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Certifies that this is the approved version of the following thesis:

Promoting Women's Health in Texas: Suggestions for Maximizing the Benefits of the Women's Health Program

APPROVED BY
SUPERVISING COMMITTEE:

Supervisor: ______________________________
Minette E. Drumwright

____
Michael Mackert

Promoting Women's Health in Texas: Suggestions for Maximizing the Benefits of the Women's Health Program

by

Mary Elizabeth Bennett, B.A.

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Abstract

Promoting Women's Health in Texas: Suggestions for Maximizing the Benefits of the Women's Health Program

Mary Elizabeth Bennett, M.A.

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Supervisor: Minette E. Drumwright

This thesis presents a collection of recommendations on how to increase participation in a Texas Medicaid family planning program, called the Texas Women's Health Program, or WHP. Based on findings discovered during a series of thirteen elite interviews, these suggestions range from communications strategies, such as preferred media channels, to general policy and program implementation recommendations. A review of marketing and health communication literature was also employed as a means of supporting and complementing interview findings. Set in the bitter family planning climate of a Bible-belt state, this study provides an in-depth look at how public health policies and outreach efforts can be improved by taking a marketing approach.

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Chapter 1: Introduction

Family planning is a tough sell in Texas. In recent years, even the most basic reproductive health services have become conflated with the heated moral debate over abortion.[1] But according to the Texas Commission of Health and Human Services (HHSC), a lack of access to affordable family planning services is causing high birth rates among low-income women. More than half of the 400,000 babies born in Texas in 2008 were delivered using Medicaid funds because their mothers lacked the money or the insurance necessary to pay for these services.[2] And the percentage of Medicaid births in Texas is steadily increasing. Each Medicaid birth costs an estimated $8,500, 40 percent of which is paid for with state money.[3] The State of Texas recognized a growing dependence on government-funded pregnancy and delivery care and consequently decided to allocate increased funding to pregnancy prevention efforts.

In 2005, the Texas legislature enacted a five-year Medicaid Research and Demonstration Waiver, called the Texas Women's Health Program (WHP), in an attempt to reduce the amount of Medicaid-funded births in the state. Medicaid waiver programs are authorized through Section 1115 of the Social Security Act and are developed in partnership with the national Centers for Medicare and Medicaid Services (CMS).

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[1] Emily Ramshaw, "To Some House Representatives, Family Planning = Abortion," *Texas Tribune*, April 7, 2011, http://www.texastribune.org/.

[2] Usha Ranji et al., State Medicaid Coverage of Perinatal Services: Summary of State Survey Findings, 11, http://www.kff.org/womenshealth/upload/8014.pdf.

[3] Legislative Budget Board, Fiscal Note, S.B 747, S. Doc. No. 79-79R 3929 UM-F (2005), http://www.legis.state.tx.us/.

Through these waivers, states are granted permission to implement "experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute."[4] Policymakers often choose to participate in waiver programs when existing Medicaid policies are not hospitable to achieving unique state health goals.[5] By offering family planning services at no cost to women at or below 185% of the Federal Poverty Level (FPL), the WHP expanded Medicaid programming in Texas, a feat that has historically been difficult to accomplish.[6] Because WHP provides preventive care, it is eligible for a 90 percent federal funding match rate instead of the 60 percent match rate that applies to Texas Medicaid deliveries. A federal match rate represents the proportion of Medicaid expenses that are covered using federal funds as opposed to state funds. The annual cost of WHP is $241 per woman participating, of which Texas pays only $24. This is remarkably lower than the expense of a Medicaid birth, which costs the state roughly four thousand dollars per delivery. Clearly, WHP had the potential to give the state a huge return on its investment.[7]

After the legislature passed WHP in June 2006, the program faced its key challenge: enrolling women who were not previously eligible for Medicaid. According to the Health and Human Services Commission:

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[4] U.S. Department of Health and Human Services, "Research & Demonstration Projects - Section 1115," Centers for Medicare and Medicaid Services, https://www.cms.gov/.

[5] Rose Hayden, "Medicaid and CHIP: Running these Programs in Context - Political, Operational, and the Limited Resources after Mid-Term Elections" (lecture, April 6, 2011).

[6] Toni P. Miles, "Gender Issues, Health Care Inequity and Health" (lecture, April 13, 2011).

[7] Women's Health Program: Hearings on House Bills 1138 and 1478 before the House Public Health Committee, 82d Leg., Regular (Tex. 2011) (statement of Janet Realini, President, Healthy Futures of Texas), http://www.capitol.state.tx.us/.

> The success of this demonstration project depends largely on the state's ability to enroll newly eligible women who are not currently in the Medicaid system, and to develop strategies to facilitate access to services. The challenges are formidable, given the size of the state, the cultural diversity of its residents, and the variety of communities ranging from large urban enclaves to sparsely populated rural areas.

Prior to WHP, the Texas Department of Health and Human Services (DSHS) estimated that only 25 percent of women in need were able to access publicly funded family planning services.[8] Policymakers developed this program to meet that need.

Though the program has been in place for four years, it has failed to enroll a significant percentage of eligible participants. This failure represents Texas' overall failure to place a high priority on women's reproductive health. Though the Legislative Budget Board projected annual enrollment at roughly six hundred thousand women, the program fell significantly short of the projection: WHP enrolled only 221,459 women during its first three years. Moreover, only 75 percent of women enrolled in WHP actually use the services offered.[9] Even if one assumes that the legislature correctly estimated the extent of consumer need, most WHP eligible women lack either the awareness or the access necessary to participate in the program. The goal of this thesis is (1) to determine why women have not enrolled in WHP and (2) to recommend ways to increase participation.

This thesis analyzes WHP through a marketing lens and recommends improved program implementation and outreach strategies to increase participation. Public health

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[8] Texas Health and Human Services Commission, *State of Texas: 1115(a) Research and Demonstration Waiver*, 4, http://www.cms.gov/.

[9] Texas Health and Human Services Commission, *Medicaid Women's Health Program Implementation Report: Biennial Report to the Texas Legislature*, 25, http://www.hhsc.state.tx.us/.

program design is not typically analyzed using a marketing approach. Traditional marketing strategies address consumer needs for the purpose of selling products or services. As this analysis will show, WHP outreach goals, such as awareness and access, are comparable to the outreach goals related to selling products or services. For this reason, marketing techniques can and should be applied in efforts to develop and promote public health programming.

Chapter 2: Background

Both marketing theories and public health research impacted these research findings. This chapter reviews relevant marketing concepts that will be referred to throughout the WHP market analysis. Marketing concepts include the product life cycle, the SWOT analysis, and consumer insights. The chapter also provides an overview of public health outreach theories. As this background information will show, the goals of the public health community have typically been to educate and inform the public. This strategy differs from the marketing perspective, which more often relies on theories of persuasion and emotional appeals. A review of marketing and public health theories will help to identify the nature and extent of the differences between them.

THEORIES OF PERSUASION

Persuasion theories inform a wide range of disciplines, including marketing, politics, and psychology, among others. This group of theories examines the processes involved in influencing a person's attitudes or behaviors. Theories such as the Elaboration Likelihood Model and Social Judgment Theory are especially relevant to this study of public health promotion. Both of these models address the way in which behavior can be modified through persuasive communication.

Elaboration Likelihood Model

The Elaboration Likelihood Model (ELM) posits that attitude change in a message recipient is dependent upon the recipient's "elaboration" on (or processing of)

the message.[10] Elaboration is thought to vary based on multiple conditions of the message recipient. These conditions include the individual's ability to comprehend, level of attentiveness, and personal interest in the message content. Recognizing that not all human decisions are the result of deliberation, the ELM proposes two separate routes for information processing. Central route processing is employed when a message recipient is both capable and willing to contemplate a given message. Peripheral route processing takes place when individuals have neither the ability nor the will to process the message. Central and peripheral route processing can be demonstrated simply by comparing two decision-making scenarios. To use a health example, the decision to eat a high-calorie food, such as a donut, will most likely be made using peripheral route processing. Thus, donut producers tend to appeal to superficial consumer preferences, like flavor and color. Central route processing is usually employed in the decision to seek out healthier foods, requiring increased information and increased elaboration. Because the ELM addresses different types of message processing, this theory is usually applied when messages are being crafted to suit differing audiences.

Social Judgment Theory

Individual perceptions form the basis for Social Judgment Theory (SJT). SJT assumes that, upon receipt of a message, an individual will judge its acceptability according to his or her personal beliefs. In order for a message to be persuasive, it must somehow challenge an individual's pre-established attitude. Otherwise, no change in perception or behavior will occur. On the other hand, if persuasive messages are too

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[10] George E. Belch and Michael A. Belch, *Advertising and Promotion: An Integrated Marketing Communications Perspective*, 4th ed. (Boston: Irwin McGraw-Hill, 1998), 159-162.

inconsistent with existing beliefs, the discrepancy could cause total message rejection. For example, a message that tries to dissuade alcohol consumption in religious or moral terms will have little impact on nonreligious drinkers, who do not consider alcohol in moral terms. However, if alcohol consumption is framed as a health issue, transcending religious or moral judgments, nonreligious drinkers will be more likely to accept the message. This example demonstrates the importance of knowing one's audience. If the persuading force is not sufficiently familiar with an audience's beliefs, communicators will have difficulty addressing those beliefs through messaging. SJT encourages communicators to find the right balance between challenging and supporting the attitudes of their selected audience.

OVERVIEW OF MARKETING CONCEPTS

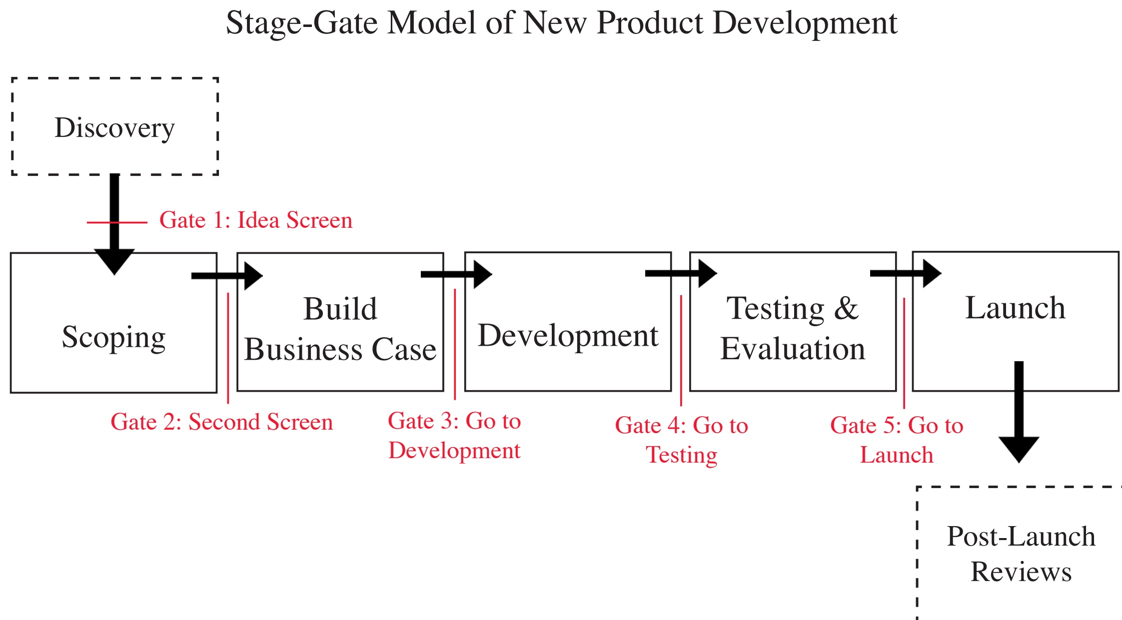
While informed and influenced by persuasion theory, traditional marketing plans tend to rely heavily on practical marketing concepts and tools. The marketing lens applied in this analysis relates some of these concepts to the development and promotion of WHP. Relevant concepts include the stages of new product development, the SWOT analysis, the collection of consumer insights, and social marketing.

