doi: 10.1111/hex.12247

Regional media coverage influences the public's negative attitudes to policy implementation success in Sweden

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Accepted for publication
13 July 2014

Keywords: health literacy, implementation, media, patients' rights, Sweden, waiting times

Abstract

Background One central aspect of health literacy is knowledge of patients' rights. Being an important source of information about health and health care, the media may influence health literacy and act as a policy implementer.

Objective To investigate whether regional news media coverage in Sweden is linked to (i) the public's awareness and knowledge of a patient's rights policy, the *waiting-time guarantee* and (ii) the public's attitudes to how the guarantee's time limits are met, that is, implementation success.

Design and data Three types of data are used. First, a national telephone survey of the public's awareness, knowledge and attitudes; second, media coverage information from digital media monitoring; and third, official waiting-time statistics. Bivariate and multivariate regression analyses are performed with the 21 Swedish county councils/regions as a base.

Results In the county councils/regions, non-awareness ranged from 1 to 15% and knowledge from 47 to 67%. There are relatively large differences between population groups. The amount of regional media coverage shows no significant correlation to the level of awareness and knowledge. There is, however, a significant correlation to both positive and negative attitudes; the latter remains after controlling for actual waiting times.

Discussion and conclusions At the national level, the media function as a policy implementer, being the primary source of information. At the regional level, the media are part of the political communication, reporting more extensively in county councils/regions where the population holds negative views towards the achievement in implementing the guarantee. We conclude that Swedish authorities should develop its communication strategies to bridge health literacy inequalities.

Introduction

This article examines news media's role in implementing health policy, more specifically its role as an information channel between national policy-makers and the general public. This may be described in terms of political communication – an interaction and exchange of messages between policy-makers, media and the public.[1] Generally, the media is said to be agenda-setting, that is, being able to control the topics debated and addressed by the public.[2] Furthermore, as the media today is one prominent source of information when it comes to health and health care;[3,4] it potentially has great influence over *health literacy* in the population. Health literacy refers to 'the ability to obtain, process, and understand basic health information and services needed to make appropriate health decisions'.[5, p. 35] Hence, health literacy is essential for good health and to be able to navigate the health system. In this respect, mass media campaigns on health-risk behaviours, such as use of tobacco and alcohol and actions such as organ or blood donation, have been shown to produce positive changes across large populations.[6] But the influence of media can be both benign and malign. The media often choose narrow scope angles and concentrate on conflicts, while news stories are dependent on political interest in specific issues, as well as being governed by the ideological position of, for example, newspapers.[5,7]

One central aspect of health literacy is knowledge of patients' rights. Not least is this important in reducing health inequalities. Information about patients' rights policies may reach the public and patients in several ways. Patients may, for example, be made aware of such policy content in clinical settings, although it has been shown that health professionals often fail to anticipate patients' information needs.[5] Similarly, in the case of the *Swedish waiting-time guarantee* – the focus of this article – it was found in 2010 that doctors do not believe that it is their responsibility to inform patients about the waiting-time guarantee.[8] In addition, the regional authorities that are responsible for the financing and delivery of health care as well as implementing the waiting-time guarantee (the county councils/regions) have reported that they perceive the communication of the waiting-time guarantee to the public to be costly and inefficient.[9] Hence, it is relevant to ask: What role do the media play in informing the public of the waiting-time guarantee, that is, in the implementation of the reform? And, in addition: Do the media influence the public's attitudes to the waiting-time guarantee's success, that is, how well it is implemented in the 21 county councils/regions? In this article, we investigate whether regional media coverage is linked to the public's awareness, knowledge and attitudes to how well the waiting-time guarantee's time limits are met in the county councils. We test the hypothesis that the extent of media coverage of access-enhancing policies in the county councils and regions correlates with the public's awareness and knowledge of the waiting-time guarantee and with the public's attitudes.[10]

McQuail argues that although media is generally assumed to have significant effects on public opinions and behaviours, there is little agreement on the nature and extent of the assumed effects.[11] In this article, two types of effects discussed in the media research literature are investigated: cognitive and affective (behavioural, attitudinal). As explained by Potter: 'with the public, cognitions show up as public knowledge' and 'attitudes show up in public opinion polls as evaluations of public figures and issues'.[12, p. 904] In a broader perspective, this article deals with how media news coverage affects the public's level of health literacy and whether the media affect public perception of success in health policy implementation.

