Restoring Public Legitimacy to the Nonprofit Sector: A Survey Experiment Using Descriptions of Nonprofit Ownership

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The authors argue that declining legitimacy of the nonprofit sector in American society can be traced to a limited public understanding of nonprofit enterprise. In this article, they explore the nature and correlates of ownership-related expectations in medical care. Data from a new national survey document that most Americans believe that ownership affects medical care. However, about a third of the public does not understand ownership; those who do not have decidedly less favorable attitudes toward nonprofits. Expectations for nonprofits are more positive among those who feel vulnerable to bad outcomes in medical care, but are substantially more negative among minority groups. Using an experimental design incorporated into the survey, the authors demonstrate that having additional information about ownership improves expectations about nonprofit performance but to varying degrees, depending on the content of the explanation, the particular dimension of performance, and the level of prior understanding.

Keywords: *nonprofit; for-profit; medical care; public opinion; trustworthiness*

The nonprofit sector in the United States is facing a crisis of legitimacy. In the words of one recent review essay, "A serious fault line seems to have opened in the foundation of public trust on which the entire nonprofit edifice rests"

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(Salamon, 2002, p. 19). One can identify four sets of concerns that compose this threat.

The first involves a blurring of the distinguishing role of nonprofit activities. This is sometimes referred to as "mission vagueness" (Weisbrod, 1998, p. 289). When nonprofit and for-profit organizations are delivering similar services, certain similarities of style or function are inevitable. As nonprofit service providers increasingly compete with for-profit firms, and more extensively contract with government agencies, their image has become even less distinct, as their behavior is increasingly constrained by isomorphic pressures (DiMaggio & Anheier, 1990). For example, social pressures to appear efficient in their use of funds and donations may further induce nonprofits to emulate the "businesslike practices" of their for-profit competitors (Clarke & Estes, 1992; Kramer, 2000). Under these circumstances, the public may doubt whether nonprofit organizations can maintain their historical image of delivering services in a trustworthy and reliable manner.

A second threat to legitimacy stems from concerns about inadequate accountability.

> To a large degree, nonprofits are now paying the price of their success. The nonprofit sector's claims to exist for the public good are no longer being taken on faith, and more people believe that they have a stake in the accountability of nonprofits. (Brody, 2002, p. 472)

Perceived failures of accountability have been fueled by well-publicized reports and government investigations about fraudulent practices, incompetent administration, or nonprofits that appear to spend fewer resources on the public good than the tax benefits they are receiving (Fleishman, 1999; Lipman, 2001; Sullivan & Karlin, 1999).

A third threat emerges from the public's evident difficulty in understanding the nonprofit sector. As growing numbers of nonprofit organizations become involved in the delivery of newly created services (Powell & Owens-Smith, 1998), experiment with unprecedented hybrids that combine nonprofit and for-profit arrangements (Gray, 1991; Kramer, 2000), or serve newly emerging populations or social needs (Diaz, 2002), the conventional public image of nonprofit activity can become ever more discordant with the evolving nature of the sector.

> Thanks to the pressures they are under and the agility they have shown in responding to them, American nonprofit organizations have moved well beyond the quaint Norman Rockwell stereotypes of selfless volunteers ministering to the needy and supported largely by charitable gifts. Yet popular and press images remain wedded to this older image, and far too little attention has been given to bringing popular perceptions into better alignment with the realities that now exist and justifying these realities to a skeptical citizenry and press. (Salamon, 2002, p. 48)

A fourth threat may emerge when the values that are extolled by many contemporary political leaders appear fundamentally at odds with the popular conception of nonprofit enterprise. For example, social reforms that emphasize the role of markets and individual choice may seem inconsistent with notions of public goods and collective action. "A growing confidence in the market . . . is feeding the idea that the nonprofit sector is not even the best, let alone the only, guardian of public worth" (Brody, 2002, p. 472).[1]

These perceived threats have had little impact to date on the research agenda for nonprofit scholarship. In contrast to the multitude of empirical studies of the size of the "third sector" or the comparative performance of nonprofit, for-profit, and government enterprise (Powell & Steinberg, in press), there has been remarkably little study of public expectations about nonprofit ownership. This gap in knowledge is most evident in the United States, despite the fact that the nonprofit sector plays a larger role in the allocation of vital goods and services in that country than in any other industrialized democracy (Rose-Ackerman, 1996).[2]

The article is designed to partially fill this rather gaping hole in our understanding of the nonprofit sector. We use health care as a case study of public expectations of nonprofits. Using a new, nationally representative survey, we describe Americans' attitudes about the relative performance of nonprofit and for-profit health care in terms of competence, trustworthiness, provision of public goods, and humane treatment of clients. We compare ownership-related attitudes regarding both established and new services to determine whether public attitudes depend on deeply rooted historical experiences. By estimating a set of multivariate models with these attitudes as dependent variables, we identify the extent to which variation in the perceived performance of nonprofits is related to respondents' understanding about ownership, their concerns about accountability, the personal salience of a distinctive nonprofit mission, and their embrace of alternative arrangements for institutional accountability.

Our data collection also incorporated a survey experiment in which randomly selected subsets of respondents were exposed to varied definitions of ownership, constructed to capture the marginal impact of four attributes of nonprofit ownership. This unique survey design allows us to offer the first empirically based estimates of the potential malleability of public perceptions of nonprofit enterprise and suggest some directions for enhancing its legitimacy. Our findings have implications for both academic theory and public policy.

WHAT IS KNOWN ABOUT PUBLIC EXPECTATIONS OF THE NONPROFIT SECTOR?

Although research on public attitudes toward the nonprofit sector has been limited, there is at least fragmentary evidence available regarding four ques-

tions: (a) What proportion of the American public has generally positive expectations of the nonprofit sector? (b) How much does the public understand about "ownership" as an attribute of an organization? (c) What personal characteristics are associated with more or less favorable attitudes toward the nonprofit sector? and (d) What other attitudes and perceptions are correlates (perhaps determinants) of positive attitudes toward the nonprofit sector?

PERCEPTIONS AND UNDERSTANDING OF OWNERSHIP

General impressions of third-sector performance. Evidence on public expectations has been collected in several surveys. The measures most commonly used concern (a) public confidence in the nonprofit sector, (b) whether the administrators of nonprofit organizations are seen to be mostly honest and ethical, and (c) whether nonprofit organizations are perceived as effective in pursuing their organizational missions.

The overall pattern of responses to these questions can be best described as mixed. Between 35% and 50% of the American public express high levels of confidence in charitable organizations, with some variation across services and geography (Light, 2002; Toppe & Kirsch, 2003; Wilson & Hegarty, 1997).[3] Public confidence appears to have increased moderately in the latter half of the 1990s (Salamon, 2002). A significantly larger portion of the American public (roughly 65%-70%) report nonprofit organizations to be "honest and ethical" (Keirouz, 1998). These positive assessments declined from 71% to 60% between 1990 and 1996 in response to some well-publicized scandals involving national charities (Toppe & Kirsch, 2003). They rebounded (to about 75%) in the aftermath of the September 11 terrorist attacks but by mid-2002 had fallen back to about 64% (Toppe & Kirsch, 2003). The third measure of general public attitudes involves the perceived effectiveness of nonprofit organizations.[4] Assessed in terms of change, roughly half of all Americans report that effectiveness in nonprofits is increasing over time, though this vaguely positive assessment appeared to have weakened during the 1990s (Keirouz, 1998; Salamon, 2002).

There is some disagreement in the literature about how to interpret these findings. This is in part because the sector has been described in inconsistent ways in these questions. Some surveys use "charitable organizations," others "nonprofit" or "voluntary organizations," still others use all three terms for different questions. Because each term carries different connotations ("charities" and "volunteers" evoke an image of community engagement that may not be captured by the term "nonprofit") and may trigger impressions of quite different services ("charitable" organizations call to mind homeless shelters and soup kitchens, whereas "voluntary" organizations evoke religious organizations, hospice programs, and the like), differences across surveys may have more to do with wording than with real variation in public opinion.

A second challenge is a consequence of vague response scales. For example, if a respondent expresses "some confidence" in nonprofit organizations or "some agreement" with the claim that "most charities are honest and ethical," does this signal a positive or skeptical assessment of the third sector? Reflecting this ambiguity, scholars have drawn divergent conclusions from these survey findings. Some conclude that events over the past decade "have shaken public confidence in charitable institutions" (Salamon, 2002, p. 20), whereas others see this same evidence as providing "a generally favorable impression of the sector" (Brody, 2002, p. 474).[5]

Understanding about nonprofit ownership. Past studies have explored two different aspects of public understanding. First, do most Americans understand the meaning of ownership sufficiently to provide a coherent, reasoned response to survey questions assessing the performance of nonprofit and for-profit organizations? Second, does the public understand ownership sufficiently to take it into account in making decisions about the goods and services that they personally purchase?

Questions about the relative performance of nonprofit and for-profit organizations in delivering particular services generally result in 25% to 30% of respondents being unable to answer the questions (Schlesinger, Mitchell, & Gray, in press). This uncertainty could reflect a lack of experience with the service in question rather than limited understanding of ownership. But when asked on a 1996 survey about their reaction to the general concept of "for-profit health care," 24% of the respondents indicated that they were not familiar with the term.[6] It therefore seems safe to conclude that at least a quarter of the population has too little understanding about ownership to meaningfully answer questions about the performance of the nonprofit sector.

