

## **UC Davis**

### **Recent Work**

#### **Title**

The Biomedical Legacy in Minority Health Policy-Making, 1975-2002

#### **Permalink**

<https://escholarship.org/uc/item/3mh9t5dk>

#### **Authors**

Halfmann, Drew

Rude, Jesse

Ebert, Kim

#### **Publication Date**

2005-08-11

Peer reviewed

## **The Biomedical Legacy in Minority Health Policy-Making, 1975-2002**

Drew Halfmann

Jesse Rude

Kim Ebert

Department of Sociology

University of California, Davis

### **ABSTRACT**

Through content analysis, the study traces the relative prominence of “biomedical” and “public health” approaches in congressional bills aimed at improving the health of racial and ethnic minorities over a 28-year period. It documents a surge of interest in minority health during the late 1980s and early 1990s and highlights the dominance of biomedical initiatives during this period. Drawing on historical methods and interviews with key informants, the paper explains these patterns by detailing the ways in which policy legacies shaped the interests, opportunities and ideas of interest groups and policy-makers.

Since the mid 1980s, the United States has witnessed marked growth in policy-making on the health of racial and ethnic minorities.<sup>1</sup> This expansion began with the 1985 report of the U.S. Department of Health and Human Services (HHS) Task Force Report on Black and Minority Health—the first government report to deal comprehensively with the issue of racial and ethnic health disparities (U.S. Department of Health and Human Services, 1985). Subsequent developments included the establishment of minority health offices in the Public Health Service (PHS), the National Institutes of Health (NIH) and most states, as well as the elevation of the NIH office to center status, giving it independent grant-making authority.

In this paper, we examine proposals for improving the health of racial and ethnic minorities that reached the congressional agenda from 1975 to 2002 in the form of introduced bills. We address two questions: First, what was the relative prevalence of "biomedical" and "public health" idea packages over time? Second, what explains these patterns? We begin by describing our methods, including the identification of five minority health policy “packages” and six “sub-packages”. We follow this with an overview of minority health policy-making, attending to congressional enactments that incorporated the biomedical and public health packages. We then present historical trends in the relative prevalence of these packages in congressional bills. Finally, we offer an explanation for those trends that shows how policy legacies influenced the interests, opportunities and ideas of policy-makers and interest groups, and highlights the role of events exogenous to the minority health policy domain such AIDS and women’s health movements and the development of the “new perspective on health”.

## **MEASURING POLICY PACKAGES**

The study combines content analysis, interview and historical methods. We conducted confidential interviews with 45 key informants—members of Congress and their staffs, federal

and state officials (both appointed and non-appointed), as well as researchers and representatives of interest groups. The organizational affiliations of the informants are listed in Table 1. The study also draws on observations at the 2002 annual legislative conference of the Congressional Black Caucus Health Brain Trust and at the 2002 Department of Health and Human Services National Leadership Summit on Eliminating Racial and Ethnic Disparities in Health.

### **TABLE 1 ABOUT HERE**

For the content analysis, we first developed a list of possible policy proposals for addressing the health of racial and ethnic minorities. We based this list on several sources: the HHS *Healthy People 2000* report, congressional hearings on minority health, interviews with key informants, and selective reading of academic journals, the prestige press, and reports of major foundations. Our list contained 63 possible proposal codes. We then conducted subject searches in the U.S. Congress's THOMAS database and identified all bills (N=147) that dealt with health and explicitly targeted racial and ethnic minorities from 1975 to 2002 (see Methodological Appendix for selection criteria). We then performed content analyses of the bill summaries using our proposal codes.

Gamson and Modigliani (1987; 1989) argue that policy ideas on particular issues are “organized and clustered” into “packages”. Through our reading of a wide variety of works on minority health and the bills themselves, we arrived at five main proposal packages that encompassed the 63 proposal codes: *Biomedical*, *Public Health*, *Non-Health Social Welfare*, *Government Capacity and Accountability*, and *Community Participation*. Below, we provide a brief description of the five packages and offer a more detailed description in Table 2.

### **TABLE 2 ABOUT HERE**

#### **Biomedical Package**

Lavis (2000:314) contrasts the Biomedical and Public Health packages as follows:

The public health model adopts a multicausal and ecological perspective that allows for reciprocal associations among variables. Its focus is groups of people, usually communities, and its goal is health promotion and disease prevention.

The biomedical model “typically refers to a unidirectional, biological cause-and-effect relationship between an agent and host” (Runyan 1985:605). Its focus is individuals and its goal is the medical cure of disease.

Our Biomedical package includes three sub-packages: biomedical research; access and utilization of medical and mental health care (including dental care); and the quality and equality of medical and mental health care. Proposals within the *Biomedical Research* sub-package include conducting research on particular diseases, conducting research on biological differences between racial and ethnic groups, including and protecting minorities in research trials, and recruiting and training minority biomedical researchers. Proposals within the *Biomedical Access* sub-package include increasing insurance coverage for minorities; setting up clinics in neighborhoods, schools and public housing; and ensuring that health care facilities are located in areas that serve minorities. The *Biomedical Quality* sub-package includes proposals on increasing the linguistic and cultural competence of health care providers and institutions, enforcing anti-discrimination laws, and recruiting and training minority health providers.

### **Public Health Package**

The Public Health package also contains three sub-packages: clinical preventive services, health promotion and health protection. The *Clinical Preventive Services* sub-package includes immunization and vaccination, and the screening, monitoring and early diagnosis of diseases.

Proposals within the *Health Promotion* sub-package include reducing unhealthy or risky individual behaviors relating to drugs, alcohol, tobacco, sexual behaviors, diet, exercise, homicide, suicide, and accidents. The *Health Protection* sub-package includes proposals on the reduction of health risks through population-level rather than individual-level interventions. Such interventions include the legal regulation or taxation of guns, crime, drugs, alcohol and tobacco, as well as efforts to ensure auto and highway safety, food safety, sanitation, and occupational health and safety. This category also includes environmental regulation and cleanup.

### **Non-Health Social Welfare Package**

Relevant policies within the Non-Health Social Welfare package include education (non-health), housing, residential integration, income support, employment policies, and income redistribution. This package is no doubt under-represented because we only analyze bills that explicitly address health. To do otherwise would expand the scope of the project beyond our resources.

### **Government Capacity and Accountability Package**

The Government Capacity and Accountability package includes establishing offices of minority health in federal and state bureaucracies, mandating strategic plans, and improving data collection on health disparities.

### **Community Participation Package**

Proposals within the Community Participation package include attempts to promote the participation of members of local and minority communities in the planning of health care provision, in public health interventions, and in research on health disparities.

Below, we present data on the prevalence of these packages, paying particular attention

to the interplay of biomedical and public health approaches in minority health policy. First, however, an overview of the history of minority health policy-making is in order. As our subsequent discussion of policy legacies shows a complex interaction of historical forces has driven the trends in minority health policy over the past three decades. A better understanding of this history can help us to explain these trends.

## **AN OVERVIEW OF MINORITY HEALTH POLICY-MAKING**

In this section, we detail major events in minority health policy-making, including executive actions, legislative enactments and focusing events (see Table 3). In the section that follows this one, we focus not only on legislative *enactments*, but on all 147 bills introduced in Congress.

### **The Ford and Carter Administrations**

In the 1970s, attention to minority health was minimal and most enactments were biomedical. The 94<sup>th</sup> Congress enacted an alcoholism treatment and prevention bill that targeted minorities (S. 3184), and in the 95<sup>th</sup> Congress, a health care research and statistics bill called for regular assessment of the health problems of low-income and minority groups (S. 2466).

In 1979, the Surgeon General released the first *Healthy People* report, establishing five broad national health goals but none of these goals targeted racial and ethnic or income-based health disparities (U.S. Department of Health Education and Welfare, 1979). However, the following year, when it established 219 objectives for the attainment of these goals, the Public Health Service named five specific objectives for reducing racial and ethnic or income-based health disparities (in infant mortality, maternal mortality, low-weight births, prenatal care, and homicide).

Meanwhile, the 96<sup>th</sup> Congress enacted three minority health bills. It enacted a drug abuse, prevention, and treatment bill that targeted minorities and people with limited English language skills, created the position of Associate Director for Underserved Populations in the National Institute on Drug Abuse (NIDA) and required state drug abuse plans to address the needs of minorities. It also established the position of Associate Director for Minority Concerns within the National Institute of Mental Health and required data collection on the supply of minority health personnel (S. 525, S. 1177 and S. 7203).