Policy focus – the Swedish waiting-time guarantee

Access has been described as the Swedish health-care system's Achilles' heel.[13] Accordingly, access to health care and waiting-lists have been the most visible health policy issues in print media.[14] Efforts to address the problem with long waiting times began in 1992. In 2005,

the current waiting-time limits were set, and incorporated into the Swedish Health and Medical Services Act (1982:763) in 2010. The *waiting-time guarantee* states that patients shall receive contact with primary care on the same day, be able to visit a GP within seven days, if needed, visit a specialist within 90 days, and receive treatment/operation within another 90 days. In addition, to spur the county councils/regions to reduce waiting times, from 2009, the government introduced the *queue billion* – a performance-based compensation fund of one billion SEK (~116 million EUR) per year to be shared between county councils based on their actual waiting times.[15]

The waiting-time guarantee is one of a series of recent Swedish policies empowering the patient, which traditionally has had a weak position in Sweden. However, patterns of waiting-time guarantee utilization and patient–provider information have not yet been investigated. Thus, there is a lack of understanding of the reform's impact and implementation in terms of, for example, socio-economic group, age, gender and medical need. Actually to strengthen the individual's position as intended, it is important that both the public and the patients are aware of their rights. That is, to be a conscious consumer of health care, the individual needs to know that the waiting-time guarantee exists and, generally, what it is. The extent to which the public is aware of this, and whether such awareness is influenced by the media, is investigated in the article.

Methods

Type of media

The media landscape is continuously changing and the public increasingly obtains its knowledge through the Internet.[7] Print and broadcast media today also have an online presence, and they reach both an old audience and the new; they are thus part of the online media landscape. In this article, we have investigated media coverage among print media and broadcast media online. No Swedish media of importance are missing online. The daily news feed – and not campaigns or advertisements – were investigated.

Design and data analysis

The public's *awareness, knowledge* and *attitudes* are dependent variables, measured in a national telephone survey. *Media coverage* is one of the independent variables, the source being digital media monitoring. Media coverage is investigated regarding both the waiting-time guarantee and the queue billion, as those access-enhancing measures are closely intertwined. The descriptive analysis of media coverage is limited to the years 2009–11, as the queue billion was introduced in 2009. The analysis of the correlation between awareness, knowledge and attitudes, and media coverage is carried out for the period January 2009 to October 2010, when the national telephone survey was conducted (see below). Data for awareness, knowledge and attitudes among the public, as well as media coverage, were available at county level, and thus the analyses were performed with the 21 county councils as a base. To reduce the influence of the county councils' population size, the number of regional media and their range, the extent of media coverage, was estimated as the average number of news items (mentioning the access-enhancing policies) in the county councils' three main sources reporting on the waiting-time guarantee and the queue billion. *Actual waiting times* were used as an independent variable, controlling for the media's impact on awareness, knowledge and attitudes.

Bivariate linear regression was used to analyse correlations between media coverage and public awareness, knowledge and attitudes. Multiple regression analysis was used when controlling the media coverage's impact on attitudes for actual waiting times. The level of significance was set at $P < 0.05$.

Data sources – a national telephone survey

On behalf of the National Board of Health and Welfare, Synovate, Sweden carried out a

telephone survey in 2010 (between October 26 and November 21). The purpose of the survey was to investigate the public's knowledge of and attitudes to the waiting-time guarantee. It was conducted from members of the general public aged 18 years and older. Eight thousand four hundred and forty-one persons among the public were asked to participate, resulting in 4200 interviews, with 200 in each county council/region in a random sample of households and respondents in those households. The response rate was thus about 50%. The national-level results were weighted to compensate for differences in response rates by sex, age and county council. Results presented at county council level were weighted by sex and age to represent the county council profile. The results from three questions in the survey are used in this article (Table 1).

