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Dr. Reagan's Precription: The 1985 Task Force on Black and Minority Health

By

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THESIS

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Abstract:

From 1983 to 1985, the U.S. Department of Health and Human Services (DHHS), under the leadership of Margaret Heckler, created a Task Force on Black and Minority Health that sought to catalog and detail information never before systematically compiled regarding health disparities among minority populations in the U.S. The goal of the Task Force was to build a roadmap to eliminating health disparities among the American public. With this research, I study the changing historical memory of the Task Force of Black and Minority Health across the late twentieth-century using feminist theory, methods of racial capitalism and science and technology study's framework of "co-production". I seek to understand how the Task force's place within a larger history of racialized public health initiatives and Reagan era austerity politics coded the methods of researchers in ways that re-pathologized the very communities the Task Force sought to aid. I elucidate how the Task Force offered little material change to the health status of Black, Native, Latinx, and Asian/Pacific Islander communities in the U.S., despite the Task Force's memorialization as a crucial step forward in the history of U.S. public health. The resulting project will use the Task Force's multivolume reports to analyze race, science, and politics in the context of twentieth-century public health initiatives, their structural binds, and their subsequent historical memory.

Introduction

On March 9th, 1983, a woman stood next to President Ronald Reagan with her right hand raised and her left hand on a bible held by her daughter. After her oath was sworn, she lowered her hand and took her place on the podium in front of her, and spoke loudly and clearly, "I saw your prescription for America and, indeed, I could call you "Dr. Reagan," because I believe the medicine is working. Indeed, although we enjoy spring in Washington, in a sense we are enjoying as well, the beginning of a harvest of the economic wisdom that you have so wisely shared with our government and with the American people."[1]

Those of us familiar with the 1980s Reagan presidency may recognize this woman as the administration's Secretary of Health and Human Services, Margaret Heckler. The moment at hand was Heckler's 1983 swearing-in ceremony. Heckler, a congressional politician, was one of the few women in Ronald Reagan's cabinet, about to take her position as the first woman to head the Department of Health and Human Services. Heckler described herself as a prescription, one prescribed by the man she called "Dr. Reagan." We may find a nickname like this sardonic if our minds drift enough to recall historical assessments of Ronald Reagan's infamous passivity during the AIDS epidemic of the 1980s.[2] To Heckler, however, the name signaled her own understanding of her functionality within Reagan's administration, and presidency more broadly.

In 1983, Margaret Heckler undertook a massive new project in public health by creating the Task Force on Black and Minority Health. In the decades to come, this project would

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[1] President (1981-1989 : Reagan). White House Television Office. *The Swearing in of Margaret Heckler as the New Secretary of Health and Human Services by Justice Sandra Day O'Connor then Remarks by President Reagan in the Oval Office on March 9, 1983.* Video Cassette. California: Simi Valley, 1983. From Ronald Reagan Presidential Library. Records of the White House Television Office (WHTV) (Reagan Administration), 1/20/1981 - 1/20/1989, Video. https://catalog.archives.gov/id/68886119 (Accessed Oct 23rd, 2020).

[2] President (1981-1989 : Reagan). White House Television Office. *The Swearing in of Margaret Heckler as the New Secretary of Health and Human Services by Justice Sandra Day O'Connor then Remarks by President Reagan in the Oval Office on March 9, 1983.* Video Cassette. California: Simi Valley, 1983. From Ronald Reagan Presidential Library. Records of the White House Television Office (WHTV) (Reagan Administration), 1/20/1981 - 1/20/1989, Video. https://catalog.archives.gov/id/68886119 (Accessed Oct 23rd, 2020).

immortalize Heckler and the Task Force on Black and Minority Health as champions of public health equity. However, the Task Force is not merely a scientific triumph of a new and ambitious leader within public health. The Task Force's importance is undeniable, it was the first time the federal government convened all sectors of the Department of Health and Human Services to comprehensively and systematically compile data regarding minority health. The Task Force's subsequent eight-volume report was the first to synthesize and present the state of knowledge regarding major factors that contributed to health disparities among Black, Native, Asian/Pacific Islander, and Latinx communities.[3] Nevertheless, when placed within the broader context of the 1980s and the history of public health in America, the Task Force and Margaret Heckler exemplify the way structural powers influence the production of and dissemination of scientific research. Further, The Task Force elucidates how structural binds often stifle well-intentioned science in ways that re-pathologize the very communities scientists seek to aid.

At its core, this work reassesses the Task Force on Black and Minority Health's mythic, historical memory and seeks to interrogate the structural and historical forces that create, reproduce and sustain racial pathology in science. The Task Force sought to be a blueprint for finally "closing the gap" and eliminating the health disparities among white and non-white people of color.[4] Heckler's Task Force ultimately failed to do so in the months following its inception. Yet, the conversations that surround the Task Force's memory are mythic, almost untouchable. In public discourse, the Task Force on Black and Minority Health is celebrated as a triumphant moment where public health officials seemingly *transcended* race to extend health

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[3] United States. Department of Health and Human Services. Task Force on Black and Minority Health, *Report of the Secretary's Task Force on Black & Minority Health Volume I.* PDF. Washington, D.C. : U.S. Dept. of Health and Human Services, [1985-1986]. From The National Library of Medicine. https://collections.nlm.nih.gov/catalog/nlm:nlmuid-8602912-mvset (Accessed July 14th, 2020).

[4] United States: Department of Health and Human Services Press Conference, Box 119, Folder 43, Margaret Heckler papers, CA.1998.004, John J. Burns Library, Boston College.

benefits to non-white people of color.[5] This work removes the Task Force from the shadow of its mythic remembrance, acknowledging that while this moment in public health history was important, longer histories of racialization in public health and austerity politics of the Reagan years shaped its emergence and possibilities.

In utilizing historical analysis and focusing on the Heckler's Task Force in isolation for the first time since its inception, I make sense of the disjuncture between the structural forces that shaped the Task Force, its material consequences on people of color's health, and its mythic memory. The Task Force exemplifies a continuation of contentious and racialized scientific research in the public health sphere that had been going on in America decades before the 1980s. As a result, Heckler's Task Force inherited the fraught nature of scientific research and the racialized frameworks of its predecessors. These inheritances ultimately coded how the Task Force ran in the 1980s, the results it produced, and limited what it could do for people of color. The Task Force's place within histories of racialization in public health, and debates surrounding race's "place" within scientific research generated racial pathology, heterogeneity, and contradictions in the volumes produced by researchers. Far from a uniform and concise blueprint, the Task Force was messy, contradictory, and reflective of the heterogeneity of its team of researchers and the ways in which they struggled to understand the place of race and people of color in scientific research.

Yet, a massive, federal research project without uniformity was not politically beneficial, so Margaret Heckler created uniformity through her public presentation of the Task Force. Far from a free agent, the politics of the Reagan administration bound Heckler. In her public presentation of the Task Force, which responded to the political strategies of the Reagan Era

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[5] J. Nadine Gracia, "Remembering Margaret Heckler's Commitment to Advancing Minority Health," *HealthAffairs* (blog), November 16th, 2018, **https://www.healthaffairs.org/do/10.1377/hblog20181115.296624/full/.**

more broadly, Heckler re-pathologized Black and non-Black people of color. Ironically, the choices and performance of Margaret Heckler also cast the Task Force as a productive consequence of Reagan's "Morning in America," a moment in which the Reagan administration sought to craft a narrative of progress and forward-looking politics in the U.S.[6] Meanwhile, the fraught inheritances of race science, racialized public health initiatives, and Reagan style politics would ultimately deem Black and non-Black people of color unworthy of material investment, relegating them to the shadows of "Morning in America."

This work is grounded in a variety of primary and secondary source material. My research examines the Margaret Heckler papers from Boston College's John J. Burns Library which houses documents regarding Heckler's involvement in the Department of Health and Human Services (DHHS). The documents include all volumes of the Task Force report (eight total), press conference transcripts, letters of correspondence among DHHS staff, briefings, summary reports of the Task Force's findings, photos, and Q&A summaries. In addition, I will use newspaper articles from The Washington Post, the Alexandria Daily Town Talk, and The New York Times to assess public perception of the Task Force as well as public broadcasting videos and interviews of Margaret Heckler provided by the Reagan Library and the Center for Medicare & Medicaid Services.

For years, the Task Force on Black and Minority Health's quantitative data captured the attention of scholars. Similarly, the Task Force's role in the creation of the Office of Minority Health also received extensive attention. One of the first places the Task Force appears is in health-care attorney Daniel E. Dawes's *150 Years of Obamacare,* which explains the Affordable Care Act by contextualizing the long history of public health interventions in America, including the Task Force on Black and Minority Health. The Task Force's data has also been utilized by

[6] Lou Cannon, *President Reagan: The Role of a Lifetime* (New York, NY: Public Affairs Press, 1991), pg, 887.

scholars in order to analyze and quantify the health disparities among Black and non-Black people of color. Notably, Sociologist Sabrina Strings utilizes the Task Force's data in her discussion of the mutual constructions of fat-phobia and anti-Blackness in *Fearing the Black Body*.[7]

Materially, the Task Force provides critical data and information, but in the 1980s, it did not receive immediate praise. The quantitative data produced by the Task Force has been invaluable in revealing the extent to which people of color suffered from health disparities in the 1980s, and it is true, the Office of Minority Health was created as a result of the Task Force on Black and Minority Health. However, quickly after the Task Force's findings were presented publicly in 1985, Margaret Heckler was made ambassador to Ireland. Heckler's personal life became the subject of media scrutiny as she went through a very public divorce, and some hypothesized this, along with animosity within the Reagan administration was the reason for her "promotion."[8] Heckler would not be around to see the ways in which the Office of Minority Health would develop or function, it was not her project. Similarly, not all research produced by the Task Force benefited people of color, and in fact, some helped nationally justify the federal disinvestment from their lives. Consequently, I argue it is important to analyze not only the positive consequences of the Task Force on Black and Minority Health, but also the structures that shaped its emergence and presentation, what methods it used, and what consequences these methods had for Black and non-Black people of color in the 1980s.

To understand how structural forces shaped the Task Force on Black and Minority health, I draw on methods that predominate the study of science and race research from within history,

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[7] Sabrina Strings, *Fearing the Black Body: The Racial Origins of Fatphobia* (New York: New York University Press, 2019).

[8] The MacNeil/Lehrer NewsHour," 1985-10-16, NewsHour Productions, American Archive of Public Broadcasting (WGBH and the Library of Congress), Boston, MA and Washington, DC, accessed October 23, 2020, http://americanarchive.org/catalog/cpb-aacip-507-rn3028q98d

science and technology studies (STS), and feminist theory. I explicitly move away from focusing solely on the Task Force's quantitative data and its role in the emergence of the Office of Minority Health. Instead, I situate the Task Force within histories of public health from the 1930s to the 1980s. In addition, I situate the Task Force within the context of Ronald Reagan's austerity politics in the 1980s.

