# Back and to the Future. SOPHE Presidential Address

**Clarence E. Pearson**

Forty years is a long time. And this organization has come a long way. It has come through a lot and it has accomplished a lot. We members of SOPHE have much to be proud of.

Our 40th anniversary offers one of those important opportunities for a little nostalgia—for looking back, reflecting on our beginnings, and reviewing our accomplishments. So I'm going to do a little reflecting and reviewing—but not much. I want to take this occasion to make some very practical proposals for strengthening the future of health education because this has always been an organization with its eyes on the future.

Anyone who knows our history knows that its most important lesson lies in the pioneering spirit of the men and women who built this organization. It was a spirit that faced the challenges of the future head-on. It was a spirit they inherited from the founders of our profession—people like Horace Mann and Lemuel Shattuck, who 150 years ago laid the groundwork for what we now call health education. It's a spirit we must preserve and pass on to the next generation of pioneers.

I believe that the most important lesson of our past is to look to the future, and that's what I want to do today. But it is also important to recognize how far we've come.

It was 40 years ago today, on October 22, 1949, that the members of a temporary steering committee, meeting in New York, adjourned and reconvened as the Society of Public Health Educators, Interim Commission. Twenty-seven professionals attended the first annual meeting a year later. By 1951, the Society had 60 members. Today, including those who are members of local chapters, we exceed 3,500.

Not only SOPHE, but also the profession as a whole has grown dramatically since those early days. Dr. Eunice Tyler estimated that in 1947, there were 460 health educators employed by official and voluntary organizations. Today, ap-

This is the text of Presidential Address given at the 40th Annual Meeting of the Society for Public Health Education held in Chicago, October 22, 1989.

---

Clarence Pearson is the President of the National Center for Health Education and Former Director, Health and Safety Education Division of the Metropolitan Life Insurance Co.

*Address reprint requests to* Mr. Clarence Pearson, President, Universal Health Concepts, Suite 2346, 175 Fifth Avenue, New York, NY 10010.

*Health Education Quarterly*, Vol. 17(4): 371–377 (Winter 1990)
 CCC 0195-8402/90/040371-07$04.00

proximately 25,000 of us belong to more than a dozen established health education or related professional groups. The total number of health educators may be twice that number—around 50,000—since probably just as many of us don't belong to professional organizations.

Over 300 colleges and universities now train individuals at the baccalaureate and graduate levels in various aspects of health education. Their graduates include former nurses, physicians, social workers, journalists, pharmacists, exercise physiologists, and teachers of biology, home economics, and social studies. Our professional colleagues make use of their experience and training in a remarkable variety of settings. Ours has become a diverse field indeed.

SOPHE's membership reflects that diversity. And SOPHE continues to be unique—the only independent professional organization in the field. Our diversity is one of our greatest strengths. It has helped bring us this far, and we need to use it to our advantage as we face the challenges of the future. By forging a strong organization out of a diverse population, SOPHE can provide the leadership our profession needs as it enters the 21st century.

As we move into the last decade of *this* century and on to the year 2000, there is a sense of anticipation about what the future will bring to each of us and what *we* can bring to the future.

Much of the achievement of health education and health promotion is only just beginning to be recognized. And the very real promise they hold for the future is only just beginning to be evident. To achieve that promise will require substantial realignments of priorities in the largest industries and in government. It will require the expenditure of considerable public and private funds.

It is during such times that genuine leadership is required. We need leaders with vision—with the ability to see beyond the blinders of their everyday concerns and vested interests. We need leaders who can redirect some of our energy to ensuring the more equitable distribution of societal opportunities and benefits in the interest of the common good. These leaders need not be professional—in fact, what needs to be done requires the support and action of some of our top corporate and lay leaders of our nation.

But that kind of vision doesn't have much value if it isn't accompanied by an ability to see the world in terms of what is achievable and how it can be achieved. If SOPHE's history shows that its members have traditionally looked to the future, it also shows that they have been practical men and women, able to translate long-term goals into real-world accomplishments.

In that spirit, I'd like to make some concrete proposals for what our profession, including the many organizations that make up our profession, can seek to accomplish in the decade ahead. Let me hasten to add that these proposals are not expected to be implemented by SOPHE alone. In fact, it will take a much larger constituency base than SOPHE to make what I am suggesting happen. These proposals don't make up a comprehensive program for national health promotion and health education nor the health education agenda for SOPHE. There are many other vital steps we should be taking. But they do represent concrete goals that can help secure the gains we've already made and lay the groundwork for even greater achievements in the future. Accomplishing them would take us to a new and higher level of national commitment in a critical area of social policy.

Here, then, are 15 practical proposals for advancing the cause of health education, health promotion and disease prevention in the decade ahead.