New Product Development

WHP represents a new "product" in the health care marketplace. For this reason, several business concepts related to new product development (NPD) are integrated into

this analysis. There are many variations of the NPD process, but one classic illustration is Cooper's Stage-Gate Model, which is featured in Figure 1.[11]

Figure 1: Cooper's Stage-Gate Model



This model recognizes the unique challenges involved in creating a valuable new product. As these stages suggest, the NPD process is typically long and costly. The process begins with extensive "scoping" (research) to identify consumer needs in the marketplace. Then, multiple rounds of evaluation and testing are implemented. New product promotion differs from other marketing endeavors because of the high level of financial risk undertaken by the parent company. Contributing to this risk is the fact that the awareness critical to new product sales must be created from scratch. Therefore,

[11] Robert G. Cooper, Winning at New Products: Accelerating the Process from Idea to Launch, 2nd ed. (Cambridge, MA: Addison-Wesley, 1993), 129-141.

product success or failure is often attributed to the success or failure of the product launch, which relies heavily on marketing outreach.

SWOT Analysis

One very practical marketing tool applied in this thesis is the Strengths, Weaknesses, Opportunities, Threats (SWOT) analysis. SWOT analyses examine a product's position in the marketplace according to the four SWOT variables. This analysis is a valuable assessment tool for both new and existing products because it provides marketers with a helpful framework for approaching marketing challenges. Performing a SWOT analysis identifies product attributes that deserve to be highlighted in promotional messages (strengths). The tool also points out areas for product improvement (weaknesses). Multiple forms of competition are considered as potential threats to a product's success. In general, marketing plans based on SWOT analyses attempt to address identified threats while also pointing out ways to capitalize on key growth opportunities.

Consumer Insights

In recent years, marketers have relied on consumer insights to guide product development and promotion strategies. These insights are collected in order to more accurately describe (1) the needs of a market segment and (2) the ability of a product to meet those needs. The end goal of consumer insight collection is to develop a product that effectively meets a valid and compelling need in the marketplace. Tactics associated with the integration of consumer insights are market segmentation, consumer opinion surveys, concept testing, and pilot testing. All of these tactics help marketers understand

the thoughts and opinions of their target market. This understanding provides the basis on which product messages can be formed. In other words, the successful promotion of a product is dependent upon the extent to which consumer needs are met.

Social Marketing

The concept of marketing social causes, called social marketing, could greatly inform efforts to promote WHP. Beginning in the 1960s with campaigns promoting family planning, social marketing quickly earned broad acceptance in both the communications and public health fields. Consisting largely of integrated marketing communications campaigns, social marketing has been shown to successfully change health behaviors, including child immunizations and smoking habits. Social marketing specialist Alan Andreasen believes that "what makes social marketing potentially unique is that it (1) holds behavior change as its "bottom line," (2) therefore is fanatically customer-driven, and (3) emphasizes creating attractive exchanges that encourage behavior (the benefits are so compelling and the costs so minimal that everyone will comply)."[12] Taking these principles into account, WHP's free family planning services seem to be a perfect fit for a social marketing approach. However, despite having a large amount of customer need and an extremely attractive offering, WHP has failed to influence the health behaviors of Texas women. Andreasen explains further, "[social marketing] tenets…imply central roles for consumer research, pretesting, and monitoring; for careful market segmentation; and for strategies that seek to provide beneficial,

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[12] Alan R. Andreasen, "Marketing Social Marketing in the Social Change Marketplace," *Journal of Public Policy & Marketing* 21, no. 1 (Spring 2002): 7, Business Source Complete (6569473).

popular, and easy-to-implement exchanges to target audience members."[13] Incorporating several potentially helpful marketing concepts, the social marketing approach will certainly play a role in recommendations for improved WHP design and outreach.

HEALTH BEHAVIOR THEORY

In the context of this thesis, health behaviors are framed as consumer behaviors; however, there are important differences in the marketing and public health approach that must be addressed. In practice, effective public health outreach strategies have typically been influenced by theories of health behavior change.[14] Health behavior change theories attempt to understand the motivations and influences that affect individual health behaviors. For instance, in order for a woman to receive WHP services, she must schedule an appointment with a WHP provider and specifically request family planning services. She may need to leave work or arrange for childcare while she sees her health care provider. Therefore, a woman's decision to receive WHP services depends on many factors in addition to her need of family planning care. Health behavior theories reviewed for this thesis include the Health Belief Model, the Social Ecological Model, and the Model of Constrained Choice.

Health Belief Model

The Health Belief Model (HBM) is one of the most commonly cited theories of health behavior change. Devised in the 1950s by a group of social psychologists, HBM

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[13] Andreasen, "Marketing Social Marketing in the Social Change Marketplace," 7.

[14] Karen Glanz and Donald B. Bishop, "The Role of Behavioral Science Theory in the Development and Implementation of Public Health Interventions," *Annual Review of Public Health*, no. 31 (January 2010): 400, doi:10.1146/annurev.publhealth.012809.103604.

represents one of the earliest attempts at describing the decision-making process behind human health behaviors. The classic version of the model outlines four primary dimensions thought to impact health behavior: perceived susceptibility, perceived severity, perceived barriers, and perceived benefits. Subsequent researchers have enhanced the model by including factors like an individual's demographic profile and potential external cues to action.[15] Figure 2 illustrates the Health Belief Model, as interpreted by Jans and Becker.

HBM assumes that individuals reflect on each established dimension and then make a rational health decision based on careful consideration of all factors. In this way, HBM follows the traditional public health approach of relying on education and information to encourage behavior change. It assumes that once an individual has been provided with the right information, he or she will rationally determine next steps accordingly. This strategy does place any emphasis on the important role that persuasion can play in changing behavior patterns.

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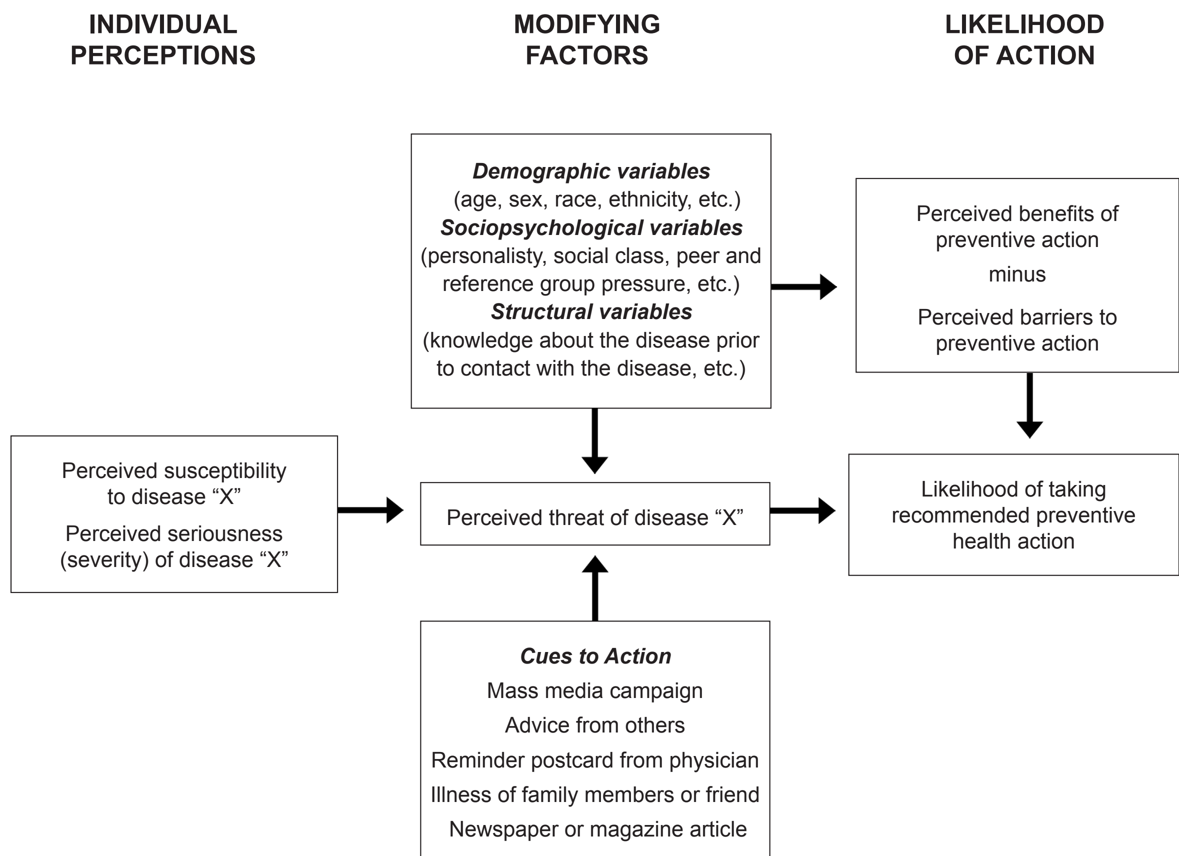
[15] Nancy K. Janz and Marshall H. Becker, "The Health Belief Model: A Decade Later," *Health Education Quarterly* 11, no. 1 (Spring 1984): 4, Web of Science.

Figure 2: Health Belief Model



Persuasion is not the only factor that is absent from HBM. In their report entitled, *Health Belief Model: A decade later*, Janz and Becker promote HBM as a useful tool in outlining an individual's health beliefs, but suggest that the model may neglect important social and environmental influences on personal health decisions:

> It is important to remember that HBM … is limited to accounting for as much of the variance in individuals' healh-related behaviors as can be explained by their attitudes and beliefs. It is clear that other forces influence health actions as well; for example…many health-related behaviors are undertaken for what are ostensibly nonhealth reasons…and [sometimes] economic and/or environmental factors prevent the individual from undertaking a preferred course of action.[16]

[16] Janz and Becker, "The Health Belief Model: A Decade Later," 44.

The limitations of HBM make it less useful as a comprehensive model for health outreach design. Nevertheless, the attitudes and beliefs of WHP participants will certainly inform any recommendations for program outreach.

Social Ecological Model

Social ecological models address the perceived gaps in the Health Belief Model by assuming that humans are social animals by nature and that human behavior is highly influenced by personal relationships as well as larger societal structures.[17] According to these models, multiple factors are taken into account when personal health decisions are made: "Social ecological models emphasize multiple levels of influence (such as individual, interpersonal, organizational, community, and public policy) and the idea that behaviors both shape and are shaped by the social environment."[18] For instance, many cities across the country have imposed ordinances that prohibit smoking in enclosed workplaces. While this societal change has not technically prohibited individuals from smoking, it has contributed to healthier work environments for non-smokers. Whereas HBM relies primarily on the individual, social ecological models focus on change within entire communities.

Model of Constrained Choice

Bird and Rieker's Model of Constrained Choice (MCC) proposes that health decisions are often limited because of larger social constructs. In their 2008 book, entitled *Gender and Health*, Bird and Rieker concur with the main assumption of social

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[17] Glanz and Bishop, "The Role of Behavioral Science Theory," 403.

[18] *Ibid.*

ecological models: they see the individual as inseparable from his or her environment and social status. However, they suggest that individual choices are not merely shaped, but are often constrained by external factors: "[W]e contend that a wide variety of decisions and actions by governments, states, communities, employees and families can…, both directly and indirectly, constrain individual choices to varying degrees."[19] Much like the social ecological models of change, the MCC recognizes that individuals' decisions regarding their personal lives are constrained by their socio-economic situations. A new mother who'd like to re-enter the workforce, for example, is constrained by the high costs of private childcare in the United States. If her total salary cannot cover the weekly expenses related to infant care, that mother will likely opt to stay at home instead of pursue her own interests. For this reason, the model challenges communities to adopt positions and policies that increase access to and incentivize healthy choices.

Public health programs, such as WHP, represent a unique balance of social and individual choice. As this background review has shown, marketing appeals and public health outreach efforts influence individual health behaviors in different ways. Marketing tends to rely more on persuasive techniques, whereas public health promotion focuses on providing information and education. This thesis attempts to discover whether traditional marketing techniques or public health tactics will be more successful at increasing WHP participation.

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[19] Chloe E. Bird and Patricia P. Rieker, *Gender and Health: The Effects of Constrained Choices and Social Policies* (Cambridge: Cambridge University Press, 2008), 58.

