Political Discourse and the Framing of Health Equity

Words and Deeds: Presidential Discussion of Minority Health, Public Policies, and Minority Perceptions

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Abstract What are the different rhetorical approaches presidents used to address minority health inequality? More importantly, how have the efforts of presidents impacted minorities' perceptions of health? I offer a historical perspective that describes the three major periods of presidential engagement in discussions of minority health since the 1960s. I couple this historical overview with an empirical assessment that introduces a novel and extensive dataset of every presidential discussion of minority health spanning five decades (1960–2016). This study finds that, since the early 1990s, presidents have transported their discussion of minority health beyond the confines of Washington, DC, traveling to speak to local communities throughout the nation that have a disproportionate number of blacks and Latinos. Moreover, a presidential discussion of minority health leads to greater salience on this issue and thus increases public health awareness. This work suggests that presidential messaging on minority health provides a framework for minority groups to understand and discuss the health disparities that may plague their communities.

Keywords minority health disparities, presidential politics, racial and ethnic public attitudes

The federal government has made much progress in addressing discrimination and inequality in America since the 1960s, however, an area in which inequality has persisted over time lies within the area of health.

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From President Johnson's discussion of discrimination in hospitals to President Clinton's discussion of the AIDS epidemic in black communities to even President Obama's discussion of the Affordable Care Act, presidents in the modern presidency have attempted to address minority health. In their attempts to do so, they have all had to wrestle with the looming racial tensions that are invoked when politicians broach the topic of race. While these discussions are at times contentious, the president has a unique opportunity to increase health awareness and improve the public's understanding of minority health disparities through political discussions. Given the persistence of health disparities in the United States, I ask what are the different rhetorical approaches presidents have taken in addressing minority health? Moreover, have these discussions impacted citizens' perceptions of health?

In providing answers to these questions, I highlight the benefits that stem from presidential health discussions that are linked to an open and honest discourse about race. In particular, this article develops a discursive government hypothesis, which contends that the political rhetoric of presidents can move beyond the walls of government to shape the social-political agenda of black and Latino organizations as well as everyday conversations in the minority community. Political discourse initiated by the president raises the salience of health and provides pertinent information on program opportunities, new initiatives, and important statistics that are relevant for the minority community once the political dialogue is framed in racial terms. The information provided by the president is at times filtered through the minority media and later establishes credibility that resonates with individual citizens' perceptions of health. Taken collectively, politicians' rhetoric on race emerges as a vehicle to shape minorities' cultural attitudes on health.

The theoretical importance of this work lies in establishing value in race-conscious dialogue in government. As a consequence, this work conceptualizes politicians as being more than just policy makers. Politicians are also conveyors of important health information for minority communities when the discussion is framed in terms of race. Many prior works have viewed the role of discussing race as being important for political elections or public policy (e.g., Mendelberg and Oleske 2000; Wilson 1990). I argue, however, that discourse on race is important for policy implementation because it provides a medium to alter citizens' behavior on important issues in which government has begun to play a larger role, such as health. The argument advanced here, therefore, has important implications for theories

of deracialization, as this article demonstrates that the dialogue on race has tangible benefits that move beyond policy creation.

In what follows, the article begins with a brief review of the existing scholarship on minority health and the use of deracialized rhetoric in government, proposes a modification that highlights the benefits a presidential dialogue on minority health can have for the minority community as far as increasing the importance of health, and continues with a historical assessment of the different rhetorical approaches presidents used to address minority health in the modern presidency. The subsequent empirical analysis supports the theoretical claims that presidents are able to alter public perceptions of health. The concluding section outlines the critical role that the political discourse of the president plays in improving health awareness in the minority community.

Presidential Discussions of Minority Health: The Fear and the Benefits of Discussing Racial Inequality

In the post–civil rights era, federal politicians' explicit discussions of race—in which they highlight the black experience, racial inequities, or race-specific governmental programs—have come under heavy scrutiny by scholars and political practitioners. Instead of a race-specific agenda, some scholars and practitioners have pushed for racial transcendence and written about the positive attributes associated with deracialization or a race-neutral discussion. These benefits have largely been advocated in agenda-setting and electoral strategies.

The advantage of decreasing the discussion of race at first took the shape of electoral benefits. Advising the Democratic Party in 1976, Charles Hamilton (1977) believed that presidential hopefuls would have a better chance of assuming office if they minimized their discussion of issues that were only relevant to the black community and broadened their rhetoric to discuss issues that affected blacks and whites equally, such as unemployment. The benefits of running the kind of deracialized campaign Hamilton advocated have been seen outside of presidential politics. In a 1989 off-year election, for example, a deracialized approach helped bring about what McCormick (1989) refers to as "Black Tuesday," when several black mayors were elected to office and Douglas Wilder became the first African American to win a gubernatorial race (McCormick and Jones 1993). Even in congressional elections in the early 1990s, black candidates who ran a deracialized campaign and expressed moderate views on race were more

successful than black candidates who only advocated for black issues (Canon, Schousen, and Sellers 1996). As a consequence, more political candidates have either shied away from a political discourse that addresses race or deemphasized its importance in political campaigns (Gillespie 2012).