### **The Reagan Administration**

In the early 1980s, attention to minority health remained low and enactments incorporated both public health and biomedical approaches. The 97<sup>th</sup> and 98<sup>th</sup> Congresses revised the Older Americans Act (OAA) of 1965 (which includes nutrition and long-term care services) to target minorities. The 97<sup>th</sup> Congress required services under the Act to be linguistically competent (S. 1086). The 98<sup>th</sup> Congress required the Office on Aging to consult with national minority organizations to develop training packages to help states reach elderly minority groups, called for the inclusion of minorities on advisory councils, and directed agencies to expand outreach to minorities (S. 2603).

A shift in minority health policy occurred in the mid-1980s, owing in large part to HHS Secretary Margaret M. Heckler. In 1984, Heckler released the department's annual report on the nation's health status and noted that minority groups suffered a "persistent and continuing disparity in the burden of death, illness and disability." She disputed critics who argued that Reagan's budget cuts had contributed to a widening in these disparities. She then announced the creation of a task force on minority health to be directed by Thomas E. Malone, the African-



American deputy director of the NIH (*New York Times*, January 18, 1984, p. A17; *Washington Post*, January 18, 1984, p. A2).

In October 1985, Malone's group released a seven-volume report that likely went beyond the Reagan Administration's wishes (U.S. Department of Health and Human Services, 1985). It estimated 60,000 “excess” deaths among African Americans each year. Eighty percent of these were the result of disparities in six major causes of death: cancers; cardiovascular disease; homicide, suicide and unintentional injuries; diabetes; infant mortality and cirrhosis. The report also showed differences in death rates between whites and Hispanics and Native Americans. Although the report mentioned poverty, lack of health insurance, and poor prenatal care as causes of health disparities, Heckler, under Administration orders, did not propose new funds or programs. She did allocate \$3 million for a new Office of Minority Health (OMH) in the HHS that would target existing funds and monitor minority health.

In response to the report, black and minority health was a major subject at the 1986 annual convention of the Congressional Black Caucus. That same year, the Association of Minority Health Professions Schools (AMHPS), a group of eight historically-black schools of medicine, pharmacy and dentistry, teamed up with organizations of black medical professionals and the Children’s Defense Fund to form the National Health Coalition for Minorities. The Coalition fought Reagan Administration budget cuts that threatened Medicaid and Medicare, research on minority health, and the training of minority health professionals. The most visible individual in this coalition was Dr. Louis W. Sullivan, president of the Morehouse School of Medicine (*Washington Post*, April 12, 1986, p. A7; *Washington Post*, October 14, 1986, p. Z17).

The Malone report resulted in a flood of legislation in the late 1980s. The 100<sup>th</sup> Congress enacted four minority health bills. It established a “National Minority Cancer Awareness

Week.” It mandated state grants for demonstration projects to provide drug treatment targeted to minorities. It gave grants to health professions schools for the education of minorities. And the omnibus public health service bill required the NIH to include minority groups in AIDS research, mandated research on the supply of minority health professionals, and required a study of the availability of language appropriate health care for Hispanics (H.J.RES. 119, H.R. 5210, S. 769 and S. 2889).

In 1988, the state of Ohio established the first state office on minority health. Several other states soon followed. In all, thirty-five states have established minority health offices and seven others have designated minority health liaisons. Only seven states have done neither (Alaska, Colorado, Idaho, Kansas, North Dakota, South Dakota and Washington) (Office of Minority Health Resource Center, 2002).

### **The Bush Administration**

President Bush appointed Sullivan, life-long Democrat and friend, to head HHS. Sullivan pledged to improve the health of minorities, but in his first year he was widely perceived as an ineffective outsider with only weak ties to the White House. His stock rose, however, when he began a series of public attacks on the tobacco industry for marketing cigarettes to African Americans and working-class women.

The 101<sup>st</sup> Congress enacted three minority health bills. It expanded perinatal facilities in states where infant mortality rates for the poor and minorities were above the national average. It required the National Bone Marrow Donor Registry to increase the number of minorities in the donor pool. It also enacted the *Disadvantaged Minority Health Improvement Act of 1990*. The \$112 million Act legislatively established the already existing Office of Minority Health within HHS; mandated the creation of an information clearinghouse on minority health; provided

finding for primary care and counseling in public housing projects; established grants to increase the number of minority health professionals; directed the National Center for Health Statistics to collect data on minority health; and reauthorized community and migrant health centers (H.R. 5112, S. 2946 and H.R. 5702).

In 1991, the Public Health Service released the *Healthy People 2000* report. In contrast to the 1979 report, the reduction of health disparities was one of three major goals. The report devoted considerable attention to "special populations"—people with low income, racial and ethnic minorities, and people with disabilities. Of its 300 objectives, 50 targeted special populations. Typically, these objectives represented a narrowing of the gaps in health status between special populations and the general population, but they did not seek to eliminate those gaps (U.S. Department of Health and Human Services, 1991).

The 102<sup>nd</sup> Congress enacted four minority health bills. It authorized substance abuse treatment demonstration projects targeted to minorities. It required Older Americans Act state agencies to set specific goals for providing services and developing advocacy and outreach programs for low-income and minority individuals. It provided grants to health professions schools to increase the number of minority faculty and students. And it approved training Head Start personnel to provide services to children from non-English language backgrounds (S. 1306, H.R. 2967, H.R. 3508 and H.R. 5194).

### **The Clinton Administration**

In 1992, the NIH Office of Research on Minority Health (ORMH) launched its Minority Health Initiative, funding biomedical and behavioral research at an initial budget of \$45 million (Office of Research on Minority Health, 2002). In the same year, the Clinton Administration released its annual report on the nation's health. As usual, the report showed major racial and

ethnic health disparities. HHS Secretary Donna Shalala argued that the disparities demonstrated the need for passage of the Administration's health reform plan (*Los Angeles Times* September 16, 1993, p. A18).

The 103<sup>rd</sup> Congress required state developmental disabilities plans to include assurances of minority participation. It also required the Veteran's Administration to include women and minorities in clinical research. The NIH Revitalization Act formally established the Office of Research on Minority Health (ORMH) and required that all NIH-sponsored phase III clinical trials include enough women and minorities to perform valid subset analyses (S. 1284, H.R. 3313, S. 1).

The election of a Republican majority resulted in a decline in minority health proposals—especially in public health. The 104<sup>th</sup> Congress enacted two bills with minority health provisions. It required Ryan White planning councils to reflect the demographics of HIV. It also directed the EPA to identify groups at greater risk from contaminants in drinking water (S. 641, S. 1316).

In the late 1990s, minority health received new impetus from the White House. In May 1997, President Clinton apologized for the Tuskegee experiment, in which the syphilis of 400 African-American men went untreated so that PHS researchers could observe the trajectory of the disease. The next month, Clinton launched the President's Initiative on Race, leading to the publication of a chart book that included health indicators broken down by race and ethnicity. In 1998, Clinton made minority health disparities the subject of a Saturday radio broadcast and established the goal of eliminating them by 2010. In February of that year, he announced the HHS Initiative to Eliminate Racial and Ethnic Disparities in Health. The initiative included the Racial and Ethnic Approaches to Community Health program (REACH 2010), which was

funded at \$10 million in its first year and provided grants to 32 community coalitions to reduce health disparities in 18 states. The initiative also called for public-private public collaboration and established an HHS taskforce on disparities. Subsequently, HHS established goals to eliminate disparities in six areas by 2010: infant mortality, cancer, cardiovascular disease, diabetes, HIV/AIDS, and immunizations.

The 105<sup>th</sup> Congress required the bone marrow donor registry to give priority to minorities. It called on the NIH to research the causes of cardiovascular disease among women and, in particular, among African Americans and other minorities. It also reauthorized grants to health professions schools for minority recruitment, established an advisory committee for the Office of Minority Health in HHS, and funded data collection on minority health by the National Center for Health Statistics (H.R. 2202, S. 1722, and S. 1754).

In 1999, the Clinton Administration and the Congressional Black and Hispanic caucuses developed the Minority HIV/AIDS Initiative. The package of programs provided \$156 million in grants administered by OMH, CDC, NIH, the Substance Abuse and Mental Health Services Administration (SAMHSA), the Indian Health Services (IHS), and the Health Services and Resources Administration (HSRA) (COSMOS Corporation, 2000). That same year, the IOM released a report finding that the NIH's efforts to research cancer among minorities were inadequate (U.S. Institute of Medicine, 1999). Senator Bill Bradley made racial and ethnic health disparities an important issue in his presidential campaign.

