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Jennifer K. Benz, Oscar Espinosa, Valerie Welsh and Angela Fontes
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By Jennifer K. Benz, Oscar Espinosa, Valerie Welsh, and Angela Fontes

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Awareness Of Racial And Ethnic Health Disparities Has Improved Only Modestly Over A Decade

Jennifer K. Benz

(benz-jennifer@norc.org) is a research scientist at NORC at the University of Chicago, in Illinois.

Oscar Espinosa is a senior research scientist at NORC at the University of Chicago.

Valerie Welsh is a senior health policy analyst and the performance improvement and evaluation officer in the Office of Minority Health, Office of the Assistant Secretary for Health, at the Department of Health and Human Services, in Rockville, Maryland.

Angela Fontes is an assistant professor in the Family and Consumer Sciences Department at Illinois State University, in Normal.

ABSTRACT Documented disparities exist in the United States between the majority white population and various racial and ethnic minority populations on several health and health care indicators, including access to and quality of care, disease prevalence, infant mortality, and life expectancy. However, awareness of these disparities—a necessary first step toward changing behavior and compelling action—remains limited. Our survey of 3,159 adults age eighteen or older found that 59 percent of Americans in 2010 were aware of racial and ethnic disparities that disproportionately affect African Americans and Hispanics or Latinos. That number represents a modest increase over the 55 percent recorded in a 1999 survey. Meanwhile, in our survey, 89 percent of African American respondents were aware of African American and white disparities, versus 55 percent of whites. Yet the survey also revealed low levels of awareness among racial and ethnic minority groups about disparities that disproportionately affect their own communities. For example, only 54 percent of African Americans were aware of disparities in the rate of HIV/AIDS between African Americans and whites, and only 21 percent of Hispanics or Latinos were aware of those disparities between their group and whites. Policy makers must increase the availability and quality of data on racial and ethnic health disparities and create multisectoral partnerships to develop targeted educational campaigns to increase awareness of health disparities.

Many aspects of health in the United States have improved over the past several decades. Nonetheless, disparities in health and health care among Americans remain, especially among different racial and ethnic populations.¹ Disparities exist in a wide range of health measures, including access to health insurance; rates of infant mortality; life expectancy; and the prevalence of specific diseases such as HIV/AIDS, hypertension, and diabetes. Public awareness of racial and ethnic differences in health care and health status can both influence the actions that policy makers

take to address the problem and determine whether and how individuals and communities respond to it. But although persistent racial and ethnic health disparities are well documented,² data indicate that the general public is often unaware of their nature and extent.

In 1999 a Kaiser Family Foundation survey titled *Race, Ethnicity, and Medical Care: A Survey of Public Perceptions and Experiences* measured public awareness of racial and ethnic disparities in health care.³ The survey found that a majority of Americans, including many members of racial and ethnic minority groups, were not aware that African Americans and Hispanics

or Latinos fared worse than whites in infant mortality, health insurance coverage, and other key health indicators. (Throughout this article, the term *white* refers to non-Hispanic whites.)

Since the 1999 Kaiser survey, various national initiatives, reports, and educational campaigns have directed public attention to racial and ethnic disparities in health. For instance, in 2000 the Department of Health and Human Services issued *Healthy People 2010*, its strategic plan for the nation's health, which made eliminating health disparities one of only two overarching national health goals.⁴ The 2003 report by the Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, presented widespread evidence that racial and ethnic minorities are treated differently than whites in the US health care system, resulting in poorer health for millions of Americans.⁵ Also in 2003, the Agency for Healthcare Research and Quality issued the first of its annual reports that measure and track data on access and quality disparities in health.⁶

National Health Disparities Summits convened in 2002, 2006, and 2009 by the Department of Health and Human Services' Office of Minority Health highlighted the continuing need for greater awareness and resources to reduce racial and ethnic disparities in health care and health status. And a 2008 PBS series—*Unnatural Causes...Is Inequality Making Us Sick?*—focused attention on the need to be aware of and promote solutions for the root causes of socioeconomic, racial, and ethnic disparities in health.⁷ These reports and campaigns were widely disseminated, but mainstream media coverage of health disparities declined between 1998 and 2005.⁸

Impact Of Awareness On Health Outcomes

Despite the great attention focused on disparities through all of these efforts, no studies have been conducted to discern whether Americans have achieved a higher level of awareness about this important topic over time. Nor, until now, have any studies expanded on the 1999 Kaiser Family Foundation survey to measure awareness of health disparities affecting other racial or ethnic groups in the general population.

