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"Healthy People" development process, LaLonde Report, Horace Ogden, and establishment of Bureau of Health Education, HERR Grants and the BRFSS.
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My name is Dennis Tolsma, and I have been involved in this for maybe the latter two-thirds of my professional life. I took a health education course in my Columbia Master's program. But it wasn't until I got involved in the Healthy People process that I actually began to get much more in-depth about the underlying science base that's supported. And the reason that we were able to bring that forward at that time is the strength of the science base that had been put in place. So, this would have been mid-1970s probably.

Well, I think like much of public health the science base is really a fruit of the powerful growth of epidemiology at the time. And it was more in the area of chronic disease epidemiology. Some of the great people in the field were doing remarkable work. Some of what was around physiological sorts of conditions such as high blood pressure or cholesterol, and others were more around the risk factors that might have led to elevated cholesterol. And so it was the risk factors area, of course, that predominantly provided us answers to questions that said: Lack of exercise is a risk factor; smoking is a risk factor. And you go back to smoking just as a good case on this. It wasn't until 1964 in the Surgeon General's report that it really had a high level acceptance that science base was clear-cut at that point. And public acceptance took a while longer from that.

And then by the mid-'70s, we were looking for ways to apply and to determine what are we going to need to do about these issues that we now know to be major parts of future of human health.
It was part of Healthy People. Let me just talk a bit about that. And I want to credit here Bill Fagee at CDC as sort of the guru who grasped this and set out to develop something we called a prevention plan for CDC. He had just been named director of CDC. A senior physician Center director at CDC and I were tasked to pull all of the CDC's stuff together into a document that would say: What is the plan for the future of prevention? And I will tell a little story about that.

So, we finished this and most of the CDC principles were involved in this. I think it was a pretty good document. Bill's boss at that time was Julius Richmond, the Surgeon General and the assistant secretary for Health, combined both jobs. Julie had worked with Rosalynn Carter on a mental health task force and then had been named the Surgeon General.

So, Bill took this document up to him and said: I would like to publish this. And so Julie said: Bill, let me take it home next weekend and read it.

So, he called back Monday and he said: Bill, I don't want you to publish it. And Bill was sort of I think -- he said, I was kind of taken back. And I said: Well, why not? He said: Because I want to do this for the whole public health service. So we would like to redo this process but broaden it to the entire public health service. And that was the beginning of the Healthy People process and the objectives for the nation that became part of that.

So, you can -- you can logically say that we've positioned this all around a prevention document, and within that prevention document were a number of the kinds of things that derived out of that science base that included these risk factors. It was a small part of CDC at the time, but it turned out to be a very substantial part of the prevention plan. So, moving forward, the CDC prevention plan had kind of positioned these issues. We were highly cognizant of the work being done at Canada at the time, which was called "A New Perspective on Health of Canadians," or the LeLonde Report, after the minister who had been responsible for it.

And so when Julie said, I want to do that for the entire public health service, do the same thing, he had a young fellow from Joe Califano's office called Michael McGinnis, and Bill tabbed me to go up and work with McGinnis to, in essence, redo this, expand it, broaden it, bring in lots of external constituencies which was the new part of that and lots -- and all of the various agencies.

So, let me think about that. That would have been '76 possibly, mid '70s anyway that we were doing that because the document originally was published in '78. So, say, '76, '77, around then. What proved to be powerful in this Healthy People development process and the ultimate publication were two or three things. I talked earlier about science base. We were able really to document that and on a very almost real-time basis. We had plenty of resources to dig out of the NIH and the Library of Medicine and so on.

The second part of that was that we had the LeLonde Report. And the LeLonde Report had segmented the Canadian approach into basically lifestyles, environment, human biology and medical care interventions, or sectors, domains use what words you choose. And as we began to put our stuff together in this and bring in the agencies together and bring in the physician papers into this, bring this external world into it, what began to loom bigger and bigger is the future for Healthy People. And by the way, we named it "Knowledge of Aforethought Healthy People" because that both reflected what our aspirations were and what the goals of prevention would be.