The 106<sup>th</sup> Congress enacted two minority health bills. The first was an amendment to the Older Americans Act that required the Administration on Aging to take corrective action if new co-payments reduced participation by minorities. The second was a \$350 million bill that upgraded the Office of Research on Minority Health in the NIH to center status. The bill also set

up "Centers of Excellence" for research on health disparities and the training of minority health professionals, established extramural loans for health disparities research, requested a report of NIH resources devoted to health disparities research, required healthcare disparities research by Agency for Healthcare Research and Quality, directed the Institute of Medicine to study HHS data collection on race and ethnicity, and required HHS to undertake a public awareness campaign (H.R. 782, S. 1880).

In his January 2000 State of the Union Address, President Clinton decried racial and ethnic health disparities and touted the NIH centerbill (*Washington Post*, April 10, 2001, p. A17). In the same year, PHS released its *Healthy People 2010* report. Eliminating health disparities was one the report's two central goals. While the previous *Healthy People* report had contained separate targets for special populations and the general population, accepting that a gap would persist, the latest report included the same targets for both.

### **The George W. Bush Administration**

In March 2002, the IOM issued a report finding that racial and ethnic minorities receive lower-quality health care regardless of income or insurance status. The report suggested that the HHS Office of Civil Rights receive more money to adequately enforce anti-discrimination laws in health care (U.S. Institute of Medicine, 2003). Meanwhile, the 107<sup>th</sup> Congress required the inclusion of minorities in FDA pediatric studies (S. 1789).

This historical overview reveals ebbs and flows in attention to minority health, the number of legislative enactments, and the degree to which they incorporated public health or biomedical proposals. Table 3 summarizes bill enactments over the 28-year period. As the table shows, Congress enacted 28 bills containing biomedical proposals, but only 10 bills containing

public health proposals. Between 1993 and 2002, Congress enacted 10 bills containing biomedical proposals, but only 2 bills containing a public health proposal.

### **TABLE 3 ABOUT HERE**

In the following section, we move away from a focus on legislative enactments and executive branch activity to focus on the proposals (enacted or not) considered by Congress over the same period. These proposals reveal how Congress thought about minority health and how it tried to address it.

### **TRENDS IN MINORITY HEALTH PROPOSALS, 1975-2002**

An analysis of minority health bills from 1975 to 2002 reveals considerable variation in their frequency and content over time. As Figure 1 shows, there were approximately five bills on minority health per Congress until 1987-88 when the number of bills doubled and eventually peaked at just over 20 bills in 1993-94. In 1995-96 and 1997-98, the number of bills declined, but began to rise again in 1999-2000.

### **FIGURE 1 ABOUT HERE**

Turning to the content of the bills, approximately 43 percent focused primarily on minority health while the remaining 57 percent dealt mainly with the health of the general population or low-income people while targeting minorities in some way. If we sort the minority health bills into the five packages and six sub-packages discussed above, access and utilization of medical (and mental health) care was the most prevalent, followed by government capacity and accountability, health promotion, quality of medical care, and biomedical research (see Figure 2). Only a small number of bills dealt with clinical preventive services, health protection, non-health social welfare policies or community participation. Because of the complexity of many of the bills, we included some in more than one package—a common approach in studies

of this type (Burstein et al., 1995). Within these packages and sub-packages, the most common individual proposals were as follows: creating new government institutions (including advisory committees) (39 bills), recruiting and training minority health providers (31), targeting biomedical research towards diseases with large disparities (21), improving data collection on health disparities (21), improving cultural competence of health providers (including language competence) (20), drug abuse prevention and awareness (18), alcohol abuse prevention and awareness (13), recruitment and training of minority biomedical researchers (11), inclusion of minorities in biomedical research trials (9), and prevention of pregnancy and sexually-transmitted diseases (9).

### **FIGURE 2 ABOUT HERE**

If we divide the bills into the two packages of biomedicine and public health, we find that 84 percent of the bills contained biomedical proposals while only 46 percent contained public health proposals. Thirty-three percent of the bills contained both types of proposals. In addition to the prevalence of biomedical bills, an indicator of biomedical dominance is that 61 percent of biomedical proposals appeared in bills without public health proposals. By contrast, only 30 percent of public health proposals appeared in bills without biomedical proposals. In other words, public health proposals most often appeared in combination with biomedical proposals, but biomedical proposals most often appeared alone.

Examining the two packages over time, our analysis suggests five relatively distinct periods for minority health proposals (see Figure 3). In the first (1975-1980—the Ford and Carter administrations), there were few bills of either type, but bills containing biomedical proposals outnumbered those containing public health proposals. During the second period (1981-1986—the first six years of the Reagan Administration), there were still few minority



health bills, but there were roughly equal numbers of each type of proposal. An upsurge in minority health bills occurred in the third period (1987-1994). This was the period immediately following the release of the Malone report and included the Bush and early Clinton Administrations. The number of both types of bills increased, but the number of biomedical bills increased much more than public health bills. In the fourth period (1995-1998) with a new Republican congressional majority, both types of bills declined, but public health bills declined more sharply. In the fifth period (1999-2002), the number of minority health bills rose again as the Clinton administration committed to eliminating health disparities by 2010. Both types of bills increased, but biomedical bills continued to outpace public health ones. Surveying all five periods, biomedical bills outnumbered public health bills in every period, but public health bills were still fairly well represented, and there were about the same number of both types of bills during the second period and the early part of the third.

### **FIGURE 3 ABOUT HERE**

Dividing the biomedical package into the biomedical research sub-package and medical care (the biomedical access and biomedical quality sub-packages) offers a more nuanced view of the trends. Figure 4 indicates that there were very few biomedical research bills until the 1987-88 Congress when the number of these bills began to increase. After that time, biomedical research bills accounted for a large portion of the gap between biomedical and public health bills.

### **FIGURE 4 ABOUT HERE**

These trends provoke three main questions. First, the biomedical package is dominant in most years. What accounts for this dominance? Second, although the biomedical package was dominant in most years, this was not uniformly the case. Notably, in the early 1980s, public health proposals were almost as numerous as their biomedical counterparts. What accounts for

this period of relative parity? Third, when the minority health issue achieved national prominence in the late 1980s and early 1990s (Period 3 of our analysis), Congress responded with more biomedical proposals than public health ones, and an important component of this increase was an increase in biomedical *research* proposals. Given the skepticism of many in the scientific community about the existence of innate, biological differences among racial or ethnic groups (Foster & Sharp, 2002) what explains the marked ascendancy of biomedical research initiatives for addressing racial/ethnic health disparities during this period?

### **THE “NEW PERSPECTIVE ON HEALTH” AND PUBLIC HEALTH PARITY**

Within the last three decades of minority health policy, the early 1980s appear to be anomalous in that public health proposals in Congress nearly equaled those with a biomedical orientation. To understand this period in minority health history, we must return to the decade immediately preceding it. Beginning in the 1970s, numerous scholars argued that medical care was only a small determinant of population health in comparison with factors such as sanitation, nutrition, healthy behaviors, environmental and workplace conditions, and income inequality (Fuchs, 1975; Marmot et al., 1984; McKeown, 1976). The "new perspective on health", as it was then called, became influential in academia, medicine, public health, state bureaucracies, and Congress. It was enshrined in government reports in Canada, Britain, and the U.S. (the Healthy People Report) (Great Britain Department of Health and Social Security, 1980; LaLonde, 1974; U.S. Department of Health Education and Welfare, 1979).

But the new perspective attracted the attention of progressives, who emphasized the need for greater structural changes and saw in it opportunities to ameliorate social conditions that lead to bad health for the poor and minorities. At the same time, the new perspective attracted the

attention of neo-conservatives, who emphasized personal responsibility for minority health outcomes and saw in it opportunities to cut health spending (Marmor et al., 1994).