A deracialized approach, however, does not end with elections. Political figures who run deracialized campaigns later support race-neutral policies or fail to support bills that target minority interests (Orey and Ricks 2007). Scholars have supported continuing this strategy of deemphasizing race, indicating that a race-neutral approach would mean a greater alliance of politicians who are willing to support universal governmental programs that disproportionately benefit the more disadvantaged members of minority groups (Wilson 1990). In presidential politics, some argue that even President Obama embraced this race-neutral approach and has benefited from it by achieving electoral successes (Harris 2012).

Although much has been written about the benefits of deemphasizing discussions of race, little is known about the societal value of retaining a race-conscious dialogue in government. This is because the debate around politicians' discussion of race has largely been framed with two goals in mind: politicians getting elected to office, and the successful passage of policies that address disparities. There are good reasons for scholars to focus on these facets of the political process. Elections provide an opportunity to place in office those individuals who can best advocate for minority interests. And public policies provide structural opportunities to combat the institutional norms that have historically hindered minorities from achieving equality. While political rhetoric can certainly have an effect on these two goals, it is also possible that the political dialogue on race has a more far-reaching influence on society's cultural norms.

One area where political rhetoric may have a more extensive reach is within the issue of health. Political scientists rarely study the politics of health. However, sweeping reforms to the health care system with the Affordable Care Act have catapulted government into the center of the health care debate. It has also forced politicians to create a political dialogue that communicates important health information to the American public and thus shapes public health awareness. The health information conveyed by government is important because the growing racial health disparity gap is coupled with a burgeoning information gap that exists along racial lines (Lorence, Park, and Fox 2006). The information gap has been shown to partially explain certain health disparities that disproportionately impact racial and ethnic minority groups (Goswami and Melkote

1997; Viswanath et al. 2006). The lack of health information is reflected in low levels of health awareness in the minority community.

Scholars have long advocated that policy makers become involved in the process of increasing awareness on racial and ethnic disparities in health care and with health conditions more generally (Betancourt and King 2003). However, politicians may need to engage in a discourse on race alongside their discussions on health in order to promote health awareness. Indeed, some argue that the most telling evidence of the inadequacy of a race-neutral or color-blind approach to governance has been found in health and health care (Wise 2010). In considering the best practices to discuss racial and ethnic health inequality, some scholars suggest that the messaging of racial health inequality should focus on social determinants of health (Kim 2010). Others push for a broad message that invokes interconnections and shared responsibility among citizens (Wallack, Lawrence, Park, and Fox 2005). Regardless of the approach, there is a large consensus that government cannot ignore the issue of racial health disparities.

I argue that when political officials talk about race they initiate a component of what I refer to as discursive governance. In discursive governance, politicians' statements have influence beyond the policy-making process. The political discourse on race permeates throughout influential minority institutions within the black and Latino public sphere that seek to set the agenda for the minority community. The minority press, like other minority institutions, is keen to the political dialogue on race (Knobloch-Westerwick, Appiah, and Alter 2008). The race-related political discourse in government allows minority institutions to see the implications that follow from public policy, examine how public policies have considered and incorporated the minority experience, and ascertain possible opportunities to influence government. When federal politicians discuss race with regard to a secondary issue, such as health, they add salience to the secondary issue and thus increase the likelihood that the minority press covers this topic. For health issues this is particularly important because it allows politicians, who are typically not considered providers of health information, to increase health awareness at the macro level.

Presidential speeches may have a direct or indirect influence on individuals. Presidents have often been viewed as opinion leaders (see, e.g., Cohen 1995; Wood 2009). The mere words of presidents have been found to change economic conditions and even consumer behavior (Wood 2009). Presidents' discussions of racial issues can place minority concerns on the public's agenda as an important topic (Cohen 1995). Recent research has

even shown that when presidents speak about social issues in a context that references racial and ethnic minority groups, minorities are more inclined to view this topic as being one of the most important issues facing America (Gillion 2013). Given that fluctuations in racial minorities' political behavior and attitudes are shaped by governments' attention to the minority community (Dawson 1994), presidential statements on citizens' well-being that are presented in the context of race provide a frame in which the issue of health becomes more salient for blacks and Latinos. These arguments lead me to propose the following hypothesis: presidents' race-conscious discussions of health will increase the importance of health for racial and ethnic minority citizens. Before I proceed to test this hypothesis, I offer a brief historical assessment of presidents addressing minority health.

Historical Snippets of Presidential Approaches to Addressing Health Inequality in the Minority Community

Presidents' discussions of minority health can be categorized into three different eras. In the 1960s, presidents addressed minority health alongside the fight for civil rights. The 1970s and 1980s witnessed a more conservative approach to addressing racial health inequality. By the 1990s and 2000s, however, presidents not only returned to a more aggressive discussion of addressing minority health disparities, but presidents in this era took their minority health messages to local communities.