I draw heavily from historian of public health Natalia Molina, whose work elucidates how public health helped craft race in the early twentieth century.[9] I also rely on the work of John Duffy, whose scholarship provides the fundamental historical background of U.S. public health from the 1600s to the 1980s which has allowed me to identify the ongoing reproduction of racial pathology from the 40s to the 70s.[10] This work also takes inspiration from sociologist Jenny Reardon, whose work has elucidated the debates surrounding race's place in science research following WWII.[11] Analyzing the history of public health prior to the 1980s makes clear the ways fraught histories of racialization within public health continued to affect science research long after the first half of the twentieth century, producing racial pathology and heterogeneity within research due to the contentious nature of race as an analytical category in science. In addition, analyzing public health history prior to the 1980s in conjunction with Reagan era politics explains why heterogeneity needed to be contained, and how Margaret Heckler reproduced pathology in her public presentations of the Task Force as a result of limitations placed on her by the Reagan administration broadly.

To understand Reagan era austerity politics, I rely on Lou Cannon's, *President Reagan: The Role of a Lifetime* as well as Gil Troy's, *Morning in America* for historical context. However,

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[9] Natalia Molina, *Fit to be Citizens?: Public Health and Race in Los Angeles, 1879-1939* (Berkeley: California University Press, 2006).
[10] John Duffy, *The Sanitarians: A History of American Public Health* (Chicago: University of Illinois Press, 1992).
[11] Jenny Reardon, *Race to the Finish: Identity and Governance in the Age of Genomics* (Princeton: Princeton University Press, 2004)

my work approaches these two works by utilizing racial capitalism as a methodology to analyze how Margaret Heckler weaponized federal budgets publicly to individualize health disparities and minimize the government's responsibility in the lives of people of color. As historians Destin Jenkins and Justin Leroy have noted, racial capitalism is the process by which "the key dynamics of capitalism—accumulation/dispossession, credit/debt, production/surplus, capitalist/worker, developed/underdeveloped, contract/coercion, and others—become articulated through race."[12] In this work, the use of budgets to justify disinvestment was a response to broader austerity politics. Nevertheless, the consequence was the production of more racial pathology. In other words, this work reveals how a facet of racial capitalism (budgets) became articulated through race and had consequences for racialized groups. Science and technology studies' framework of "co-production" also serves to explain the reproduction of pathology through Heckler's presentation of scientific research. Co-production posits scientific knowledge and social order are produced simultaneously. I argue Heckler's public presentation of the Task Force nationally shaped the way white Americans viewed the culture, psychology and social lives of non-white people which ultimately justified disinvestment in the lives of Black, Native, Asian, Pacific Islander, and Latinx communities.

Public Health as a Site of Racialization

What followed Heckler's entrance into public health in 1983 was the creation of The Task Force on Black and Minority Health. Yet, this is not a purely triumphant story of when Public Health officials, led by a new and enthused leader, finally got things right. The appearance of meticulous research and grand undertakings often give the illusion of what Natalia Molina has

[12] Destin Jenkins and Justin Leroy, *Histories of Racial Capitalism* (New York: Columbia University Press, 2021), 10.

called a forward-thinking and sophisticated image of progress.[13] However, the Task Force had its own limitations as all public health initiatives had since the U.S.'s inception. The Task Force arose in the shadows of previous debates regarding race's place in science and health care. As a result, it would often reproduce the very disparities it sought to understand and eliminate.

The Task Force on Black and Minority Health was not Margaret Heckler's idea alone. The Task Force on Black and Minority Health's origins lay in the concerns of medical professionals and health experts at Historically Black Universities (HBCUs). The January following Margaret Heckler's swearing in as Secretary of Health and Human Services, reports from organizations like the National Academy of Medicine emerged, reflecting the effects lack of care was having on minority health.[14] As Daniel E. Dawes has identified Dr. Louis Sullivan, founding dean and president of Morehouse School of Medicine; Dr. David Satcher, president of Meharry Medical College; Dr. Walter Bowie, dean of Tuskegee University; and Dr. M. Alfred Haynes, dean of Charles R. Drew University of Medicine and Science, were all a part of the group of medical experts that brought their concerns to Heckler.[15] The news came in the form of the annual report card on the status of American people.[16] However, it was Congressman Louis Stokes, who had worked with Heckler during her time as a congresswoman that pushed her to address the health disparities presented by medical experts.[17] From the beginning, Heckler's lead role in the Task Force was a result of experts around her.

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[13] Natalia Molina, *Fit to be Citizens?: Public Health and Race in Los Angeles, 1879-1939* (Berkeley: California University Press, 2006), pg, 91.
[14] Daniel E. Dawes, *150 Years of Obamacare* (Baltimore: Johns Hopkins University Press, 2016).
[15] Daniel E. Dawes, *150 Years of Obamacare* (Baltimore: Johns Hopkins University Press, 2016), 80.
[16] United States. Department of Health and Human Services. Task Force on Black and Minority Health, *Report of the Secretary's Task Force on Black & Minority Health Volume I.* PDF. Washington, D.C. : U.S. Dept. of Health and Human Services, [1985-1986]. From The National Library of Medicine. https://collections.nlm.nih.gov/catalog/nlm:nlmuid-8602912-mvset (Accessed July 14th, 2020). 7
[17] Daniel E. Dawes, *150 Years of Obamacare* (Baltimore: Johns Hopkins University Press, 2016), 68.

The disparity between white and non-white life longevity in the reports brought to Heckler by experts along with Heckler's desire to prove herself as Secretary of Health and Human Services were the catalysts for the creation of the Task Force on Black and Minority Health. The first pages of the first volume of the report contained a signed opening letter written by Heckler, stating, "there was a continuing disparity in the burden of death and illness experienced by Blacks and other minority Americans as compared with our population as a whole."[18] When she compared the rates to that of white Americans, she desired to learn more, and to understand everything about the role she had been newly ushered into which she admittedly knew little about.[19]

It was clear from the beginning, Heckler was not as qualified to attend to matters regarding public health as the experts that surrounded and consulted her. Heckler herself came from a very fraught congressional career in Massachusetts. To Reagan white house officials, Heckler appeared uncertain of herself as a politician.[20] White House Officials claimed Heckler was known, not for her legislative triumphs, but for her indecisive personality, often recalling the ways she withheld her votes until others had cast theirs, always fearful of being on the "wrong side" of a vote.[21] Thus, when white house officials heard the woman who had just lost her

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[18] United States. Department of Health and Human Services. Task Force on Black and Minority Health, *Report of the Secretary's Task Force on Black & Minority Health Volume I.* PDF. Washington, D.C. : U.S. Dept. of Health and Human Services, [1985-1986]. From The National Library of Medicine. https://collections.nlm.nih.gov/catalog/nlm:nlmuid-8602912-mvset (Accessed July 14th, 2020).

[19] *Margaret Heckler: Past, Present, and Future of Health Equity*, *YouTube* (YouTube, 2016), https://www.youtube.com/watch?v=Uw32HaEkjPo&t=607s. [Ms. Heckler, the former Secretary for the Department of Health and Human Services, shares her perspectives on the past, present, and future of health equity at the Medicare & Medicaid at 50: Their Past, Present and Future Impact on Health Equity conference in Baltimore, MD.]

[20] *Margaret Heckler: Past, Present, and Future of Health Equity*, *YouTube* (YouTube, 2016), https://www.youtube.com/watch?v=Uw32HaEkjPo&t=607s. [Ms. Heckler, the former Secretary for the Department of Health and Human Services, shares her perspectives on the past, present, and future of health equity at the Medicare & Medicaid at 50: Their Past, Present and Future Impact on Health Equity conference in Baltimore, MD.]

[21] *Margaret Heckler: Past, Present, and Future of Health Equity*, *YouTube* (YouTube, 2016), https://www.youtube.com/watch?v=Uw32HaEkjPo&t=607s. [Ms. Heckler, the former Secretary for the Department of Health and Human Services, shares her perspectives on the past, present, and future of health equity at the Medicare & Medicaid at 50: Their Past, Present and Future Impact on Health Equity conference in Baltimore, MD.]

congressional representative race in Massachusetts to a freshman Democratic candidate was hand-picked by Ronald Reagan to head the Department of Health and Human Services, gossip ensued.[22]

White house officials worried Margaret Heckler did not have the experience to head the Department of Health and Human Services and its 276 billion dollar budget. Many worried she had little administrative experience and charged that her congressional loss and office turnover reflected poor management skills.[23] In reality, Heckler had lost due to charges of being a "Reagan clone" who blindly followed and supported Reagan's economic policies.[24] Further, white house officials noted Heckler's committee service had not exposed her in any great capacity to issues of health care, particularly among people of color. One white house aid commented on Heckler's appointment, stating, "It's a terrible appointment, it was done much too quickly and she doesn't have the background . . . They wanted a woman--I could have found them a woman...What qualifies her? She needed a job."[25] It was comments from those who were skeptical of her promotion Heckler sought to prove wrong. Heckler was the head of the Department of Health and Human Services and she was determined to be more than a mere spokesperson or "Reagan clone" that her detractors, predominantly white house affiliates, implied she was.[26]

Heckler viewed herself as a free agent, often referring to herself as "unbossed and unbought," and so in 1984, following the push from experts and colleagues she worked with,

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[22] "Heckler, Margaret M.," *History, Art & Archives, U.S. House of Representatives,* https://history.house.gov/People/Listing/H/HECKLER,-Margaret-M--(H000440)/. (Accessed December 11th, 2020).
[23] Lois Romano, "Heckler: Tough Campaigner for HHS," *The Washington Post,* February 13, 1983. https://www.washingtonpost.com/archive/lifestyle/1983/02/13/heckler-tough-campaigner-for-hhs/0dbb240d-7f14-4ddb-a3b1-910e9af7678e/ (accessed December 10, 2020).
[24] "Heckler, Margaret M.," *History, Art & Archives, U.S. House of Representatives,* https://history.house.gov/People/Listing/H/HECKLER,-Margaret-M--(H000440)/. (Accessed December 11th, 2020).
[25] Lois Romano, "Heckler: Tough Campaigner for HHS," *The Washington Post,* February 13, 1983. https://www.washingtonpost.com/archive/lifestyle/1983/02/13/heckler-tough-campaigner-for-hhs/0dbb240d-7f14-4ddb-a3b1-910e9af7678e/ (accessed December 10, 2020)
[26] "Heckler, Margaret M.," *History, Art & Archives, U.S. House of Representatives,* https://history.house.gov/People/Listing/H/HECKLER,-Margaret-M--(H000440)/. (Accessed December 11th, 2020).

Margaret Heckler called for the creation of a special unit to investigate the health disparities she noted in the U.S. annual health report.[27] The Task Force on Black and Minority Health began recruiting members in January of 1984. Dr. Thomas E. Malone was chosen to head the Task Force as chairperson and Dr. Katrina W. Johnson acted as the Director of Study.[28] In the Task Force's creation, Heckler sought to include professionals from within the Department of Health and Human Services as well as outside of it.[29] Dr. Thomas E. Malone was a logical first choice to chair the study as he was the deputy director of the National Institute of Health (NIH).[30] Dr. Malone's career at the National Institute began in 1962, and he was named the sixth deputy director of NIH in March 1977. Unfortunately, less is said about Dr. Johnson's recruiting. Following the recruitment of the two overseers of the Task Force, Heckler and her team reviewed every sector of the Department of Health and Human Services to find their Task Force members as well as their alternates.