This conflict played itself out in the aftermath of the 1985 Malone report. The report had concluded that many health disparities were preventable and stressed efforts to educate minority groups on ways to reduce health risks. According to HHS Secretary Margaret Heckler, "much of the health gap suffered by minority Americans—perhaps even most of it—is related to knowledge and lifestyle. Smoking, alcohol, diet and obesity are clearly linked to the higher cancer, cirrhosis, cardiovascular, infant mortality and other disease rates affecting our minorities." A critic from the Children's Defense Fund complained that "the report is misleading in its emphasis on self-help because it suggests that self-help is going to significantly narrow the gap between blacks and whites." Others complained it was hypocritical for the Reagan Administration to release its report while attempting to cut spending on Medicaid, community health centers, family planning and public health programs (*Washington Post*, October 17, 1985, p. A1; *New York Times*, October 17, 1985, p. A16).

The conflict between progressive and conservative versions of the "new perspective" was also evident within minority communities themselves. Many liberals and African Americans criticized HHS Secretary Sullivan for his emphasis on personal responsibility for health. In March 1990, Sullivan told a mostly black audience that African Americans "cannot hope to solve the problems confronting our young black men until we put a halt to the finger-pointing and the scape-goating and understand that it is primarily up to us—individually, our families, our communities, our institutions, our traditional ethical standards and cultural strengths—to save our young men. We must build our vision for a better future on the solid rock of personal and community responsibility" (*Boston Globe*, May 20, 1990, p. 22). Although the NAACP and the

NMA credited Sullivan for raising the nation's consciousness about minority health disparities, they criticized his opposition to national health insurance and other progressive reforms (*Washington Post*, August 18, 1990, p. A4). Thus, the rise in public health approaches during the 1980s was likely the result of the development of “the new perspective on health” and its embrace by both progressives and conservatives during a period of conservative government.

## **SOCIAL MOVEMENTS AND BIOMEDICAL RESEARCH**

While the events above help explain why public health proposals reached parity with biomedical proposals in the early 1980s, they cannot account for the expansion of biomedical research proposals in the late 1980s and early 1990s. This was a period of fairly stagnant NIH funding (though funding would eventually double between 1998 and 2003), so it is unlikely that the increase was the result of new levels of enthusiasm for biomedical research. Instead, we need to look at the experience of two contemporaneous social movements—the HIV/AIDS movement and the women’s health movement. These movements increased both the visibility of biomedical research and demands for its accountability during the late 1980s (Epstein, 1996, 2004; Weisman, 1998). HIV/AIDS activists pushed for the inclusion of more women and minorities in clinical trials because such trials offered access to otherwise unobtainable experimental treatments. And women’s health activists questioned whether the findings of clinical trials with only male participants could be extrapolated to women (Epstein, 2004). Both movements ended up producing minority health proposals. The women’s health movement pushed several bills that sought the inclusion of women and minorities in NIH and FDA clinical trials. And other bills sought the inclusion of minorities in AIDS research. The minority health movement largely embraced and echoed these demands. Some within it, however, argued that requirements for the inclusion of minorities in clinical research actually fostered racism because

they were predicated on the notion that race is a biological rather than a social category and that there are significant biological differences among races (Epstein, 2004).

Though the new perspective on health and contemporaneous social movements can help us to understand the period of parity between biomedical and public health bills and the rise in biomedical research proposals at the end of the 1980s, they cannot explain why biomedical proposals have been dominant for most of the period under consideration and remain so into the 21<sup>st</sup> century. For this, the concept of policy legacies is required.

### **POLICY LEGACIES AND BIOMEDICAL DOMINANCE**

Policy legacy arguments suggest that new proposals will build on previous policies—using them as positive or negative examples. They also suggest that existing policies may affect political actors' resources, incentives, cognitions, and access to information, as well as their normative beliefs about the legitimacy of certain practices, forms of organization, and organizations themselves (see Amenta, 1998; Bonastia, 2000; Esping-Andersen, 1990; Hall, 1989; Hall, 1986; Hecl, 1974; Pierson, 1992, 1994; Skocpol, 1992; Steinmo et al., 1992; Weir, 1992).

This theoretical orientation suggests that legacies of existing general health and minority health policies would have profound effects on the content of subsequent minority health proposals. Our data support this claim and suggest multiple mechanisms whereby policy legacies shaped the content of minority health proposals. We show that policy legacies have operated in four distinct ways. They have: (1) structured the minority health interest group sector (2) provided opportunities for the attachment of minority health proposals to broader bills (3) provided opportunities for the incremental expansion of minority health policies, and (4) shaped the cognitions of policy-makers and interest groups.

## **Structuring the Minority Health Interest Group Sector**

The United States spends more on health than any other country (14.6 percent of GDP in 2002) and approximately 45 percent of this is government spending. Spending on public health and prevention is minimal. Estimates range from one to five percent of all health spending (Brown et al., 1992; OECD, 2004; U.S. Public Health Service, 1993). In other words, the United States has a policy legacy of massive government investment in medical care and minimal investment in public health and prevention. This policy legacy has provided resources for the formation of medical interest groups and incentives for their participation in policy-making. As a result, the most numerous and most influential interest groups in minority health policy-making are offshoots of the medical care system (for a similar argument about general health policy, see Lavis & Sullivan, 2000). Of 36 national groups active on minority health, 44 percent are organizations of medical professionals. Another eight percent are not made up of health care professionals but are solely devoted to medical care issues (*Gale Group Associations Unlimited*).

The group that has been the most successful in influencing Congress is the Association of Minority Health Professional Schools (AMHPS). A founder and former president of the organization, Louis Sullivan, served as the Secretary of HHS during the first Bush Administration, and a former AMHPS board member, David Satcher, served as the Surgeon General and the Assistant Secretary for Health during the Clinton Administration. Employing a full-time Washington lobbyist and working closely with Congressman Louis Stokes (D-OH), AMHPS has secured the enactment of more minority health legislation than any other single actor. The two most important enactments, the Disadvantaged Minority Health Act of 1990 and the creation of the NIH Center on Minority Health and Health Disparities, were both proposed by AMHPS and resulted in considerable resource flows to its institutional members. After AMPHS,

the most influential group in minority health is the National Medical Association, an organization of African American doctors. NMA officials are well represented in the Congressional Black Caucus (CBC) Health Brain Trust and, according to one Congressional staff member, any major new piece of legislation on minority health must first be discussed with the NMA.

Several scholars have argued that the medical industry supports increased expenditure on medical care and opposes prevention and public health initiatives that might cut into that expenditure (Lavis & Sullivan, 2000; Marmor et al., 1994; McGinnis et al., 2002). In the case of minority health policy, the main effect of medical interest groups has not been to oppose legislation, but to propose it. When we asked members of Congress and their staffs why they had introduced particular proposals, they often answered that an interest group (usually a medical one) had come to them with the idea. Richard Hall (2000) argues that because of extreme demands on their time and attention, Congresspersons rely heavily on interest groups for policy ideas and proposals. Interest groups bear most of the costs of bill introduction—providing an informational and labor subsidy to members of Congress. Often an interest group develops the proposal, drafts the bill, helps write the Congressperson's speeches and press releases, and develops strategies for passing the bill. Our interviews uncovered a great deal of this type of behavior.

### **Providing Opportunities for Attaching Minority Health Proposals to Broader Bills**

Approximately 57 percent of minority health proposals were attached to bills with a broader purpose than minority health. Our research indicates that proposal attachment occurred in three different ways. First, a legislator (or interest group) decided to add a provision targeting minorities to her own broader bill—either because the legislator had an interest in minority

health, or because doing so provided an additional selling point or coalitional opportunity for the bill. Second, a legislator (or interest group) became aware of a broader bill and lobbied to have it target minorities. Third, a legislator (or interest group) sought to have her pre-existing minority health proposal attached to a broader bill.

An example of the first type of attachment is provided by the demands of the women's health movement for the inclusion of women in NIH and FDA clinical trials. The movement also demanded that minorities be included in such trials, apparently without being specifically requested to do so by minority health advocates. Thus, the women's health activism accounted for part of the increase in biomedical research proposals among minority health bills from 1989 to 1994 (103<sup>rd</sup> Congress, S. 1).

An example of the second type of attachment is provided by the Ryan White Care Act. In 1990, the Act provided primary care and supportive services to people with HIV/AIDS (P.L. 101-381). After the Act was implemented, minority interest groups complained that not enough Ryan White money was going to minorities. As a result, the 1996 reauthorization of the Act required that the health services planning councils that provide advice on Ryan White grant distribution be reflective of the demographics of the epidemic in their geographic area (104<sup>th</sup> Congress, S. 641). In another example, when the NIH budget doubled from 1998 to 2003, legislators concerned about minority health sought to ensure that a portion of the new money went to research on minority health. When we asked one legislative aide why his congressman had advocated for the expansion of the minority health office in NIH rather than in some other part of HHS, he replied, "Because that's where the money is."