Chapter 3: Methods

Interviews were selected as the primary research methodology for this thesis study because qualitative interviews allow the researcher to identify in-depth informant opinions and insights. Prior to the formation of a final research protocol, preliminary interviews were conducted among four subject experts. The findings from these preliminary interviews were used to develop an elite interview research design that would ascertain current opinions from experts in several disciplines. A total of 13 elite informants shared their opinions on the governmental, social, promotional, and medical issues that affect WHP participation. These experts were divided into two main categories: (1) health communications experts and (2) experts in women's health and family planning policy. The interview protocols for both groups can be found in the appendix section.

Four health communications experts shared their opinions on the principles of successful health promotion. This group of informants included professors of communication, a health advocacy marketing specialist, and a state employee working in health outreach. These four individuals were asked to give their opinions on the strengths and weaknesses of traditional public health outreach strategies versus an integrated marketing approach.

A series of nine elite interviews was conducted among experts in women's health and family planning policy. This group of informants included two state health officials, a Texas legislator, public health educators, and women's health practitioners. These

experts were selected because of their extensive knowledge of and personal involvement in women's health and family planning. Informants in this group were divided into two subgroups (public policy and public health), but both groups responded to questions about the strengths and weaknesses of WHP, as well as the benefits and drawbacks of similar health programs. These informants were also asked to reflect on the general public health benefits associated with family planning.

The interview protocols for this research differed between the two informant groups and among individual informants, according their unique professional and academic experience. Despite these differences in protocol, each interview contributed to an overall assessment of WHP and the development of a series of recommendations for WHP growth. The opinions of both informant groups are woven into a comprehensive WHP market analysis, which can be found in Chapter 4.

Secondary methods of case study and document review support and complement these research findings. A recent case study of an influential health-related promotional campaign was examined as a potential model for WHP outreach strategies. While a pharmaceutical company led this effort instead of a state agency, this campaign's effective targeting and messaging strategies were considered as credible alternatives to traditional public health outreach strategies. A review of government documents aided this assessment of the successes and failures of WHP by providing insights into individual program policies. Documents reviewed included state reports on health programming, legislative texts, and web content from government websites.

Chapter 4: Findings

The unique mix of perspectives collected during this interview research established a framework for a comprehensive market analysis of WHP. Prior to the analysis of WHP, two case studies are discussed in order to establish a set of expectations for the ways in which marketing techniques can and do influence public health outcomes. Although marketing strategies are not typically applied to public health issues, there are a few relevant case studies in marketing and public health literature. One of the most prominent case studies in the field of public health marketing is the "truth" anti-smoking campaign. Another relevant case study, Merck's "One Less" campaign, actually pertains to women's reproductive health, which makes it a useful point of comparison for WHP. Comparing marketing and public health case studies to current WHP strategies informs and enhances later recommendations for increasing WHP participation. The WHP market analysis that follows these case studies employs two of the marketing tools referenced previously: (1) the new product development process and (2) the SWOT analysis.

CASE STUDIES: MARKETING AND PUBLIC HEALTH

"truth"

Widely recognized as a both a marketing and public health success, the "truth" anti-smoking campaign reduced the prevalence of youth smoking through a nontraditional health marketing approach. Beginning in 2000, "truth" sought to reduce teen smoking through mass media advertising, grassroots street marketing, and an online presence. Targeting teens who were deemed especially vulnerable to tobacco addiction,

the "truth" campaign relied heavily on market segmentation and consumer insights. Focus groups with members of the target audience allowed "truth" marketers to shape messages that would be particularly relevant and effective. A 2005 study in the *Journal of Public Health* showed significant evidence that exposure to "truth" advertisements led to a decreased likelihood of youth smoking."[20] The attitudinal and behavioral shift among youths exposed to the campaign was credited to its particular approach: "The 'truth' campaign appeal[ed] to youths with hard-hitting ads that…reveal deceptive tobacco industry marketing tactics."[21] The campaign avoided paternalistic anti-smoking messages and opted instead for dramatic illustrations, such as body bags, to dissuade teen smoking. Framing the public health message as an exposé rather than as an admonition, "truth" resonated with youths and successfully influenced youth health behavior.

While the "truth" campaign provides strong evidence supporting the ability of marketing to improve overall health, public health communicators have been reluctant to employ mass media.[22] On one hand, the public health community argues that mass media encourage primarily unhealthy behaviors, such as drinking alcohol and smoking. Media effects research, including the Hypodermic Needle Theory (HNT), is often cited in

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[20] Matthew C. Farrelly et al., "Evidence of a Dose-Response Relationship Between 'truth' Antismoking Ads and Youth Smoking Prevalence," *American Journal of Public Health* 95, no. 3 (March 2005): 425-431, Academic Search Complete (16260705).

[21] Farrelly et al., "Evidence of a Dose-Response Relationship," 429.

[22] John R. Finnegan Jr. and K. Viswanath, "Communication Theory and Health Behavior Change: The Media Studies Framework," in *Health Behavior and Health Education*, 2nd ed., ed. Karen Glanz, Frances Marcus Lewis, and Barbara K. Rimer (San Francisco: Jossey-Bass Inc., 1997), 317-336.

support of this position.[23] Unlike later theories of cognitive processing, such as the ELM, the HNT proposes that messages are always perfectly received and fully accepted by message recipients. Therefore, according to HNT, audiences will mirror any and all negative behaviors that are portrayed in the media. This theory has become all but obsolete in recent years, as researchers have repeatedly rejected its oversimplification of the communication process. On the other hand, mass media are thought by the public health community to disproportionately reach privileged consumers. This claim refers to Knowledge Gap Theory, which directly correlates media consumption and income level.[24] Knowledge Gap Theory can be traced back to a time before the advent of the Internet, prior to wireless mobile devices and the overall proliferation of media technology. Since those developments, mass media are no longer predominantly consumed by the wealthy: in fact, many argue that Americans are currently saturated with media content. Despite the outdated nature of these principles, public health communicators have remained skeptical of traditional marketing and the mass media.

Merck/Gardasil

One theme that surfaced repeatedly in my interviews with health communication experts was the notion that pharmaceutical companies have been extremely successful at influencing health behavior change. Particularly applicable to the promotion of WHP is Merck's market introduction of Gardasil, an HPV vaccine, in 2006. The "One Less" campaign marketed Gardasil as a product that could prevent cervical cancer, causing one

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[23] Finnegan and Viswanath, "Communication Theory and Health Behavior Change," 317-320.

[24] Finnegan and Viswanath, "Communication Theory and Health Behavior Change," 320-323.

less woman to die from the disease. The campaign targeted multiple target groups via diverse information sources, including media outlets and members of the medical community. Beginning with an unbranded awareness campaign about the potential link between HPV (Human Papillomavirus) and cervical cancer, “One Less” created primary demand for a “cure.” By creating this demand amongst the general public, Merck primed its target market for the second phase of the campaign, which offered up its new drug, Gardasil, as the solution to this dangerous problem. Despite the fact that the primary motivation behind this campaign was to sell an HPV vaccine, the “One Less” campaign raised awareness about cervical cancer. As one informant remarked,

> The example that I always go back to is Gardasil, because frankly, it is the best-executed health campaign…I’ve seen. …Step 1 was awareness and social buy-in. They put real effort into teaching people about cervical cancer. The campaign successfully reached multiple audiences with the message that they needed to hear. They got buy-in from the medical community by publishing articles in medical journals. Because they had the medical community onboard from the start, the campaign worked in both directions.

Mirroring concepts from both the Social Ecological Model and the Model of Constrained Choice, Merck’s effort to encourage health behavior change was focused on achieving buy-in across entire communities. Targeting young women, parents, legislators, and the medical community as individual market segments, Merck ensured that when its product hit the market, it would be met with plenty of demand.

The messaging and media involved in the “One Less” campaigned differed according to each target group. Young women were targeted with mass media messages

of empowerment and self-actualization.[25] For example, in a “One Less” television advertisement, young women speak confidently about getting vaccinated while engaging in activities like skateboarding, drumming, and dancing. Parents received highly targeted messages about cervical cancer risks and were encouraged to have their daughters vaccinated. One such message was communicated via web banner advertisements, an example of which is shown in Figure 3. Another way that Merck targeted parents and young adults was to advertise Gardasil via individual health care providers. A provider-mediated advertisement is shown in Figure 4. Capitalizing on the trust that patients often feel toward their medical providers, this media tactic lends credibility to the Gardasil message. Of course, this type of provider participation was the result of another of Merck’s careful marketing strategies: scholarly outreach to the medical community. Merck targeted legislators with startling cervical cancer statistics and lobbied for mandatory HPV vaccination.[26] Although Merck failed to achieve its legislative goal of instituting mandatory HPV vaccination, the campaign was groundbreaking in its holistic approach.[27]

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[25] Jennifer Vardeman-Winter, "Using the Cultural Studies Approach to Understand Health Decision-Making Among a Teen Public," *Public Relations Review*, no. 36 (June 2010): 384, doi:10.1016/j.pubrev.2010.06.004.

[26] Lawrence O. Gostin and Catherine D. DeAngelis, "Mandatory HPV Vaccination: Public Health vs. Private Wealth," *Journal of the American Medical Association* 17, no. 297 (2007): 1921-1923, doi:10.1001/jama.297.17.1921.

[27] Vardeman-Winter, “Using the cultural studies approach,” 385.

Figure 3: Unbranded Merck Web Banner

YOU COULD HELP GUARD YOUR DAUGHTER AGAINST CERVICAL CANCER. CLICK HERE TO LEARN MORE.

Figure 4: Online Outreach via Medical Providers

WHP PRODUCT DEVELOPMENT

The Texas market poses many challenges to marketing a product like family planning. These challenges can be attributed to Texas' large and diverse population, which is difficult to target broadly, as well as to anti-abortion sentiments that dominate current public opinion. Despite these difficulties, WHP is still an attractive product to promote because it satisfies a valid and compelling need for Texas women. As

demonstrated by a 70 percent rate of unplanned pregnancy among women in their 20s, there is certainly a great need for publicly funded family planning in Texas. The ability of WHP to meet that need has been proven to Texas legislators, who know that WHP averts unplanned Medicaid births. The following WHP market analysis addresses these issues by following the typical new product development process and by evaluating WHP according to its strengths, weaknesses, opportunities, and threats.

Eligibility: Defining the WHP Consumer

When developing a new product or service, an organization must first identify a need within the market. In response to the number of Medicaid-funded births in Texas, state legislators created WHP to target low-income women of reproductive age. Prospective WHP participants were defined by a set of established criteria, including an income level at or below 185% of the Federal Poverty Level (FPL) and Texas residency, among others. Figure 5 includes detailed information on program eligibility. The income criteria of 185% FPL is an important variable: prior to WHP, women with an income level at 185% FPL would only have qualified for Medicaid services after becoming pregnant. By offering family planning services to this same group of women, the state hoped that the number of Medicaid-funded births per year would decrease. Eligibility requirements are described in Figure 5.[28]

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[28] Texas Health and Human Services Commission, "The Medicaid Women's Health Program: Information for Providers," The Medicaid Women's Health Program, accessed April 10, 2011, http://www.hhsc.state.tx.us/WomensHealth.htm.

Figure 5: WHP Eligibility

Who is eligible for WHP?

WHP is for women who meet the following qualifications:

- Ages 18 to 44. Women can apply the month of their 18th birthday through the month of their 45th birthday.
- U.S. citizens and qualified immigrants.
- Reside in Texas.
- Do not currently receive full Medicaid benefits, Children's Health Insurance Program benefits, or Medicare Part A or B.
- Are not pregnant.
- Have not been sterilized, is infertile, or is unable to get pregnant due to medical reasons.
- Do not have private health insurance that covers family planning services, unless filing a claim on the health insurance would cause physical, emotional or other harm from a spouse, parent, or other person.
- Have a countable household income at or below 185 percent of the federal poverty level.

