Coverage and Framing of Racial and Ethnic Health Disparities in US Newspapers, 1996–2005

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In the United States, racial and ethnic health disparities persist despite overall improvements in population health.[1,2] Studies suggest that social inequalities, not individual behaviors, are the main reason why racial and ethnic minorities get sicker and die sooner than the rest of the population.[3,4] This "social determinants of health" perspective—which has gained increased attention in recent years—asserts that the root causes of disparities in health are inequalities in social, economic, physical, and environmental conditions, because these directly influence health and indirectly constrain opportunities for healthy behaviors, access to health care, and even genetic predisposition for disease (e.g., through gene-environment interactions).[5–8] For these reasons, behavioral interventions can only be palliative, and government action is needed to enact redistributive policies that address the underlying root causes of disparities in health.

Making the case that social determinants are a fundamental cause of racial/ethnic health disparities remains a formidable challenge in a society that values individual responsibility.[9–11] Furthermore, negative stereotypes about members of minority populations may predispose nonminorities to blame minorities for having poor health, even when there is strong evidence to the contrary. Researchers argue that health disparities are a social injustice and that we have a moral imperative to ensure health equity for all,[12–14] especially for the most disadvantaged; but it is unknown whether this ethical argument is effectively communicated to the public. The social determinants of health have been long documented[15–17] and widely recognized by the World Health Organization and the governments of the United Kingdom and Canada,[18] but similar efforts have not gained critical momentum in the United States. In fact, the American public is largely unaware of racial/ethnic health disparities[19] and prioritizes medical care and personal behaviors as the strongest influences on health.[20] However, public support for redistributive policies could increase if the

Objectives. We examined how causes of and solutions to racial/ethnic health disparities are covered and framed in newspapers over time.

Methods. We used LexisNexis to identify articles on racial/ethnic health disparities published from 1996 through 2005 in 40 US newspapers. We coded articles for diseases and racial/ethnic groups mentioned; whether causes and solutions were framed as genetic, behavioral, health care, or societal responsibility; and whether a social-justice rationale for eliminating racial/ethnic health disparities was invoked.

Results. We identified 3823 racial/ethnic health disparity articles. Coverage peaked in 1998 and has declined since. Disparities in HIV/AIDS, cardiovascular disease, and cancer generated the most coverage. Articles focused primarily on African Americans. Only 30% of articles provided causal or solution explanations, with academic researchers providing the most causal explanations and advocacy groups providing the most solutions. For both causes and solutions, behavioral explanations dominated the discourse, followed by societal, health care, and genetic explanations. Only 4% of articles invoked a social-justice rationale.

Conclusions. The dominance of behavioral explanations may limit public support for policy solutions to eliminate racial/ethnic health disparities. Future research should examine the design and dissemination of effective messages about the social determinants of health. (*Am J Public Health.* 2010;100: S224–S231. doi:10.2105/AJPH.2009.171678)

social-determinants perspective were effectively communicated to the public.[21]

How issues are covered in the news media profoundly affects how Americans understand and relate to social problems and solutions for change. The media help shape what issues the public thinks about and how they think about these issues.[22] In turn, public opinion can influence how government shapes public policies. Agenda setting is the process by which media act as gatekeepers, selecting what issues to cover and how much prominence to give them.[23–25] Framing is the process by which the media construct meanings of social problems by diagnosing causes, performing moral evaluations, recommending solutions, and motivating support for resolution.[26,27] Studies find that when coverage of issues is highly personalized with descriptions of individual or group characteristics, the public is more likely to blame individuals for their conditions.[28] Conversely, when issues are framed thematically and described as a societal

problem, the public is more likely to hold government responsible for resolving the issue.[29] Studies find that news coverage of racial disparities tends to blame victims for their status[30,31] and to distort the issue as Whites against Blacks, which decreases White support for governmental programs that are designed to reduce racial disparities.[32,33]