Data sources – digital media monitoring

The analysis of media coverage of the access-enhancing policies is based on the material supplied by a media monitoring service specializing in digital media monitoring (NewsMachine AB, Stockholm, Sweden). Digital media monitoring means that information is sought on the Internet. A so-called web crawler or web spider – software that systematically and continuously browses the World Wide Web and collects the specified information – was used. The web crawler browsed the websites of Swedish print media and broadcast media, and collected information on the reporting on the two access-enhancing policies. The search profiles were: 'waiting-time guarantee OR queue billion', 'waiting-time guarantee NOT queue billion', 'queue billion NOT waiting-time guarantee', and 'waiting-time guarantee AND queue billion'. A 'report' or 'news item' means that the waiting-time guarantee or queue billion is mentioned at least one time; it ranges from short news items or references to long articles. In the statistical analysis, the search profile 'waiting-time guarantee OR queue billion' was used.

Data sources – waiting-time statistics

In Sweden, there are official statistics for three types of waiting times (www.vantetider.se). In this article, waiting times to meet a primary care physician means the proportion that received a doctor's appointment within seven days. Waiting times to consult/meet a physician within specialized health care is calculated as the number of patients waiting more than 90 days divided by the total number of patients waiting for a consultation. Waiting times for treatments/surgery within specialized health care is calculated as the number of patients waiting more than 90 days for treatment/surgery divided by the total number of patients waiting for treatment/surgery. Waiting times are calculated as a monthly average between January 2009 and September 2010.

Results

National telephone survey

A majority among the general public, 60% of the 3864 persons that answered that they had heard of the waiting-time guarantee, reported

Table 1 Questions used from the national telephone survey

	Question	Characterization
1.	Have you heard of the waiting-time guarantee? *Those who stated that they had heard of the waiting-time guarantee were given the follow-up question if they knew what it is about. The answers were 'spontaneous', i.e. the respondents were not given any alternatives to choose between*	Awareness
2.	Do you know what the waiting-time guarantee is about? *In Sweden, the name of the reform 'the care guarantee' does not connote waiting-times*	Knowledge
3.	What is your opinion about how your county council/region meets the time limits in the waiting-time guarantee?	Attitude

that they had obtained information about the guarantee through media. Nine percent stated that their information source was relatives and friends, 6% had had written information when they visited a health-care provider and 3% had searched for information on a county council website.

The survey also indicated relatively large differences between population groups in terms of awareness and knowledge. In short, familiarity with the waiting-time guarantee increases with age up to 75 years, and then declines. In the oldest age group (85 years and older), 31% are not aware of the guarantee; and of those who are aware, 29% does not know what the guarantee is about. Women have a higher level of knowledge than men, 62% compared to 53%. Those born outside the Nordic countries have a lower knowledge in general (44%), which is particularly accentuated among those born outside Europe (29%). Familiarity increases with level of education and is most pronounced among those with a university education, of whom 73% knows of the guarantee (Table 2).

Divided into county council/region level, there are also relatively large differences. This applies to the level of awareness and knowledge as well as to attitudes among the public (Table 3). The proportion of the public in the county councils that had never heard about the waiting-time guarantee ranged from 1 to 15%. The proportion of the public in the county councils that knew the guarantee is about waiting times ranged from 47 to 67%. The opinion that the county council meets the time limits in the guarantee 'rather well' ranged from 15 to 42%, and 'rather badly' from 6 to 29%.