The apparent understanding and salience of ownership for making choices among service providers varies sharply from one service to the next. In a survey of parents with children in day care, only about 14% indicated that ownership was a relevant criterion for choosing a service provider (virtually all who thought that it was favored a nonprofit center) (Ortmann & Schlesinger, 1997). By contrast, for consumers choosing among health insurance plans, 56% reported that ownership was relevant (82% of whom favored nonprofit plans) (Ortmann & Schlesinger, 1997). When asked about the relevance of ownership for choosing "health care, education, human or social services, or child care," 61% of the residents of Michigan reported that ownership was a relevant consideration (the proportion favoring nonprofits was not asked) (Wilson & Hegarty, 1997). It appears that at least 60% of the American public believes that they understand ownership sufficiently to assess when it matters for particular services.

CORRELATES OF OWNERSHIP-RELATED EXPECTATIONS

Who favors nonprofit ownership? Only a handful of studies have examined the relationship between sociodemographic characteristics and perceptions of nonprofit ownership. Those that did found that (a) women tend to have more favorable attitudes toward nonprofit ownership than men, (b) racial minorities tend to be more skeptical of the honesty and ethical performance of the nonprofit sector than Whites, (c) those with higher educational attainment tend to have more favorable impressions of nonprofit ownership, and (d) Democrats tend to be more supportive of nonprofit organizations than Republicans (Keirouz, 19998; Wilson & Hegarty, 1997). Respondents in poor health status reported less confidence in the nonprofit sector, particularly in health care (Keirouz, 1998).

What perceptions are related to favorable impressions of the nonprofit sector? Research from the United Kingdom has been the prime source for identifying perceptions related to positive expectations for nonprofit enterprise (Sargeant & Lee, 2002; Tonkiss & Passey, 1999), though a handful of American studies offer some insights. The nonprofit sector in the United Kingdom appears to be facing the same sort of challenges to its legitimacy as experienced in the United States: "Voluntary organizations are subject to what is seen as a general 'crisis' of confidence in public institutions, with only 33 percent of the respondents declaring 'a great deal' or 'quite a lot' of confidence in charities" (Tonkiss & Passey, 1999, p. 262).

Concerns about declining legitimacy stimulated a number of opinion surveys and focus groups. These suggest that British confidence in nonprofit organizations depends in part on the public's familiarity with particular organizations, in part on general attitudes toward philanthropy. But the crucial determinant of legitimacy involves the extent to which people trust these organizations to behave in a manner that is both ethical and fair.[7] Ethical behavior is seen to involve the propensity of administrators to spend resources appropriately, not diverting resources to frivolous activities or personal benefit. Fairness is seen primarily as a norm for appropriately allocating resources among beneficiaries. Trust is also affected, to a lesser extent, by perceptions of "role competence"—that is, "an understanding of the needs of beneficiaries, changes therein, and the best way to resolve these issues" (Sargeant & Lee, 2002, p. 79).

Trustworthiness thus appears to be the foundation upon which rests the public legitimacy of the nonprofit sector in the United Kingdom.[8] Researchers in the United States reached a similar conclusion by comparing survey responses to questions about "confidence" in charitable organizations with responses to questions that ask whether those organizations are "honest and ethical."

> Seeing charities as honest and ethical is a necessary but not sufficient condition for having confidence in them. . . . That is, one can consider charities to be honest and ethical without automatically having confidence in their ability to accomplish their missions. Without being viewed as honest and ethical, charities inspire little confidence. About 90 percent of those who do not consider charities honest and ethical do not have high confidence in them. (Toppe & Kirsch, 2003, p. 4)

PAST STUDIES AND THE SALIENCE OF THREATS TO NONPROFIT LEGITIMACY

Although past research helps us understand public perceptions of the nonprofit sector, it offers few insights into the relative importance of specific threats to legitimacy identified in the literature. Although we know that at least a quarter of Americans report that they do not understand ownership, we have no evidence of whether this ignorance affects perceptions of nonprofit performance. Although surveys document that 25% to 40% of Americans doubt the ethics of nonprofit administrators, no research considers whether these concerns could be ameliorated through greater accountability. Although the finding that Republicans have a more jaundiced view of nonprofits than do Democrats is consistent with market values undermining nonprofit legitimacy (Schlesinger, 2002), no studies have directly linked consumer empowerment to more negative views of nonprofit performance.

Perhaps most important, past studies neither measure nor assess the consequences of an increasingly blurred mission for the nonprofit sector. Questions framed in terms of a general confidence are ill suited to determine if the public is vague about the factors theorized to distinguish nonprofit performance. Though past surveys demonstrate that evaluations of ownership vary among individuals, none measured the personal characteristics that theory suggests are most relevant to positive public perceptions. More precisely, academics have long argued that greater trustworthiness among nonprofits would be most salient for consumers who perceive themselves to be vulnerable to exploitation (Hansmann, 1980; Hirth, 1997; Holtmann & Ullman, 1993). But none of these earlier studies even measured vulnerability, let alone connected it with ownership-related expectations.

A NEW SURVEY OF OWNERSHIP-RELATED ATTITUDES IN HEALTH CARE

To more fully explore the determinants of and threats to nonprofit legitimacy, we designed a new survey to more comprehensively measure public expectations about ownership-related performance and assess the impact of personal knowledge, attitudes, and characteristics.

HEALTH CARE AS A SETTING FOR STUDYING OWNERSHIP-RELATED EXPECTATIONS

The survey asks respondents about their expectations and experiences in health care. These goods and services have high public salience, in some cases involving matters of life and death. Health care is a field in which nonprofit and for-profit agencies compete—in some services for centuries, in others just for the past few decades (Gray & Schlesinger, 2002). In American medicine, concerns about fraud or incompetence are rampant, market policies have been advanced yet many consumers remain ill informed, and accountability has become an increasing focus of contemporary policy debates (Institute of Medicine, 2002).

Health care is, in short, a field in which the legitimacy of nonprofit activities has been frequently and publicly challenged (Bloche, 1998; Salkever & Frank, 1992; Srinivasan, 1998), leading some observers to describe the end of the 20th century as the "twilight of nonprofits" offering medical care in the United States (Van Til, 1998). Under these circumstances, popular doubts about nonprofits in health care appear to be consistent with more general concerns about the voluntary sector. Among the 13 services regularly included in the Independent Sector's national surveys of attitudes toward charitable organizations, health care ranked ninth in terms of public confidence (Toppe & Kirsch, 2003, p. 4).[9]

QUESTIONNAIRE DESIGN

Our survey collected information on respondents' expectations about ownership, their understanding of ownership, and experiences that might have enriched that understanding.

Ownership-related expectations. Respondents were asked 10 questions about the comparative performance of nonprofit versus for-profit organizations. These were divided into two sets of questions, each covering five dimensions of performance. The first set focused on health insurance plans, the second on hospitals. Hospitals have played an important role in the health care system for more than 150 years, creating deep historical roots in many communities (Stevens, 1982). Although nonprofit facilities have long dominated most local markets, for-profit hospitals have a significant presence in some locales (Norton & Staiger, 1994). By contrast, health plans in their modern incarnations (a combination of insurance and provider networks) have become familiar to the public only in the past 30 years (Hoy, Curtis, & Rice, 1991). Until the mid-1980s, this was primarily a nonprofit industry. Dramatic changes in ownership transformed the field into one dominated by large investor-owned corporations (Gray, 1999; Schlesinger, Gray, & Bradley, 1996).

For each dimension of performance, respondents were asked whether they expected the behavior to be more common in "a non-profit plan (or hospital), a for-profit plan (hospital), or are they about the same?" Following the findings of earlier studies of the attitudes that affect confidence in the nonprofit sector, we included questions that measured (a) role competence, (b) ethical behavior, (c) the provision of public goods, and (d) humane treatment.

The role competence of hospitals and health plans was assessed by their perceived ability to deliver high-quality medical care.[10] Respondents on this survey were asked whether nonprofit or for-profit hospitals were more likely "to provide high quality health care," and whether nonprofit or for-profit health plans were more likely "to provide access to high quality health care."

Ethical behavior is measured in terms of perceived trustworthiness. But "trustworthiness" is too vague a term to be asked about directly. To assess perceived linkages between ownership and trustworthiness, we instead asked about specific practices that reflect trade-offs between cost and quality of care, as well as questions related to pricing practices.[11] In the hospital module, the cost-quality trade-off was assessed by whether nonprofit or for-profit facilities were more prone to "discharge sick patients if their insurance runs out," deceptive pricing by whether nonprofits or profits were more likely to "charge for services that patients don't really need." In the health plan module, the cost-quality trade-off was examined by asking whether nonprofit or for-profit plans were more likely to "provide all necessary tests and procedures, regardless of cost." Pricing practices were assessed by the perceived risk that plans would "overcharge for health insurance."

Scholars have long argued that nonprofit firms are more likely than their for-profit counterparts to provide public goods (Kingma, 2003). Although most past academic and policy discussions have focused on the treatment of indigent patients, this standard does not translate well to health plans, who enroll only those who purchase insurance. We instead inquired about public goods related to norms of fairness.[12] We asked specifically about fairness with respect to race, an issue that has become a major concern in the American health policy over the past decade and thus should have salience for public opinion (Institute of Medicine, 2003). For both hospitals and health plans, respondents were asked whether nonprofit or for-profit organizations would be more likely to "treat patients fairly, regardless of race."