This omission has been unfortunate because lack of awareness of and knowledge about health disparities has the potential to contribute to a lack of both attention to the problem and action to address it. The literature provides examples of how awareness of racial and ethnic disparities can influence change at multiple levels. At the individual level, patients and physicians may

change their behavior if they are aware that pertinent disparities exist.^{9,10} At the community level, awareness may lead to the mobilization of groups to push for change in social arrangements or public policy.^{11,12}

Importantly, public awareness of racial and ethnic disparities in health status must reach beyond the clinical context. It is a necessary first step for focusing action at multiple levels to address and solve this entrenched social problem.^{13,14}

We designed our study to begin to fill the knowledge gap on public awareness of health and health care disparities. Specifically, we sought to answer the following questions: To what extent is the US public aware of racial and ethnic health disparities?^{15,16} Did the level of public awareness change between 1999 and 2010? And do Americans differ by race or ethnicity in their awareness of the effects of race and ethnicity on their health status and health care, and those of others?

Study Data And Methods

We modeled our study on the 1999 Kaiser Family Foundation survey, using a questionnaire that replicated key questions from that survey (our survey's questions are presented in the online Appendix).¹⁷ We conducted a national random sample of 3,159 telephone interviews with adults age eighteen or over during April–June 2010. The survey included 1,329 whites, 855 African Americans, 591 Hispanics or Latinos, and 179 Asian Americans or Pacific Islanders. Interviews were conducted in the respondent's language of choice, using study interviewers for those conducted in English and Spanish and Language Line Services interpreters for those conducted in other languages.

The study employed a stratified random sample of telephone exchanges based on the concentration of racial and ethnic minorities within each exchange.¹⁸ We used the Council of American Survey Research Organizations' guidelines to calculate the unweighted response rate for this survey, which was 31.3 percent. Weighting techniques were used to align the sample distribution with that of the 2006–08 American Community Survey population. We used weighted data for all analyses and present those data here.

MEASURING AWARENESS OF DISPARITIES Individual questions from the survey reliably measured specific aspects of awareness of health disparities. In addition, we created an index—a single measure that summarized this awareness—to calculate a general measure of awareness among different populations (see the Appendix for a full description of the index

and its construction).¹⁷ We used this index to report the study's results to a broad audience. The measure included twenty-four items related to comparisons between whites and African Americans, Hispanics or Latinos, and Asian Americans or Pacific Islanders.

Respondents were categorized as "aware" if they perceived a disparity for at least 25 percent of the survey items (six of the twenty-four) included in the index. This index can also be used to examine awareness of disparities for a specific race or ethnicity. For example, the eight items related to African American and white disparities can be isolated to indicate the proportion of respondents aware of disparities—perceiving a disparity for at least two of the eight items—for African Americans.

In addition to descriptive statistics, we compared levels of awareness across groups and over time using difference of proportions tests. Significant differences in the article refer to significance based on two-tailed tests with a 0.05 significance level.

LIMITATIONS It is important to note that these data do not provide causal evidence regarding the source of awareness. All of the relationships discussed are correlations. Changes in levels of awareness between 1999 and 2010 cannot be directly attributed to any one policy, program, awareness campaign, or event. Furthermore, with only two data points, we could not determine the pattern of change in public awareness of racial and ethnic disparities. That is, we do not know if there was a steady increase in awareness over the decade or a period with no change in awareness followed by a large change.

As is frequently the case with data collected on racial and ethnic minority groups, smaller sample sizes increased the margins of error and limited our ability to detect significant effects. Although Asian Americans or Pacific Islanders were oversampled to generate additional data in

this study, the relatively small size of this group in the US population (roughly 4.5 percent) resulted in limitations on sample size and, therefore, on statistical power.