An example of the third type of attachment is provided by Senator Matsunaga's (D-HI) bill to make the Assistant Secretary of the Veterans' Administration (VA) responsible for



monitoring and promoting minority access to VA services and benefits (101<sup>st</sup> Congress, S. 564). This bill was referred to committee and later became part of a much broader veterans' health care bill that passed the Senate (S. 13).

These examples suggest that the pool of broader bills available for attachment helps determine what types of minority health proposals are put forward. This pool is heavily dependent upon existing policies since much of policy-making involves building on existing bills or reauthorizing them. In fact, in his study of the reauthorization process, Hall (2002) found that the vast majority of bills introduced in Congress are related to pending reauthorizations. Since there are more biomedical policies in need of reauthorization than there are public health ones, the pool of bills available for attachment has a strong biomedical skew.

### **Providing Opportunities for Incremental Expansion of Minority Health Policies**

Not only were minority health proposals attached to bills that addressed broader health issues, but minority health proposals also built on existing minority health policies. Since most of these policies had a biomedical focus, new proposals did too. For example, in 1987, four historically-black health professions schools received federal funding for the establishment of Centers of Excellence for the training of medical care providers (100<sup>th</sup> Congress, S. 769). A few years later, Hispanic and Native American groups successfully sought such funding as well (100<sup>th</sup> Congress, H.R. 5702). To cite another example, in 1992, Congress established the Office of Research on Minority Health in NIH (103<sup>rd</sup> Congress, S. 1). In 2000, minority health advocates successfully upgraded this office to the National Center on Minority Health and Health Disparities (106<sup>th</sup> Congress, S. 1880).

## Shaping the Cognitions of Policy-Makers and Interest Groups

Policy legacies are also located in the minds of policy makers and interest groups. As “bounded rationality” theorists note, policy-makers act under conditions of uncertainty and ambiguity and have limited time, resources, and information. As a result, they rarely canvass all possible options, but instead rely on short lists, heuristics and rules-of-thumb. One insight of bounded rationality theory is that policy-makers often rely on old solutions to solve new problems (Cohen et al., 1972; Kingdon, 1984; Lavis, 2002; Zahariadis, 1999). In this case, the old solution is medical care. Despite widespread acceptance within academia of the proposition that medical care is only a minor determinant of disparities in health status, members of Congress and their staffs and representatives of minority health interest groups rarely mention non-medical interventions as a method of reducing disparities.

When we asked congressional informants how they prioritized or chose among different means of addressing minority health—biomedical, public health, or non-health social welfare policies—the question typically drew stammers or blank stares. We think this occurred for two reasons. First, although our informants in federal bureaucracies and academia had clearly spent a great deal of time thinking about this question, congressional informants seemed to think more at the level of individual proposals than at the level of these broader, somewhat abstract, categories. Second, as a rule, members of Congress and their staffs do not *explicitly* budget their time and attention between issues. Instead, they react to each individual issue on its own merits as it comes along. Our interviews uncovered few attempts by legislators to develop strategic plans or priority lists for addressing minority health. Some of this did take place within the Congressional Black Caucus, but it is not clear that this led to much legislation. The absence of abstract discussion of policy options and the reactive allocation of time and attention to proposals

suggest that policy-makers do not so much brainstorm a set of new solutions for a particular policy problem as evaluate proposed solutions (often with the help of interest groups) to determine if those proposals serve their policy and political goals. This practice serves to reinforce the use of old tools since these are the proposals that policy-makers are exposed to through incremental policy-making and the reauthorization of existing policies.

Furthermore, interest groups are adept at framing their preferred policy outcomes as solutions to the problems that legislators wish to solve. One interest group representative pointed out that AMPHS was particularly skilled at this:

Is the establishment of a national center the appropriate response to health disparities, or is the establishment of a national center the appropriate response to an IOM study that comes out and says that the Cancer Institute is not spending enough money on minority cancer research? It was AMPHS's solution to that problem. The establishment of a national center was their solution to any number of things that came up that they could use to demonstrate the need for the [Center]... You asked a lot about pipeline [minority recruitment to the health professions] and why have these solutions been put in place in response to these problems and the answer is because those are the solutions that AMPHS has been pushing.

The informant made a similar comment about AMHPS's role in the Disadvantaged Minority Health Improvement Act of 1990:

They've been talking about health status; they've been talking about disparities; they've been talking about improving access and all those kinds of things that you hear about at the Black Caucus. The trick that they've been able to perform is to

say, okay, you've got these things out there, you've got these issues, you've got these challenges, here's a solution that's in the national interest.

## **CONCLUSION**

In this study, we examined proposals for improving the health of racial and ethnic minorities that reached the congressional agenda from 1975 to 2002. We found that biomedical proposals dominated in most years and that a large part of the biomedical dominance after 1988 involved an increase in biomedical research proposals, spurred in part by the HIV/AIDS and women's health movements. There was a brief period of parity between biomedical and public health proposals during the early 1980s, which was related to the emergence of the "new perspective on health" and its embrace by both progressives and conservative budget cutters during the Reagan Administration.

We also argued that policy legacies have been and continue to be a key determinant of biomedical dominance in minority health policy-making. Policy legacies affected the interests, opportunities, and ideas of policy-makers and interest groups. They structured the minority health interest group sector, provided opportunities for attaching minority health proposals to broader bills, provided opportunities for the incremental expansion of minority health policies, and shaped the cognitions of policy-makers and interest groups. All of these mechanisms served to fuel the momentum of the biomedical package during the late 1980s and early 1990s. These mechanisms should prove useful in the study of other policy domains as well.

The policy legacy mechanisms discussed here present pitfalls for minority health policy-making. Because of them, rational actors may not always produce rational outcomes for those whom their policies are meant to assist. Racial and ethnic health disparities persist and most observers agree that biomedical solutions alone will not eliminate them. Our study suggests that,

in order for health disparities to be reduced or eliminated, policy legacies that inhibit innovation and reinforce biomedical dominance will need to be overcome.

Future research should compare the congressional arena with others, such as federal and state bureaucracies, state legislatures, the courts, philanthropy, academia, and the media, in order to determine if biomedical dominance is equally pronounced in those areas and if policy legacies play a similar role. Future research should also add a cross-national component—examining discourse and policy-making on health disparities in other nations in order to determine the degree of biomedical dominance in minority health policy-making in other contexts and the forces that produce it.

## **NOTES**

<sup>1</sup>For the purposes of this paper, we use the language of Congress without interrogation. Thus, we use terms such as “minority”, “race”, “ethnicity” and “Hispanic” without examining their problematic social construction. (For such an examination, see Cornell & Hartman, 1998; Omi & Winant, 1994; Ramaga, 1992; Wilkinson, 2000).

## **ACKNOWLEDGEMENTS**

We thank Rashi Fein, Rick Hall, Jim House, Paula Lantz, Catherine Lee, Andrew Levine, Mark Mizruchi, David Mechanic and Mark Peterson for their useful comments. We thank Deepali Pallegar, Brian Swierczek, Gail Pieknik, Theresa Ramirez, Paula Song, Bridget Metzler, Tracy Finlayson, and Alyssa Pozniak for research assistance. We acknowledge funding from the Robert Wood Johnson Foundation, the Horowitz Foundation for Social Policy, the UC-Davis Institute for Governmental Affairs, and the UC-Davis Committee on Research.

## METHODOLOGICAL APPENDIX

We attempted to identify all relevant congressional bills from 1975 to 2002 that addressed the health of racial and ethnic minorities (contact authors for search criteria). We uncovered 400 bills. We then excluded bills that dealt solely with Native Americans since this group is small and more importantly has a unique political situation related to tribal governments, treaties, and the Indian Health Service. We also excluded appropriations and budget reconciliation bills, and bills that, although indexed as relating to minorities and health, did not actually address minority health. We included bills if they referred to minorities, particular racial or ethnic groups, diversity, under-represented groups, or border areas. We did not include bills that referred to the medically underserved since these included low-income whites and residents of rural areas. After excluding these various bills, we were left with 219. We double-checked our dataset against the “minorities” index of the *Digest of Public General Bills and Resolutions*—up until 1990 when the *Digest* ends (Congressional Research Service, 1975). This index did not include any bills that our dataset did not and missed many bills that our dataset did include. It was quite common for multiple bills in the same Congress to contain identical or highly similar proposals for addressing minority health. Legislators often introduce the same bill in both houses so that it may proceed concurrently in each and initial bills are often folded into later ones. We excluded 72 duplicate bills in order to avoid over-counting the proposals that they contained. This left us with 147 bills. Many bills contained more than one proposal, and many proposals could be categorized with multiple codes. As a result, some bills received as many as nine topic codes—though 70 percent received three codes or fewer. In most instances, bill summaries were sufficient for our coding purposes but, when necessary, we consulted the full text of the bill.

