985), as well as Kotler and Clarke (1987) have examined that marketing is a necessary management practice for non-profit firms, particularly hospitals.

The progress made by hospitals using marketing techniques; the role of marketing in the hospital; and the reasons advanced by proponents' quoting marketing as a solution to problems faced by hospitals are the focus of some recent studies (Clarke 1978; O'Conner 1982; Academy of Health 1987; Sanchez 1984).

The literature on the misconceptions of marketing and its application in the health care field abounds (Cavusgil 1986; Fryzel 1978; Keith 1981; O'Conner 1982). Cavusgil (1986) and Kotler (1987) point out some distinctive aspects of hospital marketing, which deserve attention. These include:

1. Hospitals address multiple publics or constituencies made up of physicians, patients, employees,
donors/supporters, suppliers and reimbursing agencies, as well as regulatory agencies.

2. Both profit and non-profit hospitals pursue monetary and non-monetary objectives.

3. Hospitals offer services (treatment) rather than goods. Services are characterized by their intangibility, inseparability, variability and perishability.

4. Hospitals have two tiers of management. Physicians, nurses and other medical staff provide treatment, while managers and administrators are responsible for the day-to-day functioning of buildings, equipment and staffing.

5. Hospitals are limited in their flexibility to innovate, since they are the subjects of close public scrutiny.

The unique characteristics/concerns cited above do not include the application of marketing techniques and concepts, because hospitals have traditionally used marketing principles however, without its manifestation in carefully formulated programs. Thus hospitals present a challenging setting for the application of marketing (Malhotra 1986).

The major benefits of health care marketing have been the focus of a series of articles written in the summer of 1977 (Ireland 1977). Since then numerous authors have examined the merits of marketing in hospitals (Cavusgil 1986; Kotler and Clarke 1987; Thomasson 1984; Whittington...
Some of the major benefits of adopting a marketing orientation involve:

1. A marketing orientation determines the needs and wants of target markets and satisfies them through the design, communication, pricing and delivery of appropriate and competitively viable products and services (Kotler and Clarke 1987).

2. Careful application of marketing techniques will allow effective and efficient competitive strategies to be developed.

3. Marketing skills can help hospitals develop satisfactory services for patients and other consuming publics.

4. Marketing techniques provide a means to integrate activities within a hospital to satisfy needs.

5. Marketing provides a systematic and disciplined method to improve the attraction of resources, including physicians, nurses, volunteers, and public support.

6. Marketing provides adequate and quality information to serve target market needs (Kotler and Clarke 1987; O'Conner 1982; Sanchez 1984).

Hospitals through the use of marketing techniques, discover the needs, wants and perceptions of individuals and, organizations with whom the hospital wishes to establish a relationship (Keith 1981).
Health Care Marketing Defined

Marketing has been defined in health care literature in several ways. Keith (1981) defines marketing as a commitment on the part of top management to determine the wants, needs and desires of the hospitals' target population. Ireland (1977) in his definition states that health care marketing is a management philosophy, that effectively links the hospital with all the elements of its service community. A comprehensive definition is offered by Cooper (1985). Cooper (1985) defines health care marketing management as follows:

The process of understanding the needs and wants of a target market. The purpose of health care marketing management is to provide a viewpoint from which to integrate the organization, analysis, planning and control of the health care delivery system (Cooper 1985).

The above definition captures the management philosophy of both profit and nonprofit hospitals today. Central to this definition is the idea that selection of appropriate medical services should rest on careful identification of consumer wants, needs and values. A close parallel to the above definition is offered in Peter Drucker's statement:

The aim of marketing is to make selling superfluous. The aim of marketing is to know and understand the consumer so well that the product or service fits him and sells itself (Cooper 1985).
Central to the definition of marketing is the term "exchange relationship." An exchange relationship according to MacStravic (1977) is the act of offering something of value, to someone else who offers something else of value in return. Further, the author adds that a strong customer-orientation and the ability to monitor progress periodically, are two factors that should not be overlooked.

The Elements of Marketing

Analysis and management of four essential factors: product, price, place and promotion, is the key to marketing success. The four factors (elements) are traditionally referred to as the 4 P's of the marketing mix. The key to the successful application and understanding of the marketing mix lies in -- getting the right product or service at the right place at the right time with the right promotion to the consumer.

Cooper (1985) has suggested alternative terms to describe the elements of the marketing mix. He suggests the use of 'service' instead of the product element, indicating that health care deals specifically in services. Instead of the place element, he offers the term 'access.' Access is more apt to health care services since the term implies consumers' concern for availability of services. For the third element price, Cooper suggests the usage of "consideration" instead of price. Consideration involves
everything of value beyond "cost" or "price," forsaken by the consumer in exchange for healthcare services. Finally, the promotion element carries the same meaning in health care, except that the definition has more emphasis on the role of public relations and health education. The four P's are reviewed in some detail in the next section.

Product Element

Most products of the health care system are services (Kotler 1987). Kotler (1987) asserts that health care services are characterized in 4 important ways: intangibility, inseparability, variability and perishability. In defining the service attributes Kotler (1987) notes that health care services are intangible—they cannot be felt, heard or tasted prior to being produced. Further, Kotler writes that services are inseparable in that the production and consumption occur simultaneously. For example, a visit to a doctor's office for a routine medical checkup (service) cannot be completed unless the doctor is present. Cavusgil (1986) points out, hospital services are characterized as being variable. Depending on when the service is provided, who provides the service and the presence or absence of state of the art technology, services provided will differ in terms of quality control. Finally, the author notes, hospital services are perishable in that services cannot be stored in warehouses.
Kotler and Clarke (1987) believe that when a patient thinks of medical care, he or she envisions care in terms of the "people," who help deliver the service. In effect, the physician, the nurses, the aides, physical therapist and the housekeeper are the individuals who the patient thinks of as making up a hospital. Thus the fifth 'P' of marketing is the organization's people. Health care services are people-based.

Providers may adopt several strategies to increase the patient's confidence in them. Branding is increasingly being adopted by health care firms, particularly multi-hospital systems. Humana the nation's second largest hospital chain has utilized branding. According to Silver (1986) Humana with over 78 hospitals (owned or managed) carry the Humana name. Mayo Clinic with three branches has achieved a national branding image. Little (1985) asserts that branding creates public awareness and has a halo effect.

Hays (1987) reports in a recent article the salient elements that constitute quality, in terms of delivery of health care services. When consumers were asked what they perceived as connoting high quality care, the most prominent replies in the decreasing order of importance included:

1. Patient relations or employees caring attitudes.

2. Highly qualified medical staff -- availability of
specialists, physicians overall competence and knowledge.

3. Advanced technological services and a wide variety of services.

4. Finally, employees friendliness, competent administration and efficient billing were associated with high-quality care.

One third of the consumers surveyed, said that they were willing to pay costs not reimbursed by their insurance to receive services from a hospital, they believe offers high-quality care (Hays 1987). The author believes that since consumers have the ability to distinguish "services" on the basis of quality, it is time hospitals' beef up their marketing practices.

Robert Fey, Vice President of a leading medical center in Maryland states that hospitals need to pay attention to the physicians' needs to serve patients better (Super 1987). The author writes that there are implicit benefits such as:

1. Physician loyalty can be gained.

2. Hospitals' can develop a relationship with physicians' whereby they are supportive of the hospital.

Further, Super (1987) points out that hospitals can provide better services to physicians if they know the stage of a physician's practice's lifecycle. There are 5 product related decisions that need to be made, by hospitals, to cater to the needs of physicians, patients
and other groups served (Malhotra 1986).

1. Product Portfolio Management, whereby a hospital evaluates its mix of services in comparison to that of other hospitals in the vicinity (region) to determine which programs should be added or eliminated.

2. The need to move away from inpatient services to outpatient surgeries is being realized slowly by hospitals. Because outpatient surgery offers tremendous potential for growth, the need to revitalize existing programs substantially and add new ones is beneficial.

3. Fear in the minds of consumers' can be allayed through proper positioning of services offered.

4. New product development with the potential to attract new segments in addition to the changing needs of the customer base.

5. Finally, product line management is a critical factor to control and manage the variety of services marketed by hospitals.

Delivery of quality care services and assuring patient satisfaction is tantamount to the programs offered. This way, both the provider and consumer are happy. Lutz (1987) further adds that product line management techniques help hospitals meet the needs of consumers, increase efficiency and hasten the hospital decision making process. Hospitals through innovative and quality services will be able to satisfy consumer needs.
The Price Element

Cooper (1979) defines price as "out-of-pocket payment of money in return for receipt of a given product or service." A plethora of literature exists on the price element and its implication in health care marketing (Anderson and Near 1983; Ireland 1977; Keith 1981; Kotler and Clarke 1987; Malhotra 1986). Most of the authors are in agreement, that the cost of a service includes transportation, parking, time off from work and convenience of payment. Some of the salient issues concerning pricing include:

1. The role of pricing in health care marketing is not straightforward due to the dominance of third party payors in paying for services.

2. Consumers' are becoming more price conscious because of the increasing costs to them. Consumers have the option of shopping around, looking for the most effective way to cut out-of-pocket costs.

3. Customers who utilize services incur 3 costs in addition to the price for services. These include effort costs, psychic costs and waiting costs. It is imperative for hospitals to evaluate these costs since they lead to better patient-hospital relations.

4. As the government seeks ways to contain soaring hospital costs, it is speculated hospitals will engage in price negotiations, price reductions and price
discrimination measures.

Pricing and quality care will play an important role in the marketing mix for health care in the years ahead (Kotler and Clarke 1987). Reimbursement policies are currently changing, and the future appears bright for the role of price in health care — a right of the consumer.

The Promotion Element

Promotion or "marketing communication" is the most critical marketing decision variable to hospital marketers, in the changing health care environment. Fryzel (1978) states that promotion stimulates demand by relating services to potential buyers' needs and wants. The author purports that there are four objectives of promotion:

1. To inform and/or educate prospects about the existence of a product and its capabilities.

2. To remind present and former users of the product's continuing existence.

3. To persuade prospects that the service is worth purchasing.

4. To inform the consumers of where and how to obtain/use the service (Fryzel 1978; Lovelock 1977).

Fryzel (1978) views promotion in the health care field as usually in the form of publicity, trade shows, institutional brochures and personal selling between health executives and potential customers. From the early 1970s through the early 1980s Fryzel (1978), Ireland (1977) and
Keith (1981) wrote that health care firms do not advertise their services, however they conduct a form of advertising which informs and educates the public. The salient factor in all those articles was that promotion is of critical importance to the institution and it exists in the hospital setting.

Since FTC took action to remove the bans against advertising by doctors (Bloom 1977) there has been an abundance of research conducted with reference to the advertising practices of health care firms. Since the removal of the ban, hospitals' have increased advertising efforts and, they have adopted a hard sell approach to promotion (Fitch 1986; Fisher 1985; Stephon 1987). According to a report published in the Television/Radio Age (1983), television advertising by members of the medical and dental community have increased at an average annual rate of 48 percent since 1977.

Physician advertising has traditionally been condemned by members of the physician community (Bloom 1977). Robinson and Whittington (1979) in a survey of hospital administrators, revealed that patient oriented advertising and direct mail promotion, would not be included in a hospital marketing program. Likewise, in another study Bernacchi and Kono (1979) found that members of the profession have a negative view toward advertising. Consumer seem to favor the practice of advertising in the
health profession, arguing that advertising will result in more intense competition, which should improve the quality of services offered and lower prices (Bloom 1977).

Cunningham (1977) presents a different viewpoint on advertising commenting that:

The basic message of most advertising doesn't help anybody even when it is disguised in the subtle syllables of public relations (Cunningham 1977).

The author views advertising of services that is not demanded by the community as pure selling, and not information oriented advertising as the providers contend. Cunningham (1977) further cautions stating advertising that relies upon superiority claims (we can do anything better than you) is construed as bland and uninteresting promotion, which does not accomplish anything. In a recent report in Time (1987) magazine, it was found that hospitals are adopting savvy marketing techniques (toll-free telephone numbers, speedy service) to attract patients, who know they have choices.

Berkowitz, Hillestad and Effertz (1982) conducted a mail survey of hospital public relations directors, on the future use of advertising. Paid hospital advertising is seen by PR directors as an accepted growing force within the marketing function. Findings presented, predicted that paid advertising will comprise a quarter of the hospital advertising budget efforts in the future. Results from this
study implied that advertising is in the operational phase and the shift is toward developing sophistication in effectively using this promotional tool.

The literature on the use of direct mail and public relations in health care is limited (Cooper 1986). Direct mail is growing as a medium in health care marketing. According to an article in *The Wall Street Journal* (1986), direct mail is the most effective way to get the attention of patients. Kotler and Clarke (1987) write, there is growing confusion over the roles of PR and marketing in health care firms, particularly hospitals. PR has for long been used by hospitals for communicating with their outside publics. An interesting similarity offered by authors (Kotler and Clarke 1987), is that both PR and marketing start their analysis and planning from the point of view of satisfying outside groups, meaning both are external functions of a hospital. Some views are conflicting in nature. PR and marketing are viewed as separate but equal functions; equal and overlapping functions; or with PR as a dominant function. Richman (1987) writes on the benefits of sponsorship of major sports events.

1. Sponsorship gets the hospitals' name around and the privilege of being referred to as "official corporate sponsors;"

2. The hospitals' sponsorship assists the games as well as informs the local community that hospitals can
take time out to sponsor sports events.

An excellent summary of the major sales promotion tools commonly used by hospitals can be found in Fisher (1985), Malhotra (1986) and Tracy (1984). Kotler and Clarke (1987) present four reasons concerning the increasing use of sales promotion.

Reasons cited include:

1. Sales promotion is used as a quick response to overcome the pressures facing hospitals today.

2. To increase competition.

3. Because competition is using sales promotion increasingly.

4. Consumers are incentive oriented because of recession and inflation.

Since the early 1980's personal selling in health care firms, specifically hospitals, has assumed a pivotal role in the marketing of services writes Malhotra (1986). Health care facilities use sales representatives to market their services to businesses. As an element of the marketing mix, personal selling can be more effective than advertising states MacStravic (1977) in building conviction and action on the part of buyers because: (1) It builds interactive personal relationship between two or more persons; (2) cultivates a relationship which is much beyond a matter-of-fact selling relationship and; (3) makes the buyer feel obligated after having listened to the
representative. Response may result in a polite "thank you" only. All of the elements of the promotional mix—advertising, personal selling, sales promotion and PR have a synergistic effect, the combined effect of each element individually. Hospitals need to assess their own personal situation prior to choosing an effective combination, because each tool performs different tasks.

The Delivery Element

Delivery of health care goes beyond the question of location. The new trend is one of "bringing" health care to the consumer, rather than forcing the consumer to come to the source of health care delivery. On the "delivery" of healthcare, Malhotra (1986) asserts that 3 trends can be identified:

1. Health maintenance organizations (HMOs) and Preferred Provider Organizations (PPOs) are emerging as alternative forms of health care delivery. Another organizational form in the experimental phase is a prepaid health plan that is neither an HMO nor a PPO. The plan as stated by McIntyre (1984) is a joint venture between a group of doctors and a hospital.

2. Outpatient service delivery by hospitals is increasing.

3. Franchising and networking has made an entry in the hospital field.

According to Kotler and Clarke (1987), hospitals that
make marketing decisions in a systematic way and choose their target markets carefully will succeed in the long run. The decision variables product, price, promotion and place need to be combined together as a single unit to reach a target market in order to overcome the host of problems facing traditional care hospitals. The time has arrived for members of the hospital community to realize that marketing is a planning and educational tool that is necessary for their survival (Cooper 1985).

Overview Of Planning Literature

Marketing Planning In Hospitals

It is imperative for hospitals to assess factors that affect the internal operations of health care firms, with reference to the environment was the focus of an article by Ireland (1977).

He notes that:

Ideally a hospital that is developing a marketing program should begin by conducting a series of research studies to gather information that will help define the characteristics, needs and wants of its market and market segments, so that it can develop or revise its services and accommodations accordingly (Ireland 1977).

In examining the hospital industry and the market environment surrounding it currently, Freiberg (1981) stated:

Some type of planning process is integral to organizations that seek long-run survival. This is
true during a period of volatile economic change, and it is especially true for organizations that find themselves in structurally changing industries.

Hospitals exist in such an environment and the key to their survival depends on careful planning for the future. Traditional health planning as outlined by Hyman (1975) incorporates the following steps:

1. Specification of goals
2. Translation of goals and objectives into operational objectives.
3. Development of strategies to achieve the goals and objectives.
5. Feedback or evaluation to modify current strategies.

In this health planning model, Hyman (1975) fails to include the consumer of health services — physician, patient or government, as the focal point of attention for all activities. Further, the hospital's environment is not taken into perspective until after the strategies are defined. Also, the need for services offered by the hospital are not examined or researched before production. Figure 11 shows the sequential process for the model.

Keith (1960) developed another approach to the marketing planning sequence. This approach embraces the marketing concept and considers the consumer at the beginning of the planning process. Consumers are grouped on
the basis of their needs. Included in the situation analysis stage (Stage 1), is the consideration of the strength of the firm. Step 2 entails delineating segment-specific strategies. Forecasts of potential demand are attempted. After this step, the healthcare firm considers specific goals and objectives and, the means for implementing the chosen strategies. Please see Figure 12 for the stages in marketing planning.

This marketing planning approach is suited for hospitals, since it involves formulation of consumer-responsive strategies (Berkowitz and Flexner 1978). A report on the marketing planning practices of firms in diverse industries (industrial product, consumer product, service), outlining the basic elements of the marketing plan was the focus of a study by Hopkins (1981). Cosse and Swan (1983) examined the marketing planning procedures used by product managers in large multi-product firms.

Marketing research has been found to be a frequent topic of discussion in the health care marketing literature (Cooper and Hisrich 1987). The authors contend that marketing information is vital to decision making. Further, in terms of general planning various marketing research techniques can provide vital consumer information about needs as well as perceptions of the health care firm (Cooper and Hisrich 1987). Cosse and Swan (1983) in a comprehensive study of marketing planning practices in
hospitals, identified factors reflecting planning thoroughness.

1. For every product, both at the firm and industry levels sales forecasts are needed.

2. Financial information inclusive of product contribution estimates and long-term profitability of the offering for each alternative product-market.

3. Market share information inclusive of market share projections for the firm and its competitors; value of market share points and market share relative to that of the leading competitor.

A national survey of 1000 consumers conducted by a consulting firm and Hospitals magazine, indicated that 68.5 percent of health care decision makers are women; a vital input in the hospital marketing planning efforts. This study parallels a recent development in health care marketing (Swett 1983), which points out that hospitals around the country are gauging the opinions of important publics such as employees, patients and physicians.

In a recent nationally conducted survey by a leading research firm National Research Corporation (Hays 1987), it was found that consumers ranked 'caring staff' followed by qualified medical staff as two key attributes to determine quality medical care delivery. On the other hand, physicians ranked qualified medical staff followed by sophisticated technology as two important attributes to
ascertain quality delivery. Employers opinions matched the views of consumers. In the rapidly changing health care environment, the type of planning utilized by a majority of the hospitals is strategic planning (Whittaker 1978).

Strategic Marketing Planning in Hospitals

Strategic market planning in hospitals has been defined by authors in multiple ways. Strategic market planning is the compatibility developed between a firm's resources and opportunities/threats prevalent in the environment (Hofer and Schendel 1978). According to Milch (1980) strategic market planning is concerned with "doing the right thing" in addition to "doing things right." All variables that influence the destiny of an organization are incorporated in a strategic plan. For this study the following definition which embraces the marketing concept has been adopted.

Strategic market planning is a philosophy of management designed to provide a collective sense of purpose and direction for an organization (Zallocco, Joseph and Doremus 1984).

The above definition implicitly considers that hospitals: (1) looking into the future; (2) monitoring where the environment is going; (3) deciding upon objectives, strategies as well an organizational structure that would be appropriate, are engaged in strategic planning activities. Flexner (1981) and Fournet (1982)
discuss the value of strategic market planning in health care institutions. Zallocco, Joseph, and Doremus (1984) with reference to a hospital setting, elaborate upon the pertinence of the various contemporary approaches to strategic market planning. Further in a recent study Joseph, Zallocco, and Markovic (1985) focussed upon the progress made by hospital administrators in formulating and implementing strategic plans, and the extent of familiarity with and incidence of using standardized portfolio planning models.