Study Findings

AWARENESS OF DISPARITIES In 2010, based on our index, 52 percent of Americans were aware of health status and health care disparities between racial and ethnic minorities and whites. Public awareness of disparities between whites and Hispanics or Latinos increased significantly—by eight percentage points—over the decade, while awareness of disparities between whites and African Americans remained steady (Exhibit 1).

Overall awareness of disparities in 2010 differed significantly by educational level. Fifty-five percent of respondents with at least a high school education were aware of racial and ethnic health disparities, compared to 36 percent for those who had not graduated from high school. This difference was driven primarily by awareness of disparities between whites and African Americans, which was at 63 percent for those with a high school education but 38 percent for those with less education. We found no significant differences in awareness for other key demographic variables, such as sex or age. Differences in awareness by racial and ethnic identification were significant and are discussed in detail below.

CHANGES IN AWARENESS OVER TIME Although overall changes in awareness from 1999 to 2010 were modest, a few large changes occurred in awareness of specific health indicators.¹⁹ Exhibit 2 shows the differences between 1999 and 2010 for eleven specific disparities in health care access and health status. For example, awareness of disparities between African Americans and whites increased significantly in four cases, decreased significantly in one, and remained statistically unchanged in six (Exhibit 2).

Awareness of disparities in getting routine care, specialty care, and health insurance for African Americans compared to whites all increased significantly. However, all of these changes were relatively small—less than nine percentage points—and no more than 51 percent of the respondents were aware of any of these disparities. The only significant decline in awareness was of race or ethnicity's being a problem for African Americans in getting care.

Public awareness of disparities in the ability of Hispanics or Latinos to get needed care, routine care, or health insurance, and in the cost of care being problematic, compared to whites, all

EXHIBIT 1

Changes In Public Awareness Of Racial And Ethnic Health Disparities, 1999-2010

Disparities between whites and	Percent of respondents aware	
	1999	2010
African Americans and Hispanics or Latinos and Asian Americans or Pacific Islanders	— ^a	52
African Americans and Hispanics or Latinos	55	59
African Americans	57	59
Hispanics or Latinos	53	61**
Asian Americans or Pacific Islanders	— ^a	18

SOURCES For 1999: data from Note 3 in text. For 2010: data collected and analyzed by the authors.

NOTE Significance is between 1999 and 2010. ^aData not collected. ***p* < 0.05

EXHIBIT 2

Public Awareness Of Specific Health Care Access And Health Status Disparities, 1999–2010

Disparity	Percent of respondents aware of disparities between whites and				
	African Americans		Hispanics or Latinos		Asian Americans or Pacific Islanders
	1999	2010	1999	2010	2010
Worse off in getting needed health care than whites	38	40	38	49**	13
Worse off in getting routine care than whites	31	39**	37	45**	13
Worse off in getting specialty care than whites	34	37**	40	44	13
Worse off in having health insurance than whites	44	51**	50	61**	17
Cost of health care is a problem for the racial or ethnic group	84	82	77	82**	64
Lower quality of health care received than whites	29	27	35	37	12
Access to providers is a problem for the racial or ethnic group	66	66	61	64	49
Race or ethnicity is a problem for getting care for the racial or ethnic group	66	54**	61	58	36
Worse off in infant mortality than whites	44	43	37	34	9
Worse off in life expectancy than whites	42	45	35	35	9
Worse off in general health than whites	28	35**	27	34**	7

SOURCES For 1999: data from Note 3 in text. For 2010: data collected and analyzed by the authors. **NOTE** Significance is between 1999 and 2010. ***p* < 0.05

increased significantly from 1999 to 2010 (Exhibit 2). Awareness of disparities in getting needed care and having health insurance increased by eleven percentage points.

The 1999 and 2010 surveys both asked about disparities in infant mortality, life expectancy, and general health (Exhibit 2). Awareness of disparities in general health increased significantly during the period, but awareness of specific health status disparities did not change significantly. Infant mortality rates are more than twice as high for African Americans as they are for whites, and up to 40 percent higher for some Hispanic or Latino subgroups than for whites.² Yet in 2010 only 43 percent of respondents were aware of the first disparity, and only 34 percent were aware of the second. These percentages, like those for awareness of life expectancy disparities between African Americans and whites, and between Hispanics or Latinos and whites, were unchanged over the decade.