Monthly Income Limits for Women's Health Program Coverage

Family Size	Monthly Countable Income 185% FPL
1	$1,670
2	$2,247
3	$2,823
4	$3,400
5	$3,976
6	$4,553
7	$5,130
8	$5,706
For each additional person add:	$577

Market Segmentation

When dealing with a diverse consumer population, like the population of WHP eligible women, marketing campaigns typically break down a large group into smaller sub-groups. This process is referred to as market segmentation. Generally speaking, market segmentation facilitates the development of more effective strategies for product distribution and promotion. Market segmentation can rely on demographic characteristics, like age or ethnicity, or psychographic characteristics, like religious beliefs or leisure activities. Behavioral characteristics are also taken into account because they can help identify key behavior patterns of a target group. To use a health-related example, it is important to distinguish individuals who regularly visit the doctor from individuals who do not. Outreach strategies for such disparate groups as these are likely to be very different.

The large consumer population for WHP was segmented into only two groups: (1) Latinas, and (2) everyone else.[29] Latinas were chosen as a key market segment for WHP services based on their high rate of fertility and on the fact that, as of 2003, 69 percent of births to Latinas in Texas were paid for by Medicaid.[30] Latinas are also at higher risk for cervical cancer than their non-Latina cohorts, making them a valuable target for the cervical cancer screenings covered by WHP.[31] Finally, Latinas in Texas are more likely than African American or white women to live below the poverty level, a status that is

[29] The word “Latinas” has been substituted for the original phrase, “Hispanic women.”

[30] Texas HHSC, *State of Texas: 1115(a) Research and Demonstration Waiver*, 11.

[31] More detail on services covered by WHP will follow in the “Program Creation” section.

correlated with a higher incidence of unintended pregnancies.[32] For all of these reasons, it is clear that Latinas are a valuable target market for WHP. However, dividing WHP consumers into only two broadly defined segments likely contributed to the program's underperformance. The current WHP segmentation strategy does not account for differences among generations in the Latina community, which have a profound effect on beliefs, behaviors, and language comprehension skills. African American women and white women could have differing attitudes toward family planning, but these women are lumped together into one target audience, irrespective of attitudes or beliefs. Without addressing the specific needs of smaller, more clearly defined groups of eligible women, WHP messages are unlikely to be relevant within each group.

Program Creation: Developing a Valuable Product

According to the stages of new product development, a concept test phase should be implemented before product launch. But at its inception, WHP was itself a legislative and public health concept test. Senate Bill (S.B) 747 was enacted during the 79th Session of the Texas Legislature. S.B. 747 implemented a five-year demonstration program "relating to preventive health and family planning."[33] The bill granted WHP roughly $2.7 million per year in General Revenue funds from FY 2006 to FY 2010.[34] Qualifying for federal funds at a 90 percent match rate, WHP's annual funding totaled $16.5 million.

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[32] Texas HHSC, *State of Texas: 1115(a) Research and Demonstration Waiver*, 8.

[33] The full text of S.B. 747 can be found in the Appendix, Figure A1.

[34] Legislative Budget Board, Fiscal Note, S.B 747.

Legislators projected that WHP would save the State of Texas $26 million annually and that savings to the federal government would total $40 million annually.

While state savings did not reach initial projections right away, the program saved the State of Texas an estimated $37.6 million in averted Medicaid-funded births by the end of its second year. This represents a return of more than $10 for every $1 that the state invested in the program.[35] By increasing access to family planning services, Texas reduced Medicaid expenditures on pregnancy-related care.[36]

Benchmarks for Success

The Texas Health and Human Services Commission (HHSC) identified ten program goals to use as benchmarks for program success. These goals are listed in Figure 6.[37] According to HHSC's 2010 WHP Implementation Report, the program successfully met six of these ten goals during its first two years. Unmet goals are denoted with asterisks in Figure 6. Of the four unmet goals, numbers seven, eight, and nine were left unmet because of the program's lack of access to patient records and social security data. Goal number four could not be met because providers found it "administratively burdensome" to track patient referrals manually for services that WHP does not cover, such as STD treatment.[38] In other words, despite the fact that they had access to key information about eligible providers, WHP administrators lacked an effective system for patient referrals. In fact, as of December 2010, representatives from the Texas Health and

[35] Women's Health Program: Hearings on House Bills 1138 and 1478, (statement of Janet Realini).

[36] Texas HHSC, *Medicaid Women's Health Program Implementation Report*, 17-24.

[37] Texas HHSC, *Medicaid Women's Health Program Implementation Report*, 17-18.

[38] Texas HHSC, *Medicaid Women's Health Program Implementation Report*, 22.

Human Services Commission were negotiating with the Center for Medicare and Medicaid Service to have goal number four omitted from program requirements.

Figure 6: Performance Goals for the Texas Women's Health Program

Goal 1: Increase access to Medicaid family planning services.
Goal 2: Increase Hispanic women's access to Medicaid family planning services.
Goal 3: Increase the use of Medicaid family planning services.
Goal 4: Provide WHP participants diagnosed with a medical condition not covered by the family planning benefit package with referrals to appropriate health providers. *
Goal 5: Reduce the number of births.
Goal 6: Reduce growth of Medicaid-covered Hispanic births.
Goal 7: Increase the spacing between pregnancies to an interval of 24 – 59 months among WHP patients with a prior birth. *
Goal 8: Reduce the number of low-weight birth deliveries. *
Goal 9: Reduce the number of premature deliveries. *
Goal 10: Reduce Medicaid costs expended for pregnancy, prenatal care, delivery, and infant care.

** Denotes an unmet program goal.*

The failure of WHP to refer patients effectively represents one of the major weaknesses of the program: the inability of WHP to provide a continuity of care for its participants. This program weakness will be examined in greater depth in the WHP SWOT analysis.

Product Characteristics

Any new product must do more than simply meet consumer needs: it must also be profitable. Because averting Medicaid births is the most profitable outcome for the State of Texas, pregnancy prevention services make up the bulk of WHP offerings. The more money Texas saves on averted Medicaid births, the more state funds can be distributed for other necessary health services, like family planning.

Despite the narrow focus of this particular health program, the services that are covered by WHP continue to increase in number and scope. A full list of services is provided in Figure 7.[39]

Figure 7: Services covered by WHP

What services does WHP cover?
Covered services include:

- Annual family planning exam and Pap smear
- Follow-up visit, if related to the contraceptive method
- Counseling on specific methods and use of contraception (as part of evaluation and management services), including natural family planning and excluding emergency contraception
- Female sterilization (Essure procedure and tubal ligation)
- Follow-up visits related to sterilization, including procedures to confirm sterilization
- Certain screenings related to family planning, such as:
    - Pregnancy test
    - Rubella antibody test
    - Routine urinalysis
    - Urine culture
    - Complete Blood Count (CBC)
    - Hemoglobin and hematocrit tests
    - Blood typing
    - Blood glucose screening
    - Lipid Panel
    - Thyroid stimulating hormone test
- Sexually Transmitted Infection (STI) Screenings:
    - HIV
    - Hepatitis B
    - Hepatitis C
    - Chlamydia
    - Gonorrhea
    - Gardnerella
    - Human papillomavirus (HPV)
    - Trichomonas
    - Candida
    - Syphilis
    - Herpes

[39] Texas Health and Human Services Commission, "The Medicaid Women's Health Program: Information for Providers."

Contraceptive methods available as physician services (Provider Type 19, 20, 21, and 22) and in Family Planning Clinics (Provider Type 71):
- Fitting for a diaphragm or cervical cap
- Cervical cap
- Diaphragm
- Intrauterine Contraception (IUC), IUC insertion and removal
- Male and female condoms
- Vaginal spermicides
- Depo-Provera injection
- Single rod contraceptive implant, insertion and removal (Implanon)

Contraceptive methods available only in Family Planning Clinics (Provider Type 71):
- Oral contraceptives (up to a 12-month supply per year)
- Transdermal hormonal patch (up to a 12-month supply per year)
- Vaginal hormonal contraceptive ring (up to a 12-month supply per year)

Contraceptive methods available through Medicaid Vendor Drug Program Pharmacies, (if included on the Medicaid formulary):
- Transdermal hormonal patch
- Vaginal hormonal contraceptive ring
- Oral contraceptives
- Female condoms
- Diaphragm
- Vaginal spermicides

What services are not covered through WHP?
Services **not covered through WHP:**
- Mammography - screens for breast cancer are limited to a Clinical Breast Exam (CBE)
- Treatment for any conditions diagnosed during a WHP visit
- Visit for pregnancy test only
- Visit for STI test or treatment only
- Follow-up after an abnormal Pap test
- Counseling on and provision of emergency contraceptives
- Referrals made for medical problems to providers that perform elective abortions
- Other visits that cannot be appropriately billed with one of WHP- allowable diagnosis codes

As listed on the Texas Health and Human Services website, covered family planning services include annual female exams, STI/STD testing, and several methods of contraception. Other services, such as blood screenings for hypertension and diabetes were added to the benefit package of the WHP after its inception. In 2009, 16 new WHP benefits were added, demonstrating the capacity of this program to evolve in order to

better achieve its goals. Items that fall under the heading, “Services **not covered through WHP,**” are: STD/STI treatment, counseling on emergency contraceptives, and referrals to elective abortion providers. According to several elite informants, these gaps in coverage have made WHP less attractive to medical providers, who often feel ethically obligated to provide care for their patients. This tension between medical ethics and practical policies will be elaborated on later, in the context of WHP distribution.

Bundled Services: Packaging the Product

The way in which a product is packaged has a subtle, but remarkable effect on how consumers perceive that product. Product bundling occurs when two products are packaged together, such that they cannot be purchased separately. While bundling may occasionally cut costs for consumers, the principle behind bundling is to benefit the seller. Bundling often increases the financial benefit to the seller because of the decrease in costs associated with marketing two products as one. But the fact is, consumers don’t always need both products. Ineffective product bundling was a theme that arose frequently during my interviews with experts in women’s reproductive health.

Some experts argue that WHP’s current “packaging” of services is inappropriate. In the United States, a prescription from a physician or nurse practitioner is required in order to obtain contraceptives. In order to receive this prescription, many women are advised by their doctors to undergo additional screenings, such as pelvic exams. Pelvic exams are useful for assessing a women’s overall reproductive health, but according to the most recent guidelines from the Centers for Disease Control, they are not necessary for the prescription of birth control pills. Even the American Congress of Obstetricians

and Gynecologists (ACOG) has decried the link between oral birth control and pelvic exams as arbitrary.[40] Despite this fact, a 2010 ACOG study among U.S. doctors and advanced nurse practitioners showed that 44 percent of respondents "usually" require a pelvic exam when prescribing birth control. In other words, 44 percent of these providers often require patients to undergo an unnecessary exam when seeking out oral contraception. The authors of the ACOG study believe that the requirement presents a barrier to reproductive health care for some women: "Requiring a pelvic examination for asymptomatic women before dispensing contraception poses an unnecessary medical hurdle before a critical and time sensitive medication."[41] Conceding that some providers may be adhering to a historical precedent, the authors suggest that a financial motive may also be present.

> The necessity of pelvic examinations for optimal reimbursement of a visit may partly explain clinicians' practice patterns. In the absence of adequate financial incentives for contraceptive counseling as an important clinical activity in its own right, providers are incentivized to conduct a physical examination with a well-reimbursed billing code.

An improper dependency on reimbursement for physical exams may be causing health care providers to recommend, and even require, an unnecessary service. No matter what is motivating these providers, they are failing to follow the latest national standards for care. Because the requirement to undergo a pelvic exam could deter women from seeking oral contraception, WHP administrators may need to think carefully about how the program's services are packaged.

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[40] Jillian T. Henderson et al., "Pelvic Examinations and Access to Oral Hormonal Contraception," *Obstetrics & Gynecology* 6, no. 116 (December 2010): 1257, doi:10.1097/AOG.0b013e3181fb540f.

[41] Henderson et al., "Pelvic Examinations and Access to Oral Hormonal Contraception," 1261.

Program Alternatives and Political Tensions: Understanding the Competition

When selling a product, marketers seek to identify many forms of competition in the marketplace. Competition can be direct or indirect – tangible or intangible. While competition for WHP is diverse and abundant, the informants involved in this thesis tended to focus on two primary competitors: (1) over-the-counter birth control from Mexico, and (2) anti-abortion political activism.

