

THE SOCIAL CONSTRUCTION OF BREAST AND PROSTATE CANCER
POLICY

by

Jocilyn Martinez

A Dissertation Submitted to the Faculty of
The College of Architecture, Urban, & Public Affairs
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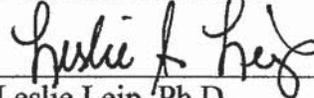
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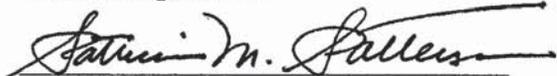


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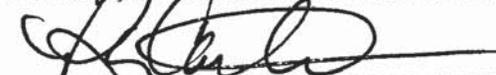


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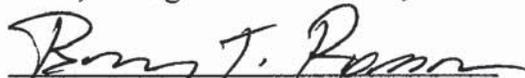
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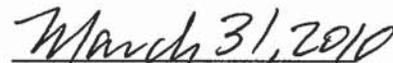
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ABSTRACT

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Breast and prostate cancers are the most commonly diagnosed forms of cancer in women and men in the United States. The federal government has played an active role in dedicating resources toward breast and prostate cancers since the early 1990s, when policy actors successfully lobbied Congress to adopt policies that increased awareness and spending. Using theories of social construction, I argue that the key to their success was the ability of these policy actors to socially construct the illnesses of breast and prostate cancers into politically attractive public issues that appealed to federal policymakers.

Through the use of embedded collective case study and content analysis of newspaper coverage and congressional data, this dissertation demonstrates how the

social constructions of these illnesses impacted the way that breast and prostate cancers were treated as they moved through the policy process. The way in which social construction influenced the types of policies that were adopted to deal with these illnesses is also examined.

Because social construction is a multidimensional and dynamic process, several different elements of this process were examined in this dissertation: the ways that policy actors attracted attention to these illnesses, how gender influenced advocacy efforts, the symbolic aspects of these illnesses, and the way the illnesses were defined on systemic and institutional agendas. Since this dissertation examines two different policy issues, the similarities and differences in breast and prostate cancer policymaking were analyzed. I found that discussing breast and prostate cancers in relation to their social constructions provides support for the importance of symbolism and non-rational policy-making processes.

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I. INTRODUCTION

I get angry sometimes that there's so many things that we could be doing in this country to combat breast cancer. I'm sorry to say this, but if this were an illness that were striking men at the rate that it is striking women, I think that society's response would be much more swift and more dramatic (Breast Cancer: Race For the Cure 16 May 1990, p. 36).

The above quote by actress Lynda Carter at a 1990 congressional hearing on breast cancer echoes the sentiments of those who feel neglected and marginalized when it comes to federal policymaking. Prior to the 1990's, federal policymaking on breast cancer was virtually nonexistent. This lack of attention left many women feeling as though their particular health problems were not important to policymakers. In order to bring about policy change, advocates consistently lobbied Congress for increased attention and funding for breast cancer. Today, the breast cancer movement has brought about enough change to establish it as a significant health policy issue that continues to attract the attention of lawmakers. Other serious illnesses, such as prostate cancer, have yet to receive the same levels of attention as breast cancer.

The nature of policymaking is such that the selection of one problem for government attention almost always ensures neglect of another. When policymakers choose to deal with certain public problems, as opposed to others, they decide what problems and which people are considered to be most valuable at that time. In this

way, policies are not just solutions selected to deal with public problems. Rather, as scholars have pointed out, they are often vehicles used to communicate messages about what problems and which people deserve the most attention from government (Birkland 2001; Dye 2005).

Rational thinking about policymaking has traditionally focused on the stages model to explain how the policy process works. In the stages model, an issue emerges, moves onto the agenda, and then a decision is made (Anderson 1975; Brewer and DeLeon 1983; Jones 1970). While the stages model has come under harsh criticism for its inability to explain why certain issues are treated by government, supporters have argued that it is beneficial in helping to provide a broad overview of the policy process (Brewer and DeLeon, 1983). Within this process, why policymakers select some public problems, and not others, has been the source of considerable debate. Policy scholars (Kingdon 1995; Rochefort and Cobb 1993) have long noted that the way public issues are defined is one of the most important factors to consider when examining why certain issues are treated favorably in the policy process. Without definitions that are consistent with public values and draw attention, many important social issues will never even reach the agenda. To that end, scholars have argued that public issues are defined through a process of social construction that determines how issues are perceived by the public and policymakers (Spector and Kitsuse, 1977).

In policy context, social construction (Berger and Luckmann, 1966) refers to the ways that people tell stories about how and why public issues exist as they do.

Social construction is a continual and multidimensional process of defining public issues that is highly susceptible to change. Scholars such as Donovan (2001) and Schneider and Ingram (1993) have analyzed the impact of social construction on public policymaking. These scholars have argued that the social constructions of public issues, as well as the people affected by the issues, significantly impact the types of policies that are adopted to deal with them. Although these scholars acknowledge that social construction does influence policy decision-making, an understanding of how social construction impacts issues as they move through various phases of the policy process is still unclear.

Examining how the process of social construction impacts issues as they move through various phases of the policy process can help policy scholars analyze its role in policymaking. Comparing how social construction affects the way that two similar policy issues are treated as they move through the policy process can give us even greater insight into how social constructions influence policymaking.

To that end, this dissertation discusses how social construction influenced policymaking on two health policy issues: breast and prostate cancers. The discussion that follows throughout this research study demonstrates how the social constructions of these two health policy issues affected the way in which these issues moved throughout the various phases of the policy process and the types of policies that were adopted to deal with them.

Breast and Prostate Cancer Policy

Cancer has been described as “a deadly arrow that could strike anyone” (Sontag, 1988, p. 38). The strike of cancer’s arrow will claim the lives of more than 500,000 American men and women this year (National Cancer Institute, 2009). Today, over 100 different types of cancer have been identified. Two of the most deadly of these are breast and prostate cancers. Second only to lung cancer, breast and prostate cancer account for the largest number of cancer deaths among American women and men (American Cancer Society Facts and Figures, 2009). The American Cancer Society reports that in 2009 alone, approximately 40,170 women in the United States were expected to die of breast cancer while 27,360 men were estimated to die of prostate cancer (American Cancer Society Facts and Figures, 2009).

The federal government has played an active role in funding continued breast and prostate cancer research, detection, and treatment efforts since the 1990s; both of these illnesses were largely invisible as issues on the national political agenda until this time. Prior to this time period, there were no public laws on prostate cancer and only three public laws on breast cancer existed. However between 1990 and 2006, 57 federal laws with provisions that specifically targeted these illnesses were passed. These laws included provisions that substantially increased spending on research, prevention, testing, and treatment efforts.

Policymaking on breast and prostate cancers has increased significantly since the 1990’s with the rise of advocacy activity around these illnesses. This surge in advocacy was the result of several different factors. During the 1980’s, increases in

scientific knowledge, combined with increasing numbers of men and women being diagnosed with these illnesses, led to an increase in public awareness. With this increased awareness came the realization that these illnesses were largely ignored on the federal policy agenda. As a result, men and women affected by the illnesses began to coalesce around their shared experiences in order to attract the attention of federal policymakers. Through redefining these illnesses and lobbying on their behalf, these groups sought to influence policies that increased spending on breast and prostate cancers. These groups were not only successful in achieving their specific policy goals, but also in creating social constructions of breast and prostate cancers that redefined the way these illnesses and the persons affected by them were perceived by the public and policymakers.

Purpose and Research Questions

The purpose of this dissertation is to demonstrate how the social constructions of breast and prostate cancers and the people affected by them influenced policymaking on these illnesses from 1990 to 2006. The study period of 1990 to 2006 was chosen because it represents the most active period of time in reference to advocacy activity coupled with policymaking on breast and prostate cancers. The goal of this discussion is to take two similar policy issues and show how their social construction processes influenced the way they moved throughout various phases of the policy process. It is also important to show how social construction impacted the types of policies that were adopted to deal with the illnesses. In exploring the impact of social constructions of breast and prostate cancers on their movement through the

policy process and the policies adopted, five research questions drive this dissertation. These five research questions explore two fundamental aspects of social construction and policymaking: who participates in creating social constructions and how social constructions are created. In particular, I examine the answers to the research questions discussed below.

The first of these questions is related to the role played by advocacy groups. Advocacy groups are composed of policy actors who help advocate on behalf of public issues. Past research has shown that the policy actors in these advocacy groups can play an important function in helping to define issues in ways that attract attention (Bachrach and Baratz 1962; Birkland 2001; Cigler and Loomis 1995; Lowi 1979; Mintrom 1997; Schattschneider 1960; Zahariadas 2003). Those public issues that are backed by advocacy groups or policy entrepreneurs (Kingdon 1995; Mintrom 1997) are the ones that tend to garner more attention. Many significant public issues fail to reach the agenda because they lack a strong base of support.

These actors are important in determining whether or not issues reach the agenda because they help establish a link between how a public issue is defined and a resulting policy decision to be made by government. When these policy actors have considerable amounts of political power and define issues in ways that resonate deeply with the public, they are better positioned to influence policy decision-making (Schneider and Ingram, 1993). To explore the influence of these actors in helping to socially construct public issues, the first research question asks: *How did policy actors attract attention to breast and prostate cancers?*

This research question examines who participates in socially constructing public issues. To that end, this dissertation explores how various types of policy actors defined what were previously regarded as private illnesses into public issues in a way that was attractive to policymakers. I also explore which actors, such as advocacy groups, policy entrepreneurs, and celebrities, helped define and attract attention to these illnesses. In doing so, I also analyze the strategies they used. I also consider how these actors used strategies such as mobilizing support, invoking the use of symbols, attracting media attention, and testifying at congressional hearings to influence the way these issues were defined. An analysis of these various strategies will show the extent to which they influenced breast and prostate cancers on their journey through the policy process.

In looking at the efforts of breast and prostate cancer policy actors, an important factor to consider is the way that gender influenced how these actors advocated on behalf of these illnesses. Gender plays an important role with respect to advocacy efforts on public issues. Men and women play different roles when it comes to the advocacy activities they engage in and the types of issues they support. Past research has shown that in terms of advocacy activity for breast and prostate cancer policy, women tend to be more active when it comes to advocacy, whereas men tend to be more passive (Kedrowski and Sarow, 2007). In terms of the types of issues they support, female policy actors have typically advocated on behalf of health and other social welfare issues such as education. Scholars (Bordin 1981; Foreman 1995) have attributed this phenomenon to the fact that health and general social welfare functions

have traditionally been carried out by women in society. As a result, women are more likely to be knowledgeable and concerned about these policy areas. To explore the influence of gender on the advocacy efforts directed toward breast and prostate cancers, the second research question asks: *How did gender influence advocacy efforts toward breast and prostate cancers?*

To answer this question, this dissertation examines how gender differences impacted advocacy efforts around these two illnesses. The tactics utilized by male and female policy actors are compared to determine if different approaches were employed for each illness. Comparisons between lobbying techniques and types of advocacy groups are analyzed. If differences in advocacy efforts are found, the extent to which those differences influenced policy adoption is considered. Understanding how gender influences advocacy efforts can help understand some of the differences in breast and prostate cancer policies.

In addition to the ways gender influences advocacy efforts, symbols are often used to help define public issues (Stone, 2002). Symbols are an important part of the social construction process because they communicate social meaning and tell us which values are most important in society. Symbols also help us to make connections to public problems. The notion of symbolism in politics has been treated extensively in the policy literature (Edelman 1964; Fishbein and Ajzen 1975; Kinder and Sanders 1990; Stone 2002; Zaller 1992). Symbols are often value-based and attributed to the shared characteristics of public problems and their related groups. Public problems that represent values and meaning that people find important are

often those that receive greater attention. Symbols also evoke emotion and emotional reactions that can drive public support for and attract attention toward issues. Because problems affect people who live in society, government treatment of those problems reinforces that meaning. In exploring how symbols contributed to the social construction of these two public issues, the third research question asks: *What symbols helped socially construct breast and prostate cancers?*

This dissertation explores how symbols contributed to socially constructing breast and prostate cancers. The female breast has attracted attention and is commonly considered to be a powerful symbol of sexuality and motherhood. Although an important part of healthy sexual function in men, the male prostate gland is less commonly recognized as a symbol of male sexuality and fatherhood. The extent to which the popularity of these gender-based symbols attracted attention to these illnesses and influenced policymaking on them are analyzed.

While symbols are a common way to attract attention to public issues, issues can gain attention in many other ways. During the agenda-setting phase of the policy process, issues and alternative solutions compete for attention that sometimes leads to policy adoption. The process of agenda-setting narrows the possible set of public issues that exist in society to a set that is treated by government (Hilgartner and Bosk 1988; Kingdon 1995; McCombs and Shaw 1972). The role that various policy actors played in helping issues gain attention and in defining them can help us to understand how these issues were framed and moved onto systemic and institutional agendas.

Policy actors are often successful in bringing greater visibility to issues by framing them as growing problems for government. Increased newspaper coverage and testimonies provided at congressional hearings also help to attract attention and move these issues onto various levels of the agenda. To understand how these illnesses were defined on different agendas, the fourth research question asks: *How were breast and prostate cancers and their affected populations defined on systemic and institutional agendas?*

It is argued in this dissertation that how these illnesses were defined on systemic and institutional agendas was a crucial aspect of their social construction processes. Often, the perception that a public issue is important can help attract attention. Policy actors assist in socially constructing important public issues by reinforcing such a definition through the news media and congressional hearings (Kingdon, 1995). An analysis of newspaper coverage and congressional hearings demonstrates how each of these illnesses was defined on different agendas.

While definitions of problems on different agendas are an important part of understanding social construction, it is also important to look at the differences between the social constructions of two policy issues. While the same general patterns may emerge when analyzing two similar policy issues, it is unlikely that their social constructions will be exactly the same. Comparisons between policy actor activity, symbols, and definitions of these issues on various agendas help identify differences in the social constructions of breast and prostate cancer. Similarly, it is unlikely that the policies adopted to deal with these two illnesses will be the same. A

comparison between the policies adopted to deal with these two illnesses in terms of policy provisions and federal research funding is critical to our understanding of how social constructions influence the way issues are treated throughout the policy process and in policy decision-making. To determine if differences exist between policies on breast and prostate cancers, the fifth research question asks: *Are there differences in policies addressing breast and prostate cancers?*

This last research question deals with differences in breast and prostate cancer policies. The previous research questions focused on the dimensions that influenced breast and prostate cancer policymaking such as the advocacy efforts of policy actors, the relationship between gender and advocacy efforts, symbolism, and definitions of the illnesses on systemic and institutional agendas. Because breast cancer advocacy seems to be more prominent than prostate cancer advocacy, I expect to find more policies adopted to deal with breast cancer than prostate cancer. It is expected that there will be more policy provisions and federal research funding dedicated to breast cancer than prostate cancer. This dissertation explores if and how the policies addressing these illnesses are different. If differences do exist, various explanations as to why these differences exist are explored.

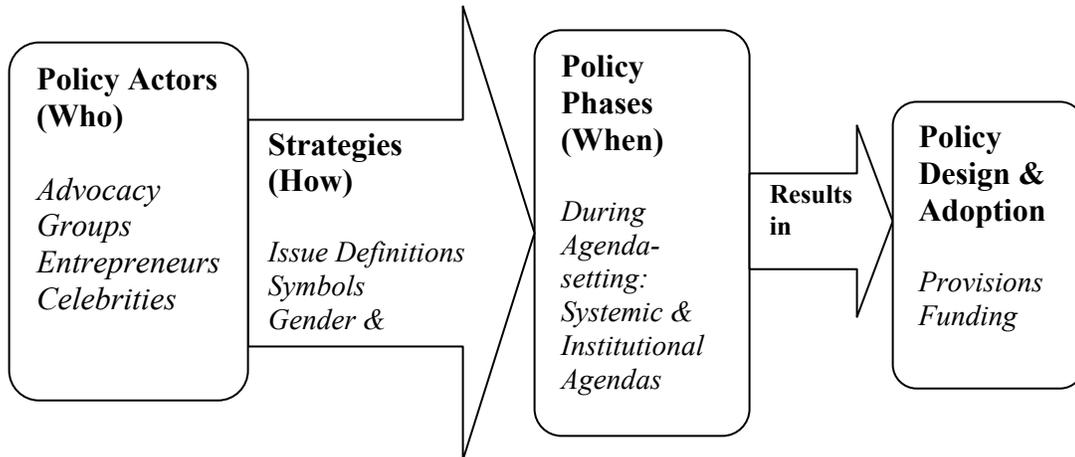
In exploring the answers to these five research questions, I seek to demonstrate how the social constructions of these illnesses and their affected populations influenced how these issues were treated throughout the policy process and in the types of policies adopted from 1990 to 2006. In doing so, I will explore how policy actors attracted attention to these illnesses, how gender influenced

advocacy efforts for these illnesses, the symbolic aspects of the illnesses, and how these issues were defined on systemic and institutional agendas. It also provides a discussion of the factors that influenced variations in policy on breast and prostate cancers. To answer these five research questions, I utilized embedded collective case study and content analysis of newspaper coverage and congressional data to provide empirical evidence that answers these questions. These research questions and subsequent answers help to improve our understanding of how the social constructions of these illnesses influenced policymaking on them.

In order to provide structure to this dissertation, a model was developed to help organize the discussion. This model is shown in Figure 1.1. The purpose of this model is to provide a visual display of the way that social construction influences issues as they move through the policy process, consistent with the arguments made in this discussion. The discussion focuses on two fundamental aspects of social construction: *who* participates in creating social constructions and *how* social constructions are created. The discussion on policy actors focuses on who participates in social construction. Policy actors such as advocacy groups, policy entrepreneurs, and celebrities help socially construct public issues by defining them, using symbols, and through the effects of gender on the various types of advocacy efforts they engage in. These three strategies determine how issues are socially constructed as they move through various policy phases. My discussion focuses on two main phases of the policy process: agenda-setting and policy adoption. The way that these illnesses were defined on systemic and institutional agendas is discussed.

Implementation is considered through an analysis of the various implementation designs identified in policy provisions found in public laws, but is not the primary focus of this discussion. I will analyze the types of policies that were adopted to deal with these issues in terms of the kinds of policy provisions adopted and the amount of research funding that was allocated.

Figure 1.1: Social Construction and the Policy Process



Significance of Research

I believe that this research is significant for a number of reasons. First, it will help improve our understanding of the social construction process and its impact on policymaking. This discussion provides a deeper understanding of how the process

of social construction takes place. Social constructs don't merely exist; they are created by people over time (Berger and Luckmann, 1966). They reflect the values that people in society agree are important at one point in history or over time. Policy inquiries that assume that policy decisions are based on rationality and objectivity discount the role that values play in policymaking (Dery 1984; Guess and Farnham 1989). Nor do they take into account the multitude of normative factors that influence why certain policy decisions are made as opposed to others. The benefit of looking at policymaking from the constructionist perspective elucidates the extent to which a collective interpretation is changeable, as are the values we share as a society.

In this dissertation, I also provide a deeper understanding of the role policy actors play in the social construction process. Social constructions are created by actors who seek to advance certain policy objectives. Social construction theories, such as those advanced by Schneider and Ingram (1993), are powerful in providing a framework to explain that social construction and political power influence policy. Yet, Schneider and Ingram's framework does not account for the ways in which policy actors coalesce around public issues and socially construct them in ways that lead to policy action. Additionally, these scholars do not seek to explain the techniques used by various groups in society to help create these social constructs. I seek to fill this gap in the discourse on social construction by providing a more nuanced and detailed discussion on the activities that policy actors engage in to define and attract attention to policy issues.

The nature of the illnesses considered in this research naturally divides the discussion among gender lines because breast cancer primarily affects women while prostate cancer only affects men. Scholars have shown how gender is important in policymaking (Campbell 2000; Stivers 2002). Considering the role of gender and policy actors might help provide important clues that help identify why breast cancer received greater levels of attention and resources than prostate cancer. I contend that examining gender differences in advocacy activities carried out by men and women and the symbolic nature of the illnesses can help contextualize the social construction of these illnesses and increase our understanding of the policy process. It can also help support or further contribute to past research which has shown that when it comes to advocacy, men and women behave differently (Bordin 1981; Foreman 1995; Kedrowski and Sarow 2007). Women are likely than men to advocate for health and social policy issues and are more likely to engage in different forms of advocacy than men. A detailed discussion on the various activities that breast and prostate cancer advocates engaged in adds to the discourse on this aspect of the policy literature.

Finally, because symbolism plays a large role in socially constructing public problems and gaining attention, the research undertaken in this dissertation contributes to a growing body of literature on symbolic politics. Symbols are a common method through which values that are important in society are expressed (Edelman, 1964). Illnesses that pose threats to parts of the body that affect one's sexuality carry an immense amount of symbolic weight. The symbolic nature of illness and gender in Western culture are an important part of understanding why

breast and prostate cancers have successfully attracted public and political attention. A deeper understanding of how symbols impact the policy process is invaluable to the study of public policy (Stone, 2002).

This dissertation shows how symbols that resonate deeply with the public can attract considerable amounts of sympathy from the public and policymakers. If policy actors utilize symbols to help frame public policies in a way that capitalizes on the emotional connections people have to them, the policy process can be manipulated to influence policymaking in their favor. This dissertation contributes to past research on symbolism by studying the ways in which symbolism plays a role in socially constructing two different policy issues. It also reveals the extent to which the interpretation of a symbol and its associated groups can influence policymaking.

Organization of Dissertation

The remainder of this dissertation is organized into six chapters. Chapter II presents a review of the multiple theories and literatures that serve as the foundation of this research: social construction, policy actors, gender and advocacy, symbolism, and agenda-setting, as well as past research on breast and prostate cancer policy. Chapter III discusses the research design and methodology used to study how these issues moved through the policy process and the types of policies adopted to deal with them. The methods used include embedded collective case study and content analysis of newspaper coverage and congressional data. Chapters IV, V, and VI present the results of the embedded collective case study and content analysis of newspaper coverage and congressional data from 1990 to 2006. Chapter IV provides

background information and discusses the way these illnesses were defined on the systemic agenda. Chapter V discusses the way that breast and prostate cancers were defined on the institutional agenda. In Chapter VI, the policy provisions identified in public laws and funding allocations for research are analyzed to compare the levels of policy attention given to each of these issues in terms of legislation and funding. Chapter VII concludes by discussing study findings, research limitations, and directions for future research.

II. THEORETICAL FOUNDATIONS AND PAST RESEARCH

In order to understand the multidimensional process of socially constructing the illnesses of breast and prostate cancer into policy issues, it is important to first explain social construction and other policy theories that are being used in this dissertation. Because the social construction process is multidimensional and dynamic, several different theoretical streams were integrated to serve as a conceptual foundation to better describe the process. The theories discussed here focus on two basic aspects of the social construction process: who participates in social construction and how social constructions are created.

The five theoretical streams include: social construction, policy actors, gender and advocacy, symbolic politics, and agenda-setting. Theories on the roles that various policy actors play in the social construction process help explain who participates in creating social constructions. Theories on gender and advocacy, symbolic politics, and agenda-setting provide a better understanding of how social constructions are created. It is the goal of this literature review to integrate these theoretical streams in order to provide a strong conceptual foundation related to the substantive policy areas of breast and prostate cancer. Past research on breast and prostate cancer policy is also included in this chapter.

To help better organize the various theoretical streams that I discuss in this dissertation, Tables 2.1 and 2.2 were created. Table 2.1 shows the various theoretical arguments that serve as a conceptual foundation to help understand how social construction impacted policymaking on breast and prostate cancers. In Table 2.2, I provide a discussion of the expectations for breast and prostate cancer policy adoption and processes based on the theoretical arguments advanced in this research.

Table 2.1: Multiple Literature Streams

Literature Stream	Theoretical Arguments
Social Construction	Social construction refers to the ways that society and its competing interests tell stories about public issues and the people affected by those issues (Berger & Luckman 1966; Donovan 2001; Rochefort & Cobb 1994; Schneider & Ingram 1993).
Policy Actors: Advocacy Groups and Policy Entrepreneurs	<p>Various types of policy actors help to socially construct issues and bring attention to them.</p> <ul style="list-style-type: none"> • Advocacy groups help attract attention to public issues (Sabatier & Henkins-Smith 1999; Schattschneider 1960). • Policy entrepreneurs with access to decision makers and resources advocate for public issues to incite policy change (Kingdon 1995; Schneider, Teske, & Mintrom 1995; Zahariadis 2003).
Gender & Advocacy	Women play a larger advocacy role in relation to the issues of health and general social welfare than men because historically these functions have been carried out by women (Bordin 1981; Foreman 1995).
Symbolic Politics	Groups use symbols to help define public issues (Cobb & Elder, 1983; Edelman 1964; Gusfield 1981; Rochefort & Cobb 1994; Stone 2002).
Agenda-Setting	There are four main levels of the agenda that issues must travel through to gain access to policymakers (Cobb & Elder, 1983). How issues are defined is important in identifying how and why issues reach the agenda (Baumgartner and Jones, 1993).

Table 2.2: Expectations of Breast and Prostate Cancer Policies

Literature Stream	Expectations of Breast and Prostate Cancer Policies
Social Construction	The process of socially constructing breast and prostate cancers and their affected groups are likely to influence policymaking on these health policy issues.
Policy Actors: Advocacy Groups and Policy Entrepreneurs	Policy actors such as advocacy groups and policy entrepreneurs are likely to play a significant role in helping to attract attention to breast and prostate cancers. These policy actors can help define breast and prostate cancers and their affected groups into politically attractive public issues to move them through various phases of the policy process.
Gender & Advocacy	Women are likely to advocate differently for breast cancer policy change than men advocate for prostate cancer policy change.
Symbolic Politics	Symbols used by groups and the symbolic value of the female breast itself attracts more attention to breast cancer than the prostate gland will for prostate cancer.
Agenda-Setting	The definitions of breast and prostate cancers on various agendas will help to move these issues through the policy process.

Social Construction and Policy

Social construction is a theory of knowledge derived from social science that considers how social phenomena are created and perceived within a particular social context. Berger and Luckman (1966) argued that knowledge originates in and is perpetuated by social interactions. When people interact, their interaction is based on a shared interpretation of reality. This shared interpretation governs how people think, how they speak, and what behaviors they engage in. When people continually act upon this shared interpretation of reality, it becomes reinforced. Berger and Luckman conclude that our understanding of social phenomena is dependent upon actors in society continually reproducing this pattern of shared interpretation, thus socially constructing reality (Berger and Luckman, 1966). While social construction attracts critics when viewed as a general theory of knowledge, scholars have argued that its greatest contribution to social science is to reveal the contingent and mutable nature of the social reality we live in (Hacking 1999; Pickering 1984; Rorty 1998; Searle 1995).

The contingent and mutable nature of our social reality is the result of a change in certain values. When applied to the study of public policy, social construction helps us understand how values influence decision-making. As opposed to technical approaches to the study of issue definition, social construction focuses on the values and meanings that various issue definitions and solutions convey. The way issues and alternative solutions are defined is often related to social construction

(Rocheffort and Cobb, 1994). Scholars (Easton 1965; Hogwood and Gunn 1984; Rocheffort and Cobb 1994; Wildavsky 1979) have previously discussed the value-based nature of problem definitions. How policymakers conceptualize policy issues and their solutions is an implicit statement about which values are most important in society (Easton, 1965), which is ultimately influenced by the social constructions of issues and solutions.

It is not only the issues and solutions themselves that are significant, but also the groups selected for treatment by government. These groups are identified in the policy literature as targets. Targets are the persons or groups that public policies are intended to serve or influence (Wiseman, 1979). A consideration of policy targets suggests that not only are the social constructions of the issues and solutions themselves important in attracting attention, but also the social constructions of related targets affected by the issue. Some scholars (Cobb and Elder, 1983) argue that issues that reach the policy agenda are those that affect the largest number of people. It has also been suggested that people and groups that convey a positive image often receive government assistance. Cook (1979) argued that “people we like and find attractive and pleasant seem to get more help” (p. 41). Scholars such as Schneider and Ingram (1993) agreed that groups with favorable public images are often the recipients of government aid, but have argued that the amount of political power people and/or groups wield is another important determinant. Schneider and Ingram (1993) argued that groups in society that have the power to control the way issues and

their affected target populations are socially constructed are often successful in reaching the policy agenda and achieving policy goals.

Schneider and Ingram (1997) developed a systematic framework that conceptualizes how political power and social construction are related. Their framework discussed four types of target populations with varying levels of political power and socially constructed stereotypes: *advantaged*, *contender*, *dependent*, and *deviant* groups. The authors also provided examples of groups for each of the four target populations.

Advantaged groups have high levels of political power and support issues that convey positively constructed images. Examples in this group are senior citizens, veterans, business, and members of the scientific community. The *advantaged* groups are the most likely to receive beneficial policy. *Contenders* are politically powerful groups but are often associated with negatively constructed images. At the time of their writing (1997), examples in this group included the rich, big unions, minorities, cultural elites, and the Moral Majority. *Dependent* groups are positively constructed but have relatively little political power. Examples of *dependent* groups are children, mothers, and the disabled. *Deviants* have virtually no political power and are associated with negatively constructed groups such as criminals, drug addicts, communists, flag burners, and gangs. The amount of political power and the strength of the socially constructed image reflect and create a group's ability to frame a specific public problem in a way that is beneficial to them.

Political power and social constructions are important not only in achieving policy goals, but also in influencing the design of public policies. In its simplest definition, policy design refers to the actual content or substance of public policy. Scholars (Alexander 1982; Dryzek 1983; Ingraham 1987; Linder and Peters 1984; May 1991; Mosher 1980; Salamon 1981; Simon 1978; Wolman 1981) have sought to provide a systematic analysis of this phase of policy formulation. Schneider and Ingram (1997) have argued that policy designs are contingent upon the way that policymakers view policy targets and their ability to logically connect those targets to social and political goals.

According to Schneider and Ingram (1997), beneficial policies are often directed toward politically powerful, positively constructed *advantaged* groups while burdensome policies are often reserved for *deviant* groups with little political power and negative social constructions. Enormous expenditures are allocated to *advantaged* groups because policies affecting these groups offer attractive political advantages to policymakers. *Deviant* groups tend to receive burdensome policies that allocate costs to members of this group. Policy for *contenders* tends to allocate benefits that are known only to the targets themselves, while the public is led to believe that policy is more burdensome in nature. This group is often the recipient of policy that involves cost-cutting measures. The language used in federal statutes aimed at *contenders* is ambiguous and vague, making it difficult to determine if policies are designed to be beneficial or burdensome. For *dependent* groups, policymakers want to give the illusion of responsiveness by designing policies that are more symbolic in nature, but

typically do little in terms of providing concrete solutions or resources. Schneider and Ingram attributed this to the fact that *dependent* groups offer few political advantages for policymakers.

The theoretical framework developed by Schneider and Ingram (1997) is a significant contribution to the policy literature because it helps to provide a causal explanation as to why some groups are more advantaged than others and how policies are designed to reinforce those advantages (Schneider and Ingram, 1997). It also helps to negate rational theories about policymaking that do not take into account the normative factors that influence the policy process. Numerous applications of the theory have proved successful in explaining how social constructions and political power influence policy. However, the framework falls short in explaining how groups gain access to political power and how social constructions are created by various groups. This dissertation fills this gap with respect to the social constructions of breast and prostate cancer by examining how these illnesses gained attention and were defined by policy actors to gain access to policymakers.

Social construction theory has been applied to various substantive policy areas. Link and Oldenick (1996) applied the framework to analyze attitudes that White Americans held about racial minorities. The authors argued that white Americans viewed racial minorities as less “hard-working”, “intelligent” and “peaceful”, and had negative views of the issues of equal opportunity and multiculturalism. The authors argued that changing negative social constructions of racial minorities can help counteract racist attitudes.

Hogan (1997) applied Schneider and Ingram's framework to changing social constructions of HIV positive inmates. She illustrated how the overabundance of fear and lack of knowledge about AIDS led to restrictive policymaking when an HIV positive woman and her boyfriend were arrested at a small town prison in 1985. Hogan concluded that the use of the framework was beneficial in identifying a change in the social construction of AIDS from a restrictive to humanistic approach.

Similarly, Donovan (2001) showed how the issue of people with AIDS (PWAs) has been socially constructed in a way that has resulted in significant policy action. His work focused on the role that target group characteristics play in policymaking by utilizing Schneider and Ingram's (1997) framework. In contrast to Schneider and Ingram's argument that target populations with political power and positive social constructions receive beneficial policy, his research showed that target groups with negative public images can be the recipients of beneficial public policy.

Donovan argued that PWAs were initially characterized as either sexual deviants or drug users. His work demonstrated how the negative stereotypes of PWAs changed in 1985 which led to an increase in AIDS legislation. During this time period two significant events occurred that altered the course of AIDS policymaking. In July of 1985, actor Rock Hudson began to speak publicly about his battle with AIDS which generated a considerable amount of media attention. In the same month, the media began covering stories about Ryan White, a young AIDS victim, who was not allowed to attend school because of his illness. Donovan argued that these two public stories helped to generate widespread fear that the illness was a public crisis that

could potentially impact people who did not fit the sexual deviant or drug user stereotypes. Donovan concluded that, when looking at AIDS policy, target population characteristics were not always good predictors of policy action.

Several other authors have experienced difficulty in applying the social construction framework to substantive policy areas. Czech, Krausman, and Borkhataria (1998) applied the framework developed by Schneider and Ingram to the U.S. Endangered Species Act to show how certain types of species receive disproportionate benefits. Political power was measured by the number of advocacy groups that were created to advocate on behalf of the different species. The social constructions of the species were measured through a survey that identified the public perceptions of the various types of animals analyzed. The authors concluded that the framework was useful in helping them determine why certain types of species benefited disproportionately from the policy. However, the authors did discuss the problems they encountered in trying to classify certain species. The most problematic species were reptiles, since some were found to have low social construction and low levels of political power (such as alligators and crocodiles) while other reptiles had positive social constructions/high levels of political power (such as tortoises and turtles).

Schroedel and Jordan (1998) applied the framework to Senate voting records on AIDS policy. From an analysis of 30 Senate roll call votes on AIDS legislation, the authors identified eleven target populations. While the authors did find legislative data to support the theory, their results did not conform to all of the theoretical

expectations suggested by Schneider and Ingram (1997). Much as Czech, Krausman, and Borkhataria (1998) found difficulty in classifying the species into the target populations framework, Schroedel and Jordan found it challenging to apply the theory because of its dichotomous nature (politically weak/powerful and negatively/positively constructed) that left little guidance in regard to the boundaries of those categories. The challenges these authors faced in terms of classifying various target groups were the result of the lack of a collective identity among target groups. This can prove to be a difficult task when policy actors seek to provide a collective definition of a public issue when the groups are so varied.

Policy Actors Play a Role in Social Construction

The social construction of issues and their related groups is often the result of policy actors from various sectors of society helping to construct a collective definition. In the cases of breast and prostate cancers, the relevant policy actors that contributed to the social constructions of the illnesses included advocacy groups and policy entrepreneurs. The media plays an important role in the social construction process, but is not identified as a policy actor in this dissertation. Because the media is often associated with agenda-setting in the policy literature, a discussion on how the media influences social construction can be found in the section on agenda-setting.

Advocacy groups play a crucial role in helping to socially construct public issues through issue definition and agenda-setting. In terms of defining public issues, Schattschneider's (1960) discussion of issue expansion helps explain how groups gain

control over problem definition. Advocacy groups go public with problems through the use of symbols and images that attract public and media attention. In this way, they help to expand the scope of conflict to include a larger audience. Agenda-setting is another avenue whereby advocacy groups can help to socially construct public issues (Andrews and Edwards, 2004). Through various activities, such as public demonstrations and lobbying, advocacy groups bring greater attention to an issue and create a greater sense of urgency. This helps their issue to compete with others for a space on the policy agenda.

Since the early 1990's scholars have noted the proliferation of advocacy groups that advocate on behalf of health policy (Heinz et al 1993; Peterson 1993). Often called grassroots victims' organizations (GVOs) or grassroots survivor organizations (GSOs) these group formations are illness-related social movements. Groups form around a specific long-term illness to advocate on behalf of the illness and its affected populations (Foreman 1995; Kedrowski and Sarow 2007). The illnesses of breast and prostate cancer lend itself to this particular type of group formation. An important aspect of GVOs and GSOs is that they tend to be disproportionately composed of women. The gendered nature of this phenomenon is particularly significant in understanding the differences between breast and prostate cancer advocacy groups.

Advocacy groups utilize the media as a powerful tool to attract attention to a public issue. Utilizing the media can be a quick and effective way to introduce an issue into public dialogue, increasing an issue's chance of making it to the agenda

(Birkland 2001; Graber 2002). Advocacy groups arouse or provoke the news media to devote greater attention to an issue or problem through the use of symbols and images to induce greater media and public sympathy for their causes (Birkland, 2001).

Through this actor interaction, issues are created, dramatized, and gain attention that places them on the public policy agenda (Dye, 2005). The media's representation (either negative or positive) of issues plays an even more significant role in helping to determine the course of policy action (Casamayou, 2001).

When advocacy groups and policy entrepreneurs advocate on behalf of public issues, those issues are better positioned to reach the agenda. Policy entrepreneurs are political actors, either inside or outside of the policymaking process, who promote policy ideas (Mintrom, 1997). These policy entrepreneurs have the ability to exert a considerable amount of influence over policymaking and seek to initiate dynamic policy change (Baumgartner and Jones 1993; Kingdon 1984; Mintrom 1997; Polsby 1984).

Scholars have argued that these policy entrepreneurs resembled economic entrepreneurs in the business world to help explain how they influence policymaking (Mintrom 1997; Salisbury 1969). Much like economic entrepreneurs, policy entrepreneurs spot policy problems, are prepared to take considerable risks to solve those problems, and seek to propose solutions to problems through policymaking.

Policy entrepreneurs must be willing to invest time, energy, reputation, and money to promote their policy goals (Kingdon 1984; Zahariadis 2003). Those that have the greatest access to resources in terms of time, money, and energy have the

greatest potential for success in influencing policy decisions. But resources are but one aspect of policy entrepreneurship. Policy entrepreneurs must develop strategies and network around government to gain access to policymakers (Kingdon 1984; Smith 1991). They gain access by identifying problems, networking in policy communities, and building coalitions. Networking and coalition-building are essential to help build credibility so as to attract the attention of policymakers. Ultimately, this can help them to better achieve their policy goals (Mintrom, 1997). More often than not, policy entrepreneurs are described as exhibiting characteristics that are traditionally masculine. However, since women have come to play a more active role in various public issues it is important to examine how gender influences policymaking.

Gender and Advocacy

From a historical perspective, socially defined gender roles have impacted the behavior of male and female policy actors. Gender is an important way in which individuals experience and perceive social life, influencing how we view ourselves and how we interact with others. Because gender plays such a large role in everyday life, it also influences the policymaking process. Historically, the policy process has been largely influenced by traditionally masculine qualities. Stivers (2002) argued that public administration has historically been characterized by masculine qualities, primarily because men have held more political power than women. Because women have traditionally been responsible for maintaining the domestic sphere, they were distanced from public life and influencing policy. Also a result of women's

experience with domestic responsibilities, women are often knowledgeable and concerned about health policy issues.

From a historical perspective, the trend of women advocating on behalf of health issues dates back to the temperance and social movements during the Progressive Era and extends all the way to the advent of groups like Mothers Against Drunk Driving (M.A.D.D.). In the United States, women have a long history of playing an important advocacy role in relation to the issues of health and general social welfare (Bordin 1981; Foreman 1995; Kedrowski and Sarow 2007). Much of the literature on women and politics concludes that female policymakers are more likely to represent these “women’s” issues and are likely to be more liberal than male policymakers (Carey, Niemi, and Powell 1998; Diamond 1977; Leader 1977). Greater liberalism in policymaking is correlated with women’s experiences in the domestic sphere (Mandel and Dodson 1993; Thomas 1994). The disproportionate role of women in health advocacy groups has been attributed to the social networks that women maintain and their greater responsibility for and sensitivity to health problems (Foreman, 1995). Women also tend to engage in different types of advocacy activities than men, due to the strength of their social networks (Foreman, 1995).

In contrast, the literature on men and health policy tends to focus on their lack of sensitivity to health problems. It has been argued that when compared to women, men tend to be less aware of their health risks and more resistant to seeking medical help (Broom 2004; Cameran & Bernardes 1998; Tudiver & Talbot 1999; Walsh 2000). This can be attributed to traditional masculine notions of men wanting to be

perceived as “strong” and “tough”. Scholars also note that men seem to express less interest in their own health concerns and are less likely to discuss their health problems than women (Broom 2004; Courtenay 2000). When advocating for policy change on health concerns that directly impact themselves, men tend to participate in advocacy activities that are considerably different than women. For example, women are more likely to discuss their health concerns publicly; men are less likely to do so because of their desire to be perceived as healthy and strong.

Symbolic Politics

Gender itself is a culturally constructed symbol that defines how men and women are treated and behave in society, as well as in policymaking. Symbols are an important part of the social construction process because they communicate social meaning and contribute to predominant stereotypes. Symbols are often value-based and are often associated public issues and the groups affected by those issues. The notion of symbolism in politics has been treated extensively in the policy literature (Edelman 1964; Fishbein and Ajzen 1975; Kinder and Sanders 1990; Stone 2002; Zaller 1992).

One of the earliest writers on the use of symbolism in politics was Murray Edelman (1964). He argued that policymakers create an imaginary world for citizens through the use of symbols and defined politics as a “passing parade of abstract symbols” (Edelman, 1964, p. 5). He discussed political dualism by dividing politics into two dimensions: instrumental and expressive. The instrumental dimension represents the rational aspects of policymaking. The expressive dimension represents

an image of policymaking that is created for the public. It is this expressive dimension that helps to connect symbols to social meaning and values.

Gusfield's (1981) research on symbolism reinforces the difference between the instrumental and expressive dimensions of policymaking. His work on symbolism and public problems discussed how myths and symbols become codified into law. His work began by looking at recidivism rates in arrests for driving under the influence. Throughout his interactions with police, offenders, judges, attorneys, academic colleagues, and DMV officials he identified an underlying consciousness regarding the issue of drunk driving. Gusfield argued that public perceptions about drunk driving had more to do with the expressive aspects of arrests for driving under the influence by reinforcing a moral order that symbolizes a "sober society" rather than actually seeking to treat the problem.

The expressive dimension is an important aspect of policymaking because symbols are often utilized to help attract attention to public issues and proposed solutions (Simon, 1983). Symbols attract attention because they have two distinct functions that include cognitive and emotive functions. Symbols are cognitive because they communicate a simple message and emotive because they arouse emotion. Zahariadis (2003) argued that the type of symbol determines how emotive the message will be. For example, higher order symbols that apply to the entire community and are easily recognizable are more likely to make political discourse more emotive than rational (Zahariadis, 2003). Higher order symbols, like the American flag, represent the core of a nation's identity and are more likely to

facilitate policy adoption. Policy is more likely to be influenced by higher order symbols when the public problem is defined ambiguously, making it more vulnerable to political manipulation (Zahariadis, 2003, p 76).

Ambiguity often occurs when symbols come to represent two or more things at the same time. Cobb and Elder (1983) argued that the benefit of ambiguous symbols lies in synchronizing differing values among citizens. When public issues have multiple meanings, visual symbols are used as a simple way to represent complex or ambiguous ideas. Deborah Stone (2002) discussed the use of ambiguity in politics as a necessary tool that helps transform individual intentions into collective results. It also allows policymakers to placate the competing interests of policy actors on various sides of a public issue. She characterized ambiguity as the “glue” of politics because it allows for multiple interpretations of policy language.

A common vehicle that is used to express symbolism is language. Linguistic devices such as narrative stories, synecdoches, and metaphors are often employed to help define public issues. Narrative stories are seemingly simple resolutions to public problems that provide explanations of how the world works. Synecdoches are figures of speech whereby a part represents the whole. Often, policy decisions are made that focus on a part of a problem that does not represent the whole problem. Metaphors are figures of speech where a word is used to describe something else and are important for the purposes of comparing two seemingly unlike things. The use of these linguistic symbolic devices is often essential to helping define public problems in a way that resonates with the public and attracts attention to them.

Issues Reach the Policy Agenda

Symbols help to emotionally connect people to public problems and attract attention. The literature on agenda-setting is concerned with how issues are defined and how they gain attention. In order to reach the agenda, issues must move through multiple levels before they are even considered by policymakers.

Cobb and Elder (1983) discussed four main levels of the agenda that issues must travel through to gain access to policymakers. The first level is the agenda universe and contains all of the possible problems and issues that exist in society. The second level is the systemic agenda whereby all issues that attract public attention and are considered to be a government responsibility travel. In order to reach the systemic agenda, policymakers must believe that many people are aware of the issue, perceive that there is widespread agreement that something must be done about the issue, and be confident that the issue falls under the purview of government authority (Cobb and Elder, 1983). The third level is the institutional agenda, which contains public issues that will be more seriously considered by policymakers. The last level is the decision agenda, which includes the issues that will be acted upon by government (Birkland, 2001). The fewest number of issues actually succeed in reaching the decision agenda; understanding how and why this occurs has been treated extensively in the literature on agenda-setting.

The way in which issues are defined is also important in determining which issues will reach the agenda. Cobb and Elder (1972) discussed how issues can be defined in terms of the number of people affected. They argued that if more people

were affected by an issue then it would be more likely to reach the agenda. Defining problems in a way that shows that many people in society are affected by the problems makes them more likely to reach the agenda. Baumgartner and Jones (1993) argued that a key aspect of agenda-setting is the way that issues are defined. Advocacy groups and the media help to provide definitions of public issues that compete for a place on the policy agenda. To do this, narrative stories and symbolic devices are often used to manipulate the issues (Cobb and Elder 1983; Stone 2002). Hence, new and different issue definitions that arise as a result can promote certain issues to higher prominence on the agenda (Rochefort and Cobb, 1994).