The final dimensions of organizational performance involved "humane" treatment. The notion that nonprofits are more responsive than government bureaucracies to the needs and preferences of individual clients has long been a rationale for privatizing certain government programs (Smith & Lipsky, 1993). A similar distinction might exist in comparison to large for-profit corporations (Gray & Schlesinger, 2002). To assess the extent to which ownership was linked by the public with humane treatment, respondents were asked

whether nonprofit or for-profit health plans would be more likely "to treat you like a number, rather than a person." The hospital question focused on treating "patients with the dignity and respect that they deserve."

Note that these questions were explicitly designed to intermix positive and negative attributions about health care. This was intended to disrupt set patterns of responses and encourage respondents to think more carefully about each question. (As we will see below, this question framing had some unexpected consequences for the survey experiment.) The specific questions were presented in a randomized order to avoid any ordering effects on responses. The ordering of "nonprofit" and "for-profit" in the questions was also randomized for similar reasons. To assess the salience of each of these issues to the American public, respondents were asked a set of 10 parallel questions earlier in the survey. For each aspect of hospital or health plan performance, they were asked how frequently they thought these occurred in American health care (responses were on a 4-point scale, ranging from *never* to *always*).

Understanding ownership. Respondents were told early in the interview (after completing only some screening and background questions), "Among the different kinds of health care organizations in the U.S., some are described as nonprofit." They were then asked "Are you familiar with the term *nonprofit*?"[13] and, if so, "Do you happen to know what makes a non-profit organization different from other kinds of organizations?" Those responding affirmatively to this second question were asked "What would you say the main differences are?" This sequence was designed to identify those who had some sense of what legal ownership entailed, rather than to determine whether their answers were accurate characterizations. To establish whether these assessments had an experiential base, we asked respondents whether they had worked in a nonprofit firm or in health care. Just less than 22% of our respondents had worked in nonprofit settings, 24.5% in health care settings, and 11.7% in both contexts.

The survey experiment. To determine the consequences of additional knowledge, we incorporated a survey experiment into our data collection. Respondents were randomly assigned to five different groups. In all five groups, respondents were informed that health care in the United States is provided by "a mixture of for-profit companies, non-profit organizations, and government agencies." In the control group (Group A), no additional information about ownership was provided. In the other four experimental groups, respondents were read a brief description of the meaning of nonprofit ownership. The specific wording of these four descriptions is provided in the appendix.

The most rudimentary (baseline) description was provided to those in Group B—it included only an operational definition of the nondistribution

constraint (Hansmann, 1980). This is generally regarded by scholars as the core feature of nonprofit ownership (Steinberg, 1997). The three other descriptions were designed to sequentially add information to this baseline description. In other words, the description read to Group C added one bit of information to the description provided to Group B, the description for Group D added two bits, and so forth. Consequently, one can readily assess the marginal impact of the information that was provided to each group by comparing it to the earlier groups.

Group C incorporated information about the role of the nonprofit board, argued to play an essential role in stakeholder theories of nonprofit behavior (Krashinksy, 1997). Group D introduced the possibility that profits in for-profit settings might be shared with physicians and administrators. Because public trust in medical providers depends in part on the financial incentives that they face (Miller & Horowitz, 2000), this description may make the nondistribution constraint more salient, particularly for perceptions related to trustworthiness.[14] Finally, Group E added a description of reporting requirements that have been implemented in some states. These mandate that nonprofit health care organizations document the community benefit that they are providing through their activities (Sullivan & Karlin, 1999).

The new information presented to Groups B and D can be seen as enhancing respondents' understanding about ownership. Conversely, the additional information introduced to Groups C and E is specifically oriented to concerns about accountability—the first at the local level, the second under the auspices of state authorities. The design of the experiment allows us to statistically assess whether this randomized exposure to information about ownership is related to respondents' expectations about ownership-related performance.

Hypothesized factors affecting ownership-related expectations. As discussed earlier, the literature on nonprofits suggests that some people will value trustworthy practices more than do others, based on their personal circumstances or perceptions of the health care system.

Populations that are vulnerable should pay more attention to organizational characteristics that might reduce their risks (Hansmann, 1980; Hirth, 1997). We assess vulnerability in two ways: by respondents' perceptions of the prevalence of problems in medical care and by their sense of vulnerability were they to encounter a problem. The prevalence of bad outcomes was measured using the same 10 dimensions (5 related to health plans, 5 to hospitals) of performance for which we obtained ownership-related expectations. Respondents were asked whether they expected each bad practice at none, some, most, or all of the health plans or hospitals (see Table 1). Between 37% and 82% of Americans expected problems to be frequent, depending on the aspect of medical care in question.

Personal vulnerability is measured by an index of four questions. These ask about respondents' concern about paying for treatment or obtaining good-

Table 1. Salience to the Public of Our 10 Measures of Health System Performance, National Representative Sample, 2002

Measures of Performance	*% of Respondents Reporting That Problems Are Frequently[a] Found Among*	
	Hospitals	*Health Plans*
Measures of organizational competence		
Do *not* provide access to high quality medical care[b]	36.9	66.1
Measures of ethical behavior		
Discharge sick patients if their insurance runs out	54.1	
Do *not* provide all necessary tests and procedures, regardless of cost[b]		82.1
Charge for services that patients don't really need	42.0	
Overcharge for health insurance		72.8
Measures of fair treatment		
Do *not* treat patients/enrollees fairly, regardless of race[b]	36.9	40.1
Measures of humane treatment		
Treat you like a number rather than a real person		62.3
Do *not* treat patients with the care and respect that they deserve[b]	42.1	

Source: Yale-New York Academy of Medicine Consumer Experiences Survey.
a. Identified as being practiced by "all" or "most" organizations on the questions with a negative valence, "some" or "none" on the questions with a positive valence.
b. The scales on these questions are reverse coded—they were asked in positive rather than negative terms.

quality medical care.[15] High levels of vulnerability were reported by just more than 28% of our respondents.

Vulnerability may also alter expectations, even if respondents do not consciously see themselves at risk. We therefore took into account personal characteristics that the health services literature suggests put people at risk for problematic treatment. This includes membership in ethnic and racial minorities, people with chronic health problems, and people who are socially isolated (Institute of Medicine, 2000b, 2003). We identified respondents from ethnic (6% Latino) or racial (9% Blacks, 2% Asian Americans) minorities, as well as those who reported having a disabling or chronic condition (14% of respondents). Social isolation is measured by whether the respondent indicated that she or he had adequate networks (social support) to assist in responding to problems.[16] Twenty-four percent reported limited social support.

Conversely, individuals who embrace market reforms in health care, become better informed about their treatment options, and more involved in decisions about treatment may well be less concerned with the purported trustworthiness of nonprofits because they feel less at risk (Schlesinger, 2002). We measure consumer empowerment with two variables: (a) an index, based on four items, capturing different aspects of health care decision making (79% reported high levels of knowledge),[17] and (b) an index based on respondents' understanding of grievance systems for complaining about health care problems (two thirds felt well informed).[18]

Control variables suggested by earlier survey research. The surveys cited above identify several personal characteristics that may affect attitudes toward ownership. These need to be accounted for to avoid spurious correlations with our measures of understanding, empowerment, and vulnerability. Assessments of nonprofit ownership are less favorable when respondents are men, have limited education, and (for some surveys) when they are younger or married (Keirouz, 1998; Wilson & Hegarty, 1997). Consequently, we measured and controlled for gender (34% male), educational attainment (32% high school or less), marital status (60% married or living with another adult), and age. We also included a measure of household income as a variable, because perceptions of overcharging may be related to the respondent's ability to pay his or her medical bills (18% had annual household incomes under $30,000).

DATA COLLECTION

Sampling methods. The sample population for the study included all Americans with private health insurance.[19] To ensure that respondents were making reasoned assessments about the comparative attributes of nonprofit and for-profit medical care, it was important to identify a sufficient number of respondents who (a) had some exposure to both forms of ownership and (b) had recent experience with the health care system. This led to a complex sampling design in which 1,000 of our 5,000 respondents were drawn from a simple random sample of the American population and the remaining 4,000 respondents were drawn from a random sample of 67 metropolitan statistical areas in which there were currently both nonprofit and for-profit community general hospitals, as well as a mix of ownership among the health plans that enrolled residents from that community. We also oversampled respondents who had health conditions that brought them into contact with the health care system.

Fielding the survey. The survey was completed by telephone between June 26 and September 20, 2002. A total of 5,000 respondents were interviewed, with the average length of interview being approximately 30 minutes. Response rate on the survey was 49.5%. Results on the prevalence of particular attitudes that are presented here are reweighted to be representative of the insured population in the United States.

The completed sample was representative of the adult population in the United States with respect to race, ethnicity, and geographic distinction. But compared to the adult American population, this sample (even after weighting) is younger, better educated, and with an upward skew to the distribution of income. This is a consequence of sampling only those with private insurance, which excludes much of the elderly population (covered only by Medicare or Medicaid) and a substantial portion of the low-income population, who are either uninsured or covered by Medicaid. Despite this skewed distribution, we have a sufficient number of respondents with less education

and lower income to allow us to statistically account for the influence of these characteristics on respondents' expectations about ownership in medical care.

STATISTICAL METHOD

We will present our findings in several stages. The first set of results presents the distribution of ownership-related expectations about hospitals and health plans. These distributions are reweighted to accurately represent the attitudes of the privately insured adult population in the United States. Simple statistical tests are presented to establish when these expectations are significantly different from what one would expect if ownership were unrelated to expectations about health plan or hospital performance. These provide a basic portrait of public impressions of the nonprofit sector in American medicine.