Over-the-Counter Birth Control

Over-the-counter birth control pills sold by Mexican pharmacies are a serious competitor for WHP enrollment along the Texas/Mexico border. For first and second generation Texans who have connections to Mexico, buying birth control across the border is a convenient alternative to scheduling an appointment with a health care provider in Texas. Furthermore, over-the-counter birth control can be purchased unbundled: women who are only interested in obtaining birth control are not subjected to the physical exams often required by U.S. physicians. Despite the fact that WHP offers birth control pills at no cost, these women might decide that a drive across the border is easier for them. As one respondent remarked, "There are hoops that you have to jump through in U.S. that you don't have jump through in Mexico and other places." She admitted that offering free contraception was a worthwhile benefit of WHP, but still expressed doubts that cost would outweigh convenience and comfort: "The problem may actually be that we are providing health care in a way that doesn't make sense to [these women]. Yes, money is an issue. But it may be that they want apples and we're selling

oranges." The ease with which Latinas on the border can obtain contraceptives in Mexico should be considered as policymakers in Texas attempt to enroll more Latinas in WHP.

Anti-Abortion Political Activism

Competition for legislative funding, brought on by anti-abortion political activism, is without a doubt the greatest source of competition for family planning programs in Texas. In response to a Texas legislative proposal that would limit access to women's reproductive health services, Republican State Representative Beverly Woolley said, "I'm absolutely worried [that] these two terms [abortion and family planning] are becoming synonymous."[42] Because one of the largest family planning providers in Texas, Planned Parenthood, is also a provider of elective abortions, some politicians and politically active Texans argue for the elimination of family planning funds from the state budget. In their effort to de-fund abortion providers, these individuals end up supporting legislation that de-funds family planning services. One attempt to de-fund Planned Parenthood happened in 2003, when the Texas Legislature tried to cut family planning funding to the organization because of its status as a provider of elective abortion services.[43] Eventually, Planned Parenthood was allowed to receive continued funding, as long as its family planning clinics and abortion clinics were legally separate entities. From that point forward, clinics that provided elective abortion services were no longer eligible to receive state funding. The Texas Department of State Health Services (DSHS)

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[42] Ramshaw, "To Some House Representatives, Family Planning = Abortion."

[43] R. B. Gold, "Key Reproductive Health-Related Developments in the States: 2003," *Guttmacher Policy Review* 6, no. 5 (December 2003): 11, http://www.guttmacher.org/pubs/tgr/06/5/gr060511.pdf.

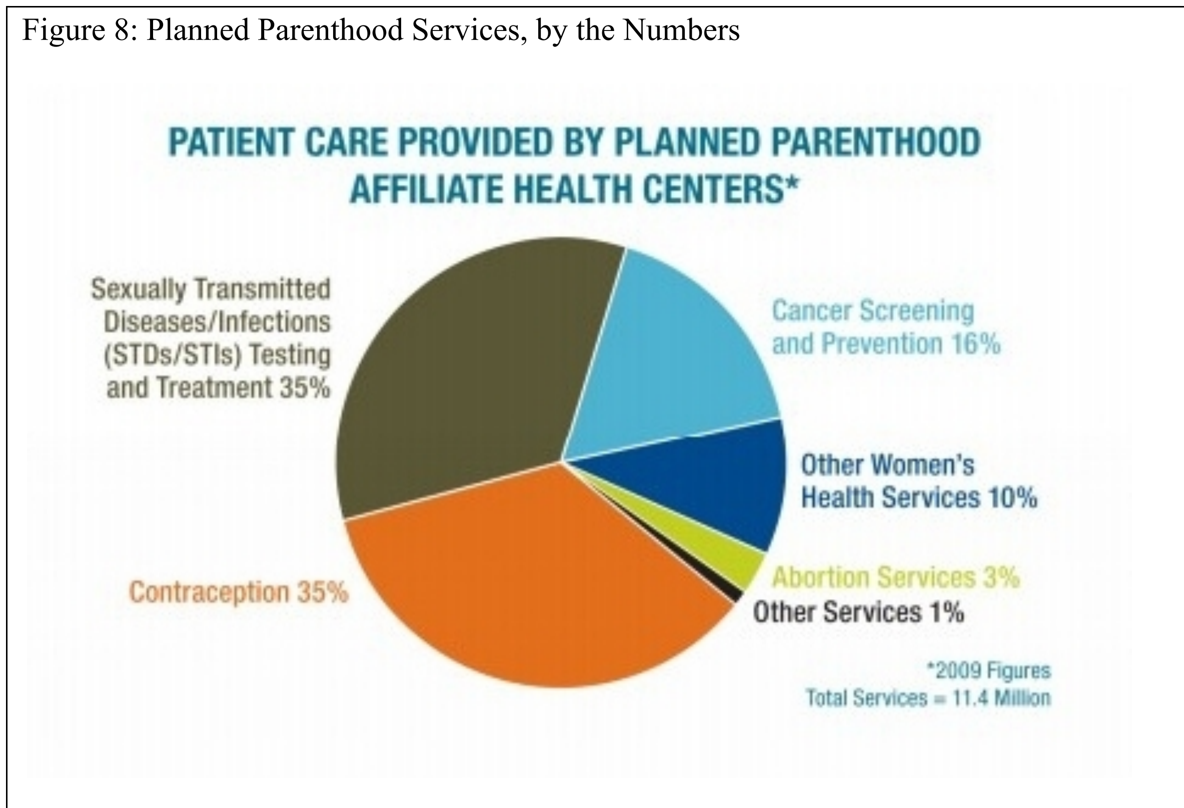
was tasked with enforcing this policy through regular audits and inspections of eligible provider facilities.

Despite the rigorous review process through which DSHS ensures compliance with this policy, many Texans remain in opposition to any funding for clinics like Planned Parenthood. When asked to comment on this issue, one informant, who is a state health official, admitted, "Unfortunately, many people feel that, regardless of whether we can prove that we're funding only family planning [services], we are still secretly funding abortions." She went on to say that the issue is simply "a morality question – and you can't argue with morality because people aren't going to change their mind[s] about that."

There may be disagreement about whether or not the State of Texas should fund Planned Parenthood, but there are a few facts that no reasonable person can deny. One of the most compelling arguments for continued government funding for Planned Parenthood Federation of America is represented by the graph in Figure 8.[44]

[44] Ezra Klein, "What Planned Parenthood Actually Does," *Economic and Domestic Policy, and Lots of It* (blog), April 8, 2011, http://www.washingtonpost.com/blogs/ezra-klein/post/ what-planned-parenthood-actually-does/2011/04/06/AFhBPa2C_blog.html.

Figure 8: Planned Parenthood Services, by the Numbers



As this graph proves, based on 2009 data, 97 percent of services provided at Planned Parenthood clinics have nothing to do with abortion. Abortion services make up 3 percent of the Planned Parenthood caseload, but these clinics primarily offer necessary family planning services to low-income women and men. Moreover, these clinics are extremely good at what they do. During one interview, an informant who is a physician and a firm believer in the benefits of family planning made the following observation.

> Whereas our primary care system is struggling to provide people with access to services, we have this vary narrow auxiliary system [family planning clinics]…that has developed and works extremely efficiently, at a very low cost, with very positive results… I've worked in primary care and in family planning clinics and the difference in terms of what women have access to and what gets done is huge.

This observation promotes the work of family planning clinics and emphasizes client access to services, which was a common theme among interview findings. But WHP access is not only influenced by political competition.

Eligible Providers: Selecting Appropriate Distribution Channels

Client access to WHP services is a major consideration in the selection of WHP providers. Just as a marketer carefully selects the distribution channels through which to offer a product or service, the State of Texas decides which medical providers should be eligible for participation in state health programs. In the case of WHP, the distribution goal is to provide as much access for the two million eligible women as possible, while still ensuring that funds are dispensed according to state and federal policy.

Providers

The list of WHP providers is made up of four tiers: (1) family planning clinics, such as Planned Parenthood, (2) Federally Qualified Health Centers (FQHCs), which are comprehensive care providers that do not perform elective abortions, (3) public health providers, such as public university health systems and city or county hospitals, and (4) private health providers, like community health centers or private health systems. Historically, the Department of State Health Services has performed the role of contracting with these entities, through recruiting, training, and certifying eligible providers. In order to boost enrollment in WHP, DSHS required their contractors to screen all female patients for WHP eligibility. According to one informant, who is a state health official, "WHP has gotten off the ground because DSHS required contractors to screen women for eligibility. So the initial round of women who got in were actually

traditional DSHS clients, who we transitioned into WHP." Today, roughly 80 percent of WHP client services are provided through DSHS contracts. Enrolling WHP clients via DSHS contractors also contributes to a better continuity of care: DSHS can use other funding streams to cover "wrap-around services" for WHP clients, allowing them to receive treatments not covered by the program.

Planned Parenthood is currently the leading WHP service provider, but its future role in the program is uncertain. Viewed through a marketing lens, the State of Texas should be keen on maintaining a healthy relationship with one of its key distributors. But recent debates over funding Planned Parenthood rely on moral arguments instead of on practical wisdom. In an effort to discontinue state funding of Planned Parenthood clinics, some Texas legislators insist that FQHCs and other comprehensive care providers must fulfill the role of providing family planning services to Texas women. One informant, a Republican State Senator who is also a physician, stated that his goal is to "shift the paradigm such that women begin to see family planning within the scope of comprehensive care." Citing the fact that family planning clinics provide a limited set of services, the Senator hopes to incorporate family planning into the established model for comprehensive primary care.

Increased access to affordable primary care would, no doubt, benefit WHP clients. But multiple informants in this thesis believe that FQHCs and primary care physicians are not yet capable of taking over family planning in Texas. As one respondent put it,

> The FQHC network doesn't have the infrastructure to absorb all of those patient needs… [M]any of them don't provide gynecological care because they know Planned Parenthood does that. …[FQHCs] need to be providing care for the largest number of patients as possible. When you bring in a gynecologist, that

> person can really only see female patients for female health concerns, which means that doctor can't be used to see children, men, elderly, etc.

Another respondent cited cultural challenges to integrating family planning into the existing network of comprehensive care providers:

> …[A]nything that has to do with sex in general [makes some providers uncomfortable]. Family planning providers are different, they're much more comfortable talking about all of the different types of sex…and they don't judge when someone talks about the amount of sexual partners they've had. It's a different sort of person who is able to put his or her own personal beliefs aside and do what the client needs. Not everyone can do that. We need those people.

This observation represents one form of the classic specialist vs. generalist argument. Generalists are equipped to treat a wide variety of conditions, but specialists have expert skills in only one area. Which is preferred? An individual with a very specific health need might prefer a specialist because of his or her increased experience treating that condition. On the other hand, the public good is often served best by generalists, who can treat a greater number of people and conditions, albeit less skillfully. While there is no right or wrong answer in the specialist/generalist debate, opponents of WHP seem to make a universal argument in favor of generalists. No matter how this debate and others resolve, WHP will either expand or stagnate, depending on which providers are allowed to carry it forward.

Provider Limitations

State policy limitations also affect the distribution of WHP services. From the program's inception, client access has been severely limited by the state's decision not to allow elective abortion providers, which are primarily family planning clinics, to participate in WHP. Initial state projections estimated this restriction would cause 63

percent of potential clients to lose access to WHP services.[45] In many regions, family planning clinics are the nearest facilities that offer low-cost reproductive health care for uninsured and underinsured patients. Further complicating the restriction on abortion providers is the fact that women who have aborted an unwanted pregnancy are a prime target group for free contraception. Increased access to family planning services decreases the likelihood that these women will need abortions in the future. Clearly, refusing to offer these services to women who seek treatment at elective abortion providers ignores a valid and pressing need in the marketplace. Texas' political decision promotes a bias against family planning clinics and results in a constrained choice for WHP-eligible women. Even if all of these women actively sought family planning services, participation for some would be difficult or impossible, based on access to WHP providers.

Fears of Channel Failure

Distribution challenges are on the horizon for WHP. If the 82nd Texas Legislature passes proposed DSHS budget cuts, the organization will be unable to fulfill its role as chief contractor for WHP providers.[46] Without DSHS administration and support, WHP enrollment is likely to drop off. If Planned Parenthood clinics are completely eliminated from WHP, comprehensive care providers will be unable to fill the gap in service without drastic infrastructural changes. Either way, the distribution system for WHP family planning services will be temporarily defunct.

[45] Legislative Budget Board, Fiscal Note, S.B 747.