Scholars (Lang and Lang 1972; McCombs and Shaw 1972; Funkhouser 1973; Eaton 1989) have been concerned with the role of the media in agenda-setting. It has been argued that the media influences the agenda through the framing of public issues (Cohen 1963; McCombs and Shaw 1972; Walgrave and Van Aelst 2006). McCombs and Shaw (1972) first discussed agenda-setting through the power of the media to influence which issues reach the agenda. They argued that the more attention a particular issue gets in the media; the more likely it will be to reach the systemic agenda. When the media place an emphasis on certain issues and present them in a positive way, the public may consider those issues to be important ones. Instead of being a passive vehicle for transmitting information to the public, it has been argued the media pursue their own agendas rather than the will of the public (Birkland 2001; Cobb and Elder 1983; Howlett and Ramesh 2003; Kingdon 1995). In this way, the

media is a policy actor that has great power in defining public issues, which contributes to the iterative process of socially constructing issues.

Discussing how policy issues move through various levels of the agendas is an important part of understanding agenda-setting. By analyzing issues at various agenda levels, a clear understanding of why certain issues move throughout the policy process and others don't can emerge. Because the media plays a large role in framing public opinions on various public issues, its influence is often included in the literature on agenda-setting. As it relates to the cases of breast and prostate cancer, an understanding of past research on breast and prostate cancer policy is also important in understanding how these illnesses attracted public and governmental attention.

Past Research on Breast and Prostate Cancer Policy

Prior research on breast and prostate cancer policy has often focused on describing media attention and the advocacy efforts of various groups who have lobbied for increased attention to these illnesses. This section presents a review of the various research studies that discuss the amount of media attention and advocacy activity on breast and prostate cancers.

Numerous studies have examined the role of the media in gaining attention and framing breast or prostate cancers (Clarke 1999; Cho 2006; Corbett and Mori 1999; Foskett, Karran, and LaFia 2002; Hoon 2005; Kedrowski and Sarow 2007; Lantz and Booth 1998). Several of these studies focus on the role of the media in bringing breast cancer to the policy agenda. Corbett and Mori (1999) examined the relationship between medical activities, media coverage, and public events regarding

breast cancer. The authors found that an increase in media coverage of breast cancer in print and television mediums correlated with the number of medical journal articles published. Corbett and Mori argued that their study provides evidence of the ability of the media to communicate to the public in a way that supports the agenda of the scientific community.

Cho (2006) analyzed the content of news story abstracts on breast cancer from major television networks. The author concluded that coverage of prevention, treatment, personal stories, and public policy increased over the 30 year study period. News stories tended to reflect important developments in research while attempting to inform the public through a more personal dialogue. These studies support the idea that the media plays an important role in setting the health policy agenda.

Past research has also focused on the role the media play in helping to frame and define breast cancer. Foskett, Karran, and LaFia (2002) studied articles on breast cancer in popular women's magazines and concluded that the overarching message conveyed was that the illness was one of "individual concern". The authors argued that this message prevented the creation of a collective identity among breast cancer sufferers. Similarly, Lantz and Booth (1998) studied the social constructions of breast cancer sufferers in popular magazines. The authors concluded that the majority of the articles portrayed breast cancer sufferers as young professionals whose lifestyle choices (such as delaying childbirth, using alcohol and tobacco products, using oral

contraceptives, and having abortions) contributed to their likelihood of being diagnosed with breast cancer.

Past research has also focused on the role the media plays in helping to frame and define prostate cancer. Clarke (1999) looked at the messages conveyed on prostate cancer in men's magazines. Findings from the manifest analysis indicated that the primary messages being communicated to men were the importance of early detection and an emphasis on growing incidence of prostate cancer. Findings from the latent analysis indicated that the primary themes included the identification of an ongoing "gender war" against women in terms of the large amount of attention paid to breast cancer, a sense of brotherhood among men diagnosed with prostate cancer, an emphasis on fighting or competing against breast cancer, an emphasis on the gloved finger (a reference to the digital rectal examination), threats to masculinity and sexuality, and lack of celebrity participation. In a similar vein, Hoon (2005) explored the content of articles on prostate cancer and impotence in four magazines with large male readerships. The study concluded that the majority of the articles focused on prevention, diagnosis, and treatment of prostate cancer and impotence.

Kedrowski and Sarow (2007) analyzed the themes portrayed in newspaper articles and television news stories on breast and prostate cancers from 1980 to 1998. Their study found that the primary themes identified in breast cancer coverage included medical discoveries, health education, personality profiles, regulations, and ethics. The primary themes identified in prostate cancer included personality profiles, medical discoveries, health education, and risk. All of these studies support the

argument that the media plays an important role in defining public issues. Given the past importance of the media, I plan to show whether and how the media played a significant role in framing breast and prostate cancers as illnesses that were worthy of governmental attention.

Although the media played a significant role in helping to define these illnesses as important public issues, advocacy groups played a crucial role in defining and attracting attention to these illnesses. Much of the policy literature on these illnesses has focused on the role of breast cancer advocacy. Numerous authors have emphasized the role of breast cancer advocacy organizations in attracting attention and influencing policymaking (Altman 1996; Batt 1994; Boehmer 2000; Cassamayou 2001; Stabiner 1997; Weisman 2002). For instance, Boehmer (2000) discussed political activism around AIDS and breast cancer. Her research looked at political and personal motivations behind women's activism. She argued that the framing of an issue as "personal" or "public" dictates whether or not women mobilize around various public issues. For example, prior to the rise of breast cancer advocacy in the 1990's, breast cancer was framed as a private, personal issue. Breast cancer advocates were successful in publicizing the issue and making it more political, eventually leading to effective group mobilization.

Weisman (2002) discussed how breast cancer policymaking was the direct result of breast cancer advocacy organizations that brought public attention to the issue. She also noted the political context of the time period, which was an appropriate environment for bringing women's health issues to the agenda. She

argued that the breast cancer policy initiatives of the 1990's would not have occurred without advocacy organizations such as The National Breast Coalition and The Susan G. Komen Breast Cancer Foundation. Casamayou (2001) traced the emergence of activism around breast cancer in the 1990's. Her work explored the creation of the National Breast Cancer Coalition (NBCC) and argued that the collective entrepreneurialism of this organization was a key factor in the positive framing of breast cancer policy.

Kedrowski and Sarow (2007) compared breast and prostate cancer advocacy efforts through content analysis of media coverage. They argued that, by and large, breast cancer advocates have been far more successful in publicizing the issue and achieving their policy goals than prostate cancer advocates. They characterize prostate cancer advocates as "reluctant champions that were able to piggyback on some of the successes of breast cancer advocates" (p. 200). The authors attributed the successes of breast cancer advocates to women's history of political activism, their political efficacy, breast cancer's high profile in various media outlets, the public face of breast cancer as being "younger" and "more tragic" than prostate cancer, the willingness of breast cancer survivors to publicly tell their stories, and the ability of advocates to attract corporate sponsors.

The study conducted by Kedrowski and Sarow (2007) was the only study in the academic literature that compared media attention and policy actor activity on breast and prostate cancers. Their study differs from the research in this dissertation in that it primarily focuses on the role the media played in defining these issues and

gaining public attention. This dissertation takes a more comprehensive approach by integrating social construction theories along with several other theoretical streams to help show how breast and prostate cancers were defined, how they gained attention, and how related groups were characterized that influenced policy adoption.

Conclusion

This chapter discussed several streams of literature that serve as a conceptual foundation to help understand how breast and prostate cancers were socially constructed into policy issues. Because of the complex nature of the social construction process, multiple theoretical streams were needed to help clearly illuminate the various elements that are involved in that process. These theoretical streams are correlated with the five research questions asked in this dissertation and help provide answers to those inquiries. The theoretical streams summarized in this chapter included: social construction, policy actors, gender and advocacy, symbolic politics, and agenda-setting. The theories discussed in this chapter focused on two primary questions about the social construction process: who participates in social constructions and how social constructions are created. Theories on policy actors help describe who participates in the social construction process. Theories on gender and advocacy, symbolic politics and agenda-setting describe how social constructions are created. Previous research on breast and prostate cancer policy was also discussed. The next chapter of this dissertation focuses on the research design and methodology used to answer the previously stated research questions.

III. RESEARCH DESIGN AND METHODOLOGY

The previous chapter provided the conceptual foundations upon which this dissertation relies to analyze how social construction impacted breast and prostate cancer policymaking. The purpose of this chapter is to provide an explanation of the research design and methodology used to answer the research questions asked in this dissertation. These research questions ask how policy actors attracted attention to these illnesses, how gender influenced advocacy efforts for these illnesses, how symbols influenced the amount of attention these illnesses received, and how these issues were defined on systemic and institutional agendas. The last research question analyzes the factors that influenced variations in policies adopted for breast and prostate cancer.

To that end, this chapter is organized into four sections that detail how this study was conducted and why specific procedures were chosen to answer those research questions. In the first section, the use of embedded collective case study analysis is discussed. In the second section, an explanation of why content analysis was chosen to analyze the selected data is provided. These two methodologies were selected because they allow for a healthy balance of breadth and depth to answer the research questions. In the third section, the type of data used in this study along with the data collection procedures that were used to gather the data are examined. In the

last section, a detailed discussion is provided on how the data were analyzed through the use of embedded collective case study and content analysis.

Embedded Collective Case Study Analysis

As defined by Stake (1986, p. xi), a case study is the study of the particularity and complexity of a case, coming to understand its activity within important circumstances. Stake (1986, p. 3-4) discussed three different purposes for using case study analysis. An intrinsic case study is conducted when the researcher is seeking a better understanding of a particular case. An instrumental case study is undertaken when the researcher intends to provide insight into a theory. A collective case study approach is used to study several cases in order to provide a better understanding of particular phenomena. In this dissertation, I chose to utilize the collective case study approach because I wanted to compare how the social constructions of two similar policy issues influenced policymaking for each of those issues. Stake (1998) characterizes this approach as an “instrumental study extended to several cases” (p. 89). I opted to use this approach because I wanted to get to a comprehensive understanding of how two issues were treated in the policy process by analyzing them through a social constructionist lens. While other methodologies may allow for a comparison of multiple cases, the collective case study allows for the understanding of multiple cases while providing insight into theory.

Case study methodology is particularly useful in this dissertation because it illuminates a decision or set of decisions that refer to questions of “how” and “why” (Shramm 1971; Yin 2003). The “how” being explored in this dissertation relates to

the ways in which breast and prostate cancers were socially constructed from private illnesses into public issues. The “why” being explored refers to the policy objectives that various policy actors sought to achieve by socially constructing these illnesses into public issues that required government intervention.

Embedded case study analysis refers to a case study that contains more than one unit of analysis (Yin, 2003). In this study, these units of analysis are the cases of breast and prostate cancer. This method is appropriate to use because this dissertation uses two cases to make inferences about the process of social construction. The embedded collective case study design integrates quantitative and qualitative methods into a format which allows for a more detailed research inquiry (Scholz and Tietje 2002; Yin 2003).

In this study, the case study narrative was integrated with content analysis performed on newspaper and congressional data to help illuminate the process of socially constructing breast and prostate cancers from private illnesses into public issues. Embedded collective case study is the most appropriate method to utilize for the purpose of integrating multiple sources of evidence into a format that allows the reader to understand each case as a whole unit in its realistic context (Scholz and Tietje, 2002). Combining multiple information sources, such as newspaper headlines, congressional hearings testimonies, and public laws, can also provide more descriptive answers to the research questions. Few research designs allow for the same level of cohesion, breadth, and depth. Because this dissertation takes a holistic approach to depict the way that social construction influences policymaking, a

methodology that allows for the integration of multiple information sources along with the aforementioned elements was considered extremely important.

Content Analysis

While embedded collective case study analysis allows for cohesion, breadth, and depth in understanding how social construction impacted breast and prostate cancer policy, a method that allowed for more detailed data analysis was also considered important. Content analysis is the study of written and verbal texts. Because texts are composed of words and concepts, they contain meaning and communicate messages. In order to make inferences about those meanings, researchers look for patterns in the relationships between words and concepts to identify the messages that are conveyed (Babbie, 2004). Content analysis was selected for use in this research because it can be used to provide more specific analysis of the data. This analysis can then be used to provide empirical evidence to help answer the research questions asked in this dissertation.

Content analysis is also a commonly used research method in the social sciences. It can be defined simply as the study of recorded human communication (Babbie, 2004). Some of the various forms of recorded human communication or documents that are suitable for content analysis include magazines, newspapers, books, websites, laws, congressional hearings, and many others. Research inquiries that seek to answer questions such as “who says what, to whom, why, and with what effect?” are particularly well-suited for content analysis (Babbie, 2004).

Content analysis is generally conducted in several steps (Neuendorf, 2001; Babbie 2004). The first step involved is to determine which content will be analyzed and why. The second step involves creating variables for study. The third step is to develop conceptual and operational definitions for the variables that have been selected. The fourth step requires the selection of a study sample to be used in the research inquiry. The fifth step requires the creation of a coding scheme. Coding is the process of transforming raw data into a standardized form (Babbie, 2004). Because coding is subject to the researcher's interpretation, clearly defined conceptual and operational definitions are essential so the reader can follow the process undertaken by the researcher. If a researcher plans to analyze data quantitatively, the coding operation must be numerical and amenable to data processing. The last step involves final data analysis and reporting of results (Babbie, 2004). Following the six step method helps to better establish validity and reliability in coding.

Validity refers to how well a measure adequately measures what it is intended to measure. Different approaches to coding can help to ensure that careful attention is paid to reliability and validity. Manifest content analysis deals with coding for the visible, surface content located in the text. This type of coding is similar to what can be achieved by using a standardized questionnaire to obtain data. The benefit of manifest content analysis is that it allows for ease and reliability in coding by letting the reader know precisely how variables are measured. While reliability is easily

achieved by coding for manifest themes, validity is harder to determine (Denzin and Lincoln, 1994).

Latent content analysis reveals the underlying meaning of a text, rather than the more recognizable themes revealed through manifest coding (Lupton, 1992). While validity is easier to achieve in latent content analysis, reliability is a greater issue. Several methodologists argue that the best way to deal with the issues of reliability and validity is to use a combination of both manifest and latent coding schemes (Babbie 2004; Denzin and Lincoln 1994).

There are numerous advantages to using content analysis. The primary benefit of utilizing content analysis for research inquiries is that it can be efficient in terms of time, money, and safety (Babbie, 2004). Content analysis also allows researchers to carry out an inquiry over a period of time, given that data is available to the researcher. Content analysis is considered to be an unobtrusive research method in that it has little to no effect on the subject being studied. However, Babbie (2004) also points out that major disadvantages to using content analysis include limiting researchers to previously recorded human communication and the fact that researchers are in danger of exercising high levels of bias when analyzing data.

Data Collection

In this dissertation, data were collected from relevant literature, major national newspapers, congressional hearings, public laws, and federal research funding reports, from 1990 to 2006. This time period was chosen because it represents the most active period of policy actor activities combined with policymaking. The early

1990s marked the beginning period of time when breast and prostate cancers became prominent and salient issues on systemic and institutional agendas. I chose to end the study period at the year 2006 because that was the congressional session that had concluded when this research study began. This section is organized into five subsections that include: policy actors and advocacy organizations, newspaper coverage, congressional hearings, public laws, and federal research funding.

Policy Actors and Advocacy Organizations

Policy actors play an important role in the social construction process by helping to define issues and attract attention to them (Bachrach and Baratz 1962; Birkland 2001; Cigler and Loomis 1995; Lowi 1979; Mintrom 1997; Schattschneider 1960; Zahariadas 2003). In order to analyze the role that various policy actors played in socially constructing breast and prostate cancers, I selected the most relevant people and advocacy organizations that I came across in the literature. I then categorized the actors and advocacy organizations to show distinctions for each category and illness. Policy actors were divided into four main categories: *celebrities*, *medical professionals*, *advocates*, and *policy entrepreneurs*. These policy actors emerged as those who were critically important, as seen from prior policy research and from the data analysis of congressional hearings that was undertaken. Also, the advocacy organizations most instrumental in attracting attention to these illnesses were identified in the literature and congressional hearing analysis. Their selection was based on the years in which the organizations were founded and whether or not those dates preceded or coincided with the study period of 1990-2006. These

advocacy organizations were divided into four main categories based on their primary activities: *fundraising/research*, *support*, *lobbying*, and groups that serve to meet the needs of *specific populations* (i.e. *African-American breast cancer victims*). The categories are listed in Table 3.1.

Table 3.1: Breast and Prostate Cancer Policy Actors and Advocacy Organizations

Policy Actors	Advocacy Organizations
<i>Celebrities</i>	<i>Fundraising/research</i>
<i>Medical professionals</i>	<i>Support</i>
<i>Advocates</i>	<i>Lobbying</i>
<i>Policy entrepreneurs</i>	<i>Specific populations</i>

Newspaper Coverage

Through the efforts of these various policy actors public issues attract public attention and move from the agenda universe to the systemic agenda (Cobb and Elder, 1983). In order to understand how breast and prostate cancers gained public prominence, I first looked at newspaper headlines on breast and prostate cancers in *The New York Times* and *The Washington Post* from 1990 to 2006. I analyzed newspaper headlines in these two newspapers to identify the various ways these two illnesses were defined on the systemic agenda. Although various media such as newspapers, periodicals, television, and the Internet are often utilized by advocacy groups as ways to help bring attention to issues, this dissertation focused only on

national newspaper coverage to understand its role in helping to define breast and prostate cancers as public issues. National newspaper sources are important in performing an agenda-setting function because they can help attract considerable amounts of attention to public issues (Eaton 1989; Funkhouser 1973; Lang and Lang 1972; McCombs and Shaw 1972) Because other media sources have not been shown to have as great an impact on an issue's ability to move onto the agenda, this research focused solely on newspapers (Baumgartner and Jones, 1993).

National newspapers such as *The New York Times* and *The Washington Post* were selected because of their scope in coverage of national public policy issues. Studies such as those conducted by Baumgartner and Jones (1993) and Donovan (2001) also utilized major national newspapers to analyze media attention given to various substantive policy issues. Baumgartner and Jones (1993) argued that national newspapers, such as *The New York Times*, adequately represent media trends on these issues because they tend to cover government actions more carefully than other newspapers (p. 295). Major newspapers such as these are also generally considered to be more complete in their coverage of national public issues and are intended to appeal to a mass audience.

Newspaper headlines on breast and prostate cancers found in *The New York Times* and *The Washington Post* during the selected study period were obtained using the LexisNexis Academic database. Headlines from these two newspapers were identified through a keyword search of the terms "breast cancer" or "prostate cancer". Utilizing these search parameters, 635 headlines were included in the final analysis.

After the sample of headlines was collected, each one was read and coded by the author into an Excel spreadsheet. A full listing of the headlines included in this analysis can be found in Appendix A.

In this research, only the headlines of feature articles were included in the final sample. Newspaper headlines were chosen for analysis because they easily summarize and draw attention to the information presented in the article (Andrew, 2007). The headline helps the reader to form a preliminary opinion about the particular topic and was considered the most relevant aspect of newspaper coverage to be considered for analysis. Other studies have used a similar technique for coding newspaper headlines (Andrew 2007; Neuendorf 2005). I was primarily looking to get a sense of the various patterns in newspaper reporting to understand which topics or themes were covered most frequently to help answer my research question.

Editorials, letters to the editor, book reviews, and question & answer pieces, were excluded from the final study sample because they are primarily opinion pieces.

Feature articles are considered to contain the information that newspaper editors find most “newsworthy” and appealing to their readers’ desire to be informed about issues of national concern. Although these opinion pieces matter a great deal in understanding which issues the public finds important, I was more interested in how these illnesses were portrayed in feature headlines only. Because this dissertation seeks to understand how breast and prostate cancers were defined on the systemic agenda, I did not feel that articles that were opinion or editorial pieces would be directly relevant to my purpose. I followed a methodology utilized in similar studies

of social construction and its impact on policymaking, such as the research conducted by Mark Donovan (2001). His study also focused on feature articles found in major newspapers.

Congressional Hearings

After public issues gain prominence on the systemic agenda, some of them move to the institutional agenda where public issues are seriously considered by policymakers (Cobb and Elder, 1993). During congressional hearings, policymakers come to understand public issues through the various definitions of public issues that are provided by witnesses. Scholars such as Baumgartner and Jones (1993) as well as Donovan (2001) have also analyzed congressional hearing data to determine how issues are defined on the institutional agenda. The definitions of breast and prostate cancers provided by witnesses in congressional hearings that took place from January 1, 1990 to December 31, 2006 were identified through content analysis. The 16-year time period was chosen for study because it represents the most active period of congressional hearing activity on breast and prostate cancers.

Testimonies provided by witnesses at congressional hearings from January 1, 1990 to December 31, 2006 were identified using the LexisNexis Congressional database. From this search, 111 congressional hearings on breast and prostate cancers were included in the study population. Once the population of hearings was identified, the transcript of each hearing was read by the author to identify testimonies related to the search terms “breast,” “breast cancer,” “prostate” and “prostate cancer.” A complete listing of the hearings analyzed can be found in Appendix B. From the

111 total hearings in the study population, 464 oral testimonies were identified. Oral testimonies provided by congressional witnesses that focused specifically on the subject of breast and/or prostate cancers were included in this research. General opening remarks, written testimonies submitted to the record, and research articles were excluded from the final population. Based on my coding scheme, it was determined that these sections of the hearings were not relevant in analyzing the ways in which these illnesses and their related groups were defined during the actual hearing itself. Given that the main focus of this dissertation centers on analyzing the way these illnesses were socially constructed by congressional witnesses, I determined that these sections were not directly relevant.

Public Laws

To understand the policy adoption phase of the policy process, I looked at policy provisions in public laws on breast and prostate cancers to determine if the patterns of social construction identified in the previous sections of the case study were reflected in federal law. Information on public laws was obtained using the LexisNexis Congressional database. All public laws passed between 1990 and 2006 that contained the keywords “breast”, “breast cancer”, “prostate”, and “prostate cancer” were identified. The search identified a total 57 public laws that were catalogued by year and public law number in an SPSS spreadsheet. A complete listing of the laws analyzed in this research can be found in Appendix C. After each law was identified and catalogued, the text of each law was read to locate and identify provisions in each law that singled out breast and prostate cancers.

In this research, a policy provision was defined as a section of a law that provided for a specific intervention (i.e. creating new institutions, new funding initiatives). In order to be considered as a provision, the language used in the corresponding statute needed to mention a specific intervention that directly related to either breast cancer, prostate cancer, or both. This same technique was used by Donovan (2001) to analyze policy provisions on AIDS.

Federal policy that is written into public law sends messages to the greater society about which public issues fall under the responsibility of government (Schneider and Ingram, 1997). Also, different populations receive different messages from policy. Some populations receive messages that encourage them to engage in policy debates on a public issue utilizing various modes of political participation, while others are discouraged from participating (Schneider and Ingram, 1997). Through the passage of these laws, social constructions of various public issues become institutionalized.

Federal Research Funding

Another important aspect of policy adoption is the amount of federal research funding that is allocated to solve public problems. To that end, I compared resource allocation of federal funds for breast and prostate cancer research from 1990 to 2006. This analysis compared the levels of federal funding for both breast and prostate cancer research in constant dollars by year and organization (ex. National Cancer Institute or Department of Defense) to show the differences in research funding between these two illnesses.

An important factor to analyze in comparing policy responses to breast and prostate cancers is to look at funding levels dedicated to research for the selected study period of 1990 to 2006. The amount of money that is appropriated to various target groups in policy makes an implicit statement about how government perceives these groups (Schneider and Ingram, 1997). To that end, data on resource allocation for this 16-year time period were collected from the National Cancer Institute and the Department of Defense, the two primary agencies that receive funding for breast and prostate cancer research. These are the two primary agencies that receive federal aid to conduct research and establish programs for breast and prostate cancers. Funding data were analyzed to compare differences in resource allocation for research between these two health policy issues to demonstrate differences in the treatment of these two issues by government.

Data Analysis

This section provides an explanation of the various analyses that were performed on the data discussed in the previous section. For each phase of content analysis, a combination of inductive and deductive approaches was used to identify the messages conveyed throughout the various texts analyzed following the six step procedure that was previously discussed. As in most research undertakings, “theory and research interact in a never-ending alternation of deduction, induction, and deduction, and so forth” (Rubin and Babbie, 2008, p. 55).

Some categories were identified for manifest content analyses before the review and coding process actually began. These preliminary categories were

identified by reviewing other studies that conducted similar research on breast and prostate cancers. The preliminary categories were also based on my own assumptions about what kind of themes I thought I would find throughout the texts. For example, I was pretty confident that many of the newspaper articles about these illnesses would be concerned with cause and treatment. I would expect this same result if I were reviewing newspaper articles about any type of illness. From my review of the policy literature, I expected some themes to be important such as gender and advocacy. However, some themes that were not commonly discussed in the policy literature were identified, such as comparisons with other illnesses.

However, as I began to spend more time with these texts I discovered additional variables that I had not initially considered. For example, when reading through the newspaper articles I expected to find more articles on celebrities being diagnosed with breast cancer than prostate cancer. I had little awareness of well-known celebrities who had been diagnosed with prostate cancer, but was more familiar with celebrities with breast cancer. But as I performed more in-depth analysis of the data, these patterns were consistently identified and included in the final analysis. I approached the congressional hearing and public law coding process in this same fashion, using a combination of inductive and deductive approaches.

Content Analysis of Newspaper Coverage

Newspaper headlines were analyzed to show how breast and prostate cancers were defined on the systemic agenda that includes major national newspapers such as *The New York Times* and *The Washington Post*. This analysis examined the manifest

themes presented in selected newspaper headlines on breast and prostate cancers from January 1, 1990 to December 31, 2006. A complete listing of these headlines can be found in Appendix A. Headlines were coded in two steps to help better understand the role of newspaper coverage in defining and attracting attention to breast and prostate cancers. In step one, newspaper headlines were coded for tone. In step two, newspaper headlines were coded for content.

First, the tone of each newspaper headline was analyzed. The categories used for coding the tone of newspaper headlines included: *positive*, *negative*, or *neutral*. I opted to code newspaper headlines for tone because I was interested in analyzing the feeling/s that each headline conveyed to readers. Although the tone of a newspaper headline is highly subjective, I tried to make the codes as clear as possible so that they would be readily apparent to all readers. Other scholars (Baumgartner and Jones 1993; Donovan 2001) have used a similar coding technique for analyzing the tone found in newspaper coverage of public issues.

Newspaper headlines were categorized as *positive* if feelings of optimism or hope were conveyed. The main feelings I was looking to capture were a sense that something was being done about these problems and that a solution existed. Articles with *positive* headlines typically reported on the development of new treatments and/or drugs, provided a story of a breast or prostate cancer survivor, discussed advocacy efforts, or contained generally favorable comments. Some examples of article headlines that were categorized as *positive* included: “New Drug Holds Promise for Type of Breast Cancer” (Pollack, 2006), “Colin Powell Has Surgery for

Prostate Cancer; Doctors Predict Complete Recovery” (Kessler, 2003) and “Effective Lobbying Increases U.S. Funds for Breast Cancer Research (Effective Lobbying Increases U.S. Funds for Breast Cancer Research, 1992)”.

Newspaper headlines were coded as *negative* if they expressed a feeling of pessimism or impending doom. The main message conveyed in *negative* headlines was that these illnesses were becoming greater problems that required attention. Articles with *negative* headlines reported problems or obstacles with treatments and/or screening tests, increasing incidence of diagnoses, unfavorable comments, and/or confusion about cause and treatment. Some examples of headlines of articles that were categorized as negative included: “Prostate Cancer Test Questioned: Researchers Say PSA Screening Yields Many False Results (Prostate Cancer Test Questioned: Researchers Say PSA Screening Yields Many False Results, 2005)”, “Researcher Falsified Data in Breast Cancer Study (Altman, 1994)”, “Little Progress on War on Breast Cancer, Survival Chances Only Scarcely Better After Decades of Research (Brown, 1991)”.

Article headlines were coded as *neutral* if no discernible tone could be identified in the headline. If articles included both *positive* and *negative* tones, they were categorized as neutral. Some examples of headlines of articles that were categorized as *neutral* included: “M.R.I. Screening for Breast Cancer (Michaels, 2004)” and “The Facts on Prostate Cancer (Samuel, 1994)”.

In the next phase of analysis, newspaper headlines were coded by content to detect discernible patterns in coverage of breast and prostate cancers. Consistent with

the theoretical streams discussed previously in Chapter II, two manifest themes were identified from the study population of newspaper headlines. These included headlines that dealt with social construction and advocacy and headlines that were disease-related. Headlines that were related to social construction and advocacy emphasized aspects of these illnesses that helped to define or characterize them as issues. Examples of headlines related to celebrities who were suffering from one of these illnesses, advocacy efforts of various advocacy organizations, or biographical stories of a person's experience with breast or prostate cancer. Headlines that were disease-related emphasized aspects of the disease such as treatments, medications, or the results of research studies. From these two manifest themes, twelve sub-themes were identified. The sub-themes that are linked directly to social construction and advocacy include: 1) a focus on the causes of either breast or prostate cancers (*cause*), 2) a discussion of advocacy efforts/political involvement (*advocacy*), 3) stories of individuals or loved ones dealing with illness (*stories*), 4) an emphasis on growing and/or sizable incidence (*incidence*), 5) a discussion related to screening/testing (*screening*) 6) mentions of celebrity (*celebrity*), 7) issues related to gender, race, and ethnic disparity (*disparity*). The theoretical linkages will be discussed in greater detail throughout the rest of the analysis. The sub-themes that are disease-related include: 8) issues related to treatment and care (*treatment*), 9) advocating early detection (*early detection*), 10) issues regarding side effects of treatment and care options (*side effects*), 11) comparisons to other diseases (*comparisons*), and 12) disadvantages to

early detection (*disadvantages*). Table 3.2 presents the coding categories of thematic content found in the selected newspaper headlines.

Table 3.2: Coding Categories in Content Analysis of Newspaper Headlines

<i>Social Construction Related Content</i>	<i>Disease- Related Content</i>
<i>Cause</i>	<i>Treatment</i>
<i>Advocacy</i>	<i>Early detection</i>
<i>Stories</i>	<i>Side effects</i>
<i>Disparity</i>	<i>Comparisons</i>
<i>Incidence</i>	<i>Disadvantages</i>
<i>Screening</i>	
<i>Celebrity</i>	

Content Analysis of Congressional Hearings

The next phase of the content analysis examined legislative activity on breast and prostate cancers to provide evidence of how these illnesses were defined on the institutional agenda. A complete listing of these hearings can be found in Appendix B. Coding of the congressional hearing data took place in four steps to demonstrate how breast and prostate cancers were socially constructed by witnesses. These steps included identifying: a) the types of witnesses, b) the various rationales provided for policy change, c) the policy solutions proposed, and d) the population types that were discussed. After the study population of hearings was coded according to the categories outlined in the various steps, the data were entered into SPSS spreadsheets to allow for ease in analysis.

The first step of coding focused on categorizing the various types of witnesses that testified at congressional hearings. The coding scheme included dividing witnesses testifying into four main groups: members of Congress (*congress*), advocates (*advocates*), celebrities (*celebrity*), and medical professionals (*medical*). This step is outlined Table 3.3.

Table 3.3: Witness Categories in Content Analysis of Congressional Hearings

Witnesses
<i>Congress</i>
<i>Advocates</i>
<i>Celebrity</i>
<i>Medical</i>

Step two identified the rationales provided by the various groups of witnesses in support of breast and prostate cancer policy change. These rationales were significant because they demonstrated the various perspectives that were used to define these illnesses, not only to policymakers but to the public-at-large. These rationales ultimately served to help legitimate the decisions made by policymakers. Of the various rationales, five main ones emerged in support of policy change on breast and prostate cancers: emphasizing a growing and/or sizable incidence (*stories of decline*), telling personal stories of one’s own or someone else’s experience (*personal stories*), emphasizing the burden placed on families (*family*), warnings that everyone is potentially impacted (*everyone*), and a focus on the burden placed on society (*burden*). Often, the *story of decline* rationale provided by witnesses was

consistent with Stone’s (2002) *story of decline* policy narrative. The story of decline follows the “things were bad, now they have gotten worse, and something must be done” narrative. This step is outlined Table 3.4.

Table 3.4: Codes for Witness Rationales in Content Analysis of Congressional Hearings

Rationales
<i>Stories of Decline</i>
<i>Personal Stories</i>
<i>Family</i>
<i>Everyone</i>
<i>Burden</i>

The analysis presented here is a list of the rationales provided by witnesses that were mentioned per hearing. As I read through the congressional testimonies, there was a notable lack of consistency amongst them. It was often the case that some witnesses provided no rationale for policy change at all, as in the case of researchers presenting the results of scientific studies. Sometimes, witnesses provided more than one rationale in a single testimony. In this case, each rationale was counted by hearing rather than by frequency. Rationales that were included in the final count were mentioned at least once in a hearing. If a rationale was mentioned more than

once in a hearing then it was still only counted once. For this reason, the total number of rationales provided (N=435) was less than the total number of testimonies (N=464).

In the third step of coding congressional hearing data, I analyzed the policy goals that witnesses were requesting from policymakers. Policy goals represent the key objectives policy actors hope to achieve through the passage of public policy. Policy goals were included in the content analysis so as to compare the desired goals to the actual policy provisions that were identified in public laws.

The coding scheme included dividing policy goals into five main groups in testimonies related to breast cancer: requests that more resources be allocated for research (*research*), requests that more resources be allocated to improve testing and early detection methods (*testing*), requests for changes to Medicare in terms of coverage for testing and treatment (*Medicare*), appeals to alter insurance coverage for treatment and the consideration by insurers of alternative treatments (*insurance*), and requests for changes to guidelines on silicone breast implants (*regulatory*).

The coding scheme included dividing policy goals into five main groups in testimonies related to prostate cancer: requests that more resources be allocated for research (*research*), requests that more resources be allocated to improve testing and early detection methods (*testing*), requests for changes to Medicare in terms of testing and treatment (*Medicare*), the consideration of alternative treatments (*treatment*), and more programs to increase awareness and education of prostate cancer (*awareness*). This step is outlined Table 3.5.

Table 3.5: Policy Goals in Content Analysis of Congressional Hearings

Breast Cancer Policy Goals	Prostate Cancer Policy Goals
<i>Research</i>	<i>Research</i>
<i>Testing</i>	<i>Testing</i>
<i>Medicare</i>	<i>Medicare</i>
<i>Insurance</i>	<i>Treatment</i>
<i>Regulatory</i>	<i>Awareness</i>

In the fourth part of the coding, I looked at the population groups that congressional witnesses referred to in their testimonies by counting the mentions of the population groups per hearing. For example, if military personnel were mentioned multiple times in one hearing I only counted it as one mention. Population groups mentioned in congressional hearings were included because various groups carry specific social constructions. An important part of socially constructing these illnesses and achieving desired policy goals was linking them to population groups that have a positive social construction (Schneider and Ingram, 1997). The coding scheme divided these populations into nine groups. This step is outlined Table 3.6.

**Table 3.6: Codes for Population Groups and Target Populations in Content
Analysis of Congressional Hearings**

Population Groups	Target Population Types
<i>Over 40</i>	<i>Advantaged</i>
<i>Family</i>	<i>Contender</i>
<i>Minorities</i>	<i>Dependent</i>
<i>Underserved</i>	<i>Deviant</i>
<i>Patients</i>	
<i>Military</i>	
<i>Congress</i>	
<i>Affluent</i>	
<i>Federal employee</i>	

It is important to note that it was often the case that several different types of population groups were discussed in one testimony. Many groups were defined with reference to one or more characteristic such as “African-American women over age 40”. As such, the total number of population groups mentioned (N=693) exceeded the total number of testimonies (N=464). The population groups included in this analysis were coded based on whether a particular group was mentioned as being affected by breast and/or prostate cancer in a single hearing. If a population group was mentioned more than once in a single hearing, it was only counted once.

These nine population groups included: 1) persons over the age 40 which is the acceptable screening age for breast and/or prostate cancer (*over 40*), 2) mentions of family and/or family members (*family*), 3) minority groups to include African-

Americans, Hispanics, Native-Americans, Asians, and general use of the term minority (*minorities*), 4) descriptions of underserved populations that included low income, uninsured, unemployed, uneducated, migrant workers, and urban/rural groups (*underserved*), 5) the term “patient” used to refer to those suffering from breast or prostate cancer (*patients*), 6) active or retired military personnel (*military*), 7) members of Congress (*Congress*), 8) references to the affluent and upper class (*affluent*), 9) federal employees (*fedemploy*).

Once these ten population groups were counted, they were further categorized into the four target population types identified by Schneider and Ingram (1997) to include: groups with positive social constructions/political power (*advantaged*), groups with negative social constructions/political power (*contenders*), groups with positive social constructions/low political power (*dependents*), and groups with negative social construction/low political power (*deviants*).

The nine groups were categorized in this way to identify whether the theoretical target population types were consistent with the population groups mentioned in congressional hearings on breast and prostate cancers. Many of the groups were consistent with the four target population types. However, some groups, such as mentions of family and family members, were not conceptualized by Schneider and Ingram (1997). When population groups were identified in hearings that were not consistent with the types of populations discussed by Schneider and Ingram, the groups were placed in the framework based on my own conceptualization of the group’s political power and stereotyped image.

Content Analysis of Policy Provisions in Public Laws

After the final population of public laws was collected, the identified policy provisions were coded in four steps. The manifest coding scheme for policy provisions on breast and prostate cancers included: 1) determining whether provisions implied a benefit or restriction (*design type*), 2) determining whether implementation of provisions was required or discretionary (*requirement*), 3) the various types of policy provisions that included testing, research, treatment, education, and symbols (*types of policy provisions*), and 4) identification of specific groups targeted as recipients of policy (*target populations*).

The distribution of benefits and restrictions is important in applying social construction theory to policy provisions. Ultimately, policy provisions do one of two things: impart a benefit or impose a restriction on the groups the policy is meant to influence. Simply put, the allocation of benefits and restrictions determines who “wins” and “loses” in the policy process (Schneider and Ingram, 1997). Policy provisions were considered to be beneficial if they created a new program, provided for increased testing and treatment services, or increased research efforts for breast and prostate cancers. Policy provisions were considered to be restrictive if they imposed strict eligibility requirements for the provision of services or labeled and/or stigmatized service recipients. The coding categories are listed in Table 3.7.

Table 3.7: Coding of Design Type in Content Analysis of Policy Provisions

Design Types	Descriptions
<i>Benefit</i>	<i>created new programs, provided testing, increased research</i>
<i>Restriction</i>	<i>imposed eligibility requirements, labeled service recipients</i>

Step two involved determining whether the implementation of a policy provision was either required or discretionary. Policy provisions that included the term “shall” were coded as required. Policy provisions that included the term “may” were coded as discretionary. By enacting policy provisions that required implementation, policymakers send a clear message that these policies were important public issues that were required in order to ensure that the policy issue was treated adequately. This lends a sense of importance and primacy to the particular policy issue being treated. By enacting policy provisions that do not require implementation, policymakers convey the message that the issue may have more than one solution. This allows for much greater discretion on the part of implementers (Schneider and Ingram, 1997). The coding categories are listed in Table 3.8.

Table 3.8: Coding of Implementation in Content Analysis of Policy

Provisions

Implementation	Descriptions
<i>Required</i>	<i>includes the term “shall”</i>
<i>Discretionary</i>	<i>includes the term “may”</i>

Step three required coding of the policy provisions and categorizing them by type. Five main types of policy provisions emerged that included: *testing*, *research*, *treatment*, *education*, and *symbols*. Policy provisions that were categorized as (*testing*) referred to the provision of mammography screenings, PSA blood tests, or the establishment of standards to ensure the quality of mammogram tests. Policy provisions that were categorized as (*research*) referred to the requirement of a specific research study to be conducted, conducting clinical trials, and/or the creation of new research programs. Policy provisions that were categorized as (*treatment*) referred to the provision of care to specific groups along with eligibility requirements for those diagnosed with either of these illnesses that qualified for government treatment. Policy provisions that were categorized as (*education*) focused on the creation of outreach programs, awareness, or providing information about breast and prostate cancers to various groups. Policy provisions that were identified as (*symbols*) consisted of general proclamations whereby government encourages, but does not

require, people to take action. These provisions generally included symbolic proclamations that designated “National Breast Cancer Awareness Month” or “Designating National Men’s Health Week”. The coding categories are listed in Table 3.9.

Table 3.9: Provision Types in Content Analysis of Policy Provisions

Provision Types	Descriptions
<i>Testing</i>	<i>providing screening tests</i>
<i>Research</i>	<i>conducting research</i>
<i>Treatment</i>	<i>providing care to various groups</i>
<i>Education</i>	<i>creating outreach or awareness programs</i>
<i>Symbols</i>	<i>making general proclamations</i>

When identifying policy provisions in public laws, there was a notable lack of consistency among them. In order to provide consistency and make it easier to code policy provisions, I divided sections of the law that pertained to breast and/or prostate cancer into the simplest form possible based on the policy intervention being identified in the law. Based on my coding, policy provisions were identified and categorized as they provided for a single and specific intervention. If a law identified more than one intervention, as was often the case, I coded each intervention as a separate policy provision. By doing so, this ensured that policy provisions were only placed in one of the five categories of provisions that I created. For example, if a

particular sentence in the text of a law provided for the creation of new research programs and public awareness programs then I coded them as two separate provisions. The first provision would be considered a *research* provision and the second would be considered an *education* provision.

Step four of coding the policy provisions found in public laws required the identification of various groups singled out for intervention, much like those identified in the content analysis performed on congressional hearings. From the coding of policy provisions eight population groups were identified to include: 1) persons over the age 40 which is the acceptable screening age for breast and/or prostate cancer (*over 40*), 2) active and/or retired military personnel (*military*), 3) persons who work in the research and/or medical field (*medical*), 4) African-American, Native-American, Hispanic, Asian, or general use of the term minority (*minorities*), 5) descriptions of underserved populations that included low income, uninsured, unemployed, uneducated, migrant workers, and urban/rural groups (*underserved*), 6) persons suffering from breast or prostate cancer (*patients*), 7) those at risk for developing breast or prostate cancer (*at risk*), and 8) those exposed to radiation (*radiation*).

Once these eight population groups were analyzed, they were further divided into the four target population types identified by Schneider and Ingram (1997) to include: groups with positive social constructions/political power (*advantaged*), groups with negative social constructions/political power (*contenders*), groups with positive social constructions/low political power (*dependents*), and groups with

negative social construction/low political power (deviants). The way in which these groups were coded and placed in Schneider and Ingram’s framework was conducted in the same fashion as the population groups identified in congressional hearings. The coding categories are listed in Table 3.10.

Table 3.10: Codes for Populations Groups and Target Populations in Content Analysis of Policy Provisions

Population Groups	Target Population Types
<i>Over 40</i>	<i>Advantaged</i>
<i>Military</i>	<i>Contender</i>
<i>Medical</i>	<i>Dependent</i>
<i>Minorities</i>	<i>Deviant</i>
<i>Underserved</i>	
<i>Patients</i>	
<i>At risk</i>	
<i>Radiation</i>	

Plan for Analysis

Throughout the case study and corresponding case study analyses, the differences between the various dimensions of social construction process that are related to breast and prostate cancers will be analyzed. In analyzing the various policy actors that helped socially construct breast and prostate cancers, the case study will

discuss the early constructions of breast and prostate cancers that led to advocacy group formation around these illnesses. The types of policy actors that comprised the breast and prostate cancer advocacy movements as well as the strategies utilized by these various groups will be compared and contrasted.

In performing content analysis on newspaper headlines, I will first count the number of headlines that deal with breast or prostate cancer and compare them in a trend analysis to determine which illness received more attention during the sixteen year study period. The data collected from newspaper headlines will then be coded for tone and content. The process of coding newspaper headlines by tone involved categorizing each headline into the three categories identified for tone (*positive*, *negative*, and *neutral*) that were previously discussed. Percentages of the three categories selected to measure tone will be compared to identify the major tones and feelings that were associated with each of these illnesses. Next, the tone of newspaper headlines will be compared in trend analyses to show the change in tone over the study period for each illness. Similarly, the process of coding newspaper headlines for content included categorizing each headline according to two primary themes: *social construction and advocacy* or *disease-related*. The percentages of headlines that were categorized into one of these two primary themes were compared for each illness. Next, the headlines were categorized into the twelve secondary themes that were previously discussed and compared by percentage for each illness.

In performing content analysis on congressional hearing testimonies, I will first count the number of hearings that deal with breast or prostate cancer and

compare them in a trend analysis to determine which illnesses received more attention during the study period. Next, I will code the hearings by type of witness and categorize each witness as a *medical professional*, *advocate*, *member of Congress*, or *celebrity*. The percentages of the four witness types will be compared in a bar graph by illness. I then plan to code the hearings by type of rationale provided by each witness. I will categorize each rationale into the five categories previously discussed (*stories of decline*, *personal stories*, *family*, *everyone*, or *burden*) and compare the percentages of each rationale provided by witnesses associated with either breast or prostate cancer. Next, I will look at the policy goals provided by each witness. I will count the number of policy goals mentioned by each witness and compare the various policy goals and type of witnesses for each illness.

Because I also want to determine the types of associated groups that witnesses mentioned in their testimonies, I will identify the major population groups mentioned in my content analysis. I will compare the percentages of population groups that were mentioned by witnesses in congressional hearings for each illness. This will allow me to adapt Ingram and Schneider's model (2009) and place the population groups that I identified in the congressional hearings within the social construction/political power framework. Then, I will categorize the population groups mentioned into the four target population types identified by Schneider and Ingram (1997). The percentages of target population types will be compared by illness in a bar graph. A similar technique will be utilized when analyzing how policymakers defined these illnesses in congressional hearings.

Policy provisions will be first identified and counted to determine if they are related to breast or prostate cancer. Then, policy provisions will be coded as either beneficial or restrictive. The percentages of burdensome or restrictive policies will be compared in a bar graph. Next, policy provisions will be coded as either required or discretionary depending on the usage of the words “shall” (required) and “may” (discretionary). The percentages of required and discretionary policy provisions will be compared in a bar graph by illness. The types of policy provisions will be identified and categorized into the five types indicated (*testing, research, treatment, education, and symbolic*) and the percentages of each provision type will be compared by illness in a bar graph. Similar to the congressional hearing analysis, population groups associated with breast and prostate cancers will be identified in the selected policy provisions. Upon identification of these population groups, they will be placed in Schneider and Ingram’s model (2009) and categorized according to their associated social constructions and perceived levels of political power. Lastly, the population groups will be categorized into Schneider and Ingram’s (1997) four target population types and compared by percentages for each illness in a bar graph.

