Public Health Policy Forum

National Health Care Reform and the 103rd Congress: The Activities and Influence of Public Health Advocates

Helen Halpin Schauffler, PhD, MSPH, and John Wilkerson, PhD

ABSTRACT

Objectives. This study examined the activities and influence of public health interest groups and coalitions on the national health care reform debates in the 103rd Congress.

Methods. Congressional staff and representatives of public health interest groups, coalitions, and government health agencies were interviewed. Content analysis of eight leading national health care reform bills was performed.

Results. The public health community coalesced around public health in health care reform; nearly all the major interest groups and government health agencies joined two or more public health or prevention coalitions, and half joined three or more. The most effective influence on health care reform legislation was early, sustained personal contact with Congress members and their staffs, accompanied by succinct written materials summarizing key points. Media campaigns and grassroots mobilization were less effective. Seven of the eight leading health care reform bills included one or more of the priorities supported by public health advocates.

Conclusions. The public health community played an important role in increasing awareness and support for public health programs in the health care reform bills of the 103rd Congress. (*Am J Public Health.* 1997;87:1107–1112)

It was clear the day after the President's speech that we were building the Spruce Goose—that the thing was never going to fly—and prevention was the upholstery on the seats in Row 5.

Lawrence O'Donnell, Jr
Majority Staff Director
Senate Finance Committee

Introduction

For many public health advocates, efforts to enact national health care reform in the 103rd Congress (1993 and 1994) represented a historic opportunity to improve the health of the American people.[1–3] Much has been written about the role of "special interests" and the media in the failure of national health care reform.[4–8] However, we are aware of no analyses of the more constructive role played by public health advocates to emphasize health improvement in health care reform during this period.[9,10]

In this paper, we investigate the politics of public health interests in the health care reform debates of the 103rd Congress. How did the public health community advocate for its issues? What influence did it have on policymakers in the Congress? Through interviews with representatives of public health interest groups and coalitions, interviews with congressional staff, and analyses of health care reform legislation, we identify the successes and failures of public health groups and effective strategies for promoting public health in future Congresses.

Methods

The research covers the period from September 25, 1993, when President Clinton first unveiled The Health Security Act, through October 7, 1994, when the 103rd Congress adjourned without enacting health care reform legislation.

Interviews

We interviewed 35 legislative staff members of the US Congress who served as key staff to the following:

- The committees or members serving on committees with primary jurisdiction over health care reform legislation (n = 27)
- Party leaders in both chambers of Congress (n = 4)
- Members participating in the House Bipartisan or Senate Mainstream Groups (n = 8)
- Legislators who did not serve on key health committees but had sponsored legislation for public health improvement (n = 2). (Note: the above numbers do not add to 35 because members can have more than one affiliation.)

The sample was not intended to be representative of the views of the average congressional staffperson or member, but instead was selected to include key staff to members who were in decision-making positions on health care reform by virtue of their leadership positions, committee assignments, or sponsorship of public health legislation.

We interviewed representatives of 24 public health interest groups and coali-

Helen Halpin Schauffler is with the Joint Program in Public Policy and Public Health, School of Public Health, University of California, Berkeley. John Wilkerson was with the School of Public Health, University of California, Berkeley, at the time the research was conducted and is now with the Department of Political Science, University of Washington, Seattle.

Requests for reprints should be sent to Helen Halpin Schauffler, PhD, MSPH, University of California at Berkeley, School of Public Health, Division of Health Policy and Administration, 406 Warren Hall, Berkeley, CA 94720-7360.

tions.* Representatives of the major public health and prevention coalitions identified interest groups on the basis of their knowledge of which groups were most active in trying to advocate for public health in health care reform. Congressional staff also identified groups that had contacted them directly about public health issues. We chose groups (including government agencies) at the national (n = 19) and state (n = 5) levels and in the public (n = 12) and private (n = 12) sectors. We also reviewed materials they distributed to their members or legislators during the health care reform debates.

Interviews with congressional staff were conducted in person on Capitol Hill from November 21 through December 15, 1994. Interviews with coalition and interest group representatives were conducted by telephone from March 2 through June 23, 1995.