(1) Our profession should use its influence and the influence of our many organizational friends to bring the President of the United States to issue a clear statement on the importance of a national commitment to health education, health promotion and disease prevention. This statement should include specific reference to the role of the executive branch in coordinating the health-related activities of all government agencies. The President's statement should also endorse the idea of including a "health component rider"—similar to an environmental impact statement—with any new legislative proposal. The Congress should be encouraged to adopt a similar requirement for its own legislation. In other words, an assessment of the implications for public health and health education would be attached to every new piece of legislative action—no matter how remote from health concerns it might at first appear. For example, housing legislation, defense appropriations, agriculture programs, energy-related programs, and foreign aid proposals all carry implications for health. This idea might at first seem cumbersome, but just as environmental impact statements have served to heighten concern for the environment, so it would be with respect to the health of the public. And no other national concern should receive higher priority than the nation's health.

(2) The President should appoint, with the advice of the Congress, a standing committee of 100 of the nation's most influential citizens. The committee would oversee the development of a 10-year strategy for health education, health promotion, and disease prevention consistent with the Year 2000 Objectives for the Nation. The group should be organized as a chartered national commission and approved by the Senate.

(3) There should be appointed a national committee of leaders in the field of business and industry that would be linked to the Presidential Commission. The business committee should include representatives of The Business Roundtable, The National Industrial Conference Board, the U.S. Chamber of Commerce, The Committee for Economic Development, and The Wellness Council of America. Its purpose would be to promote corporate understanding, leadership, and commitment of resources with regard to health education, health promotion and disease prevention. Among the committee's activities would be the issuance of policy directives encouraging the creation of smoke-free worksites and corporate sponsorship of worksite smoking-cessation programs. The committee could impose constraints on television advertising of products detrimental to health and urge sanctions for companies that fail to comply. It could explicitly discourage, through financial leverage, the sale of tobacco and other unhealthy products to the populations of developing nations.

(4) A commitment should be made by the Administration and the Congress to allocate 25–30% of the total health budget to health education, health promotion, and disease prevention. This shift in allocation could be made

over a 10-year period. The current federal allocation of health resources provides for approximately 95% curative and only 5% preventive services.

(5) A self-imposed assessment by the insurance industry should be imposed on each life and health insurance policy sold in the United States to create a national fund that would ensure long-term financial support for comprehensive school and worksite health education programs. The fund could also support programs aimed at children and youth and at the nation's elderly population. The major responsibility for administration of the fund should be given to the National Center for Health Education.

(6) The national media should develop an industry position coordinating their programming with the information-oriented goals of The Year 2000 Objectives for the Nation. The Advertising Council should take the initiative to move this plan forward, along with the President's Committee of 100.

(7) The national voluntary health organizations should be encouraged to allocate specific resources—including staff and funds—to support health education and health promotion efforts aimed at achieving The Year 2000 Objectives. These organizations within the private, voluntary sector should provide a base of support for federal health education and health promotion programs and should further support the federal health agenda through lobbying activities at the state and national levels. This effort should be coordinated by the National Health Council in concert with the National Center for Health Education.

(8) The major corporate and philanthropic foundations should begin to support long-range (10–15 year) health education projects that have already demonstrated their success and need for replication.

(9) A coalition of the largest and most influential foundations should be formed to create a special funding pool. Coalition members would contribute 3–5% of their annual allocations to the pool for the purpose of giving core support to selected national voluntary agencies working for health education, health promotion, and disease prevention.

(10) All state school systems should be required to mandate the use of comprehensive school health curricula in every district. This requirement should be enforced by denying federal and state education subsidies to any school system that does not enact such provision. In addition, public and private coalitions should be organized at the local level to increase financial support and local commitment to comprehensive school health education. State departments of education should encourage the development of such coalitions by providing matching funds. It is vital that we redouble our efforts to extend the reach of comprehensive school health curricula. At the present rate of growth, it will be the year 2020 before all of the nation's young people benefit from comprehensive health instruction.

(11) State departments of education and publishers should work together for the development and promotion of a preschool health education curriculum. Such a curriculum could reach more than half of the nation's 20 million three-, four-, and five-year-olds through public schools, day care centers, Head-Start classes, and church groups. Although there is much

evidence to support the effectiveness of preschool health education, the existing programs barely begin to meet the need.

(12) A national effort needs to be made to strengthen pre and postnatal education programs. We also need to reinforce local visiting nurse services and consider writing the option of a home visit by a nurse into each new health and life insurance policy sold. Over the long run, the costs involved will pay off in healthier and more productive lives for both mothers and children. Physicians should take a strong leadership role in implementing this intervention in their own communities along with insurance industry support.