So, that's where the name for the process came from. We sought to achieve a nation of Healthy People. And to do that you could not ignore these powerful health behavior choice risk factors. And so with that, became a principle element. Now, in fact, if I remember correctly -- and this may be a bit off -- but I think maybe a third or more of the objectives for the nation for 1990, which accompanied the Healthy People document, were around healthy lifestyles. And so Bill Fagee, the kind of genesis of this project, the guru of this idea, has said that, when we finished it, he felt that we had a -- we didn't have a national health system, and we didn't have a national health plan. But, by golly, we had a prevention plan and we had a health promotion priority in that prevention plan. So, to me that was instrumental in moving

the field from a fairly low visibility area perhaps in the states and perhaps limited to a sort of basic traditional idea of health education in some of the states to one that was really seen as a mainstream public health activity and, in fact, a high priority public health activity.

I had an opportunity to work with a very fine human being who was the CDC's leader in health education, particularly once the Bureau of Health Education had been established. It was Horace Ogden is his name, "Hod" to his friends. Hod Ogden came to CDC from a very interesting background. It was not a traditional health education background. I believe he had a degree in communications, which maybe made him ahead of his time that has become so much more visible in health education activities today.

But he had been a speech writer for the Surgeon General, for several surgeon generals. And as aside, he taught me the principle of the basic speech structure. He had been a neighbor fortuitously of Paul Volcker, who later became the chairman of the Federal Reserve. And he was a speechwriter at the time as well. So, the two of them would meet over the back fence and talked about speeches. And they finally worked out the formula for the perfect public health, or any other kind of speech I suspect, which is "Point with pride, view with alarm, and close with hope." And so I adopted that and it worked pretty well as a way to focus your strategy. But it points out that Hod was thinking: how do you communicate ideas.

And the point is that he was, as a communicator, thinking about how do you convey to people in our field what it is we are now positioned to do and what it is we are called on to do. I will tell another story about Hod. He is probably most well known within the APHA public health community and the international health education community for an alter ego. He is the inventor of something called "The Cosmic Maxims of Mohan Singh," and they are hilarious oxymoronic truths about health, but they also reflect the ability of health educators to poke a little fun of themselves. And, in fact, they have named the Mohan Singh Award in the APHA section to give an award for the most creative use of humor in public health every year. Hod Ogden, was a very interesting man and a very charming and witty man. He stands at the position between the earlier days of health education and the later days of health promotion in education and risk factor reduction.

The earlier days, CDC really did not have very much health education. Most state health departments had a health education unit, but there wasn't the relationship in other areas of public health that CDC has with the states, and health education was mostly around school health interestingly enough.

One of the elements of the history of health education that should be recognized was the establishment of the Bureau of Health Education. And the reason that it was established was something that seems almost a fantasy to me today. President Richard Nixon started a commission on health education, which one of the recommendations was that there would be a bureau in the federal government for health education. And CDC I think positioned itself to reach out and say, yeah, we would like to bring that in. We are moving away from the Communicable Disease Center to the Center for Disease Control. This is a good fit with us, and that's how it worked out. Brought in elements such as the Clearinghouse on

Smoking and Health, some of the fine people that were working in that area. Wilmadene Henrys of the world came down to CDC and brought with them expertise and connections to that part of the world that CDC really did not have. And that was good.

So, Hod Ogden ran that enterprise. We started up a series of grant programs, grants to the states, such I think we called them the Section 315 grants after the Public Health Service Act, but much of it was focused on smoking and other health behaviors amongst youth. So, this was a way to begin to function at CDC the same way the other more traditional elements functioned at CDC. So we began to build our own scientific team within this bureau. It began to have a technology transfer relationship with state health departments just as the others did and that included a financial support element to it. So, this was a powerful way to begin this process of mainstreaming health education in what had been a very science-oriented place and a very traditional health oriented place. Now, this is looking back at it from the platform of being within CDC. I am guessing at what it looked like from the other side. But probably it opened the door into CDC that may have been much less prevalent, and then much less physical at the time.

So, that transition meant that, before you had very little, then you had this period where at a bureau with a true mission and then this period that Bill Fagee took the Healthy People report and converted it into a major reorganization of CDC around these problem area lines. So it was natural that there would be a center for health promotion and education because so much of the Healthy People documents were focused on health education and risk reduction.

We probably went from having a functional orientation bureau for health education, a bureau for epidemiology, to having a problem focused orientation in part because of Bill Fagee's vision and in part because that is the message that the priority setting process in Healthy People dictated to us. So, we need to focus on these problem areas and we need to direct resources and concentrate resources in a very visible way on that.