Once the federal research funding allocations for breast and prostate cancers at the National Cancer Institute (NCI) and the Department of Defense (DOD) have been identified, the actual dollar values will be converted to constant dollars using 2006 as the base year. The funding allocations for each illness will be compared in a trend analysis that shows overall spending for breast and prostate cancers during the sixteen year study period. Also, the amount of funding research funding allocated to

each illness by year and individual federal agency (NCI and DOD) will be compared in a table. Lastly, the same tabular data will be compared in a trend analysis to show the differences in federal research funding over time by agency and illness.

Conclusion

This chapter detailed the research design, methodology, data collection and analysis procedures utilized in this dissertation. The purpose of using embedded collective case study and analysis on the selected data is to explore how breast and prostate cancers were socially constructed into public issues. These methods were selected to provide breadth and depth in understanding the process of social construction and the larger picture of how breast and prostate cancers were defined as problems as they moved through the policy process. The data analyzed in the embedded collective case study and content analysis provides answers to the research questions posed in this dissertation. These questions explored how policy actors attracted attention to these illnesses, how gender influenced advocacy efforts for these illnesses, the symbolic aspects of these illnesses, how these illnesses were defined on systemic and institutional agendas, and the factors that led to variations in breast and prostate cancer policy. The next three chapters present the embedded collective case study integrated with the results of content analysis to discuss how breast and prostate cancers were socially constructed into public issues.

IV. BREAST AND PROSTATE CANCERS GAIN ATTENTION AND MOVE ONTO THE SYSTEMIC AGENDA

The overarching purpose of the embedded collective case study and corresponding content analysis presented in the next three chapters is to show how the social constructions of breast and prostate cancer influenced how these issues moved through various phases of the policy process. Consistent with that objective, this chapter provides an analysis that shows how these illnesses gained enough public prominence to move as public issues onto the systemic agenda. This chapter also includes a discussion on how these illnesses were defined once they reached this level of the agenda.

Several dimensions of the social construction processes of breast and prostate cancers that contributed to their rise onto the systemic agenda are discussed here. These dimensions include the role of policy actors, gender and advocacy, the importance of symbols, and definitions of these illnesses on the systemic agenda. Throughout the case study and corresponding content analyses, the differences between these four dimensions as they relate to breast and prostate cancers are analyzed.

Policy Actors Attract Attention

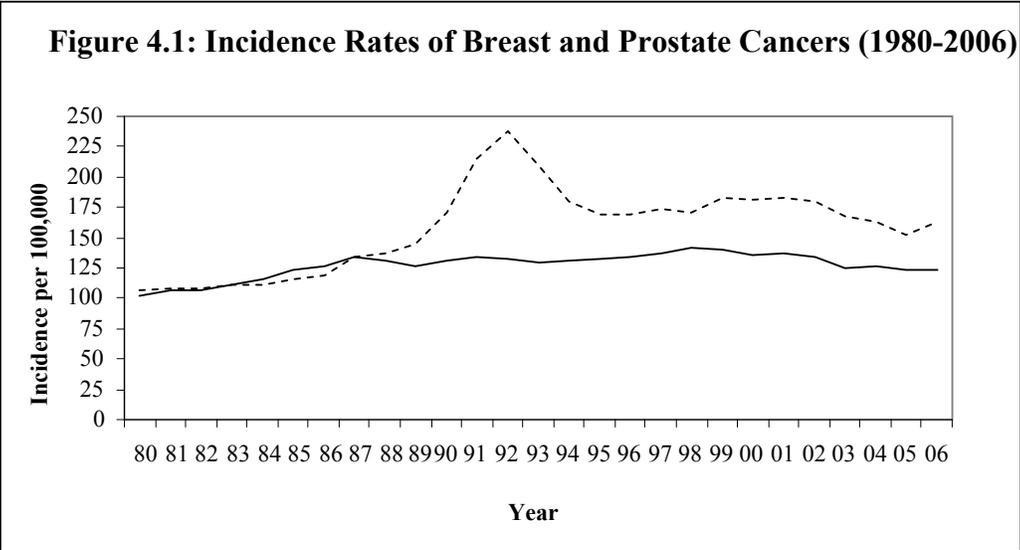
Increased attention to the illnesses of breast and prostate cancer was the result of numerous policy actors from various sectors of society advocating on behalf of policy change. Much of this attention can be attributed to a group of breast and prostate cancer policy actors and entrepreneurs from the medical community, public, private, and nonprofit sectors that consistently lobbied Congress for increased attention and funding. Policy actors and entrepreneurs were successful in creating definitions of these illnesses and those affected by them that significantly changed how the public, media, and government perceived breast and prostate cancers.

During the 1990's, breast and prostate cancers were socially constructed into serious public issues that required quick and decisive action. The overarching message was that these illnesses were complex and growing public issues that required immediate government attention. Prior to this time period, these illnesses were constructed as personal problems for the individual. Limited research on cancer up until this time focused on one's lifestyle choices as the rationale for an affliction and placed responsibility for the disease on the sick person. "Ostensibly, the illness is the culprit. But it is also the cancer patient who is made culpable. Widely believed psychological theories of disease assign to the luckless ill the ultimate responsibility both for falling ill and for getting well" (Sontag, 1988, p 57). Similar constructions of blame assessment have been associated with other illnesses, such as AIDS.

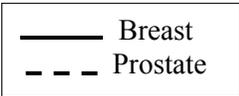
Because cancer was an illness that was perceived as largely self-inflicted, governmental responses were limited. In 1937, the National Cancer Institute (NCI)

was created to direct research and allocate funds for the purpose of eradicating cancer. The National Cancer Act of 1971 broadened the scope and responsibilities of the NCI to extend efforts toward the fight against cancer. Prior to the 1990s, there were no public laws on prostate cancer and only three laws on breast cancer.

Incidence of breast and prostate cancers has steadily increased since the 1980s. Most of this increase in incidence occurred between 1980 and 1987. A trend analysis in Figure 4.1 on the following page shows this increase in incidence since 1980 (Surveillance, Epidemiology and End Results, 2009). For breast cancer, incidence rates have risen at a relatively steady pace since that time period. Incidence rates of breast cancer rose from 102.19 cases per 100,000 in 1980 to 123.04 cases per 100,000 in 2006 (Surveillance, Epidemiology and End Results, 2009). Prostate cancer incidence has risen over time, but not at a steady pace like breast cancer. Incidence rates of prostate cancer rose from 105.99 cases per 100,000 in 1980 to 163.06 cases per 100,000 in 2006 (Surveillance, Epidemiology and End Results, 2009). Incidence in prostate cancer greatly increased in the 1990's, but decreased sharply in 1993, for reasons that are still unclear to federal researchers at the National Cancer Institute (NCI). Despite those particular decreases, the overall increases in incidence led to increased numbers of men and women being diagnosed and seeking treatment.



Source: *Surveillance, Epidemiology and End Results (1980- 2009)*



Breast cancer incidence rose as a result of the development of modern mammography technology that was used to detect the illness in the 1980’s (Feuer and Wun 1992; Lantz et al. 1991; Miller et al. 1991; White et al. 1990; Wun et al 1995). As the screening rates improved, so did the number of women being diagnosed with breast cancer. As incidence rose and more women sought treatment, scientists became concerned with the lack of clinical evidence to show that commonly used treatment practices were successful in improving the survival rates of breast cancer victims (Love and Lindsey, 2005). Because treatments had never been subjected to random clinical trials, there was no evidence to demonstrate their effectiveness. This notable

lack in research brought to light the lack of attention paid to women's health concerns at the federal level. The bottom line seemed to be that women and their distinct health concerns were not a high priority on the federal agenda (Casamayou, 2001).

Similarly, increasing incidence of prostate cancer has been attributed to the discovery of the prostate-specific antigen (PSA) blood test to diagnose prostate cancer along with an increase in those seeking treatment. In 1995, NCI researchers published a study that linked the sharp rise in new cases from 1989 to 1991 to the increased use of the PSA test (Hankey et al, 1999). Up until the 1980's, the standard treatment for prostate cancer was the radical prostatectomy. Due to a lack of clinical research at the time, surgeons believed that the only "cure" for prostate cancer was the removal of the prostate and severing of nerves that surrounded the prostate, a particularly debilitating procedure for patients (Walsh and Worthington, 2007).

Increasing incidence coupled with the lack of research being conducted during the 1980's complemented the construction of breast and prostate cancers as complex and growing public issues. These issues needed the attention of government, rather than to be seen as the result of lifestyle choices that were irresponsible. In newspaper articles, the use of statistics on the illnesses that showed dramatic increases in incidence of breast and prostate cancers lent support to the notion that these illnesses were important public issues. They also communicated a message that conveyed a feeling of "emergency" and "urgency" in finding a solution to these public problems (Cassamayou, 2001).

Policy actors such as advocacy groups and policy entrepreneurs attracted attention to breast and prostate cancers and helped complement the framing of these illnesses as serious and growing problems. The actions of these policy actors were a critical aspect of inciting policy change on these illnesses. It was not merely the fact that these illnesses were growing in incidence, but the advocacy efforts and social constructions of breast and prostate cancers by these actors that led to significant policy action. They utilized various techniques to draw attention to the illnesses. Some of the techniques used by breast and prostate cancer actors that were utilized included: mobilizing into a unified force, using direct and grassroots lobbying tactics, employing the help of policy entrepreneurs and celebrity spokespersons, and invoking symbols to help define these illnesses as public issues. Differences in the amount of policy actor activity on these two illnesses will be highlighted throughout the rest of this chapter in order to identify differences in their social construction processes.

Breast Cancer Advocacy Groups and Entrepreneurs

Early breast cancer support groups were composed of women throughout the country who had been diagnosed with the illness. These early support groups had been largely organized around the women's collective identity as breast cancer patients (Weisman, 2002). By the late 1980's these local groups began forming informal networks to share information in an attempt to influence public policy regarding the lack of concern about breast cancer within the public sector. These small, informal breast cancer groups had little influence on breast cancer policy in Washington at that time (Cassamayou, 2001).

These informal groups began growing during this time in an attempt to influence policy change on breast cancer. The early 1990's saw the birth of an advocacy movement organized by women who were being diagnosed with breast cancer in their twenties, thirties, and forties. Early advocates tended to be middle-aged, middle-class, heterosexual white women (Kedrowski and Sarow, 2007). Many of these advocates were also well-educated, which enabled them to understand highly technical information and possess good communication skills. Many of the advocates had a history of political activism in the civil rights and feminist movements of the sixties and seventies (Kedrowski and Sarow, 2007). These early advocates also tended to be the persons most commonly diagnosed with breast cancer. As the incidence of breast cancer continued to rise, these advocates were becoming increasingly more dissatisfied with the medical community's inability to deal with the illness, the lack of treatment options, and the limited research being conducted to find a cure (Kedrowski and Sarow, 2007). Frustration and anger ensued as inadequate treatments for breast cancer, such as the radical mastectomy, became standard treatment for the growing number of women being diagnosed with the disease (Casamayou, 2001).

Breast cancer advocates seized upon the political climate of the 1990's that served as an opportunity to help sensitize policy makers to the issue. The topic of abortion had become a highly controversial, polarizing issue with the 1989 Supreme Court decision in *Webster vs. Reproductive Health Services* that upheld Missouri's conservative abortion law. The case upheld a Missouri law that placed restrictions on

how state funds could be used for abortion and abortion related activities such as counseling. Pro-abortionists viewed the case as a compromise to the landmark *Roe v. Wade* (1973) which upheld a woman's right to have an abortion. The 1989 case brought to light the lack of sensitivity shown to women by policymakers and the limitations that public policy placed on the ability of women to make their own health care decisions.

The Women's Health Movement of the 1990's demonstrated that medical research on women in the National Institutes of Health accounted for a very small portion of the agency's research. The establishment of an Office of Women's Health in 1991 paved the way for a number of important women's health initiatives, an emphasis on women's health research at NIH, and the establishment of a substantial Breast and Cervical Cancer outreach and treatment program at the CDC. Congressional hearings in 1990, resulting from the Congressional Caucus on Women's Issues (CCWI) that sought to place greater national attention on health issues facing women, focused on the notable absence of women in NIH clinical trials. "The bottom line was the perception that women and their distinct health concerns did not register at all in the attitudes or behavior of administrators at the NIH, and that one reason for this was because there was the relative absence of women in these top administrative positions" (Casamayou, 2001, p 135). The Clarence Thomas-Anita Hill hearings regarding sexual harassment charges in the federal Department of Education highlighted the under representation of women in Congress and legislative inattentiveness to issues facing women.

In 1991, breast cancer support groups that were dispersed throughout the country began coalescing with the formation of the National Breast Cancer Coalition (NBCC). Founded by doctors, lawyers, and political activists, the NBCC was created to serve as a professionalized health advocacy organization that linked local breast cancer support groups, professional associations, and nonprofit organizations to lobby Congress for increased funding for breast cancer research (Casamayou, 2001). A key aspect of achieving this goal was to influence the way policymakers defined the illness. Through the advocacy efforts of the NBCC, these various groups were able to form a mobilized group of actors who helped lobby on behalf of breast cancer policy change.

The NBCC used a variety of lobbying techniques in the early 1990's to help increase attention to breast cancer. Many of these same techniques were used to promote policy change on AIDS in the 1980's. They included grassroots lobbying techniques, such as letter-writing campaigns, peaceful rallies, and petition drives. Advocates participated in direct lobbying by testifying at congressional hearings and visiting with congressional members. NBCC leaders worked directly with then president Clinton to develop a national plan to cope with the growing number of women being diagnosed. A professional lobbying firm was hired to monitor legislation. The NBCC also developed workshops that were conducted by biomedical researchers to help prepare citizen activists for roles on breast cancer committees, advisory panels, institutional review boards, and research grant panels (Casamayou, 2001, NBCC stopbreastcancer.org, 2009).

Breast cancer advocates were only one group of policy actors lobbying Congress to turn its attention toward breast cancer. Policy entrepreneurs also played an important role in helping to increase attention on breast cancer. Policy entrepreneurs with access to policymakers and resources, in terms of time, money, and energy, have the greatest potential for success in influencing policy decisions (Mintrom 1997; Zahariadis 2003). These entrepreneurs included members of Congress such as Rep. Mary Rose Oaker, Rep. John Murtha, Rep. Susan Molinari, Senator Tom Harkin, Senator Alphonse D'Amato, Rep. Barbara Vucanovich, and Senator Diane Feinstein, all of whom testified on behalf of breast cancer policy change at congressional hearings and supported breast cancer legislation (Kedrowski and Sarow, 2007). Many of these policy entrepreneurs had personal experiences with breast cancer and were willing to share their stories. This complemented the nondiscriminatory definition of the illness.

During the 1992 presidential election, advocacy leaders earned the support of Bill Clinton with his campaign focus on health policy and personal experience with his own mother, Virginia Clinton Kelley, being diagnosed with breast cancer. President Clinton and Human Services Secretary Donna Shalala, also served as policy entrepreneurs to help advance breast cancer policy by developing a federal initiative to deal with the illness.

While political entrepreneurs can play a key role in helping to attract political attention to public issues, celebrities are often successful in attracting attention to various types of public issues. Famous celebrities diagnosed with AIDS, such as Rock

Hudson and Magic Johnson, helped to emphasize the nondiscriminatory nature of that illness and gathered public and political support (Donovan, 2001). Celebrity entrepreneurs also played an important role in gaining support for breast cancer policy change. The public presence of these celebrity entrepreneurs and their willingness to talk about their experiences helped to emphasize breast cancer's nondiscriminatory nature and reinforce the definition of an illness that was growing in incidence. Some of the most notable celebrities included Linda Ellerbee, Ann Jillian, and Shirley Temple Black. Some celebrities such as Jill Eikenberry, Olivia Newton-John, and Peri Gilpin testified on behalf of breast cancer policy change at congressional hearings (Cassamayou, 2001). The combined efforts of these various entrepreneurs along with advocacy group activity helped to create an environment that was suitable for policy change on this illness.

Prostate Cancer Advocacy Groups and Entrepreneurs

A receptive political environment forged by breast cancer advocates helped to set the stage for advocacy action on prostate cancer. The early success of advocates in increasing attention to breast cancer served to catalyze prostate cancer advocates into action. Attention to prostate cancer arose largely out of the belief that men's specific health concerns were being ignored by policymakers. Advocacy efforts arose out of a genuine concern that there was a large piece of the federal funding pie that men (and their specific health concerns) were not getting. Advocates perceived this disparity between federal funding of breast and prostate cancers as a large gender gap that needed to be closed (Kedrowski and Sarow, 2007). Increased attention to breast

cancer in the form of media exposure, federal legislation and funding led to criticisms of gender-based policymaking.

Prostate cancer advocates who spoke openly about their experiences during the 1980's were few and far between. The prostate cancer advocacy movement seemed to have a much more difficult time getting men affected by prostate cancer to coalesce around the issue with the same amount of furor that breast cancer had generated. Several reasons for prostate cancer advocates' inability to create an active and cohesive advocacy movement have been identified (Clarke, 1999): men tend not to talk about personal concerns/worries in a group setting, and tend to be disproportionately less interested in their own health concerns. Several scholars (Broom 2004; Hagen, Grant-Kalischuk, and Sanders 2007; Wall and Kristjanson 2005) have noted that men with prostate cancer struggle with traditional male ways of coping with stress such as restricted expression of emotion, toughness, and stoicism. Prostate cancer advocates found that men were generally unwilling to be part of any advocacy movement related to a disease that could potentially injure their feelings of masculinity (Kedrowski and Sarow, 2007). Prostate cancer advocates' inability to generate the same level of advocacy group participation is a factor that potentially influenced the social construction process. This idea is consistent with scholars who argue that women are more likely to engage in different advocacy activities than men when advocating on behalf of health policy issues (Foreman, 1995).

However, they were willing to participate in smaller-scale support groups to help them better cope with the prostate cancer experience. In the early 1980's there

only were a handful of support and advocacy groups dedicated to the needs of men with prostate cancer. In the 1980's three groups were created to raise awareness and provide education on treatment options about prostate cancer: the American Prostate Society, Patient Advocates for Advanced Cancer Treatment, and the Prostate Cancer Education Council (Kedrowski and Sarow, 2007). The leading prostate cancer advocacy group in the United States, US TOO! was created by 5 prostate cancer survivors in 1990 in response to the number of breast cancer groups forming around the country in the 1980's. These early prostate cancer survivors provided the impetus in the 1990's for the formation of advocacy groups to publicly attract attention to the illness. Survival rates had increased, which created a critical mass of persons who would later advocate on behalf of prostate cancer policy (Kedrowski and Sarow, 2007).

The mid-1990s saw the birth of a strong prostate cancer advocacy movement, ironically carried out by women. The first women to lobby for prostate cancer were Betty Gallo, wife of Rep. Dean Gallo who died of prostate cancer, and Brooke Moran from the American Foundation for Urologic Disease (Kedrowski and Sarow, 2007). One of the primary organizations that promoted prostate cancer awareness and helped to provide cohesion to the prostate cancer advocacy movement was the National Prostate Cancer Coalition (NPCC), created in 1996. The primary goal of the NPCC was to increase federal funding of prostate cancer research, much in the same fashion as the NBCC.

The playing field changed with the creation of the NPCC. The NPCC brought together local prostate cancer support groups, professional associations, and nonprofit organizations by serving as a permanent lobbying organization. NPCC's primary agenda was to increase government funding for prostate cancer research. Like the breast cancer movement, the prostate cancer movement was developed and led by well-educated, middle class, professional men. Whereas breast cancer advocacy was generally diagnosed in women that were more educated and more affluent, the large base of men that tended to be affected by prostate cancer tended to be older and less educated (Kedrowski and Sarow, 2007). Prostate cancer also affected more minority groups, such as African-American men who have a greater risk for being diagnosed with the illness (Walsh and Worthington, 2007). Unlike breast cancer advocates, the most outspoken and visible prostate cancer advocates did not include the primary groups of men that are affected by prostate cancer such as older, less-educated, and minority men.

By and large, prostate cancer advocacy groups opted to engage in activities of a slightly different nature than those of breast cancer advocacy groups. Some have suggested that these prostate cancer groups have adopted a different approach to advocacy because of men's reluctance toward discussing what they regard as private health concerns in a public forum (Clarke, 1999). This is consistent with research on men's health and masculinity that has focused on men's reluctance to talk about their health, to become informed about health risks, and to seek help if they experience health problems (Broom, 2004; Cameran & Bernardes 1998; Tudiver & Talbot 1999;

Walsh 2000). Instead of participating in rallies and petition drives like breast cancer advocates, prostate cancer advocates pursued different tactics to try and encourage men to engage in prostate cancer advocacy activities via newsletters and internet websites. This is attributed to the fact that men are less likely to discuss their health publicly for fear of being perceived as “weak” or “sick” (Broom 2004; Courtenay 2000). These activities included tips on writing letters to editors of newspaper and health magazine, exhortations to write to members of Congress and ask them to co-sponsor legislation or sign “Dear Colleague” letters, updates on the appropriations process, and legislative achievements (Kedrowski and Sarow, 2007).

Policy entrepreneurs such as Senators Ted Stevens and Bob Dole, both prostate cancer survivors, consistently lobbied for prostate cancer policy during the early 1990s (Kedrowski and Sarow, 2007). Prostate cancer advocates sought out celebrity spokespersons to champion the prostate cancer cause. Yet, unlike celebrities and breast cancer, becoming a spokesperson about prostate cancer was not a role that many male celebrities readily embraced. Celebrities diagnosed with prostate cancer were slow to emerge in the public spotlight and speak out about their disease. Potential prostate cancer advocates Don Ameche, Steve Ross, Bill Bixby, and Frank Zappa died without the public being aware that they were affected by prostate cancer (Kedrowski and Sarow, 2007).

The movement gained a more promising public image when Bob Dole was diagnosed in 1991 with the disease and became willing to speak openly about his experiences. Other celebrities to publicly speak about their experience with prostate

cancer include Norman Schwarzkopf, Rudy Giuliani, and Robert DeNiro. This helped to drive home the message that these illnesses could strike anyone, even the most macho of personas, and that it was socially acceptable to talk openly about the illness.

A Typology of Breast and Prostate Cancer Policy Actors and Entrepreneurs

Table 4.1 visually displays the various policy actors that formed advocacy groups that helped bring attention to breast and prostate cancers. The relevant policy actors that were identified in the past research on breast and prostate cancer policy and selected data, such as congressional hearings, were divided into four main categories. These four categories included: *celebrities*, *medical professionals*, *advocates*, and *policy entrepreneurs*. The purpose of dividing these actors into different categories is to get an overall sense of the types of actors who were influential in attracting attention to these illnesses and moving them onto the agenda.

Categorizing policy actors and entrepreneurs in this way illuminates several important trends. Overall, it indicates that there were far more actors and entrepreneurs advocating on behalf of breast cancer policy. The table shows more celebrity entrepreneurs acting on behalf of breast cancer policy; fewer related to prostate cancer were identified in the literature. An interesting point to note is the notable lack of athletes advocating on behalf of breast cancer policy. Several athletes began to speak publicly about their experiences with prostate cancer. These athletes included Len Dawson, Joe Torre, and Bob Watson. Advocacy related to prostate cancer tended to include these prominent athletes talking about their own experiences

with prostate cancer to evoke images of strength and virility; no such images could be identified in relation to breast cancer. More than likely this may be attributed to the fact that most professional sports are played by males that evoke images that men can more readily identify with (Courtenay 2000; Broom 2004).

Table 4.1: Typology of Breast and Prostate Cancer Policy Actors

	<i>Breast Cancer</i>	<i>Prostate Cancer</i>
<i>Celebrities</i>	Betty Ford Happy Rockefeller The Clinton Family Nancy Reagan Marilyn Quayle Sandra Day O'Connor Shirley Temple Black Jill Eickenberry Linda Ellerbee Jill Ireland Ann Jillian Olivia Newton-John Peri Gilpin	Norman Schwarzkopf Rudy Giuliani Robert DeNiro
<i>Medical Professionals</i>	Dr. Susan Love Dr. Dennis Slamon Dr. Bernard Fischer Dr. Richard Klausner Dr. Samuel Broder Dr. Bernadine Healy	Dr. Patrick Walsh
<i>Advocates</i>	Rose Kushner Harvey Kushner Erma Bombeck Fran Visco Nancy Brisker Amy Langer Rosemary Locke Christine Brunswick	Bill Schwartz Betty Gallo Brooke Moran John Willey Heather French Henry Len Dawson Joe Torre Bob Watson
<i>Policy Entrepreneurs</i>	Rep. John Murtha Rep. Susan Molonari Rep. Mary Rose O'Carroll Rep. Barbara Vucanavich Senator Alphonse D'Amato Senator Diane Feinstein Senator Tom Harkin Senator Barbara Mikulski Donna Shalala	Rep. Randy "Duke" Cunningham Senator Bob Dole Senator Ted Stevens

In addition to individual policy actors, numerous advocacy organizations that represent these illnesses helped to attract attention to breast and prostate cancers. Table 4.2 displays a comparison of breast and prostate cancers organizations by the various activities that they engaged in. These organizations were divided into four main categories: *fundraising/research*, *support*, *lobbying*, and groups that serve to meet the needs of *specific populations*.

Table 4.2: Typology of Major Breast and Prostate Cancer Advocacy

Organizations

	<i>Breast Cancer</i>	<i>Prostate Cancer</i>
<i>Fundraising/Research</i>	Avon Foundation (1955) Komen Foundation (1982)	CaP Cure (1993)
<i>Support</i>	Y-Me (1978)	Patient Advocates for Advanced Cancer Treatment (1984) Prostate Cancer Education Council (1988) US TOO! Intl. (1990) Prostate Action, Inc. (1994)
<i>Lobbying</i>	National Alliance Breast Cancer Organizations (1982) Kendall Lakes Women Against Cancer (1985) Breast Cancer Action (1990) National Breast Cancer Coalition (1991) Breast Cancer Help, Inc. (1994)	National Prostate Cancer Coalition (1996) Prostate Cancer Action Network (1998)
<i>Specific Populations</i>	Women of Color (1991) Sisters Network (1994) Young Survival Coalition (1998)	

As per the literature consulted, Table 4.2 shows that there were eleven organizations advocating for breast cancer policy while there are only seven for

prostate cancer policy. This indicates that there were more organizations that were created to deal with breast cancer than prostate cancer. There also tend to be more support groups for prostate cancer victims and their families than breast cancer. Another important difference that was identified was the fact that several advocacy organizations were created to address the needs of specific populations dealing with breast cancer, such as African-American or young women. No groups to meet the needs of specific populations dealing with prostate cancer could be identified in the literature. For breast cancer policy, there are more groups that focus on lobbying and policymaking activities than in the case of prostate cancer. Advocacy groups play an important role in the social construction process by helping define public issues and drawing attention to them (Andrews and Edwards 2004; Schattschneider 1960). To help draw attention to these issues, they often use symbols and images that help evoke sympathy for their causes (Birkland, 2001).

Symbols

Symbolism is an important part of the social construction process because symbols communicate social meaning. The notion of symbolism in politics has been treated extensively in the policy literature (Edelman 1964; Fishbein and Ajzen 1975; Kinder and Sanders 1990; Stone 2002; Zaller 1992). Symbols are often utilized by advocacy coalitions to express values that society considers important. The symbols associated with public issues often helps determine how the issues were defined and the amount of attention they were able to attract. Various types of symbols were

associated with the illnesses of breast and prostate cancers such as sexual symbols and visual symbols.

The Breast and Prostate as Symbols of Sexuality

Symbolically, breast and prostate cancers affect parts of the body associated with sexuality. Sexuality is associated with a range of activities that are crucial parts of the human experience such as reproduction, physical pleasure, intimacy, spirituality, and power. Illnesses that can potentially threaten one's ability to take part in these activities carry a significant amount of symbolic power.

Breast cancer symbolized a serious threat, not only to a person's health but to an individual's identity, body image, and sense of self-worth (Thorne and Murray, 2000). This was an illness that was represented by advocates as an enemy that killed and destroyed the lives of individuals, their families, and to a larger extent the American social fabric. In Western culture, the female breast is an important symbol of femininity, beauty, and sexual attractiveness. The female breast also plays an important role in terms of reproduction because it is the primary way that mothers nourish their children. In these ways, the female breast represents women as objects of sexual desire and in terms of their reproductive function. "A woman's breasts symbolize both motherhood which is central to women's traditional identity and female eroticism which is key to sexual attractiveness" (Lantz and Booth, 1998, p. 910). Breast cancer advocates framed cancer as an enemy that posed a large and imminent threat to these two significant roles of women in Western culture.

Similarly, prostate cancer was framed as an illness that threatened traditional characterizations of masculinity. Prostate cancer symbolized a threat to a man's sense of self-worth and sexual identity. A healthy part of a male's sexual identity is the ability to perform sexually and produce children. An abnormality, disease, or surgical procedure that threatens a man's ability to perform normal sexual activity can be particularly damaging to a male's sense of self-worth. The male prostate plays an important role in the male reproductive system and is an important component of healthy sexual function because it aids in the production of semen (Walsh and Worthington, 2007).

While prostate cancer in its early stages doesn't affect sexual function, surgery to treat prostate cancer can often lead to impotence (Walsh and Worthington, 2007). What prostate cancer came to symbolize was a potential threat to a man's ability to reproduce (which is significant for younger men) and engage in healthy sexual activity at any age.

Yet unlike the symbolic power of the female breast to serve as a physical and aesthetic representation of a woman's femininity and sexual attractiveness, the male prostate generally did not evoke the same type of symbolic power. The prostate is a gland located inside the body and is not often directly associated with traditional images of male sexual prowess and masculinity, such as penis size. For this reason, a positive definition of an illness that affects an internal organ that people could not directly relate to proved to be more difficult for prostate cancer advocates to create. It

was also easier to evoke visual images of the female breast than the prostate gland because breasts are easy for most people to recognize.

Visual Symbols

Visual symbols, such as logos, are often used to help socially construct public issues. For both breast and prostate cancers, the symbol of a ribbon was selected to represent these issues. Ribbons that represent social causes first became popular in the 1970s during the Iran hostage crisis, when yellow ribbons were being used to lend support to the hostages (Kedrowski and Sarow, 2007). These visual images were a way to easily represent social causes and resonated with the public on an emotional and symbolic level. Various colors were selected to represent the different ribbons and indicate the social cause being represented. For example, a red ribbon is synonymous with AIDS, while a yellow ribbon often represents the return home of soldiers on military duty.

Pink ribbons were selected to represent breast cancer as a public issue. Pink is a color that is often associated with the birth of baby girls and women generally. The pink ribbon is a widely recognized symbol that has become synonymous with breast cancer. Its likeness can often be seen on clothing, food packaging, jewelry, feminine beauty products, and various other types of products (Kedrowski and Sarow, 2007).

Prostate cancer advocates also adopted the image of a ribbon to represent prostate cancer. The sky blue ribbon represents prostate cancer and is a color often associated with the birth of baby boys and “first place” in various types of competitions. Prostate cancer advocates seemed to have a difficult time trying to

decide upon a unifying color and logo to associate with prostate cancer awareness. Prior to the selection of the sky blue silk prostate cancer awareness ribbon, advocates considered the symbol of a “golden walnut”. The “golden walnut” image was a tongue-in-cheek reference to the prostate gland itself which is comparable in size to a walnut (Walsh and Worthington, 2007). However, the image never seemed to become popular within the prostate cancer advocacy community as some advocates thought the image may have been too crass (Kedrowski and Sarow, 2007).

A ribbon was then selected as a unifying symbol of prostate cancer awareness; yet deciding upon a color proved difficult as well. Advocates first considered green, blue, denim, metal, and silk ribbons in informal online surveys conducted by grassroots prostate advocacy groups in the fall of 1997. The online prostate cancer advocacy community selected a blue denim awareness ribbon, but advocates feared that a blue denim ribbon conveyed a message that was overly masculine (<http://www.prostatecancerfoundation.org/>, 2009). Amidst these ribbon debates, the sky blue silk ribbon was selected by CapCure in 1999 and remains the official symbol that symbolizes prostate cancer awareness (Kedrowski and Sarow, 2007).

The blue awareness ribbon is shared with other causes such as the fight against child abuse and non-smoking campaigns, which makes the sky blue ribbon less immediately associated with prostate cancer. It is less commonly seen printed on clothing and other commercial products. Visual symbols such as these have helped attract public attention to breast and prostate cancers. This increase in public attention eventually led to increased public attention to both illnesses in the media. Increased

coverage of these illnesses in national newspapers helped to move them from the agenda universe onto the systemic agenda.

Defining Breast and Prostate Cancers on The Systemic Agenda

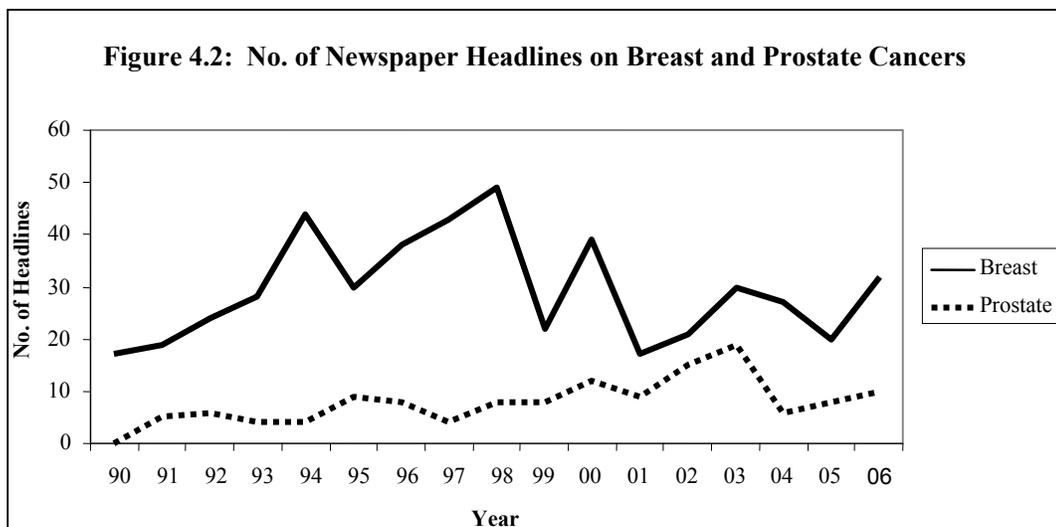
The systemic agenda includes media attention to a policy issue (Kingdon, 1995). The media often serve an important agenda-setting function in helping public issues to gain attention (Cobb and Elder 1983; Kingdon 1995; McCombs and Shaw 1972; Schattschneider 1960). The media play a significant role in the social construction process by helping to define public issues and introduce them to a wider audience (Cohen 1963; McCombs and Shaw 1972; Walgrave and Van Aelst 2006). When the mass media continually emphasize certain issues in a positive way, this helps to attract considerable levels of attention (Graber 2002; Iyengar 1991).

The media help to provide definitions of public issues that compete for a place on the policy agenda. Often, it is the way in which problems are defined that determines whether or not they will reach the agenda (Baumgartner and Jones 1993; Cobb and Elder 1983). It is argued here that increases in newspaper coverage on breast and prostate cancers in two major national newspapers were an important aspect of the social construction processes of these two illnesses.

More specifically, increased newspaper coverage on breast and prostate cancers in *The New York Times* and *Washington Post* from 1990 to 2006 helped to define these issues as important problems that were growing in incidence. Content analysis was performed on 635 newspaper headlines to analyze the role of newspaper coverage in helping to define and attract attention to these illnesses. Content analysis

was utilized because it is a method that allows researchers to analyze documents in a systematic way to help identify the superficial and underlying meanings in written texts (Krippendorff, 1980).

Figure 4.2 shows the increase in newspaper coverage via a count of headlines over time in a trend analysis. The trend analysis shows that newspaper coverage of these illnesses has increased over time. For breast cancer, the rise has been one of sharp inclines and declines. For prostate cancer, the trend has been relatively steady with a couple of less dramatic increases and decreases.



Source: New York Times and Washington Post Headlines (1990-2006)

From the total population of 635 newspaper headlines analyzed, there was significant disparity in newspaper coverage between breast and prostate cancers. Of the headlines referring to either cancer, 79 percent (N=500) of headlines pertained to

breast cancer while 21 percent (N=135) of newspaper headlines pertained to prostate cancer. This disparity in newspaper coverage shows that breast cancer was clearly given more attention than prostate cancer in these two newspapers. Perhaps, a greater emphasis on breast cancer in newspaper headlines may have made the illness seem more important to readers, as opposed to prostate cancer headlines which were less often identified in newspaper headlines. The content analysis performed on headlines was carried out in two more steps. Headlines were coded for tone and then also coded for content.

Tone of Newspaper Headlines

Newspaper headlines were first coded by tone to get a sense of the overall “feeling” conveyed about these illnesses. The categories used for coding the tone of newspaper headlines included: *positive*, *negative*, or *neutral*. Table 4.3 displays the results of the coding of newspaper headlines by tone. Results indicate that the majority of the headlines analyzed on both breast and prostate cancers contained a *positive* tone.

Table 4.3: Tone Conveyed in Breast and Prostate Cancers Headlines

	<i>Breast Cancer</i>	<i>Prostate Cancer</i>
<i>Positive</i>	40%	48%
<i>Neutral</i>	37%	31%
<i>Negative</i>	23%	21%
<i>Totals</i>	<i>100% (N=500)</i>	<i>100% (N=135)</i>

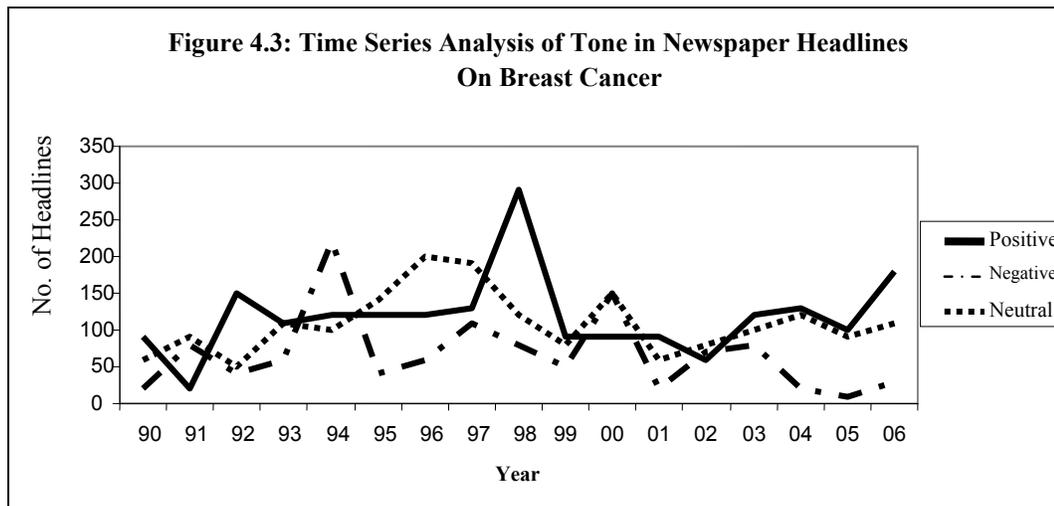
Source: New York Times and Washington Post Headlines (1990-2006)

The *positive* tone conveyed in the headlines provided significant evidence that there were optimistic and hopeful feelings about how these illnesses could be dealt with. The overarching message of these headlines was that this was a problem that potentially had a solution. For breast cancer, 40 percent (N=200) of headlines had a *positive* tone. For prostate cancer, 48 percent (N=65) of headlines conveyed a *positive* tone. It is interesting to note that given the smaller number of prostate cancer newspaper headlines, a larger percentage of the headlines on prostate cancer were *positive* in tone. The *positive* headlines cast this illness in a positive light by conveying the perception that although prostate cancer was growing in incidence, there was optimism about how to deal with this illness. Headlines on breast cancer tended to emphasize more of the political controversy and debate that surrounded this illness, hence the smaller percentage of *positive* articles. The primary methods to deal with these illnesses that were often discussed involved a greater need for more research and government attention. This may have contributed to the creation of a positive public opinion about breast and prostate cancers, helping to attract public sympathy for those dealing with these illnesses and for public policy action.

In *negative* headlines, messages conveyed were that these illnesses were urgent and in need of attention because of the severity of breast and prostate cancers. Only 23 percent (N=115) of headlines on breast cancer and 21 percent (N=28) of headlines on prostate cancer conveyed a *negative* tone. *Negative* headlines reported problems with treatments and/or screening tests and/or confusion about cause and treatment.

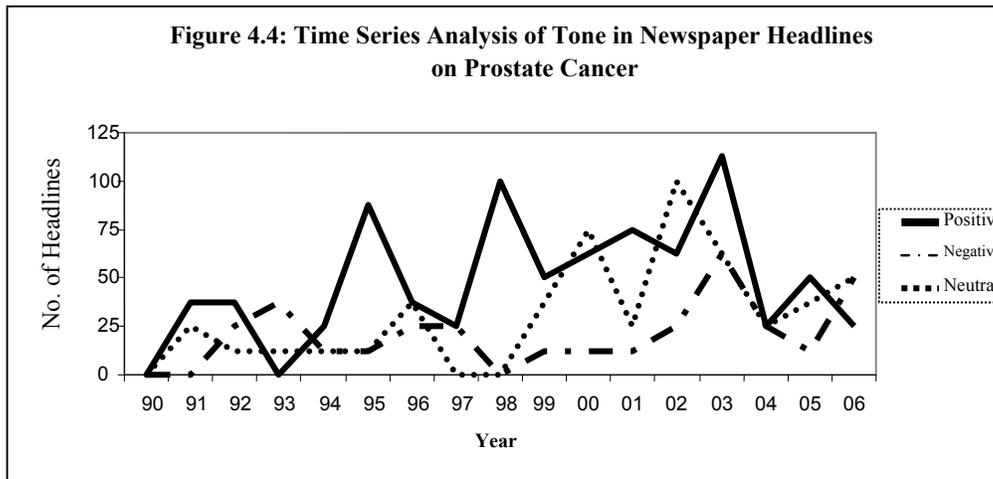
In *neutral* headlines, messages conveyed neither a *positive* or *negative* tone. In newspaper headlines for either cancer, 37 percent (N=185) of headlines on breast cancer and 31 percent (N=42) of headlines on prostate cancer conveyed a neutral tone. *Neutral* headlines reported the findings of research studies or made general statements about these illnesses without conveying a particular feeling.

Figure 4.3 shows a time series analysis of the tone conveyed in newspaper headlines on breast cancer. The data show the variations in tone seem to consistently rise and fall. The trend analysis is helpful in visually displaying this trend. The *positive* tone peaked for breast cancer in 1998 which coincides with the passage of the Women's Health and Cancer Rights Act that provided for insurance coverage of reconstructive surgery after mammograms. *Negative* tones of breast cancer newspaper coverage peaked in 1994 largely due to reports that Canadian researcher Dr. Roger Poisson admitted to falsifying data in a large-scale North American breast cancer study. As the illness received more public attention and the lack of research dedicated to breast cancer became apparent, the federal government funded research to find less invasive treatments for breast cancer. Previously, the only treatment option available to breast cancer sufferers was the radical mastectomy. Dr. Poisson was a well-known advocate for lumpectomies and received U.S. funding to conduct research on this procedure (Farnsworth, 1994).



Source: New York Times and Washington Post Headlines (1990-2006)

Figure 4.4 shows a time series analysis of the tone conveyed in newspaper headlines on prostate cancer. The tone of newspaper coverage of prostate cancer also shows variations in tone. *Positive* tones peaked at several different points in time and then dropped dramatically. This drop is most likely the result of long periods of inactivity by prostate cancer advocacy groups. The trend analysis for prostate cancer newspaper coverage shows large variation in the number of headlines that expressed either a *positive* or *neutral* tone. This large variation indicates that a changing definition or change in the amount of newspaper coverage of the illness could have led to a more complex understanding of prostate cancer. This lack of consistency in defining and covering this illness may have made it difficult for readers to form a firm opinion about prostate cancer.



Source: New York Times and Washington Post Headlines (1990-2006)

Overall, the tone of newspaper coverage for breast and prostate cancers was considerably positive. These two illnesses were presented in an optimistic way that helped attract public attention to them. Although newspaper headlines emphasized an increasing need to deal with these illnesses, the article headlines analyzed here indicate that there was a sense of optimism conveyed about possible solutions to deal with them.

Understanding the tone of newspaper headlines is but one aspect of analyzing how these illnesses were defined on the systemic agenda. Analyzing the primary themes contained in the newspaper headlines also conveys important messages about the most important aspects of these illnesses that were emphasized. This can provide us with a more detailed sense of how these illnesses were defined on the systemic agenda.

Content of Newspaper Headlines

In the next phase of analysis, newspaper headlines were coded by content to detect discernible patterns in coverage of breast and prostate cancers. Consistent with the theoretical streams discussed previously in Chapter II, such as social construction and advocacy, the manifest themes identified in newspaper headlines were divided into two distinct groups. These two were: 1) headlines linked directly to social construction and advocacy and 2) headlines related to the diseases.

Newspaper headlines that were primarily related to social construction and advocacy accounted for the largest percentage of newspaper headlines for both illnesses. In headlines on breast cancer, 68 percent of headlines were related to social construction and advocacy. In headlines on prostate cancer, 65 percent of the headlines were related to social construction and advocacy. Newspaper headlines that were disease-related accounted for a smaller percentage of newspaper headlines. In headlines on breast cancer, 32 percent of headlines were disease-related. In headlines on prostate cancer, 35 percent of headlines were disease-related.

From these two manifest themes, twelve different sub-themes were identified. The twelve sub-themes were then grouped according to whether they were associated with social construction and advocacy or whether they were disease-related. The sub-themes that are linked directly to social construction and advocacy include: 1) a focus on the causes of the disease (*cause*), 2) a discussion of advocacy efforts/political involvement (*advocacy*), 3) stories of individuals or loved ones dealing with illness (*stories*), 4) an emphasis on growing and/or sizable incidence (*incidence*), 5) a

discussion related to screening/testing (*screening*) 6) mentions of celebrity (*celebrity*), 7) issues related to gender, race, and ethnic disparity (*disparity*). The theoretical linkages will be discussed in greater detail throughout the rest of the analysis.