To date, few studies have examined how racial/ethnic health disparities are covered and framed in news media.[34,35] Amzel and Ghosh[34] examined which racial/ethnic health disparities generated the most newspaper coverage from 2000 through 2004 but did not assess how causes and solutions were framed. Taylor-Clark et al.[35] examined framing of racial/ethnic health disparities but only for health care disparities affecting African Americans. They analyzed newspaper articles for select years from 1994 through 2004 and found that more blame was attributed to patients' behaviors than to physicians or health care systems. Other researchers

have also found that individual responsibility dominates media coverage of health issues (e.g., diabetes, obesity),[36–39] but none have assessed how racial/ethnic health disparities are framed across multiple health conditions and racial/ethnic groups over time. We examined newspaper coverage and framing of multiple racial/ethnic health disparities over a decade to assess which racial/ethnic health disparities garnered the most media attention; how the social-determinants perspective competed for attention with behavioral, genetic, health care, and multi-level attributions; who shaped the discourse; and whether a social-justice rationale for eliminating racial/ethnic health disparities was invoked.

METHODS

We conducted a content analysis of articles about racial/ethnic health disparities published in 40 leading US newspapers from 1996 through 2005. We identified articles that described at least 1 racial/ethnic minority group as being at increased risk for a disease or negative health condition. We excluded articles that were about (1) the general population and did not explicitly address a racial/ethnic group; (2) racial/ethnic health disparities outside the United States (e.g., HIV rates in Africa); and (3) racial/ethnic groups having lower risk than Whites (e.g., smoking rates being lower among Asian Americans). We included articles even if racial/ethnic health disparities were not the main topic of the article (e.g., an article about a community health event that mentions racial/ethnic disparities in diabetes). We excluded duplicate articles from the same newspaper but included articles reprinted by a different source (e.g., the *Buffalo News* reprinting a *New York Times* article).

From the Audit Bureau of Circulation's list of top 100 daily US newspapers, we selected all newspapers that were archived in LexisNexis (n=62). Of those, we selected newspapers that had electronic archives available from 1996 through 2005 (n=44). From that group, we selected newspapers that provided racial/ethnic composition data about newspaper staff and their readers (n=40).[40] The final sample of 40 newspapers was not significantly different from the papers excluded with respect to circulation size, regional representation, or racial/ethnic composition of newspaper staff or readers.

We chose 1996 as the starting point for our analysis because experts note that research on social determinants has exploded since 1995.[41]

To develop a comprehensive search syntax, we first compiled a list of health terms from journal articles and key reports about racial/ethnic health disparities that reflected the leading causes of death,[42,43] the leading preventable causes of death,[44,45] and their related behaviors (e.g., cardiovascular disease [CVD], stroke, diabetes, obesity, physical activity). Second, we identified disparity-related terms in consultation with communication experts who have examined news coverage of racial disparities.[30,46] These terms included specific racial/ethnic group terms (e.g., African American, Latino), general group terms (e.g., minority), and comparative terms (e.g., disproportionately, less likely than). We tested the search syntax in a select sample of newspapers, examined the first 200 articles retrieved, and optimized the search syntax. The final precision rate—the proportion of relevant racial/ethnic health disparity articles among all articles retrieved—was 52% for all 40 newspapers (range: 41%–73%).

Measures

We examined whether the article (1) was published in the front section, health section, or another section; (2) was written as news or opinion; (3) was a reprint of a wire-service story (e.g., Reuters); (4) focused primarily on racial/ethnic health disparities (i.e., racial/ethnic health disparities were mentioned in the headline or the first 2 paragraphs); and (5) included photographs or figures to visually represent racial/ethnic health disparities.

Main disease and racial/ethnic group. We coded for the main disease and racial/ethnic group mentioned in the article (i.e., mentioned in the headline or lead, or most commonly mentioned throughout the article). If multiple diseases or groups were mentioned equally, up to 4 diseases or groups were coded per article. We coded for 35 different diseases and conditions, but we recoded these into 19 categories to combine related conditions so we could analyze time trends. For example, we grouped heart disease, blood pressure, stroke, diabetes, and obesity into a single CVD category, because these conditions are risk factors for or are causally linked to CVD. Racial/ethnic group categories included the 4 main minority groups

(African American, Asian American, Latino, and Native American) and general group terms (e.g., minorities).