[46] Cuts made in H.B. 1, 81st session of Texas Legislature, can be found in the Appendix, Figure A2.

Promotion of WHP: Market Introduction

During the launch phase of the new product development process, the cost of acquiring loyal consumers is high and demand for the product must be created from scratch. When WHP was introduced to the Texas health care market, consumer demand depended largely on program awareness and access to services. In order to achieve these goals, DSHS was permitted to use a portion of its funding to promote the new program.

Preparing for Market Launch

Counter to new product development best practices, no test phase was executed prior to launching WHP promotions. Due to WHP's limited budget for outreach efforts, most of the research that informed WHP promotions came from state data about Medicaid birth rates. No focus groups, surveys, or interviews were conducted in order to discover consumer insights and attitudes. This lack of insight into consumer motivations could have played a significant role in limiting the number of WHP participants. In the words of one reproductive health expert, "I think that we cannot underestimate the extent to which people view these services differently."

Promotional Strategies and Tactics

Lacking consumer insights, WHP promoters opted to build a grassroots campaign for program outreach. According to one informant, who promoted WHP at the state level, "We took a grassroots approach to spreading information about the program [because] it seems to be the most effective in reaching these individuals." The reasoning given for this grassroots approach was that potential clients would be more likely to trust information received through a familiar, trusted source. Therefore, community-based

organizations (CBOs) were used as the primary medium for message distribution. State health officers relied on CBOs to communicate program benefits in relevant and effective ways. A list of WHP outreach tactics employed between January 2007 and December 2009 is included in Figure 9.[47]

Figure 9: WHP Outreach Tactics

2007-2008
- Distributed bilingual "push cards"* to stakeholders and community organizations
- Distributed bilingual brochures and posters to community-based organizations and providers serving WHP clients
- Launched program website with bilingual program information
- Regional community health worker trainings provided by HHSC staff
- Transit bus advertisements targeted to Spanish-speaking population

2009
- Sent notices about WHP to women whose children receive Medicaid benefits
- Published articles in provider organization newsletters
- Bilingual posters hung at community colleges and other locations
- Created WHP curriculum for certified community health worker training
- Bilingual brochures and "push cards" provided to hospitals
- Bilingual billboard campaign in South and Central Texas

* The term "push cards" refers to smaller, two-sided brochures

Public Health vs. Mass Media

The WHP outreach tactics listed in Figure 6 incorporate elements of both traditional public health campaigns and traditional marketing campaigns. One of the primary outreach tactics employed to promote WHP relied upon elite sources, such as health care providers and educators, to disseminate health information via English and Spanish-language brochures and "push cards." This tactic is a reflection of a more traditional public health strategy, relying on elite sources rather than on the mass media.

[47] Texas HHSC, Medicaid Women's Health Program Implementation Report, 6-17.

However, transit ads and billboards were also used to promote WHP, both of which qualify as mass media tactics. These mass media advertisements likely accounted for a large percentage of the WHP promotional budget, which averaged only fifty thousand dollars per year. Compared to the promotional budget for the Children's Health Insurance Program (CHIP), which averages two million dollars per year, WHP outreach resources were extremely limited.

Outreach Goal: Awareness

Generating awareness among consumers is one of the primary marketing goals involved with the release of a new product or service. Because WHP was a new product in the health care market, building awareness was one of the key outreach goals for the program. The wide reach and geographical focus provided by billboards and posters made outdoor media a sound choice to advertise WHP. According to an informant who worked on WHP outreach, "We chose to do outdoor advertising…because… billboards give you reach. They get your message to a lot of people." Another informant pointed out that WHP billboards were "narrowly targeted to dense pockets of eligible women," giving outdoor ads both a wide reach and a targeted focus. Both outdoor and mass transit media were used to generate word of mouth among targeted communities. As one informant put it, "maybe grandma's not eligible, but she'll tell her granddaughter, who would be eligible."

Outreach Goal: Access

Motivated distributors play a critical role in making sure that consumers have access to a product. Marketers often target distributors with special messages and promotional discounts persuading them to carry and/or promote certain products. WHP's distributors consist largely of medical providers, who are instrumental in making WHP services accessible. Unfortunately, due to limited resources for outreach, the few WHP materials distributed to medical providers were brochures and "push cards" intended for distribution among potential WHP clients. Only in its third year did WHP administrators reach out to providers by publishing articles in their organizational newsletters. Overall, little effort was made to motivate providers in WHP's first three years.

Evaluation

Evaluation was another casualty of WHP's limited promotional budget. Outreach measures, such as awareness and opinion surveys, are typically woven into the fabric of any successful marketing plan. These tools help marketers determine which outreach strategies were successful and which were not. No post-campaign surveys were conducted among WHP-eligible women or among WHP-eligible providers. Without evaluating which messages affected which target groups (and how), WHP promoters had no logical basis for continuing to fund various outreach strategies. This "shot in the dark" strategy did not allow WHP promoters to form evidence-based outreach plans.

WHP SWOT ANALYSIS

Strengths

WHP's proven cost effectiveness is certainly among its chief strengths. Having saved the state more than $10 for every $1 invested, WHP makes sound economic sense. Unfortunately, this point tends to get lost in the midst of the heated abortion debate. Because the program is funded with Medicaid dollars, largely from the federal government, the State of Texas has little reason to abandon this money-saver. Even during a conversation with a Republican State Senator, who wishes to drastically change the program, it seemed clear that WHP had strong bi-partisan support in the Texas Legislature.

Several informants believed that the primary strength of WHP is its potential to promote a continuity of care for low-income women. Texas women who are newly eligible for family planning services through WHP often lack access to state-funded primary care. By offering annual exams that include tests for diabetes and hypertension, WHP becomes a source of regular patient interaction with a trained medical professional. This increased medical access could increase a patient's awareness of other medical problems that might otherwise go untreated. The strength of increased access to basic health care came up several times during interviews with women's health policy experts. As one informant observed, "[These are] women who often fall through the cracks because they lack coverage…or because they are not aware of various coverage options." She went on to call WHP "a portal into the health care system for primary care services."

Weaknesses

Despite the program's potential to introduce low-income women into the health care system, WHP funds still only cover a select set of services. If a woman is discovered to have a medical need that cannot be covered by WHP, she may have difficulty finding treatment. For example, a WHP patient who tests positive for a sexually transmitted infection during her annual exam must rely on other funds to receive STI treatment. If her health care provider does not participate in additional public assistance programs, she may have to be referred to another provider. According to one informant, this constraint on patient care creates an obstacle for physicians interested in serving WHP patients:

> [Providers] want to help the patient, regardless of whether that's covered in the program. Say you find a case of Chlamydia and you know that there is an antibiotic you can give that's relatively cheap and easy. Do you send them away to the STD clinic even though you know you can help them? You lose a continuity of care. For some providers that don't have those connections in the community, it's problematic on an ethical level.

The theme of program narrowness was common among several informants. One health policy expert called programs like WHP "medically irresponsible," while another simply referred to it as "a patch" used to make up for a lack of access to other preventive care services. Navigating the health care system is already a difficult task. The narrowness of WHP may make the navigation process more confusing for women who need more than what the program can provide.

Another weakness of WHP is the program's inability to enroll new patients into the public health care system. As stated previously, DSHS contracted providers enrolled a large majority of initial WHP clients. Many of these providers simply transitioned women from coverage under other government funding streams. Clearly, WHP

enrollment numbers have been inflated by the number of patients who were already receiving publicly funded family planning services. Since this program was designed to extend family planning services to newly eligible women, its weak enrollment numbers must be confronted and addressed.

Opportunities

The Texas Women's Health Program has enormous potential for growth in terms of total program participation. Due in large part to the number of clients transitioned from other DSHS programs, WHP enrolled two hundred thousand women during its first three years of implementation. While this statistic is reported by HHSC as a remarkable achievement, this number represents only 10 percent of the roughly two million eligible women in Texas, as estimated by the State Legislative Budget Board.[48] As referenced in Chapter 1, the Texas Legislature estimated annual WHP enrollment at six hundred thousand women, meaning that there are still hundreds of thousands of clients to enroll. And because WHP is paid for using a blend of federal and state Medicaid funds, there is no ceiling on program expenditures incurred by increased enrollment. This funding flexibility, paired with the large WHP eligible population, results in a tremendous opportunity for WHP to expand and cover more women.

Threats

The primary threat to the success of the Texas Women's Health Program is lack of resources. Currently, the future of state-funded family planning in Texas is grim. If the Texas Legislature passes the 82nd House Budget bill, roughly forty million dolloars will

[48] Legislative Budget Board, Fiscal Note, S.B 747.

be cut from the 2012 DSHS budget.[49] In the past, these DSHS funds have been designated to pay for WHP outreach efforts and to reimburse contracted providers for patient services not covered by the program. Faced with such drastic cuts, one state health official admitted, "our family planning program will never be what it has been historically, but we will try to do the best we can with what we have left." While the motivations behind these cuts are difficult to identify, many believe the cuts are politically driven. In a recent news story from the *Texas Tribune*, one anti-abortion State Representative confirmed: "There are important women's health services that are provided [at family planning clinics], many of which are very cost effective. But when it comes down to it, these votes were about political philosophy, and I voted in favor of moving the money."[50]

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[49] Exerpts from H.B. 1, including DSHS budget cuts, can be found in the Appendix, Figure A1.

[50] Ramshaw, "To Some House Representatives, Family Planning = Abortion."

Chapter 5: Recommendations and Conclusions

RECOMMENDATIONS

Although this thesis originally focused on increasing WHP participation solely by improving outreach strategies, the challenge proved to be far more complex. Therefore, the following recommendations include references to policy changes as well as outreach and communication strategies. These recommendations were informed by interview findings, by traditional marketing principals, and by the theories of health behavior change presented in the literature review.

#1: Increase WHP Outreach Funds

Increased funds should be allocated specifically for the purpose of statewide WHP outreach. Ideally, the WHP promotional budget will eventually equal that of the Children's Health Insurance Program (CHIP) promotional budget, since both programs cover a large number of eligible participants. Compared with WHP's two million eligible women, approximately 750,000 Texas children are estimated to be eligible for CHIP but not enrolled. WHP should be given an outreach budget comparable to that of CHIP: two million dollars per year. If state health funding cuts are passed as written by the House of Representatives, WHP will no longer be able to rely on DSHS for outreach and enrollment efforts. This will leave a large gap in WHP public awareness activities. Designating state substantial funds for program outreach will be necessary if the program is to continue enrolling and serving new patients.

#2: Expand WHP Services

Another serious impact of DSHS funding cuts is the loss of “wrap-around services” for WHP clients. An expansion of WHP covered services will achieve two critical goals: (1) increased consumer benefit associated with participation, and (2) increased provider willingness to serve WHP clients. My initial recommendation is that WHP services be expanded to cover STD/STI treatment, since this constraint seems to present an ethical barrier for potential WHP providers. A second phase of expansion might include coverage of additional preventive care, such as breast cancer screenings. If WHP were to begin covering a more comprehensive set of services, it would be more likely to attract both participants and bi-partisan political support.

#3: Conduct Consumer Research

Consumer research will help program administrators to define market segments and discover the extent to which attitudes toward WHP vary among those segments. This information will contribute to more appropriate messaging and media strategies for the various target groups. Focus groups and in-depth interviews are recommended for this research because of the fact that, for many respondents, family planning may be a sensitive topic. An intimate focus group setting or interview will promote candid responses to questions that might otherwise seem intrusive. Important topics to cover in these focus groups include: (1) attitudes and beliefs about family planning in general; (2) perceptions related to key family planning terms, like “birth control,” and “contraception;” and (3) opinions about current WHP outreach materials. Reflecting the “truth” anti-smoking campaign’s focus on consumer research, WHP should seek to truly

understand the motivations of its consumers. Insights gleaned from this research will help tailor WHP messages and media strategies to each unique market segment.