Members of the Task Force were selected based on their scientific expertise as well as their status as senior administrators and program managers from major Departmental agencies and units which increased chances of implementation.[31] At the time, the professional makeup of the Task Force was historic. In 1984, the Department of Health and Human Services had

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[27] United States: Department of Health and Human Services Press Conference, Box 119, Folder 43, Margaret Heckler papers, CA.1998.004, John J. Burns Library, Boston College.
[28] United States. Department of Health and Human Services. Task Force on Black and Minority Health, *Report of the Secretary's Task Force on Black & Minority Health Volume I.* PDF. Washington, D.C. : U.S. Dept. of Health and Human Services, [1985-1986]. From The National Library of Medicine. https://collections.nlm.nih.gov/catalog/nlm:nlmuid-8602912-mvset (Accessed July 14th, 2020). Pg, 2.
[29] United States. Department of Health and Human Services. Task Force on Black and Minority Health, *Report of the Secretary's Task Force on Black & Minority Health Volume I.* PDF. Washington, D.C. : U.S. Dept. of Health and Human Services, [1985-1986]. From The National Library of Medicine. https://collections.nlm.nih.gov/catalog/nlm:nlmuid-8602912-mvset (Accessed July 14th, 2020)., pg 26.
[30] United States. Department of Health and Human Services. Task Force on Black and Minority Health, *Report of the Secretary's Task Force on Black & Minority Health Volume I.* PDF. Washington, D.C. : U.S. Dept. of Health and Human Services, [1985-1986]. From The National Library of Medicine. https://collections.nlm.nih.gov/catalog/nlm:nlmuid-8602912-mvset (Accessed July 14th, 2020)., pg 26..
[31] Questions and Answers: Task Force on Black and Minority Health, Box 119, Folder 43, Margaret Heckler papers, CA.1998.004, John J. Burns Library, Boston College.

multiple programs that sought to analyze and assess health disparities experienced by minorities. However, at no time before 1984 had there been a joint effort by members of each program to designate and execute a coordinated and comprehensive study to investigate the health status of Black, Native, Latinx, and Asian/ Pacific Islander health disparities.[32]

The make-up and comprehensive goals of the Task Force were new and expansive, but methods and data came from previous public health research initiatives. The Task Force did not run new scientific trials to account for the 1983 health disparities. In its first few months, the Task Force's initial meetings merely reviewed existing health status information for white and non-white populations available in "Health, United States 1983", (the same annual report that pushed Heckler to begin the Task Force to begin) along with other supplementary data available from past research initiatives from 1979-1981.[33] The Task Force specifically looked at mortality rates from among 40 different disease categories and used a statistical framework of "excess death" to quantify the number of deaths that would not have occurred in disease categories had the population in question been white Americans.[34] It was in their analysis of mortality data from 1979 to 1981 that the Task Force identified six main causes of death that together accounted for 80% of the high mortality rates observed among Black, Native, Asian/Pacific Islander, and Latinx populations in excess compared to the white population. These six causes were cancer,

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[32]United States. Department of Health and Human Services. Task Force on Black and Minority Health, *Report of the Secretary's Task Force on Black & Minority Health Volume I.* PDF. Washington, D.C. : U.S. Dept. of Health and Human Services, [1985-1986]. From The National Library of Medicine. https://collections.nlm.nih.gov/catalog/nlm:nlmuid-8602912-mvset (Accessed July 14th, 2020). Pg., 12.

[33] United States. Department of Health and Human Services. Task Force on Black and Minority Health, *Report of the Secretary's Task Force on Black & Minority Health Volume I.* PDF. Washington, D.C. : U.S. Dept. of Health and Human Services, [1985-1986]. From The National Library of Medicine. https://collections.nlm.nih.gov/catalog/nlm:nlmuid-8602912-mvset (Accessed April 25th, 2021). Pg., 12.

[34] United States. Department of Health and Human Services. Task Force on Black and Minority Health, *Report of the Secretary's Task Force on Black & Minority Health Volume I.* PDF. Washington, D.C. : U.S. Dept. of Health and Human Services, [1985-1986]. From The National Library of Medicine. https://collections.nlm.nih.gov/catalog/nlm:nlmuid-8602912-mvset (Accessed April 25th, 2021). Pg., 12.

cardiovascular disease and stroke, chemical dependency, diabetes, homicide and accidents (unintentional injuries), and infant mortality.[35]

Ultimately, the use of older data and lack of new research trials meant many of the Task Force's findings were already coded by racialized assumptions and gaps present in past research initiatives. The team began its massive scientific undertaking following recruitment in the Spring of 1984 and ran for about fifteen months.[36] Scientists, researchers, epidemiologists, doctors, and health professionals from various sectors of Public Health Services and the Department of Health and Human Services came together for the first time to begin their studies. Once the study began, the reigns were left to the health professionals. They were to conduct their research in the manner they saw fit. Unsurprisingly, led by Dr. Malone, the Task Force noted neutrality as their guiding principle. According to Dr. Malone, he expected the Task Force to approach their research as a "scientific maneuver activity."[37] In other words, the Task Force understood itself as scientifically neutral and objective. Ultimately, this meant approaches to data remained as they had under the assumption methods and data were benignly created. Without critical reflection of the consequences the utilization of old data may have, the Task Force fell more in line with research that had occurred prior to the 1980s.

Prior to and into the 1980s, public health and medicine broadly served as important sites of racialization, pathology and scarcity. As historian Natalia Molina has argued, in the early 1930s, public health officials shaped the way white populations perceived Black and non-Black

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[35] United States. Department of Health and Human Services. Task Force on Black and Minority Health, *Report of the Secretary's Task Force on Black & Minority Health Volume I.* PDF. Washington, D.C. : U.S. Dept. of Health and Human Services, [1985-1986]. From The National Library of Medicine. https://collections.nlm.nih.gov/catalog/nlm:nlmuid-8602912-mvset (Accessed April 25th, 2021). Pg., 12.
[36] DRAFT: Statement by Margaret M. Heckler Secretary of Health and Human Services, Box 119, Folder 43, Margaret Heckler papers, CA.1998.004, John J. Burns Library, Boston College.
[37] United States: Department of Health and Human Services Press Conference, Box 119, Folder 43, Margaret Heckler papers, CA.1998.004, John J. Burns Library, Boston College.

people of color.[38] Public health officials developed and maintained social order by defining people as medical threats, developing discourses of exclusion through association with disease and illness.[39] As politics of exclusion thrived, public health officials also utilized racialized people to expand their own power and prestige by developing the scientific discourses and "objective" measurements that validated beliefs of inferiority.[40] Molina's discussion of the racialization and exclusion of undocumented Japanese and Mexican migrants reveals the way in which public health, using statistics and data, became an arena in which people were defined in relation to each other and in relation to the state.

In the 1940s and 50s public health retreated from engaging in politics to focusing more of their attention to research, but patterns of racialization and pathology continued.[41] The retreat to research resulted from public health officials' attempt at avoiding conflict with the American Medical Association.[42] Yet, research itself was not benign and it could produce as much violence as other medical interventions, particularly because researchers began struggling with the utilization of race within science after WWII. As sociologist Jenny Reardon has noted, after the disavowing of Nazi science, scientists in the U.S. began grappling with redefining and retooling "race" as an anlytical category.[43] The functionality of race was fraught and fragmented and largely depended on the context of research being done. Little consensus emerged, and as legal scholar Dorothy Roberts has argued, debate did not end after WWII, and the validity of racial

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[38] Natalia Molina, *Fit to be Citizens?: Public Health and Race in Los Angeles, 1879-1939* (Berkeley: California University Press, 2006), 4.
[39] Natalia Molina, *Fit to be Citizens?: Public Health and Race in Los Angeles, 1879-1939,* 54.
[40] Natalia Molina, *Fit to be Citizens?: Public Health and Race in Los Angeles, 1879-1939,* 53.
[41] John Duffy, *The Sanitarians: A History of American Public Health* (Chicago: University of Illinois Press, 1992), 294.
[42] For more on the AMA see: John Duffy, *The Sanitarians: A History of American Public Health* (Chicago: University of Illinois Press, 1992).
[43] Jenny Reardon, *Race to the Finish: Identity and Governance in the Age of Genomics* (Princeton: Princeton University Press, 2004), 18.

categories in biomedical research have continued into the present moment.[44] By 1953, public health began to merge again with social services as a result of pushback from health leaders.[45] This push led to the emergence of the Department of Health and Human Services (at the time referred to as the Department of Health, Education, and Welfare).[46] Very quickly, "closing the gap" became one of the main concerns of public health officials.[47]

By the 1960s substantive change occurred within medicine at large, however change was as fraught as change within public health research. In the 1960s, various legislations passed which sought to alleviate racialized health disparities, including legislation which desegregated hospitals.[48] From 1961-1968 many segregated hospitals merged, and while desegregation was a momentous step, the unintended consequence was various hospitals in areas accessible to predominantly non-white people closed.[49] Concurrently, as Brian D. Smedley et al. note, medical establishments like the American Medical Association refused to allow Black and non-Black people of color the same foothold within medical professions.[50] Medical care became less available and accessible to non-white people despite the "second reconstruction" of medicine occurring in America.[51] As a result, many communities of color had less access to good medical

[44] Dorothy Roberts, "Legal Constraints on the Use of Race in Biomedical Research: Toward a Social Justice Framework," *Journal of Law, Medicine & Ethics*, Volume 34 , Issue 3 (Fall 2006): pp. 526 - 534.
[45] John Duffy, *The Sanitarians: A History of American Public Health,* 295.
[46] John Duffy, *The Sanitarians: A History of American Public Health,* 295.
[47] John Duffy, *The Sanitarians: A History of American Public Health,* 295.
[48] Brian D. Smedley, Adrienne Y. Stith, Alan R. Nelson*, Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Washington: National Academies Press, 2003), 104.
[49] Brian D. Smedley, Adrienne Y. Stith, Alan R. Nelson*, Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Washington: National Academies Press, 2003), 104.
[50] Brian D. Smedley, Adrienne Y. Stith, Alan R. Nelson*, Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Washington: National Academies Press, 2003), 108.
[51] W. Michael Byrd and Linda A. Clayton, "Understanding and Eliminating Racial and Ethnic Disparities In Health Care Background Paper Racial And Ethnic Disparities In Health Care: A Background And History" in *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Washington: National Academies Press, 2003).

care outside of community based efforts.[52] By the 1970s and 1980s, government intervention in social welfare programs declined and funding for health research diminished.

The Task Force on Black and Minority Health emerged in this fraught history of public health and as a result, it inherited and reproduced many of the issues present in American public health and medicine since the 1930s. As Heckler became the Secretary of Health and Human Services, public health continued to concern itself with more than research. Closing the gap remained the larger goal of public health. However, the fraught history of public health research and refusal of medicine to fully address racism within the field continued to produce the mass health disparities the Task Force sought to understand. Public health's role as a space of racialization, combined with race's fraught place within research meant there was little homogeneity in the way race would be utilized and engaged within the Task Force's methods. The Task Force on Black and Minority Health changed little in their data usage or methods. Despite the Task Force's goal of remaining a scientifically neutral endeavor, the result of uncritical and heterogeneous engagement with the past history of race and public health meant the Task Force often re-pathologized Black and non-Black people of color in their research results.