AWARENESS OF DISPARITIES ACROSS GROUPS

Asian Americans or Pacific Islanders were generally viewed as doing just as well as whites on the eleven disparity indicators (Exhibit 2). This view corresponds with the documented level of disparities on broad health indicators in the Asian American or Pacific Islander population² and the more nuanced story of disparities between the two groups. For example, Asian Americans and Pacific Islanders have lower rates of cancer overall, but they are twice as likely as

whites to have stomach cancer and three times as likely to have liver cancer (data not shown).²⁰

In addition, disparities exist for subgroups within the Asian American or Pacific Islander population. For example, the infant mortality rate for Native Hawaiians was 1.7 times greater than the rate for non-Hispanic whites in 2002, while the rate for other Asian American or Pacific Islander populations was less than that of non-Hispanic whites.²¹

Exhibit 3 shows the public’s awareness of disparities among whites and all three racial and ethnic minority groups for particular health conditions. There is a striking lack of awareness about the disparate impact of several health conditions on racial and ethnic minority groups. For example, the African American population experiences nine times as many new diagnosed cases of HIV/AIDS as the white population each year, and the Hispanic or Latino population experiences three times as many.^{22,23} However, in 2010 only 37 percent of respondents believed that African Americans were more likely to be diagnosed with HIV/AIDS than whites, and only 21 percent believed Hispanics or Latinos were more likely to be diagnosed with HIV/AIDS than whites.

Similarly, cancer, hypertension, and diabetes have a greater impact on African Americans and on some Hispanic or Latino and Asian American or Pacific Islander subpopulations, compared to whites²—but awareness of these disparities remains low.

EXHIBIT 3

Public Awareness Of Disparities In Specific Health Conditions, 2010

More likely than whites to be diagnosed with	Percent of respondents aware of disparities between whites and		
	African Americans	Hispanics or Latinos	Asian Americans or Pacific Islanders
HIV/AIDS	37	21	8
Cancer	17	14	6
Hypertension	44	23	9
Diabetes	37	24	7

SOURCE Authors' analysis.

AWARENESS OF DISPARITIES ACROSS RACIAL AND ETHNIC GROUPS

We compared levels of awareness of specific health disparities within a respondent's own racial or ethnic group and in other racial and ethnic groups. In line with previously published results,²⁴ our 2010 awareness index findings indicated that African Americans tended to be most aware of the disparities that disproportionately affect the African American population, as well as disparities between whites and other minority groups.

Eighty-nine percent of African American

respondents were aware of African American and white disparities. This was significantly higher than the awareness among whites (55 percent), Hispanics or Latinos (57 percent), and Asian Americans or Pacific Islanders (60 percent). African Americans (84 percent) were also more likely to be aware of disparities between Hispanics or Latinos and whites than were Hispanics or Latinos themselves (72 percent), who in turn were significantly more aware of them than whites (56 percent) or Asian Americans or Pacific Islanders (57 percent). Furthermore, African Americans (38 percent) were statistically as likely as Asian Americans or Pacific Islanders (27 percent) to perceive a disparity between Asian Americans or Pacific Islanders and whites—a figure that was significantly higher than the percentages for whites (14 percent) and Hispanics or Latinos (25 percent).

However, awareness of several important health disparities remained quite low even among the disproportionately affected minority groups (Exhibit 4). For example, only 54 percent of African Americans were aware of disparities in the rate of HIV/AIDS between African Americans and whites, and only 21 percent of Hispanics or Latinos were aware of those disparities between their group and whites.

EXHIBIT 4

Public Awareness Of Specific Disparities, By Respondent's Race Or Ethnicity, 2010

Disparity	Percent of respondents aware of disparities between whites and		
	African Americans	Hispanics or Latinos	Asian Americans or Pacific Islanders
WORSE OFF IN TERMS OF HAVING HEALTH INSURANCE			
Whites	47	56	13
African Americans	79**	77	28
Hispanics/Latinos	46	71	23
Asian Americans/Pacific Islanders	49	56	24
WORSE OFF IN TERMS OF INFANT MORTALITY			
Whites	43	32	7
African Americans	56**	43	19
Hispanics/Latinos	35	32	11
Asian Americans/Pacific Islanders	36	30	3
MORE LIKELY TO BE DIAGNOSED WITH HIV/AIDS			
Whites	33	18	5
African Americans	54**	42	18
Hispanics/Latinos	36	21	9
Asian Americans/Pacific Islanders	46	21	9
MORE LIKELY TO BE DIAGNOSED WITH DIABETES			
Whites	30	16	4
African Americans	72 ^a	46	16
Hispanics/Latinos	38	47	9
Asian Americans/Pacific Islanders	40	15	11