Next, we report multivariate analyses, which establish the impact of knowledge about ownership and perceptions about medical care on the magnitude and direction of these ownership-related expectations. To this end, we estimated a set of 10 regression models, 1 for each of our measures of expectations regarding nonprofit versus for-profit performance. These models statistically control for the influence of sociodemographic characteristics of respondents, along with our multiple measures of vulnerability and consumer empowerment. Because these models have a categorical dependent variable, they are estimated as ordered logistic regressions. Because the coefficients on these models are nonlinear, it is more intuitive to present the results in terms of odds ratios, rather than regression coefficients. (Complete regression results are available from the authors.)

To simplify the presentation, we will discuss the multivariate results in two stages. We first present the results regarding knowledge about nonprofit ownership and other predictors of ownership-related expectations. In the second stage, we explore the effects of informing respondents about ownership through the survey experiment. To determine whether additional information has disproportionate effects among those who were initially well or poorly informed about ownership, we estimate one final set of models that include interactions between the groups from the survey experiment and respondents' previously reported level of understanding about ownership.[20]

RESULTS: THE NATURE AND CORRELATES OF OWNERSHIP EXPECTATIONS

We first discuss the nature and predictors of ownership-related expectations, then consider the impact of providing respondents with additional information about ownership (the experiment).

Table 2. Public Attitudes Relating Ownership to Organizational Performance in Medical Care, National Representative Sample, 2002

	Hospitals			*Health Plans*		
Which Organization More Likely to	% *Nonprofit Better*	% *About the Same*	% *For-Profit Better*	% *Nonprofit Better*	% *About the Same*	% *For-Profit Better*
Measures of organizational competence						
Provide access to high-quality medical care[a]	14	57	30	20	42	38
Measures of ethical behavior						
Discharge sick patients if their insurance runs out[a]	62	30	8			
Provide all necessary tests and procedures, regardless of cost				33	37	31
Charge for services that patients don't really need[a]	62	34	4			
Overcharge for health insurance[a]				72	23	5
Measures of fair treatment						
Treat patients/enrollees fairly, regardless of race[a]	32	60	7	39	52	9
Measures of humane treatment						
Treat you like a number rather than a real person[a]				43	42	15
Treat patients with the care and respect that they deserve[a]	28	60	12			

Source: Yale-New York Academy of Medicine Consumer Experiences Survey.
a. Ownership-related expectations differ from null at a 5% confidence level.

A PORTRAIT OF OWNERSHIP-RELATED EXPECTATIONS IN MEDICAL CARE

Much of the American public expects there to be differences between nonprofit and for-profit health care (see Table 2). Painted in broad brushstrokes, Americans' portrait of the nonprofit sector foresees small gains in terms of fairness, moderate benefits in terms of more humane treatment, and strong advantages in terms of trustworthiness.[21] However, the public sees compensating advantages to for-profit ownership in terms of greater role competence; both health plans and hospitals are seen to provide higher quality care when motivated by profits.

There are several interesting nuances to these general findings. First, it is noteworthy that the pattern of ownership-related expectations appears to be similar for hospitals and health plans. This suggests that the long-standing historical connections with the community that are common among hospitals are not necessary for the public to expect ownership patterns in organizational behavior. Alternatively, the public's historical experience with hospitals may

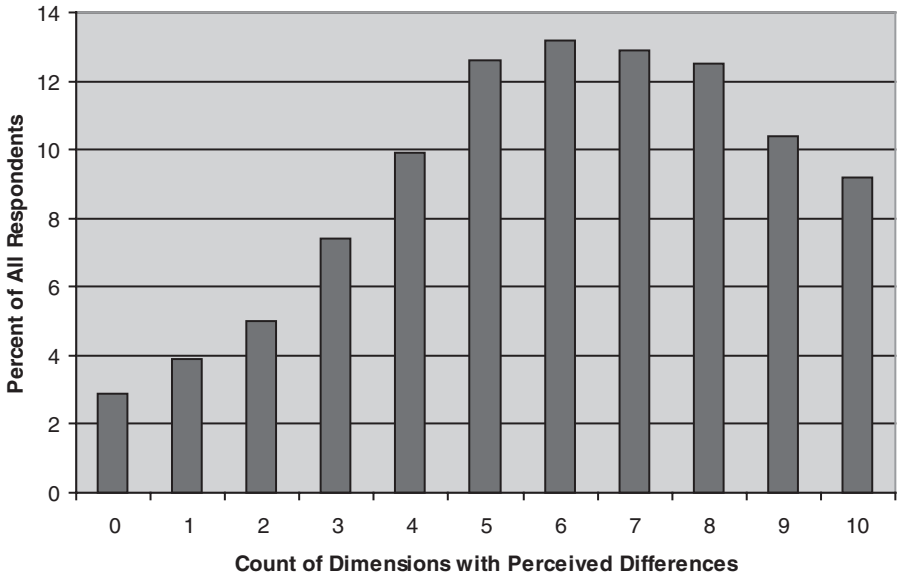

Figure 1. Prevalence of Perceived Ownership-Related Differences, 2002 (Health Plans and Hospitals)

be coloring attitudes toward health plans, more recent entrants into American medicine.[22]

A second noteworthy finding involves the number of Americans who expect that ownership matters for at least *some* aspects of organizational behavior. As Table 2 reveals, more ownership-related differences are expected among health plans than hospitals, particularly with respect to ethical behavior. What cannot be discerned from Table 2, however, is whether the same respondents are consistently expecting ownership to matter across these 10 dimensions. To explore this issue, we tabulated the number of domains in which each respondent expected ownership to matter and whether these differences favored nonprofit or for-profit ownership.

The results (see Figure 1) are quite striking. Less than 3% of all respondents expected ownership to be irrelevant for all 10 dimensions. Conversely, 88% of the American public expects ownership to matter in 3 or more dimensions of performance. More than half of the public expected there to be ownership-related differences in 6 or more of our 10 dimensions of performance. And these ownership-related expectations disproportionately favor nonprofits: Only 12.6% of all Americans see for-profit ownership as having a net benefit (more positive than negative outcomes) for health plans, and only 7.8% for hospitals (not reported in the tables).

THE IMPACT OF KNOWLEDGE ON OWNERSHIP-RELATED EXPECTATIONS OF PERFORMANCE

Recall that we measure knowledge in three ways in this study: (a) based on respondents' ability to define what makes nonprofit organizations different from their for-profit counterparts, (b) based on their exposure to nonprofit or health care settings as employees, and (c) based on the definitions of ownership that we provided to them in the survey experiment.

Knowledge of ownership. When initially asked, about 12% of our respondents admitted that they did not know what the term "nonprofit" meant.[23] Another 19% to 20% of respondents were unable to offer a coherent definition of nonprofit ownership (even applying a rather low standard of coherence). All told, then, about a third of the public lacks an even minimal understanding of ownership. An understanding of ownership was more common among Americans with higher educational attainment or with work experience in either the nonprofit or health care sectors.[24]

The impact of knowledge on ownership-related expectations. To assess how knowledge was related to expectations, we included these measures (ability to define ownership and our two measures of exposure to nonprofits) in the logistic regression models, with expectations as the dependent variables. Other perceptions and sociodemographic characteristics were also included in these models (their impact on expectations of ownership is discussed next). For purposes of comparison, we present the findings in two tables, the first involving the six expectations that were characterized in positive terms (see Table 3), the second in terms of the four expectations that were characterized in negative terms (see Table 4). The results are reported here in terms of odds ratios, for reasons discussed earlier in the article.

Because this reporting format is a bit unusual, it may be useful to walk through a couple of examples. Consider first a positively framed question (see Table 3). When asked whether nonprofit or for-profit hospitals were more likely to offer high-quality care (second column of results), those who could define nonprofit ownership were *less* likely (87% as likely) to view nonprofits favorably in this dimension compared to those who did not understand ownership. But those who had worked in health care were 17% *more* likely to see nonprofits as having a quality advantage compared to those without this experience. In other words, understanding ownership is associated with a less favorable impression of nonprofits, but working in health care a more favorable image. For the negative outcomes, the normative implications are reversed. Consider expectations for plans overcharging (first column of results in Table 4). In this case, those who understood nonprofit ownership were 20% less likely to see nonprofit plans as overcharging compared to respondents who did not understand ownership. Expecting negative out-

Table 3. The Relationship of Knowledge Measures to Ownership-Related Expectations: Outcomes Defined In Terms of Positive Performance

	Odds Ratio That Public Expects Nonprofit Ownership to Increase Chances That					
Respondent Characteristic[a]	*Health Plan Offers High-Quality Care*	*Hospital Offers High-Quality Treatment*	*Health Plan Covers Tests and Procedures*	*Health Plan Fair to All Races*	*Hospital Fair to All Races*	*Hospital Shows Care and Respect to Patients*
Understanding nonprofit ownership						
Can define "nonprofit"	0.94	0.87*	1.16*	1.20**	1.20**	1.06
Worked in nonprofit	1.16*	1.38***	1.15*	1.20**	1.32***	1.20**
Worked in health care	1.23***	1.17*	0.99	0.92	1.02	1.05
Educating about nonprofit ownership: The survey experiment						
Group B: Can't share profits	1.38***	1.03	1.24**	1.21*	1.17	1.08
Group C: Can't share profits + local board of directors	0.95	0.89	1.08	1.16	1.18	0.92
Group D: Can' share profits + local board of directors + doctors can't share profits	1.10	1.04	1.15	1.27**	1.20*	1.27**
Group E: Can't share profits + local board of directors + doctors can't share profits + report community benefits	1.07	1.03	1.04	1.29**	1.05	1.18

a. Marginal effect for each measure, controlling for measures of vulnerability, consumer empowerment, other measures of knowledge, and sociodemographic factors.
*Statistically significant at a 10% confidence level. **Statistically significant at a 5% confidence level. ***Statistically significant at a 1% confidence level.