## REFERENCES

- Amenta, E. (1998). *Bold Relief: Institutional Politics and the Origins of Modern American Social Policy*. Princeton: Princeton University Press.
- Bonastia, C. (2000). Why Did Affirmative Action in Housing Fail During the Nixon Era? Exploring the Institutional Homes of Social Policies. *Social Problems*, 47(4), 523-542.
- Brown, R., Corea, J., Luce, B., Elixhauser, A., & Sheingold, S. (1992). Effectiveness in Disease and Injury Prevention: Estimated National Spending on Prevention, 1988. *Morbidity and Mortality Weekly Report*, 24(July), 529-531.
- Burstein, P., Bricher, R. M., & Einwohner, R. L. (1995). Policy Alternatives and Political Change: Work, Family, and Gender on the Congressional Agenda, 1945-1990. *American Sociological Review*, 60(1), 67-83.
- Cohen, M., March, J., & Olsen, J. (1972). A Garbage Can Model of Organizational Choice. *Administrative Science Quarterly*, 17(March), 1-25.
- Congressional Research Service. (1975). *Digest of Public General Bills and Resolutions*. Washington, DC: Library of Congress.
- Cornell, S., & Hartman, D. (1998). *Ethnicity and Race: Making Identities in a Changing World*. Thousand Oaks, CA: Pine Forge Press.
- COSMOS Corporation. (2000). *Assessment of State Minority Health Infrastructure and Capacity to Address Issues of Health Disparity*. Washington, DC: Office of Minority Health, Office of Public Health and Science, U.S. Department of Health and Human Services.
- Epstein, S. (1996). *Impure science: AIDS, activism, and the politics of knowledge*. Berkeley: University of California Press.
- Epstein, S. (2004). Bodily Differences and Collective Identities: The Politics of Gender and Race in Biomedical Research in the United States. *Body and Society*, 10(2), 183-203.
- Esping-Andersen, G. (1990). *Three Worlds of Welfare Capitalism*. Princeton, NJ: Princeton University Press.
- Foster, M. W., & Sharp, R. R. (2002). Race, Ethnicity, and Genomics: Social Classifications as Proxies of Biological Heterogeneity. *Genome Research*, 12(6), 844-850.
- Fuchs, V. R. (1975). *Who shall live? Health, economics, and social choice*. New York,: Basic Books.
- Gamson, W. A., & Modigliani, A. (1987). The Changing Culture of Affirmative Action. *Research in Political Sociology*, 3, 137-177.
- Gamson, W. A., & Modigliani, A. (1989). Media Discourse and Public Opinion on Nuclear Power: A Constructionist Approach. *American Journal of Sociology*, 95(1), 1-37.
- Great Britain Department of Health and Social Security. (1980). *Inequalities in Health: Report of a Working Group Chaired by Sir Douglas Black*. London: Department of Health and Social Security.
- Hall, P. (1989). *The Political Power of Economic Ideas: Keynesianism across Countries*. Princeton: Princeton University Press.
- Hall, P. A. (1986). *Governing the Economy: The Politics of State Intervention in Britain and France*. Oxford: Oxford University Press.
- Hall, R. L. (2000). *Lobbying as Legislative Subsidy*. Paper presented at the Annual meeting of the American Political Science Association, Washington, DC.
- Hall, T. (2002). *When Things Really Happen: The Role of Reauthorizations in the Process of Policy Change*. Athens: Ph.D. Thesis, University of Georgia.

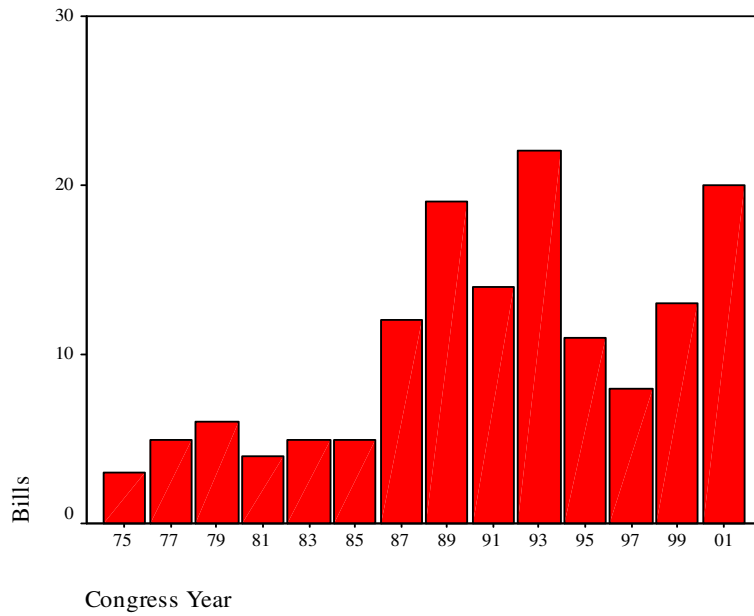
- Heclo, H. (1974). *Modern Social Politics in Britain and Sweden*. New Haven, CN: Yale University Press.
- Kingdon, J. (1984). *Agendas, Alternatives and Public Policies* Boston: Little, Brown.
- LaLonde, M. (1974). *A New Perspective on the Health of Canadians*. Ottawa: Minister of Supply and Services.
- Lavis, J., & Sullivan, T. (2000). The State as a Setting. In B. Poland & L. Green & I. Rootman (Eds.), *Settings for Health Promotion: Linking Theory and Practice*. Newbury Park, CA: Sage Publications.
- Lavis, J. N. (2002). Ideas at the margin or marginalized ideas? Nonmedical determinants of health in Canada. *Health Affairs*, 21(2), 107.
- Marmor, T. R., Barer, M. L., & Evans, R. G. (1994). The Determinants of a Populations Health: What Can Be Done to Improve a Democratic Nation's Health Status. In R. G. Evans & M. L. Barer & T. R. Marmor (Eds.), *Why are some people healthy and others not? : the determinants of health of populations* (pp. 217-230). New York: A. de Gruyter.
- Marmot, M. G., Shipley, M. J., & Rose, G. (1984). Inequalities in Death--Specific Explanations of a General Pattern? *Lancet*, 1, 1003-1006.
- McGinnis, J. M., Williams-Russo, P., & Knickman, J. R. (2002). The case for more active policy attention to health promotion. *Health Affairs*, 21(2), 78.
- McKeown, T. (1976). *The modern rise of population*. New York: Academic Press.
- OECD. (2004). *OECD Health Data*. Paris: OECD.
- Office of Minority Health Resource Center. (2002). *State Minority Health Liaisons*: Office of Minority Health Research Center. U.S. Department of Health and Human Services.
- Office of Research on Minority Health. (2002). ORMH History. *U.S. Department of Health and Human Services, National Institutes of Health, Office of Research on Minority Health Website*.
- Omi, M., & Winant, H. (1994). *Racial Formation in the United States: From the 1960's to the 1990's*. New York: Routledge.
- Pierson, P. (1992). 'Policy Feedbacks' and Political Change: Contrasting Reagan's and Thatcher's Pension- Reform Initiatives. *Studies in American Political Development*, 6, 359-390.
- Pierson, P. (1994). *Dismantling the Welfare State? Reagan, Thatcher and the Politics of Retrenchment*. New York: Cambridge University Press.
- Ramaga, P. V. (1992). Relativity of the Minority Concept. *Human Rights Quarterly*, 14(1), 104-119.
- Skocpol, T. (1992). *Protecting Soldiers and Mothers*. Cambridge, MA: Harvard University Press.
- Steinmo, S., Thelen, K., & Longstreth, F. (1992). *Structuring Politics: Historical Institutionalism in Comparative Analysis*. Cambridge: Cambridge University Press.
- U.S. Department of Health and Human Services. (1985). *Report of the Secretary's Task Force on Black and Minority Health*. Washington, DC: U.S. Government Printing Office.
- U.S. Department of Health and Human Services. (1991). *Healthy people 2000: national health promotion and disease prevention objectives, Full Report with Commentary*. Washington, D.C.: U.S. Government Printing Office.
- U.S. Department of Health Education and Welfare. (1979). *Healthy people: the Surgeon General's report on health promotion and disease prevention*. Washington: U.S. Government Printing Office.