So, a Center for Health Promotion and Education began as a somewhat smaller part of the CDC but, in fact, under the next decade of directors it really did prosper in terms of human resources and in terms of financial resources.

Now, I do have to say about the beginning is that it was slightly turbulent, and it was turbulent at the beginning of the Center for Health Promotion and Education was a bit of a turbulent process. Hod Ogden recruited me to be his deputy for programs, would have been 1981 just as President Reagan took office. President Reagan pulled back the previous President's budget, submitted what was called the Revised Presidential Budget from which was omitted all of the funds for health promotion and education. And that was a bit awkward to launch a brand new thing. It tended to focus on new problems that had little attention without any money.

Now, the director of CDC was very generous and he found money, and the Congress was very supportive of him. He had some supporters in the Senate in particular. And so they managed to find some

resources to keep us going. We also lost those grants to the states that had been just started in the Bureau of Health Education days. And so the states also found themselves in a position of having launched new program efforts in an area and having to figure out how are we going to keep that going, and it wasn't easy. It took a lot of fiscal ledger domain from people figuring how to use carryover money, how to get yourself positioned so you had a year's worth of support would give you -- buy you enough time. I think the state directors at that point became extremely creative and probably can be credited for keeping that alive in a period of budget retrenchment. And once we kept it alive, we were able in the future to find additional sources of support for it.

The HERR grants, I guess that was the acronym back in the day, Health Education Risk Reduction grants, were a pretty useful source of support for strapped state governments that probably had begun to want to do things in this area and hadn't really had a tradition of budgeting for that, and things did begin and it was a very useful beginning. It also became a way to shape the state health department relationship with community programs in those areas. And when the money evaporated, it was an awkward situation. There were new staffers that had been hired. There were programs that had been started and had people working at the local level, the community level, were drawing their salaries out of these grants.

So, it took awhile to get -- and not all of them survived obviously, but enough did or enough found ways to be morphed into something a little different that could be fit under the state health department budget in another area, and that's how we bridged this gap from a novel new idea and some money to no money to some additional sources of support in the future.

In the fairly early days of the Center for Health Promotion and Education, Hod Ogden retired from CDC. I was named the acting director and then the director of the Center for Health Promotion and Education. We had a strengthened relationship with what would today be known as the Directors of Health Promotion. And so we had collegial relationships with that state enterprise and the people who made that, and they did an annual conference.

So, I remember one year in Little Rock they asked me to come and do a keynote address about the future, where we go from here, that kind of subject. I elected to go back to the Healthy People objectives for the nation as a theme of this, and I talked about how we had been given a real leg up with this high visibility for our enterprise was a third of these objectives being in areas where we have the programs and the expertise to take advantage of this. And that they should -- They, the directors at the state level, should consider doing this as an enterprise where they would develop sometimes state counterparts of it or at least respond with a kind of a state plan for how are we going to approach health promotion in the coming decades. The Healthy People document probably had been out probably four or five years at that point. I think most people were familiar with it.

And so I rather blithely issued a challenge to the state directors. I said, go back to your states and do this at your level. Use this as a leverage, as a way of bringing higher visibility to the work depth we want

to do and build constituencies, build advocacy for this. And it sounded like a great idea, and I didn't realize the enormity of what I was asking them to do.

I will tell you a story. The director in Hawaii at that time was a woman named Chris Ling. So, I went back to CDC and went about my business, and a couple of months later she called me up. She said, "Dennis, I need for you to come to Hawaii." I said, "Why?" She said, "Because I've got the Governor and the Governor has agreed we are going to do a Healthy People for Hawaii, and I've got a conference coming up in a few months, and I want you to come out and help us do this. And I am thinking, be careful what you ask for, you might get it, because I said, gosh, you know, Governor, we have got a lot at stake here. This has to come off right. And she did a beautiful job.

And it's kind of the example of the way that I think state and local public health can be positioned. You've got the CDC as your colleague and associate and then in some cases funders, and then you have a whole community out there. And she brought in each of the islands. She brought in labor unions. She brought in hospital sectors. She brought in the political sector. Got a couple of interested state legislatures to get involved in this. Did a beautiful job of organizing. And out of that came a process in which they, in fact, developed a Hawaii specific objective to set priorities on which ones they wanted. The people in the islands had different viewpoints about which was the most important to them. It was in a microcosm just to sort of think that we in public health know how to do but don't always get to do so cleanly and accurately. It's a small state, so everybody knew everybody. She had that advantage and she had a governor behind it.