Table 4. The Relationship of Knowledge Measures to Ownership-Related Expectations: Outcomes Defined in Terms of Negative Performance

	Odds Ratio That Public Expects Nonprofit Ownership to Increase Chances That			
Respondent Characteristic[a]	*Health Plans Overcharge for Coverage*	*Hospitals Charge for Services Not Really Needed*	*Hospitals Discharge Patients When Their Insurance Runs Out*	*Health Plans Treat Enrollees Like a Number, Not a Person*
Understanding nonprofit ownership				
Can define "nonprofit"	0.80**	0.90	0.82**	0.91
Worked in nonprofit	1.19*	1.21**	1.10	1.04
Worked in health care	1.12	1.23**	1.21**	0.99
Educating about nonprofit ownership: The survey experiment				
Group B: Can't share profits	1.06	0.88	1.10	1.06
Group C: Can't share profits + local board of directors	1.09	0.96	0.99	1.04
Group D: Can' share profits + local board of directors + doctors can't share profits	0.77**	0.74**	0.85	0.97
Group E: Can't share profits + local board of directors + doctors can't share profits + report community benefits	0.85	0.72***	1.05	0.98

a. Marginal effect for each measure, controlling for measures of vulnerability, consumer empowerment, other measures of knowledge, and sociodemographic factors.
*Statistically significant at a 10% confidence level. **Statistically significant at a 5% confidence level. ***Statistically significant at a 1% confidence level.

comes to be less likely meant that these respondents had a more favorable view of nonprofit ownership.

Looking across all 10 dimensions of performance, respondents who could explain nonprofit ownership were typically more favorable toward nonprofits in their assessment of performance than were respondents who could not offer an explanation. These effects were most pronounced for perceptions of fair treatment with respect to race (see Table 3) and trustworthy behavior (e.g., overcharging patients or discharging patients who had exhausted their insurance, see Table 4). By contrast, understanding ownership was associated with a *less favorable* perception of the relative quality of nonprofit health care. Those who had worked in nonprofit settings saw a comparative advantage for nonprofits in every dimension of positive performance (see Table 3), but also saw nonprofits as more frequently overcharging patients (see Table 4). Work experience in health care led to mixed impressions of the comparative performance of nonprofit and for-profit ownership.

PERCEPTIONS AND PERSONAL CHARACTERISTICS RELATED TO OWNERSHIP EXPECTATIONS

The estimated relationships between perceptions, personal characteristics, and expectations of ownership are presented in the next two tables, again separating positive (see Table 5) and negative (see Table 6) characterizations of organizational performance. These results control for respondents' understanding of nonprofit ownership, prior work exposure, and the description of nonprofit ownership that was conveyed through the survey experiment.

Consumer empowerment. Our measures of empowerment are not consistently linked with ownership-related expectations in the six positive dimensions of performance (see Table 5), though informed consumers are less likely to see nonprofits as having an advantage in terms of fair treatment. But empowerment does not appear to alter ownership-related expectations of quality. More substantial and consistent effects appear for the negative dimensions of performance (see Table 6). Empowered consumers see nonprofit health plans and hospitals as having more problematic practices, particularly in terms of trustworthiness.

Perceived vulnerability. Conversely, respondents who see themselves as vulnerable—particularly those who believe that American medicine is beset by problems—are more likely to see nonprofit hospitals and health plans as preferable to their for-profit counterparts. The pattern in this case is more consistent for the *positive* dimensions of performance than for the negative. But here again, our measures of organizational competence (quality of care) appear to be an exception to this pattern. The only statistically significant relationship between perceived vulnerability and quality suggests that patients

Table 5. The Relationship of Perceptions and Sociodemographic Characteristics to Ownership-Related Expectations: Outcomes Defined in Terms of Positive Performance

	Odds Ratio That Public Expects Nonprofit Ownership to Increase Chances That					
Respondent Characteristic[a]	*Health Plan Offers High-Quality Care*	*Hospital Offers High-Quality Treatment*	*Health Plan Covers Tests and Procedures*	*Health Plan Fair to All Races*	*Hospital Fair to All Races*	*Hospital Shows Care and Respect to Patients*
Measures of consumer empowerment						
Has consumer information	1.31	1.29	1.15	0.92	1.09	0.77
Aware of grievance mechanisms	0.91	1.12	0.76**	0.72***	0.78**	0.85
Measures of perceived vulnerability						
Worried about problems in own care	0.91	0.77**	0.96	1.23*	1.30**	1.18
Sees frequent problems in health system	1.08	0.94	1.16**	1.23***	1.61***	1.39***
Measures of unacknowledged vulnerability						
Disabled/chronic illness	0.97	0.90	0.98	0.98	1.10	1.02
African American	0.73***	0.81**	0.82**	0.73***	0.81**	0.85
Asian American	0.47***	0.39***	0.79	0.89	0.73	0.41***
Latino	0.84*	0.74***	0.91	0.70**	0.80*	0.80**
Low social support	1.16	1.02	0.84*	0.97	1.00	0.84
Sociodemographic characteristics						
Educational attainment	1.04	0.99	1.05**	1.01	1.05*	1.03
Household income	0.97	1.01	1.01	0.97	0.99	0.98
Female	0.94	1.13*	0.84***	1.02	1.05	0.96
Married	1.11	1.03	0.97	1.01	0.99	0.92

a. Marginal effect for each measure, controlling for measures of vulnerability, consumer empowerment, knowledge about ownership, and sociodemographic factors.
*Statistically significant at a 10% confidence level. **Statistically significant at a 5% confidence level. ***Statistically significant at a 1% confidence level.

Table 6. The Relationship of Perceptions and Sociodemographic Characteristics to Ownership-Related Expectations: Outcomes Defined in Terms of Negative Performance

	Odds Ratio That Public Expects Nonprofit Ownership to Increase Chances That			
Respondent Characteristic[a]	*Health Plans Overcharge for Coverage*	*Hospitals Charge for Services Not Really Needed*	*Hospitals Discharge Patients When Their Insurance Runs Out*	*Health Plans Treat Enrollees Like a Number, Not a Person*
Measures of consumer empowerment				
Has consumer information	1.78***	1.49**	0.88	0.82
Aware of grievance mechanisms	1.28*	1.45***	1.44***	1.41***
Measures of perceived vulnerability				
Worried about problems in own care	1.11	0.87	1.06	1.12
Sees frequent problems in health system	0.83***	1.16***	0.87	0.92**
Measures of unacknowledged vulnerability				
Disabled/chronic illness	1.09	0.98	1.04	1.20**
African American	1.26**	1.07	1.28**	1.10
Asian American	0.31***	0.75	1.41	0.93
Latino	1.31**	1.04	1.21*	1.12
Low social support	1.12	0.92	1.14	1.03
Sociodemographic characteristics				
Educational attainment	0.95*	0.99	0.92***	1.01
Household income	0.99	0.98	0.99	1.00
Female	0.77***	0.80****	1.09	0.86**
Married	0.98	1.02	1.08	0.98

a. Marginal effect for each measure, controlling for measures of vulnerability, consumer empowerment, knowledge about ownership, and sociodemographic factors.
*Statistically significant at a 10% confidence level. **Statistically significant at a 5% confidence level. ***Statistically significant at a 1% confidence level.

who see themselves as most personally vulnerable think that nonprofit hospitals are *less* likely to provide high-quality care.

Unacknowledged vulnerability. But a very different pattern emerges among groups of respondents who are likely to experience greater problems with their medical care. These respondents are consistently less likely to see nonprofits performing well in the six positive dimensions of practice. Although the results are a bit less consistent for the negative dimensions, the statistically significant relationships generally have nonprofits being more likely to engage in these four problematic practices.

The results are most striking for ethnic and racial minorities. Previous state-level surveys had determined that African Americans have more critical assessments of the nonprofit sector, a pattern that is replicated for all 10 of our outcome measures (7 of which are statistically significant). Our findings suggest that the same concerns are shared by members of other minority groups. Latinos also had more negative assessments of nonprofits for all 10 performance measures (again statistically significant differences existed for 7 of the 10 expectations). Asian Americans were also more skeptical of nonprofit performance involving positive outcomes (statistically significant for 3 of the 6 measures), though this pattern did not hold for the negative outcomes.

Other sociodemographic characteristics. Two of the four remaining sociodemographic characteristics showed a consistent connection to expectations of ownership. For the most part, more educated respondents and women tended to have more favorable assessments of nonprofit performance, though the effect of gender was particularly pronounced for the negative aspects of organizational behavior. Neither household income nor marital status appeared to be related to expectations of ownership in medical settings.