Addressing Health alongside the Fight for Civil Rights (1960s)

The health inequality that existed in America along racial lines was undeniable in the middle of the twentieth century. As David Barton Smith (2005: 317) assessed, there were three major challenges the federal government faced in the 1960s: (1) the broader practice of Jim Crow that separated black and white patients, (2) the less noticeable, subtle forms of discrimination pursued by physicians through referrals and also seen through insurance status of patients, and (3) the ability to give all patients nondiscriminatory treatment once they had equal access to care. Presidents Kennedy and Johnson decided to address these concerns.

In the years leading up to the height of the civil rights movement in the 1960s, minority health was not a major issue for the executive office. Indeed, President Eisenhower, especially in his last term in office, spoke

very little on racial health inequality. This is not to say that health issues, more broadly, were not discussed. The efficiency of Social Security and medical care for the elderly were heavily addressed and greatly debated in Congress during the Eisenhower administration. Yet, these conversations rarely involved a specific discussion of minority health. However, John F. Kennedy's presidential campaign would be a major turning point for how the federal government discussed health inequality.

The Democratic Party's attention to the issue of civil rights provided an opportunity for Democratic politicians to speak broadly about racial disparities in America, including issues such as housing, jobs, and education. The inequities in minority health and well-being were also among those issues that were addressed. President Kennedy looked to address health inequality by providing racial and ethnic minorities equal opportunity to the health profession. Speaking as a senator in East Los Angeles on the campaign trail in 1960, Kennedy expressed some of these sentiments:

> If the full rights of our Constitution, the full values of human dignity, are not available to every American, then they no longer have the same meaning for any American. They no longer have the same appeal to those in other lands of other races and religions, and they are a majority whose respect we seek. And they no longer guarantee us a nation that draws upon the full talents of every citizen. We do not want a Negro who could be a doctor, in a city short of doctors, working as a messenger. (Kennedy 1960)

As President Kennedy went after African Americans' votes, he also began to consider their health concerns. By the time Kennedy arrived in office, his campaign messages turned into presidential remarks and executive actions. In a message to Congress, Kennedy exclaimed that he was directing the Justice Department to challenge the "constitutionality of the 'separate but equal' provisions which permit hospitals constructed with federal funds to discriminate racially in the location of patients and the acceptance of doctors" (Kennedy 1963: 229).

Kennedy's health messages had a racial component but these discussions were often couched alongside strengthening Social Security and medical care. This provided a broader appeal to the American public. President Lyndon B. Johnson continued this approach of speaking about race alongside broader health issues.

In less than a year after gaining office, President Johnson signed the 1964 Civil Rights Act. Title VI of the 1964 Civil Rights Act prevented institutions that received federal funding from discriminating against racial and

ethnic minorities that required health care or medical assistance. Johnson would follow this legislation up with a strong push for Medicare. Johnson believed the link between improving race relations and medical access with Medicare was more than related to one another, but rather the success of one issue depended upon the success of the other. He expressed as much during the Inauguration of the Medicare Program, "Medicare will succeed—if hospitals accept their responsibility under the law not to discriminate against any patient because of race" (Johnson 1966).

By the end of Johnson's time in office, he touted that Title VI of the Civil Rights Act, as applied to Medicare, had significantly decreased discrimination in medicine with 95 percent of hospitals achieving compliance. He often offered the example of how half the beds in all-white hospitals were empty because black patients were sent to segregated medical facilities that were overcrowded. However, after a year of implementing Medicare, the half-empty hospitals changed their policies to admit blacks and were operating at full capacity.[1]

Johnson's attempts to address minority health did not end with Medicare. He focused on infant mortality rates and argued that he wanted "to reduce infant mortality, concentrating particularly on those minority groups whose death rates is [*sic*] highest." He also addressed nutrition and healthy eating habits in the minority community by informing the American public he had petitioned Congress for 50 million dollars to programs "designed to provide adequate nutrition for disadvantaged children." Johnson was a leader on minority health issues and supported programs that provided many benefits to the minority community. Over the next several decades, however, presidential rhetoric on minority health would be less supportive and more infrequent.

A Conservative Approach to Racial Health Inequality (1970s and 1980s)

After nearly a decade of liberal Democratic presidents discussing minority health equality alongside civil rights issues, the 1970s and 1980s witnessed a more conservative presidential rhetoric from the majority of Republican presidents that governed over this period of time. The conservative approach was exemplified by the degree to which Republican presidents spoke about

1. Scholars have indicated that the Medicare certification program Johnson implemented was instrumental in exposing and eliminating much of the racism that existed in the medical field (Reynolds 1997).

minority health, and their use of rhetoric that looked to restrict governmental funds for programs that disproportionately benefited racial and ethnic minorities.