SOURCE Authors' analysis. NOTE Significance is between awareness of a disparity for respondents' own racial or ethnic group and awareness of that disparity for a different racial and ethnic group. **p < 0.05

Discussion

This study represents the first comprehensive collection of data and analysis of public awareness of racial and ethnic health disparities in the United States that allowed direct comparisons to previous data. The study provides baseline data on awareness of several health condition disparities and awareness of disparities between Asian Americans or Pacific Islanders and whites.

Findings from the study paint a broad picture of the extent to which the US population is aware of racial and ethnic health disparities, and how awareness has changed over the past decade. Our data show that people were somewhat aware of general and long-standing health disparities, such as access to routine care or having insurance (Exhibit 2). However, awareness that racial and ethnic minority groups were disproportionately affected by a number of serious diseases and conditions was much lower. Several summary points emerge from the findings.

NEED FOR PROGRESS First, 59 percent of Americans in 2010 were aware of racial and ethnic disparities that disproportionately affected African Americans and Hispanics or Latinos, a modest increase over 55 percent in 1999 (Exhibit 1). Recent analyses indicate that little progress has been made toward reducing or eliminating health disparities over the past de-

cade.²⁵ With fewer than two-thirds of respondents aware of many important racial and ethnic health disparities, there is considerable room for improvement in the efforts of the Department of Health and Human Services, its federal partners, and other stakeholders to increase Americans' overall awareness of disparities in health care.

MODEST IMPROVEMENT IN AWARENESS Second, Americans' awareness that racial and ethnic minority groups are affected by disparities in access to health care increased from 1999 to 2010. Although statistically significant, most of these increases in awareness were modest—under ten percentage points. Furthermore, awareness of disparities in several key health status indicators, such as infant mortality and life expectancy, remained at the same low level. And awareness of disparities in the rates of HIV/AIDS, cancer, diabetes, and hypertension remained low, even among the disproportionately affected populations.

DIFFERENT PERCEPTIONS Third, in spite of some awareness of disparities affecting African Americans and Hispanics or Latinos, respondents generally viewed Asian Americans or Pacific Islanders as doing just as well as whites. In general, African Americans and Hispanics or Latinos correctly perceived the disparities in Asian American or Pacific Islander communities to be significantly smaller than in their own communities for the broad health indicators included in this study.

CONCLUSIONS Given its increasing racial and ethnic diversity, the United States cannot remain healthy, strong, and vibrant as a nation unless we address the persistent disparities that place an unequal burden of illness and death on racial and ethnic minorities.²⁶

This study found that much work remains to be done by public health leaders and policy makers to increase the level of awareness and knowledge among the general public—including members of racial and ethnic minority groups—about health disparities and their importance, and also about specific health-related conditions that disproportionately affect communities of color.

In line with the federal Action Plan to Reduce Racial and Ethnic Health Disparities,²⁷ policy makers need to increase the availability, quality,

and use of data on race and ethnicity in federally supported programs, activities, and surveys. Section 4302 of the Affordable Care Act of 2010 requires the Department of Health and Human Services to develop standards for collecting and reporting on race, ethnicity, and other demographic variables and to ensure that federally supported programmatic efforts and surveys collect and report such data. This provision is designed to increase the availability and quality of the data. With high-quality data for all racial and ethnic populations, researchers can more precisely identify health care access, status, and disease disparities. This research can then be used to design specific campaigns to inform health providers, community leaders, and other advocates across multiple sectors and disciplines so that action can be taken to address such disparities in their jurisdictions.

