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117TH CONGRESS
1ST SESSION

H. R. 666

To amend the Public Health Service Act to provide for public health research and investment into understanding and eliminating structural racism and police violence.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 1, 2021

Ms. PRESSLEY (for herself, Ms. LEE of California, Ms. CASTOR of Florida, Mr. NADLER, Mrs. WATSON COLEMAN, Mr. TAKANO, Mr. DANNY K. DAVIS of Illinois, Ms. JACKSON LEE, Mr. HIGGINS of New York, Mr. COOPER, Ms. TLAIB, Ms. OCASIO-CORTEZ, Mr. SIRES, Mr. VARGAS, Ms. ROYBAL-ALLARD, Mr. RUSH, Mr. HASTINGS, Ms. NORTON, Ms. WILLIAMS of Georgia, Mr. BOWMAN, Ms. JAYAPAL, Ms. VELÁZQUEZ, Mrs. BEATTY, Ms. BUSH, Ms. MENG, Mr. BLUMENAUER, Mr. DESAULNIER, Mr. RUPPERSBERGER, Mr. ESPAILLAT, Ms. SEWELL, Mr. PAYNE, Ms. OMAR, Mr. SARBANES, Ms. MATSUI, Mr. SMITH of Washington, Mr. CARSON, Ms. CLARK of Massachusetts, Mr. COHEN, Ms. CHU, and Mr. TORRES of New York) introduced the following bill; which was referred to the Committee on Energy and Commerce

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A BILL

To amend the Public Health Service Act to provide for public health research and investment into understanding and eliminating structural racism and police violence.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Anti-Racism in Public Health Act of 2021''.

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) For centuries, structural racism, defined by the National Museum of African American History and Culture as an ''overarching system of racial bias across institutions and society,'' in the United States has negatively affected communities of color, especially Black, Latinx, Asian American, Pacific Islander, and American Indian and Alaska Native people, to expand and reinforce White supremacy.

(2) Structural racism determines the conditions in which people are born, grow, work, live, and age and determine people's access to quality housing, education, food, transportation, and political power, and other social determinants of health.

(3) Structural racism serves as a major barrier to achieving health equity and eliminating racial and ethnic inequities in health outcomes that exist at alarming rates and are determined by a wider set of forces and systems.

(4) Due to structural racism in the United States, people of color are more likely to suffer from chronic health conditions (such as heart disease, dia-

betes, asthma, hepatitis, and hypertension) and infectious diseases (such as HIV/AIDS, and COVID–19) compared to their White counterparts.

(5) Due to structural racism in maternal health care in the United States, Black and American Indian and Alaska Native infants are more than twice as likely to die than White infants, Black women are 3 to 4 times more likely to die from pregnancy-related causes than White women, and American Indian and Alaska Native women are 5 times more likely to die from pregnancy-related causes than White women. This trend persists even when adjusting for income and education.

(6) Due to structural racism in the United States, Non-Hispanic Black women have the highest rates for 22 of 25 severe morbidity indicators used by the Center for Disease Control and Prevention (CDC).

(7) Due to structural racism in the United States, people of color comprise a disproportionate percentage of persons with disabilities in the United States.

(8) Due to structural racism in the United States, Black men are up to three and a half times as likely to be killed by police as White men, and 1

in every 1,000 Black men will die as a result of police violence. Policing has adverse effects on mental health in Black communities.

(9) Due to the confluence of structural racism and factors such as gender, class, and sexual orientation or gender identity, commonly referred to as intersectionality, Black and Latinx transgender women are more likely to die due to violence and homicide than their White counterparts.

(10) Due to structural racism, inequitable access to quality health care and longterm services and supports also disproportionately burdens communities of color; people of color and immigrants are less likely to be insured and are more likely to live in medically underserved areas.

(11) Due to structural racism, older adults of color are also more likely to be admitted to nursing homes and assisted living facilities and to reside in those of poor quality, and when older adults of color do receive home and community based services, Medicaid spends less money on their services and they are more likely to be hospitalized than older White adults.

(12) In addition, the Federal Government's failure to honor the unique political status of American

Indian and Alaska Native people, to respect the inherent sovereignty of Tribal Nations, and to uphold its trust and treaty obligations to Tribal Nations and American Indian and Alaska Native people, is an ongoing and unjust manifestation of centuries of oppression, with the consequence of adverse health outcomes for Native peoples.