Nixon embodied the former type of conservatism on this issue, and spoke less about minority health issues than his Democratic peers. However, on the occasions that Nixon addressed minority health, he pursued those issues that were pertinent to the minority community at the time. One of Nixon's major focuses was on sickle cell anemia. Nixon often cited startling statistics about this condition in the black community. In a Special Message to Congress regarding Health Care in 1972, Nixon indicated "about one out of every 500 black infants falls victim to the painful, life-shortening disease called sickle cell anemia. This inherited disease trait is carried by about two million black Americans" (Nixon 1972: 392). He later went on that year to sign the Sickle Cell Anemia Control Act, the chief provisions of which improved screening, provided information and education on the disease, and established grants to fund research that explored the diagnosis, treatment, and control of sickle cell anemia.[2]

While the 1970s saw a decline in minority health discussions from the executive office, President Ronald Reagan did not shy away from speaking about federal policies that were related to minority health in the 1980s. This increased discussion, however, cemented the conservative approach of constriction. Reagan focused his efforts on restricting and reducing governmental spending on programs that had previously addressed racial health inequality. Two programs that garnered the majority of his scorn were the nutritional benefits of the food stamp program and Medicaid, which he believed had engaged in wasteful spending. He exclaimed as much in remarks at the National Legislative Conference of the Building and Construction Trades Department: "The cost of food stamps went up by 16,000 percent in the last 15 years. Medicaid and Medicare—again, essential programs—have increased by more than 500 percent in the last 10 years. We don't have a trillion-dollar debt because you aren't taxed enough. We have a trillion-dollar debt because government spends too much" (Reagan 1982).

As a consequence of what Reagan perceived as wasteful spending, 400,000 families were removed from welfare programs at the state and federal level. In addition, requirements to qualify for federal benefits became stiffer. For example, individuals had to have less than $1,000 in

2. Nixon also put forth his own Family Assistance Plan to Congress and would pitch it as a way to bring about calm from the social unrest in the black community (Quadagno 1990: 15).

financial assets to qualify for public benefits, a substantial decrease than the $2,000 limit just a year before (Marable 2015). Marable (2015) argues that these cuts hurt the black community in particular.

A thorough assessment of the conservative era, however, should not lead us to conclude that the executive office was only stagnant or even obstructive in improving minority health. On the contrary, President George H. W. Bush governed over an expansion of programs and institutions meant to address racial health disparities. Bush signed into law the Disadvantaged Minority Health Improvement Act of 1990. Later that year, led by the ambitious efforts of Louis Wade Sullivan, Secretary of the US Department of Health and Human Services, the Office of Minority Programs was established in the National Institutes of Health (NIH) Office of the Director. In 1992, the Minority Health Initiative was launched and provided federal funds to programs that addressed racial health disparities. Nevertheless, although there was an influx of institutions and programs established to alleviate racial health disparities toward the end of the conservative era, H. W. Bush took a conservative approach in addressing minority health by rarely discussing this issue with the American public.

Openly Discussing Minority Health and Universal Health Care Reform (1990s and 2010s)

The election of President William J. Clinton ushered in a new and aggressive approach for presidents to speak about minority health. Most Americans associate Clinton's efforts around health and health care with his failed proposal to establish universal health care reform in 1993. For many racial and ethnic minorities, however, the 1993 health policy is overshadowed by other health initiatives. Five years after the Health Security Act, in a radio address on February 21, 1998, Clinton put forth his Racial and Ethnic Health Disparities Initiative to combat some of the startling health inequalities that had become prevalent in the minority community. His initiative targeted those conditions that disproportionately affected African Americans, Latinos, and Asian Americans, such as infant mortality, diabetes, cancer, and heart disease. The policy was sweeping and bold. It set a national goal to eliminate racial and ethnic disparities by the year 2010. The policy initiative was also well funded. Clinton earmarked $400 million to spur prevention and outreach programs.

The president engaged in a powerful discourse on racial and ethnic health disparities during this time period. And his rhetoric on race served as the impetus for a larger discourse on this topic that rippled through other

parts of government. Secretary of Health and Human Services Donna Shalala later established a task force to discuss innovative approaches to addressing racial health disparities through existing federal programs. Surgeon General David Satcher, an African American and a graduate of the historically black Morehouse College, also launched a campaign to educate the public about racial health inequities as well as to inform Americans about opportunities to address these disparities.

The president's efforts to address issues of health continued throughout the year. By the fall of 1998, Clinton had turned his attention to the AIDS epidemic that was still unraveling in the minority community. Congress was already making efforts to combat AIDS, but Clinton wanted to amplify these efforts with his own discourse. On October 28, 1998, Clinton addressed the nation on this issue:

> Today we're here to send out a word loud and clear: AIDS is a particularly severe and ongoing crisis in the African American and Hispanic communities and in other communities of color. African Americans represent only 13 percent of our population but account for almost half the new AIDS cases reported last year. Hispanics represent 10 percent of our population; they account for more than 20 percent of the new AIDS cases. And AIDS is becoming a critical concern in some Native American and Asian American communities, as well. . . . The AIDS crisis in our communities of color is a national one, and that is why we are greatly increasing our national response. Today I am proud to announce we are launching an unprecedented $156 million initiative to stem the AIDS crisis in minority communities. (Clinton 1988: 2167)

Clinton's larger dialogue on health that incorporated references to racial and ethnic minorities was unprecedented in the executive office. While previous presidents had offered statements on health, few made a continuous effort to discuss the increasing racial health disparities in America or to recognize the most troubling conditions ailing the minority community. Based on the total number of statements in the *Public Papers of the Presidents*, Clinton dwarfed the rhetoric of previous presidents by speaking three times as much on race and health than his predecessors.