Content Analysis

Because no final health care reform bill was enacted during the 103rd Congress, we analyzed the content of four leading bills from each chamber. The four House bills were the Ways and Means Committee bill, the Education and Labor Committee bill, Majority Leader Gephardt's bill, and the Bipartisan Group bill. The four Senate bills were the Labor and Human Resources Committee bill, the Finance Committee bill, Majority Leader Mitchell's bill, and the Mainstream Group bill.[11-18] The bills were analyzed to determine if they included one or more of five legislative priorities on the agenda of public health advocates:

1. Full coverage for comprehensive clinical preventive services in the standard benefit package
2. Stable and adequate funding for core public health functions
3. Work-site wellness incentives to reward employers that implement disease prevention programs
4. A population-based, national health data system to assess Americans' health and measure its improvement
5. Federal coordination of prevention policy addressing clinical preventive services, community-based public health, and prevention-oriented social and economic policies

Results

The Public Health Lobby

Nearly all of the public health interest groups we interviewed were members of two or more prevention or public health coalitions, and over half were members of three or more. Nearly half also joined every coalition that invited them to join during the health care reform debates. Only one group declined these invitations because the coalitions' agendas were much broader than its own. Thus, there was considerable overlap among the memberships and goals of the coalitions.

Interest groups joined coalitions because there was "strength in numbers" and because the coalitions offered greater visibility, credibility, and power in the political process. Other reasons included the benefits of pooling resources, sharing information and political intelligence, maintaining a presence on Capitol Hill, speaking with one voice, and representing a broader constituency.

Each group developed a specific legislative agenda and priorities for influencing health care reform. For example, the Public Health Coalition, which represented nine national public health organizations and was spearheaded by the American Public Health Association (APHA), sought universal health insurance and stable funding for the core functions of public health. The Association of State and Territorial Health Officials and The National Association of City and County Health Officials also pushed for stable funding for core public health functions, in addition to coverage for vulnerable populations.

The Prevention Coalition, which represented more than 80 organizations and was spearheaded by the Partnership for Prevention, identified five priorities: stable and adequate public health funding, comprehensive preventive services benefits, population-based health data, federal prevention coordination, and work-site wellness incentives. The Alliance for Worksite Health Promotion also sought tax incentives for work-site wellness programs. The National Breast Cancer Coalition lobbied for comprehensive benefits for early detection and treatment of breast cancer, universal coverage, consumer choice, and increased research funding. The Coalition on Smoking OR Health, which includes the national heart, lung, and cancer associations, focused on an exclusive priority—increasing the federal excise tax on cigarettes to $2 per pack.

Approaches to Influencing Congress

Interest groups and their lobbyists attempted to influence legislation either directly, by providing policy-relevant information to legislators, or indirectly, by attempting to mobilize the public on behalf of or against an issue.

Inside access. Inside access refers to efforts by groups to influence legislators or their staffs directly through personal contact, written materials, or testimony before committees.

All 35 of the congressional staff members we interviewed reported working closely with representatives from 1 or more of the 24 public health and prevention interest groups or coalitions included in our study. However, the group mentioned most frequently by congressional staff as having worked closely with them to integrate public health and prevention into health care reform legislation was The Partnership for Prevention (16 staff members). The partnership's impact reached across both chambers of Congress and across all the major committees with jurisdiction over health care reform. Many staff members remarked that their contacts with the partnership had raised their awareness of prevention issues and had been helpful in their efforts to educate other staff and legislators about the importance of public health.

In addition, 10 staff members reported they had worked closely with representatives of the Association of State and Territorial Health Officials although a larger number reported working closely with health officials of individual states (15 staff members) and localities (12 staff

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*These consisted of 16 private groups and 8 government health agencies. The private groups were the following: Alliance for Worksite Health Promotion; American College of Preventive Medicine; American Heart Association; American Lung Association; American Public Health Association; American Association of Retired People; Association of Schools of Public Health; Association of State and Territorial Health Officials; Association for Worksite Health Promotion; Coalition on Smoking OR Health; Health Insurance Association of America; National Association of County and City Health Officials; National Breast Cancer Coalition; National SAFE KIDS Campaign; Partnership for Prevention, Prevention Coalition; and Public Health Coalition.

The government health agencies were the following: Centers for Disease Control and Prevention; Institute of Medicine; Office of Disease Prevention and Health Promotion, US Department of Health and Human Services; California Department of Health Services; Florida Department of Health and Rehabilitative Services; Oregon State Health Department; Nebraska Department of Health; and Texas State Health Department.

members). Several staff members noted that contacts from health officials in their home state conferred important credibility and provided data demonstrating public health needs and programmatic successes specific to their member's constituents.

Fewer staff members recalled interacting with representatives of other public health interest groups and coalitions. Six staff members said they had worked closely with APHA. Four reported working closely with the Public Health Coalition, the National Association of City and County Health Officials, the American Heart Association, the National Breast Cancer Coalition, or the Association of Schools of Public Health. Only four staff members reported working closely with the Alliance for Worksite Health Promotion, while three recalled first learning of work-site wellness incentives from a large employer in their state.