Abell and Hammond (1979) assess the nature of strategic market planning as involving 4 related decisions:

1. Business definition statement outlining product and scope of the market, followed by product and market segmentation;

2. Determining the mission of the business in terms of the objectives to be pursued;

3. Formulating functional strategies; and

4. Budgeting.

Abell and Hammond (1979) state a marketing plan deals primarily with the identification of target segments and the 4 P's for reaching and serving those segments. The authors state essentially 2 analytical ingredients are needed for effective strategic market planning:

1. Analysis of the market (customer, competitor, environmental trends, company characteristics).
2. Analysis of cost behavior.

A survey conducted by McKee, Varadarajan and Vassar (1986), in the southwest region using 200 hospital administrators, revealed that fewer hospitals seek information about the external competitive environment with a proactive orientation. Seldom do hospitals conduct within-hospital staff surveys, which is vital to improve the quality of health care delivery. Both small and large hospitals tend to be planning oriented. Further the authors add strategic planning encompasses the following variables at the very least: environmental, sociological, political, legal, financial, reimbursement, economic, clinical, market, competitive and facilities in addition to the firm's goals and resources.

Why is Strategic Marketing Planning suited To Hospitals?

According to Zallocco, Joseph and Doremus (1984) characteristics of a traditional care hospital that match a strategic market planning orientation include the following:

1. A complex mix of programs and services characterized by intangibility, inseparability, variability and perishability.

2. Satisfactory exchanges with the diverse group of publics or constituencies they deal with. The multiple publics hospital management interact with is a combination of voluntary exchanges (competitive groups) and compulsory
exchanges (regulatory and reimbursing agencies). The publics are made up of nursing staff, medical staff, suppliers, donors/supporters, competitive or cooperative groups, board of trustees, regulatory agencies and, reimbursing agencies, as well as client groups (Cavusgil 1986).

3. Changing environmental conditions result in total market demand to be evaluated. Demographic variables such as ethnicity, age, income and education that affect utilization rates must be evaluated. Since people over the age 65 use hospital services three times more than the general population, age is a critical factor.

4. Capital investment decisions in buildings, facilities and equipment are required of both traditional care hospitals and small private medical group practices, essential to thrive in the competitive environment.

5. Technological changes in the health care area are remarkable. For example, a visible technological development is the CAT scanner available to radiologists to diagnose and view the human body. A price tag of $750,000 for the scanner and a patient charge of nearly $300, have created a skeptical consumer.

6. Alternative delivery patterns (HMOs, PPOs, FECs) have intensified intra-industry competition and inter-organizational competition (hospitals competing with outpatient surgery centers) has increased.
The authors contend that the above factors are critical to the success of the hospital in the turbulent environment of tomorrow. Strategic market planning is valuable in the long run to the hospital's mission. Hospitals have been slow in adapting to the changing health care environment state Wood and Singh (1986). Several reasons can be cited stating why hospitals differ in their reaction. Further, Wood and Singh (1986) report that hospitals with heavy capital investment and smaller financial resources are less adaptive in the face of needed change. Additional factors influencing adaptability are these:

1. Highly regulated hospitals, health care firms run by trained professionals in clinical areas and a large hospital (size) are slower to adapt to change. Ferrell, Madden and Legg (1986) developed a strategic planning model to aid nonprofit hospitals in developing funding support. The authors addressed some specific issues including: (1) The need to develop concrete, feasible, and successful strategies linking service development and constituency support; (2) A vocal and responsive community advocacy group must be built; (3) Administrators need to be aware of the function and roles affecting support for their organization and of strategic frameworks available to them.
Summary

The health care environment requires hospitals to be adaptive. While marketing is being embraced as a "savior" for survival, it is imperative for hospitals to realize that there is danger in considering marketing as a tactic rather than as a part of a broader plan. Only through a systematic approach to planning can hospitals succeed in the long-run. Strategic market planning is a major tool which provides a framework within which hospitals can make everyday decisions diligently.
CHAPTER III

RESEARCH DESIGN AND METHODOLOGY

In this chapter the research design and its rationale are addressed. Methodological issues including sample identification and selection, the data collection techniques and instrument, and data analysis techniques are discussed.

Study Design

The current study consists of two parts, an exploratory study to generate hypotheses and a descriptive study to test hypotheses. The objective of the exploratory phase was to identify important 'target audience factors' and 'communication' related factors. Once identified, a nationwide sample of 19 for-profit and 19 non-profit medical care hospitals were utilized to test the relative importance of the factors among health care personnel. Overall, the current study was descriptive in nature since the factors to be generated in "Part I" of the study lead to the generation of hypotheses, to be tested using mail surveys. Also, the study was rigid in that hospital administrators were contacted in advance to get their
agreement to participate, that is, the "who" aspect of research was clearly delineated.

Another objective of descriptive studies is to make specific predictions, and to estimate a proportion of the population who behave in a certain way. In this study, two mini focus group interviews were conducted, in each of two local hospitals, in order to identify a list of potentially important factors. Each focus group consisted of approximately 3 to 6 personnel, with a mix of staff and medical personnel. The resultant hypotheses were utilized to test the relative importance of the factors. The research design for this study is also a cross sectional descriptive design (field survey) in terms of the hospitals to be chosen in the overall sample -- representative of traditional medical care hospitals and the way hospitals are to be chosen. The overall sample of profit and non-profit hospitals was chosen using the 'American Hospital Association Directory of Hospitals.' The broad mix of sample hospitals will enhance the ability to conduct cross-classification of variables - an objective of descriptive research study.

Another objective of the current study was to generate summary statistics on the key communication and audience related factors utilized by hospitals to design messages, which is also an emphasis of the survey method in
descriptive research. The cross sectional descriptive design is thus appropriate in this study.

The Population

The population in the study is comprised of traditional for-profit and non-profit hospitals. However, if HMOs, PPOs and IPAs are part of a hospital, or if they are connected to a hospital they will be included. The population excludes surgical clinics located in shopping malls and small locally operated private clinics. The scope of the dissertation is limited to traditional medical care hospitals, the part of the industry, perceived as having the greatest need, in the current environment, for more effective use of marketing strategies, including promotion. Time and cost considerations also influenced the decision to narrow the population to hospitals.

Pilot Study

During the initial collection phase, personal interviews with the directors of three departments (health promotion, physical therapy and quality assurance) served as the basis for designing the formal pilot study. The purpose of the initial data collection phase was to identify factors to be used in the development of a mail survey involving 19 for-profit and 19 non-profit hospitals
nationwide. Some of the major topics discussed and probed in the initial interviews included:

- Marketing goals of the hospital
- Health promotion goals
- Effect of competition upon health promotion goals
- Effect of competition upon medical care delivery
- Demographics and psychographics of the target audience
- Communication materials currently utilized.

There was general consensus on all issues, although the three key management personnel did have differing opinions on the effect of competition upon the services rendered by the hospital. Some of the key findings of the initial collection phase include:

- Both the hospitals have a person in charge of marketing (health promotion).
- Medicare and Medicaid patients were affecting the performance picture of the hospitals.
- A weakened image of the hospital (particularly the non-profit hospital) in the public's eye was identified.
- HMOs and PPOs were viewed as threats to the hospitals' success.
- Both hospitals' expressed the need to be more consumer oriented.
- Key decision makers in the hospital are typically managers and directors of departments. However,
managers often seek the opinions of employees for increased effectiveness in decision making.

-- In the wake of recent competition, both the hospitals have stepped up efforts in the area of post-hospital service care, to minimize the length of the patients' stay.

-- Patients are asked to fill out surveys to assess the effectiveness of services during their stay.

The hospitals chosen for this study to generate factors, have been serving the community needs for nearly 15 years. The two facilities are viewed as typical of hospitals facing serious competitive and financial pressures today. The demographics for the hospitals are listed in Tables 1 and 2. The sample of management personnel in each hospital (profit and non-profit) during the initial data collection phase of the formal pilot study were selected with the assistance of a representative in the marketing department of each hospital. A list of key management personnel, by functional area, was obtained for the medical facilities. There are two major reasons for selecting key management personnel as targets of the study. Initial pilot study interviews with the director of Marketing (Health Promotion) revealed that managers and directors tended to be more knowledgeable about the hospital and the changing environment. Hence, key decision makers -- managers and directors of departments were chosen
as the sample. Second, the number of years of experience, expertise and the wide age range of the members were additional criteria used in selection of sample. Specifically, in both hospitals two key decision makers were chosen from each department -- a director, and a manager. Please see a listing of the departments chosen, with the designation of the personnel from each department and important demographics in Tables 3 and 4. Details of how data was collected will be discussed later.

Major Research Propositions

The following research propositions were examined in Phase I of the current study, in regard to the major questions addressed earlier in Chapter 1. Research propositions are functional relationships between concepts. They appear in every theory in a variety of forms. Propositions represent an advancement beyond concepts toward theory formation and testing. Propositions are of extreme importance in the formation of links in the building of models -- a precursor to testing theory. Thus propositions also serve as a forerunner to hypotheses formation (Zaltman, LeMasters and Heffring 1982). With reference to this study, there is no evidence of a specific theoretical base in communication for application in the health care setting. Hence, research propositions will be utilized in Phase I of the current study. Subsequently,
based on the results of the focus groups, hypotheses were developed and tested using mail surveys. The propositions for Phase I are presented below:

P1: For profit hospitals have a greater propensity to consider audience factors or 'targets of communication,' in contrast to nonprofit hospitals, given, differences in perceptions on the competitive, regulatory and patient environments.

P2: For profit hospitals have a greater propensity to consider communication factors in contrast to nonprofit hospitals, given, differences in perceptions of the competitive, regulatory and patient environments.

P3: For profit hospitals have a greater propensity to utilize advertising, personal selling, publicity and sales promotion as tools in contrast to nonprofit hospitals, given differences in perceptions of the patient, regulatory and competitive environments.

P4: For profit hospitals have a greater propensity to wield greater personal influence, between the hospital and its employees, in contrast to nonprofit hospitals -- vis-a-vis the multi-flow interpersonal influence model chosen for the study. Given, there are differences in perceptions of the competitive, regulatory and patient environments.
P5: Administrative personnel (administrators and directors) have a greater propensity to be favorably predisposed toward 'promotion,' in contrast to other non-administrative personnel (physicians, nurses).

P6: Administrative personnel (administrators and directors) in for-profit hospitals have a greater propensity to be favorably predisposed toward promotion, in contrast to administrative personnel in non-profit hospitals.

Data Gathering Techniques and Instruments

Phase I of the study entailed using two mini-focus group interviews in a for-profit hospital and a non-profit hospital to gather qualitative information from hospital administrators and members of the medical staff. In each hospital, two focus groups were chosen, because of the different knowledge and experience levels of respondents with regard to communication. Further, if only one focus group were to be used in each hospital, a few knowledgeable people could dominate the thinking of others. The mix of departments to be actually chosen is shown in Appendix X.

A majority of the issues to be discussed in the focus group interviews relate to the respondents' existing cognitions and attitudes toward important communication related factors and audience related factors which largely determine the development of communication messages.
The Focus Group Technique

Focus group interviews are widely used in exploratory research. A variation of the personal interview technique, focus group interviews entail group rather than individual interviewing. The object of the technique is to observe group interaction when members are exposed to an idea or concept. The interviews are conducted in an informal setting without use of a structured questionnaire. But, specific topics are to be covered, under the direction of the moderator. Consumer attitudes, behavior, lifestyles, desires and needs can be explored in a flexible manner through focus group interviews. Researchers approach consumers without preconceived notions though specific topics may be part of the coverage sought. Questions are open ended and the researcher can probe deeper into feelings and thoughts that are not clearly understood (Pride and Ferrell 1985).

Focus groups provide a qualitative understanding of the consumer. Thus qualitative research is sometimes synonymous with focus group interviews. Listed below are some of the salient issues in focus group interviews.

1. Focus groups are generally used to obtain feelings and perceptions from a small group, usually 6 to 1960 people drawn from the sample of interest.

2. Researchers may be interested in "pilot testing"
certain operational aspects of anticipated quantitative research.

3. Researchers may wish to use qualitative research to generate or select theoretical ideas and hypotheses which they plan to verify with future quantitative research.

4. Focus groups are used to gain additional information to supplement mail or phone surveys.

5. Focus groups typically last about an hour or more.

6. Each focus group session is led by a moderator, who keeps the group on track, while not participating directly in a conversation (Hisrich and Peters 1982; Calder 1977). Focus groups offer several advantages (Cooper and Hisrich 1987) which include:

1. A high response rate in comparison to mail surveys.

2. Reasonable expense in comparison to personal interviews. Costs involved are the moderator compensation fees, respondent compensation and, the cost of the facility.

3. Short completion time in comparison to personal interviews.

Cooper and Hisrich (1987) in their discussion of the applicability of marketing research techniques in health care marketing areas, favor focus group interviews as an appropriate technique. The use of focus groups in general health care marketing planning and the functional areas of
pricing (monetary/nonmonetary costs), communication, access to health care and service development is recommended by the authors (Cooper and Hisrich 1987).

The use of focus groups in the current study was considered appropriate given the pilot nature of the study. The following focus group procedure was utilized:

1. The interview dates were communicated to all participants two weeks in advance, via letters addressed to every participant.

2. The interview was conducted in the client's setting (hospital).

3. The focus group interview was conducted by the same moderator in both the hospitals.

4. The respondent in the for-profit hospital was given $20 in cash for his or her participation during non-work time. However, the respondent in the non-profit hospital was not given any monetary incentive for his or her participation.

5. The interviews lasted anywhere between one-and-half to two hours.

6. Participants were apprised of the duration of the interview in advance.

7. The groups were queried on major topics related to the research purpose.

8. A tape-recorder was used to record the
conversations. Collected data was later transformed from audio tape to typed transcripts.

9. The focus group research was conducted with the intent to probe more into the "true" feelings of the respondents.

Phase II - The Descriptive Study

Mail questionnaires were used to collect information from a widely dispersed sample of full service for-profit and non-profit hospitals, offering inpatient and outpatient services. Results of the focus group interviews were used to develop hypotheses. The mail questionnaires were structured based on the hypotheses. A majority of the questionnaire items were designed to study the attitudes of respondents' (hospital administrators and medical staff members) toward: (a) Perception and utilization of 'promotion' as a marketing strategy element; (b) Important communication factors and audience related factors derived from focus group interviews in Phase I.

Mail surveys as a data collection instrument in contrast to telephone surveys and personal interviews offer several advantages such as:

1. Low in cost
2. Greater control of bias due to no interviewer-interviewee interaction.
3. Respondents are able to work at their own pace.
4. Promised anonymity encourages participants to
respond more freely to private or sensitive questionnaire items (Churchill 1983).

Some major disadvantages of questionnaires include low administration and information control. Respondent cooperation is low since directing a questionnaire to a person and actually securing a response from that person do not go together. The total time required to conduct a mail study can often be substantial since several administrative problems may arise. Surveys often get lost or the responses may come in at different time periods (Churchill 1983).

Hospital administrators were contacted in advance to get their agreement to participate in the current study. Later, questionnaires were sent to those who agreed to participate. Specifically, mail questionnaires were sent to hospital administrators who served as contact persons in each hospital. The cooperation of the contact persons were sought over the telephone or by letter. Contact persons were requested to distribute the questionnaires among the hospital personnel consisting of medical staff members and administrative staff members.

All hospital administrators who agreed to participate will be sent a summary of the findings. However, hospital administrators were not given any other incentive and the participation of hospital personnel was completely voluntary. This way there would be no additional bias. Since the respondents were not aware of the purpose of this
study, they would not provide stereotypical or precalculated answers.

Sample Identification and Selection

A non-profit city-county medical facility which provides medical services on an in-patient and out-patient basis, and a profit hospital owned by American Medical International, Inc., served as surrogates for profit and non-profit hospitals during the initial phase of the formal pilot study. Table 5 contains a listing of the characteristics (such as occupancy rate, number of employees, number of beds and average length of patient's stay) of the two sample surrogates to be used in Phase I of the study. A close examination of the sample hospitals and, the industry statistics in Table 6 indicates that the sample hospitals' are a reasonable representation of traditional medical care hospitals in the population. See Table 7 for a summary comparison of characteristics exhibited by the industry and the two sample surrogates. The commanality exhibited was the basis of the selection of the two hospitals as surrogates. Time and costs precluded the inclusion of other types of health care institutions in the sample. Both hospitals are located within 40 miles of a major city in north Texas. Several major medical centers and one other hospital are also located in the same area. A majority of the problems, identified earlier as occurring
in the hospital industry, in Chapter I, were found in the
two hospitals.

Thirty eight hospitals consisting of nineteen for-
profit and nineteen non-profit hospitals served as the sample during the second phase of data collection, in the current study. The sample of 38 hospitals were selected using a non-probability quota sample. The quota sampling plan used in the current study required the nineteen for-
profit and nineteen profit hospitals to be broken down further into small, medium and large size hospitals. The small hospitals consisted of 150 beds or less, medium sized hospitals consisted of over 150 beds but less than 300 beds, and large hospitals consisted of 300 beds and over. Five members from each hospital were chosen with the assistance of a contact person. A wide mix of personnel (medical staff and administrative personnel) made up the sample of respondents in each hospital.

Sample Selection Process In Phase II

The 1986 and 1987 editions of the American Hospital Association guide were used to prepare the list of hospital names and addresses. The directory provides the following information: address, telephone, administrator, approval code such as Joint Commission on Accreditation of Hospitals (JCAH), facility code and multi-hospital system code for every hospital. Inpatient data - beds, admissions, census, occupancy and personnel are also provided. Classification
codes reflecting the type of control was used primarily to satisfy the purpose of the study. Control types used to select hospitals from the list were: Government, nonfederal - State, County, City, City-County and Hospital District or Authority. Investor owned (for-profit) hospitals chosen were: Individual, partnership and corporation. Church operated and Government, federal hospitals (such as Air Force, Navy and Army) were excluded from the sample selection. A total of 250 hospital addresses were taken using a systematic sampling procedure, i.e., every tenth hospital address (Kth sample) was taken from the directory after a random beginning.

Description of the Questionnaire

For the second phase of data collection using mail surveys, an original questionnaire was developed. The questionnaire was pretested using two participants in the focus group study. There were some changes that needed to be done before the questionnaire was revised one final time to incorporate a few questions supplied by an outside institution. The questions from the outside institution were accepted because funding was received from the institution.

The questionnaire was divided into three major sections. Section I deals with marketing in general. In Section I statements relating to marketing objectives, attitudes toward marketing and problems in incorporating
marketing into a hospital environment are given. For example, respondents are instructed to rate each statement on the "importance of marketing objectives" in relation to their own marketing program. Five point Likert-type scales are employed for all 13 statements in that sub-section. For the Likert type scale employed, answers range from "extremely unimportant objective" to "extremely important objective." Thirteen statements on "attitudes toward marketing" are given, wherein respondents are to indicate their degree of agreement or disagreement with each statement. Five point Likert type scales are employed for all statements. In the subsection on "Problems in Incorporating marketing into a hospital environment" there are nine statements. Respondents were instructed to evaluate each statement in terms of their agreement or disagreement with the statement. Five point Likert-type scales are employed for all statements with answers ranging from "strongly disagree" to "strongly agree." In the last part of Section I respondents are asked to indicate if "marketing has grown in importance" over the last 5 years. If a respondent checked that marketing today is more important today than during the past 5 years, then they had to check several reasons that were provided following the question. A total of six reasons were provided with space for others.
Section II deals with marketing communication or promotion. First part of Section II consists of nine statements relating to the importance of goals of communication in relation to the respondent's hospital. Respondents are asked to evaluate each statement on a five point Likert-type scale. The range of values for the scale employed is "extremely unimportant" to "extremely important." The second part of Section II deals with matching "services" provided at the hospital with "target groups" of communication. A total of 19 target groups of communication were listed for the respondents to pick from and match against a "service/program." Services included: General Hospital services, Direct patient care services, community services/education programs and hospital education classes.

The second part of Section II deals with the purpose of communication tools. Ten statements relate to the purpose of advertising; six statements dealt with the purpose of special programs; six statements related to the purpose of PR and five statements dealt with the purpose of personal communication. Respondents are asked to evaluate all statements using a five point Likert type scale with answers ranging from "extremely unimportant" to "extremely important."

