As Howard Koh and his colleagues (Koh, Piotrowski, Kumanyika, & Fielding, 2011) show in this issue of *Health Education & Behavior*, the current incarnation of the *Healthy People* initiative gives social determinants of health greater prominence than previous iterations. The field of public health education, and those who identify with the profession of health education, owes a debt of gratitude to the Assistant Secretary of Health and the Secretary’s Advisory Committee, co-chaired by Jonathan Fielding and Shiriki Kuminyika, for this greater emphasis in the *Healthy People 2020* objectives for the nation. We can rejoice in this further recognition of determinants that public health education has always championed and pursued (alas, not with much support) as targets of change for population health, and for the necessary emphasis on intersectoral action that these will require.

But we might also lament the latter-day representation of social determinants and intersectoral action as a major departure from what had been called health promotion, and before that, health education. The key contrast Koh et al. make is with the “preceding emphases that focus more narrowly on disease outcomes or individual risk factors. . . .” But then the article distinguishes the *Healthy People 2020* approach in terms of refocused strategies, not outcomes. In fairness to the history of health education and health promotion, we need not interpret the limitations of past iterations of *Healthy People* as having had too much emphasis on health education or health promotion. The strategies now reflect more what the health education and health promotion concepts, originally conceived in the 1960s and proffered through to the 1980s, intended but were never so fully supported as in 2010.

We offer here an interpretation of the history of the *Healthy People* initiative showing that the outcomes remain largely the same, with appropriate decennial adjustment of the proliferating numerical targets and increased delineation of objectives for special populations. But the strategies by which those outcomes are to be pursued and achieved are increasingly akin to what our contemporaries in schools of public health and other graduate programs in the 1960s and 1970s were being taught public health education or community health education was supposed to do: namely to address not only the individual but also social determinants of health through processes of community mobilization and policy advocacy. The added value we were prepared to bring to bring to the field of public health was a focus on populations and communities with an ecological perspective (Green, Potvin, & Richard, 1996), their organization and mobilization for social change, building capacity, enabling action, and emphasizing equity. These were the ideas promoted by the pioneer professors of health education in the schools of public health during the 1960s: Lucy Morgan (Morgan & Tyler, 1947), Dorothy Nyswander (Nyswander, 1967), William Griffiths (Griffiths, 1959), Beryl Roberts (Roberts, 1960, see especially p. 31), Jerome Grossman (Grossman, 1961), Mayhew Derryberry (Derryberry, 1954), Guy Steuart (Steuart, 1971), Carol D’Onofrio (D’Onofrio, 1966), Lowell Levin (Levin, 1976), and Scott Simonds (Simonds, 1974), among others.

Similarly, we will show how the concept of health promotion was defined as an elaboration of the social-determinant dimensions of health education after the Office of Health Information and Health Promotion was created by Public Law 94-317 in 1976, and further elaborated in the Ottawa Charter (World Health Organization, 1986) for Health Promotion at the first International Conference on Health Promotion in 1986.

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The Decade Before Healthy People

Even before 1979, when the U.S. Department of (then) Health, Education and Welfare launched the first Healthy People initiative with the Surgeon General's Report on Health Promotion and Disease Prevention (U.S. Department of Health, Education, and Welfare, 1979), the decade saw growing federal and collaborative public–private national efforts to address the social and behavioral determinants of health under the rubric of health education. The budgetary focus of the federal government in health had been almost entirely on health services, minimally on environmental health, and even less on health behavior or social determinants. Estimates by the President's Committee on Health Education in 1970 were that less than one-tenth of one percent of the federal health budget went to health education (President's Committee on Health Education, 1971). The President's Committee on Health Education, in a series of regional hearings, and organizational and legislative initiatives, sought to forge a public–private partnership to broaden the potential influence on what would now be called social determinants of health (Guinta & Allegrante, 1992). A bill in Congress sponsored by Congressman Tim Lee Carter and Senator Edward M. Kennedy took up their recommendations and became law in 1976 (Viseltear, 1976).

