117TH CONGRESS
1ST SESSION

S. 162

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 SENATE OF THE UNITED STATES

FEBRUARY 2, 2021

Ms. WARREN (for herself, Ms. HIRONO, Mr. MERKLEY, Ms. SMITH, and Mr. MARKEY) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

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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.

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

3 **SECTION 1. SHORT TITLE.**

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

6 **SEC. 2. FINDINGS.**

7 Congress makes the following findings:
8 (1) For centuries, structural racism, defined by
9 the National Museum of African American History

1 and Culture as an ''overarching system of racial bias
2 across institutions and society'', in the United States
3 has negatively affected communities of color, espe-
4 cially Black, Latinx, Asian American, Pacific Is-
5 lander, and American Indian and Alaska Native peo-
6 ple, to expand and reinforce White supremacy.

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

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

17 (4) Due to structural racism in the United
18 States, people of color are more likely to suffer from
19 chronic health conditions (such as heart disease, dia-
20 betes, asthma, hepatitis, and hypertension) and in-
21 fectious diseases (such as HIV/AIDS, and COVID–
22 19) compared to their White counterparts.

23 (5) Due to structural racism in maternal health
24 care in the United States, Black and American In-
25 dian and Alaska Native infants are more than twice

1 as likely to die than White infants, Black women are
2 3 to 4 times more likely to die from pregnancy-re-
3 lated causes than White women, and American In-
4 dian and Alaska Native women are 5 times more
5 likely to die from pregnancy-related causes than
6 White women. This trend persists even when adjust-
7 ing for income and education.

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

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

17 (8) Due to structural racism in the United
18 States, Black men are up to three and a half times
19 as likely to be killed by police as White men, and 1
20 in every 1,000 Black men will die as a result of po-
21 lice violence. Policing has adverse effects on mental
22 health in Black communities.

23 (9) Due to the confluence of structural racism
24 and factors such as gender, class, and sexual ori-
25 entation or gender identity, commonly referred to as

1 intersectionality, Black and Latinx transgender
2 women are more likely to die due to violence and
3 homicide than their White counterparts.
4 (10) Due to structural racism, inequitable ac-
5 cess to quality health care and long-term services
6 and supports also disproportionately burdens com-
7 munities of color; people of color and immigrants are
8 less likely to be insured and are more likely to live
9 in medically underserved areas.
10 (11) Due to structural racism, older adults of
11 color are also more likely to be admitted to nursing
12 homes and assisted living facilities and to reside in
13 those of poor quality, and when older adults of color
14 do receive home and community based services, Med-
15 icaid spends less money on their services and they
16 are more likely to be hospitalized than older White
17 adults.
18 (12) In addition, the Federal Government's fail-
19 ure to honor the unique political status of American
20 Indian and Alaska Native people, to respect the in-
21 herent sovereignty of Tribal Nations, and to uphold
22 its trust and treaty obligations to Tribal Nations
23 and American Indian and Alaska Native people, is
24 an ongoing and unjust manifestation of centuries of

1 oppression, with the consequence of adverse health
2 outcomes for Native peoples.
3 (13) The COVID–19 pandemic has exposed the
4 devastating impact of structural racism on the
5 United States ability to ensure equitable health out-
6 comes for people of color, and made these commu-
7 nities more likely to suffer from severe outcomes due
8 to the coronavirus infection.
9 (14) Racial and ethnic inequity in public health
10 is a result of systematic, personally mediated, and
11 internalized racism and racist public and private
12 policies and practices, and dismantling structural
13 racism is integral to addressing public health.

14 **SEC. 3. DEFINITIONS.**

15 In this Act:
16 (1) ANTIRACISM.—The term ''antiracism'' is a
17 collection of antiracist policies that lead to racial eq-
18 uity, and are substantiated by antiracist ideas.
19 (2) ANTIRACIST.—The term ''antiracist'' is any
20 measure that produces or sustains racial equity be-
21 tween racial groups.

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

3 Part B of title III of the Public Health Service Act
4 (42 U.S.C. 243 et seq.) is amended by adding at the end
5 the following:

6 **“SEC. 320B. NATIONAL CENTER ON ANTIRACISM AND**
7 **HEALTH.**

8 ‘‘(a) IN GENERAL.—

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

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

23 ‘‘(B) aiming to develop new knowledge in
24 the science and practice of antiracism, including
25 by identifying the mechanisms by which racism

1 operates in the provision of health care and in
2 systems that impact health and well-being;
3 ‘‘(C) transferring that knowledge into
4 practice, including by developing interventions
5 that dismantle the mechanisms of racism and
6 replace such mechanisms with equitable struc-
7 tures, policies, practices, norms, and values so
8 that a healthy society can be realized; and
9 ‘‘(D) contributing to a national and global
10 conversation regarding the impacts of racism on
11 the health and well-being of the United States
12 and world.
13 ‘‘(2) GENERAL DUTIES.—The Secretary, acting
14 through the Center, shall undertake activities to
15 carry out the mission of the Center as described in
16 paragraph (1), such as the following:
17 ‘‘(A) Conduct research into, collect, ana-
18 lyze and make publicly available data on, and
19 provide leadership and coordination for the
20 science and practice of antiracism, the public
21 health impacts of structural racism, and the ef-
22 fectiveness of intervention strategies to address
23 these impacts. Topics of research and data col-
24 lection under this subparagraph may include
25 identifying and understanding—