ALTERING EXPECTATIONS WITH ADDITIONAL INFORMATION: THE SURVEY EXPERIMENT

The consequences of explaining ownership. Recall that our survey experiment offered four different explanations of nonprofit ownership to random subsamples of respondents.[25] Simply hearing a definition of ownership in terms of the nondistribution constraint (Group B) was associated with consistently more favorable assessments in all six dimensions of positive performance (statistically significant for three of the six, as evident in Table 3). But this explanation had no effect on expectations for the four negative outcomes (see Table 4). Introducing a local board of directors (Group C) had no measurable impact on expectations for any of our measures of performance and actually seemed to adulterate some of the effects found for the simpler explanation in terms of profit sharing.

The most powerful effects in the survey experiment emerged from the descriptions that focused on not allowing profit sharing by physicians and administrators (Group D). Respondents who were presented with this explanation of nonprofit ownership had consistently more favorable impressions of nonprofits' performance relative to their for-profit counterparts. This pattern held for all 10 measures of performance and was statistically significant for 5, affecting expectations related to public goods, trustworthiness, and humane treatment. However, this explanation did not alter ownership expectations related to quality of care.

Adding the mandatory reporting of community benefits to the definition of nonprofit ownership (Group E) did not appear to bolster expectations for nonprofit health care. Here again, in a number of the dimensions in which the nonprofit expectations were enhanced in Group D, these differences largely disappeared for this more complex explanation (see, e.g., fairness in hospital care or overcharging enrollees in health plans). For a few aspects of performance, the more positive assessments of nonprofit performance persisted for this final group (e.g., racial fairness in health plans, fraudulent charges in hospitals).

The interaction of prior knowledge and additional explanations of ownership. The findings in Tables 3 and 4 suggest that Americans who better understand ownership tend to have more positive expectations for nonprofit health care and that explaining ownership in terms of the nondistribution constraint enhances the perceived ownership-related differences. To what extent do these two informational effects interact? Does providing respondents with additional information have the largest effects on the expectations of those who were previously least informed about ownership, or those who already had some sense of what ownership meant?

To explore this question, we estimated a second set of 10 models, in this case interacting the variable measuring prior understanding of ownership with the subgroups in the survey experiment. The results are presented for positive outcomes in Table 7 and for negative outcomes in Table 8 (it is at this point that the reason for differentiating among the two sets of outcomes will become evident). As before, the results are drawn from logistic regressions that control for measures of vulnerability, empowerment, and sociodemographic characteristics.

The results are quite striking. Consider first the six positive outcomes (see Table 7). Explaining ownership to those who previously did not understand the term had little impact on expectations in these positive dimensions. Indeed, explanations of ownership were more likely to *decrease* expectations of positive nonprofit performance. By contrast, additional explanations to those who already had some understanding of ownership tended to increase the perceived advantages of nonprofit ownership. Explanations that focused on a simple description of the nondistribution constraint (Group B) had the most consistent effects for health plan expectations. For hospitals, the effects of

Table 7. The Interaction of Prior Knowledge and Additional Explanations About Ownership on Expectations: Outcomes Defined in Terms of Positive Performance

Respondent Characteristic[a]	*Odds Ratio That Public Expects Nonprofit Ownership to Increase Chances That*					
	Health Plan Offers High-Quality Care	*Hospital Offers High-Quality Treatment*	*Health Plan Covers Tests and Procedures*	*Health Plan Fair to All Races*	*Hospital Fair to All Races*	*Hospital Shows Care and Respect to Patients*
Educating about nonprofit ownership for low levels of prior understanding						
Group B: Can't share profits	1.65**	1.32	1.22	0.96	0.88	0.83
Group C: Can't share profits + local board of directors	1.30	0.98	1.17	0.74	0.68*	0.92
Group D: Can' share profits + local board of directors + doctors can't share profits	1.11	0.74	0.72	0.60**	0.67*	0.92
Group E: Can't share profits + local board of directors + doctors can't share profits + report community benefits	1.15	1.02	1.31	1.09	1.03	0.74
Educating about nonprofit ownership for higher levels of prior understanding						
Group B: Can't share profits	1.26**	0.98	1.35**	1.20 *	1.20*	1.02
Group C: Can't share profits + local board of directors	0.90	0.90	1.09	1.26**	1.28**	0.96
Group D: Can' share profits + local board of directors + doctors can't share profits	1.05	0.97	1.15	1.25**	1.29***	1.27**
Group E: Can't share profits + local board of directors + doctors can't share profits + report community benefits	0.92	0.94	1.03	1.23**	1.05	1.11

a. Marginal effect for each measure, controlling for other measures of vulnerability, empowerment, knowledge, and sociodemographic factors.
*Statistically significant at a 10% confidence level. **Statistically significant at a 5% confidence level. ***Statistically significant at a 1% confidence level.

Table 8. The Interaction of Prior Knowledge and Additional Explanations About Ownership on Expectations: Outcomes Defined in Terms of Negative Performance

	Odds Ratio That Public Expects Nonprofit Ownership to Increase Chances That			
Respondent Characteristic[a]	*Health Plans Overcharge for Coverage*	*Hospitals Charge for Services Not Really Needed*	*Hospitals Discharge Patients When Their Insurance Runs Out*	*Health Plans Treat Enrollees Like a Number, Not a Person*
Educating about nonprofit ownership for low levels of prior understanding				
Group B: Can't share profits	1.91***	1.23	1.66**	1.29
Group C: Can't share profits + local board of directors	2.16***	2.07***	1.73***	1.41*
Group D: Can' share profits + local board of directors + doctors can't share profits	1.64**	1.91***	2.32***	1.28
Group E: Can't share profits + local board of directors + doctors can't share profits + report community benefits	0.51**	0.50***	0.53**	0.68*
Educating about nonprofit ownership for high levels of prior understanding				
Group B: Can't share profits	0.95	0.86	0.96	1.08
Group C: Can't share profits + local board of directors	0.93	0.96	0.82*	0.99
Group D: Can' share profits + local board of directors + doctors can't share profits	0.65***	0.71***	0.74***	0.92
Group E: Can't share profits + local board of directors + doctors can't share profits + report community benefits	0.73***	0.72****	0.89	0.94

a. Marginal effect for each measure, controlling for other measures of vulnerability, empowerment, knowledge, and sociodemographic factors.
*Statistically significant at a 10% confidence level. **Statistically significant at a 5% confidence level. ***Statistically significant at a 1% confidence level.

explaining ownership were strongest when the descriptions involved profit sharing with physicians and hospital administrators (Group D). Adding community benefit reporting seemed only to adulterate the effects of the experimental exposures.

The results for the four negative outcomes are even more dramatic, albeit also more challenging to interpret (see Table 8). Among those who had not previously understood ownership, three of the four explanations of nonprofit ownership led to dramatically more *negative* expectations for nonprofit health care—that is, the perceived risk of bad practices in nonprofit settings was much higher for those who had ownership explained to them than those who did not. The notable exception to this pattern involves the explanation of accountability under community benefit laws (Group E). The respondents saw nonprofits as being much less likely to engage in problematic practices.

Once again, explanations of ownership had a more positive effect (in this case, reduced expectations that nonprofits would engage in negative behaviors) for respondents who had previously understood what ownership implied. But for these more informed respondents, neither the simple nondistribution constraint nor the presence of a local board of directors had much impact on ownership-related expectations involving negative outcomes. When ownership is described as limiting profit sharing for both administrators and physicians, however, respondents were much less likely to expect problems in nonprofit settings (Group D). This effect persisted, but was somewhat diminished when community benefit accountability was added to the explanation (Group E).

DISCUSSION AND CONCLUSION

Americans have distinct impressions of the comparative strengths of nonprofit and for-profit health care. We established in this study that (a) most Americans (88%) expect there to be ownership-related differences for three or more aspects of medical care; (b) these differences, on balance, favor nonprofit health plans and hospitals over their for-profit counterparts; (c) ownership-related differences are expected to be most pronounced for trustworthiness (seen as a domain of nonprofit advantage), least so for role competence (as measured by quality of care, perceived to be a domain of for-profit advantage); and (d) nonprofits are seen as having a moderate advantage in offering humane treatment and public goods, such as fair treatment. Ownership-related differences were slightly more pronounced for recently established services (health plans) compared to those with deep community roots (hospitals). But there is considerable variation among respondents in terms of their perceptions of nonprofit health care.

Our multivariate analyses help us understand the sources of this variation. In terms of the four "threats" to nonprofit legitimacy described in the introduction, we find evidence that at least three of these factors pose serious con-

cerns for nonprofit medical care. The most striking involves the public's failure to understand ownership. A third of all Americans can make little sense of the term "nonprofit." They have consistently more negative impressions of the relative performance of nonprofit health care. Efforts to explain ownership to this group were more likely to be counterproductive than constructive, even though the same explanations enhanced nonprofit legitimacy among those who previously had a better understanding of ownership.

Our findings also reinforce the concern that market-oriented reforms may undermine the legitimacy of the nonprofit sector. Respondents who saw themselves as empowered consumers had persistently more negative impressions of the performance of nonprofit health care relative to for-profit hospitals and health plans. Although we could less directly measure the effects of concerns about nonprofit accountability, the findings from the survey experiment suggest that doubts about accountability may be particularly pronounced among Americans who do not really understand ownership. It was this group that responded most favorably when told about state accountability requirements, particularly for concerns about trustworthiness. This suggests that their previous doubts about nonprofits had been driven in part by concerns about accountability.