The Re-pathologization of People of Color

The pathologizing effects of replicating old data and methods was apparent in the Task Force's first and second volume reports. The Task Force on Black and Minority Health produced eight volumes relating to the six diseases they identified as major causes of death among communities of color. Cancer, cardiovascular disease and strokes, chemical dependency,

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[52] For more on community based health care see: Alondra Nelson, *Body and Soul:* The Black Panther Party and the Fight Against Medical Discrimination (Minneapolis: University of Minnesota Press, 2011).

diabetes, homicide and accidents (unintentional injuries), and infant mortality all received their own volumes in order to allow researchers adequate time to deeply dive into the data behind a given disease category. However, select papers from volumes one and two highlight the ways in which communities of color were re-pathologized due to the use of old data and replication of prior public health methods. In addition, the juxtaposition between select papers in volume one and two highlight the ways researchers from varying departments of the Department of Health and Human Services struggled with race's place in scientific research. The researchers within the Task Force on Black and Minority Health used race as a social category, albeit indirectly and not always in uniform ways. According to legal scholar Dorothy Roberts, social frameworks often study the way racism affects access to care.[53] The Task Force took up this approach in volume two while using social characteristics of race in more incendiary ways in volume one. The struggle among researchers produced pathologizing ideas of culture and psychology, but also produced scientific heterogeneity.

In volume one, the Task Force's use of "social characteristics" of race reinscribed racist stereotypes onto Black and non-Black people of color while also taking for granted and homogenizing racial categories. Racial categorization within the Task Force's report described Black, Native, Latinx, Asian/Pacific Islander communities. However, particularities among people were presented in extremely limited ways. If and when distinctions were made among racial categories, they were limited. For example, when discussing Latinx people, only Mexican, Cuban, and Puerto Rican people were compared, and it was unclear whether Afro-Latinx people were considered under this category at all.[54] Similarly, only Southeast Asian people were

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[53] Dorothy Roberts, "Legal Constraints on the Use of Race in Biomedical Research: Toward a Social Justice Framework," *Journal of Law, Medicine & Ethics*, Volume 34 , Issue 3 (Fall 2006): pp. 526 - 534.
[54] United States. Department of Health and Human Services. Task Force on Black and Minority Health, *Report of the Secretary's Task Force on Black & Minority Health Volume I.* PDF. Washington, D.C. : U.S. Dept. of Health and Human Services, [1985-1986]. From The National Library of Medicine. https://collections.nlm.nih.gov/catalog/nlm:nlmuid-8602912-mvset (Accessed July 14th, 2020). Pg. 60.

compared in the large category encompassing Asian/Pacific Islanders.[55] Nevertheless, smaller subsets of people were said to represent trends as a whole, which was a fraught assertion as racial definitions are historically and nationally specific.[56] Specificity regarding whether people had recently migrated to the U.S. was also missing. This would affect data as health trends may have varied based on how long someone or their families had been in the U.S., or whether they were the first in their families to reside in the U.S.[57] However, homogenization and oversimplification of racial categories in methodology was not unique to the Task Force.

Homogenizing racial categorization in science had its roots in U.S. census methods and the Task Force's first volume did little to develop new frameworks of categorization that accounted for difference.[58] Ultimately, state-sanctioned but ill-defined categories of race entered medical research through census method and as Braun et. al note, the categories operated in an attempt to ensure full racial inclusion, but had unanticipated consequences for health outcomes.[59] In the case of the Task Force, the consequence was the inscription of distinct racial stereotypes onto large groups of people whose existence and multiplicity could not easily be captured by narrow racial categories.

Among the racial categories it used, the Task Force assessed social characteristics such as demographic profiles (where people lived), nutritional and dietary practices (what people ate), environmental and occupational exposures (what people were exposed to based on locality and

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55 United States. Department of Health and Human Services. Task Force on Black and Minority Health, *Report of the Secretary's Task Force on Black & Minority Health Volume I.* PDF. Washington, D.C. : U.S. Dept. of Health and Human Services, [1985-1986]. From The National Library of Medicine. https://collections.nlm.nih.gov/catalog/nlm:nlmuid-8602912-mvset (Accessed July 14th, 2020). Pg. 55.
56 Lundy Braun, Fausto-Sterling A, Fullwiley D, Hammonds EM, Nelson A, Quivers W, et al., "Racial Categories in Medical Practice: How Useful Are They?" *PLoS Med,* Volume 4, Issue 9 (2007), 1423-1428.
57 Lundy Braun, Fausto-Sterling A, Fullwiley D, Hammonds EM, Nelson A, Quivers W, et al., "Racial Categories in Medical Practice: How Useful Are They?" *PLoS Med,* Volume 4, Issue 9 (2007), 1424.
58 Lundy Braun, Fausto-Sterling A, Fullwiley D, Hammonds EM, Nelson A, Quivers W, et al., "Racial Categories in Medical Practice: How Useful Are They?" *PLoS Med,* Volume 4, Issue 9 (2007), 1423-1424.
59 Lundy Braun, Fausto-Sterling A, Fullwiley D, Hammonds EM, Nelson A, Quivers W, et al., "Racial Categories in Medical Practice: How Useful Are They?" *PLoS Med,* Volume 4, Issue 9 (2007), 1424.

occupation), and stress coping patterns (how people coped with psychological and physical stress).[60] Researchers devoted just two and a half pages to the social characteristics of each racial category they identified. Pathologizing assertions lined these pages, and noticeably absent was the historical context for why any given detail about a particular group was or was not true. This relegated social traits to individual communities rather than structural forces that had shaped their lives. If and when structural forces were discussed, they were touched upon very broadly and vaguely, stating that "majority" populations had perhaps upended "minority" populations' social habits. This was particularly the case for discussions around Native American alcoholism where the use of vague language like "majority" and "non-majority" obfuscated the impacts of white settler colonialism on Native health.[61] The Task Force also asserted most people of color lived within inner cities, with little discussion surrounding phenomena such as white flight.[62] In a particularly incendiary moment, The Task Force discussed the "high fertility" of Latinx women who lived in the Southwest, reifying a common stereotype about hypersexuality often applied to many Black, and non-Black women of color. [63] Asian people were also said to suppress feelings of illness in an attempt to exemplify respectability and self sufficiency.[64] The

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[60] United States. Department of Health and Human Services. Task Force on Black and Minority Health, *Report of the Secretary's Task Force on Black & Minority Health Volume I.* PDF. Washington, D.C. : U.S. Dept. of Health and Human Services, [1985-1986]. From The National Library of Medicine. https://collections.nlm.nih.gov/catalog/nlm:nlmuid-8602912-mvset (Accessed July 14th, 2020). Pg. 56.

[61] United States. Department of Health and Human Services. Task Force on Black and Minority Health, *Report of the Secretary's Task Force on Black & Minority Health Volume I.* PDF. Washington, D.C. : U.S. Dept. of Health and Human Services, [1985-1986]. From The National Library of Medicine. https://collections.nlm.nih.gov/catalog/nlm:nlmuid-8602912-mvset (Accessed July 14th, 2020)., Pg. 59.

[62] United States. Department of Health and Human Services. Task Force on Black and Minority Health, *Report of the Secretary's Task Force on Black & Minority Health Volume I.* PDF. Washington, D.C. : U.S. Dept. of Health and Human Services, [1985-1986]. From The National Library of Medicine. https://collections.nlm.nih.gov/catalog/nlm:nlmuid-8602912-mvset (Accessed July 14th, 2020)., Pg. 56.

[63] United States. Department of Health and Human Services. Task Force on Black and Minority Health, *Report of the Secretary's Task Force on Black & Minority Health Volume I.* PDF. Washington, D.C. : U.S. Dept. of Health and Human Services, [1985-1986]. From The National Library of Medicine. https://collections.nlm.nih.gov/catalog/nlm:nlmuid-8602912-mvset (Accessed July 14th, 2020)., Pg. 53.

[64] United States. Department of Health and Human Services. Task Force on Black and Minority Health, *Report of the Secretary's Task Force on Black & Minority Health Volume I.* PDF. Washington, D.C. : U.S. Dept. of Health and Human Services, [1985-1986]. From The National Library of Medicine. https://collections.nlm.nih.gov/catalog/nlm:nlmuid-8602912-mvset (Accessed July 14th, 2020)., Pg. 53.

Task Force blamed individual communities' reluctance to seek medical care on an assumption they trusted their own traditional healing practices more than western medicine, this was the case for all minority groups.[65] What was not discussed was the inaccessibility of western medical care or the structural forces that may have barred people of color access to abundant and non-racist medical care. Instead, the absence of medical care in non-white lives was said to be the result of an attachment to traditional, cultural practices and individual habits.

The lack of context and data's origins from past research initiatives already inscribed with racialized assumptions about people's diet, culture, sexual life and psychology re-pathologized communities of color and created arbitrary distinctions among each based on data that had been stripped of historical context. There was no information regarding how this information came to be, why it was undertaken or how racialized assumptions coded their production, information was merely pulled from previous programs and research initiatives within the Department of Health and Human Services and compiled into a single inventory assessed by researchers.[66] Most importantly, the use of previous data in the section on "social characteristics" made it so the responsibility of illness was located within people's culture, social habits and family structures. Ultimately this meant the structural role of poverty and racism for health disparities among minority populations was obfuscated.

Although the Task Force produced pathologizing research, the sheer number of researchers involved also produced scientific heterogeneity. The Task Force on Black and Minority Health eludes easy categorization. In other words, the project is neither a magnificent

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[65] United States. Department of Health and Human Services. Task Force on Black and Minority Health, *Report of the Secretary's Task Force on Black & Minority Health Volume I.* PDF. Washington, D.C. : U.S. Dept. of Health and Human Services, [1985-1986]. From The National Library of Medicine. https://collections.nlm.nih.gov/catalog/nlm:nlmuid-8602912-mvset (Accessed July 14th, 2020)., Pg. 53, 55, 57, 59.
[66] United States. Department of Health and Human Services. Task Force on Black and Minority Health, *Report of the Secretary's Task Force on Black & Minority Health Volume II.* PDF. Washington, D.C. : U.S. Dept. of Health and Human Services, [1985-1986]. From The National Library of Medicine. https://collections.nlm.nih.gov/catalog/nlm:nlmuid-8602912-mvset (Accessed July 14th, 2020). Pg 2.

scientific endeavor nor a purely racist project with inherently cruel intentions. It was a product of its flawed methods as much as multiplicity among its researchers. The Task Force was made up of what Political Sociologist Ruha Benjamin calls politically promiscuous bedfellows.[67] This meant there were too many people to account for and political objectives were always different among researchers. Consequently, as Ruha Benjamin has argued, science and its endeavors, in this case the Task Force, would not fall along typical or easily categorizable socio-political boundaries.[68] Heterogeneity within research was almost unavoidable and heterogeneity within the Task Force was most visible in its subcommittee reports. Subcommittees of the Task Force were tasked with further elucidating and supporting the initial summarical reports provided by the first volume of the Task Force. Subcommittees were formed to explore why and to what extent the six identified disease categories accounted for health differences among minority communities and to explore what the Department of Health and Human Services could do to reduce disparity.[69] In juxtaposition to volume one and the other six volumes, volume two of the Task Force reports was solely devoted to looking at social factors that contributed to health disparities rather than a particular disease or summarical data.

Volume two approached health disparities with close attention to social factors that caused health disparities among each particular community it assessed as opposed to social characteristics of people of color. Attention was paid to structural factors that contributed to health inequalities reflected in the data, signaling the different approaches of researchers allegedly following a homogenous scientific protocol. The second volume's subcommittee began

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[67] Ruha Benjamin, *People's Science: Bodies and Rights on the Stem Cell Frontier* (Stanford: Stanford University Press, 2013), pg, 7.