Agent quoted and causal and solution explanations. We coded articles for explanations of why racial/ethnic health disparities exist and what can be done to eliminate them, and for the type of agent providing these explanations. Up to 4 agents were coded per article, and each agent could give up to 4 causal or solution explanations. If no agent was specified, the cause or solution explanation was attributed to the journalist writing the article. Type of agent included academic researcher, health practitioner, federal agency, city or state agency, advocacy organization, research institute, politician, laypeople, and journalist or media.

We examined 8 causal explanations but recoded these into 4 major categories:

1. Genetic—racial/ethnic differences in genetic makeup;
2. Behavioral—racial/ethnic differences in knowledge, attitudes, behaviors, or cultural norms;
3. Health care—racial/ethnic groups having limited access to health care or receiving poor-quality or discriminatory medical care; and
4. Societal—racial/ethnic groups living in unhealthy social, physical, or environmental conditions (e.g., unsafe neighborhoods, density of fast-food restaurants, lack of green space).

We examined 8 solution explanations but recoded these into 4 major categories:

1. Genetic—racial/ethnic-targeted genetic testing or pharmacotherapy (e.g., BiDil [NitroMed Inc, Charlotte, NC], a prescription drug for African Americans with heart failure);
2. Behavioral—culturally tailored behavioral interventions, educational programs, and media interventions;
3. Health care—increasing health insurance access or coverage, or improving medical treatment or systems (e.g., cultural sensitivity training of physicians); and
4. Societal—redistributive policies to improve social, physical, or environmental conditions (e.g., zoning laws limiting number of fast-food restaurants).

Because an agent could provide up to 4 explanations for causes or solutions, we also coded for mentions of multilevel explanations (e.g., behavioral and societal).

We coded whether any of the following words were used to invoke a social-justice rationale for eliminating racial/ethnic health disparities: (in)justice, unjust, (un)fair, fairness, (in)equity, equitable, inequality, and unequal.

Data Collection and Analysis

We used a standardized coding instrument and codebook to train 4 research assistants during a 4-hour training session. Twenty articles were double-coded by all coders to assess interrater reliability, which was high for all measures (κ statistic range = 0.67–0.99; mean = 0.81; P < .01). Therefore, each article was coded independently by 1 coder. All coders attended meetings at least biweekly to report progress and discuss questions as they arose. Any coding discrepancies were resolved by A.E.K. Coding assignments were equally distributed across all 4 coders and were completed between February and June 2007.

We ran descriptive frequencies on all variables. The unit of analysis is the article level for newspaper characteristics, racial groups, disease mentions, and social-justice words. For causal and solution explanations, the unit of analysis is the number of agents providing an explanation. Analyses of time trends were conducted using ordinary-least-squares models, and we regressed disease and causal/solution explanations with a measure of linear time. Pairwise t tests were used to test the significance of year-to-year changes in coverage and framing. All analyses were conducted using Stata version 10.1 (StataCorp, College Station, TX).

RESULTS

We identified 3823 articles about racial/ethnic health disparities published from 1996 through 2005. On average, national papers covered racial/ethnic health disparities more than regional papers (Table 1). Racial/ethnic health disparity coverage peaked in 1998 (470 articles) and has declined significantly since then (P < .001). Nearly 40% of articles appeared in the front section of the newspaper,

and approximately 60% were news stories. Although the majority of articles (91.7%) were full length and primarily written by newspaper staff (87.6%), racial/ethnic health disparities were the main focus in only 43.3% of the articles. Few articles included a photo or visual graphic (8.0%). Only 3.6% of articles used specific terms that invoked a social-justice rationale for eliminating racial/ethnic health disparities (Table 1).