The sub-themes that are disease-related include: 8) issues related to treatment and care (*treatment*), 9) advocating early detection (*early detection*), 10) issues regarding side effects of treatment and care options (*side effects*), 11) comparisons to other diseases (*comparisons*), and 12) disadvantages to early detection (*disadvantages*). Table 4.4 presents the results of the twelve sub-themes found in the selected newspaper headlines.

Table 4.4: Sub-Themes Found in Breast and Prostate Cancers Headlines

	<i>Breast Cancer</i>	<i>Prostate Cancer</i>
<i>Treatment</i>	26%	25%
<i>Cause</i>	21%	16%
<i>Advocacy</i>	19%	0%
<i>Stories</i>	11%	6%
<i>Incidence</i>	6%	2%
<i>Screening</i>	6%	10%
<i>Early Detection</i>	5%	7%
<i>Celebrity</i>	3%	27%
<i>Disparity</i>	2%	4%
<i>Side effects</i>	.8%	.4%
<i>Comparisons</i>	.2%	.4%
<i>Disadvantages</i>	0%	2.2%
Totals	100 (N=500)	100 (N=135)

Source: *New York Times and Washington Post Headlines (1990-2006)*

The primary messages found in headlines on breast and prostate cancers were varied. The three most commonly identified sub-themes identified in newspaper headlines on breast cancer included: *treatment*, *cause* and *advocacy*. Out of these three sub-themes identified in newspaper headlines on breast cancer, only one (*treatment*) was considered to be disease-related. The other two themes are directly related to social construction and advocacy. The two themes include headlines that discussed issues associated with the cause/s of breast cancer (*cause*) and those that focused on advocacy efforts (*advocacy*).

For headlines on breast cancer, the primary message (*treatment*) focused on coverage of treatment and care issues such as surgery, chemotherapy, and prescription drugs. Headlines that focused on *treatment* for breast cancer are considered to be disease-related. These headlines dealt with discussions on various treatment options and presented the results of research studies on new treatments and/or drugs.

The second sub-theme (*cause*) related to issues such as identifying the causes of breast cancer. Newspaper headlines that focused on *cause* would be considered to be related to social construction and advocacy because they often included reports of research studies that identified genetic linkages or other lifestyle factors that could influence a person's chance of being diagnosed with breast cancer. Although genetic linkages are considered to be outside the realm of one's control, lifestyle choices are the result of an individual's decision. The lifestyle choices most commonly identified in the newspaper headlines included diet, alcohol use, smoking, lack of exercise, abortions, and late childbearing. Lifestyle choices are individual factors that assign blame for being affected by breast cancer to the individual, consistent with early constructions of the illness as personal in nature (Foskett, Karan, and Lafia 2002; Lantz and Booth 1998). Less commonly identified factors included environment and early menstruation and/or late menopause, which are factors that don't necessarily assign direct blame to an individual and are considered external factors that may have caused the illnesses.

The third sub-theme (*advocacy*) focused on the efforts and accomplishments of advocacy groups, such as fundraising and political accomplishments. Headlines on advocacy are related to social construction and advocacy because of the key role that advocacy groups play in this process. Advocacy groups often utilize the media as a way to introduce an issue into public dialogue, attract attention, and help the issue move to the next agenda level (Birkland 2001; Dye 2005; Graber 2002). The breast cancer advocates mentioned in the headlines were often described as “tough”, “aggressive”, “angry/outraged”, and “persistent”. These descriptions help to depict breast cancer advocates, primarily female, as serious about the illness and willing to take action to achieve their policy goals.

For headlines on prostate cancer, the three most commonly identified sub-themes included: *celebrity*, *treatment*, and *cause*. Out of these three primary sub-themes identified in newspaper headlines on prostate cancer, only one (*treatment*) was considered to be disease-related. The other two are directly related to social construction and advocacy. The two sub-themes include headlines that emphasized celebrities dealing with prostate cancer (*celebrity*) and issues associated with the cause/s of prostate cancer (*cause*).

For headlines on prostate cancer, the primary message (*celebrity*) was a focus on celebrities. These headlines named well-known athletes, government officials, musicians, and actors who had been previously diagnosed with prostate cancer. It was often the case that these celebrities were described as being “expected to make a full recovery” and emphasized the fact that they would quickly be returning to work.

Celebrities play a significant role in the social construction process because they help draw attention to public issues. This phenomenon was seen when actor Magic Johnson announced that he had AIDS (Donovan, 2001), which helped change stereotypes about the type of person diagnosed with the illness.

The second sub-theme (*treatment*) focused on treatment and care issues such as surgery, radiation, and prescription drugs. Disease-related headlines focused on treatment issues such as “watchful waiting” and patient preference. Watchful waiting is an approach that requires no medical intervention. This is a passive approach that allows the disease itself to make the first move, rather than more aggressive forms of treatment like the prostatectomy.

The third sub-theme (*cause*) focused on identifying the causes of prostate cancer such as age, ethnicity, genetic linkages, or vasectomy. Commonly discussed risk factors such as age, ethnicity, and genetic linkages are considered to be blameless; one can not stop the aging process or choose ethnicity and/or genetic history. In terms of socially constructing the cause of this illness, personal responsibility was rarely assigned to those with prostate cancer. The only individual lifestyle choice that could be identified in the headlines analyzed here was that of a vasectomy, but it was not commonly discussed. In contrast to breast cancer headlines, prostate cancer did not seem to experience the same level of personal blame assessment for the illness.

One interesting pattern that emerged from the content analysis of manifest themes in newspaper articles was a notable lack of headlines on prostate cancer that

discussed the topic of advocacy efforts (*advocacy*). For newspaper headlines on breast cancer, 19 percent dealt specifically with the advocacy efforts of breast cancer policy advocates. These newspaper headlines focused on the efforts and accomplishments of breast cancer advocacy groups such as fundraising and political achievements. No headlines that discussed the advocacy efforts of prostate cancer actors and entrepreneurs could be found in the headlines analyzed here. This disparity in the coverage of advocacy efforts between breast and prostate cancer policy actors shed light on differences in the levels of attention each of the advocates for these illnesses sought. Consistent with the theories on gender and advocacy, prostate cancer headlines did not emphasize the advocacy efforts of policy actors advocating for action on this illness. This may be attributed to the fact that women have generally played a greater advocacy role in health related issues than men (Bordin 1981; Foreman 1995). It may also be attributed to the fact that women are also more likely to discuss their health concerns, whereas men are not as likely to do so (Broom 2004; Courtenay 2000). In prostate cancer headlines, there was more talk of communication gaps between doctors and patients and a need for dealing with sensitive issues.

In review, the newspaper coverage on breast and prostate cancers helped to define these illnesses as significant health issues that required governmental attention. Increases in media coverage were crucial in helping attract attention to these illnesses and moving them onto institutional agenda (McCombs and Shaw, 1972). Content analysis performed on newspaper headlines on breast and prostate cancers in *The New York Times* and *Washington Post* from 1990 to 2006 demonstrated the overall

messages conveyed in terms of tone and content. Results indicate that the majority of the articles analyzed on both breast and prostate cancers contained a *positive* tone that conveyed feelings of optimism and hope. An analysis of the content of newspaper headlines indicated that the majority of newspaper headlines for both breast and prostate cancers contained manifest themes that were associated with social construction and advocacy. Results indicate that the three primary sub-themes found in content analysis of breast cancer newspaper headlines included treatment and care issues (*treatment*), identifying causes of breast cancer (*cause*), and discussing advocacy efforts (*advocacy*). Results indicate the three main sub-themes found in content analysis of prostate cancer newspaper headlines included a focus on celebrities (*celebrity*), a focus on treatment and care (*treatment*), and identifying causes of prostate cancer (*cause*).

The content analysis demonstrates the social construction role of the media in moving breast and prostate cancers onto the agenda and positively constructing these illnesses. The analysis presented here has shown that findings of newspaper headlines on breast and prostate cancers were significant in helping to frame these issues (Cohen 1963; McCombs and Shaw 1972; Walgrave and Van Aelst 2006). By virtue of breast and prostate cancer advocates presenting these issues as worthy problems that deserved government attention, these illnesses attracted public attention and were able to move onto the systemic agenda (Baumgartner and Jones, 1993). Providing new and different issue definitions in a media outlet, such as national newspaper headlines, can help elevate issues onto a higher prominence on the agenda (Rochefort

and Cobb, 1994). In the cases of breast and prostate cancers, positive definitions of these illnesses on the systemic agenda helped to move them onto the next agenda level, the institutional agenda.

Conclusion

In this section of the embedded collective case study and content analysis of newspaper coverage, the way in which breast and prostate cancers emerged into public dialogue and were defined on the systemic agenda were discussed. This chapter emphasized how these illnesses attracted widespread public attention during the early 1990's. Several different factors that helped them attract public attention were discussed in this chapter, including the role of policy actors, gender and advocacy, and the symbols associated with these illnesses. The combination of these factors contributed to this increased attention and helped to move breast and prostate cancers onto the systemic agenda. This chapter also analyzed the way these illnesses were defined on the systemic agenda, to explain how they were portrayed at this particular phase of the policy process. Understanding the factors that helped them move onto the systemic agenda and how they were represented can provide a better understanding of how breast and prostate cancers were successful in traveling to the next level of the agenda.

V. DEFINING BREAST AND PROSTATE CANCERS ON THE INSTITUTIONAL AGENDA

After public issues reach the systemic agenda, they may then move to the institutional agenda where they are seriously considered by policymakers (Cobb and Elder, 1983). To understand how breast and prostate cancers were defined on the institutional agenda, I analyze congressional hearings held on these illnesses between 1990 and 2006. The role that advocacy groups and policymakers play in socially constructing public issues is emphasized by studying the definitions of these illnesses in congressional hearings.

In the embedded collective case study and content analysis of congressional hearings presented here, I also examine several different aspects of issue definition: the types of witnesses that testified, the rationales for policy change provided, the policy goals requested, and the various population groups that were identified as being affected by these illnesses. In addition, the way that policymakers defined these illnesses is discussed. Throughout the chapter, the differences between breast and prostate cancers in terms of how they are portrayed in congressional hearings are considered.

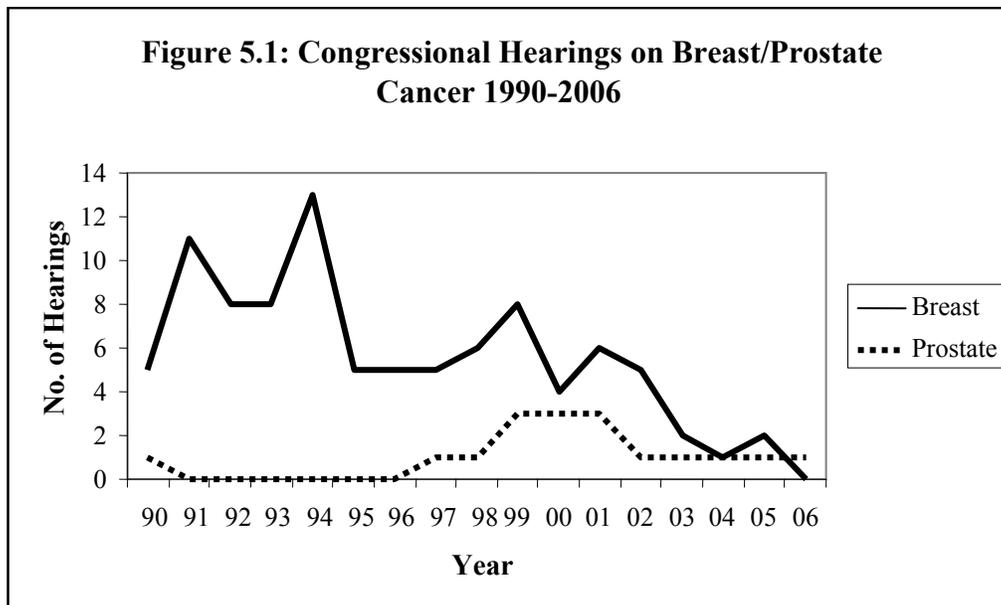
Breast and Prostate Cancers on the Institutional Agenda

Scholars such as Baumgartner and Jones (1993) as well as Donovan (2001) have analyzed congressional hearing data to determine how issues are defined on the institutional agenda and how those definitions influence policymaking. Hearings provide witnesses with the opportunity to define public issues and their related populations for policymakers (Baumgartner and Jones, 1993). By testifying at congressional hearings, policy actors defined breast and prostate cancers as serious public issues that demanded the attention of policymakers (Kingdon, 1984). Congressional witnesses provided rationales, suggested policy solutions, and linked specific groups to these illnesses in an attempt to influence policy decision-making. As discussed in Chapter III, content analysis was utilized to analyze the testimonies provided by witnesses at congressional hearings because it allows researchers to study the meanings in written texts (Krippendorff, 1980).

Testimonies identified in congressional hearings on breast and prostate cancers that took place from January 1, 1990 to December 31, 2006 were analyzed through the use of content analysis. This period of time was chosen because it represents the most active period of policymaking and policy actor activity on these illnesses. These hearings were identified by searching the LexisNexis Congressional database. From a keyword search of this database, 111 congressional hearings on breast and prostate cancers were identified and included in the final study population.

From the total number of congressional hearings, 94 of the hearings focused on breast cancer, while 16 hearings pertained to prostate cancer. Figure 5.1 displays

the disparity and trend over time in the number of congressional hearings held on breast and prostate cancers. For hearings related to breast cancer, the number of hearings has decreased significantly over time while hearings related to prostate cancer have slightly increased since 1990.



Source: U.S. Congressional Hearings (1990-2006)

From the 111 total hearings in the study population, 464 oral testimonies were identified. I analyzed these hearings to discover how breast and prostate cancers and their affected populations were defined by congressional witnesses. Once these testimonies were identified, they were placed into groups based on whether they pertained to breast or prostate cancer. From the population of testimonies, I found that 86 percent of the testimonies dealt specifically with breast cancer, while 14 percent focused on prostate cancer.

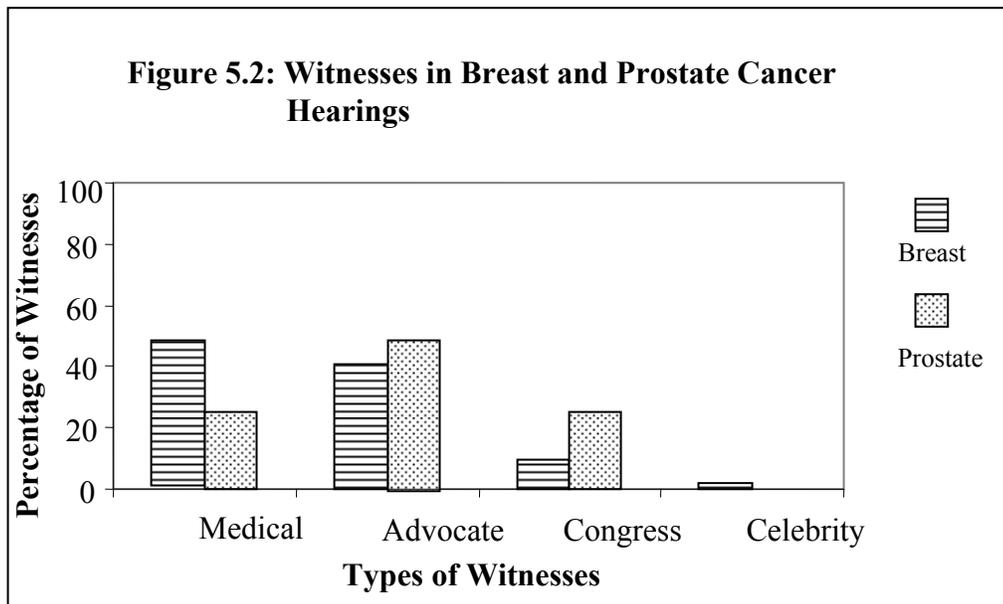
The testimonies in this section were analyzed to determine if specific events could be correlated with the increases and decreases observed in the number of

congressional hearings conducted. Two significant peaks in breast cancer history occurred over the study period. In 1991, there was a significant increase in hearings, which coincided with the creation of the National Breast Cancer Coalition. In 1994, there was an even greater increase in the number of hearings, which coincided with results of reports that Canadian researcher, Dr. Roger Poisson, admitted to falsifying data in a North American breast cancer study. As a result of increased attention to breast cancer, the federal government funded a large-scale research study in an attempt to find less aggressive treatments for breast cancer. Dr. Poisson was one of the most outspoken advocates for lumpectomies and was conducting research to show that the procedure was a more effective and less disfiguring way to treat the illnesses (Farnsworth, 1994). Reports of Dr. Poisson's faulty research and misuse of research funds led to increased attention on how federal monies were being spent on breast cancer research.

Congressional hearings on prostate cancer experienced a significant peak in 1999, which coincided with the sale of Viagra in 1999. Although prostate cancer itself does not directly lead to impotence in men, prostate removal surgeries often can (Walsh and Worthington, 2007). As incidence rates of prostate cancer increased, discussions on the need for a drug to help men engage in healthy sexual function became more prominent within the medical community. Congressional attention experienced a significant decrease after 2002, for both breast and prostate cancers, after a decline in advocacy group activity.

Policy Actors Testify at Congressional Hearings

Various types of policy actors that testified at congressional hearings were identified using a combination of inductive and deductive reasoning, as was previously discussed in Chapter III. The coding scheme included dividing congressional witnesses into four main groups: members of Congress (*congress*), advocates (*advocates*), celebrities (*celebrity*), medical professionals (*medical*). Figure 5.2 displays the different types of witnesses who testified at breast and prostate cancer hearings.



Source: U.S. Congressional Hearings (1990-2006)

The testimonies of these various policy actors demonstrate which types of policy actors played a large role in helping to define these illnesses. As discussed in the previous chapter, various types of policy actors play a role in the social construction process by bringing attention to issues and defining them in ways that are attractive to policymakers in order to influence policy change (Kingdon 1995; Schattschneider 1960).

Scientists, defined here as medical professionals, are accepted as arbiters of facts on the basis of their professionalism, autonomy, and superior intellect (Schneider and Ingram, 1997, p. 154). Advocates from advocacy and interest groups often attract attention to public issues (Schattschneider, 1960). Policymakers play a role in defining issues by providing their own definitions of public problems (Schneider and Ingram, 1997). When celebrities speak openly about illnesses, this can often times encourage the public to change their behavior and focus on their health concerns. Dearing and Rogers found this to be the case with AIDS, whereby increases in the number of celebrities that spoke publicly about the disease encouraged considerable behavior changes amongst the public (1996, p. 82-83).

As seen in Figure 5.2, in testimonies related to breast cancer, witnesses who identified themselves as medical professionals were the largest group to testify, comprising 44 percent (N=177) of the testimonies. Advocates, such as members of the National Breast Cancer Coalition (NBCC), were the second largest group of witnesses to testify, comprising 40 percent (N=161) of the total population. Of the total number of witnesses who provided testimonies on breast cancer policy, 33

percent (N=130) of the witnesses identified themselves as breast cancer survivors or relatives of someone diagnosed with breast cancer. Hearing the testimonies from witnesses that conveyed personal experiences with the illness may have been beneficial in helping to evoke sympathy from policymakers (Kingdon, 1984). Emotional accounts of personal experiences with the illness made the hearings less formal and procedural.

In testimonies related to prostate cancer, witnesses that identified themselves as advocates, such as members of the National Prostate Cancer Coalition, were the largest group to testify and comprised 47 percent (N=30) of the testimonies. The next largest group of witnesses included medical professionals, providing 28 percent (N=18) of the testimonies, followed by members of Congress, who provided 25 percent (N=16) of the testimonies. Of the total number of witnesses who provided testimonies on prostate cancer policy, 44 percent (N=28) of the witnesses identified themselves as prostate cancer survivors or relatives of someone diagnosed with prostate cancer.

In spite of the greater attention given to advocacy efforts in newspaper headlines on breast cancer, there was a higher percentage of advocates identified in the congressional hearings on prostate cancer policy than breast cancer policy. This may be attributed to the fact that prostate cancer was not as popular of an issue as breast cancer; hence advocates for prostate cancer policy change were eager to attract congressional attention during this time period. As previously discussed, advocacy

activity that focused on prostate cancer arose as a result of the considerable amounts of attention that advocates for breast cancer had already generated.

Although celebrities were frequently mentioned in newspaper headlines on prostate cancer, there were no celebrities identified in the congressional hearings on prostate cancer policy. This may be attributed to men's lack of desire to talk about their health concerns in private, much less a public setting such as a congressional hearing (Broom 2004; Courtenay 2000). This may be a possible explanation as to why more celebrities testified on behalf on breast cancer policy.

Rationales

Analyzing policy rationales provided by these various policy actors is an important clue to understanding the social construction process. These rationales can directly influence policy decision-making. Policy rationales provided to Congress explain why a particular problem requires government attention. Politically successful policy rationales make the link between a public problem and a solution that benefits society very clear. Policymakers must often try to make decisions that are responsive to the public by showing how the policies they enact reflect public values (Arnold 1990; Habermas 1975; Offe 1985; Schneider and Ingram 1997). This allows them to pursue the multiple goals of solving public problems and being viewed favorably by the electorate (Schneider and Ingram, 1997).

Various types of rationales provided by the witnesses in support of breast and prostate cancer policy were identified in the congressional hearings analyzed.

Witnesses were able to successfully define these illnesses as growing public problems

in need of government attention. Five different rationales helped to create a sense of urgency and need, which is one of the most fundamental political claims as identified by Deborah Stone (Stone, 2002, p. 86). These rationales included: emphasizing a growing and/or sizable incidence (*stories of decline*), telling personal stories of one's own or another's experience (*personal stories*), emphasizing the burden placed on families (*family*), warnings that everyone is potentially impacted (*everyone*), and a focus on the burden placed on society (*burden*). It was often the case that some witnesses provided no rationale at all, as in the case of researchers presenting the results of scientific studies. For this reason, the total number of rationales provided (N=435) was less than the total number of hearings (N=464). Table 5.1 shows the policy rationales provided by congressional witnesses.

Table 5.1: Policy Rationales in Congressional Breast and Prostate Cancer

Debates

	<i>Breast Cancer</i>	<i>Prostate Cancer</i>
<i>Stories of Decline</i>	73%	46%
<i>Personal Stories</i>	14%	26%
<i>Family</i>	6%	14%
<i>Everyone</i>	6%	10%
<i>Burden</i>	1%	4%
Totals	100% (N=339)	100% (N=96)

Source: U.S. Congressional Hearings (1990-2006)

Stories of Decline

Testimonies that emphasized a growing and/or sizable incidence of these illnesses were commonly used by congressional witnesses. This complemented the initial message that these illnesses were significant and growing public issues that required immediate government attention. Similarly, Donovan (2001) found that witnesses testifying on behalf of AIDS policy used a similar rationale to define that illness. In his analysis of congressional hearings held in 1990 on AIDS, advocates emphasized the fact that the disease was “spreading and must be contained” (p. 62). Witnesses attempted to demonstrate to members of Congress that the number and frequency of people being diagnosed with these illnesses were on the rise and would continue to increase without government intervention. More often than not, these witnesses provided statistics to indicate the number of people being diagnosed and the

number of people who were expected to die from the disease as a way to validate their claims. This commonly used rationale helped to define these illnesses as fast-growing problems that required immediate governmental attention.

Often, the rationales provided by witnesses were consistent with Stone's (2002) *story of decline* policy narrative. The story of decline follows the "things were bad, now they have gotten worse, and something must be done" narrative. According to Stone (2002, p. 138) the story of decline always begins with the recitation of facts and figures showing how things have gotten worse. The two excerpts provided here follow this same storyline in emphasizing a growing and/or sizable incidence of breast and prostate cancers. Witnesses providing this rationale concluded that the best way to deal with these policy issues was to allocate more funds for research on these illnesses. An excerpt from testimony by advocate Fran Visco, then president of the National Breast Cancer Coalition (NBCC) and a breast cancer survivor, on the need for quality mammogram screenings in 1992 forms an example:

Because 181,000 women will be diagnosed with breast cancer this year, and 46,000 will die, the victims need support from Congress more than ever to prevent needless deaths. Breast cancer affects real women's lives. We are not addressing a hypothetical situation, as some of you are aware. This disease is claiming women's lives in increasing numbers. The tragedy is that, when detected early, it is treatable, but when it goes undetected, it grows beyond treatable size. Many members of the coalition have died of breast cancer. Some members survive today due to early detection. Others are dying due to misdiagnosis when cancer was in its early stages (Access to Quality Mammography Screening, 5 June 1992, p. 77-78).

Advocates testifying on behalf of prostate cancer policy used a similar rationale. A testimony by advocate Heather French Henry, a former Miss America, on quality of life issues for military veterans in 2005 provides another example:

Prostate cancer is the most commonly diagnosed cancer in men, accounting for 33 percent of all cancer cases in men. More than 230,000 men will learn they have prostate cancer in 2005. Roughly 30,000 will die from the disease. As we have seen, those with a family history of prostate cancer are more susceptible to the disease. Also, veterans and others exposed to defoliants and African American men remain at higher risk. Currently, there is no cure for advanced or metastasized prostate cancer (Military Quality of Life and Veterans Affairs, and Related Agencies Appropriations for 2006, Part 6, 17 April 2005, p 1059-1070).

Both of these testimonies emphasized the idea that these illnesses were growing in incidence and would continue to worsen. The use of statistics helps to create a sense of urgency and framed these illnesses as serious public problems that were in need of government attention. Congressional witnesses advocated for increased attention to these issues by emphasizing a growing incidence of these illnesses. The examples of testimonies provided here also mentioned the various types of people who were affected by these illnesses such as members of the NBCC, veterans, and Americans. Stories about breast and prostate cancers victims helped to personalize these illnesses and evoke greater sympathy for the people dealing with them.

Personal Stories

Another commonly used rationale provided by witnesses included *personal stories* of breast and prostate cancer victims. These *personal stories* were often told by the victims themselves or by witnesses discussing someone else's experience with or death from one of these illnesses in order to provide an example of a typical breast or prostate cancer victim's experience. Telling *personal stories* helped to reinforce a positive definition of the affected populations because it helped to make a victim's experiences more personal and emotional to congressional members. As Schneider and Ingram (1993, p. 336) note, techniques such as the telling of *personal stories* are often used in socially constructing issues and populations to help to create a sense of proximity to the illness, allowing policymakers the ability to connect the illnesses to the type of people that would directly benefit from policies.

This image was conveyed when actress Jill Eikenberry testified on breast cancer policy change in 1991. This testimony by an attractive, healthy, young, and well-known actress emphasized her decision to have her diseased breast removed as a means of survival. Her testimony sent a clear message to members of Congress that this was not only a serious illness, but that breast cancer could happen to just about anybody. Testimonies such as these help to construct the illness as one that affects advantaged groups with positive social constructions and political power (Schneider and Ingram, 1997).

Five years ago, I was diagnosed with breast cancer. I was over 35, and had never had a screening mammogram. I had never practiced breast self-examination. I wasn't even regular about my pap smear. But on a routine visit

to my gynecologist, she found something to concern her and scheduled a mammogram for me. I went to the mammography clinic with great trepidation. It was mobbed. I had an endless wait for the first initial test, and then because they needed more pictures, I had to wait longer. The next step was a visit to the breast specialist, who looked at my x-rays and said I had cancer. And I will never forget that moment. I felt as if I was facing a firing squad. The specialist said, "There are a few treatment options, but I would take the breast off. It is the procedure I do most often." And without hesitation, I said, "Take it off. I want to live" (Why Are We Losing the War on Breast Cancer? 20 June 1991, p. 8-11).

Similarly, in a 1997 hearing, Hall of Fame Quarterback Len Dawson Hall spoke about his decision to have prostate removal surgery. His testimony emphasized the amount of physical pain he endured as a professional football player of 27 years. His testimony showed that even the strongest of professional athletes could be affected by prostate cancer, complementing the nondiscriminatory nature of the illness.

Through further examination they found that I did indeed have a malignant tumor on the prostate gland and gave me my options. One of the options was surgery and they said that the chances are is it is contained within the prostate gland, in 95 percent of the cases it will be fine and I would never have a problem again. Well, as an exquarterback, that is a no-brainer, the 95 percenter (Hearing on Prostate Cancer: The Silent Killer 23 September 1997, p. 8-10).

Both of these testimonies emphasized how the individuals diagnosed with these illnesses were affected. Testimonies like those of Jill Eikenberry and Len Dawson often emphasized how their illnesses affected them health-wise, emotionally, and financially. Many witnesses also discussed how a diagnosis of breast or prostate cancer had affected them, as well as the people in their personal lives. More

specifically, the impact that these illnesses had on family members was frequently mentioned in testimonies.

Family

Another rationale that was frequently provided by witnesses included images of *family* and how families of those suffering from these illnesses have been affected. The most commonly mentioned family members tended to be spouses, parents, grandparents, children, and siblings. A rationale that emphasized the *family* provided evidence that these illnesses not only affected the individual victim, but also their loved ones. The *family* image helps to deconstruct prior beliefs that breast and prostate cancers were personal problems to be dealt with by the sufferer (Foskett, LaFia, and Karan, 2002).

Maintaining the family structure is an extremely significant part of the American value system and anything that threatens this structure is considered worthy of government attention. Public issues that threaten family values are politically attractive to policymakers because of how deeply this aspect of American culture resonates with the public. Because policymakers generally seek to solve public problems that are consistent with public values in order to be viewed favorably by their electorates (Arnold 1990; Habermas 1975; Offe 1985; Schneider and Ingram 1997), any issue that potentially threatens the family structure tends to gain the attention of policymakers.

Witnesses often emphasized the growing threat that these illnesses placed on American families. Testimony provided by Marilyn Quayle, wife of Vice President

Dan Quayle and Honorary Co-Chairman for the Susan G. Komen Race for the Cure, at a 1990 hearing provides an example:

The Washington, DC race [Race for the Cure] is emphasizing that breast cancer is a family issue. Husbands who care about their wives, children who care about their mothers, and brothers who care about their sisters, should insist that their loved ones have a mammogram, and should encourage monthly breast self-examinations. They should also encourage research for prevention or a cure of breast cancer. Let's face it, more than one life is touched when breast cancer rears its ugly head. Women play an integral part in all aspects of human life. The void left by a mother felled by late detected breast cancer can never be filled. The lives of her husband and her children will never be the same (Breast Cancer: Race For the Cure 16 May 1990, p. 25-26).

Invoking slightly less emotion than Mrs. Quayle, Joe Torre, a prostate cancer survivor who served as manager of the New York Yankees, provided family images in his testimony in 1999. His testimony extends the family image a bit further by emphasizing that governmental action can not only preserve current generations of families, but can protect future generations from the ravages of prostate cancer:

For too many families, this holiday is a time to remember the fathers, husbands, and brothers who have been lost to this disease. By providing increased research funding, you can stem rising rates of prostate cancer and protect future generations of men and their families from its devastation (Prostate Cancer: A Special Hearing 16 June 1999, p. 38-40).

These testimonies emphasized the growing threats that breast and prostate cancers could have on American families. By constructing these illnesses as family problems, policy actors were able to frame them in a way that was consistent with public values about family. In addition to the families of breast and prostate cancer

victims, congressional witnesses also emphasized the threats these illnesses posed to virtually everyone in society.

Everyone

Another rationale provided by witnesses placed an emphasis on how breast and prostate cancers not only affected the victims and their families but had the potential to affect *everyone*. Witnesses framed these illnesses by focusing on the non-discriminatory aspects of the illnesses; it could strike anyone at any time regardless of age, race, or lifestyle choices. Similar to the rationale that emphasized these illnesses as family problems, the *everyone* rationale helped to negate the idea that these illnesses were the result of lifestyle choices perceived as irresponsible (Foskett, LaFia, and Karan 2002; Lantz and Booth 1998).

Advocate John Willey, prostate cancer survivor and board member of the National Prostate Cancer Coalition, used this rationale in his testimony in 2002. His testimony specifically mentioned well-known personalities who struggled with prostate cancer that helped reinforce the message that this illnesses really could happen to *everyone*, even well-to-do and powerful people.

Prostate cancer research is vital to the future health and well-being of all American servicemen, and, indeed, all Americans. The disease knows no bounds. It affects men of all races, ethnicities, economic backgrounds. New York City Mayor Rudy Giuliani, retired General H. Norman Schwarzkopf, baseball manager Joe Torre, Dusty Baker, even member of this committee have faced prostate cancer (Department of Defense Appropriations FY2003 June 2002, p. 771-775).

Erma Bombeck, syndicated columnist and breast cancer survivor, also provided this rationale in her testimony in 1992. Her testimony was significant in that she argued that she doesn't fit within the well-established stereotypes that determined who was at risk for breast cancer. Bombeck argued that even though she did not participate in activities that society portrays as negative, such as smoking or drinking, she was still diagnosed with breast cancer. Testimonies such as these helped negate the validity of then commonly espoused risk factors. Testimonies like hers helped to challenge institutionalized thinking about the specific populations affected by this illness and emphasize its nondiscriminatory nature (Foskett, LaFia, and Karan 2002; Lantz and Booth 1998). Her testimony emphasizes the fact she was diligent in living a healthy lifestyle, helping to frame her illnesses as one that had the potential to strike perfectly healthy people.

This not a disease that we earned by smoking or abusing our bodies. I don't even fit the profile. I don't drink. I don't smoke. My mother never had cancer. My grandmother never had it, and if I put the bathroom scale on a really soft carpet I am not really very obese, but now I discover that breast cancer is reaching down to the 30- and the 40-year-olds. I am going to say that breast cancer has touched the lives of every single person in this room. I don't even have to take a poll. I don't have to go back. I don't have to look behind me and see who is there. I can tell you this. It is true. And yet we cannot seem to get the attention of the Nation and we go back to why (Breast Cancer: Winning the Battles, Losing the War 1 October 1992, p. 39-41).

By emphasizing the fact that breast and prostate cancers could happen to anyone, policy actors were able to frame this illness as nondiscriminatory. Defining the illness in this way help to create a sense of fear and anxiety about who could potentially be affected. To reinforce this fear, policy actors also mentioned the

financial impact that these illnesses could have on society if not given proper attention by government.

Burden

A final rationale provided by witnesses included how these illnesses placed a financial *burden* on affected individuals and also society at large. Although used less frequently, this rationale helped to communicate the message that these illnesses were public problems that required the attention of government. This emphasis on potential financial burden helped to characterize these illnesses as major crises, a tactic used by other groups as seen in past research on social construction (Donovan 2001; Schneider and Ingram 1997). By framing these illnesses as potential financial crises, policy actors were able to show how preventive actions were required on the part of policymakers to curtail the negative effects of breast and prostate cancers before they wreaked financial havoc on the healthcare system. A 2002 statement by John S. Kovach, Director of The Long Island Cancer Center at Stony Brook University Hospital, emphasized this point:

The tireless efforts of predominantly women have cast a spotlight on the multifaceted problem of cancer, bringing issues of causation, early detection, least damaging, most effective treatments and psychological and financial cost to the patient, family, and society to national scrutiny and debate. We are fortunate the advocates knew in which direction to go (Environmental Contributors to Breast Cancer: What Does the Science Say? 22 June 2002, p. 13-14).

Dr. Robert Wichkam from the American Association of Clinical Urologists communicated a similar message in his 1993 testimony. His statement focused on an

intangible return on investment rationale, to be achieved by investing money in prostate cancer programs and research.

Urological diseases, including prostate cancer, affect millions of people in this country at great medical expense. Research into the field of urology is extremely limited and we believe strongly that a relatively modest increase in this investment would pay huge dividends in terms of the ultimate reduction of human suffering and medical expense (Departments of Labor, Health, and Human Services, Education, and Related Agencies Appropriations for 1994. Part 7: Testimony of Members of Congress and Other Interested Individuals and Organizations September 1993, p. 149-160).

In comparing the rationales provided for breast and prostate cancer policy, some interesting trends can be discussed. It is interesting to note that the percentage for the *personal stories* rationale is higher for prostate cancer witnesses than the percentage for breast cancer witnesses. This data does not paint a picture of men that are unwilling to speak about their personal matters. The testimonies that were categorized as *personal stories* not only include men discussing their own experiences with prostate cancer, but also the wives of these men who had died as a result of a prostate cancer diagnosis testified. For example, Betty Gallo, widow of Rep. Dean Gallo, often spoke of her husband's experience with and death from prostate cancer. Also, several witnesses testified multiple times during the selected study period. Some examples of these witnesses included Betty Gallo who testified on five separate occasions and executive member of The National Prostate Cancer Coalition (NPCC) and prostate cancer survivor William Schwartz who testified on four separate occasions.

The data also show that in the testimonies provided by witnesses testifying for policy change on breast cancer, there was an emphasis on the *stories of decline* rationale which included the use of more clinical language. When speaking about policy change for these illnesses, this is the language often used by Members of Congress themselves. In comparison to witnesses testifying for prostate policy change, witnesses tended to use language that was more personal in nature in *personal stories, family, and everyone* rationales. This may be indicative of a significant time lag in advocating for these two illnesses. The breast cancer advocacy movement began earlier than the prostate cancer advocacy movement and significant amounts of attention had already been directed toward breast cancer. Hence, witnesses testifying for breast cancer policy change were more focused on achieving their policy goals and less so on establishing the illness of breast cancer as an important public issue. Whereas prostate cancer witnesses were still trying to establish the illness as a significant public issue through the use of rationales that emphasized the personal nature of the prostate cancer.

These various rationales provided by witnesses helped to frame these illnesses in ways that helped to legitimate the various policy goals they were trying to achieve. Policy rationales help policymakers understand why a problem requires the attention of government. Rationales provided by witnesses often define public problems in such a way that policymakers can clearly identify a solution to remedy the problem. The policy goals provided by witnesses during hearings represented the various solutions that policy actors proposed to deal with breast and prostate cancers.

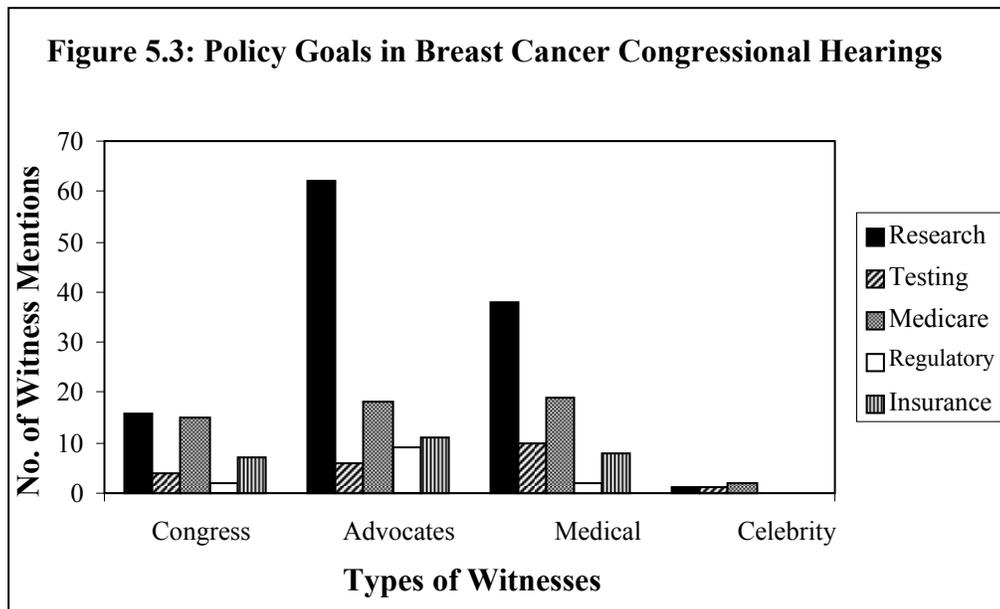
Policy Goals

Policy rationales are significant in helping to define public issues for policymakers. Policy goals represent the various solutions to the public issues that are being proposed by witnesses. More often than not, policy actors with political power are most successful in defining public issues and in proposing solutions to solve them (Schneider and Ingram, 1997). Analyzing the policy goals of the various congressional witnesses helps identify the most commonly proposed solutions and which policy actors requested them. To that end, the policy goals analyzed in this section indicate the various policy goals that witnesses testifying on behalf of breast and prostate cancer policy change requested of Congress.

The results of the coding scheme developed for this phase of the content analysis included dividing policy goals requested by witnesses testifying on behalf of breast cancer policy change into five main groups. The five goals included: a) requests that more resources be allocated for research (*research*), b) requests that more resources be allocated to improve testing and early detection methods (*testing*), c) requests for changes to Medicare in terms of testing and treatment (*Medicare*), d) appeals to alter insurance coverage for treatment and the consideration of alternative treatments (*insurance*), and e) requests for changes to guidelines on silicone breast implants (*regulatory*).

In looking at the policy goals provided by the various witnesses on breast cancer policy change in Figure 5.3, some trends emerge. A policy goal that emphasized increased *research* on breast cancer was most commonly mentioned by

advocates (N=62), medical professionals (N=38), and members of Congress (N=16). Requests for changes to *Medicare* coverage were most strongly supported by medical professionals (N=19), advocates (N=18), members of Congress (N=15), and celebrities (N=2). The several celebrities that testified most often requested changes to *Medicare* coverage for mammography testing for women who did not have access to them.

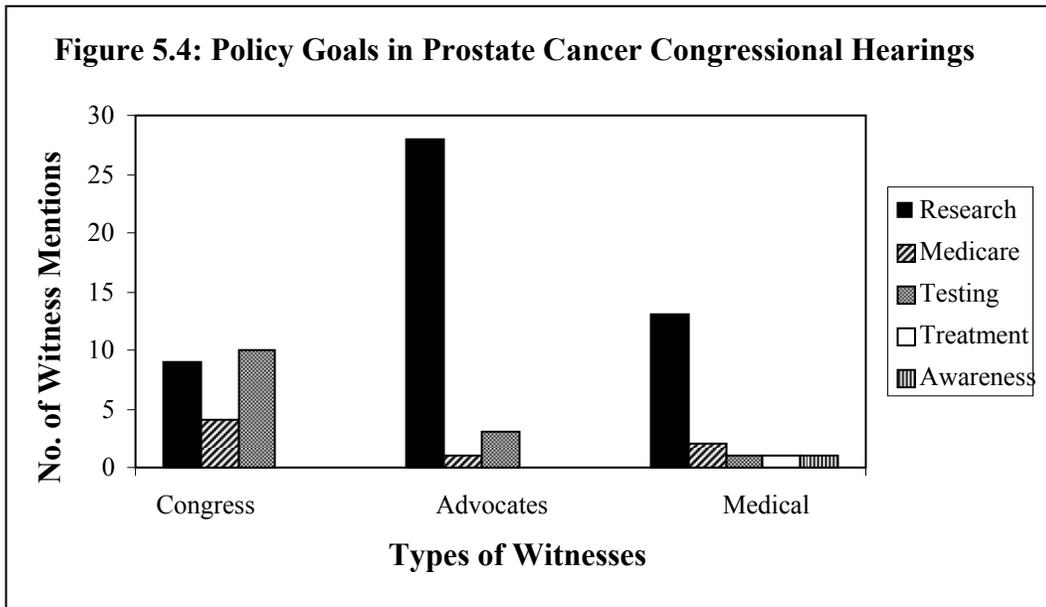


Source: U.S. Congressional Hearings (1990-2006)

The coding scheme for prostate cancer policy goals was slightly different than the coding scheme developed for breast cancer policy goals. The results of the coding scheme divided the policy goals requested by witnesses testifying in behalf of prostate cancer policy change into five main groups. The five goals included: a) requests that more resources be allocated for research (*research*), b) requests that more resources be allocated to improve testing and early detection methods (*testing*),

c) requests for changes to Medicare in terms of testing and treatment (*Medicare*), d) requests for the consideration of alternative treatments (*treatment*), and e) requests for an increase in public awareness campaigns (*awareness*).

Some similar patterns emerge when looking at the policy goals provided by witnesses testifying on behalf of prostate cancer policy change in Figure 5.4. For the most commonly requested policy goal of increased *research*, the data indicate that advocates (N=28) and medical professionals (N=13) were responsible for the majority, of these requests. This finding was consistent with requested breast cancer policy goals, where advocates and medical professionals were also the strongest supporters for more *research*. Members of Congress were also very supportive in their testimonies of increasing *testing* standards for prostate cancer (N=10), followed by advocates to a much lesser extent (N=3). With regard to more *Medicare* coverage, members of Congress provided the strongest support in their testimonies for this goal (N=4), followed by medical professionals (N=2). Interestingly, the data in Figure 5.3 show that celebrities did not request any policy goals. As previously indicated, no celebrities could be identified in testimonies from hearings on prostate cancer during the selected study period.



Source: *U.S. Congressional Hearings (1990-2006)*

In comparison, the policy goals requested by breast and prostate cancer witnesses were similar. The allocation of more resources for *research* was most strongly supported by advocates and medical professionals for both breast and prostate cancers. However, the primary difference between the goals for these illnesses is the fact that several celebrities requested goals for breast cancer policy change, while no celebrities could be identified making such requests in prostate cancer hearings. The various proposed policy goals and the types of witnesses that advocated for them are important in helping to identify why certain policy decisions are made. In the next chapter, these proposed policy goals will be compared to the various policy provisions that were identified in public laws to see if there was any consistency between the requested goals and the policy actions that were actually adopted. It is also important to look at the people that these actors identify as the

recipients of the policy solutions, since the manner in which policy targets are defined is another essential part of the social construction process (Schneider and Ingram, 1997).

Population Groups and Target Population Types

The last phase of congressional hearing analysis included coding the various population groups that witnesses identified in their testimonies. An important part of socially constructing these illnesses and achieving desired policy goals was to link them to population groups that had positive social constructions (Schneider and Ingram, 1993). The coding scheme utilized here identified the various population groups that were mentioned in congressional testimonies at least once per hearing: 1) persons over the age of 40, which is the acceptable screening age for breast and/or prostate cancer (*over 40*), 2) references of family and/or family members (*family*), 3) minority groups to include African-Americans, Hispanics, Native-Americans, Asians, and general use of the term minority (*minorities*), 4) references to underserved populations that included low income, uninsured, unemployed, uneducated, migrant workers, and urban/rural groups (*underserved*), 5) references to “patient” were used to describe persons suffering from breast or prostate cancer (*patients*), 6) active or retired military personnel (*military*), 7) members of Congress (*Congress*), 8) references to affluent or upper class, (*affluent*), and 9) federal employees (*fedemploy*).