Implications for the threat of mission vagueness are more mixed. On one hand, the public seems to have a reasonably well-defined sense of nonprofits as being less competent (that is, lower quality), but somewhat more humane and considerably more trustworthy. On the other hand, a majority of Americans do not see nonprofits as superior to for-profits in terms of fair or humane treatment of patients. The distinctions that do exist, moreover, are more pronounced among respondents who saw themselves as most vulnerable—those who saw health care having frequent problems and saw their own care as threatened by those problems. This identifies one ongoing trend that may actually bolster nonprofit legitimacy. As the public becomes more aware of errors in medicine, questionable billing practices, and the like (Kaiser Family Foundation, 2003), they are more likely to see nonprofits as a bulwark against those threats.

On the other hand, our study did reveal one substantial threat to nonprofit legitimacy that has not been recognized in the literature. Racial and ethnic minorities have consistently more negative assessments of nonprofits than do otherwise comparable White, non-Hispanic respondents. Because the proportion of racial and ethnic minorities in the United States is growing over time, positive perceptions of nonprofit health care may become more attenuated in the future.

When interpreting the findings from the regression models, it is important to recognize that the odds ratios associated with particular respondent characteristics capture the *marginal change* in expectations associated with that characteristic. The net impact on the perceptions of the nonprofit sector depends on the baseline expectations for the general population. For example, the results in Tables 5 and 6 suggest that African Americans generally have a more

negative view of nonprofits (or more positive assessment of for-profits) than White respondents. But that does not mean that they see nonprofit health care as less trustworthy than for-profit treatment, only that their perceptions of that performance are less positive than for Whites, because the baseline level of most measures of trust in nonprofits is quite high for all Americans. Conversely, when baseline attitudes are relatively neutral with respect to ownership (e.g., trust in plans to provide all necessary tests), the regression results suggest that African Americans actually trust nonprofit health plans less than they do for-profit plans.

All of our findings need to be interpreted in light of certain methodological limitations. First, our measures were collected at a single point in time, so it is impossible to determine how stable public expectations are or how they are influenced by contemporary events.[26] Similarly, although our findings suggest that ownership-related expectations can be changed with additional information, we cannot establish whether these changes persist over time. Second, because we sought to measure the expectations about health plans, we interviewed only people with insurance. Our sample therefore has higher socioeconomic status than the general population, though we have a sufficient number of respondents with low income and limited education to control for their impact on expectations related to ownership.

Other limitations involve issues of measurement. Our measures of expectations covered only five dimensions; others may also be relevant. For example, it would be useful in future research to determine the extent to which the public sees nonprofit health care organizations as having a comparative advantage in terms of treating indigent patients, engaging in medical research, or other activities that provide community benefits.[27] And our measures of ownership-related expectations are relatively crude—defined by whether nonprofit or for-profit providers are thought to engage in a particular behavior more frequently. This tells us nothing about the magnitude of the perceived difference. As a result, we cannot discern whether the reported differences are sufficiently large to affect consumer behaviors, such as selection of a hospital or health plan. Finally, the relationship between public expectations of ownership and actual experiences is uncertain, though one would expect that perceptions of ownership will tend over time to become congruent with typical experiences.

Each of these limitations could and should be addressed by additional research. But even viewed as preliminary evidence, our findings suggest a number of possible implications for leaders of the nonprofit sector, for public policy, and for academic research.

Recent declines in the public legitimacy of the nonprofit sector have been laid on the doorstep of its leaders and advocates. This is an indictment they endorse. A recent poll of senior officials from the country's most prominent nonprofits found that a majority faulted themselves for their inability to address concerns about accountability or to maintain the public's trust (Dundjerski, 1999). Our findings, particularly those related to the survey

experiment, suggest some promising avenues for restoring public legitimacy to the nonprofit sector. Simply explaining the meaning of ownership to the public has the potential for enhancing expectations of nonprofit performance.

But our findings also suggest caution. The nature of these explanations needs to be matched to the public's current understanding of ownership. More precisely, messages to segments of the public less informed about ownership need to emphasize accountability, whereas messages directed to those who already understand ownership should emphasize aspects of the nondistribution constraint that affect clinical decisions. If this matching of message to audience is not effective, the consequences may well be counterproductive, further eroding trust in nonprofit enterprise.

On the policy front, it is clear that proposals to eliminate tax advantages for nonprofit health care cannot be justified (as some proponents have asserted in the past) on the grounds that Americans no longer care about ownership status. Not all Americans care. And among those that do, not all care equally about every dimension of performance. But most Americans believe that ownership-related differences exist. And those who are most vulnerable place the greatest trust in nonprofit ownership. Whether these expectations are consistent with performance or are sufficiently large to merit public support for nonprofit medical care is a matter of continued debate (Bloche, 1998; Gray, 1997).

A second policy-relevant matter involves the practices that policies are intended to promote. With growing concerns about accountability for nonprofit health care providers, a number of states have enacted community-benefit laws designed to increase that accountability (Gray & Schlesinger, 2002). But these policies focus primarily on ownership-related differences in the treatment of uninsured patients or other services to the local community (Pauly, 1996). Issues of trustworthiness, fairness, or humane treatment rarely enter into this policy discourse. Our findings suggest that policy makers ought to pay more attention to these dimensions of performance.

Turning to implications for future study of the nonprofit sector, our findings are relevant to a number of theories explaining the role of nonprofits in modern society (Anheier & Ben-Ner, 2003). The longest standing rationales for a nonprofit sector emphasize either the provision of public goods (Kingma, 2003) or a propensity for more trustworthy behavior (Ortmann & Schlesinger, 1997). Past empirical studies of public goods provided by nonprofits have focused more on the provision of services to the poor than on the sorts of public goods embodied in fair treatment. This latter aspect of organizational performance clearly is of concern to many Americans: Roughly a third expect unfair treatment to be frequent in medical care. A substantial number (40%-50%) of respondents expect that ownership is related to fairness. Whether these expectations accurately capture health care delivery requires additional study.[28]

Theories that link the nonprofit sector to trustworthiness suggest that the most vulnerable consumers choose nonprofit settings. Our study provides evidence that consumers *who see themselves as vulnerable* do care more about nonprofit ownership, though groups that experience mistreatment but are not aware of that risk have more jaundiced views of nonprofit health care. And not all measures of trustworthiness are seen by the public to be equally related to ownership. Further research must establish if these expectations translate into choices between nonprofit and for-profit health plans or hospitals.

Perhaps the most intriguing directions for future research involve two aspects of our findings that initially appear quite unrelated to one another: (a) The nature and correlates of ownership-related expectations seem to be quite different for positive and negative outcomes, and (b) more expansive explanations in the survey experiment often produced less change in expectations than did simple explanations, even though the more elaborate explanations contained the simpler ones within them. Both of these patterns initially seem puzzling. If nonprofits are seen as more socially responsible, why should this play out differently for positive and negative outcomes? If simple explanations change expectations, why do these effects not persist even when something is added to that explanation (because the respondent could simply ignore the additions if they seem confusing or irrelevant).

We believe that both patterns can be explained by theories of bounded rationality—models of how people make sense of complex situations and make choices among uncertain alternatives. (In social psychology, this perspective is captured in work related to prospect theory; in economics, by the branch of microtheory labeled behavioral economics.) This line of scholarship claims that in many situations and most choices, people lack the time and energy to carefully think through all the details. Consequently, they must make assessments and decisions without complete information.

The comparison of nonprofit and for-profit health care can be seen as analogous to the choice between two alternatives, one better known (for most people, nonprofit health care), one less familiar. Past research has shown that people's choices among uncertain alternatives depends on whether the outcomes are framed in positive or negative terms—people tend to favor more risky choices under positive framing, more certain alternatives when the outcomes are framed in negative terms (Rothman & Salovey, 1997). It remains to be seen whether framing effects can explain the patterns in our findings about when the perceptions and personal characteristics alter ownership expectations for positive versus negative outcomes.

This same line of research has shown that providing people with more choices does not always make them better off. More specifically, there is evidence that given a sufficiently large number of alternatives, people will make no choices at all, so overwhelmed by the range of options that they cannot determine how to choose any alternative. Something similar may be occurring

with the survey experiment. Providing a relatively simple explanation may be easy for people to process, that is, to interpret in ways that allow them to sensibly revise their expectations about ownership. More complex explanations may bring to bear too many different considerations, so that the respondent falls back on his or her established expectations, rather than trying to sort through the complex implications of the more detailed description. In short, more information is not necessarily better, when it takes effort to make sense of that information. It remains for future research to establish what types of explanations about ownership can be most readily interpreted, as well as how that relates to peoples' prior understanding of ownership or to the extent of their experiences with particular types of services.

Ultimately, researchers, policy makers, and advocates would all benefit from a better understanding of how Americans view ownership in medical care. We have provided a foundation for that study, but much remains to be done. It would be useful to understand whether the expectations that appear to hold for both hospitals and health plans extend to other aspects of medical care, such as nursing homes, hospice programs, ambulatory care centers, and the like, where there is also a mix of ownership but for which past research suggests that ownership may lead to a very different pattern of outcomes (Schlesinger & Gray, in press). Ownership clearly matters to the American public. It is essential for researchers to understand why and to determine how consistent public expectations are with the actual behavior of nonprofit and for-profit health care providers.

Appendix
Wording of the Four Descriptions of Nonprofit Ownership That Were Used in the Survey Experiment

SURVEY EXPERIMENT MODULE

As you may know, health care in the United States is provided by a mixture of for-profit companies, nonprofit organizations, and government agencies. I'd like to get your general impressions about some ways that nonprofit and for-profit health plans might be different.