Main Health Topics and Racial/Ethnic Groups

Figure 1 shows the yearly distribution of articles on racial/ethnic health disparities by mention of primary disease or topic. Three health topics dominated coverage. On average, 22% of articles were about HIV/AIDS (range: 14%–27%), 21% were about CVD (range: 16%–26%), and 20% were about cancer (range: 15%–26%). Racial/ethnic disparities in health care made up about 11% of coverage (range: 6%–16%). All other health topics (e.g., asthma, infant mortality) each made up less than 5% of articles each year.

With respect to time trends, coverage of health care disparities increased significantly, from 6% of articles in 1996 to 12% in 2005 (P < .001), whereas coverage of cancer disparities declined slightly during this time (P = .058). There was no overall linear trend in coverage of HIV/AIDS or CVD disparities across the 10-year period; however, there were some significant fluctuations from year to year. For example, HIV/AIDS coverage declined by 12% from 2001 to 2003 (P < .001), then increased by 13.7% from 2003 to 2005 (P < .001).

With respect to race/ethnicity, most articles focused on racial/ethnic health disparities affecting African Americans (76.5%), and relatively few articles focused on Latinos (8.2%), Asian Americans (2.0%), or Native Americans (1.2%; Table 2).
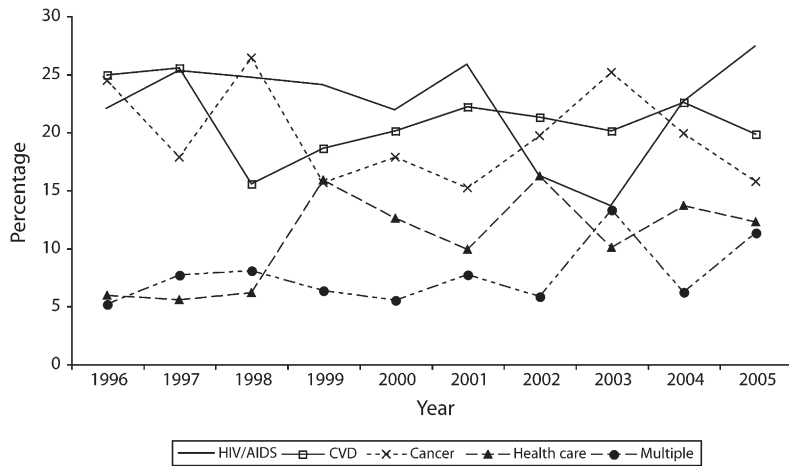
Agent Providing Explanations

Overall, 69.6% of articles did not provide either a causal explanation or a solution for eliminating racial/ethnic health disparities (Table 2). Of the articles providing at least 1 causal or solution explanation (n = 1164), a majority focused on causes (85.9%), and fewer than half provided solutions (46.0%). Overall, academic researchers (26.7%) were most

commonly quoted, and politicians were least quoted (2.7%). More than half of the causal explanations were provided by academic researchers (22.4%), the media (19.2%), and nonacademic health professionals (17.1%). In

TABLE 1—Characteristics of Articles About Racial/Ethnic Health Disparities (N = 3823): 40 US Newspapers, 1996–2005

	No. of Articles	%
Region		
National (n = 3)	587	15.4
South (n = 12)	1091	28.5
West (n = 12)	830	21.7
Northeast (n = 7)	703	18.4
Midwest (n = 6)	612	16.0
Year		
1996	405	10.6
1997	325	8.5
1998	470	12.3
1999	441	11.5
2000	398	10.4
2001	415	10.9
2002	376	9.8
2003	338	8.8
2004	337	8.8
2005	318	8.3
Section of paper		
Front	1446	37.8
Health	285	7.5
Other	2092	54.7
News brief	318	8.3
Opinion vs news		
News	2258	59.1
Editorial/commentary	1022	26.7
Human interest	406	10.6
Letter to editor	63	1.6
Other	74	1.9
Author or source		
Staff writer	3348	87.6
Associated Press	107	2.8
Reuters	15	0.4
Knight-Ridder	43	1.1
Other	310	8.1
Photo or visual graphic	305	8.0
Racial/ethnic health disparities central focus of article	1656	43.3
Social-justice words	138	3.6

Note. CVD = cardiovascular disease. All other health conditions (e.g., asthma, infant mortality, influenza, pneumonia, sexually transmitted diseases and infections, substance abuse) each accounted for less than 5% of articles per year.