In addition, the first goal of the Department of Health and Human Services' recently released National Stakeholder Strategy for Achieving Health Equity is to increase awareness of the importance of health disparities and their impact on the nation.¹⁴ The document recommends that partnerships among public, nonprofit, and private entities be formed to build on the efforts of organizational networks to increase awareness of disparities; foster greater attention to the issue by the media; and employ best practices in marketing and communication in adopting strategies to build awareness. It also recommends that national and local educational campaigns to increase awareness of health disparities target certain racial and ethnic groups to inform them about specific health conditions, their impacts on society, and needed actions to eliminate disparities.

These recommendations are consistent with research showing that the effective use of communication and marketing resources and strategies is essential to influencing individuals, social networks, communities, and populations to foster health-promoting environments, and to advance public health.²⁸ Although awareness of the importance of health disparities is not sufficient by itself to eliminate those disparities, it is a necessary first step. ■

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NORC for their contributions to the study. The content is solely the responsibility of the authors and does not necessarily reflect the views of HHS, NORC, or Illinois State University.

NOTES

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- 15 The phrase *racial and ethnic health disparities* includes health and health care disparities and refers to racial and ethnic differences in the occurrence of disease, health outcomes, or access to health care. This definition is adapted from the broader definition of health disparities in the Affordable Care Act of 2010.
- 16 Awareness is an indicator of respondents' experiences and the inferences they have drawn from those experiences, rather than an inquiry into their factual knowledge of an actual disparity. This measure therefore allows us to answer the question: Do average people understand, in general, that racial and ethnic health disparities exist?
- 17 To access the Appendix, click on the Appendix link in the box to the right of the article online.
- 18 Oversampling was achieved by completing the following steps: We estimated the racial and ethnic composition of each telephone exchange by matching the exchange to census data at the block group level; we stratified the random-digit dial sampling frame of telephone numbers by telephone exchange based on the racial and ethnic composition of each exchange; we estimated the racial and ethnic composition of each telephone exchange stratum from exchange-level information; we determined the stratum sample size based on the required number of interviews per racial and ethnic group; and we selected the sample systematically and independently from each stratum.
- 19 Because of differences in question wording and response choices, direct comparisons should not be made between disparities in Exhibit 2. For example, several questions asked respondents if a racial or ethnic minority group was better off, just as well off, or worse off compared to whites on a health indicator, while other questions asked if a health indicator was a major problem, minor problem, or not a problem at all for a racial or ethnic minority group. Rather, comparisons should be made over time for the same disparity.
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ABOUT THE AUTHORS: JENNIFER K. BENZ, OSCAR ESPINOSA, VALERIE WELSH & ANGELA FONTES



Jennifer K. Benz is a research scientist at NORC at the University of Chicago.

In this month's *Health Affairs*, Jennifer Benz and coauthors report on a recent survey of public awareness about health and health care disparities undertaken by the US Department of Health and Human Services' Office of Minority Health and NORC at the University of Chicago. Overall, the survey found that this awareness remains relatively low. The authors argue that policy makers should undertake educational campaigns to increase awareness of disparities as a critical step toward eliminating them.

Benz, who served as the lead analyst for this survey, is the project manager for several federal evaluations and research projects for clients in the Department of Health and Human Services. She is also a research scientist at NORC at

the University of Chicago. Her research has focused on health disparities, issues in primary care, and the translation of research into policy and practice. She earned her doctorate in political science from the University of North Carolina at Chapel Hill.



Oscar Espinosa is a senior research scientist at NORC at the University of Chicago.

Oscar Espinosa, a senior research scientist at NORC at the University of Chicago, specializes in the evaluation of programs that deliver health services to minorities and other vulnerable populations. He earned a master's degree in sociology, with a focus on survey research methods, at George Mason University.

Valerie Welsh is a senior health policy analyst and the performance improvement and evaluation officer in the Office of Minority Health,

Office of the Assistant Secretary for Health, at the Department of Health and Human Services. She has a master's degree in community health education from Southern Illinois University.



Angela Fontes is an assistant professor at Illinois State University.

Angela Fontes is an assistant professor in the Family and Consumer Sciences Department at Illinois State University. Her research focuses on disparities in family financial well-being, and her work has been published in the *Journal of Family and Economic Issues*, the *Journal of Women, Politics, and Policy*, and *Financial Counseling and Planning*, among other journals. Fontes received her doctorate in consumer behavior and family economics at the University of Wisconsin–Madison.