1 "(i) policies and practices that have a
2 disparate impact on the health and well-
3 being of communities of color;
4 "(ii) the public health impacts of im-
5 plicit racial bias, White supremacy, weath-
6 ering, xenophobia, discrimination, and
7 prejudice;
8 "(iii) the social determinants of health
9 resulting from structural racism, including
10 poverty, housing, employment, political
11 participation, and environmental factors;
12 and
13 "(iv) the intersection of racism and
14 other systems of oppression, including as
15 related to age, sexual orientation, gender
16 identity, and disability status.
17 "(B) Award noncompetitive grants and co-
18 operative agreements to eligible public and non-
19 profit private entities, including State, local,
20 territorial, and Tribal health agencies and orga-
21 nizations, for the research and collection, anal-
22 ysis, and reporting of data on the topics de-
23 scribed in subparagraph (A).
24 "(C) Establish, through grants or coopera-
25 tive agreements, at least 3 regional centers of

1 excellence, located in racial and ethnic minority
2 communities, in antiracism for the purpose of
3 developing new knowledge in the science and
4 practice of antiracism in health by researching,
5 understanding, and identifying the mechanisms
6 by which racism operates in the health space,
7 racial and ethnic inequities in health care ac-
8 cess and outcomes, the history of successful
9 antiracist movements in health, and other
10 antiracist public health work.

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

19 ''(i) be comprehensive and
20 disaggregated, to the extent practicable, by
21 including racial, ethnic, primary language,
22 sex, gender identity, sexual orientation,
23 age, socioeconomic status, and disability
24 disparities;

25 ''(ii) be made publicly available;

1 "(iii) protect the privacy of individuals
2 whose information is included in such data;
3 and
4 "(iv) comply with privacy protections
5 under the regulations promulgated under
6 section 264(c) of the Health Insurance
7 Portability and Accountability Act of 1996.
8 "(E) Provide information and education to
9 the public on the public health impacts of struc-
10 tural racism and on antiracist public health
11 interventions.
12 "(F) Consult with other Centers and Na-
13 tional Institutes within the Centers for Disease
14 Control and Prevention, including the Office of
15 Minority Health and Health Equity and the
16 Center for State, Tribal, Local, and Territorial
17 Support, to ensure that scientific and pro-
18 grammatic activities initiated by the agency
19 consider structural racism in their designs,
20 conceptualizations, and executions, which shall
21 include—
22 "(i) putting measures of racism in
23 population-based surveys;
24 "(ii) establishing a Federal Advisory
25 Committee on racism and health for the

1 Centers for Disease Control and Preven-
2 tion;
3 "(iii) developing training programs,
4 curricula, and seminars for the purposes of
5 training public health professionals and re-
6 searchers around issues of race, racism,
7 and antiracism;
8 "(iv) providing standards and best
9 practices for programming and grant re-
10 cipient compliance with Federal data col-
11 lection standards, including section 4302
12 of the Patient Protection and Affordable
13 Care Act; and
14 "(v) establishing leadership and stake-
15 holder councils with experts and leaders in
16 racism and public health disparities.
17 "(G) Coordinate with the Indian Health
18 Service and with the Centers for Disease Con-
19 trol and Prevention's Tribal Advisory Com-
20 mittee to ensure meaningful Tribal consulta-
21 tion, the gathering of information from Tribal
22 authorities, and respect for Tribal data sov-
23 ereignty.

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

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

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

13 **SEC. 5. PUBLIC HEALTH RESEARCH AND INVESTMENT IN**
14 **POLICE VIOLENCE.**

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

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

24 (1) the understanding and promotion of knowl-
25 edge about the public health impacts of uses of force

1 by law enforcement, including police brutality and
2 violence;
3 (2) developing public health interventions and
4 perspectives for eliminating deaths, injury, trauma,
5 and negative mental health effects from police pres-
6 ence and interactions, including police brutality and
7 violence; and
8 (3) ensuring comprehensive data collection,
9 analysis, and reporting regarding police violence and
10 misconduct in consultation with the Department of
11 Justice and independent researchers.
12 (c) FUNCTIONS.—Under the program under sub-
13 section (a), the Center shall—
14 (1) summarize and enhance the knowledge of
15 the distribution, status, and characteristics of law
16 enforcement-related death, trauma, and injury;
17 (2) conduct research and prepare, with the as-
18 sistance of State public health departments—
19 (A) statistics on law enforcement-related
20 death, injury, and brutality;
21 (B) studies of the factors, including legal,
22 socioeconomic, discrimination, and other factors
23 that correlate with or influence police brutality;
24 (C) public information about uses of force
25 by law enforcement, including police brutality

1 and violence, for the practical use of the public
2 health community, including publications that
3 synthesize information relevant to the national
4 goal of understanding police violence and meth-
5 ods for its control;
6 (D) information to identify socioeconomic
7 groups, communities, and geographic areas in
8 need of study, and a strategic plan for research
9 necessary to comprehend the extent and nature
10 of police uses of force by law enforcement, in-
11 cluding police brutality and violence, and deter-
12 mine what options exist to reduce or eradicate
13 death and injury that result; and
14 (E) best practices in police violence preven-
15 tion in other countries;
16 (3) award grants, contracts, and cooperative
17 agreements to provide for the conduct of epidemio-
18 logic research on uses of force by law enforcement,
19 including police brutality and violence, by Federal,
20 State, local, and private agencies, institutions, orga-
21 nizations, and individuals;
22 (4) award grants, contracts, and cooperative
23 agreements to community groups, independent re-
24 search organizations, academic institutions, and
25 other entities to support, execute, or conduct re-

search 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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