FIGURE 1—Distribution of articles on racial/ethnic health disparities, by mention of primary disease or health topic: 40 US newspapers, 1996–2005.

contrast, most solutions were provided by advocacy groups (18.4%), the media (17.9%), nonacademic health professionals (13.5%), and lay people (12.7%).

Causal Explanations

The majority of causal explanations focused on multilevel factors (34.3%), followed by behavioral (30.1%), societal (16.7%), health care (12.6%), and genetic (6.2%) factors (Table 2). The top multilevel cause was behavioral/societal (26.3%), followed by societal/health care (18.0%), behavioral/health care (17.3%), and behavioral/health care/societal (13.6%) factors. When we break out the multilevel group into these separate categories and examine time trends for all causal categories, behavioral causes lead the discourse (Figure 2a).

There was no significant linear trend in any of the causal explanations from 1996 to 2005 (behavioral, $P=.696$; multilevel, $P=.134$; societal, $P=.970$; health care, $P=.251$; genetic, $P=.587$). However, some significant year-to-year changes suggest patterns of competing attention. For example, behavioral causes decreased significantly by 10% from 1998 to 1999 ($P=.027$) and by 15% from 2001 to 2002 ($P=.010$), times when health care causes increased significantly by 10% ($P=.005$ and $P=.014$, respectively; Figure 2a).

Solution Explanations

Nearly half of the solutions focused on behavioral-level changes (48.1%), followed by societal-level policies (23.2%), changes in health care access and the health care system (12.7%), and genetic therapies (4.5%; Table 2). Unlike causal explanations, there were relatively few multilevel solutions (11.5%). The top multilevel solution was behavioral/societal (38.9%), followed by societal/health care (25.0%) and behavioral/health care (13.9%) solutions.

Only behavioral-level solutions declined significantly ($P=.011$) from 1996 to 2005; there was no significant linear trend in any of the other solution explanations (societal, $P=.209$; genetic, $P=.845$; health care, $P=.234$; multilevel, $P=.675$; Figure 2b). There were some significant year-to-year changes in solution explanations, suggesting patterns of competing attention. For example, behavioral solutions decreased significantly by 26% from 1997 to 1999 ($P=.002$) and by 24% from 2001 to 2002 ($P=.005$), times when societal solutions increased significantly by 22% ($P=.003$) and 12% ($P=.099$; Figure 2b).

DISCUSSION

Our results suggest that media attention to racial/ethnic health disparities has been declining over the study period, despite increased academic research on racial/ethnic health disparities during this time.[41] Although racial/ethnic health disparities are prominently covered in the front section of newspapers, racial/ethnic health disparities are not often the central focus of articles that mention them, which may explain why nearly 70% of articles in our sample did not provide causal or solution explanations.

Despite the decline in the total number of articles, the relative attention to diseases and racial groups remained stable over time. Three diseases (CVD, HIV/AIDS, cancer) and 1 racial group (African American) dominated the media discourse on racial/ethnic health disparities, which is consistent with Amzel and Ghosh's findings.[34] Although attention to specific racial/ethnic health disparities fluctuated from year to year, no single health topic garnered more than 5% to 25% of all racial/ethnic health disparity coverage in any given year. This may be because arenas for public debate have a finite carrying capacity,[47] forcing issues to compete for attention in the same limited space.[48] Indeed, CVD, cancer, and HIV/AIDS have consistently competed for attention in the top 3 spots each year. Their prominence may be attributable to disease burden; African Americans have the highest rates of mortality from CVD, cancer, and HIV/AIDS of any racial/ethnic group in the United States.[1,2] Previous studies suggest that overall disease burden, strong advocacy contingencies, and controversies surrounding the issue can influence media agendas.[49] Further exploration of factors driving racial/ethnic health disparity coverage is warranted.