[68] Ruha Benjamin, *People's Science: Bodies and Rights on the Stem Cell Frontier* (Stanford: Stanford University Press, 2013), pg, 7.

[69] United States. Department of Health and Human Services. Task Force on Black and Minority Health, *Report of the Secretary's Task Force on Black & Minority Health Volume II.* PDF. Washington, D.C. : U.S. Dept. of Health and Human Services, [1985-1986]. From The National Library of Medicine. https://collections.nlm.nih.gov/catalog/nlm:nlmuid-8602912-mvset (Accessed July 14th, 2020). Pg. 8.

their work by acknowledging the limitations of their data.[70] The committee elucidated why the broader framework of the Task Force may be limiting, citing that "excess death" could not account fully for disparities as their comparative approach depended largely on the death rates of white communities and the size of minority groups being assessed.[71] For this committee, excess death was only a useful approach when assessing city-level or county analysis.[72] The committee acknowledged the comparative framework of excess death allowed for the identification of the six leading causes of high mortality rates, but did not adequately explain them and was not a replacement for epidemiological and investigatory techniques.[73] It was this gap they intervened in.

In particular, one paper by researchers Mary N. Haan and George A. Kaplan entitled "The Contribution of Socioeconomic Position to Minority Health," exemplified the varied approach to race, science and social health disparities within the Task Force as Haan and Kaplan argued for moving past attributing health disparities to cultural and social habits. This particular paper commissioned by the subcommittee sought to investigate the role of SEP in minority health disparities. SEP stood for a person's socioeconomic position and was defined as socioeconomic measures derived from income, education, or occupation.[74] However, when

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[70] United States. Department of Health and Human Services. Task Force on Black and Minority Health, *Report of the Secretary's Task Force on Black & Minority Health Volume II.* PDF. Washington, D.C. : U.S. Dept. of Health and Human Services, [1985-1986]. From The National Library of Medicine. https://collections.nlm.nih.gov/catalog/nlm:nlmuid-8602912-mvset (Accessed July 14th, 2020). Pg 23.
[71] United States. Department of Health and Human Services. Task Force on Black and Minority Health, *Report of the Secretary's Task Force on Black & Minority Health Volume II.* PDF. Washington, D.C. : U.S. Dept. of Health and Human Services, [1985-1986]. From The National Library of Medicine. https://collections.nlm.nih.gov/catalog/nlm:nlmuid-8602912-mvset (Accessed July 14th, 2020). Pg 17.
[72] United States. Department of Health and Human Services. Task Force on Black and Minority Health, *Report of the Secretary's Task Force on Black & Minority Health Volume II.* PDF. Washington, D.C. : U.S. Dept. of Health and Human Services, [1985-1986]. From The National Library of Medicine. https://collections.nlm.nih.gov/catalog/nlm:nlmuid-8602912-mvset (Accessed July 14th, 2020). Pg 17.
[73] United States. Department of Health and Human Services. Task Force on Black and Minority Health, *Report of the Secretary's Task Force on Black & Minority Health Volume II.* PDF. Washington, D.C. : U.S. Dept. of Health and Human Services, [1985-1986]. From The National Library of Medicine. https://collections.nlm.nih.gov/catalog/nlm:nlmuid-8602912-mvset (Accessed July 14th, 2020). Pg 17.
[74] United States. Department of Health and Human Services. Task Force on Black and Minority Health, *Report of the Secretary's Task Force on Black & Minority Health Volume II.* PDF. Washington, D.C. : U.S. Dept. of Health and Human Services

relevant, the researchers utilized measures outside of this very specific definition. In their paper, Haan and Kaplan argued that SEP was an important and plausible area of explanation for health disparities among minority communities. In general, they believed the role of SEP in health disparities had long been ignored in scientific research.[75] Instead, health differentials between white and Black/non-Black people of color were attributed to differences in culture, lifestyle or genetics.[76] Haan and Kaplan called for a serious analysis of the relationship between SEP and health status, arguing their data suggested a strong correlation between the two.[77] For Haan and Kaplan, the social characteristics of minorities were not sufficient in assessing health disparities and left immense gaps that did not consider structural barriers to good health. This argument was in complete juxtaposition to what was published in the first volume of the Task Force's reports, despite subcommittees' intended role of supporting the data in the first volume. More contradictions than consistencies arised, and this was in part to the sheer diversity of researchers despite the overarching model of excess death and theme of scientific homogeneity the Task Force discussed publicly.

Haan and Kaplan's work differed so strikingly because their methodology was more complex than other facets of the Task Force at large. Haan and Kaplan's methodology included several stages. The first stage examined the role of SEP's association with varying disease

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Human Services, [1985-1986]. From The National Library of Medicine. https://collections.nlm.nih.gov/catalog/nlm:nlmuid-8602912-mvset (Accessed July 14th, 2020). Pg 70.

[75] United States. Department of Health and Human Services. Task Force on Black and Minority Health, *Report of the Secretary's Task Force on Black & Minority Health Volume II.* PDF. Washington, D.C. : U.S. Dept. of Health and Human Services, [1985-1986]. From The National Library of Medicine. https://collections.nlm.nih.gov/catalog/nlm:nlmuid-8602912-mvset (Accessed July 14th, 2020). Pg 84.

[76] United States. Department of Health and Human Services. Task Force on Black and Minority Health, *Report of the Secretary's Task Force on Black & Minority Health Volume II.* PDF. Washington, D.C. : U.S. Dept. of Health and Human Services, [1985-1986]. From The National Library of Medicine. https://collections.nlm.nih.gov/catalog/nlm:nlmuid-8602912-mvset (Accessed July 14th, 2020). Pg 84.

[77] United States. Department of Health and Human Services. Task Force on Black and Minority Health, *Report of the Secretary's Task Force on Black & Minority Health Volume II.* PDF. Washington, D.C. : U.S. Dept. of Health and Human Services, [1985-1986]. From The National Library of Medicine. https://collections.nlm.nih.gov/catalog/nlm:nlmuid-8602912-mvset (Accessed July 14th, 2020). Pg 84.

outcomes.[78] Haan and Kaplan then assessed the association between SEP and membership in a minority group. In other words, whether being from a particular minority group inherently necessitated poor health. They then assessed to what extent poor health among non-white and white people could be associated with low SEP.[79] Ultimately, Haan and Kaplan found that low SEP was a powerful risk factor for infant mortality, cancer, cardiovascular disease, and general mortality and morbidity. In justifying their claims, Haan and Kaplan cited a study of Alameda county done in 1965. In 1965, the Human Population Laboratory of the California Department of Health Services selected 7,000 Black and white adults to participate in a longitudinal study, The mortality rates of the cohort were assessed from 1965-1982.[80] The study found Black people's chance of survival was notably lower than that of whites. However, when income was factored in, the survival rate was not as significant.[81] Ultimately, this meant that SEP accounted largely for the differential survival experiences between Black and white people.[82] The connection between minority status and SEP remained consistent in all sections of Haan and Kaplan's report. Haan and Kaplan, not only cited past research, they applied new methods, here the SEP factor, which ultimately changed the trajectory of their research outcomes.

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[78] United States. Department of Health and Human Services. Task Force on Black and Minority Health, *Report of the Secretary's Task Force on Black & Minority Health Volume II.* PDF. Washington, D.C. : U.S. Dept. of Health and Human Services, [1985-1986]. From The National Library of Medicine. https://collections.nlm.nih.gov/catalog/nlm:nlmuid-8602912-mvset (Accessed July 14th, 2020). Pg 69

[79] United States. Department of Health and Human Services. Task Force on Black and Minority Health, *Report of the Secretary's Task Force on Black & Minority Health Volume II.* PDF. Washington, D.C. : U.S. Dept. of Health and Human Services, [1985-1986]. From The National Library of Medicine. https://collections.nlm.nih.gov/catalog/nlm:nlmuid-8602912-mvset (Accessed July 14th, 2020). Pg 69.

[80] United States. Department of Health and Human Services. Task Force on Black and Minority Health, *Report of the Secretary's Task Force on Black & Minority Health Volume II.* PDF. Washington, D.C. : U.S. Dept. of Health and Human Services, [1985-1986]. From The National Library of Medicine. https://collections.nlm.nih.gov/catalog/nlm:nlmuid-8602912-mvset (Accessed July 14th, 2020). Pg. 81.

[81] United States. Department of Health and Human Services. Task Force on Black and Minority Health, *Report of the Secretary's Task Force on Black & Minority Health Volume II.* PDF. Washington, D.C. : U.S. Dept. of Health and Human Services, [1985-1986]. From The National Library of Medicine. https://collections.nlm.nih.gov/catalog/nlm:nlmuid-8602912-mvset (Accessed July 14th, 2020). Pg. 75.

[82] United States. Department of Health and Human Services. Task Force on Black and Minority Health, *Report of the Secretary's Task Force on Black & Minority Health Volume II.* PDF. Washington, D.C. : U.S. Dept. of Health and Human Services, [1985-1986]. From The National Library of Medicine. https://collections.nlm.nih.gov/catalog/nlm:nlmuid-8602912-mvset (Accessed July 14th, 2020). Pg. 75.

In one of the most striking juxtapositions from the first volume, Haan and Kaplan directly stated that being a minority alone did not inherently determine poor health, shifting blame from the individual to the structural.[83] The first volume of the Task Force's report assessed social characteristics of minority health in ways that often re-pathologized communities of color, blaming their culture, psychology, or personal choices for health disparities. For Haan and Kaplan, it was not the culture, lifestyle, or genetics of a particular minority group that inherently determined health disparities. Haan and Kaplan strongly stated that it was not minority status itself that led to poor health, rather, it was "the association of low SEP with minority group membership which has consequences for health."[84] However, the importance of Haan and Kaplan's work was the extent to which they acknowledged the limitations of even their own assessment. Haan and Kaplan acknowledged that understanding SEP largely depended on available data, and data was scarce, particularly for Native and Latinx populations.[85]

The implementation of new methodology and a scrutinization of older data prevented Haan and Kaplan's work from re-pathologizing communities of color. Yet, the decisions to do this cannot be solely attributed to deep investment in the lives of people of color. Not enough is known of the researchers within the Task Force at large. It can however be certain there was multiplicity and complexity in the ranks, and this produced heterogeneity that was not presented in volume one of the report, which was the report most cited in public appearances. Haan and

[83] United States. Department of Health and Human Services. Task Force on Black and Minority Health, *Report of the Secretary's Task Force on Black & Minority Health Volume II.* PDF. Washington, D.C. : U.S. Dept. of Health and Human Services, [1985-1986]. From The National Library of Medicine. https://collections.nlm.nih.gov/catalog/nlm:nlmuid-8602912-mvset (Accessed July 14th, 2020). Pg. 85.
[84] United States. Department of Health and Human Services. Task Force on Black and Minority Health, *Report of the Secretary's Task Force on Black & Minority Health Volume II.* PDF. Washington, D.C. : U.S. Dept. of Health and Human Services, [1985-1986]. From The National Library of Medicine. https://collections.nlm.nih.gov/catalog/nlm:nlmuid-8602912-mvset (Accessed July 14th, 2020). Pg. 85.
[85] United States. Department of Health and Human Services. Task Force on Black and Minority Health, *Report of the Secretary's Task Force on Black & Minority Health Volume II.* PDF. Washington, D.C. : U.S. Dept. of Health and Human Services, [1985-1986]. From The National Library of Medicine. https://collections.nlm.nih.gov/catalog/nlm:nlmuid-8602912-mvset (Accessed July 14th, 2020). Pg. 85.