#4: Identify Market Segments

WHP administrators should separate the large, diverse population of eligible women into smaller segments according to shared traits, such as age, race, or ethnicity. Segmenting the WHP target audience in this way will help tailor outreach efforts such that each market segment is reached in the most appropriate way, with the most appropriate message. Instead of segmenting the market only by distinguishing Latinas from non-Latinas, WHP administrators should identify more precise groups within these communities. For example, first generation Texas immigrants should be distinguished from second-generation Latinas who were born and educated in Texas. Religious affiliation should also be taken into account when segmenting Latinas. Devout Catholic women may have been discouraged from using contraception since birth. Therefore, family planning messages targeted to these women must be sensitive to those beliefs. As Social Judgment Theory has shown, consumers will either accept or reject a message depending on how it compares with their pre-established views. In addition to segmenting based on beliefs, the WHP audience should be divided according to age. An 18-year-old who has recently become sexually active will have different opinions and motivations that vary greatly from those of a 37-year-old mother. Finally, the WHP target audience should include additional stakeholder groups, such as medical providers and the general public.

#5: Evaluation

Evaluation is another key benefit to consumer research. After focus group feedback is assessed and incorporated into new WHP outreach efforts, another round of research should be conducted for the purpose of evaluating that process. Surveys should test for WHP awareness among targeted market segments. Attitudes toward family planning should be re-assessed among women exposed to outreach materials. Results from this evaluation can be correlated with enrollment and utilization levels in order to assess the effectiveness of program outreach.

#6: Pursue Community Buy-In

As the literature has shown, communities play a critical role in the encouragement of health behavior change. Relying heavily on social marketing principles, such as careful market segmentation, the State of Texas should develop and implement an awareness campaign about how family planning benefits both women and families. A social marketing campaign will not only increase demand for WHP services, but will encourage community support for efforts to make family planning accessible and affordable for all Texans. Directed at legislators, medical providers, reproductive-age women, and the general public, this campaign should work to re-brand family planning as a positive, worthwhile investment in Texas' future. The campaign should focus largely on the realities of unintended pregnancy in Texas, revealing the startling statistic that nearly half of Texas births are unplanned.[51] Different campaign messages should be crafted for each

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[51]. Janet P. Realini, "Reducing the Costs of Unplanned Pregnancy in Texas" (powerpoint presentation, Infant Health Alliance, January 2010), Texans Care for Children, http://texanscareforchildren.org/Texas-Infant-Health-Alliance/Meetings.

target group, helping to ensure message relevance and effectiveness. Campaign messaging targeted to eligible women should point out the risk factors associated with unintended births and would highlight the benefits of planned, well-spaced pregnancies. Outreach to legislators and to the general public should point out the social and economic benefits of increased access to contraception. By taking family planning out of the context of the abortion debate, this awareness campaign will promote WHP buy-in among multiple stakeholder groups in Texas communities.

#7: Motivate Providers

Once awareness has been generated among key stakeholders in Texas communities, WHP administrators will need to increase access to services by building and strengthening the program's provider network. Outreach about program benefits should be targeted to eligible providers who are not currently participating in WHP. And instead of using current WHP providers as merely a medium for client outreach, WHP promoters should craft unique messages for the medical community. For example, new materials should be distributed to keep providers updated on family planning in Texas. A newsletter that can be viewed digitally or printed would be an appropriate format for this kind of outreach. Initially, these materials should emphasize adherence to the new CDC guidelines for prescribing birth control. Couching this information within WHP outreach materials will help ensure that WHP clients are not required to undergo unnecessary exams in exchange for a birth control prescription.

Increased knowledge of the CDC guidelines will certainly educate medical providers, but an increased reimbursement rate for family planning counseling is likely to

be more persuasive. As mentioned in Chapter 4, researchers from the American College of Obstetricians and Gynecologists believe that family planning providers may be incentivized to "bundle" services in order to receive a better reimbursement. Because family planning and contraception counseling are critically important to reducing expensive Medicaid births, provider services should be reimbursed accordingly. Just as marketers use bulk discounts and coupon programs to motivate a product's distribution channel, pay for performance incentives for WHP providers could help grow and strengthen the WHP provider network.

#8: Continue Outdoor and Transit Media

Focusing messages in targeted locales is a sound media strategy for reaching WHP-eligible women. As state research has shown, consumer need for publicly funded health services tends to be concentrated in low-income, and often minority, communities. Outdoor media can be placed according to zip code, and can thus be targeted to specific neighborhoods or districts based on census data. Mass transit media, such as bus placards, are also useful tools for reaching Texans of a lower income level. Both outdoor and transit media offer WHP a wide reach among its target market: if placed correctly, these strategies can result in highly targeted and meaningful message exposures.

 # 9: Explore Mobile Media

In light of recent advances in technology, concerns relative to media access are rapidly becoming obsolete. The advent of the Internet and the proliferation of mobile technologies, like smart phones and other personal media devices, have democratized the information landscape. Gone are the days when news and information came from only a

few elite sources; the average consumer today has access to numerous, unique sources of information on a daily basis. For example, according to a June 2010 study by the Pew Internet & American Life Project, six out of ten American adults now access the Internet via some form of mobile device. The increasing level of media engagement on the part of the American public suggests a need for the public health community to begin embracing increased usage of mass media strategies. One way in which mobile media might be useful for younger targets of WHP outreach is through geo-based mobile applications. The creation of a WHP Provider App that displays nearby WHP service providers would make scheduling an appointment to receive WHP services quicker and easier for mobile clients.

#10: Evaluation

As previously mentioned, evaluation of WHP outreach tactics is necessary in order to craft more relevant, effective campaign messages. Post-campaign awareness and opinion surveys should be conducted among each target group. Additional interviews and focus groups should be conducted to assess how these groups perceived and responded to WHP messages. Without regular, thorough evaluations of WHP offerings and outreach, program outcomes are unlikely to improve.

PUBLIC POLICY IMPLICATIONS

This thesis attempts to cast state health programming in a new light by applying marketing principles to a program analysis. The Texas Women's Health Program is a valuable product that deserves to reach a broader market. And while the Texas "market" is full of complexity and tough competition, the merits of WHP tend to speak volumes.

However, if WHP is to reach its full potential, the program will need to expand its offerings, build and strengthen its provider base, and motivate community support of family planning. Without taking these important steps, it is doubtful that WHP will gain the traction it needs to grow and thrive throughout the state.

Implications of Health Reform

The future of health care in the United States will have a significant impact on experimental state programs like WHP. Signed into law on March 23, 2010, the Patient Protection and Affordable Care Act represents dynamic change in Medicaid programming. The act extends Medicaid coverage to Americans living at income levels up to 133% of the federal poverty level. Policy officials estimate that this expansion will extend Medicaid services to 16 million of the roughly 45 million Americans who are currently uninsured. Anticipating passage of the new health reform laws, the bi-partisan National Governors Association (NGA) released a set of “Medicaid Reform Principles” in an effort to express their beliefs to federal policymakers. This set of principles includes assertions pertaining to Medicaid waiver programs, like WHP:

> To the extent possible, current waivers should be replaced with clear statutory and regulatory authority. Where waivers are necessary the process should be made more hospitable to state experimentation. Where state waivers are consistent with earlier approved waivers in other states or health care reform, they should be expedited. …[T]he waiver process should be transparent, grounded in policy, consistent across states and streamlined.[52]

[52] National Governor's Association, "HHS-27. Medicaid Reform Principles" (principles reaffirmed during Winter Meeting 2011), National Governor's Association: Health Reform Implementation, http://www.nga.org/.

This statement calls for increased federal support of state experimentation in health programming. It also seeks to streamline the process of developing and implementing such programs, which has tended to be administratively burdensome in the past. In the case of WHP, increased federal support could allow for more program funds to be allocated to the development of a user-friendly automatic system for patient referral tracking.

In addition to increased programming flexibility, NGA principles request permission to implement experimental changes to the provider payment system:

> The federal government should allow states to experiment with provider payment reforms to improve quality and contain costs. These reforms include pay for performance incentives, payment for care coordination services, for example by medical homes, and bundled payment for services.[53]

Reforms to the Medicaid system for provider payment could result in more provider incentive to serve Medicaid patients. Whereas WHP-eligible providers currently have little incentive to participate in the program, an increase in reimbursement for family planning counseling could encourage more providers to participate. This increase in distributors would, in turn, increase patient access to WHP services.

Continuity of Care

Even with an expansion of WHP services, many low-income clients who do not qualify for full Medicaid benefits could still lack access to important primary care services. At the federal level, the Centers for Medicare & Medicaid Services (CMS) has

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[53]. National Governor's Association, "HHS-27. Medicaid Reform Principles."

attempted to address this problem by stipulating that Medicaid family planning waiver programs, like WHP, must implement a system for providing patient referrals:

> Since 2001, CMS has required states to promote access to primary care services for individuals enrolled in family planning programs, in recognition that enrollees may have medical needs beyond the limited benefits available through the waiver. To meet this requirement, states arrange formal partnerships with and referrals to community health centers and primary care providers; they also educate and inform enrollees about health care programs for the uninsured.[54]

Despite the good intentions of CMS, WHP administrators could not maintain an effective patient referral system. As mentioned in the "Program Creation" section of Chapter 4, the Texas Health and Human Services Commission has appealed to CMS to omit patient referral from its list of program goals.

Referral Restriction: Defining "Affiliate"

Prior to the 2005 passage of S.B. 747, Republican State Senator Bob Deuell attached an amendment to bill that restricted the distribution of WHP funds. The amendment states that WHP funds shall not be allocated to "entities or affiliates of entities that provide or promote elective abortions." Until early 2011, the constitutionality of this amendment remained in question. Apparently, the definition of "affiliate" was unclear. For example, are Planned Parenthood family planning clinics "affiliated" with Planned Parenthood abortion clinics even though they are legally separate entities? According to Texas Attorney General Greg Abbot, the answer is yes. In a February 2011 Opinion, Abbot upheld Deuell's restrictive amendment:

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[54] Sara Sills and Brett Johnson, "Medicaid 1115 Family Planning Demonstration Waiver Programs," *State Health Policy Monitor* 2, no. 4 (November 2008): 3, http://www.nashp.org/publication/ medicaid-1115-family-planning-demonstration-waiver-programs.

> Human Resources Code section 32.0248(h), which applies to women's health care demonstration project services, provides that the Health and Human Services Commission may not contract with entities that are affiliates of entities that perform or promote elective abortions.[55]

Because of WHP's status as a demonstration project, state lawmakers can exclude providers from program eligibility. In a press release on Senator Deuell's website, the Senator acknowledges the influence of public opinion: "Although not all Planned Parenthood affiliates perform abortions, I believe that we should reduce the amount of tax money being funneled to clinics that many taxpayers oppose." The Senator does not mention the percentage of WHP patients who have been served by Planned Parenthood, and no credit is given for Planned Parenthood's achievements in the program. The Senator closes his argument with an air of skepticism toward family planning services: "This is about increasing the number of medical services available to women, and making sure that all Texans -- and taxpayers -- can agree that those services absolutely necessary."[56] If the current rate of Medicaid births in Texas does not prove the necessity of family planning services, it is unlikely that anything else will.

CONCLUSION

The aim of this thesis is to demonstrate the value of integrating marketing concepts into public health communication. As social marketing case studies like the "truth" campaign have shown, marketing principles and processes clearly have much to contribute to the in the field of public health. With a pronounced focus on consumer

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[55]. Greg Abbott. "Opinion No. GA-0844," https://www.oag.state.tx.us/opinions/opinions/50abbott/op/2011/htm/ga-0844.htm.

[56]. Robert Deuell, "Sen. Deuell Asks Attorney General To Clarify Family Planning Funding Laws," The Senate of Texas: Senator Bob Deuell, last modified August 6, 2010, http://www.deuell.senate.state.tx.us/pr10/p080610a.htm.

benefit, instead of on consumer education, marketing strategies can result in more persuasive public health messaging. Increased consumer research can help public health program developers to better meet client needs through program services. Instead of being merely an afterthought in the realm of public policy, marketing strategies such as market segmentation and SWOT analyses should influence health program development from the outset. In practice, some health marketing raises ethical concerns, including conflicts of interest related to financial gain. For example, much debate surrounded the motivations behind Merck's effort to institute mandatory HPV vaccination for all adolescent girls. But low-risk, high-benefit programs like WHP are a prime opportunity to employ social marketing techniques to improve public health outcomes.