Both congressional staff and interest group representatives agreed that early and sustained personal contact (in person or by phone) with members and their staff was the most effective way to influence incorporation of public health into health care reform bills.

Publications that succinctly summarized key points were also an important source of information for staff. However, materials went unnoticed unless a representative either delivered them in person or followed up a mailing with a phone call or visit.

The most widely used publication (19 staff members) was the *Model Legislative Language* report prepared by the Partnership for Prevention.[19] Staff members indicated this report had been useful because it provided precise legislative language that could be incorporated nearly verbatim into legislation.

In addition, 12 staff members reported they had used the US Preventive Services Task Force report to define preventive service benefits.[20] Several staff members also mentioned that materials distributed by the Association of State and Territorial Health Officials describing a "day in the life" of public health were effective in illustrating the important, but often hidden, ways that public health programs benefit their member's constituents.[21]

Staff members also reported learning about public health from advocates who testified before their committees.[22-24] Twelve staff members mentioned they had used the recommendations in the report *Health Promotion and Disease Prevention in Health Care Reform*, presented during the Senate Labor and Human Resources Committee hearings on public health in health care reform, to justify including public health in the bills.[25]

Outside initiatives. Groups used outside initiatives to influence Congress' perceptions of public attitudes towards a policy. Groups used media campaigns to try to expand the size of the public that was attentive to an issue and to shape its attitudes. They used grassroots-mobilization campaigns to try to demonstrate the intensity of public support for or opposition to a policy.

Several groups used media campaigns in their attempts to generate support for public health. These groups used many of the same tactics, including writing op-ed pieces, holding press conferences, and preparing information packages for the media. A few groups with greater resources or dedicated media staff implemented more extensive campaigns. For example, former Surgeon General C. Everett Koop and former tobacco lobbyist Victor Crawford made television advertisements for the Coalition on Smoking OR Health that were targeted at the districts of legislators who were on key committees or undecided on the cigarette excise tax. The coalition indicated it had no way of determining the influence of its advertisements, but was disappointed with the results; most bills included only a 45-cent-per-pack tax, instead of the $2 tax the coalition had proposed.

The National SAFE KIDS Campaign also appointed Dr Koop as its spokesperson and sponsored a SAFE KIDS Summit on Capitol Hill. The campaign also hosted a special episode of the television show *Rescue 911* on the same day as a Senate hearing on childhood injury prevention. A follow-up study by the campaign found that its summit had generated 600 television broadcasts, 71 magazine articles, and 1421 newspaper stories.

APHA sponsored a media campaign that broadcast radio advertisements in the states and districts of members on key committees who did not support stable funding for public health.

However, congressional staff reported that the only media effort that had any noticeable impact on the debate was the $15 million dollar "Harry and Louise" television, radio, and print campaign of the Health Insurance Association of America.[26] Public health campaigns had significantly less impact for several reasons. First, the Health Insurance Association of America campaign itself received extensive, national coverage from the press.[26] Second, public health groups had relatively little money to spend on advertising, with many groups reporting very small or no budgets for media, often relying on one or two staff members to conduct their campaigns. Others indicated they had failed to coordinate their campaigns with their lobbying efforts, initiated their campaigns too late in the legislative process, or simply failed to attract the attention of the press or public.

Grassroots mobilization was viewed as a central element in many groups' efforts to shape the legislative agenda. The organizations that attempted to mobilize their members on behalf of public health used many of the same tactics. These included educating members on how to lobby the Congress; issuing calls to action on specific issues; organizing letter-writing, postcard, and fax campaigns; and encouraging members to meet with their legislators in their districts and on Capitol Hill. Collectively, however, the interest groups were frustrated with their limited ability to mobilize their members to take political action.

Congressional staff also said they had little or no contact with the general public regarding public health. According to both congressional staff and interest group representatives, the National Breast Cancer Coalition's grassroots-mobilization effort was the most successful. The Breast Cancer Coalition organized a postcard campaign that generated a flood of mail from women concerned about future funding levels for breast cancer research and coverage for mammography screening. Some congressional staff members recalled receiving hundreds of postcards and phone calls from women in their district or state who were concerned that they would lose their mammography benefits under health care reform.

The only other grassroots efforts congressional staff mentioned were contacts from individual health professionals from their state or district, including state and local health officials, deans of schools of public health, physicians, and, in the case of work-site wellness, representatives of major corporations.