Consistent with previous research on media coverage of health[37–39] and health care disparities,[35] we found that behavioral explanations were most commonly presented in newspaper coverage of racial/ethnic health disparities, for both causes and solutions. However, societal-level explanations made up a sizable proportion of both causal and solution attributions, second only to behavioral-level explanations. Although previous studies have suggested that individual blame dominates the media discourse about health, our findings indicate that this may be less true for news coverage of racial/ethnic health disparities. In a recent study[37] of newspaper coverage of type 2 diabetes, Gollust and Lantz found that articles mentioning racial/ethnic or
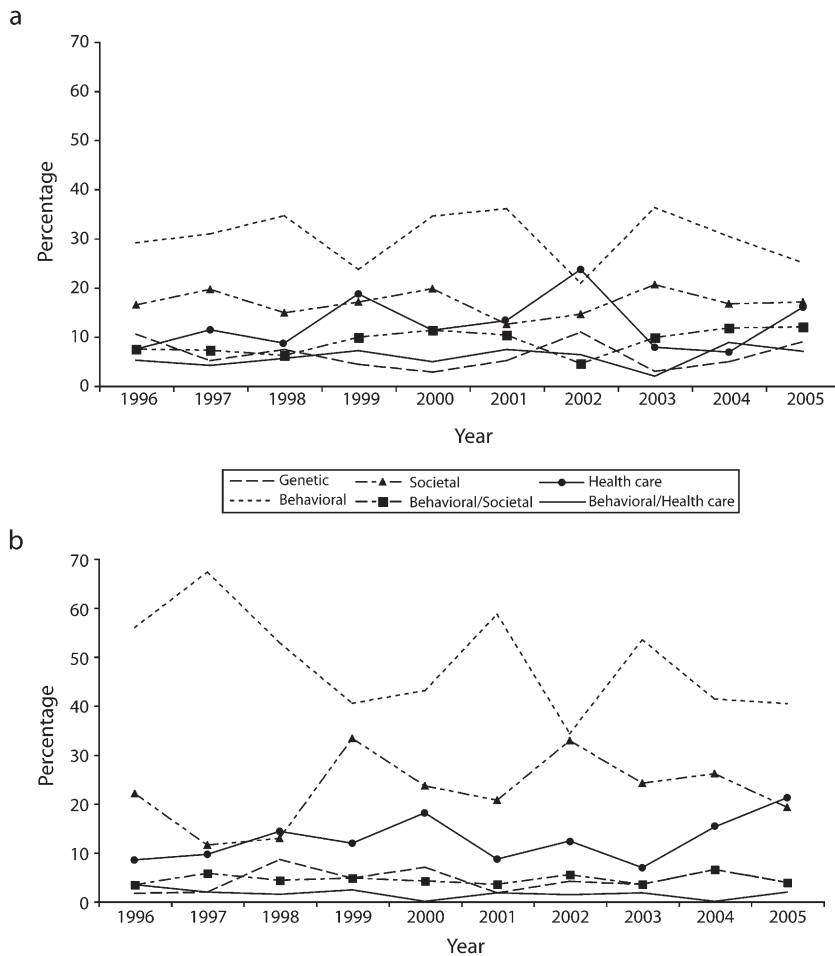
TABLE 2—Distribution of Articles on Racial/Ethnic Health Disparities, by Primary Racial/Ethnic Group Mentioned, Agent Providing Causal/Solution Explanations, and Type of Causal/Solution Explanation: 40 US Newspapers, 1996–2005