Once these nine population groups were identified, they were further categorized into the four types of target populations created by Schneider and Ingram (1997) based on my interpretation of the various population groups that were

discussed. I categorized these population groups according to my interpretations of the descriptions provided by Schneider and Ingram (1997) of the various target population types. These four types include: groups with positive social constructions/political power (*advantaged*), groups with negative social constructions/political power (*contenders*), groups with positive social constructions/low political power (*dependents*), and groups with negative social construction/low political power (*deviants*). This was done to identify whether the mentions of population groups provided by witnesses at congressional hearings were consistent with the four types of target populations conceptualized by Schneider and Ingram (1997).

It is important to note that the categorizations of the population groups is based on this author's interpretation and conceptualization of the population groups identified in congressional hearings and the target population types discussed by Schneider and Ingram (1997). Some populations were identified in the congressional testimonies, such as *families*, but not necessarily discussed by Schneider and Ingram. This made the categorization of these populations more challenging. The discussion of the various population groups and target population types in the remainder of this chapter explains this in greater detail. Figure 5.5 adapts the model provided by Ingram and Schneider (2009) to visually display the convergence of social construction and political power of various populations groups identified in breast and prostate cancer congressional hearing testimonies.

Figure 5.5: Population Groups Identified in Breast and Prostate Cancer

Congressional Hearings

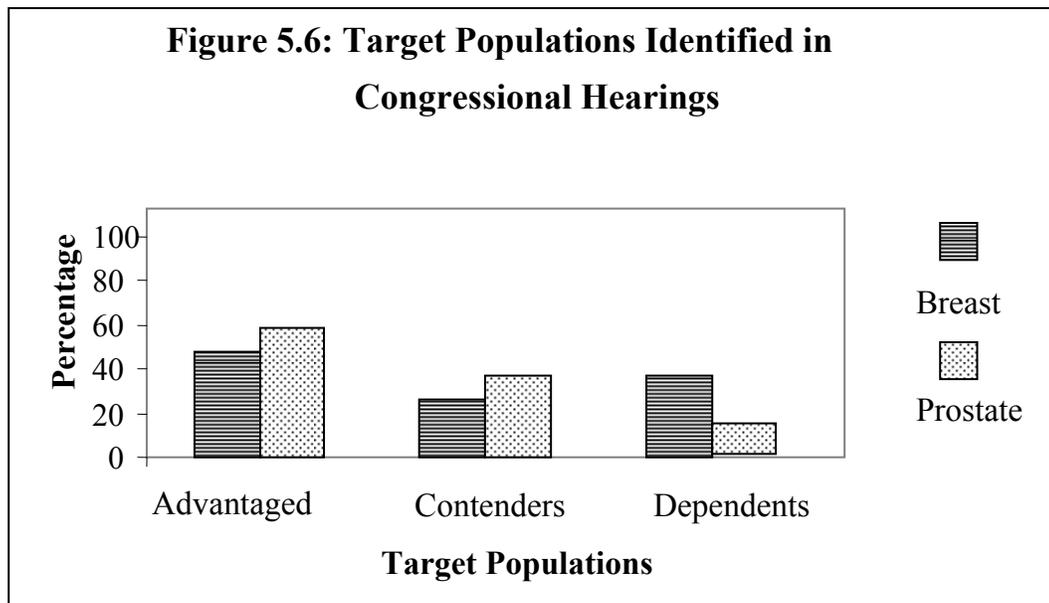
		Social Construction	
		<i>Deserving</i>	<i>Undeserving/Greedy</i>
Political Power/ Resources	<i>Higher</i>	“Advantaged” Over 40 Military	“Contenders” Affluent Congress Federal employee Minority
	<i>Lower</i>	“Dependents” Family Sick Underserved	“Deviants”

Source: Adapted from Ingram & Schneider (2009)

From the typology of target populations, the groups identified in breast and prostate cancer policy debates were categorized within three of the four target population types described in Ingram and Schneider’s framework (2009). These include *advantaged*, *contender*, and *dependent* populations. The only type of target population not included in testimonies by witnesses at congressional hearings was *deviants*. In hearings on breast and prostate cancer policy, *advantaged* groups were

the most commonly identified target population identified in congressional hearings.

This data is displayed in a bar graph in Figure 5.6.



Source: U.S. Congressional Hearings (1990-2006)

According to Schneider and Ingram (1997) *advantaged* groups tend to have positive social constructions and yield considerable amounts of political power that allows them to exert influence over policymaking. Stereotypes associated with *advantaged* groups consider them to be “deserving”, “respectful”, and “worthy” of receiving the benefits of policy. In looking at the mentions of population groups provided by witnesses on breast and prostate cancer policy, the largest group identified was the *advantaged*. Policy actors testifying at congressional hearings emphasized populations groups that I categorized as *advantaged* in 44 percent of

testimonies on breast cancer policy and 52 percent of testimonies on prostate cancer policy. These *advantaged* groups included: mentions of persons over age 40 (*over 40*) and military personnel (*military*). Figure 5.3 shows how these groups are categorized in Ingram and Schneider's (2009) framework.

Some examples from the text of various hearings show how these populations were described. A sample from a testimony by Diana Truglio, founder of The Women's Outreach Network in Long Island and a breast cancer survivor, in a 1991 hearing on breast cancer in Long Island, New York provides an example that I categorized as *persons over 40*. Her testimony emphasized the fact that women over 65 were confused by Medicare coverage, causing them to delay getting preventive mammogram screenings which could endanger their health.

The coverage for [mammography] screening which is biennial after the age of 65 is not in keeping with the recommendation of the American Cancer Society and this is often received with confusion by the elderly. Waive deductible and co-payment for screening mammography. The deductible is an impediment. It is a worrisome thing for these elderly. They do not get their mammograms in January, February, March, or April, until they have to go to a doctor for other reasons, and then they will have a mammography because they have already met the deductible, but they have to be forced into it. They wait until the very last moment (Breast Cancer on Long Island: An Avoidable Tragedy 13 September 1991, p. 21-24).

A sample from a testimony provided by Bill Schwartz, the Vice President of the National Prostate Cancer Coalition and a prostate cancer survivor, at a 1999 hearing on Defense Department Appropriations emphasized how prostate cancer affects active *military* personnel:

While this program plays an important role in finding a cure to protect all men, it can have a direct life-saving application for men in uniform. There are

nearly 2 million men in active service or in the Reserves. By the numbers, 1 in 6 will be diagnosed with clinically significant prostate cancer, so more than 300,000 of these men can expect to be diagnosed with this disease in their lifetime, and more than 50,000 will die from it. An investment in treatment programs, and eventually a cure for this disease will have the significant favorable impact on the cost of treating military personnel (Department of Defense Appropriations for 2000, Part 2 March 1999, p. 986-999).

Policy actors frequently mentioned the population groups that I categorized as *advantaged* because they already have positive public images and access to political power, irrespective of their association with breast and prostate cancers. Policy actors capitalized on these stereotypes to help achieve their policy goals. These groups were described by witnesses as victims of these illnesses who deserved governmental assistance. The *advantaged* have a history of favorable treatment by government, making the allocation of beneficial policy easier for these groups to attain. However, other population groups without positive social constructions and a history of favorable policy treatment, such as *contenders*, were also threatened by these illnesses and emphasized by policy actors during congressional hearings.

According to Schneider and Ingram (1997), *contender* groups tend to have negative social constructions but wield considerable amounts of political power. Several population groups mentioned by witnesses during congressional hearings were categorized as *contenders*. However, there was a notable distinction between breast and prostate cancer population groups here. In hearings on breast cancer, only 23.2 percent of the population groups identified were categorized as *contenders*. In hearings on prostate cancer, 38 percent of the population groups identified were

categorized as contenders. I identified more *contender* groups in hearings on prostate cancer policy. This may be attributed to the fact that specific minority groups, such as African-Americans, were frequently mentioned because they are considered one of the highest risk prostate cancer groups in the world (Walsh and Worthington, 2007).

The population groups mentioned by witnesses on breast and prostate cancer policy that I classified as *contenders* included the affluent (*affluent*), federal employees (*fedemploy*), members of Congress (*congress*), and minorities (*minority*). Figure 5.3 shows how these groups are categorized according to Ingram and Schneider's (2009) framework. According to Schneider and Ingram (1997, p. 108-109), the affluent and members of Congress tend to be very powerful but are considered greedy, inconsiderate of the effects of their actions, and undeserving. Hence, these authors view these groups as *contenders* who have political power but are typically constructed negatively. In hearings on breast cancer policy, the affluent were often portrayed by congressional witnesses as rich and/or upper-class women.

Members of Congress (*congress*) tend to be viewed by Schneider and Ingram (1997) as having an unfair advantage in the policy process because of their knowledge, experience, and kinship with colleagues. Similar to portrayals of Members of Congress, federal employees (*fedemploy*) are viewed as having an unfair advantage because of their knowledge of the political process combined with negative stereotypes about bureaucrats. It is important to understand this difference because *contenders* tend to have more political power, but typically negative social constructions. However, the testimonies provided by witnesses as researched in this

dissertation did not necessarily portray these population groups in a negative way. In fact, I found that these groups were often portrayed as needy and deserving of government attention. Some examples of these positive portrayals of stereotypically negative population groups demonstrate this trend.

In a 1993 hearing on the causes of cancer and environmental carcinogens, Dr. Devra Lee Davis portrayed *affluent* women with breast cancer as victims of the conflicting messages given to them by government and the medical community. In this way, Dr. Davis portrays a population with negative stereotypes and considerable political power as a needy group unable to use its resources to get answers about the causes of breast cancer. These women were mistakenly accused of being responsible for their own breast cancer diagnosis as a result of socioeconomic status, dietary habits, and childbearing choices. Her testimony is reminiscent of early depictions of breast cancer victims that assigned personal responsibility to victims as a result of their lifestyles and choices (Fossett, LaFia, and Karan 1990; Lantz and Booth 1998).

For almost a decade, as you are well aware, women on Long Island have been raising Cain about the high rates of breast cancer there. At first, they were told that the rates weren't really that high and, more recently, it was suggested that it was all just their fault. They were too rich, and too fat, and had eaten the wrong foods for years and, by the way, they had forgotten to have their children early enough. (Link Between Cancer and Environmental Contaminants and Industrial Carcinogens 30 October 1993, p. 111-114).

In a similar vein, Len Dawson, a Hall of Fame football player, prostate cancer survivor, and advocate, identified congressional members as a population group that was affected by prostate cancer being in a 1994 hearing. His testimony helped characterize politicians with negative public stereotypes and considerable political

power as likely victims of this illness. Portrayals such as these by congressional witnesses helped to dissolve previously constructed stereotypes about the kind of people that could be affected by this illness.

I also testify on behalf of the projected 165,000 men that will be diagnosed in 1993 with prostate cancer and for the projected 35,000 men that will die this year from this disease that we still know so little about. Many of your colleagues in Congress have been afflicted with the disease while others will soon stand a one-in-eight chance of being impacted (Departments of Labor, Health, and Human Services, Education, and Related Agencies Appropriations for 1994. Part 7: Testimony of Members of Congress and Other Interested Individuals and Organizations March 1993, p. 171-182).

Federal employees were also characterized as victims of these illnesses and of the federal health insurance system that did not help provide for their medical needs.

Renay Frances McCarty discussed her experience with the illness and lack of responsiveness from her federal health care plan in a 1994 hearing. She emphasized the fact that her health insurance plan “failed” her when she needed coverage for a bone marrow transplant, which helps to reinforce the fact that she was the victim of a bureaucratic system she served as a loyal employee for over 23 years.

I have had high option Blue Cross/Blue Shield under the Federal Employees Health Benefits Program for 23 years, my entire Federal career. I have had breast cancer for 14 years. In 1992, I knew that I either wanted to die or I wanted a bone marrow transplant. It took until 1993 to finally become an acceptable candidate for a bone marrow transplant at Emory University Hospital. That is in 1993, I became a candidate at Emory, and that is when I discovered that the entire Federal system and Blue Cross/Blue Shield failed me. I was denied coverage for the bone marrow transplant. I had fallen through the cracks of this system, and I was faced with having to come up with \$150,000 myself for treatment. Others need it and are sitting on a time bomb (Oversight Hearing on Federal Employees Health Benefits Plan FEHBP

Coverage of HDC/ABMT Treatment for Breast Cancer 11 August 1994, p, 17-19).

Other important *contender* groups with stereotypically negative images include various minority groups. Minorities are often portrayed as less powerful among the *contender* groups, but are still traditionally considered to be “undeserving” of beneficial policy (Schneider and Ingram, 1997). This is important to mention because minority groups tend to vary along the political power/social construction framework. For example, African-Americans tend to have a negative social construction and wield lesser amounts of political power than other groups in the contender group. Native-Americans tend to have a more positive social construction, are considered to be more “deserving” of beneficial policy, but wield less political power than African-Americans.

The minority groups mentioned in congressional hearings on breast and prostate cancer policy were both portrayed in a positive light. In testimonies on prostate cancer, African-Americans were often portrayed positively by witnesses because of the high-risk factor associated with this population group (Walsh and Worthington, 2007). Apart from this trend in hearings on prostate cancer policy, minority groups were generally grouped together and discussed as populations that were seriously impacted by these illnesses and in need of governmental assistance. Some examples from congressional hearings demonstrate this trend.

In a 1997 hearing on prostate cancer policy, Dr. David Crawford emphasized the need for greater attention to the needs of African-American men. African-American men were often characterized by witnesses as needy victims of government assistance because they have the highest incidence and death rates of prostate cancer in the world (Walsh and Worthington, 2007).

The bad news is this: that men have not declared war on prostate cancer. They need to do that. They need to recognize the important of it. We need to get African-Americans in for screening. They have the highest mortality in the world for prostate cancer (Hearing on Prostate Cancer: The Silent Killer 23 September 1997, p. 31-33).

Native Americans were often mentioned within a subset of minority groups in general. Special emphasis was placed on minority groups, in general, as a deserving population because these men and women tend not to get preventive health care (Love and Lindsey, 2005). In a 1993 hearing, Dr. Chryala emphasized a growing need for outreach to various minority groups that included Native American women without necessarily emphasizing this particular minority group.

Women who benefit from initiative activities include all women who are at risk for breast and cervical cancer. Special emphasis, however, is placed on outreach to African-American, Hispanic, and Native American women, and all their healthcare providers (Public Health Service Programs Reauthorization 19 April 1993, p. 62-76).

Although *contender* groups, despite having political power are generally seen in negative terms (Schneider and Ingram, 1997), with regard to hearings on breast and prostate cancer policy, I found that key policy actors discussed these groups in a positive way to help attract the attention of policymakers. Other groups, such as

dependents, presented a different challenge. These groups typically have positive social constructions, but little political power to influence policy. Because these groups lack power, there are few political advantages for policymakers in addressing their needs in public policy (Schneider and Ingram, 1997, p. 123).

Because *dependent* groups lack political power, congressional witnesses capitalized on the positive stereotypes of this population group and emphasized the neediness and deservedness of these groups by portraying them as victims of these illnesses. Consistent with the argument provided by Schneider and Ingram (1997), a heavy emphasis was placed on their helplessness to attract political attention. Population groups mentioned by witnesses on breast and prostate cancer policy that I categorized as *dependents* included: underserved populations (*underserved*), the sick (*patients*), and references to family (*family*). Figure 5.3 shows how these groups are categorized in Ingram and Schneider's (2009) framework. In hearings on breast cancer policy, I categorized 32 percent of the population groups mentioned by witnesses as *dependents*. In hearings on prostate cancer, 9 percent of the population groups mentioned were categorized as *dependents*.

Positive constructions of the poor and the sick tend to emphasize their helplessness that has given them to a “deserving” status (Schneider and Ingram, 1997). In breast and prostate cancer debates, underserved populations (*underserved*) tended to include low income, uninsured, unemployed, uneducated, migrant workers, and urban and rural groups with virtually no power to influence the policy process or help themselves. Portrayals of these groups by witnesses that emphasized the lack of

attention given to them by the healthcare system and policymakers helped elevate them to a more “deserving” status. In a 1991 hearing on breast cancer in Long Island, Dr. Clare Bradley emphasized the needs of uninsured women who were in desperate need of federal assistance to obtain mammograms. She focused on the changing demographic of women that were in need of federal assistance that created a burden in health clinics as a result of government inattention.

The Federal Government has to find a way to provide mammography coverage for those women who have no health insurance as well, and that is a very serious and growing problem. Congressman, in our health clinics we are seeing more and more people come into those clinics without insurance, laid off defense workers, construction workers and their families who don't have coverage because of the downturn in the national economy. It is no longer your traditional at-risk populations that utilize our health clinics. We are being overwhelmed by people who previously had health coverage, but lost it because they are unemployed or underemployed, so it is important to extend that coverage to all women, regardless of their means (Breast Cancer on Long Island: An Avoidable Tragedy 13 September 1991, p. 8-10).

When referring to those suffering from breast or prostate cancer, witnesses often used the term “patient” when talking about themselves or others. The word “patient” conjures up images of a person who is suffering from the disease. The sick (*patients*) are generally considered to be a deserving population, if afflicted with a disease that is not self-induced by virtue of one's lifestyle choices. The terms *patient* or *sufferer* were commonly used to refer to victims and/or survivors of breast and prostate cancers. In a 1992 testimony, Denise Villareal described her experience with breast cancer and portrays herself as a victim of a medical establishment that ignored her health concerns.

In February of 1990 I started experiencing problems with my right breast, but I was assured by a physician at a breast cancer screening clinic that I had nothing to worry about. A few months later, August of 1990 found me still having serious problems. I had moved to a new State and did not have a primary care physician, so I went out to a local hospital as an emergency room patient. Cancer had called at my door and was knocking with a vengeance (Breast Cancer: Winning the Battles, Losing the War 1 October 1992, p. 47-49).

The family and family members (*family*) were frequently mentioned in testimonies by witnesses in both breast and prostate cancer hearings. Similar to the discussion provided earlier on how the *family* was used as a rationale to incite policy change, families were commonly discussed by witnesses. This often included discussions of spouses, parents, grandparents, children, and siblings of those who were affected by a diagnosis of breast or prostate cancer. Although *family* does not necessarily have a place on the political power/social construction continuum provided by Schneider and Ingram (1997), the notion of *family* does convey a powerful, positive image that helps to strengthen the social constructions that breast and prostate cancer advocates were trying to create that is worth noting here. Because policymakers often seek to enact policies that are consistent with public values (Schneider and Ingram, 1997), emphasizing the *family* was an effective way to characterize victims of these illnesses. A 1990 hearing by NCI Director, Samuel Broder, emphasized the fact that families were victims of breast cancer as well as the person suffering with the disease.

Breast and lung cancer are leading women's health issues. The death and suffering cause by breast cancer is also a family issue. Breast cancer can

disrupt families and can have indirect but profound effects on children and young people (Breast Cancer: Race For the Cure 16 May 1990, p. 58-62).

The various population groups affected by breast and prostate cancers that were mentioned by witnesses are an important aspect of understanding the way these illnesses were defined by policy actors at congressional hearings. By framing these population groups as victims of these illnesses who required and deserved government attention, policy actors sought to portray positive images of these groups. By doing so, policy actors showed that these illnesses were nondiscriminatory in nature which helped to complement the framing of breast and prostate cancers as critical public issues for government to solve.

Policy actors testifying for both breast and prostate cancer policy also sought, at times, to deconstruct negative images associated with some of the groups. They presented policymakers with new and different images of these groups that disassociate them from socially constructed stereotypes that portray them as negative or undeserving of policy attention. For instance, Donovan (2001) notes that they may have redefined these groups with negatively constructed stereotypes or little political power in ways that made the allocation of benefits to these groups more politically attractive to policymakers.

In addition to the other policy actors, policymakers themselves often play a role in defining various population groups and public issues. Social constructions are also created by policymakers because they have policy goals to achieve and target populations that they are seeking to influence. Because policymakers are “always

anxious not to be caught in opposition to prevailing values, elected political leaders often succumb to prevailing images and stereotypes—or participate in creating new ones” (Schneider and Ingram, 1997, p. 192). In this way, policymakers play an important role in the social construction process. The next section focuses on the testimonies provided by members of Congress themselves to understand how policymakers defined these illnesses and their related population groups.

Policymakers Define Breast and Prostate Cancers on the Institutional

Agenda

Up until this point, the content analysis discussed here has focused on the congressional testimonies by different types of policy actors such as medical professionals, advocates, celebrities, and members of Congress. The goal of policy actors such as medical professionals, advocates, and celebrities was to define breast and prostate cancers in ways that were politically attractive to policymakers so as to influence their decision-making.

Ultimately, however, it is congressional members, in their role as policymakers, who decide what policy actions to take. In the data analyzed here, the testimonies of congressional members were examined to understand how these policy actors perceived breast and prostate cancers as well as those who suffer from these diseases. These testimonies show the significant role policymakers themselves play in the social construction process, by providing their own definitions of the public issue/s under consideration (Schneider and Ingram, 1997). By analyzing the rationales

and target populations provided by congressional members themselves, we have a better understanding of how policymakers themselves conceptualized the illnesses and related groups.

Congressional members frequently provided their own rationales for breast and prostate cancer policy change during hearings. Similar to the data presented in the previous sections, the most commonly provided rationales emphasized *stories of decline* that indicated the number of people being diagnosed with these illnesses would continue to increase. Congressional members advocating on behalf of breast cancer policy tended to use the *personal stories* rationale more frequently than congressional members who advocated on behalf of prostate cancer policy. More often than not during breast cancer hearings, congressional members told stories about their own diagnosis, that of another member of Congress, or a constituent's experience with the illnesses. These testimonies tended to be very emotional and personal in nature. Fewer of these types of testimonies were identified in prostate cancer debates because members of Congress tended to emphasize the growing financial *burden* placed on society by an increasing incidence of the illness. Generally, although there were exceptions, congressional members testifying on behalf of prostate cancer policy tended not to discuss their personal experiences or those of others. This is consistent with the argument that men are less likely to discuss their health concerns than women (Broom 2004; Courtenay 2000). The data is presented in Table 5.2.

Table 5.2: Primary Rationales by Policymakers in Congressional Breast and Prostate Cancer Debates

	<i>Breast Cancer</i>	<i>Prostate Cancer</i>
<i>Stories of Decline</i>	65%	79%
<i>Personal Stories</i>	18%	1%
<i>Family</i>	11%	7%
<i>Everyone</i>	0%	0%
<i>Burden</i>	6%	13%
<i>Totals</i>	<i>100% (N=65)</i>	<i>100% (N=15)</i>

Source: U.S. Congressional Hearings (1990-2006)

Similar to the data discussed in the previous section, members of Congress frequently mentioned the various population groups that were affected by these illnesses. I identified the various population groups that members of Congress discussed in their testimonies and categorized them into the four target population types identified by Schneider and Ingram (1997). I categorized these population groups according to the descriptions of various target groups provided by Schneider and Ingram (1997). That data is presented in Table 5.3. Members of Congress testifying on behalf of policy change for these illnesses discussed different population groups. Congressional members in hearings related to breast and prostate cancer emphasized populations that were categorized as *contenders*. In hearings on breast and prostate cancers, the most commonly mentioned population by congressional

members were other congressional members had personal experiences with the illnesses. This is consistent with Kingdon’s (1995, p. 57) argument that policymakers frequently draw upon their own experiences or the experiences of friends and/or colleagues to positively define public issues that they support. Donovan (2001) also found that it is important for policymakers to get the support of other congressional members by making policy proposals attractive to their congressional colleagues (p. 17). Using Schneider and Ingram’s classification scheme, I categorized mentions of other congressional members by policymakers as being part of the *contender* group.

Table 5.3: Target Populations Identified from Policymakers’ Testimonies in Congressional Hearings

	<i>Breast Cancer</i>	<i>Prostate Cancer</i>
<i>Advantaged</i>	3%	36%
<i>Dependents</i>	39%	28%
<i>Contenders</i>	58%	36%
<i>Deviants</i>	0%	0%
Total	100 % (N=119)	100% (N=33)

Source: U.S. Congressional Hearings (1990-2006)

Another important finding to mention when analyzing the population groups discussed by congressional members is the difference between *advantaged* populations mentioned in breast and prostate cancer debates. In hearings related to

breast cancer, population groups, such as *persons over 40* and *military* personnel that could be categorized using Schneider and Ingram's framework as *advantaged* groups, were not frequently mentioned by congressional witnesses. However, in prostate cancer debates *advantaged* groups such as *persons over 40* and *military* personnel were more frequently mentioned by these congressional witnesses. This can be attributed to the fact that many congressional members, often male, are supportive of issues that relate to older populations and the military since these groups generally have considerable amounts of political power. Many of congressional members also shared characteristics of the *advantaged* population groups by virtue of age and previous military service.

Examples of these various trends can be seen in the testimonies of several policymakers who had personal experiences with these illnesses. Bob Dole, a former U.S. Senator from Kansas, was a frequent witness at hearings addressing issues related to prostate cancer. Dole's *personal story* helped to reinforce the nondiscriminatory nature of the illness. His testimonies are particularly notable because they are often preceded by light-hearted conversations and joke-telling with other members of Congress during hearings. This may be attributed to the fact that men have traditionally been less comfortable when talking about their health problems (Walsh, 2000) and may reveal some level of discomfort when discussing prostate cancer. This type of discourse differed greatly from the type observed in hearings on breast cancer, which was of a more serious and emotional nature. Former

Senator Dole provided a *personal story* of his prostate cancer diagnosis at a 1997 hearing:

So I thought, first of all, it had to be a mistake because I couldn't have had anything like this. But it was me and I wasn't even certain that I knew---you know, I had heard about prostate cancer but I never really focused on it because I thought it always happened to somebody else. I remember talking to Dr. Krasner, who was the Capitol physician. He didn't find anything serious about my exam but he did give me a blood test called a prostate specific antigen test or PSA, and the first test turned up a level of 4.8 and this I was told was considered to be elevated, but not by much. Usually 0 to 4 is normal so I said well, it would probably be better next time. It was better; it was 6.9 and then to 8. I finally had the biopsy and was told, "You have a problem." The result was positive. On December 18, 1991, I underwent what they call a radical prostatectomy by Dr. David McLeod who will be here later this morning. He advised me that they had gotten it all and everything was going to be all right and the good news was that I would need no further treatment, other than periodic PSA tests. Almost 6 years later my PSA test remains at 0. I guess after the operation I was relieved, like anybody would be after any operation, man or woman, regardless of what it may be (Prostate Cancer: The Silent Killer 23 September 1997, p. 3-6).

In a 1999 hearing, Rep. Randy "Duke" Cunningham emphasized a growing and sizable *incidence* of prostate cancer by discussing his experience and made mention of other congressional members who have been affected by the illness.

Mrs. Gallo [wife of late Rep. Dean Gallo who died of prostate cancer], unlike Strom Thurmond, I didn't know Abraham Lincoln, but I did know your husband and he reminded me a lot of my dad. He was a big, unassuming guy and I can still remember his smile. We all miss him. And I would say to my former colleague, Senator Dole, the day after I found out I had prostate cancer, I called Bob Dole (Fighting Prostate Cancer: Are We Doing Enough? 23 September 1999, p. 52-55).

Similarly, congressional members testifying on behalf of breast cancer policy also told of their personal experiences with breast cancer. In a 1990 hearing, breast

cancer victim Rep. Barbara Vucanovich discussed her own experience with breast cancer. In response, Rep. Mary Oakar applauded her for her willingness to tell her story and reinforced the fact that many other members of Congress have experience with the illness.

Rep. Vucanovich: My interest in helping to drive down the tragic number of deaths from breast cancer stems from my own personal experience. Although I had always been very conscientious about regular checkups, and although I was 61 years old, no one had ever mentioned anything about mammograms to me before (Breast Cancer: Race For the Cure 16 May 1990, p. 27-28).

Rep. Oakar [in response]: And thank you for your leadership on this issue and for talking about your personal experience. It's interesting to me how many of us have members of our families who have had breast cancer are affected by this terrible disease, and we need to have more people like yourself come out and speak about it (Breast Cancer: Race For the Cure 16 May 1990, p. 29-30).

Results of this section of the content analysis demonstrate the important role that policymakers play in defining public issues and their associated populations. It is important to understand the role policymakers play in this significant phase of the social construction process because it can reveal important clues as to why certain policy decisions are made as opposed to others. While policy actors are significant in understanding how issues and their related populations are defined, the definitions that policymakers provide during hearings gives insight into how they themselves conceptualize issues and their related populations.

Analyzing the way that policymakers discussed these illnesses also provides important insights into theories on gender and illness. From the literature on gender

and illness, it has been suggested that men and women behave very differently when it comes to talking about their own health problems. Women are characterized as being more sensitive and forthcoming when it comes to talking about their own health problems (Foreman, 1995). Men are less aware of their own health problems, much less likely to talk about their health concerns, and express less sensitivity about their health than women (Broom 2004; Courtenay 2000).

An interesting phenomenon that was discovered in the congressional hearings analyses conducted here was the fact that men and women behaved differently when it came to discussions of their own health concerns and of the health concerns of the opposite sex. For hearings on both breast and prostate cancer policy, both male and female policymakers testified on behalf of policy change for both of these illnesses. It is important to note that the number of male policymakers testifying on behalf of breast cancer policy was considerably larger than the number of female policymakers testifying on behalf of prostate cancer policy. In fact, only two female policymakers testified on behalf of prostate cancer policy while 15 male policymakers testified on behalf of breast cancer policy.

Curiously, male policymakers seemed to express more emotion and sensitivity when talking about breast cancer. The overall tone of their testimonies was more somber and sympathetic. During prostate cancer debates, the overall tone of the testimonies provided by primarily male policymakers seemed to be more light-hearted, less serious, and notably less emotional. In the analyses discussed here, this implies some support for the argument that men and women behave differently when

it comes to talking about the health problems of the opposite sex, as well as their own. Further research is needed to determine if this phenomenon is consistent when males and females discuss other illnesses that are gender-specific or if this finding is specific to breast and prostate cancers.

Conclusion

Once on the institutional agenda, public issues are under serious consideration by policymakers. Hence, it is extremely important that these issues are defined in ways that policymakers will find politically attractive. This chapter discussed the way that breast and prostate cancers were defined by advocacy groups and policymakers in congressional hearings held from 1990 to 2006. The embedded collective case study and content analysis of testimonies provided at congressional hearings show how these definitions contributed to the social construction processes of these illnesses. This chapter examined the types of witnesses that testified, the rationales witnesses provided for policy change, the policy goals proposed by witnesses, and the various population groups that were linked to breast and prostate cancers. I also analyzed the similarities and differences between breast and prostate cancer in terms of the types of witnesses that testified, the rationales provided, policy goals proposed, and population groups mentioned in the testimonies. Examining how breast and prostate cancers were defined on this level of the agenda provides important clues that help indicate why certain types of policies are adopted to deal with public issues.

VI. BREAST AND PROSTATE CANCER POLICY ADOPTION

After issues are debated on the institutional agenda, policymakers must then make decisions on the types of actions that are appropriate to deal with them. During policy adoption, policymakers must make critical decisions about which issues and which people affected by them are considered most important. Ultimately, the policy adoption phase of the policy process reveals how the social constructions of public issues in previous phases of the policy process were interpreted by policymakers and enacted into law. The purpose of this chapter is to examine the various types of policies that were adopted to deal with breast and prostate cancers. Policy provisions that were identified in public laws passed on these illnesses were analyzed to understand the specific types of policy solutions that were chosen to deal with breast and prostate cancers.

To that end, the embedded collective case study and content analysis in this chapter analyzes the policy provisions found in public laws passed on breast and prostate cancers from 1990 to 2006. The first part of the chapter presents the results of content analysis performed on policy provisions identified in public laws on breast and prostate cancers to understand how the social constructions of these illnesses impacted federal policy. The second part focuses on the amount of money allocated to research on breast and prostate cancers from 1990 to 2006, to understand and

highlight differences in research funding allocated to these illnesses. A consistent theme that is analyzed throughout this analysis is the difference between breast and prostate cancer policy provisions.

Policy Adoption

Policy provisions identified in public laws on breast and prostate cancers were analyzed to show how the social constructions of these illnesses influenced policymaking. Content analysis was conducted on policy provisions related to breast and prostate cancers that were identified in public laws passed from 1990 to 2006. From the 57 public laws passed on breast and prostate cancers that were identified in a search of the LexisNexis Congressional database, 184 policy provisions were identified. Of the provisions identified, 129 provisions were related to breast cancer while 55 provisions were related to prostate cancer.

The manifest analysis of policy provisions on breast and prostate cancers was carried out in four steps to understand how the social constructions of these illnesses impacted policy. Within each of the four steps, each provision was only counted one time per step. For the purposes of consistency, the same 184 policy provisions were analyzed in each of the four steps of analysis. These four steps included: a) determining whether provisions implied a benefit or restriction (design type), b) determining whether implementation of provisions was required or discretionary (requirement), c) determining the type of policy provision (types of policy provisions), and d) identifying specific groups targeted as recipients of policy (population groups).

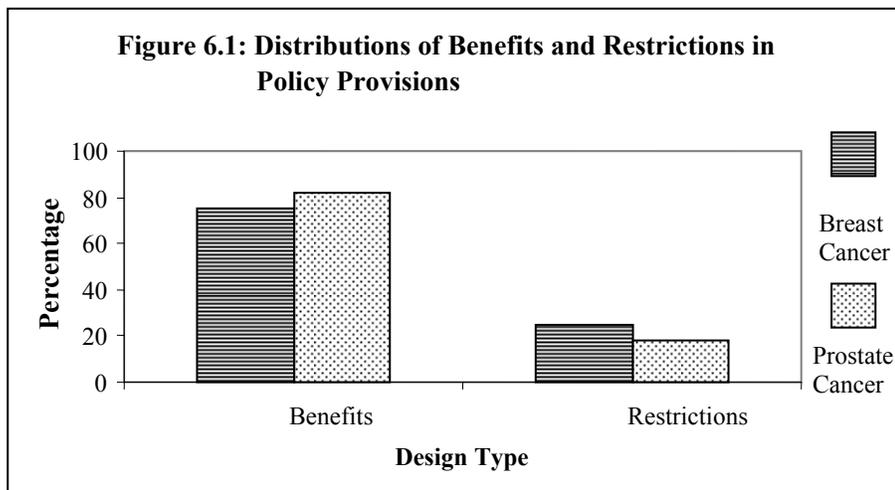
Design Type

According to Schneider and Ingram (1997, p, 112-113), the distribution of benefits and restrictions (or burdens) is important in understanding social construction in relation to policy design. Policies communicate messages to the public about values that are considered to be most important in society. Policy designs confer worth and deservedness to various groups through the allocation of benefits and burdens (Schneider and Ingram, 1997 p. 112). Beneficial policies convey messages that represent policy targets as worthy or deserving of government assistance. Restrictions (or burdens) in policy designs convey messages that policy targets have less worth and deservedness in society.

In this dissertation, I used Schneider and Ingram's (1997) conceptualization to identify benefits and restrictions conferred in breast and prostate cancer policies. Using their definition, the policy provisions identified in public laws on breast and prostate cancers allocated more beneficial than burdensome policy. From the 184 policy provisions identified, 75 percent of breast cancer provisions allocated benefits while 82 percent of prostate cancer provisions allocated benefits. This data is shown in a bar graph in Figure 6.1.

Interestingly, these findings are consistent with Donovan's (2001) argument that policymakers prefer to allocate beneficial policy in order to placate the electorate. Utilizing the same method of analysis, Donovan (2001) examined policy provisions found in public laws on AIDS and needle exchange. The results of his study showed

that target populations with negative public images, such as those diagnosed with AIDS, were often the targets of beneficial policy interventions.



Source: Policy Provisions Found in Public Laws (1990-2006)

Beneficial policy included provisions that created new programs or allocated funds. Two examples are provided from the text of public laws that included beneficial policy provisions: The Stamp Out Breast Cancer Act and a Department of Defense Appropriations Act. In 1997, The Stamp Out Breast Cancer Act was passed to create a new program with the U.S. Postal Service that allowed postal patrons to contribute to funding for breast cancer research through the voluntary purchase of specially issued postage stamps.

In order to afford the public a convenient way to contribute to funding for breast cancer research, the Postal Service shall establish a special rate of postage for first-class mail under this section (P.L. 105-41, 1997).

In 1993, The Department of Defense Appropriations Act allocated funds to the Army in order to establish a peer reviewed breast cancer research program. A more detailed discussion of this program at The Department of Defense is provided in the section on funding allocations for breast and prostate cancer research. The Act stated that:

That \$ 210,000,000 of the funds appropriated in this paragraph shall be available for a peer reviewed breast cancer research program with the Department of the Army as executive agent (P.L. 102-396, 1992).

Although the majority of provisions conferred benefits to policy targets, restrictive or burdensome policy provisions were also identified. Policy provisions were considered to be restrictive (or burdensome) if they imposed strict eligibility requirements for the provision of services or limitations on spending. From the total population of policy provisions identified, 25 percent of breast cancer policy provisions allocated restrictions, while only 18 percent of prostate cancer provisions allocated restrictions.

Examples of restrictive policy provisions for both breast and prostate cancers include restrictions on grant money, requirements on services provided to outpatients, requirements of non-federal contributions for grant approval, and/or requirements that agencies use superior screening technology that meet federal guidelines. Some examples of restrictive policy provisions were: The Breast and Cervical Cancer Mortality Prevention Act and the Preventive Health Amendments Act. The Breast and Cervical Cancer Mortality Prevention Act of 1990 was enacted to establish a program

of grants for the detection and control of breast cancer. Grants allocated for the provision of programs and services for breast cancer contained restrictions on how money could be allocated, indicating that only a certain percentage of funds be used for administrative expenses.

Limitation on Administrative Expenses. The Secretary may not make a grant unless the State involved agrees that not more than 10 percent of the grant will be expended for administrative expenses with respect to the grant (P. L. 101-354, 1990)

The Preventive Health Amendment of 1992 was established to revise and extend the program of block grants for preventive health and health services, and for other purposes. Grants allocated for prostate cancer screenings were included with strict requirements that prevented the use of grant funds for inpatient services.

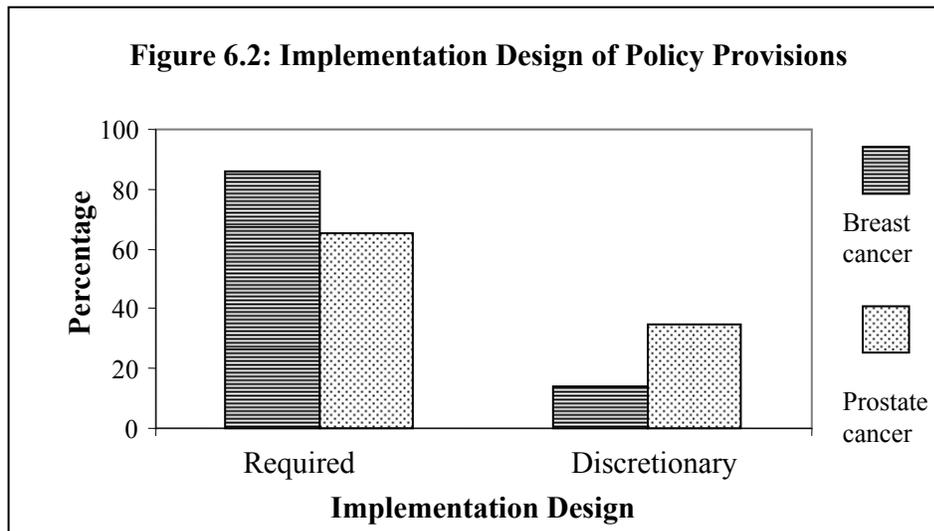
Restrictions on use of grant [for prostate cancer screenings]. The Secretary may not make a grant under subsection (a) unless the applicant involved agrees that the grant will not be expended to provide inpatient hospital services for any individual (P.L. 102-531, 1992).

In terms of comparing the benefits and restrictions identified from policy provisions in public laws on breast and prostate cancers, there are notable differences once again. Although both cancers received more beneficial policy than restrictive, prostate cancer received more beneficial policies than breast cancer as a percentage of the total number of provisions for each cancer. This can be attributed to the fact that more funding was allocated to breast cancer, along with more rules and restrictions placed on how programs would be implemented and how money would be spent.

Because there was less funding allocated to prostate cancer, restrictions on that funding were not quite as prevalent.

Implementation

Beneficial and restrictive policy provisions are important because they allocate values to various target populations (Schneider and Ingram, 1997). Similarly, required and discretionary policies also assign values to policy implementers. Implementation designs can allocate discretion to or restrict it from those that implement the policy decisions made by policymakers (Schneider and Ingram, 1997). Policy provisions contain messages about the relative significance of a policy action through the use of terms such as *shall* (required) and *may* (discretionary). For both breast and prostate cancer provisions, over 60 percent of the provisions articulated measures that were required. For breast cancer, 86 percent of the policy provisions stated requirements while 65 percent of prostate cancer provisions did so. Results are shown in Figure 6.2.



Source: Policy Provisions Found in Public Laws (1990-2006)

Policy provisions where implementation was required (*shall*) conveyed the message that the policy issues being treated were important and required direct action. Little room was left for discretion on the part of policy implementers. With required policy provisions, implementers are unable to stall or prevent a policy from being implemented. Policy provisions that were coded as required included the word “shall” in the text. Some examples of policy provisions that were coded as requirements are provided below. The National Defense Act for FY1994 required the provision of medical care to female members and former members of the uniform services.

Female members and former members of uniformed services entitled to medical care under section 1074 1074a of this title *shall* (emphasis added) be entitled to primary and preventive health care services for women as part of such medical care such as breast examinations and mammography (P.L. 103-160, 1993).

The Stamp Out Breast Cancer Act of 1997 required the U.S. Postal Service to provide postal patrons with a specially issued stamp to contribute to funding for breast cancer research.

In order to afford the public a convenient way to contribute to funding for breast cancer research, the Postal Service shall (emphasis added) establish a special rate of postage for first-class mail under this section (P.L. 105-41, 1997).

Policy provisions where implementation was discretionary (“may”) allowed implementers to exercise more discretion in how they spent federal dollars, whether or not they implemented a program, and/or how they chose to do so. Policy implementers were given greater control and decision-making power with discretionary policies. An example of a policy provision that was categorized as discretionary is provided in the Preventive Health Amendments Act of 1993 that revised and extended the program of grants related to preventive health measures with respect to breast cancer. This provision gives the Secretary of Health and Human Services discretion in distributing grant monies.

The Secretary, acting through the Director of the Centers for Disease Control and Prevention, *may* (emphasis added) make grants to tribes and tribal organizations for the purpose of carrying out programs described in section 1501(a). (P.L. 103-183, 1993).

Required and discretionary policy provisions allocate discretion to those that implement policy decisions (Schneider and Ingram, 1997). Policy provisions communicate messages about the significance of public policy through the use terms

such as *shall* (required) and *may* (discretionary). The results from this analysis of policy provisions on breast and prostate cancers indicate that required policy was most commonly identified in public laws on these illnesses. This shows the extent to which policymakers considered these illnesses to be important public issues that required implementation.

In comparing required and discretionary policies on breast and prostate cancers, there were slight differences. The overall percentage of required policy provisions on breast cancer was considerably greater than the overall percentage of required policy provisions on prostate cancer. Based on this analysis, it can be concluded that policymakers desired greater amounts of control over the implementation of breast cancer policy provisions than prostate cancer provisions. This can be attributed to the fact that because breast cancer was a more popular political issue, the perceived electoral benefits to policymakers were considered more important. This is consistent with Schneider and Ingram's (1997) argument that policymakers exert greater control over implementation designs when it is politically advantageous to them.

Types of Policy Provisions

In addition to understanding how important implementation designs are in policy provisions, it is also important to look at the various types of policy provisions that policymakers selected to deal with public issues. The types of provisions selected

are critical because they are intended to modify the behavior of the persons or groups a particular policy is attempting to target (Schneider and Ingram, 1997, p. 93). Policy provisions are important because they send messages about how populations targeted for policy are to be treated. Depending on the type of provision, they may be treated coercively or noncoercively, as smart or stupid, and as clients of a deserving service or objects to be manipulated (Schneider and Ingram, 1997, p. 93).

In public laws on breast and prostate cancers, five main types of policy provisions were identified: *testing*, *research*, *treatment*, *education*, and *symbols*. Next, the types of policy provisions that were identified in public laws were compared with the policy goals identified by witnesses at congressional hearings on breast and prostate cancers discussed in Chapter V. This comparison helps us to better understand how issue definitions provided during congressional hearings influenced policy decision-making. Policy goals provided during congressional hearings represented the problem solutions that were recommended by policy actors. Those policy actors that have the power to define public issues and propose solutions that are politically attractive to policymakers are better positioned to achieve their policy goals (Schneider and Ingram, 1997). Results of the content analysis on policy provisions will indicate if the proposed policy solutions debated during congressional hearings found their way into public law.

The most common policy provision identified for policies on both breast and prostate cancers was a type of provision that I labeled as *testing*. Policy provisions on *testing* emphasized the need for better screening guidelines, greater availability of

screening tests to underserved or at-risk groups, and changes in insurance coverage.

In breast cancer policy provisions, 40 percent pertained to *testing* while 32 percent of prostate cancer policy provisions were related to *testing*.

Some examples from the text of public laws demonstrate a policy provision that emphasized testing. The Balanced Budget Act of 1997 provides prostate cancer screening tests for men that are eligible for Medicare coverage.

Prostate cancer screening tests shall be provided for the purpose of early detection of prostate cancer to a man eligible for Medicare coverage over 50 years of age who has not had such a test during the previous year to include DRE (digital rectal exam) and PSA (prostate-specific antigen) tests. (P.L. 105-033, 1997)

This particular provision emphasizes the availability of prostate cancer screenings tests to men, but contains eligibility restrictions based on the age of a man and the date of last screening test. *Testing* provisions similar to this one are not intended to be coercive, but attempt to influence men to get preventive screening tests. In *testing* provisions like this, the responsibility for taking action on policy is placed on the group of persons that this specific policy provision targets. Policy goals that emphasized changes to policies on testing for breast and prostate cancers were commonly mentioned by witnesses at congressional hearings. This type of provision sends the message that policymakers are taking a proactive approach to reducing incidence by providing the screening tests.