For the next part, respondents are required to "fill in" the name of the person who makes the final
decision regarding the type of communication tools to be used in the hospital. The next part of Section II deals with the type of communication media used in hospitals. Three more questions specifically related to marketing/marketing communication follow. Respondents are asked to continue if they hold a marketing position/title in the hospital. Finally, respondents who hold a marketing title are asked to evaluate twenty statements concerning 'Factors' considered prior developing communication messages. Respondents are asked to rate the statements on a five point Likert type scale with values ranging from "extremely unimportant" to "extremely important."

Section III consists of questions for classification purposes only. Respondents are asked to indicate their title in the hospital and the number of years they have served as a professional in the hospital field. Questions on hospital demographics pertain to the size of the hospital (for-profit and non-profit) and location of the hospital. At the end of the questionnaire the respondents are thanked for their cooperation.

Mail Survey Administration

Data was collected in three major steps, using mail surveys. In step 1, a private market research firm "Fenton and Swanger" was hired to call the national sample of hospitals. Telephone interviewers were instructed to ask to speak with the hospital administrator and find out if he or
she and administrative staff/medical staff members would be willing to participate in the survey. Instructions for the telephone interviewers are shown in Appendix 1. A packet containing a cover letter with five questionnaires and a stamped self-addressed return envelope was mailed on April 28th, 1988 to hospitals that agreed to participate. Also enclosed in the same packet was a transmittal form to be filled by the administrator concerning number of questionnaires distributed and number of questionnaires returned. The cover letter offered instructions to the administrator to minimize his/her commitment of time, assured him or her of complete confidentiality and asked for a business card in a separate envelope if they wished to receive a summary of the survey results. The transmittal form, cover letter and questionnaire are shown in Appendices 2, 3 and 4. A reminder letter was mailed out on May 12th. Please see Appendix 5. Hospitals that could not be reached over the telephone were sent a letter containing information about the purpose of the study and an invitation to participate in the survey. The letter is shown in Appendix 6. Efforts were taken to ensure that the packets with questions were mailed directly to the hospital administrator to personalize the survey and improve the response rate.
Analytical Techniques

Data collected using focus group interviews and mail questionnaires were analyzed with statistical techniques. The different techniques to be used are content analysis, a non-parametric test 'Chi-Square' and parametric tests T-Test and 'Analysis of Variance.' Pearson Correlation Coefficients have also been reported.

Content Analysis - Overview

Transcripts of focus group audio tapes were analyzed using "Content Analysis." A review of definitions of content analysis (Berelson 1952; Hisrich and Peters 1982; Krippendorff 1980) advanced in technical literature provides six distinguishing characteristics:

1. Content analysis is applicable only to social science generalizations.

2. Content analysis is useful for making replicable and valid inferences from data into their context.

3. Content analysis is primarily used to determine the effects of communication.

4. Content analysis applies only to the syntactic and semantic dimension of language.

5. Content analysis processes data in a quantitative fashion and provides an objective, systematic appraisal of the content of communication.

Berelson's definition (1952) of content analysis calls for the quantification of content elements. To assess
the pertinent aspects of the content, 'units' or 'subdivisions' of the content are used. Units of content analysis may appear as words, themes, characters and items. According to Berelson (1952), a theme is an assertion about a subject-matter and it represents the most useful unit of content analysis, particularly for the study of the effects of communication. Appropriate categories or compartments will be defined to place the 'themes' established from the tape recordings (Berelson 1952).

In this study, units will be developed using transcripts of the original tapes. Later, the units will be evaluated to establish themes in the focus group. A theme represents a concept expressed in one or more terms.

Topics including 'The importance of marketing in hospitals,' 'relation of marketing to promotion,' and 'factors considered prior to developing messages' discussed by focus groups served as the subject-matter categories. Subject-matter categories ranged from broad to narrow in scope and from general to specific. With reference to this study, the total number of themes for each topic area will be tabulated. Similar themes were grouped into 'categories' derived from the focus group participants' responses. The number of units in a theme category were determined by the number of responses.
Non-Parametric and Parametric Tests

A non-parametric test, Chi-Square, parametric tests, T-Test and Randomized Block Analysis of Variance (ANOVA) were used to test for differences among hospital employees within each hospital and to test for differences across hospital types -- profit and non-profit. Results of the hypotheses to be tested in Phase II of the current study, will serve as data for analysis purposes. Given the sample size in each hospital (5 members) and the unknown nature of the population distribution, the choice of the non-parametric test was appropriate to test for differences among medical staff members and administrative staff members within a given hospital. As discussed by Conover (1980), non-parametric tests can be used on data with a nominal scale of measurement. The non-parametric test has been used with the nominal data, generated from the mail questionnaires. T-test has been used to test for differences across for-profit and non-profit hospital types. Randomized Block ANOVA has been used to test for differences across the three types of hospitals -- small, medium and large. Since the three hospitals differ in size, the use of analysis of variance (ANOVA) is appropriate in the current study. Descriptive measures, including mean and median, were also computed based on demographic data.

SPSSX Inc. was used to compute the descriptive measures and to test the hypotheses.
There are general problems of 'Validity' and 'Reliability' related to the use of content analysis. Content analysis is valid to the extent its inferences are upheld in the face of independently obtained evidence (Krippendorff 1980). Reliability refers to measuring the degree to which the data are independent of the measurement instrument (Berelson 1952). There are two kinds of consistency that are important in the analysis of communication content:

1. Similar results should be produced when different analysts apply the same set of categories to the same content; and

2. Similar results should be produced when the coder applies the same set of categories to the same content at different times, that is, consistency through time. In this study, to ensure internal consistency, each of the independently conducted focus groups was lead by the same moderator. Further, the reliability coefficient 'alpha' has been reported in Chapter IV.
CHAPTER IV

FINDINGS

The purpose of this chapter is to present findings of the data analysis related to the two phases of data collection. First, the focus group results will be discussed followed by data analysis in relationship to the proposed hypotheses.

The Focus Group Study Results

Phase I of the data gathering process was based on two sets of mini focus group interviews conducted in a for-profit hospital and a non-profit hospital. In each hospital two focus groups were chosen. One group consisted of department directors, physicians and other medical staff members. The other group consisted of administrative staff members and marketing directors. A total of nineteen focus group participants, exhibiting diverse managerial responsibilities, represented the two hospitals. Ten participants were employed by the for-profit hospital and nine by the non-profit hospital.

During the focus groups, participants were asked a series of questions addressing their perceptions of marketing and marketing communication (promotion) issues.
During each two hour session, groups of four to five individuals discussed a series of general questions relating to marketing and marketing communications which served as a framework for maintaining consistency in the discussions. The following major themes emerged from the discussions in all of the focus groups.

The Practice of Marketing Is In Its Infancy

Though all the focus group participants, in both hospitals, except for individuals who had responsibility for the marketing function in the for-profit hospital, believe that marketing is imperative for survival, none of the participants could offer a precise definition of marketing. Individuals responsible for the marketing function defined marketing as an overall program that encompasses the traditional four Ps of marketing: product, price, place and promotion (communication).

Marketing Is Nothing More than Promotion

With the exception of the marketing director in the for-profit hospital, it was interesting to note that none of the other participants indicated that marketing and promotion were different.

To quote one of the participants in the non-marketing group:

"As far as I am concerned marketing and promotion are very closely related with no significant difference."
To quote another:

"The distinction between marketing and promotion is not an obvious one. In marketing, promotion is expected to lead to an exchange of money in favor of the marketer."

On the basis of these observations, it appears that the overall consensus of views about promotion/advertising being similar to marketing is attributable to the fact that the department directors and physicians do not clearly understand the distinction between the two concepts.

The Consumer Is Sovereign

All focus group participants agreed that the patient public must be offered superior care in order to counter stiff competition from hospitals offering similar services in the area and also to create a positive image. Over half of the participants in both hospital groups felt it is imperative to present a positive image for the hospital and its employees to the patient public. This is especially true if there have been negative images in the past.

Targeting Physician Needs and Community Needs

All of the focus group participants emphasized the need to "market" marketing to internal targets including physicians and other medical staff members who make up an important part of the hospital community. However, the marketing directors in both hospitals revealed they were not doing enough in this area. As one participant put it:
"We need good inside marketing to succeed in the marketing of healthcare products outside."

Participants responsible for the marketing function believe that even though "customer(patient) service" is an overriding tenet of hospital marketing, physicians need to be included in the formation of a formal marketing plan since their decisions are vital for day to day operations.

Women And Older Age Groups Are a Primary Target Group

Women over 35 were identified as a primary target group of communication because, today, women make key health decisions in families, are insured, and have significant discretionary income. Individuals, including women, sixty years and older are primary targets for wellness and preventive medicine programs.

Implementing The Marketing Concept

Most of the participants believed it necessary to identify services required by the community prior to developing messages directed to community groups. All participants agreed that a hospital's success hinges upon its degree of community involvement and the ability of its administrators to establish a one on one relationship with various community leaders. When asked to identify other factors important to consider prior to developing messages, participants responsible for the marketing function in both hospitals mentioned the following:
-- Financial ability of the patient public
-- Type of insurance coverage of patient public
-- Educational levels of patient public
-- Lifestyles of patient public
-- Age composition of patient public
-- Social factors
-- Total number of people in the community
-- Content of the message
-- Prior experience of the patient public with services
-- Personality factors of patient public
-- Reference group network of target audience
-- Prior beliefs/attitudes toward our hospital
-- Number of patients to be reached in community
-- The nature of the message
-- Person delivering the message, if in print or broadcast media
-- Is the message theme unified across all media

Based on their observations all the participants unanimously agreed that the key to survival in the 1980s is to be 'consumer oriented.' They also agreed the physician is an important factor in success.

Enhance Name Recognition In The Community

The different communication tools preferred and/or used by both hospital groups are identified here. First, the focus groups in the for-profit hospital indicated that through the use of advertising on radio and on television
the parent corporation must gain "corporate identity" using national identity campaigns. At the local level, physicians and hospital administrators must jointly participate in cooperative advertising efforts to establish a local identity. Participants in both hospitals indicated that special programs such as "health fairs" at the malls and free blood pressure checkup and free eye tests were excellent tools of communication for name enhancement. Focus group participants from the non-profit hospital indicated a strong preference toward newspaper and billboard advertising. Second, participants in both hospital groups felt it was important to build good public relations with the community and to maintain a positive reputation. PR was ranked as the number one communication tool in terms of credibility. The need for honesty and truthfulness in all communication about services available through the hospital surfaced time and again during the discussion. Overall, advertising, sales promotion, PR and personal communication were identified as communication tools of preference, by both hospital groups.

Physicians Are Selfish To Some Extent

Though members of the medical staff did not agree that they put their needs before meeting patient needs, most of the nursing staff, department directors and other administrative/marketing staff nearly unanimously agreed they did. According to them, the physicians consider their
own personal convenience as one criterion in referring a patient to one hospital over another. Other criteria include: services provided by the hospital; quality of care provided by staff; and equipment available at the hospital. There was agreement on these latter criteria.

Competition

Both hospital groups had definite opinions on alternative forms of medical care. Managed care was viewed as a threat. HMOs were perceived to be a serious threat to "docs-in-box" clinics (clinics in shopping malls) only if they can implement cost cutting measures.

The focus group study identified several interesting similarities/differences between the for-profit hospital and non-profit hospital respondents. Using the transcripts developed from the original session tapes, similarities/differences in attitudes were inferred. With the differences in perceptions on competitive, regulatory and patient environment in both hospitals taken for granted as stated under research propositions in Chapter 1, it appears there were no statistically significant differences in their attitudes toward:

1. The need to consider audience factors and communication factors prior to developing communication messages.

2. Propensity to use Personal communication, PR, sales promotion and advertising as communication tools.
The two groups in both hospitals emphasized the need for hospital administrators to meet with physicians and other department directors on a formal and/or informal basis periodically. Participants in the for-profit hospital were favorably predisposed toward utilization of the four major communication tools: advertising, personal communication, public relations and sales promotion. However, participants in the non-profit hospital were skeptical of TV advertising because of its expense. Also, they cited the difficulty of assessing results associated with advertising in general.

There were some differences in attitudes toward promotion in the for-profit hospital. The assistant administrator repeatedly emphasized that his experience is typically operations oriented and hence he is not very favorable towards promotion. He defined marketing as "the promotion of services in the form of advertising." In contrast to the administrative personnel, the marketing director was favorable toward promotion. In neither hospital were physicians favorably disposed toward promotion.

As one physician put it:

"In a hospital setting both promotion and PR are corrupt and do not serve the patient."

In both the settings, department directors and
Registered Nurses held favorable attitudes toward promotion.

Content Analysis

The general topics covered in the focus group discussion are listed in Appendix XIV. Please refer to Appendix XV for the list of general questions that were used to generate ideas for phase one of the study.

The following procedure was used in analyzing the focus group discussions. First, information was gathered through listening to the audio cassette tapes. Next, using content analysis, "themes" were established for every major topic area discussed. A theme is defined as an assertion about a certain subject matter (Berelson 1952). For each topic area themes were established by the frequency of occurrence of "words" describing the same topic. For example, it took a physician twenty words to describe what marketing involves while the marketing director described the same issue in less than ten words. Both were credited with eliciting the same theme. Table 8 shows the "number of different themes" recorded for each topic.

Similar themes were grouped together into "categories." The "number of times" a theme was mentioned was determined by the number of responses. See Table 9 for the results.
<table>
<thead>
<tr>
<th>Topic Area</th>
<th>Number of Themes</th>
<th>Percent* of Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>What does Marketing involve</td>
<td>5</td>
<td>9.3</td>
</tr>
<tr>
<td>Marketing Activities Include</td>
<td>4</td>
<td>7.5</td>
</tr>
<tr>
<td>Importance of Marketing</td>
<td>2</td>
<td>3.8</td>
</tr>
<tr>
<td>Marketing and Promotion</td>
<td>2</td>
<td>3.8</td>
</tr>
<tr>
<td>Importance of Internal marketing vis-a-vis External marketing</td>
<td>3</td>
<td>5.7</td>
</tr>
<tr>
<td>Strategies to elevate the importance of marketing within hospital</td>
<td>3</td>
<td>5.7</td>
</tr>
<tr>
<td>Targets of communication</td>
<td>4</td>
<td>7.5</td>
</tr>
<tr>
<td>Factors considered prior to developing messages</td>
<td>9</td>
<td>17</td>
</tr>
<tr>
<td>Communication Tools Used</td>
<td>9</td>
<td>17</td>
</tr>
<tr>
<td>Purpose of Tools</td>
<td>3</td>
<td>5.7</td>
</tr>
<tr>
<td>Timing of Messages</td>
<td>2</td>
<td>3.8</td>
</tr>
<tr>
<td>Factors important to physicians to refer patients to a hospital</td>
<td>4</td>
<td>7.5</td>
</tr>
<tr>
<td>Competition</td>
<td>3</td>
<td>5.7</td>
</tr>
<tr>
<td></td>
<td>53</td>
<td>100</td>
</tr>
</tbody>
</table>

* Using a base standard of 100%
<table>
<thead>
<tr>
<th>Theme Category</th>
<th>* Number of Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marketing is critical to hospitals for survival in the 1980s</td>
<td>18</td>
</tr>
<tr>
<td>Marketing is nothing more than promotion</td>
<td>18</td>
</tr>
<tr>
<td>Physician Marketing comes before patient marketing</td>
<td>19</td>
</tr>
<tr>
<td>Assess patient needs carefully</td>
<td>19</td>
</tr>
<tr>
<td>Enhance name recognition</td>
<td>17</td>
</tr>
<tr>
<td>Financial ability of patient public is a critical factor to consider prior to developing messages</td>
<td>16</td>
</tr>
<tr>
<td>Competition faced by Docs-in-Box Clinics and HMOs is not a serious threat</td>
<td>19</td>
</tr>
</tbody>
</table>

* Total number of focus group participants including both hospitals = 19
Summary of Focus Group Results

The focus groups identified several interesting findings related to the field of healthcare (hospital) marketing and the direction the field is taking. First, marketing in hospitals is still thought to be in its early growth stages. Second, marketing as currently practiced is viewed as synonymous with advertising and public relations. Finally, given the financial pressures facing hospitals today, it appears marketing will eventually evolve as a major functional area on par with other functional areas.

Restatement of Research Propositions as Hypotheses

Research propositions presented in Chapter III were examined in Phase I. A list of important factors considered prior to developing messages by both the administrative staff and marketing staff of both the hospitals was developed from the focus group results. One of the objectives of the second phase study was to test the "factors" identified by the focus group participants, using a larger national sample of hospitals.

Before, phase two could be implemented the research propositions were restated as hypotheses. In addition to the original six hypotheses, twenty additional hypotheses were tested in Phase II of the study. Presented below is a list of the hypotheses tested in Phase II.
H1: For-profit hospitals have a greater propensity (tendency) to consider audience factors or 'targets of communication' in the development of communication messages, in contrast to non-profit hospitals, given, differences in perceptions on the competitive, regulatory and patient environments.

H2: For-profit hospitals have a greater propensity to consider communication factors in the development of communication messages, in contrast to non-profit hospitals, given, differences in perceptions of the competitive, regulatory and patient environments.

H3: For-profit hospitals have a greater propensity to utilize advertising, personal selling, publicity and sales promotion as tools in contrast to non-profit hospitals, given, differences in perceptions of the patient, regulatory and competitive environments.

H4: For profit hospitals have a greater propensity to wield greater personal influence between the hospital and its employees in contrast to non-profit hospitals -- vis-a-vis the multi-flow interpersonal influence model chosen for the study. Given, there are differences in perceptions of the competitive, regulatory and patient environments.

H5: Senior staff members (administrators and marketing staff) have a greater propensity to be favorably predisposed toward 'promotion' in contrast to other
staff members (medical staff and department directors).

H6: Senior staff members (administrators and marketing staff) in for-profit hospitals have a greater propensity to be favorably predisposed toward promotion, in contrast to other staff members (medical staff and department directors).

H7: Respondents in large hospitals (over 300 beds) have a greater propensity to consider the importance of communication goals than those in smaller hospitals (under 300 beds).

H8: Respondents in for-profit hospitals have a greater propensity to consider the importance of communication goals than those in non-profit hospitals.

H9: Respondents who have spent significant number of years (over 20 years) as a professional in the hospital field have a greater propensity to consider the importance of communication goals, than those who have spent less number of years (less than 20).

H10: Respondents in large hospitals (over 300 beds) have a greater propensity to utilize promotion than those in smaller hospitals (under 300 beds).

H11: Respondents who have spent significant number of years (over 20 years) as a professional in the hospital field have a greater propensity to utilize promotion
in contrast to those who are less experienced professionals (less than 20 years).

**H12:** Respondents in for-profit hospitals have a greater propensity to be favorable toward the use of Special Programs than those in non-profit hospitals.

**H13:** Respondents in large hospitals (over 300 beds) have a greater propensity to be favorable toward the use of Special Programs than those in smaller hospitals (under 300 beds).

**H14:** Respondents in large hospitals (over 300 beds) have a greater propensity to be favorable toward the use of Personal communication as communication tool in contrast to respondents in smaller hospitals (under 300 beds).

**H15:** Respondents in for-profit hospitals have a greater propensity to be favorably predisposed toward "marketing" than those who are in non-profit hospitals.

**H16:** Respondents who spent significant number of years (over 20) as a professional in the hospital field have a greater propensity to be favorable toward marketing than those who have spent fewer number of years (less than 20).

**H17:** Respondents who are key decision makers of marketing communication in for-profit hospitals have a greater
propensity to be favorable toward "marketing" than those in non-profit hospitals.

H18: Respondents who belong to large hospitals (300 beds or more) tend to be more favorably predisposed toward marketing than those in smaller hospitals (300 beds or less).

H19: Respondents in for-profit hospitals have a greater propensity to believe "marketing is more important today" than those respondents in non-profit hospitals.

H20: Respondents in large hospitals (300 beds or more) have a greater propensity to consider "marketing objectives" than those in smaller hospitals (300 beds or less).

H21: Respondents in for-profit hospitals have a greater propensity to consider "marketing objectives" than those in non-profit hospitals.

H22: Respondents who have spent significant number of years as a professional in the hospital field (over 20) have a greater propensity to consider marketing objectives than those who have spent fewer (less than 20) number of years.

