

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

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.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the “Anti-Racism in Public
3 Health Act of 2021”.

4 **SEC. 2. FINDINGS.**

5 Congress makes the following findings:

6 (1) For centuries, structural racism, defined by
7 the National Museum of African American History
8 and Culture as an “overarching system of racial bias
9 across institutions and society,” in the United States
10 has negatively affected communities of color, espe-
11 cially Black, Latinx, Asian American, Pacific Is-
12 lander, and American Indian and Alaska Native peo-
13 ple, to expand and reinforce White supremacy.

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

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

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

1 betes, asthma, hepatitis, and hypertension) and in-
2 fectious diseases (such as HIV/AIDS, and COVID-
3 19) compared to their White counterparts.

4 (5) Due to structural racism in maternal health
5 care in the United States, Black and American In-
6 dian and Alaska Native infants are more than twice
7 as likely to die than White infants, Black women are
8 3 to 4 times more likely to die from pregnancy-re-
9 lated causes than White women, and American In-
10 dian and Alaska Native women are 5 times more
11 likely to die from pregnancy-related causes than
12 White women. This trend persists even when adjust-
13 ing for income and education.

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

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

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

1 in every 1,000 Black men will die as a result of po-
2 lice violence. Policing has adverse effects on mental
3 health in Black communities.

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

10 (10) Due to structural racism, inequitable ac-
11 cess to quality health care and longterm services and
12 supports also disproportionately burdens commu-
13 nities of color; people of color and immigrants are
14 less likely to be insured and are more likely to live
15 in medically underserved areas.

16 (11) Due to structural racism, older adults of
17 color are also more likely to be admitted to nursing
18 homes and assisted living facilities and to reside in
19 those of poor quality, and when older adults of color
20 do receive home and community based services, Med-
21 icaid spends less money on their services and they
22 are more likely to be hospitalized than older White
23 adults.

24 (12) In addition, the Federal Government's fail-
25 ure to honor the unique political status of American

1 Indian and Alaska Native people, to respect the in-
2 herent sovereignty of Tribal Nations, and to uphold
3 its trust and treaty obligations to Tribal Nations
4 and American Indian and Alaska Native people, is
5 an ongoing and unjust manifestation of centuries of
6 oppression, with the consequence of adverse health
7 outcomes for Native peoples.

8 (13) The COVID–19 pandemic has exposed the
9 devastating impact of structural racism on the
10 United States ability to ensure equitable health out-
11 comes for people of color, and made these commu-
12 nities more likely to suffer from severe outcomes due
13 to the coronavirus infection.

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

19 **SEC. 3. DEFINITIONS.**

20 In this Act:

21 (1) **ANTIRACISM.**—The term “antiracism” is a
22 collection of antiracist policies that lead to racial eq-
23 uity, and are substantiated by antiracist ideas.

1 (2) ANTIRACIST.—The term “antiracist” is any
2 measure that produces or sustains racial equity be-
3 tween racial groups.

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

6 Part B of title III of the Public Health Service Act
7 (42 U.S.C. 243 et seq.) is amended by adding at the end
8 the following:

9 **“SEC. 320B. NATIONAL CENTER ON ANTIRACISM AND**
10 **HEALTH.**

11 “(a) IN GENERAL.—

12 “(1) NATIONAL CENTER.—There is established
13 within the Centers for Disease Control and Preven-
14 tion a center to be known as the ‘National Center
15 on Antiracism and Health’ (referred to in this sec-
16 tion as the ‘Center’). The Director of the Centers for
17 Disease Control and Prevention shall appoint a di-
18 rector to head the Center who has experience living
19 in and working with racial and ethnic minority com-
20 munities. The Center shall promote public health
21 by—

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

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

6 “(C) transferring that knowledge into
7 practice, including by developing interventions
8 that dismantle the mechanisms of racism and
9 replace such mechanisms with equitable struc-
10 tures, policies, practices, norms, and values so
11 that a healthy society can be realized; and

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

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

20 “(A) Conduct research into, collect, ana-
21 lyze and make publicly available data on, and
22 provide leadership and coordination for the
23 science and practice of antiracism, the public
24 health impacts of structural racism, and the ef-
25 fectiveness of intervention strategies to address

1 these impacts. Topics of research and data col-
2 lection under this subparagraph may include
3 identifying and understanding—

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

7 “(ii) the public health impacts of im-
8 plicit racial bias, White supremacy, weath-
9 ering, xenophobia, discrimination, and
10 prejudice;

11 “(iii) the social determinants of health
12 resulting from structural racism, including
13 poverty, housing, employment, political
14 participation, and environmental factors;
15 and

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

20 “(B) Award noncompetitive grants and co-
21 operative agreements to eligible public and non-
22 profit private entities, including State, local,
23 territorial, and Tribal health agencies and orga-
24 nizations, for the research and collection, anal-

1 ysis, and reporting of data on the topics de-
2 scribed in subparagraph (A).

3 “(C) Establish, through grants or coopera-
4 tive agreements, at least 3 regional centers of
5 excellence, located in racial and ethnic minority
6 communities, in antiracism for the purpose of
7 developing new knowledge in the science and
8 practice of antiracism in health by researching,
9 understanding, and identifying the mechanisms
10 by which racism operates in the health space,
11 racial and ethnic inequities in health care ac-
12 cess and outcomes, the history of successful
13 antiracist movements in health, and other
14 antiracist public health work.