Results – digital media monitoring

Between 2009 and 2011, Swedish media reported on the waiting-time guarantee and the queue billion 7000 times in 387 different print and broadcast online sources (Table 4). An average month counted for 194 media reports. The waiting-time guarantee was more frequently mentioned in the media compared with the queue billion; 4613 times compared to 1094 times. Online print media accounted for 73% of the media reports and online broadcast media for 14%. Over the 36 months, it is possible to see a declining time-trend in the aggregated number of media reports per month (-3.162*, $R^2 = 0.112$). A curve estimation regression shows that from a media coverage peak in November 2009 (425 reports), the decline is more accentuated, with an average decline of 9.5 reports per month over the remaining 25 months (-9.535**, $R^2 = 0.441$).

Scrutinizing the media sources, it is evident that regional media have a prominent role in covering the two access-enhancing policies. Among the top 20 broadcast media sources,

Table 2 Knowledge of the waiting-time guarantee among the Swedish public

Question: Do you know roughly what the waiting-time guarantee is about? $n = 3864$[1]
Answer: (%) waiting times in healthcare/similar

Age						Education		
18–35	36–55	56–65	66–75	76–85	86+	Elementary school	Secondary school	University
37↓	66↑	69↑	74↑	58	29↓	42↓	51↓	73↑

Gender		Place of birth				
Female	Male	Sweden	Nordic countries	Other parts of Europe	Outside Europe	↑significantly above average ↓ significantly below average
62↑	53↓	58↑	62↑	44↓	29↓	

Source: National telephone survey conducted by Synovate Sweden in October–November 2010.
[1]Those who stated that they had heard of the waiting-time guarantee were given the follow-up question if they knew what it is about. The percentages in the table refer to the share of respondents answering waiting times in health care or similar.

Table 3 Awareness, knowledge, and attitudes in the county councils/regions

Questions from the national telephone survey	Min	Max	Mean
1. *Awareness*[1]			
Never heard of the waiting-time guarantee (%)	1	15	8
2. *Knowledge*[2]			
Do you know roughly what it is about? Waiting times in healthcare (%)	47	67	57
3. *Attitude*[3]			
What is your opinion about how your county council/region meets the time-limits in the guarantee? (%) The limits are met...			
Very well	2	15	7
Rather well	15	42	28
Neither good nor bad	8	23	16
Rather badly	6	29	15
Very badly	1	15	4

The table presents the answers to questions 1–3 at county council/region level. (%) is proportion of the public. Min/max/mean presents the county council with lowest/highest/and average proportion among the public answering 1. They have never heard of the waiting-time guarantee, 2. They know roughly what it is about, and 3. The county council/region meets the time-limits in guarantee very well, rather well, neither good nor bad, rather badly, very badly.
Source: National telephone survey conducted by Synovate Sweden in October–November 2010.
[1]n = 4200, [2]n = 3864, [3]n = 2394.

regional/local media account for 16 of those. Concerning print media, 19 of the 20 top sources are regional/local media. The amount of media coverage varies considerably between the county councils/regions. The average number of reports in the county councils' three main sources in reporting on the two access-enhancing policies ranged from 8 to 77 during the investigated period. The average was 39 news items per source.

Awareness, knowledge and media coverage

When it comes to awareness and knowledge of the waiting-time guarantee, there was no significant correlation between the extent of regional news coverage and the proportion of the public that answered (i) they had heard about the guarantee or (ii) they knew it is about waiting times.

Regarding awareness, four county councils/regions diverged sharply from the expected pattern, that is, that the extent of media coverage would increase the public's awareness of the waiting-time guarantee. In the case of knowledge, two county councils different from each other regarding, for example, population size, demographic structure and health-care structure diverged from the expected pattern (Y and M, see Fig. 1). In these two county councils/regions, media coverage was extensive, above the 90th percentile, but knowledge was below average, for (M) even below the 10th percentile (statistically significant lower proportion of knowledge than the average). In these two county councils/regions, 52% respective 48% of the persons that had heard of the waiting-time guarantee knew it is about waiting times. If these two county councils are excluded, there is a correlation (0.464*) between the extent of media coverage and the public's level of knowledge of the waiting-time guarantee in the county councils.