The second most commonly identified policy provision was for *research*. In breast cancer provisions, 24 percent were related to *research* while 23 percent of

prostate cancer provisions were related to *research*. The Cancer Registries Act of 1992 was passed to conduct research studies in certain states to determine the factors that were contributing to elevated breast cancer mortality rates.

(a) In General. Subject to subsections (c) and (d), the Secretary, acting through the Director of the National Cancer Institute, shall conduct a study for the purpose of determining the factors contributing to the fact that breast cancer mortality rates in the States specified in subsection (b) are elevated compared to rates in other States. (b) Relevant States. The States referred to in subsection (a) are Connecticut, Delaware, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Rhode Island, Vermont, and the District of Columbia. (P.L. 102-515, 1992).

A focus on *research* is intended to enable learning about a particular policy issue. By providing money for research on these illnesses, government communicates the message that more knowledge needs to be gained about breast and prostate cancers. Increasing knowledge on public issues can help catalyze new and different approaches to dealing with these illnesses. It also represents a deviation from past patterns of treating these illnesses. This helps signal an openness to change, instead of a rigid adherence to conventional thinking about these illnesses (Schneider and Ingram, 1997, p. 96). Policy provisions on *research* focused on the allocation of funds to various government agencies for increased research, the creation of new research programs, and the requirement of specific research studies to be conducted.

In congressional hearings analyzed in Tables 5.2 and 5.3 in Chapter V, witnesses emphasized *research* as a policy goal most frequently in congressional debates on breast and prostate cancers. In the cases of breast and prostate cancers, it

can be concluded that policy actors were successful in recommending specific policy changes that were then enacted into law.

An understanding of the influence that congressional witnesses had on policy decision-making on breast and prostate cancers can be linked to agenda-setting theory. Issues that reach the federal agenda are often defined in ways that make them attractive to policy makers (Baumgartner and Jones 1993; Cobb and Elder 1972). By defining these illnesses as growing in incidence, policy actors successfully ensured that breast and prostate cancers would reach the decision agenda. Policy actors such as advocacy groups and congressional members with access to political power provided policy goals to deal with these illnesses, goals that were translated into federal law. This is consistent with the argument provided by Schneider and Ingram (1997) that those in society who control the definitions of public issues and have access to considerable power are often able to achieve their policy goals. Although the most commonly identified policy provisions included a focus on *testing* and *research*, several other types of provisions were also identified.

The third most commonly identified policy provision related to *treatment* services. In breast cancer provisions, 24 percent pertained to *treatment*, while 24 percent of prostate cancer provisions were related to *treatment*. The percent of provisions that focused on *treatment* was the same for both illnesses. These provisions primarily emphasized the treatment services that were provided to specific population groups such as the underserved, at-risk, or minority populations. An example of a policy provision that focused on treatment was identified in the

Department of Defense Appropriations Act of 1999. This Act provided Department of Defense funding for users of the Defense Health Network to have access to treatment for breast cancer. In 1999, \$25 million dollars was dedicated to breast cancer prevention, education, and diagnosis. The allocation of these monies for treatment was due to the public attention that breast cancer had received, the lobbying efforts of breast cancer advocates, and the number of women being served by the Defense Health Network at the time which was more than 2 million women in 1998. An excerpt from this 1999 Act serves an example of a policy provision that was categorized as *treatment*.

For expenses, not otherwise provided for, for medical and health care programs of the Department of Defense, as authorized by law; \$ 10,149,872,000, of which \$ 9,727,985,000 shall be for Operation [**2295] and maintenance, of which not to exceed 2 per centum shall remain available until September 30, 2000, of which \$ 402,387,000, to remain available for obligation until September 30, 2001, shall be for Procurement, and of which \$ 19,500,000, to remain available for obligation until September 30, 2000, shall be for Research, development, test and evaluation: Provided, That of the amounts made available under this heading for Operation and maintenance, not less than \$ 25,000,000 shall be only for breast cancer treatment and access to care. (P.L. 105-262, 1998)

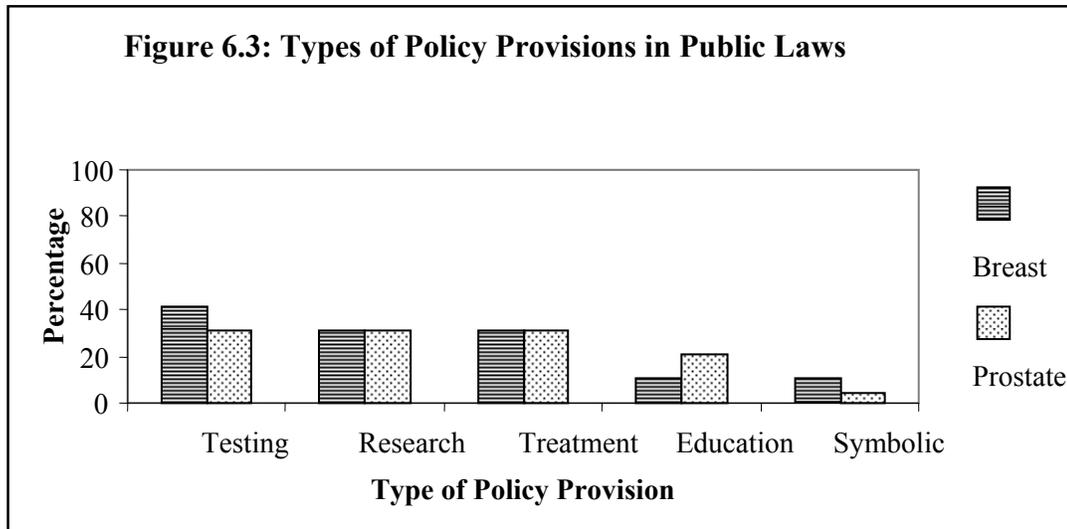
Less commonly provided provisions related to *education* and those that were primarily *symbolic* in nature. Policy provisions that focused on *education* were primarily concerned with the creation of public awareness campaigns and outreach programs to educate the public about these illnesses. An example of a policy provision from The Breast and Cervical Cancer Mortality Act of 1990 that was

related to *education* is provided. The Act allowed for the Secretary of Health and Human Services to establish a program of grants for the detection and control of breast and cervical cancers. A stipulation in the grant allocated to states to prevent breast cancer required the development and dissemination of public information programs.

(a) In general. -- The Secretary, acting through the Director of the Centers for Disease Control, may make grants to States on the basis of an established competitive review process for the purpose of carrying out programs "(3) to develop and disseminate public information and education programs for the detection and control of breast cancer. (P.L. 101-354, 1990).

Often, policy provisions are not passed to invoke policy change, but to bring awareness to certain public issues. *Symbolic* provisions are general statements to the public that do not engender policy change, but are just general announcements and public proclamations. Provisions such as these are significant because they aim to change public values or convince the public that the behavior needed to achieve policy objectives is consistent with the values already held (Schneider and Ingram, 1997, p. 95). A 1994 policy provision permitted that the St. Louis Gateway Arch to be adorned with pink lights to celebrate Breast Cancer Awareness Month is an example of a *symbolic* policy provision. This *symbolic* provision did not attempt to influence the behavior of specific policy targets, but simply to honor those who have suffered from breast cancer and draw attention to the issue.

In honor of breast cancer awareness month, the Secretary of the Interior shall authorize the Gateway Arch in St. Louis, Missouri, to be illuminated by pink lights for a certain period of time in October, to be designated by the Secretary of the Interior. (P.L. 108-348, 2004)



Source: *Policy Provisions Found in Public Laws (1990-2006)*

In policy provisions on breast and prostate cancers, provisions that emphasized *testing* and *research* were most commonly identified. With the exception of provisions that emphasized *testing* or *education*, the percentages of policy provisions for each illness were relatively consistent. Policy provisions are helpful in understanding how policymakers sought to influence the behavior of policy targets, but do not tell us much about the policy targets themselves. Identifying the various population groups that were singled out for policy treatment gives us more detailed information about the groups that policies targeted for treatment.

Population Groups and Target Population Types

Policy provisions were also analyzed to identify the various population groups and target population types singled out for intervention. From the total population of 184 policy provisions that were identified from public laws on breast and prostate cancers, 203 mentions of various population groups were identified. These groups were categorized in a similar method to the population groups and target population types identified in congressional hearings on breast and prostate cancer policy. From the coding of policy provisions, eight population groups were identified to include: persons over age 40 (*over 40*), active and or retired military personnel (*military*), persons who work in the research and/or medical field (*medical*), African-American, Native-American, Hispanic, Asian, or general use of the term minority (*minorities*), *underserved*, *sick*, *at risk*, and those exposed to radiation (*radiation*).

The population groups identified in policy provisions were similar, but not identical to the groups identified in congressional hearings. The population groups identified in congressional hearings and in policy provisions are compared in Table 6.1. Five population groups commonly mentioned in congressional hearings were also the targets of policy treatment in policy provisions including: *persons over 40*, *minorities*, *underserved*, *patients*, and *military*.

Table 6.1: Comparisons of Target Populations Identified in Congressional Hearings and Policy Provisions

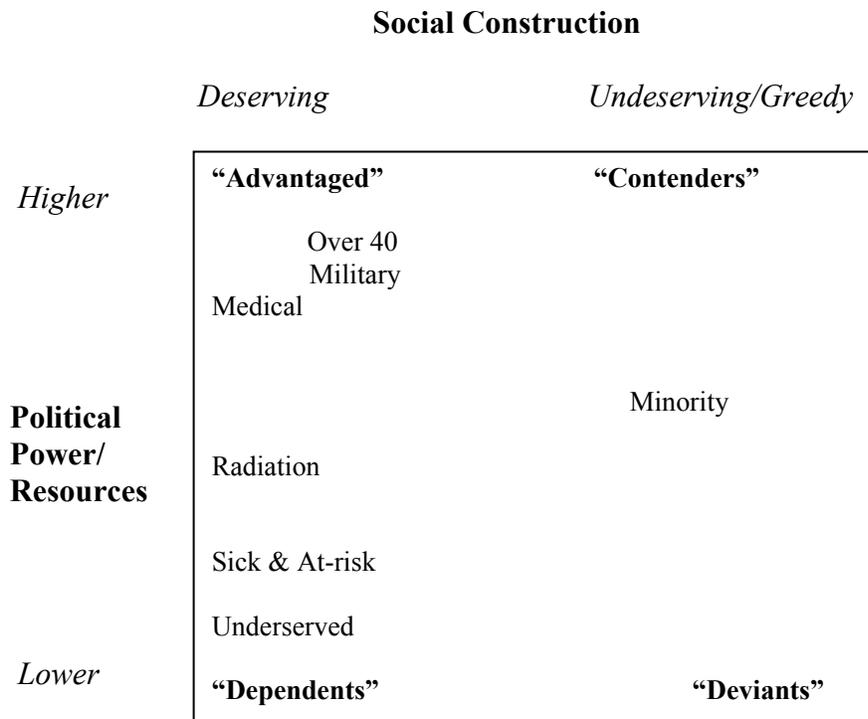
Congressional Hearings	Policy Provisions
<i>Over 40</i>	<i>Over 40</i>
<i>Minorities</i>	<i>Minorities</i>
<i>Underserved</i>	<i>Underserved</i>
<i>Patients</i>	<i>Patients</i>
<i>Military</i>	<i>Military</i>
<i>Congress</i>	<i>Radiation</i>
<i>Affluent</i>	<i>Medical</i>
<i>Federal employee</i>	<i>At risk</i>
<i>Family</i>	

Source: Policy Provisions Found in Public Laws (1990-2006)

The eight population groups were then categorized into three of the target population types conceptualized by Schneider and Ingram (1997). These include *advantaged, contender, and dependent* groups. Figure 6.4 adapts the model provided by Ingram and Schneider (2009) to visually display the social constructions and political power of various population groups identified in breast and prostate cancer policy provisions.

Figure 6.4: Population Groups Identified in Breast and Prostate Cancer

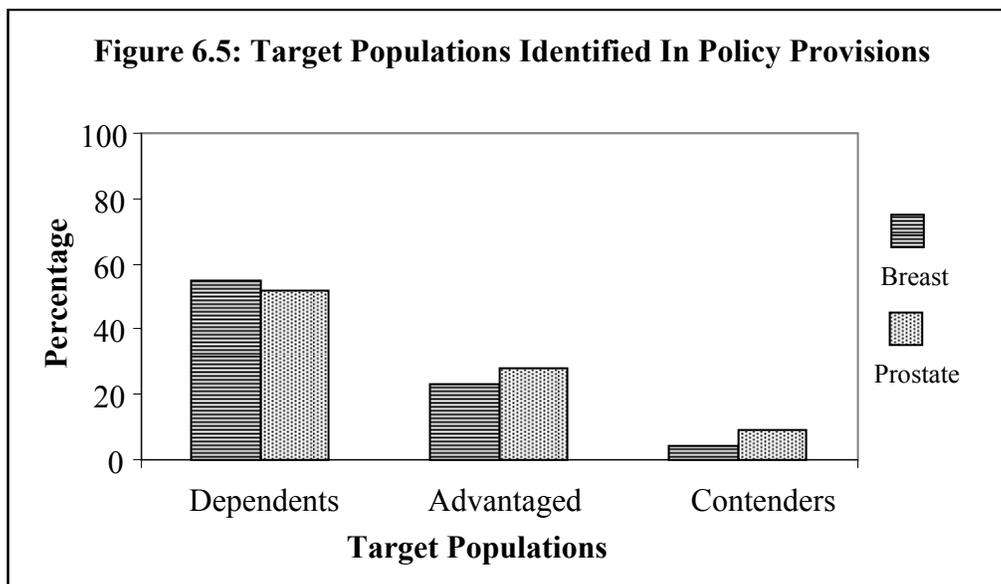
Policy Provisions



Source: Adapted from Ingram & Schneider (2009)

In policy provisions on breast and prostate cancers, the most commonly identified target population type was *dependents*. Fifty-five percent of breast cancer policy provisions targeted *dependents*, while 52 percent of prostate cancer policy provisions targeted *dependents*. In policy provisions on breast and prostate cancers, the second most commonly identified target population type was *advantaged* groups. Twenty-three percent of breast cancer policy provisions targeted the *advantaged*,

while 28 percent of prostate cancer policy provisions targeted *advantaged* groups. In policy provisions on breast and prostate cancers, the third most commonly identified target population type was *contenders*. Four percent of breast cancer policy provisions targeted *contenders*, while 9 percent of prostate cancer policy provisions targeted *contender* groups. Figure 6.5 displays a bar graph of these results.



Source: Policy Provisions Found in Public Laws (1990-2006)

Dependent target populations possess little political power but often convey a positive social construction (Schneider and Ingram, 1997). *Dependents* identified in policy provisions on breast and prostate cancers included: *underserved populations, the sick, previously screened, those exposed to radiation, and at risk populations*. In breast and prostate cancers policy provisions, *underserved* populations tended to

include low income, uninsured, medically needy, migrant workers, and urban and rural groups with little power to influence the policy process. The *sick* are often considered to be a deserving population. The term “patient” was commonly used to refer to victims of breast and prostate cancers.

At risk populations, such as those with symptoms of breast and/or prostate cancer, or those with prior or family history of illness are considered a dependent and “needy” population according to Schneider and Ingram’s framework (1997).

Radiation refers to populations who were previously exposed to large amounts of radiation that may have led to a diagnosis of breast and/or prostate cancer. These populations were generally provided monetary compensation for any exposure that may have led to illness through their employment or military service and were classified as *dependents* in Schneider and Ingram’s framework (1997).

As discussed earlier, *advantaged* groups tend to have positive social constructions and wield considerable amounts of political power (Schneider and Ingram, 1997). In looking at the policy provisions on breast and prostate cancers, mentions of *persons over 40*, *military personnel* and *medical professionals* were categorized as *advantaged* groups. Because breast and prostate cancers tend to disproportionately affect older men and women, although not limited to older age groups, population groups over the age of 40 (*over 40*) were frequently mentioned. *Military* personnel, whether on active duty or retired, generally have a positive public valence and these groups tend to have high levels of political participation. *Medical* professionals are positively constructed as being intelligent and who have the ability

to produce new information that will contribute to society and advance medical knowledge of disease.

Contender groups tend to have negative social construction but have considerable amounts of political power. Policy provisions in public laws on breast and prostate cancers sometimes referred to *minority* groups. Minorities are often portrayed as less powerful among the *contender* groups, but are still considered to be “undeserving” of beneficial policy in the target population typology (Schneider and Ingram, 1997). However, mentions of minority groups provided by policy actors at congressional hearings discussed in the previous chapter indicated that these groups were portrayed as needy and deserving of government attention.

Results of the content analysis of population groups and target population types identified in policy provisions were markedly different from the similar analysis of populations provided by witnesses in congressional hearings. In congressional hearings, the most frequently mentioned target population type was the *advantaged* while the least frequently mentioned target population type included *dependents*. Those target populations are consistent with Schneider and Ingram’s (1997) argument that *advantaged* groups tend to receive beneficial policy treatment because it is politically advantageous to policymakers, while *dependents* are largely ignored because they offer few political opportunities (p. 125-129).

However, content analysis of population groups and target populations identified in policy provisions on breast and prostate cancers were considerably different from the conceptualizations of target populations discussed by Schneider

and Ingram (1997). The results indicate that *dependents* were frequently singled out for beneficial policy treatment in laws adopted to deal with breast and prostate cancers. *Dependent* population groups identified in policy provisions on breast and prostate cancers included: *underserved populations, the sick, those exposed to radiation, and at risk populations.*

These results indicate that by framing certain groups as deserving of policy treatment, policy actors were successful in deconstructing the negative stereotypical images associated with each of these groups. By doing so, policy actors showed that these illnesses were nondiscriminatory in nature which helped to complement the framing of breast and prostate as critical public issues. When policy actors redefine public issues they must also redefine the population groups associated with those issues. To do so effectively, policy actors must present policymakers with new and different images of these groups that disassociate them from socially constructed stereotypes that portray them in negative ways. Defining these population groups in ways that made them seem more politically palatable to policymakers in congressional hearings may have led to the allocation of considerable amounts of beneficial policy action for *dependents.*

Beneficial policies for *dependent* groups allocated a significant amount of federal funding for research on illnesses that affected populations which have been systematically ignored in public policymaking. To fully understand the impact that the definitions of these population groups had on policymaking, a detailed analysis of

the amount of money that was allocated to conduct research on these illnesses is presented in the next section.

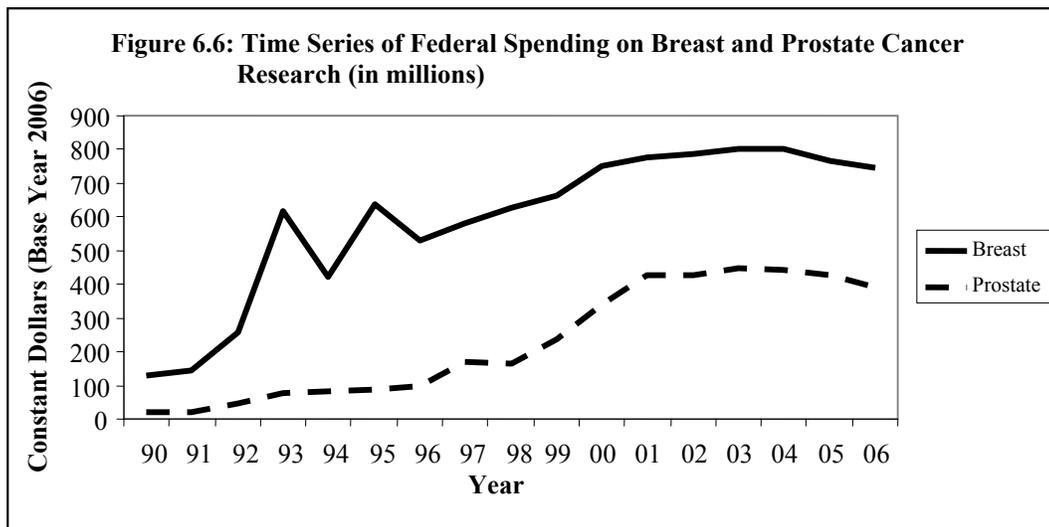
Federal Research Funding

The purpose of this section is to analyze the amount of federal resources directed to research on these illnesses during 1990 to 2006. This is the final section of the case study analysis presented in this dissertation. The amount of federal dollars allocated to various public issues communicates messages about the importance of public issues (Schneider and Ingram, 1997). Generally speaking, the more money government spends on public issues indicates the relative importance of various issues. This is an important aspect of the social construction process because it tells us, in dollars and cents, how government interprets these issues.

The data presented here examines research funding from three major sources. These sources account for the largest amount of federal research spending on breast and prostate cancer research by the federal government. The three sources include The National Cancer Institute, The Department of Defense, and the U.S. Postal Service. The extent to which there are differences in federal funding for research on these two issues will be compared to see if they received equitable treatment in funding.

Figure 6.6 shows in a trend analysis the difference in total spending on breast and prostate cancer research from 1990 to 2006 at The National Cancer Institute and Department of Defense combined. Much like the trend in incidence of breast and prostate cancers, federal spending on research for these two illnesses has increased

significantly since 1990. The financial data presented in this section is reported in constant dollars converted to 2006.



Source: NCI Fact Books & DOD CDMRP Annual Reports (1990-2006)

At the NCI, spending for breast and prostate cancer research has increased significantly. The NCI was the only federal agency conducting research on cancer in 1990. After the rise of breast and prostate cancer advocacy efforts in the 1990's, federal spending on research increased dramatically. Breast cancer research experienced a dramatic increase in funding at the NCI from \$130.85 million in FY 1990 to \$612.38 million in FY 2006 in 2006 dollars (NCI Fact Book, 2007). Prostate cancer research experienced a dramatic increase in funding at the NCI from \$21.32 million in FY 1990 to \$307.08 million in FY 2006 in 2006 dollars (NCI Fact Book, 2007). The total spending on breast and prostate cancer research at the NCI amounts to over \$10 billion for the study period in this dissertation.

Funding for research of both illnesses has also increased with federal spending at the Department of Defense. For breast cancer research, spending increased significantly in 1992 when the DOD created a research program to allocate grant funding for breast cancer research. For breast cancer research, the increases and decreases shown in Figure 6.6 are consistent with funding provided to the Department of Defense. Federal funding of prostate cancer research has risen more steadily, being influenced less by changes in defense spending since it has received considerably less money for research than breast cancer has over time.

It is an unusual finding that the Department of Defense would play such a large role in spending money on breast and prostate cancer research. Yet, the Department of Defense has a long-standing history of spending money on cancer research. Most of the original knowledge about cancer originated from research performed by military scientists during World War II, after American soldiers developed cancer as a response to extreme exposure to radiation. Research on chemotherapy was also conducted by military scientists around this time as way to turn war technology into a valuable product to use during peacetime (Patterson, 1987).

Often viewed as one of the most traditionally male-dominated federal agencies, the Department of Defense has played a key role in conducting and funding breast and prostate cancer research. Since the early 1990s the Department of Defense has been designated money for research on breast and prostate cancers through its biomedical research programs. The creation of these programs at the DOD was

largely the result of policy entrepreneurs such as Sen. Tom Harkin, Sen. Alphonse D'Amato, and Rep. John P. Murtha (Cassamayou, 2001). In 1992, \$37.62 million was appropriated to the Department of Defense's medical research program to conduct breast cancer research and treatment (DOD CDMRP Annual Report, 2004).

This funding was largely a result of advocacy efforts and the help of policy entrepreneurs such as Senator Tom Harkin and effective lobbying by breast cancer advocates. Senator Harkin, who had lost two sisters to breast cancer, had tapped into money in the defense budget from the Cold War "peace dividend" (Casamayou, 2001). In 1997, \$108.27 million dollars was appropriated for a similar program on prostate cancer research. Up until 1997, the DOD had spent close over \$500 million on breast cancer research. The DOD's research programs have become second to the NCI in funding breast and prostate cancers research (DOD CDMRP Annual Report, 2007). Table 6.2 displays the data on funding for breast and prostate cancer research at the National Cancer Institute and the Department of Defense. The dollar figures here were converted to constant dollars using 2006 as the base year.

Breast and prostate cancer advocates have lobbied consistently for increases in research funding at the Department of Defense since the inception of these programs. Advocates have not only been successful in receiving more funding, but also in playing a significant role in how those research dollars are spent. A unique finding about these research programs at the Department of Defense is the active role that citizen advocates have played in spending these funds. Breast and prostate cancer advocates from national advocacy groups such as the National Breast Cancer

Coalition and the National Prostate Cancer Coalition Prostate participate in peer review programs and serve on research program integration panels. This level of advocacy group participation is a unique partnership of scientists and consumers whereby advocates have direct influence over how research monies are spent (DOD CDMRP Annual Report, 2007). Groups like the NBCC even offer training courses through a program called Project LEAD which teaches citizen advocates how to engage in forums where breast cancer decisions are made (<http://www.stopbreastcancer.org/>, 2009). By including advocates in breast and prostate cancer decision-making at the Department of Defense, other target population groups are empowered to take action in dealing with public issues (Schneider and Ingram, 1997, p. 94).

Table 6.2: Federal Spending on Breast and Prostate Cancer Research (in millions)

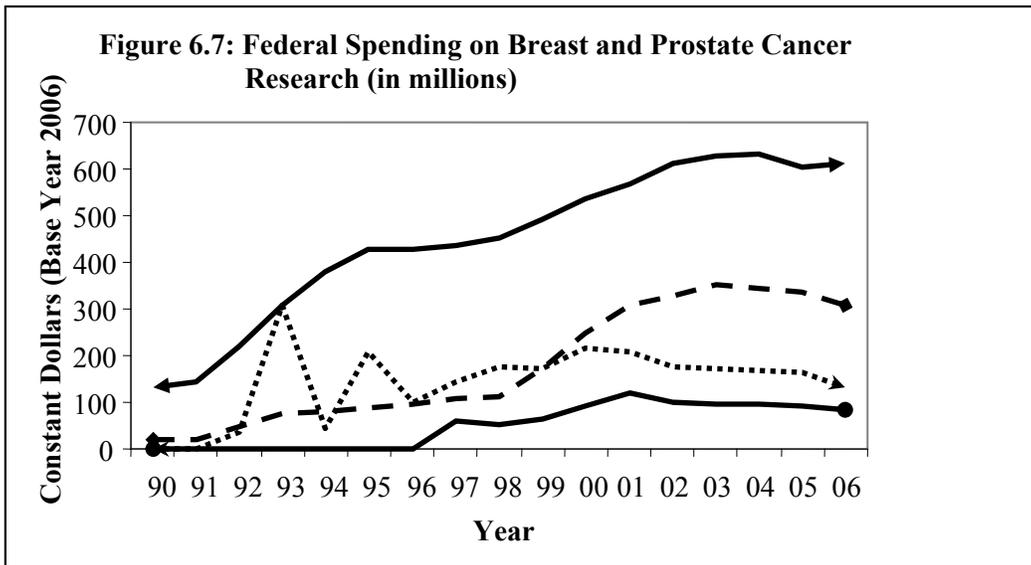
Fiscal Year	NCI (BC)	NCI (PC)	DOD (BC)	DOD (PC)
1990	\$130.85	\$21.32	NA	NA
1991	\$143.71	\$21.39	NA	NA
1992	\$218.22	\$47.26	\$37.62	NA
1993	\$309.04	\$74.67	\$306.85	NA
1994	\$381.25	\$79.93	\$42.74	NA
1995	\$427.69	\$89.08	\$207.82	NA
1996	\$427.27	\$96.49	\$100.93	NA
1997	\$436.76	\$108.27	\$142.47	\$59.2
1998	\$451.69	\$112.57	\$174.87	\$51.81
1999	\$490.72	\$171.98	\$171.09	\$63.37
2000	\$537.91	\$249.15	\$214.58	\$91.96
2001	\$566.55	\$307.59	\$208.64	\$119.22
2002	\$613.36	\$326.75	\$176.05	\$99.76
2003	\$629.64	\$350.22	\$172.13	\$97.54
2004	\$632.87	\$344.83	\$167.66	\$95.01
2005	\$605.54	\$334.07	\$162.17	\$91.9
2006	\$612.38	\$307.08	\$133.54	\$83.79
Totals	\$7615.45	\$3042.65	\$2419.16	\$853.56

Source: NCI Fact Books & DOD CDMRP Annual Reports (1990-2006)

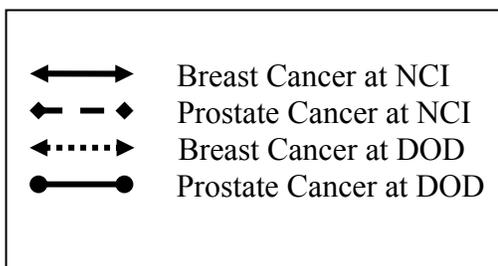
In addition to congressional allocation of funding of breast cancer at the NCI and DOD, Congress passed The Stamp Out Breast Cancer Act in 1997 to help raise funds and awareness for breast cancer research through the sale of semi postal stamps. The stamp was first offered for voluntary sale to the public in August 1998 and was the first stamp issued by the United States Postal Service to generate revenue for nonpostal purposes. Proceeds from the sales of the semi postal stamps are allocated for breast cancer research to the NCI (70 percent) and DOD (30 percent). Currently, there is not a semi postal stamp available to generate research funding for prostate cancer. A similar bill to issue prostate cancer research stamps was introduced

in by Rep. Randy “Duke” Cunningham (R-CA) in 1999, but the bill failed to pass both times that it was introduced. This failure has been attributed to a lack of advocacy activity around prostate cancer to promote the stamp (Catalona et al., 1999). Because men tend to participate in different forms of advocacy than women, not enough advocacy support has been generated on a prostate cancer semi-postal stamp (Bordin 1981; Foreman 1995; Kedrowski and Sarow 2007).

What emerges from a discussion of federal support of breast and prostate cancer research funding is a notable disparity. Figure 6.7 shows a time series data of federal funding of breast and prostate cancer research from 1990 to 2006. The dollar figures used in the analysis were converted into constant dollars using 2006 as the base year. The trend for both cancers in terms of federal spending on research over the selected time study period demonstrates one of increased growth (with the exception of a high peak in spending on breast cancer research at the DOD in 1993 and then a notable drop the next year). The two lines at the top of the figure show funding trends at the National Cancer Institute. The disparity between funding of breast and prostate cancers research is a sizable one. Breast cancer research has received over \$7 billion, while prostate cancer research has received over \$3 billion since 1990. The two lines at the bottom of the figure show funding trends at the DOD. There, breast cancer research has received close to \$2.5 billion, while prostate cancer research has received only \$850 million.



Source: NCI Fact Books & DOD CDMRP Annual Reports (1990-2006)



The total amount of federal spending on breast cancer research (almost \$10 billion) from 1990 to 2006 is almost three times as much as federal spending on prostate cancer research (almost \$4 billion). Prostate cancer advocacy efforts arose largely out of this disparity in funding. Increased attention to breast cancer in the form of media exposure, federal legislation and research funding has continually led

to criticisms of gender-based policymaking (Kolker, 2004). Prostate cancer advocates have been largely critical of this gap in research funding, which has led to an ever growing political debate about gender inequities. Criticisms of gender inequity in federal health policymaking have increased in number and intensity as the disparity in funding between breast and prostate cancer research continues to grow (Kedrowski and Sarow, 2007; Kolker 2004).

A focus on federal research funding of breast and prostate cancers reveals clues about the population group that has benefitted from increased policymaking on these illnesses. When analyzing federal funding directed toward research, it seems that *medical professionals* have received the lion's share of federal dollars for both breast and prostate cancers. As Schneider and Ingram (1997) predict, doctors and scientists play an important role in social construction because "science offers a degree of safety and security in politically dangerous situations" (Schneider and Ingram, 1997, p. 151). As an *advantaged* population that has positive social constructions and political power, doctors and scientists are viewed as unbiased and able to give expert advice when it comes to policymaking. In the cases of breast and prostate cancer, policymakers were able to make logical connections between the public issues and a solution that required doctors and scientists to "solve" these problems. The allocation of more research dollars toward breast cancer than prostate cancer provides a relative measure that indicates which illness policymakers viewed as a more significant public issue to deal with during the selected study period.

Conclusion

The types of policies selected to deal with public issues reveals important clues about how those issues and the persons affected by those issues are perceived by policymakers. The way that issues and their affected population groups are socially constructed throughout various phases of the policy process impacts the types of policies that are adopted to deal with them. The discussion presented in this chapter examined the extent to which the social constructions of breast and prostate cancers impacted the way these issues were treated during the policy adoption phase of the policy process. The various types of policies that were selected to deal with these issues were examined.

Policy provisions identified in public laws passed on breast and prostate cancers from 1990 to 2006 were analyzed in four different ways: a) whether policies were beneficial or burdensome, b) if implementation was required or discretionary, c) identifying the type of policy provision, and d) determining the population groups that were singled out for policy intervention. The analysis of policy provisions on breast and prostate cancers indicated that the majority of provisions directed benefits rather than burdens or restrictions to policy targets. Beneficial policy provisions reflected the positive social constructions conveyed by policy actors about the population groups affected by breast and prostate cancers. In terms of implementation, results of content analysis indicated that required policies were most commonly identified in public laws on breast and prostate cancers. The amount of discretion allowed in the implementation of a policy is an indication of how

policymakers prioritize public issues. In terms of the types policy provisions that were identified in public laws, testing and research were the most commonly identified types for breast and prostate cancers. These types of provisions indicated that policymakers intended to take a new and proactive approach to dealing with these illnesses, instead of repeating conventional policy responses. Dependent groups were the target population most commonly singled out for treatment in breast and prostate cancer policy provisions. Typically, dependent groups have positive images associated with them but relatively low amounts of political power. The findings here indicate that the way groups are socially constructed may have a greater impact than political power in policy decision-making.

The amount of money allocated to fund research on these illnesses was also examined to understand the differences in spending on breast and prostate cancers. I found that more resources have been allocated to breast cancer research than prostate cancer research during the selected study period. Federal spending on breast cancer research (almost \$10 billion) is almost three times as much as federal spending on prostate cancer research (almost \$4 billion). The results of the analysis in this chapter also discussed the distinctions between policies adopted on breast and prostate cancers and provided explanations for those differences.

VII. CONCLUSION

Throughout the legislative and other policy processes, issues can move through various stages in order to become adopted into public policy. In this dissertation, I contended that the way in which issues are socially constructed has a significant influence on how issues move through the policy process and influence policy adoption. The research presented in this dissertation was undertaken to understand how social construction influences public issues specifically with regard to agenda-setting and policy adoption. I also sought to understand how social construction influences policymaking by analyzing the policy provisions identified in public laws and the associated resource allocations. My research included a comparative element because I studied two illnesses, breast and prostate cancers, to gain knowledge about the various aspects of social construction that affected their journey through the policy process and the types of policies that were adopted to deal with them. Analyzing how social construction influences issues as they move through the policy process and are adopted into public policy is important because it emphasizes the role that social and cultural values play in the policy process.

The social constructionist perspective offers a comprehensive view of public policymaking because it takes into account the multiple elements that influence the way that public issues are constructed. Some of the basic elements that comprise this process include the people that participate in creating social constructions and the

methods that they use to do so. The dissertation has examined these basic elements as they pertained to policymaking on breast and prostate cancers through several different research questions. Variations in these basic elements influence how various policy issues are socially constructed, which in turn impacts policymaking.

Research Questions

In this research, I used a unique format for discussing the multiple elements of the social construction process by using research methods that included embedded collective case study and content analysis. The combination of these methodologies served as a vehicle that provided answers to the research questions originally posed in this dissertation. My research questions focused on the major actors that participated in socially constructing these illnesses and the techniques they used. More specifically, the research questions explored how policy actors attracted attention to these illnesses, how gender influenced advocacy to attract attention to these illnesses, the symbolic aspects of the illnesses, and how they were defined on systemic and institutional agendas. From the case study discussion, several important conclusions can be drawn.

My first research question in this dissertation asked how policy actors attracted attention to breast and prostate cancers. In my research, I found that policy actors, as expected, did play an important role in defining issues in ways that attracted public and governmental attention. More specifically, policy actors such as advocacy groups, celebrities, and policy entrepreneurs redefined what were previously regarded as private illnesses into public issues. By creating images of nondiscriminatory

illnesses that could potentially affect anyone, breast and prostate cancer policy actors attracted considerable amounts of attention. These images became reinforced through the actions taken by these various actors to include: mobilizing into unified forces, employing policy entrepreneurs and celebrity spokespersons, using direct and grassroots lobbying, invoking symbols to help construct the illnesses, utilizing the media, and testifying at congressional hearings.

From the case study and content analysis of the social constructions of breast and prostate cancers, it can be argued that public issues with a variety of mobilized policy actors advocating on their behalf will receive policy attention. This is consistent with traditional thinking on advocacy groups and public policymaking (Dye, 2005). In comparing breast and prostate cancers, it can be concluded that public issues that have greater numbers of policy actors advocating on their behalf receive more policy attention. There were more advocacy groups and policy entrepreneurs advocating on behalf of breast cancer policy than prostate cancer policy. In turn, this resulted in greater policy attention directed toward breast cancer than prostate cancer.

The second research question in this dissertation asked how gender influenced advocacy efforts toward breast and prostate cancer policy. Not only are the numbers of policy actors important in understanding how their participation in the social construction process influences policymaking, but the gender of these policy actors is also important to consider. Although policy actors advocating on behalf of breast and prostate cancer policy defined these illnesses in similar ways, the efforts undertaken by advocates for each illness varied considerably. An important factor that influenced

those differences was gender. Historically, women have been more active advocates for health and social welfare issues than men (Bordin 1981, Foreman 1995). Women have also been more willing to openly discuss their health concerns, whereas men tend to be reluctant to do so (Broom 2004; Courtenay 2000). Women also tend to engage in different approaches to advocacy than men. Women were more active advocates for policy change on breast cancer than men were for prostate cancer, which helped breast cancer attract more attention than prostate cancer.

This finding extends previous research on social construction by highlighting the way that gender impacts how issues and target populations are socially constructed. The framework provided by Schneider and Ingram (1997) does not take into account how male and female policy actors behave when constructing public issues. Their framework focuses primarily on the way that target populations are socially constructed, but does not examine the characteristics of the people that participate in creating those social constructions. The research conducted here shows that gender differences influence how men and women advocate on behalf of public issues, which impacts the way they are socially constructed. These differences in how they are socially constructed also impacts the way they are treated by government. Future research on social construction that takes into account the gender of the persons advocating on behalf of public issues may provide greater insight into the role that gender plays in public policymaking. Including gender as an additional factor in the social construction process may be important for certain issues because of the symbolic meaning attached to men and women in society.

The third research question asked what symbols were associated with breast and prostate cancers. This dissertation has argued that the symbolic nature of these gender-based illnesses was another critical aspect of analyzing their social construction processes. Breast and prostate cancers were framed as illnesses that posed physical and symbolic threats to the health of both females and males. This framing helped to attract attention to them and help them move them onto to the agenda. However, the levels of attention directed toward these illnesses in policy decision-making were clearly different in that breast cancer received more policy outputs than prostate cancer. An important reason for those differences was arguably the symbolic meaning attached to these illnesses.

Both breast and prostate cancers affect specific parts of the body associated with sexuality and reproduction. However, the female breast is a universal and overtly visible symbol of femininity that resonates deeply with both males and females. It is a higher order symbol that evokes images of female sexual attractiveness and motherhood. The prostate gland is not a well-known symbol of masculinity. While it is an important part of healthy sexual function in men, it is a less commonly associated symbol of male sexual prowess and fatherhood. The male penis is a more commonly recognized symbol of male sexuality and power than the prostate gland. This may be attributed to the fact that the prostate gland itself is an internal organ, whereas body parts such as breasts and the male penis are externally visible parts of the body.

The symbolic power of the female breast was considerably greater than the symbolic power attributed to the male prostate gland because breasts are a well-established sexual and maternal symbol that people can readily identify with. As a result, it was considerably easier for breast cancer advocates to attract attention to a public problem that was already salient and resonated with the public and with women themselves. From this distinction, the implications are that public issues that are associated with symbols that people can readily identify with are more likely to receive greater policy attention. This finding extends Schneider and Ingram's (1997) work by showing that the symbolic meaning associated with public issues also plays an important role in how they are socially constructed. Although the stereotypes associated with target populations are important in understanding policy decision-making, an understanding of the symbolic power that is associated with public issues provides even deeper insight into why certain public problems are selected for treatment by government. This research has shown that well-established symbols that are deeply rooted in the human psyche often receive greater levels of policy attention. In looking at the two policy issues discussed here, it has been argued that breast cancer advocates were able to capitalize on the symbolic significance of the female breast in a way that prostate cancer advocates were unable to do which ultimately may have led to greater policy attention directed toward breast cancer on the policy agenda.

The fourth research question asked how breast and prostate cancers were defined on systemic and institutional agendas. Once public issues reach the agenda,

the way they are defined helps influence policy action. Policy actors were initially successful in defining these illnesses as nondiscriminatory illnesses that deserved public attention. This early image helped to reframe breast and prostate cancers from private illnesses to public issues, which helped them move onto systemic and institutional agendas. Once these issues reached the agenda, it was important to construct them as serious public issues that were worthy of treatment by government. Policy actors created a perception of growing need by focusing on the increasing numbers of men and women that were being diagnosed with these illnesses. This was reinforced by increased newspaper coverage and by testimonies provided at congressional hearings. Representing these illnesses as growing public problems that required government action helped to influence policymakers to take action on breast and prostate cancer policy by passing a significant amount of legislation.

The social construction of these illnesses into public issues led to significant action on the part of government in the form of increased policymaking. From 1990 to 2006, 57 public laws were passed to address these illnesses. A consistent theme found in the data on public laws was that breast cancer received more policy attention than prostate cancer. This inequality can be partially attributed to the previously discussed differences in the social construction processes of these two illnesses that included differences in the number of policy actors, gender distinctions in terms of advocacy activities, and the symbolic significance of the female breast and male prostate gland.

Policy provisions identified in public laws also demonstrate the manner in which target populations affected by these illnesses were socially constructed. Content analysis of policy provisions demonstrated that groups that have positive social constructions (*dependents* and *advantaged*) received the greatest share of policy attention for both breast and prostate cancers. This supports Schneider and Ingram's (1997) argument that groups with positive social constructions tend to receive more policy attention. However, the data showed that in the policy areas of breast and prostate cancers, groups with positive social constructions and little political power (*dependents*) were the primary recipients of beneficial policy as measured by numbers of provisions. This is inconsistent and somewhat contrary to Schneider and Ingram's (1997) argument that groups with positive social constructions and high levels of political power tend to receive greater beneficial policy attention. Greater attention to how policy actors associate issues with the people affected by the issues reveals important clues about which persons in society are targeted for policy treatment by government.

My fifth research question asked if there were differences in policies addressing breast and prostate cancers. The simple answer to this question is yes, there are significant differences in policies that address breast and prostate cancers. One thing is clear from the case study and content analysis conducted here: breast and prostate cancers have received very different amounts of treatment when it comes to policy decisions and provisions that have been adopted. A large part of this research has been focused on trying to identify why these differences exist and what factors

account for them. In this dissertation, those differences have been attributed to differences in the number of advocacy groups and the activities they engaged in, the gendered nature of the advocacy groups and the types of advocacy efforts they pursued, the greater symbolic significance of the female breast than the male prostate gland, and variations in the amount of attention they received on the systemic and institutional agendas.

An interesting finding from the comparisons of these two issues is the similarities in terms of how they were defined. As public issues, breast and prostate cancers were defined in similar ways on the systemic and institutional agendas. Both of these illnesses were described as complex and growing public problems that required government attention. Both of these illnesses were associated with similar types of target populations that were associated with positive public images. However, the amount of attention they received, and continue to receive, is clearly unbalanced in terms of the number of policy provisions and amount of money allocated for federal research. Comparing how these illnesses were treated throughout the policy process and in the types of policies they received has important implications for policymaking.

Limitations

As in all research undertakings, the theoretical framework utilized in this dissertation has several limitations. The greatest limitation of this research is the classification of population groups and target population types. While the target population classification scheme provided by Schneider and Ingram (1997) may be

useful in some substantive policy areas, in the cases of breast and prostate cancers it was not helpful in predicting policy provisions. This research has shown that stereotypical population characteristics are not always good predictors of policy design (Donovan, 2001).

When policy actors define problems and related groups according to the ingrained stereotypes and images with which they are commonly associated, the typology created by Schneider and Ingram (1997) may be useful in predicting policy provisions. However, breast and prostate cancer policy actors significantly redefined these illnesses and the population groups associated with those issues. This required policy actors to present policymakers with new and different images of these groups that disassociated them from traditional stereotypes. Because policymakers prefer to allocate benefits rather than burdens, policy actors who “are able to create, control, and change social constructions are able to generate new political capital for themselves” (Schneider and Ingram, 1997, p. 192).

Additionally, the framework is based on one-dimensional stereotypes of various population groups that doesn't account for changes in how these groups are perceived. People that are categorized into the various population groups discussed by Schneider and Ingram (1997) are multi-faceted and rarely fit into one stereotyped category. The framework is not robust in that it does not account for various aspects of one's personal identity nor does it account for stereotypes that can change over time. A framework that allows for greater overlap among population group categories

that can provide a more accurate depiction of the individuals who comprise these groups is needed.

There is a notable lack of consideration of the various ways that gender can influence how public issues and their related groups are socially constructed. In the cases of breast and prostate cancer policy, it has been argued that the gender of the persons advocating on behalf of policy change on these issues affected their social constructions. Schneider and Ingram's framework (1997) takes into account the stereotyped images of population groups but does not emphasize the gender of the persons constructing those populations. By expanding the discussion to include the effects of gender on advocacy and social construction we can determine if gender is an important aspect to consider when analyzing other public issues.