READ DESCRIPTION BASED ON EXPERIMENTAL GROUP ASSIGNED.

GROUP A (n = 1,008)
No additional description. These respondents relied on their own knowledge of ownership.

GROUP B (n = 1,013)
First, I should explain what we mean by for-profit and nonprofit. *For-profit* hospitals and health plans have owners who can share the organization's profits. In a *nonprofit*,

any earnings must be used to support the organization's mission and cannot be shared with individuals.

GROUP C (n = 985)
First, I should explain what we mean by for-profit and nonprofit. *For-profit* hospitals and health plans have owners who can share the organization's profits. *Nonprofits* are usually run by local boards of volunteers. In a nonprofit, any earnings must be used to support the organization's mission and cannot be shared with individuals.

GROUP D (n = 1,015)
First, I should explain what we mean by for-profit and nonprofit. *For-profit* hospitals and health plans have owners who can share the organization's profits. Managers and affiliated doctors can also receive part of the profits. *Nonprofits* are usually run by local boards of volunteers. In a nonprofit, any earnings must be used to support the organization's mission and cannot be shared with individuals.

GROUP E (n = 979)
First, I should explain what we mean by for-profit and nonprofit. *For-profit* hospitals and health plans have owners who can share the organization's profits. Managers and affiliated doctors can also receive part of the profits. *Nonprofits* are usually run by local boards of volunteers. In a nonprofit, any earnings must be used to support the organization's mission and cannot be shared with individuals. In some states, nonprofits must report how their activities affect their local community.

Notes

1. Even policies that are intended to promote some segments of the third sector may destabilize other nonprofits. For example, policies that promote faith-based initiatives can threaten the legitimacy of secular nonprofits engaged in similar types of activities (Smith, 2002).

2. For example, there has been considerably more research on the determinants of public confidence in the nonprofit sector in the United Kingdom than in the United States. We discuss this research in the next section of the article.

3. The level of confidence that is reported for the public varies by report. Some authors include "some confidence" in the positive assessments, which brings confidence levels up to the 65% to 80% range (Keirouz, 1998).

4. Unfortunately, this aspect of performance has been addressed in a somewhat peculiar manner. Respondents were asked whether the effectiveness of charitable organizations had increased over the previous 5 years. Consequently, it is impossible to determine whether most Americans see nonprofits as generally effective or to determine whether they are seen as more or less effective than for-profit or government organizations.

5. There is some irony in these conflicting assessments. Salamon is typically seen as a staunch defender of the nonprofit sector, whereas Brody is most often portrayed as a critic.

6. This question was a part of a survey conducted in the summer of 1996 by Princeton Survey Research Associates. It was identified from the archives of the Roper Center for Public Opinion Research at the University of Connecticut The question cited in the text has the Roper Center identification number USPSRA.073086,R05H.

7. Sargeant and Lee (2002, p. 80) found that perceptions of ethical behavior were the single most important predictor of trust in nonprofits, followed closely by respondents' assessment of the groups that were patronizing nonprofit organizations. Although judgments about whether recipients of services "deserve" their benefits are an important theme in establishing the legitimacy of the nonprofit sector, it is not one explored in this article. Further research is clearly merited to determine if changing perceptions of recipients can account for changes in the legitimacy of the nonprofit sector in the United States.

8. Studies in both the United Kingdom (Sargeant & Lee, 2002) and United States (Toppe & Kirsch, 2003) have found that trust is closely correlated with a willingness to donate to these organizations. This connection between attitudes and behaviors is thought to validate that reported attitudes have meaningful consequences for the individuals who express them.

9. The relative confidence and trust in health care, compared to other sectors of nonprofit activity, varied considerably across states and measures of performance. In Indiana, the public was more confident in health care than in any other aspect of the nonprofit sector (Keirouz, 1998). But in Michigan, nonprofits in health care ranked lowest in terms of public confidence (Wilson & Hegarty, 1997).

10. Since the late 1990s, there have been a series of well-publicized reports from the prestigious Institute of Medicine that have warned about quality shortfalls in American medicine (Institute of Medicine, 2000a, 2000b, 2002). In reaction to these reports, roughly half of all Americans now report that they fear medical errors when they go to the doctor or to the hospital (Kaiser Family Foundation, 2003). Quality of care is no longer assumed to exist in the American health care system—it is an attribute that must be carefully sought. This makes it an appropriate marker for role competence among organizations providing medical services.

11. Previous studies have documented that Americans have clear norms of ethical practice that they apply to both price setting by firms and the trustworthiness of health care providers to not shirk on quality (Hall, Dugan, Zheng, & Mishra, 2001).

12. Recall that studies from the United Kingdom have shown perceptions of fairness to be an important determinant of confidence in the nonprofit sector. Notions of fair treatment also have been a persistent, albeit minor, theme in scholarship on the nonprofit sector.

13. Because this question played a central role in the survey, we were forced to administer the interview only in English. We could not identify a Spanish translation of *nonprofit* that conveyed the correct meaning without also suggesting other connotations that were not a part of the term in English.

14. But the findings of past research are not entirely consistent: Some suggest that payment arrangements are not a major threat to perceived trustworthiness. Thus, it remains unclear whether this description will have a distinctive impact on perceptions of trustworthiness or simply reinforce positive attitudes about nonprofit performance more generally.

15. Respondents were asked how concerned they were about their ability to (a) "deal with problems in your medical care (21% were very concerned), (b) "obtain adequate health insurance" (27% very concerned), (c) "find good doctors" (25% very concerned) and (d) "pay for your medical care" (31% very concerned). These responses were closely correlated with one another, making this a good candidate for an index (Cronbach's alpha = .87).

16. Respondents were asked whether they typically had "someone available to help you if you had to make an important decision" (74% reported that they did) or "get the information that you need to understand a situation" (64% reported that they did). The correlation between the two component measures was again high enough to reliably form an index (Cronbach's alpha = .81).

17. Respondents were first told that "many Americans report that the health care system can be pretty confusing," to reduce their natural reluctance to admit to ignorance about an important purchasing decision. They were then asked whether they would know what to do if (a) "you found an error in your medical bills," (b) "you had a question about your health benefits," (c) "you wanted to learn more about a medical condition," or (d) "you thought that your physicians were making an error in your treatment." Twelve percent admitted that they would "probably" or "

definitely" not know what to do if they found an error in their medical bill. Eight percent reported comparable levels of ignorance for health benefits, 9% involving health conditions, and 22% for errors in medical care. These measures were closely correlated with one another (Cronbach's alpha = .78).

18. These were based on questions about knowledge of their health plans' appeals process (23%-27% were ignorant, depending on the type of appeal), confidence about using the appeals process (19% were not confident), and knowledge of state laws regulating the practices of health plans (56%-63% were ignorant, depending on the law).

19. This included those enrolled in private plans that had contracted with either the Medicare or Medicaid programs to provide coverage to their beneficiaries (9.8% and 2.6% of our respondents were covered by these two programs, respectively).

20. Because the coefficients on the other variables in the model do not change much from our main results, we will present only the results on these interaction terms. But it is important to recognize that they were derived from the complete model, controlling for other attitudes, forms of knowledge, and sociodemographic characteristics of the respondents.

21. Note that the question of plan coverage of tests and procedures appears to be an exception to this general pattern. The even distribution of responses on this question could represent either of two perceptions: (a) The public is really divided about ownership-related effects, or (b) respondents failed to understand this question and were answering more or less at random. Analyses in another paper suggest that this question is more difficult to understand, but that even among respondents who best comprehend ownership and health care, there are relatively modest differences related to ownership.

22. The former explanation seems more plausible than the latter. Most Americans have far more frequent experiences with their health plans than with hospitals. Consequently, it seems likely that health plan–based expectations will be more salient than those for hospitals. If this is true, plan expectations should influence expectations for hospitals rather than the other way around.

23. This is consistent with the responses from earlier surveys about public attitudes involving medical care, which typically had a rate of item nonresponse between 12% and 15% on the questions about ownership-related expectations (Schlesinger, Mitchell, & Gray, in press).

24. Perhaps surprisingly, 20% of those who said they had worked in nonprofit, nongovernmental organizations were unable to offer even a minimally coherent explanation for how nonprofit and for-profit ownership differ from one another. Of course, it is possible that some of these respondents did not really know whether they had worked for a nonprofit to begin with.

25. Because these were randomly drawn, it could be argued that the findings from the survey experiment should be presented without controlling for other respondent characteristics. In separate analyses, we modeled the impact of the experimental exposures without other control variables. The pattern of findings was generally similar to those reported in the text, though there were a few differences in terms of the statistical significance of particular experimental groups. Because these may have been produced by spurious correlations with other respondent characteristics, we prefer to report the results from the full regression models.

26. See our companion paper (Schlesinger et al., in press) for a discussion of trends over time in ownership-related expectations, using data assembled from other surveys that are in the public domain.

27. Attitudes related to treatment of the indigent might be inferred from the perceived propensity of for-profit hospitals to discharge patients who have exhausted their insurance. But it is a somewhat different matter to discharge patients prematurely versus avoiding their admission or enrollment in the first instance. For a discussion of these issues, see Schlesinger, Dorwart, Hoover, and Epstein (1997).

28. One recent study found that the magnitude of racial disparities in outcomes was somewhat smaller in nonprofit than in for-profit health plans, although this pattern did not hold for all the outcomes being studied (Schneider, Cleary, Zaslavsky, & Epstein, 2001).

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