Positive attitudes and media coverage

Those who answered that they knew what the waiting-time guarantee is about (n = 2623) were asked to consider how they thought the county council/region met the time limits in the

Table 4 Media coverage 2009–11

Search profiles	Waiting-time guarantee OR queue billion	Waiting-time guarantee NOT queue billion	Queue billion NOT waiting-time guarantee	Waiting-time guarantee AND queue billion
Total 2009–11	7000[1]	4613	1094	1293
Per month 2009–11	Maximum: 425 Minimum: 59 Average: 194			

Source: NewsMachine.
[1]Print media online: 73 %, Broadcast media online 14 %.

guarantee. The answers 'very well' or 'rather well' are regarded as a *positive attitude* to the county council's implementation. The analysis shows that there is a significant correlation between the extent of media coverage in the county councils and a positive attitude among the public in the county councils (−0.575**). Thus, there is less news coverage in county councils where the public is more positive.

Negative attitudes and media coverage

The answers 'very badly' or 'rather badly' are regarded as a *negative attitude* to the county council's implementation of the guarantee. As for the positive attitude, there is a significant correlation between the extent of media coverage in the county councils and negative attitude among the public (0.651**). More extensive news coverage correlates with a negative attitude. As reported, two county councils/regions stand out regarding the extent of news coverage. In one of them (Y), 44% of the population had a negative attitude towards the county council's achievement, a statistically significant higher proportion compared with the average. In the other county council (M), that proportion was 17% (Fig. 1).

Correlation with actual waiting times

A reasonable assumption is that public attitude to the county councils' compliance with the waiting-time guarantee is decided by the actual waiting times in the county councils/regions, not by regional media coverage. Table 5 shows the correlation between public attitudes and waiting times (1) to a primary care physician, (2) to consult/meet a physician in specialized healthcare and (3) to treatment/surgery.

The results show that there is no significant correlation between the proportion of patients that receives an appointment with a primary care physician within seven days and positive or negative attitudes. There are, however, significant correlations between waiting times to consultations within specialized health care

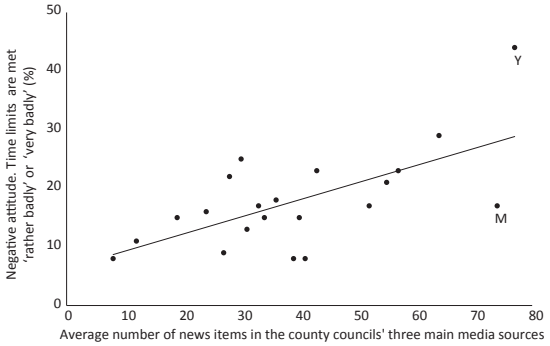

Figure 1 Negative attitudes and media coverage in the county councils.Figure 1 shows the correlation between the extent of regional media coverage and the public perception of how well the county council meets the time limits in the waiting-time guarantee. In county councils where the perception is that the county council meets the time limits 'rather badly' or 'very badly' media coverage is more extensive. In county council Y and M regional media coverage is extensive.

(between 38 and 6.5% of patients had waited more than 90 days) and surgery/treatment in specialized health care and positive (−0.745**, −0.588**) as well as negative (0.792**, 0.597**) attitudes. Furthermore, there is a correlation between waiting times to consultations within specialized health care and the amount of media coverage (0.500*).

A multivariate analysis that takes into account both waiting times (for consultations that correlated most strongly with the public's attitudes) and the amount of media coverage shows that media coverage does not correlate with positive attitudes when controlling for waiting times (−0.270). There is still a correlation between waiting times and positive attitudes when controlling for media coverage (−0.610**). However, when it comes to the public's negative attitudes, there is a correlation between media coverage and negative attitudes also when controlling for waiting times (0.340*). In controlling for media coverage, there is a significant correlation between negative attitudes and waiting times (0.622**).