(13) We should establish a national volunteer health promotion service corps, which would draw on the knowledge, experience, and skills of the nation's retired population. Linking older individuals with young people in health education and health promotion activities would allow constructive use of a vast but largely ignored resource. The corps could be developed by a coalition of AARP, NEA, PTA, SOPHE and the Committee for Economic Development. Retirees could serve as full- or part-time assistant teachers, counselors, and advisors to students and educators, and in a broad spectrum of other roles. Because older Americans comprise such an important part of the nation's human resources bank, the U.S. Department of Education should allocate core funding for this program over a period of no less than 10 years. It could require states and localities to match the federal share, so that the final mix might be one-part federal, one-part state, one-part local private, and one-part local public funding. The program should be administered locally with little operational monitoring from state or federal sources.

(14) The National Institutes of Health should be required to set aside an amount equal to or greater than 2% of their total budget each year for research and development related to health education, health promotion, and disease prevention. Until now, NIH agencies have been able to meet federal requirements for contributing to knowledge on prevention largely by relabeling certain aspects of existing research. The new requirement should specifically provide that the 2% cannot be taken from existing research allocations.

(15) The federal government, through direct grants to the cities, should take the leadership role in reaching inner-city youth. Cities should also encourage small businesses to become involved in improving the health of their neighborhoods. It is important that we rethink the ways we try to reach young people in urban neighborhoods, because most current funding for the purpose goes to existing organizations for whom inner-city youth are not natural constituents.

In all of these proposals, SOPHE can have an important role and in some instances lead the way. We have a responsibility to make our voices heard. I urge the new board of trustees and the officers of SOPHE to develop a mechanism for assessing and implementing these suggestions.

In closing, I would like to look at one scenario of what the future may have in store for us 40 years from now.

Several years ago, I served on a task force of The American Council of Life

Insurance whose purpose was to look at the future of the health-care system. We published our work in the form of three Reports from the Year 2030 A.D. Here is a selection from one of those reports.

> By the end of the 20th century, most people believed that physical disease was only a symptom of some underlying emotional, mental, social-psychological, or spiritual pathology. It was also widely accepted that a society's assumptions about the world and the way people were expected to behave had a great deal to do with the health status of its population.
>
> For example, it is now realized that the 20th-century emphasis on the individual, or on ego separateness, was a primary cause of many diseases. The stress associated with maximizing profit, survival of the fittest, and other forms of competition were seen as triggers that broke down the body's ability to maintain equilibrium. And the results of this emphasis on the individual, such as unequal distribution of food, were responsible for most of the health problems associated with both affluence and poverty.
>
> The relationship between stress and illness had been understood by the 1990s. Employers were expected to take responsibility for eliminating stressful or disease-producing environments. Early programs in stress management became commonplace. Efforts were made to reduce stress between family and work roles by legislating flexibility in work and nonwork schedules.
>
> By 2010, most of the old hospitals were gone; a few remained as regional repair centers for the limited amount of crisis intervention that was still necessary. The grand old medical institutions, including the Mayo Clinic, typically were converted into health education and fitness centers. Now that many Americans have substituted retreats for vacations, these centers are well frequented.
>
> One of the reasons for the demise of the hospital was that other structures were devised to do what hospitals used to do—only better. Indeed, as early as the 1980s, an individual with any life transition or psychosocial problem (pregnancy, mid-life crisis, alcohol addiction, terminal disease) could find a care unit or group specifically designed to support him or her through that experience.
>
> Traditional care providers faced unexpected competition, then obsolescence. Professionals, particularly physicians, had an especially difficult time adjusting to the decreased reliance on professionals and on egalitarian relationships between professionals and consumers.
>
> By the 1990s, most people accepted the fact that the body was its own finest laboratory. Children were taught techniques that allowed the body to follow its best adaptive course when they were ill.
>
> In the third decade of the 21st century, our greatest challenge is finding healthful and meaningful work opportunities for our very large senior population.
>
> Since 2000, more than 80% of the population in the developed world has lived in urban areas. We have daily reminders of global interdependence. The developed northern hemisphere and developing southern hemisphere have had to learn new ways of sharing resources. In this context, energy-wasting behavior, chemical pollution, and dehumanizing work conditions are as much disease states as the cholera, typhus, and malnutrition of the 19th century.

That's one vision of the future. The reality may include some of those elements, but it's likely to be quite different. It's up to SOPHE to help forge that reality. After all, many of you will still be very active in our field in the year 2030.

By building on our diversity and on the pioneering spirit of the past, by taking practical steps into the future, we can look for even greater successes in the next 40 years than we've seen in the last 40.

Being your president for the past year has been particularly gratifying to me, not only because of my close ties to many of you, but also because I believe that it's committed, knowledgeable people like you who make things happen in medical care, public health, and education for health. And I hope that the leadership of your board of trustees and house of delegates has made a difference.