Each hypothesis is tested using the statistical package SPSSX, 1986, 2nd. ed.
Response Rate for Phase II

Fenton and Swanger, the independent market research firm hired to make telephone calls to hospital administrators, was successful in completing 71 telephone interviews. In addition to the 71 hospitals who agreed to participate, 9 more hospitals that were contacted independently agreed to participate in the survey. Of the total 400 (80 * 5) questionnaires that were mailed, 25 questionnaires were returned back to the researcher marked "refuse to participate." Of those 25 questionnaires, 15 questionnaires (3 hospitals) were returned because of "time constraints," 5 questionnaires (1 hospital) were returned because the hospital was a small 48 bed hospital that made a time count to remain competitive. Reasons offered by another hospital for 5 returned questionnaires were:

"Our hospital is busting at the seams, hence we do very little marketing. However, we do have shortages of nurses, medical technologists and X Ray technicians for which we have publications."

One hundred fourteen usable questionnaires were received by June 4, 1988 which served as the cut-off date for responses to be received by the researcher. Since that date, 9 usable questionnaires have been received and 2 hospitals returned the questionnaires expressing their inability to participate due to time pressures. 38 hospitals responded with usable questionnaires to give a 51 percent (38 divided by 75) usable response rate. The 114
usable questionnaires that were received gives a 30.4 percent usable response rate translating to an average of 3 (114 divided by 38) usable questionnaires received for every hospital. Table 10 presents a summary of the response rates.

Hypotheses Tests

This section of the chapter presents the findings of the data analysis and interpretation of these results in relationship to the proposed hypotheses. First, the frequency runs for all questionnaire items will be reported followed by a description of the hypotheses-testing results.

Discussion Of The Major Frequency Distributions

A brief presentation of the major frequency distributions for the two hospital types serves the purpose of providing an overall summary of the data.

The total sample of 114 usable cases was divided evenly between the for-profit hospital respondents and the non-profit hospital respondents. Respondents included 61 females and 51 males and two unspecified as to gender. The percentage of female respondents and male respondents (54% females and 45% males) was approximately the same as found in the focus group study (58% females and 42% males). In
### Table 10
Response Rates

<table>
<thead>
<tr>
<th>Reasons for Refusal to Participate</th>
<th>Number of Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time Constraints</td>
<td>3</td>
</tr>
<tr>
<td>Small hospital/No time</td>
<td>1</td>
</tr>
<tr>
<td>Very little marketing currently used</td>
<td>1</td>
</tr>
</tbody>
</table>

Total number of hospitals who refused to participate: 5

#### Hospitals

- **"Any response" Rate**
  \[
  \frac{38 + 5}{(75 + 5)} = \frac{43}{80} = 53.75\% 
  \]

- **Usable Response Rate**
  \[
  \frac{38}{(80-5)} = \frac{38}{75} = 50.67\% 
  \]

#### Questionnaires

- **Average Number of Usable Questionnaires Received per Hospital**
  \[
  \frac{114}{38} = 3 
  \]

- **Any Response Rate**
  \[
  \frac{114 + 25}{400} = 34.75\% 
  \]

- **Usable Response Rate**
  \[
  \frac{114}{(400-25)} = \frac{114}{375} = 30.4\% 
  \]
terms of size, 44 respondents indicated their hospital were small (0 to 150 beds), 31 respondents worked in medium size hospitals (150 beds to 300 beds) and 39 respondents indicated their hospitals were large (over 300 beds). Therefore 39.0 percent of respondents represented small hospitals, 27.0 percent of respondents, medium size hospitals and 34 percent, large hospitals.

Application of the CROSSTABS technique shows the relationship between the 'hospital size' and the 'type of hospital.' CROSSTABS results are presented in Table 11. As shown in Table 11, only 11 respondents are from non-profit medium size hospitals. There is approximately even parity in the number of respondents in the other cells. Of the total 113 respondents who indicated the number of years they have served as a professional in the hospital field, over half of them had 15 years or less of experience.

Fifty-four percent of the total sample indicated they had 17 or more years of experience. Based on the distribution of years of experience among respondents, the respondent group was matured and appropriate for the study. Fifty-six percent of the respondents were classified as administrative staff (administrators; board members; marketing directors) and forty-four percent were non-administrative staff members (such as medical staff and department directors). A summary of the key characteristics of the respondent groups is presented in Table 12.
<table>
<thead>
<tr>
<th>Hospital Type</th>
<th>Hospital Size</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Small</td>
</tr>
<tr>
<td>For-Profit</td>
<td>19</td>
</tr>
<tr>
<td>Non-Profit</td>
<td>24</td>
</tr>
</tbody>
</table>

Table 11
Summary Of Relationships Between Hospital Type and Hospital Size
Table 12
Summary Of The Major Frequency Distributions

<table>
<thead>
<tr>
<th>Topic</th>
<th>Frequency (Number)</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of Usable Cases</td>
<td>114</td>
<td>100.00</td>
</tr>
<tr>
<td>Number of Usable Cases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For-profit hospitals</td>
<td>57</td>
<td>50.00</td>
</tr>
<tr>
<td>Non-profit hospitals</td>
<td>57</td>
<td>50.00</td>
</tr>
<tr>
<td>Gender of Respondents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>51</td>
<td>44.70</td>
</tr>
<tr>
<td>Female</td>
<td>61</td>
<td>53.50</td>
</tr>
<tr>
<td>Did not indicate gender</td>
<td>2</td>
<td>1.80</td>
</tr>
<tr>
<td>Number of Usable Cases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-150 beds</td>
<td>44</td>
<td>38.60</td>
</tr>
<tr>
<td>150-300 beds</td>
<td>31</td>
<td>27.20</td>
</tr>
<tr>
<td>Over 300 beds</td>
<td>39</td>
<td>34.20</td>
</tr>
<tr>
<td>Position/Title</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Board member/Administrator/Assistant</td>
<td>64</td>
<td>56.10</td>
</tr>
<tr>
<td>Administrator/Assistant Administrator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marketing Director</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physicians/Nursing Staff/Department</td>
<td>50</td>
<td>43.90</td>
</tr>
<tr>
<td>Directors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Years of Experience as a Professional in the Hospital field</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 10 years</td>
<td>30</td>
<td>26.50</td>
</tr>
<tr>
<td>10-25 years</td>
<td>68</td>
<td>60.20</td>
</tr>
<tr>
<td>Over 25 years</td>
<td>15</td>
<td>12.40</td>
</tr>
<tr>
<td>Did not Indicate Experience</td>
<td>1</td>
<td>0.90</td>
</tr>
<tr>
<td>Hospital Location</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inner City/Metropolis</td>
<td>39</td>
<td>34.20</td>
</tr>
<tr>
<td>Suburb/County</td>
<td>29</td>
<td>25.50</td>
</tr>
<tr>
<td>Village/Rural Area</td>
<td>45</td>
<td>39.40</td>
</tr>
<tr>
<td>Did not indicate</td>
<td>1</td>
<td>0.90</td>
</tr>
</tbody>
</table>
Discussion Of Mean Rating Scores For Statements In the Questionnaire

Mean scores for various statements related to marketing and marketing communication were obtained for all respondents using FREQUENCIES in SPSSX. The highest mean score rating for the most important marketing objective in the questionnaire was found to be 'making consumers aware of available services.' 'Creative pricing approaches can be developed' was rated as the least important marketing objective. A summary of the mean responses are reported in Table 13.

There were thirteen statements which related to the attitudes of respondents' toward marketing. 'It is ethical for my hospital to market its services' was rated as the statement most respondents agreed upon, with a mean rating score of 4.526. A mean rating of 1.711 was found to be the least score obtained for the factor (statement) 'marketing consists of merely clever promotional gimmicks. See Table 14 for a summary of the results.

Nine statements pertained to 'Problems in Incorporating marketing into a hospital environment.' The highest mean score rating was obtained for the factor 'the practice of applying marketing in today's hospital environment goes beyond using advertising and PR. The lowest mean rating was obtained for the statement related to 'whether hospitals that depend heavily on marketing typically provide lower quality healthcare than those who
<table>
<thead>
<tr>
<th>Statement</th>
<th>Mean Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Making consumers aware of available services</td>
<td>4.421</td>
</tr>
<tr>
<td>Attracting superior quality resources such as physicians and nursing staff</td>
<td>4.404</td>
</tr>
<tr>
<td>Improved satisfaction of patient markets</td>
<td>4.386</td>
</tr>
<tr>
<td>Finding out what patients want</td>
<td>4.298</td>
</tr>
<tr>
<td>Improved satisfaction of physician markets</td>
<td>4.123</td>
</tr>
<tr>
<td>Improved efficiency in keeping patients informed of program and service offerings</td>
<td>4.097</td>
</tr>
<tr>
<td>Improved morale of physicians and other hospital employees</td>
<td>4.088</td>
</tr>
<tr>
<td>Improved ability to increase utilization of under-utilized programs and services</td>
<td>4.044</td>
</tr>
<tr>
<td>Improved ability to contain costs</td>
<td>3.789</td>
</tr>
<tr>
<td>Improved ability to monitor competition</td>
<td>3.623</td>
</tr>
<tr>
<td>Increase in healthcare choices for consumers</td>
<td>3.526</td>
</tr>
<tr>
<td>Improved ability to eliminate under-utilized programs and services</td>
<td>3.500</td>
</tr>
<tr>
<td>Creative pricing approaches can be developed</td>
<td>3.386</td>
</tr>
<tr>
<td>Statement</td>
<td>Mean</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>It is ethical for my hospital to market its services</td>
<td>4.526</td>
</tr>
<tr>
<td>Marketing should develop ongoing market research programs to aid in determining the hospital's overall objectives</td>
<td>4.263</td>
</tr>
<tr>
<td>The practice of marketing has become a necessity for hospitals to survive</td>
<td>4.202</td>
</tr>
<tr>
<td>Management in our hospital supports the use of marketing completely</td>
<td>3.728</td>
</tr>
<tr>
<td>Marketing should have significant input in determining which new services should be offered to the community</td>
<td>3.623</td>
</tr>
<tr>
<td>Hospitals typically implement marketing programs</td>
<td>3.439</td>
</tr>
<tr>
<td>Marketing should have significant input in determining which services should be given priority in the marketing effort</td>
<td>3.434</td>
</tr>
<tr>
<td>Patients tend to be favorably predisposed toward a hospital that adopts a marketing orientation</td>
<td>3.158</td>
</tr>
<tr>
<td>Marketing should have significant input in determining prices for services</td>
<td>3.096</td>
</tr>
<tr>
<td>Staff employees in our hospital support the use of marketing completely</td>
<td>3.053</td>
</tr>
<tr>
<td>The misapplication of marketing could result in filling beds at the expense providing needed services</td>
<td>2.772</td>
</tr>
<tr>
<td>Marketing is nothing more than advertising, selling and public relations</td>
<td>2.132</td>
</tr>
<tr>
<td>Marketing consists merely of clever promotional gimmicks</td>
<td>1.711</td>
</tr>
</tbody>
</table>
do not utilize marketing.' A summary of the scores are reported in Table 15.

Ninety percent of the respondents (n = 103) reported marketing is more important today, based on the past five years in their hospital. Six percent stated that based on the past five years in their hospital, marketing has not changed in importance. Four percent of the respondents stated marketing is less important today in comparison to the past five years. See Table 16 for a summary of the results. 'Marketing is more important today because it helps achieve hospital's objectives' was cited as the most important reason. The respondents rated 'marketing is more important today because it contains rising healthcare costs' as the least important reason. See Table 17 for a summary ranking of the responses.

Section II of the questionnaire deals with marketing communication. In the first part, statements concerning the goals of communication are addressed. 'To enhance the image of the hospital among doctors, patients and hospital employees was rated as the most important goal of communication. Respondents rated 'to entice people away from non-physician providers as the least important goal of communication. See Table 18 for a summary of the mean responses related to goals of communication.

In the second part of Section II which focuses upon matching target groups of communication with services
<table>
<thead>
<tr>
<th>Statement</th>
<th>Mean Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practice of applying marketing in today's hospital environment goes</td>
<td>4.465</td>
</tr>
<tr>
<td>beyond using advertising and public relations</td>
<td></td>
</tr>
<tr>
<td>There is a general belief that hospital marketing can create a commercial</td>
<td>2.693</td>
</tr>
<tr>
<td>rather than a caring public image</td>
<td></td>
</tr>
<tr>
<td>Hospital administrators feel quite strongly that they should not expend</td>
<td>2.254</td>
</tr>
<tr>
<td>precious marketing resources to foster competition</td>
<td></td>
</tr>
<tr>
<td>Information sought via Marketing often invades the privacy of people</td>
<td>2.158</td>
</tr>
<tr>
<td>Marketing is too expensive and wastes valuable healthcare dollars</td>
<td>2.000</td>
</tr>
<tr>
<td>Creating a marketing position title is a solution to a hospital's need to</td>
<td>1.965</td>
</tr>
<tr>
<td>be more marketing oriented</td>
<td></td>
</tr>
<tr>
<td>Overall, Marketing is intrusive and manipulative</td>
<td>1.877</td>
</tr>
<tr>
<td>Enough Marketing is being done already via the Public Relations function</td>
<td>1.816</td>
</tr>
<tr>
<td>Hospitals that depend heavily on Marketing typically provide lower</td>
<td>1.737</td>
</tr>
<tr>
<td>quality health care than hospitals that do not utilize marketing</td>
<td></td>
</tr>
</tbody>
</table>
Table 16
Summary Of Responses Related To Importance of Marketing

<table>
<thead>
<tr>
<th>Statement</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marketing is MORE important today</td>
<td>90</td>
</tr>
<tr>
<td>Marketing has not changed in importance</td>
<td>6</td>
</tr>
<tr>
<td>Marketing is less important today based on the past 5 years</td>
<td>4</td>
</tr>
</tbody>
</table>

Table 17
Summary Of Rankings Concerning Why Marketing Is More Important

<table>
<thead>
<tr>
<th>Reason(s)</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helps achieve hospital objectives</td>
<td>1</td>
</tr>
<tr>
<td>Key to economic survival</td>
<td>2</td>
</tr>
<tr>
<td>Uncovers public-image problems</td>
<td>3</td>
</tr>
<tr>
<td>Counter tremendous competitive pressure</td>
<td>4</td>
</tr>
<tr>
<td>Overall number of patient admissions is falling</td>
<td>5</td>
</tr>
<tr>
<td>Need to contain rising health care costs</td>
<td>6</td>
</tr>
<tr>
<td>Statement</td>
<td>Mean</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>Enhance image of hospital among doctors, patients and hospital employees</td>
<td>4.377</td>
</tr>
<tr>
<td>Improve patient census</td>
<td>4.272</td>
</tr>
<tr>
<td>Increase awareness of hospital</td>
<td>4.263</td>
</tr>
<tr>
<td>Increase use of out-patient services</td>
<td>4.237</td>
</tr>
<tr>
<td>To generate revenues through increased referrals</td>
<td>4.142</td>
</tr>
<tr>
<td>To attract scarce resources, such as nurses and doctors</td>
<td>4.079</td>
</tr>
<tr>
<td>Contain costs and improve public relations</td>
<td>3.832</td>
</tr>
<tr>
<td>Increase use of specialized in-house clinics</td>
<td>3.589</td>
</tr>
<tr>
<td>Entice people away from non-physician providers</td>
<td>2.938</td>
</tr>
</tbody>
</table>
offered at the hospital, it was found respondents had
difficulty with the length of the section. Since the
responses obtained were not very valuable, mean scores will
not be reported here.

In the next part on communication tools, the
respondents marked that the most important purpose of
advertising is 'to keep the community informed of services
available at the hospital.' Furthermore, the least
important purpose of advertising is 'to combat competitive
claims. See Table 19 for a summary ranking of mean
responses.

The most important purpose of 'Special Programs' is to
generate positive behavior. 'To combat fears of rising
advertising costs' was rated as the least important
objective of special programs. See Table 20 for a summary
of the rankings of mean responses related to special
programs. Most of the respondents rated 'to generate
awareness and goodwill' as the most important purpose of
Public Relations. 'To provide an entertainment orientation'
was rated as the least important purpose of public
relations. See Table 21 for a summary of mean responses
related to Public Relations.

Most of respondents rated 'to maintain a positive
reputation in the community' as the most important purpose
of personal communication followed by the statement 'to
reach a large audience' as the least important purpose of
### Table 19
Mean Rating Scores For The Purpose Of Advertising

<table>
<thead>
<tr>
<th>Statement</th>
<th>Mean Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inform our community of the available services</td>
<td>4.469</td>
</tr>
<tr>
<td>Build a long term relationship with our community</td>
<td>4.345</td>
</tr>
<tr>
<td>Build name recognition</td>
<td>4.301</td>
</tr>
<tr>
<td>Increase hospital utilization</td>
<td>4.248</td>
</tr>
<tr>
<td>Remind people about us</td>
<td>4.186</td>
</tr>
<tr>
<td>Build morale of hospital employees</td>
<td>4.159</td>
</tr>
<tr>
<td>Tie-in with special offers</td>
<td>3.589</td>
</tr>
<tr>
<td>Offset competitive claims</td>
<td>3.321</td>
</tr>
<tr>
<td>Enhance social causes such as anti-smoking</td>
<td>3.295</td>
</tr>
<tr>
<td>Combat competitive claims</td>
<td>3.259</td>
</tr>
<tr>
<td>Statement</td>
<td>Mean</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Generate positive behavior</td>
<td>4.054</td>
</tr>
<tr>
<td>Increase patient census in the wake of rising competition</td>
<td>3.884</td>
</tr>
<tr>
<td>Win consumer goodwill</td>
<td>3.866</td>
</tr>
<tr>
<td>Induce patients in the short-run to participate in various educational programs/services</td>
<td>3.750</td>
</tr>
<tr>
<td>Offer incentives (to patients) to build loyalty to our hospital</td>
<td>3.929</td>
</tr>
<tr>
<td>Combat fears of rising advertising costs</td>
<td>2.634</td>
</tr>
<tr>
<td>Statement</td>
<td>Mean</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Generate awareness and goodwill</td>
<td>4.411</td>
</tr>
<tr>
<td>Strengthen community involvement with our hospital</td>
<td>4.389</td>
</tr>
<tr>
<td>Change negative public attitudes toward our hospital</td>
<td>4.232</td>
</tr>
<tr>
<td>Foster overall marketing purposes of our hospital</td>
<td>3.856</td>
</tr>
<tr>
<td>Contribute to the quality of life in the community</td>
<td>3.821</td>
</tr>
<tr>
<td>Handle and anticipate potential problems in our hospital</td>
<td>3.628</td>
</tr>
<tr>
<td><strong>Entertainment Orientation</strong></td>
<td>2.482</td>
</tr>
</tbody>
</table>
personal communication. See Table 22 for a summary of responses on personal communication.

Forty percent of the respondents in the total sample, indicated administrators as key decision makers within the hospital regarding types of communication tools to be used. CEOs were identified by twenty percent of the total sample as decision makers with the final authority, regarding types of communication tools to be used. Seven percent of the respondents identified the decision makers as a group of individuals comprising of administrators, marketing directors and board members.

Newspapers were ranked as the number one communication medium in terms of use in hospitals, in comparison to billboards which was ranked as the least used communication medium by this sample of hospitals. See Table 23 for a summary ranking of media used in hospitals.