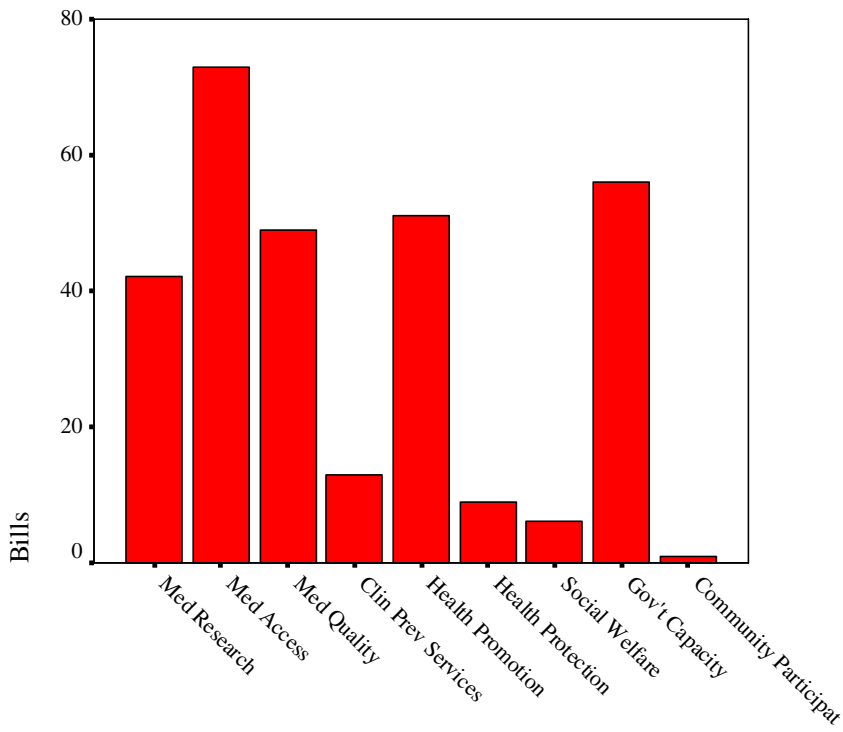
- U.S. Institute of Medicine. (1999). *The unequal burden of cancer: an assessment of NIH research and programs for ethnic minorities and the medically underserved*. Washington, D.C.: National Academies Press.
- U.S. Institute of Medicine. (2003). *Unequal treatment: confronting racial and ethnic disparities in health care*. Washington, D.C.: National Academies Press.
- U.S. Public Health Service. (1993). Health Care Reform: A Paper on Population-Based Core Functions. *Journal of Public Health Policy*, 19(4), 394-419.
- Weir, M. (1992). *Politics and Jobs: The Boundaries of Employment Policy in the United States*. Princeton, NJ: Princeton University Press.
- Weisman, C. S. (1998). *Women's health care: activist traditions and institutional change*. Baltimore: Johns Hopkins University Press.
- Wilkinson, D. (2000). Rethinking the Concept of "Minority": A Task for Social Scientists and Practitioners. *Journal of Sociology and Social Welfare*, 27(1), 115-132.
- Zahariadis, N. (1999). Ambiguity, Time and Multiple Streams. In P. A. Sabatier (Ed.), *Theories of the Policy Process*. Boulder, CO: Westview Press.