Public Health Provisions in Health Care Reform Legislation

To what extent did the efforts of public health interest groups and coalitions translate into legislative influence? We were interested in five issues advocated by the largest and most broadly

TABLE 1—Public Health in Health Care Reform Legislation in the 103rd Congress

Bill	Clinical Preventive Services Covered	Stable Funding for Public Health Functions	Work-Site Wellness Incentives	Population-Based Health Data System	Federal Prevention Coordination
			House		
Ways and Means Committee bill	Some benefits added	Claims no jurisdiction over public health programs	No provision	No provision	No provision
Education and Labor Committee bill	Full coverage for clinical preventive services	Creates an entitlement for public health programs	Health plan premium discount for qualified programs	Technical assistance to states for health information systems	Three expert panels for preventive services, community health, and policy
Majority Leader Gephardt's bill	Some benefits added	Creates an entitlement for public health programs	Survey to evaluate effectiveness and feasibility of incentives	No provision	No provision
Bipartisan Group bill	No benefits specified	No provision	No provision	No provision	Health Quality Advisory Council assesses health plan performance on prevention
			Senate		
Labor and Human Resources Committee bill	Full coverage for specified list of comprehensive preventive services benefits	"Dedicated" appropriation for public health programs	Defines eligibility criteria, rebate method, and state administration	Uniform public health reporting for health promotion and disease prevention	National Health Board modifies clinical preventive services in benefit package
Finance Committee bill	Full coverage for clinical preventive services	Claims no jurisdiction over public health programs	Health plans may offer up to 10% discount to employers with work-site wellness	Provisions addressing population health status data	National Health Board defines clinical preventive services
Majority Leader Mitchell's bill	Full coverage for clinical preventive services	"Dedicated" appropriation for public health programs	Health plans may offer up to 5% discount to employers with work-site wellness	Uniform public health reporting for health promotion and disease prevention	National Health Board defines clinical preventive services
Mainstream Group bill	Full coverage for clinical preventive services	Public health funded through annual appropriations	No provision	No provision	National Health Board defines clinical preventive services

representative of the public health coalitions, the Prevention Coalition. We also considered reasons, other than the advocacy and lobbying efforts of the public health community, that specific provisions might have been included in a bill, including the different jurisdictions of the committees and other political considerations. Most, if not all, of the bills used President Clinton's Health Security Act as a baseline. The president's bill included language relating to only one of the five priorities supported by public health advocates.

In the House, the interest groups and coalitions consistently targeted the staff of leaders (on both sides) of the Energy and Commerce, Education and Labor, and Ways and Means committees. Representative Henry Waxman (D-Calif), chair of the Health and Environment Subcommittee of the Energy and Commerce Committee, was most frequently targeted in the House. The Energy and Commerce Committee never produced a bill, but much of its work on public health was incorporated into the Education and Labor Committee bill.

In the Senate, public health groups targeted staff of the Labor and Human Resources and Finance Committees. Senator Edward Kennedy (D-Mass) and Sen Paul Wellstone (D-Minn), who co-chaired public health hearings, were most frequently targeted in the Senate. Interest groups reported that access to the Finance Chair Daniel Patrick Moynihan (D-NY) and his legislative director was difficult. More than half of the coalitions and interest groups also mentioned that Sen Bob Graham (D-Fla) and Rep Jim Moran (D-Va), who cosponsored the Public Health Improvement Act of 1994, were key contacts even though they did not serve on health committees.

Table 1 presents the findings of the content analysis of the eight bills. All of them, except the House Bipartisan Group's bill, included language incorporating one or more of the five priority issues of the Prevention Coalition and its members:

- *Coverage of comprehensive clinical preventive services in the standard benefit package.* The president's bill included coverage for comprehensive clinical preventive services in the standard

benefit package, and lobbying efforts sought to maintain or increase coverage for these benefits. Every bill included either a specific list of preventive services or (unspecified) clinical preventive services in the standard benefit package.

- *Stable and adequate funding for core public health functions.* The president's bill included authorizations for funding the core functions of public health and population-based health programs, but funding was subject to annual appropriations and was below the level desired by public health advocates. Lobbying efforts sought to identify a stable source of funding or an entitlement for public health and to increase funding equal to 3% of national health care expenditures.

Unlike the National Institutes of Health, public health advocates were not successful in securing a fixed percentage of the health insurance premium for their programs, but they were successful in adding language creating entitlement programs for funding core public health functions. In the Senate bills, funding for core public health functions and categorical disease programs was consolidated into a block grant with a "dedicated" or "direct" appropriation, a legislative sleight of hand that would have, in effect, created a new entitlement program. Similarly, the House bills provided for block grants for core public health identified as "entitlements on behalf of the populations of the states," with budget authority in advance of appropriations.