Discussion

We have investigated how media news coverage affects the public's level of health literacy

Table 5 Bivariate and multivariate regressions

	Positive attitudes		Negative attitudes		
	Beta	Sig.	Beta	Sig.	Media coverage
1. Primary care physician	0.275	(0.228)	−0.301	(0.185)	
2. Consultation specialist healthcare	−0.745**	(0.000)	0.792**	(0.000)	0.500* (0.021)
Controlled for media coverage	−0.610[2]**	(0.002)	0.622[1] **	(0.000)	
3. Treatment/surgery specialist healthcare	−0.588**	(0.005)	0.597**	(0.004)	
4. Media coverage	−0.575**	(0.006)	0.651**	(0.001)	
Controlled for consultation specialist healthcare	−0.270[2]	(0.129)	0.340[1]*	(0.031)	

[1]Adjusted R^2 0.682; *Significant $P < 0.05$.
[2]Adjusted R^2 0.567; **Significant $P < 0.01$.

and whether media influences public perception of success regarding implementation of a patients' rights policy. In the following discussion, we focus on three main findings.

First, the results from the telephone survey show that the media is the public's primary source of information about the waiting-time guarantee. Sixty percent of the general public obtained its information about the guarantee through media (of any kind). This suggests that the media's role in implementing this specific patients' rights policy is extensive, and supports the proposition that the media matter throughout the policy process, not just as agenda-setter in the early stages.[16] The media is not, however, a neutral transmitter of information about government policies and actions. Strömbäck and Esser,[17] for instance, speak of a tension between the media logic and the political logic; that is, a tension between, on the one hand, what is of interest to the public and thus commercially viable and, on the other, the needs of the political system as regards information dissemination. Although the media in this case seem to have incorporated aspects of the political logic, persons in the age group of 18–35 years and 86 years and older, men, people with only primary education and those born outside Sweden or Scandinavia are still overrepresented of among the 8% that does not seem to get information from the media (or from the authorities). Thus, this important aspect of health literacy is lower among groups that generally have more extensive needs for health care, making persons from these groups less able to take active responsibility for activating the waiting-time guarantee.

Second, the results indicate that there is no significant correlation between *the extent* of *regional* media coverage and the public's level of awareness and knowledge regarding the waiting-time guarantee, although the trend in the data is in the expected direction. One possible explanation for the unconfirmed hypothesis is methodological, in that the regional media coverage calculation does not accurately capture the exposure to the specific issue. Other plausible explanations draw on the proposition that media effects depend on the interplay of media content, individual characteristics of media consumers and the context in which media consumers take part of the media, as well as characteristics of the media sources.[11] Hence, one explanation may be that the public's level of awareness and knowledge is influenced by the extent of, or its exposure to, simultaneous news reporting from national and regional media, together creating enough media attention to exceed the threshold necessary for effects to arise.[18] As to the relationship between local/regional and national media, it has been suggested that the role of the media as a source of information is more pronounced at the national level, as the impact of alternative sources of information such as personal observation and interpersonal channels are emphasized more at the local level.[19] Furthermore, media studies from Sweden suggest that the national press cover more fundamental

issues such as government reform policies, legislation, etc., while the stories of the provincial media is more event- and incident-oriented.[14] This may explain why the extent of regional media coverage correlates with the public's attitudes but not with awareness and knowledge. Another plausible explanation is that it is not the actual extent of regional media coverage that explains the level of awareness and knowledge, but rather the content of the regional media reporting and the trustworthiness of the sources. The news message in itself can be more or less relevant, attention-grabbing, interesting and comprehensible,[11] thereby influencing the potential effect in terms of public awareness and knowledge.

Nonetheless, that awareness and knowledge increases with the extent of regional coverage, although not statistically significant, suggests that regional media may affect the level of health literacy – in this case, the knowledge of patients' rights. Unexpectedly, the residents in the two county councils/regions with the most extensive regional coverage present levels of knowledge below the average. Although different in the demographic structure, both county councils/regions have relatively large proportions of groups associated with low knowledge; in county council Y, a high proportion over the age of 75 and a low proportion of highly educated, and in county council M, a high proportion of foreign born. Plausible explanations for the extensive coverage may for Y be that the extraordinary long waiting times have triggered extensive media response. For M, a restructuring in 1999 contributed to an increased media focus on health policy issues,[20] which may still persist.