	Articles (N = 3823), No (%)	Articles With ≥ 1 Causal or Solution Explanation (n = 1164), No. (%)	Total Causal Explanations[a] (n = 1267), No. (%)	Total Solution Explanations[a] (n = 624), No. (%)
Primary racial/ethnic group mentioned				
Black/African American	2925 (76.5)			
Latino/Hispanic	314 (8.2)			
Asian	76 (2.0)			
Native American	45 (1.2)			
Multiple races	81 (2.1)			
Nonspecific characterization	382 (10.0)			
No causal/solution explanation	2659 (69.6)			
≥ 1 causal/solution explanation	1164 (30.4)			
Agent providing explanation[b]				
Academic researcher		311 (26.7)	284 (22.4)	74 (11.9)
Media		307 (26.4)	243 (19.2)	112 (17.9)
Health professional		256 (22.0)	217 (17.1)	84 (13.5)
Advocacy group		216 (18.6)	147 (11.6)	115 (18.4)
Laypeople		154 (13.2)	107 (8.4)	79 (12.7)
Federal agency		149 (12.8)	117 (9.2)	54 (8.7)
City/state agency		123 (10.6)	82 (6.5)	67 (10.7)
Research institution		57 (4.9)	52 (4.1)	11 (1.8)
Politician		32 (2.7)	15 (1.2)	25 (4.0)
Causal explanation		1000 (85.9)		
Genetic			79 (6.2)	
Behavioral			382 (30.1)	
Societal			212 (16.7)	
Health care			160 (12.6)	
Multilevel causes			434 (34.3)	
Top 5 multilevel causes[c]				
Behavioral/societal			114 (26.3)	
Societal/health care			78 (18.0)	
Behavioral/health care			75 (17.3)	
Behavioral/societal/health care			59 (13.6)	
Genetic/behavioral			45 (10.4)	
Solution explanation		536 (46.0)		
Genetic				28 (4.5)
Behavioral				300 (48.1)
Societal				145 (23.2)
Health care				79 (12.7)
Multilevel solutions				72 (11.5)
Top 5 multilevel solutions[c]				
Behavioral/societal				28 (38.9)
Societal/health care				18 (25.0)
Behavioral/health care				10 (13.9)
Behavioral/societal/health care				7 (9.7)
Genetic/behavioral				5 (6.9)

[a]We coded for up to 4 causal and solution explanations per agent per article. These totals represent the number of causal and solution explanations given by all agents who provided explanations.
[b]We coded for up to 4 agents mentioned per article. Thus, totals are greater than total number of articles and sum to more than 100%.
[c]All other multilevel causal/solution categories made up less than 4% of the total.

a

b

Note. For the multilevel attribution categories, only the top 2 are presented.

FIGURE 2—Percentages of all causal and solution explanations given in articles on racial/ethnic health disparities, by year, for (a) causal explanations and (b) solution attributions: 40 US newspapers, 1996–2005.

socioeconomic disparities were more likely to discuss social-determinant causes (odds ratio [OR]=10.1; 95% confidence interval [CI]=5.16, 19.7; *P*<.001) and policy-level solutions (OR=3.16; 95% CI=1.74, 5.73; *P*<.001) than were general articles about diabetes. These findings and our study results suggest that the social determinants of health perspective may be given more attention in newspaper articles about health disparities than previously hypothesized.

However, public exposure to the social-determinants perspective may be limited, given that news articles about health disparities represent only 0.1%[34] to 13.6%[37] of all health news. Furthermore, although social-movement

theory suggests that use of "injustice frames" can help mobilize public action,[50] our results show that racial/ethnic health disparities have not been framed as a social injustice, which may limit our ability to mobilize public support for policy solutions to eliminate racial/ethnic health disparities. Finally, the prominence of multilevel causal explanations, which focus most on behavioral causes in combination with another factor, may diminish the salience of societal-level causes and underscore the importance of behavioral causes above all else.