The framework provided by Schneider and Ingram (1997) does not focus on the symbolism associated with the issues that are being constructed. In the cases of breast and prostate cancer, the issues themselves already had preexisting beliefs associated with them based on the parts of the body these illnesses affect. Breasts were already viewed favorably by the public because of the well-established symbolic associations with sexuality and motherhood. The prostate gland did not generate as much public attention prior to the increase in prostate cancer advocacy; thus it may have been more challenging to draw attention to prostate cancer. The extent to which these pre-existing beliefs influenced the way breast and prostate cancers were socially constructed is an important factor to consider when looking at the social construction of these issues. Schneider and Ingram's theoretical framework (1997) could be

expanded to provide a more nuanced discussion of symbolic associations which scholars could apply to other policy areas.

Lastly, this research focused primarily on the design phase of the policymaking process to provide a discussion on the factors that influence the types of policies that are chosen to deal with public issues. However, this research largely ignored the later phases of the process such as implementation and evaluation. Based on the results of this research study, one can not make assumptions or claims regarding policy outcomes. Expanding social construction theory to the later phases of the policy process can provide a deeper understanding of how social construction influences the outcomes of policy decision-making.

Implications for Public Policy

While this dissertation has focused primarily on the policy issues raised in respect to breast and prostate cancers, generalizations from this research can be applied to multiple policy areas. This research has discussed social construction as a multidimensional process that shaped the way the public and policymakers perceived public issues. Those shared perceptions influenced how these illnesses moved through the policy process and how they were treated in policymaking. From this discussion, several important conclusions can be made.

First, an understanding of how issues come to be socially constructed is a critical factor that determines how they move through the policy process and influence the types of policies adopted to deal with them. Past policy research has often focused on describing one-dimensional aspects of the social construction

process such as media attention or the advocacy efforts of various interest groups on either breast or prostate cancer (Lantz and Booth 1998; Kolker 2004). While these studies are significant contributions to the policy literature, they do not provide a comprehensive view of the various interacting elements of the social construction process that influence how issues are treated. These elements include the people who participate in creating the social constructions and what they do to create those constructions. This dissertation extends previous research by taking a multi-dimensional approach and analyzing the actions of various types of policy actors organized into advocacy groups. I also analyze how these groups successfully created collective definitions of these illnesses and the people affected by them that influenced the way that they were perceived by the public and policymakers. Ultimately, it is who socially constructs issues and how they do so that helps policy scholars understand how public issues come to be socially constructed and how they are treated by government.

Second, because social construction contains many different elements, multiple literatures are necessary to gain a deeper understanding of the process. Because of its focus on the multidimensional social construction process, this dissertation utilized several different theoretical streams that served as a conceptual foundation to help better understand how the social construction process of these two illnesses influenced the policy treatment they received. The theories utilized in this dissertation included: social construction, policy actors, gender and advocacy, symbolic politics, and agenda-setting. Multiple theoretical strands provide a more

holistic picture of the social construction process that allowed for a more detailed comparison of these two illnesses. Using multiple theoretical streams, along with methods such as case study and content analysis, allows us to penetrate the superficial meanings that are associated with different public issues and their related populations. This helps to better identify how powerful policy actors in society promote values that can influence not only how we think about public issues, but also communicate implied messages to us that are codified into public law.

Finally, policymakers play a crucial role in determining how public issues are socially constructed. What a comparison of breast and prostate cancer policy has revealed is that the people that create social constructions and the methods they use to do so make a difference in terms of how public issues are treated by policymakers. This dissertation has also argued that the people who interpret the social constructions and how they interpret them are important in understanding why certain policy decisions are made as opposed to others. In the cases of these two illnesses, analyses of congressional hearings and public laws showed that policymakers themselves have been impacted by these illnesses, either as survivors, family members, or colleagues. Having greater proximity to these illnesses clearly made a difference in how policymakers interpreted the social constructions created by the various policy actors discussed throughout this dissertation.

By extending research efforts to other substantive policy areas utilizing these same elements, scholars can gain a more comprehensive understanding of the influence these elements have on policymaking. Comparing two policy areas can help

identify how differences in social constructions are translated into public policy. Focusing on the various factors that influence social constructions by using multiple theoretical frameworks can provide scholars with a more comprehensive conceptual foundation that helps them to better understand policy decision-making. The use of case study and content analysis helps reveal the messages that social constructions communicate and how they are reinforced when written into law. An understanding of the most influential policy actors that support action on public issues demonstrates that public policy is highly vulnerable to people in society with the resources, knowledge and power to define issues in ways that are consistent with their policy goals. Although this study was not without limitations, future research should seek to understand how social constructions are created, who creates them, and how they are interpreted by policymakers to better understand how they influence modern day policymaking.

Who Benefits from Breast and Prostate Cancer Policymaking?

Unfortunately, the answer to questions about the benefits of policymaking on breast and prostate cancers is not a simple one. The amount of policy attention paid to breast and prostate cancers since 1990 has led to significant improvements such as more research, better screening guidelines, more public awareness, and increased treatment options. From the selected policies analyzed here, the issue of breast cancer seems to emerge as the clear winner in terms of federal policy and research funding. In the case of breast cancer policy, policy actors were successful in reframing a private illness into a politically attractive public issue. By defining breast cancer as a

complex illness that did not discriminate by age, race, or socioeconomic status, these policy actors reshaped institutionalized thinking about the illness and those affected by it. Policy actors were successful in characterizing associated population groups in ways that led to considerable amounts of beneficial policy treatment. Breast cancer policy actors effectively changed the political landscape of women's health and empowered women to fight against a long-standing history of gender inequity in federal policy.

However, the political ramifications of breast cancer's policy successes paint a picture that is less than positive. Because breast cancer has become an amazingly popular public issue that has resulted in the allocation of billions of public dollars, numerous criticisms of political and financial exploitation have been made. Why? Because breast cancer is still a disease that claims the lives of thousands of American women every year, no matter how it is socially constructed and how much policy attention it attracts.

Some have even described some forms of breast cancer advocacy as a "cult" or "religion" that is another means of infantilizing women instead of empowering them (Ehrenreich, 2001). The extent to which breast cancer advocacy has resulted in truly beneficial policy outcomes is a concern that many, including advocates themselves, have expressed. Advocacy groups such as The National Breast Cancer Coalition (NBCC) are now encouraging policymakers to "look past the pink of breast cancer awareness" (www.stopbreastcancer.org, 2009) and enact policies that truly help prevent the thousands of deaths that breast cancer causes every single year.

Although the issue of prostate cancer still receives less public and federal attention than breast cancer, prostate cancer advocates are not willing to throw in the towel on prostate cancer policy. Because prostate cancer continues to claim the lives of thousands of American men each year, advocates have continued to petition government for more attention and criticize the amount of money directed toward breast cancer research. Prostate cancer victims have continued to speak publicly about their illness in an attempt to garner public attention. One of the most compelling stories is provided by *New York Times* editor, Dana Jennings, who blogs about his experience with prostate cancer. He talks openly about the physical and emotional pain he has experienced with entries that discuss testicle shrinking, hot flashes, and Kegel exercises (<http://well.blogs.nytimes.com/tag/jennings/>, 2009). His candid blog entries can help to break down stereotypes about masculine ways of dealing with illness, which may encourage other men to talk about their experiences with prostate cancer. Increasing the dialogue about prostate cancer may lead to increased federal policy to help combat the illness, or even prevent it.

In addition, there is a laundry list of other illnesses that claim the lives of women each year, but are given considerably less federal attention. Illnesses such as heart disease and lung cancer are serious diseases that receive considerably less policy attention than breast cancer. Men are also affected by breast and lung cancers, as well as heart disease. However, the amount of public and political attention directed toward these illnesses pales in comparison to the amount of attention breast

cancer has received. Prostate cancer is only one example of the unbalanced nature of federal policymaking on public health issues.

As a result of increased breast and prostate cancer policymaking, the death rates for both breast and prostate cancers have decreased significantly since 1990. From 1990 to 2006, the death rates for breast cancer decreased by 36.5 percent while the death rates for prostate cancer decreased by 24 percent (Jemal, Siegel, Ward, Hao, Xu, Thun, 2009). These decreases have been attributed to better methods of early detection and improved treatments. However, American men and women are still suffering from these illnesses. In 2009, breast cancer was estimated to claim the lives of 40,170 American women while prostate cancer was expected to claim the lives of 27,360 American men (ACS Facts and Figures, 2009).

The medical community has been harshly criticized for its inability to prevent the thousands of lives that are lost each year to breast and prostate cancers, despite the billions of dollars that have been allocated to conduct research on these illnesses. Although *dependent* populations were identified as the primary recipients of beneficial policymaking, the data analyzed here show that *medical professionals*, such as scientists and doctors, appear to have received a considerable amount of federal research funding for both breast and prostate cancers. Schneider and Ingram (1997) accurately predict that due to the social construction of scientific knowledge, these members of the scientific community often play a significant role in socially constructing public issues. As a population group that is often associated with positive public perceptions coupled with considerable amounts of political power, it is

not difficult for policymakers to connect this group with beneficial policy outputs. By contributing to the framing of breast and prostate cancers as public issues that were solved by focusing on more research, *medical professionals* effectively changed the shape of breast and prostate cancer policymaking by directing the benefits of public policy toward themselves and not the people most commonly affected by these illnesses.

There are not only criticisms directed toward medical professionals such as researchers, oncologists that prescribe new drugs, and surgeons, but also toward pharmaceutical companies, cosmetic companies, corporate entities, retailers and other beneficiaries who profit and benefit from increased breast cancer awareness.

Although the breast cancer movement has recruited increasing numbers of followers who are now more aware of the illness, it has not made significant strides in terms of understanding the environmental factors that lead to breast cancer and the corporate entities whose actions may be contributing to the increasing numbers of those afflicted with the illness (Ehrenreich, http://ehrenreich.blogs.com/barbaras_blog/, 2009).

There is also disparity in terms of the ethnic groups that have seen positive outcomes from increased policy action on breast and prostate cancers. While there have been considerable reductions in the death rates of those afflicted with these illnesses since 1990, data from The American Cancer Society indicate that the decreases in death rates for these two illnesses have not been equally distributed among racial groups. African-American men and women still experience notably

higher death rates for both cancers than white men and women. African-American women diagnosed with breast cancer have a death rate that is 38 percent higher than white women that are diagnosed with breast cancer (ACS Cancer Facts and Figures for African-Americans, 2009). Similarly, African-American men diagnosed with prostate cancer have a death rate that is 40 percent higher than white males that are diagnosed with prostate cancer (ACS Cancer Facts and Figures for African-Americans, 2009).

The American Cancer Society attributes the differences to social and economic disparities between African-Americans and whites, not biological differences. Factors such as access to treatment and the utilization of early detection methods were cited as causes of the disparity in death rates. From a policy standpoint, a greater emphasis on studying the factors that lead to these differences in tangible outcomes for various races and a focus on how policy can correct for those differences is an important factor to examine in future research on breast and prostate cancers.

Future Directions for Research

This study has served as a point of origin that can help policy scholars to better understand how social constructions influence policymaking. Future policy research should examine the extent to which the social constructions created by powerful policy actors lead to beneficial, tangible, and equitable policy outcomes. The question of whether beneficial policy truly benefits the population groups singled out in legislation should always be asked, in relation to breast and prostate cancers

and in other substantive policy areas. Future research should lead to an increased understanding of how the meanings assigned to various public issues through their social constructions can result in truly effective policy solutions.

APPENDIX A. NEWSPAPER HEADLINES

Newspaper headlines on breast and prostate cancers that were used in this dissertation were gathered from a search of the LexisNexis Academic database. Article headlines printed in *The New York Times* and *The Washington Post* from January 1, 1990 to December 31, 2006 were identified using the keyword search terms “breast cancer” and “prostate cancer”. These terms must have been found in the article’s headline to be included in the study population. Also, only the headlines of feature articles were included in the study population. Other types of articles such as editorials, letters to the editors, question and answer pieces were not included in this population. Once the final population was identified, the headlines were entered into Excel spreadsheets. The final study population included 635 headlines.

Once the population of headlines was identified, they were read and coded for tone and content. A numerical coding system was developed and used to label each headline by tone and content. The first step of coding was to code the articles for tone. Article headlines were identified as *positive*, *negative*, or *neutral*. I used the following numerical coding scale:

Neutral=0
Positive=1
Negative=2

Articles were labeled *neutral* if no discernible tone could be identified in the headline. If articles included both *positive* and *negative* tones, they were categorized

as neutral. Some examples of headlines of articles that were categorized as *neutral* included: “M.R.I. Screening for Breast Cancer” and “The Facts on Prostate Cancer.”

Newspaper headlines were coded *positive* if feelings of optimism or hope were conveyed. Articles with *positive* headlines often reported the development of new treatments or drugs, provided a story of a breast or prostate cancer survivor, discussed advocacy efforts, or contained generally favorable comments. Some examples of headlines that were categorized as *positive* included: “New Drug Holds Promise for Type of Breast Cancer”, “Colin Powell Has Surgery for Prostate Cancer”, and “Effective Lobbying Increases U.S. Funds for Breast Cancer Research.”

Newspaper headlines were coded as *negative* if they expressed a feeling of pessimism or impending doom. The main message conveyed in *negative* headlines was that these illnesses were becoming greater problems that required attention. Articles with *negative* headlines reported problems or obstacles with treatments and/or screening tests, increasing incidence of diagnoses, unfavorable comments, and/or confusion about cause and treatment. Some examples of headlines of articles that were categorized as *negative* included: “Prostate Cancer Test Questioned: Researchers Say PSA Screening Yields Many False Results”, “Researcher Falsified Data in Breast Cancer Study”, “Little Progress on War on Breast Cancer, Survival Chances Only Scarcely Better After Decades of Research.”

The second coding step was to code the articles for content. The purpose of coding the headlines for content was to get a sense of the various types of themes that were most prevalent during this time period. Two primary manifest themes were

identified from the analysis of headline content. These themes included headlines that were related to social construction and/or advocacy and those that were primarily disease-related. From these two manifest themes, twelve sub-themes were identified. The following numerical coding scheme was developed to categorize the sub-themes found in headlines:

Early detection=1
Incidence=2
Celebrity=3
Comparisons=4
Treatment=5
Stories=6
Focus on cause=7
Disadvantages of/problems with early detection=8
Screening=9
Disparity=10
Side effects=11
Activism/political activity=12

Headlines that focused on advocating the benefits of early detection and stressed prevention techniques were labeled as *early detection* (1). An example of this headline was: “U.S. Prostate Cancer Study Stresses Prevention.”

Headlines that discussed the growing incidence rates of breast or prostate cancer and gave statistics about incidence or death rates were placed in the *incidence* (2) category. An example of an *incidence* headline was: “Little Progress In War on Breast Cancer; Survival Chances Only Scarcely Better After Decades of Research”.

Newspaper headlines that discussed various celebrities that were diagnosed with or died as a result of breast or prostate cancer were categorized as *celebrity* (3). An example of a *celebrity* headline is: “Justice Stevens Is Treated for Prostate Cancer; Complete Recovery Expected.”

Headlines that compared breast and prostate cancers in terms of medical treatments or political attention were categorized as *comparisons* (4). An example of a *comparison* headline is: “War Between Sexes Rages Over Research; Funds to Study Prostate, Breast Cancer at Issue.”

Multiple headlines that discussed the success of treatments or new ways of treating breast and prostate cancers were identified as *treatment* (5). An example of a *treatment* headline is: “Radiation Benefit for Breast Cancer Shown.”

Often times, newspaper headlines discussed someone’s personal experience with breast or prostate cancer. These headlines told of the individual’s struggle or success with one of these illnesses. These headlines were labeled *stories* (6). An example of a *story* headline is: “Long Island; I Got Breast Cancer. Why Me.”

Newspaper headlines frequently discussed the various causes of breast and prostate cancers such as family history, diet, the use of alcohol and/or tobacco, and other risk factors. These headlines were labeled *cause* (7). An example of a *cause* headline is: “Breast Cancer: New Trends on Age and Family History.”

Some headlines talked about some of the problems with screening techniques such as mammograms and PSA tests. These headlines often emphasized the lack of reliability these tests have. These headlines were labeled *disadvantages* (8). An

example of a *disadvantages* headline is: “Prostate Cancer Test Questioned; Researchers Say PSA Screening Yields Many False Results.”

Other headlines discussed information about screenings tests or access to tests. The primary tests that were discussed in these headlines included mammograms and PSA testing. These headlines were labeled *screening* (9). A headline that was related to screening is: “Access to Breast Cancer Screenings is Shrinking, Experts Warn.”

Some headlines discussed issues that dealt with disparity between different ethnicities. These articles emphasized that some ethnic groups were at greater risk for being diagnosed with one of these illnesses. These headlines were labeled *disparity* (10). An example of a headline that was placed in the *disparity* category is: “Racial Component is Found in a Lethal Breast Cancer.”

Other headlines dealt with the side effects of treatments that breast and prostate cancers patients received. These headlines were labeled *side effects* (11). An example of a headline that was placed in the *side effects* category is: “Survival Trade-off; More Treatment Lowers Quality of Life After Breast Cancer, New Study Says.”

Headlines that dealt with political activism and advocacy efforts were also identified in the study population. These headlines discussed advocacy events, such as Race for The Cure, or the efforts other politically active advocacy groups. These headlines were labeled *activism/political activity* (12). An example of an activism/political activity headline is: “Transformed by Passion and Politics, Breast Cancer Movement Gains Power.”

The following tables contain listings of the final study population of newspaper headlines that were utilized in this research. The four tables are organized by illness and by newspaper. The tables here include only the headline itself, the newspaper it was found in, and the year it was printed.

New York Times Headlines on Prostate Cancer

ID	Year	Title
1	1991	Vasectomies and Prostate Cancer: A Link?
2	1991	Long Ignored, Prostate Cancer Gets Spotlight as Major Threat
3	1991	The Media Business; Chairman of Time Warner Treated for Prostate Cancer
4	1991	Full Recovery Seen For Dole in Surgery For Prostate Cancer
5	1992	Justice Stevens Getting Treatment For Prostate Cancer, Court Says
6	1992	Study Suggests Early Prostate Cancer May Be Best Left Alone
7	1992	Protein Is Linked to Prostate Cancer
8	1992	Nationwide Tests Set For Prostate Cancer, But Doubts Surface
9	1993	2 New Studies Link Vasectomy To Higher Prostate Cancer Risk
10	1993	Advances in Detection Create Dilemma on Prostate Cancer
11	1993	Whether Positive or Negative, Result of Prostate Cancer Test Can Create Maze of Questions
12	1993	Drug Trial on Prostate Cancer
13	1994	Education Secretary Has Prostate Cancer
14	1994	Personal Health; Prostate cancer: the neglected killer.
15	1995	Sports People: Auto Racing; Petty Has Surgery for Prostate Cancer
16	1995	Gene Is Shown to Block the Spread of Prostate Cancer in Mice
17	1995	Pro Football; Bills' Levy Has Prostate Cancer
18	1995	Low-Fat Diet in Mice Slows Prostate Cancer
19	1995	Tomatoes Found to Cut Risk of Prostate Cancer
20	1996	Scientists Zero In on a Gene Linked to Prostate Cancer
21	1997	A Lack of Volunteers Thwarts Research on Prostate Cancer
22	1998	Routine Screening For Prostate Cancer Is Said to Cut Deaths
23	1998	Support Group for Men With Prostate Cancer
24	1998	Mineral May Cut Risk of Advanced Prostate Cancer, Study Says
25	1998	A Protein Is Said to Predict Prostate Cancer's Virulence
26	1999	N.F.L. : Roundup -- Kansas City; Hunt Being Treated For Prostate Cancer
27	1999	Baseball; Yankees Learn Torre Has Prostate Cancer
28	1999	Amgen Gets Rights to Prostate Cancer Drug
29	1999	Baseball; Finding and Treating Prostate Cancer
30	1999	New Hope in Prostate Cancer Therapy
31	1999	Navigating the Options for Prostate Cancer
32	1999	National News Briefs; Castration Found to Save Lives in Prostate Cancer
33	2000	In brief; Aid for Prostate Cancer

34	2000	Murdoch Contracts Prostate Cancer
35	2000	Giuliani Is Tested For Prostate Cancer
36	2000	Giuliani Fighting Prostate Cancer; Unsure on Senate
37	2000	Police Commissioner Has Prostate Cancer
38	2000	Safir Announces That He Has Prostate Cancer
39	2000	Tech 2010: #20 No Surprises
41	2000	Free Screening for Prostate Cancer
42	2000	Giuliani Says He Is Being Treated With Hormones for Prostate Cancer
43	2000	Mayor, Backtracking, Is Undecided On Treatment for Prostate Cancer
44	2000	More Options, and Decisions, for Men With Prostate Cancer
45	2001	Badillo Shares His Own Story On Bout With Prostate Cancer
46	2001	Prosecutor Nominated to Lead the F.B.I. Has Prostate Cancer
47	2001	Mandela Is Being Treated for Prostate Cancer
48	2002	Dr. William Fair Dies at 66; An Expert on Prostate Cancer
49	2002	2nd Gene Found Linked to Prostate Cancer
50	2002	Confronting Cancer; Prostate Cancer:
51	2002	National Briefing Science And Health: Study Denies Vasectomy Link To Prostate Cancer
52	2002	Prostate Cancer Surgery Found to Cut Death Risk
53	2002	Perspectives; Dilemma on Prostate Cancer Treatment Splits Experts
54	2002	The Prostate; Facing Prostate Cancer, But How?
55	2002	Emperor of Japan Has Prostate Cancer
56	2003	Company News; Abbott Halts Trial of Prostate Cancer Drug
57	2003	Kerry to Undergo Surgery for Prostate Cancer Today
58	2003	National Briefing South: Virginia: Broadcaster Has Prostate Cancer
59	2003	Mixed Results for Drug Used to Prevent Prostate Cancer
60	2003	A Fallible Prostate Cancer Test
61	2003	Bruno Has Prostate Cancer, But Says Prognosis Is Good
62	2003	Powell Has Surgery to Treat Prostate Cancer, Staff Says
63	2003	Vital Signs: Disparity; Prostate Cancer: A Racial Divide
64	2003	Obesity Can Add to Danger In Men With Prostate Cancer
65	2004	Advice for Treating Prostate Cancer Revival
66	2004	A Study Questions Blood-Test Results On Prostate Cancer
67	2004	Study Offers New Solid Indicator Of Prostate Cancer Danger Level
68	2004	Technology Briefing Biotechnology: Prostate Cancer Treatment Approved
69	2005	Prostate Cancer Vaccine Shows Promise in a Trial
70	2005	Study Backs Caution In Treating Some For Prostate Cancer
71	2005	Study Finds Benefit In Some Surgery For Prostate Cancer

72	2006	Report Casts Fresh Doubts On Prostate Cancer Testing
73	2006	Virus Link to Rare Form of Prostate Cancer Revives Suspicions of Medical Detectives
74	2006	Scientists Discover Gene Linked to Higher Rates of Prostate Cancer
75	1006	Prostate Cancer Genes
76	2006	Prostate Cancer Decisions Often Based on Fallacies
77	2006	National Briefing Science And Health: Overtreatment Of Prostate Cancer
78	2006	Profit and Questions as Doctors Offer Prostate Cancer Therapy

Washington Post Headlines on Prostate Cancer

ID	Year	Title
1	1991	Vasectomies May Be Linked To Prostate Cancer
2	1992	Justice Stevens Is Treated for Prostate Cancer; Complete Recovery Expected
3	1992	Early Treatment Benefits Debated in Prostate Cancer
4	1994	Blood Test Approved For Prostate Cancer; FDA Stops Short of Recommending Procedure
5	1994	Genetic Defect Tied To Prostate Cancer; Flaw Said to Hinder a Needed Enzyme
6	1995	Barry's Diagnosis Prompts Surge In Queries About Prostate Cancer
7	1995	Prostate Cancer Poses Tough Choices
8	1995	Prostate Cancer Detection and Treatment
9	1995	Dealing With Sensitive Issues Is Key to Treating Prostate Cancer
10	1996	Radiation 'Seeds' Score Against Prostate Cancer
11	1996	Genetic Test May Predict Prostate Cancer Likelihood; Gland's Sensitivity to Testosterone Is Measured
12	1996	President Adds VA Benefits After Agent Orange Study; Prostate Cancer, Nerve Disorder Covered
13	1996	Of Privilege and Prostate Cancer
14	1996	Prostate Cancer Aims at Poorer Black Males
15	1996	Impotence Treatment Keeps Urologists Busy
16	1996	Prostate Cancer Gene Evidence Found
17	1997	Prostate Cancer Test
18	1997	Prostate Cancer Exam Benefits Are Questioned; Association Counsels Against Routine Tests
19	1997	Mayor Showing No Recurrence of Prostate Cancer
20	1998	Vitamin E May Cut Risk of Prostate Cancer, International Study Shows
21	1998	Prostate Cancer Tests
22	1998	Survivors Push Prostate Cancer Screening
23	1998	Seeds' Show Effect on Early Prostate Cancer
24	1999	Torre Battling Prostate Cancer
25	2000	PETA Ad Campaign Draws Experts' Rebuke
26	2001	U.S. Prostate Cancer Study Stresses Prevention
27	2001	FBI's Mueller Has Prostate Cancer Surgery

28	2001	Who Wants to Know?; A Simple Biopsy Technique Can Detect More Prostate Cancers Than Are Usually Caught
29	2001	Milk Study Stirs Debate; Research Linking Calcium And Prostate Cancer Settles . . . Nothing
30	2001	Prostate Cancer Cryosurgery
31	2001	K.C. Jones Has Prostate Cancer
32	2002	Prostate Cancer New U.S. cases
33	2002	Tackling a Man's Disease; Female Urologist Crusades Against Prostate Cancer
34	2002	The Facts on Prostate Cancer
35	2002	Prostate Cancer
36	2002	Prostate Cancer Therapies About Equal; Having Surgery May Extend Patient's Life
37	2002	U.S. Envoy Diagnosed With Prostate Cancer
38	2003	Prostate Cancer Thrives on Ignorance, Fear
39	2003	U-Conn.'s Calhoun to Have Surgery for Prostate Cancer
40	2003	Kerry to Have Surgery For Prostate Cancer; Doctors Give 90% Chance of Full Recovery
41	2003	Study Finds Baldness Drug Lowers Prostate Cancer Risk
42	2003	Powell Has Surgery for Prostate Cancer; Doctors Predict Complete Recovery
43	2003	Treatment Powell Had Is Usually Effective
44	2004	Prostate Cancer Differences
45	2004	Testosterone Linked To Prostate Cancer; Older Men With Higher Level Are at Risk
46	2004	Widely Used Test Often Misses Prostate Cancer, Researchers Report
47	2004	Safety in Numbers; When Fighting Prostate Cancer, the 'Wisdom of Crowds' Trumps Any One Expert's Opinion
48	2004	At Sherwood, There's No Doubting Thomas; Despite Prostate Cancer, Football Coach's Intensity 'Is Second to None'
49	2005	Prostate cancer Hormone drugs
50	2005	Treatment for Prostate Cancer Shows Promise
51	2005	Prostate Cancer Test Questioned; Researchers Say PSA Screening Yields Many False Results
52	2005	Diet, Exercise and Reduced Stress Slow Prostate Cancer, Study Finds;
53	2005	prostate cancer Radiation ma ...
54	2006	Woods Ready to Play Despite Father's Fight Against Prostate Cancer

55	2006	Prostate Cancer Drugs May Pose Danger
56	2006	Prostate Cancer Hormone Therapy
57	2006	Study Disputes Wait-and-See Approach to Prostate Cancer

New York Times Headlines on Breast Cancer

ID	Year	Title
1	1990	Rose Kushner, 60, Leader in Breast Cancer Fight
2	1990	Breast Cancer Drug May Benefit the Heart
3	1990	Needless Breast Cancer Deaths Reported Among New York's Poor
4	1990	Insurer to Finance Test of a Treatment For Breast Cancer
5	1990	Breast Cancer: New Trends On Age and Family History
6	1990	Sunlight and Breast Cancer: Danger in Darkness?
7	1990	Some Genetic Pieces Are Falling Into Place In Breast Cancer Puzzle
8	1991	Turning Disease Into Political Cause: First AIDS, and Now Breast Cancer
9	1991	Women Face 1-in-9 Chance Of Breast Cancer, Group Says
10	1991	Research on Drug For Breast cancer
11	1991	Fiber May Help in Preventing Breast Cancer
12	1991	Breast Cancer Cases Fewer Than 1 in 9
13	1991	Dr. Jerome Urban, 77, Surgeon Who Specialized in Breast Cancer
14	1991	Quandary Created by Gain In Detecting Breast Cancer
15	1991	Many With Breast Cancer Can Have Limited Surgery
16	1991	Screening for Breast Cancer: Questions of Cost and Quality
17	1991	After Breast Cancer, Women Face Dilemma Over Estrogen Therapy
18	1991	Powerful Hormone to Be Tested In War to Prevent Breast Cancer
19	1991	Study Set on Abortion Pill's Use in Breast Cancer
20	1992	Study on Breast Cancer Finds Therapy Is Effective for Years
21	1992	Dr. Louis Venet, 77, a Surgeon And Specialist in Breast Cancer
22	1992	Better Odds; Faulty Math Heightens Fears of Breast Cancer
23	1992	Large Study Will Test Whether Drug Prevents Breast Cancer
24	1992	Citing Breast Cancer Rates in Nassau and Suffolk, Group Asks for Research
25	1992	Risk in Breast Cancer Therapy Called Falling
26	1992	Chance of Breast Cancer Is Figured at 1 in 8
27	1992	The Media Business: Advertising -- Addenda; Effort Against Breast Cancer
28	1992	Breast Cancer Unit For Sloan-Kettering
29	1992	Long Island Presses for Answers on Breast Cancer

30	1992	Effective Lobbying Increases U.S. Funds for Breast Cancer Research
31	1992	Big New Study Finds No Link Between Fat and Breast Cancer
32	1992	Questions Raised on Drug Used in Breast Cancer Study
33	1992	Legal Aid for Breast-Cancer Queries
34	1992	Clue to Spread of Breast Cancer
35	1993	New Studies on Breast Cancer Sought by D'Amato and Women
36	1993	Charles Breed Jr., 78, Breast Cancer Expert
37	1993	Ideas & Trends; Rethinking The Statistics Of 'Epidemic' Breast Cancer
38	1993	Breast Cancer: Patients See Employer Bias
39	1993	Study Fails to Link Dietary Fat and Breast Cancer
41	1993	Risk of Hereditary Breast Cancer Is Reduced
42	1993	The Doctor's World; Vitamin A and Breast Cancer Risk
43	1993	1990's: Aug. 15, 1993; The Anguished Politics of Breast Cancer
44	1993	On L.I., Using Politics To Fight Breast Cancer
45	1993	Clinton Pledges Money To Fight Breast Cancer
46	1993	Weighing Spending on Breast Cancer
47	1993	New Activism Over Breast Cancer
48	1993	Abortion Pill Approved for Breast Cancer Test
49	1993	U.S. to Finance Project to Study Breast Cancer On Long Island
50	1993	Implants Found to Curb Spread of Breast Cancer
51	1993	Hormone Clue to Breast Cancer Risk
52	1993	Breast Cancer Screening Under 50: Experts Disagree if Benefit Exists
53	1994	Researcher Falsified Data in Breast Cancer Study
54	1994	Breast Cancer Advice Unchanged Despite Flawed Data in Key Study
55	1994	Data on Risks Create Debate About Drug to Prevent Breast Cancer
56	1994	Federal Officials to Review Documents in Breast Cancer Study With Falsified Data
57	1994	Fall of a Man Pivotal in Breast Cancer Research
58	1994	L.I. Breast Cancer in Possibly Linked to Chemical Sites
59	1994	U.S. Approves Drug For Breast Cancer
60	1994	April 10-16: A Study of Risks; Breast Cancer Near Chemical Sites
61	1994	New Report on Breast Cancer Affirms Flawed Study's Result
62	1994	Flawed Breast Cancer Study Faces Cutoff of Financing

63	1994	Smokers Have Higher Breast Cancer Death Risk
64	1994	A Day With: Dr. Susan M. Love; A Surgeon's War on Breast Cancer
65	1994	Vexing Pursuit of Breast Cancer Gene
66	1994	Mothers, Daughters and the Pain of Breast Cancer
67	1994	Deadliness of Breast Cancer In Blacks Defies Easy Answer
68	1994	F.D.A. Seeks More Testing of a Device to Detect Breast Cancer
69	1994	Estrogen After Breast Cancer
70	1994	Scientists Identify a Mutant Gene Tied to Hereditary Breast Cancer
71	1994	Regimen of Moderate Exercise Tied to Drop in Breast Cancer
72	1994	Breast Cancer Twice as Deadly in Blacks
73	1994	New Study Links Abortions and Increase in Breast Cancer Risk
74	1994	The 1994 Campaign: Long Island; Breast Cancer as a Political Issue
75	1994	Breast Cancer Gene Isn't Making Screening Easy
76	1995	Breast Cancer Deaths Fell Nearly 5 Percent in Three Years
77	1995	Breast Cancer Weapons: Fruit, Vegetables and, Maybe, Olive Oil
78	1995	Television Review; Daughters, Mothers and Breast Cancer
79	1995	2 Studies Equate Treatments Of Early Breast Cancer Cases
80	1995	Ellen Hermanson, 42, Advocate For Survivors of Breast Cancer
81	1995	Personal Health; Weighing evidence for ways to avoid breast cancer.
82	1995	U.S. Sues Hospital on Breast Cancer Study
83	1995	Moving to Different Country Alters Risk of Breast Cancer
84	1995	Breast Cancer Gene in 1% of U.S. Jews
85	1995	.D.A. Panel Backs New Breast Cancer Drug
86	1995	Ideas and Pain Shared Over a Common Enemy, Breast Cancer
87	1995	Research Links Single Gene To Almost All Breast Cancers
88	1995	Researchers Say Newly Identified Gene May Promote Breast Cancer
89	1995	Limited Use of Breast Cancer Drug Urged
90	1995	Scientists Speedily Locate a Gene That Causes Breast Cancer; Better Screening Is Seen
91	1995	Company News; Zeneca Group Cleared in U.S. on Breast Cancer Drug
92	1996	Breast Cancer In Young Tied To Faulty Gene
93	1996	No Link Seen Between Fat and Breast Cancer

94	1996	Surprising Role Found for Breast Cancer Gene
95	1996	Breaking Ranks, Lab Offers Test To Assess Risk of Breast Cancer
96	1996	NEW JERSEY DAILY BRIEFING; A Plan to Fight Breast Cancer
97	1996	Findings on Breast Cancer Have Only Complicated the Puzzle
98	1996	Breast Cancer Death Rate Dips Again, but Race Differences Remain
99	1996	Drug Approved In Bid to Fight Breast Cancer
100	1996	Survivor's Breast Cancer Stamp
101	1996	Detecting Breast Cancer More Accurately
102	1996	Maurice M. Black, 78, an Expert on Breast Cancer
103	1996	No Long-Term Link Is Found Between Pill and Breast Cancer
104	1996	Confronting the Specter of Breast Cancer
105	1996	2d Breast Cancer Gene Found in Jewish Women
106	1996	The Media Business: Advertising; National Breast Cancer Awareness Month
107	1996	Fewer Women Dying From Breast Cancer
109	1996	Analysis of 23 Studies Suggests Abortion Can Slightly Raise the Risk of Breast Cancer
110	1996	Long Island; I Got Breast Cancer. Why Me?
111	1996	Discovery of Breast Cancer Gene Produces Clues but No Answers
112	1996	Paradox in Ovarian and Breast Cancer Risk Intrigues Scientists
113	1996	Genetic Defect in Women Who Smoke Is Linked To High Risk of Breast Cancer After Menopause
114	1996	New Technique Eases Mapping of Breast Cancer
115	1996	Drug Protects Bones In Breast Cancers
116	1996	On Radiation And Breast Cancer
117	1997	Advent of Testing for Breast Cancer Genes Leads to Fears of Disclosure and Discrimination
118	1997	Estrogen Gene Tied To Breast Cancer Risk
119	1997	New View Sees Breast Cancer As 3 Diseases
120	1997	Scientists Discover Role of 2 Genes in Breast Cancer in Families
121	1997	Study Bolsters Idea That Exercise Cuts Breast Cancer Risk
122	1997	On Breast Cancer, the Vote Favors Aggressive Screening
123	1997	35 and Mortal: A Breast Cancer Diary
124	1997	Wanting a Chance to Choose Their Time
125	1997	World Breast Cancer Forum Blames Environmental Ills
126	1997	Race to Help in Breast Cancer Fight

127	1997	For Men With Breast Cancer, Loneliness Follows Surprise
128	1997	Patents; A dark horse has scored a victory in the race to commercialize breast cancer gene
129	1997	U.S. Survey Clears Silicone Implants of Role in Breast Cancer
130	1997	Television View; Scheduling Breast Cancer in Prime Time
131	1997	Television View; Scheduling Breast Cancer in Prime Time
132	1997	Television Review; Breast Cancer Brings 'Murphy Brown' Close To Real-Life Tragedy
133	1997	Television Review; Seeking Something to Blame When Breast Cancer Strikes
134	1997	Personal Health; Breast Cancer Awareness May Carry Its Own Risks
135	1997	Trans Fatty Acids Tied to Risk of Breast Cancer
136	1997	National News Briefs; Breast Cancer Video Called Unfit for Families
137	1997	Study Discounts DDT Role in Breast Cancer
138	1997	Oct. 26-Nov. 1; DDT and Breast Cancer
139	1997	Study Finds Big Weight Gain Raises Risk of Breast Cancer
140	1998	F.D.A. Approves Test That Predicts Recurrence of Breast Cancer
141	1998	Studies Confirm Relationship Of Alcohol to Breast Cancer
142	1998	Growth Pains on Breast Cancer
143	1998	.D.A. Advisers Back Breast Cancer Pill
144	1998	Kay Coltoff, 61; Aided Others With Breast Cancer
145	1998	Researchers Find the First Drug Known to Prevent Breast Cancer
146	1998	Breast Cancer Breakthrough
147	1998	Breast Cancer Drug Dilemma: Who Should Take It, and When?
148	1998	2d Drug May Reduce Risk of Breast Cancer
149	1998	Studies Show Another Drug Can Prevent Breast Cancer
150	1998	Getting Out the Message on Breast Cancer
151	1998	Drug Is Found to Fight Return of Breast Cancer
152	1998	Drug Is Shown to Shrink Tumors in Breast Cancer Characterized by Gene Defect
153	1998	Ferraro Assails D'Amato Over Breast Cancer Effort
154	1998	Drug for Advanced Breast Cancer Is Also Found Effective in Early Treatment
155	1998	Proposals Awaited for L.I. Breast Cancer Study
156	1998	Disclosure of How a Gene Causes Breast Cancer
157	1998	Drugs to Fight Breast Cancer Near Approval
158	1998	Metro News Briefs: New Jersey; Breast Cancer Rate Shows

		Decline Since '92
159	1998	Carol Hochberg, 40, Advocate For Victims of Breast Cancer
160	1998	Long Island Journal; When Breast Cancer Invigorates a New Life
161	1998	Q&A/Isidore Tepler; Making Strides Against Breast Cancer
162	1998	Transformed by Passion and Politics, Breast Cancer Movement Gains Power
163	1998	Book on Breast Cancer Diet Is Misleading, Critics Assert
164	1999	January 10-16; A Harsh Strategy For Breast Cancer
165	1999	In Breast Cancer Data, Hope, Fear and Confusion
166	1999	Fraud Found In Analyzing Breast Cancer
167	1999	Centers Publish Breast Cancer Guide
168	1999	Strand of Hair May Point To Who Has Breast Cancer
169	1999	Breast Cancer And Diet Fat: No Link Found
170	1999	Results Due on Use of Marrow Transplants for Breast Cancer
171	1999	Doubts Raised on a Breast Cancer Procedure
172	1999	Conference Divided Over High-Dose Breast Cancer Treatment
173	1999	Breast Cancer Study on Alternative Therapy
174	1999	A Study Plays Down Estrogen Link to Breast Cancers
175	1999	Drug Slashes Breast Cancer Risk, Study Shows
176	1999	National News Briefs; Doctor From Antarctica Confirms Breast Cancer
177	2000	Metro News Briefs: Connecticut; State Ranks No. 2 In Breast Cancer
178	2000	Breast Cancer Study Points To Difference in Recurrence
179	2000	Breast Cancer Researcher Admits Falsifying Data
180	2000	Scientists Do the Math to Fight Breast Cancer
181	2000	Insurer Drops a Therapy for Breast Cancer
182	2000	Treatment of Advanced Breast Cancer
183	2000	Breast Cancer in Blacks Spurs Hunt for Answers
184	2000	Test Helps Predict Breast Cancer Recurrence
185	2000	The 2000 Campaign: The Ad Campaign; Making Breast Cancer a Political Issue Against McCain
186	2000	Metro Matters; Exploiting Breast Cancer For Politics
187	2000	The 2000 Campaign: The Ad Campaign; Breast Cancer and Politics II
188	2000	Breast Cancer Is Pinpointed By ZIP Code
189	2000	Breast Cancer Incidence by Zip Code, 1993-1997
190	2000	Breast Cancer in Nassau, 1993-97

191	2000	Researchers Stalk a Breast Cancer Gene to See How It Kills
192	2000	High Level of Insulin Linked To Breast Cancer's Advance
193	2000	Hormone Replacement Therapy Linked to Form of Breast Cancer
194	2000	Nassau Budget Hamstrings Breast Cancer Project
195	2000	Costs and Delays Stir Clash Over a Breast Cancer Center
196	2000	Use of Breast Cancer Drug Questioned in Dutch Study
197	2000	Incomplete Breast Cancer Care Found
198	2000	Pre-1975 Pill Tied to Breast Cancer in High-Risk Families
199	2000	The Ad Campaign; Lazio's Breast Cancer Efforts Assessed
200	2000	Access to Breast Cancer Screenings Is Shrinking, Experts Warn
201	2000	Breast Cancer Groups Question New Study
202	2000	National News Briefs; Breast Cancer Therapy May Shift to New Drug
203	2001	A Breast Cancer Survivor's Story, Told in E-Mail Messages
204	2001	A Campaign By Avon on Breast Cancer
205	2001	National Briefing Science And Health: Breast Cancer Drugs Approved
206	2001	Company News; CYTYC Buys Maker of Breast Cancer Testing Device
207	2001	Briefer Regimen May Fight Breast Cancer
208	2001	Breast Cancer Is a Complicated Enemy
209	2001	Conflicting Breast Cancer Studies Creating Unsettling Uncertainties
210	2002	Tests for Breast Cancer Gene Raise Hard Choices
211	2002	Study Said to Show Added Benefit of Genentech Breast Cancer Drug
212	2002	Confronting Cancer; Breast Cancer: Mammography Finds More Tumors. Then the Debate Begins
213	2002	For Now, Medical Advisory Panel Rejects Switching to a New Drug for Breast Cancer
214	2002	GOLF; Pro-Am Fights Breast Cancer
215	2002	Spotting Breast Cancer: Doctors Are Weak Link
216	2002	Study Finds No Link Between Breast Cancer and the Pill
217	2002	Breast Cancer Drug Is a Uterus Cancer Risk
218	2002	Breast Cancer Mythology on Long Island
219	2002	Detecting Breast Cancer Before It Starts
220	2002	Breast-Cancer Study Finds Benefit in Chemotherapy Every Two Weeks Instead of Three

221	2002	Lynne Abraham, 60; Spoke Out on Breast Cancer
222	2002	Breast Cancer: Genes Are Tied To Death Rates
223	2002	Boat Show ; Help for Breast-Cancer Patients Is on the Agenda
224	2003	Abortion and Breast Cancer
225	2003	Breast Cancer Service Finds Few to Serve
226	2003	Delinking Abortion and Breast Cancer
227	2003	National Briefing Science And Health: Gene Sheds Light On Breast Cancer
228	2003	National Briefing Health And Science: U.S. Changes Breast Cancer Guide
229	2003	Surprise Role for Ex-Senator: Male Breast Cancer Patient
230	2003	Male Breast Cancer
231	2003	Company News; Finland Approves a Lilly Drug to Fight Breast Cancer
232	2003	New Study Links Hormones to Breast Cancer Risk
233	2003	VITAL SIGNS: PROGNOSIS; A Breast Cancer Reassurance
234	2003	National Briefing Science And Health: Obesity Linked To Breast Cancer Risk
235	2003	New Drug Regimen Greatly Cuts Risk of Recurring Breast Cancer
236	2003	Halting a Breast Cancer Trial
237	2003	CASES; Long-Term Questions Linger In Halted Breast Cancer Trial
238	2003	Women With Genetic Mutation at High Risk for Breast Cancer, Study Confirms
239	2003	Company News; ICAD Wins Approval for New Breast Cancer Screening
240	2003	Study Suggests Switching Drugs Could Aid Breast Cancer Patients
241	2003	Study of Women With Breast Cancer Finds Half Didn't Get All Suggested Chemotherapy
242	2003	Company News; Additional Promotion Permitted for Breast Cancer Test
243	2004	Study Suggests Breast Cancer Is Linked to Use of Antibiotics
244	2004	A Debate on Radiation in Breast Cancer
245	2004	Treatment Is Seen to Cut Breast Cancer Recurrence
246	2004	Study Doesn't Link Abortion To Higher Breast Cancer Risk
247	2004	Choosing Breast Cancer Surgery
248	2004	Heeding a Call to Test Breast Cancer Treatments
249	2004	M.R.I. Screening for Breast Cancer
250	2004	Radiation Is Questioned in Breast Cancer Surgery After Age 70