(13) The COVID–19 pandemic has exposed the devastating impact of structural racism on the United States ability to ensure equitable health outcomes for people of color, and made these communities more likely to suffer from severe outcomes due to the coronavirus infection.

(14) Racial and ethnic inequity in public health is a result of systematic, personally mediated, and internalized racism and racist public and private policies and practices, and dismantling structural racism is integral to addressing public health.

SEC. 3. DEFINITIONS.

In this Act:

(1) ANTIRACISM.—The term ''antiracism'' is a collection of antiracist policies that lead to racial equity, and are substantiated by antiracist ideas.

(2) ANTIRACIST.—The term ''antiracist'' is any measure that produces or sustains racial equity between racial groups.

SEC. 4. PUBLIC HEALTH RESEARCH AND INVESTMENT IN DISMANTLING STRUCTURAL RACISM.

Part B of title III of the Public Health Service Act (42 U.S.C. 243 et seq.) is amended by adding at the end the following:

''SEC. 320B. NATIONAL CENTER ON ANTIRACISM AND HEALTH.

''(a) IN GENERAL.—

''(1) NATIONAL CENTER.—There is established within the Centers for Disease Control and Prevention a center to be known as the 'National Center on Antiracism and Health' (referred to in this section as the 'Center'). The Director of the Centers for Disease Control and Prevention shall appoint a director to head the Center who has experience living in and working with racial and ethnic minority communities. The Center shall promote public health by—

''(A) declaring racism a public health crisis and naming racism as an historical and present threat to the physical and mental health and well-being of the United States and world;

''(B) aiming to develop new knowledge in the science and practice of antiracism, including by identifying the mechanisms by which racism operates in the provision of health care and in systems that impact health and well-being;

''(C) transferring that knowledge into practice, including by developing interventions that dismantle the mechanisms of racism and replace such mechanisms with equitable structures, policies, practices, norms, and values so that a healthy society can be realized; and

''(D) contributing to a national and global conversation regarding the impacts of racism on the health and well-being of the United States and world.

''(2) GENERAL DUTIES.—The Secretary, acting through the Center, shall undertake activities to carry out the mission of the Center as described in paragraph (1), such as the following:

''(A) Conduct research into, collect, analyze and make publicly available data on, and provide leadership and coordination for the science and practice of antiracism, the public health impacts of structural racism, and the effectiveness of intervention strategies to address

these impacts. Topics of research and data collection under this subparagraph may include identifying and understanding—

''(i) policies and practices that have a disparate impact on the health and well-being of communities of color;

''(ii) the public health impacts of implicit racial bias, White supremacy, weathering, xenophobia, discrimination, and prejudice;

''(iii) the social determinants of health resulting from structural racism, including poverty, housing, employment, political participation, and environmental factors; and

''(iv) the intersection of racism and other systems of oppression, including as related to age, sexual orientation, gender identity, and disability status.

''(B) Award noncompetitive grants and cooperative agreements to eligible public and nonprofit private entities, including State, local, territorial, and Tribal health agencies and organizations, for the research and collection, anal-

ysis, and reporting of data on the topics described in subparagraph (A).

"(C) Establish, through grants or cooperative agreements, at least 3 regional centers of excellence, located in racial and ethnic minority communities, in antiracism for the purpose of developing new knowledge in the science and practice of antiracism in health by researching, understanding, and identifying the mechanisms by which racism operates in the health space, racial and ethnic inequities in health care access and outcomes, the history of successful antiracist movements in health, and other antiracist public health work.

"(D) Establish a clearinghouse within the Centers for Disease Control and Prevention for the collection and storage of data generated under the programs implemented under this section for which there is not an otherwise existing surveillance system at the Centers for Disease Control and Prevention. Such data shall—

"(i) be comprehensive and disaggregated, to the extent practicable, by including racial, ethnic, primary language, sex,

gender identity, sexual orientation, age, socioeconomic status, and disability disparities;

"(ii) be made publicly available;

"(iii) protect the privacy of individuals whose information is included in such data; and

"(iv) comply with privacy protections under the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

"(E) Provide information and education to the public on the public health impacts of structural racism and on antiracist public health interventions.