Effectively communicating the social-determinants perspective is not without challenges. First, previous research suggests that

health-disparity articles may inadvertently elicit negative emotional reactions and lower intentions for healthy behaviors among racial/ethnic minorities.[51] Therefore, efforts to educate the larger public must be balanced with the need to minimize unintended harm to racial/ethnic minorities. Second, research suggests that the public's perceptions about who deserves what in our society ultimately influence public support for government action.[52] For example, Gilens[52] found that although the public supports the basic principle that government should help ensure equitable opportunities for all, people were largely opposed to welfare programs because of perceived racial stereotypes that welfare recipients are poor Blacks who are undeserving, despite evidence to the contrary. The extent to which perceived racial stereotypes may also influence public support of government policies to address racial/ethnic health disparities should be examined. Third, individuals are difficult to mobilize if they do not have a personal stake in a policy outcome,[50] so societal-level solutions need to address how the larger public benefits from eliminating racial/ethnic health disparities (e.g., lowering national health care costs). In a recent review, Niederdeppe et al.[53] provided a framework of communication strategies for designing messages about the social determinants of health. Their strategies included the use of narratives depicting individuals facing structural barriers and evocative visual images. More research is needed to understand how these strategies can be maximized in designing effective messages.

In the interim, public health professionals can support ongoing media advocacy and public education efforts to raise awareness about the social determinants of health. For example, California Newsreel's documentary *Unnatural Causes: Is Inequality Making Us Sick?* examines the underlying causes of health disparities and has been used by communities and organizations nationwide to initiate dialogue about the social determinants of health.[54] Additionally, the recent Robert Wood Johnson Foundation report, *Beyond Health Care: New Directions to a Healthier America*, provides policy recommendations such as funding food-stamp programs and investing in early education as strategies for ensuring equitable health for all Americans.[55] These resources can be used to raise awareness and spur action around policy

initiatives to eliminate racial/ethnic health disparities. Finally, researchers can help shape the media discourse by influencing how their work is framed in interviews and press releases. This point is especially important, as we found that researchers were quoted most heavily for causal explanations, but considerably less for solution recommendations.

Limitations

To our knowledge, our study is the first to examine how the news media frame causes and solutions for racial/ethnic health disparities across multiple health conditions and racial/ethnic groups in a representative sample of US newspapers across a decade. However, this study is not without limitations. Although we took extensive steps to develop a comprehensive search strategy, we may have missed some articles about racial/ethnic health disparities, thereby limiting the generalizability of our findings. Furthermore, we only examined newspaper coverage, so our results may not be generalizable to other news sources (e.g., television, Internet). Finally, our data do not examine factors that influence fluctuations in coverage and framing of racial/ethnic health disparities. The focus of this paper was to provide a broad landscape of how racial/ethnic health disparities and causal and solution framing attributions compete for attention over time. In follow-up analyses, we are examining whether the level of attributions varies by disease, racial/ethnic group affected, and characteristics of newspapers and their audiences.

Conclusions

Newspaper coverage of racial/ethnic health disparities has focused primarily on 3 diseases and 1 racial/ethnic group. Although the social-determinants perspective has been represented in the media discourse, it still trails behind behavioral-level explanations for why racial/ethnic health disparities exist. The declining coverage of racial/ethnic health disparities and the media bias toward individual-level explanations may partly explain why the public is largely unaware of disparities in health and why people in our society prioritize individual responsibility for health problems. If we are to move beyond individual solutions to eliminate racial/ethnic health disparities, more research

is needed to better understand how the public interprets these competing explanations and how we can design effective messages to raise awareness about the social determinants of health. ∎

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Contributors

A. E. Kim conceptualized the study, supervised all aspects of its implementation, and led the data analysis and the writing of the article. S. Kumanyika assisted with study design, measures development, and interpretation of findings. D. Shive conducted all data analysis and assisted with writing the article. U. Igweatu and S.-H. Kim assisted with data collection and writing the article. All authors reviewed drafts of the article.

Human Participant Protection

Institutional review board approval was not necessary for this study because the data were obtained from publicly available newspaper articles.

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