- *Work-site wellness incentives.* Lobbying around this issue sought to add provisions permitting health plans to offer discounts of from 5% to 10% to employers who offer comprehensive work-site wellness programs. The specific approaches ranged widely, from the Gephardt bill, which called for a study to evaluate work-site wellness incentives, to the Senate Labor and Human Resources Committee bill, which defined in detail the qualifying criteria, rebate methodology, and state administration for a work-site wellness incentive.

- *Population-based data systems.* Lobbying efforts on this issue sought to create a national health data system and a set of national measures to assess the health and risk status of the population and achievement of the *Healthy People 2000* objectives.[27]

- *Federal prevention policy coordination.* Lobbying on this issue sought to create three expert panels at the federal level to ensure that investments in the public's health are based on the best evidence from research and population health data. There is presently no mechanism for periodic federal review of research to guide programmatic and policy development for public health programs. The president's bill created a National Health Board, which would oversee future modifications to the health insurance benefit package, but made no provision for similar oversight for public health programs or policy. However, most congressional staff members were not familiar with the problem of, or the need for, federal coordination.

In summary, most of the issues promoted by public health advocates were included in or added to most of the health care reform bills as they emerged from committee or were sent to the floor of each chamber. However, considerable differences remained to be resolved prior to enactment.

Conclusion

In the end, the biggest barrier to promoting public health in the 103rd Congress was the failure of comprehensive health care reform. However, our findings suggest that the public health community played an important role in increasing awareness of and support for public health programs during the debates in Congress.

Congressional staff cited stable funding for core public health functions and health insurance coverage for clinical preventive services as their highest prevention-related priorities. However, when asked for definitions, many staff members displayed a limited understanding of public health or prevention. To some, "public health" meant public health clinics for the poor. This perception led several staff members to label public health as a liberal issue. To many, "prevention" meant only changing individual behaviors or screening and immunizations and did not include population-based public health programs or policy, such as public health surveillance or cigarette taxes. And for many, a major selling point of covering clinical preventive services was the often mistaken belief that it would reduce overall government expenditures on health care. There was considerable misunderstanding among staff members who thought that the cost-effectiveness of most preventive services meant they also saved costs for the health care system.

Within Congress as a whole, only a small number of members and their staff are interested in prevention or public health policy. As one staff member put it, public health is not the kind of "sexy" issue that will win a legislator respect within the chamber or political support within his or her district. This lack of attention may have made it easier for advocates to insert public health provisions into legislation early in the process. However, this same apathy might have led to the rapid deletion of these provisions in subsequent debates, especially when it was discovered that the Congressional Budget Office was not scoring public health programs as cost saving.

Our findings also offer clues about tactics likely to be most effective in influencing public health on Capitol Hill. Early, sustained contact with members is important because of the difficulties of anticipating when legislative opportunities will arise and of responding quickly enough when they do. Groups that were involved while Congress was still conducting hearings and sketching draft bills were more likely to influence the content of legislation than groups that waited until later in the process.

This lesson applies to printed materials as well. Members were flooded with mail. Materials were most likely to be used if they were available early in the process and were followed up with a phone call or visit. With respect to content, policymakers wanted concise, relevant information for drafting legislation and for demonstrating the value of their proposals to skeptics. For example, the US Preventive Services Task Force report proved extremely valuable in defending some preventive services benefits and fending off others.[20]

Policymakers were also more likely to notice and support proposals or programs that had local relevance. Congressional staff members were responsive to contacts from state and local health officials and large employers headquartered in their member's districts. They were interested in data and information that demonstrated the importance and consequences of a program for their member's constituency.

Legislative staff also paid particular attention to views expressed directly by their member's constituents. However, the interest groups found it difficult to mobilize the public on behalf of public health. The notable exception was the successful postcard campaign of the National Breast Cancer Coalition. The ability to mobilize

the public increased when the issue was framed as the potential loss of an existing benefit or program or as a crisis requiring immediate attention.

Comment

Although public health has not recently been high on Congress' list of priorities, sustained efforts by the public health community may have long-term benefits. The influx of new members in both chambers presents an opportunity to educate and to avoid a broad-brush labeling of public health as the sole domain of liberals. Interests that are both supportive of public health goals and credible in more conservative political circles, such as medicine and big business, can play an important role. In addition, state and local health officials could capitalize to a greater degree on their contacts with constituents and credibility with congressional representatives.

The central challenge for the public health community is to educate both the media and the general public about how society presently benefits from public health programs, and how the public may be harmed if federal support is reduced or eliminated. □

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