So, to me that was a reflection that this vehicle, Healthy People, this one-third of the objectives focusing on healthy behaviors, was a powerful engine that could be used to drive resources into areas that were not getting those kinds of resources to gain visibility for our programs and, in fact, to prioritize, to decide which of those many things that can be done are the ones we need to do in our state. The Behavioral Risk Factor Surveillance System was a parallel aspect of the Healthy People planning process that was underway in part because you didn't have that kind of data -- very good data at the national level, but you certainly often didn't have that kind of data at the state level. It's rather different than doing surveillance of salmonella outbreaks.

And so that began to spread through the states and gave everybody a quantitative way to say: Here's where we stand on the objective on tobacco smoking; here is where we stand on the objective on lack of physical activity. And you can use that, first of all, for planning at the level that all states don't have the same priority areas and they don't all have the same problems. But I think my colleagues in these states found that they could get extremely good media coverage when they would put out their reports on the state of X is the most obese state in the nation. Well, you know, that would make the evening news in the State Capitol. And we found that CNN -- or not CNN, but USA Today loved this because they loved these little gibbets of things about states are different and just mind that.

So, the publicity and the ability to use that as a communication strategy actually exceeded what we had originally imagined. We sort of thought of it simply as a good planning tool and, after all, CDC always

does surveillance, so we need to do surveillance here too. Turned out to be much more broader and more useful than that.

When the Center for Health Promotion and Education began, we didn't have all of the skill sets that we needed to have within CDC, and naturally we looked out to the states and we looked out to the schools of public health for that. And fairly quickly the name of Marshall Kreuter kept coming up. Now, we knew Marsh, but people kept saying, well, you've got to get Marsh. He has had his academic time. He has had his state health department time in Utah. He knows it all. And it turned out to be true.

So, Marsh brought his leadership and charisma and his background in the area, and in effect we recreated the Bureau of Health Education as sort of a division of health education within the center, and it became the leadership base within the federal side for doing health education and health promotion. And from that, came many of the various interventions, strategies that we then launched in partnership with the state and local people. Marsh was active in Utah during the Bureau of Health Education era, so it was sort of natural that we could bring him in and make him the principle health educator in effect for the new center that CDC had created.

When the White House conference -- When Nixon's White House conference on health education basically called for the establishment of a federal focus for health education, public health service decided, give that to CDC and CDC would set it up.

So, it was a very different enterprise for CDC than the things it had been accustomed to in the past. And when Hod Ogden came down from Washington and begin to establish that bureau, the only space that could be found for him were two houses next to the building that had been purchased by CDC as additional office space. And so for us, that seemed like kind of lonely outpost for this stepchild, and health education is often 11th on a list of ten priorities for budget while it was that way in space too. So, in a way, to me, the transition of that from somewhat inadequate space they stored the mowers in the garage of that former house. So it tells you something about the quality of the office space. The transition from that space to, you know, mainstream part of CDC by the time it became the Center for Health Promotion and Education and then later as the programs expanded and got additional personnel and the staffing grew. I think that says that CDC had discovered that the area that we work in, the educating people about healthy behavior of choice and giving them the skills and the motivation and the backup to accomplish those behavior changes, had to be part of public health in the latter half of the 20th century. And so to me that's sort of a symbol of, well, it wasn't exactly considered very important at the beginning, but it clearly became important later on.

In thinking about the role of cost containment, it is possible that that is one of the sources of congressional support, although I must admit that this is a two-edged sword. On the one hand, we knew that reducing tobacco smoking and basically tobacco use was going to lower the trajectory of very costly health care complications in the future. But we also were going to lower the payments to farmers and the profits of tobacco companies and convenience stores that sold cigarettes and so on.

So I am not sure whether in the Congress there was someone on one side of that question and someone on the other side of that question. I continue to think that it was an idea whose time had come that you had only to look at the trajectory of an aging population in the United States. You had only to look at the very clear-cut science that said, this is causally related to that and that the only intervention is going to be helping people to change their behavior to -- it had to happen. It just had to happen. I mentioned Healthy People earlier. That allowed it to go from very good ideas that we in the states and the feds and the academics knew to an idea that had a powerful cohesive vision about it.