Segmenting large, diverse consumer populations in order to better understand target audience motivations will make a profound difference in state health program participation. Like many publicly funded health services, family planning services are safe and beneficial to women and families. The government stands to save millions in averted Medicaid births. Similar preventive care programs, such as obesity prevention, have the potential to reduce the enormous state costs associated with increased incidence of diabetes, heart disease, and other adverse health outcomes. Analyses that identify the best ways in which to benefit consumers will help program developers to launch more successful health programs. Marketing concepts and persuasion theories will improve health program outreach because of their ability to help communicators craft meaningful, effective messages. As WHP and other state health programs enroll and serve more Texans, entire communities will be better for it.

Appendix

FIGURE A1: TEXT, S.B. 747

S.B. No. 747

1 AN ACT
2 relating to establishing a demonstration project for women's health
3 care services.
4 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:
5 SECTION 1. Subchapter B, Chapter 32, Human Resources Code,
6 is amended by adding Section 32.0248 to read as follows:
7 Sec. 32.0248. DEMONSTRATION PROJECT FOR WOMEN'S HEALTH CARE
8 SERVICES. (a) The department shall establish a five-year
9 demonstration project through the medical assistance program to
10 expand access to preventive health and family planning services for
11 women. A woman eligible under Subsection (b) to participate in the
12 demonstration project may receive appropriate preventive health
13 and family planning services, including:
14 (1) medical history recording and evaluation;
15 (2) physical examinations;
16 (3) health screenings, including screening for:
17 (A) diabetes;
18 (B) cervical cancer;
19 (C) breast cancer;
20 (D) sexually transmitted diseases;
21 (E) hypertension;
22 (F) cholesterol; and
23 (G) tuberculosis;
24 (4) counseling and education on contraceptive methods

1 emphasizing the health benefits of abstinence from sexual activity
2 to recipients who are not married, except for counseling and
3 education regarding emergency contraception;
4 (5) provision of contraceptives, except for the
5 provision of emergency contraception;
6 (6) risk assessment; and
7 (7) referral of medical problems to appropriate
8 providers that are entities or organizations that do not perform or
9 promote elective abortions or contract or affiliate with entities
10 that perform or promote elective abortions.
11 (b) A woman is eligible to participate in the demonstration
12 project if the woman is at least 18 years of age and:
13 (1) has a net family income that is at or below 185
14 percent of the federal poverty level;
15 (2) participates in or receives benefits under any of
16 the following:
17 (A) the medical assistance program;
18 (B) the financial assistance program under
19 Chapter 31;
20 (C) the nutritional assistance program under
21 Chapter 33;
22 (D) the Supplemental Food Program for Women,
23 Infants and Children; or
24 (E) another program administered by the state
25 that:
26 (i) requires documentation of income; and
27 (ii) restricts eligibility to persons with

1 income equal to or less than the income eligibility guidelines
2 applicable to the medical assistance program;
3 (3) is presumed eligible for one of the programs
4 listed in Subdivision (2) pending completion of that program's
5 eligibility process; or
6 (4) is a member of a family that contains at least one
7 person who participates in or receives benefits under one of the
8 programs listed in Subdivision (2).
9 (c) The department shall ensure that the standards of care
10 provided to a woman participating in the demonstration project are
11 consistent with the requirements of law and current best practices
12 for provision of public health services.
13 (d) The department shall develop procedures for determining
14 and certifying eligibility for services under the demonstration
15 project at the point of service delivery using integrated
16 procedures that minimize duplication of effort by providers, the
17 department, and other state agencies. The department may not use a
18 procedure that would require a cost in excess of 10 percent of the
19 total costs of actual preventive health and family planning
20 services provided under the demonstration project. The eligibility
21 procedure may provide for expedited determination and
22 certification using a simplified form requiring only family income
23 and family size.
24 (e) The department shall compile a list of potential funding
25 sources a woman participating in the demonstration project may be
26 able to use to help pay for treatment for health problems:
27 (1) identified using services provided under the

1 authorization and may delay implementing that provision until the
2 waiver or authorization is granted.
3 SECTION 3. Not later than September 1, 2006, the state
4 agency responsible for implementing the demonstration project
5 required by Section 32.0248, Human Resources Code, as added by this
6 Act, shall implement the demonstration project.
7 SECTION 4. This Act takes effect immediately if it receives
8 a vote of two-thirds of all the members elected to each house, as
9 provided by Section 39, Article III, Texas Constitution. If this
10 Act does not receive the vote necessary for immediate effect, this
11 Act takes effect September 1, 2005.

FIGURE A2: EXCERPTS FROM H.B. 1, 81ST LEGISLATIVE SESSION

The following paragraphs represent entire programs that have been cut from the Texas State budget.

66. Use of Family Planning Funds. The Department of State Health Services (DSHS) shall use a portion of funds appropriated above in Strategy B.1.3, Family Planning Services, to reimburse contracted providers for family planning services not covered by the Women's Health Program. To the extent funds are available and federal approval has been granted, DSHS shall also use a portion of funds appropriated above in Strategy B.1.3, Family Planning Services, for comprehensive outreach and education about the Women's Health Program and family planning services.

82. HIV Testing. Out of funds appropriated above in Strategy A.2.2, HIV/STD Prevention, the Department of State Health Services shall allocate not less than $4,419,989 in fiscal 2010 in All Funds and $4,419,990 in fiscal year 2011 in All Funds for the purpose of increased testing for HIV in high morbidity areas, with Houston and Dallas receiving top consideration, in emergency rooms, or in primary care clinics associated with the large indigent care providers.

Department of State Health Services:

Section 317 Immunizations (Prevention and Wellness)	$	3,160,681
Prevention and Wellness Fund: Prevention Services and Programs	$	400,000
Infection Reduction Activities	$	2,137,389
Temporary Assistance for Needy Families (TANF) to Title XX	$	4,200,000
Reduce Federal Funds - Title XX	$	(4,200,000)

Cuts to Medicaid Funding:

	2010	2011
Department of State Health Services	171,586,284	170,410,003
	2012	2013
Department of State Health Services	132,052,179	158,719,628
Total Cut:	**$ 39,534,105**	**$ 11,690,375**
	2010	2011
Health and Human Services Commission	15,811,441,567	16,081,151,347
	2012	2013
Health and Human Services Commission	11,893,077,468	15,033,507,293
Total Cut:	**$ 3,918,364,099**	**$ 1,056,644,054**

FIGURE A3: ELITE INTERVIEW PROTOCOLS

Interview Protocol (Political Informant)

The Texas Women's Health Program (WHP) was created in 2005 as a sort of legislative experiment to see how much money could be saved on Medicaid-funded births in Texas. The WHP saved the state $40 million in 2008 alone. Now that we're entering a new legislative session, during which spending cuts are eminent, I'd like to ask you some questions regarding your opinions on the value of the WHP.

1. **What do you see as the strengths of the Women's Health Program?**

   Prompts: Has it proven to be an effective program? Has it met its legislative goals? Were its legislative goals commendable? Is any other piece of legislation addressing the same issue?

2. **What do you see as the weaknesses of the Women's Health Program?**

   Prompts: Are there any controversies surrounding the program? Are there misunderstandings about the purpose of the program? Has the program been effectively implemented and communicated?

3. **How has the Women's Health Program affected Texas citizens?**

   Prompts: Do you have evidence that women have been impacted positively? negatively? How is it viewed by the population it serves? By the population in general? How are eligible women made aware of the program? Does it have a healthy enrollment?

4. **What do you think would make the Women's Health Program more effective?**

   Prompts: Is there more that the state could be doing to increase enrollment in the program? Is there more that public health workers could do? Is there more that private health professionals could do? How should the benefits of the program be communicated to women?

5. **a) What do you see as the biggest threat to the renewal of this program in this legislative session? b) Do you have any suggestions as to the best way(s) to promote its renewal?**

   Prompts: Which are the main sources of competition for this legislation? Is the majority opinion of the program among legislators favorable or unfavorable? What is the most compelling evidence of its value to the state budget?

Interview Protocol (Public Health Informant)

The Texas Women's Health Program (WHP) was created in 2005 as an experimental program, providing family planning services to low-income women. The WHP averted more than 10,000 Medicaid-paid births in 2008 alone. Now that we're entering a new legislative session, during which many social programs may be cut or reduced in size, I'd like to ask you some questions regarding your opinions on the value of the WHP.

1. **What do you see as the strengths of the Women's Health Program?**

   Prompts: Has it proven to be an effective program? Has it met its public health goals? Were its public health goals commendable? Is any other piece of program addressing the same public health issue?

2. **What do you see as the weaknesses of the Women's Health Program?**

   Prompts: Are there any controversies surrounding the program? Are there misunderstandings about the purpose of the program? Has the program been effectively implemented and communicated?

3. **How has the Women's Health Program affected Texas citizens?**

   Prompts: Do you have evidence that women have been impacted positively? negatively? How is it viewed by the population it serves? By the population in general? How are eligible women made aware of the program? Does it have a healthy enrollment?

4. **What do you think would make the Women's Health Program more effective?**

   Prompts: Is there more that the state could be doing to increase enrollment in the program? Is there more that public health workers could do? Is there more that private health professionals could do? How should the benefits of the program be communicated to women?

5. **a) What do you see as the biggest threat to the renewal of this program in this legislative session? b) Do you have any suggestions as to the best way(s) to promote its renewal?**

   Prompts: Which are the main sources of competition for this program? Is the majority opinion of the program among health workers favorable or unfavorable? What is the most compelling evidence of its value to the state budget?

Interview Protocol (Health Communications Expert)

The Texas Women's Health Program (WHP) provides family planning services to low-income women. Though it successfully averted over 10,000 Medicaid-paid births in 2008 alone, only a small percentage of women eligible for the program are actually enrolled in it. As enrollment in the program depends upon awareness among Texas women, public health communication may be a key factor to increasing enrollment. Thus, I'd like to ask you a few questions about best practices in the field of public health communication.

1. **What do you see as the strengths and weaknesses of hierarchical, social systems public health communication strategies?**

   Prompts: Do they accurately portray public health information? Do they succeed in educating the public? Do they successfully discourage harmful health behaviors/encourage healthy behaviors? Are they more successful at one or the other?

2. **What do you see as the strengths and weaknesses of direct-to-consumer public health communication strategies?**

   Prompts: Do they accurately portray public health information? Do they succeed in educating the public? Do they successfully discourage harmful health behaviors/encourage healthy behaviors? Are they more successful at one or the other?

3. **What is an example of an unsuccessful* health-related awareness campaign (*did not increase awareness or alter behaviors)? b) In your opinion, what limited its success?**

   Prompts: Was it social systems or direct-to-consumer? Who sponsored the campaign? What was its objective? What were the principal tactics employed? Who were the primary targets for messaging?

4. **a) What is an example of a successful* health-related awareness campaign (*increased awareness and altered behaviors)? b) In your opinion, what made it successful?**

   Prompts: Was it social systems or direct-to-consumer? Who sponsored the campaign? What was its objective? What were the principal tactics employed? Who were the primary targets for messaging?

5. **If you were tasked with increasing awareness of the Women's Health Program, which case studies would you keep in mind and why?**

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Vita

Mary Beth Bennett currently works for the RGK Center for Philanthropy and Community Service within the LBJ School of Public Affairs at The University of Texas at Austin. As a Program Coordinator for the Dell Social Innovation Competition, Mary Beth coordinates community events and global communications in support of student social entrepreneurship. In August 2009, Mary Beth was awarded a Graduate School Recruitment Fellowship from UT's Department of Advertising and Public Relations. Mary Beth's graduate studies in Advertising focused primarily on nonprofit communications. This thesis is the result of Mary Beth's personal interest in promoting women's reproductive health. Mary Beth has worked as a communicator in both the for-profit and non-profit sectors. During her graduate studies at the University of Texas, Mary Beth interned and volunteered at several local nonprofit organizations. For the Austin-based Texas Archive of the Moving Image, she wrote and designed promotional materials for statewide distribution. In fall 2009, while a member of the External Affairs Committee of the Austin Museum Partnership, Mary Beth helped to plan and execute a citywide passport program to encourage museum visits among Austin residents. Mary Beth enjoys photography and graphic design and is an avid Francophile.

Permanent email: bennett.marybeth@gmail.com

This thesis was typed by Mary Beth Bennett.