Clinton's aggressive approach to discussing minority health would later be emulated by President Barack Obama. On March 23, 2010, Obama accomplished a historical feat by signing into law the Affordable Care Act, which put in place comprehensive health insurance reforms and looked to make health care more affordable, accessible, and of a higher quality. In the lead up to passing this law, President Obama rarely spoke about minority health. Actually, previous research showed that, in his first two years in

office, Obama spoke less about race more generally than his democratic predecessors (Gillion 2013). However, in the years following the Affordable Care Act, Obama increased his discussion of minority health and attempted to broaden the public's understanding of how health disparities in black and Latino communities should concern all Americans.

> I said then that if a young child is stuck in an overcrowded and underperforming school, it doesn't matter if she is black or white or Latino, she is our child, and we have a responsibility to her. That if millions of Latinos end up in the emergency room because they don't have health care, it's not just a problem for one community, it's a problem for all of America. When millions of immigrants toil in the shadows of our society, that's not just a Latino problem, that is an American problem. We've got to solve it. That's why we passed health insurance reform. . . . (Obama 2010)

Obama's discussions of minority health also moved beyond the issues of health care. He spoke about his White House Initiatives to address health disparities for Asian Americans and Pacific Islanders by promoting increased access to and participation in Federal programs. He discussed the harms of viral hepatitis, which disproportionately impacts the minority community. And similar to Clinton, he spoke about the pervasion of HIV in the black community, indicating that HIV infection rates among black women are almost twenty times what they are for white women. By the end of Obama's second term in office, his attention to minority health had surpassed previous presidents and was only rivaled by the extraordinary attention of Clinton.

An Empirical Approach to Understanding a Presidential Discussion on Minority Health

While the historical perspective is helpful in providing greater context to the discussion of minority health, we may gain more by charting this discussion over time and empirically assessing its influence. In order to further explore the link between a race-conscious dialogue on health and the response from the minority community, I rely on several datasets that provide information on the rhetoric used by presidents, and attitudes gleaned from individual-level surveys.

Like many scholars who explore race in sociology and communication (e.g., Bobo 1997; Coe and Schmidt 2012), I consider a broad definition of race that examines discussion of racial and ethnic minorities. In the post–civil rights era, the concerns and interests of underrepresented racial

minorities have become linked. More importantly, presidents have come to use references to race and ethnicity interchangeably in the public discourse (Coe and Schmidt 2012). Not only have politicians broadened the discussion of race, but the attitudes and behavior of citizens have been shaped through a racial prism or racial hierarchy that includes the ethnic groups of Asian Americans and Latinos (Kim 2003; Masuoka and Junn 2013). Masuoka and Junn argue that, for issues with "clear racial undertones such as immigration policy, position in the racial hierarchy is the key feature to explain differences in public opinion" (2013: 5). Thus, I conceptualize a race-conscious dialogue as one encompassing references to immigration, Latinos, and Asian Americans.

Measuring the President's Dialogue on Minority Health

To examine presidents' statements that highlight health and race, I employ a well-established process of content analysis to assess electronic copies of presidential speeches found in the *Public Papers of the Presidents* series published by the Office of the Federal Register, which is a part of the *American Presidency Data Project* (Peters and Woolley 2015). While previous studies have focused only on major speeches such as the State of the Union Address to understand the president's discussion of race (Coe and Schmidt 2012), I incorporate an extensive array of presidential remarks that include public speeches, addresses, signing statements, press conferences, and comments in presidential debates, as well as State of the Union addresses. This novel data collection effort should increase our understanding of the messages coming from the president.

To examine presidents' remarks, I use the same classification process to separately code health-related statements and those related to race. The initial stage of the classification process required a training set to classify statements.[3] Scholars suggest that classifying 500 documents is sufficient for training programs, and as little as 100 can suffice for producing accurate results (Hopkins and King 2010). For increased accuracy, two research assistants separately read and classified a random sample of 1,200 paragraphs drawn from the complete dataset of presidential remarks across four presidents (1990–2012), with 300 paragraphs being drawn from each president.[4] For issues of health, the training set was classified into two

3. The training set is a dataset of speeches that has been classified by human coders and is then used to train computers to recognize health-related or race-related remarks during the supervised learning process.

4. The different presidents that were covered included Presidents George H. W. Bush, William Clinton, George W. Bush, and Barack Obama.

groups: statements that mentioned a health-related issue and those that did not.[5] For issues of race, the training set was classified into paragraphs dealing with race and those that did not. Identifying issues of health were coded based on explicit presidential mentions of health conditions, health insurance, governmental health programs, and even discussions of physical fitness and best health practices.[6] Classifying race involved explicit statements that included references to blacks, Latinos, Asian Americans, or minorities as a collective group. It also included mentions of racial disparities, racial discrimination, minority government programs, and broader discussions of the state of race relations.[7]

Having established the training sets, I use an ensemble approach that incorporates multiple supervised learning algorithms to classify representative speeches, a technique that improves the accuracy of classification (Grimmer and Stewart 2013, Jurafsky and Martin 2008).[8] Three different learning algorithms (general linearized models, maximum entropy, and support vector machines), also referred to as classifiers, were programmed by the training set and later classified the entire dataset of presidential speeches.[9] To validate the classification process, a fivefold cross-validation procedure was used to compare the training set with the computer-programmed classifications.[10] The interaction of health and race is simply those paragraphs that were separately identified as dealing with health issues *and* race-related issues. I refer to the intersection of these two paragraphs as being minority health statements or race-conscious health statements.