"(F) Consult with other Centers and National Institutes within the Centers for Disease Control and Prevention, including the Office of Minority Health and Health Equity and the Center for State, Tribal, Local, and Territorial Support, to ensure that scientific and programmatic activities initiated by the agency consider structural racism in their designs, conceptualizations, and executions, which shall include—

"(i) putting measures of racism in population-based surveys;

"(ii) establishing a Federal Advisory Committee on racism and health for the Centers for Disease Control and Prevention;

"(iii) developing training programs, curricula, and seminars for the purposes of training public health professionals and researchers around issues of race, racism, and antiracism;

"(iv) providing standards and best practices for programming and grant recipient compliance with Federal data collection standards, including section 4302 of the Patient Protection and Affordable Care Act; and

"(v) establishing leadership and stakeholder councils with experts and leaders in racism and public health disparities.

"(G) Coordinate with the Indian Health Service and with the Centers for Disease Control and Prevention's Tribal Advisory Committee to ensure meaningful Tribal consultation, the gathering of information from Tribal

authorities, and respect for Tribal data sovereignty.

''(H) Engage in government to government consultation with Indian Tribes and Tribal organizations.

''(I) At least every 2 years, produce and publicly post on the Centers for Disease Control and Prevention's website a report on antiracist activities completed by the Center, which may include newly identified antiracist public health practices.

''(b) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary to carry out this section.''.

SEC. 5. PUBLIC HEALTH RESEARCH AND INVESTMENT IN POLICE VIOLENCE.

(a) IN GENERAL.—The Secretary of Health and Human Services shall establish within the National Center for Injury Prevention and Control of the Centers for Disease Control and Prevention (referred to in this section as the ''Center'') a law enforcement violence prevention program.

(b) GENERAL DUTIES.—In implementing the program under subsection (a), the Center shall conduct research into, and provide leadership and coordination for—

(1) the understanding and promotion of knowledge about the public health impacts of uses of force by law enforcement, including police brutality and violence;

(2) developing public health interventions and perspectives for eliminating deaths, injury, trauma, and negative mental health effects from police presence and interactions, including police brutality and violence; and

(3) ensuring comprehensive data collection, analysis, and reporting regarding police violence and misconduct in consultation with the Department of Justice and independent researchers.

(c) FUNCTIONS.—Under the program under subsection (a), the Center shall—

(1) summarize and enhance the knowledge of the distribution, status, and characteristics of law enforcement-related death, trauma, and injury;

(2) conduct research and prepare, with the assistance of State public health departments—

(A) statistics on law enforcement-related death, injury, and brutality;

(B) studies of the factors, including legal, socioeconomic, discrimination, and other factors that correlate with or influence police brutality;

(C) public information about uses of force by law enforcement, including police brutality and violence, for the practical use of the public health community, including publications that synthesize information relevant to the national goal of understanding police violence and methods for its control;

(D) information to identify socioeconomic groups, communities, and geographic areas in need of study, and a strategic plan for research necessary to comprehend the extent and nature of police uses of force by law enforcement, including police brutality and violence, and determine what options exist to reduce or eradicate death and injury that result; and

(E) best practices in police violence prevention in other countries;

(3) award grants, contracts, and cooperative agreements to provide for the conduct of epidemiologic research on uses of force by law enforcement, including police brutality and violence, by Federal, State, local, and private agencies, institutions, organizations, and individuals;

(4) award grants, contracts, and cooperative agreements to community groups, independent re-

search organizations, academic institutions, and other entities to support, execute, or conduct research on interventions to reduce or eliminate uses of force by law enforcement, including police brutality and violence;

(5) coordinate with the Department of Justice, and other Federal, State, and local agencies on the standardization of data collection, storage, and retrieval necessary to collect, evaluate, analyze, and disseminate information about the extent and nature of uses of force by law enforcement, including police brutality and violence, as well as options for the eradication of such practices;

(6) submit an annual report to Congress on research findings with recommendations to improve data collection and standardization and to disrupt processes in policing that preserve and reinforce racism and racial disparities in public health;

(7) conduct primary research and explore uses of force by law enforcement, including police brutality and violence, and options for its control; and

(8) study alternatives to law enforcement response as a method of reducing police violence.

(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated, such sums as may be necessary to carry out this section.

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