15 “(D) Establish a clearinghouse within the
16 Centers for Disease Control and Prevention for
17 the collection and storage of data generated
18 under the programs implemented under this
19 section for which there is not an otherwise ex-
20 isting surveillance system at the Centers for
21 Disease Control and Prevention. Such data
22 shall—

23 “(i) be comprehensive and disaggre-
24 gated, to the extent practicable, by includ-
25 ing racial, ethnic, primary language, sex,

1 gender identity, sexual orientation, age, so-
2 cioeconomic status, and disability dispari-
3 ties;

4 “(ii) be made publicly available;

5 “(iii) protect the privacy of individuals
6 whose information is included in such data;
7 and

8 “(iv) comply with privacy protections
9 under the regulations promulgated under
10 section 264(c) of the Health Insurance
11 Portability and Accountability Act of 1996.

12 “(E) Provide information and education to
13 the public on the public health impacts of struc-
14 tural racism and on antiracist public health
15 interventions.

16 “(F) Consult with other Centers and Na-
17 tional Institutes within the Centers for Disease
18 Control and Prevention, including the Office of
19 Minority Health and Health Equity and the
20 Center for State, Tribal, Local, and Territorial
21 Support, to ensure that scientific and pro-
22 grammatic activities initiated by the agency
23 consider structural racism in their designs,
24 conceptualizations, and executions, which shall
25 include—

1 “(i) putting measures of racism in
2 population-based surveys;

3 “(ii) establishing a Federal Advisory
4 Committee on racism and health for the
5 Centers for Disease Control and Preven-
6 tion;

7 “(iii) developing training programs,
8 curricula, and seminars for the purposes of
9 training public health professionals and re-
10 searchers around issues of race, racism,
11 and antiracism;

12 “(iv) providing standards and best
13 practices for programming and grant re-
14 cipient compliance with Federal data col-
15 lection standards, including section 4302
16 of the Patient Protection and Affordable
17 Care Act; and

18 “(v) establishing leadership and stake-
19 holder councils with experts and leaders in
20 racism and public health disparities.

21 “(G) Coordinate with the Indian Health
22 Service and with the Centers for Disease Con-
23 trol and Prevention’s Tribal Advisory Com-
24 mittee to ensure meaningful Tribal consulta-
25 tion, the gathering of information from Tribal

1 authorities, and respect for Tribal data sov-
2 ereignty.

3 “(H) Engage in government to government
4 consultation with Indian Tribes and Tribal or-
5 ganizations.

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

12 “(b) AUTHORIZATION OF APPROPRIATIONS.—There
13 is authorized to be appropriated such sums as may be nec-
14 essary to carry out this section.”.

15 **SEC. 5. PUBLIC HEALTH RESEARCH AND INVESTMENT IN**
16 **POLICE VIOLENCE.**

17 (a) IN GENERAL.—The Secretary of Health and
18 Human Services shall establish within the National Center
19 for Injury Prevention and Control of the Centers for Dis-
20 ease Control and Prevention (referred to in this section
21 as the “Center”) a law enforcement violence prevention
22 program.

23 (b) GENERAL DUTIES.—In implementing the pro-
24 gram under subsection (a), the Center shall conduct re-
25 search into, and provide leadership and coordination for—

1 (1) the understanding and promotion of knowl-
2 edge about the public health impacts of uses of force
3 by law enforcement, including police brutality and
4 violence;

5 (2) developing public health interventions and
6 perspectives for eliminating deaths, injury, trauma,
7 and negative mental health effects from police pres-
8 ence and interactions, including police brutality and
9 violence; and

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

14 (c) FUNCTIONS.—Under the program under sub-
15 section (a), the Center shall—

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

19 (2) conduct research and prepare, with the as-
20 sistance of State public health departments—

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

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

1 (C) public information about uses of force
2 by law enforcement, including police brutality
3 and violence, for the practical use of the public
4 health community, including publications that
5 synthesize information relevant to the national
6 goal of understanding police violence and meth-
7 ods for its control;

8 (D) information to identify socioeconomic
9 groups, communities, and geographic areas in
10 need of study, and a strategic plan for research
11 necessary to comprehend the extent and nature
12 of police uses of force by law enforcement, in-
13 cluding police brutality and violence, and deter-
14 mine what options exist to reduce or eradicate
15 death and injury that result; and

16 (E) best practices in police violence preven-
17 tion in other countries;

18 (3) award grants, contracts, and cooperative
19 agreements to provide for the conduct of epidemio-
20 logic research on uses of force by law enforcement,
21 including police brutality and violence, by Federal,
22 State, local, and private agencies, institutions, orga-
23 nizations, and individuals;

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

1 search organizations, academic institutions, and
2 other entities to support, execute, or conduct re-
3 search on interventions to reduce or eliminate uses
4 of force by law enforcement, including police bru-
5 tality and violence;

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

14 (6) submit an annual report to Congress on re-
15 search findings with recommendations to improve
16 data collection and standardization and to disrupt
17 processes in policing that preserve and reinforce rac-
18 ism and racial disparities in public health;

19 (7) conduct primary research and explore uses
20 of force by law enforcement, including police bru-
21 tality and violence, and options for its control; and

22 (8) study alternatives to law enforcement re-
23 sponse as a method of reducing police violence.

1 (d) AUTHORIZATION OF APPROPRIATIONS.—There is
2 authorized to be appropriated, such sums as may be nec-
3 essary to carry out this section.

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