An example of a minority health statement comes from President Obama during a 2009 address to the NAACP Centennial Convention: "We know that even as spiraling health care costs crush families of all races, African Americans are more likely to suffer from a host of diseases, but less likely to own health insurance than just about anybody else." President Obama

5. All texts were pre-processed by removing punctuations, numbers, white spaces, and stop words, which are common words that are used so frequently that they have little informational value. The preprocessing produces improved estimates during the classification process (Meyer, Hornik, and Feinerer 2008).

6. While word order is often unimportant for quantifying text (Jurafsky and Martin 2008), our experience revealed that retaining the word order of health-related terms such as "Medicaid Benefits," "High Blood Pressure," or "Working Out," improved the performance of the classifiers. Thus, we include bigrams (word pairs) and trigrams (word triples) to retain word order.

7. Given that only explicit statements were used, the intercoder reliability was high at 95 percent and 92 percent, respectively, for health and race. The author was the final arbitrator of the conflicting statements and classified these remarks for the training set.

8. Incorporating as few as four different algorithms for machine learning correctly corresponds to human classification 90 percent of the time (Collingwood and Wilkerson 2012).

9. The program *RTextTools* in the statistical program *R* was used to classify the sentences.

10. The fivefold cross-validation process yielded 85 percent mean accuracy for overall minority concerns.

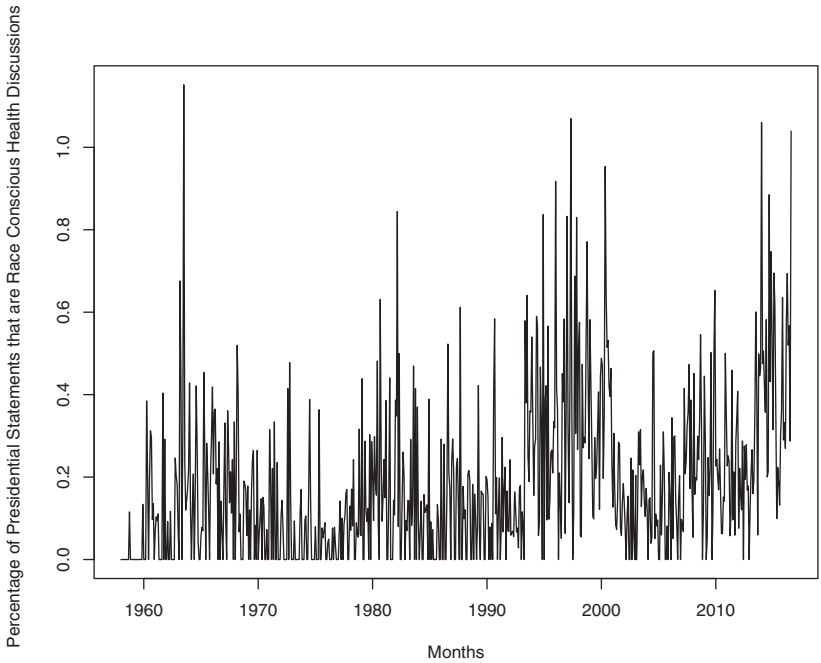

Figure 1 Presidents' Discussions of Health Issues in the Context of Race

discussed a broad issue, health insurance, which is not intrinsically related to race. However, the president intersects a dialogue on health with race by recognizing the racial disparities that exist for those who have health insurance. The coding process described above attempts to capture this interaction.

A more encompassing understanding of presidents' efforts to engage in a discussion of minority health is presented when we chart presidents' discourse over time. In fig. 1, I present presidents' discussions from 1960 to 2016. The unit of analysis is the percentage of minority health statements a president made in a given month. I consider one paragraph in the *Public Papers of the Presidents* to be a statement. Given this metric, the first point of note is that presidents rarely discuss health issues in the context of race, at least when we look at such remarks as a percentage of their overall discourse. At its highest level, such discussion made up only 1.2 percent of Clinton and Johnson's statements.

As one might expect, during the passage of civil rights legislation, Johnson spoke about minority health on several occasions and has the

largest spike in a month out of any president. Other Democratic presidents displayed similar levels of discussion. While Republican presidents traditionally did not speak as much about minority health as their Democratic counterparts, Reagan was considered the exception. Reagan's discussions of cutting back on Medicaid and food stamp programs were just as aggressive as Johnson's remarks to eliminate discrimination in hospitals.

Arguably, the greatest level of discussion came under Clinton. In the two years before President Clinton came into office, George H. W. Bush's health statements were largely devoid of race-related issues. However, when Clinton arrived in office and made a major push for health care reform, his efforts for universal coverage included discussing racial health disparities. Though the proposal failed, it provided the groundwork for a larger dialogue on health and race that would come later in his administration. In June 1997, President Clinton announced his new race initiative that included the goal of addressing health care for racial minorities. Figure 1 shows its largest spike soon afterward.