Kaplan did not suggest any radical reinvestments in the lives of minorities. They did not call for an allocation of funds to minority communities or the hospitals and care facilities they went to, which were generally severely underfunded and lacking in doctors willing to take patients who may or may not have had the means to pay what their insurance would not cover.[86] This would have gone against the ideas of scientific neutrality the Task Force sought to abide by.

Nevertheless, Haan and Kaplan's work, when compared to that of the first volume of the Task Force's report highlights the fraught nature of scientific research in the 1980s, how deeply researchers varied in their approaches to race and what consequences this had for people of color within scientific research and politicians in charge of the initiatives. The Task Force sought to be a scientifically neutral endeavor that comprehensively brought together different sectors of the Department of Health and Human Services to build a roadmap for ending the health disparities of minorities. However, neutrality was never a possibility, disaggregation from the past was impossible, and heterogeneity was inevitable. The Task Force was always bound by public health's history as a space of racialization and the replication of old methods re-inscribed the very disparities the Task Force sought to alleviate. It was only when methods were challenged and expanded that the Task Force produced work that did not re-pathologize those it sought to help. However, despite the heterogeneous nature of scientific research, uniformity needed to be crafted to make the Task Force politically generative. Margaret Heckler was instrumental to the crafting of uniformity through her public presentation of the Task Force, but much like the science itself, Heckler was also bound by structural forces around her. Heckler was bound by

[86] United States. Department of Health and Human Services. Task Force on Black and Minority Health, *Report of the Secretary's Task Force on Black & Minority Health Volume II*. PDF. Washington, D.C. : U.S. Dept. of Health and Human Services, [1985-1986]. From The National Library of Medicine. https://collections.nlm.nih.gov/catalog/nlm:nlmuid-8602912-mvset (Accessed July 14th, 2020). Pg 301.

Reagan era politics that sought to convince the American people that "Morning" had arrived again in America.

Pathology through the Public Performance of Science

In the same way the Task Force was bound by histories of racialization in Public Health, Heckler herself was bound by the crises that encapsulated the Reagan era. Before her time at the Department of Health and Human Services, Heckler's congressional slogan often claimed she was "unbossed and unbought," a free thinker not easily swayed by any president.[87] This was a source of pride for Heckler who was often accused of being a "Reagan clone."[88] Despite her slogans, Heckler was less of a free agent than she believed. From the Task Force's inception, there were limitations on what it could and could not do, and these limitations were a direct consequence of the austerity politics of the Reagan era. It was the politics of Ronald Reagan that would bind Heckler and simultaneously contribute to the re-pathologization of Black, Native, Asian/Pacific Islander and Latinx people. Ironically, austerity politics would also cement the Task Force on Black and Minority Health as Margaret Heckler's greatest achievement as Secretary of Health and Human Services.

From the beginning, the Task Force on Black and Minority Health was prevented from recommending new funds and investments into the health of Black and non-Black people of color.[89] Margaret Heckler was often asked by reporters whether the White House had prevented her from allowing the Task Force to recommend new spending in order to alleviate health

[87] "Heckler, Margaret M.," *History, Art & Archives, U.S. House of Representatives,* https://history.house.gov/People/Listing/H/HECKLER,-Margaret-M--(H000440)/. (Accessed December 11th, 2020).
[88] "Heckler, Margaret M.," *History, Art & Archives, U.S. House of Representatives,* https://history.house.gov/People/Listing/H/HECKLER,-Margaret-M--(H000440)/. (Accessed December 11th, 2020).
[89] United States: Department of Health and Human Services Press Conference, Box 119, Folder 43, Margaret Heckler papers, CA.1998.004, John J. Burns Library, Boston College.

disparities among people of color.[90] In an effort to assert herself as a free agent, Heckler often answered by reiterating that the Task Force was her idea, it was her preoccupation alone and the White House had allowed her to run things as she wished.[91] However, the illusion of freedom fell away relatively quickly. Heckler often said she chose to run the Task Force under guidelines traditionally held by the Department of Health and Human Services.[92] Ultimately, she asserted that because she was keenly aware of the precarity of federal deficits and the fact money was "finite," she alone chose to impose fiscal barriers on the Task Force.[93] However, despite the fact the project emerged from the recommendations of those around her, because the Task Force was Heckler's project, she was forced to abide by Reagan Era politics to give the project a chance to get up and running. The "typical" guidelines for the Department of Health and Human Services were themselves a result of the calamities facing the Reagan administration more broadly.

In the 1980s, the fear of economic collapse consumed the Reagan administration, and these politics were what Heckler often alluded to in interviews regarding the limitations she placed on the Task Force. Around the time of the Task Force's inception, the Reagan administration was exceedingly trying to ensure a good public image, particularly regarding marginalized communities and federal budgets. Early on, the Reagan administration was entangled with the threat of economic calamity.[94] In January 1981, runaway inflation was the specter looming over the Reagan administration's transitional period. The early days, months, and years of Reagan's presidency were entirely devoted to restoring "a sense of stability and

[90] United States: Department of Health and Human Services Press Conference, Box 119, Folder 43, Margaret Heckler papers, CA.1998.004, John J. Burns Library, Boston College.
[91] United States: Department of Health and Human Services Press Conference, Box 119, Folder 43, Margaret Heckler papers, CA.1998.004, John J. Burns Library, Boston College.
[92] United States: Department of Health and Human Services Press Conference, Box 119, Folder 43, Margaret Heckler papers, CA.1998.004, John J. Burns Library, Boston College.
[93] United States: Department of Health and Human Services Press Conference, Box 119, Folder 43, Margaret Heckler papers, CA.1998.004, John J. Burns Library, Boston College.
[94] Lou Cannon, *President Reagan: The Role of a Lifetime*, 198.

confidence" in the nation, particularly in the realm of the economy.[95] Reagan charged that administrations before him were overindulgent and abusive in their taxation policies.[96] According to Reagan, past presidents had not trusted the American people and so they were heavy-handed in the lives of the American public.

To address the looming spectre of economic collapse, Ronald Reagan ushered in an era of federal budget axing which disproportionately affected the management of budgets in projects affiliated with the administration. The era of budget axing began with the director of the Office of Management and Budget David Stockman at the helm. The cuts were meant to fend off what Stockman called "economic Dunkirk."[97] Under Stockham, 41.4 billion dollars were cut from the Carter era budgets and fatal cuts to various federal programs were ushered in. Supply-side economics became the name of the game. As opposed to Keynesian economics which encouraged governments to spend more to end recessions, supply-side economics sought to cut taxes and manage money supply.[98] In the beginning, the cuts were called the Reagan Revolution, but the revolution was short lived. With Stockman at the helm, a 200 billion dollar deficit was created.[99] From late 1981 to 1982, the "Reagan Recession" generated as much unemployment as the Great Depression, and as historian Gil Troy has argued, during Reagan's first term pundits were "eulogizing about another failed administration."[100] Although brief, the recession reassured Reagan that his administration's efforts needed to highly prioritize the economy and the prevention of its collapse above all else which meant federal welfare programs and social programs had to function under the fiscal grip of the administration.

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[95] Lou Cannon, *President Reagan: The Role of a Lifetime*, 141.
[96] Lou Cannon, *President Reagan: The Role of a Lifetime*, 146.
[97] David A. Stockman, "How to Avoid an Economic Dunkirk," *Challenge,* 24, no. 1, (March/April 1981). Pages 17-21.
[98] Gil Troy, *Morning in America,* 67.
[99] Gil Troy, *Morning in America,* 107.
[100] Gil Troy, *Morning in America,* 13.

The tight management of budgets was meant to reinforce the narrative Ronald Reagan and his election had brought "morning" back to America by inheriting the Carter Era's economic malaise, and coming out on the other side.[101] In 1983, Reagan tapped into a mythic bravado and claimed his first election had saved the soul of the nation.[102] Reagan's reelection, unexpected economic recovery, and overhaul would only add to the forward-looking trajectory of the American mythos crafted in the 1980s. Morning had arrived again in America.[103] In 1983 and into 1984, as morning arrived for some, poverty exploded in Black communities and communities of non-Black people of color.[104] Ronald Reagan refused to view the poverty and death of minorities as a social issue.[105] As biographer Lou Cannon has noted, if and when Reagan gave racial issues his undivided attention, he viewed the issues as budget problems, instead of larger structural issues.[106] Concurrently, activists like Jesse Jackson called the budget slashes "another case of mass murder, of economic genocide."[107] In referring to social issues as budget problems, the administration sought to control social order and avoid charges of racism by shifting blame onto budgets through austerity politics.

Presenting social issues as budget problems was necessary in the maintenance of social order and projects within the administration, like the Task Force on Black and Minority Health, quickly followed suit. In order to assess the maintenance of social order through a scientific project like the Task Force on Black and Minority Health, I draw heavily from science and technology studies' framework of "co-production." Sociologist Jenny Reardon describes this framework as one that seeks to understand how scientific knowledge and social order are

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[101] Gil Troy, *Morning in America,* 171.
[102] Gil Troy, *Morning in America,* 154.
[103] Gil Troy, *Morning in America,* 154.
[104] Lou Cannon, *President Reagan: The Role of a Lifetime*, 672.
[105] Lou Cannon, *President Reagan: The Role of a Lifetime*, 674.
[106] Lou Cannon, *President Reagan: The Role of a Lifetime*, 674.
[107] Gil Troy, *Morning in America,* 91.

produced simultaneously, or co-produced.[108] As Reardon explains, the production of scientific order and political order come into being together.[109] Co-production serves to analyze emerging phenomena. As Reardon states, it is at the point of emergence when actors decide how to recognize, name, investigate and interpret new objects that one can identify ways scientific ideas and practices and societal arrangements come into being. Similarly, science and technology studies scholar Kim Tallbear argues science and technology are actively entangled with social norms and hierarchies.[110] They are not discrete categories, rather, "one determines the other in a linear model of cause and effect, "science" and "society" are mutually constitutive" ultimately meaning they reinforce, shape, and disrupt the actions of the other in often heterogeneous ways.[111]

In the public presentation of the Task Force's research findings, Margaret Heckler shaped the societal understandings of the Task Force, which reinscribed and legitimized ideas of pathology onto Black and non-Black people of color. October 16th, 1985 marked an important day in the history of the Task Force on Black and Minority Health. It was on this day that Heckler would attend a press conference regarding the Task Force at the Hubert Humprey building located in the Department of Health and Human Services.[112] October 16th also marked the day PBS would air an interview with Heckler on The Macneil/Lehrer Newshour in which she would disseminate information regarding the Task Force on a national scale. In her interview with PBS reporter Judy Woodruff, Margaret Heckler explained health disparities by departing