251	2004	D.D. Approves New Use of a Novartis Breast Cancer Drug
252	2004	Invasive Breast Cancer Is Diagnosed in Elizabeth Edwards
253	2004	Travel Companion on the Breast Cancer Journey
254	2004	Another Way to Fight Breast Cancer Relapse
255	2004	Certain Type of Breast Cancer Drug Shows Better Result in Study
256	2004	Data Mounts on Avoiding Breast-Cancer Chemotherapy
257	2004	Connecticut Governor Undergoes Surgery for Breast Cancer
258	2005	New Form of Breast Cancer Drug Approved
259	2005	A Breast Cancer With a Built-In Quandary
260	2005	Breast Cancer Recurrence Is Cut in Half by a Drug
261	2005	Therapies Cut Death Risk, Breast-Cancer Study Finds
262	2005	Study of Breast Cancer Patients Finds Benefit in Low-Fat Diets
263	2005	National Briefing Science And Health: Breast Cancer Treatment Study Is Cut Short
264	2005	Annie Toglia, 56; Aided Breast Cancer Survivors
265	2005	National Briefing Science: Drug Effective Against Breast Cancer
266	2005	National Briefing Science And Health: Promising Breast-Cancer Drug
267	2006	After Breast Cancer, Changing the World One House at a Time
268	2006	Studies Challenge Traditional Breast Cancer Treatments
269	2006	Studies Challenge Traditional Breast Cancer Treatments
270	2006	Drug Found to Help Lower Breast Cancer Risk
271	2006	A New Breast Cancer Option
272	2006	Sorting Out Pills to Reduce Breast Cancer Risk
273	2006	Shift in Treating Breast Cancer Is Under Debate
274	2006	New Drug Holds Promise For Type of Breast Cancer
275	2006	Quality of Life Found Equal With 2 Breast Cancer Drugs
276	2006	Racial Component Is Found In a Lethal Breast Cancer
277	2006	Linking Menopause, Weight and Breast Cancer
278	2006	Breast Cancer History Is a Two-Sided Family Tree
279	2006	In Breast Cancer, There is a Single Agenda: Stay Alive
280	2006	Dr. Arthur Holleb, 85; Promoted Screening for Breast Cancer
281	2006	National Briefing Science And Health: Breast Cancer Drug Is Approved For Early Cases
282	2006	L.P.G.A. Golfers Unite to Battle Shared Burden of Breast Cancer
283	2006	Second Opinion May Aid Breast Cancer Treatment

284	2006	Reversing Trend, Big Drop is Seen in Breast Cancer
285	2006	A Big Drop in Breast Cancer
286	2006	Breast Cancer News Brings a Range of Reactions

Washington Post Articles on Breast Cancer

ID	Year	Title
1	1990	Remembering Rose Kushner, a Crusader For the Rights of Breast Cancer Patients
2	1990	New Guidelines Debated For Breast Cancer Therapy
3	1990	Politics May Hold Cure for Breast Cancer
4	1990	Drug Treatments for Early Breast Cancer; Panel of Experts Offers Little Guidance to Women
5	1990	Breast Cancer & the '90s Woman
6	1990	Blue Cross Agrees to Fund Breast Cancer Experiment; Women to Undergo Bone-Marrow Transplants
7	1990	Estrogen, an Aid Against Heart Disease, Raises Breast Cancer Risk in Study
8	1990	Va. Health Insurer to Aid Study on Breast Cancer
9	1990	Scientists Narrow Search For Breast Cancer Gene
10	1991	The Washington Post, Risk of Breast Cancer Rises To 1 in 9 American Women
11	1991	Quest for a Breast Cancer Cure
12	1991	Tamoxifen Use Debated For Breast Cancer Study
13	1991	Medicine: Laser Screening for Breast Cancer
14	1991	Little Progress in War on Breast Cancer; Survival Chances Only Scarcely Better After Decades of Research
15	1991	MRI Tests vs. Mammography In Detecting Breast Cancer
16	1992	Breast Cancer Drugs Prove Effective; Study Finds Enduring Benefits to Hormone Treatment, Chemotherapy
17	1992	Obese Women Increase Risk Of Recurring Breast Cancer
18	1992	U.S. to Test Potential Breast Cancer Preventive in 16,000 Women
19	1992	Battling Breast Cancer
20	1992	Men Must Join Breast Cancer Fight
21	1992	Breast Cancer Funds Spark Budget Skirmish
22	1992	Confronting the Trauma of Breast Cancer; Pastor's Revelation Sets Silver Spring Congregation on a Shared Journey
23	1992	Coping With Breast Cancer Together; Shared Disease Bonds Women at Silver Spring Church, Amy Goldstein
24	1992	Breast Cancer Drug's Benefits Defended Despite Side Effects
25	1993	Fear of Breast Cancer
26	1993	Breast Cancer Tracks Growth in Population
27	1993	Breast Cancer Surgery and Menstrual Cycles

28	1993	Mary Maotil's Reprieve from Breast Cancer; After Treatment With the Experimental Drug Taxol
29	1993	Spanish Study Links Wine, Breast Cancer
30	1993	TV Preview; Not for Women Only; A Powerful Special on Breast Cancer
31	1993	A Growing Chorus Against Breast Cancer; In Rally, Meeting With Clintons, Activists Push for More Funding
32	1993	Studies Give Pesticides Role in Breast Cancer; Scientific Evidence Growing
33	1993	Breast Cancer-Abortion Link Under Attack; Authors Outraged by Religious Right's Interpretation of Studies
34	1993	New Use for Taxol; FDA Panel Recommends Drug Be Approved for Breast Cancer
35	1994	If Your Wife Has Breast Cancer.
36	1994	Breast Cancer's Link to Estrogen Exposure
37	1994	Breast Cancer Experiment to Be Reexamined ; Agency Will Audit Patient Charts After Allegations of Fraud by Canadian Researcher
38	1994	Director of Breast Cancer Study to Step Aside; Additional Patients Barred
39	1994	Montreal Doctor Backs Falsifying Breast Cancer Data
41	1994	Va. Breast Cancer Victim Beats System ; Crusade Results in Law Requiring Insurers to Offer Special Coverage
42	1994	Breast Cancer Drug Warning
43	1994	Scientists Track A Familial Gene For Breast Cancer,
44	1994	Breast Cancer
45	1994	Researchers Plan Changes At University of Pittsburgh; Action Follows Breast Cancer Test Scandal
46	1994	Breast Cancer Studies Face New Questions; Federal Office Orders A Misconduct Inquiry
47	1994	Less Chemotherapy Found To Raise Breast Cancer Risk
48	1994	Breast Cancer Drug Testing Will Continue; Potential of Tamoxifen Is Said to Outweigh Risks
49	1994	FDA Panel Votes to Resume Tamoxifen Trials; Breast Cancer Study, Interrupted by Data Probe
50	1994	Tamoxifen on Trial; Thousands of Healthy Women are Risking Fatal Side Effects
51	1994	Gene for an Inherited Form Of Breast Cancer Is Located; Finding Called 'Important' -- but Not a Cure
52	1994	Breast Cancer Gene's Impact Limited; Environment, Lifestyle, Diet Account for 90 Percent of Cases

53	1994	Golfers Raise Consciousness And Money; \$ 10,000 Goes Toward Breast Cancer Research
54	1994	Higher Risk of Breast Cancer Found In Young Women Who Had Abortions
55	1994	Breast Cancer and Politics, Abigail
56	1994	Md. Congregation Continues Battle With Breast Cancer
57	1995	Exercise and Breast Cancer; Activity's Effect on Hormones and Immune Cells May Reduce Risk
58	1995	Pentagon May Hold Up AIDS Study Funds; Breast Cancer Research Also in Danger; Both Are Regarded as Not Essential to Military
59	1995	The First Lady's Women's Crusade; Some Critics Say Hillary Clinton Has Taken On a 'Safe' Issue
60	1995	Black Women Find Strength In a Breast Cancer Support Group of Their Own
61	1995	Breast Cancer, Estrogen Link Is Affirmed
62	1995	26,000 Join to Run for Our Lives; Race Raises Money To Fight Breast Cancer
63	1995	Rare Gene Mutation May Raise Risk of Breast Cancer Fivefold
64	1995	Rare Gene Mutation May Raise Risk of Breast Cancer Fivefold
65	1995	Woman Wins Ruling in Breast Cancer Case
66	1995	Transplant Drugs May Cut Breast Cancer Risk
67	1995	The Misunderstood Statistics of Breast Cancer
68	1995	Audit Finds No New Abuses in Tainted Breast Cancer Study
69	1995	Study Backs 5-Year Limit on Breast Cancer Drug
70	1995	Reengineering the Birth Control Pill; Fairfax Firm Hopes to Cut Risk of Breast Cancer by Using Hormone Melatonin
71	1996	Antiabortion Message Gets Free Ride on Metro System; Ads Linking Procedure, Breast Cancer Disputed
72	1996	New Study Shows Weak Link Between Abortion, Breast Cancer
73	1996	Linkage of Breast Cancer, Dietary Fat Is Discounted; Analysis of 7 Studies Doesn't Settle Question
74	1996	'Breast Cancer Gene' May Be Useful in Treating the Disease; Its Protein Slows Formation, Growth of Tumors in Lab
75	1996	Ultrasound Approved for Breast Cancer Tests
76	1996	Breast Cancer Death Rates
77	1996	Race Participants Seek Finish Line for Breast Cancer
78	1996	War Between Sexes Rages Over Research; Funds to Study Prostate, Breast Cancer at Issue

79	1996	Review of 23 Studies Links Abortion and Breast Cancer
80	1996	Dialing for Breast Cancer Information
81	1996	Smoking Linked To Breast Cancer; Weak Protective Gene Increases Risk for Women, Study Finds
82	1996	Breast Cancer and Radiation
83	1996	Alcohol Can Elevate Levels Of Estrogen, Study Suggests; Hormone Could Raise Women's Risk of Breast Cancer
84	1996	Breast Cancer Drug Treatment
85	1997	Study Disputes Breast Cancer, Abortion Link; No Added Risk Seen in Early-Term Procedures
86	1997	More Women Are Getting Mammograms; Experts Agree That the Test Has Played Big Role in Reducing Deaths From Breast Cancer
87	1997	A Champion of Breast Cancer Patients
88	1997	3-Year Inquiry Exonerates Breast Cancer Researcher; Fraud-Tainted Data Didn't Constitute Misconduct
89	1997	A Fear Close to the Heart
90	1997	Scientists Decode Breast Cancer Genes
91	1997	Breast Cancer Drug Aids Heart
92	1997	New Players Join the Race for the Cure; Black Women See Apt Cause In Fight Against Breast Cancer
93	1997	Medicine: Diagnosing Breast Cancer
94	1997	Breast Cancer Study Suggests Putting Chemo First
95	1997	Breast Cancer Bills Need Undivided Attention
96	1997	Late Breast Cancer Diagnosis Linked to Weight; Study of Black and White Patients Offers Clue in a Medical Mystery
97	1997	Ferreira Gets Around to Win Harvest Moon 10K
98	1997	HRT and Breast Cancer
99	1997	The Beauty In Bald; With Breast Cancer, It's Part of the Cure
100	1997	Breast Cancer-Pollutant Link Unproven; Study Fails to Resolve Whether Exposure to PCBs, DDT Increases Risk
101	1997	Living With Advanced Breast Cancer
102	1997	Defense Department Battling Breast Cancer
103	1997	Weight Gain Increases Risk of Breast Cancer
104	1997	Chemotherapy Endorsed for Early Breast Cancer
105	1998	Oncor Puts Its Future to the Test; A Gene Screen for Recurring Breast Cancer Could Determine the Firm's Profit Outlook
106	1998	Figure Skater Fleming Has Surgery for Breast Cancer
107	1998	Nancy Reagan Influenced Breast Cancer Treatment
109	1998	For N.C. State's Yow, Forward in March; Breast Cancer Survivor on Verge of Final Four

110	1998	Gene Testing Questioned As Breast Cancer Screen
111	1998	The Time to Fight Breast Cancer
112	1998	Drug Shows It Cuts Risk of Breast Cancer; Trial Is Halted
113	1998	Tamoxifen Lowers Risk of Breast Cancer; Despite Drug's Success in Study, Recommendations for Individuals May Not Be Easy
114	1998	High Volume Helps in Breast Cancer Surgery
115	1998	Breast Cancer 'False Positives' Termed Frequent
116	1998	U.S. Assessing Breast Cancer Drugs
117	1998	Breast Cancer Patients Deserve Better
118	1998	Drug May Prevent Breast Cancer; Doctors to Release Raloxifene Data
119	1998	Taxol Found To Aid in Early Breast Cancer
120	1998	Wall St.'s Race for the Cure; Gains in Breast Cancer Research Lifting Stocks
121	1998	Ferraro Lashes Out On Mastectomy Bill; Outraged D'Amato Demands Apology, And Breast Cancer Groups Defend Him
122	1998	Smoking May Protect Some High-Risk Women From Breast Cancer
123	1998	New Drugs Are Rays of Hope for Breast Cancer Survivors
124	1998	Breast Cancer in Poland: A Needless Tragedy
125	1998	Stamping Out Breast Cancer, One Envelope at a Time
126	1998	FDA Panel Endorses Breast Cancer Drugs; Tamoxifen Intended to Prevent Disease
127	1998	FDA Approves Treatment For Advanced Breast Cancer; New Engineered Antibody Slows Tumors
128	1998	Minister in Silver Spring, Dies at 55; Her Battle Against Breast Cancer Transformed Congregation's View of the Disease,
129	1998	Tamoxifen Ads Won't Mention Prevention
130	1998	That's Quite Enough About Breast Cancer
131	1999	Medicare HMOs' Breast Cancer Care Lauded; Federal Study Says Groups Are Superior to Fee-for-Service Plans on Early Stage Tumors
132	1999	Sophisticated X-Ray Test of Hair Appears to Reveal Breast Cancer
133	1999	Breast Cancer Treatment Is Challenged; Studies See No Difference In Treatment,
134	1999	Breast Cancer Roulette; For women with aggressive tumors, bone marrow transplants have been regarded as the best hope for a cure
135	1999	Inside Prince George's; Run for--But Don't Hide From--Breast

		Cancer Detection
136	1999	Inside Prince George's; A Freedom Circle for Breast Cancer Survivors
137	1999	One Couple's Struggle Gives Rise to Breast Cancer Web Site
138	1999	Free Breast Cancer Exams at Pr. William Hospital; Grant Makes Mammograms Available to Uninsured Women
139	1999	U.S. Plane Rescues Doctor from South Pole; After Treating Herself for Breast Cancer for 5 Months, Researcher Coming Home,
140	2000	Aetna Stops Covering a Breast Cancer Treatment
141	2000	Bush Ads Hit McCain Stance On N.Y. Breast Cancer Programs
142	2000	Breast Cancer Study Spurns Transplants
143	2000	Bush Begins N.Y. Swing Talking Breast Cancer
144	2000	Foot Soldiers in the Battle Against Breast Cancer; 2,500 Walking in Three-Day Fundraising Effort
145	2000	Joy Wrought From Pain; 2,800 Walkers Survive Heat and Fatigue To Raise \$6 Million for Breast Cancer Fight
146	2000	She'd Rather Die Beautiful
147	2000	'We Think We Can Help Save Lives'; Skinner Leads LPGA Charge Against Breast Cancer
148	2000	Sensitive Choices; Procedures that are less invasive and more precise than surgical biopsies can effectively diagnose breast cancer
149	2000	Birth Control Pill May Raise Breast Cancer Risk for Some
150	2000	Panel Backs Combination Of Breast Cancer Drugs; Post-Surgical Use Improves Survival
151	2000	With a Little Help from Her Friends; Breast Cancer Survivor Credits 'Angels'
152	2000	Experts Dispute Breast Cancer Test Standards; Labs' Arbitrary Measures Can Affect Drug Therapy
153	2001	Femara Approved As 1st-Line Drug For Breast Cancer
154	2001	Too Young to Die; Media Images Aside, Breast Cancer Usually Hits After 50
155	2001	On Breast Cancer Walk, A Brother Looks Back; Sister's Illness Made D.C. Man Realize How Much He Cared
156	2001	On Breast Cancer Walk, A Brother Looks Back; Sister's Illness Made D.C. Man Realize How Much He Cared
157	2001	Hormones May Lower Risk Of Breast Cancer's Return
158	2001	Breast Cancer Chemotherapy
159	2001	Drug Combination Approved for Breast Cancer
160	2001	Two Studies Link Night Work, Breast Cancer

161	2001	Breast Cancer's Neglected Victims; Men Are Affected, Too, And Have a Role to Play
162	2001	Long Shot, Sweet Finish; When You've Rebounded From Metastatic Breast Cancer, Everything Seems Possible
163	2002	Breast Cancer New U.S. cases
164	2002	Survival Trade-off; More Treatment Lowers Quality of Life After Breast Cancer, New Study Says
165	2002	Not Too Far to Walk; Survivors and Friends Take Steps Against Breast Cancer
166	2002	Study: Birth Control Pills Not Linked to Breast Cancer
167	2002	Mothers Who Nurse Have Less Breast Cancer Risk; Study Cites Disease Rate In Developed World
168	2002	Breast Cancer Puzzle in Marin; California County's Rate of Disease Is Almost 40% Higher Than U.S. Norm
169	2003	Breast Cancer Patients Alone No More; Hospital's Center Offers Support And Knowledge
170	2003	Study Discounts Link Between Abortion, Breast Cancer Risk
171	2003	1 Million Gift to Fund Breast Cancer Clinic; SE Site to Treat Low-Income Women
172	2003	A Better Diagnostic Tool for Breast Cancer?
173	2003	Ex-Senator Details His Battle With Breast Cancer
174	2003	Breast Cancer Survivor Chronicles Her Fight for Life; Filmmaker Hopes Work Touches Younger Women
175	2003	Breast Cancer Drug Reduces Relapse Risk; Experts End Research Early After Seeing Striking Benefits
176	2003	Breast Cancer Drug Reduces ...
177	2003	Experts: No Rush To Test; Mass Screening for Breast Cancer Genes Is Not Needed
178	2003	For Breast Cancer Survivors, Lymphedema Adds Insult to Injury
179	2003	Catch and Relief; At a Fishing Retreat, Breast Cancer Survivors Learn to Cast for Therapy, Answers
180	2004	Antibiotics May Raise Risk for Breast Cancer
181	2004	Drug Switch Could Reduce Breast Cancer Recurrence
182	2004	Abortion's Link to Breast Cancer Discounted; Scientists Compared 53 Studies and Based Findings on Better-Designed Research
183	2004	Aspirin May Avert Breast Cancer; Risk of Estrogen-Related Types Falls With Use, Study Finds
184	2004	Race for the Cure Isn't Just for Survivors; Breast Cancer 5K Run Focuses on Families and Supporters, Including Men
185	2004	Hitting Streets of D.C. To Beat Breast Cancer; Survivors,

		Family, Friends Race for Cure
186	2004	Mr. Don't-Fix-It; Nine Really Dumb (If Well-Intentioned) Things a Guy Tends to Do When the Woman in His Life Has Breast Cancer
187	2004	Split Decision; A New Effort Aims to Sway Breast Cancer Patients to Opt for Conservative Rather Than Radical Surgery
188	2004	For Packers, It's Been a Year of Hardships; Latest Setback: Favre's Wife Has Breast Cancer
189	2004	Elizabeth Edwards Has Breast Cancer; Stage of Disease Not Yet Known
190	2004	New Drug Shows Promise in Cutting Risk of Breast Cancer Recurrence
191	2004	Genetic Test Is Predictor Of Breast Cancer Relapse; Results May Let Some Skip Chemotherapy
192	2005	The Breast Cancer Crew
193	2005	Survivors, Supporters Stride Toward Victory; Rain, Cold, Pain Endured to Fight Breast Cancer
194	2005	Detecting Breast Cancer
195	2005	Overstating Aspirin's Role In Breast Cancer Prevention
196	2005	Therapies Shown to Cure Breast Cancer; Large Study Backs Aggressive Regimen
197	2005	Study of Breast Cancer Pill Raises Hopes and Concerns
198	2005	Exercise Can Cut Risk of Dying From Breast Cancer
199	2005	Obesity May Affect Treatment of Breast Cancer
200	2005	Breast Cancer, Handedness Could Be Linked; Study Finds Higher Rate of Disease in Left-Handed Women
201	2005	Better Breast Cancer Imaging
202	2005	Radiation Benefit for Breast Cancer Shown
203	2006	breast cancer When used first
204	2006	Estrogen Alone Does Not Boost Risk of Breast Cancer
205	2006	A Boost For Breast Cancer Prevention; Osteoporosis Drug Lowers Risk With Fewer Side Effects
206	2006	Too Early to Declare Victory In the War Against Breast Cancer
207	2006	Hope Blossoms From Seeds of Friendship; Women Recall a Breast Cancer Fighter
208	2006	Many Voices, One Goal; Benefit Draws Thousands Affected by Breast Cancer
209	2006	Yoga May Have Benefits For Breast Cancer Patients; Preliminary Findings Suggest Improved Function
210	2006	Robert B. Dickson, 54; Professor, Breast Cancer Expert
211	2006	Elizabeth Edwards Writes of Her Battle With Breast Cancer

212	2006	U.S. Breast Cancer Rate Stabilizes; Scientists Are Unsure Whether This Is a Trend or an Aberration
213	2006	For Breast Cancer Care, a Women's Effort
214	2006	Breast Cancer Risk Linked To Red Meat, Study Finds

APPENDIX B. CONGRESSIONAL HEARINGS

The congressional hearings that were analyzed in this research were identified through a search of the LexisNexis Congressional database. Hearings that took place between January 1, 1990 and December 31, 2006 were identified using a keyword search of the terms “breast”, “breast cancer”, “prostate”, and “prostate cancer.” From this search, 111 congressional hearings were identified. Once this population was identified, the hearings were read to identify the testimonies of witnesses. From this 464 testimonies were identified. Once the total population of hearings was identified they were entered into an SPSS spreadsheet. Each hearing was assigned a number. I was looking for several things. The first step was to look at the type of witnesses that were testifying. This was relatively straightforward since a description of each witness is given before their testimony in the transcripts I was reading. I developed a numerical coding scheme to identify the different types of witnesses:

Congress=1
Advocates=2
Medical =3
Celebrity=4

Next, I looked at the various rationales that were provided in support of breast and prostate cancers. To identify these rationales, each testimony was read and categorized into five different groups. In reading through the hearings, it was often the case that no rationale was provided. This was the case in testimonies that emphasized the presentation of research results. For this reason, the number of rationales provided (N=435) was less than the total number of testimonies. The

following numerical coding scheme was developed to label the various rationales provided.

Testimonies were categorized as *incidence* if a congressional witness emphasized that there was a growing and/or sizable incidence of breast or prostate cancer.

Stories of Decline

0=no mention

1=mention

Testimonies were categorized as *personal story* if a congressional witness told a personal story about their personal experience with breast or prostate cancer or if they discussed the experience of someone else (either living or dead) that was dealing with or had dealt with these illnesses.

Personal Story

0=no mention

1=mention

Testimonies were categorized as *family* if a congressional witness emphasized the impact that breast and/or prostate cancer had on one's family members.

Family

0=no mention

1=mention

Testimonies were categorized as *everyone* if a congressional witness emphasized the impact that breast and/or prostate cancer had on potentially everyone in society.

Everyone

0=no mention

1=mention

Testimonies were categorized as *burden* if a congressional witness emphasized the negative financial impact that breast and/or prostate cancer had on society.

Burden

0=no mention

1=mention

Next, I looked at the various policy goals that congressional witnesses suggested in their testimonies. A numerical coding scheme was developed that divided the goals into five main groups:

Policy goals were labeled as *research* if witnesses made requests that more resources be allocated to increase research efforts on breast and prostate cancers.

Research

0=no mention

1=mention

Policy goals were labeled as *testing* if witnesses made requests that more resources be allocated to improve testing and early detection methods for breast and prostate cancers.

Testing

0=no mention

1=mention

Policy goals were labeled as *Medicare* if witnesses made requests for changes to Medicare in terms of testing and treatment for breast and prostate cancers.

Medicare

0=no mention

1=mention

Policy goals were labeled as *insurance* if witnesses made appeals to alter insurance coverage for treatment and the consideration by insurers of alternative treatments for breast and prostate cancers.

Insurance

0=no mention

1=mention

Policy goals were labeled as *regulatory* if witnesses made requests for changes to FDA guidelines on silicone breast implants for breast cancer patients.

Regulatory

0=no mention

1=mention

Policy goals were labeled as *treatment* if witnesses made requests for changes in the various treatments that were available to breast and prostate cancer sufferers.

Treatment

0=no mention

1=mention

Policy goals were labeled as *awareness* if witnesses made requests for programs and/or campaigns that were intended to educate the public about breast and/or prostate cancer.

Awareness

0=no mention

1=mention

In a separate SPSS spreadsheet, I looked at the various population characterizations that were mentioned in congressional testimonies. It is important to note that it was often the case that several different characterizations of populations were discussed in one testimony. Many populations were defined with reference to one or more characteristic such as “African-American women over age 40”. As such, the total number of population characterizations (N=693) exceeded the total number of testimonies. The characterizations included in this analysis were coded based on how frequently (at least once per hearings) a particular population group was mentioned in a single testimony. The numerical coding scheme I developed was used as follows:

Over 40 (persons over age 40)

0=no mention

1=mention

Family (images of family and/or family members)

0=no mention

1=mention

Minorities (minority groups such as African-American, Hispanic, Native Americans, Asians, and general use of term minority)

0=no mention

1=mention

Underserved (descriptions of underserved populations that included low income, uninsured, unemployed, uneducated, migrant workers, and urban/rural groups)

0=no mention

1=mention

Patients (the term “patient” used to refer to those suffering from breast or prostate cancer)

0=no mention

1=mention

Military (active or retired military personnel)

0=no mention

1=mention

Congress (members of Congress)

0=no mention

1=mention

Affluent (references to the affluent or middle class)

0=no mention

1=mention

FedEmploy (federal employees)

0=no mention

1=mention

Once these nine population groups were analyzed, they were further grouped into the four population types identified by Schneider and Ingram (1997) to include: groups with positive social constructions/political power (*advantaged*), groups with negative social constructions/political power (*contenders*), groups with positive social constructions/low political power (*dependents*), and *groups with negative social construction/low political power (deviants)*.

Tables that included listings of the 111 congressional hearings utilized in this research are provided here. They are categorized by breast and prostate cancers. For each hearing, the year, title, and committee/chamber are provided.

Prostate Cancer Congressional Hearings

ID	Year	Title	Committee/Chamber
1	1993	Departments of Labor, Health, and Human Services, Education, and Related Agencies Appropriations for 1994. Part 7: Testimony of Members of Congress and Other Interested Individuals and Organizations	Committee on Appropriations/ House
2	1997	Hearing on Prostate Cancer: The Silent Killer	Committee on Aging, Special/ Senate
3	1998	Department of Defense Appropriations for 1999, Part 2	Committee on Appropriations/ House
4	1999	Department of Defense Appropriations for 2000, Part 2	Committee on Appropriations/ House
5	1999	Prostate Cancer, Special Hearing	Committee on Appropriations/ Senate
6	1999	Fighting Prostate Cancer: Are We Doing Enough?	Committee on Government Reform/ House
7	2000	Department of Defense Appropriations for 2001, Part 3	Committee on Appropriations/ House
8	2000	Department of Defense Appropriations, FY 2001	Committee on Appropriations/ Senate
9	2000	Departments of Labor, Health, and Human Services, Education, and Related Agencies Appropriations for 2001. Part 7B: Testimony of Members of Congress and Other Interested Individuals and Organizations	Committee on Appropriations/ House
10	2001	Department of Defense Appropriations, FY2002	Committee on Appropriations/ Senate
11	2001	Departments of Labor, Health, and Human Services, Education, and Related Agencies Appropriations for 2002. Part 7A: Testimony of Members	Committee on Appropriations/ House

		of Congress and Other Interested Individuals and Organizations	
12	2001	Department of Defense Appropriations for 2002, Part 3	Committee on Appropriations/ House
13	2002	Department of Defense Appropriations, FY2003	Committee on Appropriations/ Senate
14	2003	Department of Defense Appropriations, FY2004	Committee on Appropriations/ Senate
15	2004	Department of Defense Appropriations, FY2005	Committee on Appropriations/ Senate
16	2005	Military Quality of Life and Veterans Affairs, and Related Agencies Appropriations for 2006, Part 6	Committee on Appropriations/ House
17	2006	Department of Defense Appropriations, FY2007, Part 2	Committee on Appropriations/ Senate

Breast Cancer Congressional Hearings

ID	Year	Title	Committee/Chamber
1	1990	Medicare Benefit Improvement Act of 1990	Committee on Ways and Means/ House
2	1990	Women's Health	Committee on Energy and Commerce/ House
3	1990	Breast Cancer: Race For the Cure	Committee on Aging, Select/ House
4	1990	Preventive Health Care and the Elderly	Committee on Aging, Select/ House
5	1990	Is the FDA Protecting Patients from the Dangers of Silicone Breast Implants?	Committee on Government Operations/ House
6	1991	Improving the Quality of Mammography: How Current Practice Fails	Committee on Labor and Human Resources/ Senate
7	1991	Departments of Labor, Health, and Human Services, Education, and Related Agencies Appropriations for 1992. Part 8B: Testimony of Members of Congress and Other Interested Individuals and Organizations	Committee on Appropriations/ House
8	1991	Women at Midlife: Consumers of Second-Rate Health Care	Committee on Aging, Select/House
9	1991	Efficiency and Cost Effectiveness of the U.S. Health Care System: A Comparison with Canada	Committee on Government Operations/ House
10	1991	Why Are We Losing the War on Breast Cancer?	Committee on Labor and Human Resources/ Senate
11	1991	Medicare Preventive Benefits Act of 1991	Committee on Ways and Means/ House
12	1991	Exclusive Agreements Between Federal Agencies and Bristol-Myers Squibb Co. for Drug Development: Is the Public Interested Protected?	Committee on Small Business/ House
13	1991	Breast Cancer on Long Island: An Avoidable Tragedy	Committee on Aging, Select/House

14	1991	Failure and Successes of Current Mammography Practice: The Need for Strong Federal Quality Standards	Committee on Labor and Human Resources/ Senate
15	1991	Health Promotion and Disease Prevention	Committee on Labor and Human Resources/ Senate
16	1991	Breast Cancer Research and Treatment: Progress and Failures in the 20-Year War on Breast Cancer	Committee on Government Operations/ House
17	1992	Breast Implants: Ramifications of the FDA Ruling on Consumers	Committee on Aging, Select/ House
18	1992	Combating the Rising Incidence of Breast Cancer: Prevention, Early Detection, and Treatment	Committee on Labor and Human Resources/ Senate
19	1992	Long Island Solid Waste Crisis and Toxic Chemical Exposure-Induced Breast Cancer	Committee on Science, Space, and Technology/ House
20	1992	Access to Quality Mammography Screening	Committee on Energy and Commerce/ House
21	1992	Departments of Labor, Health, and Human Services, Education, and Related Agencies Appropriations FY1993. Part 2: Nondepartmental Witnesses	Committee on Appropriations/ Senate
22	1992	Medical Research: Federal Investments to Improve Public Health and The Nation's Economy	Committee on the Budget/ House
23	1992	Breast Cancer: Winning the Battles, Losing the War	Committee on Aging, Select/ House
24	1992	Breast Cancer Prevention Study: Are Healthy Women Put at Risk by Federally Funded Research	Committee on Government Operations/ House
25	1993	Public Health Service Programs Reauthorization	Committee on Energy and Commerce/ House
26	1993	Department of Defense Appropriations for 1994, Part 3	Committee on Appropriations/ House
27	1993	Departments of Labor, Health, and Human Services, Education, and Related Agencies Appropriations for 1994. Part 4: National Institutes of Health	Committee on Appropriations/ House

28	1993	Health Care Reform (Part 2)	Committee on Energy and Commerce/ House
29	1993	Standard Health Benefits: The Impact on Women's Health	Committee on Government Operations/ House
30	1993	Health Effects of Estrogenic Pesticides	Committee on Energy and Commerce/ House
31	1993	Health Care Reform, Vol. XI	Committee on Ways and Means/ House
32	1993	Link Between Cancer and Environmental Contaminants and Industrial Carcinogens	Committee on Government Operations/ House
33	1994	Health Care Reform (Part 8)	Committee on Energy and Commerce/ House
34	1994	Health Care Reform, Vol. XII	Committee on Ways and Means/ House
35	1994	Departments of Labor, Health, and Human Services, Education, and Related Agencies Appropriations for 1995. Part 7: Testimony of Members of Congress and Other Interested Individuals and Organizations	Committee on Appropriations/ House
36	1994	Health Care Reform and Possible Effects on Innovative Therapies: Cancer as a Case Study	Committee on Science, Space, and Technology/ House
37	1994	National Cancer Institute's Revision of its Mammography Guidelines	Committee on Government Operations/ House
38	1994	Women's Health Care in the President's Health Care Plan	Committee on Labor and Human Resources/ Senate
39	1994	Department of Defense Appropriations for 1995, Part 5	Committee on Appropriations/ House
40	1994	Scientific Misconduct in Breast Cancer Research	Committee on Energy and Commerce/ House
41	1994	Breast Cancer in Northeast Ohio	Committee on Energy and Commerce/ House

			House
42	1994	Oversight Hearing on the Federal Employees Health Benefits Plan FEHBP Coverage of HDC/ABMT Treatment for Breast Cancer	Committee on Post Office and Civil Service/ House
43	1994	Department of Energy's Human Genome Project Issues Arising from Research	Committee on Science, Space, and Technology/ House
44	1994	Minority Women and Breast Cancer	Committee on Government Operations/ House
45	1994	Uses of Military Technology and Information in War Against Breast Cancer	Committee on Armed Services/House
46	1995	Departments of Labor, Health, and Human Services, Education, and Related Agencies Appropriations for 1996. Part 7: Testimony of Members of Congress and Other Interested Individuals and Organizations	Committee on Appropriations/ House
47	1995	Department of Defense Appropriations for FY1996	Committee on Appropriations/ Senate
48	1995	Food Quality Protection Act of 1995	Committee on Commerce/House
49	1995	Allegations of F.D.A. Abuses of Authority	Committee on Commerce/House
50	1995	F.D.A. Regulation of Medical Devices, Including the Status of Breast Implants	Committee on Government Reform/ House
51	1996	Cancer Patient Access to Unapproved Treatments	Committee on Commerce/House
52	1996	Department of Defense Appropriations, FY97	Committee on Appropriations/ Senate
53	1996	Department of Defense Appropriations for 1997, Part 2	Committee on Appropriations/ House
54	1996	Women's Health Issues	Committee on Appropriations/ Senate
55	1996	Technological Advances in Genetics Testing: Implications for the Future	Committee on Science/House

56	1997	Mammography, Special Hearings	Committee on Appropriations/ Senate
57	1997	Department of Defense Appropriations for 1998, Part 2	Committee on Appropriations/ House
58	1997	Department of Defense Appropriations, FY98	Committee on Appropriations/ Senate
59	1997	Winning the War on Cancer and Medicare: Physician Practice Expenses, Special Hearings	Committee on Appropriations/ Senate
60	1997	Health Care and Quality	Committee on Labor and Human Resources/ Senate
61	1997	Women's Health and Cancer Rights Act of 1997	Committee on Finance/Senate
62	1998	Health Care Information Confidentiality	Committee on Labor and Human Resources/ Senate
63	1998	Department of Defense Appropriations, FY99	Committee on Appropriations/ Senate
64	1998	Department of Defense Appropriations for 1999, Part 2	Committee on Appropriations/ House
65	1998	Tamoxifen and Breast Cancer, Special Hearing	Committee on Appropriations/ Senate
66	1998	Reauthorization of Mammography Quality Standards Act	Committee on Commerce/House
67	1998	Genetic Information and Health Care	Committee on Labor and Human Resources/ Senate
68	1999	Department of Defense Appropriations for 2000, Part 2	Committee on Appropriations/ House
69	1999	Department of Defense Appropriations, FY2000	Committee on Appropriations/ Senate
70	1999	Medical Records Confidentiality in the Modern Delivery of Health Care	Committee on Commerce/House

71	1999	Role of Early Detection and Complementary and Alternative Medicine in Women's Cancers	Committee on Government Reform/ House
72	1999	Breast and Cervical Cancer Federally Funded Screening Programs	Committee on Commerce/House
73	1999	Medical Assistance for Certain Women Found to Have Breast or Cervical Cancer	Committee on Finance/Senate
74	1999	Biotechnology Summit: Putting a Human Face on Biotechnology	Committee on Economic/Joint
75	1999	F.D.A. Modernization Act: The Implementation of the Law	Committee on Health, Education, Labor, and Pensions/Senate
76	2000	Department of Defense Appropriations for 2001, Part 3	Committee on Appropriations/ House
77	2000	Department of Defense Appropriations, FY2001	Committee on Appropriations/ Senate
78	2000	Departments of Labor, Health, and Human Services, Education, and Related Agencies Appropriations for 2001. Part 7A: Testimony of Members of Congress and Other Interested Individuals and Organizations	Committee on Appropriations/ House
79	2000	Issuance of Semipostal Stamps by the U.S. Postal Service	Committee on Governmental Affairs/Senate
80	2001	Department of Defense Appropriations, FY2002	Committee on Appropriations/ Senate
81	2001	Patients First: A 21 st Century Promise to Ensure Quality and Affordable Health Care Coverage	Committee on Energy and Commerce/House
82	2001	Department of Defense Appropriations for 2002, Part 3	Committee on Appropriations/ House
83	2001	Breast Cancer Research and Development, Special Hearing	Committee on Appropriations/ Senate
84	2001	Cancer Clusters in Long Island, NY	Committee on Environmental and Public Works/Senate

85	2001	Fulfilling the Promise of Genetics Research: Ensuring Nondiscrimination in Health Insurance and Employment	Committee on Health, Education, Labor, and Pensions/Senate
86	2002	Department of Defense Appropriations, FY2003	Committee on Appropriations/Senate
87	2002	Making Sense of the Mammography Controversy: What Women Need to Know	Committee on Health, Education, Labor, and Pensions/Senate
88	2002	Departments of Labor, Health, and Human Services, Education, and Related Agencies Appropriations for 2003. Part 7B: Testimony of Members of Congress and Other Interested Individuals and Organizations	Committee on Appropriations/House
89	2002	Environmental Contributors to Breast Cancer: What Does the Science Say?	Committee on Science/House
90	2002	Harming Patient Access to Care: The Impact of Excessive Litigation	Committee on Energy and Commerce/House
91	2003	Department of Defense Appropriations, FY2004	Committee on Appropriations/Senate
92	2003	Mammography Quality Standards Act	Committee on Health, Education, Labor, and Pensions/Senate
93	2004	Department of Defense Appropriations, FY2005	Committee on Appropriations/Senate
94	2005	Military Quality of Life and Veterans Affairs, and Related Agencies Appropriations for 2006, Part 6	Committee on Appropriations/House

APPENDIX C. PUBLIC LAWS

The analysis of public laws was slightly different. Because breast and prostate cancers were often treated together in one public law, only one database was maintained for analysis. Information on public laws was obtained using the LexisNexis Congressional database. All public laws passed between 1990 and 2006 that contained the keywords “breast”, “breast cancer”, “prostate”, and “prostate cancer” were identified. The search identified a total 57 public laws that were catalogued by year and public law number in an SPSS spreadsheet. After each law was identified and catalogued, the text of each law was read to locate and identify provisions in each law that singled out breast and prostate cancers. In this research, a policy provision was defined as a section of a law that provided for a specific intervention (i.e. creating new institutions, new funding initiatives). In order to be considered as a provision, the language used in the corresponding statute needed to mention a specific intervention that directly related to either breast cancer, prostate cancer, or both. Provisions were labeled according to whether they applied to breast or prostate cancer using the following numerical coding scheme:

Breast cancer

0=no mention

1=mention

Prostate cancer

0=no mention

1=mention

After the final population of public laws was collected, the identified policy provisions were coded in four steps. The manifest coding scheme for policy provisions on breast and prostate cancers included: 1) determining whether provisions implied a benefit or restriction (*design type*), 2) determining whether implementation of provisions was required or discretionary (*requirement*), 3) the various types of policy provisions that included testing, research, treatment, education, and symbolic (*types of policy provisions*), and 4) identification of specific groups targeted as recipients of policy (*target groups*).

In step one, policy provisions were coded based on whether conferred benefits or restrictions (burdens) to policy targets. The following numerical coding scheme was used to determine if provisions were beneficial or restrictive:

Design Type

0=burden
1=benefit

In step two, policy provisions were coded based on whether their implementation was required (shall) or discretionary (may). The following numerical coding scheme was used to determine if provisions were required or discretionary:

Implementation

0=discretionary
1=required

In step three, policy provisions were coded by type. Five main types of policy provisions were identified that included: testing, research, treatment, education, and symbolic provisions.

Testing (referred to the provision of mammography screenings, PSA blood tests, or the establishment of standards to ensure the quality of mammogram tests)

0=no mention

1=mention

Research (referred to the requirement of a specific research study to be conducted, conducting clinical trials, and/or the creation of new research programs)

0=no mention

1=mention

Treatment (referred to the provision of care to specific groups along with eligibility requirements for those diagnosed with either of these illnesses that qualified for government treatment)

0=no mention

1=mention

Education (focus on the creation of outreach programs, awareness, or providing information about breast and prostate cancers to various groups)

0=no mention

1=mention

Symbolic (consisted of general proclamations whereby government encourages, but does not require, people to take action)

0=no mention

1=mention

In step four, I looked at the various population characterizations that were mentioned in policy provisions. Eight primary population groups were identified in the study population of policy provisions. The numerical coding scheme I developed was used as follows:

Over 40 (persons over age 40)

0=no mention

1=mention

Military (active or retired military personnel)

0=no mention

1=mention

Medical (persons who work in the research and/or medical field)

0=no mention

1=mention

Minorities (minority groups such as African-American, Hispanic, Native Americans, Asians, and general use of term minority)

0=no mention

1=mention

Patients (the term “patient” used to refer to those suffering from breast or prostate cancer)

0=no mention

1=mention

Underserved (descriptions of underserved populations that included low income, uninsured, unemployed, uneducated, migrant workers, and urban/rural groups)

0=no mention

1=mention

At risk (those at risk for developing breast and/or prostate cancer)

0=no mention

1=mention

Radiation (those exposed to radiation)

0=no mention

1=mention

Once these eight population groups were analyzed, they were further grouped into the four population types identified by Schneider and Ingram (1997) to include: groups with positive social constructions/political power (*advantaged*), groups with negative social constructions/political power (*contenders*), groups with positive social

constructions/low political power (*dependents*), and *groups with negative social construction/low political power (deviants)*.

Tables that included listings of the 57 public laws analyzed in this research are provided here. For each law, the year, title, and public law identification number are provided.

Public Laws on Breast and Prostate Cancers

ID	Year	Name	Public Law
1	1990	Breast and Cervical Cancer Mortality Prevention Act of 1990	101-354
2	1990	Designating October 1990 as “National Breast Cancer Awareness Month”	101- 415
3	1990	Radiation Exposure Compensation Act	101-426
4	1990	Omnibus Budget Reconciliation Act	101-508
5	1990	District of Columbia Appropriations Act 1991	101-518
6	1991	District of Columbia Appropriations Act 1992	102-111
7	1991	Designating October 1991 as “National Breast Cancer Awareness Month”	102-120
8	1991	Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act 1992	102-170
9	1992	Pacific Yew Act	102-335
10	1992	Designating October 1992 as “National Breast Cancer Awareness Month”	102-370
11	1992	Foreign Operations, Export Financing, and Related Programs Appropriations Act of 1993	102-391
12	1992	Department of Defense Appropriations Act of 1993	102-396
13	1992	DES Education and Research Amendments of 1992	102-409
14	1992	Cancer Registries Amendment Act	102-515
15	1992	Preventive Health Amendments Act of 1992	102-531
16	1992	Mammography Quality Standards Act of 1992	102-539
17	1992	Indian Health Amendments Act of 1992	102-573
18	1992	Veterans Health Care Act of 1992	102-585
19	1993	National Institutes of Health Revitalization Act of 1993	103-43
20	1993	Designating October 1993 as “National Breast Cancer Awareness Month”	103-84
21	1993	Designating October 19, 1993 as “National Mammography Day”	103-109
22	1993	Department of Defense Appropriations Act of 1993	103-139
23	1993	National Defense Authorization Act for FY1994	103-160
24	1993	Preventive Health Amendments of 1993	103-183
25	1994	Designating the week of June 12 through 19, 1994, as "National Men's Health Week"	103-264

26	1994	Designating October 1994 as “National Breast Cancer Awareness Month”	103-367
27	1994	Designating October 19, 1994 as “National Mammography Day”	103-370
28	1996	Foreign Operations, Export Financing, and Related Programs Appropriations Act of 1996	104-107
29	1996	Omnibus Consolidate Rescissions and Appropriations Act of 1996	104-134
30	1996	National Defense Authorization Act for FY 1997	104-201
31	1996	Health Centers Consolidation Act of 1996	104-299
32	1997	Balanced Budget Act of 1996	105-33
33	1997	Stamp Out Breast Cancer Act	105-41
34	1997	Veterans’ Benefit Act of 1997	105-114
35	1998	Department of Defense Appropriations Act of 1997	105-262
36	1998	Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999	105-277
37	1998	Women’s Health Research and Prevention Amendments Act of 1998	105-340
38	1999	Treasury and General Government Appropriations Act of 2000	106-58
39	2000	Radiation Exposure Compensation Act Amendments of 2000	106-245
40	2000	Semipostal Authorization Act	106-253
41	2000	Breast and Cervical Cancer Prevention Act of 2000	106-354
42	2000	Departments of Veterans Affairs and Housing and Urban Development and Independent Agencies Appropriations Act, 2001	106-377
43	2000	National Aeronautics and Space Administration Authorization Act of 2000	106-391
44	2000	Veterans Benefits and Health Care Improvement Act of 2000	106-419
45	2000	Public Health Improvement Act	106-505
46	2000	Consolidated Appropriations Act of 2001	106-554
47	2001	Treasury and General Government Appropriations Act	107-67
48	2002	Native American Breast and Cervical Cancer Treatment Act of 2001	107-121
49	2002	Health Care Safety Net Amendments of 2002	107-251
50	2002	Veterans Benefits Act of 2002	107-330
51	2003	Consolidates Appropriations Resolution	108-7
52	2003	Medicare Prescription Drug, Improvement, and Modernization Act of 2003	108-173

53	2004	Gateway Arch Illumination for Breast Cancer Awareness Month	108-348
54	2004	Mammography Quality Standards Reauthorization Act of 2004	108-365
55	2005	Breast Cancer Stamp Program Extension	109-100
56	2006	Deficit Reduction Act of 2005	109-171
57	2006	John Warner National Defense Authorization Act for FY 2007	109-364

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