After President Clinton, a clear pattern of deemphasizing race in health discussions emerged. President George W. Bush's discussions of Medicare and Medicaid, health issues he targeted during his time in office, often did not involve discussions of race. Although the dialogue on minority health improved with the election of the first black president in 2008, it was a moderate increase at first. Even with President Obama's extensive discourse on overhauling the health care system through the Affordable Care Act in 2009 and 2010, the discussion of race in his first term in office could not match the levels we witnessed under Clinton. Obama's second term in office is a different story. He aggressively discussed minority health issues and maintained this level of discussion for several years.

Not only can we assess the discussion of minority health over time, we can also explore the discussion across space. In fig. 2, I plot the places in which presidents engaged in a discussion of minority health. The figure is divided into two maps. The map on the top indicates the discussion of minority health before 1992, and the map on the bottom illustrates the discussion of minority health after 1992. It is clear that the discussion of minority health drastically increased across the country after 1992. Post-1992, presidents begin to transport their discussion of minority health beyond the confines of Washington, DC, to speak to local communities throughout the nation where there is a disproportionate number of blacks and Latinos. Cities such as Chicago, Philadelphia, Miami, and Houston have served as the epicenter for presidents to appeal to minorities about the importance of health. Although presidents are more frequently visiting these specific cities, the potential change in citizens' perceptions of health

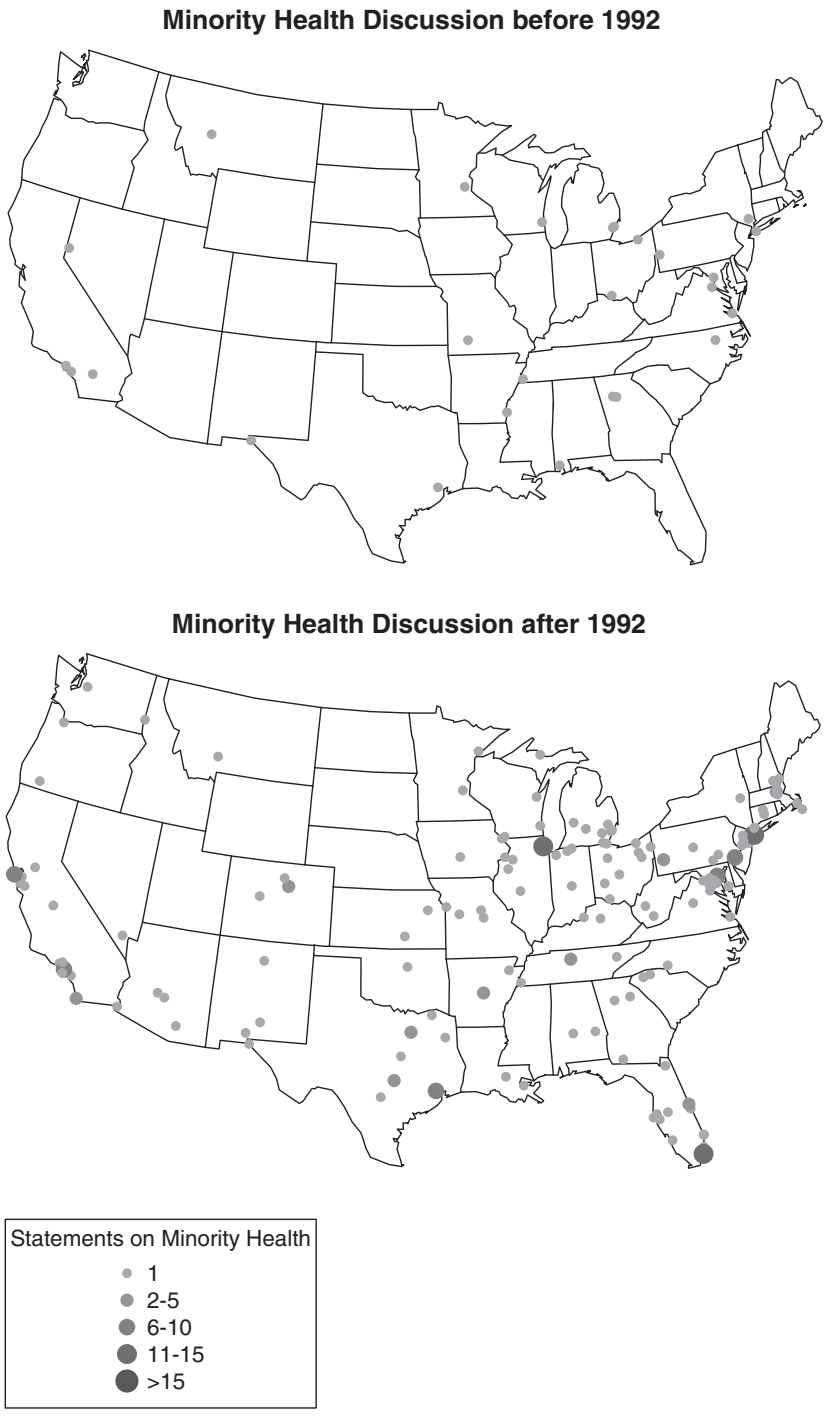

Figure 2 Geographical Location of Minority Health Discussion

in these areas could change the issues being discussed more broadly in black media outlets throughout the country.