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[108] Jenny Reardon, *Race to the Finish: Identity and Governance in the Age of Genomics* (Princeton: Princeton University Press, 2004), pg, 16.
[109] Jenny Reardon, *Race to the Finish: Identity and Governance in the Age of Genomics.,* 18.
[110] Kim Tallbear, *Native American DNA: Tribal Belonging and the False Promise of Genetic Science* (Minneapolis, MN: University of Minnesota Press, 2013). 11.
[111] Kim Tallbear, *Native American DNA: Tribal Belonging and the False Promise of Genetic Science,* 11-12.
[112] United States: Department of Health and Human Services Press Conference, Box 119, Folder 43, Margaret Heckler papers, CA.1998.004, John J. Burns Library, Boston College.

from the mass amounts of data and heterogeneous reasons provided by her teams of researchers. Instead, she focused on the history of the Department of Health and Human Services at large.[113]

In relegating health disparities to the longer history of the Department of Health and Human Services, Margaret Heckler reinforced the idea disparities had long been a part of American history, meaning funding and budget expansion was not the solution to alleviating the problem. In her interview, Heckler stated,

> This [the health disparity] was not a new piece of information, Judy, what's happened is, throughout our history I've learned that since this department, HHS, has been keeping records as the official health statistician for the country, we've learned that the disparity has always existed And I ask why and what could be done about it. So that that was the purpose of this whole scientific inquiry.[114]

In reflecting on the history of health in the U.S., Heckler deflected social issues away from structural causes, and instead turned to Reagan era politics that centered budgets. Heckler's justification for refusing to spend new money and her justification for prohibiting the Task Force from recommending new spending, played on the idea that because health disparities had always existed, new spending and an expansion of federal budgets was not going to solve the issues. The Reagan years had seen mass budget cuts, and those cuts often affected the poor-working class. As subcommittees showed, income proximity often signified the level of health citizenship offered to any given group. The larger social issues of health access, poverty, and inequality were obfuscated by a discussion of budgets and fiscal responsibility. Heckler pushed the idea of education, which only reasserted that the issue was not the government, it was not the

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[113] "The MacNeil/Lehrer NewsHour," 1985-10-16, NewsHour Productions, American Archive of Public Broadcasting (WGBH and the Library of Congress), Boston, MA and Washington, DC, accessed October 23, 2020, http://americanarchive.org/catalog/cpb-aacip-507-rn3028q98d

[114] "The MacNeil/Lehrer NewsHour," 1985-10-16, NewsHour Productions, American Archive of Public Broadcasting (WGBH and the Library of Congress), Boston, MA and Washington, DC, accessed October 23, 2020, http://americanarchive.org/catalog/cpb-aacip-507-rn3028q98d

carelessness of fiscal budget axing, it was not Ronald Reagan, Heckler or the Department of Health and Human Services. The problem was Black and non-Black people of color.

Ultimately, to justify austerity politics, Margaret Heckler turned to pathology and individual blame. In a moment, Heckler decided to give a small but telling example. Heckler emphasized the role of experts in the Task Force, and proceeded to tell Woodruff that one reason health disparities existed was the prevalence of myths among communities of color.[115] Heckler drew on myths of "hopelessness" in the Black community, stating, "Surveys show that among black people that there was a sense of hopelessness about cancer. Therefore they did not go to a physician early and ask for help. So early detection and the developments that could extend survivability were never the benefits that the black population enjoyed."[116] Woodruff herself appeared confused at Heckler's answer. Heckler had not identified causes of all minority health disparities but had instead offered an example that shifted blame onto Black people for an alleged misguided sense of when and where to seek medical care.

In another example of racial pathology and blame shifting, Heckler discussed the Task Force's decision to categorize homicide as a health issue. It was in her discussion of homicide that Heckler revealed "homicide" actually referred to the trope of "Black on Black" crime.[117] In fairness, Heckler also mentioned that homicide within one's own race occurred across the spectrum, white people included, but the decision to specifically use Black communities as an example on national television, in a moment where racialized ideas of criminality were

[115] The MacNeil/Lehrer NewsHour," 1985-10-16, NewsHour Productions, American Archive of Public Broadcasting (WGBH and the Library of Congress), Boston, MA and Washington, DC, accessed October 23, 2020, http://americanarchive.org/catalog/cpb-aacip-507-rn3028q98d
[116] The MacNeil/Lehrer NewsHour," 1985-10-16, NewsHour Productions, American Archive of Public Broadcasting (WGBH and the Library of Congress), Boston, MA and Washington, DC, accessed October 23, 2020, http://americanarchive.org/catalog/cpb-aacip-507-rn3028q98d
[117] The MacNeil/Lehrer NewsHour," 1985-10-16, NewsHour Productions, American Archive of Public Broadcasting (WGBH and the Library of Congress), Boston, MA and Washington, DC, accessed October 23, 2020, http://americanarchive.org/catalog/cpb-aacip-507-rn3028q98d

exploding, only further pathologized and shifted blame for health disparities onto racialized communities, in particular Black communities. In the conference held at the Department of Health and Human Services, Heckler elaborated on the solution for homicide, stating children needed to be educated to "manage hostility and confrontation and aggression."[118] Although Heckler did not explicitly say whose children, the statement prior to this assertion was discussing Black communities, specifically. In Heckler's statements, there was little regard for the increase in poverty ushered in by budget cuts and what effects this had on impoverished communities. There was no discussion of the hyper criminality imposed onto racialized groups. There was only "culturally competent" education targeted at children meant to teach them the "right" way to handle their allegedly inherent aggression. The blame was again shifted onto communities of color and Black communities in particular were presented nationally as hyper-criminal and undeserving of material investment.

In presenting the Task Force's heterogeneous findings in simplified and pathologizing ways, Heckler not only responded to the austerity politics around her, but used scientific research to nationally legitimize the idea all people of color were to blame for their own health disparities. This meant the solution was also out of the government's hands. In Heckler's interview, Judy Woodruff inquired about the role of the government following the Task Force's findings. Heckler reassured Woodruff the government had a role to play, but the importance lied in the participation of marginalized groups and individuals to truly bring the visions of the Task Force to fruition.[119] Once again, the core of the responsibility fell onto racialized communities themselves. In presenting the Task Force's findings on national television, Margaret Heckler

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[118] United States: Department of Health and Human Services Press Conference, Box 119, Folder 43, Margaret Heckler papers, CA.1998.004, John J. Burns Library, Boston College.
[119] The MacNeil/Lehrer NewsHour," 1985-10-16, NewsHour Productions, American Archive of Public Broadcasting (WGBH and the Library of Congress), Boston, MA and Washington, DC, accessed October 23, 2020, http://americanarchive.org/catalog/cpb-aacip-507-rn3028q98d

shaped social order by solidifying for the American public that the government had done all it could and spent all it had on Black and non-Black people of color.

Centering budgets in her public performance contributed to the further dispossession of communities of color while simultaneously obfuscating deep inequalities through the guise of caution liberalization. Interdisciplinary historian Crystal Mun-Hye Baik defines cautious liberalization as the act of slowly incorporating racialized subjects into existing social structures while cautiously liberalizing federal policies.[120] The Task Force was meant to be a scientifically neutral endeavor that extended the triumphs of scientific research and health to marginalized communities. Heckler often evoked colorblind politics to push the idea of cautious liberalization, proclaiming the Task Force was not about differences among majority and minority, but about differences among *Americans.*[121] However, as historians of racial capitalism have noted, the Task Force, like many other allegedly "color-blind" aspects of capitalism meant to extend prosperity and opportunity to people of color, was actually a deeply racialized project.[122] The Task Force researched health disparities among minorities and offered solutions to remedy them, though none of these solutions included material investment in health infrastructures or the lives of people of color. Solutions were instead, education meant to rid people of color of social habits said to be the cause of health disparities.Heckler's ties to the austerity politics of the Reagan era produced pathology in the same way public health history produced pathology within the research of the Task Force.

Racial capitalism offers an intervention into the often pathologizing rhetoric of Heckler's 1980s Task Force, and reveals the Task Force as an act of cautious liberalization. Understanding

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[120] Crystal Mun-Hye Baik, *Reencounters: On the Korean War and Diasporic Memory Critique* (Philadelphia: Temple University Press, 2020).
[121] United States: Department of Health and Human Services Press Conference, Box 119, Folder 43, Margaret Heckler papers, CA.1998.004, John J. Burns Library, Boston College.
[122] Destin Jenkins and Justin Leroy, *Histories of Racial Capitalism* (New York: Columbia University Press, 2021).

budgets as tools of dispossession and obfuscation elucidates how "inclusion" offered by the Task Force invisibilized the ways in which the Reagan administration had little to no intention of actually reinvesting back into the health programs budget slashers deemed unimportant. The Task Force was an "extension" of health citizenship to communities of color, one that reinforced the forward-looking image Reagan desperately wanted to project in the 1980s. However, this image frequently disregarded the lives of marginalized communities, except when beneficial for public image crafting.

Reporters and people involved in state level organizations invested in public health quickly picked up on the pathologizing rhetoric of Heckler's public presentation and fired back. Following October 16th's press interviews, newspaper articles and Q&A's from the events revealed the public's key concerns regarding Heckler's public appearances. The central story following the PBS interview revolved around Heckler's discussions of budgets. Newspapers largely emphasized Heckler's caution regarding new spending, particularly in a time of such a high deficit.[123] Critics were interviewed, and expressed their shock, charging the administration of being hypocritical and vapid. The Children's Defense Fund, a public advocacy group, immediately voiced its concerns. The director of the Child's Defense Fund's health sector, Sarah Rosenbaum spoke to a Louisiana newspaper, claiming "It [sic] not just hypocritical for the Reagan administration to issue this report, it is also cruel."[124] Rosenbaum went on to elaborate, claiming that any one in their right mind would love to be healthier, but poverty often restricted that ability.[125] A journalist present at the Department of Health and Human Services conference also inquired about the role of money, accusing Heckler of "dancing around the problem" when medical professionals were becoming more and more convinced that poverty played a major role

[123] "Minorities Have Higher Cancer, Murder Rates," *Alexandria Daily Town Talk* (Alexandria, LA), Oct. 17, 1985.
[124] "Minorities Have Higher Cancer, Murder Rates," *Alexandria Daily Town Talk* (Alexandria, LA), Oct. 17, 1985.
[125] "Minorities Have Higher Cancer, Murder Rates," *Alexandria Daily Town Talk* (Alexandria, LA), Oct. 17, 1985.

in health disparities, something cultural education for lifestyle changes could not fix.[126] For Rosenbaum, like others, if the Reagan administration was not planning to materially invest new money into the issues they identified, the report was insulting at best and entirely oblivious at worst. Yet, this came to matter very little and the Task Force still solidified itself as a critical moment in public health history.

Ironically, it was Heckler's presentation of the Task Force and its ties to Reagan era politics, themes, and strategies that allowed her to dodge even the most aggressive criticism. The Task Force and Heckler, much like Reagan, remained generally unscathed. White Americans continued to support Ronald Reagan in large numbers. 1985 saw Ronald Reagan's approval rating sitting comfortably at 65%.[127] In 1986, the Office of Minority Health was created, with Heckler no longer acting as Secretary of Health and Human Services. Consequently, effort alone seemed to be enough to view the Task Force as a momentous byproduct of morning in America. After all, for Heckler the Task Force was a beginning, not an end. According to Dr. Malone, the Task Force was meant to be a blueprint, constantly adapting to what was required of it.[128] However, the more time passed and the less the Task Force adapted, the more Heckler clung to the idea the Task Force was merely an open door to the future, its job was to be nothing more than a catalyst. It had done all it could, and the rest was up to continued research and people of color. In the years to come, the Reagan Administration would claim a forward-looking public health trajectory and Margaret Heckler would claim political victory as poverty continued to explode and as public health's infrastructure continued to be skeletonized.