## FIGURES AND TABLES

**Figure 1. Minority Health Bills, Two-Year Congressional Terms 1975-2002**

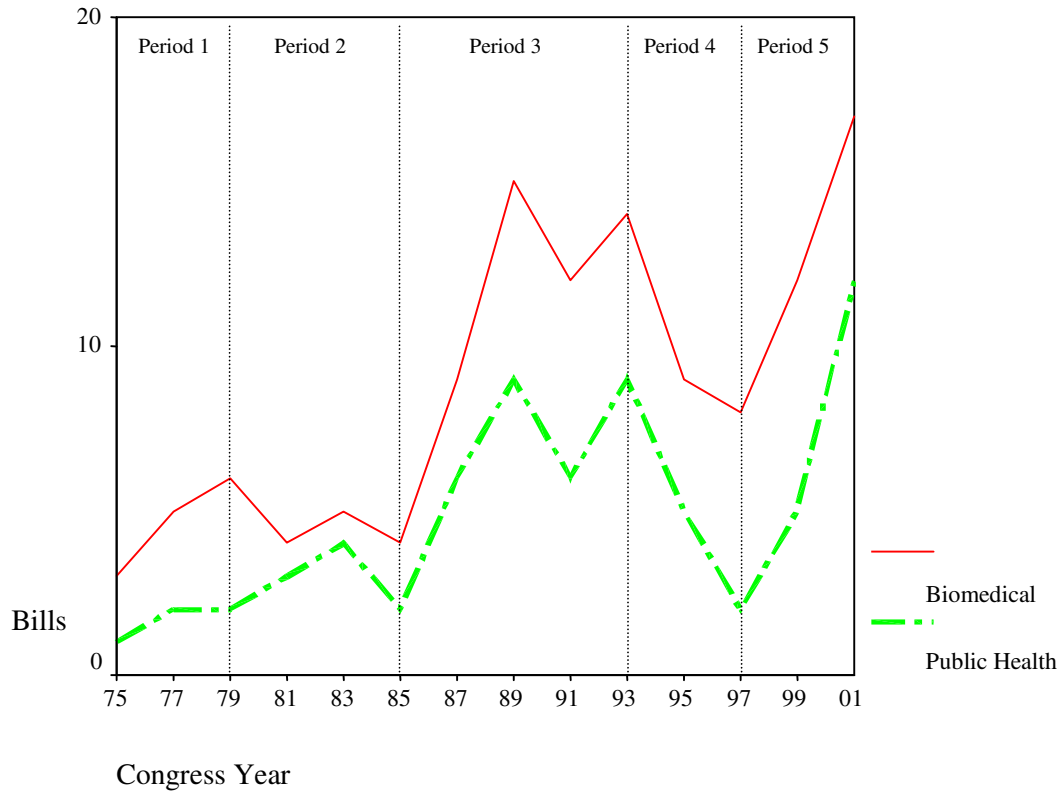


**Figure 2. Proposal Packages of Minority Health Bills, 1975-2002**



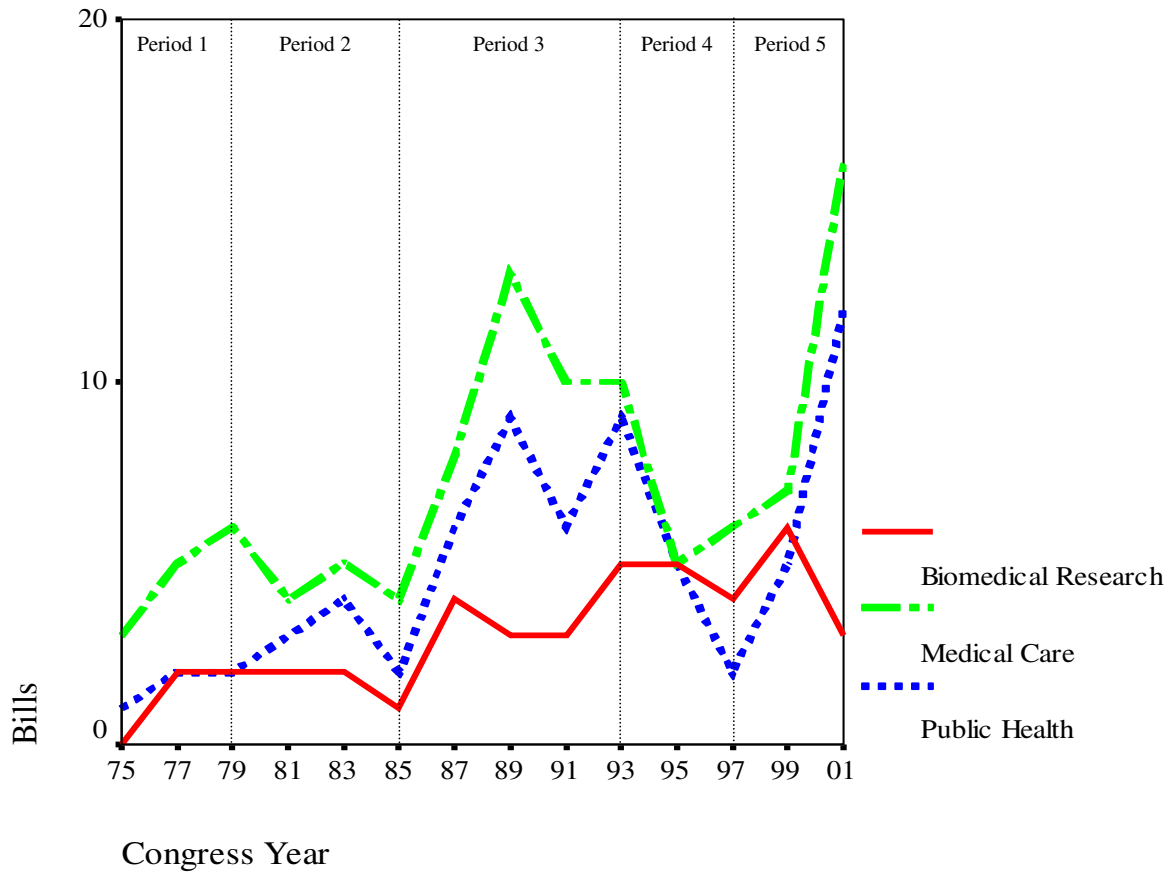
Note: Some bills are included in multiple packages.

**Figure 3. Minority Health Bills Containing Biomedical or Public Health Proposals, Two-Year Congressional Terms, 1975-2002**



Note: Some bills are included in multiple packages.

**Figure 4. Minority Health Bills Containing Biomedical Research, Medical Care and Public Health Proposals, Two-Year Congressional Terms, 1975-2002**



Note: Some bills are included in multiple packages.

### **Table 1. Organizational Affiliations of Informants**

9	US House of Representatives (members and staff)
3	US Senate (members and staff)
5	Offices of the Secretary and Assistant Secretary, Health and Human Services
7	Centers for Disease Control and Prevention (CDC)
4	Office of Minority Health, HHS
2	National Institutes of Health (NIH)
1	Health Resources and Services Administration (HRSA)
1	Substance Abuse and Mental Health Services Administration (SAMHSA)
2	State offices of minority health
3	Institute of Medicine (IOM)
2	Schools of medicine
6	Schools of public health
3	Think tanks
12	Interest groups
2	Foundations
45	<b>TOTAL INTERVIEWS</b>

---

Note: Some informants are included in more than one category.

**Table 2. Minority Health Proposal Packages**

<i>Package</i>	<i>Position</i>	<i>Summary of Proposals</i>	<i>Sample Signature Elements</i>
Biomedical	Policy proposals should focus on curative medicine and individuals.	See Biomedical sub-packages	See Biomedical sub-packages
Public Health	Policies should focus on groups of people (i.e., communities) and the overall goal should be health promotion and disease prevention.	See Public Health sub-packages	See Public Health sub-packages
Non-Health Social Welfare	The health of racial and ethnic minorities is related to their disadvantaged socioeconomic position. Policy proposals should address the social welfare of minority populations.	Proposals include education (non-health), housing, residential integration, income support, employment policies and income redistribution.	“AIDS Short-Term Supported Housing and Services Demonstration - Amends the Stewart B. McKinney Homeless Assistance Act to authorize the Secretary to make grants for programs to prevent homelessness among persons with AIDS and to provide them with short-term supported housing and related services. Provides for minority outreach” (H.R. 3423, 1989).
Government Capacity and Accountability	Policies should establish new institutions, planning processes, or systems for gathering information on health disparities.	Proposals include the establishment of offices of minority health in federal and state bureaucracies, mandating strategic plans, and improving data collection on health disparities.	“Associate Director for Minority Concerns - Establishes ...the position of Associate Director for Minority Concerns within the National Institute of Mental Health.” (S. 1177, 1980).
Community Participation	Policies should ensure that members of local and minority communities participate in the planning of minority health initiatives.	Proposals include attempts to ensure that members of local and minority communities participate in the planning of health care provision, public health interventions and research on health disparities.	“Activities carried out by such a project shall include the following: (1) Planning, organizing, and conducting a symposium of all major elements of the community to identify the best ways to reach and influence African American individuals in the community” (H.R. 1218, 2001).

Biomedical Research (Biomedical sub-package)	Same as Biomedical	Proposals include conducting research on particular diseases and on biological differences among minority groups; including and protecting minorities in research trials; and recruiting and training minority biomedical researchers.	“Requires the Director to...conduct or support research to expand the understanding of the causes of, and to find a cure for, lupus, including research to determine the reasons underlying the elevated prevalence of the disease among African-American and other women” (H.R. 1111, 1997).
Biomedical Access (Biomedical sub-package)	Same as Biomedical	Proposals include increasing insurance coverage for minorities; setting up clinics in neighborhoods, schools and public housing; and ensuring that health care facilities are located in areas that serve minorities.	“Medically Underserved Access to Care Act of 1999...To require managed care organizations to contract with providers in medically underserved areas.” (H.R. 1860, 1999).
Biomedical Quality (Biomedical sub-package)	Same as Biomedical	Proposals include increasing the linguistic and cultural competence of health care providers and institutions, enforcing anti-discrimination laws, and recruiting and training minority health providers.	“Directs the Secretary to: (1) develop educational materials on providing health services in a culturally competent manner; (2) establish a Center for Linguistic and Cultural Competence in Health Care; and (3) carry out cultural competence demonstration projects at two hospitals.” (H.R. 5595, 2000).
Clinical Preventative Services (Public Health sub-package)	Same as Public Health	Proposals include immunization and vaccination, and the screening, monitoring and early diagnosis of diseases.	“Amends the Public Health Service Act to authorize the Secretary of Health and Human Services to...assist States in preventing or reducing morbidity and premature mortality resulting from diabetes, with particular emphasis on Hispanics and other populations at risk” (H.R. 3259, 1987).
Health Promotion (Public Health sub-package)	Same as Public Health	Proposals include reducing unhealthy or risky individual behaviors relating to drugs, alcohol, tobacco, risky sexual behaviors, diet, exercise, homicide, suicide and accidents.	“Expands the purposes for which the Secretary may make grants to public and nonprofit private entities to include alcoholism treatment and prevention services, with emphasis on underserved racial and ethnic minorities...” (S. 3184, 1976).
Health Protection (Public Health sub-package)	Same as Public Health	Proposals include interventions such as the legal regulation of guns, crime, drugs, alcohol and tobacco, efforts to ensure auto and highway safety, food safety, sanitation, occupational health and safety, and environmental regulation and cleanup.	“Environmental Justice Act of 2002 - Requires Federal agencies to include achieving environmental justice in their missions through identifying and addressing any disproportionately high and adverse human health or environmental effects of their activities on minority and low-income communities” (H.R. 5637, 2002).



Table 3. Enactments of Bills Targeting Minority Health, 1975-2002

Year	Congress	Biomedical	Public Health
1975-76	94	S. 3184	S. 3184
1977-78	95	S. 2466	
1979-80	96	S. 525, S. 1177, S. 7203	S. 525
1981-82	97	S. 1086	S. 1086
1983-84	98	S. 2603	S. 2603
1985-86	99		
1987-88	100	H.J.RES. 119, H.R. 5210, S. 769, S. 2889	H.J.RES. 119
1989-90	101	H.R. 5112, H.R. 5702, S. 2946	H.R. 5702
1991-92	102	H.R. 2967, H.R. 3508, S. 1306, H.R. 5194	H.R. 2967, H.R. 5194
1993-94	103	H.R. 3313, S. 1, S. 1284	
1995-96	104	S. 641	S. 1316
1997-98	105	H.R. 2202, S. 1722, S. 1754	
1999-00	106	H.R. 782, S. 1880	H.R. 782
2001-02	107	S. 1789	
<b>TOTAL</b>		<b>28</b>	<b>10</b>

Note: Bills can contain both biomedical and public health proposals.