The passage of Public Law 94-317 in 1976 created the Office of Health Information and Health Promotion in the Office of the Assistant Secretary of Health and mandated it to coordinate across agencies of the Department, with the Bureau of Health Education in the Centers for Disease Control and Prevention (CDC), and with the new National Center for Health Education in the private sector. With “health promotion” in the title of the office, the pressure to define health promotion as distinct from health information and health education began. The term health promotion was said to have been attached to the bill as a Congressional maneuver to avoid having a bill with the term health education get referred to the Education Committees of Congress where it would have faltered in the face of other priorities in public school education. The Office of the Assistant Secretary for Planning and Evaluation commissioned one such effort to define the role and effectiveness of health education in federal policy (Green, 1978). Other efforts, most notably those by the National Institutes of Health (NIH), Fogarty Center, and the American Association of Preventive Medicine (National Institutes of Health & American College of Preventive Medicine, 1976), similarly sought to advance the role and potential of health education. In 1979, the Office of Health Information and Health Promotion floated and then promulgated a definition of health promotion as “a combination of health education and related organizational, political and economic programs designed to support changes in behavior and in the environment that will improve health” (Green, 1979). This definition guided the activity of the Office of Health Information and Health Promotion, but came too late to be stamped on the first round of Healthy People “health promotion” objectives because the term environment was positioned as the purview of the “Health Protection” third of the objectives, and the term organizational was the purview of the “Preventive Health Services” third of the objectives.

The 1970s was also a decade in which the science underpinning public health education was bolstered by an infusion during the previous decade of behavioral sciences in schools of public health, with initial funding from the Russell Sage Foundation. The behavioral scientists populating most of these new faculty positions were largely from the field of psychology (Green, 2006), and NIH began funding health education research that could rise to the conventions of biomedical research in which individuals are randomly assigned to experimental and control groups. These converging benefits for health education also gave the appearance that the research guiding health education was biased in favor of individual change just when the opportunities to address broader systems and social changes might have been greater (Green, 1970).

During that decade of the 1970s, health education had a much greater federal airing, partly for reasons that pulled it away from its public health roots and conscripted it for service to the medical care sector. The cost-containment concerns of the Nixon Administration pressed for more patient education, consumer health education, and self-care education. These were seen as politically palatable ways to put greater responsibility for care on the individual and to reduce the nation’s growing financial burden on health services. Some of us were drawn into this net by the lure of NIH grants to conduct randomized controlled trials of approaches to patient education and behavioral self-management of chronic disease. We hoped to give greater scientific grounding to health education where community interventions did not lend themselves to randomization or to such other experimental controls. We might have lost our way except that we soon saw the necessity and advantages of connecting clinical health education with community health education and mobilization to address what have come to be called the social determinants of health.

The Decades Between

The interim and interregna between the first and latest decennial Healthy People objectives have seen many attempts to infuse more social determinants into the health objectives for the nation, only to have them beaten back or watered down by the political process or hampered by insufficient scientific evidence for altering course, or by the debates that have ensued over what constitutes sufficient evidence (Green, 1970, 1978, 2006; National Institutes of Health & American College of Preventive Medicine, 1976). Although the first decade of Healthy People was launched to great fanfare in 1981, shortly after the arrival of the Reagan
Administration, and with it an emphasis on smaller government and more fiscal accountability, the initiative quickly became bogged down by the limits that were imposed on new federal investments and initiatives at the time. When the support for regulatory policies to protect health and the means to deliver preventive health services as part of Healthy People’s intended approach evaporated under the weight of federal budget cuts, we witnessed the remaining emphasis on changing American lifestyles that would characterize much of the rhetoric of the program under the Reagan years, and cautioned that it could turn enlightened progress for social change into blaming the victim (Allegrante & Reagan, 1981).

Healthy People 2010 and the current Healthy People 2020 were shaped considerably by the growing recognition of health disparities and inequities, such as those that McCord and Freeman (1990) first demonstrated in their seminal report at the outset of the 1990s, and the accumulating scientific evidence that had converged by the end of the 2000s showing the impact of social determinants on population health (Commission on Social Determinants of Health, 2008). The attempts to reflect these findings repeatedly in the decennial drafts of the Healthy People objectives were sometimes tempered by White House editing, as illustrated in the preface to a privately published version of Healthy People 2000 (Green, 1991). Today’s Healthy People goals and objectives have been forged in the midst of the realization that systems thinking in public health (Homer & Hirsch, 2006; Leischow & Milstein, 2006; Mabry, Olster, Morgan, & Abrams, 2008) will be necessary to achieve new progress in meeting the challenges of complex health problems.