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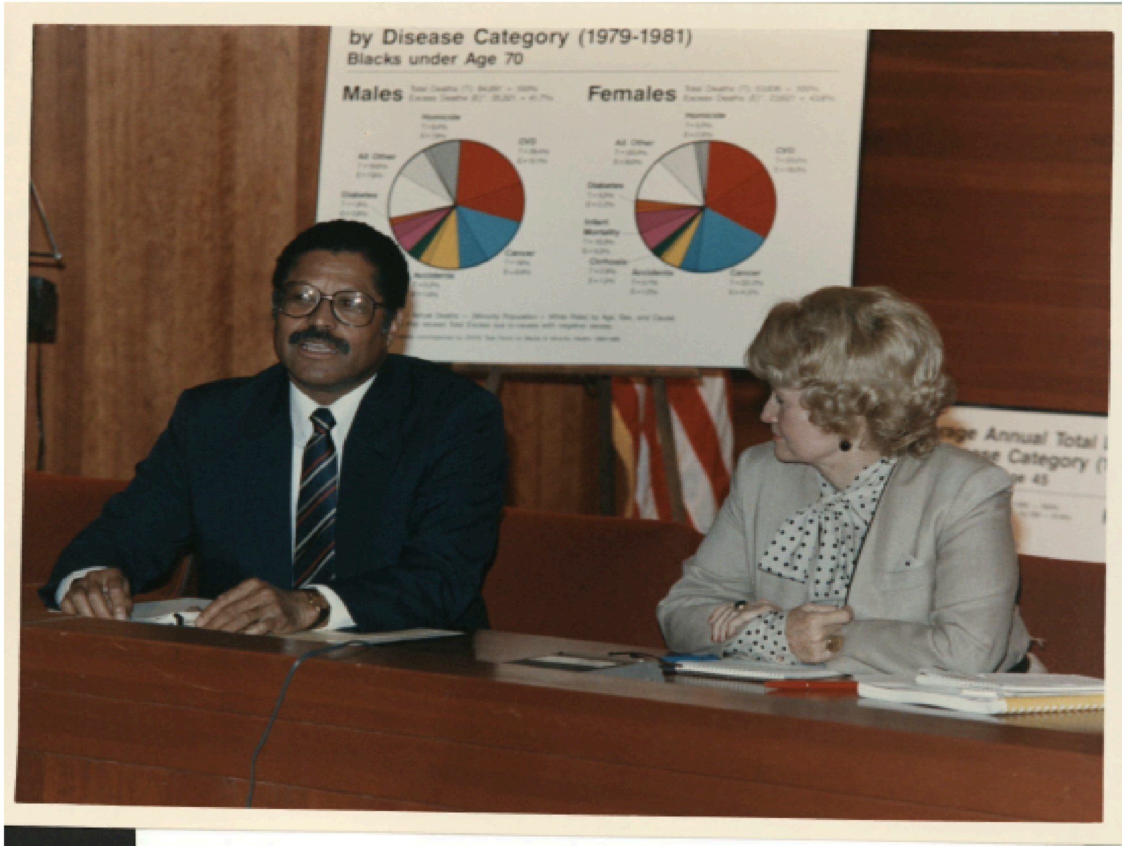
[126] United States: Department of Health and Human Services Press Conference, Box 119, Folder 43, Margaret Heckler papers, CA.1998.004, John J. Burns Library, Boston College.
[127] "*65% IN POLL APPROVE REAGAN'S PERFORMANCE*," *The New York Times,* September 1, 1985, https://www.nytimes.com/1985/09/01/us/65-in-poll-approve-reagan-s-performance.html (accessed March 8th, 2020).
[128] United States. Department of Health and Human Services. Task Force on Black and Minority Health, *Report of the Secretary's Task Force on Black & Minority Health Volume I.* PDF. Washington, D.C. : U.S. Dept. of Health and Human Services, [1985-1986]. From The National Library of Medicine. Pg 5-6.



A Photo of Margaret Heckler and Dr. Thomas E. Malone at the Department of Health and Human Services' Press Conference on October 16th 1985. (Speaking Engagement Photos, Box 119, Folder 47, Margaret Heckler papers, CA.1998.004, John J. Burns Library, Boston College.)

Conclusion: (Un)Free Agents

In 2016, Margaret Heckler's attendance at the "Medicare and Medicaid at 50: Their Past, Present and Future Impact on Health Equity" conference in Baltimore, Maryland revealed how much had changed surrounding the narrative of the Task Force on Black and Minority Health. The Task Force itself was no longer the most important aspect of Heckler's project, Margaret Heckler was. In the 1980s the first volume report was referred to by its longer name, "The Report of the Secretary's Task Force on Black and Minority Health." By the twenty-first century, the role of the Task Force itself was invisibilized and the volume was referred to simply as "The

Heckler Report." The shortened name alluded to the ways Margaret Heckler now took full credit for the entirety of the report. The historical context behind its emergence had also changed.

By 2016, the idea the Task Force on Black and Minority Health had emerged from the courage of Margaret Heckler alone took precedent. At the conference, Heckler, clad in a cobalt suit that mimicked the one she wore during her interview with Judy Woodruff, looked to the audience and asked, "You may wonder how such a thing began, and I'll share a story with you."[129] This time around, Heckler's story began with her childhood. In her youth, Heckler recalled meeting a Black woman that left a mark on her by the name of Christina.[130] Heckler did not elaborate who Christina was to her, or what relationship they shared. Later reports implied Christina was a caretaker of one of Heckler's relatives. In her speech, however, Heckler merely stated Christina had been helpful in her childhood upbringing.[131] Heckler went on to explain that when she learned of the health disparities among non-white people in the early 1980s, her mind drifted to Christina.

As opposed to the ways Black people were used in the 1980s to push forth the idea that health disparities and poverty were the results of individual responsibility, in 2016, Heckler's empathy for Black women was allegedly the catalyst for the Task Force's creation. In Heckler's statement, Christina was a faceless woman, whose kindness toward Heckler had inspired the creation of the Task Force on Black and Minority Health. Heckler played to the ideas of cautious

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[129] *Margaret Heckler: Past, Present, and Future of Health Equity*, *YouTube* (YouTube, 2016), https://www.youtube.com/watch?v=Uw32HaEkjPo&t=607s. [Ms. Heckler, the former Secretary for the Department of Health and Human Services, shares her perspectives on the past, present, and future of health equity at the Medicare & Medicaid at 50: Their Past, Present and Future Impact on Health Equity conference in Baltimore, MD.]
[130] *Margaret Heckler: Past, Present, and Future of Health Equity*, *YouTube* (YouTube, 2016), https://www.youtube.com/watch?v=Uw32HaEkjPo&t=607s. [Ms. Heckler, the former Secretary for the Department of Health and Human Services, shares her perspectives on the past, present, and future of health equity at the Medicare & Medicaid at 50: Their Past, Present and Future Impact on Health Equity conference in Baltimore, MD.]
[131] *Margaret Heckler: Past, Present, and Future of Health Equity*, *YouTube* (YouTube, 2016), https://www.youtube.com/watch?v=Uw32HaEkjPo&t=607s. [Ms. Heckler, the former Secretary for the Department of Health and Human Services, shares her perspectives on the past, present, and future of health equity at the Medicare & Medicaid at 50: Their Past, Present and Future Impact on Health Equity conference in Baltimore, MD.]

liberalization, by invoking Christina's name. As a result, the Task Force appeared to emerge solely from Heckler's dedication and empathy toward Christina and people of color broadly. In this live broadcast, Heckler solidified nationally that it was her personal character that had led to the Task Force on Black and Minority Health. It was Heckler's ambition, care and her ability to "transcend race."[132]

If articles in 2018 were any indication, this narrative was consistent across many public spaces. Articles online on HealthAffairs blogs noted that the Task Force on Black and Minority Health had emerged from Heckler's admiration of Christina's compassion. Writers argued Heckler had *transcended* race for the inspiration behind her work to end inequities in health.[133] Gone from these narratives was the Task Force's place in the larger history of racialized public health initiatives, the heterogeneity produced by the incessant back and forth debates about "race's place" in science, and the way austerity politics contributed to the re-pathologization of Black, Native, Asian/Pacific Islander, and Latinx people in the 1980s. The Task Force was now a momentous achievement celebrated in federal spaces and produced by Heckler's progressive character alone. As it turns out, by 2018, many believed Heckler was as unbossed and unbought as she always claimed.

However, neither the Task Force on Black and Minority Health or Heckler were ever truly free agents allowed to run scientific research and its dissemination on their own terms. The Task Force on Black and Minority Health was always bound by the methods and consequences of public health as a site of racialization. Only in key moments of heterogeneity did the Task Force produce research that may have benefited the people it sought to aid. However, this

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[132] J. Nadine Gracia, "Remembering Margaret Heckler's Commitment to Advancing Minority Health," *HealthAffairs* (blog), November 16th, 2018, **https://www.healthaffairs.org/do/10.1377/hblog20181115.296624/full/.**

[133] J. Nadine Gracia, "Remembering Margaret Heckler's Commitment to Advancing Minority Health," *HealthAffairs* (blog), November 16th, 2018, **https://www.healthaffairs.org/do/10.1377/hblog20181115.296624/full/.**

necessitated a constant reconfiguration of methods, challenging the common senses of science and critical engagement with the limitations of any scientific enterprise due to the lack of data or the historical context in which data was produced. This engagement rarely occurred. Similarly, Margaret Heckler was always bound by the austerity politics that encapsulated the Reagan era. Heckler had limitations on what she could allow, and her own allegiances to Ronald Reagan as a key member of his administration shaped how she could publicly present the Task Force on Black and Minority Health to a wider audience. This meant material investment in the lives and life-longevity of Black and non-Black people of color was out of the question, and in order to justify this, racial pathology was required.

A transcendence of race was impossible, and in fact, never occurred. Race always remained at the heart of the Task Force on Black and Minority Health. In fairness, the Task Force did produce useful data for scholars looking to cite specific instances of health inequality. The research undertaken did have fruitful and useful results, it would be wrong to negate this or suggest the Task Force itself should have never been. However, the initial goal of the Task Force was to finally "close the gap," a goal present in public health for decades. If the goal of "closing the gap" is considered, the Task Force was not successful in the ways the researchers or Heckler initially articulated their goals. The Task Force on Black and Minority Health, as it ran in the 1980s, could not materially change the trajectory of health disparities among Black, Native, Asian/Pacific Islander, or Latinx people. If scientific order and social order emerge together in scientific spaces, one could not solely rely on one to eliminate the other.[134] The Task Force on Black and Minority Health in particular, could not solely attend to social issues because it was too heavily implicated in the structures that produced the inequalities to begin with.

[134] J. Nadine Gracia, "Remembering Margaret Heckler's Commitment to Advancing Minority Health," *HealthAffairs* (blog), November 16th, 2018, **https://www.healthaffairs.org/do/10.1377/hblog20181115.296624/full/**.