Twenty percent of the respondents hold a marketing position or title. Seventeen percent of the sample provided responses concerning 'approximate number of dollars spent on marketing research annually. Sixty-eight percent of the sample who provided responses spend over $10,000 on marketing research annually. Twenty-five percent spend between 0 and $5,000 annually on marketing research. The rest spend over $5,000 and under $10,000 on marketing research. See Table 24 for a summary of the money spent on marketing research by respondents.
Table 22
Mean Responses Related To Personal Communication

<table>
<thead>
<tr>
<th>Statement</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintain a positive reputation in the community</td>
<td>4.372</td>
</tr>
<tr>
<td>Enhance name recognition</td>
<td>4.265</td>
</tr>
<tr>
<td>Supplement Advertising and PR efforts</td>
<td>4.009</td>
</tr>
<tr>
<td>Increase patient volume</td>
<td>3.858</td>
</tr>
<tr>
<td>Reach a large audience</td>
<td>3.616</td>
</tr>
</tbody>
</table>

Table 23
Rankings Of Media In terms of Use In Hospitals

<table>
<thead>
<tr>
<th>Medium</th>
<th>Rank*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newspapers</td>
<td>1</td>
</tr>
<tr>
<td>On-site Brochures</td>
<td>2</td>
</tr>
<tr>
<td>Community Outreach Programs (Health Fairs)</td>
<td>3</td>
</tr>
<tr>
<td>Direct Mail</td>
<td>4</td>
</tr>
<tr>
<td>Radio</td>
<td>5</td>
</tr>
<tr>
<td>Magazines</td>
<td>6</td>
</tr>
<tr>
<td>Television</td>
<td>7</td>
</tr>
<tr>
<td>Billboard</td>
<td>8</td>
</tr>
</tbody>
</table>

* 1 = Most commonly used; 8 = Least used
### Table 24
Percent Of Responses Who Spend On Marketing Research Annually

<table>
<thead>
<tr>
<th>Amount Spent</th>
<th>Percent Of Responses*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over $10,000</td>
<td>68%</td>
</tr>
<tr>
<td>$5,000-$10,000</td>
<td>17%</td>
</tr>
<tr>
<td>$0 - $5,000</td>
<td>25%</td>
</tr>
</tbody>
</table>

* Only seventeen percent of the sample provided responses on this question
Only twenty percent responses were recorded for the statement whether marketing research is conducted in-house, outside or using both in-house and outside firms. Fifty-two percent of respondents indicated research is conducted using both in-house and outside firms. Twenty percent of the respondents indicated research is conducted in-house. Twenty percent of the respondents indicated research is conducted 'in-house.' See Table 25 for a summary of the above discussion.

A response rate of twenty-one percent was reported for the question concerning methods typically used to establish the marketing communication budget. 'To establish objectives and calculate cost of achieving objectives was ranked as the method most commonly used. The method cited as the one least used was 'a level that equals your competitor's expenditure.' See Table 26 for a summary list of methods commonly used to establish the marketing communication budgets.

The final part of Section II deals with 'factors considered prior to developing messages.' Most of the respondents chose the audience related factor 'services needed by community' as the most important factor to be considered prior to developing messages. The communication related factor 'source factors' such as person transmitting a message on TV or in the print media was rated as the least important factor to be considered. A summary of the mean
Table 25
Summary Of Responses Regarding Whether Marketing Research Is Conducted In-House/Outside Firm(s)

<table>
<thead>
<tr>
<th>Method Used</th>
<th>Percent Of Responses*</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-house</td>
<td>20%</td>
</tr>
<tr>
<td>Outside Firm(s)</td>
<td>20%</td>
</tr>
<tr>
<td>Both In-house and Outside</td>
<td>52%</td>
</tr>
</tbody>
</table>

* Only twenty percent response rate was recorded for this question

Table 26
Summary Of Rankings Regarding Method Used In Establishing Marketing Communication Budget

<table>
<thead>
<tr>
<th>Method Used</th>
<th>Rank*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish Objectives and calculate cost of achieving objectives</td>
<td>1</td>
</tr>
<tr>
<td>All you can Afford</td>
<td>2</td>
</tr>
<tr>
<td>Percentage of Total Operating Expenses</td>
<td>3</td>
</tr>
</tbody>
</table>

* Rank based on number of respondents who chose a method. 1 = Most commonly used method; 3 = Least commonly used
rating scores for every statement concerning 'factors considered' is reported in Table 27.

Preparation of Composite Variables

Given the questionnaire was composed of a large number of items, several composite variables were constructed for use in the analysis as dependent variables. The reliability scores for the composite variables are reported in Table 28. The reliability score is a measure of internal consistency, which is reported using Cronbach's alpha. The composite variable names, number of items, questionnaire items and corresponding "alpha" are shown in Table 29. All the composite variables, with the exception of one, have Cronbach's alpha values above 0.83. According to Nunnally (1978) reliabilities of 0.70 or higher are considered acceptable. Two considerations indicated it would be impractical to increase the number of items to reach higher reliabilities. First, when tested to check if the alpha level of ATTMKT increased significantly with an increase in the number of items, the resulting alpha was not sufficiently different. Secondly, the squared multiple correlation among items in the composite variable was not large. Given, the exploratory nature of the study the low alpha score for ATTMKT was deemed acceptable.
Table 27
Summary Of Responses Regarding Factors Considered Prior To Developing Messages

<table>
<thead>
<tr>
<th>Statement</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services needed by community</td>
<td>4.375</td>
</tr>
<tr>
<td>Existing knowledge and attitudes of patient(s) toward our hospital</td>
<td>4.075</td>
</tr>
<tr>
<td>Past experience(s) of the patient public with your hospital</td>
<td>4.000</td>
</tr>
<tr>
<td>&quot;When&quot; to transmit the message, to reach the target groups</td>
<td>3.925</td>
</tr>
<tr>
<td>Underlying theme of all messages transmitted to the patient public</td>
<td>3.878</td>
</tr>
<tr>
<td>Number of patient(s) to be reached in the community using different communication tools</td>
<td>3.829</td>
</tr>
<tr>
<td>Financial ability of the patient public</td>
<td>3.700</td>
</tr>
<tr>
<td>Educational classes solicited by members in the community</td>
<td>3.675</td>
</tr>
<tr>
<td>Decision situation/circumstances of patient public</td>
<td>3.641</td>
</tr>
<tr>
<td>Type of insurance coverage for patient(s)</td>
<td>3.600</td>
</tr>
<tr>
<td>Communication tools used, such as Advertising, Public Relations and Price-Offs to reach target groups</td>
<td>3.575</td>
</tr>
<tr>
<td>Income levels of patient public</td>
<td>3.55</td>
</tr>
<tr>
<td>Number of messages to be transmitted within a four-week period</td>
<td>3.525</td>
</tr>
<tr>
<td>Competition</td>
<td>3.500</td>
</tr>
<tr>
<td>Personality type and lifestyles of patient public</td>
<td>3.450</td>
</tr>
<tr>
<td>Education levels of patient public</td>
<td>3.425</td>
</tr>
<tr>
<td>Statement</td>
<td>Mean</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Reference networks surrounding the patient public in your community</td>
<td>3.400</td>
</tr>
<tr>
<td>Nature of the message such as, whether emotional or straightforward</td>
<td>3.350</td>
</tr>
<tr>
<td>Neighborhood where patient(s) reside(s)</td>
<td>3.325</td>
</tr>
<tr>
<td>Source factors, such as person transmitting a message on TV or in the print media</td>
<td>3.079</td>
</tr>
</tbody>
</table>
Table 28
Variables and their Reliability Scores

<table>
<thead>
<tr>
<th>Composite Variable</th>
<th>Number of Items</th>
<th>Question Numbers</th>
<th>Cronbach's Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATTMTK</td>
<td>13</td>
<td>p. 2/p. 3, 1-4,6,8-9/1,3,5-8</td>
<td>.4014</td>
</tr>
<tr>
<td>PROMOTN</td>
<td>28</td>
<td>p. 7/p. 8, 1-28</td>
<td>.9536</td>
</tr>
<tr>
<td>FACTORS</td>
<td>20</td>
<td>p. 9/p. 10, 1-20</td>
<td>.9646</td>
</tr>
<tr>
<td>AUDFACTR</td>
<td>12</td>
<td>p. 9/p. 10, 2-14</td>
<td>.9393</td>
</tr>
<tr>
<td>COMMFCTR</td>
<td>6</td>
<td>p. 10, 15-19</td>
<td>.9262</td>
</tr>
<tr>
<td>COMMGOAL</td>
<td>9</td>
<td>p. 4, 1-9</td>
<td>.8424</td>
</tr>
<tr>
<td>MKTOBKJ</td>
<td>13</td>
<td>p. 1, 1-13</td>
<td>.8307</td>
</tr>
</tbody>
</table>
Table 29
Description of Variables

<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Variable Labels</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATTMKT</td>
<td>Attitudes toward marketing</td>
</tr>
<tr>
<td>PROMOTN</td>
<td>Attitudes toward various communication tools used</td>
</tr>
<tr>
<td>FACTORS</td>
<td>Overall factors considered prior to developing messages</td>
</tr>
<tr>
<td>AUDFACTR</td>
<td>Specific audience factors considered prior to developing messages</td>
</tr>
<tr>
<td>COMFACTR</td>
<td>Specific communication factors considered prior to developing messages</td>
</tr>
<tr>
<td>COMMGOAL</td>
<td>Attitudes toward different communication goals</td>
</tr>
<tr>
<td>MKTOBJ</td>
<td>Attitudes toward marketing objective</td>
</tr>
</tbody>
</table>
Attitudes Toward Marketing In General

The first hypotheses to be discussed will be concerned with the attitudes of respondents toward marketing. Hypotheses 15, 16, 17, 18, 19, 20, 21 and 22, discussed earlier, will be tested in this context:

A summary of statistical results is presented at the end of this section in Table 30. First it was stated in H15 that respondents in for-profit hospitals have a greater propensity to favor "marketing" than respondents in non-profit hospitals. Using T-Test (difference between the two sample means) it was found that there were no differences among respondents in both for-profit and non-profit hospitals. The group means were approximately the same for both groups. The explanation for this may be the small number of respondents from non-profit hospitals (n = 37, n = 76).

The next hypotheses, H16, stated respondents who are experienced professionals with over 20 years of experience will favor marketing over those who are less experienced professionals. The number of years of experience was broken into "year categories." The categorization was based on the outcome of the range of frequencies for the variables which changed it to an ordinal scale, "a measurement in which numbers are assigned to data on the basis of some order of objects (such as greater than)" (Churchill 1979,
### Summary of Results Related to "Marketing"

#### In General

<table>
<thead>
<tr>
<th>Variables</th>
<th>Technique</th>
<th>Significance</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>H15:ATTMKT BY Hosp. Type</td>
<td>T-TEST</td>
<td>Prob. = .894</td>
<td>rejected</td>
</tr>
<tr>
<td>H16:ATTMKT BY Years as a professional</td>
<td>Oneway ANOVA</td>
<td>Prob. = .614</td>
<td>rejected</td>
</tr>
<tr>
<td>*H17:ATTMKT BY Hosp. Type</td>
<td>T-TEST</td>
<td>Prob. = .925</td>
<td>rejected</td>
</tr>
<tr>
<td>H18:ATTMKT BY Hosp. Size</td>
<td>Oneway ANOVA</td>
<td>Prob. = .560</td>
<td>rejected</td>
</tr>
<tr>
<td>H19:Importance of marketing BY Hosp. Type</td>
<td>T-TEST</td>
<td>Prob. = .730</td>
<td>rejected</td>
</tr>
<tr>
<td>H20:MKTOBJ BY Hosp. Size</td>
<td>Oneway ANOVA</td>
<td>Prob. = .7242</td>
<td>rejected</td>
</tr>
<tr>
<td>H21:MKTOBJ BY Hosp. Type</td>
<td>T-TEST</td>
<td>Prob. = .405</td>
<td>rejected</td>
</tr>
<tr>
<td>H22:MKTOBJ BY Years as a Professional</td>
<td>Oneway ANOVA</td>
<td>Prob. = .6517</td>
<td>rejected</td>
</tr>
</tbody>
</table>

* (n = 35)
p. 655). Using One-way ANOVA (differences in 3 or more sample means) to test for differences, no differences among respondents belonging to the two hospital types. The "few" respondents in the last category of the variable "years of experience" may have impacted the results.

In hypotheses H17 it is proposed that respondents in for-profit hospitals who have key decision making authority on marketing communication will favor "marketing" over those in non-profit hospitals. A total of 35 respondents were used for analysis purposes (n = 35). Using T-Test to measure differences across two group means, no differences were found among the two groups in their attitudes toward marketing. In summary, using all cases (n = 114) and using a smaller sample size (n = 35), it was found that respondents, as a whole, did not differ in their attitudes toward marketing in general.

The fourth hypotheses, H18, was related to the variable hospital size. It was proposed that respondents in large hospitals (over 300 beds) have a greater propensity to favor marketing than respondents in hospitals with less than 300 beds. Contrary to the proposed hypotheses, no significant differences in attitudes toward marketing were found among the respondents in the small (0-150), medium (150-300) and large size (over 300 beds) hospitals.

Hypotheses H19 focussed on the importance of marketing as perceived by respondents in for-profit and non-profit
hospitals. It states that respondents in for-profit hospitals believe marketing is more important than respondents in non-profit hospitals. The results showed no differences among respondents in either hospital types. The group means were also approximately the same. It can be explained that since there were fewer respondents in the non-profit hospital group, the results were not significant.

The next set of 3 hypotheses relate to the variable "marketing objectives." Hypotheses H20 states respondents in larger hospitals (over 300 beds) have a greater propensity to consider marketing objectives than those in smaller hospitals (less than 300 beds). There were no significant differences in attitudes toward marketing objectives among respondents belonging to the three hospitals.

The second hypothesis, H21, states respondents in for-profit hospitals have a greater propensity to consider marketing objectives in contrast to respondents in non-profit hospitals. Respondents in both for-profit hospitals and non-profit hospitals do not differ in their propensity to consider marketing objectives.

Finally, the last hypotheses, H22, states that respondents with significant experience in the hospital field (over 20 years) have a greater propensity to consider marketing objectives than less experienced professionals.
(less than 20 years). There were no significant differences among respondents with different lengths of years of hospital experience.

Since no significant results were achieved using the variables hospital type, hospital size and years of experience as a professional, it was suspected that interaction was present, i.e., the type of hospital interacts with the size of hospital. Using a Two-Way ANOVA factorial design, significant interaction was detected between hospital type and hospital size, with marketing objectives as the dependent variable. It was found that respondents in for-profit hospitals with less than 150 beds and respondents in large non-profit hospitals (over 300 beds) were the two groups favorably predisposed to consider marketing objectives. There is not much to say about the medium size hospitals as indicated by the group means. Both small and large hospitals revealed group means over 4 on a 5 point Likert scale ('5' was designated as extremely important objective), while the group means for medium sized hospitals was less than 4 for both hospital types.

Table 31 shows a summary of the results reported above. In conclusion, there appears to be sufficient reason to examine the possibility of a relationship between the size of the hospital and importance of considering marketing objectives. A technique used to summarize the strength of association between nominal-interval data is the
Table 31
Summary of Results Showing Interaction Effects

<table>
<thead>
<tr>
<th>Variables</th>
<th>Technique</th>
<th>Significance</th>
<th>Remarks</th>
</tr>
</thead>
</table>

* An alpha level of .05 was used as the criterion for rejection. The significance levels calculated was found to be less than .05.
correlation coefficient. The Pearson Correlation coefficient "r" is applicable here. It was used in testing whether respondents in large for-profit hospitals have a greater propensity to consider marketing objectives than those in smaller size hospitals. The relationship was found to be significant (P = .021) at .05 level of significance. The direction of the hypothesis was not confirmed but the direction of the relationship is an inverse one. It was found that respondents in smaller hospitals (less than 150 beds) have a greater propensity to consider marketing objectives than those in larger hospitals. When a similar association was tested for non-profit hospitals the results did not prove to be significant. These results are shown in Table 32.

Findings Related To Communication Goals

After testing for differences in attitudes toward marketing in general among respondents belonging: (1) to different hospital "types;" (2) to different hospital sizes; and (3) with varied levels of experience, questions related to marketing communication/promotion programs in hospitals were examined.

First, the importance to respondents of goals of communication were tested. Table 33 provides a summary of the description of the variables used to test H7 through
Table 32
Summary of Results Showing Association Between Variables

<table>
<thead>
<tr>
<th>Variables</th>
<th>Technique</th>
<th>Significance</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Size</td>
<td>Coefficient</td>
<td>n=56</td>
<td>Accepted</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Coeff. = .3083</td>
<td></td>
</tr>
</tbody>
</table>

* An alpha level of .05 was used as the criterion for rejection. The calculated level of significance was found to be less than .05.

Table 33
Description of Variables

<table>
<thead>
<tr>
<th>Hypotheses</th>
<th>Independent Variable</th>
<th>Dependent Variable</th>
</tr>
</thead>
<tbody>
<tr>
<td>H7</td>
<td>Hospital Size</td>
<td>COMMGOAL</td>
</tr>
<tr>
<td></td>
<td>(3 levels)</td>
<td></td>
</tr>
<tr>
<td>H8</td>
<td>Hospital Type</td>
<td>COMMGOAL</td>
</tr>
<tr>
<td></td>
<td>(2 levels)</td>
<td></td>
</tr>
<tr>
<td>H9</td>
<td>Yrs. Of experience</td>
<td>COMMGOAL</td>
</tr>
</tbody>
</table>
H9. Table 34 shows a summary of the results. H7 through H9 were tested using a Randomized Block ANOVA design. First, treating "COMMGOAL" the composite variable as a dependent variable and hospital size, hospital type (for-profit/non-profit) as independent variables, the hypothesis was tested. A univariate MANOVA technique was used. It was found that there were no differences among respondents in the for-profit and non-profit hospitals. Also, no differences among respondents in small, medium and large hospitals were detected. Prior to using the blocking effect a One way ANOVA was used, i.e. only one independent variable was used to measure differences in the variable COMMGOAL. The results were not significant. Next, using COMMGOAL as the dependent variable and treating hospital size as an independent variable and blocking for the variable "years of experience as a professional in the hospital field," the hypothesis was tested. No differences among respondents were detected. Further, using a One way ANOVA design (without years of experience as a block effect) there were no differences revealed.

Interestingly, the frequency distribution for the composite variable COMMGOAL shows that over half of the respondents (n = 60) indicated a value of 4 on a 5 point Likert-type scale. '5' was designated as "extremely important goal." Thus the results here reinforce the lack of differences among respondents.
Table 34
Summary of Results Related to Goals of Communication

<table>
<thead>
<tr>
<th>Hypotheses</th>
<th>Technique</th>
<th>Significance</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>H7 &amp; H8</td>
<td>Univariate Manova</td>
<td>Prob. = .960</td>
<td>H7 &amp; H8 rejected</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prob. = .963</td>
<td></td>
</tr>
<tr>
<td>H7 &amp; H9</td>
<td>Univariate Manova</td>
<td>Prob. = .935</td>
<td>H7 &amp; H9 rejected</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prob. = .974</td>
<td></td>
</tr>
</tbody>
</table>
Findings Related to Promotion/Communication Tools Used In Hospitals

Hypothesis 3 stated that for-profit hospitals have a greater propensity to utilize the various communication tools (advertising, public relations, sales promotion and personal communication) in contrast to non-profit hospitals. Using the composite variable PROMOTN as the dependent variable, testing for differences across for-profit hospitals and non-profit hospitals did not reveal any significant differences in the utilization of the four major communication tools.

Hypothesis 10 stated that respondents in larger hospitals (over 300 beds) have a greater tendency to utilize promotion than do those in smaller hospitals (under 300 beds). The results show a marginally acceptable significance level. See Table 35. Though there are no significant differences among small, medium and large hospitals at .05 level of significance, it appears from the group means that respondents in small hospitals (0-150 beds) have a greater tendency to favor promotion over the other types of hospitals. Tukey's test was used to test for differences across groups. A reason for the marginally acceptable significance level may be the presence of a larger number of usable cases in the small hospitals ($n_s = 44$, $n_m = 31$, $n_L = 38$).
### Table 35
Summary of Results Related to Overall Promotional Tools Used

<table>
<thead>
<tr>
<th>Hypotheses</th>
<th>Technique</th>
<th>Significance</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>H3</td>
<td>T-TEST</td>
<td>.851</td>
<td>H3 rejected</td>
</tr>
<tr>
<td>H10</td>
<td>Oneway ANOVA</td>
<td>.0577*</td>
<td>H10 accepted</td>
</tr>
<tr>
<td>H11</td>
<td>Oneway ANOVA</td>
<td>.0705*</td>
<td>H11 accepted</td>
</tr>
</tbody>
</table>

* An alpha level of .10 was used as the criterion for rejection. The calculated significance level was less than .10.
The next hypothesis which relates to "years of experience as a professional" in the hospital field was tested. Recoding the independent variable "experience in years" as the ordinal scaled variable using four categories (0-10), (10-20), (21-30) and (30 and over), One-way ANOVA was used to measure the dependent variable 'PROMOTN.' Differences by "years of experience" were significant at the .10 level. Group 3, respondents with experience ranging between 21 years and 30 years in the hospital field, have a greater propensity to utilize promotion in contrast to respondents in other categories. Differences were significant at the .05 level. See Table 36 for a summary of the results.