Third, the results show that the extent of regional media coverage correlates to positive as well as negative attitudes to the county councils' implementation. A significant correlation between the extent of media coverage and negative attitudes remains when controlling for actual waiting times. This means that long waiting times lead to the public perception that the county council/region meets the time limits 'badly' or 'rather badly', and so does extensive media coverage. This finding supports the view that the media tend to focus more on negative aspects of phenomena, which applies in particular to the coverage of government organizations, against which the media play a critical watchdog role.[21] Similarly, an overview analysis of the news feed suggests that regional media coverage of the access-enhancing policies is linked to current debate and events in the county councils, especially regarding budgetary deficits, financial problems, savings in hospitals and reductions in staff (which is a form of *framing* – how 'the story is developed, supported and understood'[17]). Although most of the coverage may be accurate, negative coverage (scandals, failures etc.) may undermine the trust in government institutions and direct the public to expect failure.[21] Besides the actual waiting times and media coverage, the public's attitudes are likely influenced by personal experience. In Sweden, individuals with lower socio-economic status are generally less satisfied with a range of aspects of health care.[22] General trust in the county council organization and its services may also affect the public's attitudes. Among the two county councils/regions with extensive media coverage, residents in county council Y, where 44% thought waiting-time limits were met 'very badly' or 'rather badly', have significantly lower confidence (compared with the county council average) in the local health system. In county council M, where only 17% answered 'very badly' or 'rather badly', confidence and trust is significantly above the average.[23]

The fact that a correlation between the extent of regional media coverage and public awareness and knowledge could not be established, in contrast to the public's opinions on the regional authorities' achievement in terms of waiting times, means that the extent of regional media coverage could not be established to have a significant effect on cognitions, but on attitudes. This contrasts to what is often suggested when discussing the media's role; that the media influence *about what* the public expresses opinions (i.e. what people are aware of or have knowledge of) rather than

influencing the public's opinions (i.e. its attitudes).[16] This notion was first expressed by Cohen[24] who suggested that the press 'may not be successful in telling people what to think, but it is stunningly successful in telling its readers what to think about'. Media messages can affect individuals directly, invoking emotional and cognitive responses, or more indirectly by, for example, creating a debate, reinforcing or changing opinions or thoughts in an individual's social network or in society.[6] How the public is affected by media reporting on the waiting-time guarantee and the queue billion, we cannot say. However, as mentioned earlier, access to health care has generated much debate in Sweden, in national and regional politics as well as in national and regional media. Due to the reporting on long waiting times, and the fact that it is unclear who is responsible for informing the public about the guarantee, the waiting-time guarantee may be a policy where the media has had a particularly large impact as policy implementer.

Conclusions and implications

The results suggest that, on the national level, the media has functioned as a channel between national policy-makers and the public in communicating the existence of the waiting-time guarantee. At regional level, the media has had a part in the political communication of patients' rights, influencing attitudes towards implementation rather than the public′s cognitions. Neither the media nor the authorities have been able to change the fact that health literacy in this respect is relatively low (about half of those who have heard about the guarantee knows it is about waiting times) and that this is most pronounced in some of the least advantaged groups.

To overcome health literacy barriers, we suggest that Swedish authorities should take on a more active role and develop its communication strategies. There may be several ways. *Social media* is becoming increasingly important and has been shown to enhance communication between individuals and organizations.[25] Furthermore, *social marketing* may be a way forward for authorities pursuing health literacy goals. Social marketing implies a more systematic approach based on theories of behaviour change and the use of demographic, epidemiological and social data to tailor messengers to target audiences.[5] A more active role also includes efforts to understand the 'health consumer' and health information seeking patterns among different types of individuals[7,26] in trying to bridge health literacy inequalities, resulting in actual differences in health.

Conflict of interest

There are no conflict of interests.

Source of funding

The National Board of Health and Welfare in Sweden provided the funding for the study.

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