We return, finally, to the original issue of objectives for health versus strategies. We would submit that part of the difficulty of closing the loop is the tendency to cast the issue of national health goals in the frame of the World Health Organization’s definition of health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” This definition eludes six decades of global efforts to measure health and three decades of domestic national efforts to adjust the objective-setting process to give greater attention to social determinants than to some idealistic state of individual health and risk factors. For all its time-honored advantages of expressing an ideal of health, the World Health Organization definition needs a counterpart that offers an implicit metric of health within context (Green, Wilson, & Bauer, 1983). Health education would serve its own time-honored traditions well by building on recent discussions of this problem of reconciling definition and measurement of health in social and environmental contexts (Huber et al., 2011).

Conclusions
For all this reaching back to note with pride the public health education roots from the 1960s, among others, of the contemporary social determinants approach, and the ecological roots of health promotion from earlier public health traditions, we in public health education and health promotion owe some major debts of gratitude to others whose vision, leadership, and assiduous efforts put these firmly on the North American policy map. Thus, we should honor those on whose shoulders our efforts stand. They include, as exemplars, among many others:

- The professors of health education in the 1960s, who strived to cast our training in a more social equity and community determinants change framework than just in the individual behavioral change focus of the prevailing health research paradigm of that time;
- Clarence E. Pearson, a member of the staff of the President’s Committee on Health Education, 1971-1973, whose leadership in forging the public–private partnership helped widen the influence of health education on social determinants, particularly within the education sector (Pearson, 1988);
- Marc Lalonde, Minister of Health for Canada, for articulating a place for a social understanding of “lifestyle” in Canadian health policy in 1974, showing its importance among the prevailing preoccupation with health care organization, human biological, and environmental determinants of health (Lalonde, 1974);
- The late Arthur J. Viseltear, the public health historian of Yale University, for his work for Senator Edward M. Kennedy on the 1976 legislation that created the federal Office of Health Information and Health Promotion (Viseltear, 1976);
- J. Michael McGinnis, MD, and William H. Foege, MD, for their federal leadership in launching the Healthy People initiative in the 1970s, and for documenting the “actual causes of death” (McGinnis & Foege, 1993);
- David Satcher, MD, for giving disparities and inequities a more prominent billing in the third round of Healthy People, and making the elimination, not just the reduction, of health inequities a central feature and moral imperative of the objectives for the longer term (Satcher, 1999);
- S. Leonard Syme, a social epidemiologist at the University of California, Berkeley, School of Public Health, who was among those in the vanguard of that subspecialty in reinstating social determinants on the epidemiological map and spawning the growth of work on this subject among the Harvard School of Public Health colleagues of Dr. Koh (Syme, 2005);
- Marshall Kreuter, who led the Bureau of Health Education in organizing CDC’s first team for epidemiological analysis of physical activity well before the obesity epidemic was recognized, and led CDC’s...
new National Center for Chronic Disease Prevention and Health Promotion to its Planned Approach to Community Health (PATCH) program to guide communities in examining social determinants in planning their health promotion programs, and led the Center’s Prevention Research Centers Program to a greater appreciation of the need to engage their communities in the assessment of health needs and determinants (Doll & Kreuter, 2001);

- Ilona Kickbusch and many others abroad who weaved a strong social determinants theme into the World Health Organization’s thinking about health promotion and into the Ottawa Charter for Health Promotion in 1986, with emphases on “health in all policies” and ecological perspectives (Kickbusch, 1989); and

- Drs. Howard Koh, Jonathan Fielding, and Shiri Kuminyika, and their associate Julie Piotrowski, for stamping the Healthy People 2020 objectives for the nation with a more clearly articulated focus on social determinants.

Without the work of these and many others who supported them or worked in parallel with them, the focus on the social determinants of health would not have found its way into the place it now so prominently occupies in American health policy.

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