Since the results related to the hypotheses tested (H3, H10 and H11) imply that respondents in small hospitals with over 20 years, but less than 30 years, of experience are favorable to utilize promotion, there was sufficient reason to examine the strength of association between the composite variable 'PROMOTN' and hospital size for both hospital types (for-profit and non-profit). A strong inverse (negative coefficient) relationship was obtained between hospital size and 'PROMOTN' with all usable cases. A further examination of the association between the two variables by using only the cases in for-profit hospitals revealed a strong inverse relationship (P=.004) between the two variables. The two variables were uncorrelated for
Table 36
Summary of Results Related To Hypotheses H5 and H6

<table>
<thead>
<tr>
<th>Hypotheses</th>
<th>Technique</th>
<th>Significance</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>H5</td>
<td>Oneway ANOVA</td>
<td>.2592</td>
<td>H5 rejected</td>
</tr>
<tr>
<td>H6</td>
<td>Oneway ANOVA</td>
<td>.2800</td>
<td>H6 rejected</td>
</tr>
</tbody>
</table>
non-profit hospitals. To test for differences in the attitudes to utilize promotion by hospital type, hospital size and number of years as a professional, a Three-way ANOVA design was used. Except for hospital size, the other two variables were statistically significant by themselves at the .10 level. Interaction was detected among the three variables at the .10 level. In conclusion, it appears respondents belonging to small for-profit hospitals with considerable experience in the field are favorably predisposed to the use of promotion.

Findings Related To The Overall Promotional Mix

The total sample of 114 usable cases was reduced to 35 usable cases (n = 35) in the sample. The cases are the respondents who have the final decision making authority regarding tools of communication to be used. Differences were tested across respondents in for-profit hospitals and non-profit hospitals. There were no significant differences in propensity to utilize promotion across respondents in either hospital type.

Hypotheses Related To Hypothesis H5 and Hypothesis H6

Hypotheses H5 states that respondents in both hospitals who were administrative staff members/marketing staff members would have a greater propensity to favorably utilize promotion in contrast to other staff members such as medical staff members and departmental staff (non-
marketing) members. The results showed no significant differences among respondents in the two hospital types. See Table 36 for a summary of the results. The following hypothesis, H6, was related to hospital types. It stated administrative staff and marketing staff members in for-profit hospitals differ from their counterparts in non-profit hospitals. The results indicated that there were no significant differences among administrative staff/marketing staff members in both hospitals.

The results reported here differ from literature which states that medical staff members have negative perceptions about the utilization of promotion in hospitals (MacStravic 1986). The focus group study results reported in Phase One also indicate that physicians are not very favorable toward promotion. A plausible explanation for the contradictory results reported is that nearly one-third of the respondents who marked they were physicians also indicated they were either board members or administrative staff members. It appears that physicians (medical staff members) who have decision making authority regarding communication tools to be utilized do not differ in their attitudes from administrative staff members.

Findings Related To Various Promotion Tools Used

Advertising, Public Relations, Sales Promotion (Special Programs) and Personal Communication are four
component tools of promotion. Hypotheses were tested, to find out if respondents in for-profit hospitals differed in their attitudes toward any of the four communication tools in contrast to members in the non-profit hospitals. Differences in attitudes were also tested separately using hospital size as an independent variable. H4 and H12 through H14 were tested. The first hypothesis states that respondents belonging to for-profit hospitals have a greater propensity to wield personal influence among employees in contrast to non-profit hospitals. Using T-TEST it was found there were no differences among respondents in for-profit and non-profit hospitals in their propensity to wield personal influence. A summary of the results are reported at the end of this section in Table 37.

The next set of two hypotheses, H12 and H13, were related to the variable 'Special Programs.' Hypothesis H12 states that respondents belonging to for-profit hospitals have a greater propensity to be favorable toward the use of 'Special Programs' than those in non-profit hospitals. It was found that the hypothesis was acceptable at the .10 level of significance. The group means were higher in Group 1 (for-profit hospitals). Respondents in for-profit hospitals do have a greater propensity to use Special Programs like health fairs in contrast to non-profit hospitals. Hypothesis H13 states respondents in large hospitals have a greater propensity to be favorable toward
the use of Special Programs than those in smaller hospitals. Using a One-way ANOVA, the hypothesis was acceptable at the .05 significance level. Tukey's test was employed to test for differences across the 3 hospital sizes: small, medium and large.

Respondents in the small hospital (0-150 beds) were significantly different at .05 level in contrast to members in other hospitals. A comparison of the group means revealed similar results. The second hypothesis, H14, states that respondents in large hospitals (over 300 beds) have a greater propensity to use Personal Communication in contrast to respondents in smaller hospitals (300 beds or less). The results revealed that respondents in smaller hospitals (0-150 beds) were significantly different in their attitudes, in contrast to respondents in large hospitals. The results are shown in Table 37.

It appears respondents in small hospitals are favorable to utilizing personal communication and special programs as promotional tools, in contrast to respondents in large hospitals. The use of the other two promotional tools, advertising and PR, did not reveal any differences among respondents. To compare the attitudes of all respondents belonging to for-profit/non-profit hospitals with the respondents who were identified as key decision makers, Hypothesis H6 was retested using a reduced sample of "key decision makers." H6 will be renamed as H6'. See
Table 37
Summary of Results Related To Different Promotional Tools

<table>
<thead>
<tr>
<th>Hypotheses</th>
<th>Technique</th>
<th>Significance</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>H4</td>
<td>T-TEST</td>
<td>Prob. = .702</td>
<td>H4 rejected</td>
</tr>
<tr>
<td>H12</td>
<td>Oneway ANOVA</td>
<td>Prob. = .0702*</td>
<td>H12 accepted</td>
</tr>
<tr>
<td>H13</td>
<td>Oneway ANOVA</td>
<td>Prob. = .0354*</td>
<td>H13 accepted</td>
</tr>
<tr>
<td>H14</td>
<td>Oneway ANOVA</td>
<td>Prob. = .0302*</td>
<td>H14 accepted</td>
</tr>
</tbody>
</table>

* An alpha level of .10 was used as the criterion for rejection.
Table 38 for a description of the variables. When differences among key decision makers (n = 35) were tested within for-profit hospitals, significant differences were revealed. Chi-Square Goodness of Fit Test was used to test for differences among administrative staff and marketing staff (excluding medical staff and department directors). The results were significant at the .05 level. Chi-Square, a non-parametric test is used when the sample size is small and the shape of the population distribution is unknown. Since the purpose was to examine differences using respondents who have final decision making authority regarding the use of communication tools, Chi-Square was appropriate. However, when using non-profit hospitals it was found there were no significant differences among administrative staff and marketing staff members. The Chi-Square value was not significant at .05 level.

Next, using respondents in for-profit hospitals only (n = 56) three categories were created: administrative staff, marketing staff and department directors/medical staff members. Results obtained revealed significant differences among the groups. The largest contributor to this Chi-Square value was the administrative staff group whose observed value exceeds the expected value by 155 percent. Using the same three categories and testing for differences in non-profit hospitals (n = 57) revealed similar results. Using Chi-Square it was found that all
Table 38
Variable Description For H6'

<table>
<thead>
<tr>
<th>Variable</th>
<th>Questionnaire Item</th>
<th>Variable Label</th>
</tr>
</thead>
<tbody>
<tr>
<td>VAR89</td>
<td>p.8: Communication tools - who makes decisions</td>
<td>Key decision makers in the hospital</td>
</tr>
</tbody>
</table>

VAR89 was recoded the following way:

Administrative Staff = Group 1  
Marketing Staff = Group 2  
Medical Staff/Dept. Directors = Group 3
three groups, i.e., administrative, marketing and departmental/medical members were different in their attitudes to use communication tools. It appears that the administrative staff group contributed to a significant Chi-Square value. A summary of the results is presented in Table 39.

In summary, the findings reveal that members who have final decision making authority with regards to promotional tools to be used tend to favor promotion over the members who are not directly involved in decision making.

Findings Related To Factors Considered Prior To Developing Messages

The first two hypotheses H1 and H2 related to different factors considered by respondents prior to developing messages. H1 states for-profit hospitals have a greater propensity to consider audience factors in the development of messages in contrast to non-profit hospitals, given differences in perceptions on the competitive, regulatory and patient environments. A total of 40 respondents provided responses which are 35 percent of the total sample. The T-TEST technique was used to measure differences. No significant differences were revealed among respondents belonging to different hospital types. The group means were nearly the same. See Table 40 at the end of this section for a summary of results.
### Table 39
Results Related To H6 Retested Using Smaller n

<table>
<thead>
<tr>
<th>Hypotheses</th>
<th>Technique</th>
<th>Significance</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>H6'(profit and non-profit)</td>
<td>Chi-Square</td>
<td>.0001*</td>
<td>H6' accepted</td>
</tr>
<tr>
<td>(2 levels) (n=35)</td>
<td>(2 levels)</td>
<td>.317</td>
<td>H6' rejected</td>
</tr>
<tr>
<td>H6'(for, profit &amp; non-profit</td>
<td>Chi-Square</td>
<td>.000</td>
<td>H6' accepted</td>
</tr>
<tr>
<td>(2 levels) (n=56)</td>
<td>(2 levels)</td>
<td>.000</td>
<td></td>
</tr>
</tbody>
</table>

* An alpha level of .05 was used as the criterion for rejection

### Table 40
Findings Related To Audience & Communication Factors Considered Prior to Developing Messages

<table>
<thead>
<tr>
<th>Hypotheses</th>
<th>Technique</th>
<th>Significance</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>H1</td>
<td>T-TEST</td>
<td>.531</td>
<td>H1 rejected</td>
</tr>
<tr>
<td>H2</td>
<td>T-TEST</td>
<td>.093*</td>
<td>H2 accepted</td>
</tr>
<tr>
<td>FACTORS BY Years of Experience as a professional</td>
<td>PEARSON CORRELATION</td>
<td>.001*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PEARSON CORRELATION</td>
<td>.163</td>
<td></td>
</tr>
</tbody>
</table>


H2 states that for-profit hospitals have a greater propensity to consider communication factors in the development of messages, in contrast to non-profit hospitals given, differences in perceptions of the competitive, regulatory and patient environments. Thirty-six percent of the respondents provided answers to various questionnaire statements. The results showed the hypothesis was significant at the .10 significance level. The direction of the hypothesis was also confirmed. Respondents in for-profit hospitals do tend to have a greater propensity to consider communication factors in contrast to non-profit hospitals. The strength of association was tested using Pearson Correlation coefficient between 'FACTORS' as a summated variable and the number of years respondents have served as a professional in the hospital field. The coefficient was computed for non-profit hospitals and for-profit hospitals separately. The association was found to be inverse in nature and a significant one at the .05 level in for-profit hospitals. Further, respondents in for-profit hospitals who had spent fewer number of years as a professional (less than 20) were more inclined to consider 'factors' prior to developing messages. In the non-profit hospitals, the coefficient was found to be .163. See Table 40 for a summary of the results. In summary, respondents in for-profit hospitals do differ from their counterparts in non-profit hospitals.
Findings Related To Target Groups of Communication

One way ANOVA was used to test if respondents across hospital types differed in their attempts to identify targets of communication for various services offered in their hospitals. Services listed included general hospital services, direct patient care services, community services/education programs and hospital education classes. There were no significant differences revealed among respondents in for-profit and non-profit hospitals. In summary, it was found that the respondents had considerable difficulty with the length of this section of the survey. Because several respondents did not fill out all the items in this section, the findings will not be reported.

The next chapter will present a summary of the objectives of this study, followed by implications of the results obtained. Finally, recommendations for future research will be discussed.
CHAPTER V

SUMMARY AND RECOMMENDATIONS FOR FUTURE RESEARCH

Summary of Findings and Research Implications

The purpose of this study was to determine whether various staff personnel in for-profit and non-profit hospitals differ in their attitudes toward marketing or 'marketing communication.' Specifically, the primary intent was to: (1) identify and test the important factors considered by various hospital staff members prior to developing messages; and (2) study the attitudes of various hospital staff members toward the perception and utilization of 'promotion' as a marketing strategy element.

In this chapter, findings related to the marketing environment in general, will be presented first for both hospital types. Secondly, findings concerning 'marketing communication' will be discussed with implications. Finally, recommendations for future studies will be discussed.

Summary of Respondents' Overall Attitudes Toward Marketing

The results obtained in both phases of this study indicate that today, in contrast to five years ago, most of the staff members in hospitals (for-profit and non-profit)
realize marketing is important for survival purposes (Kotler and Clarke 1987).

The focus group study findings revealed respondents who were staff employees (non-marketing) in the two sample hospitals experienced some difficulty in differentiating marketing from its communication component. Hypothesis H15 related to attitudes toward marketing and hospital type. Hypothesis H16 related to attitudes toward marketing and years of experience as a professional in the hospital. Hypothesis H17 related to attitudes toward marketing and hospital type using a smaller sample size (n = 35). Hypothesis H18 concerns the relationship between hospital sizes and attitudes toward marketing. Hypothesis H19 relates to the importance of marketing and hospital type. All the five hypotheses were rejected for both sample sizes (n = 35 and n = 114). These results seem to indicate that most of the staff members in both for-profit and non-profit hospitals were favorable toward marketing in general. Two reasons that might help explain the lack of differences among respondents are: (1) Physicians (whose inputs were vital for the success of this survey) traditionally have held less favorable attitudes toward marketing (Kotler and Clarke 1987). Since physicians did not respond in the same numbers as administrative staff members it was suspected that the small percentage of physicians (12 percent) resulted in lack of statistical significance and; (2)
department directors in medium-size non-profit hospitals made up only a very small percentage of the sample in contrast to administrative staff/marketing staff members. Insufficient number of cases (n=4) to provide meaningful differences was suspected to contribute for lack of statistical significance.

Furthermore, the findings in Phase II revealed that consensus was achieved among all respondents in the belief that the practice of marketing goes beyond PR and advertising. However, when respondents were asked whether both management and staff employees alike would support the use of marketing, it was found that management would be slightly more favorable toward marketing than would staff employees.

Overall, the results seem to indicate that though there are no major differences among respondents (as a whole) in their attitudes toward marketing and what it consists of, there seem to be some differences toward marketing, among respondents by virtue of their position or title in the hospital. One reason for this outcome may be that out of the target group of 114 respondents, fifty-six percent consisted of management personnel. Second, and also related to the variable 'title held' is the 'number of years of experience' as a professional in the hospital field. The "years" categories established, revealed that there were fewer respondents in the first (less than 10
years of experience) and third age categories (25 years and
more of experience), which seems to explain the lack of
statistical significance (Table 12). Hence, it seems there
is not enough evidence to reject the notion that both staff
employees and management personnel in both hospital types,
differ in their attitudes toward marketing. Further
investigation of the differences between staff employees
and managerial personnel in their attitudes toward
marketing is mandated.

Most of the respondents in the focus groups indicated
that marketing to patient publics and internal marketing to
physicians on staff are critical objectives for the
hospitals' success in the future.

In phase II, the hypotheses (H20, H21 and H22) related
to the importance of considering marketing objectives in
relation to the variables hospital type and hospital size
was accepted at the .05 level of significance. Respondents
in small for-profit hospitals and large non-profit
hospitals were favorable toward the consideration of
marketing objectives in contrast to respondents in medium
size hospitals. These results reinforce the notion that a
majority of the respondents were favorably disposed to the
practice of "marketing" in general. An explanation for the
lack of association between medium sized hospitals and
marketing objectives might be that there were fewer
respondents in medium sized hospitals in contrast to the other two hospital groups.

The most important marketing objective, identified by all respondents on the questionnaire using a 5 point Likert scale was 'making consumers aware of available services.' 'Attracting superior quality resources such as physicians and nursing staff' was rated as the second most important objective. These findings reflect that most of the respondents in the sample realize the importance of the communications component of marketing. As reported by MacStravic (1986), word of mouth communication via hospital medical staff could impact the perceptions of consumers in a positive manner. The second objective reported above seems justified in the context of the task (word of mouth communication) reported in the literature. On the other hand, it is open to speculation whether respondents chose the first objective on the basis of a mistaken association between marketing and its communication component, as one and the same. Traditionally promotion has mistakenly been seen as the only aspect of healthcare marketing (Cooper 1985). According to Kotler and Clarke (1987) the survival of hospitals in the future hinges upon the ability to respond to the needs of consumers through innovative and quality services.

In the case of for-profit hospitals, findings related to the strength of association between "marketing
objectives" and "hospital size" proved to be significant at the .05 level. It was found that respondents in smaller hospitals (less than 150 beds) pay more attention to marketing objectives in contrast to respondents in large hospitals (over 300 beds). One explanation for the findings reported above is that as government increases regulations (Kotler and Clarke 1987), it appears that for-profit hospitals have started to beef up their marketing efforts to face the problems as profit-oriented businesses do.

Secondly, with predictions that nearly 500 hospitals will be forced to close down by the end of this decade (Malhotra 1986), it appears, the fears of closing their doors, have driven small hospitals to adopt and practice marketing in a systematic way. Furthermore, the supply-demand relationship for hospital facilities and hospital staff are undergoing shifts as alternative sources of healthcare delivery emerge (Kotler and Clarke 1987). In the past, demand for hospital services exceeded supply of services, however today the opposite is true of facilities, medical technology and quality resources -- physicians.

There were no differences between for-profit and non-profit hospital types in their propensity to consider marketing objectives. There were no differences between the three hospital sizes in their propensity to consider marketing objectives. However, when the association between hospital type and hospital size was tested together with
propensity to consider marketing objectives, the association between marketing objectives and hospital size (small and medium) did not prove to be significant for non-profit hospitals. The relationship was a significant one when tested using for-profit hospitals. It appears non-profit hospitals are less adaptive to change because of inadequate funding support. Wood and Singh (1986) reported that non-profit hospitals have been slow in adapting to changes in the healthcare environment. It is open to speculation whether non-profit hospitals have embraced marketing practices as a "tactic" in the short-run rather than incorporating it as part of a broader plan.

Summary of Respondents' Overall Attitudes Toward Marketing Communication

Hypotheses H7, H8 and H9 were related to the variable communication goals and (1) respondents in different hospital types; (2) respondents belonging to different hospital sizes and; (3) years of experience as a professional in the hospital field. All hypotheses were rejected implying respondents in this study share favorable attitudes toward the importance of communication goals. An explanation for these findings might be that both staff employees and managerial staff members alike are aware of the common goals set by the communication specialists (decision makers of communication). 'To enhance the image of the hospital among doctors, patients and hospital employees' was rated by all the respondents as the most
important communication goal. Another explanation for the lack of differences among respondents, toward "communication goals", might be that with respondents expressing 'image building' as the number one communication goal, it probably signals the trend toward hospitals attempting to "brand" their services in order to gain an identity in the industry.

Hypotheses H3, H4, H5, H6, H10, H11, H12, H13 and H14 were related to the dependent variables: promotion (overall), advertising, special programs, PR and personal communication. Hypotheses H10, H11, H12, H13 and H14 were found to be statistically significant at both the .05 level and at the .10 level. Respondents in small for-profit hospitals and those with over 21 years but less than 30 years of experience in the hospital field exhibited a greater propensity to utilize promotion in contrast to the other respondent categories established. This finding may be attributed to the fact that for-profit hospitals sampled in this study view promotion as a marketing decision variable, which serves the purpose of informing and educating the community of the available services. An explanation which might support the above view is that the frequency distribution for the variable 'PROMOTN' revealed respondents rated, 'to inform prospects about the available services' as a primary objective of promotion. Furthermore, since fifty-six percent of the sample consisted of
administrative staff members who were directly and/or indirectly involved in making decisions concerning utilization of 'marketing communication tools,' it appears that there is very little reason to doubt the validity of these findings.

Though no study advanced to date has linked hospital ownership to the utilization of promotional tools, these findings invite additional testing of the relationship in order to validate the direction of the hypotheses results.