As a consequence of this increased discussion in communities, we should expect there to be an influence of the president's words in a post-1990 era. We explore this proposition in the next section.

Individual Attitudes of Health Awareness

Thus far we have explored various aspects of presidential discussions of minority health. However, does the dialogue move to the micro level and change individual levels of health awareness? There are many ways to understand minority health awareness. We can conceive of it as educating the public on the benefits and consequences of health practices. Yet, the dominant narrative on minority health awareness is framed in a negative light, where the most discussed topics are, first, the lack of information society has on conditions that disproportionately affect marginalized groups, and, second, programs to remedy these disparities. Indeed, when presidents speak about health and race, they tend to highlight the racial and ethnic minority health disparities that plague American society or the inadequacy of health care insurance coverage among the least fortunate. These discussions are often a call for government action to mitigate these health disparities. Thus, presidents characterize issues related to minority health as potential problems facing America. As a consequence, when citizens receive these messages, they may also view health as a problem that must be rectified. If racial minorities recognize health as a problem, this may be interpreted as an indication of increased awareness.

In table 1, I analyze the impact that a presidential discussion of minority health has on citizens' perception of whether they feel that health care is the most important problem facing America. Various control variables are also included in the model to account for other possible explanations. On average, just 0.25 percent of presidential remarks in a given month relate to minority health. During those months that presidents offer an average level of minority health discussion, this only increases the probability that minority respondents view health as the most important topic by 1.2 percent. However, in months in which 0.65 percent of the presidents' statements were related to minority health, as was the case for Clinton and Obama, their discussion increases the probability that minorities view health as the most important topic by 7 percent.

While presidential discussions on minority health have a positive and statistically significant effect on minority respondents, non-minorities are unaffected by presidents' race-related rhetoric on health. In model 2 of

Table 1 Minority Health Discussions on Individual Responses of "Health Care" as the Most Important Problem Facing the Country

	Minority Response (Model 1)	White Response (Model 2)
President minority health discussion	1.140**	−1.78
	(−362.663)	(−195.929)
Age	−0.004	−0.007***
	(−0.003)	(−0.001)
Education	0.111**	0.013
	(−0.039)	(−0.013)
Female	0.471***	0.542**
	(−0.114)	(−0.035)
Obama in office	15.264	1.590**
	(−760.081)	(−0.579)
Presidential approval	0.171	0.347***
	(−0.168)	(−0.034)
Ebony articles on health	17.863	1.724
	(−760.084)	(−1.023)
Overlap of president and magazine	57.716	−8.131
	(−32.586)	(−14.692)
N	7554	72986
AIC	2868.431	27719.959
BIC	5363.171	31031.247
log L	−1074.216	−13499.98

Notes: Statistical significance is denoted as follows: significant at $*p < .05$; $**p < .01$; $***p < .001$.

table 1, the coefficient on presidents' minority health discussions is statistically insignificant. These results suggest that, indeed, certain political messages are interpreted differently by different segments of society. As previous research has shown, racial and ethnic minorities have a keen ear for a dialogue on race (Dawson 1994). Their attention to politicians' words is not diminished when the discussion of race is coupled with a dialogue on health.

Discussion and Conclusion

This article affords a deeper understanding of the benefits that stem from a race-conscious dialogue. Scholars often suggest there is value in discussing race but struggle to lay out the tangible benefits that follow from this discourse (McCormick and Jones 1993). This article demonstrates that presidents' race-conscious dialogue has positive cultural influences that

move beyond elections and public policy to alter societal attitudes toward health and the agenda of minority institutions. The racial dialogue on health allows presidents to enter into the minority public sphere and shape citizens' perceptions of health, thus allowing presidents to become a part of deliberative democracy.

This article also offers a reconception of the role presidents play in addressing minority health awareness. For many, health awareness is information that is typically altered by primary care physicians, family members, or even the church. Rarely do politicians enter into this discussion. Nevertheless, with major health initiatives put forth by presidents since the 1990s, the role of government has come to be perceived as more closely linked with health. As a consequence, presidents are relied on to inform the public of important health initiatives that may combat the growing minority health disparities that exist in America. While research on how the political discourse relates to policy implementation and evaluation are often ignored, it is at these stages in the policy-making process that political rhetoric is most vital. Presidential communication can change citizens' reactions to governmental health programs. But even when new programs are not created, presidents can reshape citizens' attitudes toward health issues that exist in current programs.

Finally, this work highlights the importance of considering how race influences the entire political process. Even though a deracialized or race-neutral rhetorical approach may be beneficial for political campaigns and the passage of public policy, these approaches restrict an important pathway politicians may use to influence and engage with the minority community. For some issues, this engagement may be inconsequential. But for others, such as minority health and health awareness, it is an indispensable avenue of governance.

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