Respondents in for-profit hospitals favored the use of 'special programs' in contrast to respondents in non-profit hospitals. Further, small hospitals were favorable to utilizing special programs and personal communication as communication tools. It seems both for-profit hospitals and small hospitals utilize special programs as communication tools because of the opportunity offered to communicate through a variety of channels such as health fairs and shopping malls. Interestingly, it was found that respondents in both for-profit hospitals and small hospitals were found to have a greater propensity to favor the usage of the communication media 'community outreach programs' in contrast to non-profit hospitals and medium/large hospitals. It is believed that small hospitals may be more entrepreneurial and aggressive in their promotional efforts. Reflected here is the belief that special programs generate both goodwill and additional
business. On the other hand, it is open to speculation whether special programs were favored by respondents in for-profit hospitals' as a short-term gimmick instead of being linked to longer term goals. MacStravic (1986) reports that special programs like health fairs and other incentive oriented programs have gained importance in the delivery of healthcare and consumer satisfaction.

Respondents belonging to both hospital types identified physicians, in addition to patient publics as key target groups of communication resulting in personal communication as an obvious choice for a marketing communication tool. The results indicate that most of the respondents in small hospitals identified 'maintenance of a positive reputation in the community' as a primary purpose of personal communication. Most of the respondents did not identify 'reaching a large audience' as a significant purpose of personal communication, though personal contacts can be used to involve large audiences (MacStravic 1986). Though the costs of personal contacts are likely to be higher per person exposed to a message, it appears that for-profit hospitals in this sample are more committed to using personal communication as a marketing communication tool in contrast to non-profit hospitals. This was evident when differences between the two hospital types were measured using the dollars spent on marketing research annually. Results indicated that for-profit hospitals are
more committed to market research than are non-profit hospitals.

No differences were revealed among respondents in terms of using PR and advertising as communication tools. The ANOVA design showed that the group means for the three hospital sizes: small, medium and large were close to each other. The same results were found in the case of the two hospital types. The most important purpose of advertising was rated as the ability to inform the community of available services. The respondents rated 'to generate awareness and goodwill' as the primary focus of PR. Reflected here is the fact that most respondents employed by the two hospital types believe in dissemination of information via advertising and PR in a straightforward manner (informative) without being persuasive in nature. Advertising should not be used to combat or offset competitive claims, was rated as the least important purpose of advertising by a majority of respondents.

Hypotheses H6, when tested initially was found to indicate that staff members who were key decision makers of promotional tools to be used, were more positive about promotion than were other staff personnel. For example, in for-profit hospitals it was found that administrative staff members had a more favorable attitude about promotion than did marketing staff members. The fewer number of observed cases in the category established for marketing staff might
have impacted the results in favor of administrative staff members. The differences were even clearer when department directors and medical staff members were added as a group for comparison. As expected, the department directors and medical staff members were least likely to utilize promotion. The administrative staff group was found to be the greatest contributor to the Chi-Square value. The frequencies distribution revealed that out of the sixty-four respondents (Table 12, p. 135) who held administrative positions, over seventy-five percent were either administrators, assistant administrators or Board members. Respondents who held a marketing title were a small percentage of the overall sample. Another factor that might have contributed to the statistical significance was that most respondents identified the final decision making regarding communication tools as a concerted (joint) effort. Administrators, Board members and marketing staff members jointly served as a committee during decision making.

The differences were not statistically significant when differences across the groups were tested using administrative staff and marketing staff members, for non-profit hospitals. The small sample size (n=16) might have impacted the Chi-Square value resulting in a p-value of .317. Furthermore, significant differences were revealed among the administrative staff, marketing staff and medical
staff/department directors in their attitudes toward promotion. It seems evident that addition of department directors/medical staff has contributed to the differences among the three categories established. It was found that department directors and medical staff members were least likely to favor promotion.

In conclusion, it seems that respondents as a whole in both hospital types are either moderately favorable or very favorable toward promotion. Medical staff members such as physicians and other department directors (non-marketing) tend to be negative in their attitudes toward promotion particularly in non-profit hospitals. An interesting finding in conjunction with the above results was that a majority of the medical staff members/department directors in the non-profit hospital had over twenty-five years of experience in the hospital field. It is possible that this group of non-marketing members believe in the old school of thought that marketing communications is a waste of healthcare dollars. Earlier it was found in the focus groups that medical staff members were not favorable toward promotion.

Finally, testing for the factors of importance (audience related and communication related) considered prior to developing messages with the total sample of respondents did not reveal any statistically significant differences at the .05 level. However, when the factors
were separated into categories of audience related factors and communication related factors, differences were revealed. The results of H2 show that for-profit hospitals do have a greater tendency to consider communication factors in contrast to non-profit hospitals. It appears that respondents in for-profit hospitals are more perceptive than respondents in non-profit hospitals, in terms of consideration of simple factors that make communication effective. For example, 'the appropriate timing of messages targeted toward the community' is cited as the most important communications factor, followed by the factor 'underlying theme of all messages transmitted to the patient public.' Furthermore, it seems respondents in for-profit hospitals who were identified earlier as being favorable toward image-building communications/promotion in general tend to spend more time considering messages that are worth making.

However, no differences were evident between the respondents belonging to for-profit and non-profit hospitals in terms of audience factors considered prior to developing messages. The fewer number of respondents from for-profit hospitals might have impacted the statistical significance of the results. Members in both hospital types seem to exhibit identical propensity to consider audience related factors such as 'services needed' and 'past experiences of patients with their hospital.' Since
differences were exhibited between the hospital types in terms of message related factors only, it is open to speculation whether respondents in non-profit hospitals were really different from respondents in for-profit hospitals.

Professionals who had fewer years of experience in the hospital field tend to favor consideration of factors prior to developing messages in contrast to professionals who had more number of years of experience in the hospital field. This outcome is not very surprising since older professionals believe in the old school of thought that it is unethical to make payments to convey information about services rendered (MacStravic 1986).

Overall, the present study has contributed to the existing marketing literature in two ways:

1. Most of the respondents in for-profit hospitals held favorable attitudes toward promotion (marketing communication) in comparison to their counterparts in non-profit hospitals.

2. Most of the respondents in small hospitals of 150 beds or less were favorably disposed in their attitudes toward marketing communication in comparison to their counterparts in large hospitals.
Recommendations For Future Research

Future research extending the pilot study findings might take several directions. First, in order to determine if respondents across hospital types actually differ in their attitudes toward marketing/marketing communication in general, a similar study to this one can be administered using a larger sample size and testing the same research hypotheses. The larger sample size refers to an increase in the number of hospitals to be tested (larger n). Secondly, a similar study can be conducted for testing the same research hypotheses with a different sample frame, which might include HMOs, Church operated hospitals and Government-Federal (Air Force, Navy) controlled hospitals, in addition to the two types in the present study. In the present study several relationships were rejected because of a small sample size (small percent of physicians). A larger sample might reveal these relationships which had to be rejected because of a small sample size. Furthermore, some of the results found in the present study might be confirmed.

If the findings reveal that respondents belonging to the four hospital types: (1) Nongovernment-nonfederal; (2) Investor-owned; (3) Government-federal and; (4) Government-federal hospitals, have different propensities to either favor or disfavor marketing/marketing communication, an
indepth analysis of respondent characteristics may constitute the next research step.

If findings reveal different response patterns across hospital ownership types, next, it would be interesting to examine the socio-demographic characteristics of respondents. For example, educational background of the respondents can be used to measure differences in response patterns across hospital types. Finally, a profile of respondents can be drawn based on using various personality variables and socio-demographic characteristics to measure differences in response patterns.

The outcome of the present focus group study was that a list of factors considered prior to developing messages were developed. Prior to testing the factors directly using a larger sample it is recommended that for future investigation, the list of factors developed can be reduced to determine the most important factors. Factor analysis can be used to test and reduce the long list of factors developed.

After reducing the list of important factors using Factor Analysis, a similar study can be conducted using only a sample of hospitals concentrated in rural and inner-city areas. Furthermore, respondents might include administrative staff members, marketing staff and medical staff members only. However, a problem that may arise is that respondents in those hospitals might not cooperate
through the mail due to fear of bad publicity. An alternative would be to conduct focus group studies in several hospitals located in the inner-city and rural areas within a state, to test the factors identified. Using the focus group technique, respondents in hospitals located in other areas such as city and suburban areas can be surveyed too. It would be interesting to determine whether marketing/marketing communication programs, if properly implemented, might save hospitals in rural and inner city areas from the "brinks of disaster."

The above study could be improved by conducting a parallel study using patient publics. Focus group studies can be conducted using women who make most of the healthcare decisions (Cooper 1986). The purpose of the study must focus upon the attitudes of consumers toward marketing and promotion as practiced by both hospital types. Attitudes of consumers toward utilization of promotion can be compared with the attitudes of respondents such as medical staff members who were found to have negative perceptions toward advertising in the present study. This research study might help discern whether advertising practices in the hospital field will continue beyond the 1980s, as predicted in the literature (Kotler and Clarke 1987; MacStravic 1986).

The present study represents an initial effort toward determination of the association between hospital ownership
and attitudes toward marketing communication. Overall, since for-profit hospitals were found to favor utilization of promotion over non-profit hospitals, this association can be taken a step further to determine if the association between the two variables (marketing communication and hospital ownership) can be translated into determining if the bottom-line of the hospital operations can be changed. If the variable hospital efficiency can be linked to hospital ownership, this might prove as a turning point for those hospitals who have been pressured by the dynamic changes in healthcare industry conditions.

In the present study, individual testing of the variable marketing objectives with each of the variables hospital type, hospital size and years of experience as a professional in the hospital field did not reveal any significant results. However, it was found in Chapter 4 that the independent variables were interrelated when testing for differences in the dependent variable 'marketing objectives.' Other variables that might have an impact on the importance of marketing objectives include, personality items and socio-demographic characteristics such as educational background of professionals in the marketing field. Knowledge about the extent to which each of these variables might influence marketing objectives may assist future researchers to better understand and interpret differences across respondents belonging to
different hospital types. Based on the findings and conclusions of this study, the following research recommendations are offered:

1. A) Conduct a similar study using a larger sample size (larger n).

   B) Conduct a similar study using HMOs, Government-federal and non-government/non-profit hospitals in addition to investor-owned for-profit and Government-nonfederal hospitals.

2. A) Conduct a focus group study using administrative staff members, marketing staff members and physicians for hospitals located in rural and inner-city areas.

   B) Conduct a similar study using women as patient publics to compare and contrast similarities and differences in perceptions toward marketing/marketing communication across the two publics (hospital and patient).

3. Conduct a similar study to determine if the association between hospital ownership and attitudes toward promotion can be further investigated to determine whether hospital efficiency and hospital ownership bear a relationship.

4. Conduct a similar study to determine whether personality variables and socio-demographic characteristics such as educational background of respondents in hospitals...
have an effect on attitudes toward marketing and promotion. Once an 'effect' is determined, develop a profile of respondents by title held in hospitals.

Future research in these areas described above, should:

1. identify the variables that might be incorporated into a healthcare marketing model as a theoretical framework, for applicability in hospitals to serve the purpose of effective use of marketing communication.

2. Expand existing knowledge in the area of marketing and marketing communications in hospitals, as currently practiced.
HOSPITAL TELEPHONE SURVEY - INSTRUCTIONS

Interview Record Form:

When you dial the number for the hospital, if the telephone number has changed please record the hospital name and the new telephone number on the Interview Record Form.

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Telephone Number</th>
<th>Time</th>
<th>Refused To Participate</th>
</tr>
</thead>
</table>


Hello, could you give me the Office of the Administrator:

(If Respondent is reached)

Hello, my name is _____ (Your Name). I am calling you on behalf of a Ph.D. student at the University of North Texas who is conducting a research study in order to complete the requirements of his dissertation. The objective of the study is to learn more about how hospitals' perceive marketing and marketing communications programs. In order to accomplish this study, he needs to have several people within your hospital complete a questionnaire that he will mail to you personally. Would you be willing to participate in the study by completing the questionnaire yourself after it arrives as well as asking several people on the hospital staff to complete and return the questionnaire?

(If they say they need to ask around, please find out time to call them back and record it on the Interview Record Form. If they refuse to participate, note on the Interview Record Form, terminate politely and call another number.)

(After getting consent)

Within a week, you will be receiving a packet containing 5 questionnaires addressed to you (administrator). Enclosed
in the packet will be five questionnaires to be distributed and completed by members of the hospital staff with the following title or a similar title.

A. Administrator or Assistant Administrator
B. Marketing Director/Health Promotion Director
C. Director of Physical Therapy or Director of Quality Assurance
D. Surgeon or Physician (Medical Staff)
E. Nursing Director

After distributing the questionnaires, please ask the participants to return the questionnaires within 1 week of delivery.

Each respondent may be assured of complete confidentiality. No attempt will be made to identify individual respondents. A copy of summary results will be provided to you upon your request.

A cover letter indicating the procedure to be followed will accompany the questionnaires.

A return envelope will be enclosed to mail the questionnaires back to the researcher.

If you need to call the researcher at the University of North Texas, his telephone number is (817) 565-3139. His
name is Pradeep.

I thank you very much for your time and cooperation.

Bye.
APPENDIX B

TRANSMITTAL FORM
TRANSMITTAL FORM

Number of Questionnaires Distributed

Number of Questionnaires Completed and Mailed in this Envelope
April 25, 1988

Dear:

Thank you for agreeing to participate in the Survey of Hospitals' Utilization of Marketing. The questionnaires to be completed by your administrative and staff personnel are included in this packet.

The purpose of the survey is to investigate how for-profit and non-profit hospitals manage their marketing and communication efforts with their various publics. The survey includes a national sample of hospitals dispersed throughout the country. Your participation and that of your administrative and staff personnel is vital to the success of the survey. Enclosed are five survey questionnaires. To minimize your commitment of time, the following procedure is recommended:

1. Retain a questionnaire for yourself and give the packet to the marketing director requesting him/her to distribute the questionnaires to other hospital staff members. Questionnaires must be completed by members of your hospital staff with the following title or a similar title.

   A. Marketing Director/Health Promotion Director
   B. Director of Physical Therapy or Director of Quality Assurance
C. Surgeon or Physician (Medical Staff)  
D. Nursing Director or Head Nurse  

2. The time frame for returning the questionnaires should be 7 days or less.  
3. Upon receipt of all the completed questionnaires from the marketing director complete the enclosed transmittal form.  
4. Use the enclosed envelope to mail the questionnaires and transmittal form to me. Complete confidentiality will be maintained for all individuals participating in the survey. Only summary conclusions will be drawn from the results of this survey and no attempt to identify individual hospitals will be made. If you would like to receive a copy of the summary results please send me your business card in the separate envelope that has been enclosed for your convenience.  

On a personal note this study means a lot to me. Your cooperation in this matter can influence my student and professional career. If you have any questions about the survey, please contact my dissertation advisor Dr. Barbara Coe or me at the Marketing Department, (817) 565-3120. Thank you for your cooperation.  
Sincerely,  
Pradeep Gopalakrishna
A CONFIDENTIAL SURVEY OF YOUR KNOWLEDGE AND PERCEPTIONS CONCERNING MARKETING AND COMMUNICATION PROGRAMS IN YOUR HOSPITAL. PLEASE ANSWER ALL THE QUESTIONS. YOU ARE PART OF A SELECT GROUP OF INDIVIDUALS OR PROFESSIONALS ASKED TO PARTICIPATE IN THE SURVEY. HENCE, YOUR INPUTS ARE VITAL TO THE SUCCESS OF THE SURVEY. ALL RESPONSES WILL BE HELD IN STRICT CONFIDENCE.
## SECTION I

### MARKETING

Listed below are some possible objectives of implementing marketing programs in hospitals today. Thinking about your hospital’s current marketing programs, circle the number that describes how important each marketing objective is to your hospital.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Extremely Important</th>
<th>Extremely Unimportant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Improved satisfaction of patient markets.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Increase in healthcare choices for consumers.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Improved satisfaction of physician markets.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Making consumers aware of available services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Attracting superior quality resources such as physicians and nursing staff.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Improved efficiency in keeping patients informed of program and service offerings.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Improved morale of physicians and other hospital employees.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Improved ability to contain costs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Improved ability to eliminate underutilized programs and services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Creative pricing approaches can be developed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Improved ability to monitor competition.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Finding out what patients want.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Improved ability to increase utilization of underutilized programs and services.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## ATTITUDES TOWARD MARKETING

For each of the statements below, CIRCLE the number that best describes your degree of disagreement or agreement with the statement.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. It is ethical for my hospital to market its services.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>2. The practice of marketing has become a necessity for hospitals to survive.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>3. Hospitals typically implement marketing programs only after they begin experiencing problems.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>4. Management in our hospital supports the use of marketing completely.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>5. Marketing consists merely of clever promotional gimmicks.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>6. The misapplication of marketing could result in filling beds at the expense of providing needed services.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>7. Marketing is nothing more than advertising, selling and public relations.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>8. Patients tend to be favorably predisposed toward a hospital that adopts a marketing orientation.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>9. Staff employees in our hospital support the use of marketing completely.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>10. Marketing should have significant input in determining prices for services.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>11. Marketing should have significant input in determining which services should be given priority in the marketing effort.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>12. Marketing should have significant input in determining which new services should be offered to the community.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>13. Marketing should develop ongoing market research programs to aid in determining the hospital's overall objectives.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
</tbody>
</table>
### Problems in Incorporating Marketing into a Hospital Environment

For each statement given below circle the number that best describes your degree of disagreement or agreement with the statement.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

1. The practice of applying marketing in today's hospital environment goes beyond using advertising and public relations

2. Hospitals that depend heavily on Marketing typically provide lower quality health care than hospitals that do not utilize marketing

3. Information sought via Marketing often invades the privacy of people

4. Enough Marketing is being done already via the Public Relations function

5. Creating a marketing position title is a solution to a hospital's need to be more marketing oriented

6. There is a general belief that hospital marketing can create a commercial rather than a caring public image

7. Marketing is too expensive and wastes valuable health care dollars

8. Overall, Marketing is intrusive and manipulative

9. Hospital administrators feel quite strongly that they should not expend precious marketing resources to foster competition
IMPORTANCE OF MARKETING

Based on the past 5 years in your hospital is Marketing today.....

[ ] Less Important [ ] No Change in Importance [ ] More Important

If you checked MORE IMPORTANT please check (X) the reason(s) that apply:
Marketing is MORE important today because . . . .

1. Key to economic survival
2. Helps achieve hospital objectives
3. Uncovers public-image problems
4. Overall number of patient admissions is falling
5. Counter tremendous competitive pressure
6. Need to contain rising health care costs
7. Other ___________________________ [Please fill in the reason(s)]

SECTION II

While the previous questions dealt with Marketing in general, this section deals specifically with Marketing Communications/Promotion/Advertising.

GOALS OF COMMUNICATION

Thinking about your hospital's communication program CIRCLE the number that best describes how important each goal is to your hospital.

| 1. Increase use of specialized in-house clinics | 1 | 2 | 3 | 4 | 5 |
| 2. Increase use of out-patient services | 1 | 2 | 3 | 4 | 5 |
| 3. Enhance image of hospital among doctors, patients and hospital employees | 1 | 2 | 3 | 4 | 5 |
| 4. Increase awareness of hospital | 1 | 2 | 3 | 4 | 5 |
| 5. Improve patient census | 1 | 2 | 3 | 4 | 5 |
| 6. To attract scarce resources, such as nurses and doctors | 1 | 2 | 3 | 4 | 5 |
| 7. To generate revenues through increased referrals | 1 | 2 | 3 | 4 | 5 |
| 8. Contain costs and improve public relations | 1 | 2 | 3 | 4 | 5 |
| 9. Entice people away from non-physician providers | 1 | 2 | 3 | 4 | 5 |
TARGET GROUPS OF COMMUNICATION

For each service/program listed below identify the groups who are targets of your communications/programs. Write the numbers from the list below in the blanks that correspond to each service/program offered by your hospital. For services/programs that are unavailable at your hospital, check the last column.

List of Target Group(s) of Communication:

<table>
<thead>
<tr>
<th>List of Target Group(s) of Communication</th>
<th>Check Here If the Service Is Not Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children Under 6</td>
<td>Hospital Volunteers</td>
</tr>
<tr>
<td>Pregnant Women</td>
<td>Physical Therapist</td>
</tr>
<tr>
<td>Social Service Agency</td>
<td>Nutrition Specialist</td>
</tr>
<tr>
<td>Hospital Discharge Planner</td>
<td>Medicare Patients</td>
</tr>
<tr>
<td>Physicians</td>
<td>Medicaid Patients</td>
</tr>
<tr>
<td>Clergymen</td>
<td>Privately Insured Patients</td>
</tr>
<tr>
<td>Technical Employees</td>
<td>Indigent</td>
</tr>
<tr>
<td>Nurses</td>
<td>Other</td>
</tr>
<tr>
<td>Housekeepers</td>
<td>(If using this category, please fill in the name(s) of the target group next to each service.)</td>
</tr>
<tr>
<td>Working Mothers</td>
<td></td>
</tr>
<tr>
<td>Board of Directors</td>
<td></td>
</tr>
<tr>
<td>Hospital Department Director</td>
<td></td>
</tr>
</tbody>
</table>

**Example:**
- **Service/Program:** Elderly patients
  - **Target Group:** 5, 3
- **Service/Program:** Pediatric program
  - **Target Group:** 1, 2 and 10
- **Service/Program:** Disabled patients
  - **Target Group:** 4, 5

**1. General Hospital Services such as:**
- Dietary services
- Social Service(s)
- Volunteer Service(s)
- Nursing Administration
- Quality Assurance
- Marketing/Public Relations
- Other ____________________________ (Please fill in)

**2. Direct Patient Care Services such as:**
- **A) Nursing**
  - Labor/Delivery
  - Midwifery
  - Birthing Room
  - Pediatrics
  - Coronary-Intensive Care
  - Emergency Department
  - Chemical Dependency
  - Outpatient Services
  - Recovery Room
  - Other ____________________________ (Please fill in)
<table>
<thead>
<tr>
<th>SERVICE/PROGRAM</th>
<th>TARGET GROUP</th>
</tr>
</thead>
<tbody>
<tr>
<td>B) Respiratory Care</td>
<td></td>
</tr>
<tr>
<td>C) Cardiopulmonary</td>
<td></td>
</tr>
<tr>
<td>D) Radiology</td>
<td></td>
</tr>
<tr>
<td>E) Pathology</td>
<td></td>
</tr>
<tr>
<td>F) Other (Please fill in)</td>
<td></td>
</tr>
</tbody>
</table>

3. Community Services and Education Programs
such as:
- CPR and Instructor Classes
- Health Fairs
- Physician Referral Service
- Mammography Service
- Prenatal Classes
- Lamaze Classes
- Smoke Stoppers
- Other (Please fill in)

4. Hospital Education Classes
such as:
A) Patient-Family
   - Infant CPR
   - Breast Feeding
   - Newborn Care
   - Asthma
   - Other (Please fill in)
B) Staff Education/Services
   - Safety Classes
   - Body Mechanics
   - Assertiveness
   - Pediatric Care
   - EKG Classes
   - Community Relations
C) Patient Education Programs
   - Blood Drive
   - Other (Please fill in)
### PURPOSE OF COMMUNICATION TOOLS

Thinking about your hospital's communication tools, please indicate how important it is to include each of the statements given below to describe the purpose of communication tools.

<table>
<thead>
<tr>
<th>Statement</th>
<th>EXTREMELY IMPORTANT</th>
<th>EXTREMELY UNIMPORTANT</th>
</tr>
</thead>
<tbody>
<tr>
<td>The purpose of Advertising is . . .</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Build a long term relationship with our community</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>2. Combat competitive claims</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>3. Build name recognition</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>4. Inform our community of the available services</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>5. Enhance social causes such as antismoking</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>6. Increase hospital utilization</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>7. Offset competitive claims</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>8. Remind people about us</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>9. Tie-in with special offers</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>10. Build morale of hospital employees</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>The purpose of Special Programs/Incentives (Price Offs, Gourmet dinners etc.) is . . .</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The purpose of Public Relations is...

<table>
<thead>
<tr>
<th></th>
<th>EXTREMELY UNIMPORTANT</th>
<th>EXTREMELY IMPORTANT</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>Handle and anticipate potential problems in our hospital</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>18</td>
<td>Strengthen community involvement with our hospital</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>19</td>
<td>Generate awareness and goodwill</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>20</td>
<td>Contribute to the quality of life in the community</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>21</td>
<td>Entertainment Orientation</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>22</td>
<td>Change negative public attitudes toward our hospital</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>23</td>
<td>Foster overall marketing purposes of our hospital</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>24</td>
<td>Increase patient volume</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>25</td>
<td>Maintain a positive reputation in the community</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>26</td>
<td>Enhance name recognition</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>27</td>
<td>Supplement Advertising and PR efforts</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>28</td>
<td>Reach a large audience</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>

**COMMUNICATION TOOLS -- WHO MAKES DECISIONS**

The final decision-making authority within the hospital regarding types of communication tools to be used resides with: (Please use the Person's Position or Title)

**COMMUNICATION MEDIA**

Please divide 100 % points between the following communication media in terms of their "USE" in your hospital. (The total should add to 100)

<table>
<thead>
<tr>
<th>Media</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Mail</td>
<td></td>
</tr>
<tr>
<td>Newspapers</td>
<td></td>
</tr>
<tr>
<td>Radio</td>
<td></td>
</tr>
<tr>
<td>Magazines</td>
<td></td>
</tr>
<tr>
<td>Community Outreach Programs (Health Fairs)</td>
<td></td>
</tr>
<tr>
<td>Billboard</td>
<td></td>
</tr>
<tr>
<td>Television</td>
<td></td>
</tr>
<tr>
<td>On-site Brochures</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>[Please fill in medium]</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL** 100 %
DO YOU HOLD A MARKETING POSITION/TITLE? Yes _____ No _____

IF YES, WHAT IS YOUR TITLE? ________________________________

IF YOU AREN'T IN A MARKETING POSITION MOVE ON TO SECTION III

APPROXIMATE NUMBER OF DOLLARS ($) SPENT ON MARKETING RESEARCH ANNUALLY? ____________________________
(PLEASE FILL IN $)

MARKETING RESEARCH IS DONE . . . . (CHECK ALL THAT APPLY)

[ ] IN-HOUSE  [ ] OUTSIDE FIRM(S)  [ ] BOTH IN-HOUSE AND OUTSIDE FIRM(S)

THINKING ABOUT YOUR HOSPITAL'S MARKETING COMMUNICATION PROGRAM AND USING THE MAJOR METHODS LISTED BELOW, IDENTIFY THE METHOD USED IN YOUR HOSPITAL TO ESTABLISH YOUR MARKETING COMMUNICATION BUDGET. (CHECK ALL THAT APPLY)

All you can Afford  [ ] Percentage of Hospital Revenues  [ ]
Percentage of Department Revenues  [ ]
A level that equals your Competitors' Expenditure  [ ] Establish Objectives and calculate cost of achieving objectives  [ ]
Percentage of Overall Marketing Budget  [ ] Percentage of Total Operating Expenses  [ ]
Other ______________________ (Please fill in the method used)

FACTORS CONSIDERED PRIOR TO DEVELOPING MESSAGES

Please indicate how important it is for "YOUR HOSPITAL" to consider EACH of the following factor(s) when developing Promotional/Communication messages.

<table>
<thead>
<tr>
<th>Factor</th>
<th>EXTREMELY IMPORTANT</th>
<th>EXTREMELY UNIMPORTANT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competition</td>
<td>1</td>
<td>2 3 4 5</td>
</tr>
<tr>
<td>Financial ability of the patient public</td>
<td>1</td>
<td>2 3 4 5</td>
</tr>
<tr>
<td>Type of insurance coverage for patient(s)</td>
<td>1</td>
<td>2 3 4 5</td>
</tr>
<tr>
<td>Neighborhood where patient(s) reside(s)</td>
<td>1</td>
<td>2 3 4 5</td>
</tr>
<tr>
<td>Income levels of patient public</td>
<td>1</td>
<td>2 3 4 5</td>
</tr>
<tr>
<td>Education levels of patient public</td>
<td>1</td>
<td>2 3 4 5</td>
</tr>
<tr>
<td>Services needed by community</td>
<td>1</td>
<td>2 3 4 5</td>
</tr>
<tr>
<td>Educational classes solicited by members in the community</td>
<td>1</td>
<td>2 3 4 5</td>
</tr>
<tr>
<td></td>
<td>EXTREMELY UNIMPORTANT</td>
<td>EXTREMELY IMPORTANT</td>
</tr>
<tr>
<td>---</td>
<td>---------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>9. Personality type and lifestyles of patient public</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>10. Past experience(s) of the patient public with your hospital</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>11. Reference networks surrounding the patient public in your community</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>12. Existing knowledge and attitudes of patient(s) toward our hospital</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>13. Decision situation/circumstances of patient public</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>14. Source factors, such as person transmitting a message on TV or in the print media</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>15. Nature of the message such as, whether emotional or straightforward</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>16. Communication tools used, such as Advertising, Public Relations and Price-Offs to reach target groups</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>17. Number of messages to be transmitted within a four-week period</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>18. &quot;When&quot; to transmit the message, to reach the target groups</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>19. Underlying theme of all messages transmitted to the patient public</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>20. Number of patient(s) to be reached in the community using different communication tools</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
</tbody>
</table>
SECTION III

For classification purposes only, please answer the following questions.

1. Are you . . .
   [ ] Male?
   [ ] Female? (CHECK THE APPROPRIATE BOX)

2. What is your position or title?
   ____________________________ (PLEASE WRITE ON THIS LINE)

3. Is your hospital . . .
   [ ] For Profit?
   [ ] Non-profit? (CHECK THE APPROPRIATE BOX)

4. Indicate the size of your hospital (Circle One)
   (1) 0 to 150 beds  (2) Over 150 and under 300 beds  (3) Over 300 beds

5. How long have you been a professional in the hospital field? ________ (Please fill number of years)

6. Total years in the healthcare field? __________________

7. In terms of location is your hospital located in...
   (Check all that apply)
   [ ] Inner City  [ ] Metropolitan  [ ] City  [ ] Suburb  [ ] County Area
   [ ] Village or Township  [ ] Rural Area  [ ] Regional Center

8. What is your OCCUPATION? (CHECK ALL THAT APPLY)
   [ ] Physician  [ ] Surgeon  [ ] Administrator
   [ ] Asst. Administrator  [ ] Dept. Director
   [ ] Marketing/Health Promotion Director  [ ] Head Nurse
   [ ] Board Member  [ ] Other
   ____________________________ (Please fill in)

>>> Than you for your cooperation <<<<
APPENDIX E

REMINDER LETTER
May 9, 1988

Dear:

A questionnaire was mailed to you last week regarding how non-profit and for-profit hospitals manage their marketing and marketing communication programs with their various publics. It is vital for the success of the survey, that you and your hospital personnel participate.

Since the questionnaires are anonymous, I have no way of knowing which hospitals have returned theirs. If you have completed and returned the questionnaire, please ignore this letter and accept my thanks.

Once again, thank you for agreeing to participate in the survey. If for some reason you did not receive the packet of questionnaires, please do not hesitate to call me today at (817) 565-3120. I will be glad to mail you a packet. Thank you.

Sincerely,

Pradeep Gopalakrishna
April 18, 1988

Dear:

I am a Ph.D student and for my doctoral dissertation I am investigating how for-profit and non-profit hospitals manage their marketing and communication efforts with their various publics. Despite the fact that marketing in the healthcare area is rapidly growing in importance, little is known about the marketing and communication programs utilized by hospitals. As part of my investigation I am surveying a select group of hospitals, such as yours, widely dispersed throughout the country.

Mr./Ms. , I would be extremely grateful if you would participate in the survey by telling me about your knowledge and perceptions concerning marketing and communication programs in your hospital. I am enclosing a stamped, self-addressed postcard for you to return to me if you wish to participate.

Upon hearing from you, I will mail a packet containing five questionnaires. Each questionnaire will be marked with a title designating the respondent who is required to complete the survey. Mr./Ms. , I have taken all possible precautions to eliminate "sensitive" questions and
questions that elicit proprietary information. The questions seek some general information about your hospital's marketing/communication efforts.

On a personal note, Mr./Ms. , this study means a lot to me. It will not only help me obtain a Ph.D degree but will considerably influence my future career as a teacher and researcher. This thesis could be the biggest research project in my professional career and its outcome will influence my credibility as a researcher. Ironically, enough the events of the next few weeks will determine the outcome of not only the many years I spent trying to get to this stage but will also leave an indelible mark on the many years to come. The way you react to this letter can influence my student and professional career.

Regardless of the outcome of your decision to participate, I will be very happy to send you a summary of the survey results if you write to me separately. If you have any other questions please contact my dissertation advisor Dr. Barbara Coe or me at the Marketing Department, (817) 565-3120. Thank you very much.

Sincerely,
Pradeep Gopalakrishna
Ph.D Candidate
Figure 1
Procedural Steps Followed For the Study

Phase 1 - Exploratory Study

A For-Profit Surrogate

A Non-Profit Surrogate

To Develop A List Of Important Factors Considered Prior To Developing Messages

Phase 2 - Descriptive Study
Using a National Sample of Hospitals to test Important factors derived in phase 1

19 For-Profit Hospitals

19 Non-Profit Hospitals
Figure 2
The Nicosia Model

Field One: From the Source of a Message to the Consumer's Attitude

Subfield One
Firm's Attributes

Message-Exposure

Subfield Two
Consumer's Attributes
(e specially predisposition)

Attitude

Field Two
Search for, and Evaluation of Means-End(s) Relation(s)
(Pre-action Field)

Search
Evaluation

Experience

Field Four
The Feedback

Consumption Storage

Motivation

Decision
(action)

Field Three
The Act
of Purchase

Purchasing Behavior

Figure 3
The Engel, Kollatt and Blackwell Consumer Behavior Model

Figure 4
The Theory Of Buyer Behavior - A Model

Inputs
Stimulus Display
- Significative
  - a. Quality
  - b. Price
  - c. Distinctiveness
  - d. Service
  - e. Availability
- Symbolic
  - a. Quality
  - b. Price
  - c. Distinctiveness
  - d. Service
  - e. Availability
- Social
  - a. Family
  - b. Reference groups
  - c. Social class

Perceptual constructs
- Overt Search
- Stimulus Ambiguity
- Attention
- Perceptual Bias

Learning constructs
- Confidence
- Attitude
- Motives
- Choice Criteria
- Brand Comprehension
- Satisfaction
- Intention

Outputs
- Purchase
- Intention
- Attitude
- Brand Comprehension
- Attention

Solid lines indicate flow of information; dashed lines, feedback effects.

Figure 5.
A Conceptual Model of Consumer Behavior

Figure 6
The Communications Process

Adapted from: Robertson, Thomas N., Joan Zielinski and Scott Ward (1984), Consumer Behavior, Glenview, IL: Scott Foresman and Co.
Figure 7
The Psychodynamic Model of the Persuasion Process

Persuasive Message ---→ Alters Latent Psychological Process ---→ Achieves Change In Overt Action

Adapted from: Melvin. L. De Fleur (1966), The Theories Of Mass Communication, New York: David McKay Co., Inc.

Figure 8
One Step Flow Model of Communication

Figure 9
Two Step Flow Model of Communication

Figure 10
Multi-Step Flow Model of Communication

Figure 11
A Typical Health Planning Model

- Goals and Objectives
- Strategies
  - Situational Analysis
  - Marketing Research
- Implementation
- Evaluation

Figure 12
A Marketing Planning Model

Consumer Oriented
Situational Analysis
Marketing Research

Segment Specific
Strategies

Mission, Goals
and Objectives

Implementation

Evaluation

Table 1
A Summary Of The Non-Profit Hospital Characteristics

<table>
<thead>
<tr>
<th>Number of beds</th>
<th>Percentage of occupancy</th>
<th>Number of admission per year</th>
<th>Number of employees</th>
<th>Average length of stay</th>
<th>Medicare</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>166</td>
<td>44.1%</td>
<td>3022</td>
<td>260</td>
<td>7.3 days</td>
<td>10.1 days</td>
<td></td>
</tr>
</tbody>
</table>

Source: Flow Memorial Hospital Records

Table 2
A Summary Of the For-Profit Hospital Characteristics

<table>
<thead>
<tr>
<th>Number of beds</th>
<th>Average occupancy per year</th>
<th>Number of admission per year</th>
<th>Number of employees</th>
<th>Average Length of stay</th>
<th>Medicare</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>195</td>
<td>44.6%</td>
<td>4852</td>
<td>440</td>
<td>7.5 days</td>
<td>3.5 days</td>
<td></td>
</tr>
</tbody>
</table>

Source: AMI Denton Regional Medical Center Records
Table 3  
Summary Showing The Mix Of Departments  
To be Used In Phase One  

<table>
<thead>
<tr>
<th>Department Name</th>
<th>Employee</th>
<th>Years of Experience at Hospital</th>
<th>Age of Employee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical/Surgical</td>
<td>Assistant Head Nurse</td>
<td>9</td>
<td>31</td>
</tr>
<tr>
<td>Alcohol/Chemical Dependency Unit</td>
<td>Program Director</td>
<td>1</td>
<td>49</td>
</tr>
<tr>
<td>Operating Room</td>
<td>Head Nurse</td>
<td>4</td>
<td>33</td>
</tr>
<tr>
<td>Administration/Marketing Planning</td>
<td>Director</td>
<td>9</td>
<td>N/A*</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>Registered Nurse</td>
<td>10</td>
<td>29</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Director</td>
<td>10</td>
<td>36</td>
</tr>
<tr>
<td>Health Promotion</td>
<td>Director</td>
<td>5</td>
<td>36</td>
</tr>
<tr>
<td>Personnel</td>
<td>Director</td>
<td>4</td>
<td>30</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>Director</td>
<td>8</td>
<td>53</td>
</tr>
<tr>
<td>Medical Records</td>
<td>Director</td>
<td>&lt; 1</td>
<td>25</td>
</tr>
<tr>
<td>Quality Assurance</td>
<td>Director</td>
<td>6</td>
<td>54</td>
</tr>
</tbody>
</table>

Source: Flow Memorial Hospital and AMI Denton Regional Medical Center Records

* N/A Not available with the Hospital
Table 4
Hospital Industry Summary Characteristics
By Type Of Hospital - 1984

<table>
<thead>
<tr>
<th>Type</th>
<th>Number of Hospitals (1000)</th>
<th>Beds</th>
<th>Occupancy Rate**</th>
<th>Personnel* (1000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>For-Profit</td>
<td>780</td>
<td>100</td>
<td>57.0%</td>
<td>214</td>
</tr>
<tr>
<td>State and Local Government</td>
<td>1662</td>
<td>203</td>
<td>65.9%</td>
<td>586</td>
</tr>
</tbody>
</table>

* Includes full-time equivalent of part-time personnel

** Ratio of average daily census to every 100 beds

Table 5
Summary Characteristics Of Hospital Utilization Rates
By Ownership Type

<table>
<thead>
<tr>
<th>Ownership</th>
<th>Average stay Males (days)</th>
<th>Beds Used Per day</th>
<th>Average Stay(days) Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>State and local government</td>
<td>6.1 days 56</td>
<td></td>
<td>6.6</td>
<td>5.7</td>
</tr>
<tr>
<td>Proprietary</td>
<td>6.2 days 27</td>
<td></td>
<td>6.5</td>
<td>6.1</td>
</tr>
</tbody>
</table>
Table 6
Summary Characteristics

<table>
<thead>
<tr>
<th>Total Hospitals (U.S)</th>
<th>Government Control</th>
<th>Proprietary Control</th>
<th>Non-Profit Control</th>
<th>Full-time employee (1000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>6062</td>
<td>1981</td>
<td>185</td>
<td>3296</td>
<td>2876</td>
</tr>
</tbody>
</table>


Table 7
Common Characteristics Among Sample Surrogates And Hospitals In the U.S

<table>
<thead>
<tr>
<th>Type</th>
<th>Number of beds per hospital</th>
<th>Average stay (days)</th>
<th>Occupancy rate</th>
<th>Number of employees</th>
<th>Hospital admissions per year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals -Overall Industry 200-250 (average)</td>
<td>6.1 days</td>
<td>73.0%</td>
<td>400-500</td>
<td>400-500 (average)</td>
<td></td>
</tr>
<tr>
<td>For-Profit Surrogate</td>
<td>195</td>
<td>7.5 days</td>
<td>44.6%</td>
<td>440</td>
<td>4852</td>
</tr>
<tr>
<td>Non-Profit Surrogate</td>
<td>166</td>
<td>7.3 days</td>
<td>44.1%</td>
<td>260</td>
<td>3022</td>
</tr>
</tbody>
</table>

Source: Statistical Abstract of the United States and Hospital Records
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